



Global State of Social Prescribing

A Report by the Global Social Prescribing Alliance

2025–2026 Edition



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Foreword

By Gareth Presch, Founder & CEO, Global Social Prescribing Alliance

In 2020, we set out on a journey to spark a movement. We recognized that medicine alone could not cure the systemic inequalities, social isolation, and structural challenges fracturing our communities. We needed a model that looked beyond clinical diagnostic codes to ask a simpler, more human question: *"What matters to you?"*

What began in 2020 as a collaborative alliance between the World Health Innovation Summit (WHIS) and the National Academy for Social Prescribing (NASP) quickly gained global momentum. The Global Social Prescribing Alliance (GSPA) was formally launched by the UK Secretary of State for Health and Social Care on March 10, 2021. This historic launch brought together clinical, academic, and cultural giants, including the World Health Organization (WHO), the United Nations Global Sustainability Index Institute (UNGSII), and the English National Opera, to build a unified, international framework for non-clinical health creation.

Today, GSPA is a driving force across all WHO regions, proving that when we link primary care, social care, and the natural assets of our communities, we do more than relieve pressure on overstretched health networks, we help humanity thrive.

A Mandate for Localised Action & Investment As we look to the horizon, we must be absolutely clear: **social prescribing cannot be a top-down, it must be deeply localised.** Every community possesses its own distinct cultural, geographic, and social assets. To succeed, health creation must be co-produced by the people who live there, tailored to local needs, and integrated into existing community spaces.

However, localisation cannot happen in a vacuum, **it must be supported by structured, long-term investment.** Moving away from fragile, short-term grant cycles toward sustained funding models is an absolute necessity if we are to build trust and systemic permanence.

To this end, **the GSPA stands ready to support governments, health systems, and local communities with the critical technical support, implementation advice, and strategic guidance** required to successfully turn these frameworks

into everyday reality. Together, we can construct the bridges between clinical care, community assets, and sustainable finance.

Executive Summary

Social prescribing is transitioning from an innovative local practice to a mainstream component of national health systems worldwide. This report documents that transition, the evidence supporting it, and the work of the Global Social Prescribing Alliance (GSPA) in accelerating it globally. By formalising the connection between primary care and community-hosted, non-clinical resources, health systems can systematically address the social determinants of health that clinical interventions alone cannot reach.

GSPA Global Impact Metrics

Metric	Status / Target
Global Footprint	Active and expanding worldwide engagement across all WHO regions.
Economic Value	Documented Social Return on Investment (SROI) of up to £36 per £1 invested; specific clinical pathways generating massive regional savings (e.g., AUD 518,701 per 100 end-of-life patients in Australia; USD 600,000 in Colombia).
System Relief	20% to 28% reductions in Primary Care GP Consultations; notable drops in acute care usage and unplanned hospital readmissions among high-vulnerability cohorts.
Target Horizon	Universal Primary Healthcare Integration by 2030.

Background & Historical Evolution

The Foundational Crisis & The Need for a Social Revolution

The modern healthcare system remains structurally anchored to an outdated, reactive "sick-care" model—a system that essentially waits until individuals fall ill before mobilizing clinical assets. This pathogenic approach has over-reached itself, resulting in unsustainable structural demands and exponential cost increases. These challenges are driven by global population growth, shifting demographics, and a diverse public landscape experiencing a higher incidence of chronic, age-related, and multi-morbid conditions.

Concurrently, global health institutions face unprecedented labor shocks, with an international staff shortage predicted to reach 10 million healthcare workers by 2030. It has become fundamentally evident that a rigid, one-size-fits-all medical protocol is broken. Consumer preferences are rapidly shifting toward convenience and affordability, driving a clear demand for a more efficient, empowered, and personalized healthcare delivery architecture.

This baseline fragility was completely exposed by the Coronavirus disease 2019 (COVID-19) pandemic, which unveiled severe vulnerabilities in the world's health infrastructure, medical workforces, and socio-political frameworks. The pandemic highlighted a critical lack of emergency preparedness, disjointed communication strategies, and siloed policy frameworks that focused exclusively on individual clinical conditions while failing to integrate health into broader societal activities. The resulting friction generated systemic fear and panic, not only regarding the disease itself, but concerning survival risks, ambiguous regulatory rules, and long-term economic security.

Out of this disruption arises the strategic opportunity to spark a social revolution in health and wellbeing. By establishing an innovative, value-based healthcare model centered on prevention, early intervention, and non-clinical community resources, health networks can empower individuals and local communities to thrive. This structural shift supports existing public health facilities, relieves institutional strain, and creates meaningful new jobs, all while serving as a baseline vehicle for the implementation of the United Nations' 17 Sustainable Development Goals (SDGs).

Evolving the 2021 Playbook & Student Framework Architecture

In response to these systemic failures, the World Health Innovation Summit (WHIS CIC) entered into a collaborative alliance with the National Academy for Social Prescribing (NASP) in England in 2020. This partnership established the Global Social Prescribing Alliance (GSPA) a dedicated global coalition of multi-sector stakeholders active worldwide in implementing UN Sustainable Development Goal 3 (SDG3): Good Health & Wellbeing.

A core component of this original design was the launch of the Global Social Prescribing Alliance Playbook and the International Student Movement Framework. Realizing that permanent change requires a shift in core values among the future generation of clinicians, this architectural framework mobilized global medical education networks. Led by student collectives across the UK, Australia, Japan, Portugal, and the USA, this peer-led movement utilizes live global webinars and inter-university champion networks to challenge traditional, reactive algorithmic training, replacing it with a values-driven approach focused on health creation and the social determinants of health.

21st-Century Roots: From Local Projects to Global Policy

While the conceptual roots of social prescribing date back to the historic Peckham Experiment in South London (1926–1950), its modern operational framework was solidified at the turn of the 21st century by pioneering initiatives:

- **The Pioneers (Early 2000s):** The Bromley by Bow Centre in East London integrated welfare and employment support; Voluntary Action Rotherham embedded link workers directly into primary care; the Culm Valley Centre for Integrated Health in Devon introduced therapeutic gardens and community cafes.
- **National Scaling (2014–2019):** Scotland formally committed to its Community Link Worker (CLW) and Welfare Rights schemes. In 2019, NHS England embedded social prescribing into the NHS Long Term Plan, funding thousands of local link workers. Simultaneously, international pilots gained traction, including the SingHealth Community Hospitals program in Singapore and the Alliance for Healthier Communities initiative in Ontario, Canada.

1. The GSPA Foundational Blueprint (The 2021 Playbook)

Please Note: This is a working document. It is subject to continuous review, updates, and collaborative refinement by the Global Social Prescribing Alliance (GSPA) and its partners.

In a world operating beyond the pandemic, traditional approaches to health and wellbeing are no longer enough. The 2021 Foundational Playbook established the core framework to pivot global healthcare toward prevention, early intervention, and the optimization of existing community assets.

1.1 Rethinking Medicine: Shortcomings of the Pathogenic Approach

Traditional healthcare predominantly relies on a pathogenic, "sick-care" model—waiting for individuals to fall ill before intervening. As global lifespans increase, this medicocentric culture faces strict limitations:

- **Exclusion of the Non-Diseased:** Overlooks the two-thirds of the population who are currently well, bypassing self-care and health creation.
- **Individualisation of Health:** Reduces complex human circumstances to mere biology and behavior, chasing a "one disease – one cure" magic bullet.
- **Retroactive Response:** Invests heavy funding into institutional "repair shops" rather than cultivating long-term community wellness.
- **Medical Dominance:** Positions the doctor as the sole expert, leading to lower patient activation and systemic dependency.

1.2 Tripartite Model for Wellbeing

True health resilience stands on a "three-legged stool" of holistic care:

1. **Medical Prescribing:** Traditional clinical treatments for biomedical issues.
2. **Activity Prescribing (Social Prescribing):** Connecting individuals to community assets (such as walking groups, choirs, and community gardens).

PMC - NIH

3. **Information for Wellbeing:** Providing personalized, navigation-based information platforms to help individuals orient, adapt, and build emotional resilience against complex life situations.

1.3 The Seven Steps to Build Local Social Prescribing Systems



1. Bring Everyone Together Locally: Co-produce programs with voluntary organizations, community groups, faith groups, social enterprises, and local authorities.

2. Support Community Development: Map existing community assets, address infrastructure gaps, and utilize diversified funding models (small grants, shared investment funds, personal health budgets).

3. Embed Social Prescribing Link Workers: Employ empathetic, non-clinical change agents within multidisciplinary teams to focus exclusively on community integration.

4. Create Shared Plans with the Person: Draft flexible care plans detailing patient motivations, localized support systems, and self-management strategies.

5. Train & Develop the Workforce: Provide formal, accredited training and strict clinical safeguarding supervision for link workers while establishing clear referral procedures for partners.

6. Ensure Clinical Engagement: Cultivate clinical champion schemes to shift healthcare attitudes toward a robust, biopsychosocial model.

7. Measure Impact: Standardize data collection using frameworks like the *Social Prescribing Common Outcomes Framework* to monitor healthcare usage reductions and community improvements.

1.4 The Triple Impact of Social Prescribing

Impact Area	Key Proven Benefits	Evaluated Outcomes (2021–2026 Core Data)
On the Person	• Reduces loneliness and isolation	• 49% Decrease in loneliness
	• Improves mental and physical wellbeing	• 19% Increase in social activities
	• Grants a sense of community belonging	• 12% Increase in mental health
On Healthcare & Economy	• Relieves pressure on primary care emergency assets	• 28% Average reduction in GP consultations
	• Promotes higher-value care structures	• 24% Average drop in A&E attendances
	• Creates meaningful community care jobs	• 43p Saved per £1 spent (Rotherham Evaluation)

On Society & Community

- Reduces deep-rooted health inequalities
- Stronger, more resilient community infrastructure
- Empowers civic volunteering networks
- Targeted provisioning for marginalized neighbourhoods
- Diversifies local grassroots activity groups

1.5 The Eight Principal Domains of Social Prescribing

Building on the tripartite model, the GSPA organizes local action around eight operational domains:

-  **Green Social Prescribing:** Nature-based activities like community gardening and forest bathing.
-  **Blue Social Prescribing:** Water-based environments leveraging activities like coastal walks and aquatic therapies.
-  **Arts & Culture:** Emotional resilience through music, theatre, museum visits, and art classes.
-  **Physical Activity:** Tailored mobility programs, dancing, walking groups, and sports.
-  **Social & Community:** Eliminating isolation via friendship clubs, peer support circles, and volunteering.
-  **Mental Health & Wellbeing:** Stress-resilience and grounding practices such as mindfulness and meditation.
-  **Work & Skills:** Elevating purpose and capability through job clubs and mentoring.
-  **Practical Support:** Real-world aid including housing advice, transport help, and benefits counseling.

2. The Evidence Base

2.1 Systemic and Individual Outcomes

Evaluations of local and national social prescribing systems indicate a high return on investment and clear improvements across standardised quality-of-life metrics. Data from pilot projects globally (including Canada, Austria, India, the UK, and Singapore) show:

- A 12% increase in self-reported mental health and self-management capabilities.
- A 49% decrease in chronic loneliness scores.
- A 19% increase in regular social and physical activity tracking.
- A 5% to 42% reduction in client repeat visits to primary healthcare facilities between 3-month and 9-month programmatic check-ins.
- Improved quality of life and documented reduction in acute health setting usage for people living in deprived communities.

"Social prescribing addresses the wider determinants of health that clinical care alone cannot reach, reducing pressure on healthcare systems while empowering people to thrive." — **Gareth Presch**, CEO, Global Social Prescribing Alliance

2.2 Redefining Impact: Lived Experience as Evidence

Contributor Perspective: Dr. Robert Dean — Associate Professor of Interdisciplinary Arts & Health, Lincoln School of Creative Arts, University of Lincoln, UK.

As social prescribing expands globally, there is a risk that policy and commissioning decisions continue to be shaped by what is most easily measured, rather than what participants themselves describe as most meaningful. International evaluation frameworks must move beyond an exclusive focus on quantitative referral numbers, attendance rates, service utilisation metrics, and rigid standardised well-being questionnaires.

A 2026 study drawing on 40 qualitative interviews with individuals engaged in social prescribing pathways in Lincolnshire, UK ([Frontiers in Public Health](https://doi.org/10.3389/fpubh.2026.1800306), doi: [10.3389/fpubh.2026.1800306](https://doi.org/10.3389/fpubh.2026.1800306)), demonstrated that many participants entered these

services following prolonged experiences of severe trauma, bereavement, chronic illness, financial poverty, and repeated disappointment with traditional clinical pathways.

When addressing these complex, long-term social and health challenges, the most profound impacts described by participants—such as stabilisation, reclaimed trust, systemic belonging, and reciprocal relational support—are frequently missed by conventional, narrow evaluation pipelines. Qualitative evidence and rich lived experience must be recognized globally as a core, legitimate component of the scientific evidence base.

2.3 Social Prescribing in Oncology: An Under-Recognised Dimension

Contributor Perspective: Zacharoula Sidiropoulou, MD, PhD, CEBS — Head, Breast Unit, ULS Lisboa Ocidental; Invited Professor, NOVA Medical School & University of Barcelona; Expert Collaborator, WHO Collaborating Centre, Imperial College London.

Cancer care represents one of the most compelling, yet still under-recognized, frontiers for social prescribing. People living with and beyond cancer often face challenges that clinical treatment alone cannot address: social isolation, fatigue, anxiety, disrupted identity, financial strain, and loss of purpose.

Structured referral to community activities, including arts programmes, peer support networks, physical activity groups, nature-based activities, practical support, and survivorship education, can bridge the gap between active treatment discharge and genuine community reintegration in a person-centred and equitable way.

Recommendation: Explicitly recognize oncology and cancer survivorship as a priority domain for social prescribing integration within GSPA's 2030 agenda. GSPA should call for the development of cancer-specific social prescribing pathways within national health frameworks, particularly for post-treatment survivorship, rehabilitation, and palliative care populations.

2.4 Beyond Chronic Disease: Social Prescribing for People at Their Most Vulnerable

Contributor Perspective: Dr. Rebecca Newell, Public Health Department, Brighton and Sussex Medical School, UK & Acute Medicine, Barts Health NHS Trust, London, UK; Dr. Juan Esteban Correa-Morales & Dr. Libby Sallnow, Marie Curie Palliative Care Research Department, University College London (UCL), UK.

Social prescribing has demonstrated consistent benefits across chronic disease, mental health, and social isolation. Yet one population remains largely outside its systematic reach: people facing serious illness, dying, and bereavement. These outcomes are particularly significant for people facing serious illness, dying, and bereavement, where social isolation is most acute and the gap between clinical capacity and human need is greatest. These are precisely the moments when social need is greatest, informal caring networks are most stretched, and the consequences of unmet need—manifested as avoidable hospital admissions, carer burnout, and poor bereavement outcomes—are most severe.

Evidence shows that social prescribing can significantly reduce social isolation, generate twofold increases in supportive networks for people living with advanced illness, and transform social and cultural perspectives on caring.

Compassionate communities, locally organized networks that mobilize volunteers, neighbours, faith groups, and community organizations around individuals at the end of life, represent an established, highly operational model of social prescribing for this population. They function on identical core principles: connecting individuals to non-clinical support, strengthening informal networks, and working hand-in-hand with formal clinical services rather than replacing them.

Compassionate communities improve social connectedness, reduce isolation, and bolster caring networks. Crucially, they are already active in over 75 countries across all WHO regions, including settings where formal clinical palliative care infrastructure is limited or completely absent. A significant proportion of these communities already receive informal referrals from healthcare providers, pointing to a robust, de facto social prescribing function operating across the world without formal recognition or dedicated resource allocation.

Integrating compassionate communities within formal social prescribing frameworks via structured clinical referral pathways, formal workforce recognition, and sustainable funding loops would extend social prescribing to a population it has not yet systematically reached, precisely at the point in life where the return on investment is highest.

3. Global Regional Overview

3.1 United Kingdom and Ireland

The UK remains the most advanced social prescribing ecosystem globally. England's NHS Long Term Plan formally embedded social prescribing as a core component of primary care, deploying link workers systematically across the majority of Primary Care Networks (PCNs).

Scotland, Wales, and Northern Ireland maintain distinctive asset-based frameworks linked to devolved national health and prevention strategies:

- **Scotland (Regional Spotlight):** Social prescribing is tightly woven into community asset frameworks. A prime example is *Compassionate Inverclyde*, which supports local initiatives to engage schools, workplaces, faith communities, and arts organizations around death, dying, and loss. This program has achieved a documented Social Return on Investment (SROI) of at least 3:1, with over 100 regional organizations earning a Bereavement Charter Mark, paired with significant recorded reductions in post-discharge acute hospital readmissions.
- **Ireland:** Ireland has achieved substantial progress through structural statutory and voluntary sector collaborations. Organisations like the *Chronic Health Advocate CLG* continue to pioneer innovative frontline delivery and implementation models.

3.2 Europe & The Austrian Pioneer Framework

Social prescribing is gaining rapid traction across continental Europe, driving policy development, urban planning integration, and deep academic research.

- **Portugal & Spain:** Portugal hosts a strong implementation community, with leading practitioners at ULS Algarve, MISC Portugal, and the Portuguese Society

of Health Literacy (SPLS) shifting national policy. In Spain, researchers from IDIBELL-ICO and the Barcelona Institute for Global Health (ISGlobal) lead the European evidence agenda.

- **The Getxo Zurekin Initiative:** Based in the Basque Country, this model demonstrates how social prescribing principles, systematic asset mapping, deep community engagement, and integrated clinical pathways can be seamlessly applied to vulnerable, end-of-life populations that conventional health programs fail to reach.
- **Germany & The Netherlands:** Germany's engagement via ICLEI Europe and the University of Freiburg links social prescribing directly to urban sustainability, health equity, and climate-resilient cities.
- **Austria's Integrated Healthcare Model:** The non-profit health organization PROGES offers a modern European blueprint for participatory health promotion and prevention across rural and primary care settings.

Case Study: The "GES.UND" Initiative

Implemented by PROGES in cooperation with the Primary Health Care Centre in Haslach, Upper Austria, this rural initiative covers a catchment area of 5,500 patients. Securely funded through December 31, 2026, by the Austrian Health Insurance Fund and the Federal Ministry of Social Affairs and Health, it shifts the diagnostic lens toward social health. It maps exercise circles (Walk & Talk), neighbourhood networks, and health literacy hubs (Memory Cafés). Annually, it hosts 453 group meetings, registers 2,170 verified patient interactions, and maps a dedicated community anchor hub welcoming 15 visitors per day.

3.3 South Asia & The Indian Technological Frontier

India is an emerging powerhouse of social prescribing development, bridging cutting-edge digital health technology with last-mile community engagement via academic, corporate, and non-profit collaborations.

- **The HOW Network:** Operating through Healthrytix Healthtech Solutions, this group integrates secure digital platforms directly with frontline community social routing.
- **Kerala's Neighbourhood Network in Palliative Care (NNPC):** This initiative showcases social prescribing working at massive regional scale. NNPC is a

community-led model where trained local volunteers and neighbours provide vital social, psychological, and practical support to people suffering from advanced, serious illnesses at home, working alongside clinical teams. Shifting from near-zero coverage, the NNPC achieved over 70% palliative care coverage across parts of the region—a target that clinical expansion alone could never have achieved, illustrating the power of resourcing community capacity.

- **Last-Mile Scaling via ZMQ Global:** Serving as a crucial innovation hub for AI-enabled community health ecosystems, ZMQ Global replicates scalable, equity-focused models from India across low- and middle-income countries (LMICs) under South-South Cooperation frameworks. ZMQ's field-tested strategy utilizes 7 systematic focus areas:

1. AI-Enabled Community Health Social Prescribing
2. Women and Maternal Health Social Prescribing
3. Community-Based Mental Health Systems
4. TB, Chronic Disease, and Treatment Adherence Support
5. Frontline and Community Link Worker Strengthening
6. Digital Inclusion and Health Equity
7. Behavior Change & Community Engagement

3.4 Africa

Africa represents a highly significant frontier for formalised social prescribing. While community-based mutual aid, family solidarity, and social connection have always been intrinsic to African community life, the current GSPA focus centers on providing the formalisation, standards, and policy recognition needed to secure sustainable funding for these existing assets.

- **Regional Footprint:** Nigeria maintains the largest GSPA champion footprint (spanning state hospitals, universities, and pharmacy networks), with active scaling frameworks taking root in Ethiopia, Egypt, South Africa, and Uganda. World Health Innovation Summit
- **Uganda's Frontier Framework:** The *Compassionate Communities for Uganda Initiative* works actively to bridge the gap between institutional clinics and the rural communities where people live, fall ill, and die. The initiative trains local volunteers and community health workers (CHWs) to deliver structured social and practical care alongside local clinical assets.

- **Clinical Lessons from Oncology Missions:** Direct clinical data from breast cancer surgical missions in Sub-Saharan Africa (including Guinea-Bissau) underlines that social prescribing in LMIC contexts must explicitly respond to late-stage diagnosis, intense financial toxicity, social stigma, geographic isolation, and a near-total lack of formal psychosocial infrastructure. In these environments, peer support, family-centered care models, culturally aligned community resources, survivorship education, and palliative community networks are not optional additions—they are absolute system requirements.

3.5 East Asia and Pacific

- **Singapore Population Health Transition:** The establishment of the *Singapore Community of Practice in Social Prescribing* marks a total structural shift away from reactive, hospital-bound treatment to proactive, population-wide health.
- **The Singapore Hospice Council Model:** This council has constructed highly operational, structured referral pathways connecting general practitioners directly with community end-of-life networks. The system features a real-time digital hospice capacity dashboard allowing GPs to make definitive, same-visit community referrals, backed by a specialist palliative care advisory group available to primary care physicians instantly via text.
- **Australia's Economic & Philanthropic Frameworks:** Australia features a highly mature research ecosystem anchored by Victoria University, Melbourne Integrated Psychology, and independent philanthropy.
- **The Compassionate Communities Connectors Programme:** This model embedded trained community volunteers directly within a formal health service partnership to support individuals living with advanced, terminal illness. Volunteers targeted the deep practical and social needs—such as isolation, non-clinical transport, home support, and end-of-life preparation—that traditional clinical services lack the capacity to address. A formal economic analysis of the program demonstrated net savings of AUD 518,701 from a single cohort of 100 patients, driven entirely by safely shifting acute care utilization away from crowded hospital settings toward proactive community support.
- **Hong Kong:** The *Community CareAge Foundation* continues to pioneer advanced social prescribing modules tailored for rapidly aging urban demographics.

3.6 The Americas

- **United States:** Clinical and academic research pipelines are led by Stanford

Health Care and the Indiana University School of Medicine, validating social prescribing as a necessary, high-value complement to formal US healthcare delivery. As we continue to build out this infrastructure, HL7 FHIR accelerator projects—specifically the Gravity and PACIO Projects—are establishing a standardized digital foundation for automated social prescribing, enabling the seamless tracking of social determinants of health and patient functioning in post-acute settings. By linking electronic health records with community platforms, these frameworks will allow for targeted social referrals and improved outcomes tracking.

- **Colombia's Compassionate Neighborhood Infrastructure:** *Fundación Keralty*

operates one of Latin America's most advanced, scaled social prescribing programs. Across its 25 primary care centers in Colombia, patients are systematically screened for chronic social isolation using validated tools. Individuals who test positive receive an immediate social prescription to integrated community assets, including compassionate neighborhoods completely constructed and led by local residents. In 2024 alone, 230,000 social prescriptions were issued, with preliminary economic data showing avoided hospitalization and acute care costs of roughly USD 600,000 for the tracked cohorts.

4. The Social Prescribing Workforce & Career Roadmap

4.1 Link Workers & De Facto Pioneers: The Cornerstone of Delivery

Link workers act as the relational bridge between individuals and communities, working within primary care networks to co-produce localised menus of support. GSPA's *Global Social Prescribing Workforce Development* report (2026) notes a surging global demand for link workers. In many countries, especially low- and middle-income countries (LMICs), social workers and community health workers (CHWs) act as a de facto social

prescribing workforce, and GSPA advocates for their formal recognition, proper training, and fair resourcing.

4.2 Structural Workforce Differentiations

Dimension Primary Care Social Work		Social Prescribing / Linkworking
Operational Focus	Delivering comprehensive crisis counselling, statutory case management, and legal advisory.	Facilitating direct, asset-based access to community-hosted resources and activities.
Primary Triggers	Responding to high-stakes situations including psychosocial risk, domestic violence, homelessness, legal representation, and financial crises.	Social isolation, mild-to-moderate loneliness, decreased mobility, desire for health literacy.
Typical Pathways	Executing structural interventions, conducting home protection visits, integrating child/youth welfare services, providing authority accompaniment.	Connecting to exercise circles (Walk & Talk), Memory Cafés, neighbourhood support rings, self-help groups.

Note: Roles and definitions vary by jurisdiction. In many low- and middle-income healthcare systems, these roles are frequently unified or delivered by integrated Community Health Workers (CHWs).

4.3 Educational & Career Progression Roadmap: Level 3 to PhD

To attract and retain exceptional talent, the GSPA proposes a formalised, highly flexible educational roadmap designed to map professional development from entry-level practices to advanced research leadership:

- **Flexible Learning Intake:** Incorporates the Level 3 Community Health and Wellbeing Worker Apprenticeship while seamlessly accepting candidates holding Bachelor or MSc degrees in social work, psychology, or public health.
- **Advanced Postgraduate Pathways:** Active link workers are transitioning directly into specialized MSc and PhD tracks, expanding peer-reviewed literature on preventative care.
- **Strategic Funding Mechanisms:** Leverages the Apprenticeship Levy, postgraduate bursaries, and Cross-Sector System Sponsorships via regional Integrated Care Systems (ICS).

4.4 The Clinician as Social Prescriber: Integrating the Hospital Specialist Voice

Contributor Perspective: Zacharoula Sidiropoulou, MD, PhD, CEBS — Senior Consultant Breast Surgical Oncologist, ULS Lisboa Ocidental.

The voice of the hospital clinical specialist remains an underutilised but high-impact entry point for social prescribing. Secondary care implementation experiences, such as the Barts Health secondary care prevention toolkit developed with Transformation Partners in Care, explicitly demonstrate how non-clinical prevention and social prescribing models can be embedded directly within acute specialist care pathways (including heart attack care and acute oncology).

5. The International Student Champion Infrastructure

5.1 The UK Student Champion Scheme Model

The student champion network acts as a peer-led operational network across educational institutions to challenge traditional "doctor-knows-best" structures. Established in 2017 with formal primary care support, the UK blueprint acts as a multi-centre framework operating across all UK medical schools.

5.2 The Seven-Point Checklist for National Expansion

To establish a National Student Champion Program, the GSPA utilizes a standardized Seven-Point Implementation Checklist:

- **Step I:** Concept Familiarization
- **Step II:** Health System Mapping
- **Step III:** Educational Curricular Audit
- **Step IV:** Cross-Professional Coalition Building
- **Step V:** International Alliance Onboarding
- **Step VI:** Public Introductory Webinars
- **Step VII:** Programmatic Launch

[SOCIAL PRESCRIBING INTERNATIONAL STUDENT MOVEMENT FRAMEWORK 2021](#)

6. Digital Innovation and Health Interoperability

6.1 The Evolution of the Three-Legged Stool Model

The current digital and AI-driven initiatives for 2026 expand upon the architectural model first introduced in the 2021 GSPA Playbook: the Three-Legged Stool of Holistic Healthcare. The third leg, *Information for Wellbeing*, ensures that those in the greatest social need are enabled to easily navigate fragmented healthcare web architectures.

[Artificial Intelligence in Digital Health and Social Prescribing \(2026\)](#)

6.2 Next-Generation AI Integration

Contemporary AI platforms wrap relevant localised internet content directly around the individual, acting similarly to a vehicular GPS navigation system to ensure only contextually relevant, timely, and digestible details appear on the screen at one time.

- **Opportunities:** Expanding regional access at scale, deploying predictive matching tools to assist link workers, automating longitudinal outcome data collection, and optimizing cross-language translation matrices.

- **Risks & Safeguards:** Guarding against digital exclusion, ensuring data privacy against commercial exploitation, and preventing algorithmic automation from eroding the fundamental human relationship at the heart of the link-worker model.

6.3 Health Interoperability & Open Data Standards

Contributor Perspective: Patricia Welch Saleeby, PhD, MSSA — Social Work and Health Interoperability Expert, Team Member of Stanford University WHO Collaborating Centre for Classifications, Terminologies, and Standards; ICF Content Expert for the PACIO Project, Community Member of Gravity Project.

Digital health interoperability represents the critical structural backbone for scaling social prescribing and primary care social work globally. As healthcare transitions toward holistic, person-centred models, we face a massive data fragmentation challenge: social needs assessments, clinical records, and community asset menus exist in completely disconnected digital silos.

To bridge this divide, national health systems must leverage global standards like Fast Healthcare Interoperability Resources (FHIR), driven explicitly by the technical frameworks of The Gravity Project and the PACIO Project. The Gravity Project establishes the mandatory data elements and terminology standards (using LOINC and SNOMED CT) to screen for, diagnose, and intervene in social determinants of health (SDOH) like food insecurity, housing instability, transportation barriers, and financial insecurity. Simultaneously, the PACIO (Post-Acute Care Interoperability) Project provides the essential data exchange models for functional status, cognitive health, and physical mobility. Together, these frameworks enable a secure, bidirectional loop where primary care clinicians, social workers, link workers, and community organizations can seamlessly share referrals and track outcomes without technical friction.

Recommendation: Explicitly integrate open data standards and health interoperability frameworks as a core pillar within GSPA's 2030 agenda. GSPA should call for national health frameworks to mandate FHIR-based APIs, Gravity-aligned SDOH data structures, and PACIO functional standards within all social prescribing platforms to ensure equitable, measurable, and scalable community health ecosystems.

Section 6.3 References

- Health Level Seven International. (2026). *PACIO personal functioning and engagement implementation guide*. HL7 Fast Healthcare Interoperability Resources (FHIR) Specification.
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- Welch Saleeby, P. (2026). The unseen bridge: Why interoperability is the heart of modern social work. *Health & Social Work*, 51(2), 81–83. <https://doi.org/10.1093/hsw/hlag017>.
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7. Policy Landscape and Systemic Change

7.1 National Policy Recognition & Global Mobilization History

Formal policy integration is led by nations like the UK, Ireland, Portugal, and Australia, where social prescribing is structured into national health strategies. The global scaling parameters achieved between 2021 and 2023 reflect an extensive chronology of multi-sector integration:

- **The Official Global Launch (March 10, 2021):** Formally launched by the UK Secretary of State for Health and Social Care, establishing an international blueprint spanning clinical, academic, and cultural leadership (including NASP, WHO, UNGSII, and the English National Opera).
Oxford Academic - Oxford University Press
- **G20 Policy Alignment (June 2021):** Structured directly into the Global Solutions Initiative Foundation Summit to embed UN SDG3 benchmarks into macro-policy spaces.

- **United Nations Palais des Nations (Geneva, June 2022):** Addressed international delegates to anchor cultural and social healthcare options in formal diplomatic circles, alongside direct deployment audits published within the *Praevenire Healthcare Journal* in Austria.

7.2 Funding Strategies & Institutional FinTech Vehicles: The World Health Service (WHS)

The World Health Service (WHS) functions as a specialized component fund administered by Legacy Global Programs. WHS alters traditional, reactive healthcare spending dynamics by deploying a blended capital framework that unifies public, private, corporate, and philanthropic sectors to sustain three key health architectures:

- **Social Prescribing Infrastructure:** Underwriting national-scale frameworks in partnership with the GSPA.
- **Workforce Wellbeing Systems:** Funding interdisciplinary resilience platforms to prevent clinical burnout.
- **Healthy Ageing Networks:** Scaling targeted, community-hosted resource circles to combat loneliness, mitigate fall risks, and extend independent living.

8. Challenges and Priorities for Action

8.1 Key Systemic Challenges

- **Equity Paradox:** Individuals facing the highest levels of health inequity are often the least equipped to navigate complex or digital-only referral pathways.
- **Health Literacy Gaps:** Programmes often rely on passive referral models or complex terminology, creating barriers for vulnerable populations.
- **Workforce Pipelines:** The global demand for certified link workers outpaces current regional training outputs.
- **Funding Fragility:** Reliance on short-term pilots threatens long-term community trust and stability.

8.2 Priorities for 2026–2030

1. **Standardize Training:** Establish unified global qualification frameworks for link workers while advocating for fair resourcing and formal recognition of social work and community health actors in all national settings.
2. **Integrate Lived Experience Frameworks:** Upgrade international evaluation matrices to formally track non-transactional qualitative outcomes, including stabilisation, community connection, and trust reclamation.
3. **Leverage the Student Vanguard:** Scale the International Student Champion Scheme across all active global nodes to drive preventative healthcare leadership directly within university curricula.
4. **Deploy Blended Finance Vehicles:** Scale institutional capitalization via the World Health Service (WHS) fund to transition global primary health networks from short-term programmatic grants to permanent, equity-focused financial frameworks.
5. **Recognise and Resource Compassionate Communities:** Formally establish compassionate communities as the core social prescribing infrastructure for end-of-life and palliative care. This mandate requires setting up standardized referral pathways from clinical settings, supporting dedicated workforce development for community connectors, and building sustainable funding models that directly reflect the immense health system value and cost-savings these initiatives generate globally.

9. GSPA International Engagement Matrix

The Alliance is actively engaging with, developing frameworks for, and scaling community health programmes within the following nations:

- **The Americas:** Canada, Chile, Colombia, México, United States of America
- **Europe:** Austria, Belgium, Czech Republic, Denmark, Estonia, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Poland, Portugal, Slovakia, Spain, Ukraine, United Kingdom (comprising England, Scotland, Wales, Northern Ireland, and the Isle of Man)
- **South & East Asia:** Bangladesh, Hong Kong, India, Pakistan, Philippines, Singapore, South Korea, Taiwan

- **Africa & Middle East:** Burundi, Cameroon, Egypt, Iran, Kenya, Lebanon, Malawi, Nigeria, Sudan, Uganda, United Arab Emirates
- **Oceania:** Australia, New Zealand

10. Join the Global Social Prescribing Alliance

GSPA is a global movement open to everyone who believes in a healthier, more equitable world. Whether you are a clinician, researcher, policymaker, community organisation, student, or passionate individual, there is a place for you in GSPA.

World Health Innovation Summit

"Together, we are building a global movement that puts people, not just patients, at the heart of health."

— **Gareth Presch**, CEO, Global Social Prescribing Alliance

World Health Innovation Summit

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Further resources:

Global Playbook for Social Prescribing (2026)

Artificial Intelligence in Digital Health and Social Prescribing (2026)

Global Social Prescribing Workforce Development & Opportunities (2026)

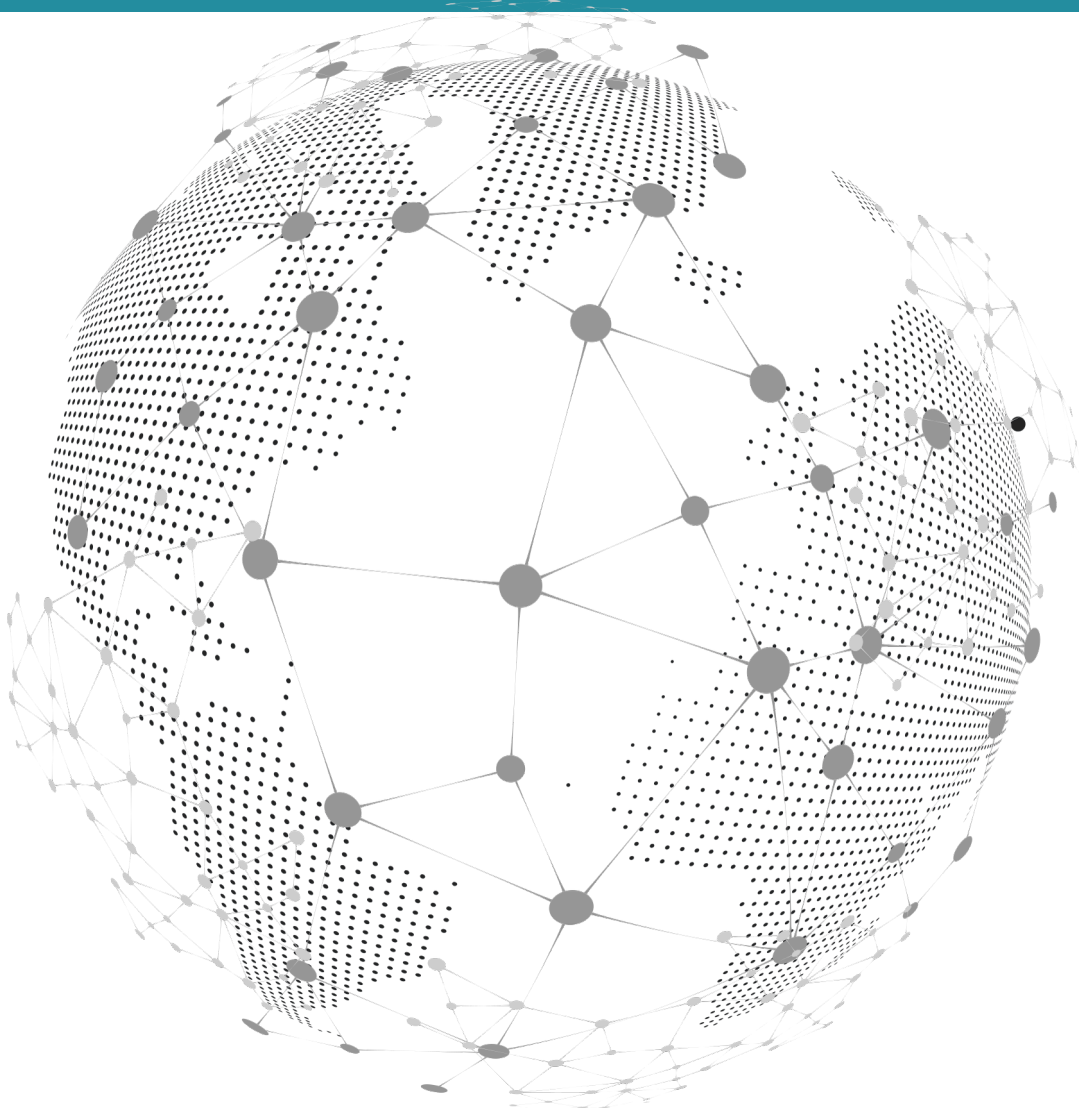
Global Social Prescribing Alliance Student Movement Playbook (2026)

Note - original architecture for the Global Social Prescribing Alliance:

GSPA International Playbook 2021

Social Prescribing Student Movement Framework 2021

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Global State of Social Prescribing

A Report by the Global Social Prescribing Alliance
2025–2026 Edition

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