Social Prescribing in the Australian Context:

A National Feasibility Study

TECHNICAL APPENDIX

AUSTRALIAN HEALTH POLICY COLLABORATION

VICTORIA UNIVERSITY

Acknowledgement of Country

Victoria University acknowledges the Ancestors, Elders and families of the Kulin Nation (Melbourne campuses), the Eora Nation (Sydney campus) and the Yugara/YUgarapul and Turrbal Nation (Brisbane campus) who are the traditional owners of University land. We also acknowledge the ongoing contribution of Aboriginal and Torres Strait Islander people across the healthcare system and in the wider community. We pay our respects to the Ancestors, Elders and families of the traditional owners of this land.

About us

The Australian Health Policy Collaboration (AHPC), led by the Health Policy group in the Institute for Health and Sport (IHES) at Victoria University, is a national collaboration of Australia's leading stakeholders in health policy, population health and chronic disease. Established in 2014, AHPC brings together a broad range of organisations and topic-specific experts, including academics, health professionals and consumers, to translate contemporary evidence and expertise into consensus-based policy recommendations aimed at preventing and reducing the impact of chronic diseases on the population.

Project team

The project team who undertook the feasibility study and developed this report comprised:

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- Professor Mark Morgan, GP expert advisor (Bond University, Royal Australian College of General Practitioners Expert Committee for Quality Care)
- Ms Leanne Wells, sector expert advisor (consultant, former CEO, Consumers Health Forum of Australia)
- Mr Andrew Wade, project economist (CIRES, Victoria University)
- Mr Tyler Nichols, report co-author (AHPC, Victoria University)

Acknowledgements

The Australian Health Policy Collaboration (AHPC) was commissioned by the Australian Government Department of Health and Aged Care (now the Department of Health, Disability and Ageing) to undertake this feasibility study and report. The report and its content have not been influenced or endorsed by the Australian Government.

The development of this project was informed and guided by an expert advisory group (EAG), made up of Australian and international social prescribing experts. We acknowledge and thank them for their generous contributions of time and expertise. The EAG membership comprised:

- Professor Yvonne Zurynski (Macquarie University);
- Dr Paresh Dawda (Prestantia Health);
- Ms Nicola Gitsham (NHS England);
- Dr Kate Mulligan (Canadian Institute of Social Prescribing);
- Dr JR Baker (Primary & Community Care Services);
- Dr Elizabeth Deveny (Consumers Health Forum of Australia);
- Ms Jayne Nelson (IPC Health);
- Ms Simone Jones (COORDINARE - South Eastern NSW PHN);
- Dr Sam Manger (James Cook University);
- Ms Tracey Johnson (Inala Primary Care).

We also acknowledge and thank others who contributed to the project, including:

- Kaylene Ryan (Australia Disease Management Association);
- Professor Carolyn Wallace (Wales School for Social Prescribing Research);
- Dr Karen Pardy (GP, Cardiff, Wales);
- Mr Jim Burt (National Academy for Social Prescribing);
- Dr Uday Yadav (Australian National University).

Suggested citation

McNamara, S., Nichols, T., Wells, L., Morgan, M., Wade, A., Calder, RV. (2025). Social Prescribing in the Australian Context: A National Feasibility Study Technical Appendix. Australian Health Policy Collaboration. Victoria University, November 2025.

DOI: 10.26196/8f3d-0745

ISBN: 978-1-86272-892-9

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Acronyms and abbreviations

ACCHS	Aboriginal Community-Controlled Health Service
ACI	NSW Agency for Clinical Innovation
ACO	Accountable Care Organisations (US)
ADMA	Australian Disease Management Association
AHC	Accountable Health Communities (US)
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ANHCA	Australian Neighbourhood Houses and Centres Association
APS	Australian Psychological Society
ASHA	Accredited Social Health Activist (India)
ASPIRE	Australian Social Prescribing Institute for Research and Education
ASRC	Asylum Seeker Resource Centre
CASCH	Canadian Alliance for Social Connection and Health
CERC	Collaborative Evaluation and Research Centre
CHAOS	Community Houses Association Outer Suburbs
CHF	Consumers Health Forum of Australia
CISP	Canadian Institute for Social Prescribing
CLW	Community link worker (Scotland)
CMS	Centres for Medicare and Medicaid Services (US)
COP28	28th Conference of the Parties (28th United Nations Climate Change Conference)
DALY	Disability Adjusted Life Year
DFV	Domestic and Family Violence
DSS	Department of Social Services
EOPC Innovation Collective	Equity-Orientated Primary Care Innovation Collective (US)
eSP	e-Social Prescribing
FDSV	Family, domestic and sexual violence
FAs	Frequent attenders
FNAs	Frequent non-attenders
GDCP	Goal Directed Care Plan
GP	General Practitioner
GPCCC	General Practice and Primary Care Clinical Committee
HA	Health Assessment
HILDA	Household, Income and Labour Dynamics in Australia Survey
HSE	Health Service Executive
IAL	Institute for Adult Learning (Singapore)
ICS	Integrated care systems (UK)
LHN	Local hospital networks, local hospital districts, health organisations, and hospital and health services.
Local Services	Mental Health and Wellbeing Locals (Victoria)
MBS	Medicare Benefits Schedule

NACCHO	National Aboriginal and Torres Strait Islander Community-Controlled Health Organisation
NALW	National Association of Link Workers (UK)
NASP	National Academy for Social Prescribing (England)
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NHHA	National Health and Hospital Agreement
NHHRC	National Health and Hospital Reform Commission
NHS	National Health Service (UK)
NPHS	National Preventive Health Strategy
OACAO	Older Adults Centres' Association of Ontario (Canada)
PaPx	Parks Prescription (Canada)
PBS	Pharmaceutical Benefits Scheme
PCCS	Primary & Community Care Services
PCN	Primary care networks (UK)
PHCAG	Primary Health Care Advisory Group
PHN	Primary Health Network
PHU	Primary Healthcare Unit (Portugal)
PLACE	Partnerships for Local Action and Community Empowerment
PROMIS- Global 10	Patient-reported Outcome Measure Information System Global 10
PUV	Person Using Violence
RACGP	Royal Australian College of General Practitioners
RCT	Randomised Control Trial
RECETAS	Re-imagining environments for connection and engagement
ROMHS	Rural Outreach Mental Health Service
SPiS	Social Prescribing in Sweden
SROI	Social Return on Investment
SSPN	Scottish Social Prescribing Network
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale
U3A	University of the Third Age
UCLA3	UCLA 3-item loneliness scale assessment
UK	United Kingdom
US	United States of America
VSPC	Victorian Social Prescribing Collective
WHO	World Health Organization
WPO	Wellbeing Promotion Office (Victorian Government Department of Health)
WSSPR	Wales School for Social Prescribing Research

1 About this feasibility study

The 2022-23 Australian Government Budget provided funding for "a feasibility study of non-medical prescribing" to assess the viability of a national preventive health program aimed at connecting primary healthcare patients with community activities, resources and other social supports to improve health and wellbeing.

The aims of the feasibility study were to:

- collate and review the most up-to-date Australian and international social prescribing evidence, including peer-reviewed research, programmatic evaluations and other relevant literature;
- analyse the key features and shared characteristics of successful international and Australian social prescribing initiatives;
- determine which social prescribing models are most applicable and appropriate in the Australian context for connecting primary healthcare patients to non-clinical interventions and community supports; and
- identify barriers and enablers to the effective, systematic implementation of social prescribing as an adjunct to primary healthcare in Australia.

These aims were addressed through a rapid evidence review of Australian and international social prescribing literature and an extensive program of consultations with leading social prescribing experts and key stakeholder groups, including primary care service providers, community sector organisations, health professionals, social prescribing program providers, policymakers and consumers. The rapid evidence review and preliminary phase of consultations guided the development of a series of 'implementation design principles' and 'operational components', to support the integration of social prescribing as an adjunct to primary healthcare in Australia.

The implementation options presented in the accompanying report, including the optimal model, were then developed, tested and refined through a secondary round of consultations and targeted semi-structured interviews with Australian and international social prescribing experts. Further detail on the project process and methodology is outlined in section 1.1.

This project builds on prior work undertaken in Australia, specifically a social prescribing roundtable, led by the Royal Australian College of General Practitioners (RACGP) and Consumers Health Forum of Australia (CHF) in 2019. The associated report, *Social Prescribing Roundtable, November 2019 Report*[1], recommended a strategic and systematic approach to incorporating social prescribing into the Australian health system, starting in primary care.

These technical appendices draw together contemporary evidence on the implementation of social prescribing within primary healthcare, both nationally and internationally, with the outcomes of an extensive series of consultations and discussions with experts, consumers and organisations involved in social prescribing developments in Australia.

Refer to the inside cover of this publication for the project team, expert advisors and other key contributors to these reports.

1.1 Project process

The AHPC project process (outlined in Figure 1) is based on the extensive experience, expertise and networks of the AHPC. It is grounded in proven methods of evidence gathering and consultation from which the AHPC has developed and delivered evidence-based, consensus-driven policy reports and proposals.

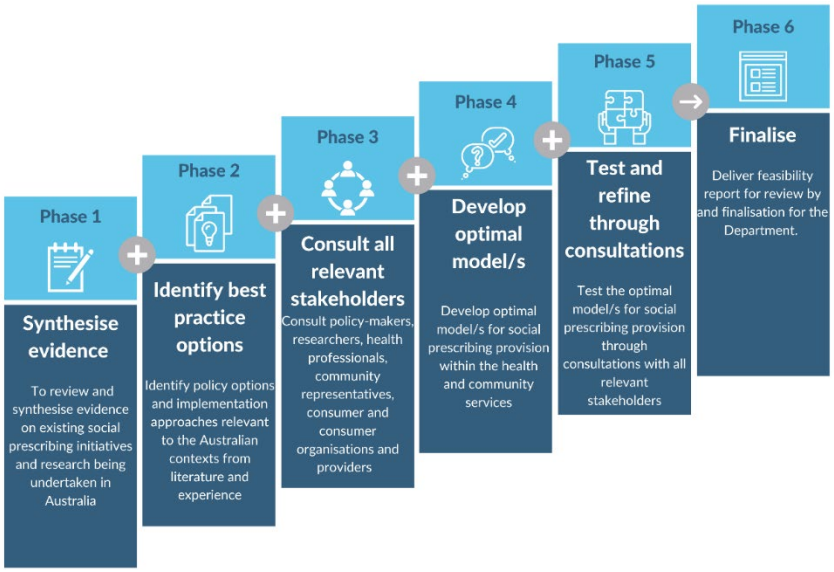


Figure 1: The AHPC approach

The key activities involved in developing the Feasibility Study report and accompanying technical appendices included:

- a synthesis of the available evidence in the literature;
- documenting and investigating established and developing models of social prescribing services;
- an appraisal of the strengths and limitations of the implementation of those services and their benefits for participants;
- a review of the evidence of experience in both Australia and internationally;
- consultations with service providers, community and consumer organisations, researchers, clinicians and administrators, with international leaders and social prescribing practitioners;
- expert advice; and
- assessment of the Australian context and contemporary policy goals.

In the initial phase of this project, a rapid evidence review of social prescribing was conducted. It described programs, initiatives and funding arrangements nationally and internationally. The review also summarised a synthesis of the existing evidence and research identifying characteristics of social prescribing initiatives considered to be effective and likely to be appropriate for the Australian context.

The consultation methodology used a Delphi-style model, a structured and systematic approach drawing on the knowledge of experts, including consumers, to develop aggregated and shared outcomes from the consultation process. The iterative process augmented the evidence on the effectiveness of social prescribing for preventive health in Australia.

Stakeholder engagement

The consultation process sought to engage social prescribing stakeholders, including:

- Policymakers in relevant Commonwealth, state and local government agencies.
- Primary Health Networks (PHNs).
- National Aboriginal Community Controlled Health Organisation (NACCHO).
- Researchers, health professionals and organisations.
- Non-government organisations (NGOs).
- Consumers, consumer organisations and community representatives.
- Providers of current social prescribing initiatives.
- Relevant overseas experts and organisations as appropriate.

Section 1.3 lists the 138 organisations that responded to invitations and were represented at the consultations.

Discovery consultations

Nine initial consultations, with a total of 145 participants, were held in the first round of consultations (discovery consultations). Seven virtual consultations were conducted over Zoom and facilitated by a project team member. Each consultation ran for 90 minutes, with approximately 15 minutes of scene setting and 75 minutes dedicated to discussion questions.

Two in-person consultations were undertaken. The first was a 60-minute session at the EACH (Environment, Activity, Connection, Health) conference, which was held on the Gold Coast in July 2023. The second was a 90-minute session with the RACGP Quality Care group in Melbourne.

All consultations were recorded using Otter.ai for transcription purposes. These were integrated and cross-referenced with the project team members' notes before being used for thematic analysis.

Following this round of consultations, several themes, design principles and operational components were identified as strongly endorsed key ingredients for social prescribing to be locally appropriate and designed by communities with system-wide components to ensure implementation fidelity. These were presented for review and debate at five *test and refine* online consultations with stakeholder groups.

Test & Refine consultations

Five virtual consultations, with a total of 107 individual participants, were held in the second round of consultations (Test & Refine consultations). These were conducted over Zoom and facilitated by a project team member. Consultations ran for 90 minutes with approximately 20 minutes of scene setting and 70 minutes dedicated to discussion questions.

As with the discovery consultations, all sessions were recorded using Otter.ai for transcription purposes. The transcripts were then integrated and cross-referenced with the project team members' notes before being used for thematic analysis.

Semi-structured interviews

Throughout the consultation period, from July 2023 to February 2024, the project team undertook several semi-structured interviews and discussions with individuals and small groups. These took the

form of 45-60 minute virtual meetings over Zoom. These discussions delved further into issues and particular experience and expertise with stakeholders.

International expert consultations

Throughout the consultation period the project team held discussions with international experts in social prescribing:

- Nicola Gitsham, Head of Social Prescribing, National Health Service (NHS) England
- Dr Kate Mulligan, Senior Director and Strategic Advisor, Canadian Institute for Social Prescribing (CISP)
- Jim Burt, Executive Director Strategy, National Academy of Social Prescribing (NASP)
- Professor Carolyn Wallace, Director, Wales School for Social Prescribing Research (WSSPR)
- Dr Karen Pardy, General Practitioner, Cardiff, Wales

These took place both in person at the EACH conference and in Melbourne, and virtually over Zoom.

1.2 Organisations consulted

Aboriginal Medical Services Alliance Northern Territory (AMSANT)
ACT Government
ACT Health
ACT The Office for Mental Health and Wellbeing
Adelaide PHN
Adventure Works Australia
Aged & Community Care Providers Association (ACCPA)
Alfred Hospital
Ambulance ACT
Ambulance Queensland
Ambulance Victoria
Australasian College for Emergency Medicine (ACEM)
Australian Catholic University (ACU)
Australian Association of Social Workers (AASW)
Australian Chronic Disease Prevention Alliance (ACDPA)
Australian Disease Management Association (ADMA)
Australian Government Department of Health and Aged Care (DHAC)
Australian Health Promotion Association (AHPA)
Australian Healthcare & Hospitals Association (AHHA)
Australian Institute of Health Innovation (AIHI)
Australian Medical Association (AMA)
Australian Medical Students Association (AMSA)
Australian Primary Health Care Nurses Association (APNA)
Australian Psychological Society (APS)
Australian Research Alliance for Children and Youth (ARACY)
Australian Social Prescribing Institute of Research and Education (ASPIRE)
Beyond Blue
Black Dog Institute
BMC consulting
Bolton Clarke
Brave Foundation
Brisbane North PHN
Canberra University
Cancer Council Australia
Circle Foundation Cooperative
CoHealth
Community Houses Association Outer Suburbs (CHAOS)
Community Information Support Services
Consumers Health Forum of Australia (CHF)
COORDINARE- South Eastern NSW PHN
Council of Ambulance Authorities (CAA)
Country SA PHN
Darling Downs and West Moreton PHN
Deakin University
Emerge Australia
Exercise Sports Science Australia (ESSA)
Federation of Ethnic Communities Councils of Australia (FECCA)
Flinders University
Footprints Community
Gippsland PHN
Gold Coast PHN
GreenX7
Griffith University
Health and Wellbeing Queensland
Health Care Consumers Association (HCCA)
Health Consumers Council WA
Health Consumers NSW
Health Consumers Queensland
Health Justice Australia
Healthdirect
Healthy North Coast
Highett Community Centre
Highett Neighbourhood Community House
Inala Primary Care, Queensland
IPC Health, Victoria
Landcare ACT
LinkWest
Lived Experience Australia (LEA)
Mental Health Australia (MHA)
Monash University
Mount Gravatt Community Centre, Queensland
Murdoch Children's Research Institute (MCRI)
National Aboriginal Community Controlled Health Organisation (NACCHO)
National Rural Health Alliance (NRHA)

National Suicide Prevention Office (NSPO)
NatureFix
Neighbourhood Houses Victoria (NHVic)
Nepean Blue Mountain PHN
NHMRC Partnership Centre for Health System Sustainability
NIB
North Richmond Community Health (NRCH)
North Western Melbourne PHN
Northern Territory PHN
NSW Health
NT PHN
Occupational Therapy Australia (OTA)
Orygen
OurPlace
Outdoor Health Australia
PanCare Foundation
Parks Victoria
Pharmaceutical Society of Australia (PSA)
Primary & Community Care Services Limited (PCCS)
Queen Elizabeth II Hospital, Queensland
Queensland Alliance for Mental Health (QAMH)
Queensland Department of Health
Queensland Department of Tourism and Sport
Queensland Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts
Red Cross
RMIT (RECETAS)
Royal Australasian College of Physicians (RACP)
Royal Australian College of General Practitioners (RACGP)
Royal Perth Hospital (RPH)
Rural Clinical School of WA
SA Department of Health and Wellbeing
SA Department of Human Services
SA Green Adelaide
Social Health Australia
South East Melbourne PHN
South West Sydney PHN
Southern Cross University
Stroke Foundation
Suicide Prevention Australia
Sydney North Health Network
Sydney North PHN
Sydney University
Terry Hills GP, NSW
The Australian National University (ANU)
The Circle Foundation Cooperative
The Heart Foundation
Troubled dog
Universities Australia
University of Canberra
University of Melbourne
University of New South Wales
University of Sydney
University of Tasmania
University of Western Sydney
UQ University
Victorian Health Consulting
Victorian Department of Health
Volunteering Australia
WA PHA
Wellbeing SA
Went West
West NSW PHN
Western Vic PHN
Western Australia Department of Health
Western Australian Council of Social Service (WACOSS)
Western Australian Mental Health Commission

2 Social Prescribing: history and context

2.1 Social prescribing

Social prescribing involves the practice of individuals being referred to a range of social supports, community-based programs and services, and other non-clinical interventions, to improve health and wellbeing[1–3]. Specific definitions of social prescribing vary across the world; however, one common, widely accepted definition, developed by an international collaboration of leading relevant experts, states that:

> *'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 by co-producing a social prescription – a non-medical prescription – to improve health and well-being and to strengthen community connections'*[3].

Social prescribing aims to improve health and wellbeing for individuals by addressing unmet non-clinical needs, which are known to influence health outcomes[1,3]. In this report, 'non-clinical needs' are defined as the social, socioeconomic, practical, emotional and behavioural factors that influence health and wellbeing, but are not directly related to the diagnosis or treatment of a medical condition. Examples of non-clinical needs include social isolation, loneliness, low health literacy and food and housing insecurity, as well as behaviours related to the major risk factors for chronic disease (e.g. physical inactivity, unhealthy diets). Non-clinical needs also closely align with many of the factors commonly referred to as the 'wider determinants of health', such as socioeconomic status, housing, educational attainment and access to resources and social support networks[4–6].

Social prescribing represents a shift away from the more traditional, siloed conceptualisation of healthcare and social care as distinctly separate from each other to a more integrated approach that emphasises the provision of holistic care and seeks to address the non-clinical factors that significantly influence health and wellbeing.

Social prescribing is a means by which general practitioners (GPs) and other primary healthcare professionals (e.g. allied health professionals, community pharmacists, primary care nurses) can connect patients with community programs, services and other social supports to address non-clinical needs and improve health and wellbeing[1,7]. In most social prescribing programs, this is facilitated by a referral from a health professional to a 'link worker', who then works with the individual to assess their specific non-clinical needs and co-produce an appropriate 'social prescription' and action plan[8]. In this report, social prescription is defined as the non-clinical intervention/s (e.g. community resource, program or service, or other social support) that an individual is referred to by a link worker or link worker equivalent role.

"Social prescribing looks at a person's whole life through a trusted relationship between person and link worker"[9]. The concept of person-centred and holistic health is not novel and has been utilised by many health care practitioners over time. The concept of social prescribing is aligned with the Aboriginal and Torres Strait Islander holistic approach to health and wellbeing. It echoes Aboriginal and Torres Strait Islander understanding of health as the social, emotional and cultural wellbeing of both the individual and community[10]. It is also aligned with the biopsychosocial model of care proposed in 1977 by George Engel[11]. This model recognised the importance of biological and psychological (thoughts, emotions and behaviours) factors, as well as the contributing influences of social, including environmental, socioeconomic and cultural factors, to health and wellbeing[11].

The Canadian Alliance for Social Connection and Health (CASCH) describes social prescribing as "a formalization of long-standing practices, a continuum rather than a novelty." Social prescribing builds on the long-standing practice of diverse health care providers and traditional healers who have long recognised the influence of non-medical determinants on health outcomes[1]. Social prescribing now is a formal description, and increasingly a formal service arrangement, for social support and care in the primary care setting.

Social prescribing is also described as a move toward preventive care in a person-centred approach. This includes recognition that the social aspects of health can be proactively 'tackled', preventing illnesses and providing a preventive approach that supports people to be more reliant on a healthy lifestyle and less on medical care[12].

The activities prescribed through social prescribing services work to facilitate social connectedness, support health awareness and skills, and promote healthy behaviours.

Social prescribing activities or services can be broadly grouped into four main types (see section 2.2):

- physical activity;
- arts and heritage;
- time in the natural environment (nature prescribing); and
- advice and information[14].

Social prescribing is not a one-size-fits-all approach. Social prescriptions should be designed collaboratively between the person referred and the link worker, to ensure that they meet the unique needs, circumstances and preferences of the individual. Both in the literature and in existing social prescribing initiatives, there is a strong emphasis on the empowerment of individuals, shared decision-making and the role of social prescriptions as an important adjunct to clinical interventions in holistic healthcare[1,3].

A critical step in the development of co-produced, personalised social prescriptions (and an integral aspect of the social prescribing process more broadly) is the 'what matters to you' conversation, between the referred person and a link worker. The purpose of this conversation is to ascertain what is important to the individual and then identify appropriate supports that align with their interests and unique strengths[1,2]. Accessibility, suitability, local availability, sustainability and a person's level of engagement and interests also need to be considered when co-producing a social prescription.

There is significant variability in the specific community-based resources and activities included in a social prescription, even among individuals presenting with similar non-clinical needs. In this report, 'community resources' describes the broad range of community activities and services, social supports and other non-clinical interventions that individuals can be referred to through social prescribing to address their non-clinical needs. This also includes community infrastructure assets relevant to social prescription activities (e.g. parks, sports facilities, libraries, community centres etc.)[15].

2.2 Four main types of social prescribing activities

Social prescriptions can be broadly categorised into four main intervention types. Some prescriptions may overlap with two categories, for example, walking in nature or gardening are both physical activity and nature-based activities. The four main intervention types are detailed below.

Physical Activity

The benefits of physical activity for health and wellbeing are widely known and recognised. Physical activity can strengthen wellbeing, reduce stress, anxiety and depression, lower the risk of chronic

illness, improve sleep, and improve energy levels. Activities include walking in nature, learning to dance, gardening as well as more typical exercise activities such as cycling, swimming, Pilates, football and running[16].

Arts, Culture and Heritage

Participation in arts, cultural and creative activities has been shown to have a positive impact on wellbeing. This involves activities such as learning a new skill, rediscovering a hobby, taking an art or music class, volunteering at a museum or engaging with local community history. These activities can connect people who are lonely or isolated and build healthy habits. Participation in these activities is known to help with stress reduction and with physical and mental wellbeing[17].

Time in the Natural Environment

There is strong evidence that time spent in the natural environment improves physical and mental health[18,19]. It has been shown to reduce stress, anxiety and depression and to improve cognitive function, brain activity, blood pressure, mental health, sleep and physical activity. Nature-based activities include growing plants, nurturing a garden, joining a local food-growing group, creative activities in green spaces, gentle walking and other outdoor activities[20,21]. There has been significant evidence on the benefit of 'green prescribing' in recent years. An evaluation of a Green Social Prescribing program for preventing and tackling mental ill health in the UK found statistically significant improvements in happiness, life satisfaction, feeling that life is worthwhile, as well as reduced anxiety and increased physical activity following nature-based activities[19]. Additionally, a Lancet systematic review from 2023 showed benefits to cardiometabolic and mental health and increases in walking from nature prescriptions[22].

Advice and Information: addressing social, financial and legal barriers

Practical or material needs such as legal, welfare and financial issues can have an impact on an individual's health and wellbeing. Limited language skills and cultural differences can also generate barriers to information and support. Advice and statutory supports include advice and information about housing, debt, education, employment and other financial and legal problems and can encompass language skills support, food purchasing and preparation information, chronic disease information and peer support. Access to these supports can reduce homelessness and improve financial management, access to education and employment opportunities and improved physical and mental health[23].

2.3 Benefits of social prescribing

2.3.1 Health and wellbeing benefits - individuals

Social prescribing can help to address non-clinical issues that influence health and wellbeing across a broad range of population and age groups. It is particularly relevant for people experiencing social isolation and loneliness and those living with chronic health conditions[1]. By connecting people with community-based activities and supports, such as exercise groups, community programs, volunteer opportunities and/or appropriate services, social prescribing has been shown to reduce health risks and improve overall wellbeing[24–26].

Social prescribing is associated with a wide range of health and wellbeing benefits for individuals, including improvements in:

- self-reported health, wellbeing and quality of life;

- mental health indicators (e.g. reduced anxiety, improved mood);
- physical health status;
- social isolation and loneliness; and
- community participation and connectedness[27–37].

There is also emerging evidence that social prescribing can contribute to improved health literacy and self-management capabilities and help to address some of the major risk factors for preventable chronic disease (e.g. physical inactivity and unhealthy diets)[24–26].

Much of the research on the health and wellbeing benefits of social prescribing has focused on adults, particularly those 65 years and older. However, recent research suggests that social prescribing can be an effective preventive intervention to reduce health risks across the lifespan, including in children and young people[38–41].

2.3.2 Community benefits

Social prescribing generates direct benefits for communities by fostering stronger social connections and networks, facilitating community participation and volunteering, and providing opportunities for cross-sector collaboration between local stakeholders[42–44]. By strengthening social connections, it reduces social isolation and can improve overall community cohesion, particularly among priority population groups[45,46]. Social prescribing initiatives also enhance awareness and utilisation of community activities and infrastructure, local services and social supports, and encourage investment in these community assets and resources[1,47].

Social prescribing programs facilitate intersectoral collaboration between health service providers, non-government organisations (NGOs), community organisations, government agencies and other relevant stakeholders within the local context[1]. They also improve 'social capital' – used in this report to describe the social connections, networks and relationships that enable individuals to work cooperatively in a group towards a common goal – within local communities[45]. Building social capital and establishing strong connections between primary healthcare providers, community organisations, service users and other local stakeholders can subsequently enhance community cohesion and capability and can drive collective action to improve community health and wellbeing[42–45].

Social prescribing can also contribute to various long-term community benefits that persist beyond an individual's engagement with the service or program. Improving the health and wellbeing of individuals subsequently enhances the social and economic wellbeing of the broader community, which in turn contributes to better education outcomes, enhanced productivity and increased long-term community participation[48]. Community participation facilitated through a social prescription can include various forms of volunteering, as well as engagement with community groups and activities. Evidence suggests that social prescribing programs can contribute to increased rates of community volunteering over the long term, which results in a range of additional, ongoing benefits for local communities[49]. See Boxes 1 and 2 for case studies on how social prescribing can lead to volunteering.

Case Study: Joe* (reproduced with permission)

Referred from Hospital Mental Health unit to support client to engage in social connection.

Wellbeing Plan:

- Experiencing agoraphobia. Refused to leave the house.
- Referred to financial counselling.
- Supported to attend a group at IPC Health for people experiencing social isolation post COVID.
- Recognising Joe's faith was important to his overall wellbeing.
- Referred to the Community Shed and the University of the Third Age (U3A)
- Discharged when settled into activities.

18 months later:

Joe is now volunteering at the Community Shed, teaching youth with disabilities to repair bikes and taking groups out on regular bike trips.

Outcomes:

- **Improvements in health and wellbeing**, including mental health and self-confidence.
- **Reduction in isolation and loneliness-** through improve connectedness to local community.
- **Changed outlook to life** through the willingness to try new things.
- **Cost saving-** reduction in ED presentations and unplanned admissions. 3 prior admissions prior to Social Prescribing Program.
- **Improved quality of life-** found purpose and is running a volunteer program at the local Community Shed.

*name has been changed

Box 1: A case study of a social prescribing participant and volunteering 1

Case study: Susan* (reproduced with permission)

Susan had completed an expression of interest at the local community house and the Social Prescribing team followed up. Her first assessment, aimed at completing her Primary Needs Assessment was held face-to-face. In this assessment, Susan stated she had recently moved to Melbourne to start a new life. She had a past history of cardiovascular disease, diabetes, anxiety and depression. She was also isolated and feeling lonely.

Susan was renting privately. She was on jobseeker and liked to participate in volunteer activities. She drove her own car, but became anxious driving in city traffic, so tried to avoid it.

Susan's interests included art, music, singing, writing and volunteer work. Since arriving in Melbourne she reported that her life felt unfulfilled and that she lacked direction.

At commencement of her social prescribing journey, Susan rated herself as follows:

- Health: fair
- Quality of life: poor

- Mental health: poor
- Satisfaction with social activities and relationships: poor
- Average pain levels: 5/10
- Sometimes felt positive about the future,
- Rarely felt relaxed
- Rarely dealt with her problems well
- Rarely felt close to others
- Often lacked companionship
- Often felt left out
- Often felt isolated from others

A week after her initial appointment, Susan received a follow-up appointment to go through the development of her Wellbeing Plan. Here, Susan's identified goal was to make connections in her local area. She wanted to participate in regular exercise, enrol in a Tafe course and look at volunteering opportunities.
Susan's Wellbeing Plan and subsequent actions included:

Goal	Action
Enrol in a course that gives me purpose	Enrolled in Cert 4 in Community Service
Support a course that I'm passionate about	Volunteer at the Community Centre Food Bank
Participate in exercise that I enjoy	Enrolled in regular yoga classes
Improve my mental wellbeing	Referred to a counselling service

Susan then received follow-up phone calls from a Wellbeing Coordinator two weeks later, and again one month later to review her progress towards her Wellbeing Plan. She had a final phone appointment two months later to review and discharge her from the program. During this appointment, Susan reported that she was:

- Volunteering at local community events
- Volunteering at the local community centre food bank
- Enjoying the TAFE course in Community Services, particularly as she was learning and making new friends.

Susan reported that she had developed a network of like-minded people who shared her same values and interests.

At the conclusion of her social prescribing journey, Susan reported:

- Has made progress towards her goals.
- Rates that she is 'very satisfied' with the program
- Rates her confidence at 9/10
- Can manage her health problems
- Feels her health is very good
- Quality of life is very good
- Mental health is very good
- Is rarely bothered by feeling anxious or depressed.

Asked for her reflections about the program, Susan relayed the following:

"When I heard about the Social Prescribing program through the Neighbourhood House I was struggling with my mental wellbeing and really needed the support provided by the Social Prescribing program. I spend much of my life giving to and caring for others and I greatly appreciate the care received by the Wellbeing Coordinator who assisted in supporting me to access mental health services, identifying my goals and referral to programs and activities to participate in. In doing so my mental health improved. It was the little things that made the big difference.

The Wellbeing Coordinator has been really supportive, she has seen who I am and what I have achieved, acknowledging my skills and abilities. Her support and enthusiasm has meant a lot as I have not had that before. I have often been taken for granted for the volunteer work I have done. This program helped me get connected to the community and (find my) purpose again. When I started the program I was new to Melbourne, I felt quite down, overwhelmed and emotionally exhausted and now I'm studying full time, made new friends and developed new connections through my interests."

Box 2: A case study of a social prescribing participant and volunteering 2

Social prescribing initiatives can create connections and partnerships across sectors and organisations including health care services, community services and organisations and government agencies[1]. This can contribute to potential collaborative and collective action to improve health and wellbeing within the community. Establishing strong connections between health services and community services, groups and activities contributes to community cohesion and resilience[42–44]. Additional support for community groups and activities to respond to individual needs within the community may be required to ensure success.

It has potential to assist community resilience in the event of climate-related disasters and extreme weather events, for example, as noted in the Australian *National Health and Climate Strategy* (2023)[50]. Published in 2023, it includes an objective to 'build a sustainable, high quality, net-zero health system'. One of the Strategy's three pillars for achieving a net-zero health system is prevention – reducing demand for care by maintaining good health and preventing disease[50]. Increasing the role of social prescribing within the Australian health system may contribute to achieving these linked goals of preventing ill-health and building a more sustainable health system.

Several international publications on social prescribing highlight the community benefits of social prescribing. The Canadian Alliance for Social Connection and Health (CASCH) have published a report on *Conceptualizing and Implementing Social Prescribing Programs*. They state that Asset-Based Community Development Social Prescribing initiatives 'can foster and empower local solutions that work for individuals and communities'[1]. The National Academy for Social Prescribing (NASP) UK, describes social prescribing as contributing to thriving communities, tackling health inequalities, providing the 'glue' within communities that links voluntary organisations with people who need their help[14]. These connections develop local solutions that work for individuals and communities by focusing on the existing resources in the community.

2.3.3 Economic and health system benefits

In addition to the wide-ranging positive impacts on communities and individual health and wellbeing, social prescribing can also provide significant benefits to the health system and broader national economy. Social prescribing relieves pressure on overloaded, capacity-constrained health

systems by reducing demand for both primary and acute care services and improving system efficiency[51–53]. Multiple studies have found that individuals require fewer GP appointments, are less likely to present to an emergency department and have fewer preventable hospital admissions after engaging with a social prescribing program or service[1,51–54].

Findings from a NASP (England) report examining the health system benefits attributable to social prescribing across multiple localities in the UK, highlight a 42-50% reduction in GP visits and a 23-66% reduction in emergency department presentations for individuals engaged with a social prescribing service[51]. An earlier NASP report also details the important role of social prescribing in alleviating pressure on overstretched nursing and mental health services[52].

Social prescribing seeks to improve health system efficiency by addressing individuals' unmet non-clinical needs in community-based, non-clinical settings, rather than in more resource-intensive clinical settings[1,28,52]. By addressing unmet non-clinical needs, social prescribing helps to prevent the escalation of issues that could otherwise lead to repeated GP visits and/or presentations to acute care services[1,28,52,53]. This results in less demand for already overstretched GP services and greater GP capacity to focus on clinical issues and the ongoing management of complex chronic conditions, rather than the non-clinical needs of patients[1,52–54]. Relieving pressure on capacity-constrained primary care and hospital services can also contribute to a range of subsequent health workforce benefits, including lower rates of health professional burnout and improved staff recruitment, retention and wellbeing in healthcare services[55].

Social prescribing also promotes more holistic service models, better care coordination and enhanced integration across the health and social care sectors, streamlining patient pathways and contributing to a more efficient, responsive, and sustainable health system[1,46,51–53].

The system benefits associated with social prescribing programs closely align with long-term health policy objectives in the Australian context – particularly more efficient service utilisation and reduced healthcare expenditure[56]. This further reinforces the potential role of social prescribing in contributing to a fit-for-purpose, sustainable and efficient health system into the future.

The economic benefits of social prescribing can extend beyond improved health system efficiency and reduced healthcare expenditure, to include broad positive impacts on workforce participation, productivity, and increased investment in local community resources and infrastructure assets. By improving mental health, reducing social isolation and supporting individuals in managing chronic conditions, social prescribing can help people remain engaged, or reengage in, work, education and volunteering, and contribute to reduced workplace absenteeism[53].

NASP (England) describes a snapshot of benefits to the health and care system arising from social prescribing services as including[7] a significant (40%) reduction in visits to the GP and alleviating the pressure on community nursing and community mental health services.

The potential benefits associated with social prescribing programs also closely align with multiple perennial health system policy objectives. These include:

- Reducing health service demand and relieving pressure on parts of the system that are currently capacity-constrained, such as general practice and secondary emergency care. This may contribute to workforce wellbeing, resilience, recruitment and retention.
- It reduces healthcare costs by meeting patients' needs in community settings rather than in medical settings which can often be resource intensive. In so doing, it allows resources to be reallocated to more efficient and effective uses.

Some evidence shows that social prescribing can also link people to health care that is appropriate to their health needs, increasing the opportunity for preventive health care and early intervention

for people who have lower levels of engagement with health services[57]. However, more robust research is needed in this area as the evidence is mixed (Costa et al., 2021; Lynch & Jones, 2022).

Ad hoc and fragmented development of social prescribing programs makes quantifying benefits difficult. As social prescribing is designed to respond to complex non-clinical issues influencing individual health, it does not correspond to a linear cause-and-effect model and is therefore difficult to evaluate using rigorous methodologies such as randomised controlled trials (RCT)[59].

2.3.3.1 Social prescribing economic analyses

There is an expanding body of research about the broad economic benefits of social prescribing. The benefits include reduced health service demand and increased primary care capacity to deal with clinical rather than non-clinical needs. There is also a strong economic case for the implementation of social prescribing initiatives across Australia.

Numerous economic analyses of social prescribing programs, both in Australia and internationally, have consistently demonstrated positive returns on investment, further reinforcing the strong economic case for social prescribing[53,60,61]. Several of these analyses have been Social Return on Investment (SROI) studies. SROI studies utilise a comprehensive economic modelling framework to systematically measure the holistic value of a program or activity, including the social, environmental and economic value. It differs from traditional return on investment analyses by assigning a monetary value to outcomes that don't typically have a market price, such as improved wellbeing[62], making it a useful tool to assess the economic impact of social prescribing.

There are multiple international examples of SROI analyses examining the overall value of social prescribing programs, which demonstrate strong returns on investment. These include:

- a large study of over 10,000 social prescribing service users in England over 30 months, which estimated an SROI of £3.42 per £1 invested[53,61]; and
- a KPMG economic analysis commissioned by the Canadian Institute for Social Prescribing (CISP), which estimated an SROI of CA$4.43 for every CA$1 invested in social prescribing programs[63].

An SROI analysis was also completed as part of this feasibility study, to assess the potential value of social prescribing in the Australian context. It used data provided by a NSW-based social prescribing program which focused on supporting injured workers to return to work (refer to section 8 of these Technical Appendices). Development of the feasibility study SROI analysis was further informed by undertaking a review of three other economic analyses (one cost analysis, two SROIs) conducted on social prescribing programs in the UK[58,60,61]. The analysis estimated that the NSW program achieved an indicative overall return on investment of AUD$5.80 for every AUD$1 invested.

The NSW Government insurance and care agency (icare) commissioned a different economic evaluation on the same NSW program, which estimated a return of AUD$3.80 for every AUD$1 invested[64]. The variation between these two analyses is largely due to the attribution of value to partial or full return to work in the modelling undertaken for this report, as this outcome was not included in the icare assessment[64].

2.4 Social prescribing can help to address major health and wellbeing issues

Individuals may be referred to social prescribing for a variety of reasons. It should be emphasised that no single 'intervention' suits everyone referred for the same reason. A social prescription should be co-designed by the individual and link worker and based on the 'what matters to you' conversation[1,2,65], to meet the unique interests and needs of the individual. Some of the major

health and wellbeing issues that social prescribing could contribute to addressing in Australia, including relevant case studies, are detailed below.

2.4.1 Mental ill-health, loneliness and social isolation

Mental ill-health, loneliness and social isolation are significant health issues in Australia[66]. It is estimated that 44% of Australians aged 16-85 have experienced mental ill-health at one point in their lives[67]. In addition to this, one-third of Australians experience loneliness[66]. Whilst there are diverse definitions of social isolation and loneliness in the literature, there is emerging evidence that the health impacts of loneliness and isolation can be as harmful as daily smoking, more damaging than obesity, and increase the risk of cognitive decline, including the development of dementia[68]. In collaboration with Swinburne University, the Australian Psychological Society (APS) undertook a survey on loneliness in Australian adults and found that loneliness has a substantial impact on the likelihood of being depressed as well as on health and wellbeing more broadly[69]. Additionally, the Productivity Commission Inquiry report on Mental Health (2020) highlighted the impact of loneliness and social isolation across the lifespan of Australians and its major contribution to health system costs[70].

The 2024 *Household, Income and Labour Dynamics in Australia* (HILDA) Survey report reported that loneliness is a particular issue for young people (aged 15-24), people in poor general health, Australians with a disability and Aboriginal and Torres Strait Islander Australians[71].

The impact of mental ill-health, loneliness and social isolation has been recognised in both Victoria and Queensland with the Royal Commission into Victoria's Mental Health System[72] and the Queensland Parliamentary Inquiry into social isolation and loneliness by the Community Support and Services Committee. The reports from both of these recommended implementation of social prescribing trials.

People with mental ill-health could benefit significantly from social prescribing. A 2024 report, *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme (NDIS)* (2024)[73], estimated a substantial unmet demand, with approximately 263,100 people aged 12-64 with moderate mental illness and 230,500 with severe mental illness requiring, but not receiving, psychosocial supports. Defined as "non-clinical, recovery orientated services, delivered in the community and tailored to individual need", these supports can include assistance with material needs such as housing as well as socialisation, building relationships and engaging in education[73]. Social prescribing is designed to address these non-clinical needs and could contribute to reducing the gap in access to psychosocial support for individuals.

Case study: social prescribing for social isolation (reproduced with permission)
John, 82 year old widower who saw information on Connect Local in the local council newsletter: I was depressed because my wife died a few months ago. As my wife's carer for many years, I felt as though I had lost my purpose in life and did not care if I was still alive. I spoke about this to my GP and others, but nobody understood my feelings and sense of loneliness, they just told me to work around in my home and move on. I know there are many programs and service in Glen Eira but I could not find any on my own. The council website has lots of information, but it is hard for me to figure out. I'm not in the habit of talking to many people and it is hard for me to step outside my house and just strike up conversations. So when I saw the information about the program, I thought I would give it a go and filled in the Connect Local online form.

The Community Connector was very understanding, pushed me in the right ways, and provided the right help and encouragement for me to move forward. She is a very caring, understanding and inspiring person. Sitting with her and talking made me feel connected and happy.

Normally I don't talk to people in my whole life, this program is really changing my personality. I am much happier and fully occupied my time during the week by engaging in local community house. I started to share my happiness and stories to my families and friends in the local communities. My family members all told me that they feel I look much better and happier than before.

I feel as though I am happy again with a sense of purpose. I feel connected and look forward to activities at Caulfield South Community House. I also feel that my sleeping is improved. I don't feel depressed in the morning when I wake up. Previously I was in a low mood with no motivation to get up and also experienced chronic pain. Now that I need to get up and get ready to go to Caulfield South Community House, I don't feel pain anymore and I sleep better. I also have energy and enjoy talking and playing. I feel my mobility is improving. Everyone at Caulfield South Community House enjoys themselves and doesn't take the games too seriously. I feel as though I have found my home.

Box 3: A case study of social prescribing for social isolation

2.4.2 Preventable chronic disease

Over one third of the burden of disease, that is, the impact of living with illness and injury and dying prematurely, in the Australian population is preventable[74]. The Australian Institute of Health and Welfare (AIHW) has estimated that 38% of the burden of disease among the Australian population could have been prevented by reducing exposure to modifiable risk factors such as tobacco use, living with overweight or obesity, dietary risks and high blood pressure[74]. In Australia, premature mortality rates, that is, deaths at earlier ages (under 75 years), are up to twice as high among the most socioeconomically disadvantaged individuals and communities compared to the least disadvantaged population groups[75]. Over more than 30 years, there has been a doubling in the premature mortality of the population living within the lowest socioeconomic status areas. The discrepancy between the least and most disadvantaged areas is widening, driven by differences in health behaviours, risk factor exposure and social determinants of health[75].

Case study: social prescribing for preventable chronic disease (reproduced with permission, not to be reproduced))

The client self-referred to the Community Connections Program and identified they were socially isolated and were not confident to access their local community or activities independently. They were already linked with Merri Health and had had a good experience with their other services. They identified several reasons they found it difficult to connect to their community, including the impact of chronic health conditions (chronic pain, anxiety, and depression).

They met with the Community Navigator by phone, then in person in the community. They scored 9/9 in the UCLA 3-item loneliness scale assessment – (UCLA3) on initial assessment. A score of 9 indicates a higher level of perceived loneliness. The Community Navigator discussed what was important to them and what they wanted to achieve through the Community Connections Program.

- A Goal Directed Care Plan (GDCP) was completed with the client, and they identified the following goals:
    - To move to another property.

- To reach out and try to reconnect to a sibling.
- To attend a Community Connections Group.
- Find a closer GP who they feel comfortable with to support their health and wellbeing.

The Community Navigator provided individual support to the client:

- to build their confidence, skills and capacity in accessing their community and work towards their goals. This included meeting at various locations within their community and support to attend the groups that they were interested in.
- to access the Community Connections social café group and mindfulness group.
- with referral to the Merri Health Duty Service (free drop-in service) to support the client with their goal to access alternate housing. The Community Navigator also provided support to access resources on housing.
- With internal referrals to physiotherapy, dietitian and exercise physiologist.

Outcomes

- Improvement in UCLA3 score at discharge from the Program.
- Able to fully or partially reach their goals on review of the GDCP relevant to Community Connections Program:
  - The client has increased contact with their sibling and reported that this is going well.
  - Independently commenced process for developing a Will and power of attorney to support preparing for their future.
  - Attended two Community Connection groups, with plans to engage in another social group.
  - They have found a GP who they are comfortable with and feel well supported. Maintaining regular health monitoring.
- The client reported that the Community Connections Program had a positive impact, including:
  - increased confidence in accessing their community and going for walks in their local area.
  - Being able to organise catch ups with work colleagues outside of work.
  - Being able to independently meet their neighbours.
  - Accessed and engaged with Merri Health allied health services, reporting they felt an improvement in their health and wellbeing.
  - Subjectively reported they felt more in control of their life and had more confidence.
- Discharged from Community Connections individual support after 6 months with the option to re-engage in the future if required.

Box 4: A case study of social prescribing and chronic health conditions

2.4.3 Food insecurity, housing instability, insecure work

Food insecurity, housing instability and insecure work are significant issues in Australia and all recognised as having an impact on health and wellbeing[76–79].

- Foodbank, a hunger relief charity, reported 3.7 million households in Australia experienced food insecurity in 2023[80].

- The 2024 Report on Government Services by the Productivity Commission reported that in 2021, 52.5% of lower-income households were in 'rental stress', defined as spending more than 30% of gross household income on rent[81].
- The 2021 Census estimated 122,494 people were experiencing homelessness, including living in overcrowded dwellings, in supported accommodation, staying temporarily in other households, living in boarding houses, in other temporary lodgings or in improvised dwellings, tents or sleeping out[82].
- According to a report by The Australia Institute's Centre for Future Work, in 2018 for the first time in recorded history, "less than half of employed Australians work in a permanent full-time paid job with leave entitlements"[83].

These are potentially underestimates of the actual scope of the issues with cost-of-living pressures increasing over recent years.

Case study: social prescribing for food insecurity (reproduced with permission, not to be further reproduced)

Introduction

Meet Helen**, a 67-year-old woman residing in a regional part of South-Eastern New South Wales. Helen's case exemplifies the complex interplay of chronic health issues, financial struggles, and social isolation, highlighting the critical role of a social prescribing link worker in addressing her multidimensional needs.

Background

Helen was referred by her GP due to her numerous health challenges, including late-stage organ disintegration, polypharmacy, and multiple chronic diseases. On top of her significant medical issues, Helen was facing severe financial hardship. Despite having reached the Medicare safety cap, her medical expenses remained burdensome. Living far from her family and support network, Helen struggled to afford basic necessities, including food and rent. Food security was particularly challenging as housing and medication costs took precedence over her food needs.

Intervention by the link worker

Upon referral, the social prescribing link worker conducted a comprehensive assessment of Helen's situation. It became evident that while her medical needs were partially met, her social and practical needs were not. The link worker's intervention focused on two primary areas: housing and food security.

1. Housing Assistance

Helen expressed a desire to move into public housing closer to her family to gain support from loved ones. The link worker assisted her with the paperwork required for New South Wales housing applications which she found too complex, ensuring she had the best chance of securing accommodation that would bring her closer to her support network.

2. Food Security

Despite the availability of local food banks, Helen felt hesitant to use these resources, believing that others were more deserving. She said, "That's for other people who need that more than me." The link worker played a crucial role in educating Helen about the adequacy of food resources and reassuring her that her needs were equally important. This intervention included:

Awareness and Reassurance: Explaining to Helen that there was sufficient food for everyone and that her accessing these resources would not deprive others in need.

Emergency Support: On several occasions, the link worker arranged for emergency purchases of basic items to ensure Helen had enough to eat.

Connection to Resources: The link worker connected Helen with local food banks and community kitchens, providing her with information and encouragement to utilise these services.

Outcomes

Through the link worker's efforts, Helen began to access the food resources available to her, improving her nutritional status and overall well-being. The support with housing applications increased her chances of relocating closer to her family, which would enhance her social support network and reduce her sense of isolation. She was also connected into free local activities to provide some more immediate social support.

Conclusion

Helen's case highlights the indispensable role of social prescribing link workers in addressing the holistic needs of individuals with complex health and social challenges. Signposting alone would not have been effective in this case. Without the link worker's intervention to provide education, literacy, comfort, reassurance, and permission to access available resources, Helen was unlikely to take up these services, given her belief that other people needed them more. This case study underscores the importance of comprehensive support systems that include both medical and social care to improve the quality of life for individuals in similar situations.

Box 5: A case study of social prescribing for food insecurity

2.4.4 Family, domestic and sexual violence

Family, domestic and sexual violence (FDSV) can cause physical injury, emotional suffering and psychological trauma. FDSV can affect anyone, but is most commonly experienced by women and children. According to the ABS Personal Safety Survey[84]:

- 1 in 6 women and 1 in 18 men have experienced physical and/or sexual violence by a current or previous cohabiting partner since age 15.
- 1 in 4 women and 1 in 7 men have experienced emotional abuse by a current or previous cohabiting partner since age 15.
- 1 in 6 women and 1 in 13 men have experienced economic abuse by a current or previous cohabiting partner since age 15.
- 1 in 5 women and 1 in 6 men have experienced sexual violence since age 15.

Case study: social prescribing for family and domestic violence (reproduced with permission, not to be further reproduced)

Local Links team act as system integrators

Context:

A 30-year-old CALD woman approached her GP regarding termination of pregnancy options and discussed severe financial, emotional, sexual, reproductive and verbal abuse that was continuing post-separation from her partner two days earlier. The financial abuse in particular had limited

her options regarding the termination and Person Using Violence (PUV) had deliberately coerced her into continuing the pregnancy despite her wishes. GP made a referral to Local Link.

Problem/Support Need:

Patient had recently relocated to a new area following separation and needed multiple supports. Between referral being accepted by Domestic and Family Violence (DFV) Local Link and contact with the patient, PUV started to escalate to threatening her family.

There were options in the state's public health system as well as a number of private options however none of the systems usually communicate regarding joint clients. DFV Local Link also needed to complete risk assessment and safety plan due to ongoing violence by PUV.

Actions/approach:

DFV Local Link completed risk assessment and safety plan for the household. Patient articulated she wanted to terminate her pregnancy as soon as possible and needs practical and financial support to do this. Local Link coordinated the following response which included significant effort across a number of services to maximise options for patient:

- Emotional support and validation.
- Referral to multicultural organisation for additional assistance outside of medical services.
- Children By Choice support options provided to patient including a support person and transport.
- Local Link supported patient to have procedure fees waived and access financial support through victims assist agency.
- Patient supported to access transport and accommodation before and after her procedure.
- Fee free pre and post-procedure counselling provided.
- Handover completed and an outcome letter sent to her GP.

Outcome achieved:

The procedure was completed without serious financial stress to the patient. The patient was linked in with a combination of counselling and culturally-safe and supportive services local to where she is currently living. Her GP and this support network are aware of her ex-partner's behaviours and all opportunities to avoid the patient having to re-tell her whole story have been utilised.

Learning outcomes:

The value of the Local Link worker in knowing which services to access to maximise the opportunity for patient support has been highlighted. There were a number of system gaps and pieces of work that benefitted from a central coordinator who knew supports available in victim-survivor's new local area. Without the Local Link as a central point, the client would have had significant difficulty communicating her support needs across different services.

Box 6: A case study of social prescribing for family and domestic violence

2.4.5 Suicide ideation

Suicide risk is linked to the social determinants of health, chronic illness, loneliness, mental health and wellbeing[85]. The ABS National Study of Mental Health and Wellbeing reported[86]:

- 1 in 6 Australians (16.7%) aged 16-85 experienced suicide ideation at some point in their lives.
- 1.5 million Australians (7.4%) Australians ages 16-85 had made a suicide plan and around 970,000 (4.9%) had attempted suicide in their lives.
- Young people aged 16-34 reported the highest prevalence of suicidal thoughts.

In 2023, those aged 40-54 accounted for 28.2% of death by suicide in males and 27.7% of death by suicide in females [87].

Case study: social prescribing for suicide prevention (reproduced with permission, not to be reproduced)

John's* story – Social Rx ®, Primary and Community Care Services (PCCS)

Needs

John is 49 years old and lives alone in rural NSW. He was referred to the social prescribing program at PCCS (Social Rx) by a local organisation after an unsuccessful NDIS application. He was having difficulties in multiple areas of his life: physical health issues, mental health issues, financial hardship and social isolation. He occasionally discussed feelings of loneliness, suicidal ideation and feeling like life was pointless.

On entry to the program, in response to "what matters to you?", John identified that his family and friends were the most important thing in his life. He wished he could be more present in their lives and feel less of a burden on them due to his poor health. He wished to find meaningful connections with others feeling the same way. John frequently mentioned feeling like no one understands him or knows how he's feeling.

Aspirations

John's main goal coming into Social Rx was around improving his physical and mental health. He was also experiencing financial hardship and was unable to afford a new CPAP machine for his sleep apnoea and daily expenses. John knew he was socially isolated, but with all the other presenting concerns; it was not high on his priority list.

John was provided with social prescriptions for his physical and mental health concerns through referrals to Silverchain (in-home health and aged care service) and Rural Outreach Mental Health Service (ROMHS) and with linkages to other services such as Salvation Army Financial counselling. The Social Rx link worker shared many social groups and opportunities with John including a face-to-face mental health support group through GROW. John took a chance and began to attend this support group.

Outcomes

John started attending the GROW support group for mental health in his hometown and instantly felt less isolated and more supported. He was surprised how the other participants had similar experiences to his own. He was also engaging with Silverchain, ROMHS and the Salvation Army for regular support. Due to the connections, he gained during his time with the Social Rx, John felt like life had meaning again and spoke more positively about his circumstances. He described feeling better than he had in years and was much more open to other socialising opportunities. John described Social Rx as 'life changing' and has never felt so supported and started enjoying life again.

Box 7: A case study of social prescribing for suicide prevention

2.5 Social prescribing in Australia

Over the last decade, various small-scale, local social prescribing initiatives have been implemented across Australia. These have been initiated by Primary Health Networks (PHNs), primary care service providers (e.g. general practices), Neighbourhood Houses/Centres, or other community and consumer organisations[88,89]. Since 2021, multiple state-government supported pilot programs have also been established.

In Victoria, the state government is piloting a program called 'Local Connections – a social prescribing initiative'. It is a social prescribing service in six Mental Health and Wellbeing Locals. 'Local Connections' was initiated to combat isolation and loneliness in response to the recommendations from the Royal Commission into Victoria's Mental Health System. Funding for the trials was announced in the 2021 Victorian state budget. The first six are located within Mental Health and Wellbeing Locals (Local Services)[90].

In Queensland, a Parliamentary Inquiry into Social Isolation and Loneliness 2021 report recommended a state-wide trial of social prescription model similar to that already occurring at the Mount Gravatt Community Centre in southern Brisbane[91]. Subsequently, the Queensland Department of Treaty, Aboriginal and Torres Strait Partnerships Communities and the Arts commissioned Queensland PHNs to undertake a feasibility study. The Queensland Government has also recently partnered with Neighbourhood Centres for the 'Putting Kids First Social Prescribing Trial'. The trial will embed link workers in the Neighbourhood Centres so families can more easily access supports, resources and services to address non-clinical impacts on health and wellbeing.

In South Australia, Green Adelaide in partnership with Appleton Institute undertook a trial of nature prescribing in 2021[92]. The study aimed to understand if connecting people with nature in Adelaide's green spaces would improve an individuals mental health and wellbeing. Despite only attracting a handful of participants, those that did attend reported benefits in wellbeing, social connections and nature connectedness[92].

Several organisations have emerged to champion the advancement of social prescribing in Australia. The Australian Social Prescribing Institute of Research and Education (ASPIRE) was established to support social prescribing in Australia through research, connections, evidence and education. ASPIRE aims to bring together global best practice and help facilitate the development of localised social prescribing models for different Australian contexts[93].

The Australian Disease Management Association (ADMA) is a national forum and resource centre promoting chronic disease quality of care, integrated care and care coordination information and programs for healthcare professionals. ADMA has previously hosted a Social Prescribing Network – an informal community of practice to share knowledge, resources and experiences of social prescribing across Australia. The network includes various health professionals, health service providers, consumers, social care workers, researchers, volunteers and policy professionals. ADMA also hosts a resource hub and collates a list and map of current social prescribing programs across Australia[94].

The Victorian Social Prescribing Collaborative (VSPC), a network of Victorian social prescribing stakeholders, was brought together in 2023 by the Wellbeing Promotion Office (WPO) of the Victorian Government Department of Health to support the evidence-based emergence of social prescribing across Victoria[95]. The RACGP has also recognised the potential of social prescribing, co-hosting a roundtable with the CHF in 2019[96] and establishing a member's Specific Interest Group on social prescribing[97].

It is important to acknowledge that the concept of social prescribing is not new in the Australian context, with holistic, integrated health and social care being a hallmark of the Aboriginal and Torres

Strait Islander community-controlled health service (ACCHS) model for several decades[98]. However, the degree to which it is undertaken varies from service to service and comprehensive, consistent implementation across ACCHSs is hindered by entrenched system barriers, including insufficient funding and resourcing for the sector.

Box 8: A case study of a social prescribing pilot in Melbourne's West

IPC Health social prescribing pilot,

IPC Health, Victoria (reproduced with permission)

IPC Health is one of twenty-four independent community health organisations in Victoria. These aim to ensure those at greatest risk of poor health outcomes and those experiencing social and economic disadvantage can access services to address their health and wellbeing needs.

IPC Health started its social prescribing journey in 2018 with the North West Melbourne PHN (NWMPHN) and the Brimbank Collaborative (Brimbank City Council and Victoria University) – who collectively researched and designed a social prescribing pilot suitable for implementation in community health. Funded by the NWMPHN, IPC Health took an iterative approach to pilot and refine the social prescribing service model, testing and adapting for community need and service interruptions experienced by the 2020-2021 COVID-19 pandemic and legislated lockdowns across metropolitan Melbourne. From April 2021 to September 2022, IPC Health piloted and evaluated a social prescribing model of care to 246 residents of Brimbank and Wyndham local government areas.

IPC Health's social prescribing model of care was implemented by Wellbeing Coordinators *(the community chosen title for the link worker role)* with clinical health backgrounds, i.e., nurses, social workers, counsellor, and a pharmacist with community development expertise. A multidisciplinary workforce ensured a professional assessment of the holistic needs of the client, including identifying current physical and psychosocial challenges impacting the client's health and wellbeing; their interests and hobbies; and the goals they would like to achieve.

This informed the development of a goal-directed wellbeing plan which articulated the client's overarching goals; the support services and activities required to address identified health challenges or barriers to participation; and the social prescriptions identified to help the client achieve their goals.

The program used validated patient-reported outcome measurement tools for physical health, mental health, social engagement, and recorded self-reported use of GP and emergency health services to evaluate the impact of the pilot social prescribing service model on our clients' health and wellbeing.

Evaluation outcomes:

Client demographic was mostly people over the age of 50 years, from low socioeconomic backgrounds, with a rich cultural and linguistic diversity and high rates of:

- comorbidity – 75% of clients reported having two or more chronic illnesses; of which 21% had 5 or more;
- persistent pain – 68% of clients reported moderate to severe chronic pain, half of which reported it to be severe (7-10 on pain scale); and

- mental illness – 84% of clients reference to the IPC Health Social prescribing pilot program were from internal referrals, and these demographics certainly fit the profile of community health clients; being client of high need of healthcare and social services.

From 186 complete pre and post patient reported outcome measures:

- 49% the participants reported an improvement in their overall health, whilst 58% reported improved mental health and 52% reported improved physical health.
- 58% of participants reported a reduction in social isolation.
- Reporting of "Minimal to no loneliness" increased by 40%.
- Reporting of "High to severe loneliness" decreased by 69%.

Economic benefits to the service system:

- 50% (87 of 174 clients) reported a decrease in the number of GP visits.
- Clients who reported visiting the GP ≥10 times in 3 months before social prescribing, reduced by 72% from 14 to 4 people.
- Of 177 clients, a 23% reduction in ED presentations (25 occasions) was recorded, saving $13,785; and a 56% reduction (72 nights) in total unplanned nights in hospitals, saving $177,522*.

Calculated using the National Hospital cost data collection – average cost of an emergency room visit in Victoria is $919; The average cost of 1 night in hospital in Victoria is $2466.[1]

See next page (*Table 1*) for detail of previous and current social prescribing initiatives in Australia.

2.5.1 Australian social prescribing initiatives

This is a non-exhaustive list of past and current social prescribing programs in Australia compiled in March 2025. These programs were sourced using ADMA's Social prescribing initiatives[99] list/map and an extensive internet search. Grey shading indicates the program is no longer operating.

Table 1: Australian social prescribing initiatives

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Access to Community (A2C)[100]	City of Yarra, City of Boroondara, City of Manningham, VIC	Under 65, unpaid carers, people who are lonely or socially isolated.	Engage in community activities and experience the benefits of social connection with a view to social inclusion.	Short-term (3-month) program connecting an individual with a volunteer Community Connector who is familiar with the local community. Connects to free or low-cost activities. This is funded through the Victorian Government Home and Community Care Program for Younger People.	
Active Practice[101]	NSW	Sequential routine care patients between 25-65yo.	GP supplied prescription for physical activity +/- supplementary booklet.	A controlled trial in 27 general practices in NSW. Control (n=386); intervention – prescription only (n=380); intervention – prescription + booklet (n=376). Self-reported physical activity levels at baseline, 6-10 weeks and 7-8 months.	Inactive people in prescription plus booklet group were significantly more likely than controls to report increase in physical activity; no significant different between prescription only and control group. Short term results.
Active Script Programme[102]	VIC	People with insufficient physical activity levels.	Improve physical activity through GP.	Developed by the Victorian health department, the program ran between 1999 and the early 2000s. It aimed to increase the capacity of GPs to provide	The program was assessed to be cost-effective with $138 expended per patient to enable them to become sufficiently active to gain health

Name	Location	Eligibility	What	Explanation	Review (if applicable)
				consistent and effective physical activity advice.	benefits and savings of $3647 per disability adjusted life year (DALY).
Campaspe Library Community Outreach Social & Recreational support[103]	Campaspe, VIC and Murray, NSW	Community members who: • Need assistance with their mental health • Have social needs which affect their wellbeing • Feel lonely or isolated	Engage in activities or community.	Campaspe Regional Library Service- Outreach services aim to reduce barriers to participation by ensuring community members have access to resources, opportunities and capabilities to engage, contribute, use local services and connect with their communities.	
Care Coordination Services, (CCS) – Brisbane South PHN[104]	Brisbane South, Logan, Redlands and Beaudesert, QLD	Adults in the Brisbane South PHN region with chronic health conditions and experiencing psychosocial risk factors impacting		Funded by Brisbane South PHN since 2019, link workers receive referrals primarily from GPs, community health Hubs, clinical teams. Individuals are linked to social supports that are meaningful to them. This program is run by Footprints Community, a not-for-profit organisation. This program won the National Academy	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
		ability to manage health conditions.		of Social Prescribing (NASP) UK, Best International Social Prescribing program in 2022.	
City of Casey Link Worker Program	City of Casey Melbourne VIC	For residents in City of Casey needing providing information and pathways to community and health services		Info here to access videos explaining the program	To showcase the program's success in 2023 officers from the Link Worker Program assisted more than: 650 people to access allied health interventions 480 older people to access aged care services 218 people to access social services such as housing, family violence, mental health and social connection activities.
Community Connections – Merri Health	Northern Metropolitan Region Melbourne, VIC	Adults under 65yrs who are Home and Community Care Program for Younger People	Psychosocial support for adults aged under 65. Particularly those with a chronic illness what has	Community Connections (formerly Living Well, Ageing Well) offers individualised support to link individuals to social and community resources. The aim is to regain independence, confidence and functioning.	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
		(HACC PYP) eligible.	led them to be isolated.		
Connected Communities Project – Innovative Models of Care (IMOC) Program	Albany, WA	Prioritise patients over 65yrs and those experiencing chronic illness or illness responsive to lifestyle modification.		Department of Health and Aged Care funded social prescribing project, run by Amity Health. Health professionals will refer patients with unmet social needs to a connect team. The connect team will refer patients on to existing community support services.	
Community Engagement & Connections, Wyndham Council	Wyndham Council VIC	Residents living in the Wyndham Council.		Community Connectors assist with a range of needs including food relief and material aid; Mental health support and counselling; Family, youth or child services; Family violence support; Aged and disability services; Homelessness and emergency accommodation; International students; Support while in isolation or quarantine; Connect with local community groups; Information about children's activities; Information about council services.	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Connecting Community in Upper Hume Phase 2 Social Prescribing Project (CCUHP2)	Upper Murray Regional Neighbourhood House Network Regional VIC	People who are socially isolated, lonely or at risk of social isolation.	Model based on Living Our Best Life by CHAOS.	Info here Commenced as Connecting Community in Upper Hume Pilot Social Prescribing Project, delivered across the Upper Murray Regional Neighbourhood House Network by five participating neighbourhood houses from November 2022 to June 2023. CCUHP2 commenced in July 2024 and is funded through the Ovens Murray Mental Health, Alcohol and Drug Alliance.	
Connecting communities to care[105]	South East Melbourne PHN,VIC	Isolated older people with chronic health conditions.	Reduce social isolation and improve mental, physical and social wellbeing.	A four-year pilot project is using a social prescribing approach to develop a social connection model of care. Project collaborators are Bolton Clarke Research Institute, Alfred Health, South East Melbourne PHN, and ADMA. The project aims to: • show a measurable reduction in social isolation and to improve mental, physical and social wellbeing. • reduce avoidable emergency presentations, unplanned hospital admissions and lengths of stay in acute care.	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
				Funding from Ian Potter Foundation.	
Connecting Communities Social Prescription Program[106]	Hervey Bay Neighbourhood Centre, QLD	Residents over the age of 18.	Reduce social isolation and loneliness and improve health and wellbeing.	A 12 week program to connect Fraser Coast residents to social events, clubs, groups and activities via a link worker.	
Get Connected Mount Alexander – Castlemaine Community House[107]	Mount Alexander Shire, VIC	Adults (25ys+) living in the Mount Alexander Shire.	Connecting people to improve health and wellbeing.	General practitioners at Goldfields Medical Group, Health Professionals at Dhelkaya, Wellbeing Unit at Council or Castlemaine Library refers individuals who would like to be more socially connected to a Community Connector at Get Connected, located in the Community House. The Community Connector presents options to the individual and stays connected with the individual while they begin to participate in activities of their choice. A volunteer may accompany new participants to their first activity. Initial funding was from an Are-Able grant	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
				and from the Mount Alexander Shire Council.	
Feros Care Social prescribing	Coolangatta QLD	All ages	Across all our services, regardless of age or background, we support people to create a social plan. We also engage directly with communities to build capacity and encourage people to live a fully connected life.	Info here	
Gippsland PHN digitally enabled Social Prescribing[108]	Gippsland PHN, VIC	People with moderate health, mental health and social support needs.	Provide healthcare professionals with a non-medical referral option to improve health and wellbeing.	Practice nurse builds relationship of trust with individual and utilises Kaleidoscope; a digital platform to support healthcare professionals develop a co-designed psychosocial care plan with a patient that tracks progress against agreed goals, referrals and patient outcomes. The program is no longer running.	
Green Scripts[109]	Ballarat, VIC	People living with dementia, all	Aiming to link people impacted	Run by Bigger Hearts Dementia Alliance Ballarat. Green Scripts is a freely available	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
		community members	by dementia with the established and emerging dementia-inclusive community activities in Ballarat.	online resource illustrating opportunities to utilise the Dementia Forest and Sensory Trail in Woowookarung Regional Park, Ballarat. Promoted to Primary Care practitioners for their use with their clients. Green Scripts is supported by a Dementia Friendly Community Engagement Grant from Dementia Australia.	
Hammond Care Arts of Prescription	Hamilton, NSW	People over 65, including those living with dementia.		A healthcare practitioner (GP, allied health professional, nurse, pharmacist, social worker) could refer individuals to an Arts on Prescription program. Delivered by professional artists and designed to promote health and wellbeing, participants could use their Home Care Package to help access the program through the Short Term Restorative Care Program. They could also pay privately to access.	
Highett Neighbourhood Community House and Hampton	South East Melbourne (Highett and Hampton),VIC	Those experiencing social isolation and loneliness which may be impacting on	Address isolation and loneliness.	A social prescribing pilot was run between July 2020 and April 2021 to address isolation and loneliness in the community. The project was funded through three grants. A doctor identifies need, refers to community connector, who co-design plan with patient and connects them to	It was hampered significantly by COVID-19 considerations and restrictions, however, of the 32 participants, 50% engaged in a new activity and 81% had a positive experience [111].

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Community Centre[110]		their mental and physical health.		relevant activities/services. Follow up was done by the community connector. The program was discontinued due to lack of ongoing funding.	
Inala Primary Care[112,113]	Inala, QLD	People attending GP appointments with social needs, particularly social isolation.		Inala is a large primary care practice in Queensland where 6% of total patient group takes up 24% of total GP appointment times. Inala has had several iterations of social prescribing. Currently they have four main streams: • By clinicians within consultations • Embedded social works (with PHN) • Reception team social prescribing • Peer-to-peer group session	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
IPC community health service[114]	Western Metropolitan Melbourne, VIC	Individuals who have social, physical or mental health needs that impact their daily lives and who want to improve their overall wellbeing.	Connect with and maintain social connections.	IPC is a community health service in Melbourne's west. The first social prescribing program was initiated in 2018, where GPs and healthcare workers could refer clients to the program. The current iteration of the program accepts referral from health care professionals, community referrals and self-referral. A wellbeing coordinator, generally from a clinical background such as a nurse or social worker, works with clients to identify their wellbeing goals and connects the individual to free or low-cost community groups and services to help achieve those goals. This is a collaboration between Brimbank City Council, Northwest Melbourne PHN.	
Latrobe Health Assembly	Latrobe, VIC	Patients at the linked health centre and attendees of the Churchill Neighbourhood House.	Reduce psychosocial unmet needs and increase use of community assets.	A pilot program initially run out of Hazelwood Health Centre and relocated to Latrobe Community Health Services (LCHS) in 2023. An evaluation is being undertaken by the Collaborative Evaluation and Research Centre (CERC) at Federation University in mid-2024.	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Links to Wellness[115]	Hobsons Bay and Altona North, VIC	People living or working in Hobsons Bay aged 18 years and older who will benefit from being connected to activities and services in the local area.		Louis Joel Arts & Community ran a social prescribing program at their centre and at Walker Close Community Centre in Altona North. Funded by Australian Neighbourhood Houses and Centres Association (ANHCA) and Hobsons Bay City Council, the program supported individuals to join activities, groups, classes and to explore volunteering opportunities, as well as connecting people with organisations that can help with housing, finances, unemployment and legal issues. Links to Wellness finished in May 2023 due to lack of continued funding.	
Living our best life project- Community Houses Association of the Outer-eastern Suburbs (CHAOS)[116]	Knox, Maroondah, Manningham, Whitehorse and Yarra Ranges, VIC	People aged 60 and over who are socially isolated, lonely or at risk of social isolation	Reduce loneliness and reduce social isolation.	A partnership between the CHAOS network, Temple Society Australia and the five Neighbourhood Houses. A co-designed trial of Social Prescribing in the City of Knox which has since been expanded to LGAs of Maroondah, Manningham, Whitehorse and Yarra Ranges. Health practitioners have a formal referral system to volunteer community connectors to facilitate engagement in community activities. Project is funded as	A project report reported that: • 85.7% of referring practitioners believed patients experience and improvement in general health • 95% of feedback from patients about connecting experience was positive • 90% of participants reported improved community engagement • 57% of referring practitioners said they consulted patients who did

Name	Location	Eligibility	What	Explanation	Review (if applicable)
				an Ageing Innovation project by the Equity Trustees. Oct 2020- ongoing.	not want to be referred and this was mostly due to timing or lack of confidence [117]
Living Well Ageing Well	Merri-bek, Hume, Darebin, Banyule, Nillumbik, Whittlesea and Yarra LGAs, VIC	A program for adults aged under 65 who may be experiencing, or at risk of, social isolation and or loneliness	Addresses the 5 key areas of wellbeing: social/emotional, sensory, cognitive, physical, cultural/spiritual, which may impact health.	A pilot program from Merri Health to enhance social connectedness and community participation. The program was to conclude in June 2022. (Continued as Community Connections (see above)).	
5 Steps to Connection - North Richmond Community Health	North Richmond, VIC	Patients at North Richmond Community Hub who are lonely, isolated or have a chronic disease.	Promote movement, engagement, a sense of belonging and ongoing health and wellbeing.	GPs at North Richmond Community Hub refer into the link worker. The link worker and participant co-design a plan to find activities/services that meet needs and interests.	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
PCCS – Plus Social (NSW)[118]	NSW	People under EML case managers who have been injured at work and unable to return to work for the last three to nine months.	Build support, increase confidence, boost mood.	Funded by Employers Mutual Limited (EML), Plus Social (NSW) is a 12-week program where a link worker connects people to services, community groups and activities based on current needs. It is delivered alongside existing medical care.	
PCCS – Plus Social (Gold Coast)[118]	Gold Coast PHN, QLD	People whose mental health significantly impacts their daily living. Aged 18+ in Gold Coast Area.	Clinical care coordination between GPs, psychiatrists and allied health workers. Connections to a range of local community services and social groups, and an after-hours community-based space (the Hub).	Plus Social® is a program that focuses on improving the individual's support network, confidence and wellbeing. It runs in conjunction with existing medical care and involves an experienced and caring Service Specialist connecting the individual to local sources of support. Only accessible through a referral from a GP or psychiatrist.	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
PCCS – Social Rx[119]	Gold Coast PHN, Central and Eastern NSW PHN, COORDINARE - South Eastern NSW PHN	People over 18 living in the PHN area: • Have or at risk of developing long term health condition • Experiencing social isolation or loneliness • Need practical help that could be significantly impacting health and wellbeing		Social Rx® is a short-term program supported by the local PHN. It is designed to link individuals to locally available support services and community based resources. Eligible consumers can be referred by GPs, practice teams, allied health providers, pharmacists and other health providers to a PCCS service specialist or social worker who links the consumer to the services from which they could benefit.	
Pilot Study: Plus Social[35]	Sydney Local Health District. NSW	People aged 18–65 years, living in Sydney Local Health District, diagnosed with serious mental	The aim was to improve quality of life, social and economic participation.	Pilot study in 2016-2017. GP refers individual to link worker in program, needs assessment and co-designed program. Participants also attended weekly arts and crafts groups for 10 weeks.	The study found significant improvements in a range of health and economic outcomes. The authors of the paper suggested that social prescribing would be an appropriate intervention in Australian settings.

Name	Location	Eligibility	What	Explanation	Review (if applicable)
		illness likely to last 6 months or longer.			
Putting Queensland Kids First	Queensland	Children and families in Queensland.	The trial will embed link workers in the Centres so families can more easily access supports, resources and services to address non-clinical impacts on health and wellbeing.	Part of a larger initiative by the Queensland Government. Ten Neighbourhood Centres are being supported to strengthen families and communities.	
Reclink Community Connector	Regional East Victoria	All ages including young.	A range of activities and programs with referrals from GPs.		

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Re-imagining environments for connection and engagement (RECETAS): testing actions for social prescribing in natural spaces	RMIT VIC and Many Coloured Sky Organisation	LGBTQIA+ refugees and people seeking asylum.	Non-medical nature-based community referral strategies Facilitator works with a peer social support group that meets for activities, excursions, education, referrals, connections, networking, and emotional and practical support.		
Social Connectedness for Older People in Hawkesbury[120]	Nepean Blue Mountains PHN, NSW	Older People in the area.	Project aims to reduce isolation and loneliness and improve mental health through community connections.	Health connectors (practice nurses) and community connectors (members of the public) collaborate to connect older people to community assets using the My Health Connectors directory. Expanded to Penrith and Blue Mountains in 2020. The program has been continued through 2024-25.	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Social Health Connect (SHC)- Brisbane North PHN[121]	Kilcoy, Caboolture and Redcliffe, QLD.	Adults who have unmet social needs that negatively impact their health and wellbeing.		Run by Footprints Community, a not for profit organisation. It provides a team of link workers work out of the community and are co-located with GPs. They receive referrals from community, self, clinical Teams, GPs, and other NGOs. A 12-month evaluation is being undertaken in mid-2024.	
Social Prescribing Bendigo	Bendigo, VIC	Participants living with chronic or complex illness, low level anxiety and depression	Connecting health with community and making social prescribing a part of the health professional tool kit to build stronger social connection and encourage wellbeing activities.	Participants referred by a health professional can be connected with a link worker through City of Greater Bendigo that will assess interests and capacity in order to connect people with local activities. Capacity building for communities through support to develop groups or activities. The program ceased in June 2023 due to lack of ongoing funding	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Springvale Neighbourhood House Social Prescribing Project	Springvale VIC	Social Prescribing Project Funded to link socially isolated and lonely participants to activities, programs and services run by Neighbourhood House & Community Organisations in the area - including Women's Friendship Cafe, Men's Clubs/Sheds, Art & Craft groups, English & Computer classes.		Social Prescribing Project is funded by the City of Greater Dandenong	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Stepped Care for Older Adults (SCOA)- Merri Health	Hume, Merri-bek, Darebin, Yarra, Gisborne, Melton, Brimbank, Melbourne, Maribyrnong, Hobsons Bay, Wyndham, Moonee Valley and Bacchus Marsh, VIC	Adults 65years and older. Aboriginal and Torres Strait Islander people aged 50 years and Older	Support older people who are experiencing mental health concerns, social isolation and/or loneliness.	Stepped Care accepts self-referral and referral from a GP. It offers individual and group sessions to people to increase wellbeing and increase social connection and community participation. It supports people to connect with local community groups, services and other wellbeing services.	
Victorian Social Prescribing Trials- Mental Health: Local Connections[90]	Frankston, Latrobe, Benalla-Wangaratta-Mansfield, Brimbank, Geelong-Queenscliff and Whittlesea, VIC	Older adults experiencing isolation and loneliness	Mental health and wellbeing outcomes	Announced in the 2021 Victorian state budget. Funding for eight social prescribing trials. Local connections is a social prescribing service co-designed by people with lived and living experience of psychological distress, mental illness and addiction. Trials are located within the six Mental Health and Wellbeing Locals(Local Adult and Older Adult Mental Health and Wellbeing Services). This was a recommendation from the Royal Commission into Victoria's Mental Health System.	

Name	Location	Eligibility	What	Explanation	Review (if applicable)
Ways to Wellness[122]	Mt Gravatt, QLD	Individuals who are identified as socially isolated or experiencing loneliness	Link worker who connects them with meaningful group programs and activities through social prescribing	Funded by the Queensland Government, Department of Communities, Disability Services and Seniors. The program accepts referrals from GPs, allied health, community members and organisation. The program was supported and evaluated as part of a 3-years ARC research project run by psychologists from the University of Queensland.	

2.6 Social prescribing internationally

More than 25 countries have started to implement social prescribing to address unmet non-clinical needs in the population and contribute to long-term systemic changes in preventive health and service delivery models. There is considerable variability in the design and implementation of social prescribing initiatives globally, resulting in an array of different service models, which encompass a diverse range of referral networks and pathways, workforce roles and funding arrangements[123,124].

2.6.1 United Kingdom

Social prescribing as an adjunct to healthcare originated within the United Kingdom (UK) several decades ago, beginning with localised small-scale initiatives[125], as a response to growing awareness that non-clinical factors can significantly influence health and wellbeing. It was formally recognised by the National Health Service (NHS) England in 2014 for its preventative focus and as a possible adjunct to primary care. More recently, social prescribing has been systematically established within England's primary care system through specific funding arrangements, including the 2019 NHS Long Term Plan[125].

While social prescribing is ubiquitous in the UK and has been identified as a pillar of the NHS's universal personalised care[126], its inception and proliferation occurred without a planned approach to implementation processes. This is evident through the diversity of models and inconsistent outcome measurements, making it difficult to quantify their effect broadly. Whilst studies have indicated positive benefits through social prescribing services, it is clear that the evidence base needs to be strengthened[127].

The 2019 *NHS England's Long Term Plan* for universal personalised care committed to funding link workers directly with a 2023/2024 target of every GP practice having access to a social prescribing link worker[125]. Most were to be employed through Primary Care Networks (PCNs), making social prescribing in England predominantly associated with primary care. NHS England provides support for the growth of social prescribing infrastructure including the National Academy of Social Prescribing (NASP) and the volunteer and community organisations that deliver the interventions[125]. This aims to facilitate a more consistent approach to social prescribing.

As of 2024, across England there were more than 3,500 social prescribing link workers who have received over 2.5 million referrals. The *NHS Long Term Workforce Plan*(2023) commits to 9,000 link workers by 2036[123].

NHS England, in partnership with stakeholders, has developed a standard model of social prescribing. The model, Figure 2 below, shows the required elements for effective social prescribing.

Figure 2: NHS England's standard model of social prescribing [128]

Like in England, social prescribing has been used in Scotland since the 1990s. It has become increasingly structured with the launch of the Community Link Worker (CLW) program in 2016. CLWs are based within primary care but are often employed and embedded within the community. Some CLWs have specialist focus areas, including working with people seeking asylum or those experiencing homelessness. They are part of a Scottish Community Link Worker Network, funded by the Scottish Government and hosted by Voluntary Health Scotland[129]. There are around 300 CLWs working as social prescribers in Scotland with varying employment models. These include employment by third-sector organisations or health boards[123]. The Scottish Social Prescribing Network (SSPN) was set up in 2020 to lead the strategic direction of social prescribing in Scotland. Additionally, SPRING social prescribing network is a partnership between 30 Northern Ireland and Scottish community organisations. These organisations embed social prescribing in community-led health organisations[129]. SPRING network link workers accept referrals from partnered primary care professionals and co-design wellbeing plans with individuals to connect them to community activities[123].

In Wales, many different organisations participate in a community-based model of social prescribing. The general model is a referral by a general practitioner or other referrers (e.g. from statutory services, self-referral) to a Social Prescribing Practitioner who undertakes a 'what matters to you' conversation and links the individual with community assets by onward referral. To ensure consistency and quality across the many approaches, Wales set out to develop effective, high-quality standards across the system. The development of the National Framework for Social Prescribing was overseen by a task and finish group chaired by the Deputy Minister for Mental Health and Wellbeing in 2023[2]. The Framework is accompanied by case studies, a glossary, an explainer video, a competence framework and standards for community asset quality[123]. This work is led by the Wales School of Social Prescribing Research (WSSPR), which was founded in 2020[129].

The National Association of Link Workers (NALW) is the professional body for link workers in the UK. They aim to offer link worker standards of practice, build capability and increase connectedness of link workers[130].

2.6.2 Ireland

In Ireland, social prescribing started as grass-roots partnerships between health services and community services[129]. In 2021, the Health Service Executive (HSE), the organisation that operated the public health services, developed a framework to mainstream social prescribing services throughout the country[131]. There are over 30 social prescribing services in various locations, delivered through community partnerships and funded by the HSE. The HSE framework proposes a delivery model including a full-time link worker for each Community Healthcare network or Sláintecare Healthy community site[131]. Social prescribing is recognised in key policy documents, including the *Sharing the Vision 2020-2030* (2020) mental health policy, the *Sláintecare Implementation Strategy and Action Plan* (2021-2023)[132] and the *Healthy Ireland Action Plan* (2021-2025)[133]. The All-Ireland Social Prescribing Network was established in 2017 to champion social prescribing in Ireland[129].

2.6.3 New Zealand

The Green Prescription was established in 1998 by Sport and Recreation New Zealand. From 2009, the Green Prescription (GRx) program has been funded by the NZ Ministry of Health as part of a health plan in alignment with services aimed at managing long-term health conditions. The GRx program aims to encourage and support patients to become more physically active, and to eat healthier. Patients are prescribed a GRx and if they then request ongoing support, a GRx support person will help them set goals and maintain contact with them for 3-4 months to monitor their progress[135]. The GRx program is an example of social prescribing as a program focused on a specific activity.

2.6.4 United States of America (US)

The US does not have a formalised approach to social prescribing. It varies by region and is typically integrated into broader models of care that support addressing the social determinants of health, such as value-based care and Accountable Care Communities. With a focus on outcomes, these models aim incentivise identifying and addressing non-medical needs, such as housing instability and social isolation[123].

Value-based funding arrangements through the capitation and bundled payments from Medicare, Medicaid and Private Health Insurance, allow health providers to leverage the flexibility to use funds where most appropriate for patients, including social needs[136]. The Accountable Care Organisations (ACOs) providing care to Medicare and Medicaid recipients, often people with disabling health conditions and/or limited financial resources, facilitate coordination of care among health professionals, while the value-based funding arrangements incentivise preventive health and social care to reduce costs[137]. Accountable Health Communities (AHCs) is a model developed by the Centres for Medicare and Medicaid Services (CMS) to support local communities to address social needs[123].

In early 2021, extensions to the US Medicaid system, which provides health coverage to low-income individuals and families, enabled primary care organisations to leverage the flexibility of payments to direct funding towards social services [138].

Social prescribing is typically implemented through healthcare systems, health centres and not-for-profit organisations. Health Leads USA is an organisation that works in partnerships with services in cities and communities across the US to enable health services and clinics to connect people to essential resources. Focused on addressing racial inequities, Health Leads initiatives use volunteers to run help desks at health services and connect people to resources on topics such as food, housing and household amenities[136].

They have similar partnerships with primary care teams[139]. In the early stages of the COVID-19 pandemic, Health Leads USA recorded an increase in demand for social services including food resources, stable housing or shelter, and caregiving services. In response to the pandemic, Health Leads has developed the Equity-Orientated Primary Care (EOPC) Innovation Collective to develop three primary care practices over three years that align "primary care strategies with community prioritised public health efforts"[140].

In response to the increase in demand caused by COVID-19, NowPow, a personalised community referral platform, developed impact screening and condition algorithms that allowed people to identify their needs quickly and easily, and then provided directions for them to verified sources[134]. Hospitals expanded their use of systems such as NowPow to help patients with non-clinical health-related needs[141].

Kaiser Permanente, a for-profit health insurer, has a 'Community Health' program that screens for social needs and refers to appropriate community-based services[129].

The U.S. Social Prescribing Student Movement was launched in 2023 by the Harvard Students for Social Prescribing in Collaboration with Social Prescribing USA, a volunteer social prescribing movement, and the Global Health Institute[123,142].

More recent developments include adoption of a state-wide arts-based social prescribing program in Massachusetts after a three-year pilot. Art pharmacy enables healthcare providers to prescribe arts and cultural participation[143]. Additionally, in California, the CalAIM Medicaid reforms have integrated housing solutions into healthcare for vulnerable populations[144].

2.6.5 Canada

Social prescribing in Canada has a diverse landscape including local projects and national initiatives. The Parks Prescription (PaPx) is a national initiative where health care professionals can refer individuals to nature prescriptions using specific resources[129]. The Rx: Community pilot program is an example of a provincially based program. This program was implemented in eleven community health centres in Ontario, Canada, between 2018 and 2020, through a health and wellbeing grant provided by the Ontario Ministry of Health. Implemented by the Alliance of Healthier Communities (the Alliance), the program used a navigator to collaboratively work with clients to connect them with appropriate non-clinical, community-based services. At its cessation in 2020, it was shown to have made an overall improvement in clients' mental health and self-management skills and to have been a useful tool for health care providers to improve their clients' wellbeing, and enable deeper integration between inter-professional teams[145]. More recently, the Links2Wellbeing program, a partnership between the Alliance and the Older Adults Centres' Association of Ontario (OACAO), funded by philanthropy, has focused on the social inclusion of older adults. Links2Wellbeing builds on the work of Rx: Community and is to be expanded throughout Ontario[146]. Other regional, local and hyper-local initiatives are underway in Canada[147].

The Canadian Institute for Social Prescribing (CISP) was established in 2022, funded by the Public Health Agency of Canada, as a national hub that hosts communities of interest. CISP is currently developing a national framework for social prescribing in Canada[129].

2.6.6 Mainland Europe

The Re-imagining Environments for Connection and Engagement: Testing Actions for Social Prescribing in Natural Spaces (RECETAS) project is a 5-year endeavour funded by a €5 million grant from the European Union's Horizon 2020 research and innovation programme. It aims to combat loneliness and improve mental health through nature-based social prescribing. Pilot studies are being run in France, Spain and the Czech Republic. There are also pilot sites outside of mainland

Europe in Finland, Ecuador and Australia. The programs will be evaluated using health, economic, epidemiological and anthropological methods as well as randomised controlled trials (RCTs)[148].

In addition to the RECETAS project, various mainland European countries have implemented other social prescribing programs.

Portugal has strong support for social prescribing through policy, despite not having a national social prescribing programme In 2021, the Portuguese Parliament recommended social prescribing in primary care and the Portugal Health Parliament Mental Health Commission has recommended scaling social prescribing[129]. Additionally, primary care-based social prescribing programs have emerged in Lisbon. Two Primary Healthcare Units (PHU) in Lisbon have social prescribing initiatives that cater for all users registered to these PHUs. They cover a range of social needs, including isolation, mental health, physical inactivity, employment issues and housing instability[149]. A social worker acts as the link worker, maintaining the connection with the individual through the implementation of an individualised co-designed plan[149]. The NOVA University Lisbon National School of Public Health recently launched the Social Prescribing Portugal Network[150].

Spain has a similar broad approach to social prescribing programs, but they do not include a link worker[151]. Primary care physicians, nurses or in-clinic social workers make direct referrals to community resources[129]. Training programs have been developed to upskill physicians on referrals and also for becoming social prescribing champions within their organisations[123].

France also has emerging social prescribing initiatives. Some GPs have adopted social risk alert systems to better support patients with social needs. In 2023, a National University Diploma was launched by Health United to train Integrative Health Care Coordinators in social prescribing[123].

The Netherlands has “Welzijn op Recept” (Wellbeing on Prescription), a program established in 2011. A subsequent knowledge network of primary care providers, welfare workers and policy officials was developed in 2018[129]. The Wellbeing on Prescription program focuses on positive health and social identity theory, rather than the deficit model of medical treatment. The program uses primary care referral to Wellbeing Coaches, who are social workers with additional training. “Welzijn op Recept” plans to be expanded to all municipalities, with around half already participating [129]. The “Welzijn op Recept” program is one of five mandatory regional programs under the 2022-2026 National Health Policy Agreement[123].

Italy does not have a formal social prescribing program but several initiatives have similar principles to social prescribing. “Social Circles” is a program in some local community centres where older adults are connected to social activities, including walking groups or theatre expeditions [129]. A recent project, the COPE-Project funded by the European Union, targeted socially excluded youths with an integrated social prescribing intervention[123].

Germany also doesn’t have a formalised social prescribing program, but instead has some locally-based initiatives. In a northern district of Germany, a community health advice and navigation service opened in 2017. Commonly, referral is from a General Practice, and nurses, social workers and allied health workers involved act as the link worker, rather than there being a formalised role[152]. The Kompetenznetzwerj Social Prescribing (Social Prescribing Competence Network) was formed in 2023. It is a collaboration of German and Austrians interested in social prescribing with an initial aim to establish standardised terminology[123].

In Austria, the Federal Ministry for Social Affairs, Health, Care and Consumer Protection funded social prescribing pilots in 2021. Health care professionals in nine primary care facilities were educated in social prescribing. They referred individuals to nurses and social workers acting as link workers in the clinic. Individuals were then referred on to appropriate community services. A

subsequent policy brief identified that the pilots were very successful, with 98% of individuals recommending social prescribing to others and a recommendation for funding more pilots [129]. A ideal model for social prescribing in Austria, a factsheet, and online awareness training developed and published in 2023[123].

In Greece, the University of West Attica is piloting a social and cultural prescribing project. Co-designed with communities and designed to be inclusive, it is being rolled out in Fyli and Nea Smyrni[123].

2.6.7 Scandinavia

In Sweden, an Arts on Prescription program was initiated in 2009 with funding from the Ministry of Health and Social Affairs and the Ministry of Culture. The program directs patients with chronic pain and mental health conditions to arts and culture interventions. Additionally, a health clinic in the north of Sweden started a Social Prescribing in Sweden (SPiS) project in 2021 to address loneliness. This pilot project has a planned evaluation with both qualitative and quantitative measures[153].

Arts of Prescription programs also exist in Norway and Denmark, but are generally initiated at a local level with no systematic, nationwide approach[154]. Nature on Prescription and Exercise on Prescription programs have gained recent popularity in Denmark[123].

In Finland, the region of Lapland has a rural model of social prescribing where health and social care professionals and employment services can refer to a social prescribing link worker, generally municipality or NGO-based. The link worker the co-designs an intervention with the individual. The Finnish Ministry of Social Affairs and Health has included social prescribing in its €25 million investment in "low threshold wellbeing services"[129].

2.6.8 Asia

In China, the approach to social prescribing focuses on loneliness and the ageing population and involves a multidisciplinary link worker team, referred to as a comprehensive evaluation team[123,151]. Primary care community health centres screen for health-related social needs in older adults during routine appointments. A comprehensive evaluation team, made up of community health workers, social workers and mental health support, acts as the link worker. Guidelines for further social prescribing implementation have also been published[129].

Singapore similarly focuses on social prescribing for the aging population. They use a wellbeing coordinator with referrals often coming from the hospital setting[151,155]. There is strong collaboration between the hospital and community partners. In response to COVID-19 and the recognition of digital exclusion, the SingHealth Community Hospital and Singapore's Institute for Adult Learning (IAL) collaborated to develop "e-Social Prescribing" (eSP). eSP aims to teach older adults digital literacy to help them remain connected. Additional benefits are the social interaction from small group lessons. Duke-NUS Medical School and Yong Loo Lin School of Medicine have both included social prescribing in the curriculum[123,129].

The first South Korean social prescribing pilot was implemented in 2019 by the Korean National Research Fund and Yonsei Global Health Centre. A 10-week intervention for older people with depression included referral to music therapy, physical activity, craft classes and a community farm. The project reported a reduction in loneliness and increased self-esteem among participants[123]. Additionally, a pilot program of social prescribing was set up during the COVID-19 pandemic for older adults in a rural setting. Interventions included nature-based activities, music storytelling, self-help groups and 'COVID-19 prevention' such as nutrition education and phone calls[156].

In Japan, social prescribing is mostly practised in hospitals. At the Saitama Medical Co-op Hospital, health professionals refer individuals to medical social workers who help them manage financial or other issues and connect individuals to community groups. Ishizaka Neurosurgery Hospital uses link workers to connect individuals to community-based activities. This program often connects older adults to activities involving children to create intergenerational bonds and prevent loneliness. The Ministry of Health plans to establish *Community-based Integrated Care Systems* with Seikatu Shien workers (Life Support workers). In 2021, a Minister for Loneliness was appointed to the Ministry of Health, Labour and Welfare to combat rising social isolation, loneliness and suicide rates. The Japanese Social Prescribing Laboratory was established in 2018[129].

While Hong Kong does not have a formalised social prescribing system, there are various individual social prescribing programs. An example is the JC InnoPower: Nature4Mind initiative targeted at primary school-aged students to address anxiety. Children are referred by Primary Care doctors to link workers who help co-design personalised plans with the child. Activities generally include a nature-based approach including natural art, water sports or forest bathing[123].

Malaysia does not have a formalised social prescribing practice but social participation for wellbeing, particularly in older adults, is well recognised. The Twelfth Malaysia Plan, an annual government policy document, promotes senior citizen social participation. Various religious, political and cultural sensitivities in Malaysia and related concerns about the privacy of digital directories are a persistent barrier to wide-spread social prescribing[123].

In Taiwan, Taipei City Hospital has a social prescribing program for patients with dementia. Established in 2018, the hospital works with various organisations to create dementia-friendly communities[129]. For example, collaborations with Museums create dementia-friendly spaces and dementia literate front-line staff[123].

India does not have a formalised social prescribing programme, but the recognition of social determinants of health and a focus on community health is strong. In 2006, the Accredited Social Health Activist (ASHA) Programme was launched to improve the long-term quality of life of disadvantaged populations in both rural and urban settings. Community Health volunteers (ASHA Workers) are local women trained to work similarly to a link worker[129].

In the Philippines, village health workers and nutrition scholars have worked in grassroots communities as health, nutrition and social care frontline staff since the mid-1990s. There is also a broad understanding of the social determinants of health, with every local authority having targeted interventions funded by both government and non-government organisations[123].

In Iran, social prescribing education or information in included in all medical schools despite it not officially being part of the curricula. Dezful University of Medical Science piloted a programme from 2018 to 2020 where students implemented social prescribing principles in rural health centres. The link worker role was fulfilled by rural health staff due to their knowledge of the local context and connection with local organisations[129].

2.6.9 Nigeria

In Nigeria, formal social prescribing initiatives are developing. In Abuja, Brookfield's Clinics Centre for Lifestyle Medicine has a 'Health & Wellbeing in Schools initiative' that includes 'Dance with Doc' and 'Chill and Paint Adventure'. These social prescribing programs are designed to promote physical, mental and social wellbeing. Nigeria has a cultural heritage of using non-medical interventions to address health issues, such as programs that use folk music to communicate public health messages[123].

3 Policy context

The term 'social prescribing' was reportedly first introduced by the UK Department of Health in 2006[157]. It began as a formal description of a health-related service and has now been formally introduced as a component of primary health care in the UK through public health policy and guidance[158]. Since then, numerous global, national and state-level developments have focused on primary healthcare as the most appropriate setting in which to integrate and embed social prescribing services[159,160]. Australia's current primary health care reforms present an opportunity to integrate social prescribing within mainstream primary care.

Primary healthcare describes any service that is the first point of contact with the health system for treatment or management of non-emergency medical issues, typically outside of a hospital or specialist setting[161]. As a local, community-based service where an individual does not require a referral to attend, it offers easily accessible healthcare as close as possible to where people live and work. Primary care is a central function of a country's health system and contributes significantly to the overall social and economic development of the community[162].

The community trust in, and regular use of, primary healthcare in Australia, particularly general practice[163], supports inclusion of social prescribing as an adjunct to clinical care. Frequent users of primary care such as those with chronic conditions, older people and those experiencing loneliness are most likely to have their health adversely affected by lack of community support and to be likely to benefit most from access to social prescribing.

In addition, integrated, coordinated team-based multidisciplinary care is considered a hallmark of contemporary, high quality primary healthcare[164]. Successive national health reviews commissioned by successive governments over the last four decades [56], including, most recently, the Strengthening Medicare Taskforce[165] have recommended reform initiatives to achieve this.

Recognising the impact that the social determinants of health have on health and wellbeing outcomes has widened the conceptualisation of multidisciplinary care[166]. It is increasingly commonplace to think in terms of healthcare or medical 'neighbourhoods' that include non-clinical workforces such as service connectors, care finders and lifestyle coaches as part of the extended care team. The NSW Agency for Clinical Innovation (ACI) is partnering with PHNs and LHDs to support the development of three local healthcare neighbourhoods – defined as all the health and social services in a specific geographic area and the people who use those services[167].

Developments towards establishment of extended multidisciplinary teams and 'health-with-social-care neighbourhoods' further demonstrate the case for implementation of social prescribing in the Australian primary healthcare system.

The following is an overview of the current policy context that supports social prescribing, drawing on relevant global, national and state level developments and highlighting the merit of including social prescribing as a component of primary healthcare in Australia.

3.1 Global context

The World Health Organisation's (WHO) *Declaration of Alma-Ata* in 1978 was the first major global statement that signalled the centrality of comprehensive primary healthcare to the protection and promotion of health. Additionally, the Declaration recognised the links between universal primary healthcare, social care systems and better health and social outcomes. The Declaration described the attainment by all peoples of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life as a key goal. Importantly, it stated that primary healthcare was central to attaining this target[162].

A further WHO publication, the *Framework on integrated, people-centred health services,* followed in 2016[168].

The framework outlines five interdependent strategies:

1) empowering and engaging people and communities;
2) strengthening governance and accountability;
3) reorienting the model of care;
4) coordinating services within and across sectors; and
5) creating an enabling environment.

Attaining these five strategies cumulatively will help to build more effective health services – and lack of progress in one area will potentially undermine progress in other areas – underscoring the reasons why a whole-of-system approach to social prescribing is advisable[168].

The principles in the WHO 2016 framework reinforce findings from a 2015 comparative study of Australia's health care system *Reviews of Health Care Quality: Australia 2015: Raising Standards*. Undertaken by the OECD, the review found that the Australian healthcare system was "too complex for patients". The review recommendations emphasised the need for simpler and more coordinated pathways for patients with chronic conditions, greater focus on improving the quality of outcomes across all sectors and the need to strengthen the primary care sector[169].

With the exception of the UK, social prescribing has emerged in healthcare in recent years and few countries have specific policies or frameworks. Both the NHS in England and in Wales have established policy frameworks that encompass social prescribing. NHS England's *Long Term Health Plan* includes provision of Universal Personalised Care, a comprehensive model for a more personalised approach to health and social care so that people have choice and control over their mental and physical health. Universal Personalised Care includes six, interrelated components, one of which is social prescribing[126]. The Welsh *National Framework for Social Prescribing* sets out the government's commitment to social prescribing and the core characteristics of a model for implementation in local communities and within primary healthcare[2].

Several countries also have 'meso' or similar forms of organised structures set up for the purposes of better integrating care and/or service systems. These include the UK's Integrated Care Systems (ICSs)[170] and PCNs[171] and PHNs in Australia[172].

3.2 National policy environment

The implementation of a national social prescribing program as a preventive health and social support measure would align with and complement various national initiatives, frameworks and strategies that are currently being or soon to be implemented in the Australian health policy landscape. These include:

- the *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (2020)[173];
- the NACCHO *Core Services and Outcomes Framework* (2021)[174];
- the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031* (2021)[175];
- the *National Preventive Health Strategy 2021-2030* (2021)[5];
- *Future Focused Primary Health Care: Australia's Primary Health Care 10 Year Plan 2022-2032* (2022)[176];
- *Strengthening Medicare* (2022)[165];
- the *National Health and Climate Strategy* (2023)[50];

- the *Unleashing the Potential of our Health Workforce - Scope of Practice Review* (2024)[177];
- the *Review of General Practice Incentives - Expert Advisory Panel Report* (2024)[178]; and
- the *National Suicide Prevention Strategy 2025-2035* (2025)[179].

The role of community cohesion and community supports is also recognised in steps to increase national capacity to build more resilient communities (*Strong and Resilient Communities, 2023)*[180] and in order to respond to and recover from climate-related natural disasters (*National Health and Climate Strategy, 2023* [50,181].

Several relevant policy initiatives have also been implemented in recent years across the social care, community support and disability sectors. These include the independent review of the National Disability Insurance Scheme (NDIS) and subsequent policy response from the Australian Government[182]; the 2023 aged care reforms[183]; and the introduction of the Australian Government's *Measuring What Matters* wellbeing framework (2023)[184], which centres on a more holistic and comprehensive approach to measuring population wellbeing[184].

3.2.1 Health environment

3.2.1.1 Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2023

The *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2023* (Primary Health Care 10 Year Plan) was commissioned by the Australian Government as part of its Long Term National Health Plan in 2019[185]. A steering group met between 2019-2021 to guide it's development.

The Primary Health Care 10 Year Plan calls for a short-term action (1-3 years) to "Support PHNs to develop, refine and scale evidence-based models of social prescribing and system navigation supports for at-risk and disadvantaged groups, including older Australians, veterans, at-risk young people, Aboriginal and Torres Strait Islander people, people with mental illness, people in socioeconomically disadvantaged circumstances, people with disability, people from CALD backgrounds, LGBTIQ+ people, people experiencing homelessness, people at risk of harm from substance misuse and people leaving criminal justice settings"[186]. This action is part of a broader commitment to person-centred, integrated care and aims to enhance prevention and improve health outcomes across Australia[186].

3.2.1.2 Strengthening Medicare

The Australian Government has set out its aspirations for the future of Medicare, Australia's universal health insurance scheme, spearheaded by its *Strengthening Medicare* reforms. As the Minister for Health and Aged Care indicated in a November 2023 speech, this includes a desire to ensure Medicare is more than just a safety net, by taking it beyond its roots as a universal health insurance scheme to a focus on universal healthcare. The vision is for an investment in healthcare rather than 'sick care' and an approach that looks beyond the medical to the social determinants of health[187].

In response to the *Strengthening Medicare Taskforce Report* (2023)[165], the government is implementing measures to strengthen and modernise Medicare. National Cabinet supported these measures in April 2023[188]. A primary goal is to offer more multidisciplinary team-based care by developing general practices to serve as one-stop health hubs – or patient and family centred healthcare homes. Enablers of multidisciplinary care include voluntary patient registration and more flexible funding streams for general practices. These recommendations add to recommendations of prior reviews such as the *Better Outcomes for People with Chronic and Complex Conditions* by the Primary Health Care Advisory Group (PHCAG) (2016)[189].

3.2.1.3 Unleashing the Potential of our Health Workforce – Scope of Practice Review (2024)

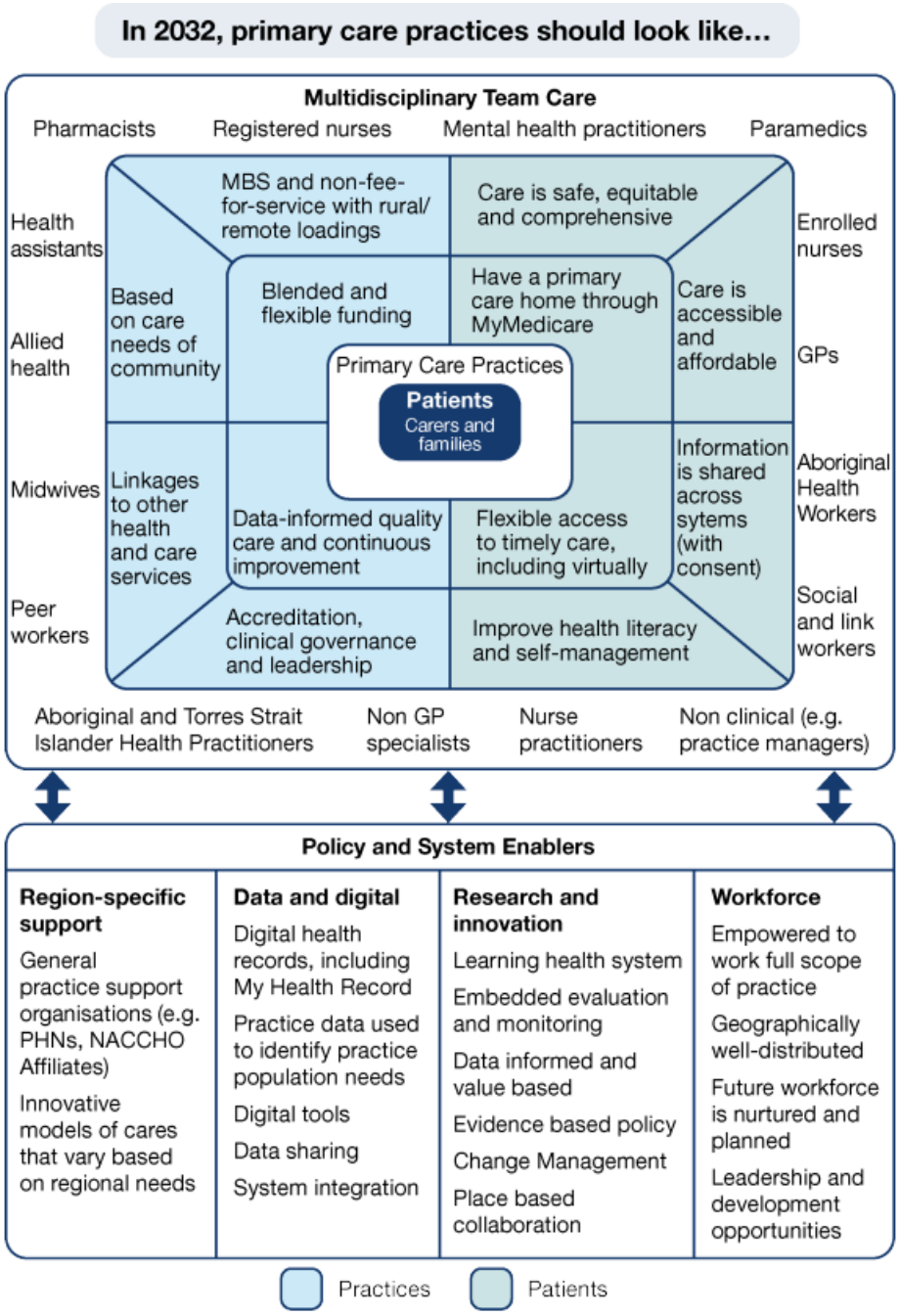
The Australian Government commissioned the *Unleashing the Potential of our Health Workforce – Scope of Practice Review (Scope of Practice Review)* to independently assess the barriers and enablers that health practitioners face in working to their full scope within primary care. The review arose from the recommendations of the *Strengthening Medicare Taskforce Report*[177]. While the *Scope of Practice Review* explored how professionals can be working to their full scope of practice, rigid service models, a dispersed primary healthcare sector and the influence of individual employers and their views have presented challenges in progressing scope of practice reform[177]. The *Scope of Practice Review* has recognised that service model reform could unlock current practice scope, as well as provide scope for new or evolved workforces to be part of future care teams[177]. This review and other developments, such as the *Eighth Community Pharmacy Agreement* (2023)[190] offer scope to consider the engagement of other health professions who deliver primary healthcare services, such as pharmacists, in a social prescribing system.

3.2.1.4 Review of General Practice Incentives (2024)

The Australian Government commissioned the *Review of General Practice Incentives* in the 2023–24 Budget. It was commissioned to provide advice on the reforms required to support the recommendations from the *Strengthening Medicare Taskforce Report*[165] and builds on the work from the *Primary Health Care 10 Year Plan*[186].

The *Review of General Practice Incentives* considered the role of a multidisciplinary primary care team, including allied health, nursing and pharmacy, among others. It suggests recommendations to redesign current general practice incentive programs to better align with *Strengthening Medicare* recommendations and to improve access to quality, multidisciplinary, patient-centred primary care[178].

The recommendations included enabling care teams within general practice with a minimum ratio of 1:1 GPs to other healthcare professionals to create multidisciplinary teams by 2032. Link workers and social prescribing were identified as a way to enhance the general practice multidisciplinary team. Funding that helps to locate link workers in practices would assist in achieving this goal. The below figure is ‘figure 1’ from the *Review of General Practice Incentives,* Long-term vision for practices and patients[178].



3.2.1.5 Preventive health and health literacy

The *National Preventive Health Strategy 2021-2030* (the NPHS)[5] considers social prescribing and enhanced referral pathways to community services as a means to improve health and wellbeing. The NPHS recognises social prescribing as a promising prevention tool and proposes that such arrangements be embedded in the health system at a local level as a policy goal to be achieved by 2030. A subsequent federal budget measure provided funding for this national feasibility study to examine contemporary evidence and suitable models[191].

The *Australian National Preventive Health Strategy 2021–2030* (the NPHS) recognises that "communities have the skills and ability to take the lead in prevention action"[5]. Community participation is one of seven principles of the NPHS, aiming to have all communities engaged in preventive health across the life course for all individuals. The NPHS envisages place-based and co-designed approaches led by communities, to empower and support individuals and to promote equitable access to health care that is tailored to diverse community needs. Social prescribing is proposed as a means to develop enhanced referral pathways to community services, embedded in the health system at a local level, to focus on self-care support and improve health and wellbeing[5].

The NPHS also committed to the development of a *National Consumer Engagement Strategy for Health and Wellbeing* and a *National Health Literacy Strategy*[5]. The *National Consumer Engagement Strategy for Health and Wellbeing*[192] was launched in 2025. There is an opportunity to 'knit' together the themes and priority afforded to improved consumer engagement in health, health literacy and self-care under the NPHS in a national approach to social prescribing.

3.2.1.6 Review of the National Health Reform Agreement Addendum

Reporting in October 2023, the *Mid-term Review* of the National Health and Hospital Agreement (NHHA) Addendum 2020-2025 made forty-five recommendations to strengthen and future-proof the health system. The review concluded that there are significant opportunities to broaden the scope of the Agreement to take a whole-of-health-system view. Better managing the interface between care sectors, integrated care and the need to accelerate action on the NHHA Long-Term Health Goals, including health literacy and prevention and wellbeing, are specifically mentioned. Another major conclusion centred on the scope for the role of local hospital networks (LHNs), PHNs and ACCHSs to be reinvigorated and authorised with flexible funding to support local initiatives[173].

With the umbrella of the NHHA arrangements in mind and recognising the gains to be made by levels of government working in cooperation, several jurisdictions have embarked on agreements to facilitate co-operation and a 'one health system' mindset, with some more advanced than others. For example, NSW has a Joint Statement between the NSW Primary Health Network, NSW Health and the Australian Government Department of Health and Aged Care setting out governance arrangements and areas for joint work[193]. Such cooperative arrangements provide 'ready-made' architecture for integrated health and social care initiatives requiring the cooperation of governments to have optimal implementation.

3.2.1.7 Mental health and suicide prevention

The Australian Government has a number of major mental health programs, including *headspac*e[194], a youth mental health service rolled out through PHNs; the *Better Access* initiative[195] which is principally funded through the MBS; and several programs intended to put in place 'stepped care' primary mental health services in each PHN region. An independent evaluation of the *Better Access* initiative showed that, while the scheme had broadened access to mental health services, it is not delivering for all Australians equally[196]. The government's response to the evaluation was released in August 2024. There is arguably a strong place for social prescribing in future stepped care mental health arrangements.

The *National Suicide Prevention Strategy 2025-2035* supports integration of social prescribing into healthcare with a recommended action to design, trial and evaluate a primary care model of social prescribing for people with suicidal thoughts and behaviours[179].

3.2.1.8 Other relevant issues: health and climate change and digital health

By increasing social connection, social prescribing has the potential to strengthen community resilience and local health systems, playing a vital role in meeting the growing need for climate

change-related emergency preparedness and recovery strategies[32,197,198]. This is evidenced in the *National Health and Climate Strategy (2023)*[50] and the Health in All Policies approach launched at the 28th United Nations Climate Change Conference (COP28)[199].

A systemic approach to social prescribing can both contribute to and be digitally enabled in line with the *National Digital Health Strategy* (2023)[200]. This is particularly the case concerning two of the four change enablers the National Digital Health Strategy identifies:

- a digitally ready and enabled health and wellbeing workforce, and
- informed, confident consumers and carers with strong digital health literacy.

A digital maturity lens should feature in social prescribing implementation. This could be through enabling software systems for care planning, screening and assessment; interactive, real-time online directories to support referral; and/or virtual modes of service delivery such as the use of nudge messaging, chatbots and the like to help reinforce and encourage the uptake of social prescriptions.

3.2.2 The macro environment, delivery infrastructure and the wider care and support economy

3.2.2.1 National Disability Insurance Scheme (NDIS)

The NDIS provides personalised care for people with disability, their families and carers. The introduction of the NDIS signalled a shift towards a more consumer-directed model of care in which participants play an active role in deciding their support needs. Twenty-six recommendations were made and a five-year transition plan set out from the review of the design, operations and sustainability of the scheme, *Working together to deliver the NDIS (*2023)[182].

Key recommendations were that the NDIS should be part of a wider system that supports people with disability, and that the government should put more money into home and community supports outside of the NDIS. The former Minister with responsibility for the Scheme has publicly stated that it shouldn't be a situation of "NDIS or nothing" for people with disabilities. However, the current availability of services outside the NDIS is low. A 2024 report, *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme (NDIS),* estimated a significant unmet demand for psychosocial supports outside the NDIS and other government-funded programs, including housing, social interaction and education[73].

This direction for disability services presents the scope for social prescribing to be considered as an essential part of new/reformed service scaffolding necessary to support the future of a more targeted, sustainable and responsive NDIS[201].

3.2.2.2 Measuring What Matters

The Australian Treasury has released *Measuring What Matters (2023)*, Australia's first national wellbeing framework, to help better track economic and social outcomes[184]. Health is one of five wellbeing themes within the framework which includes 50 indicators to measure how we are faring, including measures of health and social cohesion. Social prescribing could contribute to many of the indicators, including mental health and access to care and support services. Several Australian jurisdictions, such as the Australian Capital Territory, also have wellbeing frameworks[202].

3.2.2.3 Place-based approaches in the community sector and primary health care

The Australian Government is also building system capacity in other sectors to enable effective, joined-up approaches. The Department of Social Services (DSS) undertook preliminary consideration of a National Centre for Place-Based Collaboration (the Nexus Centre), recognising that the 'right' approach is one that reflects the needs and local arrangements that work best for individual

communities. After this foundation work, DSS, with six philanthropic partners, established Partnerships for Local Action and Community Empowerment (PLACE). PLACE is a national organisation established to address social and economic challenges in communities by supporting community-led, place-based approaches[203].

DSS is also working on developing a stronger, more diverse community sector (*Stronger, more diverse and independent community sector, 2023)* to help ensure Commonwealth grant funding reflects the real cost of delivering quality services and that there is diversity among community service organisations[204].

PHNs have been in place since 2015 and are being used to commission and coordinate a broad spectrum of Commonwealth-funded primary health services. They are also well-placed to be agents for integration and system stewardship and to be custodians of significant knowledge about the service architecture and community health needs in their catchment areas. This positions them to play a role in social prescribing implementation. A number have already commissioned social prescribing pilots and are evaluating them. The potential for PHNs to reshape health services through the implementation of new funding models and new workforce roles has been emphasised by the Grattan Institute in its report *A new Medicare: Strengthening general practice (2022)*[205].

There is a strategic alignment and a clear place for social prescribing services under these policy agendas. Social prescribing can play a practical and immediate role as a service designed to address the social determinants of health, better integrate care, reduce health socioeconomic inequity and contribute to a productive society.

3.3 Independent national reviews and think tanks

Many of the healthcare challenges that current policy developments are beginning to address were first identified in major independent national reviews commissioned by previous governments, as well as independent inquiries by bodies such as the Productivity Commission, CSIRO and various think tanks. As summarised in *Australian Health Services: too complex to navigate* (2019), a review of the national reviews of Australia's health service arrangements, all have made contributions to the national discussion[56]. Collectively, they focus on a consistent theme: the fragmented, disparate nature of Australia's healthcare services at all levels. These include the disjointed responsibilities of various tiers of government, fragmentation of the scope to improve planning and coordination between the two main 'meso' structures (LHNs and PHNs and their predecessors) and delivery of siloed care within and across care settings. These reviews have provided a solid roadmap for how to improve current arrangements to provide systematically, effectively and efficiently for chronic health conditions, their prevention, treatment and management.

The final report of the National Health and Hospital Reform Commission (NHHRC), *Healthier Future for All Australians (2009)*[206], and *Shifting the Dial: 5 year Productivity Review* (2017) by the Productivity Commission are particularly relevant to the 'bridging' role social prescribing could play to better link health and social care services for better health outcomes[207]. Their focus on enhanced and strengthened primary healthcare services, more locally flexible and integrated primary care and person-centred results aligns with key themes consistently raised in consultations for this feasibility study. The Productivity Commission recommended more nimble funding arrangements at the regional level to enable bespoke, place-based and co-designed responses to improving population health and managing chronic conditions. Connecting care was one of four reform themes recommended by the NHHRC, with an emphasis on the benefits of comprehensive care that is characterised by restoring and maintaining better health[206,207].

A policy issues paper, *Self-Care for Health: a national policy blueprint* (2020), by the Mitchell Institute at Victoria University was launched by the then Health Minister, the Hon Greg Hunt in 2020. The blueprint was developed by a network of over 50 experts, including academics, health professionals, healthcare consumers and other self-care, chronic disease and health policy experts. The paper makes the case for new policy to promote and expand the role of self-care in the Australian health system. Based on the evidence of what works, the blueprint presents a suite of priority policy proposals for implementation in Australia to support self-care through health policy and practice. The blueprint argues that enabling people to be active partners in healthcare through a national approach would contribute significantly to preventive healthcare. Social prescribing provides a scaffold that would promote and support self-care in health[208].

3.4 Aboriginal and Torres Strait Islander Community Controlled Health Services

Social prescribing as an integrated, holistic approach to improve health and wellbeing aligns with the description of Aboriginal health in the National Aboriginal Community Controlled Health Organisation (NACCHO) Constitution.

> *"Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life."*[10]

NACCHO provides an online *Connection, Strength and Resilience* portal, providing resources to ACCHSs to support resilience and reduce social and emotional harms to Aboriginal and Torres Strait Islander people. Resources include *Stay connected: social and emotional wellbeing resources*; a self-care toolkit; and *Take a Step* resources to empower Aboriginal and Torres Strait Islander young people to take charge of their social and emotional wellbeing. Whilst not using the newly emerging term or formal arrangement of social prescribing, these resources are consistent with the aims of the structured approach of social prescribing services to recognising and responding to social needs that impact on a person's health and wellbeing[209].

The NACCHO *Core Services and Outcomes Framework* (2021)[210] outlines the model for Aboriginal and Torres Strait Islander Community Controlled comprehensive primary healthcare. The framework presents 'what' core services ACCHSs will provide, and each individual ACCHS determines 'how' they will offer those core services. ACCHSs provide a comprehensive model of primary health care that includes a focus on the social determinants of health. This is particularly embedded in the *Community health promotion and empowerment* domain of the Framework. ACCHSs promote social cohesion and social capital within their communities, addressing immediate healthcare needs and advocating for and promoting change in the structural determinants of health equity. ACCHS activities include building partnerships across sectors to enable healthcare clients to access services that could improve their social circumstances, including partnerships to improve early years learning and development support; to improve access to affordable housing and to develop youth support services[211]. ACCHSs provide primary healthcare across the lifespan and, in line with the NACCHO definition of Aboriginal health, address the wider determinants of health, particularly socioeconomic factors.

The AIHW describes good health for Aboriginal and Torres Strait Islander people as a holistic concept that is more than the absence of disease or illness. It includes physical, social, emotional, cultural and spiritual wellbeing, for both the individual and the community[212]. Social and emotional wellbeing is the foundation for physical and mental health that recognises that a person's wellbeing is

influenced by the social determinants of health. For Aboriginal and Torres Strait Islander people, these have largely arisen from the inequity of government policies, institutional racism, the effects of colonisation and other past events[213].

The consultations for this study heard that 'social prescribing', not by that name, is core business for ACCHSs and that implementation of social prescribing within Australian primary healthcare should recognise, respect and support the distinct and inherent importance of social connections and social cohesion in Aboriginal health care.

4 Medicare Benefits Schedule (MBS) General Attendance items

4.1 Bulk billing rates and recaps

Under current Medicare Benefits Schedule (MBS) general practice funding arrangements, GP screening or assessment for non-clinical needs with provision of a social prescription would most likely be billed under General Attendance items (23, 36, 44, 123). These items range from 6-minute consultations to 60+ minute consultations. The following figure presents the current remuneration rates for the General Attendance item by appointment length. It illustrates the overall decrease in remuneration per hour for longer appointments under these items.

Duration	MBS item + bulk billing incentive	Rate per minute / per hour	Compensation compared with a six minute consult
6 minutes	$41.40 + $20.65 = $62.05	$10.34 per minute. $620.50 per hour.	Pays **100%** the rate of a 6 minute consult
12 minutes	$41.40 + $20.65 = $62.05	$5.17 per minute. $310.25 per hour.	Pays **50%** the rate of a 6 minute consult
18 minutes	$41.40 + $20.65 = $62.05	$3.45 per minute. $206.83 per hour.	Pays **33%** the rate of a 6 minute consult
24 minutes	$80.10 + $20.65 = $100.75	$4.20 per minute. $251.88 per hour.	Pays **41%** the rate of a 6 minute consult
30 minutes	$80.10 + $20.65 = $100.75	$3.36 per minute. $201.50 per hour.	Pays **32%** the rate of a 6 minute consult
36 minutes	$80.10 + $20.65 = $100.75	$2.80 per minute. $167.92 per hour.	Pays **27%** the rate of a 6 minute consult
42 minutes	$118.00 + $20.65 = $138.65	$3.30 per minute. $198.07 per hour.	Pays **32%** the rate of a 6 minute consult
60 minutes	$191.20 + $20.65 = $211.85	$3.53 per minute. $211.85 per hour.	Pays **34%** the rate of a 6 minute consult

Figure 3: Table of remuneration for MBS General Attendance items

While screening may be achievable in short consultations, longer consultations would be required to undertake comprehensive non-clinical needs assessments. However, with the well-known demand and cost pressures on general practice[96], GPs and practices are unlikely to be able to increase the proportion of long consultations they provide due to the overall decreasing remuneration rate per hour for longer appointments.

4.2 Options for integrating social prescribing screening, assessment and referral into existing or new MBS items

To engage GPs and general practice teams in undertaking non-clinical needs screening/assessments and referrals, appropriate funding arrangements should be established. This has been recognised in the Review of General Practice Incentives[178]. There are various options to enhance the assessment or screening for social care and non-clinical needs within the primary care system. One approach would be to create a new MBS item specifically for development of a social care plan. Alternatively,

within current funding arrangements, screening, assessment and management of non-clinical needs could be integrated with existing MBS items, such as GP chronic condition management plans, GP mental health treatment plans or Health Assessments. This section provides a brief analysis of the benefits and issues related to each of these options.

Box 9: MBS options to enhance the assessment or screening for social care and non-clinical needs in primary care

Option	Benefits	Issues
Establish a 'social care plan' • Funding mechanisms analogous to existing GP chronic condition management plans and GP mental health treatment plans.	• Creates a specific focus on social non-clinical needs with a specific MBS item.	• May require an additional financial incentives. • Requires an engagement strategy to advise and encourage GP uptake of new MBS item. • Requires additional provision to enable referral to a new workforce role not requiring registration with AHPRA.
Inclusion in established plans • Adding social needs assessment to existing GP chronic condition management plans and GP mental health treatment plans.	• Integrates the assessment into well-established MBS items. • Referrals to social prescribing services would be additional to those to allied health services and funded through direct social prescribing service funding arrangements.	• Requires changes to Medicare descriptors. • Requires additional assessment time with a commensurate increase in Medicare fees for these plans. • Requires additional provision to enable referral to a new workforce role not requiring registration with AHPRA.
Expanded eligibility for Health Assessments (refer appendix 5) • Expanding the population eligibility for Health Assessments, utilising the existing 707 Medicare item description and adjusting the other time-tiered Health Assessment items to include social and non-clinical needs assessments and referral.	• Utilises established MBS items.	• Requires expansion of Health Assessment eligibility criteria. • Requires additional assessment time with a commensurate increase in Medicare fees for these items. • Requires provisions for regular review throughout the period of the plan. • Requires additional provision to enable referral to a new workforce role not requiring registration with AHPRA.

4.2.1 Health Assessments:

The Health Assessments MBS item is a specific example of an existing item that could be adapted to allow inclusion of a social needs assessment and social prescribing referral within general practice. The following box outlines the current Health Assessment and the potential enhancements that could be made, in line with the General Practice and Primary Care Clinical Committee, to accommodate screening, assessment and referral for social prescribing.

Potential use of Health Assessments (HA) (Item numbers 701, 703, 705, 707)

What happens now:

Comprehensive health assessments (HA) are funded under the Medicare Benefits Schedule (MBS) for selected patients. The HA MBS items allow patients, practice nurses and GPs to share the work involved in producing a HA. Item numbers 701, 703, 705, 707 are based on time taken for the HA (nurse +GP) reflecting complexity.

Who is eligible now:

- 40-49 year olds at risk of developing Type 2 Diabetes Mellitus
- 45-49 year olds at risk of developing chronic disease
- People 75 years and over are eligible for an annual HA
- People with Intellectual disability
- Refugees and humanitarian entrants
- One-off veteran's health check
- Permanent resident of Residential Aged Care Facility

Components of HA

a) comprehensive information collection, including taking a patient history; and
b) an extensive examination of the patient's medical condition and physical function; and
c) initiating interventions and referrals as indicated; and
d) providing a basic preventive health care management plan for the patient

Potential enhancements of HA (as per General Practice and Primary Care Clinical Committee (GPCCC) and MBS Review taskforce findings[214], affirmed through consultations) would comprise:

- Additional eligibility criteria to include practical, social or other non-clinical needs affecting health and wellbeing.
- Increased access through biennial (every two years) assessments for all age adults
- Components enhanced to include social needs and social plan providing:
  a) Comprehensive information collection, including taking a patient history. To identify preventive needs (as per Red Book, RACGP), medical conditions, physical function, and social risks amenable to social prescribing
  b) Examination and function (unchanged)
  c) Initiating of interventions and referrals including to link worker as appropriate
  d) Preparing preventive health plan (unchanged).

* Item 715 provides for health assessment every 9 months for a patient who is of Aboriginal or Torres Strait Islander descent

5 Examples of link worker funding in Australia.

For this feasibility study, two well-established programs in eastern Australian states have generously provided data to facilitate some understanding of the likely range of, or average, costs per client. Estimates are based on operational cost data provided to the project team by the services. The data can only be considered indicative, as these costs are specific to the programs established by these service providers and are determined by the external funding available to them for provision of their programs.

The two services provide for different population groups, ranging from rural and regional communities to inner metropolitan communities. Both programs are available to adults aged 18 years and over.

One program delivered social prescribing support through link worker assessment and facilitated community connection for approximately 220 individuals over a 12-month period. Outcomes were measured using two validated tools: the EQ-5D-5L, a self-assessed, health related, quality of life questionnaire, and the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). Results showed that nearly three-quarters of participants experienced significant improvements in their wellbeing based on these measures.

The program's costs over a 12-month period were approximately $250,000, inclusive of salaries and wages, travel time, work equipment and overheads. Additional costs included promoting the service within the community and supporting partnerships between the social prescribing service, referring primary health care providers and with community organisations as well as other operating costs.

Based on this mode, the estimated cost of delivering a link worker to approximately 220 clients annually in a mixed rural and urban community is around $300,000, an average of ≤$1360 per client per year. Data from similar services could inform the development of a practice-load capacity measure to determine the optimal number of clients a link worker can effectively support. This would help ensure sustainable service delivery, maintain a manageable workload for link workers and prevent delays or negative outcomes for individuals referred to the program.

A second program in a low socioeconomic urban area delivered social prescribing support through link worker assessmentand facilitated community connection for approximately 245 individuals over an 18-month period. Outcomes were measured using several scales, including Patient-reported Outcome Measure Information System Global 10 (PROMIS- Global-10), SWEMWBS, UCLA-3 and various other self-report items. See Appendix 6.1 (below)for measurement tools. Around half of the cohort of clients who completed both pre- and post- outcome measures (n=186) were found to have significant improvements in overall self-reported health, including both mental and physical health. A significant proportion reported a reduction in loneliness and social isolation.

Program workforce costs over a 12-month period were approximately $500,000. This included salaries and wages encompassing 3.6 FTE of a 'link worker' role delivered by a nurse, social worker, counsellor or pharmacist. Additional costs incurred included work equipment, overheads, promoting the service within the community, supporting partnerships between their service and community organisations. As this was integrated in a community health service, most of the overheads and associated costs were not specified for this program.

Given the lack of data on non-workforce costs for this program, it is not possible to use this data to estimate the likely overall cost of providing a social prescribing service. Within that significant limitation, the data available suggests that potential workforce costs per participant supported by a link worker is around $1350 - $1500 per annum, without inclusion of additional non-salary and other

overhead costs. These potential costs per participant need to be considered in light of the project estimates of the social return on this investment of social prescribing.

5.1 Measurement tools used in social prescribing program in Melbourne's West

The following table outlines the measurement tools used by the social prescribing program from Box 9: A case study of a social prescribing pilot in Melbourne's West in the report.

Outcome areas	Key domains	Measurement tools
Physical health	Physical health status	Patient Reported Outcome Measure Information System – Global 10 (PROMIS Global-10)
	Health related quality of life	PROMIS Global-10
Mental health	Mental health status and experience of symptoms/problems	PROMIS Global-10
	Perceived quality of life	PROMIS Global-10
	Mental and emotional wellbeing (including indicators of positive feeling and self-esteem)	Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)
Social health	Loneliness	UCLA-3
	Social connectedness/isolation	Steptoe Social isolation index Number of group memberships[1]
	Social health	PROMIS Global-10
Health confidence	Confidence to self-manage health problems (proxy for concepts of patient engagement and self-efficacy)	My Health Confidence
Client goals	Client's program participation goals	Self-reported goals and assessment of the degree of progress or goal attainment that has occurred[1]
Utilisation of health services	Recent use of primary care services	Frequency in past three months of GP-visits; Attendance at Emergency Department; Unplanned nights in hospital[1]

[1] This measure uses a non-validated tool

6 Examples of community resources and assets

In the context of this report, community assets refers to the broad range of services, initiatives, programs and other community-based interventions that individuals can be referred to through social prescribing to address non-clinical needs and improve health and wellbeing. These include neighbourhood houses; arts and crafts groups; or community walking, gardening or similar groups. Community assets can also include community infrastructure relevant to social prescription activities (e.g. parks, sports facilities, libraries, community centres etc.). Community assets will vary between communities and locations. The table below outlines some other examples of what could be considered social prescribing community assets.

Table 1: Examples of community assets individuals can be referred to through social prescribing

Support, activity or program (asset)	
University of the Third Age (U3A)	U3A are voluntary, non-profit organisations offering low-cost educational and community-building opportunities for older people. Originally developed in France, the concept has spread world-wide with the first Australian branch starting in 1984. U3A's require a membership fee (set by each branch), usually between $20-60 per year. Reasons for joining a U3A include joining a community, meeting new people, finding a passion and finding new interests[215].
Libraries	There are over 13,000 libraries in Australia including public libraries, school libraries, university libraries and specialist libraries (e.g. health and law libraries) [216]. Libraries offer inclusive programming, digital and print resource access, volunteering opportunities and a place to connect as well as often having strong links and knowledge of the community and community groups and services[217].
Dead or Deadly program	Dead or Deadly program is a holistic health program designed to enhance health, wellbeing and cultural connection of Aboriginal women. When first set up, it initially focused on four main areas: smoking cessation, nutrition/diet information, chronic disease prevention and management and physical activity/exercise. The program now also includes yarning groups, holistic health and lifestyle medicine. The program is designed by and for Aboriginal women[218,219].
Men's Sheds	Men's Sheds are community-based, non-profit, non-commercial organisations accessible to all men. Men's Sheds primary activity is to provide a safe and friendly environment where men can work on meaningful projects. There is significant diversity in Men's Shed, including some restricted to Aboriginal and Torres Strait Islander men for cultural purposes and those open to female members, sometimes called 'Community Sheds'[220].
Neighbourhood Houses	Neighbourhood Houses are community-based organisations that offer a range of services and activities for their patrons including connections to the local community. Neighbourhood Houses are also known as community centres, learning centres, community houses or neighbourhood centres. Each Neighbourhood House has a unique offering, with place-based social

	infrastructure guided by community development and community need. There are over 1000 Neighbourhood Houses in Australia with varying densities between states. For example, Victoria has over 400, NSW has around 180 and Tasmania has 35[221,222].
rrala milaythina-ti (Strong in Country)	The *rrala milaythina-ti* project provides immersive trips across Lutruwita (Tasmania) for Aboriginal community members to access Country. It includes walks, camps and heritage excursions. It was developed to showcase that Aboriginal people are mentally, physically and spiritually stronger 'On Country'. The program improved health and wellbeing and created ongoing relationships between Aboriginal Community members[223,224].
Council run programs	Many councils around Australia run or host social groups for residents to join including women's groups and senior citizen centres or hubs.
parkrun	parkrun is an international community event that takes place in involved communities every Saturday morning. It is a free, 5km, community event where individuals can walk, jog, run, volunteer or spectate. There are over 500 parkrun events around Australia[225].
Heart Foundation Walking program	Heart Foundation Walking is a free walking program with social and motivational support. It is a social prescribing opportunity for GPs to support patients to achieve the nationally recommended levels of physical activity and improve their cardiovascular health. Patients can self-refer or be referred by a health professional to the program, where they have the option to join a walking group in their local community or sign up for a six-week Personal Walking Plan[226].
Life Activities Clubs	Life Activities Clubs are social groups for older adults (over 55 years) in Victoria that provide education and social, physical and recreational activities for members[227].
Community gardens	Community gardens and city farms are community-based and led garden spaces where people come together to grow food, learn skills and connect. Most community gardens are volunteer-based and are either free or have a small-fee to join[228].
Asylum Seeker Resource Centre (ASRC)	Beginning as a local community-funded food bank, the ASRC is now a human rights organisation providing support and resources to people seeking asylum. Based in Melbourne's West, the ASRC runs a Foodbank and community kitchen and provides healthcare, social care support, education and training and employment pathways, among other services[229] .

8 The likely benefit of investment in social prescribing: a social return on investment analysis

(note: to align with the associated report, this is referred to as appendix 8. There is no appendix 7 in this publication)

This section explores the potential public value of social prescribing program, as measured by the social return on investment (SROI). The nature and magnitude of the SROI depends upon the target population, the specific health and social conditions addressed and the program effectiveness in improving individual health and wellbeing. The analysis begins with an overview of the possible costs and outcomes from a social prescribing program, followed by an outline of the SROI methodology. It then presents from three social prescribing programs in England and Wales. The section concludes with an estimated SROI for an Australian social prescribing program and documents the data requirements for future economic evaluations of social prescribing programs.

8.1 Assessing the social return on investment of social prescribing programs

8.1.1 Delivery costs

Implementation of a social prescribing program at the local level involves a range of delivery costs , ranging from the value of health professional time spend referring a potential participant to a social prescribing program, to the cost of social activities undertaken by the participant. The most significant individuals costs is expected to be the time a link worker spends with each participant to assess needs, develop personalised plans and coordinate an appropriate pathway to services and supports.

Possible delivery costs from a social prescribing program that may be incorporated into an SROI include[230]:

- Referral to social prescribing program (e.g. health professional time)
- Social activities
- Support services

8.1.2 Outcomes

The overall goal of social prescribing is to improve participant health and wellbeing. Improvements in these two dimensions are expected to have a range of tangible and intangible outcomes. Tangible outcomes are straightforward to value, as they are based upon readily measurable financial data such as costs associated with health care system usage. In contrast, intangible outcomes are not readily valued.

Based upon the existing evidence tangible outcomes in social prescribing include reduced utilisation of the health care system, and its associated costs. This is expected to include reduced appointments with medical and allied health professionals, alongside reduced emergency department presentations and pharmaceutical usage. The costs of this health care system utilisation could be incurred by the Australian, relevant state/territory government, or the individual themselves. In some instances, participation in social prescribing could lead to an increase in health care system utilisation, due to previously undiagnosed health conditions being identified.

Other tangible outcomes that may arise from social prescribing include the value of increased labour output associated with participants either re-entering the labour force or staying in the workforce longer, working increased hours, or reduced presenteeism (when someone attends their workplace, but is not working at full productivity).

Intangible outcomes are, by their very nature, difficult to value as they are not directly part of the market economy. However, these outcomes have a social value, and are important to measure and, to the extent possible, value. In the case of social prescribing, these comprise improved physical and mental health, which then lead to the tangible outcomes discussed above. Other intangible outcomes include increased social engagement and connections, participation in education and training (which have then led to a tangible increase in labour output), improved motivation, patient empowerment to manage health and other wellbeing benefits.

There may also be intangible outcomes associated with some of the tangible outcomes from social prescribing. For example, a reduction in health care system utilisation may potentially reduce pressure on both the system as a whole and upon individual health care staff. This may result in improved wellbeing among the health system workforce, leading to improved staff recruitment and retention.

The diverse outcomes potentially attributable to social prescribing mean a wide range of data is required to assess its effectiveness and outcomes, along with collecting data for a comparator.

Possible outcomes from a social prescribing program that may be incorporated into an SROI include[230]:

Tangible

- Reduced health care system utilisation and costs, including:
    - GP appointments;
    - allied health professional appointments;
    - emergency department presentations; and
    - pharmaceuticals.
- Labour output from:
    - increased employment rate;
    - reduced absenteeism; and
    - reduced presenteeism.

Intangible

- social engagement and connections;
- participation in education and training;
- improved physical health;
- improved mental health;
- motivation;
- other improvements in wellbeing; and
- patient empowerment to manage health.

8.2 Economic evaluation of social prescribing programs

There is a well-developed process for undertaking economic evaluations of health care interventions[231]. However, the features of a social prescribing program mean the 'standard' economic evaluation methods, such as cost-effectiveness analysis, may be inappropriate for assessing social prescribing with its wide range of outcomes detailed above. At best, the 'standard' economic evaluation approaches may be costly and difficult to undertake. The challenges associated with the economic evaluation of social prescribing interventions are articulated in Wildman & Wildman[54] including:

- multiple health and non-health outcomes;

- a wide range of services/people are involved in program delivery;
- difficulty in attributing outcomes to the social prescribing program; and
- program participants may have complex needs.

For example, an application to the Pharmaceutical Benefits Advisory Committee requires an economic evaluation of the substitution of a proposed medicine for its main comparator. This economic evaluation can be either a cost-effectiveness analysis or a cost minimisation study. A cost-effectiveness analysis requires measuring the therapeutic effects of a pharmaceutical, along with the costs to the health system. In contrast, a cost-minimisation study assumes no difference in the therapeutic benefits to a comparator, but a difference in health system costs[232].

A range of non-health care system outcomes may be derived from social prescribing, such as improved employment and relationships, and improved social engagement and motivation. These outcomes are difficult to measure and incorporate into a single measure of effectiveness and are often achieved over a longer time period[54].

In this light, a wider ranging analytical approach – social return on investment (SROI) – is better able to capture and value the range of outcomes associated with social prescribing. The key output from an SROI is the ratio:

$$\text{SROI} = \frac{(Net\ Present\ Value\ of\ Impact)}{(Net\ Present\ Value\ of\ Investment)}$$

An SROI ratio of 3:1 means a program has generated three dollars in value for every one dollar invested [233].

There is a trade-off from using the broader measurement approach of SROI, with methods "being less defined, benefits are ascribed more liberally and proxies for values are frequently used"[234].

The steps in undertaking an SROI are documented in . The investment required to implement a social prescribing program is relatively straightforward to estimate, whereas valuing the program's impact is underpinned by a range of assumptions. This is because program impacts, such as improved wellbeing, need to be 'translated' into a monetary value. This 'translation' is largely a subjective process.

Figure 4: SROI stages

Source: [234]

8.3 Existing economic evidence on social prescribing

An evidence summary prepared for the NASP in the UK identified a number of economic evaluations, however, many had limitations[53]. Further, these social prescribing programs were aimed at a variety of specific populations, limiting the ability to 'pool' findings. These evaluations did largely demonstrate a favourable SROI, noting that this may simply reflect publication bias. Three studies from the UK are summarised in *Table 2*. None of these programs included a control group.

The first study comprises a cost analysis of a social prescribing program targeting psychosocial conditions; it did not include an SROI analysis. This program sought to 'activate' program participants through therapeutic and behavioural change techniques.

The second study comprises an SROI of a general wellbeing program. Participants were supported to identify and set realistic goals associated with specific challenges in their life, and to access local community activities. This program was estimated to have an SROI of 2.9:1.

The third study comprises an SROI of a UK-wide program targeting people experiencing, or at risk of, loneliness. An SROI of 3.42:1 was estimated.

Table 2: Economic evaluation studies

Study	Context	Target population	Program description	Outcomes measured	Findings
Lynch and Jones, 2022[58] Cost analysis	Four GP practices in high deprivation areas of Wales	Psychosocial conditions: anxiety, depression, low mood, isolation, stress. Referred by GP, with no inclusion criteria. n=78 Frequent non-attenders (FNAs) (<15 GP visits in past 12 months) = 57 Frequent attenders (FAs) (≥15 GP visits in past 12 months) = 20	Two social prescribers, seeing patients over 5 month period. Mental health support programs comprising 'patient activation' through therapeutic and behavioural change techniques. Use of GP appointments and prescribed medication in 5-month period compared to previous 12 months.	GP appointments, current condition, prescribed medication. 12 months prior and post intervention. Cost impact estimated by multiplying unit costs provided in a separate costing study, by change in activity. The study did not feature a control group.	Overall reduction in GP appointments by 4.7% per participant. Annual health care saving of £78.20 per participant (all participants). Savings were only achieved in FAs. Increased expenditure in FNAs due to increased healthcare usage. It is suggested that this is due to 'Patient Activation', whereby participants are better placed to manage their health care.
Kimberlee, 2016[235] SROI analysis	Wellbeing Programme at the Wellspring Healthy Living Centre, Bristol	Residents in deprived area of Bristol, England, referred from 5 GP surgeries.	The program had two parts. Branching Out – 1 to 1 support of patients, to identify and set realistic	Wellbeing metrics: PHQ 9, GAD 7, Friendship Scale, Office of National Statistics scales – life satisfied, happy, anxiety, life worthwhile,	3 month follow up – significant average improvement on all wellbeing metrics. Change in face-to-face GP attendance compared to 12 months prior: 60%

Study	Context	Target population	Program description	Outcomes measured	Findings
		n = 128, attending 'Branching Out' 945 times in total. Aimed at improving general wellbeing.	goals related to psychosocial conditions. Access local community activities – healthy eating cooking course, health and wellbeing groups, men's groups.	GP attendance. Other impacts included harnessing volunteers, patients returning to employment and training, and resuming childcare responsibilities, suicide attempts averted, community capacity enhanced, accessing appropriate services and supports (e.g. addiction problems, debt management, anger management).	participants ↓, 14% participants↑, 26% unchanged. 17% of participants re-entered employment. SROI ratio = 2.9 : 1. The method used to estimate the value of outcomes from the program are not documented in the article, or its associated report.
Foster et. al. 2021[61] SROI analysis	National social prescribing service in the United Kingdom to support people who were experiencing, or at risk of, loneliness.	18 years or older, with referrals from any source. No specific eligibility criteria. Targeted young parents, individuals with health and/or mobility issues and people recently bereaved, retired or had children leaving home.	Up to 12 weeks of support from a link worker, alongside volunteers. Operated at 37 sites across the UK. Aimed at developing confidence to socialise and access community services. Specific focus of support	Level of loneliness. Improved wellbeing. Increased confidence. Life having more purpose. Missed healthcare appointments.	72.5% of service users felt less lonely after receiving support. Improved wellbeing, increased confidence and life having more purpose. SROI ratio = 3.42:1

Study	Context	Target population	Program description	Outcomes measured	Findings
			targeted to individual's needs.	Improved wellbeing of volunteers.	The source of outcome values used in the SROI are not detailed.

8.4 Conceptual SROI example

In the absence of any Australian SROI studies of social prescribing, an effectiveness evaluation study of a social prescribing program for injured workers has been analysed[36]. This analysis used the reported results to estimate the costs, and value the range of outcomes, of the program, leading to estimates of the SROI. These estimates are indicative only and have been developed using a range of assumptions reported in section 6.6.

The program was targeted to injured workers, and aimed to address psychosocial difficulties (including pain, distress, isolation, and unmet welfare needs). The program also sought to increase confidence and capacity to recover from injury and employment loss. The program had 200 participants aged between 27 and 71 and was delivered for a 12-week period. Participants were required to live in Greater Sydney, as well as be:

- unable to return to work after a work-related injury acquired 6 months to 3 years previously; or
- returned to work on reduced hours/duties.

Participants were also required to have been assessed by a GP as experiencing psychosocial difficulties, and likely to benefit from increased social participation.

The program was delivered by Primary & Community Care Services (PCCS), which delivers a number of social prescribing programs in Sydney and the Gold Coast[118]. These programs are predominantly locally based and seek to link program participants with a range of services.

In this program, participants were first referred to a link worker who undertook a holistic needs assessment and customised care planning. Participants were then referred to appropriate health and social services, as well as enrolled in social and therapeutic activities. There was ongoing contact between the link workers and program participants over the 12-week period.

8.4.1 Program costs

The most significant costs associated with the program were the link workers. Taking into account non-contact hours, it is assumed that a link worker spent 21 hours per participant on the program, at a cost of $2,369 per participant.

Other significant costs are those associated with participants being referred to the program, undertaking social activities and accessing support services.

Referrals can be made from a range of places, including insurance scheme agents, rehabilitation providers and general practitioners.

Activities and services provided by the program include art and craft, equine therapy, financial counselling and mental health support groups.

The total program costs are estimated as $661,936 ($3,310 per participant). These costs are all incurred during the 12 weeks of the program (see Table 12).

It is instructive to compare the costs of delivering social prescribing services to the cost of delivering standard health and medical services. Some example costs are provided below in Table 3, detailing the costs incurred for an individual attending a general practitioner (8 times a year), psychologist (10 times a year) and other allied health professional (5 times a year). Under this scenario, the total cost is estimated to be $3,640 per year. The total costs of delivering medical and health care to program participants is more than the estimated costs of the social prescribing program. It is not envisaged

that the use of these health and medical services will cease following the use of social prescribing, but based upon evidence from other social prescribing initiatives, they are expected to reduce.

Table 3: Cost of standard Health and medical services: example scenario

	Visits per annum	Cost per visit	Total annual cost
General Practitioner	8	$81	$650
Psychologist	10	$250	$2,500
One of either			
• Exercise physiologist	5	$98	$490
• Physiotherapy	5	$98	$490
• Dietitian	5	$98	$490
Total	23		$3,640

Note: The number of visits per annum are sourced from expert advice. The cost per visit is based upon pricing published by service providers (GPs, exercise physiologist, physiotherapy, dietitian), or by professional associations (psychologist).

8.4.2 Program outcomes

The key objective of the program was for participants to return to work, with increased labour output the dominant outcome. Based upon the reported results, the analysis here assumed that 12.5 per cent of participants increased their working hours by 10.76 hours a week and that this increase was maintained over a 10-year period.[2] The value generated by the additional labour has been valued at $6.96 million over a 10-year period.

Health care cost savings have also been identified, valued at $1.56 million over a 10-year period. These cost savings are counted as a benefit, and not a negative cost. A detailed breakdown of costs and outcomes is provided in the Appendix to this section.

The total estimated value of the program outcomes is $8.52 million. These total outcomes must be adjusted for what is called deadweight and attribution. Deadweight is an adjustment to reflect improvement that would have occurred in the absence of the program. This is assumed to be 10 per cent. Finally, attribution is the percent of the change in outcomes that resulted from the intervention. This is assumed to be 50 per cent. After applying these adjustments, a total outcome value of $3.17 million is estimated.

Other health and wellbeing benefits attributable to the program have not been valued. These gains are important, but difficult to value in a way that is comparable with the other costs and outcomes.

[2] These estimates take into account older participants reaching retirement age.

8.4.3 Overall Social Return on Investment

Based upon the analysis above, an indicative SROI of 5.8:1 is estimated (see Table 4 / Figure 4). This is the ratio of Outcomes: Costs and compares favourably to the three example SROI studies presented in Table 2 Even if the value of the outcomes were halved, there would still be an SROI of 2.40. This is without the inclusion of any measures of health and wellbeing improvements.

The components of the SROI calculation are reported in Table 3 detailing the costs incurred in year 1, and the outcomes over a 10-year period. This differential in the timing for costs and outcomes is due to the social prescribing program typically only being accessed over a number of months, whereas outcomes are accrued over many years.

Table 4: Cost, Outcomes and Social Return on Investment estimates

Costs (in year 1 only)		**Outcomes (10 years)**	
Referrals to social prescribing program (e.g. health professional time)	$11,476	Labour output	$6,957,427
Link worker	$473,928	Hospitalisation costs ↓	$398,784
Social activities	$69,899	Other health care costs[a] ↓	$1,161,948
Support services	$106,634	Total	$8,518,159
Total	$661,936		
		Deadweight adjustment	10%
		Attribution	50%
SROI = 5.8		Revised total outcomes	$3,171,235

Note: [a] these are assumed to be solely from reduced GP appointments.

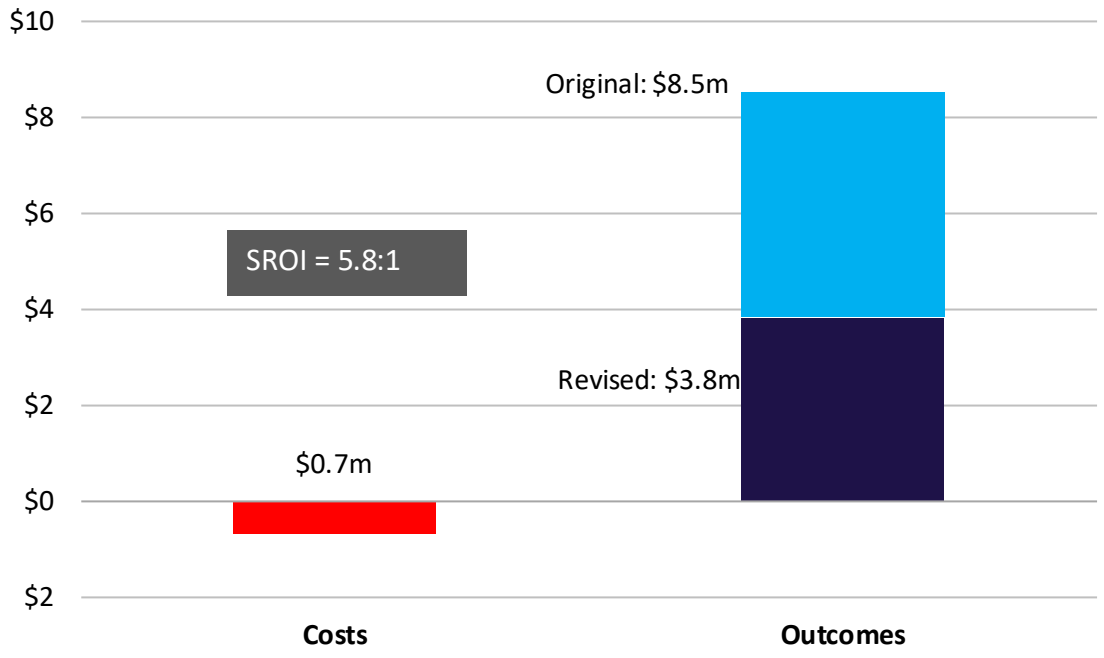


Figure 5: Cost, Outcomes and Social Return on Investment estimates

8.5 Supporting future economic evaluations of social prescribing

Undertaking an economic evaluation in the future of a social prescribing program should be relatively straightforward if planned in conjunction with an effectiveness-focused evaluation that

includes a comparator. Ideally, such an economic evaluation would comprise both a cost-effectiveness or cost-utility analysis of the type undertaken for applications for Australian Government subsidies to be on the Pharmaceutical Benefits Scheme (PBS), as well as an SROI study. As noted above, the challenge in undertaking a cost-effectiveness or cost-utility analysis is being able to appropriately capture the range of outcomes for either the effectiveness or utility metrics.

Both types of analyses would require the additional collection of data on program costs, as well as analysis that seeks to value the range of outcomes. Costs included in either analysis should be wide-ranging in scope.

The valuation of outcomes is potentially the most complex and contentious aspect of an SROI, particularly valuing health and wellbeing improvements, and attributing longer-term outcomes, such as increased labour output, to the program. This is where the inclusion of a comparator in the analysis will be beneficial.

The range of evidence required to support the implementation and ongoing development of social prescribing is detailed in Box 6. This evidence encompasses both what is required to assess the efficacy of social prescribing, in addition to being able to support economic evaluation analysis via either SROI and/or cost-effectiveness or utility analysis.

Box 10: Evidence required to support the economic case for social prescribing

Evidence objective:	Demonstrate that social prescribing is effective in improving outcomes and also estimate the associated program cost and the value of outcomes. Also required to collect identical data for the counterfactual – encompassing current practice in the absence of social prescribing.
Data requirements	Activity: Data that measures the range of activities and processes used to deliver social prescribing. Including method of referral, number of consultations, group activities, associated staffing. Also collect data to enable estimation of activity costs, including staff wages and materials. Outcomes: Data that measures the range of outcomes generated from social prescribing program, and data encompassing the range of outcomes from the counterfactual program(s).
Outcomes analysis	Statistical analysis required to identify the effect of social prescribing upon outcomes, compared to the counterfactual. It may also be necessary to estimate the longer-term outcomes associated with the social prescribing program and counterfactuals. This may need to be over a period of up to 10 years.
Valuation data	Valuation metrics that can be applied to intangible outcomes, such as improved wellbeing, to enable estimation of an overarching outcome valuation.
Economic evaluation	Following the completion of the outcomes analysis, an SROI can be undertaken valuing the effect on outcomes achieved from the social prescribing program.

Source:[236]

8.6 Assumptions for SROI

Table 5: SROI assumptions: referrals costs

	%	n	Cost per referral	Total cost
Insurance scheme agents	29%	58	$67	$3,867
Rehabilitation providers	26%	52	$67	$3,467
General Practitioners	19%	38	$102	$3,876
Self-referral	24%	48	$0	$0
Other	2%	4	$67	$267
Total		200		

Note: Distribution across referral types from Aggar et al (2020), p. 104. [36]

Table 6: Link worker costs

Hourly rate	**$112.84[a]**
Weeks of contact	12
Contact hours per week per participant	1
Non-contact hours per week per participant	0.5
Care planning (one off)	3
Total hours	21
Total cost per participant	$2,369.64
Total cost for 200 participants	$473,928

Note: [a] based on social worker salary of $1,736 per week, with 30 per cent on-costs, working 35 hours a week with a 75 per cent additional cost in overhead costs for accommodation, facilities and other expenses.

Table 7: Social activity costs

	% of participants	n	Attendance rate	Delivery Cost
Art and craft	25%	50	70%	$28,823
Yoga and relaxation	25%	50	70%	$8,316
Equine therapy	10%	20	70%	$15,960

Social groups	50%	100	70%	$16,800
Total				$69,899

Note: The delivery costs are sourced from service providers.

Table 8: Support service costs

	%	n	Attendance rate	Delivery Cost
Financial or relationship counselling	50%	100	70%	$47,393
Mental health support groups	75%	150	70%	$11,848
Housing	50%	100	70%	$15,798
Other assistance	100%	200	70%	$31,595
Total				$106,634

Table 9: Labour output assumptions

Variable	Value	Source
Change in hours worked a week attributable to program	10.76 hours	Aggar et al. (2020), p. 105 [36]
Percent returned to work at full capacity	12.5 per cent	Aggar et al. (2020), p. 105 [36]
Multiple of earnings for output value	1.89	Wages share, total factor income: Ratio[a]
Weeks worked in a year	46	

Source: 5206.0 Australian National Accounts: National Income, Expenditure and Product, Table 24. Selected Analytical Series

Table 10: Average hourly income by age

Age range	Hourly income ($)
Age 21-24	34.10
Age 25-34	38.88
Age 35-44	43.26
Age 45-54	42.26
Age 55-64	41.36

Age 65 and over	40.41

Source: Analysis of Australian Bureau of Statistics (May 2023), Employee Earnings and Hours, Australia, Table 6. [237]

Table 11: Health care system costs: Hospitalisations in year 1 only

Variable	Value
Percent of participants with hospitalisations[a]	
• Base case	28%
• After program	11%
• Change	-17%
Number of separations in year	2
Cost per separation[b]	$5,864

Source: [a]

[b] Average cost per weighted separation (2021-22), Productivity Commission (2024), Report on Government Services: 12A – Public Hospitals – Data tables, Table 12A.52. Indexation using Australian Bureau of Statistics (December 2023), 6401.0 Consumer Price Index, Australia, Table 4, CPI: Groups, Index Numbers by Capital City, Health Sydney

Table 12: Health care system costs: General practice

Variable	Value
Number of general practice consultations per annum	
• Base case	35
• After program	25.55
• Change	-9.45
Cost per consultation	$95

It was assumed that there is a progressive reduction in visits, so that by year 10, it is 72.5 per cent of the year 1 amount.

Glossary

Aboriginal Community Controlled Health Services (ACCHSs)	ACCHSs are non-government, not-for-profit organisations run by Aboriginal and Torres Strait Islander people, which provide an array of health and social care services to Aboriginal and Torres Strait Islander communities. ACCHSs emphasise the implementation of holistic, integrated and culturally safe models of care. Other terms such as Aboriginal Community Controlled Health Organisation (ACCHO) and Aboriginal Medical Service (AMS) are often used interchangeably with ACCHS[175]. In this report, ACCHSs is inclusive of the entire Aboriginal community-controlled health services sector.
Co-design	Co-design refers to an iterative and participatory engagement process in which members of the community work collaboratively with service providers, policymakers and/or other relevant stakeholders, to design new, or improve existing, services, programs and public policy. While existing definitions of co-design can vary, most emphasise a process of active (rather than passive) participation of consumers and the importance of shared decision-making in creating outcomes that are mutually acceptable to communities and service providers/program designers[238,239].
Community resources	In this report, 'community resources' is used to describe the broad range of community services, programs, activities and other supports that individuals can be referred to through social prescribing. The term also encompasses local infrastructure assets relevant to social prescription activities (e.g. parks, sports facilities, libraries, community centres etc.)[15].
Community sector	In this report, community sector is defined as the broad range of not-for-profit, non-government organisations that provide community services, programs and various other supports to individuals within the community. Community sector organisations will often undertake activities focused on community development, advocacy, addressing the wider determinants of health and/or reducing health and social inequities. They often work closely with people experiencing high levels of socioeconomic disadvantage and other priority population groups[240].
Link worker	The common title of the workforce role established in social prescribing programs that connects individuals to appropriate community resources, activities and other supports, to address the non-clinical factors which influence health and wellbeing.
Non-clinical needs	In this report, non-clinical needs are defined as the social, socioeconomic, practical, emotional, cultural and behavioural factors that influence health and wellbeing, but that are not directly related to the diagnosis or treatment of a medical condition. Examples of non-clinical needs include social isolation,

	loneliness and low health literacy, as well as behavioural factors related to the major risk factors for chronic disease (e.g. physical inactivity, unhealthy diets). Non-clinical needs also closely align with many of the factors commonly referred to as the wider determinants of health, such as socioeconomic status, housing and food insecurity, educational attainment and past experiences of trauma[4–6].
Priority population groups	There are a range of different population groups within society who experience a disproportionate burden of disease and disparities in health. The National Preventive Health Strategy 2021-2030 identifies these 'priority populations' as including, but not limited to[5,241]: • Aboriginal and Torres Strait Islander people; • culturally and linguistically diverse (CALD) populations; • lesbian, gay, bisexual, transgender, intersex, queer, asexual and/or other sexuality and gender diverse people (LGBTIQA+); • people with mental illness; • people of low socioeconomic status; • people with disability; and • rural, regional and remote populations. In this report, these groups, and others who may experience health disparities, are referred to collectively as 'priority population groups'.
Primary healthcare	Primary healthcare describes any health service that can be the first point of contact with the health system for treatment or management of non-emergency medical issues, typically outside of a hospital or specialist care setting. In the Australian context, the primary healthcare encompasses a broad range of services delivered in the community, including: • general practice; • allied health services; • oral health and dental services; • community pharmacy; • sexual and reproductive health services; • maternal and child health services; • mental health and drug and alcohol treatment services; • community health and community nursing services; and • Aboriginal Community Controlled Health Services (ACCHS)[161].
Preventive health	Preventive health is any action taken to keep people healthy and well and prevent or avoid risk of poor health, illness, injury and early death. This includes both population-level policy

	interventions and individual-based actions which aim to minimise disease burden and associated risk factors. Preventive health is of fundamental importance to overall population health and wellbeing[5].
Signposting	Signposting refers to an informal referral process in which healthcare professionals provide patients with information to help them access non-clinical, community services and support that are relevant to their health and wellbeing needs[242].
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 by co-producing a social prescription - a non-medical prescription - to improve health and well-being and to strengthen community connections"[3].
Social prescribing service	In this report, social prescribing service refers to any service or program that provides comprehensive link worker-supported social prescribing to individuals in the community. This mainly comprises the provision of link worker services but also includes working with communities and referrers to build local networks of social prescribing stakeholders.
Specialist link worker	A specialist link worker is a link worker with existing professional qualifications in a relevant health discipline (e.g. social worker, psychologist, occupational therapist) and appropriate skills and capability to work with individuals with the highest levels of psychosocial complexity and non-clinical needs.
Wider determinants of health	The wider determinants of health are the social, environmental, structural, economic, cultural, commercial and digital factors that significantly influence health and wellbeing, and are often outside the control of individuals. Health and wellbeing are inextricably linked to the environments and conditions in which people are born, grow, live, work and age, and the wider set of factors that shape those environments and conditions[4–6].

References

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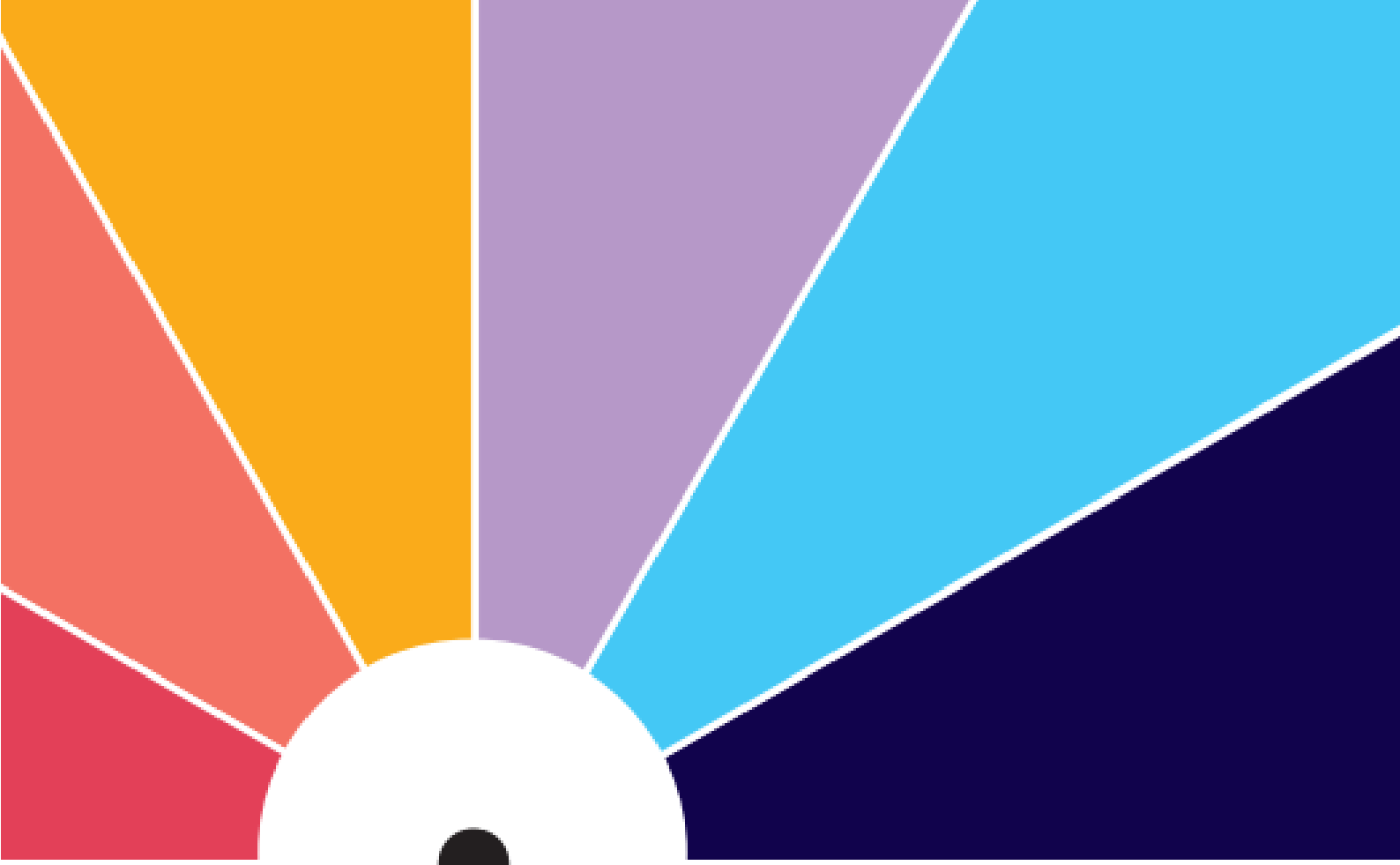

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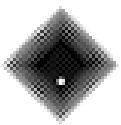

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