THOUGHT LEADERSHIP PAPER

Loneliness is the Real Killer

Why I joined Carer Hub to fight loneliness head-on — and why you should care too.

Written by
Dave Audley
CEO, Carer Hub
April 2026

This paper is written in my own voice, as a personal statement of what I believe is one of the most urgent — and most neglected — health crises facing older people in the United Kingdom today. The views expressed are mine. The research cited is real, peer-reviewed, and sobering.

I want to tell you something that most people in the care industry won't say out loud.

A significant number of elderly people in the United Kingdom are not dying because their bodies have given out. They are dying because they have given up. They are dying because nobody came. Because the phone didn't ring. Because they sat in the same chair, in the same room, and looked at the same four walls, for days and weeks and months — and somewhere in that silence, they stopped wanting to be here.

We call it natural causes. We call it old age. We write on the death certificate that the heart stopped, or the lungs failed, or the kidneys gave out. And all of that is technically true. But it is not the whole truth. The whole truth is that loneliness is one of the most lethal conditions an elderly person can experience — and we as a society are doing almost nothing meaningful about it.

One of the reasons why I am working at Carer Hub because I believe we can do something about it. Not everything. But something. Something practical. Something that reaches people where they are — in their homes, in their chairs, in their silence — and says: you matter. Someone is coming. You are not forgotten.

This is why. And this is what the evidence says.

1. The Scale of the Problem

Let me start with the numbers, because the numbers are extraordinary and they are not talked about nearly enough.

> **3.83 million**
> people in the UK are chronically lonely — up from an estimated 2.6 million in 2020. That is not people who occasionally feel isolated. That is people for whom loneliness is the persistent, daily texture of their existence.
> *COHO / UK Analysis, 2025 [1]*

One in four older adults worldwide — approximately 25% — feels lonely, according to a comprehensive 2025 systematic review and meta-analysis published in Humanities and Social Sciences Communications [2]. In the United Kingdom, the picture is not materially better. Single-person households now represent almost a third of all English homes — 6.9 million households — and the proportion is rising fastest in the North West, where Carer Hub currently operates [1].

The human reality behind these statistics is people like the woman a care worker described to me recently — a woman in her late eighties, still sharp, still warm, still full of things to say. She hadn't had a face-to-face conversation with another person in eleven days. Eleven days. Not because of illness. Not because of mobility. Because there was simply nobody in her life who came any more. Her family were busy. Her friends were gone. Her world had shrunk to the size of a living room.

She is not an outlier. She is the pattern.

> *Almost one in four elderly people in the world feels lonely. In the UK, 6.9 million households are now single-person homes. The pattern is not random. It is structural.*

2. Loneliness is Not Just Misery. It is Medicine. And It is Lethal.

The argument I am making here is not a soft, sentimental one about the importance of human connection. It is a hard, clinical, evidence-based argument about mortality. Loneliness kills people. Not metaphorically. Literally.

The most comprehensive recent study on this question was a systematic review and meta-analysis published in the European Psychiatry journal in August 2025, covering 86 studies drawn from 11,964 candidates in the academic literature [3]. Its findings were unequivocal:

+14%	+35%	+21%
increased all-cause mortality risk *from loneliness*	increased all-cause mortality risk *from social isolation*	increased all-cause mortality risk *from living alone*

Source: Nakou et al., European Psychiatry, August 2025. Meta-analysis of 86 studies. [3]

A separate longitudinal study tracking nearly 10,000 individuals over 20 years, published in Frontiers in Public Health in October 2024, found that social isolation increases 20-year mortality risk by 16% in women and 15% in men — even after adjusting for age and other risk factors [4]. And perhaps most troubling of all, a 2025 study from Imperial College London and University College London, published in Nature Mental Health, found that chronic loneliness — loneliness that persists over time rather than being a passing state — has a significantly stronger association with mortality than loneliness measured at a single point [5]. The longer a person is lonely, the more lethal it becomes.

To put this in a context that might resonate: the mortality risk associated with chronic loneliness is comparable to smoking 15 cigarettes a day, according to research frequently cited by the US Surgeon General's office [6]. We have entire public health campaigns dedicated to smoking. We have warning labels, taxation, helplines, and legislation. For loneliness — which kills at a similar rate — we have, until very recently, had almost nothing.

> *Chronic loneliness carries a mortality risk comparable to smoking 15 cigarettes a day. We tax cigarettes. We put warnings on packets. For loneliness, we have had almost nothing.*

The mechanism through which loneliness kills is not simple or singular. It operates on multiple fronts simultaneously. Loneliness is associated with elevated cortisol levels, chronic inflammation, impaired immune function, disrupted sleep architecture, and accelerated cognitive decline [3][5]. People who are chronically lonely are more likely to develop depression, anxiety, and dementia. They are more likely to neglect their own health — skipping medication, missing appointments, eating poorly. They are more likely to end up in hospital, and less likely to recover well when they do.

But there is something else. Something that the clinical literature captures only imperfectly, because it is hard to measure. It is the loss of the will to live.

3. When People Stop Wanting to Be Here

In 2021, researchers from Portugal published a study in Frontiers in Psychology examining something they called the 'will to live' among centenarians — people aged 100 and over [7]. Their findings were haunting. Of their sample, 30.6% did not want to live longer. Not because they were in unmanageable physical pain. Not because they were cognitively impaired. The most common reasons they gave for their reluctance to go on were: annoyance, uselessness, loss of meaning, disconnection, and loneliness [7].

Let that sit for a moment. Nearly a third of people who had survived to 100 years of age had decided, at some level, that they had had enough. And the primary driver was not physical suffering. It was a felt sense of disconnection. Of being unwanted. Of having nobody who needed them.

This is not an isolated finding. A 2024 study published in Frontiers in Public Health, drawing on data from the Irish Longitudinal Study on Ageing — one of the most robust cohort studies of its kind — found strong and direct correlations between social disconnection and what researchers call a 'wish to die' in older adults [8]. The more disconnected a person feels from the social world around them, the more likely they are to experience what the research calls 'death ideation' — a passive but real desire for their own death.

And a 2025 study published in the journal Geriatrics and Gerontology International, using nationally representative data from the German Ageing Survey, found that both loneliness and social isolation were significantly associated with a lower desired age at death — in plain language, lonely older people want to die younger [9].

38%

of centenarians studied expressed no clear will to continue living. Disconnection, loneliness, and loss of meaning were the primary reasons given — not physical pain.

Araújo et al., Frontiers in Psychology, 2021 [7]

A 2023 qualitative study from the Netherlands, published in Aging and Mental Health, is perhaps the most devastating piece of evidence in this whole body of research [10]. Its researchers sat with 34 people aged 55 to 92 and asked them — in depth, over extended interviews — about what it felt like to see no future for themselves. What they found was not dramatic suicidal ideation. It was something quieter and in many ways more troubling. The researchers described it as 'losing the zest for life' — a gradual withdrawal from engagement, from hope, from anticipation. The four constituents of this experience were: not sharing everyday life with others, looking for new commitments but finding none, facing present losses and future fears alone, and imagining not waking up in the morning without distress.

Imagining not waking up in the morning without distress. That phrase has stayed with me since I first read it. These are not people who are suicidal in the clinical sense. They are people who have become indifferent to their own survival. People for whom the continuation of life no longer feels like something to actively want.

And the common thread running through every account — in every country, every cohort, every study — is the absence of meaningful human connection.

> *They were not actively dying. They were simply no longer actively living. And the reason, in study after study, was the same: nobody came.*

4. Why This Is Getting Worse, Not Better

Everything about the trajectory of modern life is making this worse.

The number of people living alone in England has risen by 14% over the past decade — 6.9 million single-person households and growing [1]. Families are more geographically dispersed than at any point in modern history. Adult children live in different cities, different countries. The village and community structures that once embedded older people in networks of daily human contact have largely dissolved. And the communities that have grown up to replace them — online communities, digital networks — tend to exclude the very old in practice, whatever their theoretical accessibility.

Meanwhile, the formal care system is buckling under demand. Two million people aged 65 and over are not getting the care they need because of staff shortages and system strain [11]. The social care waiting list stands at 400,000 people. The NHS is under extraordinary pressure. The volunteer networks that once filled some of the gap are themselves under strain. The pandemic accelerated every one of these trends and the social scarring it left on older people — the habits of isolation that set in during lockdown and never fully reversed — is still visible in the loneliness data today.

We are heading towards a demographic cliff edge. The number of people aged 85 and over in the UK will more than double by 2065, growing from 3.1 million to 6.3 million [12]. This is not a projection with significant uncertainty. It is the product of people who are already alive. These people will be older, they will be frailer, and — if current trends continue — they will be lonelier than any comparable cohort in British history. And the systems we currently have in place to support them are already insufficient for the demand that exists today.

5. What Has Been Tried, and Why It Is Not Enough

To be fair to those who have been working on this problem longer than I have, there have been serious attempts to address it. In 2018, the UK Government appointed the world's first Minister for Loneliness and published a national loneliness strategy — a recognition, at the highest level, that this was a public health emergency [13]. The NHS has embedded social prescribing into its Long Term Plan, committing to refer 900,000 people to social prescribing link workers by 2024 [14]. The National Academy for Social Prescribing has championed community-based approaches to connection — befriending services, gardening clubs, arts programmes, walking groups [15].

These are good things. I mean that sincerely. They represent a genuine shift in how the health and care establishment understands the relationship between social connection and health. Social prescribing, in particular, has shown meaningful promise in connecting isolated people to their communities.

But they are not enough. And they are not reaching everyone. Social prescribing, by its nature, requires a GP to make a referral. It requires a link worker to be available. It requires community assets to exist in the right place at the right time. For the most isolated people — the ones who are not going to their GP because they cannot get there, or because they do not see the point, or because the appointment slot went to someone who seemed more urgently unwell — none of these pathways reliably reach them.

The cost of loneliness to the UK economy is estimated at more than £32 billion per year, factoring in health and social care costs, reduced productivity, and wider societal effects [1]. That figure will grow as the population ages. The structural response to it — government strategies, NHS programmes, voluntary sector initiatives — is not scaling at the rate the problem is scaling.

Something else is needed. Something more direct. Something that starts not with a referral and a waiting list, but with a person turning up at someone's door.

> *The most isolated people are often the ones who cannot navigate the referral systems designed to reach them. They need someone to come to them. Literally.*

6. Why I Helped to Build Carer Hub — and What Companionship Has to Do With It

When I started thinking seriously about the building of Carer Hub, the public conversation about care was almost entirely focused on what I would call clinical care — personal care, medication management, mobility support, dementia management. All of which matters. All of which we provide.

But the more I looked at the evidence, the more I kept coming back to a different question. What about the people who do not need clinical care yet? The people who are managing — just about — but who are managing entirely alone? The widow who cooks for one every evening and eats in silence. The retired teacher whose friends have died and whose children call on Sunday evenings if they remember. The man in his late seventies who has not had a meaningful conversation with another person in a week.

These people do not meet the threshold for a care needs assessment. They are not, in the clinical sense, unwell. But they are lonely in a way that is actively damaging their health — shortening their lives and diminishing the lives they have. And the care system, as currently structured, has almost nothing to offer them.

Companionship care — the provision of regular, genuine human company as a discrete, valued service — is not a new concept. But it is chronically undervalued, poorly resourced, and almost entirely absent from the way we talk about care as an industry. It tends to be tacked on to visiting care visits as an afterthought, or provided by volunteers in ways that are inconsistent and hard to scale.

I want to change that. Not by adding companionship as a feature. But by positioning it as a service in its own right — something a family can arrange, pay for, and rely upon. Something a care worker can offer

with pride. Something the platform facilitates with the same rigour and transparency we bring to every other service.

7. The Carer Hub Approach to Companionship

Here is what I believe, and what we are building towards at Carer Hub.

Companionship care should be as easy to arrange as any other form of care. A family should be able to go to carerhub.co.uk, describe what their relative needs — someone to visit twice a week, to have a cup of tea and a conversation, to take them for a walk, to play cards, to sit with them through an afternoon — and find a verified, insured, matched care worker who can provide exactly that. Without a GP referral. Without a waiting list. Without a social care assessment. Just a person, turning up, reliably, with time and genuine interest.

The care workers on our platform who provide companionship are not performing a lesser form of care. They are providing something that — as the research I have set out in this paper demonstrates — is as consequential for the health and survival of the person they visit as any clinical intervention. A care worker who arrives twice a week and sits with a lonely person, who listens to their stories and laughs at their jokes and calls them by their name, is doing something that has measurable, evidence-based impact on the length and quality of that person's life.

We are building a dedicated companionship care matching service on the platform. It will work alongside our visiting care and live-in care services. It will have its own search and filtering capability — care workers who are matched not just by location and availability, but by shared interests, personality fit, and the specific kind of companionship the care seeker is looking for. A person who loves gardening matched with a carer who loves gardening. A lifelong reader matched with a carer who can talk about books. A former professional matched with a carer who can engage with what their life meant, not just what their care needs are.

We are also working on a way to make this accessible to people who self-fund, and to those using local authority direct payments — because the evidence is clear that social connection is not a luxury that should be available only to those who can afford it without support.

> *A person who visits twice a week and sits with a lonely person — who listens, who laughs, who calls them by their name — is doing something measurable. The research is unambiguous. It is keeping them alive.*

8. A Personal Crusade — Because the Numbers Are Not Abstract

I am not writing this paper as a theoretical exercise. I am writing it because I have seen what loneliness does to people — not in data, but in rooms.

I have sat with people who light up at a visit like a plant that has been given water. I have heard from care workers who tell me that their regular companions look for them at the window before they even knock. I have read messages from family members who say that since their relative started receiving companionship visits, they seem more alive — literally more present, more talkative, more themselves. The transformation is not subtle.

I have also seen the other side. I know what the absence of this looks like. And I find it unconscionable that we, as a society, have constructed a care system in which clinical need is catered for, however

imperfectly, but social need — the need for company, for recognition, for the basic human experience of mattering to someone — is left almost entirely to chance.

The research I have presented in this paper is not new. The links between loneliness and mortality have been documented in the academic literature for decades. The World Health Organisation has called loneliness a 'global public health concern'. The US Surgeon General has issued an advisory describing it as an epidemic [6]. In the UK, we have a Minister for Loneliness and a national strategy. And yet the lived reality for millions of older people in this country has barely changed.

I do not think the answer to a problem this deeply human will come primarily from government strategy or NHS commissioning or national advocacy organisations. I think it will come from the accumulation of individual acts — of people with the time and the willingness to turn up, reliably and with genuine warmth, for someone who would otherwise be alone. And I think one of the most important things Carer Hub can do is make it easier to find those people, to trust those people, and to pay those people fairly for the profound service they provide.

This is the work. I am not under any illusion that it is simple, or that Carer Hub alone can make a meaningful dent in 3.83 million chronically lonely people. But we can start. We can reach the people we can reach. We can make companionship care an accessible, respected, professionally facilitated service for families across Merseyside, Greater Manchester, and beyond. And we can demonstrate, with every visit, that it works — that a person who is lonely can become less lonely, and that a person who has given up on life can be given a reason to stay in it.

That, in the end, is what this is for.

Dave Audley
CEO, Carer Hub
carerhub.co.uk | info@carerhub.co.uk
If this paper has resonated with you — whether you are a family seeking companionship care, a care worker who wants to provide it, or an organisation working in the loneliness space — I would very much like to hear from you.

References

All academic sources cited in this paper are peer-reviewed and publicly accessible. Where studies are available as open-access publications, the DOI or PubMed link is provided.

[1] COHO / Rust Tourism News. (2 September 2025). Loneliness and isolation: the number of people living alone has increased by 14%. Available at: rustourismnews.com. [Citing analysis of ONS single-person household data, UK loneliness prevalence data, and £32bn economic cost estimate.]

[2] Dehghani A. et al. (2025). The global prevalence and associated factors of loneliness in older adults: a systematic review and meta-analysis. Humanities and Social Sciences Communications. https://doi.org/10.1057/s41599-025-05304-x. [Finding: approximately 1 in 4 older adults worldwide reports loneliness.]

[3] Nakou A., Dragioti E. et al. (26 August 2025). Echoes of solitude: systematic review and meta-analysis revealing mortality risks in older adults due to loneliness, social isolation, and living alone. European Psychiatry. DOI: 10.1192/j.eurpsy.2025.1746. [86 studies; loneliness +14% mortality risk; social isolation +35%; living alone +21%.]

[4] Aartsen M., Vangen H. et al. (16 October 2024). The unique and synergistic effects of social isolation and loneliness on 20-years mortality risks in older men and women. Frontiers in Public Health. DOI: 10.3389/fpubh.2024.1432701. [NorLAG study; n=9,952; social isolation +16% mortality in women, +15% in men over 20 years.]

[5] Gao Q., Steptoe A., Fancourt D. (19 May 2025). Chronic loneliness and isolation phenotypes, incident functional impairment and mortality in England between 2004 and 2018. Nature Mental Health. DOI: 10.1038/s44220-025-00436-0. [English Longitudinal Study of Ageing; 14-year follow-up; chronic loneliness has significantly stronger mortality association than point-in-time loneliness.]

[6] US Surgeon General's Advisory. (2023). Our Epidemic of Loneliness and Isolation. US Department of Health and Human Services. [Citing Holt-Lunstad et al. meta-analysis comparing loneliness mortality risk to smoking 15 cigarettes per day.]

[7] Araújo L., Teixeira L. et al. (10 September 2021). To Live or Die: What to Wish at 100 Years and Older. Frontiers in Psychology. DOI: 10.3389/fpsyg.2021.726621. PMC8460866. [n=121 centenarians; 30.6% did not want to live longer; loneliness, disconnection, and loss of meaning were primary reasons.]

[8] Ward M., Briggs R., Kenny R.A. (21 August 2024). Social disconnection correlates of a 'Wish to Die' among a large community-dwelling cohort of older adults. Frontiers in Public Health. DOI: 10.3389/fpubh.2024.1436218. PMC11371793. [TILDA Irish Longitudinal Study on Ageing; social disconnection correlated with death ideation.]

[9] Hajek A., Zwar L. et al. (14 August 2025). Loneliness and isolation: Are they associated with the wish for an earlier end of life? Geriatrics and Gerontology International. DOI: 10.1111/ggi.70148. PMC12501667. [German Ageing Survey, wave 8; n=3,826; loneliness and isolation associated with lower desired age at death.]

[10] Van den Berg V.E., Thölking T.W. et al. (10 April 2023). Questioning the value of present life: The lived experience of older people who see no future for themselves. Aging and Mental Health. DOI: 10.1080/13607863.2023.2197850. PMC10578650. [34 qualitative interviews aged 55–92; 'losing zest for life'; four constituents including not sharing everyday life.]

[11] UK Parliament. (May 2025). Adult Social Care Reform report. Available at: parliament.uk. [Two million people aged 65+ not receiving care they need; 400,000 on waiting list.]

[12] Centre for Ageing Better. (2025). The State of Ageing 2025. Available at: ageing-better.org.uk. [Population aged 80+ to more than double by 2065, from 3.1 million to 6.3 million.]

[13] UK Government. (October 2018). A connected society: A strategy for tackling loneliness. Department for Digital, Culture, Media and Sport.

[14] NHS England. (2019). The NHS Long Term Plan. [Commitment to 900,000 social prescribing referrals by 2024.] Available at: england.nhs.uk

[15] National Academy for Social Prescribing. (2025). Combatting loneliness. Available at: socialprescribingacademy.org.uk

This paper is written in a personal capacity by the CEO of Carer Hub. It represents the author's views and analysis, drawing on peer-reviewed published research. It does not constitute medical or clinical advice. Carer Hub is an introductory platform connecting families with vetted, insured care workers across Merseyside and Greater Manchester. *© Carer Hub Ltd, 2026.*