Issue At A Glance:

Social Isolation among US Adults

This issue brief explores social isolation as an urgent public health issue affecting 20-30% of US adults and contributing to a significant burden of morbidity and mortality. Interventions for social isolation and the current state of US policy on this topic are also discussed.

Introduction

Social isolation is defined by the Centers for Disease Control and Prevention (CDC) as having an objective lack of relationships, contact with, or support from others. This contrasts with loneliness, which is defined as the feeling of being alone, disconnected, or not close to others.[1] While the two ideas are interrelated, they are distinct phenomena with distinct adverse health consequences and effective interventions.

Among US adults (18+), the prevalence of perceived social isolation is estimated to be between 20 - 30%.[2,3] While increasing age is a risk factor for social isolation[4,5] (presumably due to retirement, death of significant others, and declining health), a multitude of contemporary studies have suggested that middle aged Americans (40-65 years old) may actually have the highest rates of social isolation.[2,3,6] It is unknown whether this finding is a result of selection bias in survey-based studies, an under-recognized risk factor affecting middle age Americans, or perhaps a protective benefit conferred to older Americans by age-specific infrastructure like group-living homes or Medicare programing.

Other risk factors for social isolation include low income, minority status, low educational attainment, poor physical and mental health, being unmarried, and being male.[2-6]

Effect of the COVID-19 Pandemic

Self-reported rates of social isolation among Americans according to the University of Michigan National Poll on Healthy Aging:[6]

2018	26.6%
2020	55.7%
2022	44.4%
2024	29.2%

Health Consequences of Isolation

In 2023, the US Surgeon General published a public health advisory entitled, "Our Epidemic of Loneliness and Isolation," a document identifying loneliness and social isolation as urgent and profound threats to the health and wellbeing of Americans.[7] While loneliness is typically associated with psychological health consequences, social isolation has been found to have a broader range of adverse health associations spanning all-cause mortality, cardiovascular disease (CVD), dementia, diabetic complications, depression, and generalized markers of inflammation.[7]

A 2023 meta-analysis of studies from the US and Europe spanning 1.3 million patients found that social isolation was associated with a 33% increased hazard of all-cause mortality,[8] supporting the findings of a 2010 meta-analysis which found that low social support conferred a mortality risk on par with smoking 15 cigarettes per day.[9]

Social isolation has additionally been identified in a statement by the American Heart Association (AHA) as an independent risk factor for worse cardiovascular and brain health, conferring a 39% increased hazard of CVD10 and a 32% increased risk of incident stroke.[11] A 2022 analysis of the UK BioBank Cohort containing data for nearly half a million participants found that social isolation, independent of loneliness or depression, was associated with a 26% increased risk of dementia.[12] A different study of the same cohort found a 17% increased hazard of depression associated with social isolation.[13]

Beyond its effects on morbidity and mortality, social isolation also carries a substantial economic burden. Among older adults alone, social isolation is estimated to account for $6.7 billion in excess Medicare spending annually, an expense driven largely by increased hospital and nursing-facility utilization.[7]

Mediators of the Adverse Effects of Social Isolation

The adverse health effects of social isolation are thought to be due to a combination of behavioral mediators such as diet and smoking in addition to physiological mediators such as inflammation, disruption of neuroendocrine axes, and sleep. Social connectedness has a well-established inverse association with the physiological manifestations of chronic stress, also known as allostatic load.[5] Epigenetic research has identified pathways by which social isolation up-regulates expression of genes associated with inflammation and down-regulates genes associated with innate antiviral responses and antibody synthesis.[14]

Interventions for Social Isolation

Gaps in the Research

While a multitude of interventions have successfully demonstrated efficacy at reducing measures of social isolation, most of this research has not attempted to measure the effects of these interventions on downstream adverse health outcomes associated with social isolation.

As a result, we know that social, psychological, and digital interventions can decrease social isolation, but we cannot say with the same degree of certainty whether these interventions reduce risk of CVD, dementia, stroke, depression, or mortality.[5,15-17]

Types of Interventions

While the existing evidence base is heterogeneous and sparse, several trends emerge consistently in meta-analyses and reviews of interventions for social isolation. Perhaps unsurprisingly, interventions focused on increasing social access and social contacts consistently had the greatest reductions in social isolation, whereas psychological interventions such as cognitive behavioral therapy (CBT) showed the most benefit for improving measures of loneliness.[15-17]

Digital interventions consistently demonstrated the least benefit for social isolation — a concerning concept given that interactions of successive generations are become progressively more and more digital.[15,16] For Americans aged 15-24, the amount of time spent on face-to-face contact with friends has dropped by a staggering 70% over the past two decades, from 150 minutes per day in 2003 to just 40 minutes per day in 2020.[7] A similarly alarming trend can be seen in the number of close friendships reported by Americans. According to a 2018 survey, the majority of Americans who reported not being socially isolated also reported having at least 3 close relationships, yet the proportion of Americans reporting having fewer than 3 close relationships rose from 27% in the 90's to almost 50% in 2021.[7]

Promising Interventions

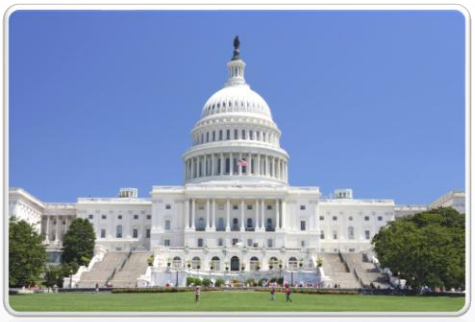
One noteworthy intervention described in the social isolation literature is the creation of bathing salons in Japan for elderly people in an attempt to reduce long-term care needs. Multiple studies based on this program demonstrated that salon participation was associated with a 50% reduction in the incidence of long-term care needs and a roughly 33% reduction in the incidence of dementia.[18]

This salon program has additionally demonstrated success in reducing barriers to low-income populations by engaging local volunteers to manage site operations, thus keeping costs low. In 2007, the proportion of salon usage in Takeyoto was higher amongst low-income groups compared with high-income groups.[18]

Another prominent intervention is a national social prescribing program initiated in England in 2019. This program utilizes "link workers" integrated into primary care to connect at-risk individuals with social opportunities, including groups, activities, and clubs. Subsequent studies in England since the implementation of this program show significantly reduced utilization of general practitioner (i.e. primary care provider) appointments, hospital admissions, and emergency services.[19]

Current US Policy

Social isolation has been formally recognized as an urgent public health issue by the US Surgeon General, yet the United States lacks any broad national policy for the prevention and mitigation of social isolation. The most comprehensive initiative is the 2023 National Strategy to Advance Social Connection outlined by the Surgeon General in the previously mentioned advisory; however, this remains a theoretical strategy that has yet to be formally translated into action.[7] Existing US policies on social isolation tend to be population-specific, such as the Older Americans Act, which allows for the screening and coordination of supportive services for older adults and is primarily implemented by the Administration for Community Living (ACL).[20] Addressing social isolation as a broad public health threat will require movement towards coordinated national policy action that promotes meaningful social connection across the lifespan.



Did you know?

In March 2025, as part of the DOGE Workforce Optimization Initiative, the ACL lost almost 40% of its staff including the entire budget and grants teams, policy and evaluation teams, and regional staff.[21]

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