



A Healthier Canada.

An Analysis of the Potential Economic and Social Impacts of Social Prescribing

White Paper
Version 1.0 – Released July 19, 2024



Anchored by
**Canadian
Red Cross**

Acknowledgements

About The Canadian Institute for Social Prescribing

The Canadian Institute for Social Prescribing (CISP) is an intersectoral collaboration initiative anchored by the Canadian Red Cross. CISP is a national hub focused on improving the health and wellbeing of Canadians by sharing, connecting, promoting, and celebrating social prescribing practices that connect the formal healthcare system with social and community supports. These practices address the social determinants of health, prioritize health equity, support community leadership, and promote collaboration.

About The Canadian Red Cross

The Canadian Red Cross has a mission to help people and communities in Canada and around the world in times of need and support them in strengthening their resilience. We are part of the largest humanitarian network in the world, the International Red Cross and Red Crescent Movement. This network includes the International Committee of the Red Cross (ICRC), the International Federation of Red Cross and Red Crescent Societies (Federation), and 192 National Red Cross and Red Crescent Societies dedicated to improving the situation of the most vulnerable people throughout the world.

Disclaimer

This report is based on insights from stakeholder interviews and information from publicly available sources. The paper was made possible by more than 15 experienced leaders who generously contributed their time and insights to inform this report through interviews. These interviews were conducted with clinicians, public health leaders, researchers, industry experts, and policy makers around the country, who have experience in social prescribing and social determinants-based approaches to care delivery and support.

Interviews were also conducted with stakeholders who have international experience in social prescribing. Publicly available information was drawn from a variety of sources, including academic publications and online jurisdictional government websites.

KPMG LLP was engaged by the Canadian Red Cross to support this analysis. KPMG LLP does not assume any responsibility or liability for losses incurred by any party due to the circulation, reproduction, or use of this report.

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Executive Summary

Understanding the economic and social benefits of social prescribing in Canada.

Social Prescribing in Canada

Social prescribing is a personalized, community-driven approach to care that addresses the social determinants of health by connecting individuals with non-clinical supports and services within their community. This approach is based on the idea that an individual's health is directly related to their connection to the community in which they live, work, and grow.

Social prescribing presents an opportunity for Canada to improve health outcomes in a health and social system that faces increasingly complex challenges, including an aging population, an overburdened health and social care workforce, a cost-of-living crisis, stretched acute care settings, and a shortage of primary care options for Canadians. Many groups have called for modernization to address Canada's healthcare crisis, including team-based and person-centered care, purpose-built communities, and local approaches to care planning that address community needs.

Social prescribing is not only aligned with modernization efforts already underway, but also presents an immediate opportunity to advance these plans, building on health and social resources that exist in our communities.

While many projects in Canada and around the world are seeing positive outcomes from implementing social prescribing, measuring and understanding its potential benefits in the Canadian context will provide a valuable basis for scaling this practice across the country. This report aims to contribute an important part of that knowledge base by providing an analytical assessment of two questions relating to the economic and social benefits of social prescribing implementation:

1. *What are the specific social and economic impacts that social prescribing can drive in Canada?*
2. *What may be the overall return on investment for a Canada-wide social prescribing implementation?*

Answering these questions requires two distinct, yet complementary methodologies.

Specific social and economic indicators

To analyze specific social and economic impacts, this report focuses on the benefits of social prescribing for two target populations (referred to throughout this report as “pathways”): aging adults and youth with mental health challenges. These pathways were selected based on two primary criteria—the availability of tangible data from social prescribing programs in Canada and globally, and consultation with social prescribing academics, advocates and practitioners.

Impacts are measured in various ways - some are financial, such as reduced hospital spending, while others are health and human impacts, such as reduced incidence of chronic heart disease or a reduction in the adolescent rate of depression. This is not to suggest that these latter human and health benefits do not offer financial benefits; rather, this section of the report is designed to measure a selection of key impacts that reflect the most reliable current data on the benefits of social prescribing.

Overall return on Investment

For those seeking to understand the “bottom line” of social prescribing, its population-wide positive benefits, including those not quantified in the first approach, are

presented in the overall return in investment section of this report. While the first section focused on a select group of outcomes, this section presents a broad economic case for social prescribing. This approach does not rely on measuring targeted interventions through specific pathways; rather, it leverages published estimates of social prescribing's Social Return on Investment (SROI) that are then adjusted for Canada's unique population needs and demographics.

These two approaches provide different yet complementary outputs, providing both granular estimates of social prescribing's impacts, as well as an aggregated view of the overall return on investment.

Results of Analysis

Impacts for Aging Adults

For aging adults, the analysis found that social prescribing is expected to provide significant health and economic benefits. These include an estimated base-case improvements of:

- **245,400 fewer days spent per year in hospital** due to falls at home.
- **\$296M in potential cost savings annually due to reductions in hospitalizations, ambulance calls and Emergency Department (ED) visits** from fall prevention.
- **16,900 fewer cases of coronary heart disease**
- **7,600 fewer cases of dementia** over the next 10 years.
- **6,500 fewer cases of stroke** over their lifetime.
- **2,000 fewer cases of avoidable deaths.**

Impacts for Youth Mental Health

In the case of youth mental health, social prescribing is expected to lead to improvements including base-case estimates of:

- **\$59.9 million annual increase in employment income during the working careers** for youth aged 15 – 17 who currently report anxious or depressive symptoms (a 14 percent increase in adult lifetime earnings for this cohort of youth).
- **1.9 million fewer primary care visits** per year for Canadian youth aged 15-24 with poor or fair perceived mental health (11 percent reduction in total primary care visits for youth aged 15 -24).

- **\$114 million in annual health system cost savings** due to reduction in primary care visits.

Overall Social Return

The SROI analysis demonstrated the significant benefits possible from a Canada-wide social prescribing program, with a base-case return of \$4.43 for every dollar invested.

\$4.43

Every dollar invested into social prescribing programs may return \$4.43 to society through improved wellbeing and reduced costs incurred on the health system and government.

Social prescribing presents an immediate opportunity to improve health outcomes and generate economic benefits in Canada, creating an integrated health and social care system with community at its core. The findings of this report can help facilitate conversations about leveraging social prescribing as a tool to address the complex challenges in Canada's health and social care systems and help set the foundation for person-centered care that delivers a healthy future for all Canadians.

The Canadian Healthcare System

Contextualizing the challenges and headwinds facing the Canadian health system.

Challenges Facing the Canadian Health System

Canada's health systems are under significant strain and, considering the evolving needs of Canadians, may be unsustainable within the current delivery model. The combination of an aging population that requires increased care, a health workforce crisis, and a health system that prioritizes expensive treatments over preventative care, has resulted in a deterioration in access to care, including amongst the longest wait times for developed countries.¹

These challenges are expected to worsen over the coming decade. In Ontario alone, the Financial Accountability Office expects that the Ontario Health Insurance Plan (OHIP) program spending will increase by nearly \$5 billion from 2022 to 2028.² Increased spending on healthcare is consistent across provinces and constrains the government's ability to spend on other programs like education that could offer a higher return on investment.³

Part of the challenge is a failure to recognize that the returns on investment in preventative care and wellness are often dispersed across multiple government sectors and departments – making them more difficult to measure. Further, governments have not traditionally evaluated the impact of investments in social care on overall health outcomes. Social prescribing presents a

solution to integrate these systems and better evaluate the impact on health, social and community outcomes.

3x Increase in the population 85 and older by 2046

A portrait of Canada's growing population aged 85 and older from the 2021 Census, Statistics Canada

“Health outcomes achieved that matter to patients relative to the cost of achieving those outcomes.”

Definition of Value-based Health Care from Michael Porter's 2013 *The Strategy That Will Fix Health Care*

¹ "How Canada Compares Results from The Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries," CIHI.

² "Ontario Health Sector: Spending Plan Review," Financial Accountability Office of Ontario (FAO).

³ "High Returns from Government Programs for Low-Income Children," National Bureau of Economic Research (NBER).

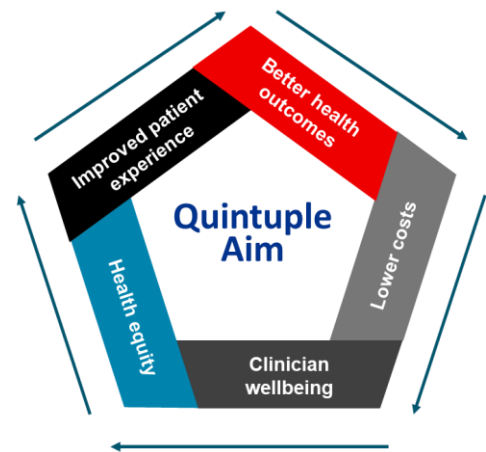
The Shift to Person-centered Care

It is widely understood that the future of healthcare needs to be more personalized, integrated and patient-led. Patient-centered care is not a new concept, this model gained traction in Canada following the 2016 Health Care in Canada Survey which found that both public and healthcare practitioners favour improved person-centered care and better partnerships to deliver evidence-based care over current, more isolated, and volume-based models.⁴ At the core of person-centered care is the recognition that individuals need to be part of the collective decision-making process with providers to develop and manage a care plan that fits their needs. This involves a fundamental shift in the roles of both individuals and providers, where individuals must take a more active role in the management of their own health and providers are required to defer to their patients to better understand their needs. Indeed, the concept of a social prescription is not a new innovation, it is a formal tool to move towards a model of care that experts have largely agreed is what is needed for a decade.

In order to enable effective person-centred care, incentive structures and outcomes need to be a part of the equation. Models such as value-based healthcare have emerged as a novel method of funding to improve outcomes while managing health system costs. This method realigns incentive structures for clinicians to reward outcomes and efficient operations. It also involves restructuring delivery models into more integrated practice units to provide more of a holistic, person-centered approach.

Support for value-based healthcare is further outlined in Dr. Dipti Itchhaporia's 2022 paper, *The Evolution of the*

Quintuple Aim, which recognizes that 70 percent of healthcare outcomes can be attributed to social determinants of health.⁵ The Quintuple Aim includes improved patient experience, better health outcomes, lower costs, clinician wellbeing, and health equity.⁶ It has been designed to support the provision of non-medical healthcare services and direct interventions to address social factors like isolation that pose major constraints to health systems around the world.⁷ In Canada it is a reasonable question to ask: if it is universally agreed that person-centered healthcare is the future and that in order to achieve this aim we need to address the social determinants of health, why do our institutions and funding models treat social interventions as a secondary responsibility?



The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Social determinants of health, World Health Organization

⁴ Montague et al, "Patient-Centred Care in Canada: Key Components and the Path Forward." 50–56

⁵ Dipti Itchhaporia, "The Evolution of the Quintuple Aim: Health Equity, Health Outcomes, and the Economy," *Journal of the American College*

of Cardiology, November 30, 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8608191/>.

⁶ *Ibid.*

⁷ *Ibid.*

Social Prescribing

A brief background of the practice of social prescribing, locally and around the world.

Why Social Prescribing?

Social prescribing is 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.”⁸ The practice represents a shift towards person-centered, integrated health and social care that removes silos surrounding health, social, and community services. It involves the deployment of link workers to co-create a non-medical prescription together with individuals to improve their health and wellbeing.⁹ Listed below are several of the modelled benefits of social prescribing:



Reduced levels of loneliness



Improved skills and confidence.



Decreased hospital admissions



Reduced primary care visits



Improved mental and physical health



Reduced ED visits

Among those who stand to benefit are individuals with long-term health conditions, those who require mental health support, assistance with food and nutrition, help with financial or legal issues, as well as those who require assistance with home-based services.

One of the key motivators for social prescribing adoption is its implementation versatility. Social prescribing provides tailored support to individuals with diverse needs across various demographics, including marginalized groups that are historically underrepresented in healthcare design and delivery.¹⁰ In Canada, these communities include older adults, children and adolescents, newcomers, Black communities, Indigenous communities, LGBTQIA+ communities, communities experiencing poverty, and other communities that may have various social determinants affecting their health and wellbeing.¹¹ For policy makers in Canada, supporting equity-deserving communities is a priority but practically challenging to address, with policy makers largely failing to meaningfully co-design with communities. Addressing the challenges faced by various equity-deserving communities is of great importance with respect to the

⁸ Muhl et al, "Establishing Internationally Accepted Conceptual and Operational Definitions of Social Prescribing Through Expert Consensus: A Delphi Study Protocol."

⁹ "Social prescribing link workers" NHS England.

¹⁰ Howarth et al, "Social prescribing: a 'natural' community-based solution"

¹¹ "Building Understanding: The First Report of the National Advisory Council on Poverty", Government of Canada

Government of Canada's commitment to enhancing the wellbeing of all citizens.

Given this context, social prescribing presents an opportunity to improve health outcomes in a health and social system that faces increasingly complex challenges including an aging population, an overburdened health and social care workforce, a cost-of-living crisis, stretched acute care settings, and a shortage of primary care options for Canadians. Many groups have called for modernization to address Canada's health care crisis, including team-based and person-centered care, purpose-built communities, and local approaches to care planning that address community needs.

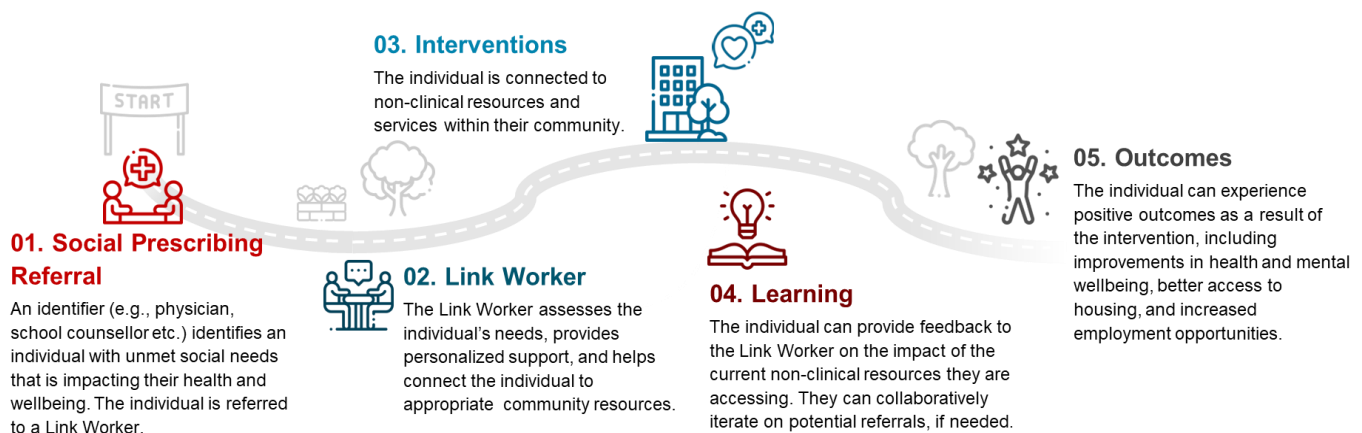
In Canada, social prescribing is not only aligned with modernization efforts already underway, but it also presents an immediate opportunity to advance these efforts, building on health and social resources that exist in our communities.

The Social Prescribing Journey

The social prescribing journey begins when an identifier, which can include anyone from a primary care physician to an employment advisor, recognizes an individual who has unmet non-medical, health-related social needs.¹² These needs, which may include but are not limited to social isolation, physical activity, debt, or financial, housing or food insecurity, can be identified by healthcare providers, social workers, community workers, family members, instructors, or even by the individual themselves. At this stage, the individual may

be connected with a Link Worker, sometimes called community connectors or navigators. The Link Worker creates a trusting relationship with the individual, usually over several one-on-one sessions, assesses their needs, co-designs a personalized care plan, and facilitates referrals to community resources that align with their needs and interests. The referral plans are based on the availability of community resources and engagement with representatives from neighborhood and community programs. Programs aim to address a range of factors influencing health and wellbeing, including loneliness and isolation, mental health, physical activity, housing, food and nutrition, financial security, and factors associated with aging such as chronic conditions.

Throughout an individual's participation in a social prescribing program, Link Workers can provide continuous support and encouragement, and follow-up to monitor their progress. These follow-ups often include evaluations that offer valuable insights into the program's impact at the individual and health system levels but may also consider the impact of the Link Worker intervention on its own, regardless of the downstream referral (much in the same way peer support models can provide value to community members without additional referrals). Once the individual's unique needs have been successfully addressed, they may choose to exit the social prescribing program, having acquired the necessary support and skills to enhance their health and wellbeing, or may continue to participate in, contribute to, or even lead these same community services.¹³



Note: Link Workers may not be present in all pathways. Referrals can come from external identifiers or through self-identification.

¹² Muhl et al, "Establishing Internationally Accepted Conceptual and Operational Definitions of Social Prescribing Through Expert Consensus: A Delphi Study Protocol."

¹³ "Current State of Social Prescribing in Canada," Bridgeable.

Social Prescribing Around the World

Considered by many as the forerunner of social prescribing programs at scale, England has expanded this practice to become a key component of their healthcare delivery nationally.¹⁴ Social prescribing was integrated into the NHS's Long-Term Plan in 2019, which aimed to refer 900,000 people to social prescribing schemes by 2023 – 2024.¹⁵ To achieve this ambitious target, the NHS invested in over three thousand Link Workers nationally, with a goal to ensure social prescribing services are offered at every Primary Care Network (PCN) in the country.¹⁶

As of 2023, social prescribing has garnered international support with initiatives implemented in over 17 countries and guidance from the World Health Organization.¹⁷ Although the programs differ slightly in execution with different eligibility models, referral systems, priority communities, staff roles, evaluation methods, and funding mechanisms, all programs share a common goal – connecting individuals with community non-medical services to improve their overall health and wellbeing.

In Canada, social prescribing has emerged as a holistic healthcare approach, with a focus on leveraging social services to improve general wellbeing. Early initiatives have prioritized the role of integrated health and social care networks to drive social prescribing adoption across the country. For example, Healthy Aging Alberta is a platform that focuses on providing programs, services, policies, practices, and research to support older Albertans aging in place in their homes and communities.¹⁸

Link Workers Play a Pivotal Role in Social Prescribing

Link Workers are the anchor of social prescribing programs and serve as the bridge between health and social services. Link Workers co-design support plans, facilitate referrals, provide warm hand-offs to community resources, monitor individuals, and provide continuous feedback about the impact of referrals to interventions. Through individualized support plans, Link Workers build trust with their clients and communities and empower

them to play a larger role in owning their health and wellbeing.

Given the demands of working in healthcare, primary care providers and other clinicians may lack awareness of the services available in their communities. Similarly, while the community and social services sector holds the community knowledge and relationships, it is equally strained and ill-equipped to address the increasingly complex social care needs of the population post-pandemic. This sector is also more fragmented, leading to significant discrepancies in service and capacity between organizations. Integration between health and social care systems will be critical to addressing this complexity in a sustainable way. Link Workers can address these challenges by acting as a conduit between social and community services and healthcare systems, focusing solely on community health. This approach differs from traditional "signposting," which provides individuals with information about available resources but leaves them to navigate the referral system independently. While both models have demonstrated success to varying degrees, the Link Worker model introduces a layer of support that is especially vital for people who have difficulty navigating services and can alleviate the burden on other healthcare professionals.^{19,20}

The Link Worker role has taken on many forms and can be delivered by both registered medical professionals, such as Social Workers, Occupational Therapists and Registered Nurses, or non-registered community health workers with clinical supervision. In the current context of the health workforce crisis in Canada, the opportunity to optimize our health workforce and provide health-promoting non-clinical support is likely to be attractive to providers and governments. Social prescribing also strengthens communities by using social and community assets more effectively, and building supports for people directly within their communities.

¹⁴ "The NHS Long Term Workforce Plan," NHS England.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Morse et al, "Global developments in Social Prescribing."

¹⁸ "About Healthy Aging Alberta - Healthy Aging CORE Alberta", Healthy Aging Alberta

¹⁹ White, Bell, Reid, and Dyson, "More than signposting: Findings from an evaluation of a Social Prescribing service," e5105-e5114.

²⁰ Moffatt et al, "Link Worker Social Prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions," e015203.

Social and Economic Impact Analysis

Quantifying the impacts of social prescribing.

This section aims to provide targeted estimates of the impacts that social prescribing can drive in Canada, focusing on specific metrics and defined populations. The results presented here should not be interpreted as a comprehensive assessment of all costs and benefits of social prescribing, but rather as a sample of those that this report chose to trace along an individual's health journey based on the best available data.

Pathway Selection

To evaluate social prescribing's estimated social and economic impacts, a literature review was conducted to uncover quantifiable evidence and statistically significant outcomes of social prescribing initiatives around the world. Over 50 studies were reviewed, including program evaluations and return on investment analyses of social prescribing programs and their effects on individual outcomes. Through these studies, priority populations, specific social prescribing interventions, and outcomes measured were documented. Next, pathways were identified based on the depth of existing literature, support from social prescribing experts worldwide, and alignment with the priorities and interests of Canadians.

The following two pathways were selected for modelling:

1. Aging at home in the community (aging); and

²¹ "Population Projections for Canada (2021 to 2068), Provinces and Territories (2021 to 2043)," Statistics Canada, August 22, 2022, <https://www150.statcan.gc.ca/n1/pub/91-520-x/91-520-x2022001-eng.htm>.

2. Youth mental health

The aging pathway was selected because the average age of the population in Canada continues to increase—like many developing countries. As of 2022, nearly 20 percent of Canadians are adults over the age of 65 – by 2030, this number is projected to increase to 22.5 percent.²¹ Advancements in medicine that increase life expectancy, coupled with a declining birth rate, has led to the oldest average age in Canada's history.²²

The growing proportion of older adults creates major strains on Canada's health system. Older adults are among the highest users of healthcare services and exert substantial pressure on government expenditures to cover the costs of care. These strains are expected to continue increasing as the prevalence of chronic conditions, use of continuing care, and need for income support programs rise. Given these pressures, addressing the needs of older adults through approaches like social prescribing should be a priority.

The youth mental health pathway was selected because one in five Canadians struggles with mental illness.²³ Every week, an estimated 500,000 Canadians are unable to work due to mental health challenges – the total economic burden is estimated to exceed \$50 billion annually.²⁴ While the impacts of mental illness are

²² Ibid.

²³ Smetanin et al, "The Life and Economic Impact of Major Mental Illnesses in Canada."

²⁴ "The Crisis Is Real." CAMH.

devastating for all age groups, the burden is acutely severe for youth and adolescents.²⁵

The prevalence of mental health challenges for youth and adolescents, aged 15 to 24, is higher than for any other age group.²⁶ Approximately 1.2 million children and adolescents experience mental illness.²⁷ Unfortunately, access to youth mental health and addiction support remains limited, with fewer than 20 percent of youth receiving the support they need.²⁸ The long wait times for mental health services can lead to devastating health impacts over the course of their lifetimes, including higher rates of substance abuse and self-harm for this cohort and an overreliance on emergency department (ED) visits to treat mental illness.²⁹ Resulting acute care interventions in turn pose a much higher strain on the healthcare system.

For both pathways, literature on social prescribing interventions that identified measurable outcomes were leveraged for this analysis. The analysis was conducted in a two-stage approach, allowing the use of the greatest available evidence base, as described below.

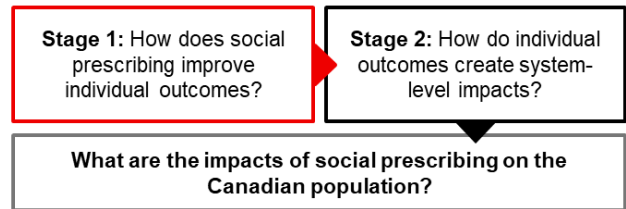
Social And Economic Impact Analysis Methodology

Given the multifaceted nature of social prescribing and the breadth of communities who stand to benefit from these initiatives, along with differing levels of rigorous evidenced-based evaluation of programs, it is difficult to precisely measure the full quantum of benefits that social prescribing can provide. To overcome this challenge, this report examines the benefits of social prescribing for the two selected pathways.

A two-stage modelling approach was used to estimate the individual-level impacts of social prescribing for the two selected pathways. Stage one identifies and measures individual outcomes based on existing social prescribing evidence. Stage two connects the individual outcomes to impacts for the individual. For example, stage one of the analysis for aging adults captures the reduction in falls at home due to social prescribing interventions, while stage two estimates the individual's reduced likelihood of hospitalization due to the reduction in the falls. The two-stage modelling approach provides the benefit of drawing from research that is not exclusive

to social prescribing, incorporating research that measures the relationships and effect sizes of improvements in outcomes driven by social prescribing with key impact measures.

Two-stage methodology



Following the two-stage modelling process, individual impacts are then aggregated to estimate system-wide impacts using relevant and comparable Canadian baseline data. For example, the aggregated analysis estimates the total reduction in hospitalization stays and associated costs in Canada due to reduced fall rates among aging adults. Building upon the Quintuple Aim of healthcare innovation, the impacts of social prescribing are mapped across these five domains:

Five domains of social prescribing impacts



It is critical to note that not all possible benefits provided by these two social prescribing pathways are quantified, and of those that are, not all have been translated into dollar values. Impacts are measured in various ways - some are financial, such as reduced hospital spending, and others are health and human impacts, such as reduced incidence of chronic heart disease or reduction in the adolescent rate of depression. This is not to suggest that these latter human and health benefits do not offer financial benefits – it is simply that this section of the report was designed to measure a selection of key impacts that reflect the most reliable current data on the benefits of social prescribing. Data is currently being collected across the country and as the practice

²⁵ "Mental Illness", National Institute of Mental Health.

²⁶ Pearson, Janz, and Ali, "Mental and substance use disorders in Canada."

²⁷ Smetanin et al, "The Life and Economic Impact of Major Mental Illnesses in Canada."

²⁸ "Children and Youth," Mental Health Commission of Canada.

²⁹ "Mental health of children and youth in Canada," CIHI.

becomes more widely adopted, the available data will grow as well—offering greater opportunities to quantify a broader spectrum of impact.

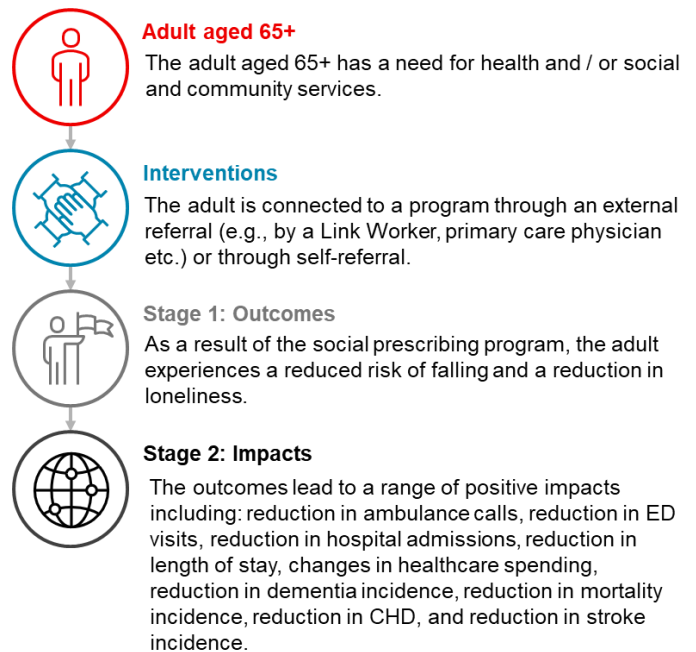
The analysis required several assumptions, which have been validated with stakeholders. For example, this analysis assumes that the entire social prescribing pathway operates in Canada, including the deployment of Link Workers, the referral to interventions, and the impacts of access to interventions. A full list of the assumptions and corresponding mitigation measures is provided in the Assumptions and Limitations section. It should be noted, however, that while the social and economic impact analysis focused on two priority pathways, the applicability of social prescribing as a tool to improve health outcomes is much broader. More information about the methodologies undertaken to develop the aging and youth mental health pathways can be found in the Pathway Methodology Appendix.

Given the uncertainty of how social prescribing may change individual outcomes, and subsequently impacts, on an individual and population level, each impact is quantified as a range. For ease of understanding, the results provided in this report are presented as the “base-case” or average result of the modelling, with the full range of impacts provided in the Appendix.

Pathway 1: Social Prescribing for Aging at Home and in Communities

Social Prescribing Can Impact Health and Mental Wellbeing Challenges by Aging Adults

This first pathway of analysis evaluates the social and economic impacts of social prescribing initiatives for adults aging at home and in the community. The evaluated initiatives are typically designed to improve outcomes through a holistic approach that considers social determinants such as loneliness and depression. Social prescribing for older adults can also help address the risk of falls and physical health challenges.



Mary is 85 years old and lives alone. At home, she enjoys knitting and reading, but often feels lonely in solitude. Mary's inactive lifestyle and her habit of excessive drinking has been adversely affecting her health and wellbeing.

01. Identification of needs

Mary visits her primary care physician during a routine check-up and expresses her concerns about her health and wellbeing.

02. External referral

Mary's primary care provider refers her to a Link Worker who is part of the primary health team.

03. Link Worker support

The Link Worker works with Mary to co-create a personalized care plan. Part of the plan involves attending a day program for seniors in her neighbourhood.

Individuals can be referred to multiple services, such as:

- Befriending groups
- Fitness classes
- Community friendship

05. Intervention outcomes

When the Link Worker checks in with Mary to see how she's feeling, Mary notes feeling less lonely and more active. She decides to continue attending the program every week.

The interventions can result in numerous outcomes, such as:

- A sense of purpose
- Increased physical activity
- Reductions in drinking

04. Intervention

Mary attends the seniors day program. At the program, she meets various seniors and builds new friendships.

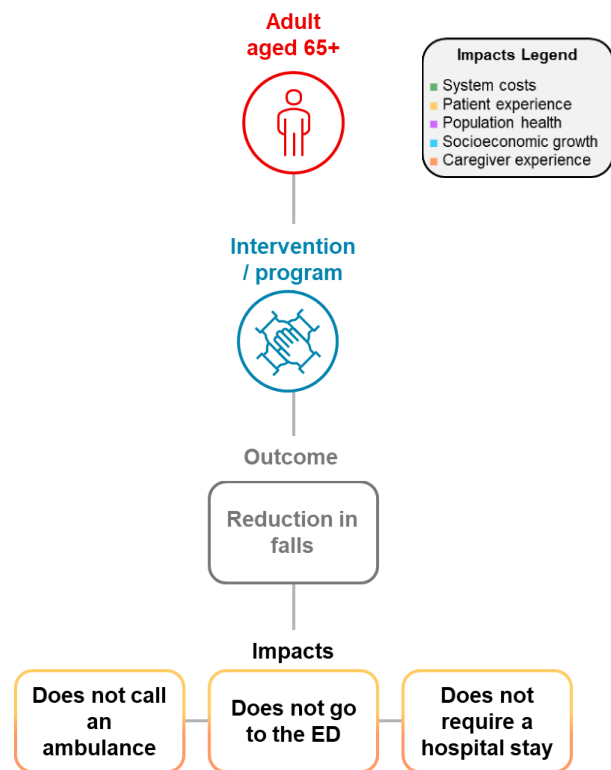
As noted in the methodology, impact modelling goes through a two-stage process. The first stage measures the outcomes of social prescribing for aging adults through three indicators:

- Reductions in falls
- Reductions in loneliness and depression
- Improvements in health-related quality of life

The second stage connects the individual outcomes to various individual impacts. The analysis then aggregates the impacts to model population-wide effects. Explained below are the findings from the social and economic assessment of social prescribing for adults aged 65 and over due to reductions in falls, loneliness, depression, and improvements in health-related quality of life.

Social Prescribing for Aging Adults Can Reduce Hospital Admissions

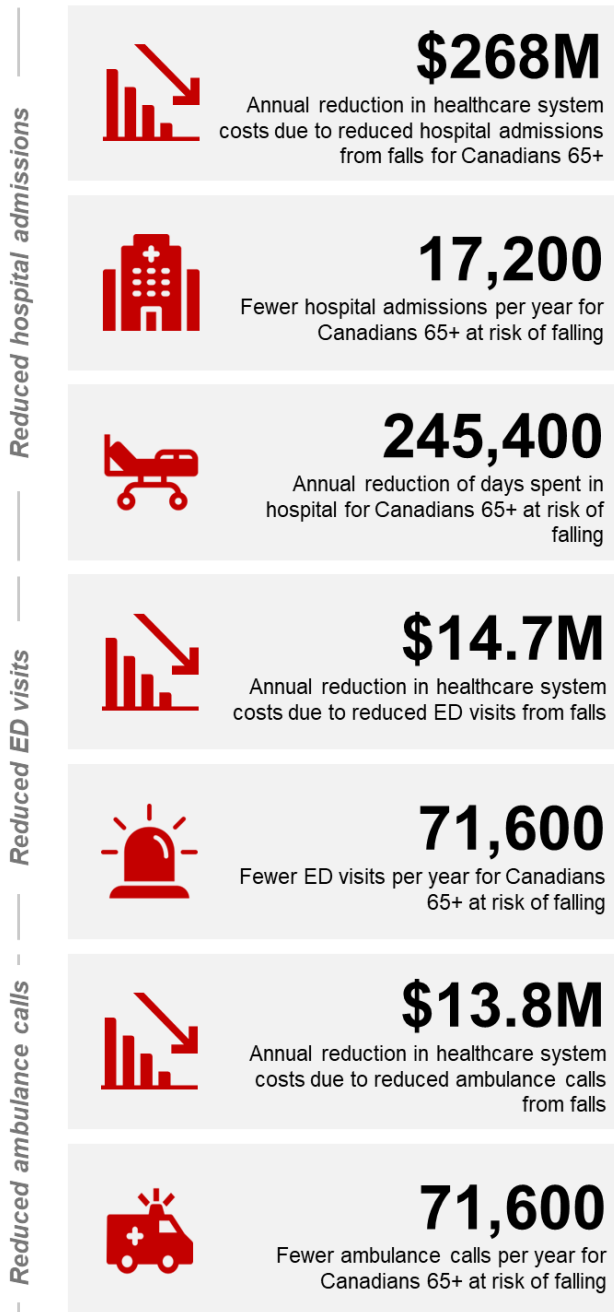
One outcome identified is that referring adults 65 and over to community programs, which include in-home strength and balance training sessions, led to otherwise isolated and sedentary individuals becoming more fit and less likely to fall. Based on the reduction in falls modelled in stage one, stage two estimates that individuals are less likely to be hospitalized and thus, spend fewer days in hospital. These impacts, at a national level, may lead to base-case reductions in hospital admissions of 17,200 for Canadians 65 and over, leading to 245,400 fewer days spent in the hospital – a 22 percent reduction to the total time spent in hospital due to falls of Canadians 65 and over. The base-case cost savings from reduced falls could be a \$268 million annual reduction in healthcare system costs due to reduced hospital admissions from falls – a 22 percent decrease in expenditures for hospital stays for this cohort. As falls among older adults represent nearly 20 percent of the \$5.6 billion annual total injury cost in Canada, fall reductions represent a substantial cost saving opportunity for health systems.³⁰



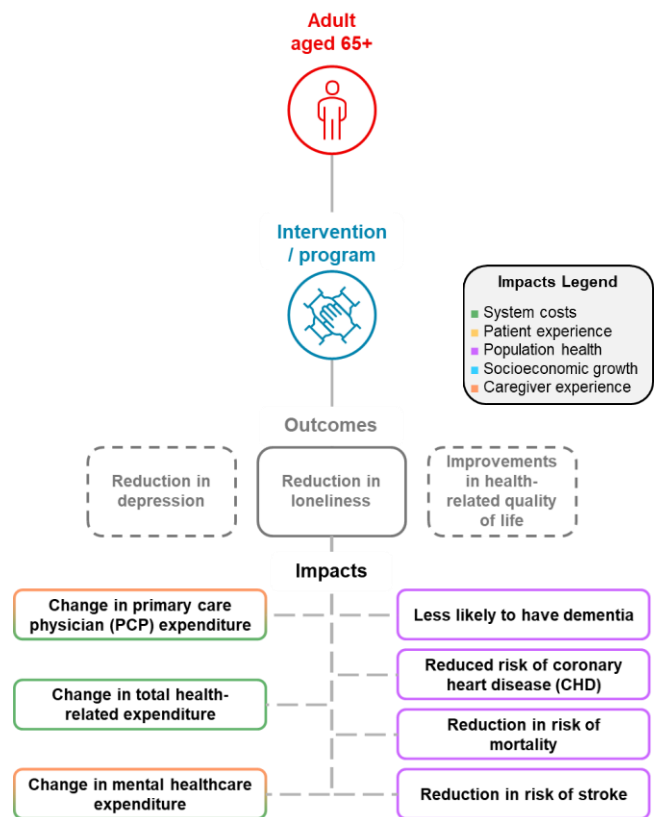
Social Prescribing for Aging Adults Can Reduce Emergency Department (ED) and Ambulatory Usage

Fall reductions were also analyzed to determine the impact on Emergency Department (ED) visits. It is estimated that the reduction in falls resulting from social prescribing programs for adults 65 and over across Canada could lead to base-case reductions of 71,600 ambulance calls and ED visits per year. The current estimated number of ED visits per year for Canadians across all age cohorts due to injury is approximately 3 million, so this would represent an estimated 2.4 percent reduction in the total number of ED visits due to injury. The system-wide impact of these outcomes projects annual savings of \$14.7 million from reduced ED visits and \$13.8 million from reduced ambulance calls. Combined with the savings in hospitalizations, this provides a total savings to the health system of approximately \$296 million per year.

³⁰ "Falls in Seniors", Parachute.



The analysis found a relationship between social prescribing and reductions in loneliness as well as improvements in health-related quality of life. Referrals to social programs like seniors' drop-in classes led to reduced feelings of loneliness. Loneliness is linked to, and a driver of, both depression and health-related quality of life. To avoid overestimation, our modelling focuses on the impacts driven through reductions in loneliness, as this implicitly accounts for the impacts of reducing depression and improving health-related quality of life.



Social Prescribing for Aging Adults Can Improve Health-Related Quality of Life

The second outcome measured for aging adults is the impact of social prescribing on reducing loneliness and depression, and improving health-related quality of life for Canadians 65 and over. Loneliness and depression are emerging as increasingly severe health issues for aging populations. One in four Canadians over the age of 65 live alone, and nearly 50 percent of Canadians over 80 report feelings of loneliness.³¹

³¹ "Report on the Social Isolation of Seniors," Canada.ca, July 20, 2016, <https://www.canada.ca/en/national-seniors->

[council/programs/publications-reports/2014/social-isolation-seniors/page05.html](https://www.canada.ca/en/national-seniors-council/programs/publications-reports/2014/social-isolation-seniors/page05.html).

Four chronic disease and personal health impacts were analyzed in stage two to determine the individual-level impact of social prescribing on loneliness: changes in coronary heart disease (CHD), dementia, stroke, and avoidable deaths for Canadians 65 and over. The base-case findings, assuming social prescribing is available to all eligible Canadians (those 65 and over who self-report as feeling always or often lonely) are included:

16,900 fewer cases of CHD among Canadians 65+

6,500 fewer cases of stroke among Canadians 65+

7,600 fewer cases of dementia over the next 10 years among Canadians 65+

2,000 fewer cases of avoidable death among Canadians 65+

To understand the significance of the base-case estimates above, the reduction in CHD implies that a Canadian aged 65 and over who self-reports always or often feeling lonely may be 7 percent less likely to develop CHD over their lifetime because of social prescribing. Similarly, social prescribing could lead to an 11 percent reduction in dementia cases over the next 10 years for the same population cohort and an 8 percent reduction in stroke cases over the cohort's lifetime. Finally, the reduction in cases of death means social prescribing may lead to a 7 percent overall reduction for the cohort.

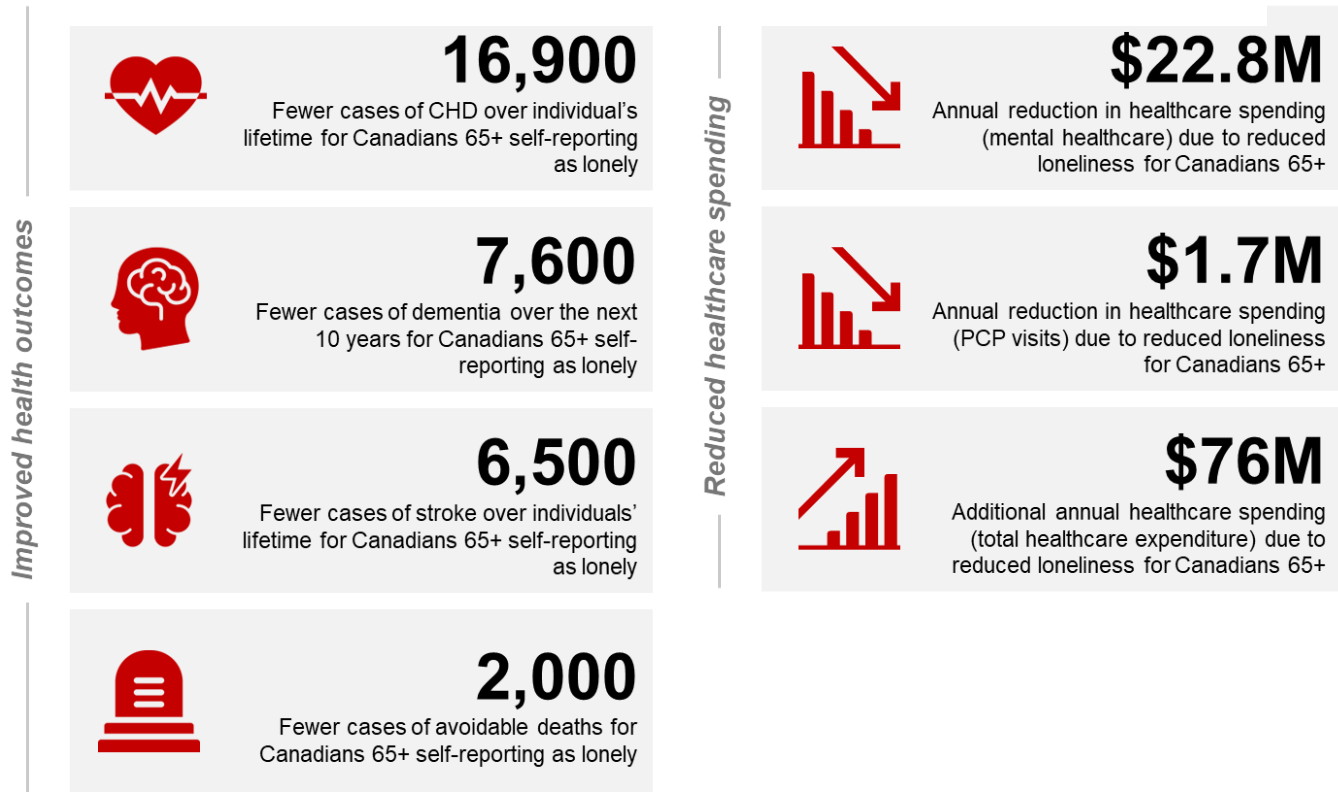
It is important to note that reductions in disease incidence will also produce downstream cost savings, as less care is required to treat these patients, freeing up caregiver time for other priorities.

Social Prescribing for Aging Adults Can Impact Healthcare Spending

The evidence suggests that reductions in loneliness and depression, along with improved health-related quality of life, may impact health system usage and lead to three system-wide economic effects. The first is an estimated annual reduction of nearly \$23 million in mental healthcare spending. The analysis also estimated a \$1.7 million reduction in spending on primary care physician visits. At the same time, the analysis estimated a base-case increase of \$76 million in total health system expenditures due to reduced loneliness and depression,

and improved health-related quality of life due to people seeking timely specialized treatment addressing issues that would otherwise remain unaddressed. However, while the short-term health expenditures due to people seeking these treatments are expected to rise because of increased health system usage, these costs should lead to positive returns in the long-term due to improved health outcomes, reduced acute care costs, improved community engagement and economic activity. Although these long-term cost savings and productivity gains cannot be measured in detail, they are included in the overall returns on investments provided through the Social Return on Investment (SROI) analysis later in this report.

Impact Highlights: Aging at Home & In Communities



Case Study The Rotherham Social Prescribing Pilot

The Rotherham Social Prescribing pilot which launched in 2012 was a two-year social prescribing initiative that delivered voluntary and community sector (VCS) liaison services to residents of Rotherham, England. The majority of participants were aged 60 and above and had complex long-term health conditions – they received referrals from primary care physicians and were connected with VCS Advisors. The advisors assessed the individuals' needs and facilitated connections to services including community activities, physical activities, and befriending support.

Individual Impacts: An evaluation of the pilot indicated that 83 percent of participants reported positive changes in measures of wellbeing including positivity, symptom management, and other indicators. Case studies showed improvements in wellbeing, decreased isolation and loneliness, increased independence, and broader access to welfare benefits.

Healthcare System Outcomes: The pilot also assessed the changes in health system outcomes due to program attendance. The evaluation revealed a 21 percent reduction in inpatient admissions, a 20 percent reduction in Accident and Emergency (A&E) attendances, and a 21 percent reduction in outpatient appointments the year following referrals. These outcomes highlighted a substantial reduction in the utilization of healthcare resources due to the social prescribing pilot.

Social and Economic Benefits: To quantify the impact of the social prescribing pilot, a return on investment (ROI) analysis was conducted. The findings indicated an ROI of £0.50 for every £1 invested, with estimated increases to £3.38 after five years, assuming that the benefits realized in the first year are sustained for five years after the pilot's completion. A social return on investment (SROI) was estimated to return positive results during the first year after program attendance.

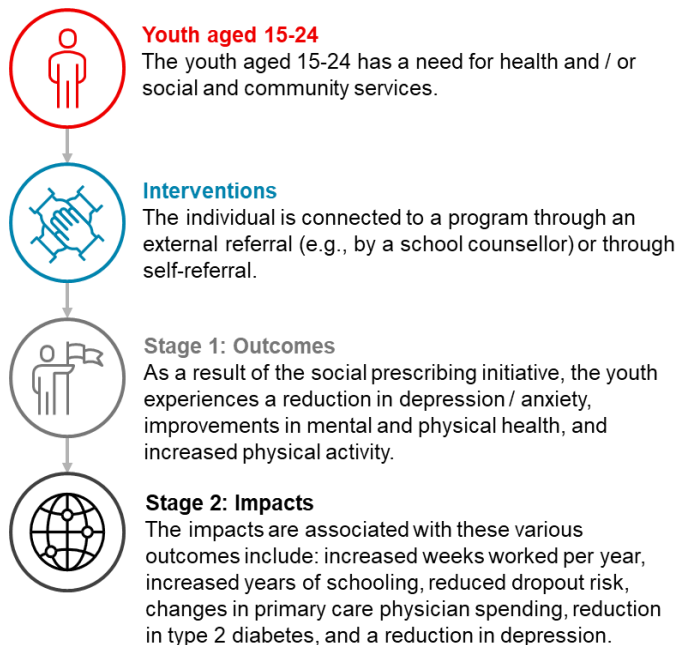
Chris Dayson, "The Social and Economic Impact of the Rotherham Social Prescribing Pilot," Sheffield Hallam University, accessed December 22, 2023, <https://shura.shu.ac.uk/18961/1/Dayson-SocialAndEconomicImpact-Rotherham%28VoR%29.pdf>.

Pathway 2: Social Prescribing for Youth Mental Health

Social Prescribing Can Improve the Mental Health of Youth

Social prescribing programs show promising evidence as a tool to support improved mental health outcomes for youth. Social prescribing often involves interventions to address the complex challenges that arise from school, family, socioeconomic status, discrimination, disabilities, and other factors. It is important to consider the long-term impacts of improved mental and physical outcomes for youth, as many benefits extend through adulthood.

The analysis for youth mental health follows the same two-stage modelling process. Stage one measures the outcomes of social prescribing for Canadian youth through three indicators: reductions in depression and anxiety, changes in healthcare expenditure, and improvements in health outcomes. The second stage of the analysis links the individual outcomes to various impacts, including better education and health measures.



AJ is a 17-year-old high school student. At school, AJ finds themselves struggling with class work, due to their ongoing challenges with depression and anxiety. AJ finds it difficult to confide in their friends or family about their struggles, which has started to negatively impact their attendance and grades.

01. Identification of needs

AJ's guidance counsellor identifies that they may be struggling with mental health challenges.

02. External referral

The guidance counsellor refers AJ to a local youth hub in their neighbourhood, where they connect with a Link Worker.

03. Link Worker support

The Link Worker assesses AJ's needs and co-designs a personalized plan with them. The coordinator introduces AJ to a youth fitness program, held at a local centre.

Individuals can be referred to multiple services, such as:

- Peer support groups
- Physical activity
- Friendship and community connection

05. Intervention outcomes

AJ reports to their Link Worker that they now feels less depressed and anxious. AJ also starts seeing positive change in their school work. They continue to visit the local hub whenever they need support.

04. Intervention

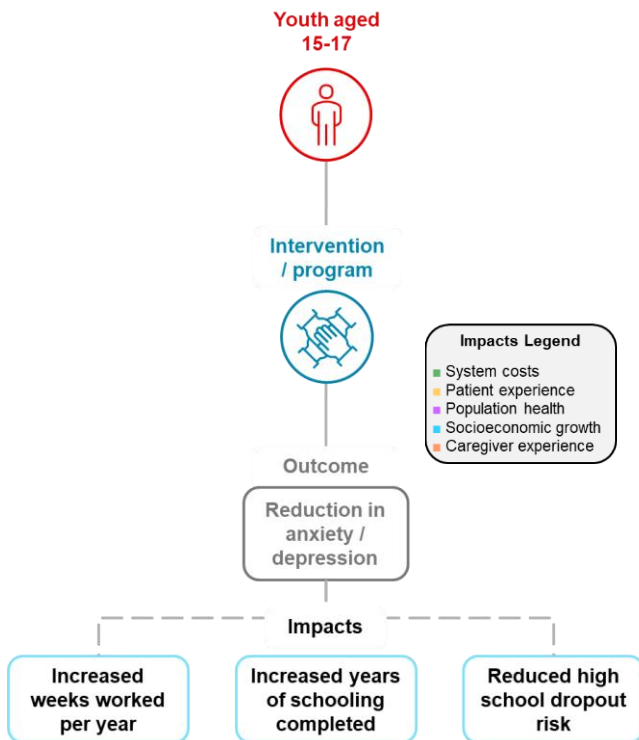
AJ attends the fitness program at their local centre. The program helps AJ increase their physical activity and introduces them to youth facing similar challenges.

The interventions can result in numerous outcomes, such as:

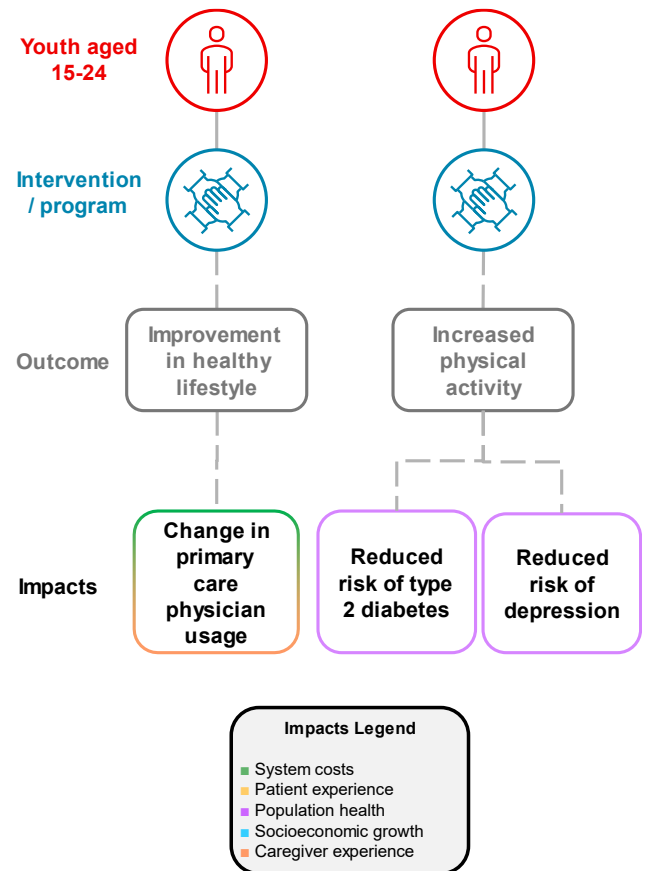
- Improved mental health
- Increased years of schooling completed
- Fewer physician visits

Social Prescribing for Youth Mental Health Can Improve Education and Employment Outcomes

The first part of the analysis measured the impact of social prescribing in Canada through reductions in depression and anxiety for youth aged 15 to 17. Stage one modelled reductions in depression and anxiety, while stage two estimated the impact of reductions in depression and anxiety on additional years of school completed, additional weeks worked, and improved likelihood of graduating.



A social prescribing initiative across Canada can lead to a base-case \$60 million increase in annual employment income during the working careers for youth aged 15 to 17 who currently report anxious or depressive symptoms – representing a 14 percent total increase in employment income for this cohort of youth over the course of their working lives. Furthermore, the analysis estimated 3,500 additional years of schooling completed among Canadian youth aged 15 to 17 with anxious or depressive symptoms. The analysis also concluded that social prescribing could lead to a reduction in dropouts, with a base-case estimate of 600 fewer high school dropouts for the same 15 to 17-year-old cohort.



Social Prescribing for Youth Mental Health Can Impact Healthcare Spending

The second part of the analysis measured the impacts of social prescribing on youth mental health through adoption of practices that improve mental and physical health.

Social prescribing programs, which aim to enhance overall wellbeing, have led to a decrease in the usage of health systems. This is achieved through the implementation of more suitable, proactive supports at an early stage, thereby reducing the need for individuals to access primary care. Social prescribing can reduce the number of primary care physician visits by 2 million for Canadians aged 15 to 24. This reduction in primary care physician visits can lead to a \$114 million annual reduction in costs across Canada’s health system.

Social Prescribing for Youth Mental Health Can Lead to Better Health Outcomes

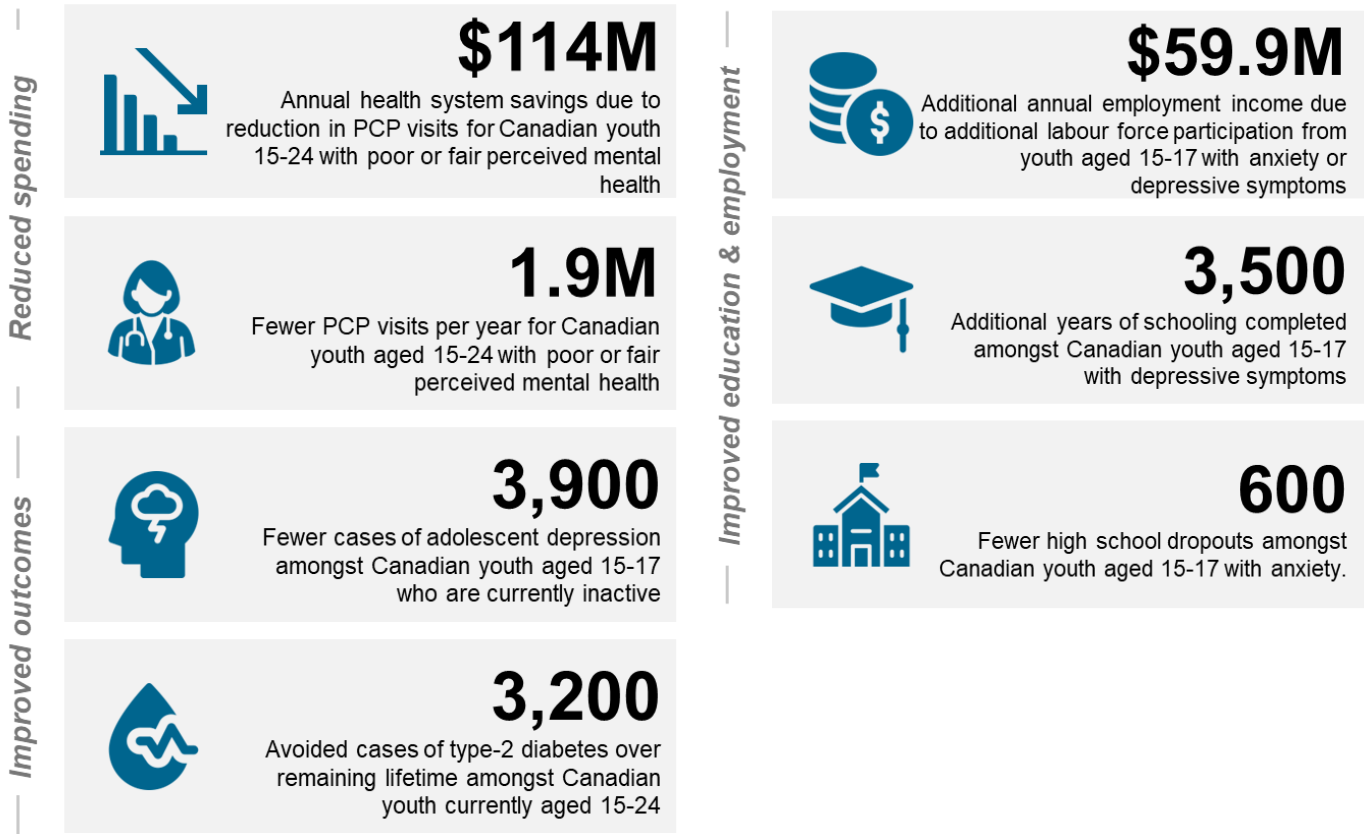
The third part of the analysis measured the impact of social prescribing on increased physical activity for youth across Canada. Over the past few years, the COVID-19 pandemic led to many young people spending more time than ever indoors, resulting in decreased levels of

physical activity.³² The lack of physical activity for youth poses a range of concerning challenges for Canada's health system, including increased rates of diabetes, obesity, and hypertension.

The social and economic impact analysis for youth mental health determined that social prescribing could lead to improvements in levels of physical activity, a stage one outcome, which in turn results in enhanced health outcomes, the stage two impact. The analysis estimated a potential Canada-wide base-case reduction of 3,900 cases of adolescent depression and 3,200 fewer cases of type-2 diabetes linked to inactivity for Canadians aged 15 to 17.

³² Colley and Watt. "The unequal impact of the COVID-19 pandemic on the physical activity habits of Canadians." 22-33.

Impact Highlights: Youth Mental Health



Case Study Linking Leeds Social Prescribing Program

Linking Leeds is a social prescribing program for the residents of Leeds, England, aged 16 and above. The program can be accessed through referrals from primary care physicians, other professionals, or via self-referrals. The program's objective is to connect individuals with a range of community services that can improve their health and overall wellbeing.

Individual Impacts: A study was conducted to evaluate the effectiveness of the Linking Leeds social prescribing program, with a particular focus on participants aged 16 to 25 who were dealing with non-medical stress-related issues between January 2019 and January 2020. The study's findings reveal that the Linking Leeds program contributed to several positive individual impacts, including a reduction in loneliness and isolation, improved happiness, improved life satisfaction, and improved wellbeing and self-esteem. These positive individual outcomes emphasize the program's effectiveness in addressing stress-related issues through a social determinant of health-based approach.

Melissa Brettell, "Linking Leeds: A Social Prescribing Service for Children and Young People," International Journal of Environmental Research and Public Health, accessed December 22, 2023, https://www.researchgate.net/publication/358171102_Linking_Leeds_A_Social_Prescribing_Service_for_Children_and_Young_People.

Social Prescribing in Equity-Deserving Communities

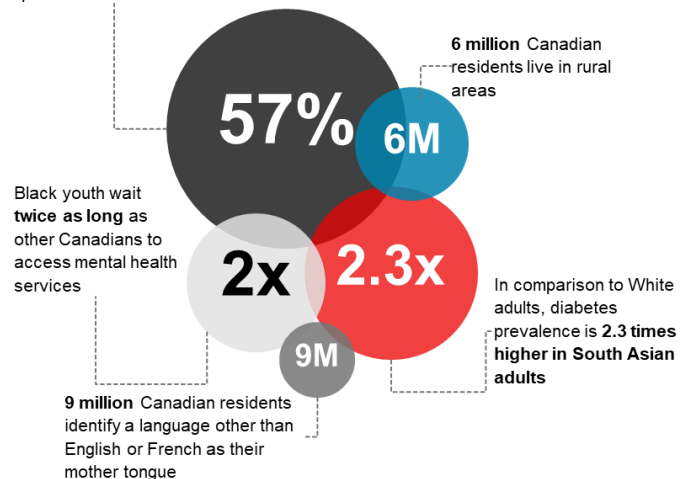
Recognizing the diverse range of health and social challenges across Canada, it is crucial to acknowledge that communities are not impacted equally. Marginalized groups continue to face barriers to care, making it essential to prioritize the implementation of social prescribing programs to support these communities, in addition to investments in culturally competent healthcare. These include communities such as Black, Indigenous, newcomers, LGBTQIA+, persons with disabilities, and any other groups that face marginalization and barriers accessing equitable care.³³

Factors related to health inequities, such as anti-Black racism, have led to worsened health outcomes for Black Canadians across the health system. For example, the prevalence of diabetes for Black Canadians is nearly twice that of White Canadians.³⁴ Additionally, the rate of young Black women between 12 and 17 who reported “excellent or very good” mental health was nearly 15 percent lower than that of White women in the same age group.³⁵

Programs designed for this population could build on the core tenets of other Black-led initiatives such as the *Supporting Black Canadians Communities Initiative*, which includes building capacity in vibrant Black communities across Canada and ensuring Black voices are reflected in policies and programs that impact their lives.³⁶ The nature of social prescribing as a community-driven and community-led policy tool aligns well with these tenets and creates an opportunity for government to meaningfully co-design solutions to help support Black Canadian communities.

Indigenous communities, including First Nations, Métis, and Inuit, also face significant health inequities, resulting in poorer health outcomes, such as higher rates of chronic conditions and mental illness. A 2021 survey on Access to Health Care and Pharmaceuticals During the

57% of Inuit living off reserve do not have a regular primary care provider



Pandemic found that First Nations, Métis, and Inuit continue to face higher rates of unmet healthcare needs, including higher rates of chronic lung conditions, asthma, chronic heart disease, and mental health conditions.³⁷ It is crucial to recognize the impact of intergenerational trauma on Indigenous communities and the need for culturally sensitive care that recognizes the impacts of the residential school system and loss of socioeconomic status due to colonialism.³⁸ Additionally, as part of developing potential social prescribing programs, practices should adhere to the Indigenous Research Statement of Principles as outlined by the Social Sciences and Humanities Research Council. This Statement of Principles “emphasizes the importance of Indigenous perspectives and knowledge systems to increase and expand our knowledge and understanding about human thought and behaviour across past, present, and future contexts.”³⁹

Other marginalized communities, including newcomers, the LGBTQIA+ community, and persons with disabilities, face ongoing barriers to care that lead to worse health outcomes. Emerging research indicates that children arriving as immigrants or refugees are increasingly vulnerable to reduced health outcomes caused by

³³ “Building Understanding: The First Report of the National Advisory Council on Poverty”, Government of Canada

³⁴ “Social Determinants and Inequities in Health for Black Canadians: A Snapshot,” Government of Canada, September 8, 2020, <https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/social-determinants-inequities-black-canadians-snapshot.html>.

³⁵ Ibid.

³⁶ “Black Communities,” Government of Canada, December 13, 2023, <https://www.canada.ca/en/employment-social-development/programs/social-development-partnerships/supporting-black-communities.html#h2.1>.

³⁷ Tara Hahmann and Mohan Kumar, “Unmet Health Care Needs during the Pandemic and Resulting Impacts among First Nations

People Living off Reserve, Métis and Inuit,” Statistics Canada, August 30, 2022, <https://www150.statcan.gc.ca/n1/pub/45-28-0001/2022001/article/00008-eng.htm>.

³⁸ Paul J Kim, “Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System,” *Health equity*, July 25, 2019, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6657289/#:~:text=Compared%20to%20the%20general%20population,having%20significantly%20reduced%20life%20expectancy..>

³⁹ “Indigenous Research Statement of Principles,” Social Sciences and Humanities Research Council, November 29, 2012, https://www.sshrc-crsh.gc.ca/about-au_sujet/policies-politiques/statements-enonces/indigenous_research-recherche_autochtone-eng.aspx.

poverty and marginalization.⁴⁰ In many cases, their health outcomes substantially worsen after moving to Canada, often due to a lack of culturally competent care that addresses the unique challenges facing newcomers.⁴¹

The LGBTQIA+ community faces a range of health inequities, including poorer general health, higher rates of chronic conditions, and increased levels of mental health challenges.⁴² These disparities are particularly severe for LGBTQIA+ youth, who experience higher rates of psychological distress, self-harm, depressive episodes, and suicide which is associated with increased levels of discrimination, harassment, and violence.⁴³

Approximately 22 percent of Canada's population lives with disabilities – this group faces baseline health challenges that are further complicated by health systems that do not recognize their unique needs.⁴⁴ Canadians with disabilities were significantly impacted by the COVID-19 pandemic, and were much more likely to experience extended hospital stays, readmission to hospitals, and increased mortality rates.⁴⁵

While health access is a concern for Canadians, health disparities in the country are more closely linked to social determinants of health rather than health access, and cannot be addressed by increasing access to care alone. Indeed, social interventions are fundamental to achieving equity. Social prescribing can be an important policy tool in this regard, aiming to address some of the underlying social determinants leading to worse health outcomes and to provide culturally informed supports that build trust and capacity within marginalized communities.

This report primarily uses a traditional approach to program evaluation and economic analysis. It should be noted that the team preparing this report considered using the methodologies applied in the first two pathways to quantify impacts for equity-deserving populations. However, after discussions with individuals with lived experience and those working closely with these populations, we concluded that such methodologies might undermine and likely understate

the complexity of health inequities faced by these groups. Additionally, using these traditional methods could perpetuate a colonial mindset as these approaches have historically disenfranchised these populations. Therefore, future research and analysis aimed at identifying impacts for equity-deserving communities should incorporate the unique knowledge of these communities, utilizing research strategies based on Indigenous, Afrocentric, and other equity-focused knowledge and measurement frameworks.

Case Study Black Focused Social Prescribing Program

The Black Health Committee launched a Black-focused social prescribing pilot project in July 2022 to test the effectiveness of social prescribing across four Community Health Centres (CHCs) in Ontario. These programs were structured around the principles of Black and Afrocentric values, with an added emphasis on supports for youth and families. The pilot was launched in response to the impacts from the COVID-19 pandemic, which saw disproportionately devastating impacts on Black Canadians.

Run through CHCs in Ontario, these pilot programs offer clinical services, physiotherapy, counselling, mental health and addictions, diabetes support and other programs to participants. Further, the objectives of the social prescribing pilots are to improve health outcomes by addressing social determinants, including access to nutritious food, income security, education, and social connections.

Although formal program evaluations measuring the impact of social prescribing through the Black-focused pilot are not yet available, a similar pilot conducted by the Alliance for Healthier Communities in March 2020 reported positive outcomes for participants, including a near 50 percent reduction in feelings of loneliness and 19 percent increase in participation in social activities.

*New Black-Focused Social Prescribing Project Aims to Improve Health in Black Communities with a Proven Holistic Approach Grounded in Afrocentric Principles of Wellbeing." Alliance for Healthier Communities, July 12, 2022. <https://www.allianceon.org/news/New-Black-focused-Social-Prescribing-Project-aims-improve-health-Black-communities-proven>.

⁴⁰ "Chronic Health Disparities among Refugee and Immigrant Children in Canada," Canadian Science Publishing, accessed December 20, 2023, <https://cdnsiencepub.com/doi/10.1139/apnm-2017-0407>.

⁴¹ "Migration and Health in Canada: Health in the Global Village," Canadian Medical Association Journal, accessed December 20, 2023, <https://www.cmaj.ca/content/cmaj/183/12/E952.full.pdf>.

⁴² Public Health Agency of Canada, Programs and interventions promoting health equity in LGBTQ2+ populations in Canada through action on social determinants of health, December 15, 2021, <https://www.canada.ca/en/public-health/services/reports-publications/health-promotion-chronic-disease-prevention-canada-research-policy-practice/vol-41-no-12-2021/programs-interventions->

[health-equity-lgbtq2-populations-canada-action-social-determinants-health.html](#).

⁴³ Ibid.

⁴⁴ "Disability - a Chronic Omission in Health Equity That Must Be Central to Canada's Post-Pandemic Recovery," Government of Canada, July 19, 2023, <https://www.canada.ca/en/public-health/services/reports-publications/health-promotion-chronic-disease-prevention-canada-research-policy-practice/vol-43-no-7-2023/disability-chronic-omission-health-equity-post-pandemic-recovery.html>.

⁴⁵ Ibid.

Social Return on Investment

The overall return on investment for social prescribing.

Social Return on Investment Analysis

This section aims to estimate the overall return on investment for a nation-wide implementation of social prescribing in Canada. Unlike the social and economic impact analysis, which focused on specific cohorts and measured targeted impacts, this analysis provides an aggregated assessment of the total costs and benefits-filling the gaps in the question of overall return to social prescribing that could not be answered in the analyses of the two pathways of aging adults and youth mental health.

A Social Return on Investment (SROI) measures the total social, economic, and environmental returns generated by a program, calculated per dollar invested. An SROI greater than 1 indicates a positive return from the program. The SROI analysis considers the entire cost of social prescribing implementation, including administrative costs for hiring Link Workers, the program costs for supporting expanded intervention referrals to social and community care programs, and any additional governance costs required for health systems to manage social prescribing programs.

The methodology used for the SROI analysis began with a comprehensive desktop research scan to identify publications highlighting social prescribing. From an initial 30 publications, 12 were selected for their relevance and granularity applicable to the Canadian context. Our methodology relied on leveraging findings from social prescribing analyses in other jurisdictions since Canada has yet to conduct a comprehensive SROI program evaluation on social prescribing.

The target populations from the studies were identified and mapped to the relevant population cohort that could be prioritized in Canada. Benefits outlined in the SROI publications were categorized and mapped to benefit categories such as volunteering, social inclusion, training programs, financial stability, wellbeing index, improved optimism, employment, therapeutic benefits, managing physical health, system cost savings, daily living, mortality / morbidity improvements, managing mental health, and carer wellbeing. The population-weighted SROIs by benefit category were calculated for all studies to get a value by benefit category. The overall SROI for all benefits was calculated using the population-weighted SROIs and total population for each corresponding benefit category.

\$4.43

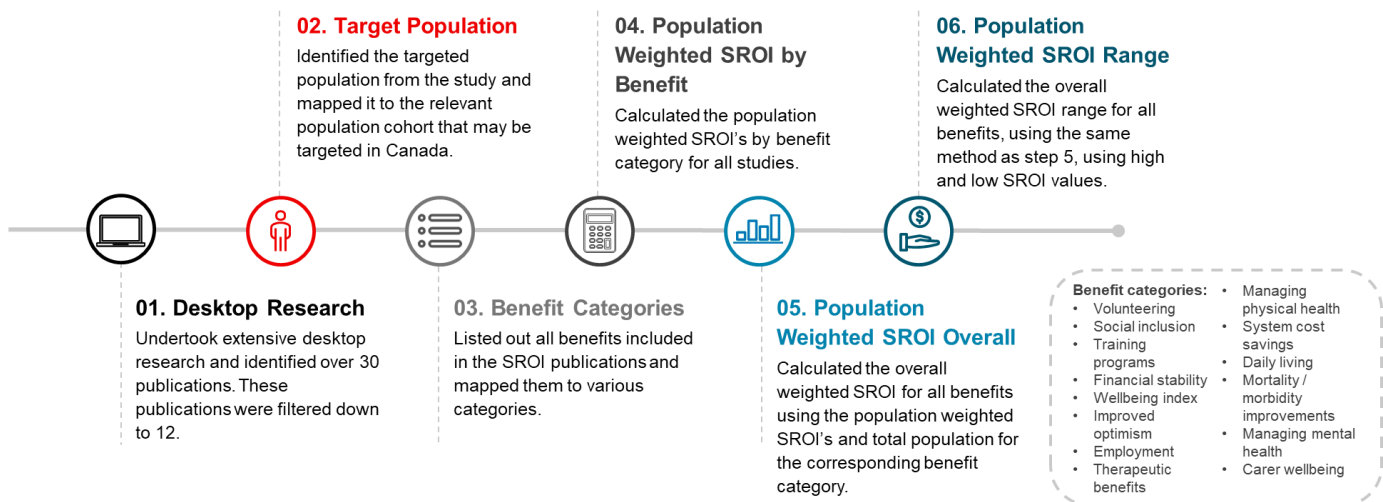
Every dollar invested into social prescribing programs may return \$4.43 to society through improved wellbeing and reduced costs incurred on the health system and government.

It was estimated that the base-case SROI for social prescribing in Canada is \$4.43 (range of \$2.97 to \$5.89). The positive SROI is attributed to the benefits social prescribing creates for participants, including improvements in health and mental wellbeing, improved engagement, and changes in health service usage. It is important to clarify that while the SROI is significant, it will likely be observed dispersed across several sectors and government departments. Thus, from a whole-of-government perspective, there are immediate benefits from adopting social prescribing as well as the long-term benefits that accrue over time, generated by the impact of preventative healthcare measures. Due to the broad range of outcomes that are achieved with social prescribing, other sectors that derive indirect benefit from social prescribing, including social and community services, education, and housing, will also see positive returns.

The SROI analysis offers insight to the potential benefits for individuals, providers, communities, and the systems they participate in. From an individual's perspective, social prescribing offers an opportunity to improve health and wellbeing through non-medical interventions addressing the social determinants affecting health outcomes. For providers, social prescribing reduces the strain on healthcare services, leading to more efficient resource allocation and improvements in care delivery.

This analysis also provides further support for the Government of Canada's Quality of Life framework, which seeks to support evidence-based budgeting and decision-making processes within the federal government. The SROI findings provide evidence to support the federal government's use of the framework as a valuable decision-making tool to address the social

determinants of health. More information on the process to determine the SROI can be found in the Appendix, under SROI Methodology.



The Path Forward for Canada

What this means for Canadians

Social Prescribing Presents an Opportunity to Improve Lives

This report assessed the potential impact of social prescribing in Canada through a two-part evaluation: a social and economic impact analysis on two pathways (aging adults and youth mental health) and an assessment of overall Social Return on Investment (SROI). The results of both analyses find positive social and economic impact from social prescribing, justifying its expanded use in Canada.

The economic analysis found that social prescribing has the potential to reduce healthcare costs for older adults aged 65 and above by decreasing falls and reducing loneliness, which are key drivers of poor health outcomes. Additionally, social prescribing has the potential to improve population health and wellbeing for older adults resulting in a reduction of healthcare expenditures.

Similarly, the analysis for youth mental health demonstrates an opportunity to improve outcomes for Canadian youth aged 15 to 24, including improved educational attainment, greater workforce participation, improved health outcomes, and better mental wellbeing.

The results from this analysis demonstrate the potential to alleviate the workforce crisis impacting healthcare professionals by establishing dedicated Link Worker roles to manage referrals to non-medical programs. Notably, this could reduce the burden on primary care

physicians, who are often required to fulfill the role of a Link Worker

Finally, the SROI analysis identified the opportunity for social prescribing in Canada to generate positive overall economic benefits. The base-case estimate of \$4.43 means that for every dollar invested, social prescribing can yield a positive economic return in addition to positive social, community, and health benefits.

Social prescribing presents an exciting opportunity to improve health outcomes through a person-centered approach that bridges the gap between health, social and community services. However, social prescribing alone cannot address the complex and interconnected challenges impacting Canada's health system. The capacity needs of the community and social sector must be considered as part of implementation plans. Further, consultation with key stakeholder groups, including governments, healthcare professionals, medical associations, and individuals, is critical to ensure that the social prescribing practices reflect the needs and interests of the communities they seek to serve.

Overall, these analyses find the opportunity that social prescribing presents from an economic and social return on investment perspective is significant and aligns well with some of the core challenges to equitable health and care facing this country. Social prescribing also presents a chance to leverage the collective strength of our health and social care systems to create a person-centered, integrated model that addresses the unique challenges of people and communities across the country.

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Appendix

Assumptions and Limitations

The social and economic impact analysis and the SROI analysis highlighted the numerous potential benefits of social prescribing implementation in Canada. However, it is important to note that there were several limitations and assumptions built into this evaluation, which should be considered in the interpretation of the results. To ensure that the analyses reflect accurate and comprehensive insights, mitigations steps for each assumption/limitation were incorporated into the analyses.

Assumption / Limitation	Mitigation Strategy
The figures provided are modelled results built using assumptions and estimates. We cannot guarantee these estimated results would occur should social prescribing be implemented.	Key modelling assumptions and directionality of estimates were validated with stakeholders, including researchers and practitioners of social prescribing. While evidence is still emerging, we are already observing positive impacts and can expect these to improve over time if we consider the theoretical progression. Based on the emergence of trends to-date and conservative estimates, we expect the results to improve over time if we consider theoretical progression.
The analysis relied solely on secondary research therefore, it is challenging to validate the accuracy of the modelling inputs.	Authors of research papers used to inform the modelling were interviewed to ensure that results were interpreted correctly. The modelling is based on the observed results from these papers.
The majority of the studies included in the analysis were not conducted in Canada thus, the results may not account for jurisdictional differences.	Research was filtered to use cases and population samples that are relevant and comparable in Canada. The analysis assumes the impacts measured in other jurisdictions are replicable in Canada. Additionally, while we don't have evidence on how social prescribing helps specific equity-deserving groups in a Canadian context, it stands to reason that the greatest benefits will emerge by focusing on groups with lower base health outcomes.
The analysis assumes that social prescribing is implemented in totality and for the entire relevant Canadian population, including Link Workers/ connectors as well as the intervention.	The analysis assumes full implementation across of social prescribing. Results have been calculated at the provincial/territorial level and then aggregated to all of Canada.
The analysis has conservatively estimated the attribution effects of social prescribing to account for other factors that may contribute to changes in outcomes.	The attribution effects were derived directly from existing program evaluations of social prescribing programs. We are conservative in our approach as we don't yet have long-term studies to draw from or studies on the concurrent/compounding effects of outcomes.
Canadian baseline data does not perfectly match how impacts were measured in social prescribing program evaluations that were used as modelled inputs. As such, assumptions were made as to how impacts at an individual level can be scaled to estimate the impacts at the population level.	To avoid overestimation of the potential benefits of social prescribing when aggregating to the Canadian population, we have taken conservative estimates of the targeted population for each impact. Furthermore, we did not consider compounding effects where a modelled impact can lead to further benefits through its association with downstream impacts.
For each modelled outcome and impact there is limited research to draw from, the point estimate effect size for a given outcome may be drawn from only 1-2 sources.	Results were calculated as wide ranges. This reflects the uncertainty of effects in both the measurement of outcomes and impacts across existing research, including standard errors and variation across studies. Further, in the emerging and fast-growing area of healthcare, more studies continue to come with which to confirm and validate our findings.

The SROI analysis cannot account for how much each benefit contributes to the positive effects of Social Prescribing.	The aggregated SROI weights studies based on the targeted population in a Canadian context as well as the inclusion of a given benefit.
The analysis cannot account for overlap in the population targets of each SROI study.	To account for measurement error, low and high ranges of the SROI were quantified based on sensitivities in existing research.
The analysis is only based on the implementation of SROI in the programs evaluated and actual observed results of the programs.	The analysis considered all available SROI studies that had enough granularity to be included in the analysis.
The studies used in the analysis evaluate different indicators for the same benefits. This analysis assumes the benefits are implicitly the same.	The mapping of the benefits has been tested with key stakeholders.
A specific analysis about potential outcomes and impacts is not conducted for equity-deserving communities.	While we have not conducted an analysis on the impacts of social prescribing for specific equity-deserving communities a Canadian context, it stands to reason that the greatest benefits will be seen by focusing on groups with baseline health outcomes.

Sensitivity Analysis

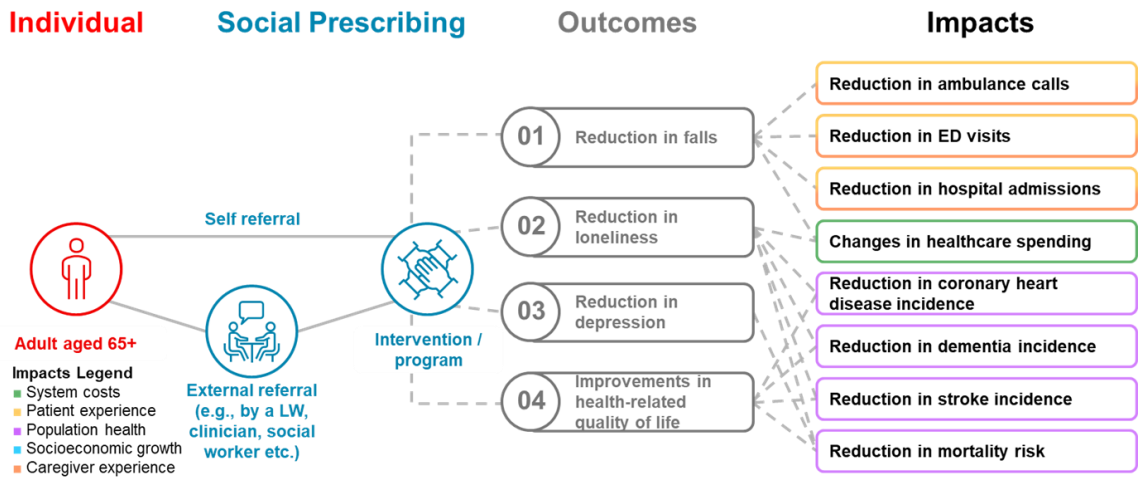
The results presented in this report are the base-case values. There is a range of possible evidence presented in existing literature. Thus, results have been calculated as a wide range to account for uncertainties and variations across studies.

Outcome	Impact	Base-case	Low case	High case
<i>Aging at Home and in the Community</i>				
Reduction in falls	Annual reduction in ambulance calls	71,600 fewer ambulance calls	10,900 fewer ambulance calls	126,900 fewer ambulance calls
	Annual reduction in healthcare system costs due to reduced ambulance calls	\$13.8M reduction in costs	\$2.1M reduction in costs	\$24.5M reduction in costs
	Annual reduction in ED visits	71,600 fewer ED visits	10,900 fewer ED visits	126,900 fewer ED visits
	Annual reduction in healthcare system costs due to reduced ED visits	\$14.7M reduction in costs	\$2.2M reduction in costs	\$26.1M reduction in costs
	Annual reduction in hospital admissions	17,200 fewer admissions	2,600 fewer admissions	30,400 fewer admissions
	Annual reduction in healthcare costs due to decreased hospitalization	\$268M reduction in costs	\$40.9M reduction in costs	\$474.6M reduction in costs
	Annual reduction in number of days spent in hospital	245,400 fewer days	37,500 fewer days	435,100 fewer days
Reduction in loneliness, depression, and improvements in health-related quality of life	Reduced rates of dementia over the next 10 years	7,600 fewer cases of dementia	800 fewer cases of dementia	31,600 fewer cases of dementia
	Reduction in avoidable deaths incidence	2,000 fewer cases of avoidable deaths	300 fewer cases of avoidable deaths	4,000 fewer cases of avoidable deaths
	Annual reduction in healthcare spending (due to primary care physician visits)	\$1.7M reduction in costs	\$0.9M reduction in costs	\$3.5M reduction in costs
	Annual reduction in healthcare spending (due to mental healthcare)	\$23M reduction in costs	\$5.4M reduction in costs	\$44.3M reduction in costs
	Additional annual healthcare spending (total healthcare expenditure)	\$76M in additional costs	\$19.0M in additional costs	\$133.1M in additional costs
	Reduced incidence of coronary heart disease (CHD) over individuals' lifetime	16,900 fewer cases of CHD	2,300 fewer cases of CHD	34,300 fewer cases of CHD
	Reduced incidence of stroke over individuals' lifetime	6,500 fewer cases of stroke	800 fewer cases of stroke	13,900 fewer cases of stroke
<i>Youth Mental Health</i>				
Reduction in anxiety / depression	Estimated reduction in high school dropouts amongst the cohort of Canadian youth aged 15-17 with anxious or depressive symptoms	600 fewer high school dropouts	140 fewer high school dropouts	1,100 fewer high school dropouts

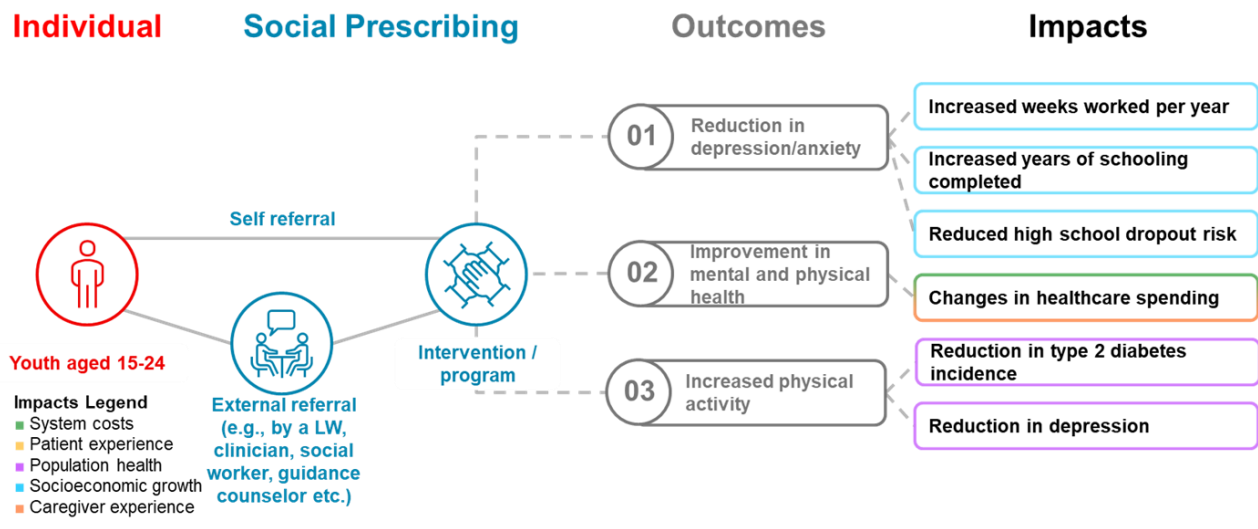
	Annual increase in employment income due to additional weeks of work as an adult for the cohort of Canadian youth currently aged 15-17 with anxious or depressive symptoms	\$60M in additional employment earnings	\$48.6M in additional employment earnings	\$71.1M in additional employment earnings
	Estimated increase in lifetime years of schooling completed amongst the cohort of Canadian youth aged 15 – 24 with poor or fair perceived mental health	3,500 additional years of schooling completed	2,800 additional years of schooling completed	4,100 additional years of schooling completed
Improvement in healthy lifestyle	Annual reduction in primary care physician visits	2M fewer primary care physician visits	0.5M fewer primary care physician visits	3.3M fewer primary care physician visits
	Annual health system cost savings due to reduction in primary care physician visits for Canadian youth aged 15 – 24 with poor or fair perceived mental health	\$114M reduction in health systems costs	\$30.4M reduction in health systems costs	\$200.3M reduction in health systems costs
Increased physical activity	Estimated reduction in lifetime type 2 diabetes incidence for the cohort of Canadian youth aged 15-24 with poor or fair perceived mental health	3,200 cases of type 2 diabetes amongst this cohort of Canadians	1,580 cases of type 2 diabetes amongst this cohort of Canadians	5,200 fewer cases of type 2 diabetes amongst this cohort of Canadians
	Reduction in adolescent depression incidence for the cohort of Canadian youth aged 15-17 with anxious or depressive symptoms	3,900 fewer cases of adolescent depression amongst this cohort of Canadians	900 fewer cases of adolescent depression amongst this cohort of Canadians	6,000 fewer cases of adolescent depression

Pathway Methodology

Aging – Social Prescribing Patient Journey Map



Youth Mental Health – Social Prescribing Journey Map



SROI Methodology

SROI by Benefit Category

Benefit Category	SROI	SROI Low	SROI High	Number Of Studies
Volunteering	\$3.45	\$2.29	\$4.60	5
Training programs	\$6.98	\$4.62	\$9.33	3
Wellbeing index	\$3.45	\$2.29	\$4.60	5
Employment	\$3.13	\$2.03	\$4.23	4
Managing physical health	\$2.50	\$1.79	\$3.22	3
Daily living	\$4.36	\$2.95	\$5.77	6
Managing mental health	\$2.51	\$1.72	\$3.30	5
Social inclusion	\$6.34	\$4.30	\$8.38	5
Financial stability	\$3.32	\$2.04	\$4.60	2
Improved optimism	\$7.56	\$5.08	\$10.04	2
Therapeutic benefits	\$7.85	\$5.32	\$10.38	2
System cost savings	\$3.05	\$2.07	\$4.03	4
Mortality/morbidity improvements	\$10.00	\$6.77	\$13.23	1
Carer wellbeing	\$10.00	\$6.77	\$13.23	1

SROI Study Details

Study Name	Mapped Canadian Population Share	Benefits Measured	SROI Mean	SROI High	SROI Low
Hackney Social Prescribing Scheme ¹¹	12%	A,B,C	\$3.51	\$4.64	\$2.38
Waltham Forest ¹²	13%	A,C,D,E,F,G	\$1.51	\$1.92	\$1.09
Young People Social Prescribing (YPSP) pilot ¹³	4%	A,C,D,G,H	\$5.04	\$6.67	\$3.41
Redbridge CVS ¹⁴	17%	A,B,C,D,I	\$4.64	\$6.42	\$2.86
St Helen's Creative Alternatives arts on prescription program ¹⁵	17%	B,F,H,J,K	\$11.55	\$15.28	\$7.82
Yoga4Health ¹⁶	11%	D,F,K,L	\$2.19	\$2.90	\$1.48
Doncaster Social Prescribing Service ¹⁷	10%	M	\$10.00	\$13.23	\$6.77
Rotherham SP Mental Health Service ¹⁸	11%	F,G,H,I,J	\$1.32	\$1.84	\$0.79
Self-Care Social Prescribing Kensington & Chelsea Social Council ¹⁹	19%	F,G,L	\$2.80	\$3.70	\$1.90
Promoting Activity, Independence, and Stability in Early Dementia (PrAISED) ²⁰	0%	E,F,H,L,N	\$4.71	\$5.95	\$3.46
Coed Lleol—Small Woods Wales Program ²¹	11%	E,G,H	\$3.62	\$4.67	\$2.57
British Red Cross National SP Initiative ²²	37%	A,C,L	\$3.42	\$4.52	\$2.32

Benefit Category Index	
A	Volunteering
B	Training programs
C	Wellbeing index
D	Employment
E	Managing physical health
F	Daily living
G	Managing mental health
H	Social inclusion
I	Financial stability
J	Improved optimism
K	Therapeutic benefits
L	System cost savings
M	Mortality/morbidity improvements
N	Carer wellbeing



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+ Canadian Red Cross