Decade of healthy ageing

ADVOCACY BRIEF:

Social isolation and loneliness among older people

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Decade of healthy ageing

Social isolation and loneliness among older people: advocacy brief

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Decade of healthy ageing

Advocacy brief: Social isolation and loneliness among older people

Summary

- Social isolation and loneliness among older people are growing public health and public policy concerns which have been made more salient by the COVID-19 pandemic.
- Social isolation and loneliness among older people are widespread. For instance, 20–34% of older people in China, Europe, Latin America, and the United States of America are lonely.
- Social isolation and loneliness are harmful. They shorten older people's lives, and damage their mental and physical health and quality of life.
- But they can be reduced:
  - Through face-to-face or digital interventions such as cognitive behaviour therapy, social skills training and befriending;
  - By improving infrastructure (e.g. transport, digital inclusion, built environment) and promoting age-friendly communities;
  - Through laws and policies to address, for instance, ageism, inequality and the digital divide.
- A strategy for reducing social isolation and loneliness among older people should aim to:
  - Implement and scale up effective interventions to reduce social isolation and loneliness;
  - Improve research and strengthen the evidence for what works; and
  - Create a global coalition to increase the political priority of social isolation and loneliness among older people.

Decade of healthy ageing

Human beings are fundamentally social animals. To have survived for millennia as hunter-gatherers in often harsh environments, individuals depended for their lives on strong bonds with a tightly knit social group. High-quality social connections are essential for our mental and physical health and our well-being – at all ages.

Social isolation and loneliness have serious consequences for longevity, health and well-being. In older age, social isolation and loneliness increase the risks of cardiovascular disease, stroke, diabetes, cognitive decline, dementia, depression, anxiety and suicide. They also shorten lives and reduce the quality of life. Life transitions and disruptive life events [such as retirement; loss of a spouse, partner or friends; migration of children or migration to join children; and disability or loss of mobility], which are more likely to affect older people, put them at particular risk *[1, 2]*.

Until recently, however, social isolation and loneliness, including among older people, were neglected social determinants of health. In some countries, these problems have started to be considered pressing public policy and public health issues. The COVID-19 pandemic and the attendant physical distancing measures have increased the salience of these topics *[3–5]*. For instance, in 2018, the United Kingdom Government appointed a "loneliness minister" and published "A connected society – a strategy for tackling loneliness" *[6]*. In 2021, Japan followed suit, partly in response to the pandemic; the Prime Minister added a "loneliness minister" to his cabinet and created an inter-ministerial task force to address the issue *[7]*. In the United States of America in 2020, the National Academies of Sciences, Engineering and Medicine published a consensus report entitled "Social isolation and loneliness in older adults: opportunities for the health care system"*[2]*.

Several windows have opened for international, regional and national policies, described below, to change the way in which social isolation and loneliness are addressed. One of the most prominent is the United Nations Decade of Healthy Ageing 2021–2030 *[8]*, which includes four interconnected action areas for safeguarding the health and well-being of older people, their families and their communities: [i] change how we think, feel and act towards age and ageing; [ii] ensure that communities foster the abilities of older people; [iii] deliver integrated care and primary health services tailored to older people; and [iv] ensure access to long-term care for older people. Although social isolation and loneliness occur throughout the life-course, this advocacy brief focuses on older people.

What we know about social isolation and loneliness among older people

We know enough to state with confidence that social isolation and loneliness are widespread among older people in most regions of the world, that they have serious consequences for their physical and mental health and longevity and that we should, therefore, invest in effective interventions and strategies to reduce social isolation and loneliness in this population. Many questions and uncertainties remain, however, which should be addressed by the research community *[2, 9, 10]*.

Social isolation and loneliness are distinct but related concepts. "Loneliness" is the painful subjective feeling – or "social pain" – that results from a discrepancy between desired and actual social connections *[11–13]*. "Social isolation" is the objective state of having a small network of kin and non-kin relationships and thus few or infrequent interactions with others. Some studies have found only a weak correlation between social isolation and loneliness *[14–16]*: socially isolated people are not necessarily lonely and vice versa. How lonely a person feels depends partly on their own and their culture's expectations

of relationships *[17]*. For some aspects of the problem – such as its scale, distribution and trends – more evidence is available on loneliness than on social isolation.

The scale of social isolation and loneliness

Although there are currently no global estimates of the proportion of older people in the community who are experiencing loneliness and social isolation, estimates for some regions and countries are available. For instance, 20–34% of older people in 25 European countries *[18]* and 25–29% in the USA *[10]* reported being lonely. A study in 2021 indicated a prevalence of loneliness of 25–32% in Latin America, 18% in India but only 3.8% in China *[19]*. Other estimates of the prevalence of loneliness among older people, however, were 29.6% in China *[20]* and 44% in India *[21]* – on a par with or higher than in the rest of the world. Few comparable estimates of the prevalence of social isolation are available. Those available are 24% in the USA *[22]*, 10%–43% in North America *[23]* and 20% in India *[24]*.

Differences in methods may account for some of the differences in the estimates, such as the type of measure used, the mode of data collection [e.g. face-to-face or self-administered questionnaires], the representativeness of the sample and the inclusion criteria [e.g. older people in institutions, homeless people, and ethnic minorities] *[10, 19, 25]*. In general, there are few comparable estimates for low- and middle-income countries *[19]*. Although there are many instruments for measuring social isolation and loneliness, there is no standard, international, widely used, cross-culturally valid measure of the two concepts *[19, 26, 27]*.

The prevalence of loneliness among people living in long-term care institutions appears to be higher than that in the community. A review of 11 studies – three in middle-income and eight in high-income countries – indicated that 35% of older people in residential and nursing care homes were very lonely. All four studies that made direct comparisons between care-home residents and people living in their own homes in the community reported a higher prevalence of loneliness in care homes *[28]*.

Age and loneliness

It is not clear whether loneliness increases or decreases with age. Some studies show a U-shaped curve along the life-course, loneliness being more prevalent at younger and older ages *[18, 29–31]*. Others suggest a steady decrease in loneliness through life *[25, 32]*, sometimes with an increase after 75 years *[33]*. Yet others suggest that the relation between loneliness and age is non-linear and fluctuates during the life-course *[34–36]*. A nationally representative study in the USA, for instance, found peaks in the oldest and young adults and in those aged 50–60 years *[34]*.

Gender and loneliness

A recent review of 575 studies on gender differences in loneliness indicated similar levels in males and females across the lifespan. Males were slightly more lonely in childhood, adolescence and young adulthood [with the largest differences], but these small gender differences disappeared in middle adulthood and at older age *[37]*. Loneliness among older women is a concern, as life changes such as widowhood and relocation, which are associated with greater vulnerability to social isolation and loneliness, affect women more than men *[38]*.

Recent trends

It is not known whether global rates of loneliness among older people are increasing overall. A review of 25 studies in China found large increases in loneliness between 1995 and 2011, which were correlated with increasing rates of urbanization, divorce, unemployment and social inequality *[38]*. In a study in the USA, the prevalence of loneliness increased

by 7% between 2018 and 2019 *[39, 40]*. In contrast, no increase in the rate of loneliness among older people in recent decades was found in Sweden *[41]*, and studies in Finland and Germany suggest that loneliness may have decreased *[42, 43]*. The increasing longevity and ageing of the global population could nonetheless result in more older people experiencing loneliness and social isolation [Box 1].

Social isolation and loneliness shorten lives

A review conducted in 2015 indicated that social isolation and loneliness were associated with a 29% and 26% increased likelihood of mortality, respectively. Both significantly predicted premature mortality, and equivalently so, and middle-aged adults may be at greater risk of mortality than older adults when they are socially isolated or lonely *[50, 51]*.

The relation between social isolation and loneliness and mortality [and the other negative health outcomes described below] might be causal, but it is difficult to demonstrate *[2, 52, 53]*. Social isolation and loneliness affect mortality similarly to well-established risk factors such as obesity, lack of physical activity, smoking, other forms of substance abuse and poor access to health care *[2, 50]*.

Social isolation and loneliness damage older people's health and quality of life

There is strong evidence that social isolation and loneliness increase the risks of older adults for physical health conditions such as cardiovascular disease and stroke and for mental health conditions such as cognitive decline, dementia, depression, anxiety, suicidal ideation and suicide *[2, 43, 54–57]*. There is also evidence, although it is not as strong, that social isolation and loneliness increase the risks of other health conditions [e.g. type-2 diabetes mellitus, high cholesterol] and limit mobility and activities of daily

Box 1. Living arrangements, loneliness and social isolation of older people

"Living alone" is defined as occupying a one-person household. Most studies show that living alone is a risk factor for both social isolation and loneliness, with some mixed results *[44–48]*.

Not only population ageing but also social and economic changes are reshaping the context in which older people live, including the size and composition of their households and their living arrangements. The changes also include decreased fertility; changes in patterns of marriage, cohabitation and divorce; higher educational levels of younger generations; continued rural-to-urban and international migration; and rapid economic development *[49]*.

Globally, more older people live alone. In western Europe and the USA, intergenerational residence has decreased dramatically, and most older people now live either in single-person households or in households consisting of a couple only or a couple and their unmarried children. In many less developed countries, despite the persistence of traditional family structures and cultural norms that favour multi-generational households, a slow shift is occurring towards smaller families and different types of household, including living alone *[49]*.

Globally, more older women than men live alone. Between 2006 and 2015, older women were twice as likely as older men to live alone [24% vs 11%]. The gender gap was widest in Europe and Northern America [37% vs 18%], followed by Australia and New Zealand [33% vs 18%]. Whereas, globally, 15% more older men than older women lived with a spouse [38% of men, 23% of women], the gap was wider in Europe and North America [56% vs 33%] *[49]*.

living *[2, 57]*. Social isolation and loneliness are also risk factors for violence and abuse against older men and women, the prevalence of which, at least in the USA, appears to have increased during the COVID-19 pandemic *[2, 58]*. Some more limited evidence indicates that social isolation and loneliness worsen the quality of life of older adults *[2, 57]*.

The effect of social isolation on mortality has been studied more extensively than that of loneliness, while the effect of loneliness on health has been studied more extensively than that of social isolation. The relative effects of each on health are, however, complex and not fully understood. Little attention has been paid to the discordance between social isolation and loneliness [e.g. high social isolation but low loneliness] and its impact on health *[2, 59, 60]*.

Currently, three plausible causal mechanisms have been proposed for the effects of social isolation and loneliness on health [Fig. 1]. First, they lead to excess stress reactivity, and, in the absence of the stress-buffering effect of social support, the physiological systems of lonely and isolated individuals may absorb more of the stressors encountered in daily life *[2, 10, 61, 62]*. Secondly, they result in inadequate or inefficient physiological repair and maintenance processes. For example, social isolation and loneliness affect the quality and quantity of sleep, which influence a variety of physical health conditions [e.g. cardiovascular disease, diabetes]; and poor sleep is associated with increased mortality *[2, 61]*. Thirdly, some, albeit mixed, evidence indicates that social isolation and loneliness lead to behavioural risk factors, such as lower physical activity, poorer diet, poor adherence to medical treatments and more smoking and alcohol consumption *[2, 10, 57, 61]*.

The costs of social isolation and loneliness

Social isolation and loneliness appear to impose a heavy financial burden on society, but the extent of the burden is not well understood. A review of studies on the economic costs of loneliness at all ages included only four studies on the costs of social isolation and loneliness in older people and addressed the costs of health and/or long-term care in high-income countries *[63]*. In a study in the United Kingdom, the excess costs for health and long-term care due to loneliness was estimated to be GBP 11 725 per person over 15 years *[64]*. Lonely older people are more likely to visit their doctor for social contact rather than for medical treatment, thus increasing medical costs *[65, 66]*. In the USA, an estimated US$ 6.7 billion in annual federal spending has been attributed to social isolation among older adults *[67]*.

Why are older people at risk of social isolation and loneliness?

A complex range of individual, relationship, community, societal and system level factors put people at risk of social isolation and loneliness *[68–70]*. Identifying risk factors at these four nested and interacting levels helps to make sense of the many interventions and strategies which target these risk factors to reduce social isolation and loneliness [Fig. 2].

At the level of the individual, physical factors such as having heart disease, stroke or cancer can increase the risks of both social isolation and loneliness, although the relation is often bi-directional *[2]*. Decreases in intrinsic capacity, such as sensory impairment and hearing loss, increase the risks, as do psychiatric disorders such as depression, anxiety and dementia *[2]*. Certain personality traits – such as neuroticism [i.e. negative affect], disagreeableness and low levels of conscientiousness – increase the risk of loneliness, and these are partly genetically determined *[71–73]*.

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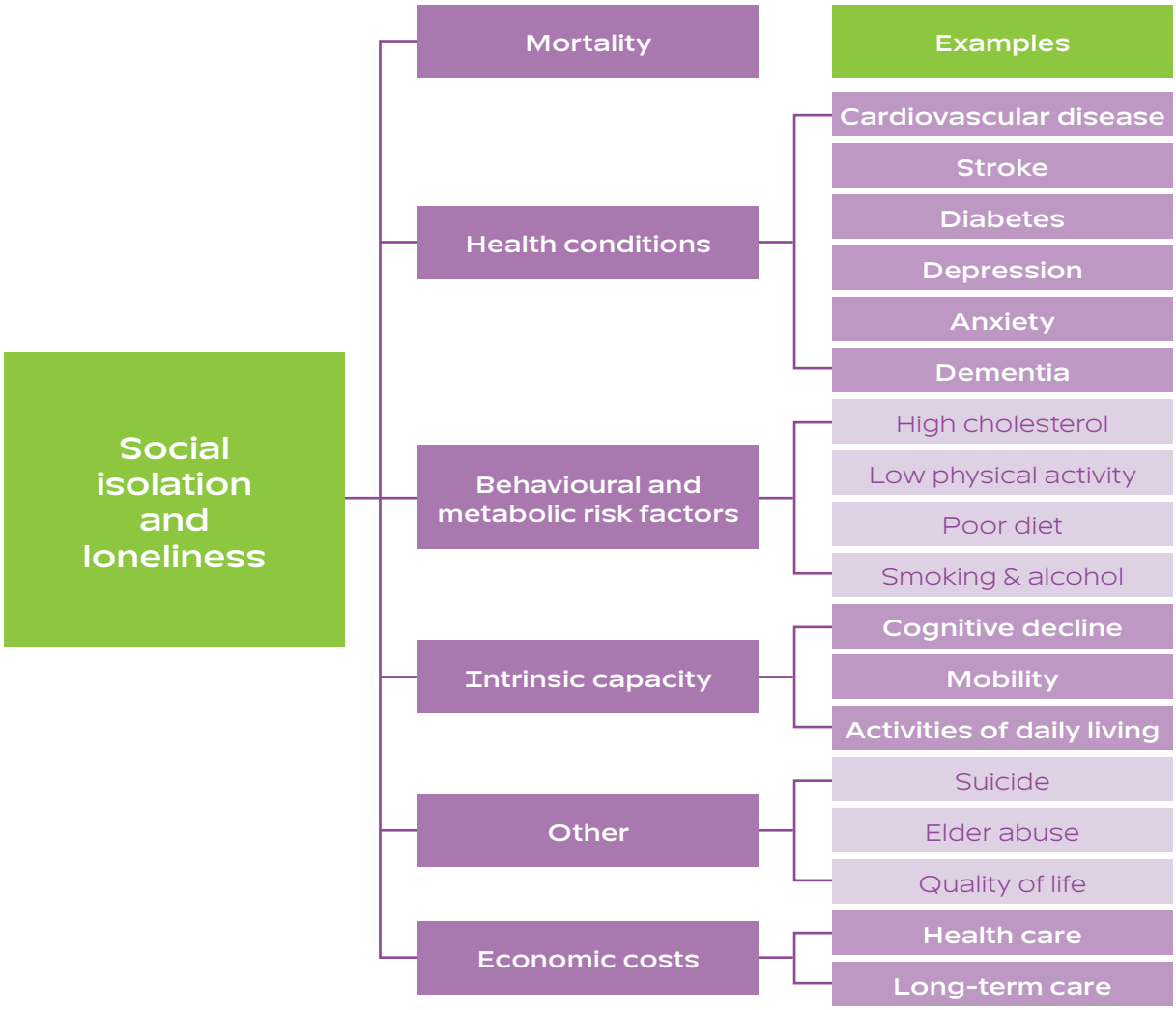
Fig. 1. Consequences of social isolation and loneliness



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