Legal and Policy Interventions to Address Social Isolation

Public Health and the Law

James G. Hodge, Jr., Erica N. White, and Claudia M. Reeves

Self-reported senses of loneliness and insignificance by millions of Americans reflect more than a downward societal trend. Social isolation (SI) extending from the actual or perceived breakdown of relational ties is increasingly shown to have substantial health impacts among multiple populations of varied ages.[1] Known and suspected causes are manifold — changes in familial structure, rise of smartphones, mental health stigmatization, inhospitable environments, increased urbanization, and even caustic political discourse.[2] Yet, as a primary social determinant of health, lack of connectedness contributes to excess morbidity and lowered life expectancies similar to risk factors like tobacco use and obesity.[3] Researchers in a 2015 study intimate SI may increase mortality risks by nearly 30%.[4] Negative health effects tied directly to diminished social ties include heightened rates of coronary heart disease, stroke, immuno-suppression, diabetes, depression, and dementia.[5] Worse yet, SI may lead to substance use or other perilous health behaviors escalating rates of suicide among adolescents and young adults.[6] Loneliness can be a foreboding yet silent killer across all levels of society.[7]

Greater recognition of isolation as a significant cause of excess morbidity and mortality is key to prevention. Yet, a remaining challenge is how to address SI from a public health legal perspective. Legal and policy interventions to control infectious diseases, curb chronic conditions, or mitigate injuries are well-established and efficacious. Ameliorating a "national epidemic"[8] of loneliness through law is complicated.[9] Besides tangential efforts to date, U.S. public health authorities have not accurately measured or targeted SI as a distinct, remediable condition (despite greater awareness in other countries).[10] Americans have constitutional rights to be left alone which aggressive legal interventions may infringe. Seeking to strike appropriate balances, we present a series of inventive law and policy approaches addressing SI juxtaposed against potential legal, political, or practical objections underlying a prevalent, yet personal, harm to human health.

SI Surveillance

Effective public health prevention and response efforts rely on accurate data. Yet, data on the incidence and prevalence of SI are highly unreliable.[11] Lacking strong, affirmative measurements, explicit attempts to positively intervene are patchwork. Generating better data through legally-authorized surveillance requirements of SI is theoretically possible, but abstruse.[12] What specific information should be measured, and by whom? Isolation is not a diagnosable illness like COVID-19 or chronic health conditions. Loneliness may be an observable trait, but traditional surveys like UCLA's Loneliness Scale are prone to subjectivity, misreporting, and inconsistences.[13] Relying on health care practitioners, mental health professionals, social workers, teachers, or long-term care providers to perceive SI among individuals is impractical and raises informational privacy concerns. SI

About This Column

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surveillance should focus instead on its manifestations.[14] Like syndromic surveillance, which detects early signs of outbreaks, contaminations, or chronic conditions,[15] SI reporting must gauge indicators tied to isolative impacts (e.g., depression, heart disease, suicide attempts, substance misuse) aggregated as a "SI index." Tracked over time, verifiable trends based on reliable SI data may illuminate its incidence and validate legal interventions.

Zero Patient Cost Sharing

Efficacious treatments for SI remain under-utilized as many Americans decline mental health care services due to costs or privacy concerns.[16] Interventions specifically targeting maladaptive thinking such as Cognitive Behavioral Therapy (CBT) can help combat SI conditions like depression and anxiety by challenging unproductive cognitive distortions and behaviors.[17] However, efficacious therapy services on weekly or monthly bases are expensive. Out-of-pocket payments pose financial barriers for individuals that decrease access. Additional barriers involve insufficient insurance networks, rural provider deficiencies, and non-ACA compliant association health plans. Diminishing these concerns, specifically costs, are essential.[18] The Affordable Care Act (ACA) requires all private insurers to provide coverage for specified preventive services, with no patient-cost sharing,[19] heightening utilization of cancer screenings and other exams to improve long-term population health. Adding mental and behavioral health services to ACA-mandated preventive care coverages will increase use of one-on-one or group therapies and pharmaceutical access. As with annual physicals provided via ACA coverage, mental health visits may face caps as well to deter over-utilization.

Solitude Tax Policies

With 28% of Americans choosing to live alone in 2018,[20] government economic interventions can directly alleviate public health repercussions tied to isolative behaviors.[21]The power to tax has always included the ability to incentivize health-conscious behaviors,[22] such as reduced consumption of tobacco products or sugar-sweetened beverages. Property, excise, income, and vehicular taxes may all be wielded to influence individual choices against isolative behaviors. Standard income tax deductions already reward married or jointly filing individuals. Americans living in long-term, single-resident housing may face higher occupancy taxes. Sales taxes can target isolative products, such as sole-player video games. Commuters in single-occupancy vehicles may be charged higher tolls. Whether explicit or implicit, these and other tax burdens can lend to socially-beneficial activities. Even if legally-viable, taxing isolative behaviors or products is politically contentious. Lawmakers and voters tend to disdain taxes designed to alter autonomous choices in perceived paternalistic ways,[23] or that fall more heavily on vulnerable populations. Greater public understanding of the known harms of SI may help generate some support, but ameliorative tax approaches must still be artfully propositioned.

Pet Ownership Tax Incentives

One tax scheme that might enjoy overwhelming popular support, however, relates to pets. In 2019, 67% of U.S. households owned pets, spending $75.38 billion for care and maintenance.[24] Americans' adoration for pets carries significant health benefits. Research suggests that 80% of pet owners experience decreased loneliness, 76% agree human-animal interaction curtails social isolation, and 54% report improved social connections compared to non-pet owners.[25] Dog ownership is attributed with decreasing all-cause mortality by 24% between 1950-2019 due, in part, to alleviated social isolation[26] via increased interactions with community members and animal-friendly, shared public spaces (e.g., parks, trails, dog-friendly eateries). Currently, federal tax deductions may be allowed beyond a certain threshold for isolative medical expenses or costs of dedicated service animals for specific health conditions (e.g., seizure, epilepsy, sensory impairments).[27] Considerably greater incentives to enhance pet ownership, and address SI, may stem from a tax credit for reasonable pet-related expenses. Subject to annual caps, limits, and protections against possible animal abuse,[28] crediting individuals for pet ownership would be politically popular, but economically controversial. Decreasing federal revenues to support pet ownership may be viewed as specious against so many other desper-

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ate human needs. Yet, attributing a pet tax credit to improved individual and communal health and social outcomes with commiserate cost savings may alleviate some criticism.

Smartphone-free Zones

Sharp increases in SI correspond with near-ubiquitous smartphone and social media usage among adolescents and young adults. In 2018, 95% of teens had access to smartphones and 45% reported being online "almost constantly."[29] Coincidentally, the numbers of high school seniors reporting feelings of loneliness rose from 26% in 2012 to 39% in 2017.[30] Suicide rates among young adults doubled from 2007 to 2016.[31] Though negative health impacts are not fully correlative, decreasing use through limited "smartphone-free zones" may enhance personal social interactions.[32] Restricting access to harmful products is a common public health legal intervention.[33] Smoke-free laws inhibit tobacco use or vaping in many public settings. Alcohol-carry laws prohibit public intoxication. The federal Gun-Free School Zones Act[34] limits minors' exposure to firearms in primary and secondary schools. Of course, smartphones are not inherently as dangerous as guns, tobacco, or alcohol. Possession and use of smartphones can encourage virtual networking and enhance personal safety, especially among at-risk adolescents and young adults. Still, regulatory institution of limited "smartphone-free zones" in classrooms, dining facilities, and other select school or university settings provide opportunities for social engagement.[35] Separating individuals from their smartphones in select environments may infuse additional interactions with corollary health benefits.

Social Program Modifications

Researchers consistently point to a lack of connectedness as a definitive cause of societal loneliness.[36] Many Americans experience isolation in their communities even as they rely on social programs conducted by public and private sectors. Federally-funded Medicare insures over 44 million seniors and disabled persons.[37] State-based Medicaid plans cover millions more Americans. The U.S. Department of Agriculture's Women, Infants, and Children (WIC) program[38] and Supplemental Nutrition Assistance Program (SNAP)[39] benefits, among others, provide essential needs for individuals — many of whom regularly report being lonely. In partial response, public programs may generate new legal incentives for recipients to "get connected" through benefits. Given patently unlawful state efforts to set unreasonable work requirements for Medicaid beneficiaries,[40] receipt of benefits cannot be conditioned on incentives to stimulate connectedness. However, program perks and add-ons may be offered to nurture active participation in socially-beneficial activities. SNAP benefits, for example, could reward recipients buying from local farmers' markets (where greater socialization may arise). WIC recipients may be encouraged to participate in support groups for young mothers. Voluntary, at-home "well" visits among Medicare enrollees living alone provide opportunities to socialize. So long as recipients of government benefits are not penalized for failures to engage, positive social motivators may ameliorate SI.

Corporate Wellness

Persons across all ages and levels report social isolation at work: 56% of senior executives and 73% of Gen-Z workers feel alone.[41] Telework initiatives, workplace earbud use, demanding schedules, and office structures contribute to these findings. Harvard researchers found that employees in open plan offices have 73% less face-to-face interaction and compensate with 67% greater electronic use.[42] Solutions may extend from multiple managerial or other interventions as well as modifications in work-related benefits. Most corporate wellness programs, for example, prioritize improved physical outcomes (e.g., body mass indices, blood pressure, glucose). Yet, employee mental wellness carriers significant costs exceeding $210.5 billion in 2015 for medical treatments and absenteeism.[43] Several company initiatives, including Cigna's Community Ambassador Fellowship program, target social isolation by facilitating community volunteering.[44] Other companies foster social wellness through special interest clubs, team-building activities, and sports activities. Additional wellness initiatives may include therapy check-ins, qualifying social gatherings, book clubs, nature visits, library card acquisition, or lessened social media usage. Uptake of these efforts could be motivated by contractual conditions of employment or financial incentives such as reduced insurance premiums or gift cards, so long as employees are not unlawfully stigmatized or subjected to privacy infringements.

Built Environment Modifications

Urban and workplace built environments must be redesigned to be accessible, equitable, and responsive to enhanced social connectedness. The United Nations predicts that by 2050, the percentage of people living in cities globally will increase from 50% to 67%.[45] Dense urban living, however, does not always facilitate neighborly contacts. Many inner-city residents report feeling isolated.[46] Built environments centered on vehicular transportation and lacking in accessible parks, plazas, and common areas inhibit social congregation.[47] Increasing community spaces is key. For decades, zoning laws have been wielded in the interests of public health, including requiring greater community space options and uses. Suburban developments increasingly feature sidewalks, set-aside recreation areas, and multi-use community centers. Parks and other open spaces may host "friendship benches" that facilitate conversations with trained mental health care workers.[48] Research shows that persons who regularly visit these sites over extended periods enjoy marked improvements in mental health conditions such as depression, stress, and suicidal thoughts.[49] Adaptations in the built environment may be resisted by developers due to one-time construction costs. In reality, infusing these and other socially beneficial features into urban and

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building design are major selling points for consumers. They are also stimulants for lowered public health impacts of SI.

Note

The authors have no conflicts to disclose.

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