Creative Health Commissioning:

An economic business case for improving population health and reducing health inequalities

Contents

About this resource

This template business case has been developed as part of the Mobilising Community Assets to Tackle Health Inequalities research programme to support investment in Creative Health across the UK. It is designed as a practical resource for commissioners to develop local business cases and secure organisational support for Creative Health programmes. The business case should be used alongside the *Guidelines on Economic Evaluation in Creative Health* (August 2026), available at: https://ncch.org.uk/uploads/Guidelines-on-Economic-Evaluation-in-Creative-Health.pdf

This resource is primarily intended for NHS Integrated Care Boards (ICBs), place-based commissioners, neighbourhood health teams, local authorities and their partners. It can be used to:

- develop local Creative Health business cases;
- support commissioning decisions;
- inform neighbourhood health and prevention strategies;
- identify opportunities for partnership working across health, social care, culture and the VCSE sector.

The document provides a strategic, economic and implementation framework that can be adapted to local population needs, existing community assets and commissioning priorities.

The resource positions Creative Health not simply as a discrete intervention or referral destination, but as part of neighbourhood and community health infrastructure. By connecting health and care services with cultural, community and voluntary-sector assets, Creative Health can support prevention, engagement, and self-management.

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Economic Business Case for Investment in Creative Health

Better health, lower demand, stronger communities

Executive Summary

THE CHALLENGE

Demand continues to outstrip capacity

NHS faces growing pressure from:

- Ageing population
- Rising long-term conditions
- Increasing mental health need
- Persistent health inequalities
- Workforce and financial pressures

THE PROPOSAL

INVEST IN CREATIVE HEALTH

Engage people in culture, arts, heritage and nature-based activities improving health and wellbeing through:

- Prevention and early intervention
- Supporting self-management of long-term conditions
- Strengthening community and social support networks
- Delivering person-centred neighbourhood health services

THE EVIDENCE

Dirven et al. (2025) | Goldsmith& Kokolakakis (2021) | Jones et al. (2016) | Taylor et al. (2017) | Papon et al. (2026) | Wang et al (2020) * | Elsden et al. (2023) *

*Frontiers Economic monetisation (2024)

RECOMMENDATIONS

Commission Creative Health as part of:

- Neighbourhood Health Services
- Population Health Management
- Core20PLUS5 delivery to address health inequalities

Start with proven, scalable interventions and expand based on outcomes.

VALUE CREATED

NHS	Communities	Economy
Reduced demand	Reduced loneliness	Improved productivity
Better outcomes	Stronger social networks	Support for local providers
Prevention	Community resilience	Social value creation

Creative Health offers a practical route to prevention, reducing health inequalities and person-centred care. The strongest evaluations indicate potential health and economic benefits, while local commissioning should include proportionate evaluation to establish outcomes, costs and effects on service use.

1. The Strategic Case: The Case for Change

The NHS faces rising demand driven by an ageing population, increasing multimorbidity, poor mental health, widening health inequalities, workforce pressures and constrained public finances. At the same time, national policy is increasingly focused on three shifts: From hospital to community, from analogue to digital, from sickness to prevention. Creative Health supports all three of these priorities.

Many drivers of rising demand stem from social determinants of health, including isolation, poverty and poor social connectedness. Creative Health approaches help address these factors by strengthening social connections, supporting wellbeing and self-management, and building individual and community resilience, with evidence suggesting potential to reduce avoidable healthcare utilisation in some populations and settings.

The statements and evidence summaries presented in this section draw on the sources listed in Supplementary Materials, including the World Health Organisation's (WHO) scoping review of arts and health evidence, the National Centre for Creative Health (NCCH) Creative Health Review, NHS England guidance, National Academy for Social Prescribing (NASP) evidence reviews, the Department for Culture, Media and Sport's (DCMS) Culture and Heritage Capital evidence bank, and relevant peer-reviewed studies.

Creative Health spans a continuum from clinical interventions and targeted health programmes to social prescribing and everyday creative participation, improving health and wellbeing by addressing the social determinants of health through cultural, community, nature-based and creative assets.

The evidence demonstrates how Creative Health contributes to:

Figure 1. Creative Health meeting NHS priorities

2. Creative Health: Evidence and Impact

Although the economic evidence base for creative health is still developing, several studies suggest that arts and creative interventions can generate health improvements at relatively low cost when compared with established NHS thresholds. The Creative Health Economic Evidence Bank compiles economic evaluations from across the creative health continuum. This evidence, informed by the DCMS Culture and Heritage Capital (CHC) approach (Culture and Heritage Capital portal - GOV.UK), highlights the extensive reach of arts, cultural and nature-based interventions throughout the health system, spanning acute care, rehabilitation, mental health, long-term condition management, ageing, wellbeing, child and adolescent development.

Economic methods and findings vary considerably. Higher-confidence studies indicate that some Creative Health interventions may improve outcomes at a reasonable cost and help to reduce healthcare use. Wider studies also identify substantial wellbeing and social value.

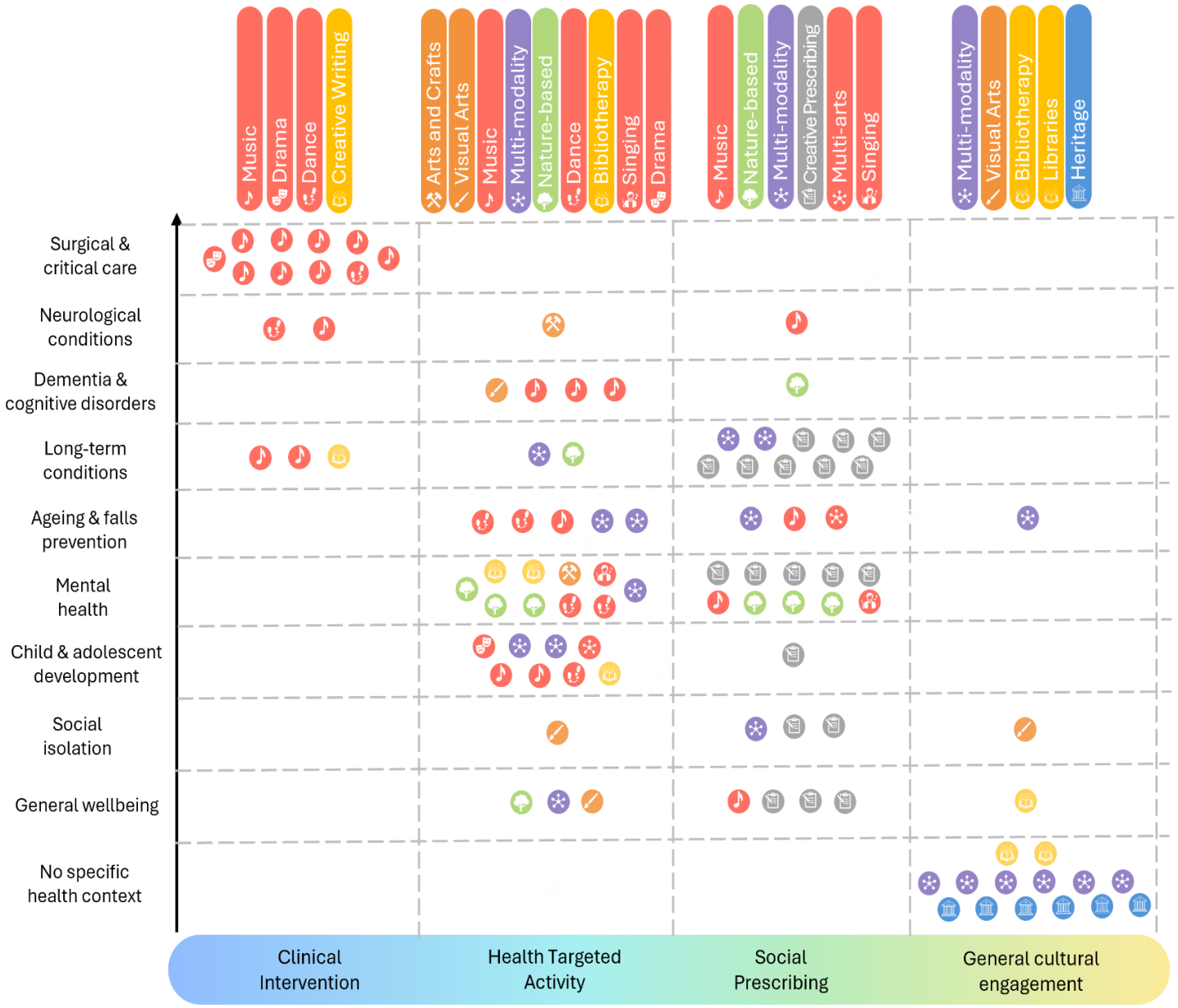


Figure 2. Creative Health Economic Evaluation Evidence Bank scatter chart

Economic Case: Why creative health represents value for money

The economic evidence demonstrates benefits across four levels of value within the health system and a tiered grading framework was used to assess the confidence of evidence using four domains:

1. study design and empirical strength;
2. quality of the economic evaluation;
3. transparency and robustness of methods and assumptions; and
4. relevance to UK Creative Health commissioning.

Scores were combined to provide an overall confidence rating, enabling consistent comparison across diverse Creative Health evaluation methods and settings.

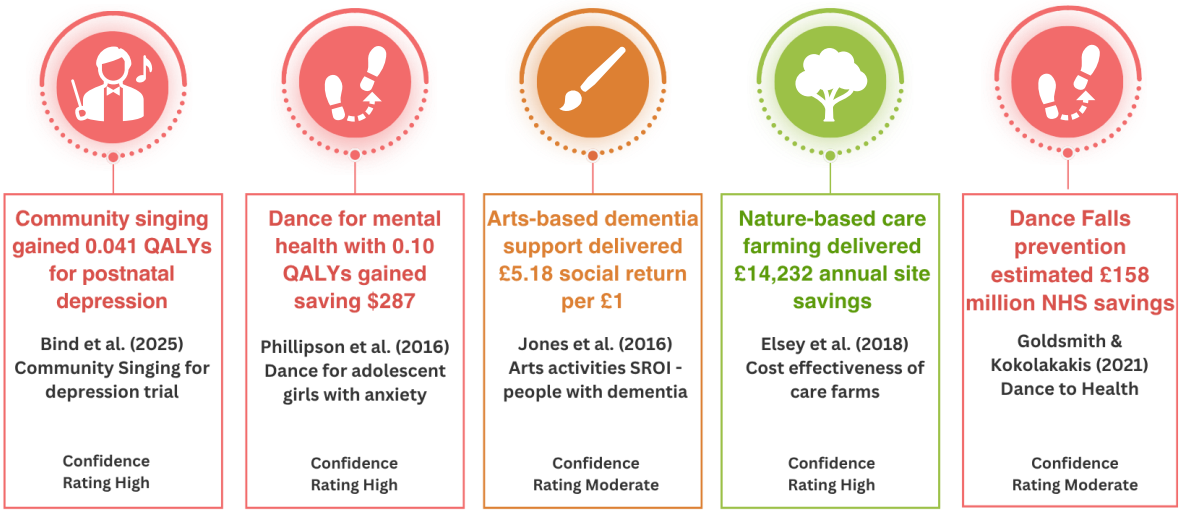
Low 1 - 5 **Moderate 6 - 11** **High 12 - 16**

Further details of the grading criteria and the grading breakdown can be found in the Creative Health Economic Evidence Bank.

Clinical Value – Some creative interventions have been associated with reduced healthcare or medication use, although the strength and transferability of this evidence vary.

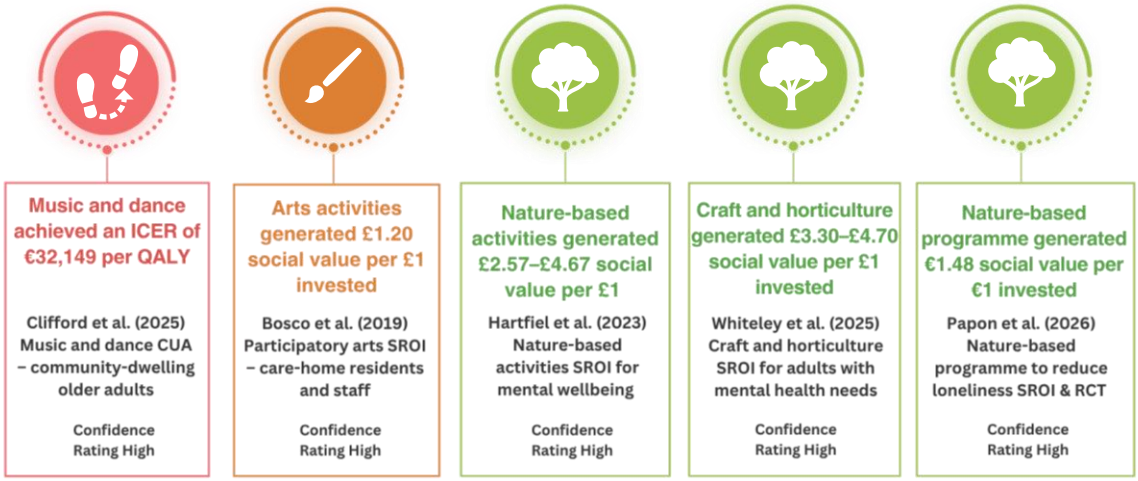
Music provides the strongest economic evidence in clinical settings, supporting a reduction in patient-level costs and improved outcomes. The savings arise through shorter hospital stays, reduced service use, and more efficient procedures and recovery. Medical clowning and creative writing show promising savings, but estimates are less certain. The dance study demonstrates positive patient outcomes, although its impact on costs remains uncertain and a larger cost-effectiveness trial is required to confirm the economic benefit.

Prevention and Harm Reduction Value - Targeted creative health activities help to address major NHS demand drivers before escalation.



Dance, singing, visual arts and nature-based activities report benefits for mental health, dementia, rehabilitation, healthy ageing and disease prevention. The strongest economic evaluations use QALYs, comparison groups and sensitivity analyses.

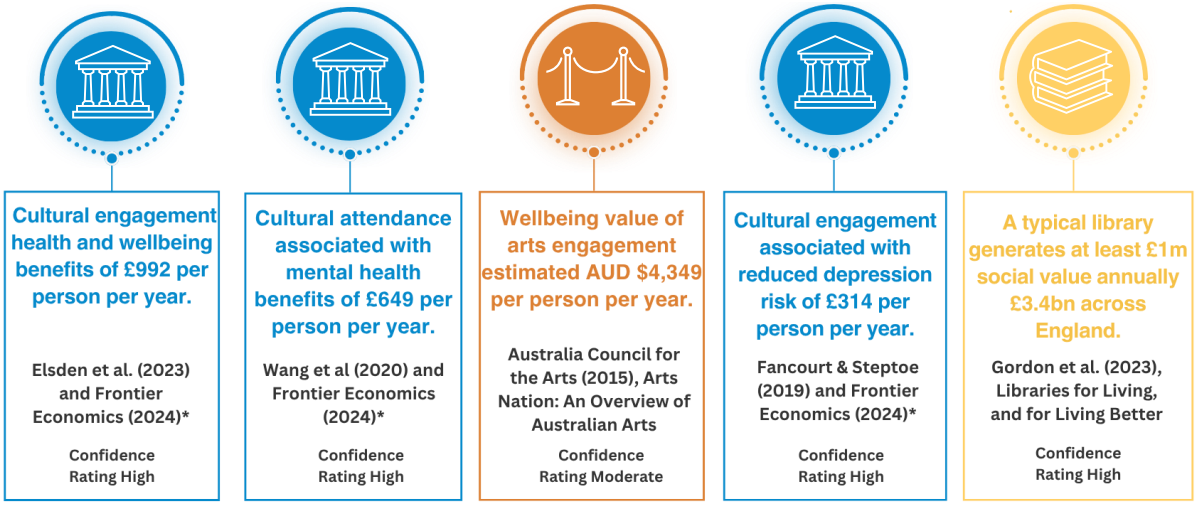
Social Value - Creative Health strengthens the economic case for social value and reducing health inequalities.



The evidence for arts-, nature-, music- and movement-based social prescribing suggests improved wellbeing, quality of life, social connection and loneliness outcomes at relatively modest cost. These interventions support prevention and warrant targeted commissioning with ongoing evaluation of both participant outcomes and healthcare utilisation.

Involve Kent's social prescribing service delivered excellent value for money, generating health gains at just **£2,548 per QALY across 6,112 patients**, around **three times more cost-effective than comparable interventions** and well below NHS cost-effectiveness thresholds. (Mundra, 2026a)

General Population Wellbeing Value – Evidence indicates that cultural assets can form part of an integrated health and wellbeing infrastructure.



The DCMS Culture and Heritage Capital (CHC) programme demonstrates that cultural participation can generate measurable health and wellbeing value. Elsden et al. (2023), Wang et al. (2020) and Fancourt & Steptoe (2019), were subsequently monetised by Frontiers Economics using Green Book- and DHSC-recognised methods, supporting their use in Social Cost Benefit Analysis (SCBA) and public-sector decision-making.

Preferred Economic Option

A locally commissioned Creative Health approach, delivered through neighbourhood health partnerships, local authorities and community organisations, offers the greatest potential to generate health, social and economic returns.

Option 1 — Do nothing

- Rising service demand continues.
- Prevention opportunities missed.
- Existing inequalities remain.
- Poor quality of life.

Option 2 — Maintain current limited activity

- Local innovation continues.
- Community and neighbourhood models are under resourced.
- Limited scale and evaluation.

Option 3 — Implement a National Creative Health Infrastructure Model

- Integrate into Neighbourhood Health Models
- Target specific health populations
- Develop creative social prescribing pathways
- Co-produce an outcomes framework
- Feed into national evidence infrastructure

*** Option 3 offers the greatest potential to generate health, social and economic returns while supporting national NHS reforms.**

3. Strategic Opportunity

While further research is needed, existing evidence suggests that Creative Health may provide a flexible approach to supporting a range of health, social, and economic priorities. It may also offer practical, evidence-informed ways of contributing to responses to systemic challenges within health and care services.

System challenge / Impact	Creative Health Solution	Evidence
Rising demand driven by comorbidities and health inequalities (Darzi, 2024)	Creative health offers person-centred l interventions that address wellbeing, self-management, social connection and resilience.	Arts on Prescription Gloucestershire has shown a 37% drop in GP consultation rates and a 27% reduction in hospital admissions. (CHWA, 2023)
Low engagement with services, particularly among high-need groups (Local.gov.uk, 2025)	Community-led hubs and non-clinical spaces along with arts and culture engagement to reach people by embracing culture, identity and community knowledge.	Everton in the Community's BEAT Breathlessness Hub deliver health checks in non-clinical settings reaching over 1,100 residents, identifying undiagnosed COPD, hypertension and heart failure. (Sankaranarayanan, 2025)
Growing pressure on services with limited capacity for prevention (Darzi, 2024)	Creative health supports prevention and improves self-management.	*Melodies for Mums* singing programme for postnatal depression achieved a 35% reduction in symptoms within six weeks. (Fancourt et al,2018)
Fragmented services operating in silos (NHS England, 2023)	Creative health programmes operate through partnerships.	A review of 69 UK creative health strategies found that successful programmes bring together health services, cultural organisations, VCSE partners and communities. (ReCITE Blog, NCCH, 2025)

Social value is created for individuals, communities and systems by strengthening the social determinants of health and enabling people to live healthier, more connected and more fulfilling lives. Creative Health can therefore be understood as a system-wide prevention and wellbeing infrastructure, supporting health creation, neighbourhood health, population health improvement and sustainable economic growth.

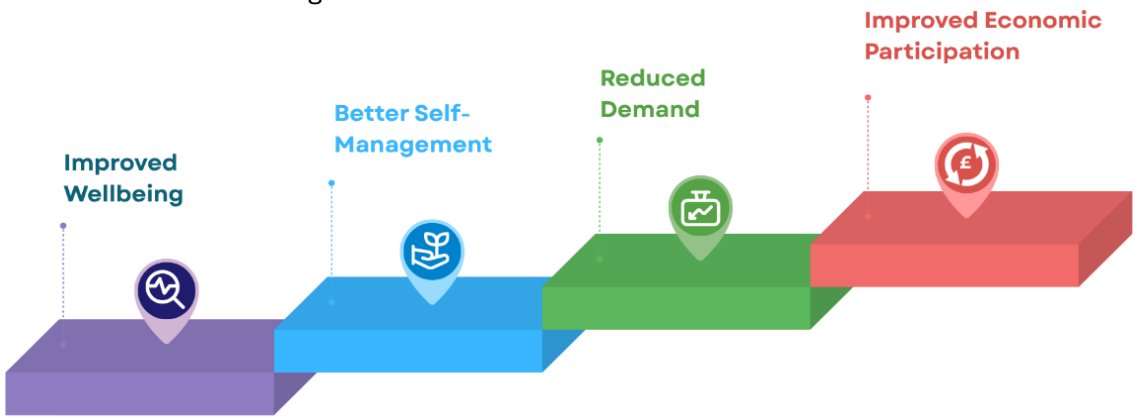


Figure 3. Creative Health = Improved Wellbeing → Better Self-Management → Reduced Demand → Improved Economic Participation

Social value is created simultaneously across the integrated health ecosystem: NHS, Adult Social Care, Local Government, DWP, communities and boosting local economies.

4. Commercial Case

Delivery Model

Creative Health is delivered through a distributed provider ecosystem rather than a single provider organisation. Delivery is typically provided by a diverse range of community, culture and arts organisations, and individual experts.

The cultural sector contributes £40.3 billion in Gross Value Added (GVA) annually and supports around 700,000 jobs, while the wider creative industries contribute £145.8 billion and support 2.4 million jobs across the UK (DCMS, 2026).

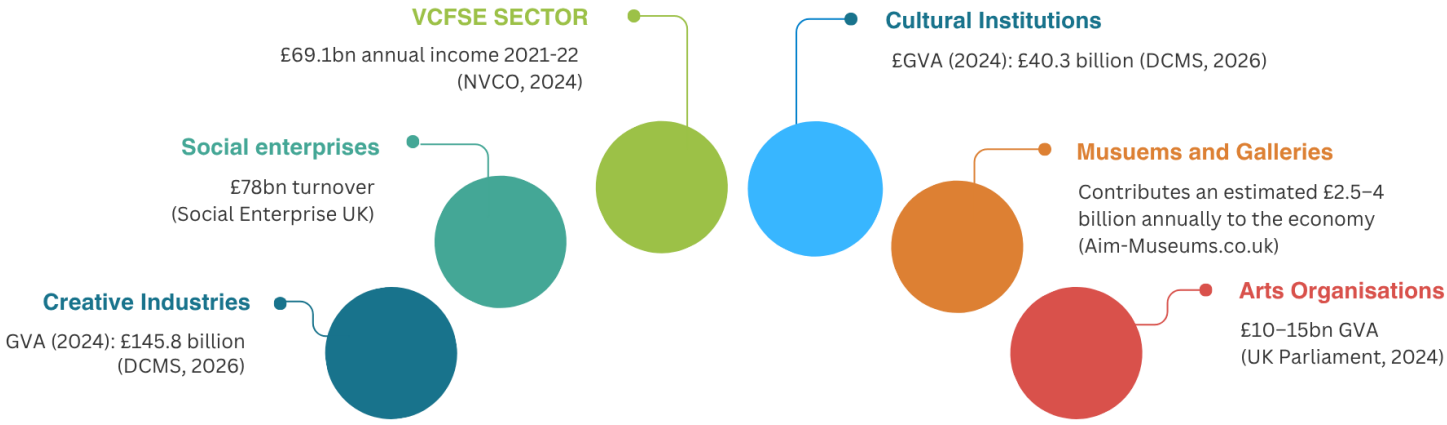


Figure 4. Creative Health Provider Infrastructure

Commissioning principles for creative health and community-based services

Creative Health commissioning is most cost effective when delivered via a partnership and ecosystem approach rather than a single-provider procurement model. Similar approaches are already established within Integrated Care System (ICS) partnerships. Commissioning should be designed to:

- **Create social value** by delivering wider community benefits alongside health and wellbeing outcomes.
- **Promote collaboration** across health, social care, cultural, voluntary and community sectors.
- **Strengthen local provider markets** by supporting the sustainability and development of diverse local organisations.
- **Enable co-production** by involving communities, service users and delivery partners in the design, delivery and evaluation of services.
- **Encourage innovation** by allowing flexibility in service models and supporting new approaches to meeting local needs.

Creative Health example: West Yorkshire Combined Authority's £500,000 investment is building regional networks, workforce and evaluation capacity, referral routes, coordination and future funding pathways, providing infrastructure to support the sustainable development and scaling of Creative Health. (WYCA, 2026)

5. Financial Case

Investment Requirement

With UK healthcare expenditure now exceeding £240 billion annually, marginal reductions in costly acute services could translate into significant savings. Creative Health is therefore attractive because it requires relatively modest investment while offering cost benefits and reduced healthcare utilisation, aligning with NHS priorities to shift care from hospitals into communities and from sickness to prevention.

Intervention	Cost per participant and NHS cost context	Main outcome or economic finding
Community singing for older adults	£18.88 for 14 sessions. Approx. **10% of one average outpatient attendance (£181).**	RCT found reduced anxiety and depression at 3mths, improved quality of life at 6mths. The intervention was marginally more cost-effective than usual activities.
Music for diagnostic / clinical procedures	For paediatric echocardiography, the cost was US$13.21 **producing an estimated saving of US$74.24 per procedure.**	Music reduced procedure time and staff requirements and released 184 registered-nurse hours.
Individualised music for people with dementia	£2.40 per resident per week, or approximately £125 a year. **Annual cost is approx. 69% of one outpatient attendance (£181).**	Personalised music was associated with greater discontinuation of antipsychotic and anxiolytic medication and improvement in behavioural symptoms.
Dance for adolescent mental health	US$670 per participant—approximately £500–£600. **Around 46–56% of an average NHS day case (£1,077).**	RCT reported a 0.10 QALY gain, approx. US$287 lower healthcare costs and an estimated US$3,830 per QALY gained, with a high probability of cost-effectiveness.
Group singing for people with post-stroke aphasia	£344.56–£399.33 per participant (depending on training costs). **Approx. 1.0–1.2 Type 1 A&E attendances (£334 each).**	RCT demonstrated that the programme and its evaluation were feasible and acceptable but was not designed to establish clinical or cost-effectiveness.
Visual arts participation after stroke	£245–£657 per participant (depending on location and group capacity). **Approx.1.4–3.6 outpatient attendances (£181 each).**	RCT found that delivery was effective, and recruitment and attendance affected the cost per participant. It did not provide definitive evidence of effectiveness or cost-effectiveness.
Nature-based wellbeing programmes	£428–£669 per participant. **Approx. 1.3–2.0 Type 1 A&E attendances (£334 each)**	Improvements reported in wellbeing, physical activity, confidence and social trust. Estimated social value ranged from £2.57 to £4.67 per £1 invested.

Long-Term Financial Benefits

The evidence identifies several opportunities to reduce demand across health and care services. These benefits may arise through prevention, earlier intervention, improved self-management and greater engagement with existing pathways. This should be interpreted as potential cost avoidance or efficiency gains, not guaranteed cash savings, until further economic evaluations can provide robust evidence.

Reduced GP appointments

Evaluations report reduced healthcare use: Artlift 37% fewer GP consultations and Tameside social prescribing found 42.2% fewer GP appointments. (APPGAHW, 2017, NASP, 2024)

Reduced A&E attendance

Social prescribing evaluations reported 15–24% fewer A&E attendances and reductions in A&E costs of up to 39% (NASP, 2024).

Reduce hospital admissions

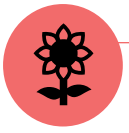
Evaluations associate arts and social prescribing with between 2–27% reductions in hospital admissions (Hou et al., 2026; APPGAHW, 2017).

Reduced falls

Goldsmith and Kokolakakis (2021) reported 58% fewer falls and modelled an estimated £158 million in NHS savings over two years.

Delayed social care need

A systematic review linked sustained cultural engagement to reduced dementia, cognitive decline and frailty risks (Viola et al., 2024).



Improved staff wellbeing and productivity

Creative activities at Manchester University Hospital Foundation Trust improved staff wellbeing and feeling valued, with evidence of reduced burnout and stress (Polley et al., 2023).

A systematic review of arts-based interventions for healthcare workers found evidence of medium-to-large effects on burnout, work-related stress and common mental health problems (Tjasink et al., 2023).

Not all economic or fiscal benefits are immediately cashable. Creative Health may reduce demand and generate fiscal value without producing equivalent immediate budget savings.

The Greater Manchester Combined Authority (GMCA) Research Team (formerly New Economy) pioneered a cost benefit analysis (CBA) methodology to articulate the fiscal, economic and social value of interventions. The GMCA Cashability paper suggests commissioners should distinguish between economic value, fiscal benefit and cashable savings, which may increase when sustained interventions reach scale. The examples given for the NHS distinguish short-term/small-scale from long-term/large-scale cashability, using 20% and 50% respectively to indicate that short-term savings tend to relate to marginal treatment costs, whereas substantial fixed-cost changes require greater scale. (GMCA, 2023)

6. Management Case

Deliverability

Creative Health is highly deliverable because cultural and community assets already exist. The challenge is coordination rather than creation.

The Mobilising Community Assets programme demonstrates the potential to mobilise capacity across cultural, natural and community assets, alongside health, social prescribing and community practitioners (Mughal et al., 2024).

Implementation Approach

Build Infrastructure

- Asset mapping
- Governance
- Evaluation framework
- Workforce development
- Prioritise pathways

Scale Delivery

- Strategic commissioning
- Neighbourhood Health Centre integration
- Population health targeting
- Outcomes dashboard

National Embedding

- Routine commissioning
- Shared metrics
- National evidence platform
- Continuous improvement

funding for service availability should combine stable with payment for delivery and achievement of agreed quality and outcome measures. An illustrative model is:

- **40% service infrastructure and accessibility**
- **40% delivery and engagement**
- **10% quality and reporting: accessibility, safeguarding, data completeness and participant experience;**
- **10% outcomes: agreed improvement in wellbeing, activation, mobility or another relevant measure.**

The final proportions should be determined locally. Quality and outcome payments should use proportionate, risk-adjusted measures and should not expose smaller providers to unsustainable financial risk.

7. Measurement & Accountability

Measurement, governance and accountability should be proportionate to the nature and level of risk of Creative Health activity, reflecting its broad spectrum from clinically embedded interventions and targeted health activity, through social prescribing, to wider community-based cultural engagement. Community-led approaches should retain flexibility for innovation, co-production and outcomes that matter to communities, while clinical interventions and formal care pathways require appropriate governance, risk management and professional oversight.

All commissioned services should collect a standardised minimum dataset, combining economic measures with supplementary outcomes that capture Creative Health's wider, multidimensional impacts.

Core Outcomes	Outcome Measure	Economic use
Health utility	EQ-5D or EQ-VAS	Estimation of QALYs and cost per QALY
Wellbeing	ONS Life Satisfaction	Estimation of WELLBYs and cost per WELLBY
GP utilisation	Number of GP contacts	Estimation of service effects and potential cost consequences
A&E utilisation	Number of A&E attendances	Supporting evidence and understanding of how change occurs

Supplementary measures can include:

- SWEMWBS, Loneliness measures, PHQ-2 / GAD-2
- Self-efficacy, Community participation, Cultural participation

Evaluation Approach

Large-Scale Programmes - Where investment is significant, evaluation should provide stronger evidence of causal impact and value for money. • Matched control groups • Difference-in-Difference analysis • Propensity Score Matching • Interrupted Time Series approaches	**Smaller Programmes -** Where robust control groups are not feasible: • Pre/post measurement • Participant attribution questions • Conservative deadweight adjustments • Qualitative evidence

Reporting requirements

Providers should report:

- ☐ Participation numbers
- ☐ Completion rates
- ☐ Outcome changes
- ☐ Cost per participant
- ☐ Cost per QALY (where possible)
- ☐ Cost per WELLBY (where possible)
- ☐ Healthcare utilisation changes or a self-management scale

*** An annual commissioner dashboard should be developed to monitor performance against key outcomes and commissioning objectives.**

8. Risks & Mitigations

Risk	Potential Impact	Mitigation
Over-reliance on weaker evidence	Some creative health interventions are supported primarily by SROI studies, wellbeing valuation or observational evaluations rather than RCTs or QALY-based analyses.	Prioritise commissioning interventions with the strongest economic evidence base (e.g. Dance to Health, community singing, hospital music interventions, nature-based mental health programmes). Use less mature interventions as pilots or innovation projects.
Modelled savings not realised	Economic projections may overestimate actual NHS savings because many studies model future healthcare reductions rather than directly measure them.	Present projected savings as potential benefits rather than guaranteed cash savings. Distinguish clearly between observed savings and modelled savings within the business case.
Attribution uncertainty	Improvements in wellbeing or reduced healthcare use may partly result from other services or wider life circumstances rather than the creative health intervention alone.	Use robust evaluation designs wherever feasible, including matched comparison groups, quasi-experimental methods or control groups. Collect baseline and follow-up data consistently.
Insufficient local evidence	National evidence may not fully reflect local populations, pathways or service utilisation patterns.	Implement phased roll-out with local evaluation from the outset. Use existing evidence to inform commissioning while building a local evidence base.
Difficulty demonstrating NHS impact due to inconsistent outcome measurement	Benefits may be seen in wellbeing and social outcomes before reductions become visible. Different outcome measures can reduce comparability and limit economic evaluation.	Measure both health outcomes (QALYs, EQ-5D, EQ-VAS) and wider wellbeing outcomes (WELLBYs, life satisfaction, SWEMWBS), alongside GP and A&E utilisation.
Benefits may not be sustained	Some evaluations have relatively short follow-up periods, creating uncertainty around the duration of benefits.	Use conservative assumptions regarding benefit duration and undertake longer-term follow-up where possible. Include sensitivity analysis in economic modelling.
Variation in provider quality	Outcomes may differ depending on facilitator skills, delivery model and participant engagement.	Develop minimum service specifications, workforce standards and quality assurance requirements for commissioned providers.
Low engagement from target populations	Programmes may not reach those most likely to benefit, reducing value for money.	Prioritise referral pathways into high-need populations, including people with long-term conditions, frailty, loneliness, mild-to-moderate mental health needs and communities experiencing health inequalities.
Evidence gaps for some art forms	Limited economic evidence currently for creative writing, crafts, and environmental arts.	Commission these activities within innovation, pilot or research programmes rather than relying on them as the principal economic case for investment.
Governance arrangements that aren't aligned to the intervention	Unclear accountability, safeguarding, risk management or pathway integration may increase delivery risks, particularly for clinical interventions and higher-need populations.	Ensure governance arrangements are proportionate to the intervention. Where creative health forms part of a clinical pathway, establish appropriate oversight, accountability and risk management while maintaining flexibility and community-led delivery.

9. Recommendations & Next Steps

Recommendations

Creative health should be commissioned as part of the neighbourhood health infrastructure, using existing community assets and prioritising populations and pathways where evidence and local need are strongest.

- **Establish system leadership** Identify Creative Health Leads and establish a multi-sector Creative Health board
- **Identity health needs and map community assets** Assess local health needs and align with existing cultural, community, faith and nature-based assets.
- **Commission a defined initial portfolio** Prioritise evidence-supported provision addressing mental health, loneliness, long-term conditions, frailty, falls prevention, rehabilitation and healthy ageing.
- **Invest in provider infrastructure** Use multi-year funding for coordination, workforce development, accessibility, safeguarding and sustainable delivery.
- **Apply consistent standards** Standardise specifications, quality requirements and datasets measuring outcomes, costs and healthcare use.
- **Evaluate, learn and scale** Begin with phased implementation, compare performance against baseline or suitable comparators, and expand provision where outcomes, equity and value for money are demonstrated.

Next Steps

Mobilise

Appoint leadership, establish governance, map assets and agree priority populations.

Design

Co-produce pathways, specifications, measures, funding arrangements and referral processes.

Deliver

Commission an initial portfolio and monitor reach, quality, outcomes, costs and inequalities.

Review & Scale

Assess effectiveness and value, improve delivery and expand successful approaches.

Key principle:

Move from repeated short-term projects to coordinated, evidence-informed infrastructure that enables Creative Health approaches to reduce health inequalities and contribute consistently to effective prevention and neighbourhood care.

Supplementary materials

Section	Description	References
Resources	**DCMS Culture and Heritage Capital –** particularly useful to monetise wellbeing benefits or undertake cost-benefit analysis consistent with HM Treasury Green Book principles	Department for Digital, Culture, Media and Sport (2025) *Culture and Heritage Capital Portal*. London: DCMS. Available at: https://www.gov.uk/guidance/culture-and-heritage-capital-portal Department for Culture, Media and Sport (2021) *Valuing culture and heritage capital: a framework towards informing decision making*. London: DCMS. Available at: https://www.gov.uk/government/publications/valuing-culture-and-heritage-capital-a-framework-towards-decision-making/valuing-culture-and-heritage-capital-a-framework-towards-informing-decision-making
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	National Centre for Creative Health – current UK policy recommendation	National Centre for Creative Health (NCCH) and All-Party Parliamentary Group on Arts, Health and Wellbeing (2023) *Creative health review: how policy can embrace creative health*. Oxford: NCCH. Available at: https://ncch.org.uk/creative-health-review
	National Academy for Social Prescribing – introduces value-for-money and return-on-investment arguments	Polley, M., Seers, H., Toye, O., Henkin, T., Waterson, H., Bertotti, M. and Chatterjee, H.J. (2023) *Building the economic case for social prescribing*. London: National Academy for Social Prescribing. Available at: https://socialprescribingacademy.org.uk/nasps-evidence-reports/building-the-economic-case-for-social-prescribing/
	What Works Centre for Wellbeing – independent evidence reviews and synthesis on the relationship between culture, arts, sport and wellbeing outcomes	What Works Centre for Wellbeing. (2019). *Culture, arts and sport evidence programme*. London: What Works Centre for Wellbeing. Available at: https://whatworkswellbeing.org/category/culture-arts-and-sport/

Executive summary (page 5)	**Music**	Dirven, T.L., Kappen, P.R., van der Beek, F.T.H. *et al.* (2025). The effect of music interventions compared to standard-of-care on the prevention of delirium in neurosurgical patients: an analysis of costs and cost-effectiveness based on the MUSYC-trial. *Acta Neurochirurgie,* 167, 46. https://doi.org/10.1007/s00701-025-06448-0
	Dance	Goldsmith, S. and Kokolakakis, T. (2021). A cost-effectiveness evaluation of dance to health: a dance-based falls prevention exercise programme in England. *Public Health*, 198, 17–21. https://doi.org/10.1016/j.puhe.2021.06.020
	Visual arts	Jones, C., Windle, G. and Edwards, R.T. (2020). Dementia and imagination: a social return on investment analysis framework for art activities for people living with dementia. *Gerontologist,* 60(1), 112–123. https://doi.org/10.1093/geront/gny147
	Creative writing	Taylor, L.A., Wallander, J. L., Anderson, D., Beasley, P., and Brown, R.T. (2003). Improving health care utilization, improving chronic disease utilization, health status, and adjustment in adolescents and young adults with cystic fibrosis: A preliminary report. *Journal of Clinical Psychology in Medical Settings*, 10(1), 9–16. https://doi.org/10.1023/A:1022897512137
	Nature-based crafts – improved wellbeing, physical activity, €1.48 social value per €1 invested	Papon, A., Puntscher, S., Masó-Aguado, M. *et al.* (2026). Evaluating the social return on investment of nature-based social prescribing to alleviate loneliness: a randomised controlled trial in Barcelona. *Frontiers in Public Health: Health Economics,* 14. https://doi.org/10.3389/fpubh.2026.1774155
	Cultural attendance and mental health – Frontier calculates £649 per person per year for adults aged 30–49 attending cultural events once a week or more, using the Green Book	Wang, S., Mak, H.W. and Fancourt, D. (2020). Arts, mental distress, mental health functioning and life satisfaction: fixed-effects analyses of a nationally-representative panel study. *BMC Public Health,* 20(208). https://doi.org/10.1186/s12889-019-8109-y

	Cultural engagement and depression – Frontier monetises the resulting reduction in depression risk at £314 per person per year, comprising quality-of-life, NHS/social-care and productivity benefits	Fancourt, D. and Steptoe, A. (2019). Cultural engagement and mental health: Does socio-economic status explain the association? *Social Science & Medicine*, 112425(236). https://doi.org/1016/j.socscimed.2019.112425
Clinical value (page 8)	**Clowning –** reduced anxiety, pain and surgical care costs	Kocherov, S., Hen, Y., Jaworowski, S. *et al.* (2016). Medical clowns reduce pre-operative anxiety, post-operative pain and medical costs in children undergoing outpatient penile surgery: a randomised controlled trial. *Journal of Paediatric Child Health,* 52(9):877–81. https://doi:10.1111/jpc.13242
	Creative writing – reduced health utilisation and self-management of cystic fibrosis	Taylor, L. A., Wallander, J. L., Anderson, D. *et al.* (2003). Improving health care utilization, improving chronic disease utilization, health status, and adjustment in adolescents and young adults with cystic fibrosis: A preliminary report. *Journal of Clinical Psychology in Medical Settings,* 10(1), 9–16. https://doi.org/10.1023/A:1022897512137
	Dance – feasible rehabilitation programme improving recovery after brain injury	Adey-Wakeling, Z., Block, H., Hutchins, S. *et al.* (2026). Impact of a therapeutic dance program compared with circuit physiotherapy in rehabilitation of older people with recent acquired brain injury: a randomized controlled feasibility trial with embedded qualitative assessment. *Arch Archives of Rehabilitation Research and Clinical Translation,* 23, 8(2),100587. https://doi:10.1016/j.arrct.2026.100587
	Music – reduced ICU anxiety and favourable cost-effectiveness outcomes	Chlan, L.L., Heiderscheit, A., Skaar, D.J. et al. (2018). Economic evaluation of a patient-directed music intervention for ICU patients receiving mechanical ventilatory support. *Critical Care Medicine,* 46(9), 1430–1435. https://doi.org/10.1097/CCM.0000000000003199
	Music – prevented delirium, improving outcomes and cost-effectiveness	Dirven, T.L., Kappen, P.R., van der Beek, F.T.H. *et al.* (2025). The effect of music interventions compared to standard-of-care on the prevention of delirium in neurosurgical patients: an analysis of costs and cost-effectiveness based on the MUSYC-trial. *Acta Neurochirurgie,* 167, 46 https://doi.org/10.1007/s00701-025-06448-0

Prevention and harm reduction value (page 9)	**Dance –** reduced falls by 58%, generating substantial NHS savings	Goldsmith, S. and Kokolakakis, T. (2021). A cost-effectiveness evaluation of dance to health: a dance-based falls prevention exercise programme in England. *Public Health*, 198, 17–21. https://doi.org/10.1016/j.puhe.2021.06.020
	Dance – dance for mental health with 0.10 QALYs gained saving $287	Philipsson, A., Duberg, A., Möller, M. *et al.* (2013). Cost-utility analysis of a dance intervention for adolescent girls with internalising problems. *Cost Effectiveness and Resource Allocation,* 11(1), 4. https://doi:10.1186/1478-7547-11-4
	Singing – community singing for postnatal depression gained 0.041 QALYs	Bind, R.H., Sawyer, K., Hazelgrove, K. *et al.* (2023). Feasibility, clinical efficacy, and well-being outcomes of an online singing intervention for postnatal depression in the UK: SHAPER-PNDO, a single-arm clinical trial. *Pilot Feasibility Studies,* 9, 131. https://doi:10.1186/s40814-023-01346-5
	Nature-based care farming – improved quality of life, costing £14,232 less than comparator	Elsey, H., Bragg, R., Elings, M. *et al.* Cade JE, Brennan C, Farragher T, et al. Impact and cost-effectiveness of care farms on health and well-being of offenders on probation: a pilot study. *Public Health Research*. 6(3). Southampton: NIHR Journals Library. https://doi:10.3310/phr06030
	Visual arts – arts-based dementia support delivered £5.18 social return per £1	Jones, C., Windle, G. and Edwards, R.T. (2020). Dementia and imagination: a social return on investment analysis framework for art activities for people living with dementia. *Gerontologist,* 60(1), 112–123. https://doi.org/10.1093/geront/gny147
Social value (page 9)	**Music and dance –** improved social connection, quality of life, cost-effectiveness	Clifford, A.M., Cheung, P.S., O'Malley, N. *et al.* (2024). Findings from a pragmatic cluster randomised controlled feasibility trial of a music and dance programme for community dwelling older adults. *Archives of Gerontology and Geriatrics,* 122, 105371. https://doi.org/10.1016/j.archger.2024.105371
	Nature-based crafts – improved wellbeing, physical activity, £2.57–£4.67 return per £1.	Hartfiel, N., Gittins, H., Morrison, V. *et al.* (2023). Social return on investment of nature-based activities for adults with mental wellbeing challenges. *Int J Environ Res Public Health,* 2, 20(15), 6500. https://doi:10.3390/ijerph20156500
	Nature-based crafts – improved wellbeing,	Papon, A., Puntscher, S., Masó-Aguado, M. *et al.* (2026). Evaluating the social return on investment of nature-based social prescribing to alleviate loneliness: a randomized

	physical activity, €1.48 social value per €1 invested	controlled trial in Barcelona. *Frontiers in Public Health: Health Economics,* 14. https://doi.org/10.3389/fpubh.2026.1774155
	Nature-based crafts – improved wellbeing and self-efficacy, reducing GP demand	Whiteley, H., Lynch, M., Hartfiel, N. *et al.* (2025). Health economics-informed social return on investment (SROI) analysis of a nature-based social prescribing craft and horticulture programme for mental health and wellbeing. *International Journal of Environmental Research and Public Health,* 22(8), 1184. https://doi.org/10.3390/ijerph22081184
	Visual Arts – improved wellbeing and cognition, £1.20 return per £1 invested.	Bosco, A., Schneider, J., and Broome, E. (2019). The social value of the arts for care home residents in England: a social return on investment (SROI) analysis of the Imagine Arts programme. *Maturitas,* 124, 15–24. https://doi:10.1016/j.maturitas.2019.02.005
General population wellbeing value (page 10) As part of DCMS CHC programme, research was conducted by Frontier to monetise the health and wellbeing impacts of engaging with culture and heritage	**Green book aligned economic evaluations**	Frontier Economics. (2024). *Culture and Heritage Capital: monetising the impact of culture and heritage on health and wellbeing*. London: Department for Culture, Media and Sport.
	Cultural engagement and depression – Frontier monetised the reduction in depression risk at £314 per person per year, comprising quality-of-life, NHS/social-care and productivity benefits	Fancourt, D. and Steptoe, A. (2019). Cultural engagement and mental health: does socio-economic status explain the association? Soc Sci Med, 236, 112425. https://doi:10.1016/j.socscimed.2019.112425
	Cultural attendance and mental health – Frontier Economics calculated £649 per person per year for adults aged 30–49 attending cultural events once a week or more, using the	Wang, S., Mak, H.W., Fancourt D. (2020). Arts, mental distress, mental health functioning & life satisfaction: fixed-effects analyses of a nationally-representative panel study. *BMC Public Health,* 11, 20(1), 208. https://doi: 10.1186/s12889-019-8109-y

	Green Book valuation.	
	General engagement with culture and heritage – Frontier Economics estimated £992 per person per year for adults aged 30–49 engaging every few months or more.	Elsden, E., Bu, F., Fancourt, D. *et al.* (2022). Frequency of leisure activity engagement and health functioning over a 4-year period: a population-based study amongst middle-aged adults. *BMC Public Health,* 30, 22(1), 1275. https://link.springer.com/article/10.1186/s12889-022-13670-3
	General engagement with galleries and museums	Australia Council for the Arts (2015). *Arts Nation: an overview of Australian arts*. Sydney: Australia Council for the Arts. Available at: https://creative.gov.au/sites/creative-australia/files/documents/2025-03/arts-nation-october-2015-5638269193891.pdf
	General engagement with libraries	Gordon, J., Blackett, A., Fordham, R. *et al.* (2023). *Libraries for living, and for living better: The value and impact of public libraries in the East of England*. UEA Publishing Project. Available at: https://ueaeprints.uea.ac.uk/id/eprint/92105/
Strategic opportunity – system challenge impact (page 11)	**Rising demand –** driven by comorbidities, health inequalities, and growing pressure on services with limited capacity for prevention	Darzi A. (2024). *Independent Investigation of the National Health Service in England*. London: Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england
	Low engagement – with services, particularly among high-need groups	Local Government Association. (2025). *Place and Health: bridging the gap in health inequalities*. London: LGA. Available at: https://www.local.gov.uk/publications/place-and-health-bridging-gap-health-inequalities. [local.gov.uk] Care Quality Commission. (2025). *Addressing Health Inequalities through Engagement with People and Communities*. Newcastle upon Tyne: CQC; Available at: https://www.cqc.org.uk/local-systems/integrated-care-systems/framework-engaging-people-and-communities/health-inequalities-engagement-framework. [cqc.org.uk], [cqc.org.uk]
	Fragmented services operating in silos	NHS England. *Integrated Care Systems: guidance*. (2024 - originally published 2021). London: NHS England; Available at: https://www.england.nhs.uk/publication/integrated-care-systems-guidance/

Strategic opportunity – evidence (page 10)	**Arts on Prescription –** CHWA reports that Arts on Prescription, Gloucestershire demonstrated a 37% reduction in GP consultation rates and a 27% reduction in hospital admissions, alongside a social return on investment of £4 to £11 for every £1 invested	Culture, Health & Wellbeing Alliance. *Social Prescribing: facts and links*. Available at: https://www.culturehealthandwellbeing.org.uk/key-themes/social-prescribing
	Singing for postnatal depression – study underpinned the Melodies for Mums programme, found mothers with moderate to severe postnatal depression experienced approximately 35% reduction in symptoms within six weeks	Fancourt, D., Perkins, R., Ascenso, S. *et al.* (2028). Effect of group singing interventions on symptoms of postnatal depression: three-arm randomised controlled trial. *British Journal of Psychiatry,* 212(2), 119–121. doi:10.1192/bjp.2017.29. https://journals.sagepub.com/doi/abs/10.1177/0305735617742197
	Community health screening – sport-based health intervention	Sankaranarayanan, R., Hartshorne-Evans, N., McLean, L. *et al.* (2025). *Early detection of cardiorespiratory diseases at Everton BEAT-Breathlessness Community Hub: how football can help save lives*. JACC: Heart Failure. Available at: https://pubmed.ncbi.nlm.nih.gov/40047766/
	ReCITE blog – NCCH	National Centre for Creative Health. (2025). *Four lessons from creative health strategies across the UK*. NCCH Blog. Oxford: NCCH. Available at: https://ncch.org.uk/blog/four-lessons-from-creative-health-strategies-across-the-uk
Commercial case (page 12)		Association of Independent Museums (AIM). (2024). *Economic Impact of the Independent Museum Sector: 2024 economic impact key findings report*. Association of Independent

	Museums. Available at: https://aim-museums.co.uk/resources/economic-impact-of-independent-museum-sector/ Department for Culture, Media and Sport (DCMS). (2026). *DCMS Sectors Economic Estimates 2024 (provisional): gross value added*. London: Department for Culture, Media and Sport. Available at: https://www.gov.uk/government/statistics/dcms-economic-estimates-gva-2024-provisional National Council for Voluntary Organisations (NCVO). (2024). *UK Civil Society Almanac 2024*. London: NCVO. Available at: https://www.ncvo.org.uk/news-and-insights/news-index/uk-civil-society-almanac-2024/ Social Enterprise UK. (2025). *State of Social Enterprise 2025: backbone of Britain*. London: Social Enterprise UK. Available at: https://www.socialenterprise.org.uk/seuk-report/backbone-of-britain-state-of-social-enterprise-2025/ West Yorkshire Combined Authority. (2026). *New programme to boost health and back the NHS through creativity in West Yorkshire*. Available at: https://www.westyorks-ca.gov.uk/news/new-programme-to-boost-health-and-back-the-nhs-through-creativity-in-west-yorkshire/
Long-term financial benefits (page 14)	All-Party Parliamentary Group on Arts, Health and Wellbeing (2017). *Creative Health: The Arts for Health and Wellbeing*. London: APPG on Arts, Health and Wellbeing. Available at: https://ncch.org.uk/appg-ahw-inquiry-report National Academy for Social Prescribing. (2024). *The Impact of Social Prescribing on Health Service Use and Costs: examples of local evaluations in practice*. London: NASP. Available at: https://socialprescribingacademy.org.uk/media/t13fg02l/the-impact-of-social-prescribing-on-health-service-use-and-costs.pdf Hou, B., Moss, R.H., Hammad, M. *et al.* (2026). Can social prescribing intervention reduce unplanned hospital usage in an ethnically diverse and deprived population: a quasi-experimental study using a dynamic staggered difference-in-differences approach. *BMJ Open*, 16(5), e107259. https://bmjopen.bmj.com/content/16/5/e107259 Goldsmith, S. and Kokolakakis, T. (2021). A cost-effectiveness evaluation of dance to health: a dance-based falls prevention exercise programme in England. *Public Health*, 198, 17–21. https://doi.org/10.1016/j.puhe.2021.06.020 Viola, E., Martorana, M., Ceriotti, D. *et al.* (2024). The effects of cultural engagement on health and well-being: a systematic review. *Frontiers in Public Health*, 12, 1369066. https://doi.org/10.3389/fpubh.2024.1369066 Polley, M., Seers, H. and Sabey, A. (2023). *Evaluation of Create+ A Lime arts and health wellbeing project with NHS*

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Management case (page 15)	Mughal, R., Reynolds, R., Thomson, L.J. *et al*. (2024). *Mobilising Community Assets to Tackle Health Inequalities: a synthesis and review of Phase 2 case studies*. London: University College London Available at: https://ncch.org.uk/uploads/MCA_Phase-2_Case_Study_Synthesis.pdf

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