Creative Health Economics:

Building the foundations for a commission-ready sector

MOBILISING COMMUNITY ASSETS

National Centre for Creative Health

UKRI Arts and Humanities Research Council

UCL

Contents

About this report

This Creative Health Economics report is part of the Mobilising Community Assets to Tackle Health Inequalities research programme to bridge the field of economics with creative health evaluation methods and support investment in Creative Health across the UK. It provides the research background to resources for the public sector, commissioners, and providers.

- Public Sector: *Guidelines on Economic Evaluation in Creative Health* (August 2026), available at: https://ncch.org.uk/uploads/Guidelines-on-Economic-Evaluation-in-Creative-Health.pdf
- Commissioners: Creative Health Commissioning: An *Economic Business Case for Creative Health* (August 2026), available at: https://ncch.org.uk/uploads/Creative-Health-Commissioning_An-Economic-Business-Case.pdf
- Creative Health Providers: Delivering Commission-ready Creative Health: *The Economic Business Case for Investment* (August 2026), available at: https://ncch.org.uk/uploads/Delivering Commission-ready Creative Health: The Economic Business Case for Investment.pdf

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> "The evidence for creative health is growing, and so is the case for investment. Alongside improvements in health and wellbeing and growing evidence of social and economic value, creative health helps us better understand the communities we serve. At a time when strategic commissioning is increasingly focused on population needs, outcomes and prevention, creative health offers both a powerful intervention and a valuable source of insight for better investment decisions."
>
> **Stephen Sandford - Strategic Lead for Neighbourhood Health and Chief Allied Health Professions Officer, NHS Lancashire and South Cumbria Integrated Care Board**

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> "The evidence base for investing in creative health is growing and increasingly points to value for money with interventions that can ease pressure on stretched services while improving people's health and wellbeing. For commissioners under real financial pressure, that's a compelling case for investment, grounded in evidence rather than good intentions."
>
> **Ellie Hobart, Deputy Director of Health Equity and Inclusion, NHS North East London ICB**

Sketching the Landscape

Insights from Creative Health Economics Research

1. Executive Summary

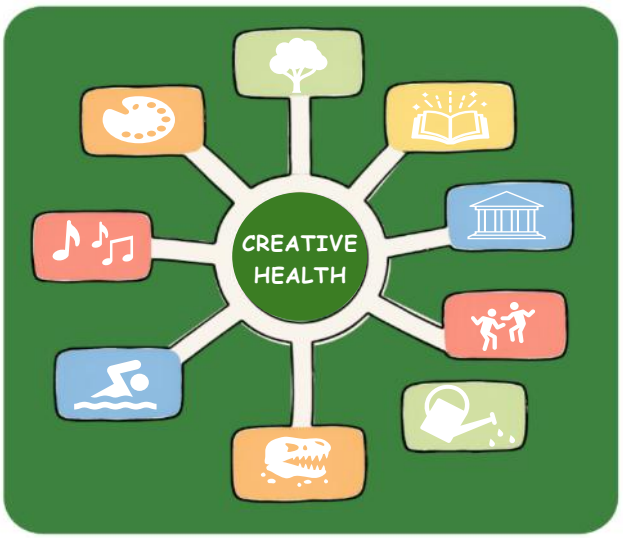
THE CHALLENGE

Creative health generates health, social, cultural, equity and economic value, but investment remains limited.

Existing economic evidence is promising but fragmented, inconsistent and uneven across interventions.

Commissioners need comparable outcomes, transparent costs and credible evidence aligned with NHS and HM Treasury requirements.

Conventional economic evaluation approaches overlook relational, preventative and lived-experience dimensions of value.



THE RESEARCH

Synthesised evidence from systematic and scoping reviews of creative health and social prescribing.

Mapped evaluation practices, data and economic activity across the MCA programme.

Gathered insights from project leads, health-system leaders, funders, practitioners and people with lived experience.

Tested Green Book-aligned methods through exploratory economic evaluations of two creative health projects.

Co-produced guidance and business-case resources for providers and commissioners.

THE FINDINGS

The sector is not data-poor: valuable data exist but remain disconnected and under-translated into economic evidence.

Economic findings are strongest in some hospital-based music interventions and cultural engagement, with promising evidence for dance and nature-based activity.

Small providers face limited evaluation capacity, inconsistent funder requirements and restricted access to health-service data.

Economic claims are more credible when methods, assumptions, uncertainty and full delivery costs are transparent.

A shared core dataset should be combined with flexible measures reflecting local context and participant priorities.

THE NEXT STEPS

Agree and implement a proportionate national minimum dataset for creative health.

Test the guidance through collaborative, place-based demonstrator sites involving diverse populations and interventions.

Connect community evidence with NHS, public health and social care data through shared infrastructure.

Build evaluation partnerships involving academia, health systems, local authorities, VCFSE organisations and lived-experience contributors.

Strengthen evidence of creative health's contribution to prevention, equity, service capacity, workforce wellbeing and inclusive economic growth.

2. Background

The Mobilising Community Assets to Tackle Health Inequalities (MCA) programme identified a persistent challenge across the creative health ecosystem: despite growing evidence of the health and wellbeing benefits of creative health interventions, investment from health and public health systems remains limited. Sajnani and Fietje (2023) identify several barriers, including the perceived separation between arts and science, the complexity of creative interventions and their mechanisms of action, and insufficient investment in large-scale research examining effectiveness and scalability.

Economic evaluation for this sector remains particularly underdeveloped. Davies et al. (2026) provide the first national-level assessment of the economic impact of the arts on the NHS and social care in Wales and demonstrate the potential of Creative Health Economics as an emerging field. Equally, the Department for Culture, Media and Sport's Culture and Heritage Capital programme provides important foundations for creative health economics by standardising how cultural assets and their health, wellbeing and societal benefits are identified, measured and valued (DCMS, 2026).

Economic evidence for creative health that is aligned with NHS commissioning processes and HM Treasury Green Book requirements is limited. Diverse methods, inconsistent data and unsuitable evidence formats make findings difficult for commissioners to compare, interpret, and apply. A lack of shared language between creative health practitioners and health-system stakeholders further limits adoption at scale.

In response, this workstream adopted a whole-system approach. It explored how creative health operates within health and public health systems, what enables successful commissioning, how evaluation is undertaken in delivery settings, whether social prescribing affects healthcare utilisation, and how people with lived experience understand value and quality of life. It also identified opportunities to improve consistency in data collection, economic evaluation and evidence use.

Three interconnected work packages supported this activity:

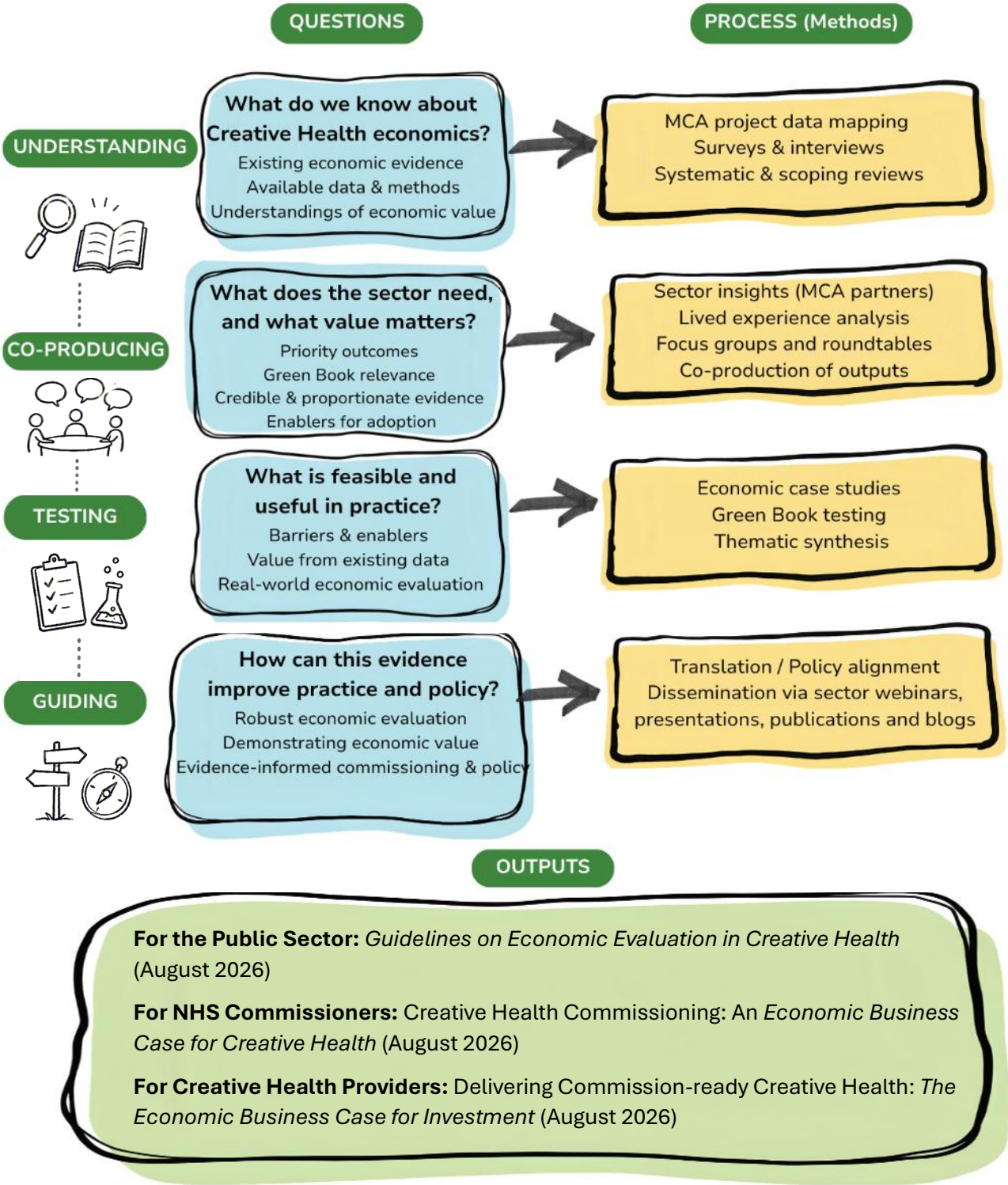
- **Ecosystems and commissioning readiness:** mapping creative health and public health ecosystems, identifying enabling conditions and co-producing guidance on commissioning readiness, data alignment and dashboard development.
- **Evidence base and health service utilisation:** systematically reviewing existing economic evidence and analysing whether referrals to creative health interventions reduce healthcare use and pressure on NHS services.
- **Business case and economic evaluation:** developing Treasury-aligned evaluation frameworks, equity analysis and practical guidance, culminating in a UK-wide business cases for creative health.

Together, the work packages moved beyond reviewing published studies. They combined evidence synthesis, ecosystem mapping, real-world evaluation practice, lived-experience perspectives and social-prescribing data to strengthen the evidence base, support commissioning decisions, and create practical resources for more sustainable investment in creative health.

3. Participatory Research Process

This creative health economics research uses a participatory action research approach, blended with established research methods, including interviews, focus groups, surveys, and evidence reviews, to capture 360-degree input from commissioners, providers and participants (Figure 1). These different forms of lived, professional and health system experience are placed at the forefront of understanding current practice, identifying which benefits matter and what value means to co-produce evidence and guidance resources that are credible and useful in practice (Minkler et al., 2003; Oetzel et al., 2018).

Figure 1. Creative Health Economics Research Framework



4. Mapping Ecosystems and Understanding Value

MCA projects contributed to this creative health economics research by sharing how evidence is generated, interpreted, and used in community settings. Across the portfolio, they identified current quantitative and qualitative practices, alongside practical, methodological and ethical challenges in measuring holistic, person-centred participation and capturing complex, relational, and intangible outcomes in practice.

Partnerships with **NHS organisations, local authorities, community groups and voluntary-sector providers** revealed opportunities for collaborative data collection, referral pathways and evidence generation. Project teams also identified effective participant engagement and trust-building strategies, as well as the support, infrastructure, skills and co-production approaches needed to strengthen future creative health economic research.

Arts4Us: Building the Economic Evidence Base for Children and Young People's Creative Health (Preprint)

The Arts4Us team's systematic review of creative health interventions for children and young people identified a growing evidence base alongside challenges in evaluating preventative, developmental and long-term outcomes, including improvements in wellbeing, confidence, resilience, social connection, educational engagement and mental health. It reports social return on investment (SROI) ratios returning £1.98 – £7 per monetary unit invested. When longer term impact is considered benefit-cost ratios suggest that for every monetary unit invested there is return of £5.89 – £32. The reporting quality in 11 studies was strong, and the findings aligned with those from less well-reported studies. The review highlights the need for robust approaches capturing short- and long-term benefits for children, families, and public services. (Preprint: Flynn et al., 2026).

Creative Health Boards: Democratising How Creative Health Value is Measured

The Creative Health Boards project sought to democratise valuation by enabling voluntary, community, and social enterprise providers and participants to generate meaningful evidence. It explored practical, low-burden approaches using Wellbeing Life Years (WELLBYs) and the Patient Activation Measure (PAM). WELLBYs translate changes in life satisfaction into monetary values using HM Treasury guidance, while PAM estimates potential reductions in healthcare demand arising from improvements in people's ability to manage their health. (Dayson, C. 2025).

MCA illustrative designs are taken from Creative Minutes by www.temjam.com as part of a Mobilising Community Assets Online Knowledge Exchange

MigRefHealth: Integrating Social, Economic and Human Perspectives

MigRefHealth uses a multi-dimensional approach to understand how migrant and refugee support creates value across individual, service, organisational and wider structural levels. A key methodological contribution is the use of paired provider–beneficiary data, allowing beneficiaries' experiences to be linked to the organisational conditions under which support is delivered. More favourable service quality is associated with better physical and mental health, quality of life, autonomy, independence, hopefulness and future outlook, while more responsive wider support services are also associated with economic participation. Safer housing and stable internet access are associated with better physical and mental health. More frequent discrimination is associated with poorer assessments of service quality, service fit and food quality, and stronger demand for improvement. Volunteer involvement is associated with more positive beneficiary experiences. The organisational case studies complement this analysis by showing how early intervention, sustained support and coordinated, language-sensitive care can strengthen stability, independence and continuity while reducing pressure on more intensive services. The case studies also provide invest-to-save assessments for commissioners, including the value of moving clients from crisis to greater stability and the value of personalised care in reducing NHS resource use.

REALITIES in Health Disparities: researching evidence-based alternatives in living, imaginative, traumatised, integrated, embodied systems

This Scottish consortium uses a novel health economics approach to explore the feasibility and usefulness of some 'standard' health economic evaluation tools within the REALITIES model context, settings and populations (ex-offenders; young people at the edge of care; asylum seekers; refugees and economic migrants; those experiencing mental ill health and/or in recovery; people with (learning) disabilities). They continuously work with local communities to re-conceptualise and re-define measures of 'value' and 'quality of life' to help assess how community assets and co-design can lead to alternative community-led economic models informed by creative-relational infrastructures.

Understanding the real costs of creative health delivery

MCA project leads and partners highlighted a persistent challenge in how creative health activities are costed and valued. Providers reported that commissioning models often focus on affordability, cost per participant, and short-term savings, often overlooking the resources required to deliver high-quality, sustainable services. Partners also emphasised the importance of recognising participant costs, including transport, childcare, digital access, and accessibility support, which can significantly affect participation and contribute to health inequalities. Similarly, training, workforce development, supervision, evaluation, project management, and organisational infrastructure are often underestimated.

Valuing effective engagement and building trusting relationships

MCA projects also recognised how relational activities were often overlooked, including trust-building, safeguarding, partnership coordination and long-term engagement. This demonstrates the crucial role of community researchers, connectors, and ambassadors who bridge communities and health services, encouraging engagement and integration, representing a much-needed shift from hierarchical models of healthcare delivery towards collaborative, networked and relationship-based approaches better equipped to address complex health inequalities.

Notably, all MCA projects acknowledged that conventional economic evaluation measures can be challenging within creative health settings. Projects reported that the questions required for health economic valuation are often perceived by both participants and providers as intrusive and poorly aligned with creative health practice. In response, some project evaluations use population-level data rather than individual participant data to assess changes in service use and uptake against a counterfactual and participatory approaches that prioritise outcomes meaningful to communities are being further explored.

The challenge of linking creative health outcomes with healthcare utilisation data is not simply a matter of skill or evaluation capacity. Arts, culture and community organisations rarely have direct access to patient-level or routine health-system data. They also may not have the governance arrangements, secure infrastructure or analytical permissions required to store and analyse them. Robust economic evaluation therefore requires partnership rather than expecting individual providers to undertake every measure independently.

Equally, providers should not be expected to access or analyse complex healthcare data in isolation. Their contribution is to provide accurate information about what was delivered, to whom, at what intensity and cost, alongside participant outcomes and experience. Where healthcare utilisation or linked population data are required, commissioned creative health programmes should establish partnerships with NHS, public health and/or academic organisations that have the necessary data sharing permissions, infrastructure and analytical expertise.

> "The NHS is on is under huge pressure. As the ten year plan outlines, this is in large part because we continue to focus on responding to ill-health, rather than creating a society of wellbeing. We need to think creatively to address the needs of our populations. Effectively measuring creative health benefits in language commissioners understand is essential to demonstrate value, inform investment decisions and embed prevention within mainstream health and care."
>
> **Prof Andy Knox MBE, Co-Medical Director NHS Lancashire and South Cumbria Integrated Care Board, GP Partner, Ash Trees Surgery, Carnforth**

5. Foregrounding Lived Experience

Lived experience involvement is a central practice and principle within creative health and is evident across all MCA projects. Co-production is used both to understand core issues and design service delivery (see McNeill et al., 2026), as well as to construct qualitative evaluations (see Clini, Thomson and Chatterjee, 2019). However, lived experience perspectives are often absent from health economic evaluations, suggesting that assumptions about what constitutes 'value' and which methods are appropriate for measuring it go unchallenged.

Participatory Action Research (PAR) sessions with community-embedded researchers (CERs) in the REALITIES project and the scoping interviews with the other MCA projects explored experiential definitions of 'value' and the relational trust necessary before data collection. Alternative outcome measures were tested through co-developed outcome questionnaires with REALITIES' CERs, trialling methods which engage with contextual understandings of value.

The following differences in research practices and principles highlight areas where cross-disciplinary collaboration is needed (Table 1). Working across these areas can support the development of health economic evaluations that genuinely incorporate lived experience perspectives of 'value':

Table 1: Differences Between Economic Evaluation Practices and Creative Health Practices

	ECONOMIC EVALUATION PRACTICES	CREATIVE HEALTH PRACTICES
Pre-intervention Data Collection	Baseline data collection	Builds relationships and trust first
Duration and Participant Group	Bounded duration and participant group	Ongoing and open-door activities
Defining 'Benefits'	Predefined outcome measures, often those that can be valuated	Centres lived experience knowledge and definitions
Bounds of 'Health'	Focus on physical health and illness	Focus extends to prevention, awareness raising, and systems change
Level of Measures of Health	Individual-level	Community-level
Presenting Results	Presents aggregate value	Concerned with health disparities

Importantly, co-production must extend to evaluation methods. Incorporating lived experience involves both conceptual and practical questions; the question of what should be measured concerns the assumptions of *what* 'benefits' mean, and the question of *how* these benefits should be measured deals with the practices of data collection. Moving beyond simply including lived experience perspectives, economic evaluation practices must be guided by lived experience practices – relational and trust-based data collection which is attentive to the diverse and often intangible benefits to community members.

6. Case Studies: Economic Evaluation of MCA Creative Health Projects

An economic evaluation was conducted of two MCA partner creative health projects, applying this Green Book-aligned framework (see Section 7) to the greatest extent possible. A key aim of this study was to assess the extent to which current data collection and evaluation practices within the creative health sector are sufficient to support high-quality economic evaluation, and to demonstrate what can currently be achieved using the best available programme data. In both cases, the available outcome data centred on wellbeing measures, so wellbeing benefits were treated as the primary quantified benefit and a limited number of secondary benefits were inferred from the wellbeing change observed.[1] Table 2 outlines the application of the guidance's key features and highlights some of the assumptions and adjustments applied.

These assumptions and adjustments allowed for an exploratory application of the guidance despite the use of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) and Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), which are not valuated outcome measures, and the absence of a concurrent control group. Health and social care service use data were not gathered directly from participants; instead, secondary benefits are estimated from the relationship between SWEMWBS score changes and healthcare use in the UK Household Longitudinal Study - Understanding Society (USoc) panel, which is itself based on self-reported data. This represents a limitation in two respects, as the secondary benefits are both estimated rather than observed directly and drawn from a data source with its own reporting limitations. Additionally, only four secondary benefits were estimated and monetised – GP visits, outpatient attendances, hospitalisation, and presenteeism, where applicable. This assessment highlighted the limitations of the data currently available to properly analyse the secondary benefits of the programmes, the results of which are considerably lower than expert consensus would suggest.

Table 2: Applying Economic Evaluation Guidance and Adjusting for Missing Data

ACTION	METHOD	RATIONALE
Valuating Primary Benefits	Used WELLBY framework and longitudinal data from Understanding Society (USoc)	To place monetary value on primary benefits
Estimating Secondary Benefits	Used USoc data to estimate the relation between SWEMWBS score changes and different secondary outcomes	To estimate secondary outcomes (spillover effects from primary benefits)
Valuating Secondary Benefits	Used external unit cost and earnings data to estimate monetary value of secondary outcomes	To place monetary value on changes in secondary outcomes
Creating a Control Group	Used USoc data, Propensity Score matching (PSM), and Difference-in-differences (DiD) model	PSM to match participant characteristics to control group characteristics and DiD to account for deadweight
Adjusting for Benefit Duration	Used a 0.5 duration factor (DCMS Culture and Heritage Capital Programme (2024) assumption)	To adjust benefits to account for how benefits of programme are sustained over time
Comparing Costs and Benefits	Calculated ratio between benefits and costs	To demonstrate the return for every £1 invested

[1]The terms primary and secondary benefits follow the Green Book aligned framework used throughout this assessment. In this application, however, secondary benefits reflect only the portion of effect operating through the wellbeing pathway measured (SWEMWBS/WEMWBS); any direct effect of the programmes on these outcomes not mediated via wellbeing is not captured, so the figures represent a lower bound. A full assessment of social value would need to incorporate outcomes beyond those mediated via wellbeing.

Table 3: Findings for Flip of the Coin

FLIP OF THE COIN, PER BENEFICIARY	
Cost	£756.48
Primary Value	£10,043.68
Secondary Value	£76.58
Total Social Value	£10,120
Return for Every £1 Invested	£13.38

**Figures after adjusting for deadweight and duration factor*

Flip of the Coin combines creativity, nature, and community connection in its work with people who have lived experience of intergenerational trauma, poverty, poor mental health, substance use, and contact with the criminal justice system. It is based in the Scottish Highlands and is part of the wider REALITIES network of creative health hubs across Scotland (Table 3). This economic evaluation was conducted with 33 participants, using WEMWBS as an outcome measure.

Table 4: Findings for Odd Arts

ODD ARTS, PER BENEFICIARY	
Cost	£707.30
Primary Value	£9,008.96
Secondary Value	£20.79
Total Social Value	£9,030
Return for Every £1 Invested	£12.77

**Figures after adjusting for deadweight and duration factor*

Odd Arts' Wellbeing Your Way programme uses theatre and creative activities in custodial, community, and school settings which face inequalities and disadvantages in Manchester (Table 5). This economic evaluation was conducted with 61 participants, using SWEMWBS as an outcome measure. Odd Arts are part of the Arts4Us partnership network.

Implications

Creative Health demonstrates significant social value, with the largest share coming from primary wellbeing benefits, meaning direct improvement in participants' quality of life.

*** The analysis of Flip of the Coin and Odd Arts should be regarded as an exploratory and pragmatic application of economic evaluation to the best available creative health data, using the principles of the Green Book wherever possible, rather than a definitive causal assessment of programme impact.**

**** The small secondary benefit figures should not be read as a lack of wider effect. They are likely to be underestimated given the limitations described above, pointing to the need to collect this type of data more consistently.**

***** While the sector collects diverse forms of impact data, it is often not in a form suitable for economic evaluation, highlighting the need for greater data alignment.**

7. Evidence from Social Prescribing

These studies provide encouraging evidence that creative health interventions can reduce healthcare use and generate resource savings, social value, and wider economic benefits. They strengthen the case for scaling arts, cultural, heritage, nature-based, and community referral pathways, while emphasising sustained engagement and robust long-term evaluation.

Assessing the Impact of Social Prescribing on Health Service Utilisation: Evidence from the UK Bu, F., Kurland, J.S., Hayes, D. & Fancourt, D. Pre-print: DOI/Weblink: https://doi.org/10.64898/2026.01.30.26345222

Using longitudinal administrative data from 4,547 participants, this study found that social prescribing was associated with substantial reductions in healthcare utilisation within three months. The outcomes were measured using self-reported GP visits, A&E attendances and hospital admissions in the last three months. Data were analysed using Bayesian growth curve modelling, with Poisson or hurdle lognormal models tailored to the specific outcome. The findings demonstrate consistent patterns of reduced health service utilisation across all outcome measures and model components.

Findings demonstrate consistent patterns of reduced health service:
- **GP visits fell by 53.1%,**
- **A&E attendances by 62.6%,**
- **hospital admissions by 61.7%,**

indicating substantial reductions in healthcare utilisation and potential cost savings.

The Economic Impact of Social Prescribing: A Systematic Review Fancourt, D., Munford, L., Crudgington, H., Morgan-Daniel, J., Pyche, C., Rodriguez, A.K., Sanhueza, C., Celebi, S., Sajnani, N., Pesata, V., Arslanovski, N., Hayes, D., Aughterson, H., Booth, R., Kurland, J.S., Munoz, T.T. & Sonke, J. [Preprint forthcoming]

A systematic review of 76 studies containing 83 economic analyses. This evidence showed a diverse range of partial and full economic evaluations as well as a smaller number of decision modelling studies. The evidence is heavily centred in the UK (which has had the largest national programme so far), but other countries represented included New Zealand, USA, Spain, Australia, Canada and Ireland. Although this review included 39 peer-reviewed economic analyses and 44 grey literature economic analyses, there was no evidence that non-peer-reviewed outputs contained inflated estimates. Overall, 58 of the 83 evaluations and models (70%) suggested economically favourable outcomes from social prescribing, although we saw substantial variation in the specific figures across economic approaches and intervention characteristics.

Creative health social prescribing demonstrated promising economic value, with costs of **$4,999 to £12,111 per QALY**, ROI reaching **£4.33 per £1 invested**, and SROI ranging up to **£7.08**, increasing to **£15.80 per £1** when wellbeing valuation was included.

Overall, the review highlighted the economic value of a range of creative health social prescribing interventions including nature-based, arts, cultural and heritage prescriptions. However, results varied by implementation characteristics, particularly dose and frequency of engagement. Higher-engaging participants sometimes generated substantially greater economic benefits (e.g. one study found approximately five times greater cost reductions among the highest-engaging patients compared with the group average).

Economic estimates were also sensitive to assumptions about duration of participation and whether individuals actually received and engaged with the prescribed intervention. Findings support the economic potential of social prescribing but highlight the need for more robust evaluations with longer follow-up, broader outcomes and healthcare utilisation, and assessment of differential effects. Further evidence is needed particularly for children and young people, secondary and tertiary care, and countries beyond those currently studied.

Evidence from Involve Kent Social Prescribing: Cost-Effectiveness and Wellbeing Value

Two economic briefing reports prepared by Mundra (2026a & 2026b) for the National Academy for Social Prescribing (NASP), using routine service and outcomes data from Involve Kent, provides a useful methodological case study for Creative Health economics. The first assessed cost-effectiveness using Quality-Adjusted Life Years (QALYs), while the second measured wider wellbeing value through the Wellbeing-Adjusted Life Year (WELLBY) framework recommended in HM Treasury Green Book guidance. Although the analyses evaluated the social prescribing pathway rather than Creative Health activities specifically, they demonstrate how community-based provision can be valued through complementary health economics and wellbeing economics approaches.

Cost-effectiveness using QALYs

The QALY analysis (Mundra, J., 2026a) indicates that the social prescribing service generated health improvements at a cost substantially below established NHS benchmarks:

- **£2,548 per QALY across 6,112 service users.**
- **Approximately 80% below the estimated NHS marginal cost benchmark of £13,000 per QALY.**
- **Around eight times lower than the £20,000 lower NICE willingness-to-pay threshold.**
- **Particularly strong value among people with mental health conditions (£1,927 per QALY) and complex needs (£1,781 per QALY).**

Routine pre- and post-intervention data were drawn from primary care networks, integrated care services, children and young people's services, and adult services. Comparisons with published NHS interventions suggest that the pathway performed favourably against health coaching and exercise referral schemes and remained well below commonly used cost-effectiveness thresholds.

This demonstrates the potential value of collecting a validated health-related quality-of-life measure alongside participation and experience data. Where creative health forms part of a social prescribing pathway, QALY analysis can help communicate its contribution in language familiar to NHS commissioners.

Wellbeing value using WELLBYs

The complementary wellbeing analysis (Mundra, J., 2026b) also reported strong economic value:

- **£718 per WELLBY across 6,443 service users.**
- **Approximately 71% below the indicative £2,500 marginal wellbeing comparator.**
- **Comparable with highly regarded community interventions, including parkrun and National Lottery-funded wellbeing programmes.**
- **An estimated gross benefit-to-cost ratio of approximately 18:1, based on HM Treasury's central WELLBY value of £13,000.**

The analysis used changes in life satisfaction before and after support to estimate average wellbeing gains over six months. This approach is particularly relevant to Creative Health because many of its benefits, such as confidence, belonging, purpose, social connection and improved life satisfaction may not be fully captured by clinical or health-service measures. WELLBY analysis can therefore complement QALYs by recognising broader outcomes that matter to participants and align with the preventative, relational and community-based character of creative health.

Demand reduction and potential return on investment

The reports also draw on wider social prescribing evidence suggesting potential reductions in healthcare use:

- **Approximately £418 in NHS benefit per person per year through reduced healthcare utilisation.**
- **QALY, WELLBY and return-on-investment evidence point in a consistent direction: social prescribing can improve health and wellbeing while potentially reducing pressure on NHS services.**

These estimates cannot be attributed to individual creative health activities because these findings relate to a combined pathway of link-worker support, community referrals and follow-on services. However, they illustrate how creative health can contribute to system-level value when activities form part of an effective, integrated social prescribing pathway.

Implications for Creative Health economics

The Involve Kent analyses offer four important lessons for creative health:

1. **Use complementary measures of value.** QALYs can capture health-related quality-of-life gains, while WELLBYs are better suited to recognising wider improvements in wellbeing and life satisfaction.
2. **Identify creative health's contribution.** Outcomes may arise through the combined effects of link-worker support, creative health activity and connections to other community or statutory services. Evaluation should reflect this complexity rather than claiming that one component caused the entire change.
3. **Prioritise equity and distribution.** The strongest cost-effectiveness findings were observed among people with mental health conditions and complex needs. Creative health evaluations should examine who benefits, not simply calculate an overall average.
4. **Connect outcomes with resource use.** Where feasible and proportionate, providers should collect information on programme costs, participation and dose, health and wellbeing outcomes, and changes in service use. This enables commissioners to assess both participant value and potential system benefits.

Overall, the findings provide a credible case for incorporating creative health into neighbourhood health models. They also show the importance of combining NHS-facing economic measures with methods capable of valuing the wider social, relational and wellbeing outcomes central to creative health.

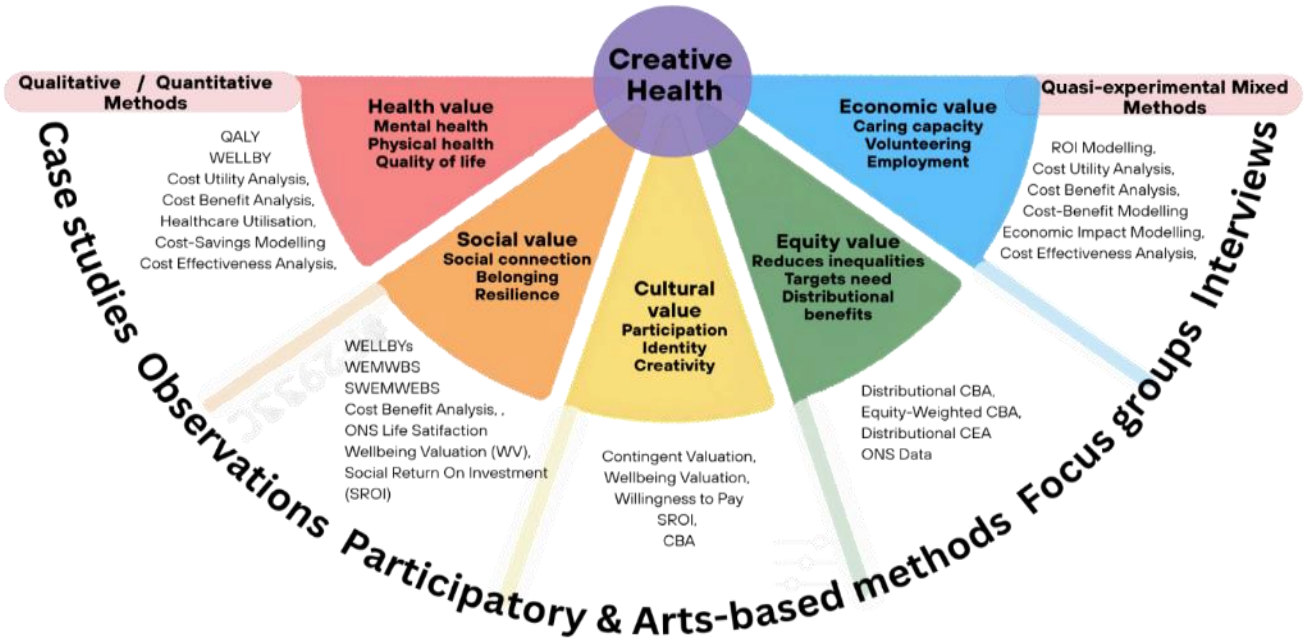
8. The State of Play: Translating creative health value into economic evidence

Eight interconnected themes emerged from the data analysis of interviews, roundtables, and academic reviews. They explore how creative health generates value, why this value is difficult to capture economically, and what is needed to strengthen future evaluation.

Multidimensional and interconnected value

Creative health has potential to benefit everyone, everywhere. While some interventions are specifically designed to address health inequalities and support people experiencing the greatest health, social, and economic disadvantage, the benefits of creative health extend across the wider population. Engagement in arts, culture, and creativity can enhance wellbeing, quality of life, social connection, confidence, resilience, and a sense of belonging throughout the life course.

Figure 2: Spectrum of Values and Measures for Creative Health



A data-rich but fragmented system

Figure 2. highlights the diversity of outcomes that creative health can generate, but also the challenge of capturing this value in a consistent way. The sector is data-rich, with organisations collecting a wide range of quantitative, qualitative, and participatory evidence. However, what counts as meaningful data for practitioners, participants, researchers, and commissioners often differs. Outcome reporting and measurement approaches vary considerably, and datasets rarely connect across organisations or sectors. As a result, comparing interventions, synthesising evidence, and demonstrating wider system-level impact remains difficult.

Bridging the economic translation gap

Evidence of participant benefit alone is rarely sufficient to support commissioning or investment. Decision-makers require clearly defined interventions, transparent costs, credible outcomes, justified assumptions and findings presented in formats appropriate to their responsibilities. Evidence must therefore be translated into comparable measures of effectiveness, equity, affordability and value for money. Longer-term, coordinated commissioning may also generate economies of scale that fragmented, short-term project funding cannot achieve.

Different perspectives on what constitutes value

Stakeholder groups may prioritise different forms and scales of evidence, from individual outcomes to community, population and societal impacts. Table 5 below outlines these differing, but overlapping, emphases on measures, outcomes and evidence.

Table 5: Stakeholder Perspectives on Outcomes of Creative Health

STAKEHOLDER GROUP	OUTCOMES PRIORITISED	EVIDENCE NEEDS
People with Lived Experience	Quality of life; meaningful activity; empowerment; social relationships; benefits for families and carers	Evidence of personal, social and wellbeing impacts; lived-experience accounts; changes in participation and everyday functioning
NHS Commissioners	Healthcare utilisation; service demand; system efficiency; clinical outcomes	Comparable outcome measures; healthcare resource use; cost-effectiveness; budget impact; evidence of equity
Government Departments	Population health; social and economic outcomes; reducing inequalities	Wider societal impacts; distributional effects; long-term public value; cross-sector benefits
Local Authorities	Prevention; community wellbeing; social inclusion; reduced demand on local services	Community-level outcomes; social value; return on investment; impacts on health inequalities
Arts Councils and Cultural Funders	Participation; artistic quality; cultural engagement; community benefit	Evidence of engagement, inclusion, cultural value, creative outcomes and broader social impact

Credible and proportionate standards of evidence

Most creative health economic benefits are extrapolated from small studies, due to current small-scale funding models. The large return-on-investment estimates often generate scepticism where the underlying evidence is weak. Credibility requires conservative modelling, transparency, sensitivity analysis, and acknowledgement of uncertainty. Evidence expectations should also reflect an intervention's scale, cost, maturity, and intended use. Small or emerging programmes should not face the same requirements as established interventions seeking national commissioning, although standards should strengthen as programmes mature and move towards wider implementation.

> *"Most Creative Health activity is community-led and should be commissioned in ways that enable innovation, co-production, and a focus on outcomes that matter to people and communities. Where creative health programmes include clinical interventions or form part of more formal care pathways, commissioners should ensure that appropriate governance, risk management, and professional oversight arrangements are agreed with relevant health and care partners. Such arrangements should be proportionate to the nature and level of risk associated with the intervention."*
>
> ***Music Therapist & Chief Allied Health Professions Officer, NHS Lancashire and South Cumbria ICB***

Consistent, meaningful and feasible measurement

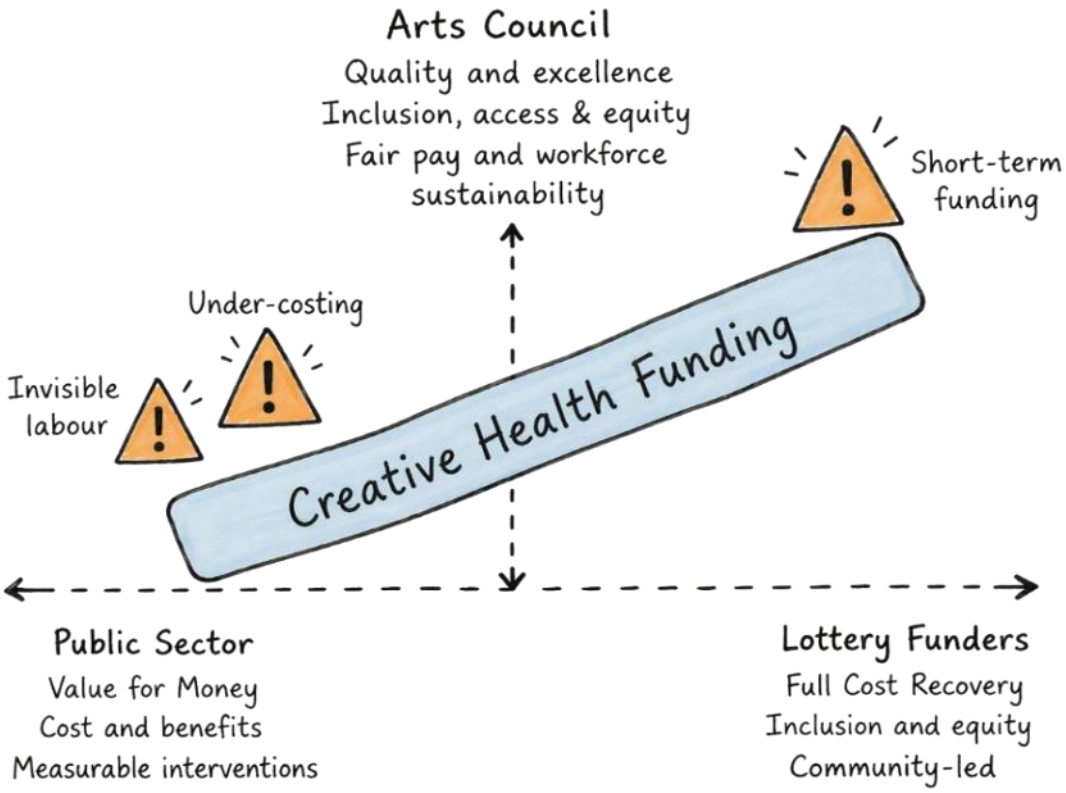
Providers reported a fragmented and overcomplex evaluation landscape. A national minimum dataset covering participation, wellbeing, quality of life, equity, costs, and healthcare use could improve consistency while allowing space for context-specific measures and qualitative evidence. Accessible, low-burden approaches, supported by inclusive digital tools and dashboards, are needed to capture outcomes without disrupting creative practice or therapeutic relationships.

> *"The voluntary sector does a lot of stuff, but they never measure any of it."*
> **Choices, MCA Project Interview**

Full and equitable costing

Funding streams for creative health have varying requirements for outcomes based on their priorities (See Figure 3). Commissioning often prioritises affordability and cost per participant which often overlooks the resources required for sustainable, high-quality delivery. Economic evaluations should account for the full range of resources required to deliver and sustain creative health activity, including the relational and organisational inputs that support participation and long-term impact. Failure to incorporate these factors, alongside participant costs and fair remuneration, risks producing estimates of value that are not achievable in routine practice and may inadvertently reinforce underinvestment in the sector.

Figure 3: Creative Health Funders and Commissioners Priorities



Mazzucato (2025) argues that arts and culture should be recognised as essential public infrastructure rather than discretionary spending. Policymakers should view culture as a strategic investment that helps shape the direction of economic growth, strengthens communities, and supports wider social, economic, and environmental goals.

Mazzucato's key recommendations include:

- **Recognising culture as a driver of economic transformation. Arts and culture help define societal goals, foster civic participation, and support inclusive and sustainable growth.**
- **Embedding arts and culture within policy and industrial strategy, using creative approaches to help design, deliver, and mobilise collective action around public missions such as health, sustainability**
- **Investing in cultural ecosystems, including artists, cultural organisations, educators, and supporting infrastructure, to ensure that creative activity can contribute sustainably to public value and economic development.**

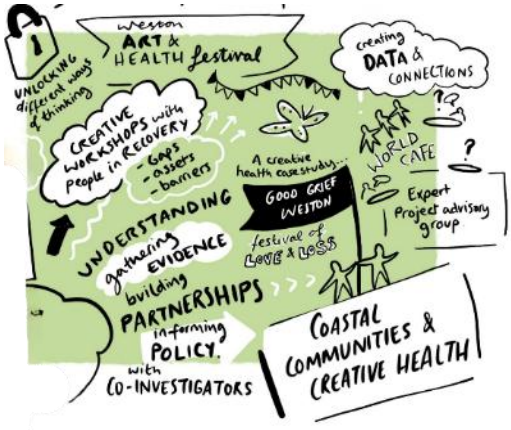
Shared responsibility and national infrastructure

While creative health providers may not be able to conduct complex economic evaluations or link data across systems independently, partnerships involving creative health providers, researchers, NHS organisations, local authorities, funders and VCFSE organisations would provide the necessary support and expertise. Importantly, people with lived experience help to define meaningful outcomes and interpret findings.

"We collect data consistently and follow guidance to ensure the data is usable beyond our own organisation. Alongside this, safeguarding, trauma informed practise & quality provision still comes first. Practitioners are trained to collect data using participant-centred approaches."
Rebecca Friel, CEO Odd Arts

A UK-wide minimum dataset, supported by shared definitions, practical guidance, proportionate governance and interoperable infrastructure, would enable evidence to be analysed and compared across interventions, populations and settings. This approach should be tested through collaborative, place-based demonstrator sites. Sustained leadership, capacity-building and implementation support will be essential to strengthen investment evidence without losing creative health's relational and person-centred foundations.

Coastal Communities Creative Health project has developed a prototype data dashboard which has significant potential as a creative health economics resource by bringing together community and creative asset data with health, demographic and place-based indicators in a single accessible platform, enabling a richer understanding of how community infrastructure contributes to mental health and wellbeing outcomes.



The dashboard could provide an important contextual evidence layer for economic evaluation, helping to demonstrate the preventative, system-wide, and place-based value of creative health activities beyond individual outcomes and traditional short-term metrics.

9. Economic Evaluation Guidance (Green Book aligned)

Developing economic evaluation guidelines for creative health interventions which are aligned with established principles of public-sector appraisal, particularly the HM Treasury Green Book (2026), is important to help evaluators produce evidence that is proportionate, credible and useful for decision-making.

Creative health interventions can generate multiple forms of value, including improvements in health, subjective wellbeing, and broader social value. Some of these forms of value are easily measurable and valuated, while others are not, highlighting the need for specific guidelines which address creative health's characteristics rather than relying on clinical health-oriented guidelines.

Key features of the guidance include:

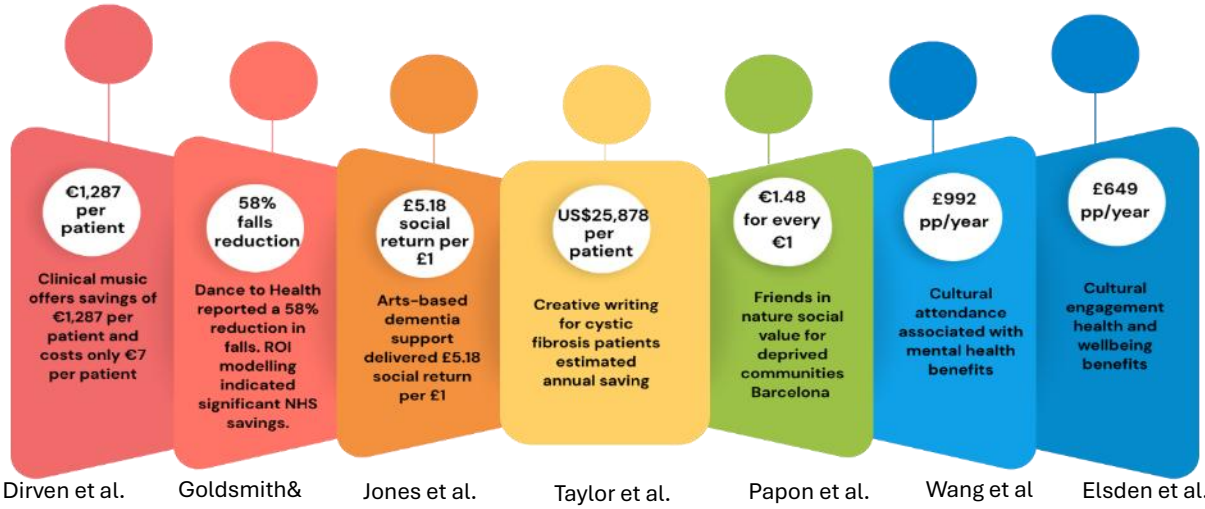
- Cost-Benefit Analysis (CBA) and Cost-Effectiveness Analysis are recommended based on Green Book endorsement;
- Diverse outcome measures should be used to capture creative health's value, including:
- Primary benefits – outcomes directly experienced by individuals as a result of participating in the intervention;
- Secondary benefits – spillover outcomes from primary impacts, such as changes in service use;
- Valuated outcome measures – outcome measures for which a monetary price can be associated, such as the EQ-5D, EQ-VAS, and ONS Life Satisfaction;
- Supplementary outcome measures – outcome measures which are not linked with monetary values, but which are often more health condition-specific;
- Evaluation standards should be proportional to the scale and resources of an intervention;
- For larger interventions, distributional analysis may be used to identify who benefits most from public spending and whether public spending is reaching groups with the greatest need and where social value-creation prospects may be highest.

Fujiwara, D., Dolan, P., Muelas, A., Segarra, E., Ruiz, C., Newton, U., McNeill, E., de Andrade, M., Fancourt, D., Mundra, J. and Chatterjee, H.J. (2026). *Guidelines on Economic Evaluation in Creative Health*. London: University College London. Available from: https://ncch.org.uk/uploads/Guidelines-on-Economic-Evaluation-in-Creative-Health.pdf

10. Creative Health Commissioning: An Economic Business Case for Creative Health

The co-produced economic business case for commissioners argues that creative health should be commissioned as part of neighbourhood health infrastructure to improve population health and reduce health inequalities.

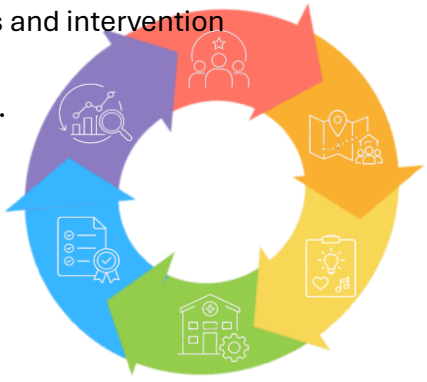
Figure 4: Economic Evidence for Creative Health



*Frontiers Economic monetisation (2024)

Responding to growing NHS pressures from ageing populations, rising long-term conditions, mental health needs, health inequalities, and financial constraints, the business case demonstrates how creative health aligns with national priorities by supporting prevention, early intervention, self-management, and community-based care.

Evidence from a large-scale evidence synthesis suggests that creative health interventions can generate positive outcomes across multiple domains of health and wellbeing (see Figure 4). These interventions have been linked to enhanced psychological wellbeing, reduced loneliness and social isolation, strengthened social relationships and social capital, and, in certain contexts, lower levels of healthcare utilisation and pressure on health and care services. While the strength of evidence varies across populations and intervention types, the overall direction of findings supports the integration of creative approaches within public health and health care systems.



The report recommends commissioning creative health through partnerships across health, social care, cultural, and voluntary sectors, supported by robust evaluation, shared outcome measures, and long-term infrastructure investment.

It concludes that creative health offers a practical, scalable, and cost-effective approach to prevention, neighbourhood care, and reducing health inequalities.

McNeill, E., Newton, U., de Andrade, M., Fancourt, D., Fujiwara, D., Mundra, J., Moss, D., Rule, E., Hobart, E., Sutcliffe, A. & Chatterjee, H.J. (2026). Creative Health Commissioning: An *Economic Business Case for Creative Health* Available from: https://ncch.org.uk/uploads/Creative-Health-Commissioning_An-Economic-Business-Case.pdf

11. Delivering Commission-ready Creative Health: Building the Business Case for Investment in Creative Health Programmes

This business case guide for creative health providers sets out a practical framework for making programmes commissioner-ready while protecting the relational, community-led and co-produced qualities that make them effective. It helps providers translate creative practice into a credible offer aligned with health priorities, prevention, and neighbourhood models.

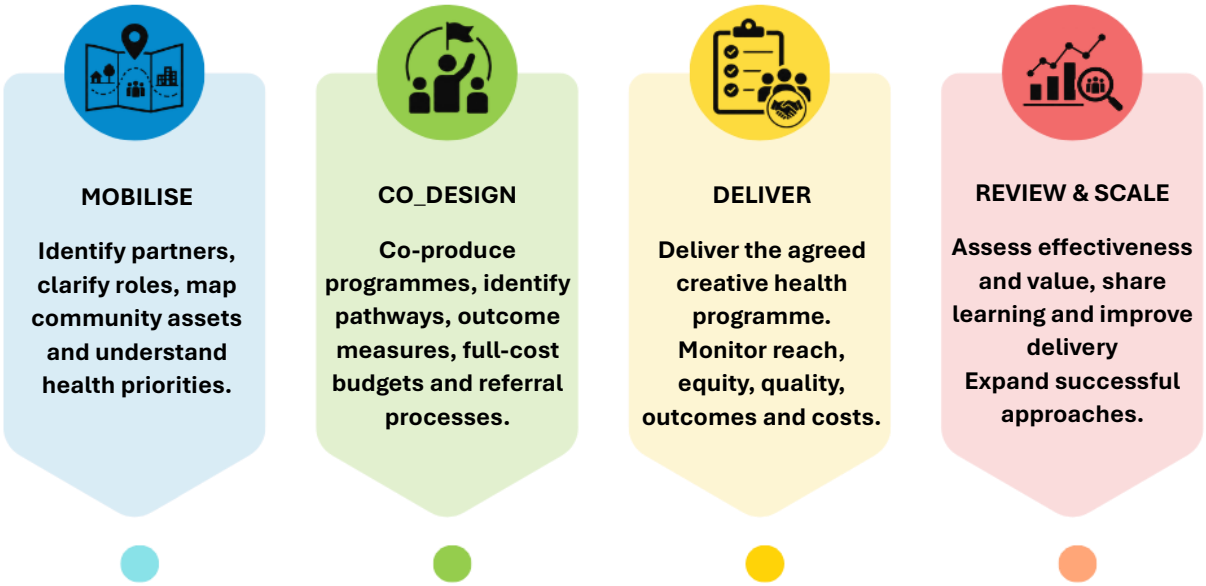
The document guides providers through the commissioning cycle:

- identifying need and strategic fit;
- co-producing an intervention and pathway;
- defining the target population, referral arrangements and delivery model;
- developing realistic budgets and sustainable prices;
- agreeing outcomes and measures; and
- managing mobilisation, performance and risk.

A central principle is full-cost recovery. Prices should reflect not only artist time and materials, but also relationship-building, coordination, safeguarding, accessibility, workforce development, supervision, data collection, evaluation and organisational infrastructure. Providers are supported to demonstrate value for money without overstating cashable savings or causal impact.

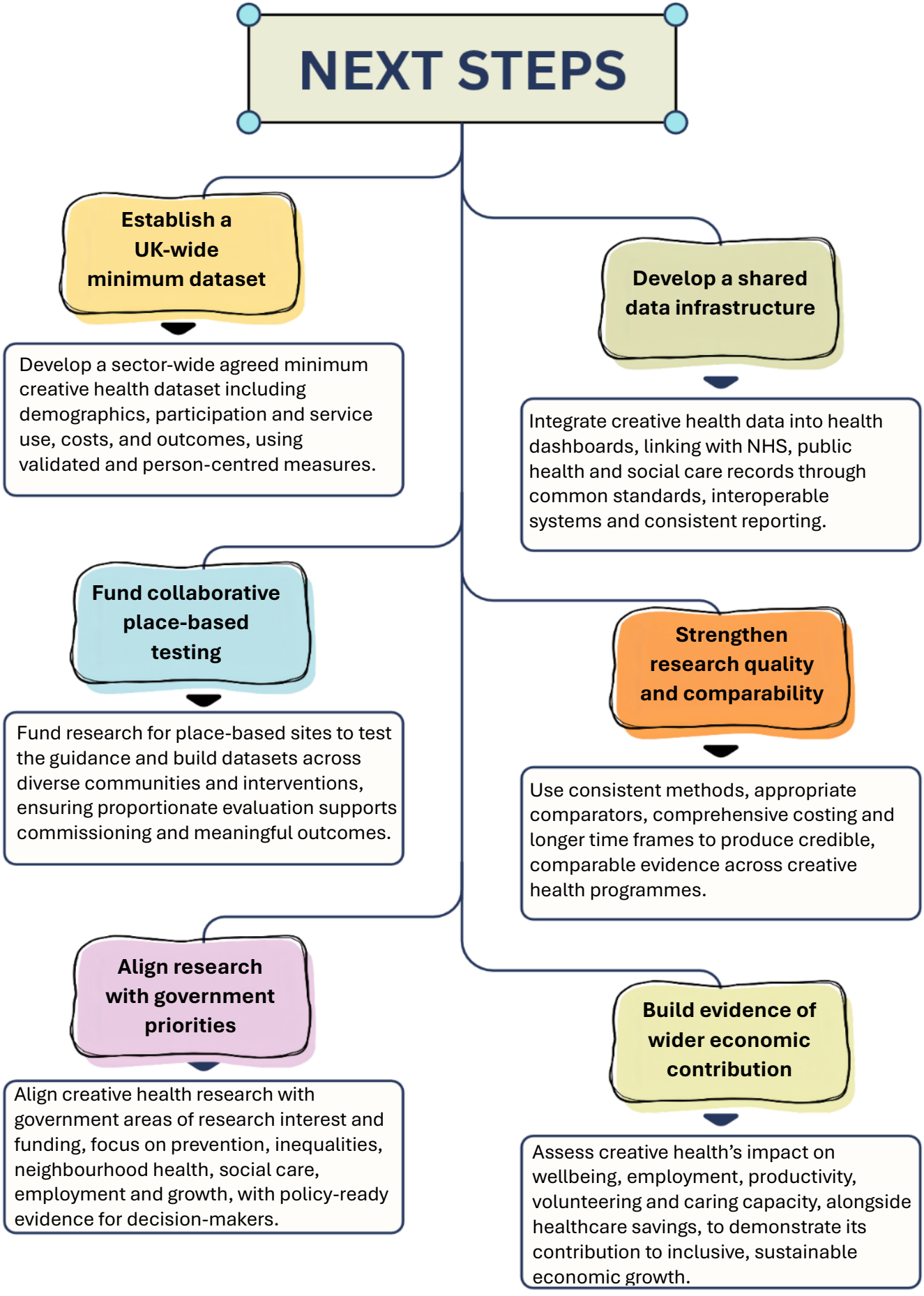
Proportionate evaluation is recommended combining validated measures with outcomes meaningful to participants. A minimum dataset should capture reach and equity, engagement and dose, health and wellbeing outcomes, participant experience, costs and resources, and relevant service use. Evaluation requirements should reflect the intervention's scale, maturity and risk.

Figure 5: Next Steps for Creative Health Providers



Overall, the document supports providers to present creative health as an investment: strategically aligned, evidence-informed, inclusive, financially sustainable, measurable and capable of continuous improvement, while retaining the flexibility and trusted relationships essential to effective delivery (see Figure 5).

12. Next Steps and Recommendations



13. Supplementary materials

The following evidence list brings together published economic evaluations of creative health interventions across different modalities, health contexts, populations and evaluation approaches.

The entire economic evaluation reference list is available here: https://ncch.org.uk/uploads/Supplementary Material: Creative Health Economic Evaluations Reference List

Section	Description	References
Resources	**World Health Organisation –** international evidence base	Fancourt, D. and Finn, S. (2019). *What is the evidence on the role of the arts in improving health and well-being? A scoping review*. Health Evidence Network Synthesis Report 67. Copenhagen: WHO Regional Office for Europe. Available at: https://www.who.int/europe/publications/i/item/9789289054553
	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/
About this report (page 3)	**Creative Health Economics Evaluation** guidance and business cases	Fujiwara, D., Dolan, P., Muelas, A., Segarra, E., Ruiz, C., Newton, U., McNeill, E., de Andrade, M., Fancourt, D., Mundra, J. and Chatterjee, H.J. (2026). Guidelines on Economic Evaluation in Creative Health. London: University College London. Available from: https://ncch.org.uk/uploads/Guidelines-on-Economic-Evaluation-in-Creative-Health.pdf

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	Economic Assessment of Arts and the Impact of Health	Davies, J., Flynn, G., Tudor Edwards, R. and Karkou, V. (2026) *Assessing the Economic Impact of the Arts on Health and Healthcare Services in Wales*. Bangor University and Edge Hill University. Commissioned by Arts Council of Wales. Available at: https://arts.wales/sites/default/files/2026-01/FinalReport_Assessing%20the%20Economic%20Impact%20of%20the%20Arts%20on%20Health%20and%20Healthcare%20Services%20in%20Wales.pdf (Accessed: 4 September 2026)
	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
Participatory Research Process (page 7)	**Community-based participatory research** and implications for public health funding	Minkler, M., Blackwell, A.G., Thompson, M. and Tamir, H. (2003). Community-based Participatory Research: Implications for Public Health Funding. *American Journal of Public Health*, 93(8), pp.1210–1213. doi:10.2105/ajph.93.8.1210.
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Foregrounding Lived Experience (page 11)	**Participatory research centring lived experience in marginalised communities**	McNeill, E., Mughal, R., Mezes, B., Wigglesworth, P., Anderson, W., Braithwaite, L., Boydell, S., Dartnell, S., Dempsey, Z., Flowers, S., Gordon, E., Gregory, M., Lee, L., Molyneux, C., Parker, M., Plumb, N., Reeds, K., Richardson, S., Robinson, C., Santa, K., Tarpanian, B., Wilson, M. & Chatterjee, H.J. (2026) Ketamine use in Blackpool. A Participatory Research Study. London: University College London. Available at: https://ncch.org.uk/uploads/Blackpool-Ketamine-StudyReport.pdf
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Evidence from Social Prescribing (page 14)	**UK evidence linking social prescribing with healthcare utilisation.**	Bu, F., Kurland, J.S., Hayes, D. and Fancourt, D. (2026) 'Assessing the impact of social prescribing on health service utilisation: evidence from the UK'. *medRxiv* [Preprint]. Available at: https://doi.org/10.64898/2026.01.30.26345222.
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Evidence from Involve Kent Social Prescribing: Cost-Effectiveness and Wellbeing Value (page 15)	**Economic Evaluations by the National Academy for Social Prescribing with Involve Kent**	Mundra, J. (2026a), on behalf of the National Academy for Social Prescribing. *Cost-Effectiveness of Social Prescribing – A Case Study*. London: National Academy for Social Prescribing. Based on data and content provided by Involve Kent. Available at: https://socialprescribingacademy.org.uk/media/h30jq42x/involve-kent-briefing-v4-nasp-final.pdf Mundra, J. (2026b), on behalf of the National Academy for Social Prescribing. *Social Prescribing Wellbeing Value: Cost-per-WELLBY Briefing*. London: National Academy for Social Prescribing. Based on data and content provided by Involve Kent. Available at: https://socialprescribingacademy.org.uk/media/kzuc0pwg/involve-kent-briefing-wellbys.pdf
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	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
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