Editorials

Time to reshape our delivery of primary care to vulnerable older adults in social housing?

HOUSING IS A SOCIAL DETERMINANT OF HEALTH

Housing is a social determinant of health that fundamentally affects health and wellbeing.[1] A UK study found housing to be a unique predictor of health outcomes, after accounting for income.[1] Although social housing can improve health through the financial benefit of lower rent,[2] it also has negative impacts due to building disrepair,[2] and policies resulting in clusters of residents with poor mental health and substance issues.[3] Social housing exists in many formats across the globe: council estates in the UK; projects or public housing in the US; social housing in Canada; social or public housing in Australia; and state housing in New Zealand.

MANY OLDER ADULTS LIVE IN SOCIAL HOUSING AND ARE VULNERABLE

In the US, it is predicted that, by 2035, one in three public housing units will be occupied by an individual aged ≥65 years,[4] while in the UK that is already the situation.[5] In Ontario, Canada alone, approximately 75 000 older adults live in social housing.[6]

Older adults on low incomes are a vulnerable population with increased risk of chronic disease, falls, social isolation,[7] and poor outcomes from COVID-19. In-person restrictions have heightened the importance of internet-based solutions for access to health care, information, basic necessities (for example, grocery apps), and friends and family. However, older adults on low incomes have limited ability to access services launched specifically for COVID-19 due to poor health literacy[8] and lack of internet.[9] This compounded social isolation can have a detrimental impact on older adults' mental health and resilience, especially in social housing.

HOW CAN WE RETHINK THE PRIMARY CARE THAT WE DELIVER TO RESIDENTS OF SOCIAL HOUSING?

The COVID-19 pandemic reveals weaknesses in our primary care systems and illustrates how older adults on low incomes could benefit from access to their primary care team, though health care is understandably stretched during the pandemic. Traditionally, GPs have visited those most vulnerable in their homes; however, it is not practical, nor acceptable for infection control, to expect GPs to personally visit everyone. Nonetheless, the delivery of health care virtually has not been carefully conceptualised for vulnerable populations,[10] leaving them even more open to disparities of primary care access. The burden of care provision for older adults in social housing is worth attention to ensure that effective primary care can be maintained with this marginalised population. Some issues in primary care delivery are evident:

Administering influenza vaccinations. In recent years, traditional vaccination delivery has been moving beyond the GP's office to community-based locales to boost administration of the annual flu vaccine through local initiatives. Vaccination task-shifting has included community-based flu clinics administered by nurses and outreach by paramedics to frequent callers of emergency health services. Growing these local initiatives into widespread standard practice and consolidating efforts via these delivery mechanisms could enable provision of influenza vaccine to a greater proportion of older adults in their homes or nearby, improving accessibility and coverage. This strategy could be expanded to pneumonia and shingles vaccinations, as well as COVID-19 vaccinations in the future.

Maintaining primary care connections with the movement to telehealth/virtual health. The pandemic has accelerated the transition to remote primary care provision using telehealth or virtual health. Although increasing accessibility to primary care for many, it leaves older adults on low incomes stranded because of limited internet access or technology user-challenges, and older adults' perceptions of using technology for health care is mixed.[11] However, these are not insurmountable hurdles. Social housing working effectively with community organisations and volunteer groups can aid residents in using technology, facilitating connection with their GP. Many programmes exist in the UK and North America pairing the lay public or healthcare students with older adults by phone, mitigating loneliness.[12,13] Such programmes could expand to have volunteers facilitate connections between older adults and their GP. These efforts could be enhanced through government investment in internet services for social housing buildings or organisations donating tablets for use with residents. Older adults can be supported in keeping the critical connection with their GP while also encouraging broader social engagement through technology.

Ensuring monitoring of patients with chronic diseases. Although volunteers can facilitate a primary care connection, they cannot conduct medical assessments. Instead, task-shifting, utilising other healthcare professionals, is a potential strategy. In Canada, paramedic services implemented the Community Paramedicine at Clinic (CP@clinic) programme[14] in social housing common rooms to decrease cardiometabolic risks and improve quality of life of residents. This programme reduced emergency medical calls from those buildings, benefiting the health system.[14]

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Residents had their health concerns addressed by a community paramedic and socialised with other residents in this new venue. CP@clinic programme modifications now include over-the-phone health risk assessments and infection control measures. In-person assessments will only be utilised if needed. All health findings are faxed to the primary care providers so that the GP can contact their patients when an assessment result is flagged as abnormal, reducing unnecessary COVID-19 exposure. In the UK, modelling the CP@clinic programme's methods, expansion of the traditional health team with paramedics is being piloted in an effort to increase the reach of primary care.[15] The aim is to offer an alternative to people directly accessing GP services as the first point of contact for healthcare issues.

These additional supports should be co-delivered with GPs so that they are more aware of the preventable health issues their older adult patients in social housing face. Many in this marginalised, vulnerable population may have multiple health-related conditions that are not currently being effectively managed and who would benefit from improved disease management through communication and information sharing with GPs. Connecting social housing residents back to primary care benefits healthcare service delivery and promotes continuity of care.

CONCLUSIONS

Reshaping primary care delivery at any time seems unattainable and fraught with challenges, let alone during a global pandemic when healthcare resources are stretched. COVID-19 has forced us to confront our healthcare system's weaknesses and further acknowledge the inequities that exist. However, it can push us to be innovative, leveraging untapped resources that exist within and beyond the system of healthcare professionals.

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