National Academy for Social Prescribing

Evidence briefing

The economic impact of social prescribing

The National Academy for Social Prescribing (NASP) commissioned its Academic Partners to review and summarise the evidence on the economic impact of social prescribing, including value for money, cost-effectiveness and social return on investment. This NASP briefing captures the headline findings.

The Academic Partners' review of the academic literature, and other reports and evaluations found that, despite considerable policy interest and need, there were very few economic evaluations of for social prescribing. Those found were often small-scale and hard to find, and only a small number of studies met the criteria for inclusion in the evidence summary.

All the findings and examples referred to in this briefing are drawn from individual high-quality studies that met the criteria for inclusion in the evidence summary. In total the evidence summary drew on 34 studies, reports or evaluations. See summary for full list of references.

All the included studies were relatively short, used a wide variety of different techniques to assess economic value (i.e. data collection was not consistent across studies) and the small scale of many studies made it hard to generalise the findings.

What we know

The evidence suggests that social prescribing can reduce pressure on Primary Care and save costs.

For example:

- Statistically significant reductions in visits to GPs were found in one study looking at participants who were referred to the social prescribing service in Shropshire due to their risk of cardiovascular disease. This study reported a reduction in the number of visits to the GP of 0.76 per person over the study period (when comparing a 3-month pre and 3-month post social prescribing intervention period). A retrospective case-matched control group showed no change in number of GP visits.

The evidence about impact on secondary care was inconclusive. However, some studies did report a link to reduction in secondary service use.

For example:

- Evaluation work on the Rotherham Social Prescribing Service (RSPS) has consistently tracked a cohort of patients through secondary care data. The data showed that there was a small overall increase in the number and cost

- of RSPS patients' inpatient spells and accident and emergency attendances in the 12 months following referral. However, when the data were explored in more detail the likelihood of a RSPS patient seeing a reduction in their secondary care use following their referral was predominantly affected by how many times a patient accessed secondary care in the previous 12 months, with the highest users seeing the largest reductions; and age, with younger patients more likely to see a reduction than older patients.

The evidence demonstrated a favourable social return on investment (SROI) in most cases where a range of outcomes and costs were considered.

Evaluations of social prescribing consistently found positive outcomes, across a range of methodologies. SROI values in the included studies ranged from 1:1.09 to 1:8.56. For example:

- One study used a pre-post analysis of over 10,000 users of a national social prescribing service over 30 months up to December 2019. The final net value of the service incorporated the subjective wellbeing value with missed healthcare appointments, volunteer wellbeing, and service delivery costs. The SROI was valued at £3.42 per £1 invested, with an investment of £4.7m leading to outcomes worth £11.5m.
- Simpler return on investment (ROI) studies that do not take into account the wider societal impact of social prescribing have a wide range of results, but with smaller returns than SROI studies, ranging from 1:1.011 to 1:1.43.

A study on the gain in Quality Adjusted Life Years (QALYs) from social prescribing found good value for money

- The Evaluation of the Doncaster Social Prescribing Service attempted to measure the Quality Adjusted Life Year (QALY) gain associated with a social prescribing and estimated the cost per QALY of £1, 963. The National Institute for Health and Care Excellence (NICE) threshold over which treatments are less likely to be recommended for use in the NHS is £20,000 so this represents a very cost-effective intervention in terms of increasing QALYs.

The gaps - what we still need to understand

The studies included in the summary represented a diversity of social prescribing approaches, aimed at a variety of target populations. These differences in population, pathway, and outcomes meant that a quantitative synthesis across the different studies was not possible. In the future, we need more studies to:

- Report on economic impact with suitable control or comparator groups

- Account for the cost or contribution of delivery services following service user referral, as these services are often being provided by the voluntary sector.
- Report on the full cost of interventions from inception to delivery, including all economic and financial costs, as this has not been reported in any studies.
- Capture longitudinal information on economic impact.
- Be representative of the population as a whole, so that they can be used to inform decision making.

There is also a need to promote more consistent approaches to collecting a range of data, including financial and economic costs, personal impacts, information on delivery models, demographics and outcomes relating to social determinants of health. This highlights the need for better data linkage between primary and secondary care and local public health databases.

There are many challenges around complexity in collecting this information, and around the ability to attribute economic outcomes to interventions. We are committed to working with partners to continue to identify and address priority evidence needs.