EuroHealthNet

European partnership for
health, equity & wellbeing

EuroHealthNet Country Exchange Visit

– Promoting health in the community: social prescribing and other strategies

Host: the National Institute of Health Doutor Ricardo Jorge (INSA) in Portugal

Lisbon, 4-5 May 2022

On 4-5 May 2022, EuroHealthNet, in partnership with its member the National Institute of Health Doutor Ricardo Jorge (INSA) organised a Country Exchange Visit (CEV) in Lisbon. The purpose was to discuss examples of social prescribing and other health promoting primary care strategies and explore the political, financial and practical enablers that connect community and primary health care and social services. The visit took place within EuroHealthNet's contract agreement with the European Commission's DG Employment, Social Affairs and Inclusion programme of the European Social Fund Plus (ESF+).

The meeting was moderated by Luciana Costa, Researcher at INSA, and Caroline Costongs, Director of EuroHealthNet. Cristina Abreu dos Santos, Executive Board Member of INSA, offered welcome remarks. Ten EuroHealthNet member organisations took part in the meeting (See Annex 1 for the list of participants). They not only had the opportunity to visit several community-based initiatives taking place in Lisbon linked to social prescribing efforts, but also share a wealth of information about relevant activities in their countries. Participants discussed how these initiatives could be supported by EU-level tools and funding programmes, and fit in the broader frameworks of the European Commission, such as the European Pillar of Social Rights (see Annex 2 for the meeting agenda). This report provides an overview of the strategies and activities raised and the main discussion points that emerged.

Picture 1. Cristina Abreu dos Santos, Executive Board member of INSA, Luciana Costa, Researcher at INSA, and Caroline Costongs, Director of EuroHealthNet, opening remarks

* Cover picture was taken during the site visit in Mouraria district in Lisbon by Lina Papartyte

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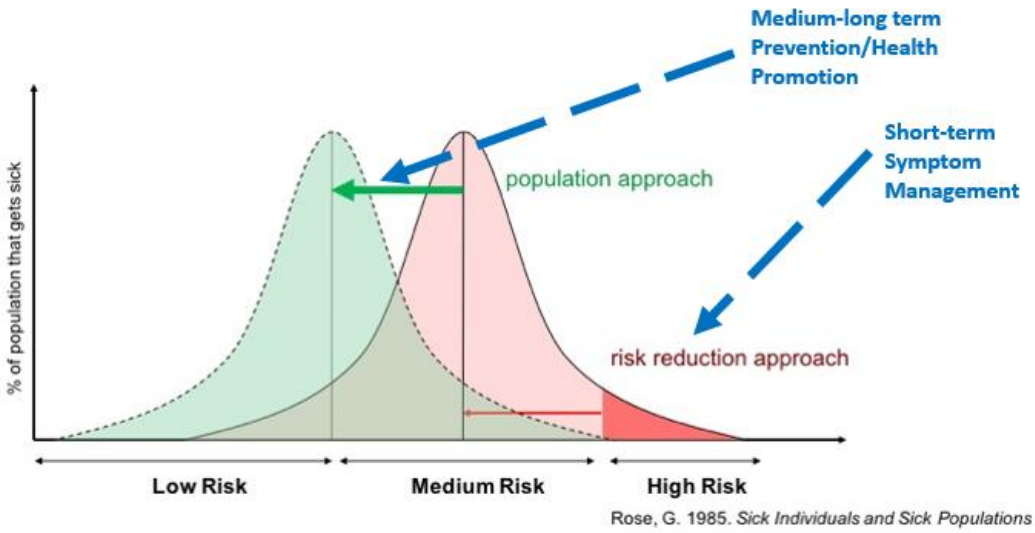
1 Building foundations for promoting health in the community

Health System Foundations for Health Promoting Community Services and Social Prescribing – Dr. Anant Jani, *University of Oxford*

Dr. Jani began his presentation by setting out the rationale for investing in health promoting health systems, including social prescribing approaches. He noted that the idea of addressing health-related social factors is not new, as early as 1848, Dr Jules Guerin in France, suggested using 'social medicine' to advance the public good and to help create a new society, as expected from the French revolution. The same year in

Germany, Rudolf Virchow promoted health care reform after the March 1848 revolution to address social factors related to health.

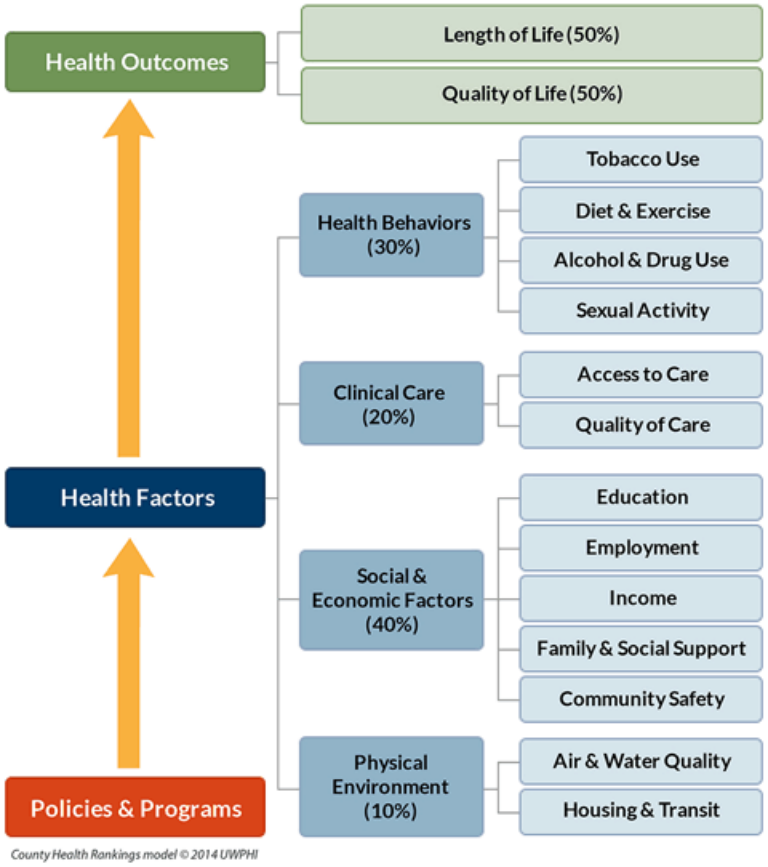
According to Rose, G. 1985 (see Graph 1 below), most health systems focus on treating a small percentage of the population that is at high risk of becoming ill (dark red colour in the graph below). If people fall to that category, it can, however, be seen as a failure of the health system, that should also focus on ensuring that people don't become 'high risk' in the first place. By investing more in health promotion and disease prevention (acting on social drivers of health), health systems can shift the risk profile of the population to the left (green arrow), creating a new lower risk profile in our society (green bell shape figure). A failure to do this, and continued 'rightward' shifts, means that more and more interventions will be needed to keep our populations from getting severely sick. It will also increase the cost of health care and reduce the health of the population.



Graph 1. Population health (Dr. Jani presentation)

Looking at health outcomes (see Image 1 below), disaggregated to length of life and quality of life, and using these metrics as a starting point, clinical care contributes to roughly 20% to the health outcomes, while the other 80% can be attributed to social determinants. Social prescribing delivers on the social aspect of health.

Image 1. Health-related social factors (Dr. Jani presentation)



Anant then presented some data on the use of Social Prescribing in England (2020-2021):

- Women had 1,5 times higher social prescribing referrals than men
- There were 2 times more referrals for 65+ demographic compared to other age group
- Referrals for children were almost non-existent

Data is only as good as that collected by the GPs, but it gives some clues of what is happening.

There were 15 million instances of individuals presenting social needs in primary care. There were, however, 4.4 million instances of referrals for non-medical interventions were registered in primary care health records, indicating many missed opportunities.

In England, they are trying to build a social prescribing blueprint, so that they can standardise, rationalise and integrate social prescribing into formal care pathways. The aim is to make social prescribing the default, rather than an add-on. This requires having evidence, synthesising the evidence, looking at pricing and reimbursement, and building 'formularies', both at the local and aggregate at the national level.

Introduction to social prescribing movement in Europe, Dr. Bogdan Chiva Giurca, Development Lead at Global Social Prescribing Alliance, Clinical Champion Lead at National Academy for Social Prescribing in the UK

Dr. Chiva Giurca began by introducing the Global Social Prescribing Alliance, that aims to establish a global working group dedicated to the advancement of social prescribing

through promotion, collaboration and innovation. It was established with support from the WHO and the UN. Bogdan invited EuroHealthNet members to get involved in the network. They are building an interactive map of social prescribing activities across the world.

He then focused on the question of 'what counts as social prescribing'? There are different names for those that connect the GP practice with services in the community, such as "link worker" (used in England) or "social prescribers". He noted that there is no need to create new roles, but to draw on those that already exist in the system. In many countries the connector role is filled by a social worker, who has received extra training.

Bogdan noted that the audience and the target population for social prescribing can differ, based on the context, the narrative and the needs of each country. In Romania, for example, there are many projects focusing on Roma community and health inequalities. In the Nordic countries, there is a lot of emphasis on loneliness and social connection.

In relation to funding this process of inter-sectorial collaboration, the Arts Council England, Natural England, and Sports England have come together to establish the Thriving Communities fund. It supports local organisations delivering social prescribing and has grown into a network of 9,000+ community groups learning from each other.

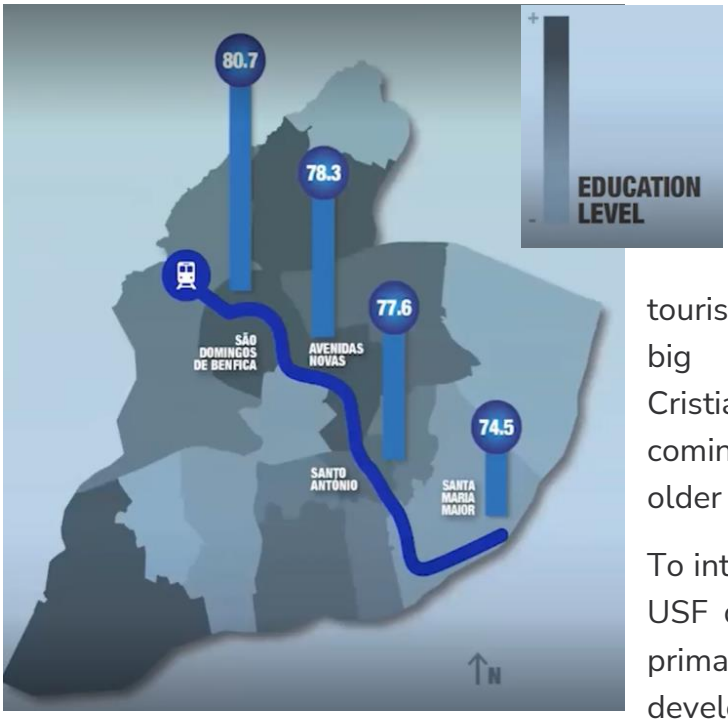
Social prescribing developments in Portugal, Dr. Cristiano Figueiredo, USF da Baixa, Central Lisbon Health Centre Cluster, National School of Public Health, NOVA University Lisbon

Dr. Figueiredo began by setting the scene in relation to the health status of the population in Portugal. Life expectancy in Portugal (81.1) is higher than the EU average (80.6). Health services function well in treating the causes of mortality. Primary care is also doing a great job managing chronic conditions measured by age-standardised rate of avoidable admissions per 100 000 population aged 15+, which stand at around 200, while the EU average is around 600. However, looking at healthy life years at birth, Portugal is under performing (57.8 for women and 60.6 for men).

A map of the blue metro line in Lisbon (Image 2) reflects how life expectancy at birth is 6,2 years higher in the wealthier 'uptown' areas of the city than in downtown Lisbon.

This is not due to lower number of health care centres in Santa Maria Maior area, where Cristiano works, but because people in downtown Lisbon face different socio-economic realities than people living in São Domingos de Benfica.

Image 2. A metro line map of Lisbon depicting life-expectancy



The healthcare centre, USF Baixa, covers 16,000 patients in downtown Lisbon. The Santa Maria Maior area is poorer, and the population is on average older. The area experiences pressures from tourism, notably AirBnB, but also hosts big migrant communities. 30% of Cristiano's patients are migrants, mostly coming from South Asia and 25% are older people.

To introduce social prescribing practice in USF da Baixa, Cristiano's team secured primary care centre leaders' support, developed a project, created an electronic referral platform and secured social workers' buy-in.

It was important to motivate health professionals to be more sensitive to the social determinants of health and empower them to engage in social prescribing. Health professionals co-designed the new service. Monthly feedback about the project implementation was provided to all involved.

It was also important to get buy in from the third sector social partners as well. They had to be mobilised, and some scientific papers were provided so they could become familiar with the concept. Social partners were also invited to monthly project meetings.

The most difficult group to engage are the patients themselves, who are not aware of social prescribing. Often, those who could benefit most from social prescribing, are the most resistant. They feel they don't have the time or motivation to be physically active, to socially connect, etc.

Cristiano noted that Facebook is a good tool to connect stakeholders and advertise the activity.

Cristiano set out the profile of some of the patients that consult him (e.g., a young woman from Bangladesh, 20 weeks pregnant, who has been living in Portugal for the last 9 months and speaks neither Portuguese nor English. Her husband is away all day

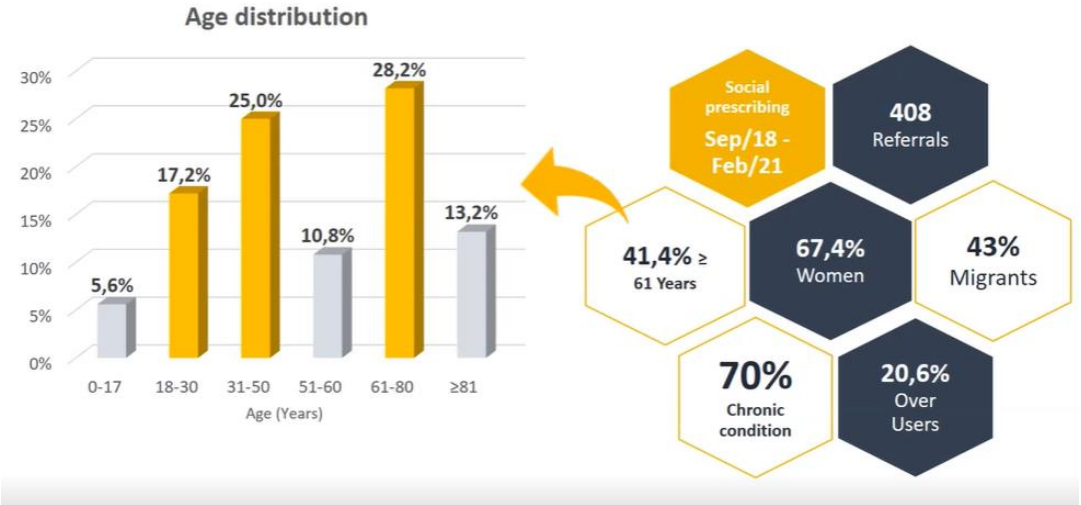
working, and they have no family nor friends, so she stays at home alone). He questioned whether pills are really what these patients need, to address the problems they are facin+g that can manifest in ill health. “Probably not”, he concluded, but it is the only thing he can provide if the health system is not equipped with alternatives.

Image 3. This is how the social prescribing works

Who were the users?

Cristiano provided some statistics from his practice on patients that had received a social prescription (Image 4). Between September 2018 and February 2021, there were 408 referrals. Most of the prescriptions were issued to female patients, people over 60 years old and with a migrant background.

Image 4. Social prescribing in USF Baixa primary care centre



He noted that **social prescriptions are very rarely made for children**; they are missing from the picture, as also highlighted by Dr. Jani. Given the importance of early childhood experiences to health and well-being across the life-course, there should be more of a focus on social prescribing for children.

Tools and initiatives from EU Institutions that can be used to support (sub)-national organisations and advance health promotion, *Ingrid Stegeman, Programme Manager and Lina Papartyte, Project Coordinator, EuroHealthNet*

Ms. Ingrid Stegeman indicated that there are no single specific set of tools, or sources of funding at EU level that are 'earmarked' to help organisations implement social perscribing or similar initiatives to build more health promoting health systems. There are however a great deal of mechanisms and opportunities available to help support this. We must be inventive in demonstrating how the application of these funds, to start and strengthen social perscribing initiatives, can help to advance relevant EU and national level priorities. Image 5 sets out a list of mechanisms that can be used to cover different aspects and stages of the system change for health promoting health systems including social prescribing.

Image 5. List of EU mechanisms that can help to launch and support social prescribing

Ingrid and Lina set out different EU mechanisms to support health in the community (Image 5). More information on these is included in the EuroHealthNet publication

breaking down the Multi-annual Financial Framework (2021-2027) The mechanisms they mentioned include:

- EU4Health programme – most suitable for funding pilot projects.
    - The new EU NCDs initiative "Healthier Together" will offer a set of practical tools, including funding, to reduce the burden of NCDs and improve citizens' health
- The European Pillar of Social Rights – The Action Plan sets out concrete initiatives to help Member States make progress in delivering on key principles of Social Protection and Social Inclusion, Equal Opportunities and Access to the labour Market, and Fair Working Conditions, and encouraging to invest in those areas where they fall short.
- Recovery and Resilience Facility - **675.2 billion Euro** to mitigate the pandemic's economic and social impact and to make Europe more sustainable, resilient and better prepared for future challenges and opportunities (Image 6)
    - Funds to be spent on system reforms and long-term investments.
    - 37% 'Green' and 20% Digital
    - Investments in 'hard' infrastructure initiatives to e.g., Power up, Renovate, Recharge and Refuel, Connect, **Modernise**, Scale Up and **Reskill and Upskill**

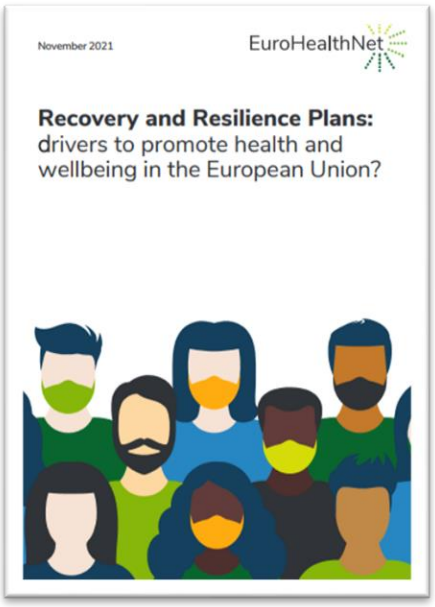


Image 6. EuroHealthNet analysis of Recovery and Resilience Plans

- Technical Support Instrument (TSI) - an EU programme (€864 million) that provides tailor-made technical expertise to authorities in Member States to design and implement policies and reforms on a range of topics. The support offered take the form of strategic and legal advice, studies, training and expert visits on the ground. It can cover any phase in the reform process and does not require co-financing from Member States.
- The European Social Fund Plus (ESF+) – the main financial instrument to strengthen Europe's social dimension, by putting the principles of the European Pillar of Social Rights into practice. ESF+-funded programmes and projects will concentrate on

social challenges identified under the yearly European Semester cycle, the main mechanism for economic and social policy coordination in the EU.

- EU skills Agenda – helpful for workforce training and peoples' skills for life
  - Relevant to ensure **social fairness**, putting into practice the first principle of the European Pillar of Social Rights: access to education, training and lifelong learning for everybody, everywhere in the EU
  - Funding comes from different EU programmes, see here.

2 Practices of social prescribing and related strategies for services in the community from EuroHealthNet member institutes

The EuroHealthNet Country Exchange allowed for a rich round table discussion about ongoing initiatives carried out by all members present. See Annex 1 for the list of participants. This section brings the various experiences of what works (or doesn't) and why in practice.

Austria, National Public Health Institute (GOEG)

- The GOEG has been working on social prescribing since 2019. It started with a development of a factsheet (in DE) and organisation of a colloquium.
- Within the framework of "Health Promotion 21+" financed by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection, a project call for primary care facilities was launched in 2021. It enabled the first steps to develop social prescribing in 9 facilities. GOEG supported the facilities by providing training for health professionals with link worker function (in total 2 days), networking meetings, documentation guideline.

- Key elements are sensibilisation of health care professionals for health related, non-medical needs, link working, network management and quality assurance. Quality assurance refers to:
    - Evaluation and documentation are extremely important (they already have the first impressions from the first 6 month of the project)
    - It is also important to consider at the outset which person can refer, and what services they can be referred to, and the benefits and the duration of each option
    - Also provide a short training course for the professionals involved so they can develop a response to social prescribing and see how it works in comparison to other methods.
- The first implementation experiences show that different professional groups can take over the link working function, social workers, nurses, dieticians, occupational therapists.
- Patients are referred to a wide range of services - depending on their needs - including legal advice, career counselling and health promotion measures. Further definition of pathways is still necessary.
- Within the framework of "Agenda Gesundheitsförderung" (2022-2024), further work can be done on the implementation of social prescribing. Further funding calls are planned to enable implementation experiences and the development of an ideal model to embed the concept in the Austrian primary care landscape.
- GOEG, in collaboration with WHO Regional Office for Europe, is writing a guidance document on primary care and public health services and a policy brief on health promoting primary care.

Finland, Finnish Institute for Health and Welfare (THL)

- Physical activity on prescription is successfully used in Finland since 2001; and arts and culture on prescription were introduced in 2015.
- A Social prescribing pilot project in Lapland was launched in 2020 - 2022. It received funding from the Ministry of Social Affairs and Health, but the continuation should be ensured via municipalities. Other stakeholders include the University of Lapland, the University of Applied Sciences in Lapland and some private sector organisations.
- In the 6-months **pilot project** the target group was adults older than 20 years. **The main reason to seek help was loneliness and isolation.** Patients found the project

too short to provide adequate support; the results were also affected by the COVID-19 pandemic.

- They have made 63 referrals, 70% of patients were satisfied with the pilot project. For the remaining 30%, it is possible that while patients needed the support, they did not want to get the service offered.
- The evaluation found that in municipalities with around 10.000 people in Lapland, the costs amounted to around 33.000 EUR per year, allowing for around 60-80 social prescribing referrals.
- The full **evaluation** results are still pending. The social prescribing will continue in Lapland after the pilot project ends.

Picture 2. CEV participants at INSA

Hungary, The National Public Health Center (NPHC)

- Hungary has a network of Health Promotion offices that were established and initially run using European Structural funds in 2013.
- The goal in the short-term was to establish offices that provide community services in the most disadvantaged areas of the country.
    - The first round saw the establishment of 20 offices
    - Now they have more than 100 offices. Some offices are based in hospitals but some are on the municipality level, so no GPs are present.
    - With 175 districts in total, the future goal is to establish offices in every district.

- Several obstacles:
    - In Hungary the social and the health services are separated, thus health promotion offices are more focused on the provision of health services (smoking cessation, addictions, physical activity)
    - The offices have a very low-budget since they are no longer financed through Structural Funds, and the allocation from the state budget is not enough.
    - The services provided by the Health Promotion offices are minimally evaluated; there is a need to establish an evaluation system.

Italy, The National Institute of Health (ISS)

- The Italian national service dates back to 1978 but there were many reforms. Since the beginning there were local health and social units which created informal social health system.
- In one of the national health service reforms in 1999, there was a discussion about the boundaries between social health and health care. In that reform, social activities related to health were defined, as well as health activities with social relevance.
- Health services in Italy are organised at regional level.
- Since the mid 90s social workers are devoted to the alleviation of poverty or social distress. Health promotion activities focus on lifestyle and are a municipal-level responsibility. There is often a lack of connection between such services and the third sector, although this differs per region.
- In the most recent national plan for prevention (2020-2025):
    - The idea is to combine community strategies and individual strategies
    - This opened the way to the individual counselling provided by doctors and nurses
    - It stated that the counselling can be strengthened with the availability of interventions (not only on physical activity but also theatre, networking, etc.) in the community or specific working groups.
- In Emilia Romagna, the regional law allows GPs to prescribe (adapted) physical activity. There is a **certification system** for the organisations/gyms that GPs can refer patients to

- Overall, there are plenty of activities in Italy, but they are not coordinated. GPs are not involved in the concept of social prescribing.

The Netherlands, National Institute for Public Health and the Environment (RIVM)

- In 2012 social prescribing started in one municipality. Currently one-third of all municipalities in the Netherlands apply social prescribing.
- This increase in social prescribing can be attributed to the Ministry of Health and Welfare's support for greater collaboration between primary healthcare and public health. The Ministry is in this respect supporting four specific kinds of interventions: social prescribing, combined lifestyle interventions, approaches for childhood obesity and fall prevention initiatives for older people.
- Regarding social prescribing, municipalities are allowed to create plans according to their own needs. Quality assurance of services are the responsibility of the municipal level as well.
- Most referrals are done by the GP or nurse practitioner on mental health. Other organisations can also refer but most are from primary care, who can refer patients to a welfare coach, a person that knows about the community activities. Most referrals are done to social or physical activities or voluntary work. The target group is mostly older people experiencing loneliness and mental health issues.
- A discussion ensued about the many kinds of 'coaching' professions that are becoming accredited and linked to health systems in the Netherlands. 'Welfare coaches' link people to community activities, but also help older patients with e.g., falls prevention. In addition, there are lifestyle coaches that aim to guide people, such as overweigh adults, in a process of behaviour change, to lead healthier lifestyles. There are also neighbourhood sport coaches. The lifestyle coaches are accredited and included in a register. This is one of the ways to ensure quality of the services. The fact there are many kinds of 'coaches' or trainers to refer to can be a disadvantage since GPs have to be aware of the different professions available.
- Combined lifestyle interventions - and in the future interventions to address childhood obesity and fall prevention - are financed by the health insurances as part of the basic health insurance package which is accessible for all Dutch citizens. Social prescribing, or the provision of physical activity and sport coaches, are seen as public services that should be covered by the municipality. This enhances the need to increase collaboration between the municipalities and health insurance providers.

- The barriers for the implementation for social prescribing:
    - Financing; funds should come from the municipalities
    - The time that GPs have available.
    - No consistent monitoring in how many patients are referred, to what activities, and the quality of the referrals. It is therefore hard to conduct a cost-effectiveness analysis. The outcomes are unclear.

Slovakia, Ministry of Health

- In Slovakia the government administration has strictly divided competencies. Healthcare services are paid by the health insurance companies and social services on the local level are paid from municipalities. Social services are oriented towards poverty reduction and address social issues rather than health promotion.
- There are good experiences from projects. Slovakia has good researchers in Kosice, working on the SCIROCCO project, they are trying to integrate social and health care.
- Under the current system, primary care is strongly about care. The Primary care practitioners' union is speaking of issues of integration of services and social prescribing. However system change will be a long and difficult process, due to the strict division between the health and social sector.
- More money could be given to local governments as they are closer to the people, however Slovakia is still a very centralised country. During the COVID-19 pandemic, municipalities proved capable of using the funds.

Slovenia, National Institute of Public Health (NIJZ)

- The health care system is based on strong multidisciplinary primary health care with an emphasis on health promotion and disease prevention. There is a long tradition of community nurses at primary health care and tight collaboration with the social services. In medical education, social analysis is constantly considered.
- The Ministry of Health, together with the Health Insurance Fund, are ensuring that health promotion, health education, disease prevention and health equity programs are prioritized by all primary health care providers.
- Two approaches:
    1. Support for Healthy Lifestyles at individual patient level

- Broad range of services within primary healthcare
- Primary healthcare is organised in community centers that offer multidisciplinary care.
- Health promotion centers, operating within the Community Primary Care Centers, offer group activities to persons at risk (physical activity, nutrition & diet, mental health, fall prevention etc.).
- The NIJZ ensures that similar programs are offered across the country. The Institute is responsible for training the providers.
- These services are all included in the compulsory health insurance packages and thus available to all persons living in Slovenia without co-payment.

2. Addressing Social Determinants of Health
   - These are a matter of the social sector which is separate to the MoH but they are in constant communication and collaborate where needed.

- Healthy lifestyles and social determinant approaches work together in the following way: the medical workers refer a patient to social services. The community nurses are the first to identify those who need social services and can alert the relevant authorities. It also works vice-versa: employment services, can refer people to health care services if they find for example that somebody does not have health insurance.
- All healthy adults are invited every five years for NCDs risk factor screening. If the risk factors are identified, patients could be referred to health promotion centres. If the person does not show up to their screening after three invitations, the community nurses pay a visit at home to check for the reasons of non-response or to conduct the screening. Every person is obliged to register with a primary health care provider. These up-to-date lists/registries allow for people to be actively cared for.
- When a child is obese, the whole family is referred to the health promotion centre. The health promotion centres not only provide physical activity, but also programs to change lifestyles and ensure their sustainability.
- In addition to these services, Slovenia has a very strong NGO sector. These organisations are financed by the national government and/or municipalities. For example, the MoH allocates 1.6 million EUR every three years to some 300 NGOs to support third sector. Their activities are promoted in newspapers, radio, at events.
- The NIJZ's regional units work closely with primary health providers, municipalities, schools and kindergartens, companies to ensure healthy workplaces, etc. The

institute is responsible for designing the programme, training the providers, implementing, monitoring, ensuring systemic financing, ensuring the follow up.

- Patient culture also matters. While patients may prefer to speak with their doctors, they may become aware that doctors have 4 minutes available, whereas the nurses can dedicate 20 minutes. In Slovenia, therefore, the patient culture started to change.
- Integrated, person-centred primary health care produces results: case study from Slovenia (2020) Copenhagen: WHO Regional Office for Europe; 2020. Licence: CC BY-NC-SA 3.0 IGO.

Public Health Wales

- Social prescribing in Wales is defined as 'connecting citizens to community support to better manage their health and well-being'
- Wales recognises that multiple terms are used to describe those working in a social prescribing service and whilst 'community connector' is often used to describe the role in Wales, the term 'link worker' is often used more in healthcare settings. Work is underway to develop a glossary of terms related to social prescribing and this is due to report later this year.
- The social prescribing model is very much relationship based. Work is in development to establish an outcomes framework to support evaluation and development of high-quality approaches.
- There is a commitment to expanding social prescribing capacity and in some areas the scope of the role that it plays. There is also a commitment to developing pathways that are focused on holistic approaches which place people at the centre and are integrated with existing and statutory services across sectors. This is a real challenge to deliver upon. One such issue pertains to the growing social prescribing workforce; the skills and competencies needed for the workforce and their training needs; their employment contracts, how the workforce is managed locally and how social prescribing is coordinated nationally.
- A variety of routes have been used to resource social prescribing services to date, but there are serious concerns that without guaranteed or at the very least much longer-term funding settlements in place for both social prescribing services and the community assets, the promise of social prescribing could be undermined.
- Technology is a real necessity going forward. Finding ways that technology – whether in systems, or in ways of making remote connections between individuals –

works for people is central to social prescribing's growth. Using a digital directory and digital platform across pathways could support social prescribing services to be person centred and responsive to changes required in the future.

- Welsh Government are due to release a consultation document on a national framework for social prescribing, which will consider many of the areas noted above, with a view to publication of the national framework following consultation, later this year.
- Carolyn Wallace et al. Understanding Social Prescribing in Wales: A Mixed Methods Study: A final report, Wales School for Social Prescribing Research, PRIME Centre Wales, Data Cymru, Public Health Wales, September 2021
- Wales School for Social Prescribing Research aims to develop a social prescribing evaluation methodology
- Evidence and resources on social prescribing and Social Prescribing projects in Wales

Insights from the discussions

- Physical activity is a good way to start social prescribing because most practitioners have a more biomedical approach, but it is important to not stop there, as other opportunities to refer may be missed. It is also important to make referrals easy, for patients to take them.
- How to follow up on social prescription? In Portugal doctors need to have feedback from the patient. It is not enough to only make a referral. When a doctor refers a patient to a social worker, that referral is easily done from the patient medical records thanks to the electronic platform they created. The referral will generate an email that goes to the social worker and the family doctor of the patient. That email can start a discussion between the social worker and the practitioner. The social worker is then in charge of cross-checking with the third sector organisations if the patient is going there, etc. While the system is in place, however, it is often not used, and the practitioners do not provide feedback.
- The holistic approach to health and care expands the provision of care from the central system to the extra health care activities and professions. The more actors there are in different information systems the more difficult it becomes to integrate and link everything.

- The digital infrastructure can help promote and advance social prescribing by creating incentives for tech companies and policymakers.
- In the Netherlands, budgeting and decision making for social prescribing does not happen at national level. The process of decentralising public health and social services is still taking place. When financial resources are not strictly assigned to specific activities, such as funding social prescribing at municipal level, they risk being used for other objectives. For health promotion, for example, money is not labelled. Municipalities have competing priorities, like addressing the climate change, etc., and money can easily be moved there.
- In Portugal there are discussions about decentralising primary care and making it the municipality's responsibility. To ensure the funds are well-spent at municipal level, however it is crucial to ensure people have a good understanding of the underlying determinants of heath. Otherwise, the discussions may turn to matters like for example the management of the buildings (who pays the bills, etc.), thus missing out on opportunities to act on social determinants of health. In addition, if municipalities receive more money for public health but do not have the right advice, they may use it to start opening clinics and introducing health services that are not necessary.

Picture 3. CEV participants at INSA, 4 May 2022

3 Site visits

The following are the key social prescribing partners from the voluntary and community sector in Lisbon, that CEV participants visited and/or heard from:

- Local government/Parish of Santa Maria Maior in Lisbon (Junta de Freguesia de Santa Maria Maior). Local government, which is smaller unit than a municipality, among other things provide social and wellbeing services to empower the population. These services include a third age university, summer holiday camps for children, social kitchen, financial coaching, shopping experience where all items are for free, social beauty salon, and many more. They are doing a lot of outreach activities to make sure that the most in need are aware of and benefit from the services.
- National Natural History Museum and Botanical Garden of Lisbon (Museu Nacional de História Natural / Jardim Botânico de Lisboa). The Museum is offering university students, elderly and patients referred via social prescribing opportunities to work in the botanical garden. The museum has a link worker that connects with the social worker and the patient to establish a flexible but fulfilling engagement.
- Association fighting loneliness and isolation (Associação Mais Proximidade). The organisation works with older people to fight loneliness and isolation by helping them to maintain their autonomy. In the area where the organisation operates, most of the houses do not have an elevator which in practice imprisons people with reduced mobility at home. Home visits, phone calls, birthday celebrations are the preferred activities.
- Santa Casa da Misericórdia de Lisboa. This 500 years-old charity is best known for its work in the area of social action but it also carries out important work in the areas of health, education and training, culture, research and innovation. It also supports the social entrepreneurship.

- Cycling without age (Pedalar Sem Idade), read about the international movement here. Volunteers offer 45-60mins bike rides to people with reduced mobility. Among its objectives, Cycling Without Age has been keen to challenge ageism, discrimination based on a person's age. It does so by creating relationships between generations, between pilots and passengers, care home employees and family members.

Picture 4. CEV participants at Mouraria Creative Hub, 4 May 2022

- National Immigration Support Centre (Centro Nacional de Apoio à Integração de Migrantes). This public centre hosts different integration services under one roof, including advice on schooling for children and the intermediation between migrants and social services.
- Portugal Multicultural Academy Association, an organization for the immigrants' support and education, including health literacy. They receive people and listen to their health needs, help accessing health system, interpret information that people receive from their doctors.
- Social centre promoting arts and mental health for the elderly, Oficina do Eu / Centro Social Polivalente São Cristóvão e São Lourenço. This is a day centre where for a symbolic fee people can socialise, play games, do their laundry, get food, etc.
- Associação Renovar a Mouraria, association promoting social participation in Mouraria district. In the district with big cultural diversity, the organisation aims to support people to reach their highest potential, including offering legal support.

Picture 5. CEV participants visiting Centro Social Polivalente São Cristóvão e São Lourenço, Lisbon

- An Intercultural Association of Lisbon (an immigration association of Nepalese people), NIALP. Established by a Nepalese doctor, the organisation supports the Nepalese integration in the society. Example of activities include a pregnant women club, language or sewing courses, etc. There are around 240,000 Nepalese living in Portugal.

- É um restaurante. With the support of the Lisbon City Hall, the mentoring of Chef Nuno Bergonse and the creativity of The Hotel, Crescer Association created a restaurant where the service is provided by people who experienced homelessness.

- Cozinha Popular da Mouraria is a social responsibility initiative that aims to involve the neighborhood and also those who visit it, in a center of multiculturalism, where there is a place for learning, experimentation and sharing. A house where everyone eats, and everyone cooks.

4 Final discussion, insights and lessons learnt

Following the site visits, participants gathered for a final discussion on what they had seen and learned from one another, and to reflect on what could be done to strengthen community care models and relevant approaches, in particular social prescribing. Dr. Cristiano Figueiredo kicked off the discussions by elaborating on how the practice had begun in Lisbon. The ensuing discussion is then summarized under different themes:

How can social prescribing be initiated?

Social prescribing is about creating a network between organisations that serve the same population. All these actors aim to achieve the same goal, healthy, happy and inclusive society, but they are rarely able to work together.

The story of the social prescribing in Lisbon started at the initiative of the Family Health Unit in Central Lisbon (USF da Baixa). In 2018, they brought together healthcare and community sector stakeholders to discuss how could they collaborate to improve health and wellbeing in the community. All the invited organisations came to the meeting, bringing their different experiences and perspectives. There was a momentum to start the first social prescribing scheme in Portugal. They ran several meetings with health and community partners to write a protocol which could fit the principles of social prescribing into their reality and resources. It was a bottom-up movement for health promotion.

A research partnership with the Portuguese National School of Public Health for monitoring and evaluation of the social prescribing pilot project was established, taking into consideration the latest recommendations from the Quality of Outcomes Framework published by NHS England. The project was supported only for the evaluation. Now they

are starting the follow up with patients to measure elements, for example, mental health outcomes, wellbeing, civic engagement, etc.

How best to introduce and scale social prescribing in a country?

Social prescribing could start on a project bases, as it is easier to develop a project to implement in several specific locations rather than in the whole country. It is also easier to apply for funding on a project basis. Monitoring is an essential part to demonstrate whether and how the project is achieving the desired outcomes, and whether it could be transferred to other places. If itis successful, it could then be scaled up, in collaboration with the Ministry of Health or Social Affairs.

In Portugal and Wales, the movements started at the grassroot level. In Wales, the impulse to work together came from the social sector with loneliness and social isolation being the main trigger. In Portugal, it was the health care sector that helped to mobilise the social sector to launch social prescribing pilot project.

In Portugal there will soon be five health care centres offering social prescribing on their own initiative. However, there are no funds allocated for the project implementation, including project management. In Slovenia, the Ministry is financing Primary Health Care centres, while they are being managed by NIJZ.

Picture 7. Final CEV discussion at the Mouraria Creative Hub

This reflects how, while initiatives to strengthen primary care, like social prescribing, may be initiated at the local level, they call for top/Ministerial level support to become embedded, mainstreamed, and sustained. Discussions also focused on how to achieve this political or government support. Providing evidence is certainly important, but it is also key to use personal contacts to convince political leaders and high-level officials as well as supportive ministerial staff members at senior level who are not affected by political change to foster these initiatives. Discussions with such key figures, setting out the benefits of approaches like social prescribing are very important. Getting positive media coverage is another avenue to attract attention from the political level.

Skills for professionals working on social prescribing

Participants noted that there is no need to create new professions to work on social prescribing, as there are so many already, but that different professionals need more efficient cooperation. The notion of 'new' professions can scare people, since there is a sense that these could replace their jobs. The emphasis should be on re-skilling and education of professionals already in the system. The EU skills agenda can provide opportunities to help fund re-skilling and upskilling.

Participants also pointed out to the need to develop competency frameworks to decide on the tasks and roles when implementing social prescribing. We are moving towards a scenario where social workers address health and health professionals deal with social determinants of health. While this is an asset to have for integrated and cross-sectoral working, there is a risk that if professionals receive some training on a topic in another field, they may begin to see themselves as qualified professionals in those fields.

At the same time, professionals may not feel qualified enough to engage with other sector activities. In the UK, for example, nurses receive a medicalised education. The nursing practice is very regulated, and they may not feel confident in referring patients to social prescribing. In Slovenia, nurses are not trained for health promotion or disease prevention either. The same is the case in Portugal, where nurses are trained in hospitals or other care facilities. Participants agreed that training and competency frameworks should be adapted to contextual circumstances and needs.

Picture 6. Caroline Costongs, Director of EuroHealthNet

Making the case and securing the funding to implement social prescribing

Introducing new ways of working often require rethinking of funding mechanisms in place to support them. (Social) innovation present certain risks to all stakeholders involved, hence it creates additional challenges to get new concepts off the ground.

How the objectives are framed can help manage the expectations. Participants noted that the argument that social prescribing can reduce the costs of health care may not be justified, since it is not clear to what extent implementing social prescribing can reduce the number of GP consultations. The evidence is not available yet. However, social prescribing is not only about the financial benefit but has a potential to offer a better service for patients. It is not just about cost reduction, but about a better, more effective use of resources and attending better to the needs of patients. This may contribute to professional satisfaction of health care workers as well.

Some co-funding from the health system to the referral and quality assurance solutions should be allocated as referring more people to the community services creates higher demand for the third sector. This could empower patients to use resources that are available in the community.

Launching new initiatives may require divesting resources from programmes that are underperforming, to invest in solutions that meet new needs. To analyse which programmes are no longer delivering value for money, one example could be England's Prioritisation framework. The OECD report on tackling wasteful spending on health provides more highlights.

More and more often private and government run insurance companies choose to invest in preventative services. Read more about Dutch and German examples here.

Financial incentives for health professionals may also be considered. It should be as easy to refer patients to social worker and community services as to have a cardiogram. Quality of outcomes framework should be established so that doctors are more focused on patient health outcomes rather than the process that they must follow. A GP may for example have to weigh their patients once a year, but there are no further guidelines of what should happen next.

Next steps

At the end of the meeting, Caroline Costongs guided the discussions towards the possible next steps to support the membership's effort to improve primary and community care services, with a special focus on social prescribing. These were:

- Technical Support Instrument – exploring to submit a TSI application together.
  - Example application from Slovakia in integrated care. The process was as follows: the MoH is applying the European Commission through the Ministry of Finance. As a result, the EC is looking for relevant experts to support Slovakia. The process is at the high political level.
  - Other health and care related examples
- Exploring Erasmus + funds and EU Skills agenda, helpful identifying who in the system can be a link worker, what are the training needs, etc.
- There are a lot of resources about social prescribing coming from the UK, but we need more European perspectives, as solutions are local. We could work together on a (policy) paper portraying European perspective.

Summary of key findings

- The challenges to launch and scale up social prescribing are related the task division and subsequent **collaboration between health and social sectors**. The competencies of the two ministries may be strictly separated with minimal collaboration (e.g., Hungary and Slovakia), or working together more closely (e.g., the Netherlands).
- What sector/who takes the lead to initiate social prescribing and make the **link between primary health care centres and the services in the community** can differ per setting and country, depending on contextual circumstances. In Portugal, for example, it was a health sector that mobilised the third sector to work together. In Wales, the third sector organisations stepped up to initiate the collaboration with health services.
- Participants noted that there is no need to create new professions to work on social prescribing but to focus on **strengthening skills** of professionals already in the system (e.g., GPs, nurses, social workers).
- **Quality control** and the **measuring of the overall effectiveness** of the services consistently emerged as a challenge.

- Who pays for delivery of social prescription? Different solutions were mentioned: co-funding, health insurance, divesting from programmes that are underperforming, etc.

Resources: Do we have sufficient evidence that social prescribing works?

A toolkit on how to implement social prescribing. Manila: World Health Organization Regional Office for the Western Pacific; 2022.

Some of the analyses are available (Evidence and resources on social prescribing in Wales).

Morse DF, Sandhu S, Mulligan K, et al. Global developments in social prescribing. BMJ Global Health 2022;7:e008524. https://gh.bmj.com/content/7/5/e008524

Hoffmeister, L.V., Nunes, M.F., Figueiredo, C.E.M., Coelho, A., Oliveira, M.F.F., Massano, P., Gama, A., Aguiar, P. and Dias, S., 2021. Evaluation of the Impact and Implementation of Social Prescribing in Primary Healthcare Units in Lisbon: A Mixed-Methods Study Protocol. *International Journal of Integrated Care*, 21(2), p.26. DOI: http://doi.org/10.5334/ijic.5592

Evidencing social prescribing, by National Academy of Social Prescribing in England

For financing health initiatives, see Policy Brief 43: European support for improving health and care systems (2021), European Observatory on Health Systems and Policies

Good health and wellbeing: Social prescribing (international playbook) by Global Social Prescribing Alliance

Calderón-Larrañaga S, Greenhalgh T, Finer S, Clinch M. What does the literature mean by social prescribing? A critical review using discourse analysis. Sociol Health Illn. 2022 Apr;44(4-5):848-868. doi: 10.1111/1467-9566.13468. Epub 2022 Apr 11. PMID: 35404485.

England Social Prescribing Observatory

The Canadian Institute for Social Prescribing (CISP)

National Academy for Social Prescribing in the UK

"Walk with a doc" – health literacy intervention, also practiced in Portugal (but also other countries in the world). GPs take 1.5 h off their clinical practice to support health of the population. These walks are organised once a month.

Annex 1. List of participants

Country	Organisation	Name	Position
Austria	National Public Health Institute	Daniela Rojatz	Health Expert
Finland	Finnish Institute for Health and Welfare	Marika Kylänen	Project Manager, Senior Researcher
Hungary	The National Public Health Center	Péter Csizmadia	Consultant, Department of Health Promotion
Italy	Federsanita	Paolo Stocco	Secretary General
	Istituto Superiore di Sanità, The National Institute of Health	Raffaella Bucciardini	Director of the Health Equity Unit
		Giovanni Capelli	Director of the National Centre of Disease Prevention and Health Promotion
Netherlands	National Institute for Public Health and the Environment	Karlijn Leenaars	Coordinator Healthy Municipality; Prevention in the healthcare system; Consultant for quality
		Djoeke Van Dale	Senior advisor, Coordinator Quality of Interventions
Portugal	National Institute of Health Doutor Ricardo Jorge	Luciana Costa	Researcher
		Alexandra Costa	Senior technical officer
	USF da Baixa, Central Lisbon Health Centre Cluster, National School of Public Health, NOVA University Lisbon	Cristiano Figueiredo	General Practitioner
		Diogo Silva	Social worker

Slovakia	Ministry of Health	Daniela Kállayová	Senior officer, Department of Public Health, Screening and Prevention
Slovenia	National Institute of Public Health	Pia Vracko	Senior Advisor, Department for Health Systems
Wales	Public Health Wales	Amrita Jesurasa	Consultant in Public Health, Primary Care Prevention
	University of South Wales	Carolyn Wallace	Professor, Community Health and Care Services, Faculty of Life Science and Education
	EuroHealthNet	Caroline Costongs	Director
		Lina Papartyte	Project Coordinator
		Ingrid Stegeman	Senior programme manager

Annex 2. Agenda

Day 1 - Wednesday, 4 May 2022

8.30 Registration at National Institute of Health Doutor Ricardo Jorge (INSA)

The session from 9.00 – 12.30 is available to follow on zoom

9.00 Welcome and introductions

- Luciana Costa, Researcher, National Institute of Health Doutor Ricardo Jorge (INSA)
- Executive Board member of National Institute of Health Doutor Ricardo Jorge (INSA)
- Ministry of Health, Portugal (TBC)

- Caroline Costongs, Director of EuroHealthNet
- (Tour de table, expectations and needs)

9.30 Building foundations for promoting health in the community

- Health system foundations for health promoting community services and social prescribing, *Dr. Anant Jani, University of Oxford*
- Introduction to social prescribing movement in Europe, *Bogdan Chiva Giurca, Development Lead at Global Social Prescribing Alliance, Clinical Champion Lead at National Academy for Social Prescribing in the UK*
- Social prescribing developments in Portugal, *Dr. Cristiano Figueiredo, USF da Baixa, Central Lisbon Health Centre Cluster, National School of Public Health, NOVA University Lisbon*
- Tools and initiatives from EU Institutions, followed by a discussion on how they can be used to support (sub-)national organisations and advance health promotion, *Ingrid Stegeman, Programme Manager and Lina Papartyte, Project Coordinator, EuroHealthNet*

10.30 Coffee break

10.50 Strategies and practices of social prescribing (or other strategies for services in the community) from EuroHealthNet member institutes. Overview from members on what works (or doesn't) and why in practice

- Austria, Finland, Hungary, Italy, Netherlands, Portugal, Slovakia, Slovenia, Wales

12.00 Time for questions and exchange

12.30 Transportation to the site visit and lunch

Lunch at Cozinha Popular da Mouraria, Substância Project, a social kitchen for neighbourhood inclusion

14.30 Site visit 1

The key social prescribing partners from the voluntary and community sector in Lisbon – presentation of services provided, challenges, opportunities, and early lessons from the intersectoral collaboration between primary care and the third sector at the Mouraria Creative

Hub, an innovation and creative centre, which also hosts community meetings to discuss and further develop social prescribing activities.

- National Natural History Museum and Botanical Garden of Lisbon (Museu Nacional de História Natural / Jardim Botânico de Lisboa)
- Association fighting loneliness and isolation (Associação Mais Proximidade)
- Cycling without age movement (Pedalar Sem Idade)
- Santa Casa da Misericórdia de Lisboa, a charity involved in social networks
- National Immigration support Centre (Centro Nacional de Apoio à Integração de Migrantes)
- Portugal Multicultural Academy Association, an organization for the immigrants' support and education, including health literacy

16.00 Site visit 2

Walking tour covering three social prescribing partners from the local voluntary and community sector in the Mouraria district.

- Social centre promoting arts and good mental health for the elderly, Oficina do Eu / Centro Social Polivalente São Cristóvão e São Lourenço
- An Intercultural Association of Lisbon (an immigration association of Nepalese people), NIALP
- Associação Renovar a Mouraria, association promoting social participation in Mouraria district

17.30 end of the Day 1

19.30 Dinner at "É um restaurante"

Day 2 - Thursday, 5 May 2022

9.00 Site visit 3

The role of local government. Junta de Freguesia de Santa Maria Maior solutions for promoting health in the community through the social prescribing lens – presentation of services provided,

challenges, opportunities, and early lessons from the role of local governments in social prescribing adoption, dissemination and sustainability.

After the site visit, the Country Exchange Visit moves to the premises of the Mouraria Creative Hub.

11.00 Coffee break

11.15 What resources are required (human, financial) to run sustainable, holistic health promoting services (including those visited)? Member discussion

- How are such services financed in your country?
- How to solve co-budgeting challenges when running integrated community services?
- How can cost-effectiveness be evaluated to make an informed budget-allocation decision?
- How to share responsibilities between different actors?
- How can we benefit more from the European initiatives and European funding schemes in place to support the transition to more holistic health promoting services in the community?

12.15 Moving forward; Member discussion

- How we can work together to achieve more integrated and community-based health and social services, incorporating social prescribing approaches?

12.45 Conclusions and closing remarks

13:00 End of meeting

EuroHealthNet

European partnership for health, equity & wellbeing

Our mission is to help build healthier communities and tackle health inequalities within and between European States.

EuroHealthNet is a not-for-profit partnership of organisations, agencies and statutory bodies working on public health, promoting health, preventing disease, and reducing inequalities.

EuroHealthNet supports members' work through policy and project development, knowledge and expertise exchange, research, networking, and communications.

EuroHealthNet's work is spread across three collaborating platforms that focus on practice, policy, and research. Core and cross-cutting activities unite and amplify the partnership's activities.

The partnership is made up of members, associate members, and observers. It is governed by a General Council and Executive Board.

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