Potential lateral and upstream consequences in the development and implementation of social prescribing in Australia

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Introduction

Social determinants of health, such as social connection, education, housing, and socioeconomic status, have a significant effect on health and are underlying factors contributing to health inequity.[1] In Australia, despite high levels of health in the general population by world standards, inequities continue to be experienced by many, such as Aboriginal and Torres Strait Islander peoples, those living in rural, regional, or remote areas, people living with mental illness or disability, sole parents, and those with low socioeconomic status.[2] One way to address social determinants of health is through social prescribing, which involves referring people to services and supports to address social needs such as food, housing, and financial insecurity, and social isolation/loneliness ([3,4], see Table 1 for a more detailed definition).

Social prescribing has been widely implemented in the United Kingdom (UK) and the United States of America (USA), where there is typically policy and funding support for adoption and scaling of social prescribing.[5] Social prescribing is less developed in other countries. There is a growing consensus on the need for social prescribing to be implemented in Australia.[6,7] For example, Australia's National Preventive Health Strategy 2021–2030 includes embedding social prescribing in the health system as a policy achievement by 2030,[6] and social prescribing is included as an action in Australia's Primary Health Care 10 Year Plan 2022–2032.[8] However, while there is local-level action on social prescribing, there is a lack of a systematic approach to the design, development, implementation, and funding of social prescribing in Australia.[7]

Research, to date, mostly from the UK and the USA, shows benefit of social prescribing to individuals and health systems.[9–12] However, variability in models of social prescribing has hampered the ability for robust synthesising and evaluation of effectiveness.[13,14] Of particular note, there is a lack of understanding of what works, for whom, and in what circumstances[15] to inform action on social prescribing in countries such as Australia, which has substantial differences compared to the UK and the USA in how the health care and social services sectors are organised, funded, and function.[16]

Consideration is also needed on the broader consequences of implementing social prescribing in Australia's healthcare and social care systems and on how these can be addressed. This includes (a) consequences at the interface between health and community and voluntary services (lateral consequences) and (b) consequences of social prescribing for policy action and structural change to address social determinants of health (upstream consequences). The aim of this commentary is to discuss the potential lateral and upstream consequences of the widespread introduction of social prescribing in Australia and to provide potential solutions for consideration.

The interface between health and community and voluntary services (lateral consequences)

Social prescribing generally involves referral from health services (e.g. primary care) to services provided by the community and voluntary sectors (e.g. housing or financial support; supports to address social isolation). Social prescribing, then, sits at the interface between health, community, and voluntary services and aims to address the lack of integration between services to better address people's holistic needs. However, concerns have been raised internationally about the potential lateral effect of increased referrals on the capacity of the existing community and voluntary services.[17] Brown et al.,[18] for example, note "concerns that existing community assets may not be able to handle the increased demand without receiving additional resources and training" (p. 620). These concerns are also relevant to the Australian context.

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Table 1: Definition of social prescribing by international consensus

Social prescribing is "a holistic, person-centred and community-based approach to health and well-being that bridges the gap between clinical and nonclinical supports and services. By drawing on the central tenets of health promotion and disease prevention, it offers a way to mitigate the impacts of adverse social determinants of health and health inequities by addressing nonmedical, health-related social needs (e.g. issues with housing, food, employment, income, social support). While it looks different across the globe, it is recognised as being a means for trusted individuals in clinical and community settings to identify that a person has nonmedical, health-related social needs and to subsequently connect them to nonclinical supports and services within the community by co-producing a social prescription—a nonmedical prescription, to improve health and well-being and to strengthen community connections. It requires collective action and collaboration among multiple sectors and stakeholders." (4, p. 9)

A related issue is that social prescribing requires services to be available in the community for it to be effective, yet this might not always be the case. Alderwick et al.[19] term this the 'road to nowhere problem', which "illustrates the limitations of social prescribing when investment in services to address the social determinants of health is lacking" (p. 716). A very real example of such challenges in the Australian context would be the lack of community assets and supports in rural and regional communities. A further issue is the need for services that are culturally appropriate and safe for Aboriginal and Torres Strait Islander and other populations[20] to ensure accessibility of social prescribing to all communities.

This discussion points to the need for a systemic and coordinated approach to social prescribing that integrates and distributes resources across multiple sectors. One solution is the provision of additional funding to address increased demand and ensure that the required services are available, recognising that such funding should be "sensitive to local needs" ([18] p. 621). Dayson,[21] for example, proposes the concept of social prescribing 'plus', which includes providing financial resources for both the social-prescribing referral process and the services to which people are referred. Similarly, Morris et al.[22] propose the community-enhanced social prescribing model, a combination of individual-level referral, community engagement, and organisational change. The aim is to address both the needs of the individual and community capacity to address those needs. Specifically, the model involves community engagement to determine community assets, resources, networks, and need (which informs funding for future interventions) and aligning the objectives of health organisations and systems with a focus on community wellbeing, in addition to individual-level referral for social needs. A collective-impact approach could also be used to engage stakeholders across health and social services to ensure integration and leveraging of resources.[23,24]

Policy action and structural change to address social determinants of health (upstream consequences)

In addition to the (arguably) more practical issue of service availability and funding discussed above, there is a deeper concern about the implications of social prescribing for how we understand and take action to address social determinants of health. For example, authors have raised concerns about the potential for social prescribing to individualise the social determinants of health. This is done through 'health responsibilisation',[25,26] whereby social conditions are repositioned as "diagnosable 'social needs'" ([27], p. 329), with the responsibility (and its corollary, blame) for addressing social determinants of health placed on individuals rather than governments and societies. There is a risk, therefore, that social prescribing might become a distraction that "allows policymakers to give the appearance of addressing health inequalities" rather than "addressing upstream factors such as poverty" ([18], p. 616).[28]

The responsibilisation of social needs reflects what Scott-Samuel and Smith[29] refer to as 'fantasy paradigms' of health inequities, a belief that inequities that result from broader, structural issues can be eliminated through action at an individual/local level.[26] While fantasy paradigms can be seen in policy discourse regarding social determinants of health, they are also evident at an individual level in the discourse of health professionals delivering social prescribing, as found by Mackenzie, Skivington, and Fergie.[26] The authors note the need to re-engage social prescribing communities of practice in what is meant by social determinants of health to address fantasy paradigms in the social-prescribing discourse.

There is limited discussion in the literature regarding how to address the upstream implications of social prescribing. However, Mackenzie et al.[26] argue that an important starting point would be to decouple narratives regarding mitigating the effects of social determinants of health from those relating to addressing the causes of health inequities. This decoupling is important in the context of the adoption of Health in All Policies in Australia and internationally, which is a public policy approach that recognises the impact of social determinants of health and promotes cross-sectoral action to improve population health and health equity.[30]

Decoupling could be done through inclusion of advocacy for action on social determinants of health from within health systems, as recommended by the USA National Academies of Sciences, Engineering, and Medicine committee[31] and as discussed by Buzelli et al.[32] in relation to the UK National Health Service action on social determinants of health. Similarly, Flavel et al.[33] identify health practitioners in Australia as "powerful advocates for policy action on the [social determinants of health]" (p. G).

Conclusion

Australia, as with many countries outside the UK and the USA, is at the start of its social-prescribing journey. It is important to open a community-wide dialogue about the potential (unintended) consequences of social prescribing as we move towards broader uptake and implementation of social prescribing in Australia. Social-prescribing programs have the potential to stimulate and direct lateral funding through developing a clear understanding of community needs via community engagement. They also have the potential to inform upstream actions through communicating key social determinants of health identified through social needs screening to government and policy makers and by lobbying for action on the social determinants of health affecting communities.[33] For this potential to be realised, these elements should be built into the model(s) of social prescribing being developed in Australia. Overall, there is a need for policy commitment that sees social prescribing as one part of a broader strategy to address social determinants of health.

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Conflicts of interest

The authors declare no conflicts of interest.

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