The Role of Primary Care in the Social Isolation and Loneliness Epidemic

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ABSTRACT

The United States is facing a social isolation and loneliness crisis. In response, the US Surgeon General issued an advisory in May 2023 recommending actions that health care, community programs, and social services can take to collaboratively improve social connection. Primary care has a critical role to play in implementing the Surgeon General's recommendations. We present social isolation and loneliness as medical issues and highlight next steps for the primary care sector to combat this epidemic.

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INTRODUCTION

The Social Isolation and Loneliness Epidemic

Social isolation and loneliness have gained significant attention in recent years and are increasingly recognized as urgent health issues in the United States. In a recent advisory from the US Surgeon General titled "Our Epidemic of Loneliness and Isolation," Dr Vivek Murphy provided recommendations for addressing this epidemic, including mobilization of health care to better address these issues.[1] This call for change follows decades of increasing evidence illustrating the high prevalence and the adverse health outcomes of social isolation and loneliness, leading to previous recommendations from the World Health Organization and the National Academies for Sciences, Engineering, and Medicine.[2,3] Although historically not considered within the scope of clinical care, we are now at a critical juncture where the health care workforce must recognize social isolation and loneliness as medical issues.[4]

Social Isolation and Loneliness as Medical Issues

Social isolation and loneliness (SIL) are interconnected and negatively impact health. Loneliness is a person's perception of social isolation or inadequate relationships,[5] while social isolation is the objective lack of social contact or relationships with others.[2] Across the life span, the prevalence of loneliness is remarkably high, with recent estimates illustrating that nearly one-half of Americans are lonely.[6] Prior to the COVID-19 pandemic, 20% of adult primary care patients of all ages identified as lonely, which is higher than the prevalence of many commonly treated diseases such as depression and diabetes.[7] There are indicators that SIL are increasing over time, including increasing time spent alone, decreasing social participation, and decreasing companionship.[8]

SIL increases the risk of chronic health conditions including cardiovascular disease, hypertension, obesity, stroke, and dementia as well as increased mortality and early death.[9] Loneliness is associated with prevalence and poor control of depression and anxiety as well as poorer educational outcomes and work productivity.[1] It is also associated with increased health care utilization in primary care patients, including emergency department visits and hospitalizations.[7] Overall, social isolation is reported to be equivalent to smoking 15 cigarettes per day in terms of premature death.[10]

The Role of Primary Care

While all health care professionals will encounter SIL in clinical settings, this is particularly true in primary care, which acts as the front line of health care for most

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Americans and considers the whole-person health of individuals, families, and communities. In many cases, primary care clinicians have already been leaders in recognizing and addressing loneliness prior to the recent recognition of the health effects and high prevalence of SIL.[11,12] There have been little systematic attempts to address SIL, however, and the primary care sector can be instrumental to addressing this epidemic through prevention, early identification, education, and intervention.

The recent Surgeon General Advisory presents a framework for action that includes 3 main pillars for the health care sector: (1) train health care providers, (2) assess and support patients, and (3) expand public health surveillance and interventions.[1] Table 1 presents the opportunities for primary care to implement this framework to address SIL. As a first step, primary care should train current and future health care clinicians to prioritize assessment and discussions about SIL in routine care.[4] Primary care training programs should provide education on SIL as medical concerns that are recognizable in clinical encounters and are vital to the well-being of patients.

Second, primary care clinicians should consider SIL assessments especially during major life transitions (ie, recent move, loss of a loved one, functional changes), during significant health crises, or concern for patient self-management of chronic conditions. A variety of tools exist to identify SIL that may be incorporated into clinic care, including the 3-item UCLA Loneliness Scale[13] and the Berkman-Syme Social Network Index.[14] Additionally, SIL should be integrated into conversations about preventative care and chronic disease management. For example, care plans for a chronic disease should understand whether SIL might be worsening patient self-efficacy (ie, belief that they can succeed).

Since the benefit of SIL identification in primary care largely hinges on the ability to reduce SIL, several efficacious primary care interventions could be implemented in primary care that have previously been implemented in some European countries. Psychological interventions, such as cognitive behavioral therapy, may address the maladaptive thinking that occurs with loneliness and help with behavioral activation to help individuals overcome their social isolation.[15,16] Social interventions, such as referrals using a social navigator to community-based programs, which is based on the United Kingdom model of social prescribing, may increase opportunity for social interaction and connection.[17] Many primary care clinics have support staff such as social workers or care managers who may be able to address barriers for socialization including transportation, financial insecurity, or comorbidities like immobility and hearing loss. Primary care can also provide linkages and referrals to community-based organizations that increase social connection (ie, congregate meal programs, community exercise programs, adult day centers).

Third, recognizing that primary care clinicians cannot in isolation care for and reduce SIL, the health care system must leverage and partner with public health groups, social services agencies, and community-based organizations. At a population level, health care systems can leverage system-wide capacity (ie, electronic health records, patient education resources, patient portal interventions) to facilitate assessment of SIL and implement strategies for linking patients to social infrastructure in their local communities. In addition, as with addressing social determinants of health, primary care clinicians cannot address SIL in a silo but could greatly enhance its effectiveness in reducing SIL by partnering with public health agencies and other community-based organizations. These partnerships and cross-sectional work to deliver SIL-reducing interventions would enhance the communities where people work, live, and play and make communities more conducive to connecting with others. Infrastructural support is needed to help primary care, public health, and community organizations create these partnerships to support connection and well-being.

Table 1. Opportunities for Primary Care Clinicians to Address Social Isolation and Loneliness

US Surgeon General Health Care Sector Recommendations (Pillar 3)	Opportunities for Primary Care
Train health care providers	Provide and encourage opportunities for the current primary care workforce to learn about importance of SIL and practical ways to assess and address SIL in patients
	Educate trainees in residency programs and medical schools on SIL
Assess and support patients	Screen patients for loneliness (eg, using 3-item UCLA Loneliness Screener[13]) and social isolation (eg, using Berkman-Syme Social Network Index[14])
	Incorporate questions and information about SIL in chronic disease management care plans
	Implement psychological interventions such as cognitive behavioral therapy to address loneliness
	Implement social interventions such as referrals to community-based organizations and other social activities to improve connections
Expand public health surveillance and interventions	Leverage system-wide capacity to identify SIL and promote partnerships to address SIL
	Foster partnerships and cross-sector collaborations to address SIL between primary care, public health, and community organizations
	Develop infrastructure to support partnerships and collaborations

SIL = social isolation and loneliness.

CONCLUSION

The SIL epidemic will not be solved without concerted efforts from entities both within and outside of health care. Addressing current shortcomings in the health care system will require significant investment from the health care sector, public health entities, policy makers, and payers. Despite these challenges, recommendations from the Surgeon General can be a guiding framework for how to respond. Primary care has a unique opportunity to play a major role in addressing this epidemic and improving health in our patients and communities. Primary care must appreciate SIL as medical issues and commit to a future that prioritizes being a part of the solution to the SIL epidemic.

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Key words: social isolation; loneliness epidemic; primary health care

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