An international review of arts inclusion policies: lessons for Hong Kong

Alvin Cheung, Charlotte Yu, Queenie Li and Helen So
Our Hong Kong Foundation

Received 11 July 2019
Revised 16 September 2019
Accepted 26 September 2019

Abstract

Purpose – The purpose of this paper is to review and compare the implementation of "arts inclusion" policies (AIPs) by 14 different public administrative systems around the world. It aims to provide a consolidated source which informs further studies in this field, and to develop a framework to compare AIPs at a global level.
Design/methodology/approach – Using "arts inclusion policy" as the search term, academic journals from a wide spectrum of fields were reviewed. A data set was extracted from the Compendium of Cultural Policies and Trends' online database which provided real-time information of national cultural policies. Another data set is from the United Nations' Inequality-adjusted Human Development Index, as the geographic scope of the review – largely focussing on UK, US, Australian, Scandinavian and Asian contexts. Using existing policy-making literature as benchmark, the authors designed and applied a comparative framework dedicated to AIPs which focussed on "policy-making structures" as the main ground of comparison.
Findings – An important finding is that the policy development and implementation of AIPs often underscore inter-sectoral involvement in many public administrations in this study. With policy leadership and financial incentives pivotal to effective AIPs, central governments should take a more concerted leadership role to include AIPs in national inter-sectoral policies, encourage evidence-based research, expand funding and advocate the recognition of the impacts of arts inclusion. It is concluded that AIPs in western countries remain more developed in targeted scopes and programme diversity compared to those of Asian countries and regions. Continued studies in this field are encouraged.
Originality/value – This review is the first of its kind to include a number of Asian and western countries within its research scope, allowing it to offer a more holistic outlook on the development and implementation of AIPs in different countries and regions. A common critique with all relevant existing literature was usually their lack of concrete comparative grounds, and the present study's all-encompassing review of literature from across different levels and sectors of respective public administrative systems contribute to a unique and comprehensive perspective in the arts and health discourse.

Keywords Arts and social inclusion, Inter-sectoral policies, Policy comparison, Policy-making structures
Paper type Research paper

Introduction

The arts can strengthen communities and engender social benefits for marginalised groups including the elderly and those living with mental illness and functional impairments (Raglio *et al.*, 2008; Gold *et al.*, 2013; Gooding, 2011; Mers *et al.*, 2009; Howells and Zelnik, 2009). Disparities affecting socially disadvantaged groups limit their mobility and ability to access social networks, services and the labour market; this further intensifies health disparities linked to their low-socioeconomic status.

These biases can be ameliorated by policies enacted by governments which redress social exclusion and pursue health equity, by encouraging social empowerment through various means of the arts. Countries and regions are increasingly turning to the arts to

Public Administration and Policy
Vol. 22 No. 2, 2019
pp. 173-191
Emerald Publishing Limited
1727-2645
DOI 10.1108/PAP-09-2019-0019

encourage social empowerment and achieve social inclusion. The strategies, objectives and rationales developed from distinct approaches are worth examining.

Defining "the arts" and "social inclusion"

"The arts" is defined in its broadest meaning for the purposes of this study. It encompasses and is not limited to different types of creative and cultural engagement in visual, photographic, musical, kinaesthetic, theatrical and literary forms. Arts participation varies from joining a master class, opening studio workshops to attending arts events. Francois Matarasso (1997) parses the wide-ranging social impacts of the arts into five areas: personal development; social cohesion; community empowerment and self-determination; local image and identity; and imagination and vision. Arts-based initiatives improve physical functionality and provide symptom relief for elderly patients suffering from severe mental disorders (Gold *et al.*, 2009). These activities help regulate emotions among people with depressive disorders (Nan and Ho, 2017) and play an essential role in fostering social inclusion through the arts' non-verbal and non-discriminatory reach (Fisher, 2002; Matarasso, 1997). Although these respective groups are commonly associated as socially excluded due to their health statuses, their physical, communication, social and relationship skills can still be improved through arts therapy (Got and Cheng, 2008). There is a growing body of evidence that participatory arts alleviate health disparities and bring benefits to personal health and well-being as well as social inclusion.

Social inclusion is a multi-faceted concept with a cross-dimensional disposition. In policy discourse, social inclusion has come about in reaction to social exclusion. There is noticeably less literature dedicated to just inclusion without presupposing a state of exclusion. Social inclusion literature often advocates removing "structural barriers" so excluded groups can better participate in society. Promoting inclusion also requires radical changes in societal attitudes beyond simply enabling excluded groups to fit into unwelcoming societies (Bates, 2005; Bates and Davis, 2004; Dunn, 1999; Gordon *et al.*, 2000; Jermyn, 2001, 2004). It is a more deliberate process of encompassing and welcoming all persons and embracing greater equality and tolerance (United Nations, 2016). Social inclusion is more than remedial steps to remove barriers to participation and also involves encouraging participation. The main focus of the research is to review how barrier-free and active policy tools improve social inclusion through the arts.

Policy making in arts inclusion

The mobilisation of the arts as a policy tool to redress social exclusion was first deployed at the turn of the twenty-first century by then UK Prime Minister Tony Blair's administration through the Social Exclusion Unit. The programme was part of a national strategy to eradicate exclusion through joint-departmental collaborations (Sandell, 1998). International awareness grew and today, there are more arts and cultural policies that address issues of diversity by building stronger and healthier communities across countries and regions. These policies include wide-ranging programmes as well as research and development into longer-term plans and strategies. The goal is social inclusion through the arts executed by two means: removing structural barriers to the arts and facilitating excluded groups' participation in society; and using therapeutic arts interventions to improve marginalised groups' well-being and further facilitate social engagement.

This study reviews the policy-making process through the lens of administrative structures – which differ significantly across governments: some adopt an inter-sectoral approach while others prefer tasking one dedicated ministry or department.

The following two cases are real-life examples showing how different countries utilise arts inclusion policies (AIPs) to foster social inclusion and how AIPs involve inter-sectoral efforts.

Case 1 – DaDaFest, UK. DaDaFest is an innovative disability-focussed arts organisation that receives recurrent annual funding from ACE as a National Partner Organisation.

They deliver the internationally renowned DaDaFest disability arts festival and other arts events to promote high-quality "disability and deaf" arts from unique cultural perspectives. It also creates ways for the disabled and the deaf to access the arts. A bi-annual event, DaDaFest International 2016, was the 13th of its kind since its inception in 2001, funded by Art Council England and Liverpool City Council amongst other trusts, charitable foundations and academic institutions in the UK (DaDaFest, n.d.)

Case 2 – The Norwegian Resource Centre for Arts and Health, Norway. The Norwegian Resource Centre for Arts and Health, established in July 2014 is a collaboration amongst Nord University, Trøndelag County, Levanger Municipality, Helse Nord-Trøndelag HF and HUNT Research Centre. The centre's primary mandate is to synergise the efforts made in research, education and practice in the fields of arts and health. Publicly funded by the Norwegian Directorate of Health, the centre ensures good use of arts resources in the health-related sectors, and encourages arts-based strategies in the training of care providers. Its target groups include children, people with mental health problems, elders and people with dementia (Norwegian Resource Centre for Arts and Health, n.d.).

The need of AIPs' comparative review due to insufficient studies

The field of AIPs is relatively new, and thus studies remain few and narrow in scope. There is a lack of comparative grounds in the reviews or papers on arts inclusion: there is no similar literature by official institutions, independent agencies or academia, with unique focus on AIPs as a theme. Even where there are, they often place specific focus on a particular geographical location. And institutional reports from the United Nations (UN) and European Union, for instance, tend to be descriptive but dogmatic and lacking comparability. A comparison of AIPs in different governmental structures is therefore necessary.

This paper aims to inform continued study in this field by: developing a framework to compare policy-making structures on AIPs at an international level; and providing a comparison of AIPs in 14 countries and regions, particularly in the field of policy-making structures.

Research methodology on comparing AIPs

This study constructs a framework to compare policy-making structures on AIPs at a global level for empirical purposes. Despite challenges in applying metrics to AIPs, this paper begins with a qualitative approach for insights on AIPs' modes by comparing case studies and decisive factors. An initial review of academic journals was conducted to map existing trends and to identify gaps which this study is to fill, focussing on geographical coverage of policies as well as policy-making considerations. Journals from a wide spectrum of fields including health, arts therapy and cultural policy were reviewed. Existing literature largely focusses on UK, US, Australian, Norwegian and Swedish experiences.

A review of academic journals ran parallel with online-resource mining with "arts inclusion policy" as the search term. The documents fell mainly into three categories: official and non-governmental arts institution reports and papers; academic papers by universities; and institutional reports on global trends. An additional data set was extracted from the Compendium of Cultural Policies and Trends' online database which provides real-time information and monitoring of national cultural policies. This review studied the geographic scopes and theoretical frameworks of these data sets to determine a value-added research structure in order to complement the existing literature meaningfully.

Defining a geographical scope for comparison

Western countries are featured prominently in cultural and inclusion policy desk research with the UK, the USA, France, Sweden, Norway, Finland, Australia, Canada and Ireland as reoccurring parties. To bring better balance and provide a more comprehensive basis for

understanding differing external and cultural contexts to policy making, this study especially included data from non-western countries, which was extrapolated from the Inequality-adjusted Human Development Index (IHDI) developed by the UN.

The Human Development Index (HDI) captures long-term trends through human development indicators across multiple dimensions including people's health, education and income for every nation and region (United Nations, 2018). It emphasises that national development should also be measured by health and education achievements, and not only the income per capita as long been the practice. To offset inequality in health, education and income distribution, the IHDI is actually less than the aggregate HDI. This is to incorporate inequality into HDI metrics and reflect its influence on a country or region's longevity, education and income (United Nations, 2018).

AIPs predominantly focus on human development rather than pure economic goals, because its major objective is to boost social equality through arts-based strategies. All countries identified from desk research were within the top 25th percentile in terms of IHDI (as shown in Table AI). It is affirmative that countries and regions with higher IHDI tend to have a better awareness on social inclusion and be more sophisticated in deploying respective instruments including AIPs. A further study on the remaining top IHDI countries and regions with existing AIPs at the ministerial level added the Netherlands, Singapore, Hong Kong, Japan and Taiwan to the list of research.

This study covers 14 countries including the UK, the USA, Australia, Canada, France, Ireland, Sweden, Finland, Norway, the Netherlands, Hong Kong, Singapore, Taiwan and Japan, which collectively provide the most pertinent comparative grounds for policymakers and researchers. The information collected from various governments' online portals, websites, academic journals, reports and literature formed the basis of the analysis of this study, to be cross-compared using an original comparative framework.

Frameworks for policy comparison

In this section, the authors discuss existing policy comparison frameworks from which applicable elements were derived to develop the own grounds of comparison (Wyszomirski *et al.*, 2003; Zuiderwijk and Janssen, 2014) (Figure 1).

From literature, a framework adopted by Zuiderwijk and Janssen (2014) that compared open data policies at different government levels is examined. It follows the six-stage policy-making cycle first suggested by Stewart *et al.* (2008), and re-categorises them into four main types, namely, policy environment and context (related to agenda setting); policy content (related to policy formulations and implementation); performance indicators (related to policy evaluation); and realising public values (related to policy change or termination) (Zuiderwijk and Janssen, 2014).

More relevant to the context of AIPs in the scope of discussion, a second framework examined is developed by Wyszomirski *et al.* (2003) that compared policies of cultural diplomacy across countries. The study identified five "major" comparative dimensions covering: terminology and role; goals and priorities; structure; programme tools; and indications of scale and support (Wyszomirski *et al.*, 2003) (Table I).

The two frameworks above offer plentiful insights on relevant comparative grounds and largely resonate with other existing frameworks. While acknowledging that a comprehensive policy analysis should follow the full course of the policy-making cycle and its related parameters, but due to the pioneering nature of this research, the metric adopted for this study shall be precise, which is why the foremost dimension of "structure" is selected.

Drawing from the studies above, and applying those to the context of AIPs, "structures" would refer to the organisational structures behind AIP development. Key questions include: how AIPs are managed administratively? Which departments/ministries or agencies are involved in AIPs development, and managing its implementation? It also

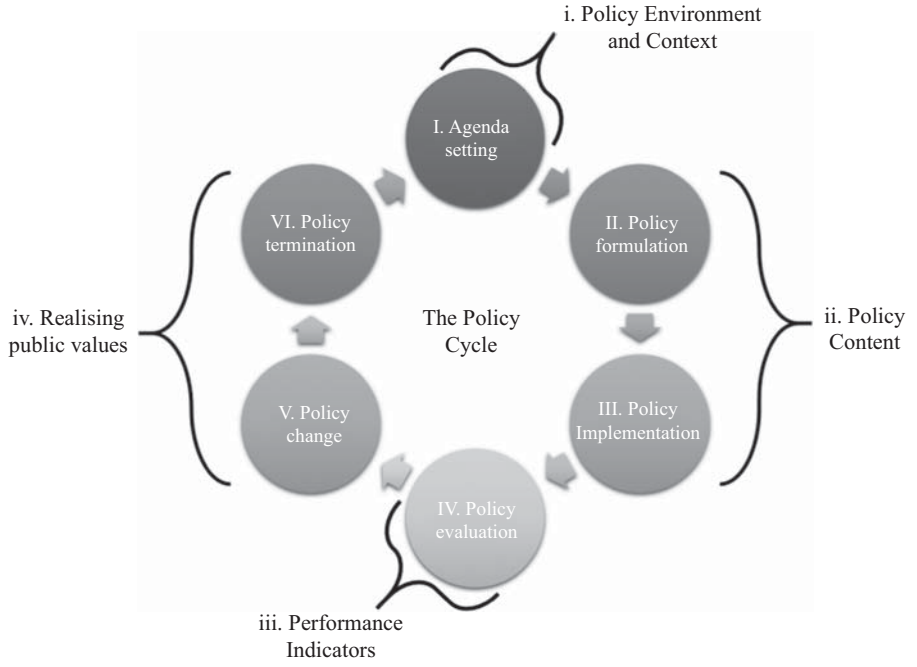


Figure 1. Frameworks used to compare open data policies

Sources: Zuiderwijk and Janssen (2014), Stewart *et al*. (2008)

Dimensions	Description
Terminology	How does each country refer to and regard what we call "cultural diplomacy"?
Goals and priorities	What are the stated goals and purposes of cultural diplomacy? Are there any explicit regional priorities?
Structure	How is cultural diplomacy managed? Which departments/ministries or agencies are involved in policy development and programme administration?
Programme tools	What are the programme tools employed in each country's cultural diplomacy efforts? A preliminary examination of cultural diplomacy programmes in a number of countries revealed a fairly common repertoire of nine kinds of programme activities. Few countries employ all nine types, but most countries do have a varied repertoire of programmatic activities
Indication of scale and support	How much does each country spend to support cultural diplomacy activities and how many activities are involved?

Table I. Five major comparative dimensions

happens that these considerations come under "policy environment and context" as coined by Zuiderwijk and Janssen (2014).

There is much literature that reify the symbiotic relationship between "organisational structures" and a policy's "environment and context". Scholars pointed to how organisational structures contribute to policy implementation effectiveness, and that "the choice for implementing officials" is "the correspondence of policy outputs" (Knill, 2005; Sabatier and Mazmanian, 1979).

This is why the authors have adopted the dimension of "organisational structure" as the first parameter of comparison in this study. In the following sections, how different

organisational structures develop AIPs, how AIPS are managed and which departments/ministries had been involved in policy development and programme administration will be examined. As institutional structures of government support for the arts become increasingly complex, focus was placed at the ministerial level for the analysis at the echelon most directly linked to policy implementation.

Results and discussion: government structure in policy implementation

In this section, a comparison of AIPs' policy-making structures is discussed. Government organisations responsible for advocating AIPs across countries and regions are reviewed and differences in targeted beneficiaries and areas of leadership explained.

Involvement of different ministries at strategic level

Ministries and government departments for arts and culture usually take responsibility for formulating AIPS as illustrated in Table II. In countries like USA, Singapore and Finland, AIPs are developed and implemented solely by the cultural sectors to foster social inclusion through the arts. Ministry involvement towards arts and culture is key to arts inclusion promotion, which is often steered top-down by virtue of national strategic plans, well-supported programmes and summits, etc.

Table II also shows a prevalence for cross-departmental structures though, mainly between separate authorities for health and culture. "Arts for inclusion" is embedded in healthcare policies in UK, Australia and Norway, featuring arts-based strategies targeting people with mental health problems, the elderly and those suffering from dementia. Often cited health benefits include enhanced motivation, improved social connection, a positive mindset, reduced isolation, increased confidence and enhanced self-esteem which constitute the "building blocks"

Country/Region	Structure	Main responsible ministry/department
UK	Cross-department	Department for Digital, Culture, Media and Sport Department of Health and Social Care
USA	Single department	National Endowment for the Arts[a]
Australia	Cross-department	Department of Communications and Arts Department of Health
Singapore	Single ministry	Ministry of Culture, Community and Youth
Canada	Single ministry	Department of Canadian Heritage
Ireland	Cross-department	Department of Culture, Heritage and Gaeltacht Department of Health
France	Cross-ministry	Ministry of Culture Ministry of Health
Japan	Cross-ministry	Ministry of Education, Culture, Sports, Science and Technology Ministry of Health, Labour and Welfare
Taiwan	Single ministry	Ministry of Culture
Hong Kong	Cross-bureau	Home Affairs Bureau Labour and Welfare Bureau
Finland	Single ministry	Ministry of Education and Culture
Norway	Cross-ministry	Ministry of Health and Care Services Ministry of Culture
Sweden	Cross-ministry	Ministry of Culture Ministry of Health and Social Affairs
The Netherlands	Cross-ministry	Ministry of Education, Culture and Science Ministry of Health, Welfare and Sport

Table II. Overview of governmental departments involved in the development of AIPs

Note: [a]The National Endowment for the Arts (NEA) is an independent agency of the United States federal government, the only funder – public or private – that supports the arts in all 50 States in the United States through grants and national initiatives

of social capital (Health Development Agency, 2000). These gains are the result of top-tier involvement by health authorities in AIPs-making processes. A primary principle behind these initiatives is to achieve the first step of health equity by reducing disparities among different groups in a prelude to tackling economic and social disadvantage (Braveman, 2014).

Objectives of "arts for inclusion" go beyond simply reconnecting people in an individual and collective capacity (Fisher, 2002; Matarasso, 1997) and include improving well-being to redress health disparities. The involvement of top health organisations contributes directly to this goal, as set out in Table I. Health policymakers promote arts-based strategies targeting people with mental health problems, the elderly and those suffering from dementia. Programmes initiated by health departments focus on clinical perspectives of arts-related processes as a means to achieve better health outcomes. Top-tier health organisations in countries including the UK, Norway and Sweden offer Arts on Prescription schemes through offering standard participatory arts programmes which encourage cultural engagement with its clinical intervention kit. For example, the UK's National Health Service highlights the role of the Arts on Prescription scheme which allows general practitioners to refer patients to an activity involving the arts or an arts-based therapy service. Arts therapy builds upon the therapeutic process of artistic participation and is delivered by professional and accredited arts therapists who closely interact with patients.

AIPs are mainly the remit of either the health or culture ministry in all countries examined, with the former focussing on mental illness through therapeutic arts interventions emphasising health outcomes, while the latter tends towards more participatory functions to foster social inclusion.

Inter-sectoral policy is key

Bettering health and equity through arts-based activities remains a prominent objective for AIPs and should form the basis for moving forward in developing inter-sectoral policies. Cultural heads usually focussed purely on inclusiveness and health tsars more concerned about therapeutic processes and will miss the indisputable potentials for synergy. In fact, most countries and regions have already been developing and implementing AIPs across several sectors. Despite differences in purposes and measures, policymakers should enhance inter-sectoral integration to maximise reach, efficiency and gains.

Many health determinants lie outside the formal health system according to the WHO and consist of social, physical and economic factors which have a critical influence upon health outcomes. The determinants' distribution remains imbalanced and is perceived to be unfair and unjust (World Health Organisation, 2008). In response, European countries developed the Health in All Policies policy approach in 2013 to reduce health inequities. The approach is founded on the understanding that health problems and inequities are created outside the health sectors (Shankardass *et al.*, 2018). It is a strategy to integrate health concerns related to the division of roles and responsibilities in different sectors and at different levels and scales (Hofstad, 2016).

The involvement of different ministries in the development of AIPs is a strong reminder that the responsibility for population health and health equity is inter-sectoral. There are wide-ranging factors which cause health disparities and a lack of coordination by health authorities limits AIPs' potential influence outside the health domain (Storm *et al.*, 2011). Implementation of AIPs does not have to remain siloed to health and cultural fields. Multi-sectoral policy making based on an integrated perspective can amplify efforts to reduce health disparity well beyond the healthcare sphere.

Rethinking the organisational structure for cross-sectoral policies

AIPs often involve inter-sectoral governance during development and implementation stages, and the difficulties in coordinating this type of inter-sectoral policy are the foci of many political science and public policy studies (Cann, 2017; Hofstad, 2016; Greer and Lillvis, 2014; Sabatier and Mazmanian, 1979). Two common difficulties afflicting inter-sectoral governance

are coordination and durability. Missions and goals vary across sectors, making relevant organisations reluctant to adopt integrated objectives. The resources spent by any other ministry promoting arts inclusion may be seen as money wasted on what should be the cultural authority's remit and financial responsibility. Different bureaucracies may also have difficulty efficiently collaborating and co-financing specific programmes (Cann, 2017).

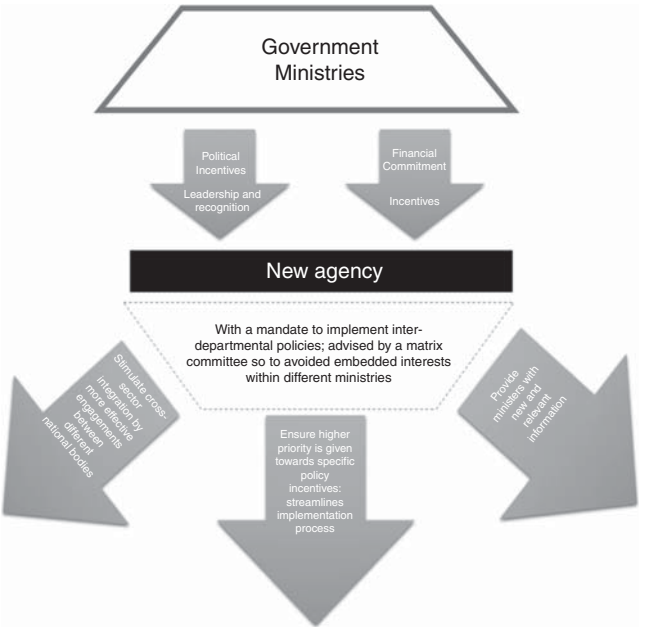
Facilitating collaboration across sectors is one approach to induce bureaucratic changes for better inter-departmental collaboration (Hofstad, 2016; Greer and Lillvis, 2014). Countries such as the UK and Norway have publicly funded organisations to bring cultural engagement into policies for health and well-being improvement. The Culture, Health and Wellbeing Alliance is one such newly formed example which provides a clear, focussed voice to articulate the role arts and culture play in health and well-being. Sabatier and Mazmanian (1979) pinpoint the essential conditions for effective policy implementation, beginning with assigning implementation to agencies which give the new programme a high priority. The appointment of new committees and officials disconnects inter-sectoral policy from embedded interests within different ministries (Hofstad, 2016). Such fresh start gives the new structure freedom to develop a special focus on health and culture, energising committees which provide ministers with new and relevant information (Greer and Lillvis, 2014). This renewed vigour will stimulate cross-sector integration of health and culture by engaging different national bodies such as the NHS to develop programmes such as Arts on Prescription. Only these dedicated agencies can accord higher or the highest priority to AIPS while coordinating and streamlining cross-departmental implementation.

Two key roles of governmental leadership

Jensen *et al.* (2017) argued that political incentives and financial commitments are essential in developing arts and health projects. These major roles taken up by respective ministries are discussed below.

Political leadership drives policy stimulation and recognition. Government organisations are the political anchor which fixes AIPs, social inclusion and health equity at the national strategic level. Political leadership can change agendas, create or redirect networks and directly make inter-sectoral policy (Greer and Lillvis, 2014). A commonality of techniques observed was the early formation of strategic plans and targets. These targets and plans are representative of a government's commitment and directly shape the agendas of subordinate ministries and organisations. A detailed plan also clarifies roles and responsibilities of different actors which is important in inter-sector policy implementation. Officials from ministries for health and culture develop strategic plans and development frameworks while commissioning research related to AIPs, as shown in Figure 2.

Australia's Ministers for Health and Culture jointly developed a 2014 National Arts and Health Framework to enhance the profile of arts and health in Australia. The framework promotes greater integration of arts and health practice as well as health promotion, services, settings and facilities (Department of Communications and the Arts, 2014). The framework's basis rests on the benefits and importance of arts and health practices. It also encourages the inclusion of the arts in health initiatives by suggesting approaches across sectors and areas through research and facility building. UK's Department of Health and Department of Culture, Media and Sport separately published white papers highlighting the crucial role of arts and culture in promoting social prescription, social contacts and social inclusion (Department for Culture, Media and Sport, 2016; Department of Health and Social Care, 2006). Sabatier and Mazmanian (1979) emphasised that policy objectives should be precise and clearly ranked for implementing agencies. UK and Australian experiences serve as excellent examples of directives to actors and supporters both inside and outside for effective implementation.



Sources: Adapted from Jensen *et al*. (2017), Sabatier and Mazmanian (1979), Ran (2013), Pressman and Wildavsky (1984)

Figure 2.
Governmental structure for effective implementation of cross-sectoral policies

Policymakers can also openly recognise arts inclusion initiatives by publicly endorsing the benefits of arts-based activities. Singapore has long recognised the relationship between the arts and inclusion; its Ministry of Information, Communications and the Arts regards arts and culture as the most socially inclusive platform for strengthening community bonding in the implementation of its Renaissance City Plan. The Japanese Government also places a strong emphasis on the arts for, and by the disabled. The Agency for Cultural Affairs, a special body under the Ministry of Education, Culture, Sports, Science and Technology, focussed on the significance of disability arts in its 44th Directions for Developing Arts and Culture. Bureaucracies are influenced by advocacy for arts inclusion by ministers and top policymakers (Greer and Lillvis, 2014). The endorsements from these policymakers serve as public commitments and stimulate policy implementation (Sabatier and Mazmanian, 1979).

Financial commitment incentivises AIPs development. The success of policy implementation requires not only political stimulation but also sufficient financial incentives (Ran, 2013; Pressman and Wildavsky, 1984). In countries such as Australia and Norway, the success of policy implementation largely depends on whether local governments and officials receive enough financial incentives from their respective central governments (Ran, 2013; Jensen *et al.*, 2017). In most countries and regions, AIPs are delivered through publicly funded organisations. Grants have long been the primary funding means for state arts agencies; similarly, grants and funding are in parity central to effective arts policies (National Research Center of the Arts, Inc., 1976; Lowell, 2004).

Funding from authorities can be divided into programmes and research domains. The Finnish Government granted €2m to the implementing agency, Arts Promotions Centre Finland to fund arts projects related to the health and social care sector (Tamm, 2008). A similar grant was made in Singapore through the WeCare Arts Fund as part of the Arts

for All Initiative which supports arts organisations and access for social service sector beneficiaries (National Arts Council, 2017). These grants expand supply, promote access and cultivate demand for AIPs. They broaden arts participation and also increase public awareness (Lowell and Zakaras, 2008).

Governments bear a significant role in funding research in culture and health. One barrier in the further development of AIPS is the scarcity of research. This is especially the case where AIPs is totally subordinate to the healthcare system. Policymakers may lack evidence to push for greater arts and cultural initiatives in relation to the healthcare system. Insufficient research restricts the scope of public service agencies to invest in new ways of increasing well-being through the arts (Cann, 2017). Ministries should take the initiative to strengthen the body of evidence detailing the impact of arts and cultural activities for health and care practices. US's National Endowment for the Arts supports research on the value and impact of the arts, and currently focusses on arts and aging. Arts Council of England also funds research and development of cultural work in the health and criminal justice sectors. The publicly funded Norwegian Resource Centre for Arts and Health was established in 2014, and its primary mandate is to bring a greater interaction between research and practice in the fields of arts and health (Jensen *et al.*, 2017).

The importance of stable and sufficient financial resources for better policy implementation has long been emphasised. Government funding is vital for implementing agencies to hire staff, administer, conduct research, develop activities and regulations, manage programme delivery, and monitor and evaluate impacts. Public funding is a necessary precondition to achieving statutory objectives in policy implementation (Sabatier and Mazmanian, 1979) (Table III).

Learning from the west: facilitating policy implementation

The in-depth inquiry into the policy-making structures of the 14 countries has one important finding: AIPs in western countries are more developed in terms of target scope and diversity of programmes when compared to those of Asian countries and regions. This section especially highlights two distinct parameters which serve as valuable testimonies for Asian policymakers to consider when designing their local-centric programmes.

More evidence-based studies on the impact of arts inclusion

The arts are long recognised as important tools for fostering health and well-being in western countries. In the UK, Arts on Prescription has existed in one form or another for about two decades (Jensen *et al.*, 2017), while arts and health policies only started emerging in Asia in the late 2000s, in countries such as Taiwan, Singapore and Japan. One possible reason for this discrepancy is that western countries have long invested in building evidence of the positive impacts of arts on health and well-being. Different countries in the west have set up research centres on arts and well-being. There are plentiful testimonies of how participation in arts activities is highly valued by the elderly, the disabled and those in rehabilitation. Leading research in the arts, health and well-being fields is mainly produced in the UK and Scandinavia, where ample research centres specialise in the field (Jensen *et al.*, 2017). The evidence gathered subsequently contributes to a robust base for sustaining investment in the arts and cultural activities. Therefore, it is of paramount importance for Asian countries to establish a localised evidence base so that public service commissioners and funders can access and acknowledge the benefits of the arts on health, and move towards mobilising the arts for social inclusion and healthcare in their own geographical contexts.

Higher public and professional recognition of the role of the arts

Public perception of the arts in enhancing health and well-being can also be cultivated by actively incorporating the arts into health and social welfare systems. In western countries

Country/ Region	Major responsible ministry/ department	Target groups					Key roles					
		The disabled	Elderly	Children and the young	People with mental problems/ the sick	Other underserved community (e. g. ethnic minority)	Funding	Proposing initiatives	Initiating programmes	Conducting research	Developing strategic framework	Promoting art-based strategies and programmes
UK	Department for Digital, Culture, Media and Sport Department of Health and Social Care	✓	✓		✓		✓		✓			✓
USA	National Endowment for the Arts	✓	✓						✓	✓		
Australia	Department of Communications and Arts	✓	✓	✓		✓					✓	
	Department of Health and Department of Communications and Arts[a]	✓	✓	✓	✓						✓	
Singapore	Ministry of Culture, Community and Youth	✓				✓	✓		✓		✓	
Canada	Department of Canadian Heritage	✓			✓	✓	✓		✓	✓	✓	
Ireland	Department of Culture, Heritage and Gaeltacht	✓		✓		✓	✓		✓	✓	✓	

(*continued*)

Table III.
Overview of the policy options and target groups of AIPs

Table III.

Country/ Region	Major responsible ministry/ department	Target groups					Key roles					
		The disabled	Elderly	Children and the young	People with mental problems/ the sick	Other underserved community (e. g. ethnic minority)	Funding	Proposing initiatives	Initiating programmes	Conducting research	Developing strategic framework	Promoting art-based strategies and programmes
	Department of Health		✓		✓				✓		✓	
	Department of Culture, Heritage and Gaeltacht			✓		✓				✓		
	Department of Health[a]											
France	Ministry of Culture											
	Ministry of Culture				✓				✓	✓		
	Ministry of Health[a]											
Japan	Ministry of Education, Culture, Sports, Science and Technology	✓	✓		✓			✓				
	Ministry of Health, Labour and Welfare	✓					✓					
Taiwan	Ministry of Culture		✓			✓	✓		✓			✓
Norway	Ministry of Health and Care Services		✓	✓	✓				✓	✓		✓
	Ministry of Culture			✓	✓	✓	✓	✓	✓	✓		✓

(*continued*)

Country/ Region	Major responsible ministry/ department	Target groups					Key roles					
		The disabled	Elderly	Children and the young	People with mental problems/ the sick	Other underserved community (e. g. ethnic minority)	Funding	Proposing initiatives	Initiating programmes	Conducting research	Developing strategic framework	Promoting art-based strategies and programmes
	Ministry of Health and Care Services		✓						✓			
	Ministry of Culture[a]							✓				
Finland	Ministry of Education and Culture		✓	✓	✓							
Sweden	Ministry of Culture		✓				✓					✓
	Ministry of Culture				✓		✓					✓
	Ministry of Health and Social Affairs[a]											
The Netherlands	Ministry of Education, Culture and Science	✓	✓	✓		✓			✓		✓	
	Ministry of Health, Welfare and Sport											
Hong Kong	Home Affairs Bureau	✓			✓	✓	✓					✓
	Labour and Welfare Bureau	✓					✓					

Note: [a]Joint-ministry effort

Table III.

including the USA, the UK and Australia, arts therapists are recognised under associations of allied health professions as legitimate members of the healthcare sector. This professional recognition enhances public trust of the role of the arts within health and well-being discourses. The increase in credibility of qualified arts therapists and professionals will facilitate the development of AIPs such as Arts on Prescription schemes. According to Gustavsson *et al.* (2018), moreover, successful implementation of a new healthcare practice depends on the healthcare providers' attitude and users' perceptions towards the new treatment. Sweden stands out as an exemplar of having an encouraging social context for the introduction of Arts on Prescription, as prior to which social prescribing had already existed locally. The Swedish Physical Activity on Prescription was launched in 2001 to promote physical activity for prevention and treatment of lifestyle-related health disorders (Gustavsson *et al.*, 2018). It was introduced in Sweden over a sustainable period and as an existing social prescription programme, helped increase public confidence and acceptance of non-clinical means for health treatment. The precursor role positively impacted public perceptions and eased the introduction of Arts on Prescription in 2009 (Jensen *et al.*, 2017).

Conclusion: policy-making structures are vital to AIPs development

Administrative structures across different countries and regions take on varied approaches to fostering social inclusion through the arts – wherein a majority deploy their cultural ministries to take the lead on AIPs development, although there are certain circumstances where health ministries also bear major responsibilities to AIPs. These inter-sectoral structures allow inclusive outcomes to manifest through participatory and therapeutic approaches to the arts. The policies ushered in by the cultural ministries are often more general and targeted towards a wide spectrum of socially disadvantaged groups via participatory arts initiatives. The policies under the health ministry are observed to be more clinically based which target patients especially with mental illness primarily via arts interventions of a "therapeutic" function. Of those, medium- to long-term benefits would include reduction or elimination of social disadvantages brought by bettering overall health (Braveman, 2014). Taken together, inter-sectoral approaches lead to more comprehensive policy development.

While tracing and evaluating the funding sources behind each policy is a necessary step for comparative analysis, the ideal role of governmental ministries should not only be limited to the remit of funding programmes. Mobilising art and culture for socially inclusive outcomes is a recent development and it is important for ministries to take a leading role in policy formation. Some ministries are independently collecting data to gauge the impacts of art activities for developing strategic plans and frameworks. The involvement of top politicians also provides incentives to policymakers to further invest, and is essential to seed and inject AIPs in areas where local research and practice remains relatively new.

AIPs in western countries remain more developed in target scope and programme diversity compared to Asian countries and regions. Learning from western models, there is ample potential to engage further in the arts to drive out public health benefits, while achieving social inclusion. Before popularising the efficacy of arts in health and social inclusion, more localised research is needed to understand the impact and value of the arts on health when applied in an Asian context.

The framework developed for this study is a useful guide for understanding how policy-making structures shape and define AIPs, particularly through studying the differences and similarities among 14 selected governments in the world. Yet it is not the scope of this study to include all the set parameters for comparison, so the authors fully acknowledge the limitations that remain, and future studies to be devoted in this area. First, the term "arts inclusion policy" is not widely adopted, thus research remains largely focussed on cultural and health policies across a small, albeit wealthy, subset of countries and regions. Second, "arts inclusion" remains a relatively new concept globally speaking, and most AIPs

are still evolving hence the evaluation of impacts across countries and regions remains scattershot and has yet to provide mature results for empirical evaluation. Third, a comprehensive policy review requires a complete investigation along the policy-making cycle, while this study has only embarked on one out of the five parameters explained in our recommended comparative framework. Nevertheless, existing programmes, more represented by the west, will continue to yield results and develop the know-how to further development of "arts for inclusion" policies. As the impacts of AIPs become increasingly visible over time, locally specific research and development corresponding to the metrics suggested in this paper for further evaluation is recommended.

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Appendix

IHDI Rank (2017)	Country/Region	2017
1	Iceland	0.879
2	Japan[a]	0.876
3	Norway[a]	0.876
4	Switzerland[a]	0.871
5	Finland[a]	0.868
6	Sweden[a]	0.864
7	Australia[a]	0.861
8	Germany	0.861
9	Denmark[a]	0.86
10	The Netherlands[a]	0.857
11	Ireland[a]	0.854
12	Canada[a]	0.852
13	New Zealand	0.846
14	Slovenia	0.846
15	Czechia	0.84
16	Belgium	0.836
17	Austria	0.835
18	UK[a]	0.835
19	Singapore[a]	0.816
20	Luxembourg	0.811
21	Hong Kong, China (SAR)[a]	0.809
22	France[a]	0.808
23	Malta	0.805
24	Slovakia	0.797
25	USA[a]	0.797

Note: [a]Regions included in our comparison
Source: UNDP (2017)

Table AI.
Inequality-adjusted HDI (IHDI)

About the authors

Alvin Cheung's research focus is on environmental, social and governance (ESG) reporting, social impact assessment (SIA) and arts innovation. He is one of the authors of Arts Inclusion Policy Research Report, Policy Review on ESG Reporting, the Social Innovation Research Report, Green Bond Study and Pay-for-Success Study published by Our Hong Kong Foundation. He has engaged different local stakeholders, including government officers, business leaders and social innovators, to promote applications of arts inclusion and facilitate communication between government and social sectors. He obtained his MPhil in Economics from The Chinese University of Hong Kong and BSc in Economics and Finance, with First Class Honors, from The Hong Kong University of Science and Technology.

Charlotte Yu worked for Our Hong Kong Foundation as Assistant Researcher focusing on arts innovation policy research, and currently works at a creative research company as Researcher and Creative Scriptwriter. She holds Master of Philosophy in Communication from the School of Journalism and Communication, The Chinese University of Hong Kong, with interests in arts and cultural studies.

Queenie Li, Assistant Researcher of Our Hong Kong Foundation, practices as a Multi-disciplinary Artist and has delivered performance lectures at University of Cambridge, UK and The University of Hong Kong, amongst a myriad of other exhibitions. She had work experience at a wide array of institutions including an international auction house, a London-based art gallery, an art charity in Oxford Hospitals and an artist studio in Shanghai. She was a D.H. Chen Foundation Scholar and a Hong Kong Scholar endorsed by the government. She holds a Bachelor Degree in Fine Art (BFA) from St Anne's College, University of Oxford and a BBA Degree in Global Business Studies from The Chinese University of Hong Kong, both with First Class Honours. She was awarded the Stuart Morgan Prize for Art History for her final dissertation at University of Oxford. Queenie Li is the corresponding author and can be contacted at: queenie.li@ourhkfoundation.org.hk

Helen So is Policy Researcher specialising in the field of Arts Innovation at Our Hong Kong Foundation, and co-author to the first policy advocacy paper that calls attention to the inclusive and preventative agency of arts in Hong Kong. She is active in the local arts and cultural scene, engages regularly with different stakeholders including government officers and business leaders to discuss policy insights, and presents in local and international conferences. Her public service includes various advisory roles appointed by the Hong Kong Government. She holds a Master of Studies (MSt) Degree in Musicology & Ethnomusicology at St Catherine's College, University of Oxford, and a Bachelor of Music (BMus) Degree at King's College London, UK.