

INTRODUCTION

Healthcare*Papers*

Social Prescribing as a Catalyst for System Transformation



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Abstract

Rising social, health and healthcare challenges in Canada signal a need for a paradigm shift. This issue centres on the case for social prescribing – connecting patients to community resources via “link workers” – as strategic infrastructure for improved population health. The papers in this issue lay out a vision for the future, building on this social prescribing model, and offer implementation lessons, such as prioritizing high-complexity clients and maintaining an equity focus. They also raise some important cautions, such as the need to maintain a strong welfare state, to avoid narrow National Health Service-style implementation and emphasize the need to ensure that community organizations are partners, not just referral endpoints.

Introduction

Health and social complexity is increasing in Canada, burdening health systems, health workers, families, caregivers and communities. Over 25% of adults and 60% of seniors now meet criteria for multimorbidity, with complex cases doubling since 2001 (Ferris et al. 2025; Steffler et al. 2021). Nearly half of physicians and nurses report burnout (CMA 2025; Duong and Vogel 2023). Reviewing commonly reported social indicators shows a worrying trend: food insecurity rose from 16.8% to 22.9% between 2019 and 2023 (St-Germain et al. 2025), and chronic homelessness and drug-poisoning deaths have both climbed sharply (Statistics Canada 2025, 2026).

Alongside these trends, healthcare spending consistently grows at a rate that exceeds economic growth and continues to prioritize hospitals, physicians and pharmaceuticals. Spending on healthcare was projected to reach \$399 billion in 2025 (CIHI 2025), while access barriers to primary and specialist care have reached record levels.

We Need a Paradigm Shift

In this current issue, Kate Mulligan, in her lead essay, “Social prescribing as strategic infrastructure,” provides a compelling diagnosis of the current crisis that emphasizes the supply side: the health system was built for acute care with no formal channel for addressing upstream drivers (Mulligan 2026a). Community organizations already provide much-needed social supports, but they remain underfunded and disconnected from the health system.

Specifically, her proposed remedy is social prescribing: healthcare providers refer patients to trained “link workers” who connect them to community resources, including housing supports, food programs and peer networks, rather than treating symptoms in isolation.

She frames this as a shift from the Welfare State era, when we achieved universal coverage but of a narrowly defined scope of health services, toward a new “Enabling State,” where public investment flows to the community infrastructure that produces health.

Commentators Provide Examples of Success Alongside Critical Warnings

Bloch and Vahidi-Williams (2026), from St. Michael’s Hospital’s SEED program in Toronto, offer implementation lessons that complement Mulligan’s vision. Drawing on their program’s first years (451 clients, 1,031 service referrals), they argue that social prescribing works best when it prioritizes people facing the highest social complexity, such as poverty, housing instability, racism and isolation, rather than starting with arts or recreation programming. They identify three key implementation needs: (1) a culture shift within health teams to value social interventions; (2) an explicit equity focus grounded in anti-oppression training; and (3) structural supports such as secure, well-compensated link-worker jobs and dedicated resources for building community asset maps and partnerships.

Pelly and Mendelsohn (2026), representing the Waltons Trust and the Canadian Centre for Caregiving Excellence, argue philanthropy can catalyze social prescribing’s transition to public funding within five years. With caregivers providing 5.7 billion unpaid hours annually and Canada’s seniors population set to reach 11 million by 2040, they position social prescribing as correcting the assumption that families absorb care indefinitely without support. Drawing on funded pilots (Healthy Aging Alberta, Links2Wellbeing, Caregiver Rx) showing reduced loneliness and improved caregiver well-being, they describe philanthropy’s role as building evidence and infrastructure,

including link workers, referral pathways and data systems, that governments then sustain.

Berkowitz (2026) supports the need to expand social prescribing to help clinicians address health-harming social conditions that clinical medicine alone cannot fix. But he pushes back on Mulligan's call to transition from a "Welfare State" to an "Enabling State," arguing that social prescribing mitigates the *consequences* of inequality without addressing its *causes*. Population health gains, he contends, require welfare-state institutions: public provision of healthcare and education and robust social insurance (pensions, disability, unemployment, child benefits) that give people bargaining power and material security. Social prescribing should supplement, not supplant, welfare-state reform aimed at restoring relationships of equality between citizens.

Husk and Dayson (2026) also caution against a linear, individual-focused model of social prescribing, drawing on England's 15 years of implementation experience. They argue that social prescribing is an "idea" rather than a coherent intervention, and that England's National Health Service-driven rollout, which was narrowly framed as a way to reduce primary-care demand, has drifted from its community-development roots, risking a "papering over the cracks" of an underfunded system. They propose a "two-pillar" model instead: a well-resourced primary care system and a strength-based, community-led development sector, bridged by link workers moving people in both directions. They highlight England's emerging "neighbourhood health" and place-based philanthropy initiatives, alongside Canada's Community Health Centre model, as promising directions. However, they warn that link-worker resources have so far been poorly matched to areas of greatest need.

Gautier and Layani (2026) support the potential for social prescribing to be transformative, but they argue that it needs firmer operational grounding. Specifically, they suggest that community organizations should not be treated as a downstream referral destination but recognized as upstream, trusted first points of contact, especially for marginalized groups, who often access community supports before formal healthcare. They also argue primary care should function as territorial infrastructure serving a defined population, not merely a gateway, pointing to Quebec's CLSC model as precedent. Without shared territorial governance, financing and data across sectors, they warn, social prescribing risks becoming aspirational rather than transformative.

The issue concludes with a captivating response by the lead author (Mulligan 2026b). Drawing on the commentaries, she supports that social prescribing must guard against becoming extractive: reaching only those easiest to serve, or letting healthcare capture savings while communities absorb uncompensated work. Moreover, she reframes social prescribing as not just an intervention but enabling a "learning health policy system" that connects local encounters to institutional learning, funding and policy change, with communities holding real authority over what is measured and how findings are used. She closes by proposing 2067 (Confederation's bicentennial) as a horizon for a networked, locally adapted, but nationally coordinated social prescribing agenda.

Those of us who are interested in working to reverse the worrying trends in health and social well-being in Canada may find this collection of papers both inspiring and instructive.

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