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Perspective

Advancing loneliness and social isolation as a global health priority: taking three priority actions

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Key points

- The evidence base for loneliness and isolation must be strengthened through consistency in definitions, measurement, and surveillance
- We need to develop a deeper understanding of the impact of chronic loneliness and social isolation and to identify effective interventions that can be implemented widely and translated into policy and practice
- Addressing complex population health challenges such as loneliness and social isolation requires the adoption of a whole-of-systems approach
- Developing global policy support will guide efforts to increase understanding, reduce stigma, and foster national action to combat loneliness and social isolation across low-, middle-, and high-income countries

Abstract

Loneliness and social isolation have been identified as critical global health issues in the aftermath of the coronavirus disease 2019 (COVID-19) crisis. While there is robust scientific evidence demonstrating the impact of loneliness and social isolation on health outcomes and mortality, there are fundamental issues to resolve so that health authorities, decision makers, and practitioners worldwide are informed and aligned with the latest evidence. Three priority actions are posited to achieve a wider and more substantial impact on loneliness and social isolation. They are 1) strengthening the evidence base; 2) adopting a whole-of-systems approach; 3) developing policy support for governments worldwide. These priority actions are essential to reduce the pervasive impact of loneliness and social isolation as social determinants of health.

Recognition of loneliness and social isolation as health priorities

Loneliness and social isolation are now recognised as critical public health issues that negatively impact individuals, communities, and economic prosperity.[1] The growing body of scientific evidence shows that loneliness and social isolation are important social determinants of health with impacts similar to those of physical inactivity and obesity.[2]

The public health importance and neglected status of these issues have led international agencies such as the World Health Organization (WHO)[3] and the European Union Joint Research Centre[4] to mobilise collaboration, awareness raising, research, and guidance to support national efforts to combat loneliness and social isolation. The establishment of the *Global Initiative on Loneliness and Connection* (GILC) in 2020 demonstrated commitment of by civil societies across the world to advance efforts to address these social drivers of health and wellbeing.[5] To make progress

globally in addressing loneliness and social isolation, we outline three priority areas for action.

Priority 1 – Strengthening the evidence

There are three areas in which we need to strengthen the evidence base.

a) Establishing consistent definitions, measurement, and surveillance of loneliness and social isolation

Loneliness and social isolation are related but distinct experiences, and it is important to define and differentiate these aspects of social wellbeing. The GILC has put forward definitions of loneliness and social isolation as a basis for monitoring and action within and across countries. The GILC defines social isolation as having "*objectively few social relationships or roles, and infrequent social contact",* while it defines loneliness as "*a subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more, or more satisfying, social relationships"*.[5]

The lack of consistent definitions of loneliness and social isolation has led to diverse measurements and, consequently, varying prevalence rates. Firstly, the measurement of loneliness and social isolation should adequately capture the diverse ways that individuals report and/or appraise their social interactions, relationships, and roles.[6] A complex but important task for surveillance and priority setting is to develop measures of loneliness and social isolation that have validity across age, gender, and cultural groups. There are also inherent challenges in measuring social isolation, and a range of social isolation indicators (e.g., amount of social contact, living alone status, remoteness) may be needed to understand the nature and extent of this experience at distinct points in the life course.[7]

To address loneliness and social isolation as global issues, we must include measures within public health surveillance systems to monitor trends, benchmark progress, and compare estimates across countries.

A 2022 systematic review of national-level estimates of loneliness highlighted marked disparities in data coverage.[8] The researchers found that data coverage was the best for European countries and much worse elsewhere, particularly in low- and middle-income countries. The pooled prevalence of problematic loneliness in Europe ranged from 5.3% in those aged 18–29 years to 11.9% in people 60 years and older. A recent meta-analysis of studies of social isolation among older people pooled prevalence data from a more diverse range of countries but remained affected by variations in definition, measurement, and data coverage. The estimated prevalence of social isolation among people above the age of 60 years from countries in Europe, the Americas, South East Asia, and the Western Pacific was 25%.[9]

There is a clear need for global agencies, such as the WHO, to support population-level surveys that use valid and comparable measures of loneliness and social isolation. Sampling representativeness, cultural and linguistic adaptation of the measurements and equity in data coverage are particularly important considerations for surveilling these social experiences. The development of a Global Index, currently planned by WHO, will increase the feasibility of comparisons across countries.

b) Understanding the impact of chronic loneliness and social isolation on health outcomes

Another important area of enquiry is the distinction between persistent (or chronic) and transient (or episodic) loneliness and social isolation.[10] Episodic or transient experiences of loneliness and social isolation may differ markedly from persistent forms because of external and/or structural barriers such as an impoverished social environment. Indeed, those experiencing loneliness and/or social isolation in an ongoing way are at markedly higher risk of an earlier death and increased acceleration to poorer health outcomes than those not experiencing loneliness and/or social isolation.[11] This points to the importance of assessments of loneliness and social isolation for use in health and social care contexts that account for the duration of these experiences. It also provides further impetus for the development of integrated, multidisciplinary models of care that can address the needs of patients across the risk trajectory; one example is the EAR (educate, assess, respond) framework for clinicians to assist with educating, assessing, and responding to patients.[12]

c) Identifying effective interventions for implementation at scale and translation into policy and practice

There has been an acceleration in intervention studies addressing loneliness and/or social isolation in the past 5 years. For example, 103 studies and 97 systematic reviews of digital interventions for loneliness and social isolation in older adults have been identified.[13] For in-person interventions on loneliness and social isolation across all age groups, 421 studies and 92 systematic reviews were identified.[14] We now need an overall synthesis of the findings from intervention studies to be undertaken with an implementation lens to derive clear recommendations of which interventions work, for whom, and in what contexts.

Outside research contexts, there is a multitude of small-scale interventions to reduce the prevalence and impacts of loneliness and social isolation, and it appears most are not appropriately evaluated. Service providers' engagement in evaluating different interventions to reduce loneliness and social isolation will provide invaluable learning about strategy implementation and impacts in diverse and complex contexts. Adopting a collaborative approach, in which practitioners and specialist evaluators

co-design and co-produce these evaluations, will ensure that the questions examined are of high, real-world relevance and that the evidence generated can be more readily translated into practice.

Furthermore, decision makers, policy makers, and practitioners who are unable to access scientific research efficiently could benefit from the development of evidence portals (i.e., what works), evidence gap maps (i.e., what is missing), guidance/guidelines, and toolkits/checklists that can inform and guide their work.[15] Access to these tools could inform evidence-based policy and programs and help direct funding towards research priorities.[13,14]

Priority 2 – Adopting a whole-of-systems approach

To make a wide impact upon loneliness and social isolation, there is also a need to move beyond individualistic responses (e.g., one-to-one therapy) to midstream and upstream population-level action (e.g., community action, policy change). Specifically, we need to move away from simplistic, downstream solutions provided by siloed services to adopt a 'whole-of-systems' approach that engages government, nongovernment, private sector, and civil society organisations in coordinated action to address the multilayered and upstream factors (i.e., policy influences) that contribute to these needs.[16,17] The WHO[18] have advocated for such an approach[18] as essential for addressing complex population health challenges and their broad societal impacts. An example of where a systems approach has been taken to improve health outcomes is the UK King's Fund project, *Driving better health outcomes through integrated care systems*.[19]

A recent evidence review found that ethnic, racial, and sexual minorities, people with a disability, those in poor physical or mental health (and carers), and those from low socioeconomic status are all more likely to report loneliness.[20] Some of these identities work together to increase the odds of loneliness, with powerful effects when the identities are stigmatised (e.g., older migrants in poor health). The fact that vulnerability to loneliness and social isolation overlaps with a range of other social inequalities[10] creates an imperative to examine and address the interconnected systems-level determinants of these issues.

Priority 3 – Developing global policy support

The upcoming establishment of the WHO Global Commission on Social Connection demonstrates a contemporary understanding of social connectedness as a social determinant of health, with cross-cutting relevance to many global priorities (e.g., healthy ageing, mental health). In parallel with this, a number of countries have embarked on large investments in the area. For example, the UK and Japan have appointed ministers with portfolio responsibility for addressing loneliness, and the governments of Denmark and the US have established expert-informed national programs of work to address loneliness, social isolation, and/or social connection. Other countries, including Australia and New Zealand, have adopted positively framed approaches that focus on improving wellbeing. However, to date, loneliness and social isolation have only featured in the public policy and public health agendas of a selection of high-income countries.

Global awareness of the detrimental impacts of loneliness and social isolation and the protective effects of social connection needs to grow to accelerate effective action. Conversations on how to address loneliness and social isolation in different contexts should avoid further stigmatisation and empower people to take steps to nurture and improve their own social connections, seek help early, and help each other (i.e., those who experience loneliness and social isolation themselves can be empowered to assist others). Further, evidence-based messaging should be adapted to be culturally appropriate.

With a deepened awareness, communities can appropriately upskill (e.g., assist people who are lonely to connect or reconnect) and identify resources that can be drawn upon in local action. Such efforts may initially require external support and funding to achieve effectiveness and sustainability. To ensure that community-level strategies are relevant, feasible, and sustainable, it is recommended that participatory co-development approaches are used.[21] A co-design framework can also empower communities to take ownership of local action and sustain efforts beyond the phase of external funding.

Given that loneliness and social isolation can be triggered and maintained by factors outside the individual's control, including community (i.e., neighbourhood poverty) and societal factors (i.e., policies in health, education, business), local, state, and national governments have a role in addressing these barriers to social connection. Furthermore, loneliness and social isolation are issues that not only have consequences for public health, but for many sectors, from education to business to community services. This also means that governments can review and modify policies that govern the way we live, learn, work, and play so that we live in communities that actively foster the development and maintenance of meaningful social interaction. One example is the Systematic Framework of Cross-Sector Integration and Action across the Lifespan (SOCIAL) Framework, which integrates the socioecological model (individual, interpersonal, institutional, community and societal) with different sectors, including clinical and population health, transportation, housing, employment, nutrition, environment and sanitation, education, and

leisure. The SOCIAL Framework can be applied to identify gaps in our existing knowledge and applications.[17]

Conclusion

While loneliness and social isolation are common across populations, the solutions need to reflect the complexity and diversity of human experiences and social environments. We need to address evidence gaps to escalate policy attention to these issues, as well as to inform the implementation of effective interventions and support the use of whole-of-system approaches. Co-developing frameworks and recommendations that recognise the contextual differences and cultural nuances of how loneliness and social isolation are experienced will be critical for global action. The three priority areas for action we have put forward must be addressed if we are to reduce the pervasive impacts of loneliness and social isolation as social determinants of health.

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None declared.

Author contributions

MHL led the manuscript, drove the conceptualisation and wrote the first draft. PQ and BS contributed to the manuscript's conceptualisation, writing and refinement. MD, CM, JHL contributed to the manuscript's writing and refinement.

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