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# Ageing with chronic conditions and older persons' experience of social connections: a qualitative descriptive study

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## ABSTRACT

**Background.** Chronic conditions may limit older peoples' social engagement and wellbeing. Reduced social connections can result in loneliness and social isolation. This study aimed to explore the experience of social connection in older people living with chronic conditions, and the factors influencing their social participation. **Methods.** A purposive sample of 19 community-dwelling older Australians (mean age 75.5 years) with one or more chronic conditions participated in a qualitative descriptive study. Semi-structured interviews explored participants' perceptions of their social connections and the potential impact of their chronic conditions. Views about the role of general practice in supporting older persons' wellbeing were discussed. Data were analysed inductively using thematic analysis. **Results.** Five themes were identified: (1) the experience of loneliness, (2) managing diminishing social contacts, (3) living with chronic conditions, (4) barriers to social connection, and (5) facilitators of social connection. Participants felt that ageing with chronic conditions contributed to loss of function and independence, which limited social connections, and increased loneliness and social isolation. Barriers to social connections included issues with mobility, transport and forming new networks. Families were a primary support, with continued community engagement and general practice support crucial to staying well and socially connected. **Conclusions.** Understanding older peoples' experiences, and the barriers and facilitators of social connections can guide clinicians' interventions. General practice is a promising intervention point because of its high use by those with chronic conditions to stay well. General practice nurses are well-placed to collaboratively address the barriers older people face in maintaining social connections.

**Keywords:** chronic conditions, general practice, nursing, loneliness, older adults, qualitative, social connection, social isolation.

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## Introduction

The global population is increasingly ageing (World Health Organization 2021). Ageing is a predisposing factor for chronic conditions, and older people are more likely to experience multiple chronic conditions (Maresova *et al.* 2019). Physical and psychological limitations associated with chronic conditions reduce older peoples' independence in activities of daily living, and ability to engage in community and social life (Maresova *et al.* 2019). Social networks are crucial for older people who draw on the social capital embedded within them for social support (Forsman *et al.* 2013). However, older adults face physical, psychological and environmental obstacles to maintaining social networks (Forsman *et al.* 2013).

Reduced social connections can result in loneliness and social isolation (Holt-Lunstad *et al.* 2017). Although loneliness and social isolation are related, they are conceptually distinct. Social connection is an umbrella term that reflects the '... structural, functional, and qualitative aspects of social relationships' (Holt-Lunstad *et al.* 2017, p. 518). Loneliness is the subjective feeling of being lonely or isolated, and is the difference between the desired and actual level of social connection (National Academies of Sciences Engineering and Medicine 2020). Social isolation refers to limited social relationships or irregular social contact (National Academies of Sciences Engineering and Medicine 2020). Globally, loneliness and social isolation affects many older people (World Health Organization 2021).

In Australia, social isolation has been estimated to affect as many as one in five older people (Beer *et al.* 2016).

Multiple risk factors influence older peoples' capacity for social participation, with health status being a major influence (Holt-Lunstad 2017; Shi *et al.* 2023). Lonely older people visit the doctor more frequently than those who are not lonely, and multimorbidity in older people drives primary care use (Gerst-Emerson and Jayawardhana 2015). Older people develop trust and confidence in their general practice, especially if they have an ongoing relationship (Veazie *et al.* 2019). Given the significant role of general practice in managing chronic conditions, this setting offers promising opportunities for interventions aimed at strengthening the social connections of older people (Galvez-Hernandez *et al.* 2022). However, despite this, many lonely and socially isolated older people struggle to have their social needs met, and general practice teams require evidence to guide best practice interventions (Halcomb *et al.* 2022).

Shi *et al.* (2023) found that older people ageing at home with chronic conditions have limited social connections, and further research is needed about how chronic conditions influence this. Taube *et al.* (2016) used the expression 'being in a bubble' to explain the experience of frail community-dwelling older people and the barriers they encounter to social engagement. Additionally, Kharicha *et al.* (2017) found lonely community-dwelling older people had concerns about the stigma associated with identifying as lonely, and doubts that general practice had the skills to assist. Given the prevalence of chronic conditions in older people (Maresova *et al.* 2019), and the health risks of loneliness and social isolation (Holt-Lunstad *et al.* 2017), there is potential for improved care.

This study aimed to explore the experience of social connection in older people living with chronic conditions and the factors influencing their social participation. Uncovering consumers' perceptions and experiences will inform future interventions.

## Methods

### Study design

A qualitative descriptive approach was used, as it supports a comprehensive understanding of the experience of social connections of older people with chronic conditions. This design allows the researcher to remain close to participants' words, and describe the human context of their experience (Kim *et al.* 2017). Qualitative description generates data directly from participants about health issues, so is highly useful in informing intervention design (Kim *et al.* 2017).

### Participants and setting

Participants were drawn from the 'Connecting Care in the Community' (Connecting Care) program delivered within the Southeastern New South Wales (NSW) Primary Health Network, Australia. Connecting Care is a free nurse-led service for community-dwelling older people (aged ≥60 years) with one or more targeted chronic conditions, including chronic obstructive pulmonary disease, hypertension, ischaemic heart disease, congestive cardiac failure or diabetes (Lucas *et al.* 2017). Health professionals could refer to the program or people could self-refer. The study was undertaken, as registered nurse (RN) program leaders identified that many participants raised their reduced social connections, and resulting loneliness and social isolation during program consultations.

The Primary Health Network extends along the south-east coast of NSW, and participants were drawn from three Local Government Areas in the region's north. The population aged ≥65 years ranged from 17.8% to 27.3% across these Local Government Areas (Ghosh 2019). The region encompassed urbanised zones, coastal hamlets and rural communities (Ghosh 2019).

### Recruitment

Participants were recruited from an initial survey that explored the impact of older peoples' chronic conditions on maintaining social connections (Halcomb *et al.* 2022). Survey participants were enrolled in the Connecting Care program, English-speaking and capable of providing informed consent. At survey completion, respondents could indicate interest in participating in an interview.

A purposive sample was drawn from interested survey respondents chosen to ensure variation across age, sex, chronic conditions and geography. Selected respondents were contacted by one of three female Connecting Care RNs. These RNs had qualitative research experience and were research team members. They explained the study, screened the person for eligibility and provided study materials. If the person was eligible and agreed, an interview time was arranged.

### Data collection

Semi-structured interviews were conducted by the three RNs in February 2021 predominantly within the older person's home. The interview schedule was developed by the researchers (RNs and nurse academics) after reviewing survey findings (Halcomb *et al.* 2022). Demographic questions about age, sex and chronic conditions were included. Open-ended questions were designed to elicit participants' perceptions of their social connections and the potential impact of their chronic conditions on social participation. Views about the role of general practice in supporting social participation were discussed. For example, questions included: 'How would you describe your social network?' and 'Can you tell me what if any changes have occurred in your social life and connections since you developed your chronic health issues?' As the COVID-19 pandemic had just emerged, issues relating to COVID-19 were explored. Field notes were documented after each

interview. Interview progress was regularly discussed by the research team, and interviews were ceased when no new data were emerging. All interviews were audio-recorded and transcribed verbatim by a transcription company before being imported into NVivo (ver. 12).

### Data analysis

An inductive approach of reflexive thematic analysis was used for data analysis (Braun and Clarke 2022). Transcripts were reviewed against the recordings by one researcher (CT) to check accuracy and ensure data familiarisation. Preliminary codes were generated. Coding was examined by all team members with a clear audit trail developed. Codes were combined into themes with analytic memos documented as a form of reflexive journaling to assist with the further identification of patterns and theme development (Braun and Clarke 2022). Themes were then reviewed against the coded extracts before consensus was reached on the final thematic structure. The research team met frequently to explore inherent biases and support confirmability (Lincoln and Guba 1985). Results were written up using participant quotations to illustrate the findings.

### Ethical considerations

Approval for this study was provided by the University of Wollongong Human Research Ethics Committee (Approval Number 2020/373). Pseudonyms are used for confidentiality.

## Results

Of the 19 participants, 57.9% ($n$ = 11) were male (Table 1), and the mean age was 75.5 years (range 63–92 years). All participants, but the youngest, had multiple chronic conditions. The most common conditions were chronic obstructive pulmonary disease ($n$ = 16, 84.2%), ischaemic heart disease ($n$ = 11, 57.9%), hypertension ($n$ = 9, 47.4%), arthritis ($n$ = 9, 47.4%) and depression/anxiety ($n$ = 8, 42.1%).

The findings are described through five themes: (1) the experience of loneliness, (2) managing diminishing social contacts, (3) living with chronic conditions, (4) barriers to social connection, and (5) facilitators of social connections.

### The experience of loneliness

Loneliness was frequently described as an inevitable part of ageing, 'you just get to live with it' (Harry). For some, loneliness resulted from the death of their spouse/partner, and for others, because their spouse/partner had moved into residential care, 'Lonely? Yes, since my wife's been placed' (Walter).

> ... occasionally I will get the lonelys real bad, and then I've got to shake my head and say oh well, that's life, and just move on and get used to, really, being on my own. (Sergio)

> ... it is a bit lonely when you're on your own and that because you haven't got your partner with you, and things like this and that. You constantly think about it ... (Walter)

Several participants described the challenges of living alone and spoke of loneliness being more acute, 'mainly of a nighttime, when it comes around teatime' (Sally), 'it's night times that are worse ...' (Sophia).

Participants still living with their spouse/partner identified this person as their primary source of emotional and often practical support.

> I live with my wife here ... my wife does a lot of the work, and everything ... Yeah, we both support each other. (Silas)

> My husband's been wonderful, as he'll tell you. I've been very lucky because I mean, anyone that didn't have a supportive husband, I don't know – it would have been really hard for them. But, no, he's been very supportive. He's well trained. (Wilma)

Loneliness had a negative effect on participants' emotional wellbeing, with some experiencing depression. For some this depression was directly linked to their chronic conditions.

> ... when I'm feeling really bad I just go to bed, and I may be there for two days ... But that's what happens when me legs start going on me, and this – lung business. (Hubert)

Some participants identified that their personal resilience helped them to deal with loneliness: 'You bounce back. You go down, and you bounce back. That's just life, yeah' (Wanda). However, others preferred not to dwell on their situation: 'I try not to think about it. Truly, I just get along with my life and try not to think about it' (Sally).

### Managing diminishing social contacts

Reduced social networks and limited social interaction led to social isolation. Participants predominantly identified friends and neighbours as important social networks, whereas families were key sources of social support. One participant stated that their 'social network is deteriorating rapidly, because my neighbours are leaving this world' (Sergio), and others described how 'a lot of them [friends] are dead' (Herman), 'we haven't got any friends whatsoever' (Hubert). Old friendships were valued, and participants spoke of enduring relationships forged at different life stages.

**Table 1.** Participant characteristics.

| Pseudonym | Age | Location descriptor[A] | Sex | Living alone | Conditions |
|---|---|---|---|---|---|
| Hubert | 84 | Major city | Male | No | Chronic obstructive pulmonary disease (COPD), ischaemic heart disease (IHD), hypertension, arthritis, depression, anxiety |
| Wendy | 70 | Major city | Female | Yes | COPD, IHD, depression, anxiety |
| Walter | 75 | Major city | Male | Yes | COPD, IHD, diabetes, depression |
| Winifred | 74 | Major city | Female | Yes | COPD, Parkinson's disease, arthritis, depression |
| Herman | 72 | Major city | Male | Yes | IHD, hypertension |
| Wayne | 69 | Major city | Male | No | COPD, IHD, hypertension, arthritis, diabetes, depression, anxiety |
| Wilma | 67 | Major city | Female | No | IHD, hypertension, cancer |
| Wade | 81 | Major city | Male | No | COPD, IHD, hypertension, arthritis |
| Wanda | 79 | Major city | Female | Yes | COPD, IHD, arthritis |
| William | 72 | Major city | Male | Yes | IHD, hypertension, arthritis, depression, anxiety |
| Sarah | 74 | Inner regional | Female | No | COPD, arthritis |
| Silas | 74 | Inner regional | Male | No | COPD, hypertension, arthritis |
| Samuel | 63 | Inner regional | Male | Yes | COPD |
| Seamus | 86 | Inner regional | Male | Yes | COPD, Parkinson's Disease |
| Sally | 76 | Inner regional | Female | Yes | COPD, hypertension |
| Stanley | 71 | Inner regional | Male | No | COPD, depression, anxiety |
| Selma | 73 | Inner regional | Female | No | COPD, chronic pain |
| Sergio | 83 | Inner regional | Male | Yes | COPD, IHD, hypertension |
| Sophia | 92 | Inner regional | Female | Yes | COPD, IHD, arthritis, depression, anxiety |

[A]Australian Statistical Geography Standard (Australian Bureau of Statistics 2021).

> On Wednesdays, I go and have a coffee with all my old football mates … We were going around to each other's houses, but now we just go down to the bottom of the hill, and have coffee … That's wonderful. Unfortunately, we'd lost two of them in the last three months, dying, you know. (Wayne)

For some, social isolation was reduced by maintaining contact with friends through letter writing or social media.

> There's a girlfriend I've had since age 15. And she is in [location], we had our first job together, our birthdays are in the same month … and so I just wrote her a letter and posted a card off to her yesterday and she sends to me. (Winifred)

> I've got a couple of mates and they tell me what's going on, because they're on social media, so they let me know who's alive and who's dead, and stuff like that. (William)

COVID-19 limited participants' interactions significantly due to cessation of usual activities and fear about participants or their family perceptions of increased risk of death should infection occur, 'Oh my husband – again, he was always scared with COVID if I went out I'd get it, and be gone' (Selma). As interaction with friends and family was minimised, contact with neighbours became especially important.

> … I had the neighbours, we'd sit out the front and have a bit of a chat, so we always had somebody to talk to – which was lovely. We didn't go inside so much, but we'd sit there and have a bit of a chat and be like, well, I've talked to somebody today, and that was good … Yes, and we all were in the same boat. (Wanda)

The pandemic highlighted the loneliness and social isolation of older people more broadly. Some participants felt that the pandemic 'normalised' their lack of social interactions.

## Living with chronic conditions

Chronic conditions resulted in changes in physical capacity, levels of independence and sense of identity that reduced participants' ability to maintain social connections, which increased loneliness and/or social isolation. For most participants, getting older was not a positive experience, and their chronic conditions amplified the negative aspects of ageing, with frustration arising from their physical limitations.

> It sucks. You just can't do what you want to do (Sophia).

I just get frustrated ... I can't do some of the simple things. Or some of the simple things I do take twice as long, if not longer ... Like I used to be able to go out and mow the lawn. Now I get somebody to mow my front lawn. (Stanley)

It's a slow, inevitable death knell, which you have to battle – you have to battle it every day. What you have to say to yourself is, 'I'm crook, but I'm here'. When I first get up in the morning, I can hardly walk. (Seamus)

Participants spoke extensively about the impact of chronic conditions, and how loss of function and independence exacerbated loneliness through diminished social connection. Indeed presenting symptoms and tiring quickly affected their ability to go out.

If I'm feeling up to it, I can get in the car and drive down to the shop. I wouldn't shop-shop, because I couldn't carry it ... I know when I'm getting tired ... and standing in the one spot – I don't know why – after a while my legs are going to jelly, and I'm thinking – I say, 'I've got to go'. And I feel awful. (Selma)

... because I was always sort of short of breath, I never really wanted to ... I stopped going shopping. My husband got the job for that. So I didn't go out very much. (Wilma)

Participants declined social opportunities if they were worried about appearing unwell. 'Sometimes I get a bit embarrassed about being so breathless when I'm with my friends' (Sally). This meant that most participants shifted from their previous active life to a more sedentary life, which reduced engagement in social activities and limited social interaction.

... I used to be active. I used to be able to do things and ... you know, I used to be able to go camping and everything else. But that's all changed in life and that now, so, you know. (Silas)

The only thing that frustrates me, which I never used to do, I never ever turned the TV on until about five o'clock, I'm not a sit down to watch TV or a movie person and I never used to sit down, I was always cleaning out a cupboard or doing something, but now I just sit most of the time, unless I can motivate myself. (Winifred)

Several participants spoke about how the time required to manage their health impacted on social activities. They also spoke about the compounding effects of multimorbidity and how exacerbations reduced their participation capacity.

Well, I've got a full book anyway now with people coming round. I've got another appointment with – the heart people sort of send people around ... I've got an appointment with my heart doctor next week ... (William)

[The GP is] becoming a pain; he wants me down there every week or so. I don't want to play every week. (Herman)

The consequences of ageing with chronic conditions were described by participants as a life of diminished independence, identity and self-confidence. 'I don't think I can do anything now, I've got so weak, my body's gone weak' (William). Participants contrasted their mental image of themselves with the reality of their older body.

Yeah, well, I am a young old person. I don't feel old ... and I don't think I have old views ... just my health restricts me a fair bit, that's all. (Sergio)

For others, this loss of independence and identity was sharply illustrated when it was suggested they move in with their adult child, as they were no longer capable of living on their own, with the fear expressed: '... You become, "This is my father. He sits on his arse and does nothing" ... my identity's gone into the background' (Seamus).

## Barriers to social connection

Barriers to social connection comprised: (1) getting around, and (2) attitudes to maintaining and forming new social connections.

### Getting around

Getting around referred to physical limitations and inability to access appropriate transport. For participants, loss of a driver's licence was a significant event, and mobility restricting conditions, particularly respiratory disease, most affected their ability to get around, imposing barriers to social connections.

I took up bowls about 15 years ago. And whenever I went, we had a ball. I no longer can play bowls, because I can't walk the length of the green without getting out of breath. (Seamus)

Several participants described how a mobility scooter allowed them to maintain community engagement.

I've got a scooter ... It goes all the way to the Club, and all the way back, and all the way downtown no problem. (Seamus)

It's fantastic [the mobility scooter]. Because my wife has got different things and we'd have to think about where I had to go to an appointment, and she couldn't go to her luncheons, or whatever. And it was depressing, sitting at home all the time, I might feel like going around to a mate's place, but I would have to get [wife's name] to drive me, pick me up, all that rubbish. With this, I can do it. If I've

got to go to a doctor or a GP, or get an X-ray done, or a blood test, I'm on it … (Wayne)

The ability to drive facilitated participants to attend appointments, meet practical needs (e.g. shopping) and attend social outings (e.g. meals), with loss of a driver's licence feared, as this restricted independence, 'I am losing all my independence, especially not being able to drive, I hate that' (Winifred). Participants spoke of the difference driving made to their independence and social engagement, '… but that's a bit of a concern to me. What happens living out here without a licence? But by the time that happens, maybe there will be public transport here, or another form of transport' (Samuel).

The unaffordability of transport was raised frequently with limited public transport particularly in regional areas.

… There's no public transport here. And the only way to get in and out of town is on the school bus. And when the school's on holidays, there's no school bus. (Samuel)

Transport costs necessitated prioritisation of medical appointments or shopping, resulting in the foregoing of social activities. Those who relied on family for transport also prioritised instrumental rather than social needs. 'My son will help me out. He'll take me if I've got to go to the doctors or something' (Silas).

### Attitudes to maintaining and forming social connections

Participants' attitudes and personality influenced both their interest in forming social connections and maintaining existing ones.

I'm mainly an inner self person. I don't go out of my way to, say, visit friends or anything like that, because I just sort of like, especially over this virus and that, to be a bit isolated. But, as I said, people that go past they all know me. (Walter)

Some participants spoke of feeling 'past it' and lacking the energy to pursue new relationships, which had not always been their attitude, but resulted from the impact of chronic conditions on their confidence and physical capacity.

I don't think I would be capable; I honestly don't think I would be capable, because I have got opportunities here. They have a morning tea over here once a month, I could easily go to that if I wanted to, but I don't want to. (Winifred)

Some participants still met with friends because of shared interests, 'I have a very sound social network, although it's probably limited in the sense that they're mostly from my golf course' (Stanley). However, several others felt their engagement was tempered by their health. 'We go out with friends every now and again, but it's the way I feel whether I go or not' (Selma).

For some, the transition to retirement living had provided the opportunity to meet new people. '… My retirement in this country has been an absolute joy' (Seamus). Others referred to the difficulties of making new friends after a relocation. 'I've tried to befriend people here in the village, because they're close by, but I've found that people are very cliquey' (Wendy). Several participants spoke of the constancy of death in their peers, 'It's not quite the same because of – as people have either died or moved on' (Wilma).

## Facilitators of social connection

Three sub-themes expressed facilitators of social connections, namely: (1) access to general practice care, (2) family contact and support, and (3) feeling part of the community.

### Access to general practice care

Quality general practice care was identified as essential to staying well. Participants spoke of the importance of relational continuity with their general practitioner (GP) in managing their chronic conditions, and most reported regular consultations.

Well, yeah, I think he [GP] knows me pretty well about my condition. It was actually, he was the one that I went to and he sent me to a specialist, and that's where they found out that I have a heart irregularity. (Walter)

When older people could manage their chronic conditions, they were able to maintain social engagement.

I've got a portable breathing apparatus they bought me, which is terrific … It's there to help you out when you want to go somewhere. (Wayne)

I use an oxygen condenser for about 15 to 18 hours a day depending on where I am. I can sit without it without any dramas providing I'm not exerting. (Stanley)

Most participants felt they could discuss with their GP how chronic conditions contributed to loneliness and social isolation, and affected their wellbeing, which was important, as good health facilitated social engagement.

Oh yeah, I can tell Dr [name] anything. I talk to him a lot. Yeah, he's a very good listener. No, he's wonderful. Anything I'm worried about, or anything at all, I just sit and talk. (Selma)

Some participants had mixed experiences of discussing loneliness and social isolation with their GP. 'He just sympathises, I think. That's all he can do' (Sophia). One participant stated, 'I have mentioned it to him a few times, and with the response, 'Well, there are several groups out there you could join', the participant responded, 'and I'm like yeah, I feel a bit dismissed' (Wendy). Several references

were made to the busyness of the GP, and short consultation times not being suitable for this sort of conversation. 'No, you're in and out' (Silas).

Although several participants were willing to raise their loneliness and social isolation with their GP, others felt unsure about whether the GP was the right person to speak to about this issue. 'I wouldn't talk to him about it' (Herman), 'I just don't think the GP is that sort of person' (Sergio). One participant had talked to the practice nurse during a wound dressing (Silas), and another spoke with a psychologist (Winifred). During COVID-19, many participants engaged with GPs via telephone consultations. Although some found this convenient, others missed the more personal face-to-face consultations, as often GP visits were one of their few social outings.

### Family contact and support

Although participants relied on friends/neighbours for social contact, many saw their family as a vital source of practical assistance and social support.

> ... my sons, they ring me nearly every day, how are you going? (William)

> And then we go to our son. Well, he, today ... well, his lady, she brings us dinner sometimes ... And she phoned last night and she said, 'I'm doing a roast pork, a slow roast pork.' She said, 'Do you want it for tea?' Well, I'm not going to turn it down. (Hubert)

Participants with geographically distant family received social, but limited, practical support. Few participants used digital technology; however, COVID-19 had led participants to try videoconferencing.

> My daughter ... visits as much as she can, and I have contact with my daughter in [location] on Skype every week, so I love that. (Winifred)

Despite this reliance on family, some participants were fearful of being a nuisance, and tried to reduce their demands upon their family by being self-reliant or reciprocate by helping their children where possible.

> As long as we can get around, we're not going to try and make a nuisance of our self. (Hubert)

> And, of course, they have their own life to live, and you can't interfere with people's lives, whether they're family or not. (Sergio)

> ... we have our grandchildren every other weekend, and school holidays and days like that, so that my son can go to work. (Wilma)

Grandchildren were an important source of joy and connection. Two participants had at least one grandchild living with them. Through grandchildren, some participants made new social connections.

> My husband and I go places sometimes where we wouldn't normally go. You know, park, Ninja places and swimming pools, and all sorts of things that we probably would never have gone there. (Wilma)

Not all participants had supportive family members, as relationships had broken down, one participant stated, '... I haven't seen them for 30 years. Don't get on' (Herman).

### Feeling part of the community

Participants often found social connections within their local communities, with shopping visits important in meeting practical and social needs. Many participants had lived locally for a long time, and their community was part of their social network. 'You're forever stopping and talking to people. It's brilliant. I'm very happy' (Seamus). 'People stand there and want to talk to me all the time' (Selma).

> I'd lived around here a long time, I might go down to get a litre of milk, and be down there an hour and a half talking. Depends on who's around and who's not around. (Herman)

However, several participants spoke of changing communities shifting their sense of belonging. 'There's no community in this road at all now' (Hubert).

> ... new people nowadays they don't – they're too busy to stop and say hello a lot of the time. (Wilma)

Most participants described service and sporting clubs as meeting places for social engagement, and several referred to social networks formed through their long associations with clubs.

> I'm the patron of the [name] Club. And I was there on Sunday at a general meeting. We had a luncheon there. And socially, it's wonderful. (Seamus)

## Discussion

This study demonstrates how ageing with chronic conditions challenges older peoples' ability to maintain social connections. Social networks diminish significantly with age, and older people can find it difficult to form new social connections. The experience of loneliness and social isolation was exacerbated in this study as a result of participants' chronic conditions. This was particularly noted when mobility

and transport access were limited, as this prevented their engagement in social activities. For some, there was a somewhat fatalistic acceptance of their situation, and sense of inertia about their capacity to change this. However, for many, families provided practical support and social connection, as did community ties. Helping participants to stay well through general practice consultations was a crucial facilitator of social engagement.

The health implications of loneliness and social isolation are well established (Holt-Lunstad *et al.* 2017). This study highlighted how reduced mobility arising from chronic conditions can lead to a more sedentary lifestyle, limiting opportunities for social connection (Yang and D'Arcy 2022). This is consistent with Schrempft *et al.* (2019), who found an association between sedentary behaviours, physical inactivity and increased social isolation in older adults. Additionally, Martins *et al.* (2021) showed that, as age increased, physical activity decreased, particularly for older people in urban areas. Physical inactivity has been associated with older people perceiving they are in poor health (Martins *et al.* 2021). Supporting older people with chronic conditions to increase physical activity and provide social support can strengthen mental wellbeing (Yang and D'Arcy 2022). Beyond physical inactivity and reduced mobility, poor access to public transport, and loss of a driver's licence were barriers to social connection in this study. Mobility restrictions create varying support needs for older people to participate in social activities.

Although a contested concept, social capital is generally seen to comprise individual and collective components, and obtained through involvement in social activities (Putnam 2000). Dimensions of social capital can be structural or objective, such as 'social networks, social contacts and participation', or cognitive or subjective, including 'social support, sense of belonging and trust' (Coll-Planas *et al.* 2017). According to Putnam (2000), social networks provide a practical source of support, and may reinforce healthy behaviours and self-care as social norms. In this study, older people identified family and life-long friends as their primary social networks, and described how the social capital embedded within these relationships grew over time. To a lesser degree, social connections were experienced through neighbours and a sense of belonging in their local community. Older people may become more reliant on community resources, as they no longer have access to resources available through employment or social groups (Nyqvist *et al.* 2016). As older peoples' networks diminish, they lose a vital source of social capital, which translates to reduced social support. This explains in part the importance of maintaining older peoples' existing social and community ties. Social capital interventions can build social networks; for example, through group-based activities, befriending and/or peer support, and have the potential to positively impact the mental wellbeing of older people (Coll-Planas *et al.* 2017).

In this study, a major facilitator of social connection was general practice access. Relational continuity with their GP and trust with the practice supported participants in staying well. Additionally, general practice nurses can create valuable connections with older people through education about loneliness and social isolation, and improved access to care (Bindels *et al.* 2015; Thompson *et al.* 2023). This study's finding that established general practice enabled older people to discuss how chronic conditions contributed to their loneliness and/or social isolation is consistent with the literature (Bindels *et al.* 2015; Kharicha *et al.* 2017). General practice teams have been shown to potentially contribute to interventions for lonely and socially isolated older people, particularly in collaboration with community-based aged and social care providers (Galvez-Hernandez *et al.* 2022; Thompson *et al.* 2023). However, lonely older people without good relationships with their general practice may be unsure about whether the GP had appropriate knowledge and skills to address loneliness and social isolation (Kharicha *et al.* 2017). For older people with mental health issues, support from appropriately trained professionals, such as psychologists and psychiatrists, may be indicated. In Australia, general practice nurses provide much of the routine care of older people, and are a professional group that is underutilised (Halcomb and Ashley 2019). They have skills that could be developed to add support within the multidisciplinary team approach for older people experiencing loneliness and social isolation from reduced social connections (Thompson *et al.* 2023). The emergence of multidisciplinary team-based general practice models has been associated with higher performance in quality metrics with changes in team roles acceptable to patients (Misra-Hebert *et al.* 2018). These models provide an opportunity to integrate strategies to address social connection into older peoples' usual care, particularly those with chronic conditions.

Finally, the stigma associated with loneliness has been identified as a barrier to older adults participating in interventions to ameliorate loneliness (Kharicha *et al.* 2017). Our study occurred after the COVID-19 lockdowns, with several participants commenting that this pandemic normalised discussions about loneliness. Recent efforts have occurred to expand national (Ending Loneliness Together 2020) and international (World Health Organization 2024) awareness of the stigma surrounding loneliness and social isolation. This is crucial, as stigma reduces the ability of health professionals to identify, assess, respond to and support those who are at risk (Roy *et al.* 2023).

## Limitations

As this study was conducted in a chronic care program in a particular locality, findings may not reflect conditions in other localities. People volunteered to participate, and this may have resulted in those with strong views volunteering. As these people were linked with a chronic care program, they were already receiving some support. The impact of chronic conditions on social connections may be even more

pronounced for those who are not engaged in a support program. There may also have been response bias, particularly social desirability bias, given the stigma associated with loneliness and social isolation (Galvez-Hernandez *et al*. 2022). Findings may have been influenced by the timing of data collection, which occurred after the experience of lockdowns and prior to widespread COVID-19 vaccine availability. People from culturally and linguistically diverse groups may have different family structures and cultural expectations, and different challenges in social connection to the English-speaking participants of this study. Further research exploring culturally and linguistically diverse groups is needed.

### Implications for policy and practice

This study provides important insights for general practice teams wanting to support older people with chronic conditions in improving their social connections and minimising loneliness and social isolation. Participants' circumstances varied, as did the factors influencing their social participation and experience of loneliness and social isolation. This suggests that a one size fits all solution may be ineffective. Government policies to encourage ageing at home are likely to be unsuccessful without tailored interventions to maintain older peoples' social relationships. It is important to assess the underlying cause of loneliness and social isolation, so that an appropriate intervention is recommended and undesirable outcomes are minimised (Galvez-Hernandez *et al*. 2022). Such interventions need to be cognisant of the personal context of each person; for example, their physical limitations, particularly mobility restrictions and access to appropriate transport (Shi *et al*. 2023). Facilitated transport support may be required because of mobility impairments arising from chronic conditions. General practitioners and general practice nurses could suggest mobility aids, advise about community transport options and/or promote digital solutions to help older people maintain social connections. Linking the older person with local aged and social care agencies may also promote access.

Physical activity interventions have been identified as a promising strategy for older people to reduce social isolation, ameliorate the impact of sedentary lifestyles and improve mental wellbeing, while accommodating physical limitations (Yang and D'Arcy 2022). Although productive social interventions may assist those with poor social networks, older people with chronic conditions are a population where further research is needed to optimise social connection interventions.

## Conclusion

Study findings highlight the importance of understanding the barriers and facilitators of social connection to inform appropriate interventions. The importance of staying well was identified, and this reliance on general practice provides a key opportunity for these health professionals to intervene with the lonely and socially isolated. Particularly important are strategies to maintain physical activity, promote access to accessible transport and identify social connection opportunities. Improving social connections for older people requires a collaborative approach, where health, aged and social care providers work with all available social networks, including families, friends, neighbours and communities.

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