Someone to talk to? The role of loneliness as a factor in the frequency of GP consultations

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SUMMARY

Background. *There are many reasons why people frequently consult their general practitioner (GP). Although loneliness is increasingly recognized as a problem affecting well-being for elderly people, it has rarely been addressed as a predictor of frequency of consultation.*

Aim. *To examine whether loneliness is associated with rates of GP consultations (home and surgery visits).*

Method. *Analysis of data collected in face-to-face interviews at the second wave of a longitudinal health survey of two adult age cohorts living in four socially contrasting urban localities in Glasgow City. There were a total of 691 subjects: 142 males and 176 females aged 40 years at interview; and 167 males and 206 females aged 60 years at interview. Frequency of reported GP consultations in the past 12 months at home or in the surgery was examined.*

Results. *After controlling for sociodemographic and socioeconomic variables and health, loneliness was significantly associated with frequency of consultation at the surgery but not with the frequency of home visits.*

Conclusion. *Loneliness may still be underestimated as a factor related independently to frequency of consultations with a GP at the surgery.*

Keywords: general practice; consultation rates; loneliness; area of residence.

Introduction

THERE are many reasons why people consult their general practitioner (GP) and the frequency with which they do so. Reasons include subjective health considerations,[1] treatment and investigation, and reassurance.[2] Frequency is associated with socioeconomic status, with individuals in lower socioeconomic groups consulting their GP more frequently for most kinds of health problems,[3,4] owing, in part, to the poorer health experienced by these groups. Housing tenure is related to rates of consultation with those who rent their homes having higher rates[5-7] even after controlling for social class, which may be because of the impact of housing conditions upon health.[8] Age and sex are associated with frequency of consultation, with children and older people consulting more frequently and women consulting more than men.[5,9] Psychological distress is associated with the likelihood of consulting a GP.[10,11] Consultation rates vary according to area of residence, and this is related to distance from the surgery, whether an urban or rural location and whether individuals have access to a car.[5,12-14] Areas differ in their provision of and access to health care services, and this is not necessarily related to need.[15,16]

Social support networks are also important predictors of consulting behaviour with those patients with well-developed social networks consulting less frequently.[17,18] Those who are widowed or divorced also tend to consult more frequently,[19] which could be a result of fewer social support networks,[20] and those who have problems in their relationships with their spouse or partner tend to consult more frequently.[11] Although loneliness is increasingly recognized as a problem affecting well-being for elderly people,[21] it has rarely been addressed as a predictor of frequency of consultation.

Because of recent proposed alternative consultation arrangements, such as a trend towards more patients being seen by nurses rather than doctors, we considered it timely to explore whether loneliness was associated with frequency of GP consultations after taking into account known predictors of consultations such as sex, age, physical and mental health, area of residence, socioeconomic circumstances (social class, housing tenure, car access), and feelings about their partner status.

Method

The data reported here were obtained in a survey conducted in 1992 of 40-year-olds (n = 318) and 60-year-olds (n = 373) in four socially contrasting neighbourhoods as part of The West of Scotland Twenty-07 Study: Health in the Community.[22] Two neighbourhoods (West End and Garscadden) were in the North West of Glasgow City and two (Mosspark and Greater Pollok) were in the South West. The West End neighbourhood was the most socio-residentially advantaged, and the Greater Pollok neighbourhood the most disadvantaged. At the 1991 Census, the proportions of the population in these areas in social classes IV and V, living in overcrowded accommodation, being male and unemployed, and reporting owning a car are shown in Table 1.

Of those who had been interviewed when resident in these neighbourhoods in 1987/8 and were still resident in 1992, 318 40-year-olds and 373 60-year-olds were interviewed by nurse interviewers in 1992 (a response rate of 85% of the target sample of those previously interviewed and still resident in the same area). The face-to-face interviews, mostly conducted in the responders' homes, collected a wide range of data on personal and social circumstances, health knowledge, health beliefs and values, health related behaviour, past and present health, and some simple physical measures. An earlier study comparing the structure of general practices in these areas found few systematic differences, although a larger proportion of GPs in the more deprived area had qualified more recently and a smaller proportion were members of a Royal College.[23]

To ascertain rates of consultation with the GP, responders were asked first: 'Over the past 12 months have you consulted a GP or family doctor on your own behalf?' If 'yes', responders were then asked, 'How many times have you visited the GP at his or her surgery on your own behalf?' and 'How many times has the doctor visited you at home on your own behalf?' Social class was categorized according to the occupation of the head of

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Table 1. Proportion (%) in neighbourhoods of households that are overcrowded, in social class IV and V, with male unemployment, and with no car (data from 1991 Census).

Area of residence in Glasgow	Overcrowded	Social class IV and V	Male unemployment	No car
West End	5.8	8.0	9.2	33.4
Garscadden	7.1	20.6	18.6	51.7
Mosspark	9.9	24.1	20.1	56.4
Pollok	16.0	28.0	29.1	64.0

household, using the Registrar General's classification of occupations.[24] We also used housing tenure as a variable because it is known to be associated with GP consultations over and above social class.[25] Housing tenure was classified as either owner-occupied or rented in the public sector (we excluded the 11 responders, 1.6% of the sample, who lived in privately rented or tied accommodation). Responders were asked if there was a car or van available for their household.

In the interviews, responders provided a range of measures of health. Here we report on four self-reported measures. Responders were asked to rate their own health as being 'excellent', 'good', 'fair', or 'poor' in the past year, and to report the number of symptoms out of 22 common symptoms they had experienced in the past month. Two psychological health measures (anxiety and depression) were obtained from the subscales of the Hospital Anxiety and Depression Scale (HADS).[26]

Information was obtained from the responders on the number of people residing in the home; a variable was derived from this on whether or not the responder lived alone. Because consultation rates are known to be associated with marital status (i.e. being widowed or divorced) and problems in relationships with a spouse or partner, we included a measure of responders' rating of their marriage/relationship (if married or cohabiting) using the Andrews and Withey Faces Scale.[27] Using the same scale, responders who were separated, divorced, widowed, or single were asked how they felt about being on their own. We used a measure of perceived satisfaction with marital/partner status, as it has been shown that how people feel about their status is more important for their well-being than the presence or absence of a partner *per se*.[28]

Levels of loneliness were ascertained from a question within a section on social support: 'Loneliness can be a serious problem for some people and not for others. At the present moment do you ever feel lonely?' If the responder answered 'yes', they were asked 'is that ... most of the time', 'quite often', 'only occasionally', or 'seldom'. This variable was subsequently collapsed into a three-point scale ('mostly/quite often', 'occasionally', and 'seldom/never').

Results

Most responders (78.1%; $n = 540$) reported that they had consulted their GP on their own behalf over the past 12 months, and almost all of these ($n = 534$) had had at least one consultation with their GP at the surgery. Around one-sixth (15%) of responders who had consulted their GP in the previous year had had a consultation at home. Very few responders ($n = 6$) reported only having received a home visit.

Univariate analysis

Loneliness. Table 2 shows the proportion of responders reporting different levels of loneliness by sex, cohort, social class, housing tenure, neighbourhood of residence, car access, self-reported health in the past year, whether or not the responder lived alone, and feelings with regard to partner status. The mean scores for the anxiety and depression subscales of the HADS measure and the mean number of symptoms reported by responders in the past month are also shown. There were significant differences in all of these measures between the three categories of loneliness ('most of the time/often', 'occasionally', 'seldom/never') except for cohort: there being no significant difference in reported loneliness between the 40-year-old and 60-year-old cohorts. Females, responders in lower social class groups, those who rented their homes, those who lived in more deprived neighbourhoods, those with no car access, those with poorer self-assessed health, those who lived alone, and those who felt more unhappy about their current marital/partner status, reported higher levels of loneliness. Mean HADS scores and number of symptoms were also significantly higher among responders who reported feeling lonely more frequently.

Mean number of consultations. The mean number of consultations at the surgery is shown in Table 3, column 1. Responders without access to a car, living in rented housing, having poorer self-assessed health, and reporting higher levels of loneliness had a significantly higher mean number of consultations with the GP at the surgery. Consultation rates were also significantly associated with number of symptoms and score on the HADS anxiety and HADS depression scales (data not shown). There were no significant differences in the mean number of consultations at the surgery by sex, cohort, social class, whether or not the responder lived alone, feelings about partner status, or neighbourhood of residence.

Social class, housing tenure, self-rated health, loneliness, and neighbourhood of residence were all significantly associated with the mean number of reported home visits (Table 3, column 3). The number of symptoms in the past month and anxiety and depression scores were also significantly associated with consultations at home (data not shown).

Multivariate analysis

To test if the significant relationship found between levels of loneliness and the number of GP consultations in the univariate analysis remained after controlling for all the independent variables, we carried out multivariate analysis (ANOVA) using SPSS for Windows. The variables were entered into the model in the following order: number of symptoms, HADS anxiety, HADS depression, sex, cohort, social class, housing tenure, neighbourhood of residence, car access, self-assessed health in the past year, whether lives alone or not, feelings about partner status, and levels of loneliness. Looking first at the mean number of consultations at the surgery (adjusted for all the independent variables), column 2 of Table 3 shows that loneliness is significantly related to the number of GP consultations at the surgery — after controlling for all the other independent variables preceding it in the model — but not with the number of GP consultations at home (column 4).

Table 2. Proportion (%) of responders reporting levels of loneliness by socio-demographic characteristics.

Characteristic	n	Most of the time/often	Occasionally	Seldom/never
Sex[a]				
Males	309	4.5	9.7	85.8
Females	382	5.5	19.4	75.1
Cohort (ns)				
Age: 40s	318	3.1	15.4	81.5
Age: 60s	373	6.7	14.7	78.6
Social class[a]				
I/II/III non-manual	319	1.9	13.8	84.3
III manual	150	3.3	8.7	88.0
IV/V	147	9.5	17.7	72.8
Housing tenure[a]				
Owner-occupier	383	2.3	13.3	84.4
Tenant	293	8.2	17.1	74.7
Neighbourhood of residence[a]				
West End	191	1.5	12.6	85.9
Garscadden	178	4.5	16.3	79.2
Mosspark	47	14.9	25.5	59.6
Pollok	275	6.2	14.2	79.6
Car access[a]				
Yes	411	2.2	14.8	83.0
No	279	9.3	15.1	75.6
Health in the past year[a]				
Excellent/good	448	2.2	13.4	84.4
Fair/poor	243	10.3	18.1	71.6
Lives alone[a]				
Yes	93	15.1	26.9	58.1
No	598	3.5	13.2	83.3
Feelings re: partner status[a]				
Better	598	2.5	12.0	85.5
Middling	44	13.6	31.8	54.6
Worse	46	30.4	37.0	32.6
		mean	mean	mean
HADS anxiety[a]	680	9.6	7.1	5.4
HADS depression[a]	678	10.0	7.2	5.8
Number of symptoms in the past month[a]	691	8.7	5.7	4.1
Total	691	5.1	15.1	79.8

[a]$P<0.001$; ns = not significant.

Discussion

Our findings show that loneliness is significantly associated with the number of consultations at the surgery, but not at home, after controlling for a number of variables (age, socioeconomic status, area of residence, and health) known to be associated with frequency of GP consultations. Responders who reported feeling lonely 'most of the time' or 'often', had almost twice as many consultations with their GP in the previous year compared with responders who felt lonely 'rarely' or 'never' (mean of 7.8 compared with 4.2), which has clear resource implications for general practices.

Our findings have highlighted the importance of loneliness in a relatively youthful study sample. This is often seen as a problem for the very old; however, the responders in our study could not be considered within this age range (they were aged 40 and 60 years at the time of interview). Responders in our study who lived alone were more likely to report being lonely, but unlike some studies,[29] we did not find that those who lived alone reported significantly greater frequency of consultation with their GP. Indeed, among those responders who reported feeling lonely 'mostly or often', it was those who lived with other people who had significantly more consultations with their GP on average over the past year (mean = 10.1) than those who lived alone (mean = 8.8). While those who lived alone had a non-significantly higher mean number of surgery visits in the past year, this difference disappeared when adjusted for other dependent variables. This may be because those living alone were more likely to be older women who are high consulters. This suggests that living alone and feeling lonely cannot be treated as equivalent predictors of consultation rates.

It is possible that GPs are fulfilling a role for those who need someone to talk to and he or she is viewed as an appropriate confidante for problems formerly seen as being the province of the clergy.[30] It is important that this role does not go unrecognized, particularly at a time when alternative consultation arrangements are currently being sought, such as more patients being seen by nurses rather than doctors.

General practitioners may need to be more alert to loneliness in patients, as it may be a precursor to more serious health problems, both mental and physical.[31] Changes made to the GP contracts in 1990 resulted, in some cases, in larger list sizes, which may have reduced the consultation time allotted to individual patients. While the provision of counselling within primary health care teams has become more widespread in recent years,[32] its effectiveness is rarely evaluated.[33] Those few studies that have evaluated effectiveness have had mixed results; a reduction in prescribing of psychotropic drugs and a lowering of GHQ scores among those receiving counselling has been found,[34,35] while others have found no difference in outcomes such as mental health (as measured by HADS) between those receiving counselling and a control group.[33]

In conclusion, we have shown that loneliness independently

Table 3. Unadjusted and adjusted number of GP visits by sociodemographic and health characteristics.

	Number of GP consultations at surgery on own behalf		Number of GP consultations at home on own behalf	
	Mean	Adjusted means[a]	Mean	Adjusted means[a]
Sex	ns	ns	ns	ns
Males	4.1	4.0	0.33	0.33
Females	4.5	4.5	0.45	0.40
Cohort	ns	ns	ns	ns
Age: 40s	3.8	4.0	0.33	0.32
Age: 60s	4.7	4.6	0.45	0.41
Social class	ns	ns	P<0.05	VALUE?
I/II/III non-manual	4.0	4.6	0.26	0.40
III manual	4.4	3.9	0.49	0.29
IV/V	5.0	4.1	0.55	0.40
Housing tenure	P<0.001	P<0.001	P<0.001	P<0.05
Owner-occupier	3.7	3.9	0.22	0.32
Tenant	5.2	4.9	0.58	0.44
Neighbourhood of residence	ns	ns	P<0.001	P<0.05
West End	3.9	4.3	0.13	0.22
Garscadden	4.1	4.1	0.26	0.23
Mosspark	3.5	3.4	0.51	0.54
Pollok	4.9	4.5	0.63	0.53
Car access	P<0.05	ns	ns	ns
Yes	4.0	4.4	0.32	0.38
No	4.9	4.3	0.50	0.35
Health in the past year	P<0.001	P<0.001	P<0.001	P<0.001
Excellent/good	3.0	3.3	0.21	0.28
Fair/poor	6.4	5.9	0.67	0.51
Lives alone	ns	ns	ns	ns
Yes	5.0	3.8	0.45	0.41
No	4.4	4.4	0.39	0.36
Feelings re: partner status	ns	ns	ns	ns
Better	4.4	4.4	0.40	0.38
Middling	4.5	3.9	0.28	0.21
Worse	5.7	3.7	0.56	0.40
Levels of loneliness	P<0.001	P<0.01	P<0.05	ns
Most of the time/often	9.5	7.8	0.94	0.57
Occasionally	4.1	3.4	0.30	0.21
Seldom/never	4.1	4.2	0.38	0.39

[a]Models are constructed sequentially in the order shown; means are adjusted for all the independent variables. The covariates of number of symptoms, HADS anxiety, and HADS depression subscales were entered first. ns = not significant.

predicts the number of consultations at the surgery after controlling for a range of socioeconomic and health variables known to be associated with frequency of consultation. This has both cost and workload implications for practitioners, as well as a hitherto unrecognized significance for patients, which needs to be considered in resource allocation and practice management.

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