Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru

Evidence briefing paper

Well-being and equalities

www.wcpp.org.uk

Well-being and equalities

What is the connection between well-being and equalities?

The importance of well-being inequality to PSBs

Well-being outcomes for people who are considered disadvantaged or vulnerable

Well-being outcomes for people who possess a protected characteristic

Well-being outcomes for children under the age of 18

Well-being outcomes for children and young people who are, or have been, looked after

Well-being outcomes for people who have need for care or support, and people who care for them

What are the evidence gaps, uncertainties, and areas to explore?

How do different groups experience well-being?

Are there any groups which have a notably different experience of well-being from others?

What are the reasons why this could be the case?

How can the evidence on equalities and well-being be used to support well-being objectives?

How can interventions be tailored to maximise well-being across different groups?

Introduction

Public Services Boards (PSBs) are required to carry out well-being assessments for their local areas every five years, in line with local election cycles. The Wales Centre for Public Policy (WCPP) has been asked to support this process by preparing briefings looking at national trends and evidence across the areas of **well-being and equalities**, **cultural well-being,** and **the impacts of Covid-19 and Brexit on well-being**.

This briefing focuses on well-being and equalities. It should be read alongside the other two briefings in the series. This briefing:

1. First provides an overview of the connection between well-being and equalities, and why well-being inequality is of relevance to PSBs.
2. It then goes on to explore differential well-being outcomes for individuals in the following five groups:
   - **2.1** People who are considered disadvantaged or vulnerable.
   - **2.2** People who possess a protected characteristic under the Equality Act (2010).
   - **2.3** Children under the age of 18.
   - **2.4** Children and young people who are, or have been, looked after.
   - **2.5** People who have need for care or support, and people who care for them.

These groups are named in statutory guidance for the preparation of well-being assessments (Welsh Government, 2015).

3. After the discussion of each of the five groups, the briefing looks at any evidence gaps, uncertainties, and areas to explore.
4. Finally, the conclusion addresses the four key questions implicitly explored in the briefing:
   - **4.1** How do different groups experience well-being?
   - **4.2** Are there any groups which have a notably different experience of well-being from others? What are the reasons why this could be the case?
   - **4.3** How can the evidence on equalities and well-being be used to support well-being objectives?
   - **4.4** How can interventions be tailored to maximise well-being across different groups?

Key findings and recommendations

- **Inequalities in subjective well-being** are being increasingly viewed as an important and informative measure of inequality by local authorities and other bodies.
  - It is important to look at well-being inequality within local areas, rather than just looking at average well-being in an area. This is to ensure that efforts to improve well-being in an area can target those who have the lowest levels of well-being.
- **Objective measures of socioeconomic status (such as income or occupation) have been consistently shown to correlate with personal well-being indicators.**
  - Unemployment has been shown to be a particularly important driver of well-being.
  - Emerging evidence also suggests that **subjective socioeconomic status accounts for additional variation in well-being outcomes**, beyond that of objective socioeconomic status.
- The ONS's self-reported well-being measures show that **there are some differences in reported well-being across protected characteristics**[1] on a UK-wide level.
  - It is important to consider that these characteristics represent overlapping identities, meaning that people often fall into multiple categories.
- Analysis conducted by the ONS that looks at how factors associated with the lowest levels of well-being come together identified the following **three groups as having the highest probability of being in the group with the poorest personal well-being**:
  - Unemployed or inactive renters with self-reported health problems or disability;
  - Employed renters with self-reported health problems or disability; and
  - Retired homeowners with self-reported health problems or disability.
- **Interventions to improve well-being should be targeted towards groups with the lowest well-being, or areas with the highest well-being inequality.**
- **A number of features associated with increased effectiveness for projects that aim to increase people's well-being have been identified.** These include: identifying local need; taking a holistic approach; engaging the target group; co-production; providing training; and flexibility.
- **The Covid-19 pandemic has exacerbated existing inequalities in well-being.** (See the accompanying briefing for a more comprehensive discussion on this.)

1 Protected characteristics refer to specific aspects of a person's identity defined by the Equality Act 2010, namely: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. It is against the law to discriminate against someone because of any of these protected characteristics.

1. What is the connection between well-being and equalities?

There are a number of factors associated with lower or higher well-being. The link between well-being and equalities can be conceptualised in two ways:

1. By looking at inequalities in subjective well-being (i.e. how subjective well-being differs between individuals, groups of people, local areas, and so on); and/or
2. By looking at inequalities in the factors that drive well-being (for example, factors such as unemployment, physical health, and so on – which will impact certain groups more than others).

Subjective well-being measures therefore allow PSBs and other bodies to consider how all the different drivers of well-being come together to impact overall well-being.

This means that subjective well-being will be dependent not only on employment status, for example, but also on how this interacts with other factors such as social connections or mental health. Where data on subjective well-being are not available, data or evidence on the drivers of well-being, which will impact certain groups in different ways, are important and useful. What Works Wellbeing has summarised the factors which have the greatest impact on well-being, based on relevant evidence (see Figure 1). A number of the factors outlined in Figure 1, as well as others discussed in the subsequent sections, align with the Welsh National Well-being Indicators (Welsh Government, 2019a).

Figure 1. Summary of well-being factors that matter

Source: Reproduced from What Works Wellbeing, 'What Affects Wellbeing' webpage

These factors cover a range of drivers that determine the conditions for well-being. They can be assessed using indicators that relate to equality (for example, the gender pay gap by area; inequality in life expectancy at birth), local conditions (such as access to green space; educational attainment of children; subjective health), and sustainability (such as tree cover).

1.1. The importance of well-being inequality to PSBs

While measures of income and wealth inequality have traditionally dominated discussions on inequality, inequality in subjective well-being is being increasingly viewed as an important and informative measure of inequality by local authorities and other bodies. There are a number of reasons for this:

1. Improving well-being is a societal goal, formalised under the Well-being of Future Generations Act 2015.
2. Data on well-being at the individual level are available (see Box 1), which allows for an assessment of the current state and trends of well-being across Wales and the UK, and at a local level.
    - However, average levels of well-being do not account for the variation in well-being across the population/local areas.
3. Focusing on well-being inequality (i.e. the *distribution* of well-being in an area as opposed to the average) ensures a more accurate reflection of well-being across a given population. It can also seek to identify people with low well-being, to ensure that efforts to improve well-being in an area can target those who have the lowest levels of well-being.
4. Focusing on well-being inequality also helps PSBs to identify where there are group-based inequalities in well-being (for example, by protected characteristic), which can support the implementation of the Equality Act 2010.
5. Assessing well-being inequality can also identify the factors that determine low or high well-being outcomes for different people, which can further inform policy and interventions.

This briefing therefore aims to take into account, as far as is possible, the distribution of well-being (i.e. well-being inequality) for different groups and areas in Wales, as well as average well-being across and within groups and areas (see Box 2). It also aims to highlight geographical variations in the presence or concentration of relevant factors to show how the population make-up of certain areas might impact levels of well-being.

It is important to note that people often fall into multiple and overlapping identities that relate to well-being outcomes. This, in turn, will have an impact on how interventions should be designed and at whom they should be targeted. In this briefing, in most cases, well-being outcomes will be explored across individual groups/dimensions/identities. This is because the data often do not allow for an intersectional analysis, which would look at how people's multiple and overlapping identities contribute to well-being outcomes. Where possible, however, the briefing does aim to take an intersectional approach.

Figure 2 shows **well-being inequality *within* Welsh local authorities** in 2014-15, based on the variation in answers to the ONS's four questions on well-being (i.e. the average standard deviation of the four questions listed in Box 1).[2] This shows Blaenau Gwent to be the most unequal local authority in Wales, with a mean standard deviation of 2.55. Ceredigion was the most equal, with a mean standard deviation of 1.95.

Figure 3 shows **average well-being *across* Welsh local authorities** in 2018-19.[3] The full table of local authority data shown in Annex 2 shows that there is a correlation between average well-being and well-being inequality, whereby areas with low levels of average well-being tend to have higher well-being inequality. However, there are exceptions to this, which highlights the value of looking at both average well-being and well-being inequalities. For example, while Anglesey showed the highest average well-being of all local authorities, it was the twelfth-most unequal. Conversely, while Gwynedd was the third-most equal local authority, it was in the mid-range in terms of average well-being scores.[4]

Box 1: Self-reported well-being measures

There are four metrics used by the Office for National Statistics (ONS) to measure well-being in individuals:

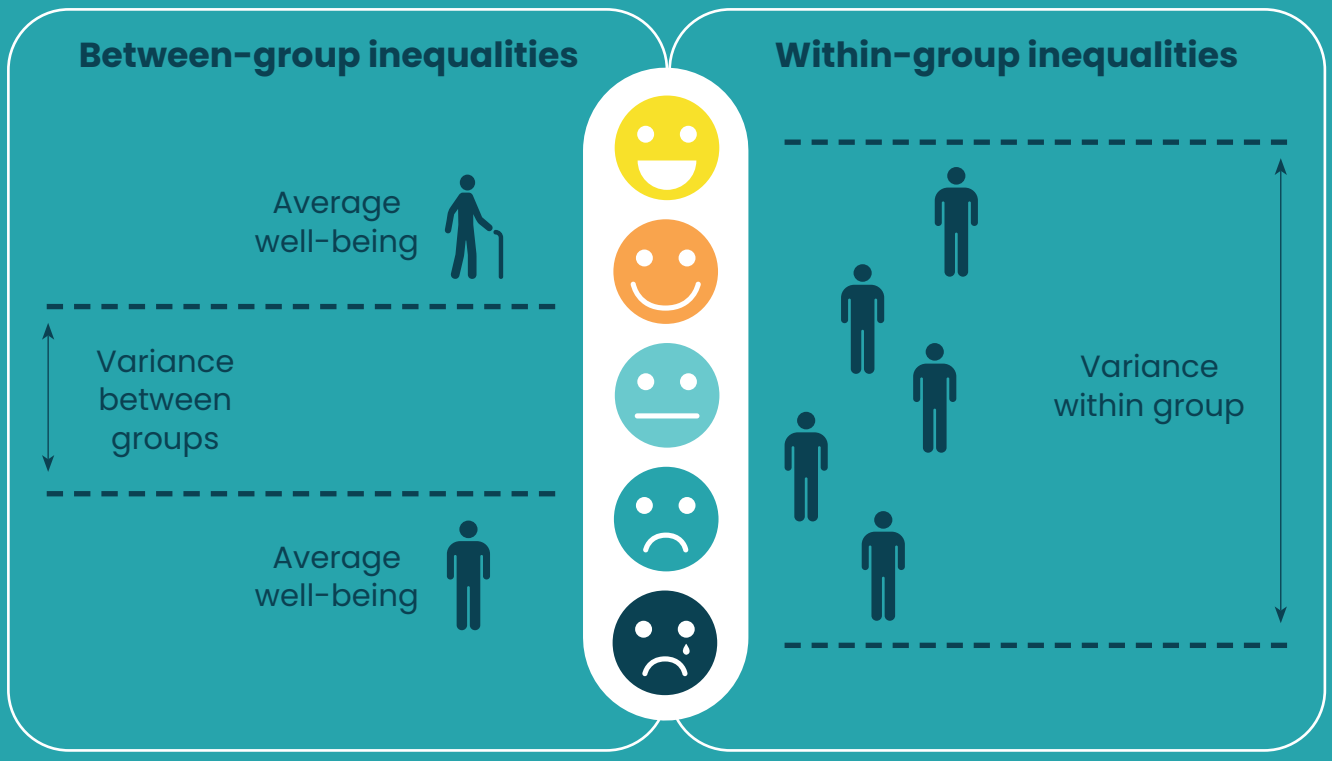
1. **How satisfied respondents felt with their life.**
2. **To what extent respondents felt that things they did with their life were worthwhile.**
3. **How happy respondents felt yesterday.**
4. **How anxious respondents felt yesterday.**

Each question is scored by respondents on a scale of 1–10.

2 The variation was calculated as the average standard deviation across each of the four ONS well-being questions, to provide an overall well-being inequality measure for each local authority. The standard deviation of each question provides the average difference between the well-being score of any individual in a local authority and the mean for that local authority. The data for Welsh local authorities were extracted from the dataset provided alongside What Works Wellbeing and the New Economics Foundation's report, Measuring wellbeing inequality in Britain (Abdallah, Wheatley and Quick, 2017a).

3 Calculated as the average score across the four well-being questions listed in Box 1 (with the scores for the question on anxiety inversed).

4 For more information on data sources and availability see Annex 1.



Box 2: Measures of well-being inequality

There are two measures of inequalities in well-being outcomes

Between-group well-being inequality: differences in well-being between different population groups – for example, older and younger people, or high- and low-income groups.

Within-group well-being inequality (or overall well-being inequality): differences in well-being within a population (for example, within a local authority), without taking into account demographic or socioeconomic factors. This could be done by comparing the top- and bottom-quartile scores of the well-being distribution, or by measuring the standard deviation.

Well-being inequality can also be assessed without data on subjective well-being

The two measures detailed look explicitly at inequalities in subjective well-being outcomes. Well-being inequality can also be considered by looking at the inequalities in the factors that drive well-being – which we know tend to affect some people or groups differently.

Source: Quick (2015). Figure is illustrative and not based on data

Figure 2. Overall well-being inequality for Welsh local authorities (2014-15)

Source: Abdallah, Wheatley and Quick (2017a), based on ONS Annual Population Survey data

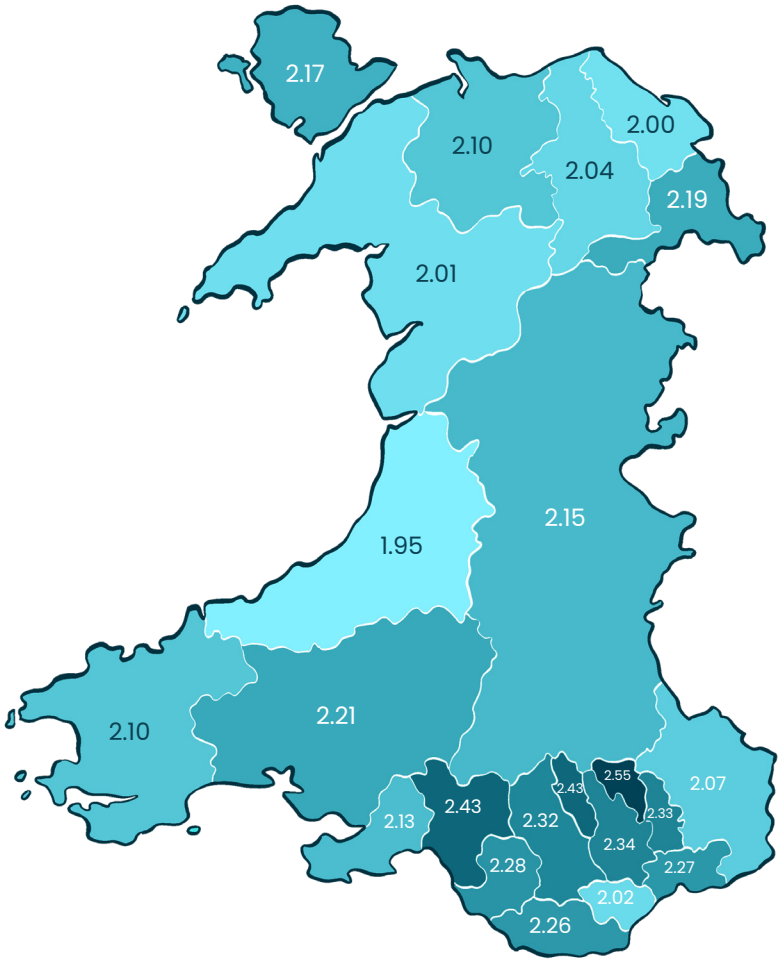
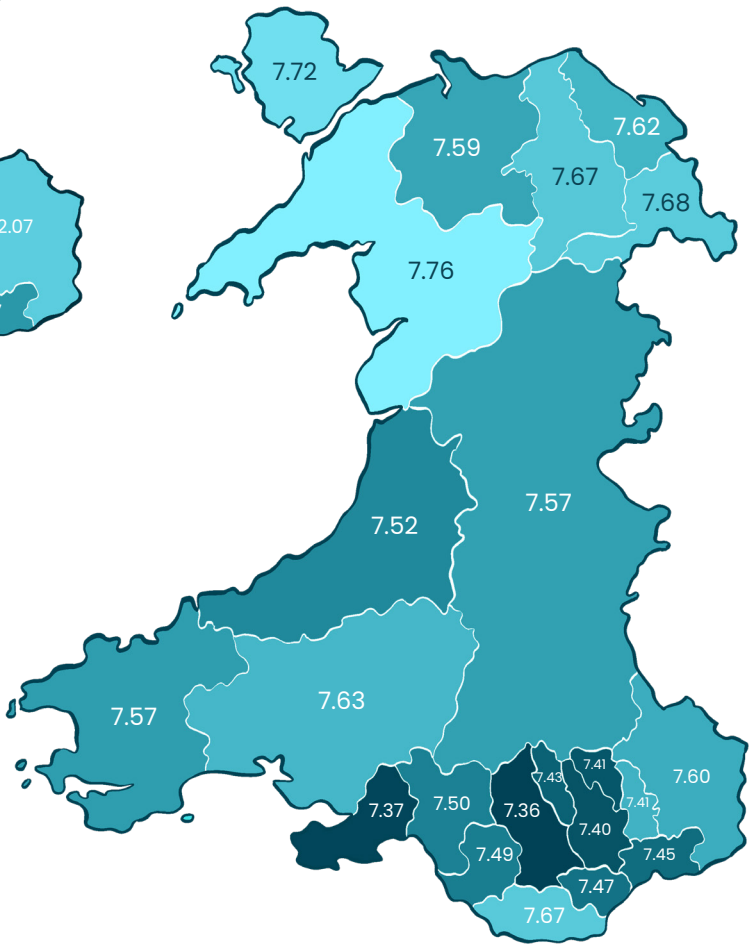


Figure 3. Average well-being scores of Welsh local authorities (2018-19)

Source: ONS (2020)



The drivers of well-being inequality

Exploratory evidence at a local authority level points to a number of drivers potentially associated with higher levels of well-being inequality (as opposed to high or low average well-being, or well-being inequality at a national level). This could help explain these trends across different areas in Wales. These are the key findings:

- Higher median income in a local authority was associated with lower well-being inequality. This association was stronger than the relationship between income and average well-being and unemployment and well-being inequality.
- Rural areas were associated with higher well-being inequality when controlling for average well-being, despite showing higher average well-being. This is potentially due to unemployment being a more important driver of well-being in rural areas. This means that the gap in well-being between the employed and unemployed is greater in rural areas than in urban areas.
- Higher levels of engagement in heritage activities and the use of green space for health or exercise were associated with lower well-being inequality in local authorities, despite not being correlated with improved average well-being (see the **cultural well-being briefing** for more information on the link between subjective well-being and engagement in cultural activities). The reason for this pattern could be that engaging in these activities has a comparatively greater impact on those with lower average well-being.
- Higher female, but not male, life expectancy in local authority populations was associated with lower well-being inequality. The reasons for this are unclear, but one hypothesis is that female life expectancy may act as a proxy for other drivers of well-being inequality. (Abdallah, Wheatley and Quick, 2017b).

It should be noted that while Figure 2 is based on 2015 data,[5] looking at trends in the average well-being scores across local authorities between 2015-16 and 2018-19 suggests little substantive change over this time. Across all local authorities, the change in average scores ranged from -1.2% to 4.5% (see Annex 3). These percentage changes across the four-year period also mask year-on-year fluctuations.

5 The average standard deviation scores that were required for this figure were only available for the years up to 2014-15. (The dataset is available here).

2. Differential well-being outcomes for five key groups

2.1. Well-being outcomes for people who are considered disadvantaged or vulnerable

Population groups who are considered to be disadvantaged or vulnerable in health inequalities research, which would also apply to well-being outcomes, include:

- Those who are socioeconomically disadvantaged (such as those who are unemployed or on a low income);
- Those living in deprived areas;
- Vulnerable migrants (asylum seekers and refugees); and
- The homeless or those in unstable housing.

As stated previously, it should be kept in mind that these dimensions frequently overlap – meaning that people often fall into multiple categories. Other groups that may be considered disadvantaged or vulnerable are also considered in the following section on protected characteristics, such as those with disabilities and Gypsy, Roma and Traveller communities.

Those who are socioeconomically disadvantaged

There is clear evidence showing a positive relationship between income and well-being, both between and within countries (Ortiz-Ospina and Roser, 2017).

The positive impact of increased income on well-being is strongest for those on the lowest wages, tapering as incomes increase (What Works Wellbeing, n.d.). Unemployment (a National Well-being Indicator) has been shown to be a particularly important driver of well-being, with its impact on well-being going far beyond what would be expected from the loss of income alone, with long-term scarring effects (What Works Wellbeing, 2017; 2021a). Employment status is one of the many factors associated with socioeconomic status that contribute to well-being (beyond the impact of income alone), with others including consumption and expenditure. More generally, decreases in well-being that occur as a result of a loss in income are greater than the increase in well-being resulting from an equal rise in income.

Comparing well-being inequality in relation to level of education[6] (as a proxy of socioeconomic status in lieu of data on income) in local authority populations is one way of examining well-being inequality between more and less socioeconomically disadvantaged groups at a local level (see Figure 4). Blaenau Gwent was the local authority where those with lower levels of education saw the largest well-being deficits, based on data from 2014-15.

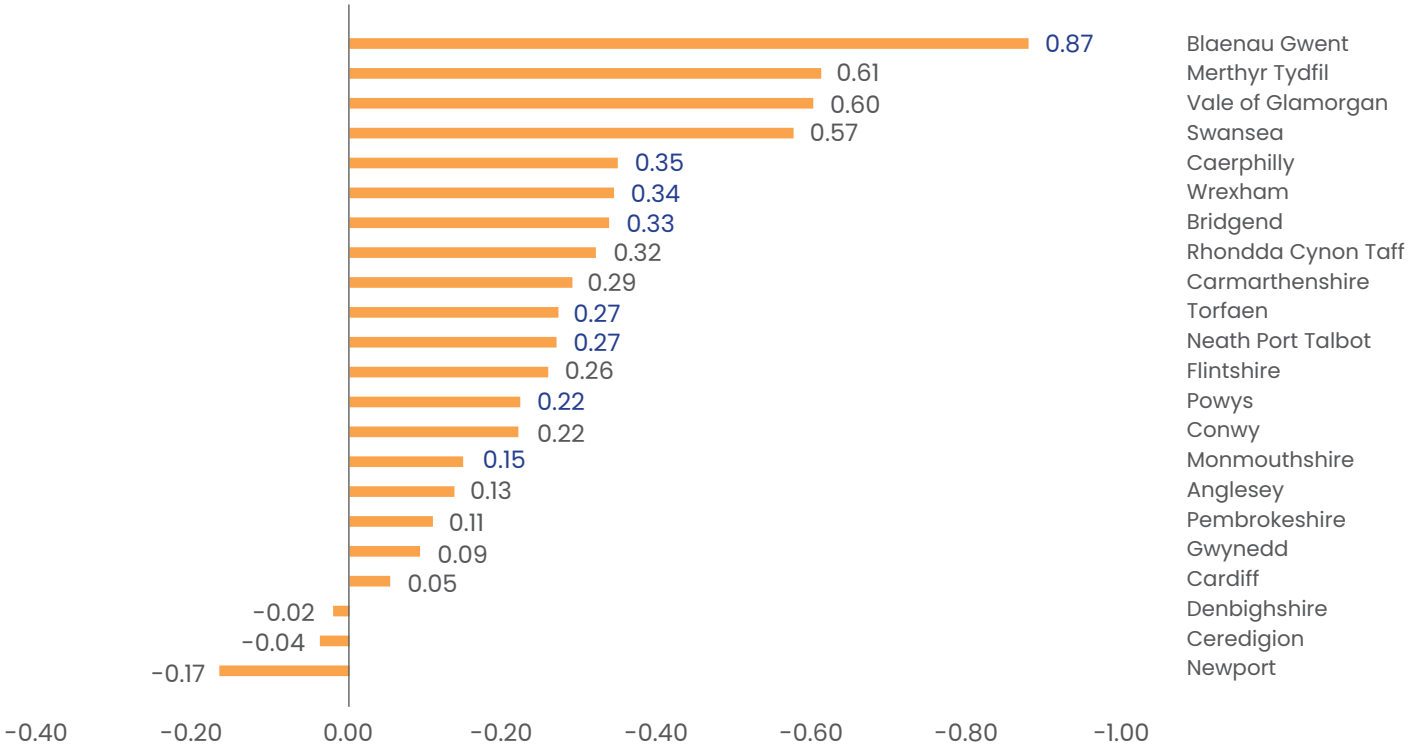
6 Measured as the difference in well-being between those whose highest qualification is GCSE level or lower, compared to those who have some form of higher education (either a degree or vocational study).

Newport showed the reverse pattern – that is, people with lower levels of education showed higher average levels of well-being than those with higher levels of education. Cardiff, Denbighshire and Ceredigion showed very little difference in well-being levels between the two groups.

These findings are based on correlations – they do not imply causality and have not been tested for statistical significance. There are a number of other factors that correlate with education (and socioeconomic status by proxy), such as age, which could impact the relationship between socioeconomic status and well-being inequality in a local authority.

There are also a number of other factors that could mediate the relationship between the two factors, such as local authority spending or social capital. (It should be noted that there is limited evidence of the independent effect of education on well-being outcomes.) A causal analysis would be needed to control for these potential factors and explain what underlies the varying correlations between different local authorities. However, these findings and caveats highlight the importance of taking an intersectional approach when assessing the impact of different factors on average well-being and well-being inequality in an area.

Figure 4. Education-based well-being inequality in 2014-15 (averaging the scores for all four ONS questions related to well-being) across Welsh local authorities



Source: Abdallah, Wheatley and Quick. (2017a), which used ONS Annual Population Survey data

Whereas evidence has shown consistent correlations between objective measures of socioeconomic status (i.e. those that tend to rely on measures of material wealth, such as income, occupation or educational achievement) and personal well-being indicators, subjective assessments of socioeconomic status also tend to show robust, positive correlations with well-being and health outcomes (e.g., Adler et al., 2000; Kraus et al., 2013; Garza et al., 2017; Navarro-Carrillo et al., 2019). A common assessment of subjective socioeconomic status is the MacArthur Scale of Subjective Social Status, which involves respondents placing themselves on a picture of a ten-rung 'social ladder' in relation to others in society. While the correlations remain relatively modest, the emerging evidence suggests that subjective socioeconomic status accounts for additional variation in well-being outcomes, beyond that of objective socioeconomic status (Navarro-Carrillo et al., 2020).

Those living in deprived areas

The Welsh Index of Multiple Deprivation (WIMD), last updated in 2019, ranks small areas in Wales (Lower Layer Super Output Areas [LSOAs]) according to their relative levels of deprivation across eight weighted domains.[7] It is possible to look at what percentage or proportion of small areas (LSOAs) in each local authority are in the most deprived 10%, 20%, 30% and 50% of all areas in Wales (Welsh Government, 2019b). This provides an illustration of the concentration of the most deprived areas in a local authority, rather than an average level of deprivation.

The proportion of the most deprived 10% of LSOAs in each Welsh local authority only shows a weak correlation with each local authority's well-being inequality (as shown in Figure 2) and average well-being scores (as shown in Figure 3).

However, a stronger correlation is evident when looking at the proportion of the local authority's LSOAs that are in the most deprived 50% of all Welsh LSOAs, with higher concentrations of multiple deprivation in a local authority correlating with higher well-being inequality (see Figure 5) and lower average well-being (see Figure 6).[8] This suggests that average well-being and well-being inequality in Welsh local authorities correlate with the concentration of multiple deprivation in an area, but only when considering less extreme categories of relative deprivation.[9]

7 The WIMD 2019 domains, in order of highest to lowest weighting, are income (23.5%); employment (23.5%); health (14%); education (14%); access to services (10%); housing (5%); community safety (5%); and physical environment (5%).

8 The local authorities with the highest concentration of the most deprived 50% LSOAs in Wales were Blaenau Gwent (85%); Merthyr Tydfil (78%); Rhondda Cyon Taf (71%); Neath Port Talbot (69%); and Caerphilly (63%). The lowest concentrations were seen in Monmouthshire (20%); followed by Powys (24%); Flintshire (32%); Gwynedd (34%); and Vale of Glamorgan (35%).

9 This may be due to the 10% cut-off representing less diffuse deprivation i.e. small pockets of extreme deprivation, which make up a small proportion of the local authority and are therefore less likely to impact well-being across the whole local authority. A 50% cut-off on the other hand does not rely on a local authority containing the most deprived neighbourhoods in the country to be comparatively deprived.

Figure 5. Correlation between well-being inequality and concentration of multiple deprivation across Welsh local authorities

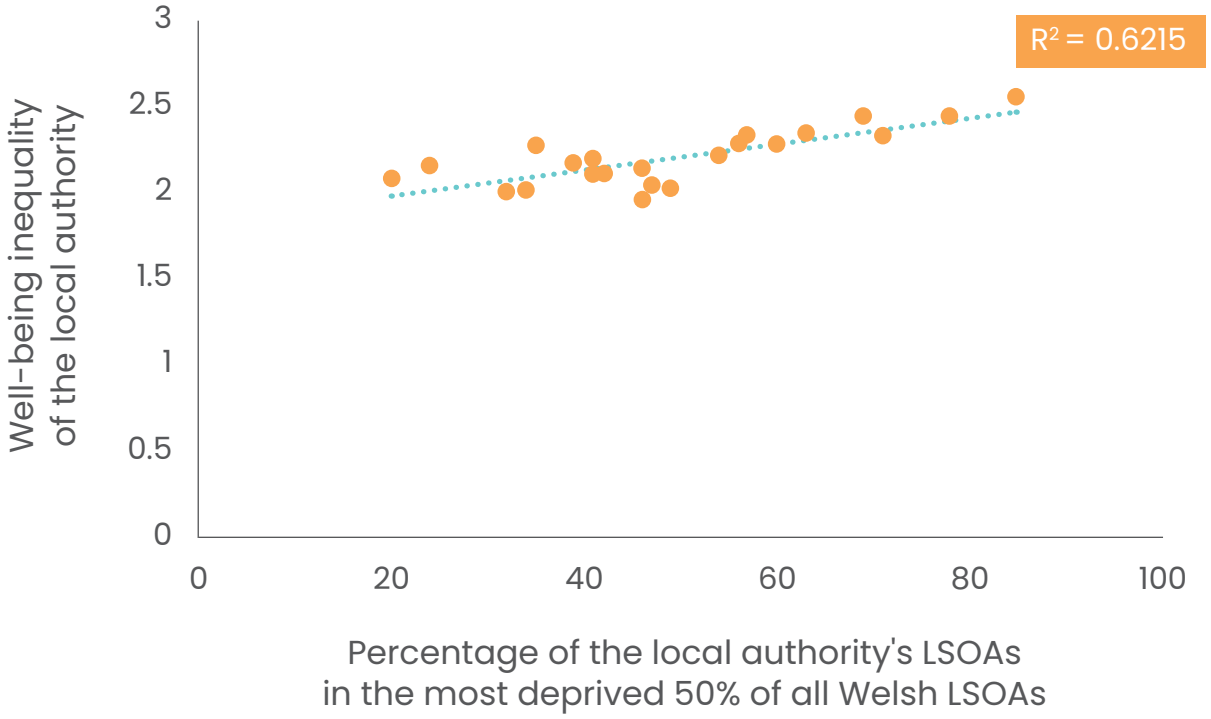
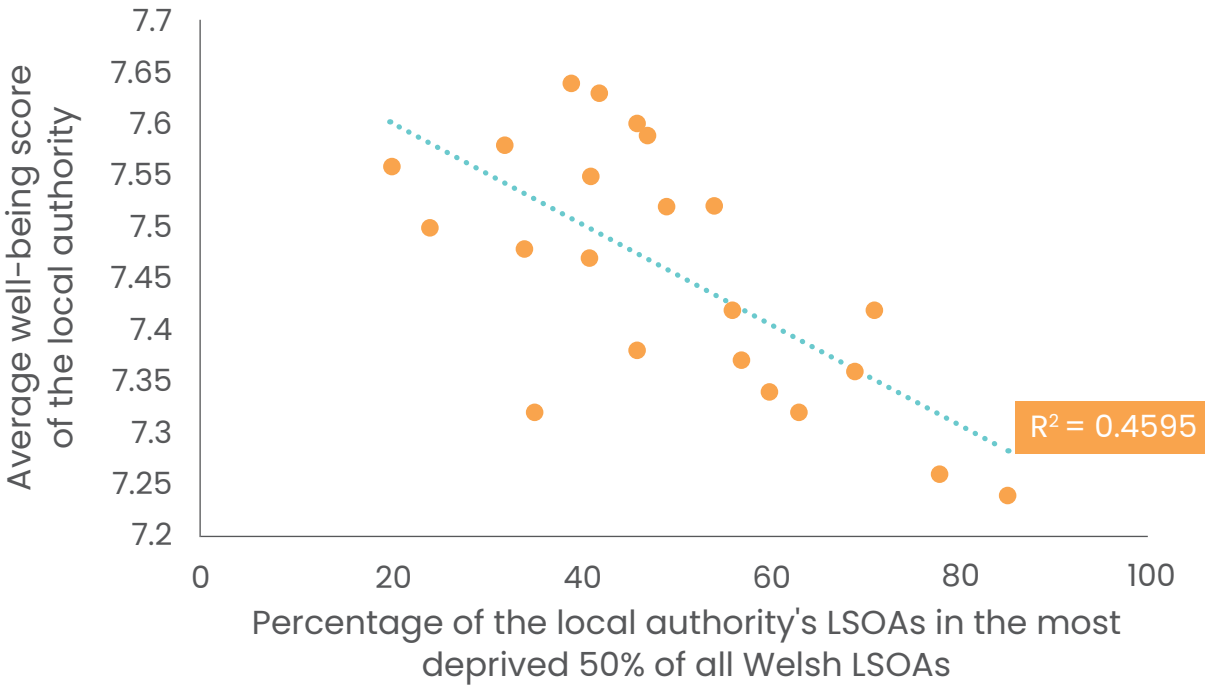


Figure 6. Correlation between average well-being and concentration of multiple deprivation across Welsh local authorities



Vulnerable migrants (asylum seekers and refugees)

Asylum seekers are dispersed around the UK by the Home Office to local authorities that have voluntarily offered to house asylum seekers according to an agreed ratio. (Asylum seekers are not given a choice in terms of location.) At the end of December 2020, there were 2,829 asylum seekers receiving government support in Wales, with the vast majority receiving support across the four Welsh dispersal areas of Cardiff (1,418), – which also showed the highest rate of asylum seekers relative to its population – Swansea (832), Newport (441) and Wrexham (123) (UK Government, 2021a).[10] Of the asylum seekers receiving government support across Wales, 28% were nationals of Middle Eastern countries, 25% were nationals of African countries, and 24% were nationals of Asian countries (UK Government, 2021b).

There were also 1,310 Syrian refugees resettled under the Vulnerable Persons Resettlement Scheme (VPRS) from 2014 to the end of December 2020, across every local authority in Wales, with the most in Carmarthenshire in terms of absolute numbers (168). However, Ceredigion had the highest rate of resettled Syrians of all Welsh local authorities relative to its population (UK Government, 2021c; UK Parliament, 2021). See Annex 4 for the absolute number and rate per population of asylum seekers receiving support and Syrians resettled under the VPRS by local authority.

While there is a lack of subjective well-being indicator data for refugees and asylum seekers in Wales, it is widely recognised that as a vulnerable population, they are at higher risk of a number of drivers associated with poor well-being – such as greater vulnerability to mental health issues (Mental Health Foundation, 2016). In general, the evidence suggests that the health of refugees and asylum seekers worsens after arrival, having often arrived in relatively good health, before improving to pre-arrival levels over a period of roughly 7–10 years. This initial worsening of their well-being can be due to a number of factors, such as limited knowledge of available services, language barriers, poor housing, lack of employment, poverty, and anxiety associated with pre-migration experiences (MILSA, 2015; Welsh Government, 2019c).

A study looking into the health experiences of asylum seekers and refugees in Wales showed that for asylum seekers,[11] short-notice relocation due to the dispersal processes of the Home Office was a key negative determinant of health and well-being (Public Health Wales and Swansea University, 2019). The study also looked at access to health services and found language barriers to be the most commonly reported obstacle, which was particularly the case among refugees on settlement programmes.

10 These figures refer to asylum seekers supported under Section 95 of the Immigration and Asylum Act 1999.

11 This is a different category from refugees on settlement programmes, such as Syrian refugees resettled through the VPRS – see previous footnote.

This is potentially due to this group having spent less time in the UK compared to other refugees. Overall, awareness and accessibility of services was significantly higher for women compared to their male counterparts, possibly related to their childcaring responsibilities. Women tended to have a higher awareness of NHS services such as health visitors and maternity and antenatal services, as well as out-of-hours GP services, and were more likely to have accessed services for their child in the last three months. The high cost of transport to access health services was also a key barrier identified by the study, particularly for asylum seekers.

The homeless or those in unstable housing

Roughly 7% of Welsh adults report lived experience of homelessness (Public Health Wales, 2019). Homelessness can cover a lack of personal access to adequate housing or living in housing below a minimum adequacy standard. This covers street homelessness and the 'hidden homeless' in temporary or unstable housing arrangements. Cardiff and Newport showed the highest number and rate per population of people recorded as sleeping rough, followed by Wrexham then Ceredigion.[12] Ceredigion showed the highest rate of people estimated to be sleeping rough by the local authority, followed by Newport then Cardiff (which showed the highest absolute number of all local authorities) (Welsh Government, 2020a).[13]

While the rates of rough sleepers do not appear to correlate with whether a local authority is urban or rural, the rates of households threatened with homelessness in 2019-20[14] were highest in urban local authorities, with the 11 highest rates (i.e. the top 50%) all occurring in urban local authorities.[15]

Similarly to refugees and asylum seekers, it is recognised that those who are homeless or in unstable housing are a particularly vulnerable group with complex needs. This, combined with homelessness being an extreme form of social exclusion, will have an impact on well-being:

"Good quality housing and sense of belonging is fundamental to good health and wellbeing. Having a home is a basic need and a stabilising factor that brings benefits to health from access to employment and education, and reduces health inequalities – a key public health priority. Inadequate housing, including homelessness, is known to directly and indirectly affect physical, social, and mental health."
(Public Health Wales, 2019, p.6)

Poor health is both a driver and consequence of homelessness. In turn, experiences of homelessness result in worsening well-being, which has been shown to be lower in homeless groups compared to the general population (Bradley and Hobbs, 2014; Leng, 2017; Fransham and Dorling, 2018). Responses to homelessness in Wales during the Covid-19 pandemic could offer learnings for ensuring that some of the successful crisis policies and practices can continue in the long term.

12 Measured as a single night count/one night snapshot count on 7th November 2019.

13 The number of people thought to be sleeping rough within each local authority area over a two-week period (14th to 27th October 2019).

14 The number of households successfully prevented from becoming homeless per 10,000 households is one of the National Well-being Indicators.

15 Data available via StatsWales here. The 11 local authorities with the highest rates of households threatened with homelessness (Section 66) from highest to lowest: Cardiff (150); Swansea (102); Neath Port Talbot (102); Blaenau Gwent (86); Caerphilly (75); Torfaen (75); Merthyr Tydfil (71); Flintshire (67); Bridgend (67); and Vale of Glamorgan (63). Numbers in brackets show the rate per 10,000 households threatened with homelessness.

Any interventions should consider that stable housing alone does not always directly correlate with improved well-being, as individuals with long-term and complex needs will likely require further interventions that address these and that are person-specific (Chambers et al., 2018).

2.2. Well-being outcomes for people who possess a protected characteristic

The ONS provides a breakdown of its self-reported well-being measures by seven of the protected characteristics.[16] This dataset shows that there are some differences in reported well-being across these characteristics on a UK-wide level (ONS, 2017). Some differences are noticeable. For instance, disabled respondents experience lower average well-being than non-disabled respondents, and some ethnic groups (in particular people from Gypsy and Traveller, mixed or multiple ethnic, or Arab backgrounds) score below average.[17] Those who observe a religion (particularly Christians and Hindus) are more likely to report satisfaction with life, that life is worthwhile, and that they felt happier than those who do not observe a religion. However, those who do not observe a religion feel less anxious than those with one.

Other differences are less noticeable. For example, the scores of female respondents indicate that they experience slightly higher average well-being compared to male respondents. However, average scores may mask within-group differences. While male and female respondents show similar responses across low (0–4) and medium (5–6) categories, male respondents are more likely to select high (7–8) responses to the four ONS well-being questions, and female respondents are more likely to select very high responses (9–10).

In addition, female respondents are more likely to report higher levels of anxiety compared to male respondents.

Married respondents or those in civil partnerships are more likely to experience higher average well-being, followed by those who are co-habiting. Divorced or separated respondents score lowest. Heterosexuals tend to have higher average well-being than other sexual orientations.

The largest differences in personal well-being observed between sexual identities were seen in anxiety scores, particularly those reporting high anxiety scores (6–8).

In terms of age, What Works Wellbeing has identified a 'triple dip' in well-being based on age (What Works Wellbeing, 2021). The triple dip refers to:

1. **Increased anxiety in early adulthood:** despite having high average well-being, the younger age groups tend to show higher levels of anxiety, with the highest levels seen in the 20–24-year age group;
2. **Low levels of life satisfaction in mid-life:** particularly for the 45–55-year age group, which shows the lowest level of average life satisfaction, along with a dip in all four ONS measures; and
3. **A lack of purpose in later years:** those aged 85+ show a marked dip in feeling that the things they do are worthwhile – lower than any other age group.

16 Sex, age group, relationship status, ethnicity, religion, sexual identity and disability.

17 More recent disaggregated data are available for England by ethnic group (UK Government, 2019).

Annex 5 shows well-being scores across the protected characteristics, relative to the overall UK average and relative to the UK average of low scores (0–4) and very high scores (9–10). This table can be used to see which groups of people show higher or lower than average well-being scores, and which groups are overrepresented at the extreme ends of well-being.

As highlighted above, while the ONS data are presented across individual protected characteristics, these represent overlapping dimensions. This means that people often fall into different combinations of these categories, as well as being affected by other dimensions known to impact well-being, such as living in areas of deprivation. These all converge to have an impact on overall personal well-being in individuals (see, for example, Welsh Government, 2020b). Broader evidence can be used to look at how multiple protected characteristics, as well as broader factors, can come together to impact well-being. For example, when it comes to age, evidence suggests that lower well-being among middle-aged people tends to be relatively consistent across geographies. In contrast, the geographical/local/area context has a greater effect on the well-being of older people, supporting the potential for area-based interventions for this group (Griffith and Jones, 2020).

Looking at gender as a cross-cutting issue, women are more likely than men to be carers (see section 2.5 for more information on care and well-being), and experience worse health outcomes (including mental health outcomes) than men (Welsh Government, 2018b).

Women are also less likely to participate in the labour market, with this most marked in those from Muslim backgrounds (Welsh Government, 2018b; Chwarae Teg, 2021).

The gender pay gap (the difference in earnings between women and men, which is one of the National Well-being Indicators) also means that on average, women's participation in the labour market is likely to be associated with lower renumeration, which will particularly influence those at the lower end of the pay scale when it comes to well-being. The gender pay gap varies considerably by local authority, with the highest gap based on 2020 data seen in Torfaen (27.7%), followed by Rhondda Cynon Taf (22.5%) and Newport (20.1%) (Chwarae Teg, 2021).[18] Despite the gender pay gap and lower labour market participation, women show better educational attainment than men and are more likely to continue in education after the age of 16 (Welsh Government, 2018b).

2.3. Well-being outcomes for children under the age of 18

The Welsh Government's report 'Well-being of Wales 2017-18: What do we know about children's well-being?' (Welsh Government, 2018a) increased understanding of children's well-being in areas such as loneliness and perceptions of safety, and how these outcomes interact across different factors such as gender and socioeconomic status.

18 The inverse pattern (i.e. women earning on average more than men) was seen in four local authorities, namely Anglesey (-4.2%), Conwy (-7.2%), Gwynedd (-7.5%) and Ceredigion (-13.5%) – however, the data fluctuate considerably year on year (Chwarae Teg, 2021).

Overall, self-rated life satisfaction remained at a roughly consistent level in Welsh children between 2002 and 2018. However, the report showed that differences in personal well-being outcomes for boys and girls increase as they progress through secondary school: girls at age 16 report notably lower well-being than boys, despite reporting similar levels at age 11. Data from the Millennium Cohort Study (2015) also showed that over one-third (36%) of 14-year-olds feel lonely at least sometimes, with a significantly higher proportion of girls responding in this way (46%) than boys (27%). Seven percent of secondary school children reported feeling lonely 'all of the time' during the school holidays, with a similar discrepancy among girls and boys. While healthy lifestyle behaviours[19] decline significantly for both boys and girls as they progress through secondary school, rates of smoking and drinking for 11–16-year-olds have decreased to an all-time low.

Socioeconomic disadvantage and deprivation contribute to children's well-being outcomes in a number of ways. For example, reception-age children living in areas of higher deprivation are significantly more likely to be obese. In addition, while the educational attainment of children in Wales has improved overall, children living in deprivation (as measured by eligibility for free school meals) show poorer attainment on all performance measures, with the gap increasing as pupils progress through school.

Analysis of the School Health Research Network Student Health and Wellbeing Survey in Wales (2017 data) demonstrated that mental well-being when children move to secondary school was 'significantly predicted by the relative affluence of a child's primary and secondary school', with well-being being lower in pupils from poorer backgrounds who moved into more affluent secondary schools (Moore et al., 2020, p.1111). The average affluence of a secondary school depends largely on the aggregated affluence of the feeder primary schools, meaning the study's results demonstrate how socioeconomic inequality in an area (including more affluent areas) can impact well-being inequality. The authors concluded that the transition to secondary school is 'a key point in which socioeconomic inequality in wellbeing may widen' and is therefore 'an important focal point for intervention' (Moore et al., 2020, p.1111).

While there has been a significant increase in social media use among children over the past ten years or so (ONS, 2018a), the evidence of its impact on children's well-being is conflicted (Frith, 2017).

19 Not smoking, not drinking above guidelines, consuming five fruit and vegetables a day, meeting physical activity guidelines. The percentage of children who have fewer than two healthy lifestyle behaviours forms one of the National Well-being Indicators (Welsh Government, 2019a).

Social media activity can have a positive impact by facilitating friendships and increasing social connections, and by providing a way for children and young people to seek support (such as for mental health issues) (Frith, 2017; ONS, 2018b; The Children's Society, 2020).

However, research findings also highlight ways in which social media use can negatively impact well-being in children, for example by contributing to poor body image or increasing the risk of cyber bullying. Some evidence points to a correlation between high levels of social media use and poorer well-being outcomes (for example, increased risk of mental health issues or lower happiness with friends). However such findings have not been robustly evaluated (Frith, 2017; The Children's Society, 2020).

The Welsh Adverse Childhood Experience (ACE) study highlights the correlation between harmful experiences in childhood and poor well-being outcomes in adulthood.[20]

The study results show that compared to those who experienced no harmful experiences, people who experienced four or more harmful experiences in childhood were:

- Four times more likely to experience high-risk drinking in adulthood;
- Six times more likely to be a smoker; and
- Five times more likely to have low mental well-being.

(Public Health Wales, 2015; Public Health Wales, 2016).

Factors that were identified as supporting resilience – which can therefore reduce the risk of outcomes related to poor well-being in those who suffered four or more ACEs – include positive relationships, community support and cultural connections (Hughes et al., 2018). The ACE study also demonstrated strong correlations between sports participation in childhood and lower lifetime mental illness.

2.4. Well-being outcomes for children and young people who are, or have been, looked after

The rate of children in care in Wales increased by over 28% over the five years to 31 March 2020.[21] There is significant variation in the current numbers and rates of children in care across Welsh local authorities, as well as in trends observed over the past few years. For example, the rate of children looked after per 10,000 population at 31 March 2020 ranged from 44 in Carmarthenshire to 225 in Torfaen, compared to the national average in Wales of 114.

A wide educational attainment gap exists between looked after pupils and all pupils in Wales, and this attainment gap increases over time. At 31 March 2019, the proportion of Key Stage 2 pupils who were looked after achieving the expected outcome was 18 percentage points less compared to all pupils, which increased to a 27 percentage point gap in Key Stage 3, and 37 percentage points in Key Stage 4 (Welsh Government, 2020c).

20 See the Public Health Wales website for the various publications related to the Welsh Adverse Childhood Experience (ACE) study: http://www.wales.nhs.uk/sitesplus/888/page/88504

21 Statistics available via StatsWales here.

Children who are looked after are also more likely to report emotional well-being issues (Social Care Wales, 2017). Wales-specific data on mental health issues in young people who are, or have been, looked after are lacking. However, analysis of British children aged 5–17 shows that looked after children are over five times more likely to have a diagnosed mental disorder than non-disadvantaged children (Bazalgette, Rahilly and Trevelyan, 2015). Rates of behavioural disorders among young people who are looked after are particularly high, at nearly two-fifths (39%).

The reasons that young people end up being looked after are complex: the relationship between their experiences before and during care, and subsequent well-being outcomes, is also complex. The literature suggests that poorer mental health and well-being outcomes for young people who are, or have been, looked after can be driven by past experience of abuse; neglect and difficult familial relationships; as well as the potential trauma of the process of being taken into care and certain in-care experiences such as frequent or short-notice moves between different placements (Bazalgette, Rahilly and Trevelyan, 2015; Munro and Hardy, 2006; Ryder, Edwards and Clements, 2017). Individual factors such as biological risk and resilience will also interact with these drivers – meaning the experience of well-being will be different for each looked after child or young person.

Children who are looked after are also more likely to feel different from other children, or that their carers unfairly restrict their freedom (Park et al., 2020).

The quality of their relationships with adults is a further key factor that impacts on looked after children's well-being – poor-quality relationships or a perceived lack of attentiveness to prioritising long-standing relationships with carers or parents can lead to lower well-being (Park et al., 2020).

2.5. Well-being outcomes for people who have need for care or support, and people who care for them

There are over 370,000 unpaid carers in Wales, of whom over 100,000 provide more than 50 hours of care per week (Social Care Wales, 2017). Around 30,000 of unpaid carers in Wales are under 25.

Well-being outcomes for people who have need for care or support

Those who require care are likely to be in poorer overall health, and may experience lower well-being through lack of access to independent living or community connection (Social Care Wales, 2017). Important factors to optimise the well-being of people who have need for care and support include: involving people in their own health and care in a way that aims to help them manage their condition(s); shaping their care to align with what matters to them; making it possible for them to maintain their independence; and drawing on resources to reduce social isolation (NHS England, 2017).

Well-being outcomes for carers

Seventy-two percent of carers in the UK report mental ill health as a result of caring, and 61% report suffering from physical ill health. Carers in the UK also:

- Report being twice as anxious as the general population;
- Are seven times more likely to be always or often lonely compared to the general population; and
- Report a level of happiness at one-third of that of the general UK population (Carers UK, 2019).

The relationship between caring and well-being differs, depending on, among other things, the type, frequency and duration of care being provided. Those reporting the highest negative impact on mental health and well-being as a result of caring responsibilities are people caring for a disabled child (81%); 'sandwich carers' – those who care for a child under 18 in addition to their caring responsibilities (80%); and carers who struggle financially (80%) (Carers UK, 2018).

Well-being outcomes for young carers

Young carers in particular are more likely to achieve poorer educational outcomes – which is a key determinant of later well-being – missing an average of 48 school days per year due to caring responsibilities (Welsh NHS Confederation, 2018). Carers aged 16–18 are twice as likely not to be in education, employment or training (NEET) compared to their peers.[22] As with adult carers, a number of factors influences the relationship between being a young carer and well-being outcomes. In addition to the type, frequency and duration of the care being provided, mediating factors include the family's socioeconomic situation and the extent of support being provided (Savage and Bailey, 2004). Other intersectional factors also have an effect – for example, while nearly half (45%) of young adult carers report having suffered from mental health problems, this increases to 88% for lesbian, gay, bisexual and transgender carers (Welsh NHS Confederation, 2018).

22 The percentage of people in education, employment or training, measured for different age groups, forms one of the National Well-being Indicators.

3. What are the evidence gaps, uncertainties, and areas to explore?

There are a number of gaps and limitations in the evidence relating to equalities and well-being which are important for PSBs to bear in mind when making their assessments and developing plans.

The impact of the Covid-19 pandemic

A key issue is future trends in this area. The evidence discussed pre-dates the Covid-19 pandemic, which later evidence shows has exacerbated existing inequalities across groups – both in subjective well-being measures and in the drivers that impact well-being. For example, while the proportion of adults worrying 'a lot' about their mental health and well-being increased across the board during the Covid-19 pandemic (from 13% in May 2020 to 31% in January 2021), those living in more deprived areas, women and younger people showed higher levels of worry (Public Health Wales, 2021).

In terms of drivers, for example, there has been a general decrease in levels of physical activity (which has positive impacts on lifetime well-being) among children during the pandemic, but the decrease has been comparatively greater for children living in low-income areas (Sport England, 2019; StreetGames, 2020).

Lack of cross-cutting data to allow for an intersectional approach

There is also a lack of data that break down across both equalities-related factors (e.g. gender, ethnicity, disability) and area/local authority.

There is also a lack of data providing equalities-related breakdowns that are updated regularly. For example, the ONS dataset on personal well-being broken down by protected characteristics is only available on a UK-wide level and is based on data from 2013–15. Without data that are broken down by equalities factors and geography, and that are not updated regularly, it is difficult to conduct an analysis that could inform future trends and interventions within specific areas of Wales.

As noted above, factors that relate to equalities often overlap, and circumstances that impact well-being will change across the lifespan. However, the available data often do not allow for an intersectional approach as they report differences in well-being across individual factors. This briefing has attempted to identify intersectional data and evidence where available, but this could be an area for further exploration.

Translating findings into practice

Finally, ensuring that high-level findings are effectively translated and connected with practice will be an important component of improving average well-being and well-being inequality. Implementing interventions that aim to improve well-being requires a consideration of the ways in which well-being is experienced differently and unequally within a local area, taking into account how the local context contributes to these differences in experience.

4. Conclusion

4.1. How do different groups experience well-being?

This briefing has outlined the ways in which well-being varies across and within different local authorities in Wales, and different groups of people. It has also aimed to highlight how different factors or identities may intersect, and how different factors or circumstances may converge to impact well-being. Furthermore, it highlights how individual factors that may increase or decrease a person's resilience or their ability to adapt to changes in circumstances should also be taken into account – as these could impact personal well-being. It is therefore important not to take too simplistic an approach when looking at well-being across different groups within an area, or between different areas, particularly as circumstances change across the lifespan. It is also important to note that well-being can also change over time.

The briefing has provided some examples of how different factors (as outlined in Figure 1 and the rest of this briefing) may come together to impact different groups' experiences of well-being. An example is in section 2.2, which looks at gender as a cross-cutting issue. As outlined at the beginning of the briefing, the association between particular factors and well-being can be looked at in one of two ways – first, by looking at inequalities in subjective well-being, and second, by looking at inequalities in the factors that drive well-being.

To provide a further example of how different factors may intersect to influence well-being, the evidence shows that being in employment and considering one's income to be sufficient are important for people's sense of well-being. People who are in material deprivation (unable to afford to meet basic needs, which is around 16% of the Welsh population) are more likely to experience lower life satisfaction and well-being (Welsh Government, 2018b). They are also more likely to be unemployed, and to have long-term illness, among other factors. Deprivation is also associated with lower life expectancy, worse health, and lower levels of educational attainment (Welsh Government, 2018b). Some groups are more likely to live in deprived areas or to have worse employment outcomes, including people from ethnic minority backgrounds and disabled people (Welsh Government, 2018b, Welsh Government, 2020d; Welsh Government, 2021).

Other intersections of well-being related factors have been demonstrated by Welsh Government research, showing that those from ethnic minority backgrounds are more likely to live in relative income poverty, for instance, and those from minority religious groups (i.e. not Christian or not observing a religion) are more likely to live in deprived areas (Welsh Government, 2018b, Welsh Government, 2020d).

Disabled people and those with long-term health conditions are also less likely to feel safe or that they belong to their local community, and are more likely to have experienced domestic abuse (Welsh Government, 2018b; Welsh Government, 2021). Evidence also shows that people from ethnic minority backgrounds and LGBT people also feel less safe or have a greater fear of crime than majority ethnic or heterosexual people (Jones et al., 2017; UK Government, 2017) .

4.2. Are there any groups which have a notably different experience of well-being from others? What are the reasons why this could be the case?

Based on its well-being data, the ONS identified that 1% of people in the UK were estimated to report low ratings across all four personal well-being questions (ONS, 2018c). Being in the group with the poorest personal well-being was highly associated with one or more of the following factors:

- Self-reported very bad or bad health (which showed the strongest association);
- Being economically inactive with long-term illness or disability;
- Being middle-aged;
- Being single, separated, widowed or divorced;
- Being renters; and/or
- Having no education or only basic education.

Self-reported health, economic activity, age, marital status, housing tenure status and education are therefore factors that seem to be related with having notably different experiences of well-being. Looking at how these different factors combine to impact well-being, the ONS identified eight groups of people who are at the greatest risk of reporting the poorest personal well-being (see Annex 6). The three groups with the highest probability are:

- Unemployed or inactive renters with self-reported health problems or disability;
- Employed renters with self-reported health problems or disability; and
- Retired homeowners with self-reported health problems or disability.

The three groups all include people who self-report health or disability problems, and two of the three groups include people who rent their homes. The results demonstrate that while the experience of poorest well-being can affect people of all ages, different factors (such as economic activity) will have a varying level of impact on the well-being of people from different age groups. The groupings identified from this analysis are useful for highlighting which combinations of equalities-related factors impact well-being most acutely.

4.3. How can the evidence on equalities and well-being be used to support well-being objectives?

This briefing has summarised the evidence that relates to well-being and equalities. This section outlines the steps that PSBs can take to use the evidence and local level data available to them to assess well-being in their area and use this information to plan interventions.

1. The first step is to **identify area-specific well-being deficits or gaps** that PSBs may seek to address using interventions, so that interventions can be targeted.

    - The simplest way to do this would be to use subjective well-being outcomes to identify subsets of the local population with the lowest levels of well-being (i.e. by looking at the distribution of well-being in a local area and which particular groups of people tend to suffer from the lowest levels of well-being).
    - However, as outlined above, often the available data do not allow for such a detailed breakdown at a local level.
    - Where data on subjective well-being outcomes at a local level are lacking, a picture can be built up by looking at inequalities in the drivers of well-being within the area, that tend to impact some groups of people more than others, and/or by identifying groups of people who are known to be at risk of the lowest levels of well-being based on the evidence.
    - The Thriving Places Index can also be used to identify key areas of well-being intervention in a local area.

2. Following this process of identifying key well-being deficits, **PSBs should draw on the evidence for which interventions are likely to work to improve well-being.**

    - A rapid evidence assessment of which interventions have been shown to have a positive impact on subjective well-being (as measured by the four ONS questions) has been completed by What Works Wellbeing and can inform decisions in this area (What Works Wellbeing, 2020).
    - There will not always be a sufficient evidence base that demonstrates the efficacy of specific interventions on well-being. If this is the case, knowing that a particular behaviour or type of intervention (such as physical activity) improves subjective well-being, it can be assumed that interventions that aim to increase these behaviours will have a positive impact.
    - Knowing which interventions are most likely to be successful will only lead to success if they are effectively implemented. As a result, in addition to basing the choice of interventions on robust evidence (as far as is possible), the general principles for tailoring interventions outlined below should be followed to ensure interventions are implemented effectively.

3. To ensure that interventions achieve the desired effect and are effective at improving the well-being of those with low well-being and reducing well-being inequality in an area, assessment and monitoring of progress will need to be carried out.

   To monitor the outcomes of individuals or a group of people, measures for subjective well-being should be used. What Works Wellbeing have put together a Wellbeing Measures Bank of metrics and measures that can be used to assess changes in well-being in a project evaluation.

4.4. How can interventions be tailored to maximise well-being across different groups?

General principles for tailoring interventions

As outlined at the beginning of this briefing, there is a general consensus that improving the well-being of those with the lowest personal well-being holds greater value than providing interventions for those who already experience high levels of well-being. Targeting interventions in this way requires looking at well-being inequality within populations rather than just average well-being scores (Abdallah, Wheatley and Quick, 2017b).

As a result, interventions to improve well-being should be targeted towards groups with the lowest average well-being, or areas with the highest well-being inequality, to maximise their effectiveness. (See Annex 2 for a list of Welsh local authorities' average well-being and well-being inequality scores.)

The effectiveness of this approach is supported by the literature, which in general shows that smaller interventions make a greater difference to those with the lowest well-being. For example, evidence has shown that the positive impact of using green space on well-being is greater for people from lower socioeconomic groups, or people with poor mental health (Hartig et al., 2014).

Analysis conducted for the Big Lottery Fund National Well-being Evaluation identified a number of features associated with increased effectiveness for projects that aimed to increase people's well-being (CLES and NEF, 2013). These included:

- **Identifying local need** – working with the local authority to target the project in line with area-specific well-being needs and gaps;
- **Taking a holistic approach** – that is, addressing broad aspects of well-being;
- **Engaging the target group** – through working with local organisations;
- **Co-production** – involving participants in the project's design and delivery;
- **Providing training** – so that more organisations can deliver the well-being project; and
- **Flexibility** – to enable the project to respond to emerging needs and focus on more effective activities.

The Thriving Places Index as a tool for tailoring interventions in an area

As the previous sections have demonstrated, the relationship between different factors and how they come together to influence individuals' well-being is complex. Consequently, interventions to maximise well-being should not take a simplistic approach – for example, by assuming a direct relationship between higher incomes and higher levels of well-being. They should instead take a holistic view of the presence or absence of factors that may contribute to high or low well-being within a local area.

What Works Wellbeing advocates the use of the Thriving Places Index to inform well-being interventions for a particular place. This aims to look at the complex relationships between well-being and local factors and 'identifies the local conditions for wellbeing and measures whether those conditions are being delivered fairly and sustainably' across local authorities. The framework is split into three levels: equality; local conditions; and sustainability.[23] These three elements are then broken down into domain and sub-domain indicators that, based on evidence, are known to impact well-being. Using published data relating to each domain and sub-domain, scores are provided for each of the three main elements and underlying domains for every local authority in England and Wales.

Author Details

Manon Roberts is a Research Associate at the Wales Centre for Public Policy.

Acknowledgements

WCPP would like to thank those who have reviewed and commented on drafts of this briefing, including **PSB members**, **Deborah Hardoon (What Works Wellbeing)** and the **Future Generations Office**.

23 A full list of the Thriving Places Index indicators can be accessed here

Annex 1: Data sources and availability

Data presented in this document have been primarily collected from the ONS (2017; 2018; 2020) and What Works Wellbeing (2017). Data relating to the Welsh National Well-being Indicators are also available from the Welsh Government (2019a).

Many indicators and other data available at a national level are available at different geographical levels, including at a local authority level. The table below summarises the data that have been drawn on or consulted in preparing this briefing, with an indication of which datasets break down by local authority, whether the local authority breakdown is presented in full in the briefing, and how often they are updated. The datasets are presented in the order in which they are referenced in the briefing.

Data	Source	Breakdown	Time period	Location of data breakdown in the briefing	Release frequency
Personal well-being estimates (by x4 ONS questions)	ONS	Local authority	2011/12-2019/20	Figure 2, Annex 2 and Annex 3	Annual
Well-being inequality (mean standard deviation of x4 ONS questions)	Dataset available via What Works Wellbeing. (Analysis is based on ONS data and is referenced in Abdallah, Wheatley and Quick, 2017a).	Local authority	2014/15	Figure 3 and Annex 2	One time release/ analysis
Education-based well-being inequality	Dataset available via What Works Wellbeing. (Analysis is based on ONS data and is referenced in Abdallah, Wheatley and Quick, 2017a).	Local authority	2014/15	Figure 4	One time release/ analysis
Welsh Index of Multiple Deprivation (WIMD)	Welsh Government	Local authority & Lower Layer Super Output Areas	2000-2019	Local authority deprivation levels correlated with well-being inequality in Figure 5 and average well-being in Figure 6	WIMD (full index): every 3-5 years Average well-being: annually Well-being inequality: 2014/15 only

Data	Source	Breakdown	Time period	Location of data breakdown in the briefing	Release frequency
Asylum seekers receiving government support under Section 95 of the Immigrant and Asylum Act 1999	UK Government Local authority data: Section 95 support by local authority	Local authority	2014-2021	Annex 4	Annually
Nationality of asylum seekers receiving government support in Wales	UK Government Asylum support: Asylum seekers in receipt of support	UK region (Wales-level data)	2014-2021	-	Annually
Syrian refugees resettled under the Vulnerable Persons Resettlement Scheme (VPRS)	UK Government Local authority data: Resettlement by local authority	Local authority	2014-2021	Annex 4	Annually
Prevention of Homelessness by Area and Measure (Section 66)	Stats Wales	Local authority	2015/16-2019/20	-	Annually
Personal well-being and protected characteristics	ONS	UK-wide (no breakdown)	2013-2015	Annex 5	TBC
Understanding well-being inequalities: Who has the poorest personal well-being?	ONS	UK-wide (no breakdown)	2014-2016	Annex 6	TBC

Annex 2: Welsh local authorities in order of highest to lowest well-being inequality, and average well-being scores (data for 2014-15)

	Local authority	Mean Standard Deviation (well-being inequality)	Average of 4 ONS questions (average well-being)
1	Blaenau Gwent	2.55	7.24
2	Neath Port Talbot	2.43	7.36
3	Merthyr Tydfil	2.43	7.26
4	Caerphilly	2.34	7.32
5	Torfaen	2.33	7.37
6	Rhondda Cynon Taff	2.32	7.42
7	Bridgend	2.28	7.42
8	Newport	2.27	7.34
9	Vale of Glamorgan	2.26	7.32
10	Carmarthenshire	2.21	7.52
11	Wrexham	2.19	7.47
12	Anglesey	2.17	7.64
13	Powys	2.15	7.50
14	Swansea	2.13	7.38
15	Conwy	2.10	7.55
16	Pembrokeshire	2.10	7.63
17	Monmouthshire	2.07	7.56
18	Denbighshire	2.04	7.59
19	Cardiff	2.02	7.52
20	Gwynedd	2.01	7.48
21	Flintshire	2.00	7.58
22	Ceredigion	1.95	7.60

Well-being inequality source: Abdallah, Wheatley and Quick (2017a), based on ONS Annual Population Survey data; Average well-being source: ONS, 2020

Annex 3: Trends and % change in average well-being scores across Welsh local authorities (2014-15 to 2018-19)

	2015-16	2016-17	2017-18	2018-19	% change 2015/16-2018/19
Vale of Glamorgan	7.34	7.73	7.63	7.67	4.5%
Gwynedd	7.49	7.54	7.76	7.76	3.6%
Torfaen	7.37	7.35	7.55	7.61	3.3%
Wrexham	7.47	7.56	7.51	7.68	2.8%
Merthyr Tydfil	7.27	7.14	7.30	7.43	2.3%
Neath Port Talbot	7.35	7.47	7.52	7.50	2.1%
Newport	7.34	7.33	7.46	7.45	1.6%
Blaenau Gwent	7.30	7.41	7.42	7.41	1.4%
Carmarthenshire	7.52	7.45	7.41	7.63	1.4%
Isle of Anglesey	7.64	7.73	7.75	7.72	1.1%
Bridgend	7.43	7.56	7.57	7.49	0.9%
Monmouthshire	7.54	7.52	7.60	7.60	0.9%
Caerphilly	7.34	7.37	7.36	7.40	0.9%
Wales	7.47	7.50	7.50	7.53	0.8%
Denbighshire	7.60	7.61	7.63	7.67	0.8%
Powys	7.52	7.72	7.67	7.57	0.8%
Conwy	7.54	7.58	7.55	7.59	0.6%
Flintshire	7.58	7.60	7.52	7.62	0.6%
Swansea	7.40	7.51	7.36	7.37	-0.3%
Pembrokeshire	7.64	7.59	7.60	7.57	-0.9%
Cardiff	7.55	7.45	7.37	7.47	-1.1%
Rhondda Cynon Taf	7.44	7.34	7.46	7.36	-1.1%
Ceredigion	7.61	7.47	7.58	7.52	-1.2%

Source: ONS, 2020

Annex 4: Dispersed asylum seekers receiving support and Syrians resettled under the Vulnerable Persons Resettlement Scheme, by local authority

	Supported asylum seekers in dispersal accommodation, by local authority Snapshot at end of December 2020		Syrians resettled under the Vulnerable Persons Resettlement Scheme, by local authority Cumulative total to the end of December 2020	
Local authority	**Dispersed asylum seekers**	**Dispersed asylum seekers per 10,000 population**	**Resettled persons**	**Resettled persons per 10,000 population**
Blaenau Gwent	-	-	10	1
Bridgend	-	-	49	3
Caerphilly	1	-	32	2
Cardiff	1,418	37	88	2
Carmarthenshire	-	-	163	9
Ceredigion	-	-	74	10
Conwy	6	1	17	1
Denbighshire	-	-	73	8
Flintshire	-	-	49	3
Gwynedd	-	-	39	3
Isle of Anglesey	-	-	20	3
Merthyr Tydfil	2	-	8	1
Monmouthshire	-	-	37	4
Neath Port Talbot	1	-	52	4
Newport	441	27	68	4
Pembrokeshire	-	-	48	4
Powys	-	-	122	9
Rhondda Cynon Taf	2	-	48	2
Swansea	832	33	138	6
Torfaen	-	-	23	2
Vale of Glamorgan	3	0	73	5
Wrexham	123	9	79	6
Wales	2,829	9	1,310	4

Sources: ONS (2021). Mid-year population estimates for 2019; UK Government (2021). Asylum and resettlement datasets: Section 95 support by local authority; and Resettlement by local authority

Annex 5: Personal well-being in the UK by protected characteristics

This table shows the average well-being scores, average 'low' scores, and average 'very high' scores across three of the four ONS questions in the three years ending December 2015. The three questions included are those concerning life satisfaction; 'worthwhile-ness'; and happiness. The data for the fourth question on anxiety were grouped across different scoring clusters and therefore could not be incorporated into the averages shown in the table.

		Relative to overall average	Relative to 'low' average*	Relative to 'very high' average*
Sex	Male	-0.06	0.06	-2.36
	Female	0.05	-0.06	2.25
Age group	16 to 19	0.17	-1.61	3.01
	20 to 24	-0.06	-0.24	-2.11
	25 to 29	0.02	-0.94	-1.21
	30 to 34	0.04	-1.29	-1.29
	35 to 39	-0.06	-0.34	-3.41
	40 to 44	-0.13	0.42	-4.21
	45 to 49	-0.20	1.32	-4.81
	50 to 54	-0.25	2.05	-4.53
	55 to 59	-0.16	1.78	-2.01
	60 to 64	0.09	0.08	3.30
	65 to 69	0.32	-1.35	8.56
	70 to 74	0.33	-1.32	9.52
	75 to 79	0.27	-0.76	8.51
	80 to 84	0.11	0.21	5.90
	85 to 89	0.01	0.95	3.58
	90 and over	-0.23	2.34	-0.69
Relationship status	Living in a couple: married or civil partner	0.29	-2.15	5.11
	Living in a couple: cohabiting or same-sex couple	0.05	-1.04	-0.90
	Not living in a couple: single	-0.31	1.77	-6.29
	Not living in a couple: widow or surviving civil partner	-0.20	2.51	0.04
	Not living in a couple: divorced or separated or former/ separated civil partner	-0.51	4.98	-6.59

		Relative to overall average	Relative to 'low' average*	Relative to 'very high' average*
Ethnicity	White	0.01	-0.02	0.18
	Gypsy / Traveller / Irish Traveller	-0.36		
	Mixed / Multiple ethnic groups	-0.28	1.34	-4.40
	Indian	0.08	-1.92	-0.11
	Pakistani	-0.05	0.14	1.19
	Bangladeshi	-0.06	-0.29	-0.22
	Chinese			-4.46
	Other Asian background	-0.01	-0.59	-0.59
	Black / African / Caribbean / Black British	-0.28	1.95	-2.68
	Arab	-0.31	3.48	-4.10
	Other ethnic group	-0.10	0.08	-1.62
Religion	No religion	-0.15	0.71	-3.99
	Christian (all denominations)	0.08	-0.37	1.90
	Buddhist	-0.09	0.35	-2.19
	Hindu	0.08	-2.04	-0.59
	Jewish	0.01		-0.05
	Muslim	-0.08	0.31	0.55
	Sikh	-0.01	-0.20	-1.21
	Any other religion	-0.19	1.72	-2.21
Sexual identity	Heterosexual or straight	0.00	0.03	0.23
	Gay or lesbian	-0.18	1.37	-4.03
	Bisexual	-0.37	3.50	-3.96
	Other	-0.25	4.06	-1.17
	Don't know or refuse	-0.18	0.72	-4.25
Disability	(Equality Act) disabled	-0.63	6.76	-6.51
	(Equality Act) not disabled	0.23	-2.39	2.76

Source: ONS, 2017

*Low = a score of 0-4; Medium = 5-6; High = 7-8; Very high = 9-10. Heat map formatting is reversed for 'low'.

Annex 6: Description of the groups identified and their odds of reporting the poorest personal well-being, 2014 to 2016

Main characteristics of the groups	Odds of reporting poorest personal well-being
Unemployed or inactive renters with self-reported health problems or disability	1/32
Employed renters with self-reported health problems or disability	1/41
Retired homeowners with self-reported health problems or disability	1/71
Self-employed people without self-reported health problems or disability	1/187
Employees owning their homes with a mortgage without self-reported health problems or disability	1/348
Student or unemployed renters without self-reported health problems or disability	1/439
Elderly employees owning their home and without self-reported health problems or disability	1/508
Retirees owning their home and without self-reported health problems or disability	1/756

Table reproduced from ONS (2018). Data source: Annual Population Survey

About us

The Wales Centre for Public Policy helps to improve policymaking and public services by supporting Welsh Government ministers and public service leaders to access and apply rigorous independent evidence about what works. The Centre works with leading researchers and policy experts to synthesise and mobilise existing evidence and identify gaps where there is a need to generate new knowledge.

The Centre is independent of government but works closely with policymakers and practitioners at national and local level to develop fresh thinking about how to address some of the key economic, social and environmental challenges facing Wales.

The Centre's work covers a wide range of policies but is currently focused in particular on:

- Promoting equality
- Tackling loneliness and social isolation
- Children looked after
- Economy and skills
- Health and adult social care
- Effective governance and implementation

For further information and to download our reports and policy briefings on these and other topics please visit www.wcpp.org.uk

---

Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru

Cardiff University, 10/12 Museum Place,
Cardiff CF10 3BG

www.wcpp.org.uk
029 2087 5345
info@wcpp.org.uk
@WCfPP

Cardiff University / Prifysgol Caerdydd
UKRI Economic and Social Research Council
Llywodraeth Cymru Welsh Government