Progress on dementia—leaving no one behind

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The *Lancet* Commission Dementia Prevention, Intervention, and Care[1] makes a timely evidence-driven contribution to global efforts to improve the lives of people with dementia and their carers, and limit the future impact on societies. The Commission proposes ambitious prevention targets, treatment of cognitive symptoms in people with Alzheimer's disease or dementia with Lewy bodies, individualised dementia care, provision of care for carers, planning for the future for patients and families, risk protection balanced with respect for autonomy, management of neuropsychiatric symptoms, consideration of dementia in end of life care, and use of technological innovations to improve care but not replace social contact. It recommends a comprehensive package of evidence-based actions that will complement wider global efforts to respond to the challenge of dementia.

On May 29, 2017, the World Health Assembly endorsed the WHO Global Action Plan on the Public Health Response to Dementia (2017–2025),[2] with member states committing to international collaboration, and national strategies with implementation plans. This plan signals an upswing in awareness of the need to address what WHO declared, in 2012, to be a global public health priority.[3] Concerted international and intersectoral collaborative action will be required to implement WHO's Plan. Equity and rights must be foregrounded to ensure that we "leave no one behind". The *Lancet* Commission, through a systematic and judicious appraisal of the evidence, has helpfully indicated what works, what might work, and what should be avoided in drafting strategies and plans. The Commission provides the "what", without necessarily specifying the "how" and the "where".

With endorsement of the WHO Global Action Plan, there is acknowledgment that dementia is a global problem that particularly impacts low-income and middle-income countries (LMICs). Alzheimer's Disease International (ADI) estimated that there were 46·8 million people living with dementia worldwide in 2015, increasing to 131·5 million by 2050.[4] 58% of people with dementia live in LMICs.[4] Given differential rates of population ageing, numbers affected by dementia are expected to double in high-income countries (HICs) but more than treble in LMICs by 2050.[4] More than half of the global increase will occur in G20 countries that are not members of the richest G7, including populous and rapidly ageing middle-income countries Brazil, China, India, Indonesia, Mexico, and Turkey.

The WHO Global Action Plan[2] calls for a public health approach with three core elements: raising awareness, ensuring universal coverage of basic health and social care, and focusing on promotion and prevention.

Awareness is the bedrock of the public health approach, and essential for progress. WHO and ADI's six-stage model envisages countries progressing from stage 1 (where the problem is ignored) through stage 2 (some awareness), stage 3 (building dementia infrastructure), stage 4 (advocacy efforts), stage 5 (policies and dementia plans or strategies), to stage 6 (normalisation, with acceptance of dementia as a disability and full rights accorded).[3] Political will, prioritisation, and investment from governments can speed this transition. Dementia-friendly communities and national dementia friends programmes, as implemented in Japan and the UK, are important instruments for change in attitudes and behaviours, enabling communities to support people to live well with dementia. The desires of people with dementia to contribute to society and be seen as people of equal status with strengths and abilities must also be recognised and supported.

The *Lancet* Commission admirably focuses on a strategy that others have referred to as "care now, if cure later".

Edgard Garrido/Reuters

Patients with Alzheimer's disease and dementia dance at the Alzheimer foundation in Mexico City

While a cure, or a disease-modifying therapy, for dementia remains a distant prospect, there should be no delay in implementing available evidence on services, treatments, and care for people with dementia and their carers. The *Lancet* Commission's evidence-based recommendations for timely diagnosis, advanced care planning, carer training and support, cholinesterase inhibitors where indicated, cognitive stimulation, and a case management for integrated continuing care align closely with those recommended in the WHO Mental Health Gap Action Programme guidelines intended for use by non-specialist health-care workers in resource-poor settings.[5] The limited coverage of these services must be addressed, urgently, with a balanced research agenda giving due priority to translating existing knowledge into policy and practice. Neglect will lead to inequity, given the limited capacity of LMICs to implement and benefit from advances in treatment and care.

In LMICs there are too few specialists, mainly restricted to urban centres, to provide services for more than a tiny proportion of people with dementia. The mountain to be climbed to achieve universal contact coverage is underlined by the modest target in the WHO Global Action Plan that half of all countries will have diagnosed half of all dementia cases by 2025.[2] In LMICs demand will increase sharply, outstripping efforts to expand the specialist workforce. An important part of the solution must be a move towards task-sharing models in which most care is delivered by non-specialist primary care and community services, trained and supported by specialists.[6] Task-sharing will have applications in HICs, where, given the scale of the dementia epidemic, health and social care systems can also be considered to be resource-poor.[6] Task sharing models aim for allocative efficiency, a relevant objective for health and social care systems around the world. Primary care staff know the person with dementia and their family best, and generalists may be best placed to deliver care that is continuing, holistic, integrated, and person-centred.[6] Attention to physical comorbidity, as discussed in the *Lancet* Commission, is critically important throughout the illness course. There is clear potential for South–North learning and knowledge translation; HICs do not have a monopoly on solutions, and, it could be argued, have largely developed a poorly integrated, over-specialised model of care.[6]

Much attention has focused on the prospect that brain health promotion and risk reduction could blunt the impact of the epidemic.[7,8] Our best hope of ascertaining the likely impact of more education and improvements in cardiovascular health is to correlate secular trends in these exposures with changes in the age-specific incidence of dementia. The message that dementia, alongside heart disease, stroke, and cancer can be prevented through effective implementation of public health strategies is one that policy makers and public need to hear, and act on. Nevertheless, caution is indicated. Current ADI projections assume that the age-specific dementia prevalence worldwide will remain constant over time,[4] and prudent policy makers should plan accordingly. More research is needed, in more settings, over longer periods to estimate trends more precisely, and their regional variation.[4,9] Reduction of risk exposures is likely to lower dementia incidence but increase survival, with a neutral effect on age-specific dementia prevalence.[9] Cardiovascular health is deteriorating in many LMICs.[10] Even with priority action,[11] dementia incidence in these settings could increase, at least in the medium term. While it is undoubtedly never too early to attend to brain health, more research is indicated into the possibility that it may also never be too late, particularly in LMICs where control of cardiovascular risk factors in later life[12] is less effective than in HICs where preventive interventions have been trialled.[13,14]

Dementia selectively affects the old and frail, women, and the socioeconomically and educationally disadvantaged. It dims the voices of those living with the condition, just when they most need to be heard. The dementia epidemic will be concentrated in LMICs where awareness is low, and resources to meet the demand are fewest. Equity requires that all those affected should be acknowledged as having equal status and value, and accorded equal access to diagnosis, evidence-based treatment, care, and support. We are a long way from achieving equity. The WHO Global Action Plan,[2] with its emphasis on the inalienable human rights of those affected, special attention to LMICs, and accountability for achieving universal coverage of health and social care, promises much for the future—if it can be delivered.

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