Whereas, Loneliness is defined as “the discrepancy between a person’s preferred and actual level of social contact,”¹; and

Whereas, Social isolation is defined as “an objective state of having minimal social contact with other individuals”¹; and

Whereas, The World Health Organization lists “social support networks” as a determinant of health²; and

Whereas, The 2018 Cigna U.S. Loneliness Index found that nearly half of U.S. adults report sometimes or always feeling lonely³; and

Whereas, Younger generations are experiencing more loneliness than older generations³; and

Whereas, Loneliness in adolescence is associated with impaired sleep, symptoms of depression, and poorer health in general⁴; and

Whereas, Loneliness is a significant predictor of functional decline and premature death equal to or exceeding the risk from obesity⁵,⁶; and

Whereas, Increased meaningful daily interactions and multiple sources of social support are associated with decreased loneliness³,⁷; and

Whereas, Decades of research provide evidence for the strong causal relationship between social relationships and health and longevity⁸; and

Whereas, The United Kingdom has recognized loneliness as an epidemic and has appointed a Minister of Loneliness to address loneliness in the UK, directed federal funding towards expanding the Shared Lives program, and encourages physicians to offer “social prescribing” to connect patients with community activities⁹,¹⁰; and

Whereas, The American Psychological Association, the National Academies of Science, Engineering, and Medicine, Surgeon General Vivek Murthy, and many other health organizations have publicly spoken out about loneliness as a public health problem in the US¹¹-¹³; and

Whereas, Our AMA has passed policy to publicly recognize the association between senior suicide and loneliness (H-25.992) and the negative effects of solitary confinement on imprisoned juveniles (H-60.922), but no policy exists addressing loneliness as a public health issue affecting people of all ages; therefore be it
RESOLVED, That our American Medical Association will release a statement identifying loneliness as a public health issue with consequences for physical and mental health (Directive to Take Action;) and be it further

RESOLVED, That our AMA support evidence-based efforts to combat loneliness. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/22

References:

RELEVANT AMA POLICY:

Senior Suicide H-25.992
It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.
Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Health Care for Older Patients H-25.999
The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and
advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum.


Policy Recommendations in the Field of Aging H-25.998
It is the policy of the AMA that: (1) Older individuals should not be isolated; (2) a health maintenance program is necessary for every individual; (3) more persons interested in working with older people in medical and other professional fields are needed; (4) more adequate nursing home facilities are an urgent health need for some older people in many communities; (5) further development of service and facilities is required; (6) extension of research on both medical and socioeconomic aspects of aging is vital; (7) local programs for older persons, especially those which emphasize the importance of self-help and independence by the senior citizen, should be a major concern of medicine, both collectively and individually; and (8) local medical society committees along with other leaders in community service, should be equipped to appraise the advantage or disadvantage of proposed housing for older people.

2. Our AMA support initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders' rights in all states.

Increased Liaison, Communication and Educational Efforts with the Elderly H-25.994
The AMA supports (1) increasing communications and understanding between organized medicine and the elderly; (2) continuing contact with organizations such as the AARP, offering speakers for their meetings, and pursuing other steps to improve their understanding of physicians’ problems and concerns; and (3) encouraging state and county medical societies to undertake similar efforts to increase liaison with the elderly.

Solitary Confinement of Juveniles in Legal Custody H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

Financing of Long-Term Services and Supports H-280.945
Our AMA supports: (1) policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability; (2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees; (3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI; (4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities; (5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy; (6) Medicare Advantage plans offering LTSS in their benefit packages; (7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit; (8) a back-end public catastrophic long-term care insurance program; (9) incentivizing states to expand the availability of and access to home and community-based services; and (10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.

A Guide for Best Health Practices for Seniors Living in Retirement Communities H-25.987
Our AMA, in collaboration with other interested parties, such as the public health community, geriatric specialties, and organizations working to advocate for seniors, will create a repository of available
resources for physicians to guide healthy practices for seniors who reside in independent living communities.
Res. 418, A-18

Senior Care H-25.993
Our AMA supports accelerating its ongoing efforts to work responsibly with Congress, senior citizen groups, and other interested parties to address the health care needs of seniors. These efforts should address but not be limited to: (1) multiple hospital admissions in a single calendar year; (2) long-term care; (3) hospice and home health care; and (4) pharmaceutical costs.
Sub Res. 181, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Clinical Preventive Services H-425.984
Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.