Delivering Commission-ready Creative Health:

The Economic Business Case for Investment

MOBILISING COMMUNITY ASSETS

National Centre for Creative Health

UKRI Arts and Humanities Research Council

UCL

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About this resource

This 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 creative health providers to develop local business cases and secure investment for creative health programmes. This business case should be used alongside:

Creative Health Economics: Building the foundations for a commission-ready sector (2026). Available at: *https://ncch.org.uk/uploads/Creative-Health-Economics-Building-the-foundations-for-a-commission-ready-sector.pdf*

Creative Health Commissioning: An Economic Business Case for Creative Health (2026). Available at: *https://ncch.org.uk/uploads/Creative-Health-Commissioning_An-Economic-Business-Case.pdf*

Guidelines on Economic Evaluation in Creative Health (2026). Available at: https://ncch.org.uk/uploads/Guidelines-on-Economic-Evaluation-in-Creative-Health.pdf

This resource is primarily intended for:

- Creative health organisations, cultural organisations, charities, social enterprises and community organisations.
- Individual practitioners and delivery partnerships preparing proposals or tenders.
- Provider leads responsible for budgets, monitoring, evaluation, partnerships or service development.
- Funders, infrastructure bodies and commissioners supporting provider readiness.

It can be used to:

- develop local Creative Health business cases;
- support greater investment in creative health programmes;
- 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.

The research is supported by UK Research and Innovation (UKRI), including the Arts and Humanities Research Council (AHRC), Biotechnology and Biological Sciences Research Council (BBSRC), Economic and Social Research Council (ESRC), Medical Research Council (MRC), and Natural Environment Research Council (NERC), in partnership with the National Centre for Creative Health (NCCH). The programme is funded across three phases from 2021 to 2027, led by University College London (UCL)'s Culture Nature Health Research Group (Grant Ref: AH/W006405/1; PI: HJ Chatterjee).

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For further information contact: h.chatterjee@ucl.ac.uk

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Contributors

Dr Elaine McNeill (University College London)
Professor Helen J Chatterjee MBE (University College London)
Dr Linda J Thomson (University College London)
Professor Daisy Fancourt (University College London)
Professor Marisa de Andrade (University of Edinburgh)
Uisce Newton (University of Edinburgh)
Dr Daniel Fujiwara (TSC Impact & Harmon)
Alberto Muelas (Harmon)
Elena Segarra (Harmon)
Carlos Ruiz (Harmon)
Jag Mundra (National Academy for Social Prescribing)
Alex Coulter (National Centre for Creative Health: NCCH)
Jayne Howard (NCCH)
Rebecca Friel (CEO Odd Arts)
Lucy Chapman (CEO/Founder Flip the Coin SCIO)
Loz Kaye (Director Lancashire County of Song)
Bev Taylor (Director, For Communities)
Guy Noble (Arts Curator, UCLH NHS Foundation Trust and Co-Director, National Arts in Hospitals Network)
Victoria Hume (Executive Director, Culture, Health and Wellbeing Alliance: CHWA)
Hollie Smith-Charles (Director, Creative Health and Change, Arts Council England)

"This report is an important step forward in revealing the nuanced and complex economic landscape around creative health. I'm looking forward to working through its recommendations with national partners, to maximise the benefits for creative health practitioners and the communities they support." ***Victoria Hume, Executive Director, Culture, Health and Wellbeing Alliance.***

Creative Health Economic Evaluation

Better health, lower NHS demand, stronger communities

Executive Summary

THE CHALLENGE

Creative health providers face limited funding to help address:

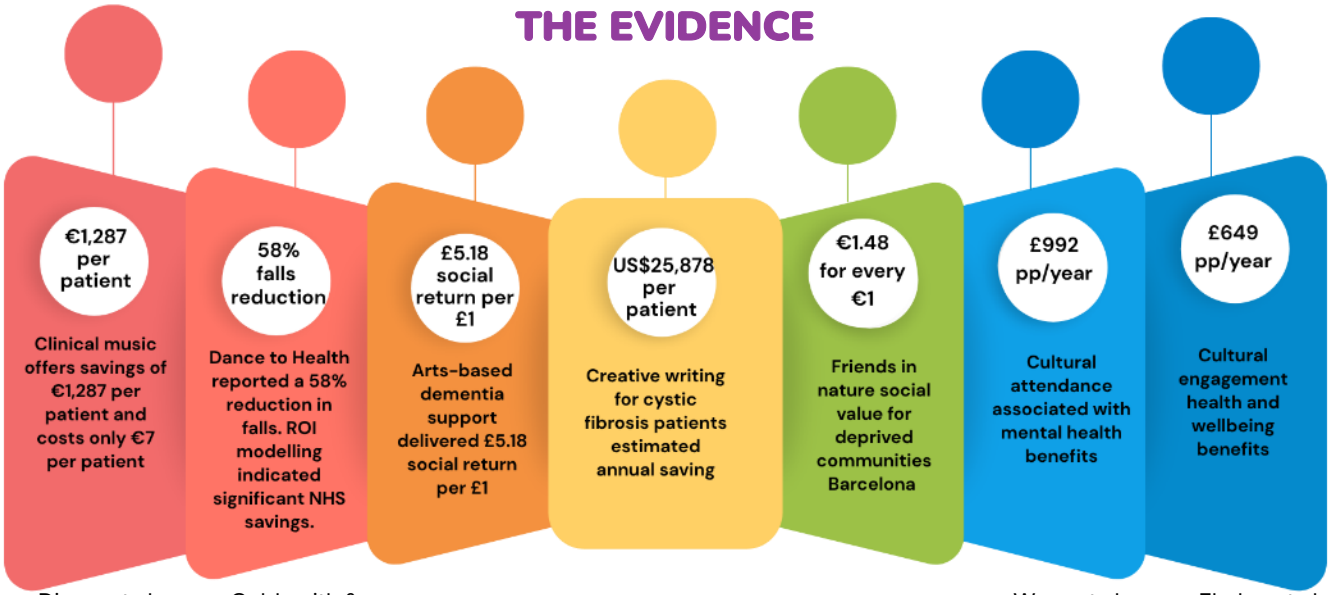
- Ageing population pressures
- Rising long-term conditions
- Increasing mental health need
- Persistent health inequalities
- Prevention activity to reduce NHS costs

THE PROPOSAL

Commission creative health as part of evidence-informed neighbourhood infrastructure:

- Build the evidence base for investment
- Apply consistent standards and datasets
- Commission a defined creative health portfolio
- Invest in sustainable provider infrastructure
- Evaluate, learn and scale provision

THE EVIDENCE



*Frontiers Economic monetisation (2024)

RECOMMENDATIONS

Creative health to be commissioned as part of: Neighbourhood Health Services, Population Health Management, Core20PLUS5 (England), and the Population Health Framework (2025-2035) and Health and Social Care Renewal Framework (Scotland) delivery to address health inequalities.

Develop evidence-informed, scalable offers and use outcomes to support improvement, investment and expansion.

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

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.

1. The Strategic Case: Address NHS priorities

Communities are facing growing challenges, including rising levels of poor mental health, social isolation, long-term health conditions, and widening inequalities. Many of these issues are shaped by the social determinants of health, such as loneliness, poverty, and limited opportunities for social connection, participation, and cultural engagement.

As pressures on health and care systems continue to increase, national policy is placing greater emphasis on prevention, early intervention, and community-based approaches that improve outcomes while reducing demand on statutory services. Creative health organisations, artists, freelancers, and voluntary sector providers play an important role in responding to these challenges. Through creative, cultural, and community-based activities, they support treatment, management and recovery, support wellbeing, build confidence, strengthen social connections, and develop resilience, complementing health and care services and contributing to healthier communities. The skills, experience and confidence that creative health activities build can lead into volunteering and employment.

Areas of NHS priorities that Creative Health contributes to:

Prevention & Population Health
Advancing prevention through wellbeing, early intervention and self-management.

Neighbourhood Health & Community Care
Supporting neighbourhood health through community-based care and partnerships.

Health Inequalities & Inclusive Access
Improving access, engagement and outcomes for underserved communities.

Digital Transformation & Innovation
Advancing digital inclusion through co-designed, person-centred approaches.

Quality, Performance & Productivity
Reducing demand while cutting costs, improving outcomes and patient/staff experience.

Integration, Workforce & System Sustainability
Strengthening partnerships, improving workforce wellbeing and integrated care delivery.

Figure 1. Creative Health meeting NHS priorities

Evidence increasingly demonstrates the positive impact of creative health on mental health, wellbeing, social connectedness, quality of life, and community cohesion. However, to secure the sector's long-term sustainability and maximise its contribution to health and wellbeing, there is a growing need to demonstrate economic value alongside social outcomes.

Public sector funding and investment decisions increasingly require evidence that aligns with HM Treasury's Green Book principles, demonstrating clear costs, benefits, risks, and value for money. Robust evidence of return on investment, cost avoidance, and social value can strengthen the case for creative health as an effective component of prevention and population health strategies. By demonstrating both social and economic value, the sector can strengthen its contribution to communities and public services.

Find out about your local health priorities through Joint Forward Plans, Joint Strategic Needs Assessments, Public Health Strategies, Health and Wellbeing Boards, and other national frameworks.

2. Creative Health: Evidence and Impact

Economic evidence for creative health is still developing, but several studies suggest that arts and creative interventions can generate health improvements at relatively low cost when compared with established NHS thresholds. An evidence bank of economic evaluations spans right across the creative health continuum from clinical interventions to targeted health activity, social prescribing to cultural engagement. 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 (Table 1).

Table 1: Creative Health Economic Evaluation Evidence by Health Context

HEALTH CONTEXT	STUDIES	HIGH CONFIDENCE	INTERPRETATION
Mental Health	19	7	Strongest combined evidence, especially singing and nature-based
Wellbeing	14	7	Strong valuation evidence, particularly cultural and multi-modality
Surgical and Critical Care	11	3	Defined music interventions show strong opportunities for cost savings
Ageing and Falls Prevention	8	2	Promising, but stronger economic evaluations needed
Child and Adolescent Development	8	2	Some strong singing, dance and bibliotherapy evidence
Dementia and Cognitive Disorders	7	3	Promising music, visual-arts and nature-based findings
Long-term Conditions	6	3	Strong social-prescribing and nature-based examples
Neurological Conditions	4	1	Early evidence, including visual arts following stroke
Social Isolation	3	1	Relevant social value evidence but limited causal analysis

"Creative Health's economic contribution reaches further than direct delivery. Across community health programmes in North Central London, participation builds confidence and skills that support progression into volunteering and paid roles. That is the same mechanism through which Creative Health strengthens local employment and connects into the wider social determinants of health." ***Guy Noble Arts Curator, UCLH NHS Foundation Trust and Co-Director, National Arts in Hospitals Network***

3. Economic Case: The evidence for creative health's value for money

The Creative Health Evidence Bank contains 86 creative health economic evaluations. Overall, performing arts account for the largest number of studies, while the strongest concentrations of higher-confidence evidence concern mental health, wellbeing, nature-based activity, community singing and selected music interventions. Heritage and visual arts have promising ratings, but much smaller evidence bases. Department for Culture, Media and Sport's evidence shows cultural participation creates measurable health and wellbeing value, supporting Green Book-aligned business cases and public-sector investment decisions.

Performing arts

Performing arts have the largest number of studies, although strength varies considerably by art form.

Community singing provides the clearest economic case. Two evaluations found community singing to be cost-effective for older adults experiencing mental-health difficulties and for mothers with postnatal depressive (PND) symptoms.

PND study estimated 0.041 additional QALYs, with cost of approx. £11k – £21k per QALY. (Bind et al., 2025)

Music has the largest individual evidence base associated with clinical pathways, including intensive care, perioperative care, delirium prevention and dementia, and illustrating the importance of sustained outcomes..

A UK dementia music therapy benefits 6mth £18,335 per QALY, but not over three months. (Eaglestone et al., 2026)

Dance provides some promising evidence. Dance to Health, reported a 58% reduction in falls and a trial-based cost-utility analysis for adolescent girls reduced school-nurse visits and a 95% probability of cost-effectiveness.

A Swedish adolescent girl dance study calculated a healthcare saving of $287 per participant. (Phillipson et al., 2013)

Visual arts

The strongest economic studies for visual arts concern stroke rehabilitation and arts activities for people living with dementia. These indicate potential wellbeing and social value, but the evidence remains too limited to support broad conclusions across visual arts.

Visual arts includes painting, drawing, crafts, making, gallery engagement and facilitated group activities delivered across community, clinical and care settings. Evidence indicates improved wellbeing, confidence, social connection and quality of life, with potential reductions in healthcare use and substantial social value for people experiencing mental ill health, isolation, stroke and dementia.

The economic evidence for visual arts is limited but promising, combining high-confidence SROI studies with feasibility work and modelled savings that require testing through larger, comparative evaluations.

Arts and crafts: 40% fewer GP appointments; estimated annual **NHS savings of £17.49 million**. (Davies et al., 2026)

Men's Sheds: **£10 in social value generated for every £1 invested.** (Schroeder et al., 2015)

Dementia arts: **£5.18 in social value generated for every £1 invested.** (Jones et al., 2020)

Reading and creative writing (and general use of libraries)

Shared reading, libraries and creative writing show promise, but interventions and outcomes are diverse, and the evidence is not yet sufficiently consistent for generalised economic claims.

Creative writing in clinical settings suggests economic benefit through improved health management. A small randomised trial of expressive writing for young people with cystic fibrosis found fewer inpatient hospital days.

Potential annual **savings of US$25k** per participant with cystic fibrosis from reduced hospitalisation. (Taylor et al., 2003)

Bibliotherapy evidence is narrower, but a high-quality parenting trial found it the least expensive effective option for addressing behavioural problems in children over four months.

US$483 cost was lower than three group-based parenting programmes. (Sampaio et al., 2016)

General library use shows positive wellbeing and economic value at population level, reflecting the combined benefits of reading, borrowing, activities, support and inclusive accessible community spaces.

Public libraries generate **savings of £3.4 billion** annually, with modelled ROI exceeding 6:1. (Gordon et al., 2023)

Nature-based activity

Economic evidence for nature-based activities is promising, indicating potential cost savings, reduced service use and positive social returns across varied interventions.

Nature-based creative health includes horticulture, care farming, woodland therapy, ecotherapy, conservation, environmental arts and other outdoor group activities. Evidence links participation with improved mental wellbeing, confidence, physical activity, social connection and belonging. Economic studies also indicate potential social value, cost-effective health gains and reductions in GP appointments and wider health, social care and public-service use.

Craft and horticulture participants reported **40% fewer GP appointments.** (Whiteley et al., 2025)

Care-farm provision **cost £14,232 less** per site annually than comparator services. (Elsey et al.2018)

Nature-based activities have a promising economic evidence base, but reported values vary and require confirmation through larger, controlled and longer-term evaluations before commissioning decisions are made.

Woodland therapy **reduced service use saving approx. €4k – €10k** per participant annually. (Rivieccio et al. 2025)

Use this evidence selectively to create a compelling case for creative health that:

1) **Aligns evidence with the intervention:** Use evidence relevant to the specific creative approach, target population, health need and delivery setting.
2) **Demonstrates value rigorously:** Distinguish between improved outcomes, social value, avoided costs and cash-releasing savings, using comparison groups where possible.
3) **Ensures transparency and lived experience context:** Present SROI and wellbeing valuations with attribution and sensitivity analysis and explain how qualitative lived-experience evidence supports the findings.

Heritage and cultural engagement

The heritage studies have a high confidence rating, particularly for wellbeing valuation and cultural participation. This provides a strong foundation for explaining the value of museums, heritage assets and cultural institutions. This evidence base primarily demonstrates population-level wellbeing value rather than the cost-effectiveness of defined health interventions.

Heritage-based creative health includes visits to museums, historic buildings and cultural institutions, alongside opportunities to explore collections, places, identity and shared history. Evidence links participation with greater happiness, life satisfaction, momentary wellbeing and self-reported health, while economic studies demonstrate that access to heritage assets generates measurable personal and public value.

Heritage has a consistently high-confidence economic evidence base, primarily demonstrating population-level wellbeing and cultural value rather than intervention cost-effectiveness or cash-releasing healthcare savings for commissioners.

Museum visiting: Estimated wellbeing **value of £3,228 per person annually.** (Fujiwara et al., 2013)

Historic-building visits: Estimated annual **wellbeing value of £1,342 per person.** (Fujiwara et al., 2014)

Natural History Museum: **Access valued at £6.65 willingness-to-pay per visit.** (Bakhshi et al., 2015)

Multi-modality programmes

Multi-modality programmes contribute 25 studies, including nine high-confidence evaluations. Stronger evidence relates to social prescribing for long-term conditions, loneliness, wellbeing, dementia peer support and community mental health. These evaluations capture the combined contribution of arts, culture, community activity and social connection.

Much of this evidence uses SROI or wellbeing valuation. These approaches are valuable for demonstrating wider social value, but their results should not automatically be presented as cash-releasing NHS savings. Providers need to distinguish monetised social value, avoided costs and directly realisable financial savings.

Multi-modality activities often combine arts, culture, movement, nature, social connection and personalised support within a single programme. Activities may include group sessions, cultural engagement, peer support and link-worker referrals. Evidence indicates improved wellbeing, reduced loneliness, stronger self-management and potential reductions in GP appointments, emergency attendance, hospital admissions and wider public-service costs.

Evaluations provide promising economic evidence across varied populations, but diverse activities, outcomes and methods limit comparison and require cautious interpretation of savings and social value.

Rotherham social prescribing modelled **£552,000 in annual NHS savings.** (Dayson et al., 2017)

Loneliness study on social prescribing generated **£3.42 in social value per £1 invested.** (Foster et al., 2021)

Dementia peer support: **Social returns ranged from £1.17 to £5.18 per £1 invested.** (Willis et al., 2018)

4. Outcome Measures, Impact and Valuation

Measurement, governance and accountability should match the activity's scale and risk, from clinically embedded interventions and targeted health activities to social prescribing and community cultural engagement. Providers should retain flexibility for innovation, co-production and community-defined outcomes, while clinical pathways require appropriate safeguarding, risk management and professional oversight.

Commissioned services should collect a proportionate minimum dataset combining costs and economic measures with health, wellbeing, social, cultural and equity outcomes (Table 2).

Table 2: Creative Health Economic Outcomes and Measures

CORE OUTCOMES	OUTCOME MEASURE	ECONOMIC USE
Health-related Quality of Life	EQ-5D where feasible; EQ-VAS as a lower-burden alternative	QALYs / health-focused CEA or CBA
Overall Wellbeing	ONS life satisfaction (0–10)	WELLBY-based wider public-sector value
Health Service Use	GP contacts and A&E attendances; other use only with a credible pathway	Potential resource use and cost effects
Programme-specific Outcome	e.g. SWEMWBS, PHQ-2, GAD-2, loneliness, self-efficacy, participation	Cost per meaningful improvement and mechanism evidence
Equity, Reach, and Experience	Demographics, referral source, attendance/dose, completion, accessibility and participant experience	Distributional impact, implementation and quality

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

General measurement rules

- Experienced providers seeking to be commissioned should ideally 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.
- Outputs are what is delivered; outcomes are changes; impacts are changes attributable to the intervention.
- Use validated wording and scoring. Record the measure version, timing, denominator and missing data.
- Report follow-up and attrition, not only matched completers.
- Use qualitative and creative methods to explain mechanisms, acceptability and outcomes not captured by standard measures.
- Report QALY- and WELLBY-based valuations separately; do not add overlapping values.
- Treat reduced use as potential cost avoidance or capacity benefit unless cash is demonstrably released.

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

An economic evaluation was conducted of two MCA partner creative health projects, applying the 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 3 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 (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 3: 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.

The REALITIES project, a 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.

Table 4: 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 inter-generational trauma, poverty, poor mental health, substance use, and contact with the criminal justice system (Table 4). Based in the Scottish Highlands, it is part of the wider REALITIES network of creative health hubs across Scotland. This economic evaluation was conducted with 33 participants, using WEMWBS as an outcome measure.

"For Flip of the Coin, data collection begins with relationships. People come to our centre because they feel safe, welcomed and part of a community, so any questions we ask have to sit gently within that trust. We gathered information through ordinary conversations and alongside creative activity, explaining why it mattered and listening when questions did not fit people's lives. The economic findings have given us another way to show the value of our work, but that value begins with people feeling connected, supported and part of something." ***Lucy Campbell, CEO/Founder, Flip of the Coin SCIO***

Table 5: 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. This economic evaluation (Table 5) was conducted with 61 participants, using SWEMWBS as an outcome measure. Odd Arts are part of the Arts4Us partnership network.

"We collect data consistently and follow guidance to ensure the data is usable beyond our own organisation. Alongside this, safeguarding, trauma informed practise and quality provision still comes first. Internal training ensures creative practitioners understand why we are collecting data and are given autonomy to influence the nuance of exactly how data is collected in their session, always putting participant experience first." ***Rebecca Friel, CEO Odd Arts.***

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.**

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

"Many of us know instinctively that taking part in creative activities feels great. Over the past six years, the Mobilising Community Assets programme has demonstrated the transformational and cost effective impact of culture and heritage, and the role creative health can play in neighbourhood health. This report now offers practical guidance for artists and practitioners, helping them to set out the economic case for investment in their work and guidance for fair pay." ***Hollie Smith-Charles , Director, Creative Health and Change, Arts Council England.***

6. Commercial Case

Creative health providers must help commissioners respond to this key question: Can this service be procured and delivered effectively? This section explains how to translate creative practice into a clear, credible and sustainable service offer while preserving the community-led, relational and co-produced qualities that underpin its value.

Commissioning principles for creative health and community-based services

Creative health services are most cost-effective when providers work through partnerships and local ecosystems rather than operating through isolated, single-provider models. Similar approaches are already established within Integrated Care System partnerships. Providers should therefore develop collaborative delivery models that combine complementary expertise, share infrastructure and data, coordinate referral pathways and respond effectively to local needs.

Effective creative health commissioning can:

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.

Delivery Model

- Lead provider, delivery partners, subcontractors and individual practitioners.
- Referral and access routes, eligibility, triage, safeguarding and clinical escalation.
- Venues, geographic coverage, digital or hybrid delivery and accessibility adaptations.
- Workforce roles, competencies, supervision, training, wellbeing and continuity.
- Capacity, mobilisation time, minimum viable scale and constraints on growth.

Articulate social value

Where possible, show how creative health strengthens local employment, skills, volunteering, cultural infrastructure, community connection and inclusive economies. Keep these contributions distinct from participant health benefits already counted in the economic analysis.

Propose a workable payment model

Funding needs to support infrastructure as well as delivery, quality and outcomes. Avoid transferring disproportionate outcome risk to small providers or tying payment to measures outside provider control.

7. Financial Case

Creative health projects are often under-costed because they focus on visible delivery while overlooking the work that makes outcomes possible. Evidence from funders, commissioners and sector bodies consistently shows that effective budgets must reflect the full requirements of safe, high-quality practice.

Commissioners and funders will want to know the service costs, and whether the price is affordable and sustainable. A credible price should be based on full-cost recovery, covering everything required for safe, equitable and high-quality delivery, not only practitioner time and materials, while demonstrating value for money and supporting the service's long-term viability (Table 6).

Building the full economic cost

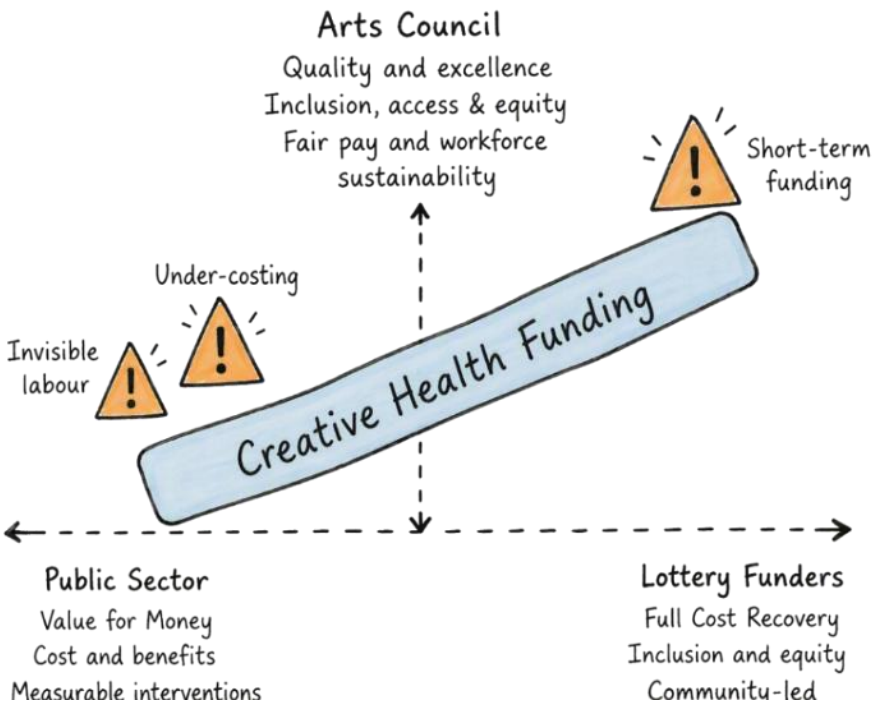
Table 6: Creative Health Full Economic Costs

COST GROUP	INCLUDE
Direct Delivery	Practitioner preparation and delivery; materials; equipment; venue; travel; digital delivery
Access and Participation	Transport, childcare, interpreters, personal assistance, access materials, refreshments and digital access
Relational and Partnership Work	Outreach, trust-building, community connectors, referral liaison, partnership coordination and follow-up
Workforce and Quality	Recruitment, training, supervision, safeguarding, reflective practice and workforce wellbeing
Management and Evaluation	Project management, administration, governance, data collection, analysis, reporting and learning
Infrastructure and Overheads	Leadership, finance, HR, IT, insurance, premises, audit, legal and organisational development
Risk and Sustainability	Contingency, inflation, mobilisation, cancellation/non-attendance, reserves and cash-flow financing
Donated Resources	Volunteer time, free space and in-kind contributions valued transparently as economic costs

Five things every creative health budget should include:

1. **Fair practitioner fees -** Pay for preparation, delivery, follow-up, meetings and reflection, not just contact time.
2. **Relationship-based practice -** Include outreach, trust-building, partnership working, referral liaison and participant follow-up.
3. **Workforce quality and wellbeing -** Budget for training, supervision, safeguarding and practitioner wellbeing.
4. **Evaluation and learning -** Build in resources for data collection, outcome measurement, analysis and reporting from the outset.
5. **Accessibility and inclusion -** Allow for transport, interpreters, personal assistance, childcare, access materials and digital inclusion support.

Figure 2: Priorities of Creative Health Funders and Commissioners



NHS and local authority commissioners emphasise outcomes and value for money.
Arts funders emphasise fair pay and sustainability.
Strong budgets demonstrate both.

While the NHS and local authority commissioners focus on outcomes, evaluation and value for money, arts funders emphasise fair pay and sustainability aligning with the Culture Health and Wellbeing Alliance (CHWA) Creative Health Quality Framework principles of collaborative, creative, equitable, person-centred, realistic, reflective, safe, and sustainable practices. The Creative Health Quality Framework recommends that funders and commissioners should ensure that "funding covers fair and equitable rates of pay" and "budgets include adequate resources for evaluation" (see Figure 2). Strong budgets demonstrate both workforce sustainability and accountability for public investment (CHWA Creative Health Quality Framework).

Converting cost into price

1. Confirm the funded activity, delivery period, capacity and expected participant flow.
2. Allocate direct costs and a defensible share of overheads.
3. Add evaluation, mobilisation, inflation, contingency and risk allowances.
4. Calculate unit costs: per participant, completed participant, session, cohort and outcome where relevant.
5. Stress-test volume, referrals, attendance, staffing, venue and inflation assumptions.
6. Set the contract price and payment schedule needed to maintain cash flow and service quality.

Examples of cost per participant costings from the evidence

With UK healthcare expenditure exceeding £240 billion annually, providers can strengthen their case by showing how relatively modest investment in creative health can reduce acute-service use and costs (Table 7). Proposals should explain how provision supports NHS priorities to move care from hospitals into communities and shift resources from treating sickness towards prevention.

Table 7: Creative Health Evidence Costing and Economic Findings Breakdown

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.

[*£18.88 rate is based on £75 per session which is a lower rate than recommended rates of pay for a musical director/choir lead]

Main funding streams

According to the State of the Sector Surveys published biennially by the Culture, Health & Wellbeing Alliance (CHWA), the main funding streams powering the creative health sector are:

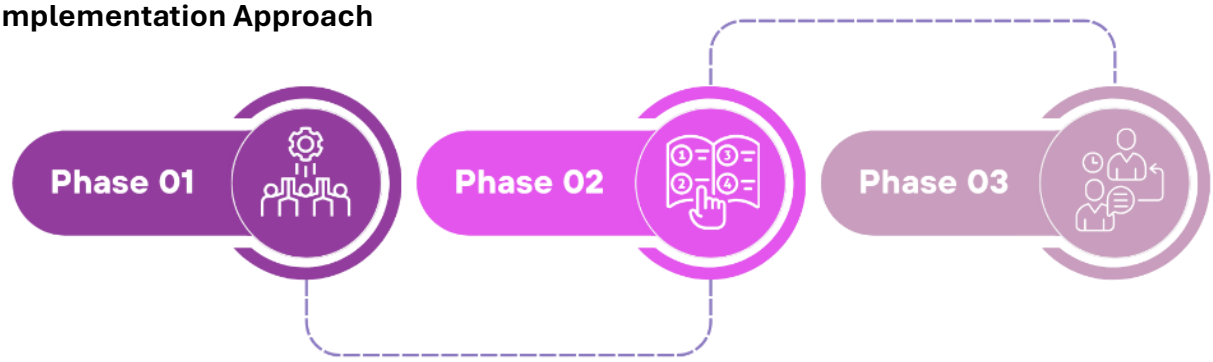
- **UK Arts Councils**
- **Trusts and philanthropic foundations**
- **Local authorities / councils**
- **NHS**

CHWA data highlights that the main funding streams rarely cover core organisational costs, practitioner training, or wellbeing support for facilitators, prompting ongoing sector advocacy for more sustainable, long-term funding.

8. Management Case

Delivery, performance, learning and how risk will be managed are equally important to commissioners and funders. A credible implementation plan should set out milestones for mobilisation, referrals, recruitment, delivery, review and continuation or closure, with clear responsibilities, dependencies and commissioner inputs. It should also include sufficient lead-in time for partnership development, community engagement, data-sharing agreements and workforce preparation.

Implementation Approach



Prepare and mobilise

- Confirm partners, roles and responsibilities.
- Agree commissioner inputs
- Establish referral pathways
- Prepare workforce and safeguarding arrangements.
- Explore data-sharing options

Deliver and monitor

- Recruit participants
- Deliver planned activities
- Monitor engagement and outcomes
- Track costs, quality and risks
- Address delivery challenges

Review, learn and sustain

- Evaluate performance
- Capture learning
- Report findings
- Agree service improvements
- Continue, scale, transition or close

Contracting and Payment Model

Commissioners are advised to use a blended payment model that funds service readiness and infrastructure alongside delivery, quality and outcomes. The illustrative model proposes:

- **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.

> "The ongoing cost to keep the choir running is a challenge. We run on a PAYD basis, with £5 being the suggested amount. The donations from the participants covers the room hire and not much else. The board, staff and relevant volunteers at our host organisation have so far been able to secure a range of grant funding to cover the cost of the choir that the members donations do not cover. The challenge of grants is that it is mostly short-term so that the future of the choir is never guaranteed, despite being busy and having already proven health benefits" ***County of Song survey participant.***

9. Recommendations

Creative Health should be developed as a shared endeavour between providers, commissioners and funders. Sustainable growth requires both provider readiness and commissioning approaches that invest in infrastructure, support effective evaluation and enable long-term delivery.

For providers

- **Build local partnerships** with health, public health, local authority and community organisations.
- **Demonstrate local need** and explain how creative health delivery meets local health priorities.
- **Define a credible creative health offer** covering population, pathway, activity, dose, access and expected outcomes.
- **Budget for sustainable delivery** by including infrastructure, workforce, accessibility, safeguarding and evaluation costs.
- **Apply consistent standards** while retaining community-led, relational and co-produced practice.
- **Collect proportionate evidence** on reach, equity, engagement, outcomes, costs and relevant service use and use learning to improve and scale.

Next Steps

MOBILISE
Understand priority populations, identify partners, and clarify roles.

CO-DESIGN
Co-produce programmes and service specifications, identify outcome measures, full-cost budgets and referral processes.

DELIVER
Implement the agreed creative health programme, monitor engagement, participant demographics, quality, outcomes and costs.

REVIEW & SCALE
Assess effectiveness and value, share learning, improve delivery and expand successful approaches.

Key principle:
Providers and commissioners should work together to move beyond repeated short-term projects towards coordinated, evidence-informed Creative Health infrastructure that supports prevention, neighbourhood care and reduced health inequalities.

10. 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.pdf

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
	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/

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
Performing Arts (page 8)	**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
	Music Therapy – music therapy for dementia was cost-effective at 6 months, with an ICER of £18,335 per QALY gained.	Eaglestone, G., *et al.* (2026). *Cost-effectiveness of a music therapy intervention for people living with dementia: a model for a UK-based economic evaluation*. *Aging & Mental Health*. https://doi.org/10.1080/13607863.2026.2639043
	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
Visual Arts (page 8)	**Arts & Crafts –** arts participation was associated with a 40% reduction in GP appointments, with potential NHS savings of £17.5m per year.	Davies, J., Flynn, G., Karkou, V. & Edwards, R.T. (2026). *Assessing the Economic Impact of the Arts on Health and Healthcare Services in Wales*. Arts Council of Wales.
	Men's Sheds (Arts & Crafts) – community arts participation for men at risk of social isolation	Schroeder, J., Sowden, J. & Watt, J. (2015). *Social Return on Investment: The Westhill and District Men's Shed, Scotland*. Scottish Men's Sheds Association.

	generated **£10 of social value for every £1 invested**.	
	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
Creative Writing, Reading and libraries (page 9)	**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
	Reading (Bibliotherapy) – bibliotherapy for child conduct problems cost US$483 per recovered case, making it the most cost-effective intervention evaluated.	Sampaio, F., Enebrink, P., Mihalopoulos, C. & Feldman, I. (2016). Cost-Effectiveness of Four Parenting Programs and Bibliotherapy for Parents of Children with Conduct Problems. Journal of Mental Health Policy and Economics, 19(4), 201-212. https://pubmed.ncbi.nlm.nih.gov/27991419/
	Libraries – public libraries generated at least £6 of social value for every £1 invested.	Gordon, C., *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 / University of East Anglia, for Libraries Connected East.
Nature-Based Activity (page 9)	**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
	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
	Woodland Therapy –	Rivieccio, G., *et al.* (2025). *Therapist-Guided Versus Self-Guided Forest Immersion: Comparative Efficacy on Short-Term*

	therapist-guided forest immersion generated an estimated €4,076-€10,189 annual value per participant, with benefits to mental health outweighing the estimated €500 annual delivery cost.	*Mental Health and Economic Value*. *Behavioral Sciences*, 15(12). https://doi.org/10.3390/bs15121618
Heritage (page 10)	**Heritage (Museums) –** museum participation generated an estimated £3,228 annual wellbeing value per person.	Fujiwara, D. (2013). *Museums and Happiness: The Value of Participating in Museums and the Arts*. The Happy Museum. Available at: https://happymuseumproject.org/wp-content/uploads/2013/04/Museums_and_happiness_DFujiwara_April2013.pdf
	Heritage – visiting historic buildings generated an estimated £1,342 annual wellbeing value per person.	Fujiwara, D., Cornwall, T. & Dolan, P. (2014). *Heritage and Wellbeing*. Historic England.
	Heritage (Museums) – access to the Natural History Museum generated a mean economic value of £6.65 per visit.	Bakhshi, H., Fujiwara, D., Lawton, R., Mourato, S. & Dolan, P. (2015). *Measuring Economic Value in Cultural Institutions*. Arts & Humanities Research Council.
Multi-modality (page 10)	**Social Prescribing –** for long-term conditions generated approximately £552,000 annual NHS savings through reduced healthcare use and delivered around £5 of	Dayson, C. & Damm, C. (2017). *The Rotherham Social Prescribing Service for People with Long-Term Conditions: Evaluation Update*. Centre for Regional Economic and Social Research (CRESR), Sheffield Hallam University.

	social value for every £1 invested.	
	Social Prescribing – to reduced loneliness in 72.6% of participants and generated £3.42 of social value for every £1 invested, creating an estimated £11.46 million net social value**.**	Foster, A., Thompson, J., Holding, E., Ariss, S., Mukuria, C., Jacques, R., *et al.* (2021). *Impact of Social Prescribing to Address Loneliness: A Mixed Methods Evaluation of a National Social Prescribing Programme*. *Health & Social Care in the Community*, 29, 1439-1449. https://doi.org/10.1111/hsc.13200
	Peer Support - for people living with dementia generated between £1.17 and £5.18 of social value for every £1 invested.	Willis, E., Semple, A.C. & de Waal, H. (2018). *Quantifying the Benefits of Peer Support for People with Dementia: A Social Return on Investment (SROI) Study*. *Dementia*, 17(3), 266-278. https://doi.org/10.1177/1471301216640184
Creative Health Funding (page 10)	**Creative Health Quality Framework –** fair and equitable pay, investment in practitioner sustainability, and adequate resources for evaluation and learning.	Culture, Health & Wellbeing Alliance (CHWA). (2023). *Creative Health Quality Framework*. Culture, Health & Wellbeing Alliance.