Social prescribing in the USA: emerging learning and opportunities

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The global prevalence of chronic diseases and high costs of health care are complex challenges that are driving countries to focus on addressing the social determinants of health and downstream social needs. These challenges require innovative health-care practices that integrate disease prevention, treatment, and management with salutogenic initiatives to promote population health. Many countries have turned to social prescribing as a promising approach. Social prescribing connects people with non-clinical support and services within their communities. While social prescribing has more commonly been adopted in countries with government-funded national health services, in this Viewpoint, we share learning from examples in the USA. We argue that social prescribing in the USA is unique given the heterogeneity of the country and its health systems, and that this aspect influences programme activities, target-populations, and models. These examples offer valuable lessons about the barriers and enablers to implementing social prescribing in different contexts, including privatised health-care systems. Ultimately, we call upon US stakeholders to recognise the benefits that social prescribing could bring to public health and take action to support its development. We also invite stakeholders from other countries to consider learnings from the USA and how social prescribing can be successfully implemented in their contexts.

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Introduction

The cost of health care is one of the biggest challenges facing governments worldwide.[1] Both out-of-pocket expenses and public spending have increased over the past two decades,[2] with the proportion of global gross domestic product spent on health care reaching 10·3% in 2021—a total of US$9·8 trillion.[3] Ageing populations, increasing prevalence of chronic diseases and comorbidity, shortages of health-care workers, and the COVID-19 pandemic have all contributed to making health care more expensive.[4–7]

Consequently, to control costs and more effectively meet the health needs of populations, health systems are starting to address the social determinants of health—these are the non-medical factors that account for 30–55% of health outcomes.[8] Downstream manifestations of social determinants of health are known as social needs and a promising approach to addressing these, particularly in countries with forms of universal health care, is social prescribing, which has now emerged in 32 countries[9–11] with varying models across Europe, Asia, Australia, and North America. A recent expert consensus defined social prescribing as follows: "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."[12]

To date, nearly 350 different outcomes have been explored in relation to social prescribing, including individual outcomes, such as mental health, lifestyle, and behaviours, and health system outcomes, including health service use and economic savings.[13] Although recent systematic reviews have highlighted some methodological weaknesses,[14,15] the quality of the evidence is increasing, with a growing number of randomised controlled trials published or in progress and greater geographical variation of where such trials are conducted.[16–19] Furthermore, this evidence base spans a broad range of prescription types, moving beyond signposting to food and housing to considering the health benefits of nature-based and arts and cultural activities.[20–22]

Notably, among high-income countries globally, the USA spends the most on health care but has the lowest relative life expectancy and the highest rates of avoidable deaths.[23] The cost of health care is a primary concern for Americans[24] and pricing for drugs and services remains a topic of debate for both Democrat and Republican political parties.[25] Culturally, a medicalised concept of health care supersedes any importance placed on the social requirements for health and wellbeing.

In response to these challenges, over the past two decades the USA has seen the emergence of health programmes designed to address social determinants of health and, primarily, basic needs, such as food, housing, transportation, and employment.[26] These programmes that include the Accountable Health Communities Model,[27] have not consistently been labelled as social prescribing, although they share many characteristics and practices with the broader global model. The focus on basic needs in the USA might reflect understanding of the effects of social factors on population health, alongside more limited social services and support in the health system compared with other nations. Only in the last few years has the USA begun to expand the scope of social prescribing beyond basic needs, and examples of programmes that involve a wide variety of community resources have started to emerge.

To increase our understanding of US social prescribing programmes, we have undertaken a major national evaluation of the emerging social prescribing landscape.[28] This work began in September, 2022 with convening, networking, and systematic identification of programmes

See Online for appendix

across the USA. The resulting report catalogues 23 examples of arts, culture, and social prescribing programmes at different stages of design and implementation (appendix p 1). Data were gathered from surveys and interviews with programme staff between January, 2023 and July, 2024. Questions focused on programme characteristics and further research is therefore needed to understand longitudinal outcomes and sustainability.

From this work, we assert that even within a largely privatised health-care system, social prescribing can be successfully integrated in different forms. Furthermore, we identify the barriers to such programmes and provide recommendations for how they can be overcome. We suggest that social prescribing can be effectively delivered in the US context for the benefit of public health and should be considered a priority for funding by the new government.

Learning from practice

The rationale for social prescribing in the USA is strong. Despite spending almost 18% of gross domestic product on health care, Americans have a shorter life expectancy and are less healthy than people in other high-income countries.[23] Furthermore, the USA sees considerable inequalities in health outcomes. These inequalities are economic due to the high costs of health insurance,[29] and social, including long-standing racial disparities that were brought to the fore once again during the COVID-19 pandemic.[30]

The development of social prescribing programmes in the USA has been intrinsically shaped by the country's unique context, which includes its mixed public–private health system, insurance-based structures, and varying political landscape across states. Although there is a growing recognition of the impact of social factors on health and exciting recent precedents for Medicaid covering traditional healing practices including arts,[10,31] the absence of social prescribing policy at a national level has led to the emergence of varied local and regional initiatives. We outline some of the different forms that social prescribing is taking across the USA, which draws on 23 programmes we identified across 11 states that leverage existing community assets to support a range of health issues, particularly mental health, social isolation, childhood obesity, and behavioural challenges such as addiction (appendix p 1).[28] We argue that these programmes offer important examples due to their emergence within a largely privatised health-care system, which is unlike most other countries that have adopted social prescribing to date.

Holistic activities

Previous research into social prescribing in the USA highlights how social prescriptions had primarily connected individuals to resources for basic needs, such as food and housing.[9,32] In contrast, our findings suggest that the USA is recognising the importance of providing varied activities to holistically support health. This approach corresponds with the UK's four pillars of social prescribing,[33] including information and practical advice related to social determinants, physical activities, nature-based activities, and arts and cultural activities. In particular, we found increasing examples of arts and cultural activities across the USA. Sometimes called arts prescriptions, they reflect a growing body of evidence for the effects of arts participation on health and wellbeing outcomes,[34,35] which involves almost any cultural activity or art form from music lessons to glassblowing workshops, museum excursions, and library memberships. However, programmes do still support people's basic needs, both proactively (eg, offering food deliveries as part of a wider support package) and responsively (eg, linking people with relevant advice when housing issues are disclosed).

While most programmes do not tailor activities specifically to participants and their health needs, many do have discussions with participants about their preferences and what type of support they might need and want, which indicates that social prescribing can be aligned with existing community assets, without necessarily requiring investment to create new and bespoke activities. Most programmes allow participants to take part as often as they like and, for some, can continue indefinitely as prescriptions are available for renewal, subject to programme funding. Mirroring research from the UK,[36] many programmes in the USA have also developed online offerings in response to the COVID-19 pandemic and physical distancing restrictions. By using existing community resources but staying flexible to the needs and preferences of participants, social prescribing can be well placed to respond quickly to changing public health priorities.

Diverse target populations

Examples from the USA also show that participants in social prescribing programmes are not restricted to a specific demographic. While the referral process is typically initiated by a health-care professional, referral can be from various sites and for a range of people and services. For example, schools and universities are another source of referrals, reflecting recent work in the UK that explores different routes to social prescribing for young people.[37] Similarly, Stanford University in California, USA prescribes campus-based arts activities to students to support their mental health, and the Clark Art Institute in Massachusetts, USA receives referrals from school counsellors of young people to take part in museum activities. Furthermore, there are other examples of referrals via insurance companies, other caseworkers, neighbourhood groups, or even with self-referral.

Participants themselves might be referred for various reasons, including specific physical or mental health

conditions, or for wellbeing concerns, such as social isolation. Some programmes focus on reaching underserved demographic groups, while others are entirely open access. Programmes span a wide range of ages. Older adults are a common focus, but there are also many programmes open to young people. Another emerging trend is initiatives aimed at families. In Massachusetts, households are offered opportunities to access nature spaces, zoos, art workshops, and more. Joint involvement of parents and children offers two interesting advantages: the potential to overcome barriers related to travelling to, paying for, and accessing programmes, and the opportunity to produce wider outcomes at a family level. In a country where many families are already linked by health-care plans provided by a parent's employer, the USA offers a fertile testbed for family-based models of social prescribing.

Varied funding and delivery models

Programmes exist at a range of scales and stages of development, from those still in planning with grants of $10 000 or less, to some providing activities to over 100 participants a month with an annual budget of more than $150 000. Typically, programmes are accessing multiple sources of funding, from public or philanthropic organisations to in-kind donations. Similar to the UK but on a lesser scale, there has been some government investment in social prescribing, for example from the City of Dallas City Office of Arts and Culture and Massachusetts Cultural Council. However, there are also novel funding models. Of particular interest is a New Jersey-based example, where a health insurance company is funding a programme led by the New Jersey Performing Arts Center, offering social prescribing support to members at risk of overspending on their plans. These examples show that social prescribing can be viably embedded in privatised health-care systems and raises the possibility of hybrid public–private programmes to suit various country contexts.

Programmes are commonly led by health or arts organisations. In Utah for instance, Project Connection sees a mental health provider offer social prescribing to individuals receiving therapy. However, there are also emerging examples of programmes led by organisations from the nature, business, and philanthropical sectors. In particular, the USA has a strong tradition of philanthropical funding and activity, and this is exemplified by programmes, such as Isolation to Connection, which is run by a philanthropical organisation to support lonely older adults in New York. It is rare for lead organisations to be working in isolation and numerous partnerships across organisations and sectors exist to support programme delivery. For example, the Veterans Community Arts Referral Program in Florida was made possible by partnerships between the Veteran Affairs Medical Center and five local arts organisations that were contracted and paid to offer free activities to participants.

Barriers and enablers

We have identified common barriers and enablers and actions needed to support the delivery and scaling of future initiatives. First, funding of programmes is an important barrier. Programmes report facing delays as funding is negotiated and inflexible funding structures and a lack of long-term funding agreements. Although social prescribing funding models vary internationally, these are common issues.[38] Funding challenges affect the delivery of social prescribing, preventing the purchase of equipment, forcing reliance on volunteers and undervaluing or even terminating this work. With many social prescribing programmes in their early stages in the USA, options for long-term financial sustainability are still being considered. Many programmes have ambitions to refine their activities and gather evidence of their cost-effectiveness to seek further funding, including becoming embedded in the portfolio of health-care payers, such as insurance companies and states.

Second, examples from the USA highlight the importance of partnerships. Most programmes identified involve more than ten organisations. Partners are often actively contributing by providing referrals or supporting programme delivery and can also provide in-kind support or strategic links to, for example, national government. Where organisations delivering social prescribing are already established and embedded in their community, this can be a benefit as the process of building relationships takes time and effort. In particular, communicating with health-care providers can be challenging, owing to the pressures the workforce is under. Some programmes also report delivering training to onboard their partners, although this can be challenging due to their heterogeneity. This theme is recognised in other international research, which has highlighted the complexity of implementing social prescribing effectively, due to the number of stakeholders involved and the challenges of intersectoral working and communication.[39]

Third, a fundamental yet recurring question is how to make programmes accessible and engaging to participants. Barriers that might inhibit people's involvement include limited awareness about social prescribing opportunities, an absence of language translation, digital exclusion, and practical considerations, such as transportation, childcare needs, and associated costs. These barriers echo wider concerns that social prescribing could exacerbate inequalities, for example, working best in areas with existing community resources and not reaching those with greatest social needs.[40,41] Many programmes are already taking action to address these issues by making provisions for participants, such as travel and food. Participant input has also been gathered to inform the design of programmes from the outset, for instance ensuring that activities are scheduled at times that do not unintentionally exclude people. As one example, a health centre in New York City has used

***Panel*: Recommended actions stakeholders can take to enable the successful implementation of social prescribing programmes**

Policy makers

- Take the lead in connecting community assets with clinical and primary care facilities, gathering buy-in from relevant parties.
- Acknowledge the extensive work that the community or volunteer sector has already put into social prescribing and encourage their leadership in developing further pathways.
- Encourage participation in social prescribing by making it relevant to Americans. Framing of the language and concept will be particularly important as the term social could be interpreted as a socialist or welfare approach to health care. We argue that social prescribing can be non-partisan and integrated with private, public, and philanthropic funding streams. For example, policy makers could explore the possibility of incorporating social prescribing, arts prescribing, and nature prescribing within Medicare to facilitate the work of accountable care organisations to better coordinate the care of Medicare patients.
- Adapt and scale already existing resources or funding for social prescribing to ensure there is adequate investment in enablers of social prescribing, such as community assets and link workers. For example, existing community health workers could be trained to facilitate social prescriptions, especially given that this workforce is growing—totalling 63 400 in 2023, and expected to increase by 13% by 2033.[44]
- Learn from other international models, such as the community connector approach used by NHS England to help people engage with their local health services.[45]
- Continue to invest in complementary action at the community level to improve wider social policies and structures, rather than viewing social prescribing as a panacea to addressing social needs.

Clinicians and other health-care practitioners

- Consult with their patients to gain valuable insight into their social needs.
- Develop high-quality training programmes for stakeholders implementing social prescribing.
- Play a key role in designing social prescribing referral pathways that suit local contexts, which will require strong knowledge of community groups, activities, and other forms of support.
- Support partnerships across clinical and community sectors.
- Strengthen outpatient clinic capacity to hire and train link workers or similar community connectors.
- Raise awareness of social prescribing among patients.
- Capture social prescriptions within electronic patient records to provide administrative and health outcomes data that can be analysed to track its scale and effects.
- Share good practices to enable efficient and informed development of programmes across locations and states.

Researchers

- Evaluate social prescribing programmes to grow the evidence base for its effectiveness, economic effect, and feasibility of implementation.
- Examine which models are best suited for different contexts and populations by measuring (in tandem) health outcomes and implementation factors important to programme success over the long term.
- Support programmes in implementing their own robust evaluation systems so that evidence generation is ongoing and can be shared nationally and internationally to guide the development of other social prescribing programmes.
- Prioritise dissemination of findings among non-academic stakeholders to make evidence on social prescribing accessible to patients, link workers, clinicians, community organisations, policy makers, and the public.

Community workers who provide social prescribing programmes

- Deliver high-quality programme activities, build relationships with participants, and serve as a caring point person.
- Raise awareness of social prescribing opportunities across communities, health care, and policy.
- Highlight good practice and advise on evolving barriers and enablers.

Social prescribing participants

- Input into programme design and share feedback on implementation and effectiveness. These insights will be key to ensure social prescribing is as effective and equitable as possible.

its long history of addressing social determinants of health and working with communities in the Bronx to inform the delivery of their new social prescribing programme. Nonetheless, equity remains a key consideration for the future of social prescribing.

Fourth, employing skilled staff members is a crucial enabler, while high staff turnover can be a major barrier to implementing programmes effectively and this applies to both the staff involved in making social prescriptions (sometimes referred to as link workers) and those delivering the selected activities. In particular, programme providers play an important role in building trusting relationships with participants. It is therefore common among new programmes to invest in their workforce, providing information or training to site staff. This guidance can focus on a range of topics, from the practicalities of programme delivery to the principles of social prescribing and having effective "what matters to you" conversations to explore individuals' interest and goals.[42] Given there is currently no formal qualification for social prescribing work, staff instead draw on relevant practice from community

organisations and other groups that have expertise on issues such as equity. The USA is not alone in having this issue and even in countries where social prescribing is more established, such as the UK, there are calls for the improvement of link worker training and supervision.[43]

Last, practical considerations, such as developing necessary protocols, integrating with other systems, and the ongoing monitoring of social prescribing programmes should also be considered. Currently, sites are mostly building on previous infrastructure and experience. However, some programmes are developing new technologies to implement social prescribing. One such example is Art Pharmacy, which originated in Atlanta, USA, and is now being scaled nationally. Art Pharmacy has developed a recommendation engine to help match patients with available activities that best fit their interests and health needs. In recent history, the USA has often been regarded as a leader of health-care innovation, for example in the development of new drugs and devices. Nowadays in the field of social prescribing, similar innovation is taking place. Should similar technologies prove effective in streamlining processes and connecting participants and activities, they might be of considerable interest to export and adapt for use internationally.

Recommendations

These programmes show the potential of social prescribing to address social needs in the USA, to lower the costs of health care, and to more adequately support Americans. Many of the systems and necessary assets for social prescribing are already in place and various models have been realised for different contexts. Examples have also highlighted the challenges that come with implementation, and with this in mind, we outline how policy makers, practitioners, and researchers can overcome these barriers (panel).

Conclusion

Social prescribing in the USA is already in action. This Viewpoint has shown that the activities, populations, and models involved are highly varied and can offer new possibilities and templates for social prescribing internationally. In particular, ongoing work highlights how social prescribing can be effectively delivered within a predominantly privatised health-care system. However, to reach its full potential as a public health tool that offers potential cost savings and health benefits, further action should be taken in response to the current barriers and enablers of social prescribing. The USA already has a wide range of assets across the arts, culture, heritage, community, and nature, but too many of these remain disconnected from people whose health stands to benefit. Now is the time to learn from existing practice and realise the promise of social prescribing across the USA and beyond.

Contributors

DF developed the concept for this Viewpoint. All authors were involved in original research upon which this Viewpoint draws inspiration. RM and ABr drafted the manuscript and all authors reviewed and edited it.

Declaration of interests

We declare no competing interests.

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