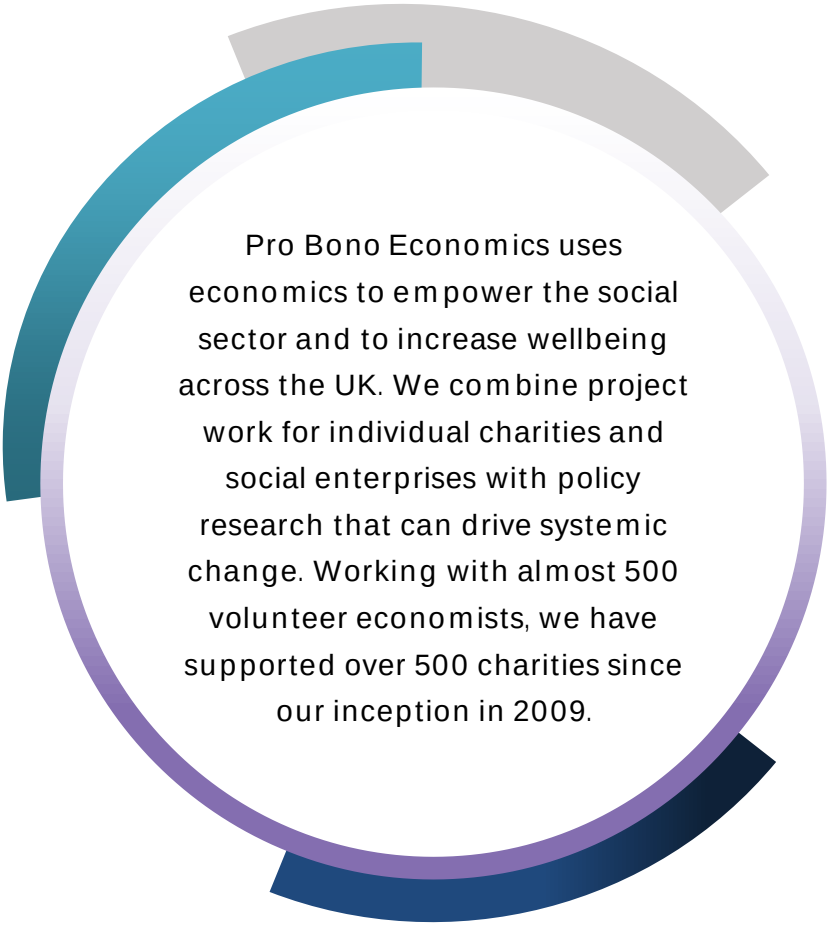
PRO BONO ECONOMICS

# Mind, body, and connection:

# Low wellbeing in the UK 2024

Jon Franklin, Daisy Harmer, Beth Kitson, Charlotte Prothero, Matt Whittaker

November 2024



Pro Bono Economics uses economics to empower the social sector and to increase wellbeing across the UK. We combine project work for individual charities and social enterprises with policy research that can drive systemic change. Working with almost 500 volunteer economists, we have supported over 500 charities since our inception in 2009.

# Contents

# Summary

How is the UK doing? It is a question that is hard to answer. On the one hand, the UK remains one of the richest countries in the world and has enjoyed a prolonged period of peace and prosperity. On the other hand, household incomes have stagnated over the last 15 years and many already-creaking public services are groaning under the weight of an ageing and sickening population.

And yet, commentators and politicians regularly purport to set out the definitive condition of Britain – especially so during an election year such as 2024. Different measures are proffered as indicators of success – or lack of it – with GDP growth, NHS waiting times, crime statistics, and school exam results being among the most cited. Illuminating though such measures tend to be, the ultimate answer to the question will almost certainly depend on who is responding.

In fact, the simplest way to understand how the country is doing is to ask its people how *they* are doing. And happily, that is something that has been happening for more than a decade. Since 2011, the Office for National Statistics has systematically been asking the nation's citizens to report on how they are feeling and functioning, incorporating simple standardised questions into a wide range of its key national surveys. As a result, there is now a rich suite of data that allows the mood of the nation to be tracked over time.

At the headline level then, the answer to the question "how is the UK doing?" is "about 7.5 out of 10". It is a response which is a little underwhelming – and perhaps goes some way to explaining why it is a figure that was conspicuously absent from the General Election debate (along with the suspicion with which statistics described as measuring 'wellbeing' are sometimes treated by those who cannot help but picture mindfulness exercises and yoga retreats). And it is more underwhelming still when set against the historical trend: 7.5 when the series started in 2012, rising to a high of 7.7 in 2019 before falling back to a low of 7.5 when the pandemic struck. The truth is the population average does not move all that much.

## The drivers of low wellbeing

But lift the bonnet, and the wellbeing data *does* carry significant power. For policymakers, and indeed anyone who cares about the state of the nation, it has two particularly important applications.

First, it provides a picture of who in the country is facing the most significant challenges in their lives, and how that is changing over time. Simply put, looking at the distribution of life satisfaction scores reveals who is living below the wellbeing 'poverty line'. Other measures such as household income and spending provide their own important insights, but the wellbeing data spotlights those people who are enduring a life below a minimum wellbeing threshold irrespective of what complex combination of factors may have pushed them there.

Second, the detailed wellbeing data allows an exploration of what triggers and drives wellbeing improvements and deteriorations. What effect does a change in income have for different parts of the population? How great a role does family and community connection have in supporting an individual's resilience? How does the impact of a policy change play out across different demographic groups?

It is with these two applications in mind that Pro Bono Economics (PBE) is releasing its first *Low wellbeing in the UK* annual report.

It shows that 3.2 million adults are currently living below the wellbeing poverty line – scoring four or less out of 10 when asked to grade their satisfaction with their life. It is equivalent to 5.7% of all those aged 16 and over across the UK, or the combined populations of Manchester and Liverpool.

## Aspirations

It is a number that is too high, but it is one that has been heading in the wrong direction too. Perhaps unsurprisingly, the pandemic prompted a spike in low wellbeing, with the proportion of adults in this position jumping from a low of 4.4% in 2018 to 5.7% in 2020. Yet, following a modest recovery in 2021, the proportion has drifted back upwards. There may be an element of noise in the year-on-year movements, but there is little to suggest that low wellbeing is set to fall back to pre-pandemic levels anytime soon.

Indeed, allowing for some population growth, the number of adults below the threshold in 2023 was 135,000 higher than recorded in 2022, and 780,000 higher than had been the case in 2018. It is the highest recorded since comparable data was first collected in 2012.

PBE believes that the government needs to establish a credible plan to reduce "wellbeing poverty" in the UK. But what should the ambition be? In a country of the UK's wealth and resource, PBE believes it should be one of eradication: that no one need endure spending a sustained period feeling so dissatisfied with their life. Getting there may not be easy or speedy, but it is a valuable aspiration. In fact, using HM Treasury's own methodology, PBE estimates that even going halfway to this target – that is, halving the number of adults living below the wellbeing poverty line – would generate benefits of some £54 billion a year. For context, that is around twice the economic benefits every year than were expected to be delivered through the Crossrail scheme in its first 30 years of existence.

To get there, it is important that the UK learns lessons from other countries, specifically those such as Finland and New Zealand that convert similar levels of national income into higher levels of happiness. But diving into the wellbeing data available can also provide valuable lessons.

Looking first at who suffers from low wellbeing, PBE's analysis shows that people of mixed ethnic backgrounds are nearly twice as likely to fall below the threshold as those of white background. Meanwhile, women are a little more likely than men to experience low wellbeing. And those in the poorest quarter of households are more than twice as likely to experience low wellbeing as those in the richest quarter of households.

But these simple prevalences mask a multitude of interactions that affect rates across different groups. Multivariate analysis that isolates the impact of different factors on low wellbeing risk shows three clear themes of mind, body, and connection.

For example, where someone's mental health affects their life "all of the time" their likelihood of experiencing low wellbeing rises by 16 percentage points relative to someone who suffers no mental health effects. Similarly, someone self-reporting "poor" general health has an 9 percentage point higher risk of enduring low wellbeing than someone self-reporting good health. And someone who describes themselves as "often" feeling lonely is

13 percentage points more likely to fall below the low wellbeing threshold than someone who is never lonely.

Other smaller but important effects are identified when risk factors are isolated in this way. For example, being of Caribbean or African ethnicity raises the probability of being below the wellbeing poverty line, even when other economic, social, and demographic factors are controlled for. Likewise, there is a specific risk factor associated with living in the private rented sector. In contrast, those living in the social rented sector appear to enjoy some protection against low wellbeing even though in raw terms the prevalence of low wellbeing is higher for those living in such accommodation.

Low wellbeing is perhaps hardest to endure for those for whom it persists over time. Among those falling below the low wellbeing threshold, 55% appear to 'escape' within four years. But 45% either 'churn' in and out of low wellbeing or – worse still – remain 'stuck' in this position in every subsequent year. Looking across the entire adult population, this means that 3.1% of people fall into low wellbeing and fail to permanently escape within four years. Likewise, around 1%, roughly the entire population of Bradford, find themselves in low wellbeing for at least four consecutive years.

There is some clear read across from a number of the low wellbeing drivers identified to the policy priority areas set out by the new Labour government under its five 'missions'. Clearly the details that sit within the administration's focus on the NHS, on building social housing, on tackling economic inactivity connected to long-term illness, and on supporting private renters will be of considerable importance, and further exploration of the wellbeing data should make a valuable contribution to shaping those details in the coming months.

### Loneliness and low wellbeing

But there are apparent policy blind spots too, not least in relation to loneliness. PBE's deep dive on this key driver of low wellbeing suggests that there are 5 million adults in the UK struggling with chronic loneliness, with disproportional representation among those aged under 30, women, those who are separated from their partners, the unemployed, and those reporting poor health.

It is a challenge that comes with a significant fiscal cost too. PBE estimates that ending chronic loneliness in the UK could reduce the need for almost a million GP appointments a year and around 100,000 in-patient episodes in hospitals.

But consultation with experts working in loneliness suggests ending chronic loneliness requires a significant escalation in action. This includes refreshing and strengthening the policy framework by publishing an update to the 2018 Loneliness Strategy; increasing collaboration with philanthropic funding to expand financial support for organisations tackling loneliness; and supporting social sector organisations to better measure and demonstrate their impact.

On this issue and many others, the public, private, and social sectors should work together in pursuit of a common interest in improving the wellbeing of the country, and the life experiences of those facing the most significant challenges in particular. And the three sectors should do so armed with the unique insights that the nation's increasingly rich suite of wellbeing data offers.

PBE hopes to make its own contribution to this important effort over the coming months and years, starting with this first state of the nation note on low wellbeing in the UK. PBE's hope is that, in future editions of the report, when the question is posed "how is the UK doing?", the answer can be: "better".

In 2023 there were

# 3.2 million

adults in the UK with low levels of wellbeing

# 1%

of UK adults remain stuck in a state of low wellbeing for at least four consecutive years

# £54bn

economic benefit each year from halving levels of "wellbeing poverty" among adults in the UK

Eradicating chronic loneliness for the 5 million adults currently suffering from it could save

# 950,000

GP appointments per year

# Section 1: Introduction

The first question people tend to ask of family and friends when they see them is a simple one: "how are you doing?" There may be plenty in the responses that might need to be unpacked, but it is an opening line designed to quickly provide an overview of the condition of loved ones. It is possible to see how they look, and potentially know what they've been doing, but what matters above all else is how they *feel*.

What is true at the individual level is true at the national level too. Whether it is industrial strategy or homelessness funding, investing in infrastructure or clamping down on crime, government policy is ultimately about improving the lived experience of its citizens. There is some altruism here: people dedicating themselves to working in public policy do so because they care about people's quality of life. But there is self-interest too: happier and more satisfied people are more likely to stick with the government they have when elections come around.[1]

In families, in boardrooms, in government there are many things to care and talk about. But at the simplest level, everyone has a shared ambition to improve the wellbeing of others.

Happily, there is a growing body of data to check in on progress against this ambition. Dedicated and standardised wellbeing questions – repeated across multiple official statistical surveys and embedded into a wide range of detailed microdata sets – capture how people feel, how they're functioning, and how they're affected by the world around them (see Box 1).

These measures deserve to be better-known and more widely reported and discussed (public debate on the condition of the nation continues to centre around more intermediary measures such as GDP growth). But in truth their value lies not in the headline aggregate figures for the happiness of the nation that they spawn but in two critical applications revealed only when the bonnet is lifted.

First, the light they shine on the way in which quality of life varies across the population – that is, on wellbeing inequality. Governments may

[1] J Larkham, Happiness on the ballot: Why wellbeing might be more relevant to the election than economic growth, PBE, June 2024.

legitimately choose to take different positions on the level of such inequality that they're content to live with, but in doing so it is necessary for them to have clear sight of it. And, in the same way that a broad consensus exists over the goal of ending absolute poverty,[2] in one of the richest countries in the world it should be a given that government does all it can to ensure that no one falls below a minimum level of wellbeing.

Second, wellbeing data is valuable because of the insight it can provide on the factors that drive or hinder wellbeing improvements for different groups of people in different places and at different times. While policymakers may care about wellbeing (and wellbeing inequality) as an outcome, the action they take on a day-to-day basis is necessarily more upstream and granular. The strength of the wellbeing data captured over the last decade therefore rests in the opportunity it provides for understanding how those daily decisions connect to the lived experience of the nation's citizens.

So, how to ensure that no one need fall below the wellbeing poverty line? First, it is important to better understand who in the UK is less than OK, why that is the case, and what barriers prevent them from escaping this condition. That is the purpose of this report – PBE's first annual state of the nation note on low wellbeing among adults in the UK.[3]

Section 2 provides context by giving an overview of trends in low wellbeing in the UK over the last decade, before Section 3 explores the profile of those falling below a minimum wellbeing threshold. Section 4 digs deeper still, providing a picture of those enduring persistent low wellbeing over several years. Section 5 then explores the drivers of low wellbeing, using multivariate analysis to identify key trigger points and risk factors, before Section 6 provides an 'in focus' consideration of one of those drivers: loneliness. Some conclusions are offered in Section 7.

[2] Absolute poverty is defined relative to a fixed income level, with those households falling below this level categorised as living in poverty. By contrast, the relative poverty threshold is set as a proportion of median income, meaning it moves over time in relation to wider income trends.

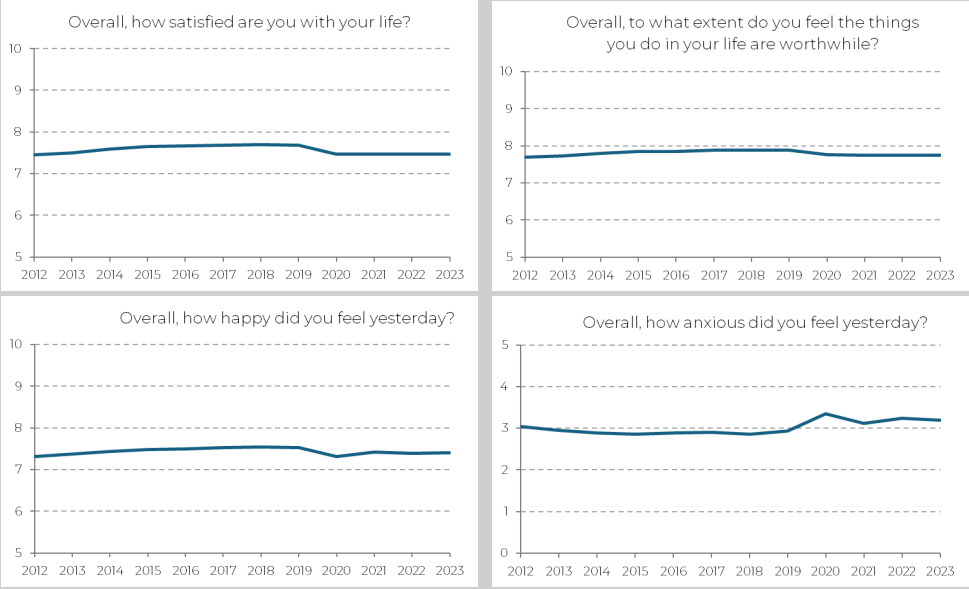
[3] The report focuses on adults because comprehensive wellbeing data is not currently available for children. Please see PBE's report Charting a happier course for England's Children: The case for universal wellbeing measurement, 2024, for further detail.

## Box 1: Measuring wellbeing in the UK

The science of measuring wellbeing has developed rapidly in the UK over the last two decades. Key to this process has been the Office of National Statistics' (ONS) 2011 roll-out of four standardised measures of personal wellbeing, known as the ONS 4. These include questions about people's satisfaction with their lives, their happiness, anxiety, and their feeling that what they do in their lives is worthwhile. What sets these measures apart is that they are self-descriptive: they ask people their own views of their wellbeing, rather than making assumptions about how objective conditions (such as people's income or health) will affect them.

### Figure 1: Personal wellbeing has not recovered to pre-pandemic levels

Average scores for the ONS 4 measures of personal wellbeing




Notes: While 2012 necessarily marks the first year of data, it is questionable how 'normal' a baseline this was for wellbeing. The country was still feeling the effects of the global financial crisis at this stage, with unemployment elevated.

Source: PBE analysis of Annual Population Survey (2024).

Average measures of wellbeing track the headline sentiments of the UK population. As described in Figure 1, there were steady improvements in headline measures of wellbeing between 2011 and 2020, before the pandemic precipitated a steep decline on all measures. Since 2020, personal wellbeing appears to have partially

recovered, but most levels remain short of where they were on the eve of the pandemic.

Though there are four measures of personal wellbeing, this report focuses on life satisfaction. While this represents a simplification of a complicated, multi-dimensional concept of wellbeing, the life satisfaction measure has become one of the key indicators of overall wellbeing. It is widely used in wellbeing research and has been adopted as the standardised unit of wellbeing in HM Treasury's policy appraisal guidance.[4] It is known to be relatively stable over time – rather than fluctuating in response to short-term feelings – and research has demonstrated that it responds in intuitive ways to things that would be expected to matter in people's lives.

[4] HM Treasury, Wellbeing Guidance for Appraisal: Supplementary Green Book Guidance, July 2021.

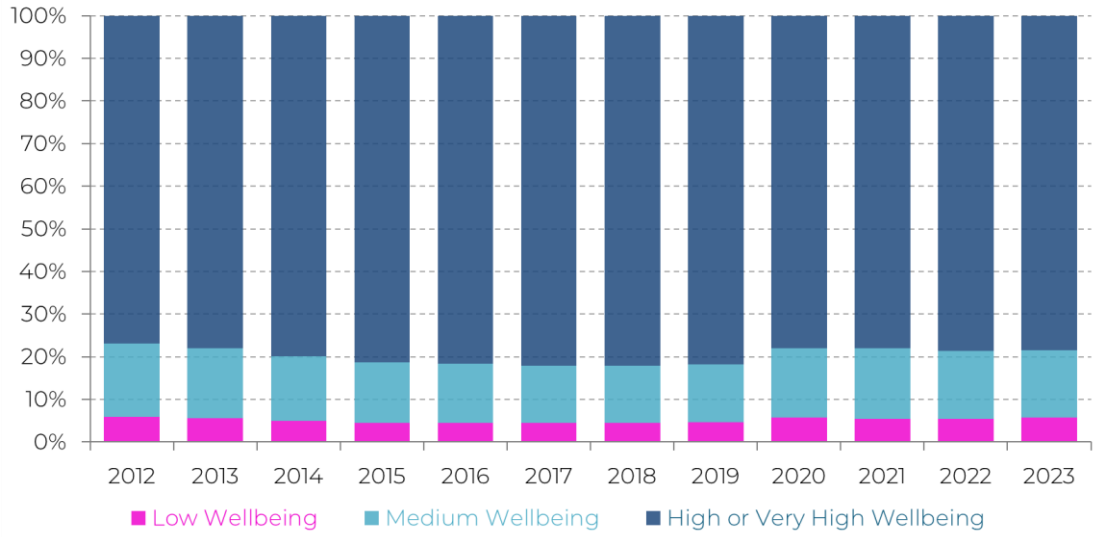
# Section 2: Wellbeing in the UK

At a headline level, wellbeing in the UK is both high and steady. Average life satisfaction among adults was 7.5 out of 10 in 2023. This is broadly unchanged compared to 2022 and little altered since the pandemic struck in 2020. With almost eight in every 10 (79%) of the adult population scoring 7 or above for life satisfaction, the average adult in the UK experiences a "high" level of wellbeing, based on the ONS's categorisation.[5]

However, the wellbeing average masks some significant inequality of experience. As Figure 2 shows, more than one in 20 (5.7%) of the population scored 4 or below on the life satisfaction scale in 2023, marking them out as living a life in "low" wellbeing.

### Figure 2: One in 20 adults in the UK experience a low quality of life

UK adult population broken down by life satisfaction category




Sources: PBE analysis of Annual Population Survey (2024) and ONS (2024) population data.

This means that 3.2 million adults in the UK were struggling with low wellbeing in 2023.[6] That is the equivalent of the entire populations of Manchester and Liverpool combined.[7] It is a very sizeable number of people

[5] Office for National Statistics, Personal well-being in the UK QMI, August 2024.

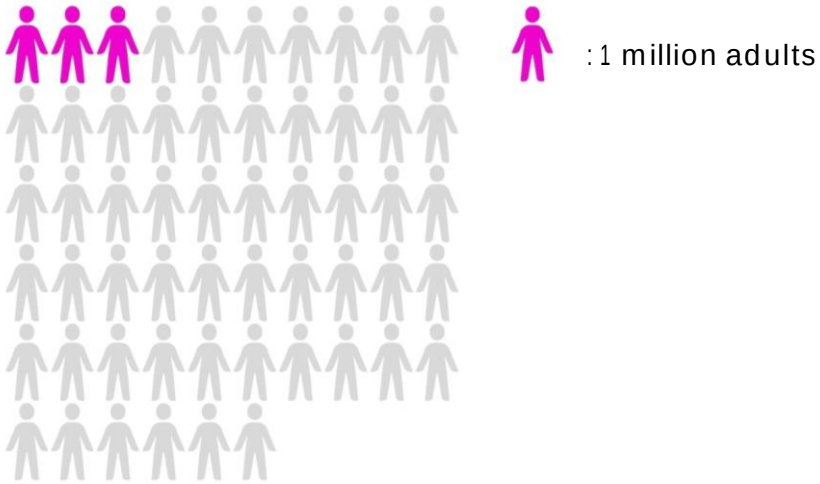
[6] The ONS defines low life-satisfaction as those scoring four or below to the question "Overall, how satisfied are you with your life?", scored on a scale of 0-10 where 0 is completely unsatisfied and 10 is completely satisfied.

[7] PBE analysis of Office for National Statistics. Annual Population Survey. Study Number 9248 - Annual Population Survey, January - December 2023. 8th Release. UK Data Service. SN: 200002, DOI: http://doi.org/10.5255/UKDA-Series-200002, 2024, and city populations taken from Centre for cities, What do the first Census 2021 results say about the state of urban Britain?, July 2022.

in the UK for whom the question "how are you doing?" elicits an answer: "not OK".

Figure 3: 3.2 million adults in the UK struggled with low wellbeing in 2023

UK adult population broken down by life satisfaction category




Sources: PBE analysis of Annual Population Survey (2024) and ONS (2024) population data.

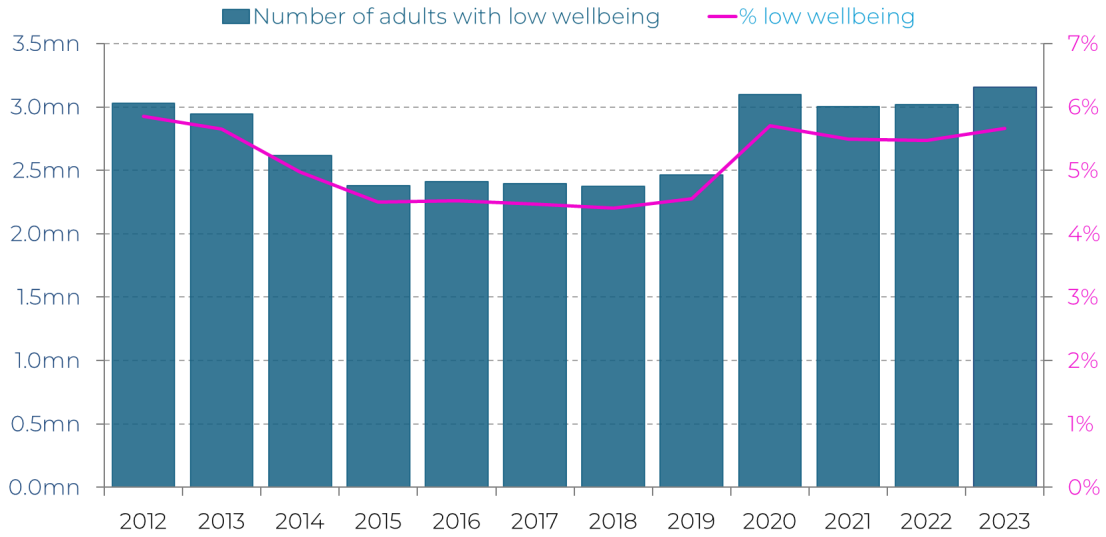
And in contrast to the broadly flat average wellbeing figure, the size of the group of people finding life hard is growing.

Figure 4 shows both the proportion and number of adults recording low wellbeing in the period since 2012. Improvements in the early part of the period (potentially reflecting continued economic recovery following the global financial crisis of 2008 and sustained reductions in unemployment), stalled from around 2015. The pandemic then prompted a significant spike in low wellbeing (from 4.6% in 2019 to 5.7% in 2020) that has not subsequently subsided.

Indeed, the 5.7% figure recorded in 2023 marks an *increase* on the previous year's figure of 5.5%. it equates to an additional 135,000 people living in low wellbeing over the course of a year and an additional 780,000 since the post-2012 low recorded in 2018. And it means more people are living in low wellbeing today than at any time since the data was first collected over a decade ago.

## Figure 4: The number of UK adults with low wellbeing is at an historical high

The number of adults with low wellbeing (millions – left-hand axis) and % of adults with low wellbeing (right-hand axis)




Sources: PBE analysis of Annual Population Survey (2024) and ONS (2024) population data.

PBE believes that the government should set a clear plan to drive down, and ultimately end, "wellbeing poverty" in the UK. The wellbeing improvements delivered by such a plan are – by definition – their own reward. However, it is also possible to attach a cash value to any recorded change in an individual's scores. Methodology devised and used by HM Treasury to assess the wellbeing impact – and therefore value for money – of proposed policy changes considers how much someone would be willing to pay for a one-point improvement in wellbeing that lasted for one year.

Taking this approach, the estimated cash benefit to an overnight halving of the number of adults living in low wellbeing is £54 billion.[8] That is around

[8] HM Treasury, Green Book supplementary guidance: wellbeing, July 2021. These economic benefits represent what the average person in the UK would be prepared to pay for an equivalent increase in life satisfaction. The average score for those with low wellbeing is 2.8 Life Satisfaction points (from PBE analysis of the Annual Population Survey), leaving an average gap of 2.2 points to reach the lower threshold of "medium" wellbeing of 5 points on the 0-10 scale. Half the population with low wellbeing is 1.6 million people and central economic cost of a single life satisfaction point is £15,347 in 2023 prices. Multiplying through, this gives a total benefit from improving life satisfaction by 2.2 points for 1.6 million people of £54bn.

twice the economic benefits every year than were expected to be delivered through the Crossrail scheme in its first 30 years of existence.[9]

Achieving such a rapid turnaround in low wellbeing would of course be unlikely. But it should be clear that today's low wellbeing levels are far from inevitable. Understanding how the UK might return to pre-pandemic levels would be a start. But the performance of international peers can also provide valuable lessons.

Looking at average scores, the UK was ranked 20th out of 143 countries in the latest World Happiness Report.[10] It is a solid showing, but it is notable that the UK was outranked by several countries possessing similar levels of national income. For example, Finland ranked first for happiness, Australia ranked 10th, New Zealand ranked 11th, and Canada ranked 15th.[11] Understanding why GDP converts into greater happiness in some countries but not others could provide clues to how UK levels of low wellbeing can be reduced.[12]

Further insights on lowering rates of low wellbeing come from a greater understanding of how the wide range of demographic, social, and health factors affecting low wellbeing interact and rank against each other. Developing a clearer sight of who in the UK is at highest risk of low wellbeing and what drives these shifts over time is critical to designing policies and services that will ensure that the UK recovers from its current low wellbeing spike and further drives down this number over time.

---

[9] Crossrail, Economic Appraisal of Crossrail, 2005.
[10] Gallup, World Happiness Report, 2024.
[11] Of those countries included in both the CIA World Factbook GDP per capita rankings and the World Happiness Report, Australia ranked 15th, Finland 17th, Canada 19th, UK 21st, and New Zealand 26th for GDP per capita using purchasing power parity.
[12] Furthermore, data from the Organisation for Economic Co-operation and Development's PISA study paints an even more worrying picture for the UK's teenagers, with the UK ranked 70th out of 73 countries for the life satisfaction of its 15-year-olds. See PBE, Charting a happier course for England's Children: The case for universal wellbeing measurement, 2024, for more detail.

# Section 3: Understanding who experiences low wellbeing

Given the large numbers of adults in the UK experiencing low wellbeing, and the potential scale of economic benefits from addressing this, it is essential that a clearer understanding of who makes up the low-wellbeing group is developed.

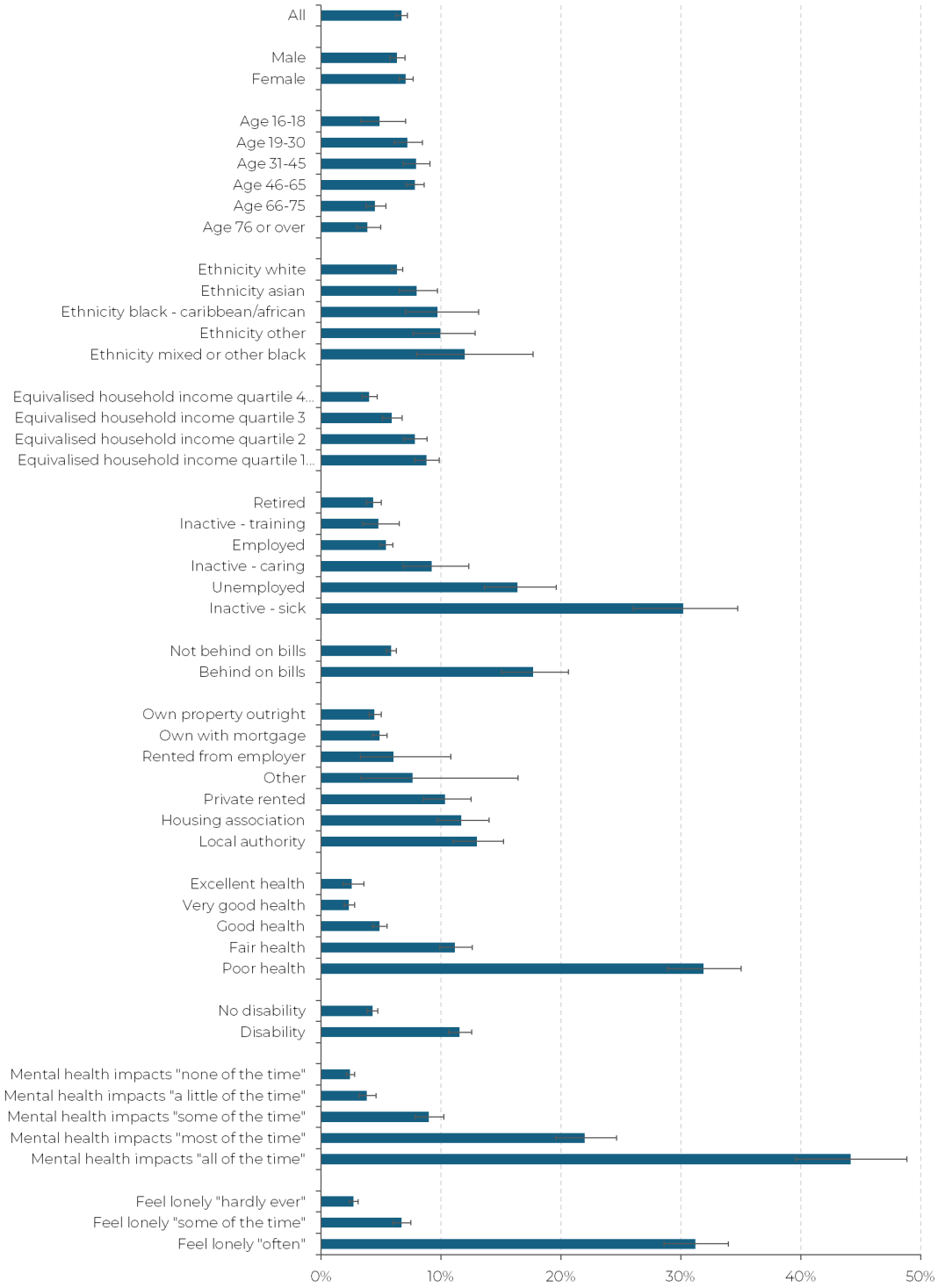
In this section, the variation in the incidence of low wellbeing across different population groups is explored using the Understanding Society dataset.[13] Figure 5 provides a summary across demographic, economic, health, and social characteristics.

At this stage, the intention is to explore the raw 'incidence' rates only. That is, the analysis is not controlling across characteristics or providing any 'causal' assessments. This is something the report returns to in Section 5. This simpler approach is taken in this section in order to provide a first look at which population groups in the UK are most likely to experience low wellbeing.

[13] University of Essex, Institute for Social and Economic Research, Understanding Society Waves 1-13, 2009-2022 and Harmonised BHPS: Waves 1-18, 1991-2009. [data collection]. 18th Edition. UK Data Service. SN: 6614, http://doi.org/10.5255/UKDA-SN-6614-19, 2023. Note, Understanding Society measures life satisfaction on a 6-point scale (from 1 to 7), rather than the ONS 11-point scale (from 0 to 10). PBE has treated anyone scoring 1 or 2 on the Understanding Society scale as experiencing low wellbeing – in the latest wave (dating from 2021 to 2022) this is the equivalent of 6.7% of adults in the UK – a slightly lower proportion than found in the ONS Annual Population Survey data used above.

## Figure 5: There are significant inequalities in the incidence of low wellbeing

Incidence of low wellbeing by characteristic 2021-2022 (blue) with 95% confidence intervals shown in (grey)[14]




Source: PBE analysis of Understanding Society Wave 13

## Health and social factors

The chart makes clear that many of the largest raw differences in the prevalence of low wellbeing are associated with health and social characteristics.

For example, individuals who say they are in good health are less likely to report low wellbeing compared to the general population. However, the situation is reversed for reporting poor health, with over three in 10 (32%) experiencing low wellbeing. Indeed, drawing a direct comparison, people with self-reported poor health are more than 12 times more likely to report low wellbeing than those in excellent health. Likewise, nearly 12% of disabled individuals report experiencing low wellbeing, a rate almost three times higher than for those without disabilities.

Figure 5 further shows that mental health has one of the strongest associations with low wellbeing. When mental health difficulties limit daily activities – such as work, social interactions, or elements of self-care – the likelihood of low wellbeing increases dramatically.[15] Over two in five (44%) people whose mental health impacts their life "all of the time" experience low wellbeing, compared to just 2.4% of those whose daily lives are not impacted by poor mental health.

This stark contrast highlights how long-term sickness can significantly impact not only health but also a person's overall sense of life satisfaction and emotional wellbeing, creating a cycle that can be challenging to break. Addressing health concerns is essential for improving wellbeing and fostering a greater sense of fulfilment in life.

Alongside these significant health factors are social ones. Relationships and friendships, at home and at work, with family, friends, and communities, all

[14] Incidence of low wellbeing is estimated based on surveys of a sample of the UK population. The accuracy of these estimates depends on the sample size for each group in the original survey as well as the variation in outcomes across different groups. Confidence intervals provide an indicator of the accuracy – they indicate that 95% certainty that the true incidence for a particular group lies between the upper and lower bounds show on the chart.

[15] In everyday speech there can be a tendency to use wellbeing and mental health interchangeably. However, in wellbeing research they represent two distinct concepts. Mental health refers to a state in which people can "successfully cope with stress, work effectively, and realise their potential", whereas wellbeing captures a much broader range of outcomes about how people are feeling and functioning. Although the two are often correlated, it is perfectly possible for someone with good mental health to struggle with low wellbeing when faced with difficult circumstances or other challenges. Likewise, someone that is managing a mental health condition may not consider themselves to be struggling with low wellbeing if they are still able to find satisfaction in life.

matter for wellbeing. Where people "often" feel lonely, almost one-third (31%) also experience low wellbeing. This is almost five times the rate of those who feel lonely "some of the time" (6.7%), and almost 12 times the rate of those who "hardly ever" feel lonely (2.7%).

## Economic factors

In many circumstances, these health and social factors are closely linked with economic ones. For example, people who are out of work due to long-term sickness, unemployment, or caregiving responsibilities are also more likely to report lower wellbeing compared to those who are employed: those who are out of work due to sickness are six times more likely to experience low wellbeing than their employed counterparts.

And significant wellbeing differences are observable even within the out of work group, with more than 30% of those unable to work due to health issues reporting low wellbeing compared with fewer than one in 20 people out of the workforce for reasons such as training, studying, or retirement (4.4%).

Given this connection, it feels likely that the increase in low wellbeing observed since the pandemic is at least partly associated with the rise in the proportion of people out of work due to long-term sickness.[16]

Other economic factors appear to be at play too though, with the pressures of making ends meet likely to heighten stress and anxiety and diminish people's quality of life. People on lower incomes, especially those in the poorest households, are twice as likely to experience low wellbeing as those in the richest households, for instance (4% and 8.8%, respectively). Meanwhile, people who are behind on bills are almost 12 percentage points more likely to experience low wellbeing compared with those that are not behind on their bills (18% and 5.9%, respectively). This might be an especially elevated challenge for many households at the moment given the scars of the cost of living crisis.[17]

Housing, and the ability to live in a safe, secure, and affordable home, also appears to be connected to wellbeing. Homeowners (both those with

[16] Office for National Statistics, Rising ill-health and economic inactivity because of long-term sickness, UK: 2019 to 2023, July 2023.
[17] Joseph Rowntree Foundation, The cost of debt for low-income households in the cost of living crisis, July 2023.

outstanding mortgages (4.9%) and those in outright ownership (4.5%)) are slightly less likely than the total population to experience low wellbeing. In contrast, more than one in 10 (11%) tenants report low wellbeing. This includes 13% of local authority tenants, 12% of housing association tenants, and 10% of people living in private rentals. (As explored in Section 5, however, once other factors are controlled for, renting from the local authority or housing association appears to provide some protection against the risk of low wellbeing when compared to private rentals.)

## Demographic factors

Wellbeing varies across different demographic groups too, with one of the biggest demographic factors correlated with low wellbeing being ethnicity. Before controlling for any other demographic, economic, or social characteristics, all ethnic minority groups in the UK report lower levels of wellbeing on average than their white counterparts. Around one in 10 people from Asian (8%), Black Caribbean or African (9.7%), or "other" ethnic backgrounds (10%) experience low wellbeing. At 12% of the group, people with mixed heritage are the most likely to experience low wellbeing.

It is noteworthy that the division in wellbeing outcomes between white people and people from ethnic minorities has fluctuated over the last 10 years, but that the gap appears to be at its widest point during the latest year of data.[18] While care should be taken not to draw too definitive a conclusion from this shift, it is at least worth monitoring whether racial inequalities in wellbeing continue to widen in the coming years.

There are also moderate demographic variations in wellbeing by gender. Women are more likely to experience low wellbeing than men, with 7.1% of women (aged 16 and over) in the UK experiencing low wellbeing compared to 6.3% of the male population.[19] This means that there are more than 2 million women across the country feeling dissatisfied with their lives.

[18] PBE analysis of Understanding Society data by calendar year suggests that 6.5% of white people experienced low wellbeing in 2021, compared to 8.8% of non-white people. This gap of 2.3% is the largest gap seen since 2011 (when the analysis started).

[19] Further PBE analysis suggests this difference in wellbeing outcomes for men and women is statistically significant at the 90% level (but not at the 95% level). The gap in outcomes has been broadly consistent since 2011.

Figure 5 also highlights some wellbeing variation by age. In broad terms, working-age adults – those aged 19-65 – are more likely to experience low wellbeing than people who are younger (aged 16-18) and older (aged 66+).[20]

[20] Differences explored by geographic region were also explored but are not shown in Figure 5 because they were not statistically significant.

# Section 4: The persistence of low wellbeing

Section 3 provided a clearer picture of who is likely to be struggling with low wellbeing in any given year, but it is also important to understand when low wellbeing occurs and how long it typically lasts for. For many people, low wellbeing can be a temporary condition – impacted by life events, such as losing a job, short-term financial pressures, or the diagnosis of a serious illness. However, for others, low wellbeing may be more enduring.

Indeed, it is not uncommon for people to experience a period of low wellbeing. Over the most recent four-year period where data is available, almost one in six people (16.3%) experienced low life satisfaction at some stage.[21] This is the equivalent of around 9 million adults.

Most of these people recovered, at least temporarily, from low wellbeing as their lives moved on or they benefited from the support of friends, family, and local services.[22] Of those people who started with low wellbeing over the years 2018 and 2019, just over half (55%) appear to have 'escaped' (see Box 2) from low wellbeing four years later.

### Box 2: The experience of low wellbeing over time

To explore the experiences of those that face episodes of low wellbeing compared to those that face persistent low wellbeing over a sustained period, PBE has used four broad definitions:

- 'Stuck': individuals who have persistent low wellbeing for at least four years in a row.
- 'Escaped': individuals who experienced low wellbeing four years ago but have spent at least the most recent two years with a higher level of wellbeing.
- 'Churned': individuals who have moved in and out of low wellbeing within a four-year period but have not 'escaped'.
- 'Never experienced': individuals who have not experienced low wellbeing at any point in the four-year window being analysed.

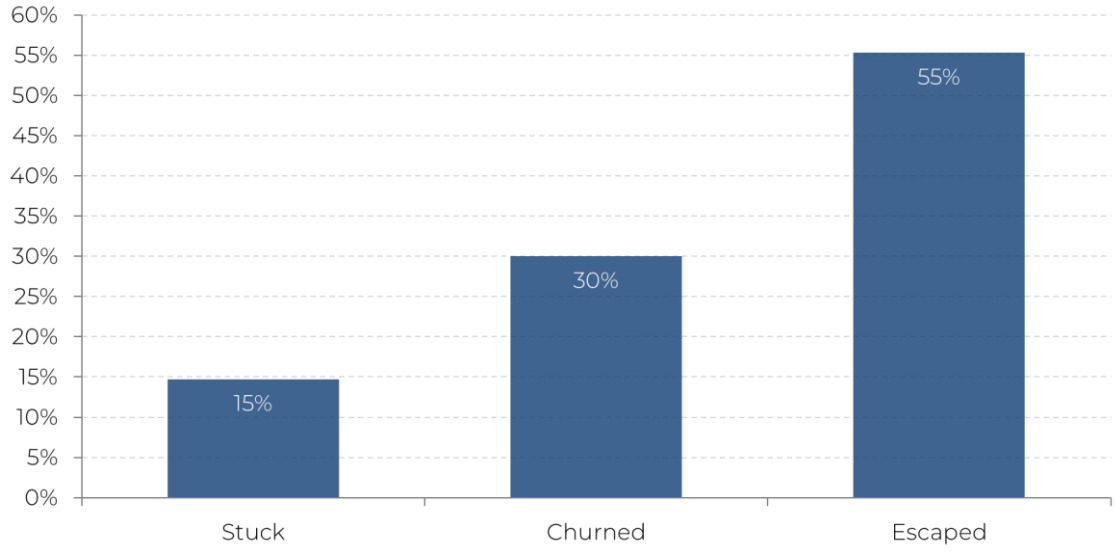
[21] Based on PBE analysis of Understanding Society Waves 10-13.
[22] Based on PBE analysis of Understanding Society Waves 10-13.

However, there is a significant minority of the low wellbeing population that remains 'stuck' in a state of low wellbeing for multiple years. More than one in six (15%) of those who started with low wellbeing in 2018 and 2019 remained there four years later, with just under a third (30%) 'churning' in and out of episodes. These proportions have remained broadly level over the last five years for which data is available.

Overall, this means that roughly 3.1% of adults in the UK fall into low wellbeing and fail to permanently escape over the course of a four-year period, with around 1% remaining stuck in that state for the entirety of that time.[23] This proportion of 'stuck' adults has remained broadly flat since 2017-18 and is equivalent to around half a million people, or roughly the same as the population of Bradford.

### Figure 6: One in six of those that experience low wellbeing remain stuck with this low quality of life four years later

% of those starting with low wellbeing in 2018-2019




Notes: 'Escaped' refers to those who experienced low wellbeing four years ago but have spent at least the most recent two years with a higher level of wellbeing; 'Churned' refers to those who have moved in and out of low wellbeing within a four-year period but have not 'escaped'; and 'Stuck' refers to those who have persistent low wellbeing for at least four years in a row.

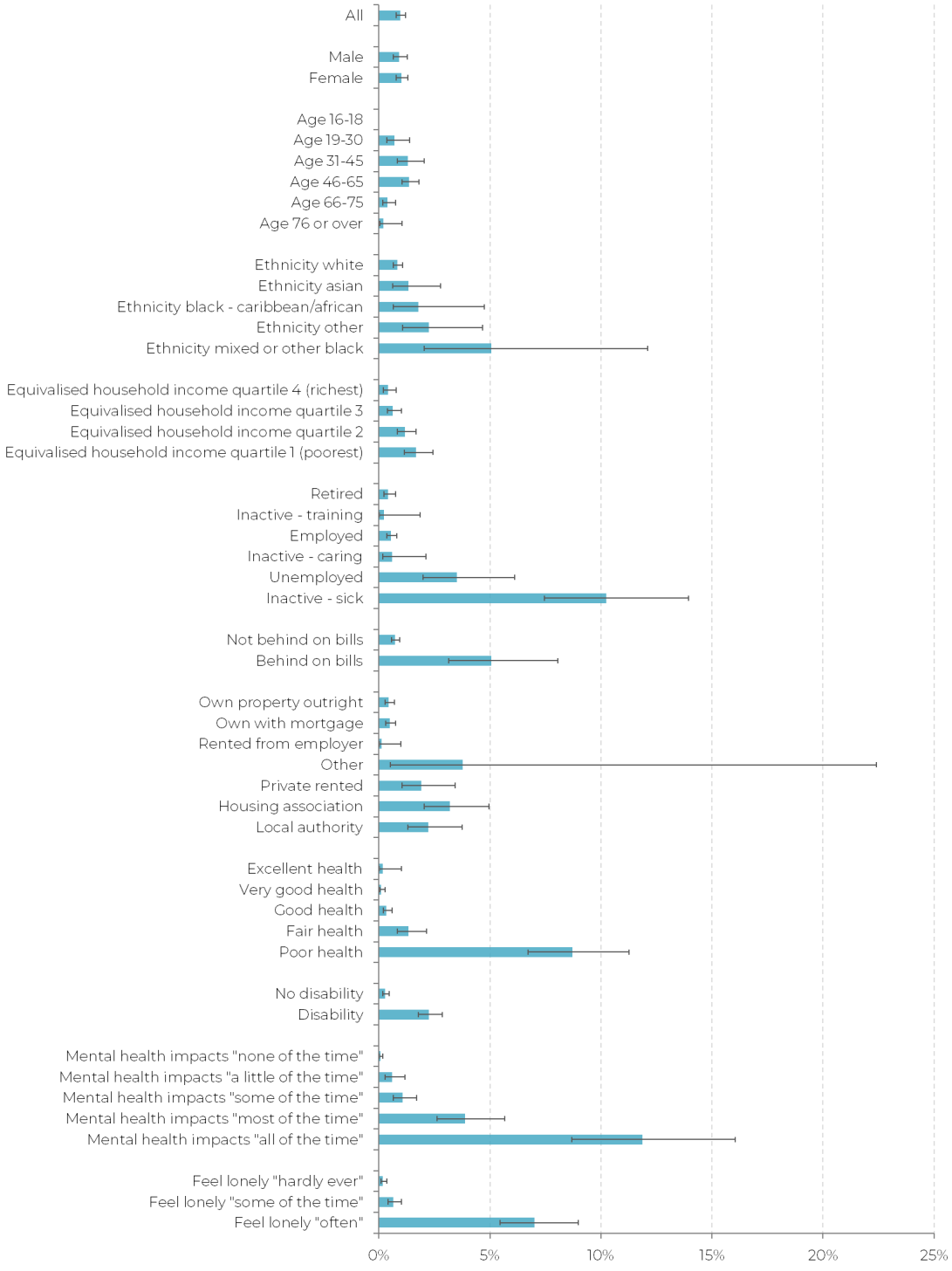
Source: PBE analysis of Understanding Society Waves 10-13.

The risk factors associated with being stuck in low wellbeing follow a similar broad pattern to the risk of experiencing any episode of low wellbeing outlined above.

[23] Based on PBE analysis of Understanding Society Waves F to M.

## Figure 7: Inequalities are exacerbated for those 'stuck' in low wellbeing

Incidence of being stuck in low wellbeing by characteristic 2021-2022 (blue)with 95% confidence intervals shown in (grey)




Source: PBE analysis of Understanding Society Waves 10-13.

There is more uncertainty around this analysis due to the smaller sample sizes available when drilling down specifically to those who are stuck for

four consecutive years, but it is possible to be confident that those who are inactive due to sickness, those who are behind on their bills, those who are facing poor health, those who are impacted by poor mental health "all of the time", and those who "often" feel lonely are all at significantly higher risk of being stuck with low wellbeing. Figure 7 provides a summary.

The chart shows that, in a number of instances, the inequalities in persistent low wellbeing are even more pronounced than they are when focusing on low wellbeing in any given year.

For example, those whose mental health impacts on them "all of the time" are 170 times more likely to get stuck in a state of low wellbeing than those whose mental health impacts on them "none of the time" (12% and 0.1%, respectively). And disabled men and women (2.3%) experience sustained low wellbeing at seven times the rate of non-disabled people (0.3%).

More generally, those who record having "poor" health (8.7%) are nearly 50 times more likely to experience sustained low wellbeing compared to those reporting "excellent" health (0.2%). Meanwhile, those who "often" feel lonely (7%) are 37 times more likely to experience sustained low wellbeing than those who "hardly ever" feel lonely (0.2%).

Those who are economically inactive due to sickness (10%) are 18 times more likely to be stuck in low wellbeing than employed people (0.5%). And those who are behind on bills (5.1%) are almost seven times more likely to be stuck with low wellbeing than those who are not (0.7%).

# Section 5: The drivers of low wellbeing

So far, so potentially obvious. Many of the social, economic, and demographic characteristics correlated with low wellbeing are somewhat predictable – though it is nonetheless illuminating to explore just how large the differences in prevalence are across different factors, and how they have altered over time.

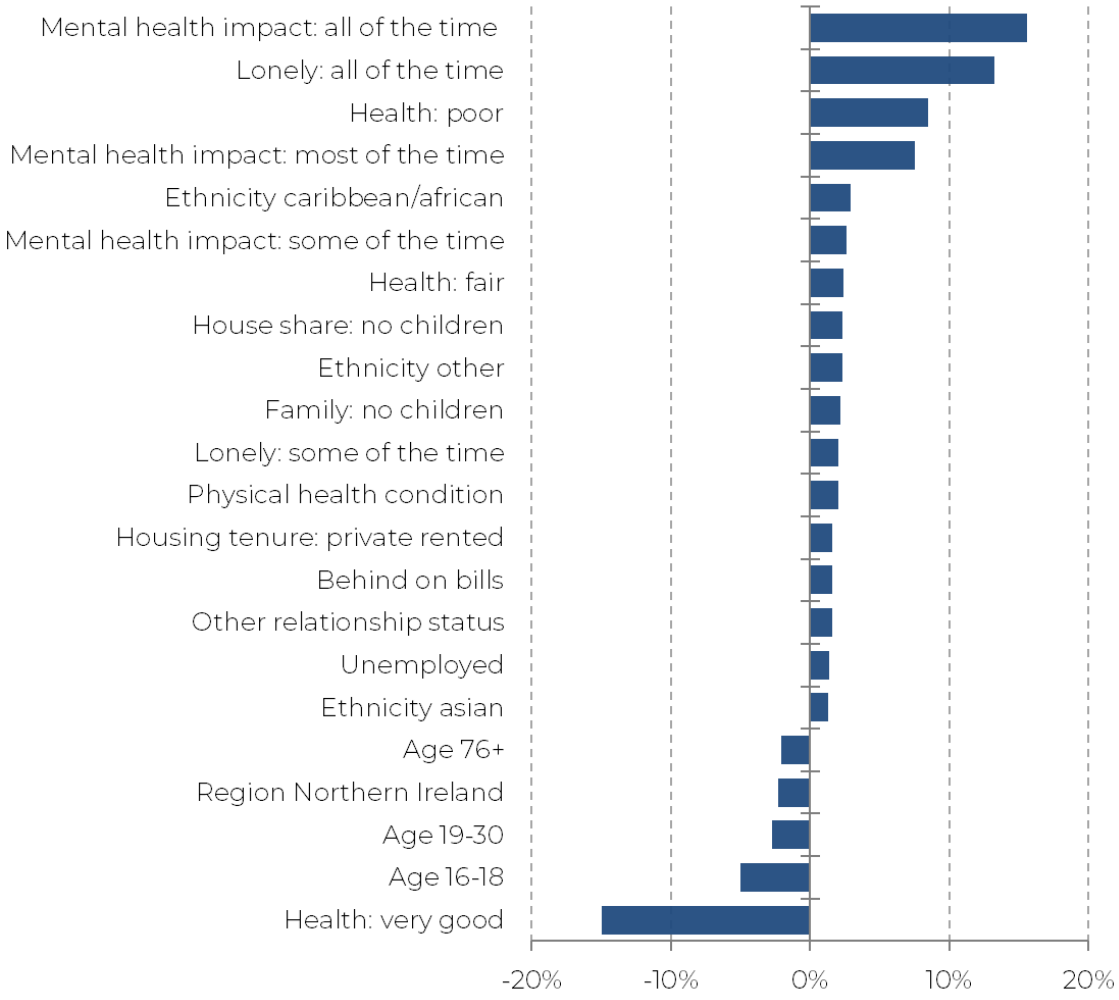
But the analysis to this point has provided only a partial picture. After all, life events can combine with socio-demographic factors to create complex relationships that are difficult to disentangle. For example, economic inactivity due to long-term sickness is linked to lower wellbeing, but is it the poor health, the loss of economic independence, the loss of income, or the loss of social contact through work that is the most important driver of this?

To answer such questions, this section goes, using statistical techniques to disentangle the effects of different characteristics and identify the strongest predictors of low wellbeing.[24] After controlling for a wide range of individual characteristics, the analysis highlights three factors that stand out as being the most predictive of low wellbeing: poor mental health, poor general health, and loneliness. To put it another way: mind, body, and connection.

[24] Further details of the approach are provided in Annex A.

## Figure 8: Mental health, general health, and loneliness are all strong predictors of low wellbeing

Impact of different characteristics on the probability of experiencing low wellbeing, holding other characteristics constant




Notes: Coefficients should be interpreted as the impact of the given characteristic on the probability of an adult experiencing low wellbeing. For example, someone whose mental health impacts them all of the time is 16 percentage points more likely to experience low wellbeing than someone who is similar in every other respect except that their mental health impacts them "none of the time".

Source: PBE analysis of Understanding Society Wave 10.

Figure 8 presents the results and shows that where someone's mental health impacts their life "all of the time", it increases the likelihood of low wellbeing by 16 percentage points. Experiencing poor health – broadly defined and self-reported – increases the likelihood of low wellbeing by 9

percentage points. Meanwhile, "often" feeling lonely increases the likelihood of experiencing low wellbeing by 13 percentage points.[25]

Some demographic characteristics as well as social and economic factors also drive low wellbeing (after controlling for other characteristics), albeit to a smaller extent than health and loneliness. For example, being from a Caribbean or African ethnicity, living in shared housing, or being behind on bills all independently increase the probability of low wellbeing. In addition, those living in private rented accommodation experience a significantly increased risk of low wellbeing compared to those in owner occupied or social housing.

While caution should be taken with interpretation of these results due to the reliance on correlations within cross-sectional data, the findings are comparable to those from other studies.[26] The emerging evidence and the scale of the impact that health and loneliness have appear to provide a good basis for focusing on these as key areas for further action to address low wellbeing in the UK.

Some of this is intuitive and adds support for current consensus about many policy priorities. Health has been a purported top priority for successive governments over the decades, and the new Labour administration is no different. This analysis also adds impetus to the government's plans to build more social homes and to improve conditions for renters through the Renters Reform Bill.

However, these findings also point to the gaps that exist between current policy and the issues most affecting people's lives. For example, the strong relationship between loneliness and low wellbeing highlights the need to ensure that effective policies are in place to address this – an issue returned to in Section 6. In addition, the focus of the current government on supporting those that are economically inactive to get back into work may not improve levels of wellbeing unless it addresses the underlying causes – particularly poor health.

---

[25] The same analysis was completed to identify those stuck in a state of low wellbeing. The smaller sample size meant that fewer characteristics were found to be statistically significant, but general health, mental health, and loneliness continued to be highlighted as key drivers.

[26] See for example: S Fleche, R Layard, Do More of Those in Misery Suffer from Poverty, Unemployment or Mental Illness? International Review of Social Sciences, 70(1), January 2017, or P Dolan, K Laffan, A Velias, Who's miserable now? Identifying clusters of people with the lowest subjective wellbeing in the UK, Social Choice and Welfare, 58, May 2022.

Moreover, the particular exposure to low wellbeing of ethnic minorities – something which goes beyond any differences that might be expected due to different economic outcomes – highlights the need to do more to tackle institutionalised inequalities facing certain groups. And while mental health is much talked about, insufficient action is being taken on the topic by employers, public services, and funders alike.

Using these drivers of wellbeing to better steer policy would allow policymakers to better prioritise relative investment on the issues that have the greatest impact on how people feel.

Importantly, the high-quality data that the UK has on low wellbeing as a result of the ONS 4, and the embedding of these standardised questions in a large range of detailed surveys over the last 12 years, also allows real, targeted focus on the people who would benefit most from that investment in support.

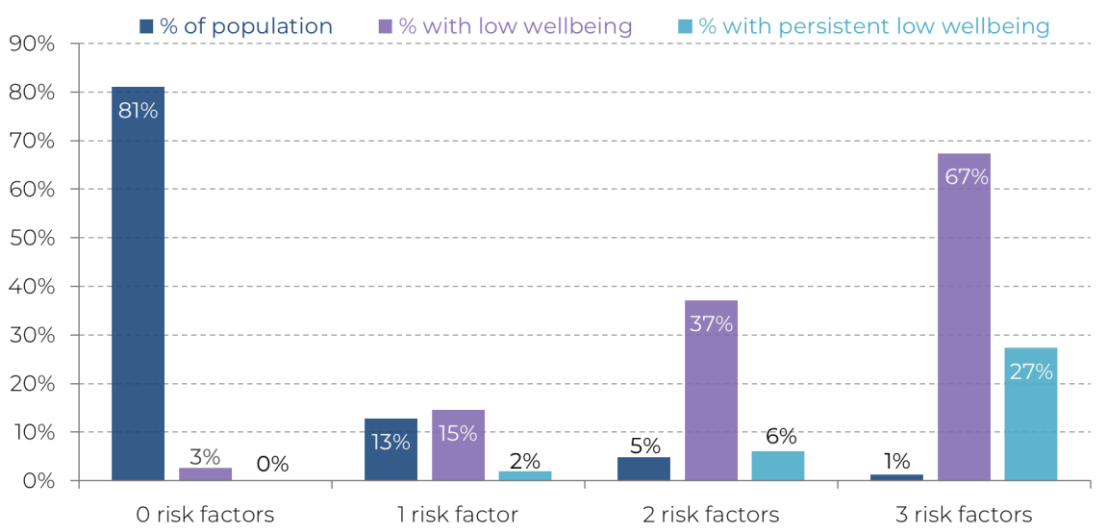
## Those most at risk of low wellbeing

The three most critical predictors of low wellbeing identified above – relating to mental health, self-reported general health, and loneliness – are interconnected and overlapping. An individual can experience combined loneliness and poor mental health, or poor mental health and poor general health, for example. Where they do so, the challenges they face may begin to feed each other. Indeed, that is precisely what this analysis suggests.

Figure 9 shows that around 3% of people showing none of the three critical risk factors identified experience low wellbeing. For those holding one risk factor, the experience of low wellbeing rises five-fold, to 15%. Where two risk factors are present, low wellbeing rises to 37%. And alarmingly, over two-thirds (67%) of people presenting with three risk factors report low wellbeing, with over one quarter (27%) enduring sustained low wellbeing.

## Figure 9: As individuals face multiple disadvantages, they are at a substantially higher risk of low wellbeing

UK population experiencing low wellbeing, by number of risk factors




Source: PBE analysis of Understanding Society Waves 10-13.

This points to the importance of interventions which deal with people in a holistic way – not simply tackling specific pathologies or issues in isolation. The social sector has a particularly important role to play in this, as a provider of support to people's 'whole selves', and particularly to people experiencing loneliness.

The analysis in this section starts to provide a clearer picture of who is likely to experience low wellbeing, but this is just the start of the story. If the UK is to be serious about ending the experience of low wellbeing – and it should be – then it is essential to identify and embed more opportunities to target and tackle the drivers of low wellbeing. And it is vital to make better use of data to support people suffering the consequences of low wellbeing in the here and now too.

Doing so will require more research and greater coordination across the public, private, and social sectors to provide pragmatic policy solutions and upstream reforms that can engage the right groups and address the right challenges. It is something that PBE will be turning to again and again in the coming years, with increasing degrees of granularity. For now, the next section provides a first look at one of the key identified themes in this report: loneliness.

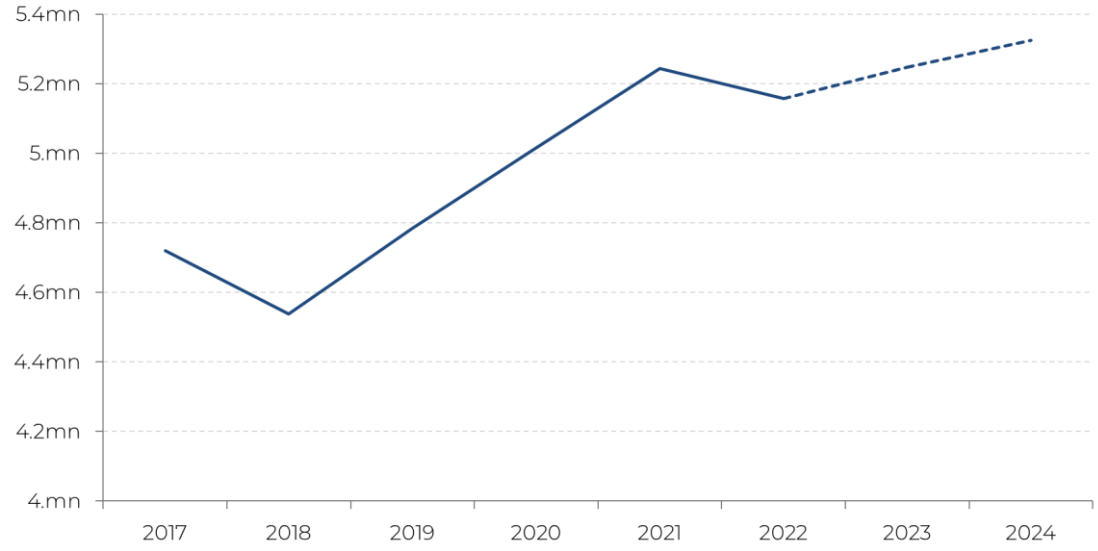
# Section 6: Loneliness in focus

As noted in Sections 2 and 5, loneliness is strongly associated with both experiencing low wellbeing and becoming stuck in a state of low wellbeing. It is a factor that remains strongly predictive of low wellbeing even after controlling for a wide range of demographic, economic, and social factors. Given this, tackling loneliness is critical to reduce the number of people struggling with low wellbeing in the UK.

Chronic loneliness impacts a large and growing number of adults in the UK. As Figure 10 sets out, there are likely to be more than 5 million adults in the UK today struggling with chronic loneliness – the equivalent of almost one in every 10 adults.[27] Moreover, the proportion has been rising over time and, when combined with the growing adult population, may leave total numbers of adults struggling with chronic loneliness at levels last seen during the depths of the pandemic.[28]

Figure 10: The number of adults struggling with chronic loneliness is potentially higher today than during the depths of the pandemic

Estimated number of adults often feeling lonely




Sources: PBE analysis of Understanding Society Waves 9-13, extrapolated to 2023 and 2024 based on trends from ONS, Opinions and Lifestyle Survey.

[27] Based on PBE analysis of Understanding Society and Opinions and Lifestyle Survey data. Chronic loneliness defined here as those that say they "often" feel lonely. Note, stakeholders have highlighted significant concern over what is the best way to measure loneliness so this should be considered an indicative figure.

[28] PBE analysis of Understanding Society Waves 9-13, extrapolated to 2023 and 2024 based on trends from Opinions and Lifestyle Survey.

The 5 million represent a diverse range of individuals, stretching far beyond the stereotyped picture of isolated older people. People below the age of 30, women (of all ages), people living in urban areas, those who have separated from their partner, those who are unemployed, and those with poor health are all disproportionately at risk of feeling lonely.[29]

Putting the composition of the group to one side, it should be clear that the number is too high. And it is putting strain on the wider economy and public services – not least on demand for health services.[30] It means the prize on offer for reversing the trend goes beyond an improvement in wellbeing for those who are directly affected.

PBE estimates that ending chronic loneliness in the UK could reduce the need for almost 1 million (950,000) GP appointments a year and around 100,000 in-patient episodes in hospitals.[31] Addressing loneliness could therefore play an important role in the government's ambition to reduce NHS waiting times.

## The policy change needed to reduce loneliness

Through consultation with stakeholders working to tackle loneliness in the UK, PBE has heard that, while policy attention on loneliness is higher than a few decades ago, there is concern that the issue has dropped down the political priority list.[32]

In 2018, Theresa May's government introduced a Loneliness Strategy (see Box 3). This was perceived at the time as a big achievement, and a solid recognition by policymakers of the importance of tackling loneliness. However, many stakeholders perceived progress on implementing the strategy to be slow. It is therefore imperative that, alongside important work focusing on the other key drivers of low wellbeing such as physical

[29] S Peytrignet, S Garforth-Bles, K Keohane, Loneliness monetisation report, Simetrica Jacobs, June 2020.
[30] F Sirois, J Owens, A meta-analysis of loneliness and use of primary health care, Health and Psychology Review, 17(2), October 2021.
[31] PBE analysis based on findings from J Christiansen et al., Loneliness, social isolation, and healthcare utilization in the general population, Health Psychology, 42(2), 2023. Further details are available in Annex B.
[32] Consultation included semi-structured interviews with 10 social sector organisations directly delivering services and campaigning to tackle loneliness during September and October 2024. The Department for Culture, Media and Sport focused work on loneliness includes: supporting a range of organisations through the Tackling Loneliness Hub (an online platform for professionals working to reduce loneliness); working to improve the evidence base around loneliness; and providing advice through the Better Health: Every Mind Matters campaign's advice pages.

and mental health, the new government renews its efforts to get to grips with loneliness. Several barriers to this were raised by those interviewed.

First, many organisations working to reduce loneliness are charities and, in common with other complaints about charity funding, are subjected to income streams that are frequently short-term and fragmented. This can lead to instability in programming support initiatives. Many smaller charities reported struggling to meet demand and manage costs. Youth services have been particularly hard hit, with funding falling by more than 74% in real terms between 2010-11 and 2020-21, despite their role in tackling loneliness among young people.[33]

### Box 3: The 2018 Loneliness Strategy

The 2018 Loneliness Strategy was a significant moment in recognising loneliness and social connection as important public health issues in the UK.[34] It formally recognised the deep impact that loneliness can have on health and quality of life. It also committed the government to: (i) do more to reduce stigma around loneliness so that people feel able to reach out for help; (ii) drive a lasting shift so that relationships and loneliness are considered in policy-making and delivery by organisations across society, and; (iii) commit to further developing the evidence base on loneliness to make a compelling case for action and better-inform decision making.

The strategy also opened new funding opportunities for loneliness initiatives through the Know Your Neighbourhood (KYN) Fund,[35] launched in January 2023. The initiative is intended to provide up to £30 million in government funding focused on tackling loneliness and widening participation in volunteering in 27 disadvantaged areas across England. By funding community-based activities and supporting people to build social connections, the KYN Fund aims to reduce chronic loneliness and improve wellbeing in these communities. A key focus of the programme is to generate and

[33] PBE analysis of Department for Education: LA and school expenditure, 2010-11 to 2021-22.
[34] Department for Culture, Media and Sport, A connected society: a strategy for tackling loneliness, October 2018.
[35] Department for Culture, Media and Sport, About the Know Your Neighbourhood Fund, October 2023.

share learning on how people in disadvantaged areas can be supported to volunteer and improve their social connections, which will help to support sustained action beyond the lifetime of the fund.

Second, stakeholders reported that effective collaboration between local authorities, healthcare services, and community organisations is often fraught with difficulty. This can create challenges ensuring that all actions to tackle loneliness are tailored to local needs. Additionally, fragmented approaches within a local area can impact on the effectiveness of support to individuals. Smaller organisations reported finding it particularly difficult to establish partnerships and engage in collective efforts because of resource constraints.

Third, many charities working to reduce loneliness find it difficult to provide robust data to demonstrate the effectiveness of their interventions. This acts as a barrier to funding and integration into local service delivery networks. There is some debate among organisations working on loneliness about how well the government's national indicator measures of wellbeing work for capturing changes within individuals for the purpose of evaluating an intervention. While new work from the Department for Culture, Media and Sport (DCMS) to review these metrics will be valuable, it will need to be accompanied by practical support for social sector organisations that often lack the expertise in measurement and evaluation.

To overcome these barriers, loneliness experts consulted suggested that the sector and government focus on three emerging areas:

1. **Refreshing and strengthening the policy framework around loneliness**

   Organisations consulted for this work felt strongly that the new government should refresh its commitment to tackling loneliness by collaborating with expert organisations to publish an updated action plan for loneliness. This should build on the strengths of the 2018 strategy, but also address the developing and emerging concerns raised across the sector and be grounded in the role that loneliness can play in helping to deliver the government's health mission.

   The expanded Community Life Survey has the potential to support this strategy setting by providing much richer evidence on how different

local authorities are tackling loneliness, identifying areas of best practice and 'cold spots' where further support could be required. It could also be used to support the government to explore strengthening how it reports on progress in tackling loneliness over time.

2. **Increasing collaboration with philanthropic funding to expand financial support for loneliness interventions**

PBE heard that the government should explore how it can work alongside philanthropic funding, potentially to co-fund activity targeted at tackling loneliness, and draw on the insights of the philanthropic sector. This could build on the rollout of the KYN Fund, offering more long-term, sustainable funding to the sector.

Co-funding and future funding should continue to build on the place-based focus of the KYN Fund, but also consider how to fund innovation and scaling-up of solutions targeted at vulnerable, disconnected populations, as well as the use of digital platforms that can be used alongside in-person interventions particularly for young people.

Case Study 1: Emily's journey – **provided by National Youth Agency**

Emily Long, 18, moved into supported accommodation in Goole, Yorkshire, in 2022. She felt isolated in her new environment but joined a boxing project called In Your Corner run by Goole Youth Action, with the support of Goole Amateur Boxing Club and government funding.

The project provided a safe space for young people, like Emily, who were at risk of being drawn into negative influences. It gave her the opportunity to meet new people and become more involved in her community.

*"In Your Corner and the youth workers there have helped me to feel part of the community. Before that I didn't feel very confident,"* she shared.

Emily's involvement in the youth club opened the door to other activities, such as participating in a 13-mile overnight walk designed

to raise awareness of mental health issues and build resilience among young people.

*"The night walk was a powerful experience. Youth work has given me hope for my future. I've learnt a lot of new skills, and it's taught **me a lot more about myself than I would have done hanging about** at the park,"* Emily said. This challenge helped Emily conquer her fear of the dark and demonstrated that with determination, she could achieve her goals.

Now studying beauty therapy at college, Emily feels more optimistic about her future. She credits youth work with giving her the tools to handle emotional struggles and build the confidence to live independently.

*"If I'm ever struggling emotionally, I turn to my youth worker. Because I feel safe and comfortable with her, I'm able to open up about my mental health,"* Emily explained. *"Taking part in youth **projects and activities has helped me feel happier and more** confident about living independently in the future."*

This case study highlights the positive impact of structured youth work on young people's wellbeing and personal development, demonstrating how projects like In Your Corner can offer vital support for those at risk of low wellbeing and helping them build a better future.[36]

### 3. Supporting social sector organisations to better measure and demonstrate their impact

Experts told PBE that government has a role to play in helping test, evaluate, and understand the efficacy of interventions that tackle loneliness. Government should support social sector organisations in their efforts to improve how they measure their impact. This should build on new work from DCMS to review which outcome measures are the right ones to use, as well as investing in initiatives that can help to gather high-quality data efficiently and provide benchmark

[36] National Youth Agency, 'A powerful experience and hope for the future' - Emily, 18, June 2024.

comparison groups to understand the additional impact loneliness services are having above and beyond what might have been expected in the absence of their support.

These efforts should go beyond theoretical guidance and include real world test cases and opportunities for organisations to share knowledge and learn from each other.

Through a combination of well-resourced support mechanisms, government-led policy influence, and effective social sector collaboration, loneliness can be tackled as both a public health issue and a societal challenge, fostering higher wellbeing and stronger, more connected communities.

PBE will undertake further work focused on loneliness over the coming months, building on the insight that charity partners can provide on the challenges faced by different groups, the nuance that exists across the country, and the lessons that can be learnt from action already underway.

### Case Study 2: Rachel's Story – provided by The Silver Line

Rachel, a retired specialist counsellor and self-described senior citizen, found herself struggling through an immensely difficult period of her life. Health complications and the weight of isolation left her feeling overwhelmed and unable to cope. *"I was in a bad place, and it came to the point where I didn't want to be here anymore, I just couldn't bear it,"* she shared.

Having spent years offering telephone counselling support to others, Rachel found herself on the other side of the conversation when she reached out to The Silver Line Helpline, a free, confidential telephone service offering support and companionship to older people.

Rachel vividly remembers her first call: *"I can't remember who it was I spoke to, but I told her that I didn't want to be here anymore. She spent a lot of time talking to me, and she really helped. She saved my life."*

The kindness of the voice on the other end of the phone was a profound comfort to Rachel. She explained her situation, and the

team member patiently listened, offering reassurance and encouraging her not to blame herself for what was happening. When the call ended, she was urged to reach out again if she ever needed to, and that reassurance became a crucial anchor for Rachel.

In the weeks that followed, Rachel found herself continuing to call The Silver Line during the most challenging moments, particularly at night when loneliness felt the most intense. The conversations not only helped Rachel survive a dark period but also provided her with new insights and the realisation that people do care about her, even when she couldn't see it herself.

*"To start with, [I'd call] when I was feeling lonely because I live on my own and I find evenings very hard to get through sometimes, but the calls can be about anything really,"* Rachel said. She cannot overstate the importance of the support she received: *"It's lifesaving. When I was on my knees and there hadn't been anybody else, honestly, I can put my hand on my heart and say I don't think I'd be here [if I didn't have The Silver Line Helpline]."*

Rachel's story illustrates the life-saving impact that services like The Silver Line Helpline can have for older individuals facing loneliness and emotional distress. Through simple, compassionate conversations, Rachel found hope, support, and a renewed sense of connection to the world around her.[37]

[37] The Silver Line, Rachel's story, June 2023.

# Section 7: Conclusion

The last few years have been challenging, putting a visible strain on the wellbeing of many in the nation. Yet, while it was perhaps inevitable that the devastation of the global pandemic would drag in a significant way on the life satisfaction of the population, it is troubling to note that the number of people living in low wellbeing shows no signs of falling, even as the Covid crisis grows smaller in the rear-view mirror.

It cannot therefore be assumed that further recovery will naturally follow. Nor can improvements secured in traditional government targets like GDP growth be relied upon. Economic progress might be considered a prerequisite of recovery, but the 3.2 million adults in the UK who are experiencing low wellbeing are being impacted by a complex web of factors that go well beyond standard considerations of jobs and money.

It is important to understand more about the mix of mind, body, and connection that in varying ways support or oppose wellbeing improvements across the population. But it is important too that the understanding of the causes and consequences of low wellbeing is connected to the collective policy approaches established across the public, private, and social sectors.

PBE believes that the government needs to outline a credible plan for reducing and ultimately ending "wellbeing poverty" in the UK. While this may not be quick and easy, already some key policy gaps can be identified – in relation to chronic loneliness, for example. While in priority policy areas such as housing and health, there are important details that need filling out and nuance that needs to be explored. Remembering that improving wellbeing is the ultimate goal and that wellbeing data provides unique insight on what matters to people and what makes a difference in their lives – and how that varies across different parts of the population – will be key.

This report marks PBE's first contribution to the cause. PBE will be digging deeper into some of the themes raised in this new annual publication in the coming weeks and months and will be working with charity partners and policymakers to better understand the practical ways in which improvements can be generated.

Above all, PBE will continue to highlight the connection between decisions made by policymakers and the lived experience of people across the country. All with the aim of ending wellbeing poverty in the UK.

# Annex A – Technical details of regression analysis

A cross-sectional logistic regression model is used to assess the contribution of different individual characteristics and circumstances on the probability that an adult in the UK will experience low wellbeing.

Data from Understanding Society Wave 13 is used. This final sample included 26,262 observations that had complete data, gathered over the period January 2021 to May 2023. Low wellbeing was defined as those responding "completely dissatisfied" or "mostly dissatisfied" to the question "how satisfied are you with your life overall?".[38] The definitions of other variables used in the regression are provided in Figure 11. Note that baseline categories were chosen based on the group with the largest frequency count in the sample.

Figure 11: Definitions of variables used in regression analysis

| Variable | Definition |
|---|---|
| Female | Equal to 1 if variable m_sex_dv=2. |
| Age X | Equal to 1 if individual is in age category X, based on m_age_dv, baseline category is age 46-65. |
| Region X | Equal to 1 if individual is in Government Office Region X based on m_gor_dv, baseline category is South East. |
| Rural | Equal to 1 if individual lives in a rural area, based on variable m_urban_dv, baseline category is "urban". |
| Ethnicity X | Equal to 1 if individual is in ethnicity category X based on 18 categories in variable m_ethn_dv, baseline is British/English/Scottish/Welsh/Northern Irish/Irish, or Gypsy/Irish Traveller. Note that some ethnicity groups needed to be merged due to small sample sizes. Groupings were made based on practice in other studies and similarity of average life satisfaction within the group. |
| Living as a couple | Equal to 1 if individual is living as a couple, based on m_marstat_dv, baseline category is "married". |
| Widowed | Equal to 1 if individual is widowed or surviving a civil partner, based on m_marstat_dv, baseline category is "married". |

[38] While this question does not perfectly align with the ONS measure of Life Satisfaction, 6.7% of adults are identified as having low wellbeing using this definition compared to 5.7% using the official ONS data.

| | |
|---|---|
| Divorced | Equal to 1 if individual is divorced or dissolved civil partnership, based on m_marstat_dv, baseline category is "married". |
| Separated | Equal to 1 if individual is separated but still legally married or in civil partnership, based on m_marstat_dv, baseline category is "married". |
| Other relationship status | Equal to 1 if individual is not falling into any of the other categories based on m_marstat_dv, baseline category is "married". |
| Unemployed | Equal to 1 if individual is not in employment but seeking employment, based on m_jbstat, baseline is employed (including self-employed). |
| Retired | Equal to 1 if individual is retired, based on m_jbstat, baseline is employed (including self-employed). |
| Inactive – caring | Equal to 1 if individual is someone that is not in work and is not seeking work due to caring responsibilities, based on m_jbstat, baseline is employed (including self-employed). |
| Inactive – training | Equal to 1 if individual is not in work and is not seeking work due to participation in education or training, based on m_jbstat, baseline is employed (including self-employed). |
| Inactive – sick | Equal to 1 if individual is not in work and is not seeking work due to poor health, based on m_jbstat, baseline is employed (including self-employed). |
| Income quartile X | Equal to 1 if individual is in income quartile X based on equivalised household income. Quartile 1 has highest income and is used as baseline. |
| Behind on bills | Equal to 1 if individual is a member of a household that is "behind with some bills" or "behind with all bills", based on variable m_xphsdba. |
| Further education | Equal to 1 if further education is individual's highest qualification, based on variable m_qfhigh_dv, baseline is higher education or degree. |
| Secondary education | Equal to 1 if secondary education is individual's highest qualification, based on variable m_qfhigh_dv, baseline is higher education or degree. |
| Other education | Equal to 1 for all other qualification levels, based on variable m_qfhigh_dv , baseline is higher education or degree. |
| Mental health impact – X | Equal to 1 for different categories of impact from mental health, based on m_scsf4a. Individuals state that in the last four weeks their mental health has meant they accomplished less "all of the time", "most of the time", "some of the time", or "a little of the time", baseline is "none of the time". |

| | |
|---|---|
| Health – X | Equal to 1 for different categories of general health, based on m_scsf1. Individuals state that "in general" their health is "excellent", "very good", "fair", "poor", baseline is "good". |
| Physical health condition | Equal to 1 if individual has been told by a doctor or health professional that they have multiple sclerosis, high blood pressure, epilepsy, diabetes, asthma, cancer, liver condition, hypo or underactive thyroid, COPD, chronic bronchitis, emphysema, stroke, heart attack, angina, heart disease, congestive heart failure, arthritis, or any other chronic condition. Based on m_hcond variables, baseline is no physical health condition. |
| Disability | Equal to 1 if individual self-identifies as having a "long-standing illness or disability", based on variable m_health, baseline is not long-term illness or disability. |
| Lonely – X | Equals 1 for loneliness category X, based on question "how often do you feel lonely?", based on variable m_sclonely, baseline is "hardly ever or never". |
| Housing tenure – X | Equals 1 for different housing tenure categories, based on variable m_tenure_dv, baseline is "owning outright". |
| Solo household | Equal to 1 if respondent lives on their own, based on variable m_hhtype_dv, baseline is a couple living with children. |
| Single parent | Equal to 1 if respondent is a single adult living with children, based on variable m_hhtype_dv, baseline is a couple living with fewer than three children. |
| Large family | Equal to 1 if respondent is part of a couple living with three or more children, based on variable m_hhtype_dv, baseline is a couple living with fewer than three children. |
| House share – no children | Equal to 1 if respondent is living with other adults (that they're not in a relationship with) and no children, based on variable m_hhtype_dv, baseline is a couple living with fewer than three children. |
| House share – children | Equal to 1 if respondent is living with other adults (that they're not in a relationship with) and children, based on variable m_hhtype_dv, baseline is a couple living with fewer than three children. |

The Average Marginal Effect of each variable is used to summarise the results of the logistic regression in Figure 12. This provides a more intuitive form for regression coefficients that can be interpreted as the average effect that the variable has on the probability of an adult experiencing low wellbeing, holding other variables constant. So, a coefficient of 0.2 implies that variable could add around 20 percentage points to the probability that

an adult experiences low wellbeing. Relationships that were statistically significant at the 90% level are shown in bold.[39]

Figure 12: Average Marginal Effects of variables used in logistic regression

| Variable | Average Marginal Effect | P-value |
|---|---|---|
| Female | -0.005 | 0.17 |
| **Age 16-18** | **-0.050** | **0.00** |
| **Age 19-30** | **-0.027** | **0.00** |
| Age 31-45 | -0.004 | 0.52 |
| Age 66-75 | -0.013 | 0.12 |
| **Age 76+** | **-0.021** | **0.05** |
| Region Northeast | -0.016 | 0.20 |
| Region Northwest | -0.008 | 0.35 |
| Region Yorkshire & Humber | -0.004 | 0.66 |
| Region East Midlands | -0.004 | 0.66 |
| Region West Midlands | -0.007 | 0.39 |
| Region East | -0.005 | 0.56 |
| Region London | -0.005 | 0.55 |
| Region Southwest | -0.007 | 0.42 |
| Region Wales | 0.011 | 0.23 |
| Region Scotland | -0.000 | 0.96 |
| **Region Northern Ireland** | **-0.023** | **0.03** |
| Rural | 0.002 | 0.68 |
| **Ethnicity Caribbean / African** | **0.029** | **0.01** |
| Ethnicity mixed / other black | 0.019 | 0.21 |
| **Ethnicity Asian** | **0.013** | **0.07** |
| **Ethnicity other** | **0.023** | **0.01** |
| Living as a couple | 0.011 | 0.13 |
| Widowed | 0.003 | 0.78 |
| Divorced | 0.007 | 0.48 |
| Separated | 0.024 | 0.13 |
| **Other relationship status** | **0.016** | **0.06** |

[39] The analysis includes a large number of dummy variables which can create instability in coefficient estimates. The regressions were re-run using data from Waves L and J of Understanding Society. While some of the individual coefficients, particularly relating to economic variables such as income and employment, did change, the key findings – that health and loneliness were major predictors of low wellbeing – remained valid.

| | | |
|---|---|---|
| **Unemployed** | **0.014** | **0.08** |
| Retired | -0.008 | 0.35 |
| Inactive – caring | 0.004 | 0.67 |
| Inactive – training | -0.019 | 0.10 |
| Inactive – sick | -0.002 | 0.78 |
| Income quartile 2 | 0.002 | 0.67 |
| Income quartile 3 | -0.001 | 0.93 |
| Income quartile 4 | -0.009 | 0.15 |
| **Behind on bills** | **0.016** | **0.014** |
| Further education | 0.009 | 0.19 |
| Secondary education | 0.000 | 0.93 |
| Other education | -0.003 | 0.53 |
| **Mental health impact – all of the time** | **0.156** | **0.00** |
| **Mental health impact – most of the time** | **0.075** | **0.00** |
| **Mental health impact – some of the time** | **0.026** | **0.00** |
| Mental health impact – a little of the time | 0.005 | 0.26 |
| Health – excellent | -0.007 | 0.35 |
| **Health – very good** | **-0.15** | **0.00** |
| **Health – fair** | **0.024** | **0.00** |
| **Health – poor** | **0.085** | **0.00** |
| **Physical health condition** | **0.020** | **0.06** |
| Disability | -0.008 | 0.14 |
| **Lonely – some of the time** | **0.020** | **0.00** |
| **Lonely – all of the time** | **0.132** | **0.00** |
| Housing tenure – owned with mortgage | 0.000 | 0.96 |
| Housing tenure – local authority rented | 0.006 | 0.42 |
| Housing tenure – housing association rented | -0.002 | 0.75 |
| Housing tenure – rented from employer | 0.001 | 0.97 |
| **Housing tenure – private rented** | **0.016** | **0.06** |
| Housing tenure – other | -0.007 | 0.71 |
| Solo household | 0.004 | 0.72 |
| **Family – no children** | **0.022** | **0.01** |

| | | |
|---|---|---|
| Single parent | -0.011 | 0.936 |
| Large family | -0.001 | 0.94 |
| **House share – no children** | **0.023** | **0.01** |
| House share – children | 0.011 | 0.24 |

# Annex B – Healthcare impacts of loneliness

There is a wide range of international evidence highlighting that loneliness is linked to increased use of health services.[40] This work draws on two high-quality studies that are based in western European countries to estimate the scale of this effect in England.[41]

The studies are based in the Netherlands and Denmark, two similarly wealthy nations to the UK with well-developed public health services, and they robustly control for potential confounding factors – such as socio-demographic characteristics and pre-existing health conditions – to attempt to isolate, specifically, the impact of loneliness. The studies suggest that loneliness is associated with an increase in the use of GP services of between 3% and 8%. For the purposes of this analysis, the lower estimate of 3% is used.

The calculation follows three basic steps:

1. **Estimate the number of people struggling with chronic loneliness in England:** Understanding Society data is used to estimate that 9.6% of adults in the UK were struggling with chronic loneliness in 2021.[42] This is estimated to have fallen to around 9.4% in 2023 based on an extrapolation of trends from the Opinions and Lifestyles Survey. ONS statistics suggest there were 55.7 million adults in the England in 2023, meaning that around 5.2 million were struggling with chronic loneliness.[43]
2. **Estimate the baseline number of GP appointments for those that are lonely:** There were 349 million GP appointments in England in 2023 and 57.7 million people (of all ages).[44] This is an average of 6.04 appointments per person. Based on the literature, it is assumed that the 9.4% of the population struggling with chronic loneliness will require 3% more than the rest of the population – this implies that the average lonely person could need 6.21 appointments compared

[40] See, for example, this meta-analysis of studies: F Sirois, A meta-analysis of loneliness and use of primary health care, Health Psychology Review, 17(2), October 2021.
[41] R Meisters et al., Does Loneliness Have a Cost? A Population-Wide Study of the Association Between Loneliness and Healthcare Expenditure, International Journal of Public Health, 66, 2021, and J Christiansen et al., Loneliness, social isolation, and healthcare utilization in the general population, Health Psychology, 42(2), 2023.
[42] Based on those that "often" feel lonely.
[43] Office of National Statistics, Estimates of the population for England and Wales, July 2024.
[44] NHS Digital, Appointments in General Practice, December 2023, February 2024, and Office of National Statistics (2024).

to 6.03 appointments for the average non-lonely person. A difference of 0.18 GP appointments for each individual that is experiencing chronic loneliness.

3. **Estimate total impact on GP appointments of chronic loneliness:** Multiplying the number of adults in England with chronic loneliness from Step 1 (5.2 million) by the average number of additional GP appointments from Step 2 (0.18) gives an estimate of the total number of additional GP appointments due to chronic loneliness (948,000).

This estimate provides an indicative impact of chronic loneliness on the demand for GP appointments. It assumes that the findings from the studies in the Netherlands and Denmark are representative of the likely impacts of loneliness in the UK. This includes an assumption that the definitions of loneliness used are broadly similar.[45] It assumes that the age distribution of GP appointments is relatively uniform between children and adults in England.

[45] The proportion of people struggling with chronic loneliness in the UK broadly aligns to those in the "severely lonely" and "very severely lonely" categories in R Meisters et al. study, although similar data was not available for the Christiansen et al. report.

PRO BONO ECONOMICS

@ProBonoEcon

www.probonoeconomics.com

020 3632 2668