

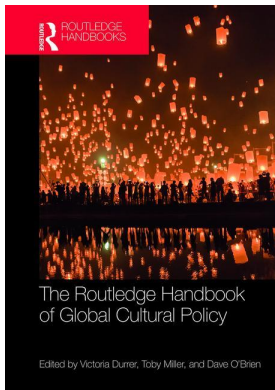
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Considering the second-order health effects of arts engagement in relation to cultural policy

Rebecca Gordon-Nesbitt

Introduction

In recent decades, there has been increased willingness to consider the social determinants of health in general and the impact of arts engagement in particular. At the same time, the shift towards evidence-based policy-making has been well documented, and the prevailing narrative in certain circles is that we lack evidence around the long-term relationship between health and engagement in arts activities beyond the clinical environment. In March 2014, Arts Council England (ACE) published an evidence review that attempted to account for the value of culture to people and society. While this review referenced large-scale Nordic research showing the positive impact of longitudinal cultural engagement, it ultimately deferred to the UK to conclude that ‘there is no evidence that these improvements are sustained in the long term, and the majority of studies have been small scale and unable to do more than report a correlation between the intervention and these benefits’ (ACE, 2014: 26).

Five months before the ACE evidence review was published, the Arts and Humanities Research Council put out a targeted call under the auspices of the Cultural Value Project, which noted that ‘A number of research studies in recent years (most prominently drawing on long-term cohort study data from the Nordic countries) have suggested a positive correlation between engagement in cultural activities and long-term physical and psychological health after adjusting for a range of income, educational and social variables’ (AHRC, 2013: 9). In response to this call, a research programme was designed that sought to build an evidence base around the longitudinal health impacts of engaging in arts activities in non-clinical settings. This suggests that engagement in the arts leads to longer lives better lived, prompting an urgent reassessment of the ways in which culture is valued and distributed within society. What follows is an account of this research programme and a consideration of its implications for cultural policy.

Context

The research outlined in this chapter took place against the backdrop of two largely unreconciled imperatives – first, that the arts should evidence their impact and, second, that we should engage with the arts for the good of our health.

On the one hand, the era of Cool Britannia witnessed the shift from a ‘something for nothing’ to a ‘something for something’ approach to the arts and their funding (Davies and Ford, 2000: 30). The nineteenth century paradigm of art for art’s sake – which was not without its critics – was deemed inadequate, and, as in other forms of public culture (notably education), the arts were compelled to prove their extrinsic worth. The two main types of impact that the arts have been expected to demonstrate are economic and social. Economic impact is inextricably bound up with the elision of the arts and creative industries, the designation of creative cities and the dream of inward investment. Expectations of social impact are discernible in the social inclusion policies beloved by New Labour and the demand that the arts justify their worth in relation to a number of societal metrics (Matarasso, 1997). A backlash against consideration of (particularly social) impact, and an attempt to debunk evidence-based policy, was spearheaded by the centre right think tank, Policy Exchange, in favour of a libertarian, anti-statist narrative (Mirza, 2006). However, a glimpse at the Culture White Paper, published by the Conservative Government in March 2016, reveals the persistence of the drive towards impact, with intrinsic, social and economic value recognised separately and, perhaps disingenuously, in that order (Department for Culture, Media & Sport, 2016).

On the other hand, there has been a groundswell of initiatives making the connection between arts engagement and health. At one end of the diverse arts and health spectrum, professionally accredited therapists administer arts activities targeted at a range of clinical outcomes. At the opposite end of the spectrum, in a continuation of the late 1960s community arts ethos,¹ thousands of organisations offer participatory arts activities throughout the UK, generally to those at a low ebb. While the former area of practice can be framed primarily in health terms and its impact measured accordingly, the latter varies widely in its approach to health impacts, and evaluation remains patchy. Nonetheless, all those working in the health-orientated community arts movement affirm the benefits of arts-based approaches.²

The field of health in the developed world is undergoing a transformation from a bio-medical to psychosocial model and from a focus on cure to an emphasis on prevention. This implies that the vast majority of communicable diseases have been eradicated and that the major challenges for current and future generations are long-term health conditions such as cancer, cardiovascular disease, dementia and obesity. The inextricability of physical and mental health is also readily acknowledged, as is consideration of the broader socio-economic factors determining health.

Between 2005 and 2008, Professor Sir Michael Marmot chaired the World Health Organization Commission on the Social Determinants of Health, which found that:

Social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, city and race. All these influences are affected by the socio-political and cultural and social context in which they sit.

(Marmot et al., 2010: 16)

Despite this acute analysis, the arts – which might usefully be thought of as psychosocial factors interacting with health and wellbeing – were conspicuous by their absence from the published thoughts of the Commission (Clift et al., 2010).

While the Commission on the Social Determinants of Health was mid-way through its work, the Chief Executive of the NHS commissioned Harry Cayton, National Director for Patients and the Public, to review the role of the Department of Health (DH) in advancing the arts and health. Cayton set up a working group, which reported that the arts were integral to health and health services and should be recognised as such. Simultaneously, DH and ACE collaborated on a prospectus for arts and health, outlining many examples of best practice and research-based evidence (Arts Council England, 2007). But, by the time the ACE strategic framework, *Achieving Great Art and Culture for Everyone*, was published in 2010, consideration of the health value of the arts had receded into the background.

Despite periodic recognition of the relationship between the arts and health, the quality of the evidence base is often cited as a reason for the arts being overlooked when health and its social determinants are discussed. Much progress is being made in this area, with a range of mixed methods approaches being used to capture the health impacts of arts activities. The research described here makes a tangential contribution to the field by taking a further step away from targeted impacts to consider the inadvertent health effects of engaging with the arts in galleries, museums, theatres and concert halls.

Methods

Literature search and study selection

A search was initially undertaken of the MEDLINE (using PubMed) and EMBASE (using Ovid SP) databases, beginning with such terms as ‘art’, ‘culture’, ‘health’, ‘longitudinal’. However, as these words are ubiquitous within the literature – with ‘culture’ frequently appearing in relation to the cultivation of cells and ‘art’ regularly occurring in phrases such as ‘state-of-the-art’ and serving as an acronym for Atraumatic Restorative Treatment, Anti Retroviral Treatment and Assisted Reproductive Technologies – this generated an excess of 10,000 results when using Ovid. Sorting the results by relevance (five stars) failed to isolate three terms together. The use of truncated versions of the search terms – such as ‘long’ (306 results when searched with ‘art’ and ‘survival’ in Medline) – and Boolean operators – e.g. ‘NOT HIV’ (216 results in Medline) – reduced the quantity of results but came no closer to isolating even those studies that were known at the outset. That these known studies used little common language ultimately precluded the use of generic search terms. The review also sought to take account of grey literature in the field, but a search of Open Grey produced 11 irrelevant studies, reinforcing the need for other methods.

In light of the above, it was decided to conduct a hand search of material, beginning with the nucleus of known studies – specifically those undertaken by a team based in Sweden, led by Lars Olov Bygren and first published in the *British Medical Journal* in 1996 (Bygren et al., 1996) and its Finnish equivalent, led by Markku T. Hyypä (Hyypä et al., 2006). From there, the review radiated outwards, taking account of subsequent research published by these two teams and the studies to which they referred. This scoping process was complemented by the use of web-based search engines and facilitated by dialogues with the main researchers in the field, either by email or in person during a week-long trip to the Nordic region. Additionally, reports issued by policy-making bodies at Westminster and Holyrood were scrutinised, and civil servants in the Department for Culture, Media and Sport (DCMS) were consulted.

The longitudinal focus of the review precluded cross-sectional studies. All known physical and mental health conditions were included, as were subjective measures, such as self-rated health. Similarly, cultural engagement was considered across the art forms, taking account of

attendance at arts events and (to a lesser extent) participation in creative activity. As arts engagement was understood to be a voluntary part of participants' lives, rather than an 'intervention', studies considering the therapeutic nature of creative engagement upon existing health conditions and those relying on randomised controlled trials were excluded from consideration.

As several of the studies only mentioned arts engagement as an incidental element of socio-cultural interaction, the ultimate criterion for inclusion became the consideration of two or more discrete cultural activities. The scoping process generated an initial long list of studies from which the eventual evidence base was culled. Data on study characteristics were extracted – including country of origin, authors, publication year, dataset, population sample size, age of respondents, outcome measure, cultural activities, confounders and results – are tabulated at the end of this report.

Results

The scoping review yielded an initial 14 key studies. A digital evidence base was compiled online (longitudinalhealthbenefits.wordpress.com), containing a précis of each study and links to the original research articles where copyright clearance was possible to secure. The online evidence base also includes a consideration of the main strengths and weaknesses of each study and a hint about the mechanisms thought to underlie any of the positive associations that were observed between the two main variables of arts engagement and health.

The evidence base was launched at the annual conference of the Faculty of Public Health of the Royal College of Physicians on 3 July 2014 and widely publicised among colleagues in the arts and health, research and policy-making fields. Since then, the scoping review has continued, and a further study has been added to the evidence base (Agahi and Parker, 2008). As of April 2016, the online repository had received 5,150 views from more than 30 different countries, including Brazil, Japan and South Africa. As this site solicits details of any omissions, the evidence base has the possibility to evolve, through attention being drawn to extant work in this area and new studies being carried out.

As suspected at the outset, the evidence base is largely centred on the Nordic region, specifically Sweden, Finland and Norway. In these countries, research teams benefit from population data collated over time, with the inbuilt possibility of linkage (through unique personal identification numbers) to registers detailing morbidity and mortality. The studies rely either on longitudinal panel surveys or on one-off questioning of a large cohort, subsequently followed up in relation to a given outcome measure. As discussed at greater length below, outcome measures range from general and cause-specific mortality to specific morbidities such as dementia and obesity, with a wide variety of potential confounders being considered. Numbers of participants range from 463 to 12,675, aged between 11 and 99. The majority of studies perform *a posteriori* analysis, with the researchers having no input into the formulation of questions and respondents inevitably being blinded to the purpose of such retroactive studies. The evidence base is variously grounded in social epidemiology, gerontology and occupational health; an interpretation of the findings of the studies in the evidence base is attempted here.

Mortality and chronic morbidity

Given the ready availability of data pertaining to date and cause of death in the Nordic countries, it is, perhaps, inevitable that several of the research teams have focused upon mortality or survival as their main outcome measure. Ten of the studies in the evidence base adopt such an approach to assess the impact of a range of socio-cultural factors upon longevity. Of these,

five consider all-cause mortality (Bygren et al., 1996; Konlaan et al., 2000; Lennartsson and Silverstein, 2001; Hyypä et al., 2006; Agahi and Parker, 2008), four introduce some differentiation among causes of death – through cancer (Welin et al., 1992; Bygren et al., 2009), cardiovascular disease (Hyypä et al., 2007), external and other causes (Väänänen et al., 2009) – and one examines coronary heart disease mortality and morbidity together (Sundquist et al., 2004).

The first study in the evidence base is unable to find a link between socio-cultural activities and cancer-related mortality (Welin et al., 1992), while another assessment of all-cause mortality from a similar perspective detects a negligible effect upon survival from socio-cultural engagement (Lennartsson and Silverstein, 2001). The main Finnish team finds that leisure social participation mildly predicts all-cause mortality (Hyypä et al., 2006), while having no discernible effect upon cardiovascular mortality (Hyypä et al., 2007). Another Finnish team finds an association between external causes of mortality (such as accident and suicide) and (particularly socially orientated) cultural participation (Väänänen et al., 2009). While these results are ambiguous, more fruitful avenues of enquiry are opened up when longevity is approached in social and cultural terms.

Emphasising the social over the cultural

Social epidemiology presumes a ‘category of environmental factors capable of producing profound effects on host susceptibility to environmental disease agents’ (Cassel, 1976: 108). In this context, environmental factors are taken to include ‘the presence of other members of the same species, or more generally, certain aspects of the social environment’ (Ibid). In turn, consideration of the psychosocial determinants of health posits that social isolation increases the risk of all-cause mortality (Berkman and Syme, 1979), with social support thought to guard against a range of chronic diseases (House et al., 1982; Schoenbach et al., 1986; Kaplan et al., 1988) and self-reported symptoms, both physical and psychological (Berkman, 1995; Seeman, 1996). Accordingly, more than half of studies in the evidence base adopt what might be described as a social capital perspective, which takes close account of the individual’s place within society.

While social capital is a multi-faceted and mutable construct that is notoriously difficult to define and measure, Hyypä et al. have sought to demonstrate a relationship between social capital and health. The first of two studies showed leisure social participation to be a predictor of survival in middle-aged Finnish men (Hyypä et al., 2006), while the second only just replicated this finding in relation to all-cause mortality but not to deaths from cardio-vascular causes (Hyypä et al., 2007).

Marmot argues that ‘living in supportive, cohesive social groups can be protective’ of health (2015: 10), changing hormonal profiles and potentially lowering the risk of heart attacks, whereas being marginal in society can increase the risk of disease. Engagement in cultural activity in the public sphere is thought to increase the sense of community cohesion and confer a health-protective effect. However, this body of work suggests that the artistic specificities of engagement are subordinate to the social milieu in which engagement occurs. In order to ascertain cultural value, this approach needs to be inverted.

Isolating the cultural from the social

A social capital approach to arts engagement permits a multiplicity of diverse leisure-time activities to be bunched together in the analysis, obviating differentiation between art forms. In distinguishing cultural from social engagement, the team comprised of Bygren, Johansson and Konlaan has led the field. In the aforementioned *BMJ* study, which formed the basis of many

subsequent research programmes, Bygren et al. initially acknowledged that the social element of cultural participation might be an important determinant of survival, suggesting that 'Perhaps cultural behaviour is so intermingled with life as a whole that it is impossible to discern its influence' (1996: 1578).² At the same time, they discovered possession of a social network to be a slight threat to male longevity and showed low (compared to regular) attendance at cultural events to significantly increase the likelihood of death. Four years later, the same team found social ties to have a negligible effect as a confounder, irrespective of their strength or quality (Konlaan et al., 2000). They also began to address the lack of differentiation between art forms – which had typified their own earlier studies and those of other research teams – to demonstrate a positive association between survival and attendance at the cinema, concerts and exhibitions. The same team's 2001 study shows a positive association between self-rated health and attendance at exhibitions, dance performances, films, popular music concerts and theatre plays, as well as establishing a directly proportional relationship between self-rated health and the number of cultural activities attended (Johansson et al., 2001).

Transferring this approach to a US context, Bygren would later collaborate on a cross-sectional study that tested this premise (Wilkinson et al., 2007). Rare cultural attendees were seen to be suffering from greater rates of cancer-related mortality than their high-attending counterparts in urban areas. Significantly, this study claims that cultural attendance evinces a potentially preventative effect, making it akin to physical activity and smoking as a predictor of cancer-related mortality, irrespective of health and socio-economic status.

Departing from the Bygren team to reconsider cultural engagement as a factor in social participation, Sundquist et al. (2004) drew up a participation index with 18 variables. It is noteworthy that those variables with the greatest significance were found to be the five forms of cultural attendance included in the index: cinema, theatre, concerts, art exhibitions and museums. These combined findings suggest that the intrinsic cultural experience has a part to play in militating against life-threatening conditions. The possible reasons for this will be discussed shortly.

Successful ageing

Another area in which the long-term relationship between arts engagement and health has been studied is that of successful ageing (Adams et al., 2011). Three of the studies in the evidence base focus on populations over the age of 65, with two focusing on survival (Lennartsson and Silverstein, 2001; Agahi and Parker, 2008) and one on the onset of dementia (Wang et al., 2002). All three consider participation in creative activity in addition to attendance at cultural events. On the understanding that 'The act of making [is] cognitively demanding and [requires] skills in planning, evaluation, counting, measurement and problem solving' (Liddle et al., 2013: 332), several of the studies in the evidence base acknowledge the mental component of arts engagement (Lennartsson and Silverstein, 2001; Wang et al., 2002; Bygren et al., 2009; Väänänen et al., 2009; Cuypers et al., 2012). In relation to dementia, attendance at cultural events has been categorised as social while participation in creative activity (such as drawing or painting) is defined as mental, with both types of activity found to exhibit a positive association with dementia prevention (Wang et al., 2002).

Weight management

With obesity looming as a major public health issue, a further area of research has centred on the relationship between socio-cultural engagement and weight gain. Focusing on the social

aspects of participation, one study alluded to arts engagement increasing the likelihood of adolescent boys becoming overweight (Lajunen et al., 2009). Yet, while another study found no association between social participation and waistline measurement in adult women, it observed a greater likelihood of maintaining weight within the recommended range for adult men (Kouvonen et al., 2012). In the same year, a third study found that, as compared to social participation, cultural participation was negatively associated with obesity in teenage girls (Cuypers et al., 2012). This finding fits with research that has discovered an element of social communicability in relation to obesity (Christakis and Fowler, 2007) and consolidates the positive effects of cultural engagement observed elsewhere.

Gender

Work carried out around both successful ageing and obesity elaborates on the gendered nature of health effects. One paper in the evidence base takes gender as its main focus, drawing on a study population as it migrates from the Swedish Level of Living Survey to the Swedish Panel Study of Living Conditions of the Oldest Old. It is here that we encounter the most direct claims of causality, with a dose-response relationship between social participation and survival being reported in women. When differentiating a range of social activities, it is found that ‘participation in cultural activities was the only activity that was significantly related to survival in both men and women’ (Agahi and Parker, 2008: 865).

Discussion

Reviewing the studies in the evidence base suggests that there is a growing body of literature surrounding the longitudinal relationship between arts engagement and health. Largely centred on the Nordic countries, the evidence base suggests that engagement in the arts – primarily as an audience member but also as a practitioner – generally has a positive impact upon life expectancy, disease resistance, mental acuity and weight maintenance, through a variety of possible means.

Common to the majority of studies is the tentative nature of their claims, speaking of association (or correlation) rather than causation. In a similarly tentative way, arts engagement is assumed to have a preventative, rather than remedial, effect. Interestingly, the potentially detrimental effects of arts engagement have also been acknowledged from the outset, with Bygren et al. speculating that ‘Negative effects of cultural activities could be that people lose their sense of reality and identify with asocial models of behaviour and are themselves encouraged towards asocial behaviour’ (1996: 1578). This is echoed by Hyypä, with the sentiment that ‘It is highly probable that not all cultural activities are beneficial for health and survival; some can even be detrimental to health’ (2010: 51). Further work is needed to establish the existence and direction of any causal relationship between the two main variables, and it is rightly argued that ‘More prospective studies on large populations are needed to answer questions on causality’ (Cuypers et al., 2011: 22).

The two greatest obstacles to attributing causality are the possibility of reverse causation and the likelihood of residual confounders. In the first case, it is generally assumed that people with poor health tend not to take part in cultural activities (or surveys), thereby skewing the results. Researchers on the HUNT Study in Norway, which provided data for the most recent study in the evidence base (Cuypers et al., 2012), have elsewhere given consideration to the biases that may arise through non-participation, finding not only disease but also socio-economic status to be the main reasons for non-response (Langhammer et al., 2012). A report

published by the Scottish Government asserts that ‘cultural engagement levels are highest in the highest household income groups in Scotland and decline to be lowest in the lowest household income groups’ (Leadbetter and O’Connor, 2013: 7). At the same time, Taking Part data consistently demonstrate that white adults from higher socio-economic groups are the main beneficiaries of Arts Council England’s strategy of ‘great art and culture for everyone’.

In the second case, ‘there is the unavoidable problem of possible unknown or latent confounders’ (Hyypä, 2010: ix). Table 20.1 at the end of this report shows the range of possible confounders that have been included in the evidence base; longitudinal research must continue to take account of individual and social factors that have an impact upon health irrespective of arts engagement.

In their seminal paper, Bygren et al. (1996) suggested that cultural participation might underlie the different survival rates observed across social classes. Low income, identified by Welin et al. (1992) as a residual confounder, was seen to be significant with respect to mortality. When subsequently considering the association between cancer-related mortality and cultural attendance, the *BMJ* team asserted that cultural attendance might serve as a ‘proxy variable for other cancer preventive factors’ (Bygren et al., 2009: 71). As the association between cancer-related mortality and cultural attendance could only be determined in urban locations, the researchers concluded that arts participation might be part of a healthy and active lifestyle and signal better access to information and health services. In much the same way, Hyypä et al. found that ‘economic status slightly modified the effect of leisure participation in men, thus emerging as a tentative mediator between social capital and health’ (2007: 594). If we are to fully explain these observations, attention needs to be paid to the relationship between socio-economic factors (across multiple indicators) and levels of access to both health and cultural resources. Many of the datasets underlying the international evidence base are available for re-examination, and scope exists to draw upon UK-based datasets. Beyond the analysis of extant data, there is scope for intervention into the questions making up the surveys, and researchers at both DCMS and the HUNT Study indicated their willingness to consider this.

In the surveys underlying the evidence base, questions pertaining to arts engagement tend to be centred on frequency. Yet, many of the studies in the evidence base acknowledge that the qualitative, rather than quantitative, properties of arts engagement might be determining factors. If we are to unravel the association between arts engagement and health, much greater attention needs to be paid to the particular experience of engaging with art, film, music and theatre.

As the name suggests, cultural value was the starting point for the umbrella project under which this research was conducted. The Cultural Value Project sought to ‘reposition first-hand, individual experience of arts and culture at the heart of enquiry’ (Crossick and Kaszynska, 2016: 7). A primary focus on cultural value – in advance of considering any second-order health and wellbeing benefits – has the welcome side effect of adding lucidity to the debate around social capital.

One of the most interesting aspects of this study comprises the mechanisms that are speculated upon in cases where a positive relationship between arts engagement and health is observed, with the most compelling being psychoneuroimmunological and epigenetic in nature. In the case of psychoneuroimmunology, the nervous, immune and endocrine systems are implicated in psychosomatic mechanisms, stimulated by cognitive interactions (such as arts engagement) and mediated by cortisol, the stress hormone. As we have seen, social epidemiology admits that environmental factors can enhance susceptibility to disease. In considering the social determinants of health, it is increasingly accepted that the converse is also true, and an enriched environment can have health-protective effects. Bygren et al.

argue that arts engagement, as a form of environmental enrichment, can contribute to lowering stress, thus engendering a range of physical and mental health benefits.

This brings us to the emerging field of epigenetics, which suggests that environmental alterations bring about changes in the non-coding part of the genome that determines which genes are switched on or off at a given time. It has recently been discovered that epigenetic shifts are communicable through the generations, meaning that positive or negative environmental effects could be passed from parents to their children (Bygren, 2013). This has clear implications in relation to the social determinants of health and their persistence through the generations while also signalling a role for arts engagement as a form of environmental enrichment. Let us turn now to a consideration of the ways in which cultural policy could respond.

Implications

However tentatively the findings of individual studies in the evidence base are reported, the sense emerges that the relationship between arts engagement and health carries important public health implications, which have consequences for cultural (and health) policy.

The aforementioned Culture White Paper makes intrinsic value synonymous with well-being and life satisfaction, and it cites health as a social benefit, on the basis that ‘There is considerable evidence of the beneficial effects of the arts on both physical and mental health. This includes improvements such as positive physiological and psychological changes in clinical outcomes; decreasing the amount of time spent in hospital; and improving mental health’ (Department for Culture, Media & Sport, 2016: 15). This medley of positive health impacts seems to encompass a consideration of arts therapies and health-orientated community arts, with art in hospitals in between. When multifarious health impacts are hybridised in this way, it is impossible to determine whether international longitudinal studies and/or attendance at non-health-orientated arts events have been taken into account, but the accompanying bibliography and case studies (all of which are drawn from the UK) suggest not.

The significance of the finding that arts engagement is generally beneficial for health is two-fold, carrying implications for cultural venues and health-orientated community arts initiatives. In the case of cultural venues, the positive effects of arts engagement provide arguments for the continued funding of arts activities, in and of themselves. This might serve to convince evidence-based policy-makers of the continued necessity of supporting the arts in a non-clinical environment. Added to this, the fact that research has been carried out at a large scale – across whole populations and extended periods of time – potentially exempts individual organisations from continually having to justify their value to the public purse. That the individual, qualitative experience of arts engagement is taken to be paramount in manifesting health effects may ultimately serve to focus attention away from quantitative measurements of cultural value.

Notwithstanding the positive implications of this research for cultural venues, the fact that these health benefits are only being accessed by an already privileged part of the population remains a source of concern. It is here that health-orientated community arts organisations come into their own, consistently reaching those experiencing mild to moderate mental health issues, often in combination with physical conditions and often as a result of multiple deprivation. In their insistence upon process over product, such organisations tend to be weighted towards ‘everyone’ rather than asking who and what defines ‘great’. The recommendation in the Culture White Paper that clinical commissioning groups and local authorities mount a concerted effort to support this work is a welcome one, offering a potential route for democratising access to arts engagement as a form of environmental enrichment and a psychosocial determinant of health.

Table 20.1 Comparative table of studies in the evidence base

<i>Authors, year, country</i>	<i>Dataset, population sample size, age</i>	<i>Outcome measure</i>	<i>Confounders</i>	<i>Cultural activities</i>	<i>Results</i>
Wellin et al., 1992, Sweden	Men born in Gothenburg in 1913 (selected in 1963 and 1973), <i>n</i> = 769 60-year-olds; 220 50-year-olds	Mortality from cardiovascular diseases, cancer and other causes to 1985	Smoking, alcohol consumption, previous stroke or heart attack, marital status, household size, income	Reading, cinema, theatre, concerts, museums/galleries,	Middle-aged men with a good 'social network' may be partly protected against non-cancer mortality. Attending cultural events at least once a week has a positive effect upon survival.
Bygren, Konlaan and Johansson, 1996, Sweden	Swedish Survey of Living Conditions 1982-3, <i>n</i> = 15, 198 (12,675) participants aged 16-74 years	Survival to 31 December 1991	Age, gender, education level, income, long-term disease, social network, smoking, physical exercise	Cinema, theatre, concerts, live music, art/other exhibitions, museums, reading, music-making, singing in a choir	Attending cultural events at least once a week has a positive effect upon survival.
Konlaan, Bygren and Johansson, 2000, Sweden	Swedish Survey of Living Conditions 1982-3, <i>n</i> = 10, 609 aged 25-74	Survival to 31 December 1996	Age, gender, cash buffer, educational level, long-term disease, smoking, physical exercise	Cinema, theatre, concerts, live music, art exhibitions, museums, music-making, reading	'Attendance at cultural events may have a beneficial effect on longevity' (p. 174).
Johansson, Konlaan and Bygren, 2001, Sweden	Swedish Survey of Living Conditions 1982-3 and 1990-1, <i>n</i> = 3, 793 aged 25-74	Self-reported health	Baseline health status, type of residence, geographical region of domicile, socio-economic status (level of education)	Cinema, theatre, concerts, live music, art exhibitions, museums, music-making, reading	'Those who became culturally less active between the first and second occasion, or those who were culturally inactive on both occasions, ran a 65% excess risk of impaired perceived health compared with those who were culturally active on both occasions' (p. 229).

Bygren et al., 2009, Sweden	Swedish Survey of Living Conditions 1990–1, <i>n</i> = 9, 011 aged 25–74	Cancer incidence in Swedish public death register to 31 December 2003	Age, gender, chronic conditions, disposable income, educational attainment, smoking status, leisure time physical activity, urban/non-urban residency	Cinema, theatre, live music, art gallery, museum	Rare and moderate cultural attendees were 3.23 and 2.92 (respectively) times more likely to die of cancer than regular attendees in urban areas.
Lennartsson and Silverstein, 2001, Sweden	Swedish Panel Study of Living Conditions of the Oldest Old 1992 <i>n</i> = 537 (463 non-institutionalised) aged 75+	Survival to 1996	Age, gender, educational level, functional impairment, presence of heart or circulatory problems, tobacco use	Cinema, cultural events, reading books or newspapers, hobbies	Solitary–active participation (e.g. gardening, hobbies) reduce mortality risk, particularly in men.
Wang et al., 2002, Sweden	Kungsholmen Project 1987–9, <i>n</i> = 1, 810 aged 75+	Onset of dementia between first follow-up (1991–3), and second follow-up (1994–6)	Age, gender, education, cognitive functioning, comorbidity, depressive symptoms, physical functioning at baseline	Theatre, concerts, art exhibitions (social), painting, drawing (mental), sewing, knitting, crocheting, weaving (productive)	‘Engagement in mental, social, or productive activities was inversely related to dementia incidence’ (p. 1081).
Sundquist et al., 2004, Sweden	Swedish Annual Level-of-Living Survey 1990–1, <i>n</i> = 6, 861, 35–74 years	Coronary heart disease morbidity or mortality to 31 December 2000	Socio-economic and educational status, housing tenure, smoking, age, gender, marital status, geographical region	Cinema, theatre, concerts, art exhibitions and museums, choir	An association found between low social participation and increased incidence of coronary heart disease morbidity and mortality. Attendance at the cinema, theatre, concerts, art exhibitions and museums had (by far, in most cases) the most significance within the social participation index.

(Continued)

Table 20.1 (Continued)

<i>Authors, year, country</i>	<i>Dataset, population sample size, age</i>	<i>Outcome measure</i>	<i>Confounders</i>	<i>Cultural activities</i>	<i>Results</i>
Hyyppä, Mäki, Impivaara and Aromaa, 2006, Finland	Mini-Finland Health Survey 1978–80, <i>n</i> = 5, 087, 30–59 years	Survival during 20 years of follow-up (first three years excluded)	Residential stability, socioeconomic status, marital status and relations, trusting relationships, alcohol consumption, smoking; mental health, self-reported chronic diseases or disabilities, self-rated overall health	Theatre, cinema, concerts, art exhibitions, reading, listening to music, drama, singing, photography, painting and handicraft	'Leisure participation predicts survival in middle-aged Finnish men and its effect is independent of demographic features, of health status and of several other health-related factors' (p. 5). Leisure participation is associated with reduced all-cause mortality in women and men (related to economic status in the latter case).
Hyyppä, Mäki, Impivaara and Aromaa, 2007, Finland	Mini-Finland Health Survey 1978–80, <i>n</i> = 7, 217, 30–99 years	Survival during 24 years of follow-up (first five excluded) with attention to all-cause and cardiovascular mortality (including strokes) up to November 2004	Residential stability, socioeconomic status, marital status and relations, trusting relationships, alcohol consumption, smoking; mental health, self-reported chronic diseases or disabilities, self-rated overall health	Theatre, cinema, concerts, art exhibitions, reading, listening to music, drama, singing, photography, painting and handicraft	Leisure participation is associated with reduced all-cause mortality in women and men (related to economic status in the latter case).
Agahi and Parker, 2008	Swedish Annual Level-of-Living Survey 1990–1 and Swedish Panel Study of Living Conditions of the Oldest Old 1992, <i>n</i> = 1, 246 men and women aged 65 to 95	Survival to 31 December 2003	A range of symptoms and diseases, functional status, age, gender, educational level (as a measure of socio-economic position), smoking, alcohol, body mass index.	Reading books, hobby activities (e.g. knitting, sewing, carpentry or painting), cultural activities (going to the cinema, theatre, concerts, museums or exhibitions), dancing, playing musical instruments, and choir singing.	Women demonstrated a dose-response relationship between overall participation and survival; men did not. 'Gender-specific analyses revealed that participation in cultural activities was the only activity that was significantly related to survival in both men and women' (p. 865).

Lajunen et al., 2009, Finland	FinnTwin12 study all twins born in Finland 1983–7, $n = 5,184$ twins aged 11–12 years	Becoming overweight during follow-up at 14 and 17 years	Pubertal timing, socioeconomic status of family	Television and video viewing, computer games, listening to music, playing musical instruments, reading, arts (drawing or painting, handicrafts, woodwork, building scale models)	Engagement in the arts in boys was detrimental to the maintenance of recommended weights. Among girls, few individual leisure activities predicted becoming overweight. However, the 'passive and solitary' cluster carried the greatest risk of becoming overweight in late adolescence.
Väänänen et al., 2009, Finland	Still Working survey (conducted by Finnish Institute of Occupational Health) 1986, $n = 7,922$, working age	Survival 1986–2004	Socio-demographic factors, socio-economic status, work stress, social characteristics, diabetes, hypertension		High cultural engagement independently associated with decreased all-cause mortality and external causes of death (with solitary activities related to the former and socially shared cultural activities to the latter).

(Continued)

Table 20.1 (Continued)

<i>Authors, year, country</i>	<i>Dataset, population sample size, age</i>	<i>Outcome measure</i>	<i>Confounders</i>	<i>Cultural activities</i>	<i>Results</i>
Kouvonen et al., 2012, UK	English Longitudinal Study of Ageing waves 2 and 4, $n = 4, 280$ age 50+	Waist circumference at follow-up	Gender, age, ethnicity, marital status, total wealth, longstanding limiting illness, depressive symptoms, smoking status and physical activity	Arts or music group	No association was found between social participation and waistline measurement in women. Men with an initial waist measurement in the recommended range who participated in education, arts or music groups or evening classes and in charitable associations were more likely to maintain their waist circumference.
Cuyppers et al., 2012, Norway	HUNT Study 1995–7, $n = 8, 408$ 13–19 years, followed up 2006–8, $n = 1, 450$ 24–30 years	Obesity (body mass index, waist circumference, waist-hip ratio and natural development of the body over the life course)	Physical activity, socio-economic status, pubertal timing and genetic proclivity to obesity	Reading a book, listening to or playing music, doing homework, watching television	Participation in cultural activities guarded girls against being overweight. This was amplified when considering those who were at the recommended weight at baseline and when television was excluded as an activity

Notes

- 1 It is interesting to note that, in seeking to detach the participatory arts from ideology while advocating social impact, François Matarasso asserted that ‘participation is not a euphemism for community arts’ (1997: 4).
- 2 An example of best practice is to be found in Salford, where the organisation Start (founded in 1993) has purchased a building and installed specialist studios for woodwork and ceramics. To watch a film about some of the benefits accrued by service users, visit www.youtube.com/watch?v=wbyVL0MrOy0.
- 3 Asterisk in References indicates inclusion in the evidence base.

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