A lonely planet: time to tackle loneliness as a public health issue

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Meaningful social relationships lie at the core of social wellbeing. Loneliness, defined as the discrepancy between one’s desired and actual social relationships, has been linked to a range of health outcomes such as cardiovascular disease, 1 cognitive impairment, 2 and early death. 3

In recent years, loneliness has become a hot topic in media and public dialogues. Some of the popular headlines include statements such as “loneliness is experienced by one third of the population” 4 and that it is a “growing problem.” However, we wanted to find out whether such statements are supported by data. So we asked ourselves—exactly how widespread is loneliness around the world?

The brief experience of feeling disconnected from others is sometimes referred to as transient loneliness, which is a common feeling we all experience at some stage in our life. Our recent research paper published in The BMJ, however, focused on “problematic levels of loneliness,” which in most studies was defined by chronicity, such as feeling lonely often or most of the time. We found national loneliness prevalence data for 113 countries and territories, suggesting a widespread interest in loneliness research. 5 Data from most countries suggest that problematic loneliness is a common experience. Secondly, there are clear data gaps by geographic regions and country income groups. Measuring and tracking social wellbeing is common in Europe—several large multi-country population surveys have provided rich data for Europeans across different age groups. By contrast, data are insufficient or non-existent for most low and middle income countries. Thirdly, the prevalence of loneliness varied considerably across countries, and even within the same region. For example, we found the lowest prevalence of loneliness in northern Europe, but some of the highest in eastern Europe. Fourth, despite the common claim of loneliness being a growing problem, we found insufficient evidence to conclude whether loneliness prevalence has increased or decreased over time.

More extensive comparisons across countries and over time have been limited by heterogeneity in methodologies, particularly in measurement instruments. Loneliness is typically measured either directly or indirectly. Direct measures of loneliness often include questions such as “How often do you feel lonely?” Indirect measures, such as the UCLA Loneliness Scale, tend to tap into the construct of loneliness without using the word “lonely.” Prevalence estimates based on the two types of measures are not directly comparable. Although single item direct measures involve minimal participant burden, there are concerns that these questions are open to respondents’ interpretations of what “loneliness” is and might lead to under-reporting due to perceived stigma. The UK Office for National Statistics recommends combining the two types of measures as the “gold standard” practice. 6

Globally, there are limited surveillance systems set up to track loneliness at the population level. While we found adolescent data for 76 countries, most of which came from the Global School-Based Student Health Survey (where loneliness was measured as a single item of a depression scale), data for adults are sparse, and primarily concentrated in Europe. In contrast to the scope and detrimental consequences of loneliness, the lack of population-level data highlights important evidence gaps.

Although loneliness was traditionally treated as an individual problem, in recent years, prominent researchers, and the US surgeon general, Vivek Murthy, have been advocating for treating loneliness as an “epidemic” and a substantial public health issue. Our findings regarding the visible variations in loneliness prevalence across countries further confirm that the extent of loneliness is likely influenced by a range of macro level factors such as economic status, demographic characteristics, inequalities, social security, and welfare.

A public health approach to loneliness depends on having reliable population level data for benchmarking, tracking progress, setting priorities, and informing solutions. We advocate incorporating loneliness measures into routine public health surveillance systems, along with traditional risk factors such as smoking and obesity. What gets measured gets done. Long term public health surveillance of loneliness helps us keep our finger on the pulse of society in terms of social wellbeing. Loneliness can be dealt with across different levels: individual, relationships, community, and society. At the individual and relationship levels, challenging maladaptive cognitions (eg, “nobody likes me”) and providing safe opportunities to socialise (eg, participating in a short conversation with a friend) is effective at mitigating feelings of loneliness. Unfortunately, these approaches rely heavily on a person recognising that they are lonely as well as having the resources to address their needs. Community based solutions enable community members to work together to maximise social opportunities by using existing community assets. For example, social prescribing, where physicians “prescribe” non-medical, community support to improve social wellbeing, has become a popular approach. These solutions have the potential to reduce loneliness, but empirical evidence supporting their effectiveness is inadequate. 7 Finally, addressing loneliness at the societal level involves creating a public awareness of loneliness and informing people of what this looks like. Several countries have
adopted this public campaign approach, such as the Campaign to End Loneliness in the UK and Ending Loneliness Together in Australia.

However, perhaps most fundamentally, re-defining loneliness as a public health problem requires shifting our dialogue from connecting individuals to creating socially connected societies. Loneliness is a systemic problem, embedded in social and structural factors such as poverty, inequalities, and culture. Addressing loneliness requires a systems approach to leverage changes in many sectors such as education, housing, urban planning, transportation, and technology. Only by working together across sectors to address the systematic drivers can we restore the third pillar of our collective health and wellbeing.