

# Supporting the Health and Wellbeing of Middle-Aged Adults Living Alone in Rural Counties

Carrie Henning-Smith, PhD, MPH, MSW

Mariana Tuttle, MPH

Ashley Hernandez, MSPH

Jonathan Schroeder, PhD, MA

Katy Kozhimannil, PhD, MPA

## Key Findings

- **13.0% of middle-aged adults (age 35-64) live alone in rural (non-metropolitan) counties vs. 12.3% in urban counties. Of the 50 counties with the highest percentage of middle-aged adults living alone, 37 are rural.**
- **Health care providers in these counties identified several characteristics related to high rates of middle-aged adults living alone, including socio-demographic characteristics (e.g., income, marital status, age distribution), lack of social support, personal choice, housing issues, and health status.**
- **Practical challenges for middle-aged adults living alone in rural counties included limited resources, transportation, accessing health care, loneliness, substance use, and difficulty with self-care.**
- **While many individuals live alone by choice and thrive in doing so, some people experience unique barriers to health and well-being when living alone. These barriers play out uniquely in rural areas and require tailored interventions to support these individuals.**

## Background and Policy Context

More people in the United States live alone today than ever before. In 1950, fewer than 10% of all households consisted of an individual living alone.<sup>1</sup> Today, more than 32 million people live alone in the U.S., making up more than 27% of all households.<sup>2</sup> For many, living alone is an intentional choice and can be a positive experience;<sup>3</sup> for others, it is associated with poorer health and increased risk of loneliness and social isolation.<sup>4-6</sup> (Loneliness and isolation are related, but distinct concepts; loneliness is a sense of social needs not being met, isolation is an objective lack of social contacts.<sup>7</sup>)

In light of increased isolation and social distancing related to the COVID-19 pandemic, understanding these heightened risks and the challenges associated with serving these individuals is all the more timely and important. Rates and experiences of living alone vary by age group, with middle-aged adults (ages 35-64) who live alone tending to be in worse health than their counterparts living with others. This same relationship is not true for younger or older individuals.<sup>5</sup>

In addition to poorer health outcomes for middle-aged adults living alone, single non-elderly adults face unique barriers to accessing support when necessary, relative to children and older adults. For example, single non-elderly adults typically have access to fewer social welfare programs and higher uninsurance rates than their older counterparts.<sup>8</sup> Basic cash welfare programs, such as Temporary Aid to Needy Families (TANF) are targeted toward adults with children, not to adults living alone.<sup>9</sup> Low income adults living alone also have more restricted access to programs like SNAP<sup>10</sup> (food assistance) and the Earned Income Tax Credit (EITC) than their counterparts with co-resident dependents.<sup>11</sup> Importantly, there is considerable variation among states, including states with large rural populations, in

per capita spending on social welfare programs and eligibility criteria.<sup>12</sup>

As health care increasingly takes into account one's housing and social situation in providing care, more information is needed on how to best support middle aged adults who are living alone. Additionally, given the unique demographic, socio-economic, housing, and health care context of rural communities, information on support for individuals living alone should be specific to geographic context. This brief shares insights from health care providers in 14 rural counties with the highest rates of middle-aged adults living alone in order to inform policy and practice in how best to support the health and well-being of this demographic.

## Approach

To understand the county-level differences in rates of living alone among adults age 35-64, we combined quantitative census data with a qualitative survey. First, we used summary data from the U.S. Census Bureau's 2013-2017 American Community Survey (ACS) 5-Year Estimates, acquired through the IPUMS National Historical Geographic Information System ([www.nhgis.org](http://www.nhgis.org)), to compute rates of living alone by rurality and age. Living alone was defined as residing in a household consisting of one person; individuals living in group quarters (e.g., nursing homes, dormitories, correctional facilities) were not included in this analysis. To determine "rurality" we used the metropolitan/non-metropolitan classes as defined by the Office of Management and Budget (OMB). Rural counties included those classified by OMB as non-metropolitan, including both micropolitan counties—with a core population center of 10,000-50,000—or non-core counties—with no population center of 10,000 people or more).

We identified 50 counties with the highest proportions of all individuals age 35-64 who were living alone; 37 of those 50 were rural counties. We then identified health care facilities (hospital or clinic) in 34 of those rural counties, excluding three counties with no facility, and reached out to a facility in each. We first asked to speak with a hospital discharge planner or care coordinator, or a designated representative, given that those individuals are actively involved in connecting individu-

als with community-based resources. In instances when we had difficulty identifying an individual contact, we asked for a referral from the state Flex Program coordinator. Once we identified an individual, we sent a survey invitation via email, inviting them to complete a brief online survey. We received responses from 14 of the 34 counties (41% response rate).

The survey included questions across four domains, asking the respondent for their perception on: causes of high rates of middle-aged adults living alone, unique challenges to providing care for this population, concerns about the health of this population, and current efforts in the county to address social isolation and loneliness. We used content analysis to code the responses for each domain.

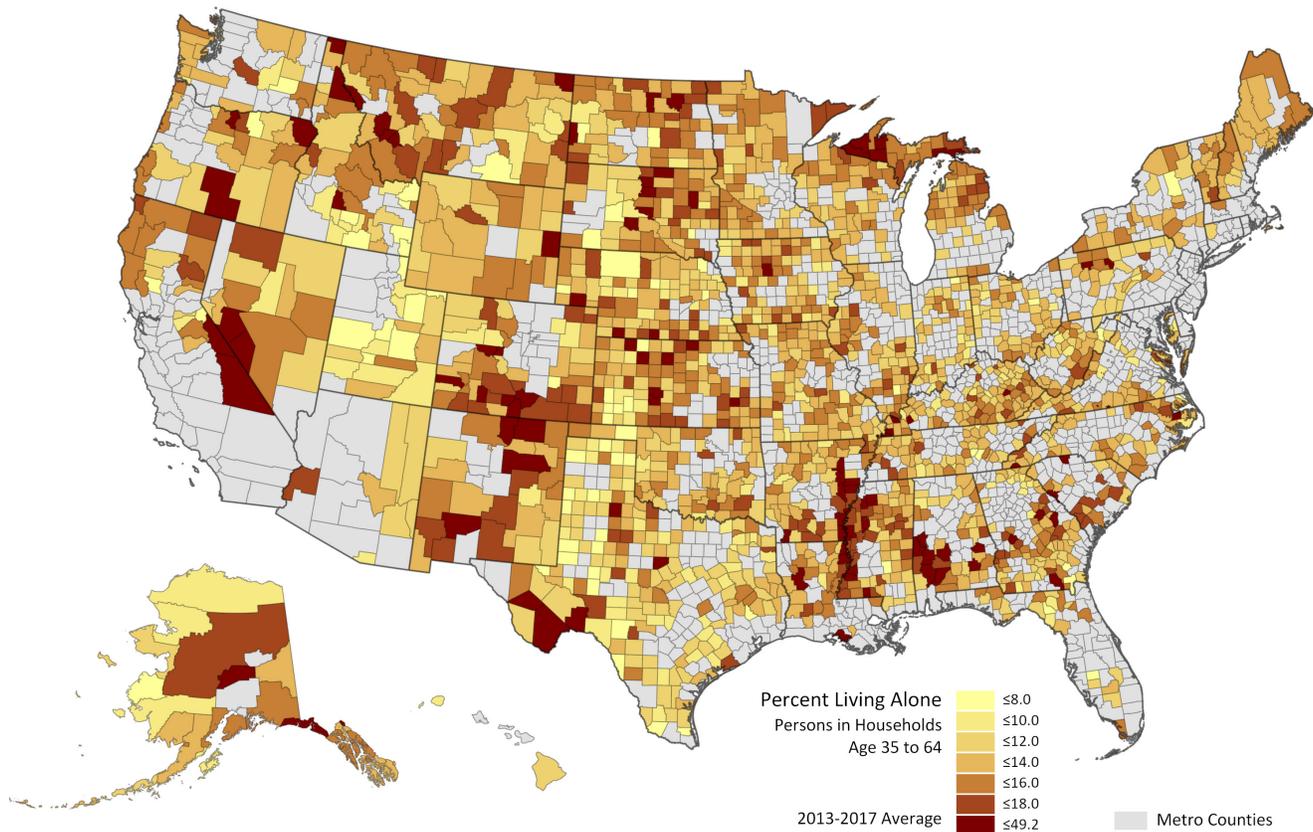
## Results

### *Distribution of middle-aged adults living alone*

Figure 1 shows the rate of middle-aged adults living alone in rural counties across the United States. On average, 13% of rural adults age 35-64 live alone, with considerable variation by county. The 50 counties with the highest rate of middle-aged adults living alone all had at least 20.5% of adults age 35-64 living alone; 37 of those 50 were non-metropolitan (rural) counties.

Of the rural counties with the highest percentage of middle-aged adults living alone, some were concentrated in the Southern "Black Belt" (predominately non-Hispanic Black, rural, Southern counties);<sup>13</sup> the Upper Peninsula of Michigan, characterized by declining mining and manufacturing and aging population and housing infrastructure; several remote, agricultural and manufacturing counties throughout the Great Plains; and mountainous counties scattered throughout the West. In the final group, some are home to well-known outdoor recreational areas (e.g., Mono County, CA and Pitkin County, CO), while others may have more in common with the economic conditions in the Upper Peninsula or Great Plains. This variation should be kept in mind when interpreting these results; what works in one place may not work in others.

**Figure 1. Percent of Middle-Aged Adults Living Alone in Rural Counties**



### Qualitative Survey Results

*What contributes to high rates of middle-aged adults living alone?*

Respondents nearly all suggested that high rates of middle-aged adults living alone in their county were related to changes in socio-demographic characteristics, including a changing age structure (growing population of older adults), declines in marriage rates, and limited financial, education, and job opportunities. Many also suggested that a lack of social support and social connections was a contributor to more people living alone (as well as a consequence of it); several respondents raised concerns about individuals not having their social and care needs met as a result. Two respondents named personal choice as a contributor – some middle-aged adults prefer to live alone, highlighting the importance of distinguishing the constructs of living alone, social isolation, and loneliness. Two also mentioned constraints on available housing and two mentioned mental health problems and addiction as contributors.

*What are unique challenges to supporting the health of middle-aged adults living alone?*

The most common responses to this question were limited resources (e.g., financial, community infrastructure, support) and limited transportation. Four respondents also mentioned barriers to accessing health care, especially mental health care and home health for individuals with functional limitations. Two respondents suggested that living alone is not a particular challenge for middle-aged adults, but is for older adults who lack the support they need. This suggests a need for interventions that focus on increasing social contacts for people who are involuntarily socially isolated, as well as a need to increase social support among individuals who are lonely, regardless of whether or not they are socially isolated. Such interventions should be tailored by age and other related risk factors (e.g., health status, socioeconomic status).

*What are your biggest concerns about the health of middle-aged adults living alone?*

Several respondents had specific concerns about poorer health outcomes for middle-aged adults living alone, including higher rates of substance use and addiction, loneliness, depression, and higher risk for not having personal care needs met. Another frequently-mentioned theme was limited access to health care, owing to higher rates of uninsurance and other barriers to care in their rural settings, all of which makes it harder to access routine, preventive care. Three respondents mentioned concerns about individuals meeting their basic needs, due to limited transportation and constrained finances. Two respondents mentioned a lack of community and family support that could lead to poor health outcomes and higher rates of social isolation and loneliness.

*What, if anything, is being done in your community to address loneliness and social isolation?*

When asked what is currently being done in their rural community to address loneliness and social isolation, the most common response was, “nothing” (n=7; 50% of responses). Still, six respondents mentioned different ways that groups are working to increase social support, including through faith-based groups, community groups, and on social media. Five respondents discussed different ways that their communities are working to address individuals’ basic needs, to stave off the worst impacts of social isolation. These included providing food and transportation, although some of those programs were specific to older adults, not middle-aged adults. Finally, two respondents mentioned efforts to increase access to health care, especially mental health care.

## **Conclusion**

Recent demographic trends suggest that the prevalence of middle-aged adults living alone will only continue to grow. In rural communities, which have unique health care, housing, and socio-demographic landscapes, tailored efforts may be required to support the health, social, and emotional needs of this population. While many people choose to live alone, and thrive in doing so, others experience poorer health and barriers to access the instrumental and social support that they need. Respondents in this study, who were mostly hospital dis-

charge planners or care coordinators in rural communities with a high proportion of middle-aged adults living alone, suggest that more work is needed to ensure that these individuals have sufficient access to health care, transportation, and basic needs in order to mitigate the potential health impacts of social isolation and living alone. Such work should include policy action, as well as additional research to better understand the experiences and outcome of rural adults living alone, including how those experiences vary by region of the U.S.

The difficulties and health risks of social isolation have come into sharp focus in the midst of the COVID-19 pandemic. Within communities where many individuals live alone, finding ways to support and engage individuals living alone is essential for ensuring good population health outcomes. In an era of physical distancing and shuttered social infrastructure, finding creative and resourceful ways to facilitate social connectedness among individuals living alone is more important than ever.

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For more information, contact Carrie Henning-Smith ([henn0329@umn.edu](mailto:henn0329@umn.edu))

University of Minnesota Rural Health Research Center  
Division of Health Policy and Management, School of Public Health  
2221 University Avenue SE, #350 Minneapolis, MN, 55414