Title

Financing Approaches to Social Prescribing Programs in England and the United States

Journal

Milbank Quarterly, 100(2)

ISSN

0887-378X

Authors

SANDHU, SAHIL
ALDERWICK, HUGH
GOTTLIEB, LAURA M

Publication Date

2022-06-01

DOI

10.1111/1468-0009.12562

Peer reviewed

THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Perspective

Financing Approaches to Social Prescribing Programs in England and the United States

SAHIL SANDHU,[*,†] HUGH ALDERWICK,[‡] and LAURA M. GOTTLIEB[§]

[*]*Harvard Medical School, Boston, Massachusetts;* [†]*Population Health Sciences Institute, Newcastle University, Newcastle Upon Tyne;* [‡]*The Health Foundation, London;* [§]*University of California, San Francisco*

Policy Points:

- The number of social prescribing practices, which aim to link patients with nonmedical services and supports to address patients' social needs, is increasing in both England and the United States.
- Traditional health care financing mechanisms were not designed to support social prescribing practices, and flexible payment approaches may not support their widespread adoption.
- Policymakers in both countries are shifting toward developing explicit financing streams for social prescribing programs. Consequently, we need an evaluation of them to assess their success in supporting both the acceptance of these programs and their impacts.
- Investment in community-based organizations and wider public services will likely be crucial to both the long-term effectiveness and the sustainability of social prescribing.

Both England and the United States have long recognized that social determinants of health play a major role in shaping population health and health equity.[1,2] The World

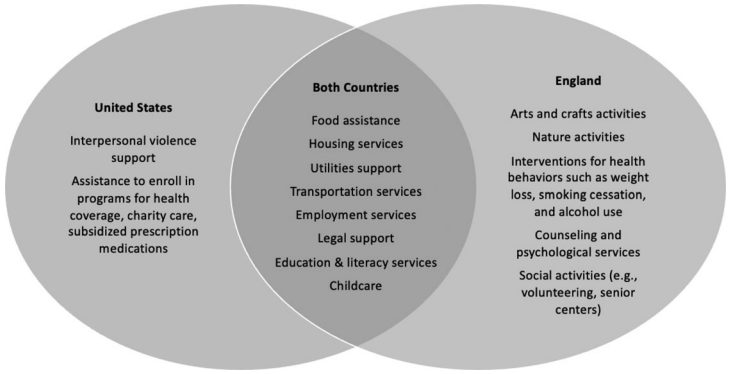
The Milbank Quarterly, Vol. 100, No. 2, 2022 (pp. 393-423)

Health Organization (WHO) defines the social determinants of health as "the conditions in which people are born, grow, live, and age," which are "shaped by the distribution of money, power and resources."[3] Social determinants include income, employment, education, neighborhood conditions, social and community context, and other social and economic factors.[4] In fact, research suggests that social determinants and related health behaviors may have a bigger impact on health outcomes than clinical care does.[5-10] This research has also contributed to new initiatives in the health care sector that involve assessing and addressing patients' social needs, such as food insecurity, housing instability, and social isolation, alongside the delivery of medical services.[11]

Forms of "social prescribing" have emerged as a common strategy for weaving attention to social conditions into the delivery of health care in both England and the United States. Broadly speaking, social prescribing refers to identifying patients' social needs and connecting patients with relevant nonmedical services to improve their health and well-being.[12] In England, social prescribing is typically used to describe efforts by general practitioners (GPs) to identify and refer patients who may benefit from nonmedical supports to a social prescribing "link worker." Link workers assess patients' needs and develop a "social prescription" to relevant services in the community.[13] Social prescriptions may include referrals to exercise programs, nature activities, employment assistance, and a range of social services (e.g., welfare support and debt advice).[14] Although little robust evidence exists regarding the effectiveness of social prescribing in England,[15] recent reviews describe existing gaps in knowledge and factors that may influence the implementation[16] and impact of interventions.[17,18]

Social prescribing programs in the United States are more commonly called "social needs" or "social care" interventions. These programs usually involve a social risk assessment or screening followed by efforts to connect patients with relevant social services or other resources. These resources may be on or off site and include health care–sponsored (e.g., on-site food pantries), government-sponsored (e.g., Medicaid-covered meal delivery programs), or community-based programs (e.g., Meals on Wheels).[19] The staff for these types of activities varies across settings and may include traditional health care staff (e.g., physicians, nurses, and medical assistants) or nonmedical staff (e.g., social workers, community health workers, and volunteer navigators).[20] Although the majority of

Figure 1. Comparing Common Types of Referrals in Social Prescribing Programs in England and the United States



studies evaluating social prescribing in the United States have focused on process measures and do not include comparison groups, a handful of randomized, controlled trials and strong quasi-experimental studies suggest that some social prescribing interventions can help reduce social needs, improve some health indicators, and, in some cases, reduce hospital utilization.[21-24]

The available evidence shows that the scope of services offered to patients in social prescribing schemes in the two countries have some similarities but also some notable differences (Figure 1).[14,25-27] Programs in the United States typically concentrate on connecting patients to resources that help meet basic material needs, such as food insecurity and housing instability.[28] Services in England also help address patients' basic social needs, as well as enabling social prescribing practitioners to refer patients to other types of services, such as arts and crafts and volunteering programs, whose purpose is to improve the patient's overall well-being and quality of life. The processes for identifying social needs and relevant services for community linkages also vary. Whereas interventions in the United States often use social risk screening tools, in England, interventions place less emphasis on standardized screening.[29,30]

As more social prescribing interventions are integrated into clinical care, policymakers in England and the United States are developing and testing a mix of policies to support adoption and scaling. Both countries are exploring how policy supports should be used to maximize programs' uptake and effectiveness, by asking about which intervention components are most likely to affect health outcomes, core training and deployment strategies for the social prescribing workforce, the appropriate use of data and technology, sustainable financing models, and more.[31]

In this paper, we describe how public-financing approaches have progressed in both countries to support social prescribing. We highlight three models: (1) traditional health care and social service funding, which provides limited or no dedicated financial support for social prescribing activities; (2) flexible funding models that may encourage, but rarely directly finance, social prescribing; and (3) direct financing mechanisms for social prescribing (Table 1). Understanding the evolution of these governmental approaches to financing and ongoing challenges in England and the United States may advance the adoption of social prescribing in both countries and globally.

Traditional Health Care and Social Services Financing in England and the United States

Health care and social services in both England and the United States have traditionally been financed and organized separately, although the amount of spending, including contributions from the public and private sectors, varies between the two countries. In 2015, the United States spent nearly double the percentage of its gross domestic product (GDP) on health care services compared to the UK (16.8% vs. 9.8%). In the same year, the UK spent 17.7% of its GDP on social programs, while the United States spent 14.9%.[32] The context for the organization and delivery of health care also varies widely. England has a comprehensive, publicly funded health care system, with services free at the point of use, whereas the United States has a market-based health care system with mixed public and private insurance and high out-of-pocket costs for individuals.

Table 1. Financing Models of Social Prescribing in England and the United States

Financing Model	England	United States
Traditional health care and social service funding	Health and social services were financed and delivered in silos despite some policy initiatives to encourage closer integration.	
Flexible funding models	The development of new models of integrated health and social care sometimes included pooling funds for health and social services to deliver a range of local services. Such models could include social prescribing.	The shift from volume-based to value-based payment incentivized new models of care delivery to improve population health and reduce costs. Such models could include social prescribing.
Direct financing mechanisms for social prescribing	The NHS committed to a national rollout of social prescribing by funding a new "link worker" role for newly formed primary care networks. Funding was supplemented with some government support and guidance on training, implementation, and measurement.	The Centers for Medicare and Medicaid Services supported an Accountable Health Communities model to systematically test social prescribing across 28 sites nationally, and state governments used Medicaid dollars and contracts with managed care organizations to explicitly fund or require social prescribing.

Health Care Services

Health care services in England are mainly organized and delivered through the National Health Service (NHS), which is primarily funded through general taxation.[33] The central government allocates overall funding for health care, and NHS England—the national agency responsible for most of the NHS's day-to-day operations—allocates funds to around 100 clinical commissioning groups (CCGs) using a formula that accounts for differences in health care needs, deprivation, and other factors and that pay for most local NHS services. For example, CCGs contract with hospital and community services to provide care for patients in the region. Reforms of the English NHS being considered would replace CCGs with 42 regional agencies, called *integrated care systems*, responsible for controlling most NHS resources.[34,35] These reforms will likely be implemented in April 2022 and will focus on changes in health system governance and decision making. Integrated care systems will coordinate local agencies' measures to improve health and reduce inequalities, improve and coordinate services, and make the best use of existing resources. These systems must also help with broader social and economic development in their community.

Around half of all GPs are self-employed private contractors; the others are salaried employees of GP partnerships or GP trainees.[36] General practices are paid through a complex mix of income streams, with about half the funds received through capitated, global sum payments for essential services and the rest through other payments, such as fee-for-service reimbursements for additional services (e.g., travel vaccinations), premise payments, and performance-related payments.[37] Capitated payments are adjusted for the patient population's sociodemographic and health characteristics, as well as market factors. Nearly all outpatient specialty care providers are salaried employees of NHS hospitals, which are reimbursed through diagnosis-related group rates and other local arrangements, such as block contracts. Hospital and other provider payment systems are evolving after major changes to the payment systems during the pandemic.[38]

Unlike the English health care system's primarily public financing, US health care services rely on a mix of private and public financing. The majority of Americans receive health coverage from private insurance companies through their employers. Beyond employer-sponsored coverage, the federal government, via the Centers for Medicare and

Medicaid Services (CMS), provides health coverage for more than 61 million older adults and Americans with disabilities through the Medicare program, and partners with states to provide health coverage for an additional 71 million low-income adults and children through Medicaid and the Children's Health Insurance Program (CHIP).[39(p12)] The federal government also finances health coverage for active members of the military, veterans, and Native Americans and Alaska Natives. Despite these coverage options, 9% of Americans still are uninsured.[40] In contrast to the capitation model in England, the majority of primary care revenue in the United States comes from fee-for-service payments, although there has been a recent push toward alternative payment models (e.g., risk-based payments and population-based payments linked to quality).[41]

Social Services

England's social services addressing nonmedical needs are financed through a combination of public and private funding. Public social spending includes income and employment support, housing and other benefits, children's services, education, and other public services. Adult social care services in England—similar to long-term services and supports in the United States—are funded through a mix of public and private spending, with publicly funded care available only to people with the lowest means and highest needs. Other social supports can be delivered through nongovernmental organizations, often known as the voluntary community and social enterprise (VCSE) sector. Examples of services delivered by the VCSE sector are debt counseling, legal advice, and peer support. The VCSE sector is funded through a combination of individual, foundation, and government funding, including some local NHS spending.

Social services in the United States also are financed through both public and private funding. Both the federal government and individual states provide a variety of social services and public benefits for Americans, such as food benefits, temporary financial assistance, housing vouchers, disability benefits, job and training programs, and early childhood development programs. The amount of spending on health care and social supports varies widely between states.[42] Many social services are also delivered by community-based organizations (CBOs), such as food pantries, homeless shelters, legal assistance agencies, vocational services,

and senior centers. CBOs are often funded through philanthropy; some receive additional funding through government grants or contracts with health care organizations.[43,44]

Flexible Funding for New Care Delivery Models

Both England and the United States have revised their funding and organizing of services over the past decade toward more integrated models of care.

English Models

England has a long history of policy initiatives to encourage the closer integration of health and social services.[45] Many of these policies are meant to improve the coordination of health care and long-term services and supports.[46] Other policies encourage the development of broader models of community-based support to improve population health and reduce inequalities, including through flexible funding models and national pilot programs.

Several policies have concentrated on coordinating the planning and spending by the NHS, local governments—responsible for funding and delivering a range of public services, including long-term services and supports, children's services, and public health—and others. Since 2015, local health and social services agencies in England have been required by national policymakers to develop cross-sector plans for improving health and care in their area.[47] The first round of these sustainability and transformation partnership (STP) plans was completed in 2016. All of the submitted plans focused on better coordination of health and social services, and around a third mentioned developing or expanding social prescribing programs.[45] The experience of developing STPs was mixed.[47] But current reforms of the English NHS seek to formalize these regional partnerships, now called integrated care systems, and to give them greater responsibility for NHS's planning and spending.[34]

Pooled financing initiatives have often been used to help fund more integrated service models in England. For example, the Better Care Fund was introduced by the government in 2013 as a mandatory budget-pooling local initiative between the NHS and local

governments.[48] Local agencies were required to pool a proportion of their spending to fund local initiatives to coordinate care for older people with disabilities (and others depending on the local context) and had to meet a mix of national objectives, such as targets to reduce hospital utilization. Some areas reported using the Better Care Fund to finance social prescribing initiatives.[49-53] The evidence suggests that the scheme helped reduce delayed transfers of care but had no effect on emergency admissions.[54,55] The Better Care Fund builds on a long history of budget-pooling programs between the NHS and local government in England, including "total place" and "community budget" programs.[56,57] At a lower level, various forms of "personal budgets"—which bring together health, long-term care, and sometimes education funding for an individual to control directly—have also been used to offer patients with complex needs the flexibility to purchase nonmedical care (e.g., home-based supports) in place of traditional health care services.[58]

A series of national pilot programs—such as integrated care pilots (2009-2011),[59] integrated care "pioneers" (2013-2018),[60] and new care model "vanguards" (2015-2018)[61]—also provided direct funding and support for testing integrated care models. These programs supported a range of approaches to coordinating local services—including within the NHS (e.g., between primary care and hospitals) and between health and social supports (e.g., through community-based multidisciplinary teams). Evaluations and descriptions of the most recent programs suggest that social prescribing interventions formed a core component of most initiatives, though we have few details about how social prescribing initiatives were developed and funded under these different models.[60,62,63] Some of the local areas involved in these programs also tested new flexible payment models for providers, to incentivize better coordination of services and investment in disease prevention, and some adopted the American language of "accountable care" to describe their efforts to do so.[64-66] But the development of these models has often been slow and challenging to implement.[65]

In sum, over the past decade the English NHS has pursued a mix of policy initiatives to promote a closer integration of health and care services in the community. But these initiatives have typically had broad and ambiguous aims, contained a high degree of heterogeneity, and delivered mixed results overall.[67] Generalizable lessons have been hard to distill and apply. Yet the current national policy continues to rely on

closer integration of services and collaboration between public sector agencies as major drivers of health system reform.[34,68]

US Models

Largely spurred by the Affordable Care Act in 2010, new payment models in the United States pushed health care payers and delivery systems to shift from volume-based, fee-for-service payment models toward value-based payment models by holding stakeholders accountable for population health, quality of care, and costs. Such models include accountable care organizations (ACOs), bundled payments, and global budgets. In the ACO model, health care delivery organizations group together to take responsibility for the care of a defined population. If the ACO keeps the costs of care below a predefined benchmark and meets certain quality measures, the ACO shares the savings with the payer. If a risk-bearing ACO exceeds the cost benchmark, the group also shares the financial losses with the payer. Although the ACO model started as part of the Medicare program, similar approaches have also been adopted by Medicaid programs and commercial insurers.[69]

Researchers and policymakers in the United States anticipated that value-based payment models would provide financial flexibility and incentives to adopt these interventions to address patients' social needs.[70] Although ACOs were early adopters of such integrated care efforts, including social prescribing,[71] the actual impact of value-based programs on social prescribing is unclear.[72] ACOs report that they lack data on their patients' social needs and the capacity of local CBOs, struggle to form partnerships with CBOs, and face financial constraints given short funding cycles and the time it takes to see returns on investments from social prescribing.[72] This suggests that value-based payment approaches may be a helpful but insufficient lever to increase the adoption of social prescribing. Indeed, a recent study showed that exposure to value-based payments for physician practices was not associated with the implementation of social risk screening, a common component of US social prescribing programs.[73]

Similarly, state governments hoped that transitioning from fee-for-service to risk-based Medicaid managed care organizations (private insurance companies that receive capitated payments from state Medicaid agencies to provide care for covered members) would also

encourage investments in social prescribing initiatives.[31] But limited data are available to evaluate the uptake of social prescribing in Medicaid managed care plans. Previous qualitative research has suggested challenges to uptake include lack of designated funding streams for social care programs and regulatory barriers.[74]

In addition to value-based payment structures, newer policies now clarify how health plans can take advantage of the new financial flexibilities to address social needs. For example, the CHRONIC Care Act in 2018 enabled Medicare Advantage plans (i.e., private health care plans that manage Medicare benefits for a group of beneficiaries) to provide supplemental benefits that are not covered by traditional Medicare, such as meal delivery, pest control, and indoor air quality equipment. The adoption of social needs–related supplemental benefits has been slow, however, with fewer than 5% of plans offering such benefits for chronically ill patients in 2019 and just over 10% in 2021.[75,76] The lack of additional funding from CMS, the optional nature of adoption by plans, and uncertainty around the parameters about these new benefits were proposed as possible reasons for the slow adoption.[77]

Dedicated Funding for Social Prescribing

Although both countries increased funding flexibility that in theory could be used to support social prescribing practices, in recent years, agencies in England and the United States have also introduced more targeted financing mechanisms that specifically require and/or pay for social prescribing activities. Some efforts in the United States also include financing approaches that directly reimburse the social service agencies to which patients are referred for assistance.

English Models

In 2019, national NHS agencies announced a new national strategy for the NHS in England—the Long Term Plan—to focus on developing more integrated models of health and social care and improving disease prevention.[78] To help achieve this, the Long Term Plan proposed an additional £4.5 billion investment in primary care and community health services.[79]

The plan devised new contracts to incentivize general practices to form primary care networks (PCN)—groups of practices covering populations of around 30,000 to 50,000 people. Although GPs' involvement was voluntary, the financial incentives to form PCNs were powerful, as most of the additional funding available for primary care promised in the Long Term Plan was available only through PCNs.[80] The result was widespread adoption: nearly all GP practices in England have formed around 1,250 PCNs.[81,82] PCNs are required to deliver defined national service specifications, ranging from structured medication reviews to improving early cancer diagnosis. PCNs are also expected to improve coordination between primary care and wider community services. PCNs receive annual core funding to support operations (~£1.50 per registered patient), payment for a clinical director, and payments for extended service hours.[83] Additional funding has also been made available to PCNs to pay for more staff in general practices, including social prescribing link workers, clinical pharmacists, and paramedics. Individual practices also receive a weighted participation payment per patient.

The funding of PCNs is the main financing mechanism for the national expansion of social prescribing. NHS England reimburses the salary, pension, and national insurance contribution of one link worker per PCN (maximum £34,113).[84] NHS England anticipated that this would support more than 1,000 link workers by the end of 2020 (and "significantly more" after that) and that 900,000 patients would be referred to social prescribing schemes by the end of 2024.[85] NHS data show that 852 link workers had been hired by the end of 2020, though only 60% of PCNs had reported data.[86] The number of link workers had increased to around 1,200 by June 2021.[86] The logic behind the exact targets for the number of link workers is unclear. In addition to new link workers, GP practices in some areas already had developed social prescribing schemes before the arrival of PCNs and link worker roles, with a mix of staff delivering them. Additional financial incentives also were introduced to encourage practices to increase the number of social prescribing referrals.[87]

The PCN network contract defines the responsibilities of the link worker (see Table 2).[84] PCNs are responsible for identifying the first point of contact to advise the link workers and a GP for supervision. Referrals to link workers must be documented in the GP's electronic health record using new national SNOMED codes. PCNs also are

Table 2. Key Responsibilities for Social Prescribing Link Workers Reimbursed in PCN Contract

Link Workers' Patient-Level Responsibilities
Assess patients' health and well-being needs
Coproduce personalized care and support plans to connect patients with community resources
Evaluate whether actions described in personalized plan meet patients' needs
Provide personalized support to individuals, their families, and carers
Develop trusting relationships with patients, focus on "what matters to them," and take a holistic approach based on patient's priorities
Link Workers' Broader Responsibilities
Manage and prioritize their own caseload
Take referrals from both PCN members and a wide range of health and social service agencies
Work with community organizations to receive social-prescribing referrals
Share intelligence with commissioners and local authorities about any gaps or problems in community services
Educate clinical and nonclinical staff on available community services

allowed to subcontract with community-based organizations to train and manage link workers.

Despite providing funding for social prescribing activities carried out by link workers, PCNs and policies related to the Long Term Plan do not offer funds to pay for the community resources to which link workers refer patients. Instead, NHS England recommends that local CCGs and PCNs explore innovative funding models to support community services (e.g., small grant-making, micro-commissioning, and shared investment funds to support local priorities).[88] In some areas, NHS and local government funding have been used to support VCSE organizations involved in social prescribing initiatives, with close coordination between NHS and VCSE agencies.[89] But the VCSE sector is concerned that social prescribing initiatives have led to increases in referrals to community organizations that are not sustainable without additional funding.[89]

US Models

New government funding mechanisms and pilot demonstrations that target social prescribing were developed at both the federal and state levels in the United States.[90] Three examples are the Accountable Health Communities model, Section 1115 Waivers for state Medicaid agencies, and state-level Medicaid managed care contracts.[31]

In 2017, the federal government, through the Center for Medicaid and Medicare Innovation (CMMI), launched a new Accountable Health Communities demonstration model to test whether social prescribing could improve health outcomes and reduce costs. Under this model, CMMI funded 28 organizations across 21 states to provide social risk screening and navigation services until April 2022. The demonstration funded organizations on two tracks, Assistance and Alignment. In the Assistance track, organizations universally screen Medicaid and Medicare beneficiaries in their area for social needs using a standardized ten-item tool created with input from a technical expert panel. Beneficiaries who reported both social needs and two or more emergency department visits in the past year are randomized into an intervention or control group. Beneficiaries in the control group are given a summary of community resources; beneficiaries in the treatment group are offered support from navigators who provide a detailed assessment, planning, a referral to community services, and follow-up.[91] In the Alignment track, participating organizations receive additional funding for supporting community-level quality improvement efforts (e.g., community advisory board, gap analysis, and multisector partnerships). Organizations in both tracks receive $86 per beneficiary per year, and organizations in the alignment track receive an additional $350,000 lump-sum payment per year. A comprehensive evaluation is now determining whether the model affects costs, utilization, and health benefits and whether CMS should incorporate program elements into new and existing payment models.[91]

At the state level, many Medicaid agencies used Section 1115 waivers to experiment with models of care that specify social prescribing–related initiatives. For example, the North Carolina Department of Health and Human Services received a waiver to use $650 million from the state Medicaid agency to implement a new social prescribing pilot called Healthy Opportunities.[92] Three health care organizations were funded to build capacity in their respective regions, contract with local managed

care organizations to manage a network of CBOs, and lead the pilot. In this model, individuals with Medicaid coverage are screened for needs related to food, housing, transportation, and interpersonal violence using a standardized tool. Individuals with identified needs are referred to community resources using a statewide technology platform that enables health care and social services providers to exchange referral information. The funded organizations use a predefined fee schedule to pay CBOs to deliver services to their beneficiaries (e.g., paying a food pantry to deliver food to patients).[93] Other state Medicaid agencies have developed their own financial models to invest in social needs. For example, California received a Section 1115 waiver to create per-member, per-month bundled payments that can support defined social interventions.[94] One county even created an incentive payment structure to reward successful transitions to community settings (e.g., connections to social supports) for patients leaving jails and mental health institutions.

State Medicaid agencies also can require or otherwise incentivize contracted managed care organizations (MCOs) to implement social prescribing activities.[95] That is, states can require social prescribing–related activities as part of broader care coordination and case management activities. For example, some states require MCOs to screen all Medicaid beneficiaries for social needs and/or to coordinate with community-based organizations. Other states require that social determinants–related activities be included in quality assessment and performance improvement (QAPY) plans; others provide MCOs incentive payments or bonuses for meeting social determinants–related target measures. The MCOs can then pass on these incentives to their contracted health care delivery systems (e.g., by adding annual social needs screenings as a delivery system quality measure).[96,97]

Cross-Country Comparison

Public funding mechanisms in both England and the United States evolved to support social prescribing care models. Traditional health care funding approaches were not designed to support these practices.[12] In the United States, the fee-for-service payment architecture does not offer financial motivation for health care providers to address upstream drivers of health. In England, GPs historically operated as small businesses receiving mostly capitated payments from the NHS. While GPs

report spending a significant amount of time discussing nonmedical issues, such as welfare benefits, with patients, they received limited dedicated resources to coordinate with nonmedical services.[98]

Over the past decade, both countries experimented with new financial models and policy initiatives that created flexibility for health care providers to redesign care delivery (e.g., value-based payment models in the United States and integrated care initiatives in England). But it is unclear how much these approaches facilitated or will contribute to a more widespread adoption of social prescribing. In England, about one-third of NHS-mandated local STP plans from 2016 mentioned developing or strengthening social prescribing initiatives,[45] although exactly what this means in practice or how far these initiatives were implemented is also not clear. In the United States, one study found that only about a fifth of physicians' practices participating in alternative payment models (e.g., bundled payment models or Medicaid ACOs) screened for five social needs recommended by the CMS through their Accountable Health Communities model.[71]

More recently, governments in both countries implemented new financing models that more explicitly fund social prescribing interventions. Financial flexibility was combined with more targeted funding and other nonfinancial supports (e.g., guidance on standardized approaches, workforce development, implementation supports).[99] England committed nationally to supporting link workers, as the workforce needed to implement social prescribing, alongside other financial incentives for social prescribing activities. National policy also has continued to encourage a broader collaboration of the NHS, local government, and wider community-based services. In the United States, policies that provide additional support for social prescribing have been more heterogeneous, differing across states. Examples are lump-sum payments to pilot social prescribing, contractual requirements to screen patients for social needs, and bonus payments for meeting social prescribing–related quality measures.[31]

Little is currently known about the impact of these newer, more targeted financing approaches, or the combination of increased funding flexibility and more targeted approaches. The NHS's explicit reimbursement of link worker roles is likely to drive uptake of social prescribing in England. Yet the additional NHS investment may not be sufficient to cover other costs associated with social prescribing, including GPs' oversight of link workers, technology infrastructure to facilitate referrals, and

time and energy to design handoff processes between GPs and link workers. It is also unclear whether the ratio of one funded link worker to every 30,000 to 50,000 patients will enable social prescribing initiatives to reach sufficient numbers of patients to be meaningful at the population level, or whether the investment in link workers could have delivered greater benefits if instead it had been invested directly in community-based supports. The approach also risks widening inequities, as there are no mechanisms to ensure that additional staff are targeted at those areas with the greatest needs.[100]

A rigorous evaluation will be critical to understanding the effectiveness and any unintended consequences of each approach. The new Social Prescribing Observatory, launched by the Royal College of General Practitioners and the University of Oxford, may be a useful tool to support such efforts. Using electronic health record data, it provides weekly updates on the volume of social prescribing referrals. Between January and September 2020, observatory researchers estimated that 250,000 social prescribing referrals were recorded using the SNOMED codes specified in the guidance to primary care networks.[101] In the United States, a broad array of federal and state-level financing approaches may inform financing approaches that can support the national adoption of social prescribing. An evaluation is thus needed to learn from the geographic and payer-level heterogeneity in payment models to inform national policy decisions.

Although evaluation efforts are continuing, comparing differences in the structure and development of financing approaches between the two countries can help find questions for policymakers in both contexts. For example, American policymakers might consider lessons from the English investment in a workforce that provides navigation to social services, including a mix of financial support and guidance for staff training and development.[102,103] The United States has no national workforce strategy for social prescribing activities; instead, staffing approaches vary across settings. Models include adding social prescribing activities to existing staffs' responsibilities (e.g., asking doctors, nurses, and medical assistants to screen patients for social needs), repurposing existing staff into new social prescribing roles (e.g., redeploying case managers as community resource specialists), and, in some cases, creating new roles (e.g., training student volunteers as resource navigators or recruiting community health workers).[20] The community health worker model is the closest to the English link worker, with some US models

demonstrating impressive clinical and cost effectiveness.[104,105] As the Biden administration considers deploying 150,000 community health workers to underserved communities,[106] policymakers and practitioners should consider combining the financial and nonfinancial supports needed to ensure their successful implementation.

Likewise, English policymakers might learn from US efforts to tie rigorous evaluation to the implementation of novel payment and delivery models for social prescribing. In the Accountable Health Communities model, for instance, CMMI developed a standardized social risk screening tool and a set of process and outcome evaluation metrics across sites. It also required sites in the Assistance track to randomize beneficiaries to control or intervention groups. This approach ideally would enable CMMI to find out which components of the model (including financial supports) influence outcomes (and for which patient populations) before the government commits to a national payment model to support this type of programming. English policymakers should consider how social prescribing interventions could be more systematically tested and evaluated before they are implemented more widely in order to ensure that policy rhetoric regarding the benefits of social prescribing matches the reality for patients and to avoid unintended consequences of interventions leading to more inequities.[15] Evaluations of England's integrated care initiatives often center on learning from broad national programs with vague goals rather than testing more narrowly defined service innovations.[67] Evaluations could also illuminate where additional investment in addressing patients' nonmedical needs would deliver the greatest benefits.

Policymakers in both countries must consider more seriously the financial supports needed for the nonmedical services to which patients are referred under social prescribing schemes. Both countries' financing models predominantly focus on assessing patients' social needs and/or connecting them to relevant social services. But social services agencies and CBOs, which often operate at a deficit, may lack the capacity to serve newly referred patients—creating a "road to nowhere" for vulnerable patients.[12,43,107,108] In addition, the COVID-19 pandemic has strained the financial support of already underfunded community assets.[109-111] Increasing payments from government or health care organizations to community-based services might improve the long-term effectiveness and sustainability of social prescribing approaches. For example, with

federal approval and clearly defined fee schedules, North Carolina's Medicaid program is testing directly paying for social services rather than only referring patients to community resources.[92] Current reforms of the NHS in England are creating new regional partnerships between the NHS, local government, and other community partners to plan and coordinate local services,[34] which may create opportunities to reallocate resources to community-based services. But the challenges of doing this should not be underestimated: NHS resources have often gravitated toward acute hospital services, and new community-based partnerships risk being dominated by powerful NHS providers.[34,112]

Ultimately, financing social prescribing interventions through the health care sector alone will be insufficient to improve population health.[11] Even though social prescribing programs have already benefited some individual patients, other investments at the state and country levels—such as increased spending on housing, income support, and other social services—will be needed to influence the structural social and economic conditions that shape health and health inequities. A health care–centered financing approach risks medicalizing social problems and viewing systemic and institutional drivers of inequalities as something that can be diagnosed and treated.[89] In England, greater health care funding for social prescribing may inadvertently result in decommissioning similar schemes funded by local governments.[89] In the United States, CBOs are concerned that becoming dependent on new income streams from health care organizations may result in unfavorable contracts, loss of flexibility, and a commodification of work into discrete, billable products.[44] Proponents for social prescribing should test multipronged financing approaches that couple health system funds for individual-level social prescribing programs with other community-level investments. They also must continue to advocate for increased government spending on social services outside the health care sector.[113] Evaluations of social prescribing programs should seek to understand which health care investments can deliver the greatest impacts for patients and populations.

While our analysis focuses on comparing financing approaches for individual-level social needs interventions in the United States and England, future research may consider a cross-country comparison of payment approaches that facilitate or incentivize community-level efforts to address upstream social determinants of health.

Conclusions

In England and the United States, social prescribing has emerged as a popular intervention to improve population health by linking patients with services and supports to help address nonmedical needs. Policymakers in each country tested flexible funding models and, more recently, targeted financial supports to influence uptake. Approaches vary given the differences in health system and country contexts, and evaluation is needed to assess the impacts of different funding models. In both countries, greater investments in community-based organizations and broader public services will likely be crucial to affect population health.

References

1. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep*. 2014;129(Suppl.2):19-31. https://doi.org/10.1177/00333549141291S206.
2. Marmot M, Bell R. Fair society, healthy lives. *Public Health*. 2012; 126(Suppl.1):S4-S10. https://doi.org/10.1016/j.puhe.2012.05.014.
3. World Health Organization (WHO). Social determinants of health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1. Accessed May 14, 2021.
4. Koh HK, Piotrowski JJ, Kumanyika S, Fielding JE. Healthy people: a 2020 vision for the social determinants approach. *Health Educ Behav*. 2011;38(6):551-557. https://doi.org/10.1177/1090198111428646.
5. Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. *Am J Prev Med*. 2016;50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024.
6. McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff (Millwood)*. 2002;21(2):78-93. https://doi.org/10.1377/hlthaff.21.2.78.
7. Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. *Annu Rev Public Health*. 2011; 32(1):381-398. https://doi.org/10.1146/annurev-publhealth-031210-101218.

8. Stringhini S. Association of socioeconomic position with health behaviors and mortality. *JAMA*. 2010;303(12):1159. https://doi.org/10.1001/jama.2010.297.
9. Jemal A, Thun MJ, Ward EE, Henley SJ, Cokkinides VE, Murray TE. Mortality from leading causes by education and race in the United States, 2001. *Am J Prev Med*. 2008;34(1):1-8.e7. https://doi.org/10.1016/j.amepre.2007.09.017.
10. Galea S, Tracy M, Hoggatt KJ, DiMaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. *Am J Public Health*. 2011;101(8):1456-1465. https://doi.org/10.2105/AJPH.2010.300086.
11. Alderwick H, Gottlieb LM. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. *Milbank Q*. 2019;97(2):407-419. https://doi.org/10.1111/1468-0009.12390.
12. Alderwick HAJ, Gottlieb LM, Fichtenberg CM, Adler NE. Social prescribing in the U.S. and England: emerging interventions to address patients' social needs. *Am J Prev Med*. 2018;54(5):715-718. https://doi.org/10.1016/j.amepre.2018.01.039.
13. Drinkwater C, Wildman J, Moffatt S. Social prescribing. *BMJ*. 2019;364:l1285. https://doi.org/10.1136/bmj.l1285.
14. Chatterjee HJ, Camic PM, Lockyer B, Thomson LJM. Non-clinical community interventions: a systematised review of social prescribing schemes. *Arts Health*. 2018;10(2):97-123. https://doi.org/10.1080/17533015.2017.1334002.
15. Bickerdike L, Booth A, Wilson PM, Farley K, Wright K. Social prescribing: less rhetoric and more reality: a systematic review of the evidence. *BMJ Open*. 2017;7(4):e013384. https://doi.org/10.1136/bmjopen-2016-013384.
16. Pescheny JV, Pappas Y, Randhawa G. Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. *BMC Health Serv Res*. 2018;18(1). https://doi.org/10.1186/s12913-018-2893-4.
17. Tierney S, Wong G, Roberts N, et al. Supporting social prescribing in primary care by linking people to local assets: a realist review. *BMC Med*. 2020;18(1):49. https://doi.org/10.1186/s12916-020-1510-7.
18. Husk K, Blockley K, Lovell R, et al. What approaches to social prescribing work, for whom, and in what circumstances? A realist review. *Health Soc Care Community*. 2020;28(2):309-324. https://doi.org/10.1111/hsc.12839.
19. Gottlieb L, Cottrell EK, Park B, Clark KD, Gold R, Fichtenberg C. Advancing social prescribing with implementation science. *J Am Board Fam Med*. 2018;31(3):315-321. https://doi.org/10.3122/jabfm.2018.03.170249.

20. Sandhu S, Xu J, Eisenson H, Prvu Bettger J. Workforce models to screen for and address patients' unmet social needs in the clinic setting: a scoping review. *J Primary Care Community Health*. 2021;12:215013272110210. https://doi.org/10.1177/21501327211021021.
21. Gottlieb LM, Hessler D, Long D, et al. Effects of social needs screening and in-person service navigation on child health: a randomized clinical trial. *JAMA Pediatr*. 2016;170(11):e162521. https://doi.org/10.1001/jamapediatrics.2016.2521.
22. Pantell MS, Hessler D, Long D, et al. Effects of in-person navigation to address family social needs on child health care utilization: a randomized clinical trial. *JAMA Netw Open*. 2020;3(6):e206445. https://doi.org/10.1001/jamanetworkopen.2020.6445.
23. Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. Addressing social determinants of health at well child care visits: a cluster RCT. *Pediatrics*. 2015;135(2):e296-e304. https://doi.org/10.1542/peds.2014-2888.
24. Berkowitz SA, Hulberg AC, Standish S, Reznor G, Atlas SJ. Addressing unmet basic resource needs as part of chronic cardiometabolic disease management. *JAMA Intern Med*. 2017;177(2):244-252. https://doi.org/10.1001/jamainternmed.2016.7691.
25. Kreuter MW, Thompson T, McQueen A, Garg R. Addressing social needs in health care settings: evidence, challenges, and opportunities for public health. *Annu Rev Public Health*. 2021;42(1):329-344. https://doi.org/10.1146/annurev-publhealth-090419-102204.
26. Sokol R, Austin A, Chandler C, et al. Screening children for social determinants of health: a systematic review. *Pediatrics*. 2019;144(4):e20191622. https://doi.org/10.1542/peds.2019-1622.
27. Zurynski Y, Vedovi A, Smith K. Social prescribing: a rapid literature review to inform primary care policy in Australia. Consumers' Health Forum of Australia. https://chf.org.au/publications/social-prescribing-literature-review. Published February 10, 2020. Accessed March 1, 2022.
28. Kreuter M, Garg R, Thompson T, et al. Assessing the capacity of local social services agencies to respond to referrals from health care providers: an exploration of the capacity of local social service providers to respond to referrals from health care providers to assist low-income patients. *Health Aff (Millwood)*. 2020;39(4):679-688. https://doi.org/10.1377/hlthaff.2019.01256.

29. Andermann A. Screening for social determinants of health in clinical care: moving from the margins to the mainstream. *Public Health Rev*. 2018;39(1). https://doi.org/10.1186/s40985-018-0094-7.
30. Moscrop A, Ziebland S, Bloch G, Iraola JR. If social determinants of health are so important, shouldn't we ask patients about them? *BMJ*. 2020;371:m4150. https://doi.org/10.1136/bmj.m4150.
31. Sandhu S, Sharma A, Cholera R, Prvu Bettger J. Integrated health and social care in the United States: a decade of policy progress. *Int J Integrated Care*. 2021;21(4):9. https://doi.org/10.5334/ijic.5687.
32. Papanicolas I, Woskie LR, Orlander D, Orav EJ, Jha AK. The relationship between health spending and social spending in high-income countries: how does the US compare? *Health Aff (Millwood)*. 2019;38(9):1567-1575. https://doi.org/10.1377/hlthaff.2018.05187.
33. Tikkanen R, Osborn R, Mossialos E. International health care system profiles. Commonwealth Fund. https://www.commonwealthfund.org/international-health-policy-center/system-profiles. Published 2020. Accessed March 1, 2022.
34. Alderwick H, Dunn P, Gardner T, Mays N, Dixon J. Will a new NHS structure in England help recovery from the pandemic? *BMJ*. 2021;372:n248. https://doi.org/10.1136/bmj.n248.
35. UK Parliament. Health and care bill publications; parliamentary bills. https://bills.parliament.uk/bills/3022/publications. Accessed September 1, 2021.
36. NHS Digital. General practice workforce. https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services. Accessed December 9, 2021.
37. King's Fund. GP funding and contracts explained. https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained. Published June 11, 2020. Accessed December 9, 2021.
38. NHS England. Developing the payment system for 2021/22. https://www.england.nhs.uk/wp-content/uploads/2021/02/Developing_the_payment_system_for_2021-22.pdf. Accessed February 2, 2022.
39. Rudowitz R, Garfield R, Hinton E. *10 Things to Know About Medicaid: Setting the Facts Straight*. San Francisco, CA: Kaiser Family Foundation; 2019.
40. Keisler-Starkey K, Bunch LN. Health insurance coverage in the United States: 2019. US Census Bureau.

https://www.census.gov/library/publications/2020/demo/p60-271.html. Published September 15, 2020. Accessed February 7, 2022.

41. Rama A. *Payment and Delivery in 2018: Participation in Medical Homes and Accountable Care Organizations on the Rise While Fee-for-Service Revenue Remains Stable*. Chicago, IL: American Medical Association; 2020.
42. Bradley EH, Canavan M, Rogan E, et al. Variation in health outcomes: the role of spending on social services, public health, and health care, 2000–09. *Health Aff (Millwood)*. 2016;35(5):760-768. https://doi.org/10.1377/hlthaff.2015.0814.
43. Wyman O; SeaChange Capital Partners. A national imperative: joining forces to strengthen human services in America. 2018. https://www.alliance1.org/web/resources/pubs/national-imperative-joining-forces-strengthen-human-services-america.aspx. Accessed February 2, 2022.
44. Taylor LA, Byhoff E. Money moves the mare: the response of community-based organizations to health care's embrace of social determinants. *Milbank Q*. 2021;99(1):171-208. https://doi.org/10.1111/1468-0009.12491.
45. Briggs ADM, Göpfert A, Thorlby R, Allwood D, Alderwick H. Integrated health and care systems in England: can they help prevent disease? *Integrated Healthc J*. 2020;2(1):e000013. https://doi.org/10.1136/ihj-2019-000013.
46. Humphries R. Integrated health and social care in England—progress and prospects. *Health Policy*. 2015;119(7):856-859. https://doi.org/10.1016/j.healthpol.2015.04.010.
47. Alderwick H, Ham C. Sustainability and transformation plans for the NHS in England: what do they say and what happens next? *BMJ*. 2017;356:j1541. https://doi.org/10.1136/bmj.j1541.
48. BCF Task Force. *Better Care Fund Policy Framework*. London, UK: Department for Communities and Local Government; 2014. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/381848/BCF.pdf. Accessed February 2, 2022.
49. Dayson C. Policy commentary—social prescribing "plus": a model of asset-based collaborative innovation? *People Place Policy*. 2017;11(2):90-104. https://doi.org/10.3351/ppp.2017.4839587343.
50. Pescheny JV, Gunn LH, Randhawa G, Pappas Y. The impact of the Luton social prescribing programme on energy expenditure: a quantitative before-and-after study. *BMJ Open*. 2019;9(6):e026862. https://bmjopen.bmj.com/content/9/6/e026862.

51. Hull CCG. Better care in Hull. https://www.hullccg.nhs.uk/better-care-in-hull/. Accessed September 4, 2021.
52. City of York Council. Better Care Fund update. https://democracy.york.gov.uk/documents/s136254/december%202019%20BCF%20update.pdf. Published 2019. Accessed February 2, 2022.
53. Rotherham's social prescribing schemes. Rotherham Clinical Commissioning Group website. http://www.rotherhamccg.nhs.uk/rotherhams-social.htm. Accessed September 4, 2021.
54. Forder JE, Caiels J, Harlock J, et al. *A System-Level Evaluation of the Better Care Fund*. Kent, UK: University of Kent; 2018. https://www.pssru.ac.uk/pub/5424.pdf. Accessed February 2, 2022.
55. Stokes J, Lau YS, Kristensen SR, Sutton M. Does pooling health & social care budgets reduce hospital use and lower costs? *Soc Sci Med*. 2019;232:382-388. https://doi.org/10.1016/j.socscimed.2019.05.038.
56. UK National Audit Office. Case study on integration: measuring the costs and benefits of whole-place community budgets. https://www.nao.org.uk/wp-content/uploads/2013/03/10088-002_Whole-Place-Community-Budgets.pdf. Accessed February 2, 2022.
57. HM Treasury. Total place: a whole area approach to public services. https://www.communityplanningtoolkit.org/sites/default/files/AlignmentR20.pdf. Published March 2010. Accessed February 2, 2022.
58. O'Shea L, Bindman AB. Personal health budgets for patients with complex needs. *N Engl J Med*. 2016;375(19):1815-1817. https://doi.org/10.1056/NEJMp1606040.
59. RAND Europe, Ernst & Young LLP. National evaluation of the Department of Health's integrated care pilots. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215103/dh_133127.pdf. Published 2012. Accessed February 2, 2022.
60. Erens B, Wistow G, Mounier-Jack S, et al. *Early Evaluation of the Integrated Care and Support Pioneers Programme*. London, UK: Policy Innovation Research Unit (PIRU); 2015. https://piru.ac.uk/assets/files/Early_evaluation_of_IC_Pioneers_Final_Report.pdf. Accessed February 2, 2022.
61. NHS England. New care models: vanguards—developing a blueprint for the future of NHS and care services. https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf. Published September 2016. Accessed February 2, 2022.

62. Checkland K, Coleman A, Billings J, et al. *National Evaluation of the Vanguard New Care Models Programme: Interim Report: Understanding the National Support Programme. Executive Summary*. Manchester, UK: University of Manchester; 2019. https://www.necsu.nhs.uk/wp-content/uploads/2019/07/2019-07-InterimReportNCM-ManchesterUniversity.pdf. Accessed February 2, 2022.
63. NHS England. Integrated primary and acute care systems (PACS)–describing the care model and the business model. https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf. Published 2016. Accessed February 2, 2022.
64. Alderwick H, Shortell SM, Briggs ADM, Fisher ES. Can accountable care organisations really improve the English NHS? Lessons From the United States. *BMJ*. 2018;360:k921. https://doi.org/10.1136/bmj.k921.
65. Sanderson M, Allen P, Osipovic D, Moran V. New models of contracting in the NHS. PRUComm. https://prucomm.ac.uk/assets/uploads/New_Models_of_Contracting_final_report__1_.pdf. Published 2019. Accessed February 2, 2022.
66. NHS England. Integrating care: contracting for accountable models. https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf. Published 2017. Accessed February 2, 2022.
67. Lewis RQ, Checkland K, Durand MA, et al. Integrated care in England—what can we learn from a decade of national pilot programmes? *Int J Integrated Care*. 2021;21(4):5. https://doi.org/10.5334/ijic.5631.
68. Alderwick H, Ham C. NHS in England embraces collaboration in tackling biggest crisis in its history. *BMJ*. 2016;352:i1022. https://doi.org/10.1136/bmj.i1022.
69. Muhlestein D, Bleser WK, Saunders RS, McClellan M. All-payer spread of ACOs and value-based payment models in 2021: the crossroads and future of value-based care. *Health Affairs Blog*. June 17, 2021. https://www.healthaffairs.org/do/10.1377/forefront.20210609.824799/full/. Accessed February 7, 2022.
70. Bachrach D. Addressing patients' social needs: an emerging business case for provider investment. Commonwealth Fund. https://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs-emerging-business-case-provider. Published May 29, 2014. Accessed March 2, 2022.
71. Fraze TK, Brewster AL, Lewis VA, Beidler LB, Murray GF, Colla CH. Prevalence of screening for food insecurity, hous-

ing instability, utility needs, transportation needs, and interpersonal violence by US physician practices and hospitals. *JAMA Netw Open*. 2019;2(9):e1911514. https://doi.org/10.1001/jamanetworkopen.2019.11514.

72. Murray GF, Rodriguez HP, Lewis VA. Upstream with a small paddle: how ACOs are working against the current to meet patients' social needs: a study of how some ACOs are attempting to address patients' social needs. *Health Aff (Millwood)*. 2020;39(2):199-206. https://doi.org/10.1377/hlthaff.2019.01266.
73. Brewster AL, Fraze TK, Gottlieb LM, Frehn J, Murray GF, Lewis VA. The role of value-based payment in promoting innovation to address social risks: a cross-sectional study of social risk screening by US physicians. *Milbank Q*. 2020;98(4):1114-1133. https://doi.org/10.1111/1468-0009.12480.
74. Gottlieb LM, Quiñones-Rivera A, Manchanda R, Wing H, Ackerman S. States' influences on Medicaid investments to address patients' social needs. *Am J Prev Med*. 2017;52(1):31-37. https://doi.org/10.1016/j.amepre.2016.07.028.
75. Meyers DJ, Gadbois EA, Brazier J, Tucher E, Thomas KS. Medicare plans' adoption of special supplemental benefits for the chronically ill for enrollees with social needs. *JAMA Netw Open*. 2020;3(5):e204690. https://doi.org/10.1001/jamanetworkopen.2020.4690.
76. Crook HL, Zhao AT, Saunders RS. Analysis of Medicare Advantage plans' supplemental benefits and variation by county. *JAMA Netw Open*. 2021;4(6):e2114359. https://doi.org/10.1001/jamanetworkopen.2021.14359.
77. Thomas KS, Durfey SNM, Gadbois EA, et al. Perspectives of Medicare Advantage plan representatives on addressing social determinants of health in response to the CHRONIC Care Act. *JAMA Netw Open*. 2019;2(7):e196923. https://doi.org/10.1001/jamanetworkopen.2019.6923.
78. Alderwick H, Dixon J. The NHS long term plan. *BMJ*. 2019;364:l84. https://doi.org/10.1136/bmj.l84.
79. NHS England. The NHS Long Term Plan. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf. Published 2019. Accessed February 2, 2022.
80. Fisher R, Thorbly R, Alderwick H. Understanding primary care networks: context, benefits and risk. The Health Foundation. https://www.health.org.uk/publications/reports/understanding-primary-care-networks. Published July 1, 2019. Accessed February 7, 2022.

81. NHS England. NHS England announces overwhelming take up of new primary care network contract. https://www.england.nhs.uk/2020/06/nhs-england-announces-overwhelming-take-up-of-new-primary-care-network-contract/. Published July 2019. Accessed September 4, 2021.
82. Pettigrew LM, Kumpunen S, Mays N. Primary care networks: the impact of covid-19 and the challenges ahead. *BMJ*. 2020;370:m3353. https://doi.org/10.1136/bmj.m3353.
83. King's Fund. Primary care networks explained. https://www.kingsfund.org.uk/publications/primary-care-networks-explained. Published November 20, 2020. Accessed April 12, 2021.
84. NHS England. Network contract directed enhanced service: contract specification. https://www.england.nhs.uk/publication/network-contract-des-specification-2021-22/. Published 2020. Accessed February 7, 2022.
85. NHS England. Social prescribing. https://www.england.nhs.uk/personalisedcare/socialprescribing/. Accessed December 9, 2021.
86. NHS Digital. Primary care network workforce. https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-network-workforce/31-march-2021. Published June 30, 2021. Accessed September 4, 2021.
87. NHS England. Investment and Impact Fund 2020/21: Guidance. https://www.england.nhs.uk/wp-content/uploads/2020/09/IIF-Implementation-Guidance-2020-21-Final.pdf. Published 2020. Accessed February 2, 2022.
88. NHS England. Finance, commissioning and contracting handbook for personalised care. https://www.england.nhs.uk/wp-content/uploads/2019/08/finance-commissioning-contracting-handbook-personalised-care-v2.1.pdf. Published August 2019. Accessed February 2, 2022.
89. National Voices. Rolling out social prescribing: understanding the experience of the voluntary, community and social enterprise sector. https://www.nationalvoices.org.uk/sites/default/files/public/publications/rolling_out_social_prescribing_-_september_2020_final.pdf. Published 2020. Accessed February 2, 2022.
90. Crook HL, Zheng J, Bleser WK, Whitaker RG, Masand J, Saunders RS. How are payment reforms addressing social determinants of health?. Milbank Memorial Fund. https://www.milbank.org/publications/how?are?payment?reforms?addressing?social?determinants?of?health?policy?implications?and?next?steps. Published 2021. Accessed February 2, 2022.

91. RTI International. Accountable Health Communities (AHC) model evaluation first evaluation report. 2020. https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt. Accessed February 2, 2022.
92. Wortman Z, Tilson EC, Cohen MK. Buying health for North Carolinians: addressing nonmedical drivers of health at scale. *Health Aff (Millwood)*. 2020;39(4):649-654. https://doi.org/10.1377/hlthaff.2019.01583.
93. First revised and restated attachment M: healthy opportunities pilot service fee. https://www.manatt.com/Manatt/media/Documents/Articles/NC-Pilot-Service-Fee-Schedule_Final-for-Webpage.pdf. Accessed February 2, 2022.
94. Alderwick H, Hood-Ronick CM, Gottlieb LM. Medicaid investments to address social needs in Oregon and California. *Health Aff (Millwood)*. 2019;38(5):774-781. https://doi.org/10.1377/hlthaff.2018.05171.
95. Center for Health Care Strategies. Addressing social determinants of health via Medicaid managed care contracts and section 1115 demonstrations. https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf. Published 2018. Accessed February 2, 2022.
96. Bailit Health. Developing a social risk factor screening measure. State health & value strategies. https://www.shvs.org/wp-content/uploads/2020/10/Developing-a-SRF-Screening-Measure_Issue-Brief.pdf. Published 2020. Accessed February 2, 2022.
97. Sandhu S, Saunders R, McClellan M, Wong C. Health equity should be a key value in value-based payment and delivery reform. *Health Affairs Blog*. November 25, 2020. https://www.healthaffairs.org/do/10.1377/hblog20201119.836369/abs/. Accessed December 12, 2020.
98. Citizens Advice Bureau. A very general practice: how much time do GPs spend on issues other than health. https://www.citizensaddvice.org.uk. Accessed February 2, 2022.
99. National Academies of Sciences, Engineering, and Medicine. Integrating social care into the delivery of health care: moving upstream to improve the nation's health. https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health. Published 2019. Accessed February 2, 2022.
100. Fisher R. "Levelling up" general practice in England: what should government prioritise? The Health Foundation. https://www.health.org.uk/publications/long-reads/levelling-up-general-practice-in-england. Published May 2021. Accessed February 2, 2022.

101. Jani A, Liyanage H, Okusi C, Sherlock J, de Lusignan S. Social prescribing observatory: a learning health system approach for using data to improve practice. https://orchid.phc.ox.ac.uk/wp-content/uploads/2021/01/FINAL-Socialprescribing-observatory-report.pdf. Accessed February 2, 2022.
102. NHS England. Social prescribing link workers: reference guide for primary care networks: technical annex. https://www.england.nhs.uk/publication/social-prescribing-link-workers-reference-guide-for-primary-care-networks-technical-annex/. Published 2019. Accessed February 2, 2022.
103. About the Social Prescribing–Learning for Link Workers programme. eLearning for Healthcare website. https://www.e-lfh.org.uk/programmes/social-prescribing/. Accessed December 9, 2021.
104. Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-based community health worker program addresses unmet social needs and generates positive return on investment. *Health Aff (Millwood)*. 2020;39(2):207-213. https://doi.org/10.1377/hlthaff.2019.00981.
105. Vasan A, Morgan JW, Mitra N, et al. Effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions: a pooled analysis of three clinical trials. *Health Serv Res*. 2020;55(S2):894-901. https://doi.org/10.1111/1475-6773.13321.
106. The Biden plan for mobilizing American talent and heart to create a 21st century caregiving and education workforce. Joe Biden for President: official campaign website. https://joebiden.com/caregiving/. Accessed January 19, 2021.
107. Hogg-Graham R, Edwards K, Ely T, Mochizuki M, Varda D. Exploring the capacity of community-based organisations to absorb health system patient referrals for unmet social needs. *Health Soc Care Community*. 2021;29(2):487-495. https://doi.org/10.1111/hsc.13109.
108. Brown RCH, Mahtani K, Turk A, Tierney S. Social prescribing in National Health Service primary care: what are the ethical considerations? *Milbank Q*. 2021;99(3):610-628. https://doi.org/10.1111/1468-0009.12516.
109. Petchel S. Covid-19 makes funding for health and social services integration even more crucial. *Health Affairs Blog*. April 14, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200413.886531/full/. Accessed April 28, 2020.

110. National Council for Voluntary Organisations. Voluntary sector will shrink following coronavirus. Press release. https://www.ncvo.org.uk/about-us/media-centre/press-releases/2760-voluntary-sector-will-shrink-following-coronavirus?highlight=WyJjb3JvbmF2aXJ1cyJd. Published 2020. Accessed February 2, 2022.
111. Nottingham Business School. Respond, recover, reset: the voluntary sector and COVID-19. http://cpwop.org.uk/wp-content/uploads/sites/3/2021/10/RRR-October-Report.pdf. Published 2021. Accessed February 2, 2022.
112. Tallock C, Charlesworth A, Kelly E, McConkey R, Rocks S. The bigger picture: learning from two decades of changing NHS care in England. The Health Foundation. https://www.health.org.uk/publications/reports/the-bigger-picture. Published 2020. Accessed February 2, 2022.
113. Bibbins-Domingo K. Integrating social care into the delivery of health care. *JAMA*. 2019;322(18):1763. https://doi.org/10.1001/jama.2019.15603.

Funding/Support: Sahil Sandhu's contribution was supported by the US-UK Fulbright Commission and Newcastle University.

Conflict of Interest Disclosures: All authors completed the ICMJE Form for Disclosure of Potential Conflicts of Interest. No conflicts were reported.

Address correspondence to: Sahil Sandhu, 107 Avenue Louis Pasteur, Box 085, Boston, MA 02115 (email: sahilsandhu@hms.harvard.edu).