

Online 4 April 2017 at the Journal of the American Geriatrics Society, doi: 10.1111/jgs.14893

AUTHOR POST-PRINT

Social inequalities in dementia care, cure, and research

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Running title: Social inequalities in dementia

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Funding

The manuscript was prepared with support from the Fonds National de la Recherche Luxembourg (FNR/P11/05, FNR/P11/05bis, PI: Louis Chauvel). The funder had no involvement in writing of the article or in the decision to submit it for publication.

The World Health Organization's Executive Board discussed the revised Global Action Plan on the Public Health Response to Dementia at the end of January 2017, with recommendations for the plan to be adopted by the World Health Assembly the following May.¹ That was a major step toward concerted worldwide efforts to address dementia care, cure, and research. With its inclusive nature, the plan aims to improve all countries' standards regarding dementia; it is thus most welcome since deficits certainly exist even in the most advanced countries.²

Two crosscutting principles of the plan target potential social inequalities in dementia. The first advocates "universal health and social care coverage for dementia" and equitable access to all relevant care services, regardless of financial resources. The second principle supports "equity," stressing that all public health responses should support gender equity and vulnerable people "specific to each national context."¹ These principles are important and well founded; however, they may not fully address the staggering ubiquity of social inequalities in dementia.

The drastic educational differences in cognitive function, decline, and dementia incidence are well known: they are commonly explained by both differences in intelligence that selects into education, and the neuroprotective effects of education that increase cognitive reserve.³ Without considering such educational differences in this letter, social inequalities in dementia can be found in virtually all fields of cure, care, and research. Here, I regard early access to diagnostic services and to anti-dementia medication as desirable—even if no cure currently exists; likewise, I consider the prescription of antipsychotic drugs potentially undesirable since such drugs have "important and potentially serious side effects" and should be prescribed only with caution and close monitoring.⁴

Social inequalities in dementia incidence exist among racial and ethnic groups.⁵ However, they are also evident in research, care, and treatment. People from ethnic minorities access diagnostic services later in life; after being diagnosed, they are less likely to receive anti-dementia medication, undergo research trials, or receive 24-hour care.⁶

Disparities according to gender (with higher prevalence of dementia in women)⁷ are to a large extent attributable to the greater longevity of women; however, this may not be the full explanation.⁷ Gender disparities are also evident in access to research since recruitment to dementia studies is more likely to involve men.⁸

Both individual and neighborhood socioeconomic differences play a large role in social inequalities in dementia care: having a lower income decreases the chances of receiving counseling.⁹ A lower income increases the likelihood of receiving antipsychotic drugs after diagnosis of dementia.⁹ In England, living in areas with higher deprivation decreases the likelihood of being prescribed anti-dementia drugs;¹⁰ living in rural areas increases the probability of receiving antipsychotic drugs.⁹

What are the implications of those social inequalities in dementia cure, care, and research? Currently, in contrast to the principle of equity stated in many national dementia plans, substantial numbers of people living with dementia do not receive optimal medical treatment or care; they lack the opportunity to participate in—and therefore benefit from—research studies. These inequalities may also extend to imbalanced access to risk-reduction interventions despite a priori different needs of risk reduction. In economic terms, persisting inequalities suggest that research funding may be targeting already more advantaged groups. Medical and care expenses are probably not being equitably allocated to those in need.

The magnitude of social inequalities in dementia—even in the most advanced countries—suggests that only concerted efforts made by different players can improve the current situation. It may be helpful to draw from two decades of experience in the field of heart disease: there, similar to dementia, inequalities in heart disease may be found in all relevant areas of diagnosis, treatment, prevention, and care, with women being systematically, seriously disadvantaged.¹¹ Strong efforts from funders, health-care providers, and policy makers became necessary to address those social inequalities, but the efforts remarkably improved the situation for women with heart disease. However, several complexities related to gender differences in presentation, risk factors, and response to treatment of heart disease remain to be clarified.¹¹

Fortunately, growing worldwide research on social inequalities is also targeting people with dementia. The evidence from such research needs to be translated into rigorous policy responses in a timely manner. Firm efforts by all parties involved in mitigating social inequalities in dementia will be needed to advance toward more equitable access to care and treatment for all individuals living with dementia.

Acknowledgments

I am grateful for helpful comments from Dr. Clare Walton.

Conflict of Interest

I am a member of the Steering Group of World Young Leaders in Dementia, a global network of young dementia experts. This role is not remunerated. On behalf of that network, I recently led a review group to comment on the draft World Health Organization plan during its stakeholder and organization consultations. That role was likewise unremunerated. I have no conflicts of interest.

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