National Dementia Strategies in OECD Countries: A Focus on Inequities

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Abstract

Background: In response to global increases of dementia prevalence, several countries have developed national strategies to address dementia as a public health priority. These strategies aim to improve dementia care, supports, and resources for all citizens, including persons living with dementia, care partners, and communities. Inequities faced by vulnerable populations impact dementia care and health outcomes, however it is unclear whether dementia strategies adequately address these. This environmental scan aims to (1) describe the trends in the different economic, political, and demographic factors that may be associated with the development of national dementia strategies in OECD countries to understand why some countries have or do not have dementia strategies, and (2) describe if and how OECD countries' national dementia strategies consider inequities as a target of concern.

Methods: This thesis uses an environmental scan to identify, analyze, and evaluate the existing national dementia strategies of countries in the Organization for Economic Cooperation and Development (OECD).Two databases of grey literature (Alzheimer Europe and Alzheimer's Disease International) were searched for national level dementia strategies, in English or French, for countries that are members of the OECD. After identifying where national dementia strategies have been developed, an analysis of the current health care context was conducted in order to identify trends and associations between dementia strategy implementation and the economic, political, and demographic contexts of the countries in which they currently exist. To do so, we looked at the Gross Domestic Product, percent of health spending, and the percent of population age 65+ of each OECD country. Dementia strategies were analyzed for the presence or absence of seven equity-focused targets of concern. These seven categories (race/ethnicity, religion, age, disability, sexual orientation/gender identity, social class, and rurality) were selected based on two well-known frameworks (The United Nations System Shared Framework for Action, and A Conceptual Framework for Action on the Social Determinants of Health), and then evaluated based on the existence of specific objectives that aim to mitigate inequity in dementia care.

Results: As of 2022, 27 out of 38 OECD countries have developed national dementia strategies. Of these, 15 strategies met the inclusion criteria. Twelve strategies were excluded (not at the national level, not in English or French, or not accessible). The included strategies were analyzed based on the following potential healthcare inequities: (1) race/ethnicity, (2) religion, (3) age, (4) disability, (5) sexual orientation/gender identity, (6) social class, and (7) rurality. 13 out of 15 (87.0%) of the national dementia strategies mentioned at least one inequity, while 1 out of 15 (6.7%) mentioned all seven inequities. Of the strategies that did mention inequities, 5 out of 13 (46.2%) had specific objectives in place to mitigate inequities.

Conclusion: Although most countries mention inequities in their national dementia strategies, few explore these inequities in depth or have concrete goals in achieving their general objectives. This scan suggests that there is a need to evaluate current national dementia strategies, determine if existing policy is adequately structured to mitigate inequities in healthcare, and if not, modify policy based on the current status of dementia globally.

Résumé

Contexte: En réponse à l'augmentation mondiale de la prévalence de la démence, plusieurs pays ont élaboré des stratégies nationales pour faire de la démence une priorité de santé publique. Ces stratégies visent à améliorer les soins, le soutien et les ressources en matière de démence pour tous les citoyens, y compris les personnes atteintes de démence, les partenaires de soins et les communautés. Les inéquités auxquelles sont confrontées les populations vulnérables ont un impact sur la prise en charge des démences et sur les résultats en matière de santé, mais il n'est pas certain que les stratégies de lutte contre les démences s'y attaquent de manière adéquate. Ce scan environmental vise à (1) décrire les tendances des différents facteurs économiques, politiques et démographiques susceptibles d'être associés à l'élaboration de stratégies nationales de lutte contre la démence dans les pays de l'OCDE, afin de comprendre pourquoi certains pays disposent ou non de stratégies de lutte contre la démence, et (2) décrire si et comment les stratégies nationales de lutte contre la démence des pays de l'OCDE considèrent les inégalités comme une cible de préoccupation.

Méthodes: Cette thèse utilise un scan de l'environnement pour identifier, analyser et évaluer les stratégies nationales de lute contre la démence existantes dans les pays de l'Organisation de coopération et de développement économiques (OCDE). Deux bases de données de littérature grise (Alzheimer Europe et Alzheimer's Disease International) ont été consultées pour trouver des stratégies nationales de lutte contre la démence, en anglais ou en français, pour les pays membres de l'OCDE. Après avoir identifié les pays où des stratégies nationales de lutte contre la démence ont été élaborées, une analyse du context actuel des soins de santé afin d'identifier les liens et les associations entre la mise en œuvre des stratégies de lutte contre la démence et les contextes économique, politique et démographique des pays dans lesquels elles existent actuellement. Pour ce faire, nous avons examiné le produit intérieur brut, les dépenses de santé et les données démographiques par âge de chaque pays de l'OCDE. Les stratégies de lutte contre la démence ont été analysées pour vérifier la présence d'une préoccupation axée sur l'équité. Ces sept catégories (race/ethnicité, religion, âge, handicap, orientation sexuelle/identité de genre, classe sociale et ruralité) ont été sélectionnées sur la base de deux cadres bien connus (The United Nations System Shared Framework for Action, et A Conceptual Framework for Action on the Social Determinants of Health), puis évaluées en fonction de l'existence d'objectifs spécifiques visant à atténuer les inéquités dans la prise en charge des démences.

Résultats: En 2022, 27 des 38 pays de l'OCDE ont élaboré des stratégies nationales de lutte contre la démence. Parmi celles-ci, 15 stratégies répondaient aux critères d'inclusion. Douze stratégies ont été exclues (pas au niveau national, pas en anglais ou en français, ou non accessibles). Les stratégies incluses ont été analysées en fonction des inéquités potentielles suivantes en matière de soins de santé : (1) race/ethnicité, (2) religion, (3) âge, (4) handicap, (5) orientation sexuelle/identité de genre, (6) classe sociale et (7) ruralité. 13 des 15 stratégies nationales sur la démence (87,0 %) ont mentionné au moins une iniquité, tandis qu'une sur 15 (6,7 %) a mentionné les sept inéquités. Parmi les stratégies qui mentionnaient des iniquités, 5 sur 13 (46,2 %) avaient des objectifs spécifiques en place pour atténuer les inéquités en question.

Conclusion: Les résultats de ce scan suggèrent qu'il est nécessaire d'évaluer les stratégies nationales actuelles en matière de démence, afin de déterminer si les politiques existantes sont structurées de manière adéquate pour atténuer les inéquités en matière de soins de santé et, si ce

n'est pas le cas, de modifier les politiques en fonction du context actuel de la démence à l’echelle mondiale.

Table of Contents

List of Figures and Tables

Acronyms

GDP	Gross Domestic Product
OECD	Organization for Economic Cooperation and Development
SDH	Social Determinants of Health
SES	Socioeconomic Status

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Contributions of Authors

In total, three reviewers contributed directly to this thesis project: Georgia Hacker, Dr. Isabelle Vedel, and Dr. Claire Godard-Sebillotte. Given these multiple contributions, the contributions of Georgia Hacker, the master's candidate and primary researcher, should be clarified with respect to those of her supervisors.

- The review of relevant literature was written entirely by Georgia Hacker, with feedback and editorial assistance from Dr. Vedel and Dr. Godard-Sebillotte.
- The methods were conceived jointly by Georgia Hacker and Dr. Vedel, however the methods section of this thesis was written entirely by Georgia Hacker with feedback and editorial assistance from Dr. Vedel and Dr. Godard-Sebillotte.
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- The results section was written by Georgia Hacker, with feedback and editorial assistance from Dr. Vedel and Dr. Godard-Sebillotte.
- The topics and reflections for the scholarly discussion were conceived by Georgia Hacker, with feedback and editorial assistance from Dr. Vedel and Godard-Sebillotte.
- Finally, this thesis document was entirely written by Georgia Hacker.

Introduction

The purpose of this thesis is to understand which elements, if any, are associated with the development of national dementia strategies, analyze if and how dementia strategies mention inequities as targets of concern, and identify the presence of objectives that countries have in place to mitigate the effects of inequities in dementia care, using an environmental scan of national dementia strategies as a health intervention. The thesis that follows has been organized in the manuscript-based style, and includes the following major sections: a review of the relevant literature, a detailed description of methods, a results section, and a scholarly discussion. Additional components include a Title Page, Abstracts in English and French, a Table of Contents, a List of Figures and Tables, Acknowledgements, an overview of the Contribution of Authors, a Reference List, and several Appendices.

Review of literature on dementia

Dementia, as defined by the World Health Organization (WHO), is a "syndrome of cognitive impairment that affects memory, cognitive abilities, and behaviour, and significantly interferes with a person's ability to perform daily activities" (1). As of 2020, an estimated 55 million persons have been living with dementia worldwide, a number that is predicted to double approximately every 20 years (2). This upwards trend is largely driven by the significant proportion of the global population reaching their older years and increased life expectancy in the older population, along with an increase in lifestyle-related risk factors like obesity, inactivity, and diabetes among young people, all of which are risk factors for dementia at early and late stages (3). Given that there are no known effective treatments for dementia, these numbers will likely continue to grow over time, and negatively impact individuals and health care systems globally (3).

The increasing global prevalence of dementia has individual and societal consequences. Dementia is a “major cause of disability and dependency” among primarily older individuals and has significant impacts on the social and financial wellbeing of family members, care partners, and communities (1). Persons living with dementia have complex and multifaceted healthcare needs, which require coordinated and multisystem collaboration among health care providers to effectively manage. Dementia also overwhelmingly impacts the economy and health care infrastructure, and if left unaddressed, could have detrimental effects on global development and economic growth (4).

Review of inequities

Health inequity is defined as “systemic differences in health status or in the distribution of health resources between different population groups arising from the social conditions in which people are born, grow, live, work and age” (5). These inequities can be due to biological determinants and genetic factors, but can also largely be impacted by certain social determinants of health (SDH). SDH are defined as “conditions in which people are born, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” (6). These non-medical factors include, but are not limited to, income and social status, employment, education, gender, race, and physical environment (7). The disparities created by these determinants can contribute to differences in diagnoses, treatment, and outcomes of disease, but can also present significant barriers to healthcare access and decision-making power of the patient.

The influence of health inequities is particularly relevant in dementia care and health outcomes. While some elements of dementia are widespread, many elements are experienced differently based on one's life and social circumstances, environments, and backgrounds (8). Differences in the SDH, particularly gender, socioeconomic status (SES), and race, among other determinants, have been shown to increase the risk of dementia and exacerbate negative outcomes of the disease; for example, lower SES has been associated with higher incidence of dementia, local deprivation has been associated with higher risks of cognitive impairment and cognitive decline (6, 9), and sex differences have been associated with specific risk factors of dementia (10). The discrepancy in the risk of developing dementia in men and women likely stems from the trends that show women live longer on average compared to men, and are also less likely to be as educated or engage in as much exercise – all of which are risk factors for dementia (10). Unfortunately, the risk factors for health inequities are not always taken into account when implementing large-scale health reform, and because of this, many persons with dementia are left experiencing significant physical, mental, and emotional hardship.

Overview of dementia strategies

Dementia has become increasingly viewed as a global public health priority because of its rising prevalence, and is recognized as a target of concern by the WHO (1). In May of 2017, WHO released their "Global Action Plan on the Public Health Response to Dementia (GAPD)", which aimed to improve the lives of persons living with dementia while decreasing the impact of dementia globally across seven target areas (1). One of these action areas is "dementia as a public health priority", which highlights the need for a multisectoral and total-government response to dementia. To address dementia as a public health priority, WHO put forward a global target of "75% of Member States to have developed or updated national policies, strategies, plans or frameworks for dementia, either stand-alone or integrated into other policies/plans, by 2025" (1). One year later in 2018, WHO released a new report, titled "Towards a Dementia Plan: A WHO Guide", which outlined technical guidelines and recommendations for governments and stakeholders to prepare, develop, and implement stand-alone or integrated dementia strategies (4). These national dementia strategies address dementia as a public health priority at the governmental level, but also push countries to address needs specific that are to their populations while identifying priority areas in their health care systems.

As of 2021, 40 countries and territories have developed dementia strategies, spanning from regional level strategies to national-scale strategies that promote the implementation of dementia-focused public health guidelines across all areas of governance, health and social services, and research (11). Although the WHO's action-based guidelines present targets towards realizing global dementia strategies, it also recognizes that each Member State faces specific challenges and unique socio-cultural situations. Therefore, these guidelines act mainly as a roadmap to successfully implement dementia strategies rather than enforcing generic recommendations upon all Member States. While this is largely beneficial to individual countries given their inherently different socioeconomic, political, and healthcare priorities, it has also led countries to develop strategies that do not necessarily address key risk factors and population-level SDH, notably, inequities in vulnerable populations (1). In order to develop policy that adequately addresses the needs of vulnerable populations, it is necessary to identify if and how these strategies currently mention inequities in dementia care, and analyze the general and specific objectives set forth in these strategies that act to mitigate inequities.

Literature Review

Premise

In this section, the reader will be introduced to the current state of dementia globally, and how the future of dementia care could be impacted by the development of national dementia strategies. First, this chapter will describe the current status of dementia, including the impact of dementia on individuals and on society, and the current gaps in dementia management. Next, it will describe what healthcare inequities are, and discuss how inequities impact dementia and dementia care. Then, the use of dementia strategies as a health intervention will be explored. Finally, this section will conclude by defining gaps in the literature, the purpose of this scan, and the overarching research questions.

Dementia as a Health Priority

As of 2020, dementia was the seventh leading cause of death among diseases, and noted to be one of the main causes of dependency and disability among adults in later life (12, 13). The strongest known factor for dementia is age; the likelihood of being diagnosed with dementia increases nearly six times in people above the age of 80 compared to those aged 65-79 (14). However, age alone is not sufficient to cause dementia, and generally, the disease both develops and progresses as a result of the interaction between multiple modifiable and non-modifiable risk factors. These include, but are not limited to, obesity, inactivity, diabetes, and depression (14-16). Given that there is currently no cure or disease-modifying treatment for dementia, it is likely that it will become even more prevalent as the population ages and life expectancy increases.

The increasing global prevalence of dementia, economic and social impact on families and communities, and the associated stigma surrounding a dementia diagnosis has severely overwhelmed the healthcare system, and has caused a significant burden on global and population health (17, 18). In 2012, the WHO deemed dementia to be a "public health priority" (18). In doing so, dementia became a central focus for advocacy, policy, and research, and is currently a priority area for public health initiatives.

Overview of dementia globally

Currently, dementia affects approximately 50 million people globally, a figure that is predicted to double by the year 2040 (19). This number represents approximately 5% of the world's population over age 65. There are nearly 10 million new cases of dementia each year, and this number is expected to rise considerably as the global population lives longer (19, 20).

Notably, the distribution of dementia throughout the global population is not equal, especially when looking at the economic and social contexts of low-, middle-, and high-income countries. The majority of persons living with dementia worldwide live in middle-income countries (21, 22). Low-income countries tend to have generally lower life expectancies, and as a result, less people are currently at risk of receiving a dementia diagnosis, thus reducing the prevalence of dementia among the population (2, 21-23). Contrarily, higher income countries are generally experiencing large-scale healthcare improvement and decreased birth rates, and while the prevalence of dementia may objectively be considered high, it may not be rising as rapidly as in other areas of the world (24). Middle income countries are facing increases in life expectancy and increased birth rates simultaneously, leading to an overall increase in both the absolute prevalence of dementia and the proportion of dementia prevalence world-wide (2). While these factors are not the only contributing factor to the unequal distribution of dementia, the trends seen in these systems might impact how the current population is experiencing dementia and dementia care.

Impact of dementia

Impact on patients and caregivers

The impact of dementia on those with the illness and their family members and caregivers is medically, emotionally, and psychologically extreme, and symptoms have been shown to profoundly affect quality of life (18). At its core, dementia affects the neurocognitive system, resulting in impaired cognitive ability that in many cases, impacts a person's ability to engage in activities of daily living (25). Dementia has also been associated with significant comorbidities and disabilities, causing many persons living with dementia to experience accelerated cognitive decline, have more difficulty managing chronic conditions, and face challenges accessing routine care, in addition to the challenges that accompany a dementia diagnosis (10, 26, 27). On average, people living with dementia who are over the age of 65 have an average of four comorbidities, and over 90% of persons living with dementia have at least one other health condition (28). These comorbidities can interact with dementia in complex ways, negatively impacting the diagnosis and outcomes of disease (10). Dementia is also a major cause of disability in older adults, and those who have the illness are likely to have impaired functioning, greater dependency needs, and greater need for social supports (18).

Dementia also uniquely impacts family members and care partners of those diagnosed. In 2020, care partners and family members of people with dementia provided a combined 15.3 billion hours of informal or social care (29). The massive burden that dementia care places on care partners impacts health and overall productivity, and compared to caregivers of people without dementia, twice as many caregivers of persons with dementia reported substantial emotional, physical, and financial difficulties (30, 31).

Economic impacts

The economic impact of dementia is devastating, and has significant implications on healthcare spending globally. This economic burden can generally be organized into three distinct areas: (1) direct medical care (physician visits, hospital admissions, long-term care, etc.); (2) social care costs (home healthcare, transportation, modifications to adapt to changes in functionality); and (3) informal care (care provided by family members or other supports) (32). According to the WHO and Reports from Alzheimer's Disease International, the total global cost of dementia, including treating and supporting persons with dementia and their caregivers, was greater than 1% of the global gross domestic product in 2010 and 2015 (18, 33). As of 2019, the estimated global cost of dementia was USD 1.3 trillion, a number expected to double by 2030 as the prevalence of dementia increases (19). The global economic burden of dementia is likely to continue to increase as both the prevalence of dementia and cost of health care rise.

Impact on the healthcare system

Persons living with dementia are high-frequency users of the healthcare system (34, 35). The management of dementia requires multisystem and highly coordinated medical care (36). The complex health needs and nature of care for persons with dementia is difficult to navigate, and as a result, many persons with dementia access the healthcare system at higher rates than those without dementia (26, 27, 37). Persons living with dementia have twice the amount of hospital use in comparison to those without dementia (38). Compared to rates by older individuals without dementia, persons living with dementia have higher rates of emergency department visits (39, 40), hospitalizations, and physician visits (41). Hospitalization rates are 65% higher for seniors living with dementia than for those without dementia, and seniors with dementia are more likely to access the emergency department more frequently and stay longer than those without dementia (42). Further, given that dementia is also associated with multi-morbidity, one can also expect that dementia-related health service use might also increase with the increase of comorbidities (26). As the population continues to age and live longer, it is likely that health service use will also continue to increase, resulting in a system that is overwhelmed by persons with dementia.

Gaps in dementia management

Given the massive burden of dementia on the community, economy, and healthcare system, it is clear that there is a need for global policies on dementia care in order to provide accessible, sustainable, and high-quality healthcare to persons with dementia and their care partners. The vast differences among countries in terms of their healthcare systems, stigmas associated with dementia, and health spending make the development of dementia-specific policy uncertain. However, current gaps in dementia care include fragmented care pathways, poor culture surrounding dementia care, limited knowledge or skills, and ineffective healthcare policies, and as a result, many persons living with dementia experience poor health management and poor disease outcomes (43). There is a need for a coordinated and multisectoral response to dementia to combat the current key issues in dementia care.

Impact of Dementia on Vulnerable Groups

Defining health inequities

As defined by the WHO, health inequities are "systematic differences in the health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work, and age" (5). The factors that cause health inequities are complex and evolving, and ultimately contribute to differences both within and between communities that are often avoidable (44, 45). Health inequities generally reflect an unfair distribution of risk, resources, and opportunities among populations, and can result in differences in diagnosis, prognosis, and severity of health outcomes.

The social and economic conditions that one is born into, and the effects that these determinants have on health outcomes, are central factors that impact the health and healthcare of all persons. These social and economic conditions are called the "Social Determinants of Health" (SDH), which are defined as "conditions in which people are born, grow, live, work, and age, and the wider set of forces and systems shaping the conditions of daily life" (46). The SDH are not medical factors, but rather encompass the biological and social factors that shape health status and health outcomes (6, 46, 47). These factors have been conceptualized into five main categories:

(1) economic stability;
(2) education;
(3) social and community context;
(4) health and healthcare; and
(5) neighbourhood and built environment (48).

More specifically, common SDH include, but are not limited to, income, education, housing, race, gender, and disability (49). These determinants often do not act alone, and recent evidence shows that when they do intersect, it results in complex effects that are nuanced and individualistic (47, 49, 50).

The SDH have an overwhelming and global impact on health inequities. Socially and economically disadvantaged groups across high-, middle-, and low-income countries continue to face poorer health than those in their more affluent counterparts, resulting in unmet health needs, poor health outcomes, and premature death (22, 23, 51, 52). Further, health inequities place populations who are already more vulnerable at an even greater disadvantage, by impacting their ability to access healthcare, receive appropriate health management, and engage with health systems (53). Achieving health equity in the context of different political, social, and economic systems is critical in achieving better health outcomes globally.

Inequities in dementia

Health inequities permeate all aspects of health and healthcare, and dementia is no exception – although core elements of dementia are experienced by all persons who are affected, people living with dementia experience the disease differently based on their own lived experiences which are shaped by the SDH (8). The SDH not only affect the incidence, prevalence, and risk of dementia, but also play a role in determining disease progression and health outcomes.

Three of the most widely known social determinants that impact dementia risk and health outcomes are race, socioeconomic status, and gender, all of which are discussed in greater detail below.

Race – race and racial discrimination have been well conceptualized as SDH that have a significant impact on dementia (54, 55). It has been widely studied that ethnic minority populations have a higher incidence of dementia in comparison to those who are not part of minority populations (56). This population is also faced with greater levels of cognitive decline and accelerated cognitive decline, in addition to a decreased likelihood of diagnosis and poorer uptake of dementia therapeutics (6, 56). These differences may be a result of biological, behavioural, and sociocultural factors, all of which must be accounted for when understanding the role of race in dementia care (52, 57, 58).

SES –Socioeconomic status, which reflects education level, income, and occupation, has significant effects on the incidence and health outcomes of dementia (6, 59). Current evidence shows that lower SES and lower levels of education are associated with a higher incidence of dementia, and similarly, higher SES and education levels seem to be protective (6). A study by *Cadar et al.* showed that the incidence of dementia was 1.68 times higher for those living in the lowest quintile of the wealth bracket in comparison to those in the highest quintile (60). Lower SES has also been associated with accelerated cognitive decline compared to those with a higher annual income at the time of diagnosis (59). Ultimately, those with a SES are at lower risk for diagnosis, and if diagnosed, have less severe prognoses than those in lower SES brackets (59).

Sex and Gender – The impact of sex and gender as drivers of health inequities are becoming increasingly recognized in dementia care. Dementia has a disproportionate impact on women, who account for approximately 2/3 of diagnosed cases (10). Although the higher life expectancy of women is a factor that may explain why dementia is seen much more frequently in women, the differences in the prevalence of dementia can also be impacted by differences in biological or sociocultural factors (10). Current research shows that genetics, which is a non-modifiable risk factor for dementia, increases the risk of developing dementia in women in comparison to men, and also may play a role in cognitive decline, prognosis, and the effects of drugs (61, 62).The sex-related and gender-related differences in dementia incidence has important implications for diagnosis, treatment of dementia, and research (62).

It is important to note that while each of the social determinants have an impact on dementia and dementia care, they are often intersectional and produce different health outcomes in each individual.

National Dementia Strategies: A Focus on Inequities

In response to the increase in the prevalence of dementia globally, WHO released their "Global Action Plan on the Public Health Response to Dementia (GAPD)", which aimed to improve the lives of persons living with dementia while decreasing the impact of dementia across seven target areas (1). One year later in 2018, WHO released a new report, titled "Towards a Dementia Plan: A WHO Guide", which outlined technical guidelines and recommendations for governments and stakeholders to prepare, develop, and implement stand-alone or integrated dementia strategies (4). These national dementia strategies address dementia as a public health priority at the government level.

What are national dementia strategies?

Dementia strategies, policies, and plans are tools that allow for government agencies and stakeholders to address the scale, impact, and cost of dementia nationally. Common elements in most dementia strategies include:

- The need for multisectoral approaches to dementia care;
- The need for accessible, affordable care that meets the needs of persons living with dementia and their families;
- Raising awareness and eliminating stigma surrounding dementia diagnoses; and
- Funding and support of research initiatives (63).

The overall purpose of dementia strategies is to improve dementia care and support across jurisdictions that will benefit all citizens, including persons living with dementia, their family members, their care partners, and health care providers.

Strengths and limitations of dementia strategies

The WHO guide for dementia plans acts as a roadmap for countries developing their own dementia strategies. The WHO guidelines do not enforce generic recommendations across all Members States, but rather provide a framework for countries to address dementia as a public health priority as they see fit. The content of dementia strategies, the goals of dementia strategies, and the level of detail differ between countries.

The inconsistency of dementia strategy development is largely beneficial to countries given their inherently different socioeconomic, political, and healthcare priorities. As noted by Dr. Chan, WHO's Director General in 2017, "…health systems are highly context specific, there is no single set of best practices that can be put forward as a model for improved performance" (17). Countries have diverse approaches to improving the health and quality of life of persons living with dementia, and have therefore developed policies that will be most beneficial to achieving their key areas of actions, objectives, and long-term goals.

However, the lack of structure among dementia strategies has also caused countries to develop dementia strategies that do not necessarily touch on key aspects of dementia care. Dementia strategies are diverse in their structures and functions, ranging from informal non-governmental documents to large-scale formal policies that prioritize dementia care within the healthcare system. This has resulted in the development of strategies that likely do not meet the needs of the entire population, specifically vulnerable populations that are more severely impacted by a diagnosis of dementia.

Research Gaps: identifying inequity-focused policy in dementia strategies

The implementation of dementia strategies is a relatively new concept for most countries. While strategies are becoming more ubiquitous, few studies exist that review international dementia strategies (64-66), none of which focus on overarching themes of health inequity. Research that focuses on inequity in dementia care, especially looking at current and future policies, is necessary to provide equitable care to all persons living with dementia globally. Although dementia strategies are continuously being updated and improved, there is a need to understand three main elements that impact the current status of dementia care internationally:

1. The environmental context of each country to determine which elements, if any, correlate with the implementation of national dementia strategies;
2. If and how dementia strategies mention inequities as targets of concern; and
3. The presence of specific objectives that countries have in place to mitigate the effects of inequities in dementia care

Research Questions

To address the knowledge gaps listed above, there is a need to conduct a synthesis that first, analyzes if countries have developed dementia strategies, and second, describes why they developed them based on the environmental contexts of the OECD countries. Finally, there is a need to analyze current national dementia strategies for the presence of inequities as targets of concern, identify inequity-focused objectives, and report on specific objectives to mitigating inequities in dementia care. Accordingly, this review aims to answer the following research questions:

(1) **Do countries currently have national dementia strategies, and are there specific environmental factors that are associated with the development of these strategies?**

(2) **Do national dementia strategies mention inequities as specific targets of concern, and if so, what are the general and specific objectives in place to mitigate the effects of inequities?**

Objectives

(1) Describe the trends in the different economic, political, and demographic factors that may be associated with the development of national dementia strategies in OECD countries to understand why some countries have or do not have dementia strategies

   a. Identify OECD countries that have national dementia strategies
   b. Describe factors that could be associated with the development of dementia strategies: percent of health spending, gross domestic product, and percent of population aged 65+

(2) Describe if and how OECD countries' national dementia strategies consider inequities as a target of concern

   a. Describe the proportion of dementia strategies that mention inequities, the type of inequities mentioned, and how they are mentioned
   b. Describe the proportion of dementia strategies that include general inequity-targeted objectives
   c. Describe the proportion of dementia strategies that include specific inequity-targeted objectives, associated with quantified target, timeframe, or specific budget

Methods

Environmental Scan

This research uses an environmental scan to understand the current health care policies and government strategies that exist to manage dementia care, and analyze those policies in the context in which they exist to understand their application and impact on the health care system (67). An environmental scan is defined as "a technique for detecting early signs of potentially important developments through a systematic examination of potential threats and opportunities, with emphasis on new technology and its effects on the issue at hand (68)," but can more broadly be realized as the analysis and assessment of current health interventions in the context that they currently exist, which is necessary to inform strategic planning in the healthcare sector (69).

In this environmental scan, the interventions or "technologies" of interest are national dementia strategies, which are instruments that promote the implementation of dementia-focused public health guidelines across all areas of governance, health and social services, and research. Given that each dementia strategy is unique to the country in which it is developed, an environmental scan is necessary to assess and inform program development in their specific economic, social, and political contexts.

Objective 1: Identify and evaluate trends in the different environmental factors that may be associated with the development of national dementia strategies in OECD countries to understand why some countries have or do not have dementia strategies

Objective 1(A): Identify the OECD countries that have existing national dementia strategies

Search strategy to identify the OECD countries that have existing national dementia strategies

Two main websites and databases were consulted to find the current national dementia strategies that exist among the 38 OECD countries: (i) Alzheimer Europe's website database of National Dementia Strategies, and (ii) Alzheimer's Disease International's list of national, sub-national, and non-governmental dementia strategies (70, 71). For the OECD countries that were not mentioned on either database, a secondary search was done to individually identify those dementia strategies using a standard Google Search.

Inclusion/Exclusion criteria

For the purposes of this analysis, only dementia strategies from OECD countries were selected for inclusion to maximize the comparability of strategies among countries that have similar standards for economic development and corporate governance, especially in the healthcare sector (72). OECD member countries are all directed by the same set of government-backed recommendations, and therefore allow for an adequate comparison of systems with similar healthcare conduct and principles.

For inclusion, national dementia strategies had to be written in English or French (the two languages mastered by our team). Only national dementia strategies were included, and for countries that published many dementia strategies over time, only the most recent version was included. Sub-national or province-specific strategies, and those that were not publicly available in the languages listed above were excluded.

Data Extraction

Selected strategies were extracted into a table that reports the country for which the dementia strategy was developed, whether the strategy was included in this analysis based on the above criteria, and if not, the reason for exclusion.

Objective 1(B): Describe factors that could be associated with the development of dementia strategies: percent of health spending, gross domestic product, and percent of population aged 65+

Choice of factors

To answer Objective 1, the different economic, political, and demographic contexts of the 38 OECD countries were compared based on the following 3 elements: percent of health spending, gross domestic product (GDP), and the percent of the population at or above the age of 65. Each of these contextual elements were chosen based on their frequent use in the literature when comparing OECD countries, as well as their association to the healthcare sector within the context of each individual country. These three factors were therefore deemed important to help understand why some countries prioritize the development of national dementia strategies while others do not. The definitions of the included factors can be seen in the table below.

Table 1: Definition of Factors

Indicator	OECD Definition
Percent of Health Spending (Percent of Gross Domestic Product directed towards health care)	Final consumption of health care goods and services (i.e. current health expenditure) including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments (73).
Gross Domestic Product (GDP) per capita	A standard measure of the value added created through the production of goods and services in a country during a certain period, also measuring the income earned from that production, or the total amount spent on final goods and services (74).
Elderly Population	Percent of population aged 65 and older (75).

Percent of Health Spending: According to University of Oxford's World in Data analysis, greater amounts of health spending correlates with a higher average life expectancy among a population (76). Given that old age is the strongest risk factor for the development of dementia, it could be understood that as health spending increases, life expectancy increases, as does the risk of developing dementia (3). The inevitable aging of the bulk of the global population will likely drive the prevalence of dementia up, and therefore, it seems possible that countries who foresee this eventual healthcare dilemma would, in turn, act to target dementia as an evolving area of concern (3).

Health spending may also reflect the priority of the government towards health and healthcare rather than towards other national programs or initiatives. If a government is devoting a larger majority of their budget towards health, it is likely because it is an important target or an area of concern in that particular country. As a result, this might indirectly reflect a government’s inclination to invest in specific areas of health, act proactively in their health spending, or design targeted initiatives or policies for more individualized health concerns such as dementia.

GDP: As *Rahman et al.* investigate in their 2018 article, GDP is associated with improved life expectancy at birth (77). As life expectancy at birth increases, it is assumed that a greater cohort of the population will live to an older age, thus presenting another avenue that could increase the prevalence of dementia in this population. As the population continues to live longer, the expectation is that more people will develop dementia later in life, and therefore it would be possible that this area of concern would be targeted through the development of a dementia strategy.

GDP might also indirectly reflect a country’s ability to spend money on policies or strategies that are more elaborate or secondary to their priority health concerns. While some countries with lower GDPs might have no room in their budget to allocate money to initiatives that aren’t central to their primary spending priorities, countries with higher GDPs may have the flexibility and the leeway to allocate money to initiatives beyond basic necessities. In this case, it may be possible that countries with higher GDPs are able to spend money on dementia strategies that are robust and target key health issues that wouldn’t necessarily be a priority for lower-income countries.

Percent of population age 65+: According to OECD 2020 data, the percent of the population aged 65+ in OECD countries has been steadily increasing over the past 50 years (75). This upwards trend is likely to act as a risk factor for a greater prevalence of dementia globally, and is another environmental factor that may correlate with the need for specific objectives to address dementia care.

Analysis

OECD countries were analyzed based on the following categories: (i) percent of healthcare spending; (ii) GDP; and (iii) percent of population aged 65+. A table reporting on the OECD countries and the three chosen factors was developed. Countries were organized in ascending order by each of the three factors, and classified by comparing their national average against the OECD average (i.e. above or below the average). For each of the three factors, the comparison among countries was followed by a visual check using graphical models. Any association between the development of national dementia strategies and the three environmental elements were identified using visual check by the research team and consensus development.

Objective 2: Describe if and how the selected national dementia strategies consider inequities as a target of concern

Conceptual frameworks

To frame the method, analysis, and discussion of objective 2, we chose to base our analysis two internationally recognized conceptual frameworks. These frameworks are widely used in addressing inequalities and discrimination in the development and regulation of global institutions: (i) Leaving No One Behind: Equality and Non-Discrimination at the Heart of Sustainable Development – A Shared United Nations System Shared Framework for Action (78), and (ii) A Conceptual Framework for Action on the Social Determinants of Health from the World Health Organization (79). As each framework alone did not include all the areas of inequities deemed important and relevant by the research team, we chose to merge both frameworks, for this current work. The following inequities were thus considered, organized by their source framework:

Framework (i) Leaving No One Behind: Equality and Non-Discrimination at the Heart of Sustainable Development – A Shared United Nations System Shared Framework for Action (78)

- Religion
- Age
- Disability
- Sexual Orientation/Gender Identity
- Rurality

Framework (ii) A Conceptual Framework for Action on the Social Determinants of Health (79)

- Social Class
- Race/Ethnicity

The formal definitions of the seven selected inequities can be found in Appendix A.

In order to examine whether the dementia strategies did consider inequities, we distinguished three different stages, as defined after, of considering inequities in a dementia strategy: mentioning inequities, having general inequity-targeted objectives, and having specific inequity-targeted objectives associated with a quantified target, timeframe, or specific budget. For the purpose of this scan, a “mention” of inequities refers to any brief naming of or acknowledgment of an inequity.

We defined a general inequity-targeted objective as one which summarizes an overall intention or goal, without necessarily mentioning tangible end points, like quantified target, timeframe, and specific budget. We defined specific inequity-targeted objective, associated with quantified target, timeframe, or specific budget, as objectives that are associated with (1) specific percent target goals to be reached; (2) specific deadlines/year targets; and (3) allocated budgets to achieve specific goals.

Data Extraction

For each included strategy, the text was scanned in full to identify any mention of inequities or objective towards addressing them. In addition, the table of contents of each dementia strategy was read thoroughly to note any potential chapters of interest. Finally, each selected national dementia strategy was searched for the following terms:

English Search Terms

- Inequ*
- Divers*
- Vulnerable
- Inclusi*
- Cultur*
- Objective*
- Recommend*
- Target
- Goal
- Program

French Search Terms

- Iniqu*
- Inégal*
- Diversif*/diversit*
- Vulnérable

- Inclusivement/inclusion
- Culture/culturellement sûr
- Objectif
- Recommand*
- Cible
- Programme

Data was extracted into a data reporting table that included the following information: (i) Country; (ii) Date of Dementia Strategy; (iii) Inequities Mentioned; (iv) Are there inequity-targeted objective? (Yes/No); and (v) List of inequity-targeted objective. Inequities were organized in seven overarching categories: (1) race/ethnicity, (2) religion, (3) age, (4) disability, (5) sexual orientation/gender identity, (6) social class, and (7) rurality, as per our chosen conceptual frameworks' categorizations. For each dementia strategy, any specific quotations were reported in the table under the most appropriate category.

Analysis

The following outcomes were considered and synthesized from the extracted data: (1) the number of strategies mentioning each of the following areas of inequity: race/ethnicity, age, disability, religion, sexual orientation/gender identity, social class, and rurality; and (2) for strategies that mention specific inequities: percent of dementia strategies that include general inequity-targeted objectives, and percent of dementia strategies that include specific inequity-targeted objectives with (1) specific percent target goals to be reached; (2) specific deadlines/year targets; and (3) allocated budgets to achieve specific goals.

To describe how inequities were mentioned, a thematic analysis was conducted analyzing the specific language, context, and area of focus for how each strategy mentions certain inequities, organized into the seven thematic categories described above.

Results

Search Results and Included Strategies

The initial search of two international databases reporting grey literature yielded a total of 50 dementia strategies. Of the 38 OECD countries, 27 had national dementia strategies. After removing dementia strategies based on the inclusion and exclusion criteria, a total of 15 dementia strategies were analyzed in full. Figure 1 shows the number of, and reasons for, dementia strategy exclusion.

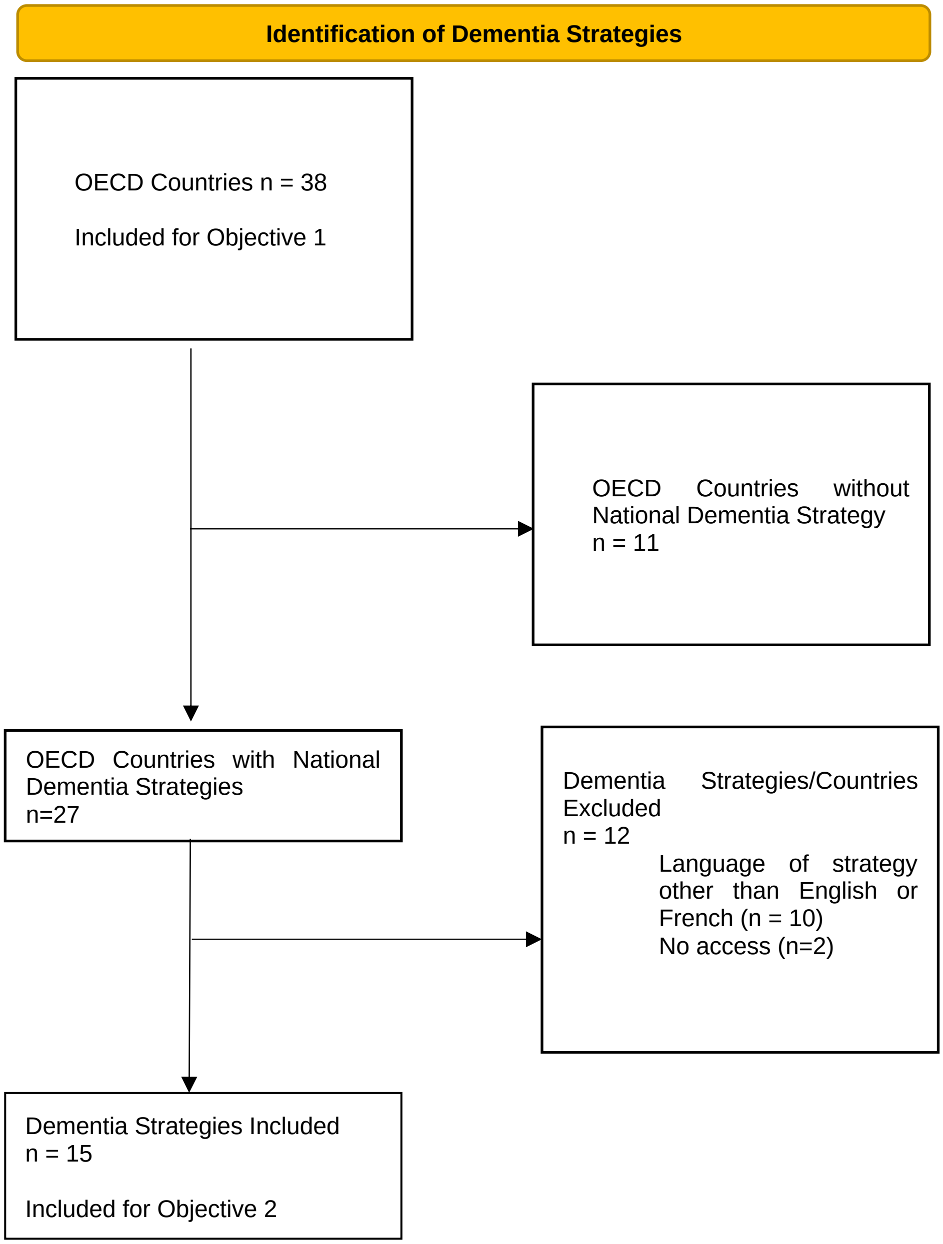

Figure 1: Adapted version of PRISMA 2020 flow diagram of included dementia strategies

Table 2: OECD Countries and National Dementia Strategies

OECD Country	**National Strategy**	**Title and date of Latest Strategy**	**Included in Environmental Scan. If NO - reason**
Australia	YES	National Framework of Action on Dementia (2015-2019) (80)	YES
Austria	YES	Dementia Strategy: Living well with dementia (2015) (81)	YES
Belgium	NO		NO – no strategy
Canada	YES	A Dementia Strategy of Canada: Together We Aspire (2019) (61)	YES
Chile	YES	Plan Nacional de Demencia (2017-2025) (82)	NO – Spanish
Colombia	NO		NO – no strategy
Costa Rica	YES	Plan Nacional Para la Enfermedad de Alzheimer Y Demencias Relacionadas Esfuerzos Compartidos (2014-2024) (83)	NO – Spanish
Czech Republic	YES	National Action Plan for Alzheimer's Disease and related Illnesses (2020-2030) (84)	NO – Czech
Denmark	YES	A Safe and Dignified Life with Dementia: National Action Plan on Dementia (2025) (85)	YES
Estonia	NO		NO – no strategy
Finland	YES	National Memory Programme: Creating a "Memory-Friendly" Finland (2012-2020) (86)	YES
France	YES	Plan Maladies Neuro Degeneratives (2014-2019) (87)	YES
Germany	YES	National Dementia Strategy (2020) (88)	YES
Greece	YES	National Action Plan for Dementia – Alzheimer's Disease (2016-2020) (89)	YES
Hungary	NO		NO – no strategy
Iceland	YES	Icelandic National Dementia Action Plan (2020-2025) (90)	NO – Icelandic
Ireland	YES	The Irish National Dementia Strategy (2014) (91)	YES
Israel	YES	Addressing Alzheimer's and Other Types of Dementia: Israeli National Strategy (2013) (92)	YES

Italy	YES	National Dementia Strategy (2014) (93)	NO – Italian
Japan	YES	Orange Plan 2015 (94)	NO – not accessible
Korea	YES	The 3rd National Dementia Plan: Living well with dementia in the community (2015) (95)	YES
Latvia	NO		NO – no strategy
Lithuania	NO		NO – no strategy
Luxembourg	YES	National Dementia Action Plan (2013) (96)	YES
Mexico	YES	Plan de Acción Alzheimer Y otras Demencias (2014) (97)	NO – Spanish
Netherlands	YES	National Dementia Strategy (2021-2030) (98)	YES
New Zealand	NO		NO – no strategy
Norway	YES	Demensplan (2025) (99)	NO – not accessible
Poland	NO		NO – no strategy
Portugal	YES	Portuguese Dementia Health Strategy (2018) (100)	NO – Portuguese
Slovak Republic	NO		NO – no strategy
Slovenia	YES	Slovenian National Dementia Strategy (2016-2020) (101)	NO – Slovenian
Spain	YES	Plan Integral de Alzheimer y otras Demencias (2019-2023) (102)	NO – Spanish
Sweden	YES	Nationell strategi för omsorg om personer med demenssjukdom (2018) (103)	NO – Swedish
Switzerland	YES	Stratégie nationale en matière de démence (2014-2019) (104)	YES
Turkey	NO		NO – no strategy
United Kingdom	NO		NO – no strategy
United States	YES	National Alzheimer’s Plan 2017: 2018 Update (105)	YES

Factors associated with the development of dementia strategies

GDP

The average GDP of the OECD countries is $46539.60 US in 2021 or latest available data. Of the 11 countries that do not have existing dementia strategies, 9 have GDPs that fall below the OECD average.

All 38 of the included OECD countries have a GDP that classifies them as a high-income country (GDP per capita of USD $12696 or above) (106), with the lowest GDP being that of Colombia at a value of USD $15370.80. As such, these countries shouldn't be compared according to high-, middle- and low- income classification of GDP, because all would be classified under the category of "high-income." To make meaningful comparisons, the results are better suited to be presented as a comparison against the OECD average, in order to determine where countries lie relative to each other.

The GDP of each OECD country can be visualized in the graph below, where a red bar indicates a country that has no national dementia strategy, a green bar indicates the countries that do have national dementia strategies, and the black bar represents the OECD average. Using a visual check, this graph suggests that the majority of the red bars fall below the OECD average, while the majority of green bars fall above the OECD average.

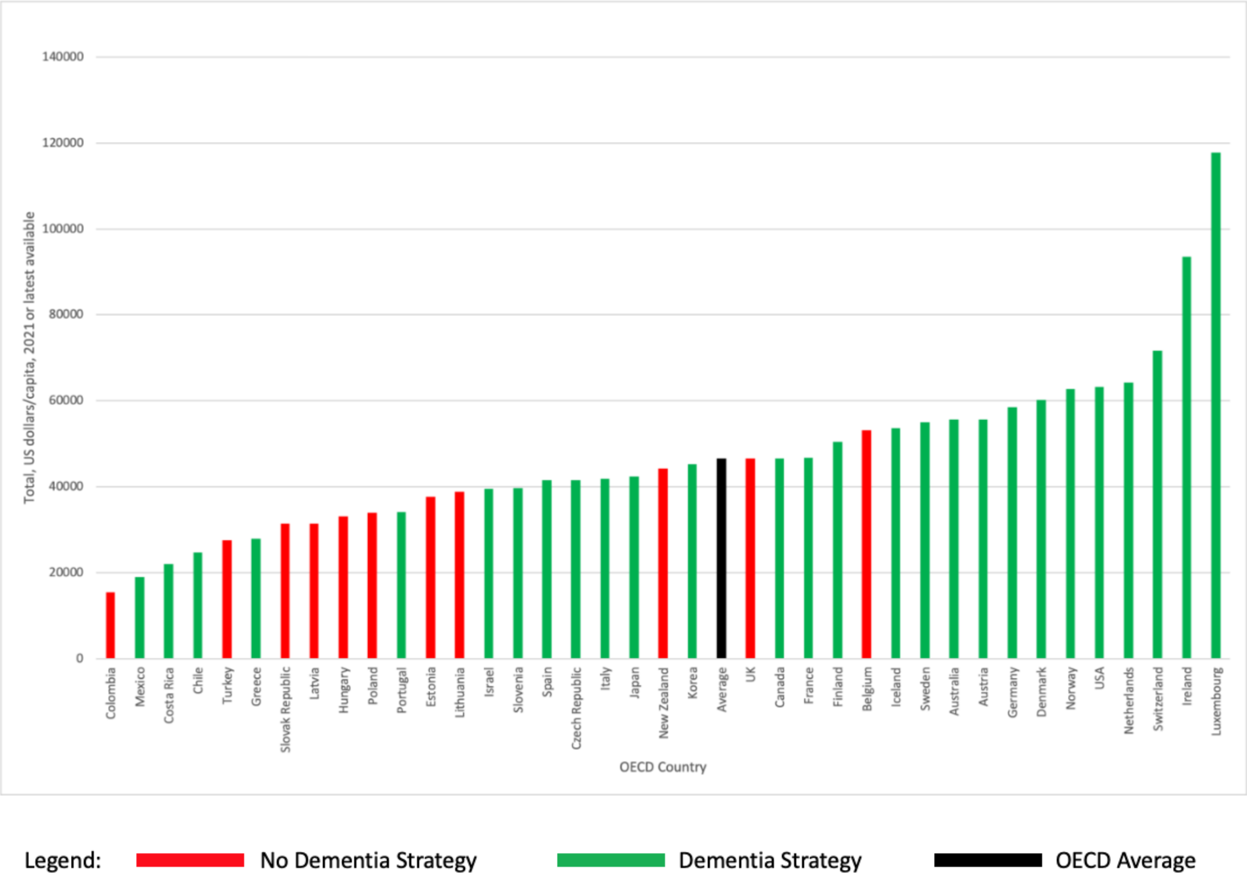

Figure 2: Gross Domestic Products of the Countries in the Organization of Economic Cooperation and Development

Percent of Health Spending

The average health spending of the OECD countries, reported as a percent of each country's GDP, is 9.33% in 2020 or latest available data. Of the 11 countries that do not currently have dementia strategies, 9 fall below the OECD average.

The health spending of each OECD country represented as percent of GDP can be visualized in the graph below, where a red bar indicates a country that has no national dementia strategy, a green bar indicates the countries that do have national dementia strategies, and the black bar represents the OECD average. Using a visual check, this graph suggests that the majority of the red bars fall below the OECD average, while the majority of green bars fall above the OECD average.

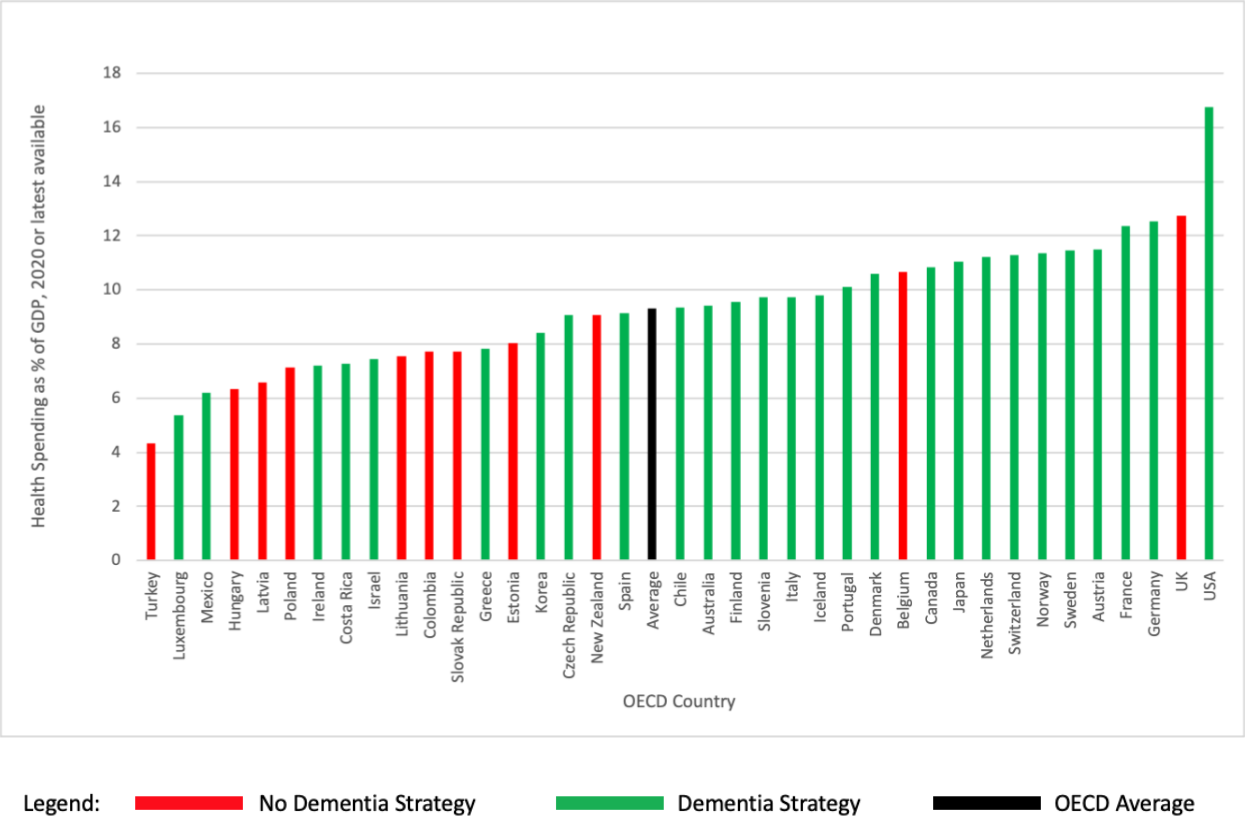

Figure 3: Percent of Health Spending of the Countries in the Organization of Economic Cooperation and Development

Percent of Population Age 65+

The average percent of population above age 65 among the OECD countries in 2020 was 17.78% (75). Of the 11 countries that do not have existing dementia strategies, 8 have elderly populations that fall above the OECD average.

The percent of the population above age 65 in each OECD country can be visualized in the graph below, where a red bar indicates a country that has no national dementia strategy, a green bar indicates the countries that do have national dementia strategies, and the black bar represents the OECD average. Using a visual check, this graph suggests that the majority of the red bars fall above the OECD average, while the majority of green bars fall below the OECD average, indication that the majority of countries without a dementia strategy have an average age above the OECD average.

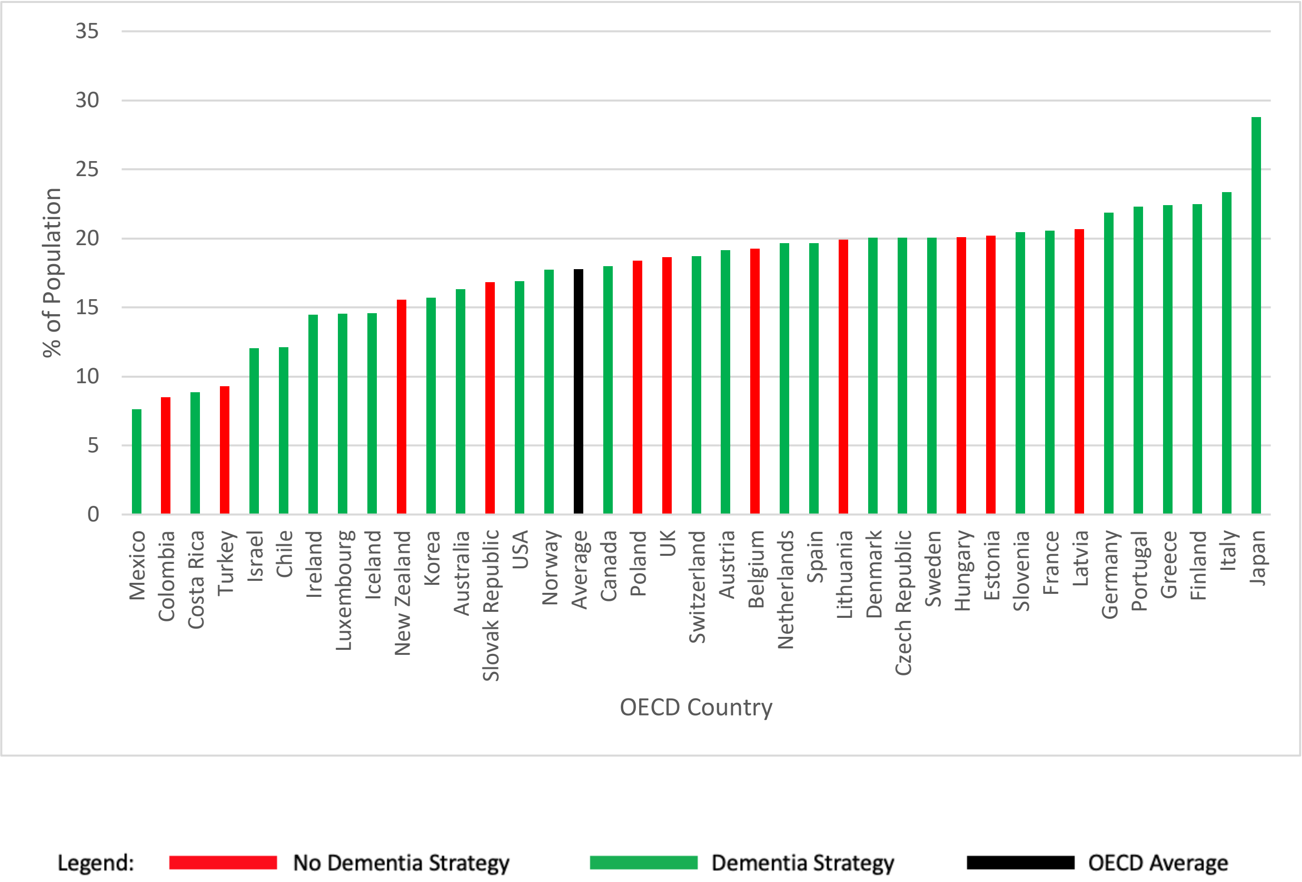

Figure 4: Percent of Population age 65+ of the Countries in the Organization of Economic Cooperation and Development

Do national dementia strategies consider inequities as a target of concern?

Of the 15 included dementia strategies, 13 mentioned at least one inequity relating to dementia. The following percentages of dementia strategies mentioned each of the seven inequities as categorized in the selected frameworks:

- 6 out of 15 (40.0%) of strategies mentioned race/ethnicity
- 1 out of 15 (6.7%) of strategies mentioned religion
- 9 out of 15 (60.0%) of strategies mentioned age
- 8 out of 15 (53.3%) of strategies mentioned disability

- 3 out of 15 (20.0%) of strategies mentioned sex/gender
- 3 out of 15 (20.0%) of strategies mentioned social class
- 6 out of 15 (40.0%) of strategies reported on rurality (See Table 3)

Table 3: Types of Inequities Mentioned by Dementia Strategies by Country

	Mention of Inequities?	Type of Inequities						
Country		Race/Ethnicity	Religion	Age	Disability	Sex/Gender	Social Class	Rurality
Australia	YES	•		•	•	•		•
Austria	YES	•			•		•	
Canada	YES	•		•	•	•	•	•
Denmark	YES			•	•			•
Finland	YES				•			
France	YES			•	•			
Germany	YES	•	•	•	•	•	•	•
Greece	YES							•
Ireland	YES			•	•			
Israel	YES	•						
Korea	YES			•				
Luxembourg	NO							
Netherlands	YES			•				
Switzerland	NO							
United States	YES	•		•				•
Total (n)	13	6	1	9	8	3	3	6

How are Inequities Mentioned in Dementia Strategies?

Theme 1: Race/Ethnicity

Six dementia strategies mentioned inequities related to race and/or ethnicity. Race and ethnicity are described as both barriers to seeking medical help, as well as barriers to receiving medical help. For example, certain dementia strategies reported on specific population that face stigma and negative perceptions about dementia care. These populations avoid seeking out dementia care for fear of it being considered “taboo” or “not a medical condition,” leading individuals in these communities reluctant to seek out or accept support. Alternatively, some dementia strategies focused primarily on equality of access to dementia care, specifically looking at targets or fields of action that could be pursued to mitigate barriers to accessing dementia care. For example, many racialized groups that actively seek out dementia care are met with barriers to communication or culturally appropriate care, and in response, dementia strategies seek to improve access to culturally safe, and strive to improve or promote multilingual and culturally sensitive counselling or medical services for persons living with dementia and their caregivers. Strong emphasis is placed on the need to improve service delivery by collaborating with people of minority or migrant backgrounds. Another focus of one of the strategies is the involvement of racialized communities in dementia care research.

Theme 2: Religion

One of the 15 dementia strategies mentioned inequities in dementia care related to religion and/or religious values of the population. Spiritual and religious needs of persons living with dementia was reported as a target of the national dementia strategy, placing emphasis on the need for support tailored to one's own life history and religious faith, both to ease the burden of dementia and to improve counselling and education on dementia.

Theme 3: Age

Nine of the 15 dementia strategies reported on inequities related to age in dementia care. Generally, age as a risk factor for inequitable health care was directed at "early onset dementia" which can be defined as an "uncommon form of dementia that affects people younger than age 65" (22). Early onset dementia was predominantly described as a barrier to accessing appropriate services, given that dementia services and programs tend to be designed around the interests and needs of older populations. Specific initiatives included the implementation of counselling and activity centers for younger people living with dementia, and programs that take into account the supports needed for early onset dementia. An emphasis was placed on the need for age-appropriate services that preserve the quality of life for younger persons living with dementia.

Alternatively, old age was also mentioned as a barrier to dementia care, specifically looking at the management of higher risk groups, groups with co-morbidities, or those who are more prone to worse outcomes of dementia. For example, initiatives included the management of older adults (aged 75+) living alone, and provincial recognition programs that take steps to be age-friendly and inclusive of seniors.

Theme 4: Disability

Eight of the 15 dementia strategies mentioned inequities related to disability. The definition of disability among the strategies greatly varied. The majority of the strategies (6) focused on persons with intellectual disability, which includes persons with cognitive impairment. There are 2 main focuses of targeted initiatives for persons with disabilities: first, decreasing the stigma surrounding mental illness or mental disabilities that may lead to the discrimination and exclusion of persons living with dementia from treatment, or that lead to the refusal of appropriate treatment, and second, communicating research and providing opportunities in ways that increase accessibility and are culturally appropriate. Specific examples of these initiatives include working on legislation that can strengthen care initiatives, and ensuring treatment for persons living with dementia who also have intellectual disabilities.

Other strategies briefly mention “people with physical disabilities” as a population that is increasingly becoming vulnerable to the development late-onset dementia.

Theme 5: Sexual Orientation/Gender Identity

Three of the 15 dementia strategies mentioned sexual orientation and/or gender identity as specific inequities of interest. Two dementia strategies mentioned specific supports relating to those who identify as lesbian, gay, bisexual, transgender, intersex, and queer (LGBTI/LGBTQ2), focusing on services that are sensitive to the needs of these communities. One of these needs is providing supports for vulnerable populations, specifically those that have difficulties accessing diagnoses and care due to potential stigma and social marginalization. Difficulties include factors like trust and disclosure of sexual orientation, fear of being mistreated, and discrimination in long-term care homes.

Two strategies listed women, specifically senior women, as a group that requires specific supports for their status as "at-risk" or more vulnerable.

Theme 6: Social Class

Three of the 15 dementia strategies referenced social class as an area of concern. Two referred to social class as an inequality relating to access of dementia care. Specific concerns included a focus on access to help for those experiencing homelessness, and supporting access to care for people living with dementia and their caregivers who may face socio-economic marginalization.

One dementia strategy focused on the impact of social class on the quality of dementia care and on the risk of exacerbated outcomes. In this case, emphasis was placed on research into the socioeconomic factors relevant to the development and treatment of dementia.

Theme 7: Rurality

Six of the 15 dementia strategies reported on rural or spatial inequities to accessing dementia care. All six of the strategies present rurality as a barrier to accessing dementia care and related resources. Specifically, there was emphasis placed on the lack of specialists and established multi-disciplinary teams in rural and remote communities. Responses to this include the call services to support regional, rural, and remote communities, ensuring that all municipalities are “dementia-friendly” with counselling services that are easily located, and focusing on rural development of “dementia-sensitive” social spaces and accessible transportation to rural areas. Another point that was particularly emphasized was the need for communicating research findings that ensures accessibility across different geographic areas.

Description of Dementia Strategies that Include Inequity-Targeted Objectives

Of the 13 national dementia strategies mentioning at least one inequity, 11 had general inequity-targeted objectives. Of these 11, 5 added at least one of the following: quantified target, timeframe, and specific budget (See Table 4).

Table 4: OECD Countries and their General and Specific Inequity-Targeted Objectives

Country	Does it mention general inequity-targeted objectives?	Does it mention specific inequity-targeted objectives?		
		Target: % increase or decrease	Target: Specific Deadline	Budget or financial allocation
Australia	•			
Austria				
Canada	•			•
Denmark	•		•	•
Finland	•			
France				
Germany	•		•	•
Greece	•			
Ireland	•			
Israel	•			
Korea	•			•
Netherlands	•		•	
United States	•			

Discussion

The purpose of this environmental scan was to identify and contextualize if countries have national dementia strategies, and if and how dementia strategies mention inequities as targets of concern. The following discussion summarizes the main findings from this scan, comments on the current national dementia strategies from an inequity-based perspective, discusses if and how national dementia strategies have specific objectives to mitigate inequities in dementia, highlights strengths and limitations of the scan, and discusses points that can further be developed in research or policy.

Dementia Strategies

The majority of OECD countries have developed national dementia strategies. This is in accordance with the "Towards a Dementia Plan: A WHO Guide" target, namely the development of stand-alone or integrated dementia strategies that address dementia as a public health priority (4). There might be a relationship between environmental factors that reflect governmental health priorities and the development of dementia strategies, specifically in relation to GDP and health spending - if a country spends more on health care, or has a higher budget that could be allocated to health care, they are more likely to have a dementia strategy (107). In contrast, there is no obvious relationship between having an older population and the development of a dementia strategy, which is contrary to the assumption that having an older population would motivate countries to develop policies that target age-associated diseases like dementia. This suggests that economic factors and economic capacity plays a greater role in the development of dementia strategies than mere need. This result would have to be further explored, including an analysis of additional environmental factors that might have a role in motivating the development of a national dementia strategy.

Inequities

For the purpose of this scan, we intentionally moved through different "stages" of analysis, starting with a very broad focus on the general mention of inequities, and ending with a narrow analysis of three specific action-based objectives to targeting inequities. This was done in order to understand the different *scopes* with which countries chose to focus on inequities in their individual strategies.

At the beginning stages of our analysis, we purposefully chose a very broad definition of the word "mentioned," referring to a brief naming or acknowledgement of an inequity. By using this classification of the word "mentioned," we could get a better sense of if a dementia strategy *objectively* considered inequities during their conceptualization. From the 15 dementia strategies analyzed, 13 mention inequities, 11 mention general inequity-targeted objectives, and only 5 have specific objectives in the form of specific deadlines/year targets, specific percent target goals to be reached, or allocated budgets to achieve specific goals.

Of the 15 dementia strategies that were analyzed, 13 (87.0%) *mentioned* at least one specific inequity. At face value, this seems like a fairly high proportion; almost all of the included countries have at least considered including inequities in their national dementia strategies.

However, when looking past just a "mention" of inequities, and looking deeper into the context in which the inequities were mentioned and the detail at which they were discussed, it is clear that first, there are discrepancies in *how many* inequities are mentioned, and second, discrepancies with *which* inequities are mentioned. Some strategies, like Germany, mention all seven key inequities (88), while some countries, like Finland, Greece, Israel, Korea, and Netherlands, only mention one (86, 89, 92, 95, 98). Therefore, while these countries would both be specifically categorized as countries that "mention inequities," it does not necessarily mean that they prioritize or discuss inequities in comparable ways. Further, countries who mentioned the same "amounts" of inequities often chose to focus on different categories. For example, Greece's dementia strategy focuses only on rurality (89), while Korea's focuses only on age (95). Thus, although some countries have comparable numbers of the inequities they mention, they do not necessarily mention the same inequities.

When looking at an even deeper level, there are clear differences in *how* and to what depth dementia strategies mention inequities – the way and context in which inequities are mentioned is highly heterogeneous. Generally, the way strategies mentioned inequities varied from country to country. Some countries, like Canada, tended to expand upon why a specific inequity was mentioned; for example, Canada's dementia strategy has a chapter dedicated to a "focus on higher-risk and equitable care," and outlines this as a key target or issue (61).

In contrast, other countries simply listed the inequity as a problem that exists without diving deeper. An example of this is in Korea's strategy, which states "support for early diagnosis of dementia" as an inequity of concern, but nothing more (95). While both Canada and Korea have technically mentioned inequities here, there is clearly a difference in the emphasis placed on them and the priority of targeting inequities in the dementia strategies. This in-depth analysis of how dementia strategies mention inequities shows clear discrepancies in the prioritization of inequities in these strategies; although the majority of countries had mentioned inequities, few acknowledged them as central themes or areas of concern in their dementia policy. Just because a strategy mentions an inequity does not mean it can be used as an indicator that alone can suggest that a strategy *addresses* an inequity – an acknowledgment of an inequity is not enough to suggest that a country has taken further steps to understand, target, or mitigate inequities in dementia care (108, 109).

Specific Objectives in Dementia Strategies

Of the 13 strategies that mentioned at least one inequity, 11 had objectives that generally targeted inequities of concern. At face value, again, this seems like a fairly high proportion; almost all of the included countries have at least generally targeted inequities through the development of goals that would mitigate inequities.

Following the pattern outlined above, the analysis of objectives related to inequities began with a very broad definition in order to understand the different *scopes* with which countries chose to address inequities in their individual strategies. Given the heterogeneity of which and how inequities were mentioned in the dementia strategies, it follows that the general objectives were also broad in their depth and scope. For example, while Australia's and Israel's strategies both have general objectives to target inequities, the thoroughness with which Australia discusses these objectives is clearly different than that of Israel (80, 92). Similar to the pattern seen above, while these countries would both be classified as ones that have general objectives, it does not mean that these objectives are explored in comparable ways.

However, when looking at a deeper level, it is clear that many countries which listed general objectives targeting inequities had few specific objectives that follow specific deadlines/year targets, specific percent target goals to be reached, or allocated budgets to achieve specific goals. Of the 11 strategies that had general objectives to target inequities, only 5 had any specific objectives in the form of specific goals, deadlines, or budget allocations. For example, although Ireland's Dementia Strategy has a general objective that intends to "…deploy resources on the basis of need and as effectively as possible to provide services for all people living with dementia, including those with early onset dementia and/or an intellectual disability" no specific objective in the form of a specific deadline, percentage goal, or budget was put forth to achieve this objective – it is unclear whether or not this objective is intended to be acted upon, and if so, with what tangible deadlines or budgets in mind (91). While countries may intend to mitigate inequities via general objectives, having these objectives might not be enough to mitigate inequities (110, 111).

Impact on Future Dementia Strategies

When looking at the mentioning of inequities and the specific objectives to targeting inequities, a clear pattern emerges: although most countries mention inequities on a superficial level, very few actually explore those inequities in depth. Similarly, while most countries touch on general objectives to target inequities, few have concrete goals in achieving these objectives. In some capacity, the concept of mentioning key words or objectives without exploring them in depth could be a type of “inequity washing” – a way for governments or countries to put forward dementia strategies that mention inequities to appear to be more inequity-conscious than they actually intend to be (this is a spin on “greenwashing” – the process of conveying a false impression about how a company is more environmentally sound, when in reality, it isn’t making any notable efforts to improve sustainability) (112).

Considering that the majority of dementia strategies mention at least one inequity, it can be assumed that most countries deem inequities an important area of concern. However, given that only 5 of the 15 strategies explore specific objectives to target inequities of concern, considering inequities as an important area of concern may not lead to a reduction of the inequities mentioned in the strategies. The lack of specific objectives in targeting inequities may be a result of dementia policy remaining a lower-priority goal, or may be related to the health spending capacities of each country and what their budget is able to accomplish. It is clear, however, that despite many countries having seemingly few specific objectives or targets to mitigating inequity in dementia care, that countries continue to “mention” inequities in their dementia strategies – while this is a good first step, this “surface-level” approach to tackling inequities might not be sufficient to make tangible changes throughout the health care system that aim to mitigate inequities; these changes might require specific, actionable goals, as seen in only five dementia strategies.

To reduce avoidable inequities, the first priority must be directly and indirectly targeting them in our policies and practices. To do so, interventions must target the population at large, as well as specific vulnerable populations (121). More specifically, interventions must shift the risk exposure distribution of vulnerable groups while also targeting large-scale social and environmental conditions that shape how groups experience risk; this approach ensures that health risk is lowered across all populations, without increasing inequities and creating more divide between groups (121). Using this implementation approach could be instrumental improving overall health of a country, and may lead to better health for all rather than excellent health for some.

When developing future dementia strategies, countries must not only consider inequities at a surface-level, but rather put forth actionable objectives that intend to lessen the impact of inequities in dementia care; this must be kept in mind when assessing dementia strategies and developing new strategies in the future. Based on the results of this scan, and using existing frameworks to support them, countries should first identify the inequities of concern in their specific populations, adopt both population and vulnerable population approaches to health interventions, and then frame specific, quantifiable, timely, and budgeted objectives towards mitigating inequities in health and healthcare. Ultimately, an evaluation of the quality of dementia strategies could consider, but not rely only on, the number or type of inequities mentioned, how they are mentioned, or the general or specific inequity-targeted objectives.

Strengths and Limitations

This environmental scan advances a valuable synthesis of national dementia strategies and their objectives to mitigate inequities in dementia care. In doing so, this scan has several noteworthy strengths. First, this environmental scan examines current dementia policy through an equity-focused lens. Given the critical impacts of inequities on dementia risk, prognosis, and care, it is necessary that current and future policy is analyzed in this context. Although there is definite value in understanding the general impacts of dementia strategies in terms of their overarching goals and themes, dementia care is not equal for everyone - as such, discussing policy through an inequity-based framework allows policy makers and practitioners to identify and address clear gaps in dementia care and who it affects most. While many studies to date focus on evaluating the goals and implementation plans of dementia strategies (64, 113, 114), little research has focused on it from an inequity perspective. This environmental scan fills an important gap in dementia policy research by synthesizing national dementia strategies from an inequity-focused point of view, which is necessary to inform future policy in a way that specifically targets vulnerable populations. Second, the analysis of economic and demographic contexts in this environmental scan advances the understanding of where and why strategies may exist in some countries but not others. Given the WHO's flexible guidelines for the implementation of dementia strategies, this environmental scan situates policy in the environment that they currently exist, and proposes certain factors that may influence a country's ability to develop strategies that align with their individualized priorities and resources. Finally, this scan looks at a broad range of how policies discuss inequities, starting with a very general definition and moving towards very specific actionable objectives. Although dementia strategies may be heterogeneous in terms of how inequities are mentioned, they each have clear priorities that could only be determined through a series of analyses at every level of detail. Without this level of detail, the strengths of these strategies would simply be boiled down to the key terms or words they mention, rather than looking at how, to what extent, and the context that they are mentioned. This environmental scan acts to fully understand the rigor and detail of dementia strategies and their objectives to mitigate inequities in dementia care, and as a result, presents a succinct and clear synthesis of the current status of dementia policy internationally.

Despite these strengths, this environmental scan emerges with some limitations. First, this environmental scan only looked at the most recent version of each country's national dementia strategy. Although this gave a somewhat comprehensive overview of the current state of international dementia policy, a more in-depth evaluation of priorities in dementia care could be realized by looking at the ongoing development of dementia strategies in the same country over time. Similarly, many of the most recent versions of dementia strategies were either implemented many years ago and left unchanged, or "expired" many years ago and lacked a more updated replacement. Again, while analyzing the most recent version allowed for the most up-to-date analysis of dementia policy, it is likely that a change in government health care priorities may not have been reflected by a change or update in policy, and therefore the most accessible versions of policies may not adequately address the most current equity issues in dementia care. Second, this environmental scan only looked at three indicators affecting policy development (GDP, health spending, and % of population age 65+), whereas in reality, policy development might be influenced by many more specific factors. These include, but are not limited to, the presence of advocacy coalitions, priority settings, and centralized vs. decentralized governmental powers (108, 115). Further analysis that encompasses more of these factors would be pertinent, especially to investigate our hypothesis that the development of dementia strategies is not solely driven by a mere need, but rather driven by several interacting factors. Third, given our inclusion criteria, some countries did not appear in our search strategy for national plans (for example, a national-level strategy from the United Kingdom that was "replaced" by more recent, but non-national level strategies). This scan could benefit from a deeper or less stringent search strategy, which would also allow for a more comprehensive understanding of how dementia strategies have been implemented both nationally and sub-nationally. Finally, this environmental scan focused only on national-level policies, and excluded all subnational or provincial level dementia strategies. Although this focus on national-level policy allowed for the most comparable analysis of national environmental factors (GDP, percent of health spending, and percent of population age 65+), it is likely that the inclusion of subnational strategies could have filled in inequity-related gaps and address more specific health priorities. Given that the subnational strategies often govern smaller groups within a population, it is possible that these strategies would have addressed more specific inequities as they pertain to smaller cohorts of a population. A more comprehensive analysis of dementia strategies and the inequities they discuss would require a more in-depth examination of each individual strategy at every level of government, which this scan does not address.

Future Research

Considering the above limitations, future research could contribute to filling gaps and extending the knowledge in this field. First, this scan would have benefitted from broader inclusion criteria (in terms of both language and level of strategy), allowing for a larger number of dementia strategies to be analyzed more thoroughly. Evaluating these additional strategies might allow the researchers to identify new trends in how specific countries target inequities, or strengthen trends that have already been discovered. Next, future research should consider more factors that might play a role in motivating countries to develop a dementia strategy, which could also contribute to a more thorough analysis of why some countries focus on inequities while others do not. As was explored in the discussion section, the development of dementia strategies is likely impacted in part by the economic context of each member country. However, it is still unclear why some specific inequities are highlighted more frequently than others. It would be interesting to explore the specific factors in each country that may be reflected through the specifically prioritized inequities in their dementia strategy. Finally, this work could benefit from a thematic analysis of the general and specific objectives, following the same structure as the above analysis of the seven specific inequities mentioned in dementia strategies. Although this was outside the scope of the current work, it would be valuable to gain a more in depth understanding of how strategies frame and discuss their objectives to mitigate inequities in the context of their broader strategies, especially given how heterogeneous strategies are in terms of the general and specific objectives that they mention. To best develop future policy in dementia care, it is necessary to understand how governmental priorities and health care objectives have changed since the implementation of the earliest strategies, and use this to guide future policy that proactively acts to mitigate inequities in dementia care.

References

1. WHO. Global action plan on the public health response to dementia 2017-2025. Geneva, Switzerland: WHO; 2017.
2. International AsD. Dementia Statistics
3. Global Dementia Cases Forecasted to Triple by 2050 [press release]. Denver, CO, July 27, 2021 2021.
4. WHO. Towards a dementia plan: a WHO guide. Geneva, Switzerland: WHO; 2018.
5. WHO. Health Inequities and their Causes: World Health Organization; 2018 [Available from: https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes.
6. Majoka MA, Schimming C. Effect of Social Determinants of Health on Cognition and Risk of Alzheimer Disease and Related Dementias. Clinical Therapeutics. 2021;43(6):922-9.
7. Canada Go. Social determinants of health and health inequalities 2010 [Available from: https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html.
8. Aranda MP, Kremer IN, Hinton L, Zissimopoulos J, Whitmer RA, DMin CHH, et al. Impact of dementia: Health disparities, population trends,
care interventions, and economic costs. Journal of the American Geriatrics Society. 2021;69:1774-83.
9. Wu Y-T, Clare L, Jones IR, Martyr A, Nelis SM, Quinn C, et al. Inequalities in living well with dementia—The impact of deprivation on well-being, quality of life and life satisfaction: Results from the improving the experience of dementia and enhancing active life study. International Journal of Geriatric Psychiatry. 2018;33(12):1736-42.
10. Sourial N, Arsenault-Lapierre G, Margo-Dermer E, Henein M, Vedel I. Sex differences in the management of persons with dementia following a subnational primary care policy intervention. International Journal for Equity in Health. 2020;19.
11. International AsD. Dementia Plans 2021 [Available from: https://www.alzint.org/what-we-do/policy/dementia-plans/.
12. Collaborators G. Global mortality from dementia: Application of a new method and results from the Global Burden of Disease Study 2019. Alzheimer's & Dementia. 2021;7(1):e12200.
13. Lisko I, Kulmala J, Annetorp M, Ngandu T, Mangialasche F, Kivipelto M. How can dementia and disability be prevented in older adults: where are we today and where are we going? Journal of Internal Medicine. 2020;289(6):807-30.
14. Risk Factors for Dementia: Alzheimer Society; 2022 [Available from: https://alzheimer.ca/en/about-dementia/how-can-i-prevent-dementia/risk-factors-dementia.
15. Chen J-H, Lin K-P, chen Y-C. Risk Factors for Dementia. Journal of the Formosan Medical Association. 2009;108(10):754-64.
16. Hsiung G-YR, Sadovnick AD. Genetics and dementia: Risk factors, diagnosis, and management. Alzheimer's & Dementia. 2007;3(4):418-27.
17. Dua T, Sivananthan S, Seeher K. Recognising dementia as a public health priority: WHO; 2017 [
18. WHO. Dementia: A Public Health Priority. World Health Organization; 2012.
19. Greenblat C. Dementia: WHO; 2021 [Available from: https://www.who.int/news-room/fact-sheets/detail/dementia.

20. Prince M, Ali G-C, Guerchet M, Prina AM, Albanese E, Wu Y-T. Recent global trends in the prevalence and incidence of dementia, and survival with dementia. Alzheimer's Research & Therapy. 2016;8.
21. Ferri CP, Jacob KS. Dementia in low-income and middle-income countries: Different realities mandate tailored solutions. PLoS Medicine. 2017;14(3):e1002271.
22. Sexton C, Snyder HM, Chandrasekaran L, Worley S, Carrillo MC. Expanding Representation of Low and Middle Income Countries in Global Dementia Research: Commentary From the Alzheimer's Association. Frontiers in Neurology. 2021.
23. Mattap SM, Mohan D, McGrattan AM, Allotey P, Stephan BC, Reidpath DD, et al. The economic burden of dementia in low- and middle-income countries (LMICs): a systematic review. BMJ Global Health. 2022;7:e007409.
24. Livingston G, Huntley J, Sommerlad A, Ames D, Ballard C, Banerjee S, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. Lancet. 2020;396(10248):413-46.
25. What Is Dementia? Symptoms, Types, and Diagnosis: National Institute on Aging; [Available from: https://www.nia.nih.gov/health/what-is-dementia#:~:text=Dementia%20is%20the%20loss%20of,and%20their%20personalities%20may%20change.
26. Griffith LE, Gruneir A, Fisher K, Panjwani D, Gandhi S, Sheng L, et al. Patterns of health service use in community living older adults with dementia and comorbid conditions: a population-based retrospective cohort study in Ontario, Canada. BMC Geriatrics. 2016;16(1):177.
27. Bunn F, Burn A-M, Robinson L, Poole M, Rait G, Brayne C, et al. Healthcare organisation and delivery for
people with dementia and comorbidity:
a qualitative study exploring the views
of patients, carers and professionals. BMJ Open. 2017;7.
28. Browne J, Edwards DA, Rhodes KM, Brimicombe DJ, Payne RA. Association of comorbidity and health service usage among patients with dementia in the UK: a population-based study. BMJ Open. 2017;7:e012546.
29. 2021 Alzheimer's disease facts and figures. Alzheimer's & Dementia. 2021;17(3):327-406.
30. Brodaty H, Donkin M. Family caregivers of people with dementia. Dialogues in Clinical Neuroscience. 2009;11(2):217-28.
31. Sorensen S, Conwell Y. Issues in Dementia Caregiving: Effects on Mental and Physical Health, Intervention Strategies, and Research Needs. American Journal of Geriatric Psychiatry. 2011;19(6):491-6.
32. Wong W. Economic Burden of Alzheimer Disease and Managed Care Considerations. AJMC. 2020;26:S177-S83.
33. Prince M, Wimo A, Guerchet M, Ali G-C, Wu Y-T, Prina M. World Alzheimer Report 2015: The Global Impact of Dementia - An analysis of prevalence, incidence, cost and trends. Alzheimer's Disease International; 2015.
34. Khanassov V, Rojas-Rozo L, Sourial R, Yang XQ, Vedel I. Needs of patients with dementia and their caregivers in primary care: lessons learned from the Alzhiemer plan of Quebec. BMC Family Practice. 2021;22(1):186.

35. Richardson A, Blenkinsopp A, Downs M, Lord K. Stakeholder perspectives of care for people living with dementia moving from hospital to care facilities in the community: a systematic review. BMC Geriatrics. 2019;19:202.
36. Weber SR, Pirraglia PA, Kunik ME. Use of services by community-dwelling patients with dementia: a systematic review. American Journal of Alzheimers Disease and Other Dementia. 2011;26(3):195-204.
37. Amjad H, Wong SK, Roth DL, Huang J, Willink A, Black BS, et al. Health Services Utilization in Older Adults with Dementia Receiving Care Coordination: The MIND at Home Trial. Health Services Research. 2017;53(1):556-79.
38. Godard-Sebillote C, Berre ML, Schuster T, Trottier M, Vedel I. Impact of health service interventions on acute hospital use in community-dwelling persons with dementia: A systematic literature review and meta-analysis. PLoS ONE [Electronic Resource]. 2019;14(6):e0218426.
39. Hunt LJ, Coombs LA, Stephens CE. Emergency Department Use by Community-Dwelling Indviduals with Dementia in the United States: An Integrative Review. Journal of Gerontological Nursing. 2018;44(3):23-30.
40. LaMantia MA, Stump TE, Messina FC, Miller DK, Callahan CM. Emergency Department Use Among Older Adults with Dementia. Alzheimer Disease & Associated Disorders. 2016;30(1):35-40.
41. Bronskill S, Camacho X, Grunier A. Health system use by frail Ontario seniors: an in-depth examination of four vulnerable cohorts. Institute for Clinical Evaluative Sciences. 2011.
42. CIHI. Seniors with dementia more likely to be hospitalized, stay longer in emergency department: Canadian Institute for Health Information; [Available from: https://www.cihi.ca/en/dementia-in-canada/dementia-care-across-the-health-system/dementia-in-hospitals.
43. Martin A, O’Connor S, Jackson C. A scoping review of gaps and priorities in dementia care in Europe. Dementia. 2018;19(7):2135-51.
44. Weinstein JN, Geller A, Negussie Y, Baciu A. Communities in Action: Pathways to Health Equity Washington, DC: The National Academies Press; 2017.
45. Asada Y, Hurley J, Grignon M, Kirkland S. Health inequalities and inequities by age: Stability for the Health Utilities Index and divergence for the Frailty Index. SSM - Population Health. 2018;5:17-32.
46. Datto A. Social Determinants of Health: World Health Organization; [Available from: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
47. Braveman P, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. Public Health Reports. 2014;129(2):19-31.
48. Healthy People 2030: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion; [Available from: https://health.gov/healthypeople/priority-areas/social-determinants-health.
49. Mikkonen J, Raphael D. Social Determinants of Health: The Canadian Facts. Toronto: York University School of Health Policy and Management; 2010.
50. Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. Annual Review of Public Health. 2011;32:381-98.
51. Marmot M, Bloomer E, Goldblatt P. The Role of Social Determinants in Tackling Health Objectives in a Context of Economic Crisis. Public Health Reviews. 2013;35(1).

52. Stringhini S, Dugravot A, Shipley M, Goldberg M, Zins M, Kivimaki M, et al. Health Behaviours, Socioeconomic Status, and Mortality: Further Analyses of the British Whitehall II and the French GAZEL Prospective Cohorts. PLoS Medicine. 2011;8(2):e1000419.
53. Haggerty J, Levesque J-F, Harris M, Scott C, Dahrouge S, Lewis V, et al. Does healthcare inequity reflect variations in peoples' abilities to access healthcare? Results from a multi-jurisdictional interventional study in two high-income countries. International Journal for Equity in Health. 2020;19.
54. Lin P-J, Daly A, Olchanski N, Cohen JT, Neumann PJ, Faul JD, et al. Dementia diagnosis disparities by race and ethnicity. Alzheimer's & Dementia. 2020.
55. Suran M. Racial Disparities in Dementia Diagnoses. JAMA Network. 2022;327(8):709.
56. Shiekh SI, Cadogan SL, Lin L-Y, Mathur R, Smeeth L, Warren-Gash C. Ethnic Differences in Dementia Risk: A Systematic Review and Meta-Analysis. Journal of Alzheimer's Disease. 2021;80(1):337-55.
57. Chen C, Zissimopoulos JM. 2018. Alzheimer's & Dementia.4:510-20.
58. Hill CV, Perez-Stable EJ, Anderson NA, Bernard MA. The National Institute on Aging Health Disparities Research Framework. Ethnicity & Disease. 2015;25(3):245-54.
59. Peterson JD, Wehberg S, Packness A, Svensson NH, Hyldig N, Raunsgaard S, et al. Association of Socioeconomic Status With Dementia Diagnosis Among Older Adults in Denmark. JAMA Network Open. 2021;4(5):e2110432.
60. Cadar D, Lassale C, Davies H, Llewellyn DJ, Batty GD, Steptoe A. Individual and Area-Based Socioeconomic Factors Associated With Dementia Incidence in England
Evidence From a 12-Year Follow-up in the English Longitudinal Study of Ageing. JAMA Psychiatry. 2018;75(7):723-32.
61. Canada PHAo. A Dementia Strategy for Canada: Together We Aspire. In: Conditions H-Da, editor.: Government of Canada; 2019.
62. Rosende-Roca M, Abdelnour C, Esteban E, Tartari JP, Alarcon E, martinez-Atienza J, et al. The role of sex and gender in the selection of Alzheimer patients for clinical trial pre-screening. Alzheimer's Research & Therapy. 2021;13(1):95.
63. Canada's National Dementia Strategy: Alzheimer Society; [Available from: https://alzheimer.ca/en/take-action/change-minds/canadas-national-dementia-strategy.
64. Edick C, Holland N, Ashbourne J, Elliott J, Stolee P. A review of Canadian and international dementia strategies. Healthcare Management Forum. 2016;30(1):32-9.
65. Fortinsky RH, Downs M. Optimizing Person-Centered Transitions In The Dementia Journey: A Comparison Of National Dementia Strategies. Health Affairs. 2014;33(4).
66. Schmachtenberg T, Monsees J, Hoffmann W, Berg Nvd, Stentzel U, Thyrian JR. Comparing national dementia plans and strategies in Europe – is there a focus of care for people with dementia from a migration background? BMC Public Health. 2020;20(784).
67. ARHQ. Overview: Horizon Scans: Effective Health Care Program, Agency for Healthcare Research and Quality; 2019 [Available from: https://effectivehealthcare.ahrq.gov/products/horizon-scan/overview.
68. OECD. Overview of methodologies, futures thinking in brief, future schooling: OECD; 2019 [Available from: https://www.oecd.org/site/schoolingfortomorrowknowledgebase/futuresthinking/overviewofmethodologies.htm. .
69. Charlton P, Doucet S, Azar R, Nagel DA, Boulos L, Luke A, et al. The use of the environmental scan in health services delivery research: a scoping review protocol. BMJ Open. 2019;9.

70. National Dementia Strategies: Alzheimer Europe; [Available from: https://www.alzheimer-europe.org/policy/national-dementia-strategies.
71. National Dementia Plans: Alzheimer's Disease International; [Available from: https://www.alzint.org/what-we-do/policy/dementia-plans/.
72. Rothgang H, Cacace M, Frisina L, Grimmeisen S, Schmid A, Wendt C. The State and Healthcare: Comparing OECD Countries2010.
73. OECD. Health Spending OECD Data2022 [Available from: https://data.oecd.org/healthres/health-spending.htm.
74. OECD. Gross Domestic Product (GDP) OECD Data2022 [Available from: https://data.oecd.org/gdp/gross-domestic-product-gdp.htm.
75. OECD. Elderly population: OECD Labour Force; 2022 [Available from: https://data.oecd.org/pop/elderly-population.htm.
76. Life expectancy vs. health expenditure, 1970 to 2015: Oxford Martin School; [Available from: https://ourworldindata.org/grapher/life-expectancy-vs-health-expenditure.
77. Rahman MM, Khanam R, Rahman M. Health care expenditure and health outcome nexus: new evidence from the SAARC-ASEAN region. Globalization and Health. 2013.
78. Coordination UNSCEBf. Leaving No One Behind: Equality and Non-Discrimination at the Heart of Sustainable Development. New York; 2017.
79. WHO. A Conceptual Framework for Action on the Social Determinants of Health. Geneva: World Health Organization; 2010.
80. National Framework for Action on Dementia 2015 - 2019. In: Welfare AIoHa, editor.: Government of Australia; 2015.
81. Institute AH. Dementia Strategy: Living well with dementia. Government of Austria; 2015.
82. Plan Nacional de Demencia 2017. In: Salud Md, editor.: Gobierno de Chile; 2017.
83. Plan Nacional Para la Enfermedad de Alzheimer Y Demencias Relacionadas Esfuerzos Compartidos (2014-2024). Republica de Costa Rica; 2014.
84. National Action Plan for Alzheimer's Disease and related Illnesses (2020-2030). In: Republic MoHotC, editor.: NAPAD; 2020.
85. Health Mo. A Safe and Dignified Life with Dementia: National Action Plan on Dementia (2025). Government of Denmark; 2017.
86. Health MoSAa. National Memory Programme 2012-2020: Creating a "Memory Friendly" Finland. Helsinki Finnish Ministry of Social Affairs and Health; 2012.
87. Strategy NH. Plan Maladies Neuro Degeneratives 2014-2019. Government of France; 2014.
88. Government GF. National Dementia Strategy. In: Federal Ministry for Family Affairs SC, Women and Youth, Health FMo, editors.: German Federal Government; 2018.
89. Association AAs. National Action Plan for Dementia – Alzheimer's Disease (2016-2020). In: Affairs SCoS, editor.: Government of Greece; 2016.
90. Svavarsdóttir S. Icelandic National Dementia Action Plan (2020-2025). In: Health Mo, editor.: Icelandic Parliament; 2020.
91. Health IDo. The Irish National Dementia Strategy. Department of Health; 2019.
92. Brodsky J, Bentur N, Laron M, Ben-Israel S. Addressing Alzheimer's and Other Types of Dementia: Israeli National Strategy Jerusalem: Ministry of Health; 2013.
93. Health Mo. National Dementia Strategy In: Health Mo, Health NIf, Italia FA, Italia AU, editors.: Government of Italy; 2014.

94. The New Orange Plan: Japan Health Policy Now; [Available from: https://japanhpn.org/en/1-2/.
95. Welfare MoHa. The 3rd National Dementia Plan: Living well with dementia in the community. Government of Korea; 2016.
96. National Dementia Action Plan. In: Ministère de la famille et de l'intégration MdlS, editor.: Le Gouvernement du Grand-Duché de Luxembourg; 2013.
97. Geriatría INd. Plan de Acción Alzheimer Y Otras Demencias, México 2014. Mexico: Government of Mexico; 2014.
98. Ministry of Health WaS. National Dementia Strategy 2021-2030. In: Ministry of Health WaS, editor.: Government of Netherlands; 2021.
99. Demensplan 2025. Government of Norway; 2020.
100. Portuguese Dementia Health Strategy (2018). In: Portuguese Health Ministry AP, editor.: Government of Portugal; 2018.
101. Slovenian National Dementia Strategy 2016-2020. In: Ministry of Health MoL, Family, Social Affairs and Equal Opportunities, Spominčica, editor.: Government of Slovenia; 2016.
102. Plan Integral de Alzheimer y otras Demencias (2019-2023). In: MINISTERIO DE SANIDAD CYBS, editor. Madrid: Government of Spain; 2019.
103. Nationell strategi för omsorg om personer med demenssjukdom. In: Socialdepartementet, editor. Stockholm: Government of Sweden.
104. Stratégie nationale en matière de démence 2014–2019. In: Département fédéral de l'intérieur (DFI) OfdlspO, editor.: Government of Switzerland; 2014.
105. National Plan to Address Alzheimer's Disease: 2018 Update. In: Services USDoHaH, editor.: United States Federal Government; 2018.
106. World Bank Country and Lending Groups: The World Bank; 2022 [Available from: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups#:~:text=%EF%BB%BF%EF%BB%BF%20For%20the%20current,those%20with%20a%20GNI%20per.
107. Network GBoDHFC. Past, present, and future of global health financing: a review of development assistance, government, out-of-pocket, and other private spending on health for 195 countries, 1995–2050. Lancet. 2019;393(10187):P2233-60.
108. Cerna L. The Nature of Policy Change and Implementation: A Review of Different Theoretical Approaches. OECD; 2013.
109. Hudson B, Hunter D, Peckham S. Policy failure and the policy-implementation gap: can policy support programs help? Policy Design and Practice. 2018;2(1):1-14.
110. Arshed N, Mason C, Carter S. Exploring the disconnect in policy implementation: A case of enterprise policy in England. Environment and Planning C: Politics and Space. 2016.
111. Tezera D. Factors for the Successful Implementation of Policies. Merit Research Journals. 2019;7(8):92-5.
112. Watson B. The troubling evolution of corporate greenwashing Guardian sustainable business: The Guardian; 2016 [Available from: https://www.theguardian.com/sustainable-business/2016/aug/20/greenwashing-environmentalism-lies-companies.
113. Chow S, Chow R, Wan A, Lam HR, Taylor K, Bonin K, et al. National Dementia Strategies: What Should Canada Learn? Canadian Geriatrics Journal. 2018;21(2):173-209.
114. Hacker-Teper M, Godard-Sebillotte C, Vedel I. Achieving the Goals of Dementia Plans: A Review of Evidence-Informed Implementation Strategies. Healthcare Policy. 2019;14(4):10-20.

115. Terwindt F, Rajan D, Soucat A. Priority-setting for national health policies, strategies and plans. Geneva: World Health Organization; 2016.
116. Krieger N. A glossary for social epidemiology. Epidemiological Bulletin. 2002;23(1):7-11.
117. Devine J, Deneulin S. Negotiating religion in everyday life: A critical
exploration of the relationship between religion,
choices and behaviour. Culture and Religion. 2011;12(1):59-76.
118. Disability and health inequalities in Australia. VicHealth; 2011.
119. Sexual Orientation & Gender Identity: International Justice Resouce Center; [
120. Plessis Vd, Beshiri R, Bollman RD, Clemson H. Definitions of Rural. Rural and Small Town Canada Analusis Bulletin. 2001;3(3).
121. Frolich KL, Potvin L. The inequality paradox: The population approach and vulnerable populations. American Journal of Public Health. 2009; 98(2):216-221.

Appendices

Appendix A: Definition of Seven Inequities

Race/Ethnicity: “Social groups, often sharing cultural heritage and ancestry, whose contours are forged by systems in which ‘one group benefits from dominating other groups, and defines itself and others through this domination and the possession of selective and arbitrary physical characteristics (for example, skin colour)’” (79, 116).

Religion: “Religion is seen as giving meaning to what people do and aspire… Because of the central place that religion occupies in the lives of people who live in impoverished circumstances, religion has increasingly become an important entry point for poverty reduction interventions, and for social and political mobilisation… it is a discrete source of value that shapes people’s attitudes and behaviour” (117).

Age: “A successfully aging population has both a good overall level of health and a fair distribution of health. Thus, when viewed from a population perspective, a key indicator of successful aging is whether health inequalities (i.e., differences) and inequities (i.e., unfair differences) in the population increase or decrease over the life course” (45)

Disability: “[The] interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others’…This definition distinguishes the impairment or health condition (e.g. paraplegia) from the restrictions on participation in society… more likely to live in poverty, have poor-quality or insecure housing, low levels of workforce participation and education, and be socially excluded or marginalised; they may also face violence and discrimination related to their disability and have difficulty accessing appropriate health care (118).

Sexual Orientation/Gender Identity: "**Sexual orientation** refers to a person's 'emotional, affectional and sexual attraction to…individuals of a different gender or the same gender or more than one gender.' **Gender identity** refers to 'each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth'…gender identity may be different than the gender that society might attribute to that person" (119).

Social Class: "Relations of ownership or control over productive resources (i.e. physical, financial and organizational). Social class provides an explicit relational mechanism (property, management) that explains how economic inequalities are generated and how they may affect health… class is an inherently relational concept. It is not defined according to an order or hierarchy, but according to relations of power and control" (79).

Rurality: "The population living in towns and municipalities outside the commuting zone of larger urban centres… emphasizing different geographic criteria such as population size, population density, labour market context or settlement context" (120).

Appendix B: Race/Ethnicity

Country	Quotes from Strategy	General Objectives	Specific Objectives		
			% Target Goal	Year/Deadline Target	Budget Allocation
Australia	Lack of awareness and access to services for Aboriginal and Torres Strait Islander people - studies indicate that the prevalence of dementia in the Aboriginal and Torres Strait Islander populations is over five times greater than the general population. While prevalence of dementia is likely to be greater in Aboriginal and Torres Strait Islander communities, awareness of dementia in these communities is lower than in the overall Australian population. Also, the perception of dementia can be quite different across Aboriginal and Torres Strait Islander communities. It is often not viewed as a medical condition, and consequently medical treatment or support is not often sought	Tailored early support services needed for those who are in diverse populations Support culturally appropriate care for people with dementia from diverse needs groups (Aboriginal and Torres Strait Islander, CALD communities) Enhance quality and availability of services for diverse needs groups through improved education and training for the workforce			

	Different cultural perceptions of dementia are present in culturally and linguistically diverse (CALD) communities. In some communities, dementia is a taboo issue which is not openly discussed, resulting in even higher levels of stigma and negative community perceptions. These cultural perceptions impact on individual willingness to access services and decrease the likelihood of accepting support.				
Austria	Focus on the equality of access to offers for help for minorities and people with migrant backgrounds				
Canada	Research findings are communicated in ways that increase accessibility and are culturally appropriate across diverse communities such as Indigenous peoples, immigrant and minority language communities For those who live on reserve, lack of access to health professionals and	Developing and sharing evidence-informed services, information and resources related to dementia care and advance care planning, and adapting them to different cultures, populations			Budget 2019 provides $50 million over 5 years, starting in 2019-20, to support the implementation of the national dementia strategy and to work with key stakeholders to: increase awareness about dementia through

	services on reserve, especially in rural and remote communities, as well as a lack of cultural safety in the health system create barriers to equitable care. Cultural differences in the understanding of and views toward dementia can result in a reluctance to talk about symptoms and may lead to under-diagnosis and difficulty connecting with networks of support that are useful following diagnosis. Understanding the impacts of dementia among ethnic minority populations is limited in Canada	and languages Work collaboratively with Indigenous communities to develop culturally safe and culturally appropriate tools for diagnosis. Improved access to evidence-informed, culturally safe and culturally appropriate guidelines for standards of care			targeted campaigns and activities that focus on prevention, reducing risk and stigma
Germany	"Migration background inequality" Intercultural competence at care counselling centers; further development and networking of culturally sensitive information services and counselling Improving multilingual, culturally sensitive assessment	Field of action - developing and expanding culturally sensitive counselling services for people with dementia and their relatives			

	instrument for diagnosing dementia				
Israel	Ensuring the inclusion of minority groups and other sub-groups in the research agenda" Developing a national program to disseminate information on dementia that is culturally adapted to Israeli society and to different cultural groups	Research includes minority groups and other sub-groups in research agenda			
United States	NIH is supporting the Reasons for Geographic and Racial Differences in Stroke (REGARDS) study and the Northern Manhattan Study (NOMAS) which are diverse longitudinal cohort studies of African American or Black, and Hispanic or Latino participants. Development of culturally-competent dementia care specialists, dementia friendly community education/awareness initiatives and translation of the Music and Memory intervention in Indian Country	Monitor and identify strategies to increase enrollment of racial and ethnic minorities in Alzheimer’s disease and related dementias studies Evaluate recruitment strategies for American Indians and Alaska Natives, create culturally tailored materials on AD-PM			

	Main goal: Decrease disparities in Alzheimer's disease for racial and ethnic minority populations that are at higher risk for Alzheimer's disease	Ensure receipt of culturally sensitive education, training, and support materials Connect American Indian and Alaska Natives to Alzheimer's disease and related dementias resources Development of culturally-competent dementia care specialists			

Appendix C: Religion

Country	Quotes from Strategy	General Objectives	Specific Objectives		
			% Target Goal	Year/Deadline Target	Budget Allocation
Germany	Religious people need support tailored to their own life history, even in old age. Knowledge about dementia, social integration and religious faith can ease the burden of the condition. More culture- and religion-sensitive support and education is therefore needed.	Supporting the spiritual and religious needs of people with dementia is one objective of the National Dementia Strategy.		By the end of 2024, culture- and religion-sensitive support and counselling services for family caregivers will be available. By the end of 2024, employees in migrant support organisations will be trained on the topic of dementia. By the end of 2022, the pastoral care for older people, offered by the evangelical and catholic churches in Germany, will be networked with other local counselling structures, and further pastoral workers for people with dementia will be trained.	

Appendix D: Age

Country	Quotes from Strategy	General Objectives	Specific Objectives		
			% Target Goal	Year/Deadline Target	Budget Allocation
Australia	Younger Australians with dementia may face many challenges similar to those of older people with dementia, however the non-normative timing of the disease and different practical considerations present challenges different to those faced by older people with dementia. Younger people may face barriers to accessing appropriate services as dementia services tend to be designed around the interests and physical abilities of older people.	Develop clinical referral and care pathways that are flexible including for people with dementia from diverse needs groups and those with younger onset dementia Provide support for people with younger onset dementia to remain in employment for as long as possible and maintain family/community participation Provide age appropriate home, residential, and acute care support services for people with younger onset dementia, their carers, and families Develop clinical referral and care pathways that are flexible including for people with			

		dementia from diverse needs groups and people with younger onset dementia			
Canada	A lack of awareness of young onset dementia can lead to delays in diagnosis which result in delays in accessing needed supports and treatments. A lack of age-appropriate services is a significant barrier to the quality of life for people living with young onset dementia and caregivers.	Support in the form of a provincial recognition program for communities that have taken steps to be age-friendly and inclusive of seniors			Budget 2019 provides $50 million over 5 years, starting in 2019-20, to support the implementation of the national dementia strategy and to work with key stakeholders to develop treatment guidelines and best practices for early diagnosis
Denmark	A timely and accurate diagnosis is crucial in order to enable the municipalities and regions to provide an appropriate treatment and a qualified care for people with dementia. This is especially the case for the group of younger people	Increase in the number of places offered in relief day care centres and more support for younger people with dementia Counselling- and activity centres for people with dementia and their relatives, including younger people with dementia			DKK 1.6 million is allocated to elaborate a tool – based on already existing tools - that can help to detect dementia at an earlier stage. DKK 37.5 million is allocated to establish counselling-

	affected by dementia, who are often even more difficult to diagnose				and activity centres for people with dementia and their relatives, focusing on younger people with dementia
France	Poursuivre les efforts en matière d‟amélioration de la solvabilisation pour réduire les inégalités sociales qui s‟aggravent avec l‟âge ou la maladie et à faire rentrer la politique de l‟autonomie dans l‟ère du numérique				
Germany	“People with early-onset dementia and their families”	Extending counselling and support structures for people with early-onset dementia and their families			
Ireland	While dementia is associated with increasing age and usually begins to present in the population after the age of 65, people in their 30s, 40s or 50s	Available resources should be deployed on the basis of need and as effectively as possible to provide services for all people living with dementia,			

	can experience it. The diagnosis of younger onset dementia is challenging, with symptoms often confused with other disorders and disabilities, such as depression and other mental health problems. People with younger onset dementia are most commonly affected by Alzheimer’s Disease, Vascular Dementia and Dementia with Lewy Bodies. Some develop younger onset dementia alongside other disorders such as Down Syndrome, Parkinson’s disease, Acquired Immune Deficiency Syndrome (AIDS), Huntington’s disease, Creutzfeldt-Jakob disease,	including those with early onset dementia			

	and alcoholism. The difficulties experienced by younger people with dementia are compounded by the fact that many are still employed in the labour market and will have financial responsibilities including mortgages. Many will also have parental and family responsibilities. People with early onset dementia usually experience greater difficulty accessing a diagnosis and fitting into existing dementia service provision, which is generally tailored to the needs of older people. This Strategy addresses the needs of all people with dementia, including those				

	with younger onset dementia.				
Korea	Management of high risk group: Older adults 75+ living alone Support for early diagnosis of dementia				Utilize the MHW 'Coping with the ageing' research development project (budget of 1.5 billion KRW) to develop aging-friendly products, and to support independent living of older adults
Netherlands	Young persons with dementia: A special group within this strategy consists of young persons with dementia. They often have other forms of dementia than persons 65 years and older. In part due to their age, diagnosing dementia under these younger persons is more difficult as dementia is often overlooked in the first instance. As these persons			No later than the summer of 2021, municipalities and care centres have acquired sufficient insight into the residential needs of older persons and other target groups	

	often have a family with children still living at home, are physically stronger, and are still part of the labour force, their needs in terms of support and care are different				
United States	The population with younger-onset AD/ADRD faces unique challenges with diagnosis, care, and stigma.	HHS will undertake the actions below to better understand the unique challenges faced by these groups and create a plan for improving the care that they receive, which will be integrated into the broader efforts to improve care for all people with AD/ADRD. Issue recommendations about standards for evaluating the effectiveness of treatments for early-stage AD/ADRD.			

Appendix E: Disability

Country	Quotes from Strategy	General Objectives	Specific Objectives		
			% Target Goal	Year/Deadline Target	Budget Allocation
Australia	People with physical and intellectual disabilities are increasingly surviving to older age and therefore are vulnerable to age-associated disorders such as dementia. It is reported that one in five people, with an intellectual disability, aged 65 and older, have dementia People with disability who are vulnerable to age-associated disorders				
Austria	Focus on the equality of access to offers for help for people with disabilities				
Canada	research findings are communicated in ways that				In 2017, the Government of Canada provided

	increase accessibility and are culturally appropriate across diverse communities such as people with intellectual disabilities Adults with intellectual disabilities have experienced stigma, discrimination and exclusion that can continue following a dementia diagnosis. Those with intellectual disabilities may also have unique care and support needs, arising from the combination of their previous disability with the overlay of dementia symptoms.				provinces and territories with an additional $11 billion over 10 years specifically targeted to improve home and community care, including palliative care, and mental health and addiction services. (5 billion for mental health)
Denmark	Several citizens with a permanently reduced mental capacity, do	The government and the political parties behind this			

	not receive the somatic treatment they need to maintain good health because they refuse to receive treatment	action plan agree to continue the work on a new legislation that can strengthen the care for this group of citizens, so treatment will be possible despite their refusal.			
Finland	Special attention must be given to the needs of vulnerable groups, such as people undergoing rehabilitation for mental health issues	Provide... residents with opportunities to take part in activities that promote brain health and for taking the needs of different kinds of people into account when planning such activities.			
France	L‟enjeu de qualité repose sur l‟accès à une médecine de premier recours de qualité et à une organisation des soins spécialisés bien				

	coordonnés. L‟ensemble des professions de santé est concerné pour répondre à des besoins diversifiés : troubles moteurs, de l‟équilibre, troubles du comportement, de la cognition, etc., conséquences de la maladie ou de son traitement. Proposer des réponses adaptées à la diversité des groupes de personnes (demi-journées dédiées à la préservation des capacités motrices, à la préservation des capacités cognitives, etc.)				
Germany	The Inclusive Social Environments Initiative (ISI) of the BMAS, in coordination with the local				

	authority associations, likewise aims to further improve the circumstances of people with disabilities.				
Ireland	"those with…an intellectual disability" "target populations particularly at risk, including people with an intellectual disability"	The Health Service Executive will examine the issues arising regarding the assessment of those with Down Syndrome and other types of intellectual disability given the early age of onset of dementia for these groups and the value of establishing a reliable baseline Available resources should be deployed on the basis of need and as effectively as possible to provide services for all people living with			

		dementia, including those with… an intellectual disability, and should be delivered in a culturally appropriate way Priority Action: target populations particularly at risk, including people with an intellectual disability			

Appendix F: Sexual Orientation/Gender Identity

Country	Quotes from Strategy	General Objectives	Specific Objectives		
			% Target Goal	Year/Deadline Target	Budget Allocation
Australia	Those people who identify as Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) require specific supports and services that are sensitive and respectful to their needs				
Canada	Research findings communicated in ways that increase accessibility and are culturally appropriate across LGBTQ2 communities Strategy fills gaps in programs and supports for at-risk and vulnerable populations, including senior women Some evidence indicates that LGB adults may experience delays in dementia diagnosis and difficulties finding supports due to stigma and social marginalization. Transgender people face additional barriers to health services with a survey showing that 23% did	The Dementia Community Investment will prioritize projects targeting various populations, such as women			

	not see a doctor or seek medical care for fear of being mistreated. Concerns have been raised by LGBTQ2 adults about possible stigma and discrimination in assisted living and long-term care homes as well as the challenges around trust and disclosure of sexual orientation				
Germany	The review will also consider the situation of foreign assistance and care staff, care provided by relatives living remotely, and issues relating to social inequality such as gender				

Appendix G: Social Class

Country	Quotes from Strategy	General Objectives	Specific Objectives		
			% Target Goal	Year/Deadline Target	Budget Allocation
Austria	Focus on the equality of access to offers for help for those who are homeless				
Canada	Ethnic minority people living with dementia and caregivers face difficulties in accessing care and support due to socio-economic marginalization				
Germany	The quality of health services for people with dementia is also affected by social inequality. This, as well as the effects of the condition on everyday life, of people with dementia, will be considered. The quality of healthcare for people with dementia is	Research will consider various factors relevant to the development of dementia and the treatment and care of people with dementia: psychosocial factors, social inequality, socioeconomic inequality and demographic patterns of ageing			

	influenced, amongst others, by psycho-social factors and social and socio-economic inequalities. For instance, a low level of education is associated, on average, with higher risks of more serious somatic disorders, including certain forms of dementia. These relationships are to be researched in greater depth.				

Appendix H: Rurality

Country	Quotes from Strategy	General Objectives	Specific Objectives		
			% Target Goal	Year/Deadline Target	Budget Allocation
Australia	People living in rural and remote communities face many challenges including access to primary and specialist health care. There may be a shortage of specialists and established multi-disciplinary teams, particularly in regional, rural and remote communities of Australia. In these locations, distance often presents a significant barrier to accessing primary and specialist care services.	There is a requirement for service responses to support regional, rural and remote communities of Australia.			
Canada	Research findings are communicated in ways that increase accessibility and are culturally appropriate				

	across diverse communities such as those who live in Rural and remote communities Development of these resources must be done in ways that ensure accessibility across cultures, languages and different geographic areas (such as rural/remote communities) Health and social supports are typically more sparse in rural and remote regions compared with urban communities, which can result in people living with dementia having to leave their communities or travel long distances for care and supports.				
Denmark	All 98 municupalities in Denmark should be dementia			Three national goals for the dementia efforts towards 2025	

	friendly - It is also important to ensure that information on the municipal efforts on dementia is easy accessible for people affected by dementia and their relatives and that counselling assistance is easily located			have been set in order to contribute to a significant boost of the field of dementia and to diminish the geographical inequality between municipalities and regions.	
Germany	Focus on rural development of dementia-sensitive social spaces, and an increase in accessible transportation in rural areas				
Greece	Geographical inequalities of the existing services, which are gathered in a few large cities Moreover, the distribution of these services and structures is uneven and not spatially correct. Major shortages are in rural areas and in the islands				
United States	Private interdisciplinary	As new resources			

	team training in recognition, assessment, and management of Alzheimer's disease and related dementias in small rural Indian Health facilities	become available, they will be distributed through a variety of venues to Indian Country			