# Reimagining social prescribing through an asset-based community development lens

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As health systems in the Western Pacific and globally grapple with widening health inequities, ageing populations, and chronic disease burdens, there is increasing consensus that medical care alone cannot produce health.[1] The upstream determinants—social, economic, environmental—are now recognised as fundamental to health outcomes, demanding a more integrated and community-oriented approach.[2] Social prescribing (SP) has emerged as a promising model, offering clinicians a structured way to connect individuals with non-clinical services that support their broader well-being.[3]

Typically involving a link worker or community connector, SP enables personalised support that connects people with community-based resources such as peer groups, exercise classes, welfare advice, arts activities, and volunteering.[4] It aims to address not only the symptoms of ill health, but also the social and emotional contexts in which people live—especially loneliness, unemployment, financial stress, and exclusion. SP has been associated with improved self-reported well-being and reduced demand for primary care, though its mechanisms and long-term outcomes remain under evaluation.[5]

However, many SP programmes remain framed within a service-oriented paradigm. The prevailing model often centres on referring people to existing services or activities, delivered by institutions or non-profits, without necessarily engaging the broader community as co-creators of health.[6] In such service-oriented models, individuals may risk being perceived as passive recipients of care, reinforcing institutional dependency rather than enabling individual and collective agency or community resilience.

Asset-Based Community Development (ABCD), conceived in the US in the early 1990s, advocates for empowering communities to improve health by identifying and building on their existing strengths and leveraging local resources. Its underpinning theory draws on social theories like social capital and networks to foster collective action. Since then, ABCD has been successfully implemented across diverse settings, including communities in North America, Europe, Africa, and Australia.[7] ABCD offers a transformative lens for rethinking the service paradigm of social prescribing.[8] ABCD acknowledges the importance of services, but also notes that they do not have a monopoly on health creation. The principles and practices of ABCD help shift the dominant focus from what communities lack to what they already possess: the skills, relationships, local institutions, and informal networks that constitute their strengths.[9] It recognises citizens not solely as service users but primarily as producers of health (who also sometimes use services), with the capacity to contribute meaningfully to their community's well-being.[10] Rather than starting with needs assessments and deficit mapping, ABCD begins by identifying, connecting, and mobilising assets—from individual talents to neighbourhood associations—through community-led discovery and connection.

The synergy between SP and ABCD is powerful. SP seeks to connect individuals back to their communities; ABCD focuses on growing communities from within. When integrated, SP becomes more than a referral tool—it becomes a vehicle for catalysing collective agency. Individuals are not only referred *to* community groups but supported *into* community life. Link workers operating within an ABCD framework move beyond case management to facilitation of connection, co-production, and citizen-led action.

This strengths-based community-centered approach is especially pertinent in the Western Pacific region, where strong traditions of mutual aid, extended kinship networks, and cultural practices of community care intersect with rapid urbanisation, social fragmentation, and demographic transition.[11] Embedding ABCD principles within SP practices can reinforce these local strengths while addressing contemporary health challenges.

To realise this integration, health and care systems must shift from transactional to relational and community development practices. Institutions should act as "alongsiders"—facilitators rather than fixers—working with communities to uncover and amplify local capacity. Training link workers in ABCD, mapping community assets collaboratively, and creating space for community-led initiatives are key steps. This also entails resourcing informal groups and neighbourhood efforts that foster inclusion and belonging—key determinants of mental and physical health.

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Furthermore, policy frameworks should support this relational model. Evaluations must go beyond narrow clinical metrics to capture relational, civic, and collective outcomes. Investment in SP should be paired with investment in the civic infrastructure of communities—spaces, platforms, and people that sustain participation over time.

When grounded in an asset-based community development approach, SP has the potential to strengthen social cohesion, reduce isolation, and enable communities to be active participants in addressing the conditions that shape their health. It is not merely a bridge between primary care and the community—it can be a foundation for citizen-led health creation. The future of SP lies not in what institutions do *for* communities, but in what people do *with* and *for* each other.

**Declaration of interests**

None.

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