Alone Together

Social Isolation & Wellbeing Among Canadian Seniors

Findings from the 2019/2020 Canadian Health Survey on Seniors (CHSS)

n = 41,550 respondents | Weighted population: 6.4 million Canadians aged 65+

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01 — THE SCALE OF LONELINESS

The Scale of Loneliness

How many Canadian seniors are lonely? Who are they? And what does loneliness actually feel like?

About 1 in 10 Canadian seniors are lonely — and another 1 in 3 report milder feelings of isolation

10.1%

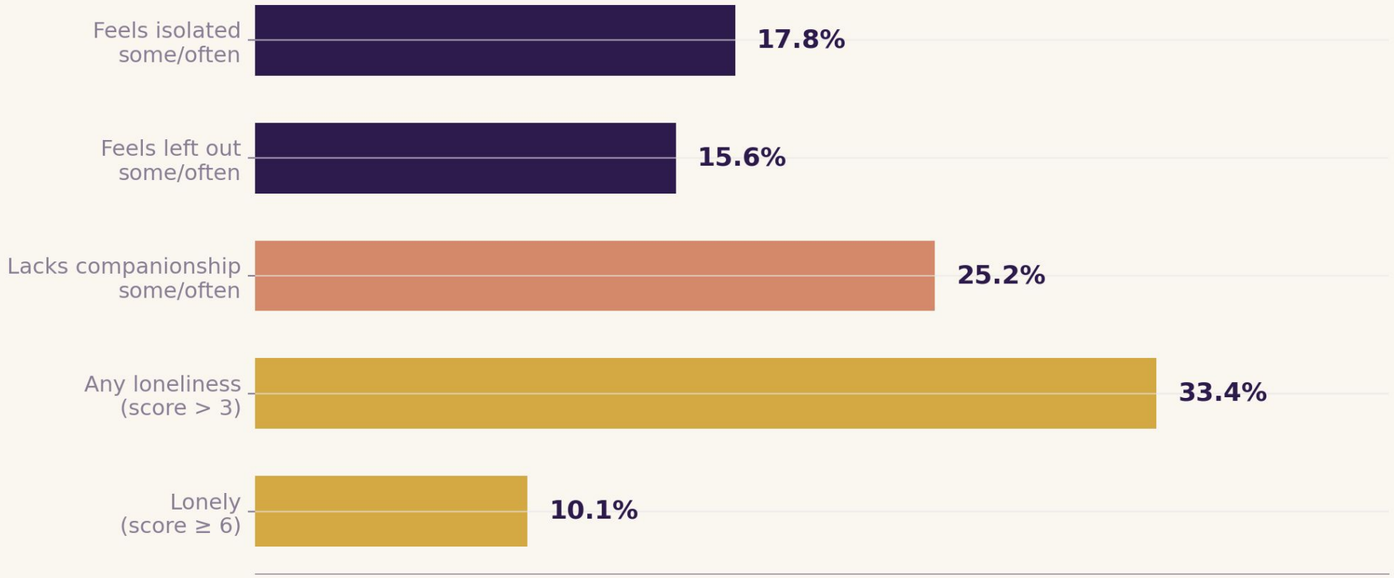
Lonely (Hughes score ≥ 6)
~597,000 seniors

33.4%

Any loneliness (score > 3)
~1,966,000 seniors

The single most-endorsed item is **"lacks companionship"** — a quarter of seniors say this happens at least some of the time.

"Feeling left out" is the least common, suggesting that what seniors experience is more often **the absence of someone** than the experience of active exclusion.

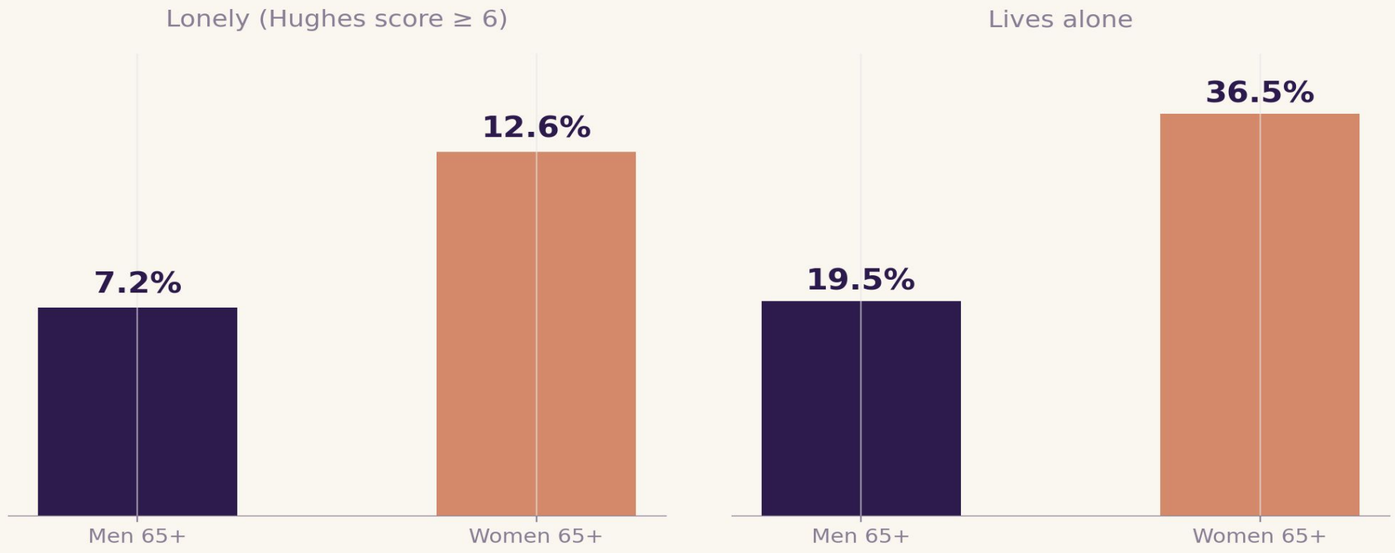


The five dimensions of loneliness show a spectrum from mild to severe.

Even among seniors who do not meet the clinical loneliness threshold, one in four lacks companionship at least some of the time.

Source: CHSS 2019/2020, Hughes 3-item Loneliness Scale

Women are 75% more likely than men to be lonely — but the gap is almost entirely structural



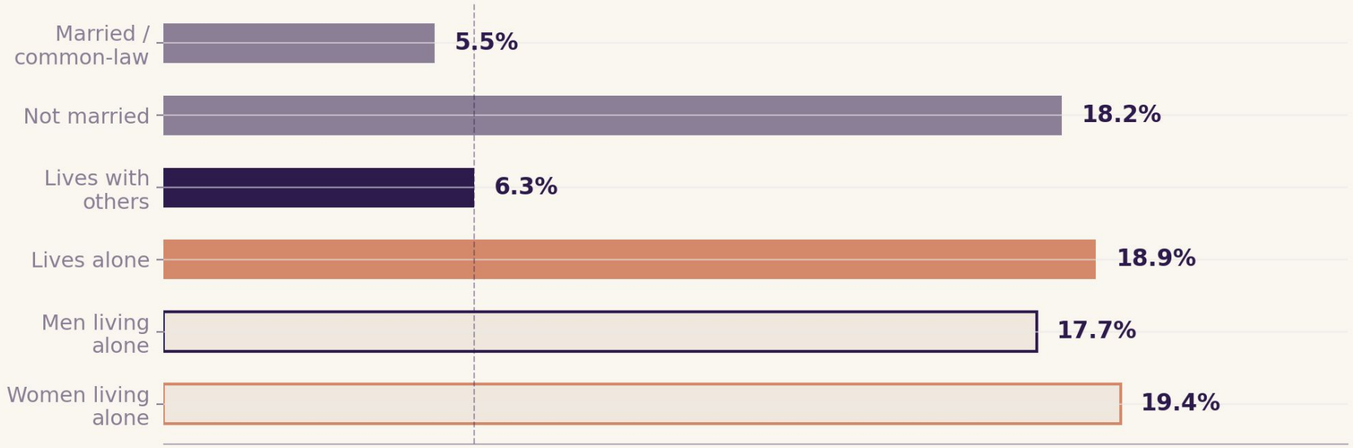
The structural driver:

Roughly **1.26 million** senior women live alone — over twice the count for men (582k).

This is a feature of senior demographics: **female longevity and widowhood**, not a psychological sex difference.

The 5.4-percentage-point loneliness gap collapses once living arrangement is controlled.

Living alone is the strongest predictor of loneliness — 3× more likely than living with others



Once you **condition on living alone**, the men/women gap collapses to under two percentage points:

Men living alone: 17.7%

Women living alone: 19.4%

The disparity in the gender gap is **structural, not psychological**. Living arrangement is the proximate cause.

Married/lives-with-others: 5.3–6.3% lonely. Lives alone: 18.9% lonely.

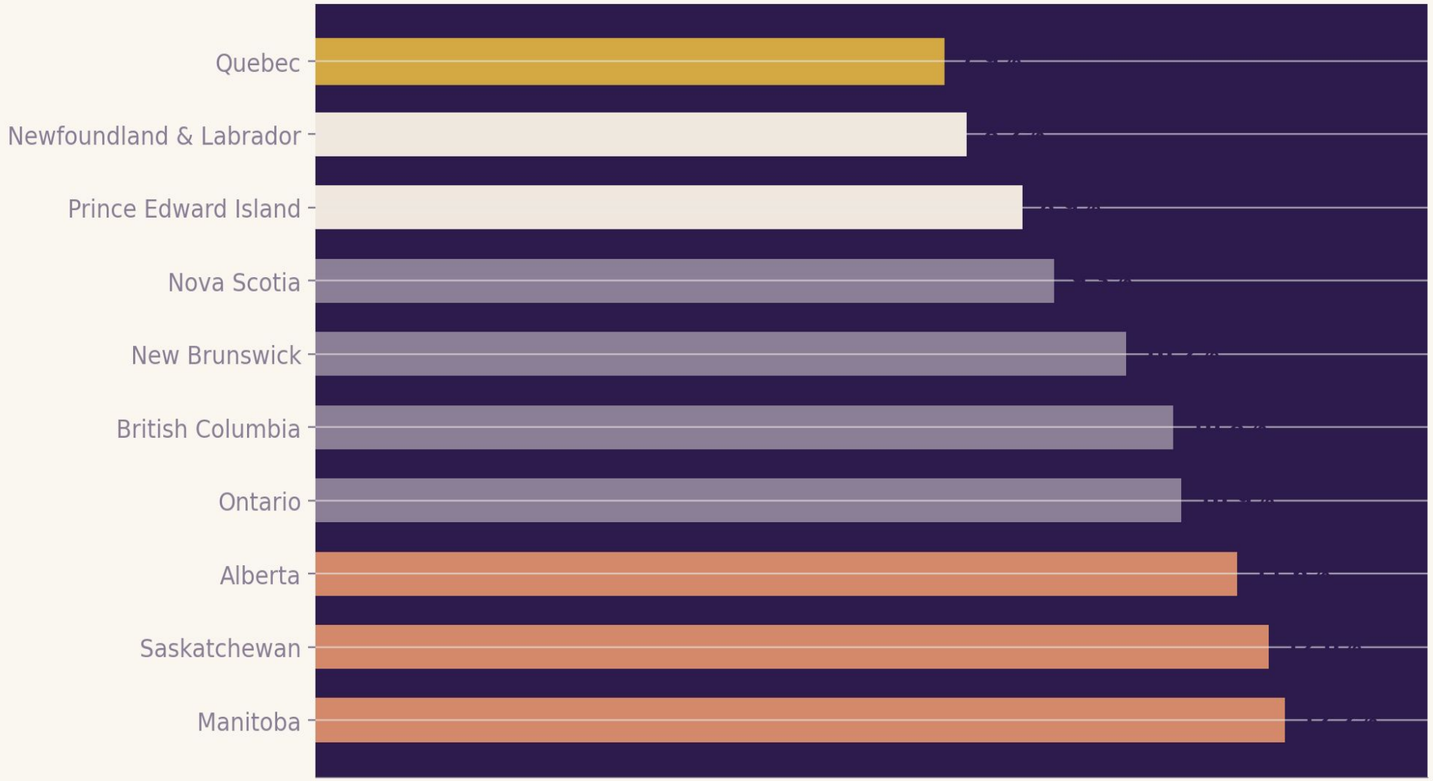
What seniors experience is more often the absence of someone than the experience of active exclusion.

02 — WHERE LONELINESS LIVES

Where Loneliness Lives

Geography, income, and the compounding of risk factors

Provincial loneliness is highest in the Prairies and lowest in Quebec — a 4.3 percentage point gap



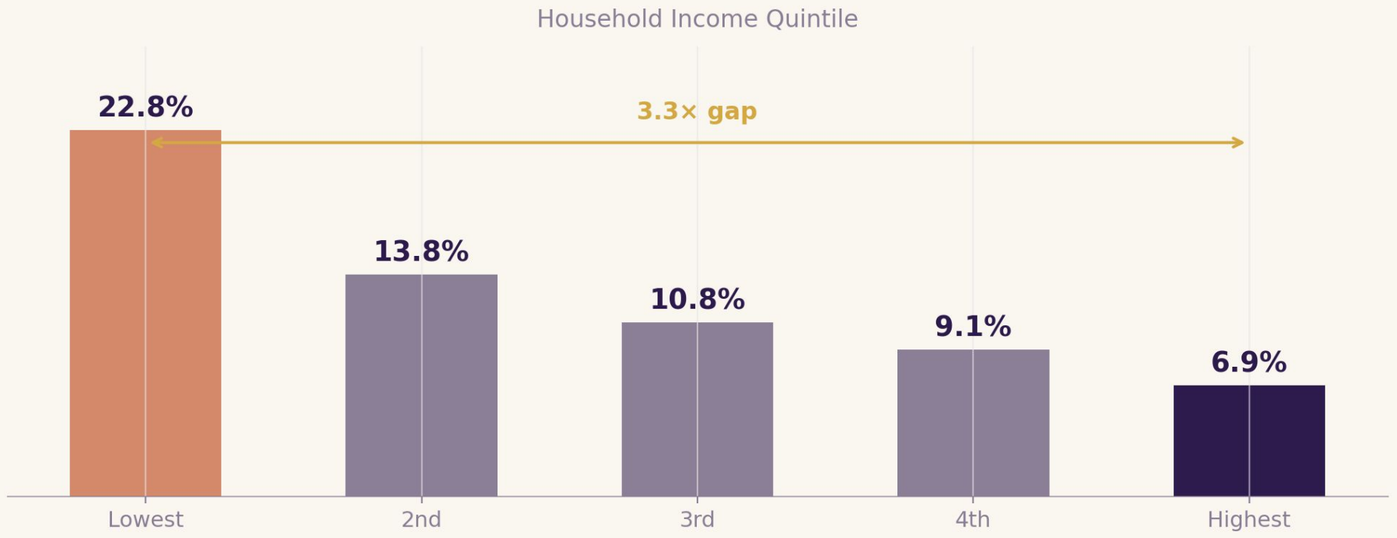
Manitoba and Saskatchewan have loneliness rates **~50% higher than Quebec**.

The QC–MB gap of 4.3 points clears any reasonable confidence interval.

Quebec's documented "social capital" effect — denser social networks and stronger community institutions — may partially explain the lower rate, although the CHSS does not measure social capital directly.

All estimates OK quality (CV < 15%).

Lowest-income seniors are 3.3× as likely to be lonely as highest-income seniors



A **clean monotonic gradient**: loneliness falls steadily as income rises.

The lowest-income quintile is also disproportionately women living alone — but even so, **22.8% loneliness in the bottom quintile is striking**.

This suggests income operates both as a **structural constraint** (limiting housing, transport, activity options) and as a **psychosocial stressor**.

Household income quintile (INCDGHH), CHSS 2019/2020

Stacking risk factors pushes loneliness rates to nearly 30% — six times the rate of married seniors

Risk Profile	Lonely rate	Multiple
Married + lives with others	5.3%	1.0×
Lives alone (any)	18.9%	3.6×
Lives alone + lowest income quintile	25.2%	4.8×
Lives alone + no driver's licence	23.1%	4.4×
Lives alone + no Internet	18.7%	3.5×
Lives alone + poor/fair self-rated health	29.7%	5.6×

Key insight: Living alone with poor health pushes loneliness to **nearly 30%**.

Notably, **not having Internet barely compounds risk** beyond living alone alone (18.7% vs 18.9%).

This suggests digital access is not the binding constraint for most lonely seniors — health, income, and mobility are.

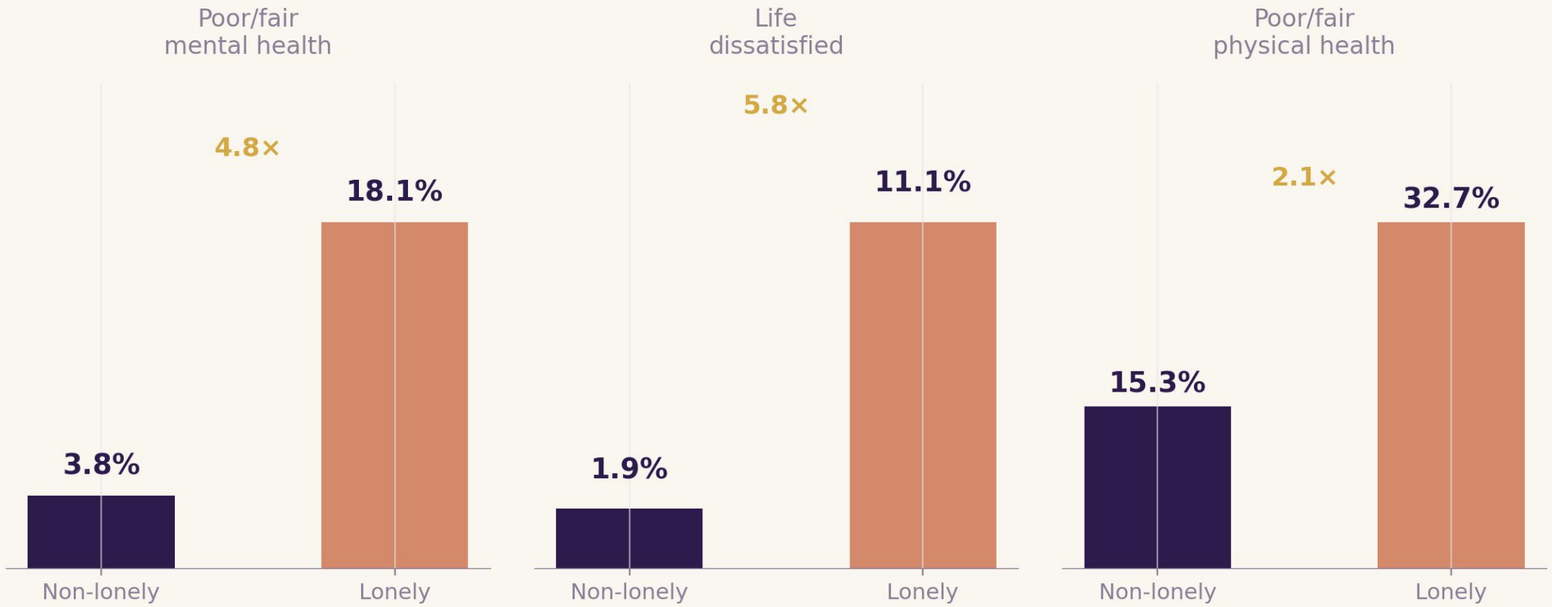
All profiles weighted by WTS_CM. CV range 3.5–8.9%.

"The QC–MB gap of 4.3 percentage points clears any reasonable confidence interval."

The Body & Mind Toll

Loneliness doesn't just feel bad — it correlates with dramatically worse mental health, sleep, falls, and stress

Lonely seniors are **4.8×** as likely to report poor mental health and **5.8×** as likely to be dissatisfied with life

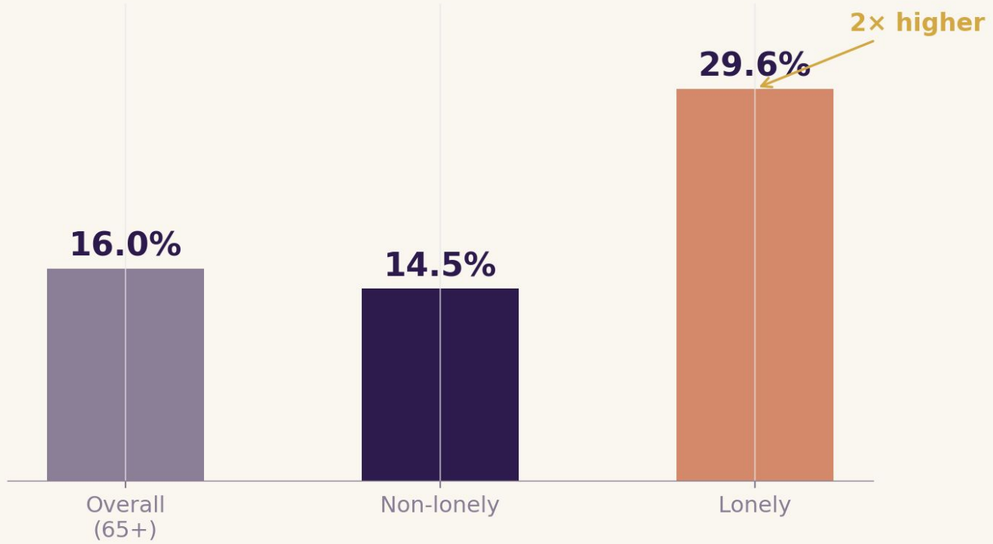


This is one of the **strongest cross-correlations** in the entire CHSS file. The co-occurrence is striking regardless of causal direction.

Because the CHSS is **cross-sectional**, we cannot determine whether loneliness causes poor health, poor health causes loneliness, or both share a common cause. But the public-health implication of co-occurrence is the same regardless: **interventions must treat loneliness and health as intertwined**.

Self-rated mental health, life satisfaction, and self-rated physical health. CHSS 2019/2020.

Lonely seniors are roughly **twice** as likely to have **frequent sleep trouble** — and sleep may be an actionable target



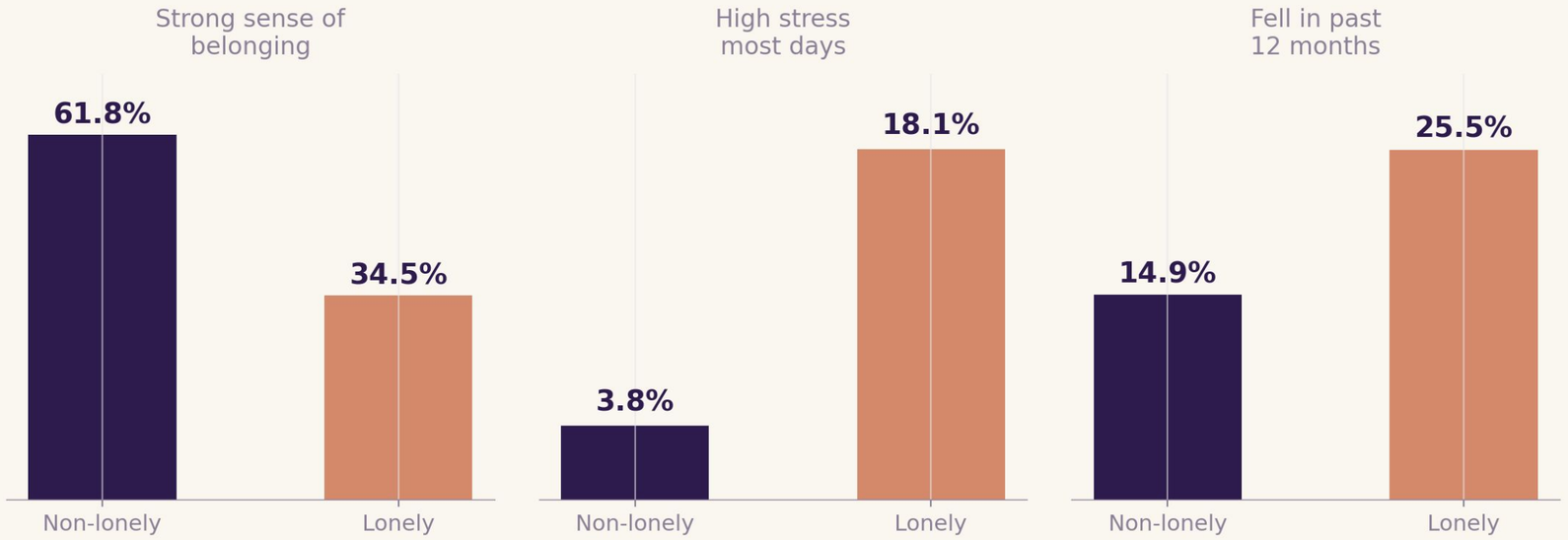
29.6% of lonely seniors report trouble sleeping most or all of the time, versus **14.5%** of non-lonely seniors.

Sleep trouble is itself a strong correlate of poor mental health: among seniors with frequent sleep trouble, **11.8%** report poor/fair mental health vs **4.0%** among those who sleep well — a 3× difference.

This makes **sleep quality** a potentially actionable proximal target: improving sleep may improve mental health, which may reduce loneliness — or vice versa.

Sleep trouble measure: "most or all of the time." CHSS 2019/2020.

Lonely seniors fall more, fear falling more, and report half the sense of belonging of their peers



Fear of falling affects 1 in 3 seniors (33.4%).

Women's rate is **1.5×** men's: 40.0% vs 25.9%.

Lonely seniors fell at **25.5%** vs 14.9% for non-lonely — a large empirical association.

Sense of belonging is the mirror of loneliness:

Non-lonely: 61.8% | Lonely: 34.5%

High stress: **18.1%** among lonely vs 3.8% among non-lonely — a **4.8×** difference.

Loneliness is, at heart, a **belonging problem**.

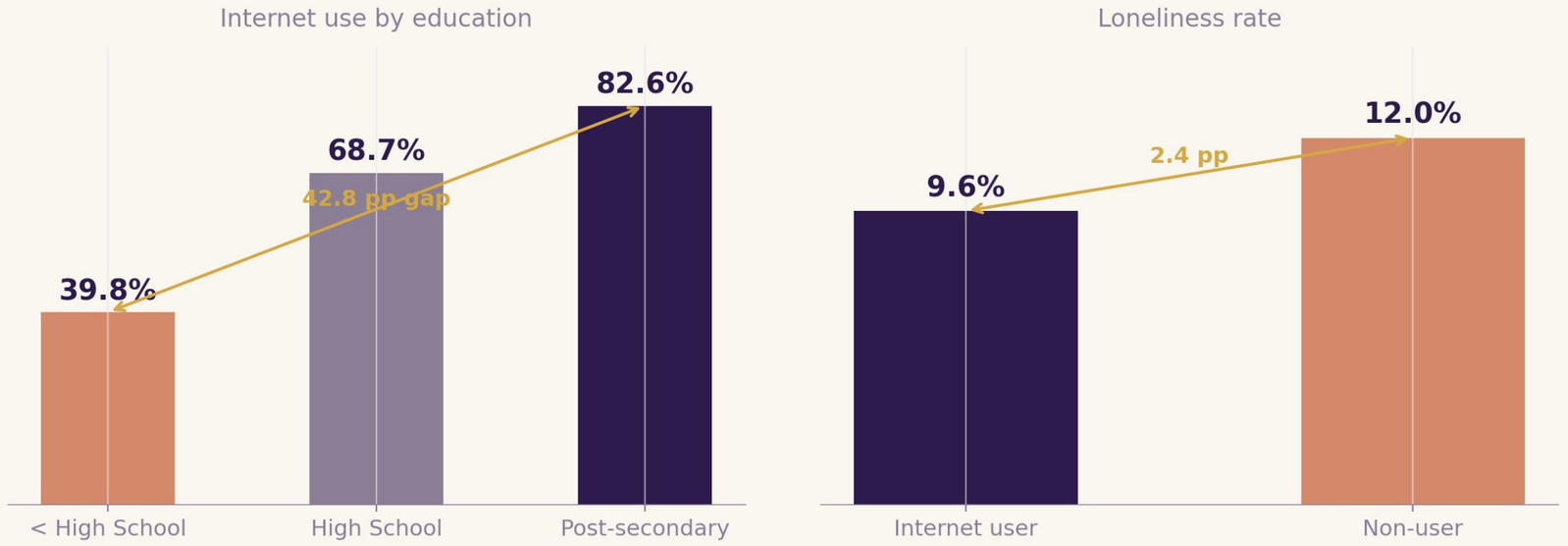
"Loneliness is, at heart, a belonging problem."

04 — MYTHS & PARADOXES

Myths & Paradoxes

What the data reveals about common assumptions — and why some truths are counterintuitive

Internet access is necessary but not sufficient — the digital divide is an equity issue, not a loneliness cure



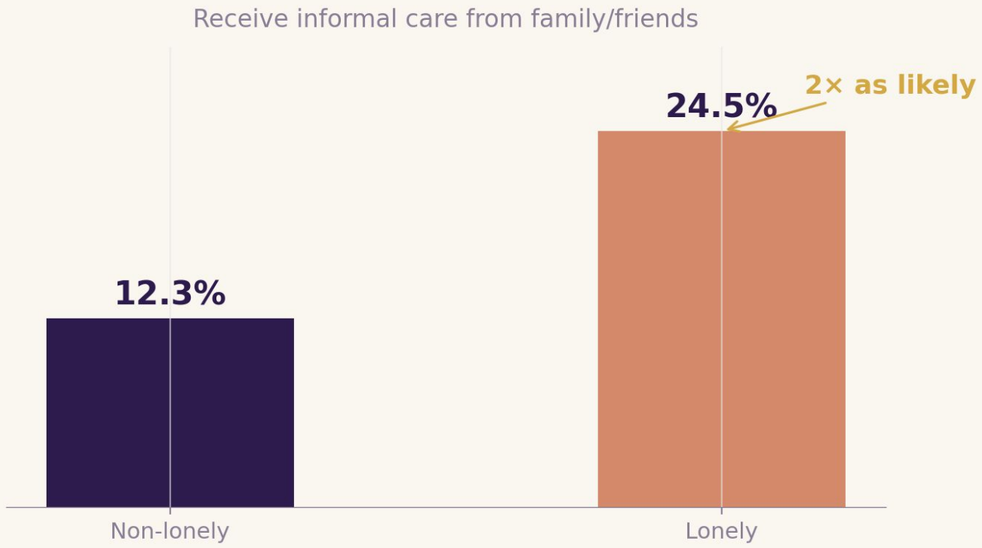
The **educational gap** in Internet use is enormous: **42.8 percentage points** between those with less than high school and those with post-secondary education — far larger than any sex, income, or geographic gap in this dataset.

Yet Internet use is associated with only a **2.4-pp lower loneliness rate** (9.6% vs 12.0%). Once you factor in selection effects — healthier, more-educated, more-partnered seniors are also more likely to go online — the protective effect probably shrinks further.

This is a useful counterweight to "give grandma a tablet" rhetoric: **digital access is equity, not a loneliness intervention**.

Internet use: CHSS variable. Post-secondary includes college, university, trades. Selection effects discussed in Insight 12.

Lonely seniors receive twice as much informal care — yet remain lonely, revealing a care-quality gap



Two non-exclusive readings:

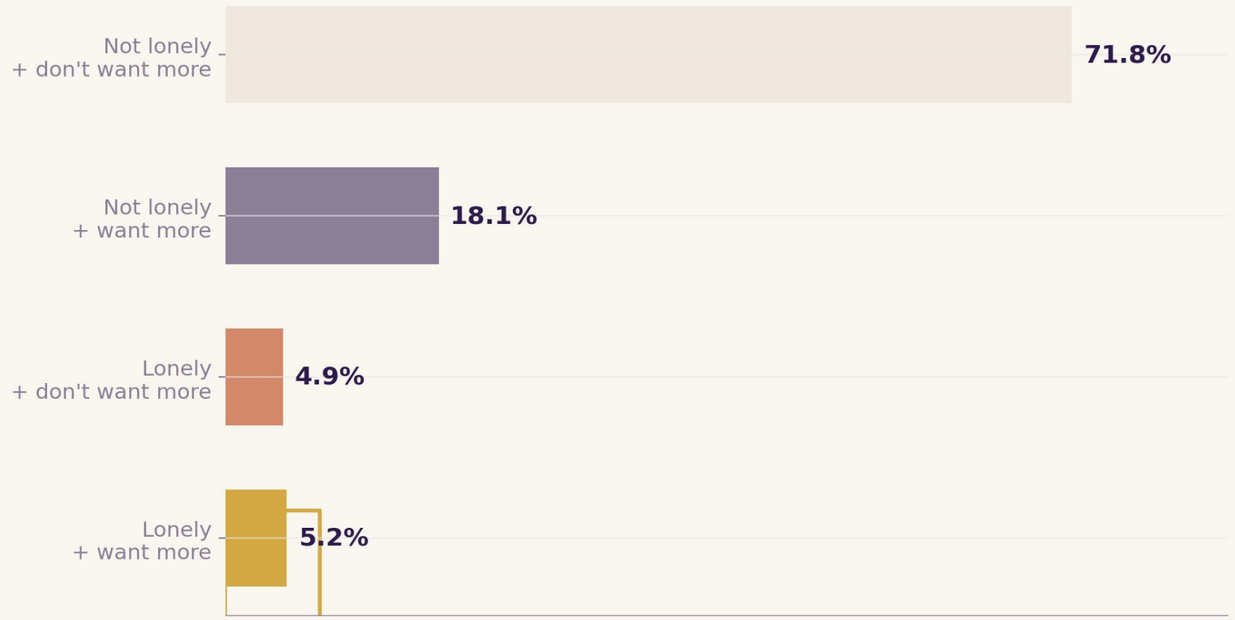
1. **Receiving care correlates with declining health** and dependency, which are themselves loneliness risks.

2. The kind of contact involved in *being helped* (instrumental, task-focused) **does not deliver the relational quality that prevents loneliness**.

This is consistent with the broader literature distinguishing **functional support** from **emotional connection**.

Informal care: help from family/friends with daily tasks. CHSS 2019/2020.

Half of lonely seniors do not want more social activity — the "lonely but not seeking" group is 290,000 people



Of the **597,000** lonely seniors, about **290,000** did **not** report wanting more social activity in the past 12 months.

This group is the **hardest to reach** with conventional outreach:

- Not on waiting lists
- Not asking for programs
- Many may have internalized social withdrawal as a feature of aging

Programs that simply offer more activities will reach **at most half** of the lonely population.

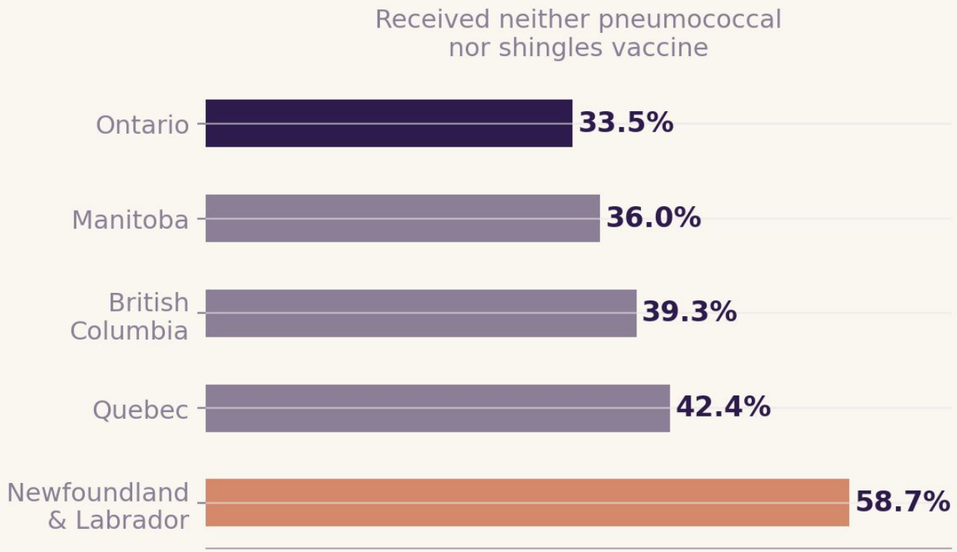
Question: "Wanted to participate in more social, recreational, or group activities." CHSS 2019/2020.

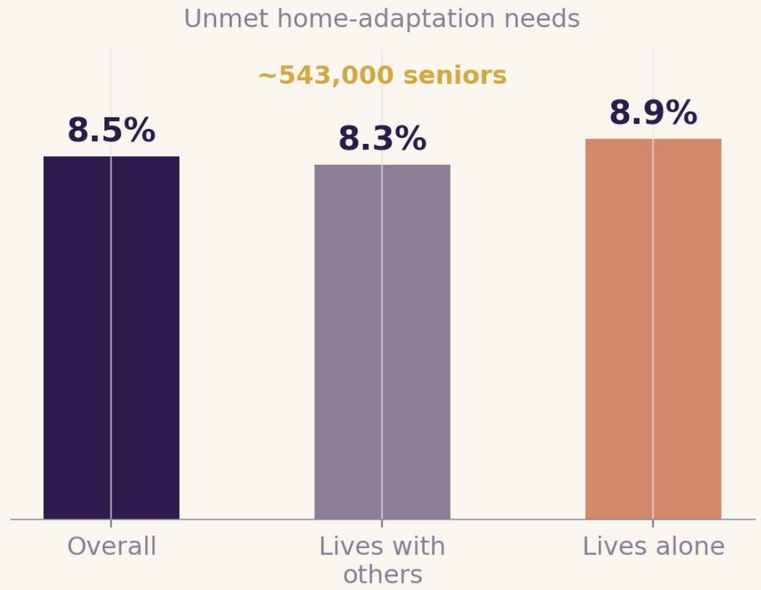
Programs that simply offer more activities will reach at most half of the lonely population.

Policy Gaps & Action

Two non-loneliness-specific gaps that matter deeply for senior wellbeing

Provincial vaccination disparity leaves 25 percentage points between Newfoundland and Ontario





Vaccination: The NL–ON gap of **25 percentage points** (58.7% vs 33.5% received neither pneumococcal nor shingles vaccine) is a striking signal of provincial program design and reimbursement policy impact. Loneliness does **not** materially predict vaccine non-receipt.

Home adaptation: 8.5% of seniors (~543,000) have unmet home-adaptation needs — surprisingly flat across living arrangements. This suggests the barrier is not inability to *recognize* need (which might be worse for those alone) but inability to **finance or arrange** the work.

Vaccination: neither pneumococcal nor shingles received. Home adaptation: unmet need for aids/modifications. CHSS 2019/2020.

What This Means

01 **Loneliness clusters** in women, living alone, lower income, poorer health, no licence, Prairies. In combination, prevalence pushes to ~30%.

02 **Mental, physical, and behavioural correlates** are large and consistent. Loneliness is not "just feeling blue" — it is tightly coupled to measurable health outcomes.

03 **Activity-based interventions reach at most half** the lonely population. Quality-of-relationship and re-engagement strategies are needed alongside opportunity-creation.

04 **Internet access is necessary but not sufficient.** The digital divide is an equity issue (42.8-pp educational gap), but tablets alone will not materially shift loneliness.

05 **Two parallel policy gaps:** a 25-pp provincial vaccination disparity (NL–ON) and ~543,000 seniors with unmet home-adaptation needs.

Methodology & Technical Notes

Source: CHSS 2019/2020 Public Use Microdata File (PUMF), pumf_chss.csv. n = 41,550 respondents representing a weighted population of 6,435,765 Canadians aged 65+ living in the ten provinces.

Weighting: All point estimates use survey weight WTS_CM. Unweighted counts reported alongside for transparency.

Sampling variability: PUMF lacks bootstrap weights. CVs approximated from Kish-effective-sample-size formula with design effect 1.5, broadly consistent with CHSS User Guide Table 10.1. Spot-checks against published lookup tables agree within ~0.5pp. Treat all CV figures as approximate.

Quality flags: OK = CV < 15% (releasable); E = 15–35% (use with caution); F = >35% or n_num < 10 (suppressed). Every estimate in this report is OK unless flagged.

COVID caveat: 2020 collection was disrupted (in-person interviews suspended; response rate fell to 41% on CCHS, 90.8% on CHSS supplement). Non-response weighting adjustments mitigate but do not eliminate potential bias. Comparisons across provinces or sub-groups carry elevated risk of residual bias.

Loneliness measure: Hughes 3-item Loneliness Scale (LON_01–LON_03, derived LONDVSCR, range 3–9). Lonely = score ≥ 6 (conventional dichotomization); any loneliness = score > 3.

Age: PUMF collapses age to 65+; no age-band breakdowns possible.

Causality: All correlations are cross-sectional. Associations between loneliness and health outcomes do not establish direction.

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