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Social Prescribing as a Model for Germany

>> Social inequality is one of the most important factors influencing health and illness. Therefore, social problems play a major role in GP care. Social problems can be the cause of illness, arise as a consequence of illness or influence the treatment of illness. Typical social problems in GP practice are loneliness, debts or problems at work. So far, such social problems pose a great challenge to GPs, as there are usually no adequate measures in the GP practice. At the same time, there are usually a large number of different local associations, counselling centres and institutions that can help with social problems.

A concept that has been implemented in Great Britain to close this gap is the so-called ‚Social Prescribing‘ (SP). In the case of a non-medical, health-related social problem, GPs can issue a social prescription. The patient then has several conversations with a so-called link worker. The link worker takes enough time to discuss the needs and resources with the patient and to narrow down the social problems more precisely. Together with the patient, an action plan is drawn up and the patient is referred to one or more local services and the family doctor is informed.

Due to the positive response, the concept is now being implemented in numerous countries, including the Netherlands, Portugal, Austria, Singapore and Canada1. In a systematic review 2 we were able to show that, on the one hand, the evaluations of social prescribing were positive, but that there is a lack of good randomised-controlled trials.

An important question is whether this concept can also be interesting for Germany. Therefore, we held the 1st German Social Prescribing Conference on 19.04.2023 at the Institute of General Medicine of the Charité - Universitätsmedizin Berlin in cooperation with the Global Social Prescribing Alliance.

After greetings from Prof. Christoph Heintze from the Institute of General Medicine, Boris Velter from the Federal Ministry of Health and Prof. Jean-Francois Chenot from the German Society of General Medicine, Kate Mulligan from the Canadian Institute for Social Prescribing introduced the topic of social prescribing. She described social prescribing on the one hand as a process of care and on the other hand as a process of system change in primary care, i.e. Kate Mulligan emphasised that SP not only benefits the individual patient, but also improves the overall networking in care.

Daniela Rojatz from the Competence Centre for Health Promotion and the Health System of Gesundheit Österreich GmbH presented the Austrian development of SP with the implementation experiences. The experiences so far are promising: structures for the implementation of social prescribing could be built up in a short time, employees felt relieved, and 98% of the patients would recommend SP to others.

Bogdan Chiva Giurca from the Global Social Prescribing Alliance gave a brief overview of the progress of SP in England and other countries around the world. In the UK, social prescribing is now implemented across the board. In many countries around the world, the concept is being taken up with different terminologies.

Sian de Bell from the University of Exeter reported on nature-based SP, where the activities taught focus in particular on engagement with the environment. She presented the results of a workshop with stakeholders from the UK and Germany in which opportunities and challenges of nature-based SP were identified.

Stephanie Tierney from the Nuffield Department of Primary Health Care Sciences at Oxford University scientifically examined the introduction of link workers into primary care. Dr Tierney discussed the boundaries Link Workers experience in their role and the extent to which they feel they belong in primary care.

In the concluding panel discussion with Maike Grube from Diakonie, Simone Borchardt MdB from the Health Committee and Anja Thiemann from the GP Association Berlin-Brandenburg, the potential implementation of SP in Germany was discussed. Important topics were who could pay for the work of the link workers and whether the services to which referrals are made need additional funding, where the link worker should be located and whether the service only conceals social inequality instead of addressing the causes.

All in all, it became clear to me what great potential the SP has and how different the concrete approaches are. From my point of view, it was remarkable that both representatives of the federal government and the opposition liked social prescribing as an approach. Of course, the question of how SP should be financed is open. The favoured solution in the discussion was that the work of the link worker could be paid for by the statutory health insurance, analogous to the National Health Service, while the referred services would remain independently financed. An important aspect is that SP only mitigates the negative effects of socioeconomic status on health and illness and does not eliminate the underlying problems.

A major advantage of SP is that it is compatible with both the current care situation and new care models such as health kiosks and primary care centres. It complements the existing wide range of services and links them better to achieve greater effectiveness.

SP can be integrated into the health kiosk model by having link workers working directly in the health kiosk, for example. Link workers could be very well located in primary care centres, as the concept of the Bromley by Bow Centre in London shows. SP supports the holistic interprofessional approach of the centres. Due to this great flexibility of the concept, it is worthwhile to pursue Social Prescribing as a model in Germany as well. <<

1: DOI: 10.1136/ bmjgh-2022-008524; 2: DOI: 10.5334/ijic.6472