Gesundheit Österreich GmbH

Social prescribing in different healthcare settings

Technical brief

On behalf of the Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection as part of the WHO CC HPH work plan agreed with the WHO Regional Office for Europe.

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This report contributes to the implementation of the 2030 Agenda, in particular to Sustainable Development Goal (SDG) 3: 'Good health and well-being'.
Vienna, October 2025

Summary

Background

Social prescribing as an approach to addressing non-physical health-related concerns is gaining momentum in many countries and settings. This technical brief addresses the similarities and differences of social prescribing in three settings: in the community, primary care and hospitals. Decision makers and healthcare providers from these settings should gain an understanding of the concept of social prescribing and its implementation in different settings.

Methods

Using desk research, relevant documents were identified and prepared on the implementation of social prescribing in the three settings. In addition, three webinars were organised with international social prescribing experts from each of the three settings. The results of the webinars were incorporated into the technical brief and formed the basis for an expert workshop where 13 experts discussed the similarities and differences of social prescribing in the three settings. These were presented in tabular form to increase the clarity of presentation. The experts were invited to provide feedback on an initial draft of the report, which was then incorporated.

Results

Similarities and differences in the conceptualisation and implementation of social prescribing in community, primary care and hospital settings were described along the following dimensions:

- structured processes
- target groups and needs
- accessibility (differences only)
- identifiers and clinical engagement/awareness
- link working and link worker training
- referral systems and collaboration with community assets (network management)
- community development
- evidence, monitoring and evaluation

Conclusions

Social prescribing is a strongly value-based concept that is gaining a foothold in more and more countries. It is being implemented in different healthcare systems and settings. There is no single form of best or good practice implementation and implementation in one setting is not better than in another. Ideally, social prescribing is offered in all of these settings to reach people where they are seeking help.

Key words

Social prescribing; hospitals; secondary care; primary care; community care

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Abbreviations

GP	General practitioner
NASP	National Academy for Social Prescribing
NHS	National Health Service (United Kingdom)
WHO CC	World Health Organisation collaborating centre

1 Social prescribing to address non-medical health-related needs

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love." (WHO 1986)

Social determinants and, thus, non-medical factors account for 80% of overall health. The lack of social networks can lead to loneliness and, consequently, to higher risks of falling ill and mortality (Holt-Lunstad et al. 2010).[1] Both the health sector and other sectors like education and social care as well as "the third sector" (not-for-profit and non-governmental organisations) play a central role in the implementation of individual and relationship strategies to address loneliness (WHO 2025).

Social prescribing addresses these needs in healthcare. One in five consultations with GPs in England can be attributed to non-medical but health-related factors (Polley et al. 2017), albeit not limited to social determinants. According to the report from the WHO Commission on Social Connection, social prescribing can be regarded as a broader element of integrated health care (World Health Organization 2025). Social prescribing is a systemic approach in health care to addressing non-medical health-related needs[2] with counselling and referrals to community services to promote well-being and social participation.

Several studies have been published on social prescribing in England, for example, demonstrating the benefits for the NHS, health professionals and patients as well as cost savings. Social prescribing in primary care, for example, has been shown to lead to[3]

- a 20-40% reduction in GP appointments for people referred to social prescribing;
- a 15-25% reduction in visits to accident and emergency departments and unplanned hospital care;
- significant improvements in health and well-being for the individuals concerned;
- a financial return on investment; evidence shows approximately £3 return for every £1 invested.

Given the funding problems and shortage of health professionals in many countries, social prescribing can contribute to relieving these problems in healthcare systems.

In England, social prescribing originally emerged as a community-led initiative, developed in collaboration with primary care providers to address non-medical needs and improve overall well-being. Today, 30 years later, the focus of social prescribing is still on primary health care but increasingly on secondary health care as well. Social prescribing is now being implemented in over 30 countries with different country- and culture-specific framework conditions like focusing on specific target groups or on the prescription of specific interventions, e.g. arts on prescription (Khan et al. 2024; Sonke et al. 2023).

1 https://www.who.int/publications/i/item/978240112360 [Accessed on: 18.09.2025]
2 Social prescribing is about health-related needs, not social determinants of health; otherwise the concept becomes too broad (expert workshop).
3 https://socialprescribingacademy.org.uk/media/ibtdvgn0/nasp_sp_impactonservice_nov24.pdf [Accessed on: 18.09.2025]

Against the background of implementing social prescribing in different countries, this technical brief highlights the similarities and differences of social prescribing in three settings: in the community, primary care and hospitals. Our aim is not to argue that implementation is better in one setting than in another. Rather, we argue that people seek help and can be reached in different places and that the implementation of social prescribing in different settings is very complementary. Ideally, social prescribing, or comparable measures to address non-medical health-related concerns, should be developed across all three settings. This technical brief raises awareness of the similarities and differences in implementation that need to be considered, arguing that social prescribing seems not to be a question of setting but rather a question of function, which is based on relationships and trust. To fulfil this function, it is important to finance staff hours in healthcare facilities as well as the costs of external services.

The technical brief is based on three webinars.[4] The speakers, along with representatives of the International Network of Health Promoting Hospitals and Health Services and the International Social Prescribing Collaborative, were then invited to a workshop to jointly reflect on the results of the webinars and deepen their exchange on similarities and differences in social prescribing in the three settings. The original intention to develop a concrete implementation tool (e.g. a checklist) was discarded based on the workshop results. Instead, the similarities and differences identified are summarised in a clear table; this can serve as a starting point for specific implementation activities, which must be adapted to local circumstances. A draft of the technical brief was sent to the WHO and the workshop participants with a request for feedback. The feedback was incorporated and the technical brief finalised.

4 https://goeg.at/SocialPrescribing_Dokumente [Accessed on: 28.05.2025]

2 Social prescribing in different healthcare settings and systems

Social prescribing originally developed as a bottom-up approach from the community setting (Munro et al. 2025). It was "delivered at the local level by community organisations working with GPs to connect local people to community activities" (Munro et al. 2025). This chapter provides insights into the definition of social prescribing as well as social prescribing in different healthcare settings and systems.

Defining different forms of social prescribing

Based on an international Delphi study, social prescribing has been defined as

[...] "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 wellbeing and to strengthen community connections." (Muhl et al. 2022) Figure 1 illustrates a typical social prescribing process in health care.

Figure 1: The ideal process of social prescribing

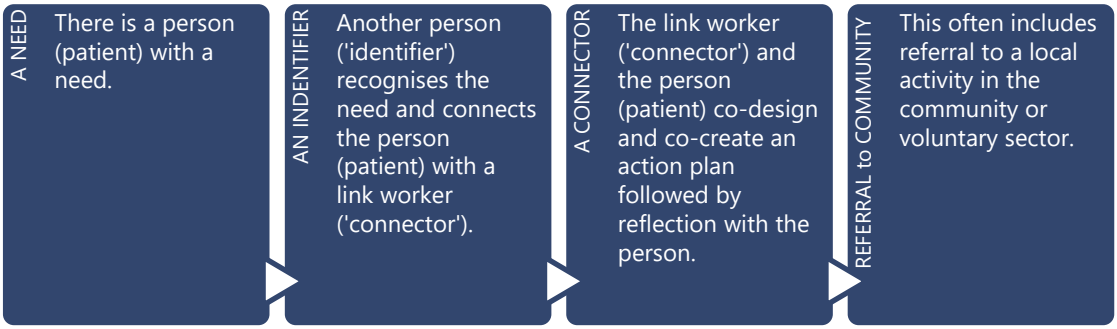


Illustration: GÖG; source: Husk et al. (2020)

Although not explicitly mentioned in the diagram, it should be noted that reflection is also a central element of the social prescribing process. Wherever possible, a follow-up appointment is scheduled after the referral to check with the patient/client whether they have taken up the offer or whether further support is needed.

According to the definition (Muhl et al. 2022), needs can be identified both within the community and in clinical settings (i.e. primary care, hospitals). This addresses the proximity of social prescribing to lay care and the community. For the technical brief, it is therefore necessary to clarify where the line is to be drawn between social prescribing in healthcare settings and social prescribing in lay care.

Social prescribing in different healthcare settings

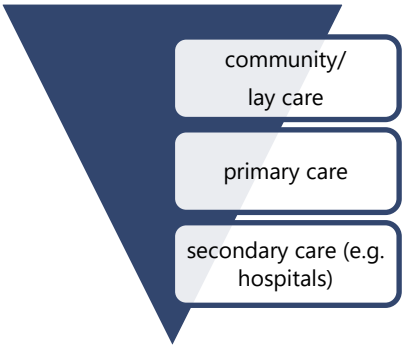
When considering social prescribing in different healthcare settings, it is necessary to differentiate between lay care, primary care and secondary care systems. Regardless of the healthcare system – whether private, state-organised (e.g. national health services) or social insurance-based – there are different levels of care (with slight differences depending on the country).

The largest part of the care system is made up of lay care, where people solve minor health issues either alone or in their social environment. A classic example of informal care is exchanging information and supporting one another. For example, if someone needs a leisure activity for their child, a neighbour or another mother at the playground can point them towards a suitable option.

When this lay care is no longer sufficient, primary care comes into play. Primary care has emerged as one of the key settings for social prescribing (Khan et al. 2024). It forms the bridge between community activities and medical care.

Secondary care (e.g. hospitals) only treats a small proportion of people, especially those with more serious health problems. Such patients tend to come to secondary care at times of crises and when they are possibly most receptive to change ("health issues as teachable moments").

Figure 2: Levels of health care



Source: GÖG

In line with discussions at the expert workshop, this technical brief distinguishes between

- social connectedness as part of lay care;
- community social prescribing at the interface between lay care and primary care;
- community-led social prescribing and social prescribing in primary care;
- social prescribing in hospitals.

We speak of **social connectedness** instead of social prescribing when needs arise in people's everyday lives and are communicated based on everyday knowledge without involving medical care. As already mentioned, one example of this is a conversation between mothers at the playground, where it turns out that one of the mothers or fathers is looking for a leisure activity for her son and the other mother mentions an appropriate community asset. The process takes place entirely in the community (= 'lay care') without involving the medical system. In this case,

without the involvement of (professional) medical care, it is questionable whether it is accurate to speak of a prescription. Therefore, we speak of social connectedness.

Community social prescribing, in turn, refers to the identification of needs in community centres or counselling facilities where trained individuals co-produce an action plan with a client and then refer the client on once a need has been identified. In this case, no doctor needs to be involved but other health/social care professionals may be. The extent to which the term 'prescription' is appropriate is also open to debate. However, in this case, we have decided to use the term 'community social prescribing'.

Social prescribing in primary care refers to raising awareness among primary care teams of health-related needs so that a structured process can be established for identifying needs, providing link working advice and referring patients to regional services. We refer to **community-led social prescribing** when this process is initiated by the community.

Social prescribing in hospitals refers to the implementation of social prescribing schemes in hospitals; in other words, hospital staff are made aware of non-medical health-related needs and a structured process can be established (see above).

For this technical report focusing on (professional) healthcare settings, only community social prescribing and community-led social prescribing will be discussed further alongside social prescribing in primary care and hospitals. Social connectedness, which can be located in lay care only, is not considered a form of social prescribing as there is no (medical) "prescription" issued by a health/social care professional.

To illustrate social prescribing in the three settings examined, one example is given of each type of social prescribing in the community, primary care and hospitals based on the webinars.

Social prescribing in the community setting – the example of Canada[5]**:** Community organisations can provide a trusted, hyper-local point of access and reach people from underserved communities or patients who cannot access a regular primary care provider. This form of social prescribing can take place in many settings, e.g. in a housing intervention or in community centres. In the Canadian setting, social prescribing is described as a centre of coproduction. They want to build a learning health policy system by using observational, qualitative and quantitative methods.

Social prescribing in primary care – the example of Austria: Since 2021 there have been regular funding calls for primary and paediatric care facilities to implement social prescribing. There are two forms of implementation, although hybrid forms are also possible: either social prescribing is implemented in a primary care unit with on-site link working as an add-in or it is implemented in individual GP practices or in a primary care network with external link working as an add-on.

Social prescribing in the hospital setting – the example of Barts Heart Centre in London: Social prescribing has been integrated into cardiac care pathways to address the social determinants of health, particularly for heart attack patients facing financial and emotional challenges. Patients are screened for social deprivation during recovery and, if necessary, referred to link working counselling.

5 https://www.socialprescribing.ca/about-social-prescribing [Accessed on: 30.10.2025]

Social prescribing in different healthcare systems

Nowadays, social prescribing is implemented in more than 30 countries (Khan et al. 2024). The form and implementation status vary: some focus on selected population groups and others on referral to specific services (e.g. arts on prescription, green social prescribing) while some are more closely related to other concepts, such as community-oriented primary health care. The implementation status also varies from pilot projects (e.g. in Austria) to widespread implementation (e.g. in the UK) with national social prescribing institutes or networks (Scarpetti et al. 2024). However it is implemented, social prescribing unites the addressing of non-medical health-related needs, time to deal with the question as to what is important for individual patients/people and referring them to regional or community services. Target groups and referral services vary depending on the country and setting (Khan et al. 2024).

Table 1: Overview of countries with social prescribingTable 1 lists countries making use of social prescribing by health system and the setting in which it is implemented, revealing that in some countries, social prescribing is implemented in several settings. The overview illustrates that social prescribing is flourishing in national health systems in particular (Marshall et al. 2025). To our knowledge, only three countries with private health systems are developing social prescribing. It was not possible to analyse the reasons in any depth, for example whether this is due to it being potentially easier to implement innovations in national health systems or to other factors, such as the existence of social work as an established professional group in the various settings or case and care management in hospitals. Irrespective of this, local developments can also arise (e.g. social prescribing in a hospital initiated by a committed doctor) or local grass roots developments.

The table also shows that social prescribing is found particularly in primary care and community settings and less frequently in the hospital sector. Although the focus below is on community settings, primary care and hospitals, it should be noted that there are also examples of social prescribing in outpatient services (oncology, gynaecology), community-based nursing, mental health teams, rehabilitation and intermediate care (Morse et al. 2022).

Table 1: Overview of countries with social prescribing

	Community settings	Primary care	Hospitals
National health systems	• Canada* • Denmark • England* • Finland • Greece • Italy • Malaysia • Nigeria • Philippines • South Korea • Wales	• Canada* • England* • Iran • Northern Ireland • Portugal • Republic of Ireland • Scotland • Spain • Sweden	• England* (10 hospitals) • Singapore
Social insurance models	• Germany • Indonesia • Netherlands* • Slovakia* • Taiwan	• Australia • Austria • China • Finland • France • Netherlands* • Poland • Slovakia* • Slovenia	• Japan • Slovakia*
Private	• Hong Kong • India • USA*	• USA*	• USA*

*Social prescribing in more than one setting.

Source: Social prescribing around the world: A world map of global developments in social prescribing across different health system contexts (Scarpetti et al. (2024) and expert workshop

3 Social prescribing in community, primary care and hospital settings

As shown above, the implementation of social prescribing differs depending on the healthcare system and local context. Therefore there is no single best practice form of implementation.

Similarities between the different forms of implementation can be found in the involvement of any form of (health) care (primary care, hospitals) and in its principles or values (Khan et al. 2024):

- a holistic and person-centred approach focusing on individual needs;
- promoting health and well-being in community settings;
- referrals to health-promoting community-based support and services;
- empowering individual control over health.

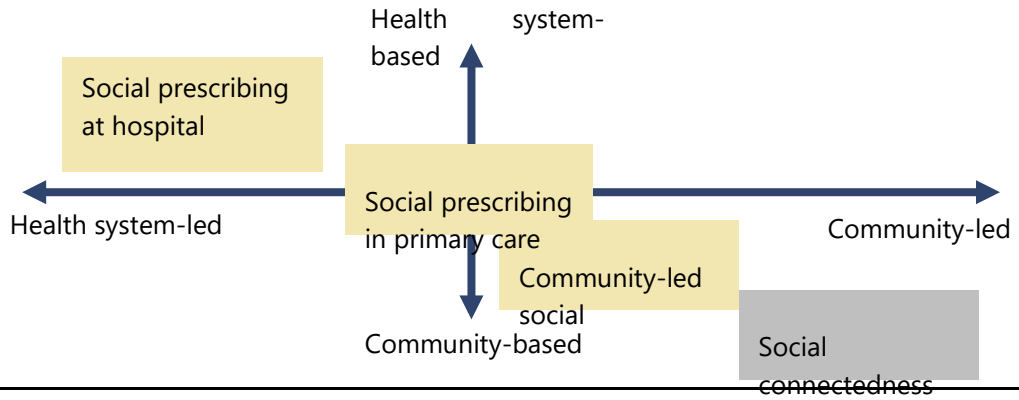
In the following, an attempt is made to illustrate the forms of implementation in the different settings along the two axes of leadership by the healthcare system or community and operational implementation (link working) in the healthcare system or in the community (Figure 3). Social prescribing can be led (initiated) by the community, by a mixture of community and primary care and by primary care alone.

Social prescribing in primary care can be **initiated by the community** (= community-led social prescribing) or (be led by) **primary care**. Social prescribing in primary care evolved from community-led social prescribing in England (Munro et al. 2025).

Community-led social prescribing is a specific form of social prescribing in primary care. In the case of community-led social prescribing, the initiative is based on residents or the community. "Community involvement in and/or leadership of social prescribing is where residents have been able to influence and/or take a lead in the design, delivery and evaluation of local social prescribing programmes, based on residents' needs and identified solutions" (Munro et al. 2025). Community stakeholders seek contact with primary care providers, raise the latter's awareness of non-medical health-related issues where necessary and expand their services. This enables primary care providers to refer patients to community resources.

In the case of **social prescribing in primary care**, the primary care team is sensitised to non-medical health-related issues, enabling them to identify and address these. When a patient with such needs is identified, they are offered link working consultations. Link working consultations focus on what matters to the patient (instead of asking what the matter is with the patient). During the consultation, needs and resources are identified and an action plan is co-developed. Based on the link worker's knowledge of regional services, patients can be referred to these where appropriate. After the patient has taken part in the service, a reflection meeting is held, where possible, to discuss whether the service was appropriate or whether changes are needed. Link working consultations can take place onsite or at a counselling facility (in the case of a community link worker) and, depending on the form of implementation, either outside the medical facility or through (fixed) consultation hours at the health facility, which are staffed by employees of the counselling facility.

Figure 3: Positioning of social prescribing in hospital, primary care and community settings according to leadership and organisational implementation



Source: Munro et al. (2025)

Based on current knowledge, **social prescribing in hospitals** often starts with committed doctors implementing the scheme on their ward or in their hospital. Here, too, counselling ideally takes place in the hospital but cooperation with counselling facilities in the community that then take over the counselling is also conceivable.

As there is no one single way of implementing social prescribing, a conceptual summary is provided of how the implementation of social prescribing is similar or different in the three settings.

A comparison of the implementation process of social prescribing in the community, primary care and hospitals shows that there are many similarities, especially in the later stages of the process.

The differences are greater at the beginning. The person's need is identified either in the community (e.g. community centre, counselling centre), in primary care or in hospital by different health/social care professionals. Depending on the form of implementation, the patient is then forwarded to a link worker.

By focusing on the implementation of social prescribing in different settings, it becomes clear that people can be reached in different settings. All of these settings offer opportunities to identify needs and suggest social prescribing. The hypothesis has emerged that social prescribing in primary care reaches those patients who do not receive sufficient support from their family or community network and that in secondary care it reaches those people who do not routinely access primary care.

Figure 4: Social prescribing in community, primary care and hospital settings

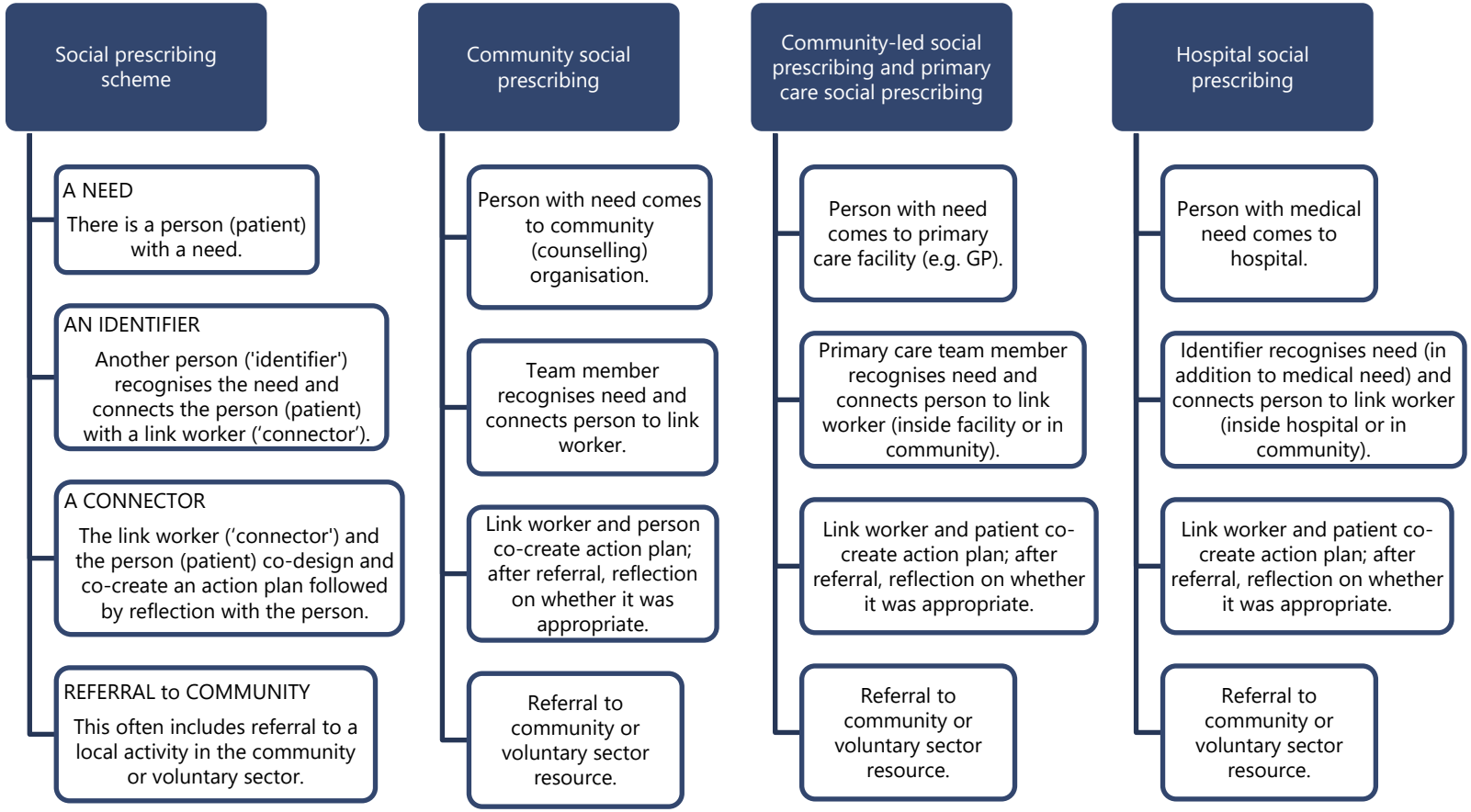


Illustration: GÖG; source: adapted from Husk et al. (2020)

4 Social prescribing similarities and differences across settings

Based on the literature research, the webinars and particularly the expert workshop, the similarities and differences identified in the implementation of social prescribing in the community, primary care (including community-led social prescribing) and hospitals are summarised below. These are presented in tabular form to make them easier to understand (see Table 2 and Table 3).

Similarities

Table 2: Similarities between social prescribing in community settings, primary care and hospitals

Factor	Community-led social prescribing/ Primary care social prescribing/ Hospital social prescribing
Structured processes	• Structured processes of identifying needs, connecting to link worker and referring to community resources (for more information see Figure 4).
Target groups and needs	• Patients/people with non-medical health-related needs (ideally at a stage prior to an acute crisis). • Experience to date shows that patients' needs are complex and rarely limited to a single need.
Identifiers and clinical engagement/awareness	• Raising awareness of the concept of non-medical health-related needs and social prescribing is key. • Continuous measures are needed to raise awareness of the importance of non-medical health-related issues, e.g. in team meetings. • Enabling (medical) staff to identify non-medical health-related needs. Note: Depending on how social prescribing is implemented, all health and social care professionals in the healthcare facility can also identify needs and initiate the social prescribing process.

link working and link worker training	• Link worker training: Ideally, social prescribing is part of the training of healthcare professionals (e.g. part of the medical school curriculum for doctors). For example, student champions in the UK get involved in learning about, teaching and promoting social prescribing within their region.
	• Link working:
	  • Co-creation of personalised action plan with patients. (Key question: What matters to the patient? instead of What's the matter with the patient?)
	  • Joint decision making, activating and strengthening social participation.
	  • In some cases, patients are supported in developing new services.

Factor	Community-led social prescribing/ Primary care social prescribing/ Hospital social prescribing
Referral systems and collaboration with community assets (network management)	Referral systems: • Referring to and connecting patients with community resources (either based purely on the person's needs or based on existing social prescribing schemes such as arts on prescription or green social prescribing). Collaboration with community assets: • The database or overview of regional cooperation opportunities that can be referred to must be updated regularly. This requires appropriate personnel. Keep in mind: • Community assets need to exist to that they can be referred to. • In many countries engaged pioneers are working in pilot projects with only short-term funding. • The network between community resources and hospitals may be underdeveloped.
Community development	• The experience gained from counselling and knowledge of the service landscape can stimulate further services and contribute to a learning healthcare system. • Social prescribing can activate the community and the creation of new activities, groups and services.
Evidence, monitoring and evaluation	• Good evidence is needed on the impact of social prescribing to convince decision makers to make long-term funding available. • There is a need to synthesise culture- or country-specific evidence that can advance culturally appropriate practices and policies in those areas. • At the systemic level, the importance of social determinants of health is well known (e.g. education and health) but little is known about how these relationships manifest themselves in individuals.

Quelle: GÖG

Differences

Table 3: Differences between social prescribing in community settings, primary care and hospitals

Factor	Community social prescribing	Primary care social prescribing	Hospital social prescribing
Structured processes	Original form of social prescribing (in England).	• Depending on the country, orientated towards a national implementation plan or pilots. • Existing guidelines can act as orientation for a specific implementation plan.	• As there is usually no implementation scheme, it involves small teams of intrinsically motivated people. • The development of an implementation plan can hardly draw on existing guidelines.
Target groups and needs	• People with non-medical health-related needs.	• People with medical and/or non-medical health-related needs.	• Patients with a specific disease/medical need, depending on the ward. • Medically complex patient population. • Can reach people who do not go to a GP on a regular basis. • Tends to address older people.
Accessibility	• Low threshold: no need to go to the GP or hospital (people from underserved communities might face discrimination in health care).	• Primary care as a safe space for patients. • Depending on the country, social insurance is required. • As many people go to a GP on a regular basis, accessibility for patients is very good (e.g. many patients go to their GP at least once a year to have a preventive medical check-up).	• (Acute) medical need. • Depending on the country, social insurance is required.

Factor	Community social prescribing	Primary care social prescribing	Hospital social prescribing
Identifiers and clinical engagement/awareness	• Social prescribing might emerge from community networks. • Community organisations can provide a trusted, hyper-local point of access.	• Social prescribing emerges from the relationship of GPs with their patients. • Multi-disciplinary team. • Acceptance of social prescribing in the team (e.g. in an interdisciplinary primary health care centre team).	• Social prescribing emerges from the medical insight that non-medical health-related needs play an important role in recovery. • Awareness of social prescribing as being challenging: a lack of protected time for clinical staff to prioritize prevention.
Link working and link worker training	• Link working role should not be (over)professionalised and therefore a short training course is sufficient. • Culture/capacity for reflection (e.g. use of services, groups or activities) might be limited in the community (more of a hands-on mentality).	• Link workers are part of a (non-)medical team and thus have access to documentation systems. • Professional link worker training. • Emerging need for specialised link workers (e.g. for patients with cancer).	
Referral systems and collaboration with community assets (network management)	• Neighbourhood quite well defined. • Cooperation with the healthcare system (GPs, etc.).	• Cooperation, particularly in the primary care catchment area (neighbourhood).	• Cooperation, particularly in the catchment area of the hospital and its extended catchment area. • Lack of meaningful representation at neighbourhood level. • Large catchment area and knowledge of community resources. • Problems with other data systems with no connections between them.

Factor	Community social prescribing	Primary care social prescribing	Hospital social prescribing
Identifiers and clinical engagement/awareness	• Social prescribing might emerge from community networks. • Community organisations can provide a trusted, hyper-local point of access.	• Social prescribing emerges from the relationship of GPs with their patients. • Multi-disciplinary team. • Acceptance of social prescribing in the team (e.g. in an interdisciplinary primary health care centre team).	• Social prescribing emerges from the medical insight that non-medical health-related needs play an important role in recovery. • Awareness of social prescribing as being challenging: a lack of protected time for clinical staff to prioritize prevention.
Community development	• More room for creativity in supporting new programmes. • Bringing community services closer to health. • Risk of having no access to other institutions that look at other aspects of patients' health. • Encouraging citizens to create new services, groups or activities according to demand or identified gaps in services. • High risk that implementation will not be sustainable if costs are cut in the municipal sector.	• Referring to existing services, sometimes supporting the development of new services, groups or activities.	• Referring to existing services, groups or activities.
Evidence, monitoring and evaluation	• As social prescribing may be very informal in this setting, detailed documentation may be limited.	• Some possibilities for integrating link working documentation into medical documentation (at least with a reference to counselling). • Many studies in the setting; Evidence is emerging in some countries.	• Depending on the country, limited evidence and underdeveloped in comparison to the other two settings.

Source: GÖG

5 Conclusion

Social prescribing supports healthcare systems in their transformation into more patient-centred care and includes new aspects in health care like behavioural and cultural insights/engagements. Social prescribing is about prevention and health promotion. It is about what truly matters to patients.

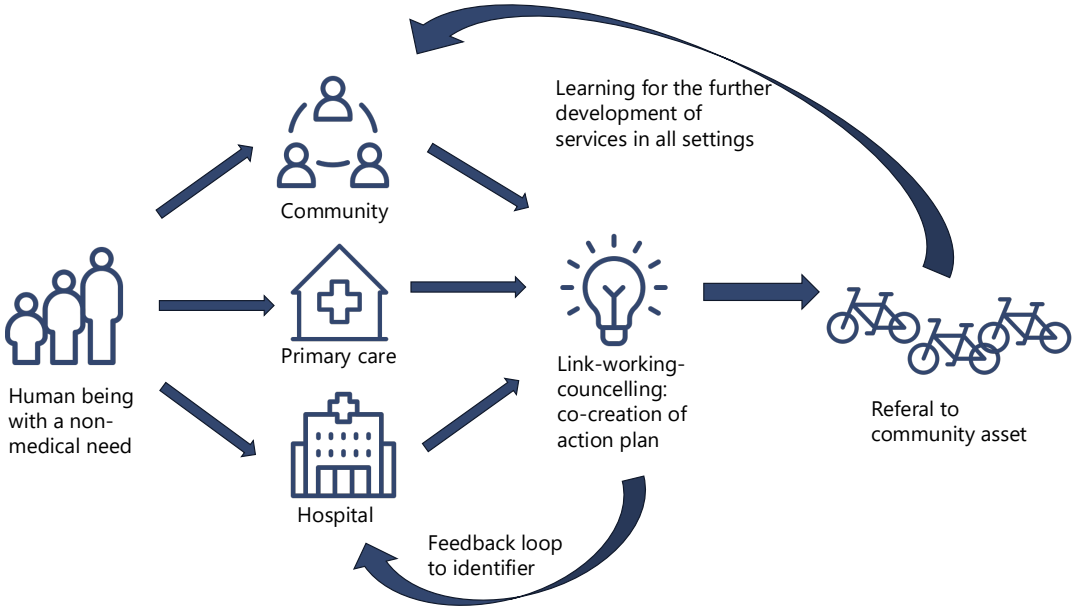
Social prescribing is a strongly value-based concept that is gaining a foothold in more and more countries. It is being implemented in different healthcare systems and settings. There is no single form of best or good practice implementation and implementation in one setting is not better than in another. Rather, the present work shows that people can be reached in different places, especially where they "learn, work, play and love" (WHO 1986). Everybody can recognise the needs of another person and identify opportunities to strengthen their resources, be it at the hairdresser's, in a pub, in a taxi or at the playground. In this context, and in line with the expert workshop, it is better to speak of social connectedness. However, it is important to identify patients in all settings no matter which setting they are in.

It is about identifying people who have no connection to other levels of care. For example, in the hospital setting, people are encountered who have "fallen through the net" in a primary care setting. In some countries, link working can only be placed in one or two settings because of certain infrastructural issues and because of different national healthcare systems. Regardless of the setting, link workers must meet the people where they are; the services should be complementary.

Ideally, social prescribing is offered in all of these settings to reach people where they are seeking help. This can also be implemented more easily through cooperation between the settings, including in the network management. Bringing together resources in every field supports the creation of health and well-being (cf. Figure 5).

In the continued development process of social prescribing, it still needs to be clarified how the role of the link worker differs from existing functions (e.g. social work, case and care management), what quality assurance looks like or can look like for regional services to which referrals are made (e.g. standardised criteria or the personal contact of the link worker with them) and, last but not least, what works for whom and under which circumstances.

Figure 5: Social prescribing in different healthcare settings



Quelle: GÖG, Grafics: FLATICON

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