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Social Isolation and Loneliness: Imperatives for Health Care in a Post-COVID World

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The importance of social determinants of health has been gaining traction in the health care sector during the last decade. Social determinants of health have been found to be responsible for [80% to 90% of health outcomes](#), and an abundance of research has demonstrated that no matter the advancements in medicine and health care, the health of individuals and communities will not improve if these root-cause social factors are not addressed. The coronavirus disease 2019 (COVID-19) pandemic is highlighting one of these factors: social isolation.

Social isolation, [defined as](#) an “objective deficit in the number of relationships with and frequency of contact with family, friends, and the community,” is associated with [increased rates of loneliness and suicide](#), hypertension, and [other physical health effects](#) that may be mediated by neurohormonal-immunological pathways. Demonstrated to be [as dangerous to health as smoking 15 cigarettes per day](#), social isolation has been identified as worthy of being a [public health priority](#).

In 2017, the [AARP reported](#) that only 14% of older adults in the US were socially isolated, but accounted for \$6.7 billion in additional Medicare spending. In a [national survey in August 2020](#), 61% of those aged 50 years or older reported experiencing social isolation since the pandemic began. The isolation is compounded for those living in [rural areas](#). Nonetheless, the US health care system seldom screens for or discusses social isolation with patients.

A 2019 National Academies of Science, Engineering, and Medicine report, [“Integrating Social Care Into the Delivery of Health Care: Moving Upstream to Improve the Nation’s Health,”](#) noted that being able to screen for patients’ social needs requires valid and reliable tools and the systems to help their use become routine. In addition to social isolation, screening tools should also include a focus on loneliness, which is [different from social isolation](#). Loneliness arises from a discrep-



ancy between desired and actual level of social connection, and is itself associated with [detrimental health effects](#).

The UK has begun to include social isolation in its policies and approaches. In 2018, [then-Prime Minister Theresa May included social isolation and loneliness as strategic priorities](#), appointing a Minister of Loneliness, dedicating funds to address the issue, and joining with tech companies to innovate creative solutions. This national focus has led to significant innovations, such as the city of Leeds [equipping frontline city workers with an app](#) that allows them, when they are out in the community, to document possible signs of isolation at an address (such as closed curtains or piles of mail); the app then creates heat maps that inform the city’s community outreach in a more efficient way. In 2020, current Minister of Loneliness, Baroness Barran, announced the [awarding of £5 million](#) (about \$6.7 million US) to nonprofit organizations for initiatives to reach out to the growing numbers of people who are at risk for loneliness.

If the COVID-19 pandemic has taught the health care community and others anything, it is that there is a capacity to adapt and change course. [Rush University](#)

[Medical Center](#) in Chicago (where 2 of the authors work) has added a social connection question in its standard social determinants of health screening tool (“In a typical week, how many times do you talk with family, friends, or neighbors?”) and have referral pathways to interventions such as a friendly caller initiative in which volunteer community members, Rush employees, students, and AmeriCorps members make weekly socialization calls to older adults who request them. To date, more than 600 friendly calls have been completed. To improve upon the approach, a co-design process is underway, engaging individuals who have reported isolation or loneliness.

Consumer groups looking at the effects of loneliness and isolation on those in long-term care facilities during the pandemic have [recommended ways](#) to expand socialization and visitation policies, while continuing to uphold infection control strategies. For instance, peer mentoring programs between residents help to maintain social connections and have demonstrated additional benefits for the resident who volunteers as a mentor. An [increasing number of states](#) are providing guidance for long-term care facilities to

allow flexibilities for “essential caregivers” to visit residents in an effort to minimize the unintended consequences of isolation on resident health and well-being.

Moving forward, there must be continued acknowledgement of the inherent connection between social isolation and the other social determinants of health, as well as leveraging of relationship-based care and community-level supports to address social needs. [Public Health Solutions](#), a public health nonprofit organization that focuses on improving the health and well-being of vulnerable families and communities in New York City, determined that older adults living in public housing were experiencing heightened social isolation during COVID-19, in part because they were unable to access and use the internet to connect for medications, health visits, access to food, and social support. This organization is working with the New York City Housing Authority to bring the internet to older adults in one public housing building in East Harlem, provide the hardware and software to connect virtually, and give the necessary instruction on its use. If successful, it will be expanded to other senior housing complexes. Initiatives of this nature will inform discussions

of treating access to broadband and the internet as [public utilities](#).

Similar innovations are happening elsewhere, but not yet at a large enough scale. Although [structural changes in society](#) can provide upstream approaches to preventing social isolation, there are 2 significant barriers for health care systems: the lack of time available as a part of routine care to screen for and discuss isolation and loneliness during visits, and the lack of direct reimbursement for such discussions under fee-for-service payment systems. Although capitated payment does create an incentive to invest in preventive care, most health systems and payers have a plethora of population health and quality improvement initiatives underway. This makes it difficult to pinpoint the return on investment of initiatives focused specifically on loneliness and isolation and thus to secure ongoing resources.

Connection to others is a fundamental piece of what it means to be human. It provides meaning and purpose in life and creates safety nets of supports that individuals turn to during adversity. Yet, to the detriment of the most vulnerable fellow humans, society has consistently prioritized values like self-reliance and independence

over connection and interdependence. The [pandemic is highlighting](#) that this must change now and continue during the post-pandemic era. ■

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Correction: This article was corrected on January 5, 2021, to add the middle initial and fix the incorrect academic degree and license for the second author in the byline.

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