The Globalisation of Dementia: Issues and Responses

Countries worldwide face a rising prevalence and a growing burden of dementia. Population ageing, a global trend, is translating into an increasing number of individuals surviving to age 60 or 65 years, and then living longer than their predecessors. In the process, the older population age segment expands, and a demand for health and social care services for people in this age group escalates. People of advanced age have a heightened risk of age-related disorders, and one such disorder is the dementia syndrome.

It is projected that the global population aged 60 years, which is over 737 million in 2010 will grow to 2 billion by 2050 (United Nations, 2010). Although population ageing is most advanced in the so-called developed world, its pace is more rapid in the developing world. Less Developed Countries (LDCs) – as classified by the United Nations – have fewer resources than their “more developed” counterparts (MDCs) with which to meet the challenges of an expanding older population. One such challenge is the present and future burden of dementia. (We use the term “burden” of dementia here consonant with its use by the World Health Organization (2008) to denote burden of disease, and its use by Alzheimer’s Disease International (2010b) to denote burden of cost – and not pejoratively, as from an apocalyptic view.)

Dementia mainly affects individuals aged 65 years and over, although early onset of the disease is not uncommon. The risk and incidence of the disease increases exponentially in successive older age cohorts, and is greatest in the oldest age group, i.e. persons aged 80 years and over. The latter age group is also the fastest growing population age segment, set to increase from 106 million in 2010 to 395 million by 2050 – by which year 69 per cent will reside in developing countries (United Nations, 2009). A global estimate of the prevalence of dementia in “older” age groups in 2010 is approximately 1 per cent in persons aged 65-69 years, increasing to approximately 20 per cent for persons aged 80 years and over, and approximately 40 per cent in persons aged 90 years and older (Alzheimer’s Disease International, 2010b). A rising incidence of dementia, particularly in the oldest age group – in which frailty and co-morbidity are likely to be greater than in younger age groups, translates into a heightened demand for care services for people afflicted with the disease. The present and future prevalence of dementia...
and its care management present inexorable challenges for society, governments and individuals alike.

Dementia refers to a syndrome that is linked to a large number of underlying brain disorders, where the individual experiences gradual deterioration in multiple areas of cognitive function, and displays associated behavioural and psychological symptoms. Dementia is a major cause of disability in late life and severely impacts the quality of life of those with the disease as well as that of family members who are often informal carers to their relative. There is no single type of dementia, but multiple “pure” and mixed types exist. The most common type is Alzheimer’s disease (AD), with other types including vascular dementia, fronto-temporal dementia, dementia with Lewy bodies and dementia associated with Parkinson’s disease. Vascular biology contributes to the aetiology of all types of dementia, and an overlap between Alzheimer’s disease and vascular dementia is acknowledged increasingly (Combrinck, 2010). The causes of these types of dementia are primary neurodegenerative diseases, with some secondary causes being hypothyroidism, central nervous system infections, vitamin B-12 deficiency, chronic subdural haematoma and tumour. The foregoing types of dementia mainly affect persons aged 65 years and over. A type of dementia being diagnosed recently, that associated with the human immunodeficiency virus (HIV), is manifested commonly (20–32%) in younger persons with full-blown AIDS – in African countries in particular (Combrinck, 2010), but increasingly in persons aged 50 years and over, who are often unsuspected of having the virus.

Aetiologically, dementia symptoms are attributed to damaged brain cells or connections between brain cells. (Clinically, activation of microglial cells releases inflammatory cytokines which cause damage to neurons and their synaptic connections, leading to cognitive impairment.) Established risk factors for Alzheimer’s dementia include age, family history, Down’s syndrome and the presence of the apolipoprotein e4 allele. Probable risk factors include depression, hypertension, head injury and a high level of homocysteine (an amino acid), while possible risk factors are gender (dementia is more common in women than in men), low education (or low neuro-cognitive reserve), and various lifestyle-related conditions such as diabetes, smoking, cholesterol and the herpes simplex virus. Possible protective factors against Alzheimer’s dementia include anti-inflammatory drugs, oestrogen, APOE e2, high neuro-cognitive reserve, cognitively stimulating activities, cholesterol lowering drugs (statins) and moderate intake of alcohol. Risk factors for HIV associated dementia include a high viral load, low CD4 counts, age, anaemia, systemic symptoms and APOE e4. Anti-retroviral drug therapy reduces the risk of HIV associated dementia and often reverses deficits (Combrinck, 2010).

A diagnosis of dementia is made with reference to criteria in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) (American Psychiatric Association, 2000). To meet DSM-IV criteria, the symptoms of dementia are a decline in memory and deterioration in at least one of the following cognitive abilities: 1) Ability to generate coherent speech, or understand spoken or written language; 2) Ability to recognise or identify objects – assuming intact sensory function; 3) Ability to execute motor activities – assuming intact motor abilities, sensory function and comprehension of the required task; and 4) Ability to think abstractly – make sound judgements, and plan and carry out complex tasks. A diagnosis of dementia means that cognitive deterioration is severe enough to interfere with daily life.

Alzheimer’s Disease International’s (ADI) World Alzheimer Report 2009 (ADI, 2010b) estimates that 35.6 million people worldwide have dementia. This figure represents a 10 per cent increase over the global prevalence reported in an ADI study published in The Lancet five years earlier (Ferri et al., 2005). Based on the new data, the ADI report estimates that dementia prevalence will nearly double every 20 years, reaching 65.7 million by 2030 and 115.4 million by 2050. These increases will be driven primarily by sharp increases in life expectancy and dementia incidence rates in Low and Middle Income Countries (LAMICs). Overall, 57.7 per cent of older people with dementia reside in LAMICs, but the figure is expected to reach 70.5 per cent by 2050 (ADI, 2010b). The report’s estimate of prevalence rates for dementia in 2010 are higher than those for 2005 in three regions: Western Europe, South Asia and Latin America. Only single dementia prevalence studies have been conducted in African countries and rates are largely unavailable for that region. The ADI report suggests that the costs associated with treating dementia in LAMICs are set to increase to the level of figures in the developed world – while those countries’ costs will escalate as well.
With an interest in informing policy and practice, it is thus apposite to explore issues and responses to the global dementia burden in a special issue of *Global Ageing*. Such an exploration can contribute to the understanding of key issues and types of responses across countries and regions, and guide governments and civil society in planning to meet the challenges of the disease, as well as to mitigate its effects on individuals and families. Levels on which to conduct such an exploration, and relevant, fundamental questions that arise might include the following: On an individual level, what lifestyle choices could reduce the risk of developing certain dementias? On a professional level, how can healthcare systems diagnose dementia earlier and act to slow the progression of the symptoms? On a community level, what services are needed for persons with dementia and their carers, and how may the services be delivered most efficiently and effectively? On a government level, what laws, policies and programmes will protect persons with dementia, promote research, provide affordable healthcare and leverage the expertise of civil society? These questions, and other issues and responses are considered more fully in our editorial, and are addressed in articles and a Forum in the special issue.

**Issues of Dementia**

Multiple issues relate on multiple levels to the impact of dementia. On an individual level, a diagnosis of dementia strikes at the core of one’s personhood and humanity. A person with dementia is robbed of how he/she experiences his/her individuality and independence, as the disease progressively causes a loss of ability to fully remember, to communicate and to make decisions, as well as orientation to time and place. When no longer cognitively capable of self-care, decisions in a number of areas need to be taken by others on the person’s behalf and are typically done so by family members. For example, arrangements may be needed to assist and supervise the person with dementia with activities of daily living (ADL) (bathing, dressing, toileting, food preparation and administration of medication), and to ensure his/her safety. Alternative housing arrangements may be called for to ensure the protection and suitable care of the person. Healthcare services will need to be accessed and legal matters, including assisted decision-making, attended to. The individual’s personal finances will eventually require management by a third party. Companionship and transportation (including removal of driving privileges) will need to be arranged. Personal relationships will change irrevocably, and family members and informal carers will need support, education and other services.

The sustainability of informal care of a family member with dementia is a related and evolving issue. The concept of familial responsibility towards a dependent older family member, while still accepted in large parts of the developing world in particular, is less uniformly compelling than, for example, the duty of parents towards their children. Societies that have traditionally relied on family care giving are increasingly finding that the capacity of families to care for older relatives is weakening due to economic conditions and urban migration. Adult children may not be available to care for a parent with dementia – through migration and geographic separation, or they may be unwilling to do so. Women are increasingly entering the labour force, and these women are unable to care for a demented relative during the day. In certain circumstances, the unsupervised care of the relative may be left to minor grandchildren.

At a community level, particularly in MDCs, issues relate to practical care arrangements, such as how and where alternative supportive and protective housing for people with dementia should be incorporated in a care continuum; how appropriate healthcare can be made more accessible and affordable to persons with dementia; and what measures should be taken to protect persons with dementia from exploitation and abuse, protect their dignity, and ensure that assisted decision-making on their behalf is imposed in the least restrictive manner. Answers to such questions may not be self-evident. What is self-evident, however, is that the level of appropriate care needed for persons with dementia is beyond the capacity of numerous families and communities who provide care, in the absence of a coordinated policy approach.

On a societal level, critical issues include the costs of dementia, and an ethical imperative to respond to the service needs of the growing number of people with the condition. The costs of dementia, present and future, to society and individuals are staggering. Indeed, the costs may transcend quantification, as many intangibles of dementia care are incalculable. Nevertheless, aspects
of the burden of care can be measured and estimated reliably in terms of morbidity and mortality, as well as direct and indirect monetary costs pertaining to dementia management.

The “burden” of dementia can be defined and measured in terms of its economic impact as well as its disease impact. Alzheimer’s Disease International has estimated the global cost of dementia to be US$ 604 billion (ADI, 2010b). In calculating the cost of dementia, ADI’s research included the replacement value of informal care, direct costs of social care (whether community based or in residential facilities) and direct costs of medical care. ADI predicts that by 2030 this cost will have ballooned by 83 per cent, due solely to the rising number of persons with dementia. The projection does not attempt to account for other factors that could contribute to an even greater increase in dementia related costs. ADI’s cost estimate of $604 billion fails to take into account the loss of productivity of persons with dementia and family carers – where either or both must forego continued engagement in the work force due to cognitive impairment or care giving responsibilities. Neither has ADI’s estimate attempted to measure the physical and mental health impact and associated costs of care giving on informal carers. It may be safely assumed therefore that the $604 billion figure underestimates dementia’s global burden. Nonetheless, a present global cost of $604 billion to care for 35.6 million people with dementia is a statistic that commands respect.

In contrast to ADI’s measure of the economic burden of disability, the WHO framework for measuring the burden of disease combines years of life lost due to premature mortality with years of healthy life lost due to disability to produce disability-adjusted life years (DALYs), which measures years of healthy life lost due to a specific disease. While dementia was the fourth leading cause of burden of disease (measured in DALYs) in high income countries in 2004, WHO projected that the global burden of dementia would increase 66 per cent between 2005 and 2030 (WHO, 2005, 2008). The connection between the years of healthy life lost and the increased costs during the years lived in disability is, of course, hardly disputable.

A general lack of public awareness of dementia and an absence of globally standardised diagnostic criteria are separate but related factors that underlie many of the issues associated with dementia. Without a doubt, there are barriers to overcoming these two hurdles—not the least of which are cultural attitudes towards ageing. Findings of the 10/66 Dementia Research Group show that persons with dementia in LDCs were less likely than their counterparts in more developed countries to acknowledge cognitive impairment (Libre Rodriguez et al., 2008). A study in South Africa found that 75 per cent of older persons were unfamiliar with the terms “dementia” and “Alzheimer’s disease” (Community Agency for Social Enquiry, 2009). Research in China showed that 49 per cent of persons with dementia were diagnosed as “normally ageing” (Kalaria et al., 2008). The combination of an uninformed populace and cultural views on ageing shared by healthcare providers and patients alike, results in misdiagnoses of dementia and skewed prevalence statistics—all of which lead to low prioritisation of dementia policy formulation. The Alzheimer’s Association and the American National Institute on Ageing have recently updated the 1984 diagnostic criteria and guidelines for Alzheimer’s disease (Alzheimer’s Association, 2011), which should enhance the dementia assessment skills of healthcare providers worldwide, while public awareness campaigns about dementia should encourage older persons and their families to report cognitive decline and be accurately diagnosed.

Yet another issue relating to dementia is disproportionate investment in research on dementia—across regions and within countries. The 10/66 Dementia Research Group has highlighted an imbalance in the amount of research conducted in developed countries relative to that conducted in developing countries, arguing, at the launch of the group’s programme in 2000, that while 66 per cent of dementia worldwide occurs in LDCs, only 10 per cent of the global research effort on dementia is carried out in these countries (The 10/66 Dementia Research Group, 2000, 2004). The group has set out to redress the low level of knowledge on dementia and associated care practices in LDCs. However, even within MDCs, research on dementia is given a far lower priority than research on several other chronic, age-related conditions, as demonstrated in estimates of Luengo-Fernandez, Leal and Gray (2010). Of a total spend of £20.1 billion on healthcare and long-term care in the UK in 2008, for example, 52 per cent was spent on dementia, 23 per cent on cancer, 13 per cent on stroke and 12 per cent on chronic heart disease (CHD). Incongruously, of £8.33 million spent by the UK
government and charities on research in this sector, 71 per cent went to cancer, 20 per cent to CHD, 3 per cent to stroke and 6 per cent to dementia. Under-spending on research on dementia is therefore fairly self-evident, and scant resources are expended on research on psychosocial aspects of the condition in particular.

Issues such as those that drive the costs of the social, economic and clinical burden of dementia care, and hinder the development of a knowledge base, among others, highlight an ethical imperative for governments and society to respond to the disease burden, to shape responses to dementia – now and in the future, and to require responses tailored to national and regional contexts and economic levels. International collaboration and multi-disciplinary planning, national law and policy making, and resource allocation are broad domains in which responses are designed and implemented. Efforts to address the dementia burden in various regions and countries are discussed below.

Responses to Dementia

Growing evidence of the consequences and costs of dementia incumbers society and governments – and global agencies – to respond to implications and effects of epidemics. A need, challenge and responsibility to respond fall to multiple stakeholders. Each of the stakeholder groups possesses unique competencies to contribute towards a comprehensive response to the challenges of the burden, but is hindered by insufficiencies. Particularly in LAMICs, governments may lack the political will and/or resources to develop and implement effective and comprehensive intervention. Health professionals worldwide may lack knowledge and skills to manage dementia, and lack interest in treating a condition for which there is no cure. Communities, families and individuals may lack awareness and neither recognise symptoms of dementia, nor seek out available care and support services.

A temporal dimension, or a poorly defined time horizon, may confound planning and execution of a comprehensive response and intervention. While experts and politicians in the developed world debate how to manage the disease and mitigate its effects on individuals and society, countries in the developing world – which largely lack resources to allocate to dementia care, do not have the luxury of time (and may lack understanding of the urgency) to plan to meet a growing demand for dementia care. Even where societies and governments have the political will to meet the future burden of the disease, there is an urgency for them to make provision to meet the needs of individuals with the disease and family carers now.

On global and regional levels, organisations concerned with the wellbeing of older persons engage in activities aimed at informing or implementing a comprehensive and effective response to dementia. These organisations include professional associations such as the International Association of Gerontology and Geriatrics (IAGG), the International Federation on Ageing (IFA) and the World Demographic and Ageing Forum (WDA Forum). Advocacy bodies which lobby governments for a strengthened response to dementia include Alzheimer’s Disease International (ADI), the Alzheimer’s Association and the American Association of Retired Persons (AARP). Professional organisations command expertise and are honed to inform policy appropriately. The ADI, for example, issued its Kyoto Declaration (ADI, 2010a) containing ten recommendations on the minimum care of persons with dementia. The recommendations are further divided into specific suggestions based on a country’s level of income. The recommendation to “make appropriate dementia treatments available” was divided as follows: Lower income countries are advised to increase the availability of essential dementia drugs; medium income countries to ensure availability of such drugs; and higher income countries to provide easier access to newer dementia drugs. Such an approach exhibits a nuanced understanding by ADI of varied responses to dementia feasible and viable in countries with different levels of economic development.

On a national level, responses to dementia vary across countries and regions. Responses in MDCs may include a national plan or a national strategy on dementia. Articles in this special issue discuss France’s National Plan for Alzheimer and Related Disorders 2008-2012 and the United Kingdom’s National Alzheimer Strategy, and both articles refer to other developed countries possessing a plan or strategy. (Features of the UK’s national strategy and France’s national plan are compared in the ADI (2010b) report.) In the United States, President Obama signed the National Alzheimer’s Project Act (NAPA) into law in January 2011, laying the foundation for an inter-agency advisory council to assist the Secretary of Health and Human Services in creating
a national Alzheimer’s plan (United States Congress, 2011). However, very few MDCs have a dementia policy and even fewer LDCs have one. Responses to dementia in LDCs are largely due to efforts of the non-governmental sector (NGOs), which constitute the backbone of the countries’ response to the disease. These organisations engage in advocacy, support and counselling; deliver support services; and provide respite opportunities for carers. While the NGOs’ efforts are salutary and may be effective overall, the organisations are largely unsupported by their governments and their efforts uncoordinated.

In “more developed” countries, formal and non-formal agencies or bodies coordinate and provide a variety of responses, such as funding for research; support services for individuals and carers; legal protection mechanisms for persons with impaired capacity; national awareness campaigns; and social protection nets (healthcare, old age and disability grants). Local responses include community centres which offer support services such as education and day care. Community groups offer carers peer support opportunities and counselling. Responses from business include the manufacture and supply of pharmaceutical drugs to treat symptoms of dementia and assistive devices to facilitate care giving, as well as the operation of residential care facilities. Clinical responses include screening and diagnosis of individuals referred for assessment – increasingly through memory clinics; pharmacological and non-pharmacological treatment; counselling of individuals with dementia and their family carers; standards to delay the onset of the disease; expanded training of health professionals in geriatric care and dementia; and interdisciplinary team care models. Pharmacological management of the symptoms of dementia in early stages of the disease, for patients who are able to pay for the drugs, has been found to have a successful response in 30–40 per cent of cases (Combrinck, 2010). Nevertheless, in efforts to prevent an onset of dementia, physicians are able to treat vascular risk factors where indicated, such as dyslipidaemia, hypertension and diabetes mellitus, and may encourage patients to make lifestyle changes such as an improved diet, weight management, exercising more, ceasing smoking and staying mentally active. Intake of vitamins D and B group, anti-oxidants, statins and non-steroidal anti-inflammatory drugs are mooted to help prevent the disease, but intervention has not been proven in randomised control trials (Combrinck, 2010). In LDCs, such responses may be implemented variably, if at all, due likely to the efforts of NGOs.

Responses to dementia across countries and regions are therefore varied, and are shaped by social, cultural and political contexts, and by a country’s level of economic development. How replicable responses tailored and implemented in MDCs may be in LDC, remains debatable. A “one-size-fits-all” approach to dementia policy formulation and programmatic intervention is no doubt inappropriate. Viable national response solutions need to take cognisance of the contexts in which people with dementia and their families live, and the government’s capacity and willingness to formulate and support a comprehensive response. Within these contexts, specific and localised responses need to be designed in consultation with persons with dementia and their carers – consistent with a human rights based approach. To this end, we argue that the question of how countries – and indeed the world – can best respond to dementia will benefit from deliberation among stakeholders at all levels within a human rights framework.

**A Human Rights Approach to Dementia**

Applying the human rights lens to discussion on dementia responses requires: 1) Use of human rights principles in the development of responses to dementia, and 2) use of the formal human rights systems which create broad norms and standards around a certain issue, or for a certain population group – in this case, persons with dementia. The use of human rights in dementia responses means identifying the human rights of persons with dementia (and their families and carers), evaluating their capacity to claim these rights, and then designing strategies to enhance that capacity. These strategies must comply with international human rights standards, and must provide for monitoring and evaluative mechanisms. Among other principles, a human rights approach involves persons with dementia (and their families and carers), evaluating their capacity to claim these rights, and then designing strategies to enhance that capacity. These strategies must comply with international human rights standards, and must provide for monitoring and evaluative mechanisms. Among other principles, a human rights approach involves persons with dementia (and their families and carers), evaluating their capacity to claim these rights, and then designing strategies to enhance that capacity. These strategies must comply with international human rights standards, and must provide for monitoring and evaluative mechanisms. Among other principles, a human rights approach involves persons with dementia (and their families and carers), evaluating their capacity to claim these rights, and then designing strategies to enhance that capacity. These strategies must comply with international human rights standards, and must provide for monitoring and evaluative mechanisms. Among other principles, a human rights approach involves persons with dementia (and their families and carers), evaluating their capacity to claim these rights, and then designing strategies to enhance that capacity. These strategies must comply with international human rights standards, and must provide for monitoring and evaluative mechanisms.
individuals and groups who may claim those rights. Human rights are codified through international treaties, regional human rights instruments and the national law of states. The United Nations has, for example, produced various human rights treaties that create binding obligations on signatory states. Older persons and the issues they experience have no specific rights treaty, although the topic is under consideration by the recently formed UN Open Ended Working Group on Ageing (OEWGA) aimed at strengthening the protection of older persons’ rights (United Nations, 2011). If a convention is to be drafted, considerable debate will ensue on topics for inclusion and standards to be articulated, with a particular emphasis on issues not adequately covered in existing treaties. As a condition primarily associated with older persons, dementia will need strong representation in those debates to ensure that the particular portfolio of issues relating to dementia is appropriately addressed in the language of the convention. Whatever the recommendations of the working group are, its work will undoubtedly raise awareness of older persons’ concerns in general. If a convention is able to attend explicitly to the rights and issues of older persons with dementia – or even cognitive impairment – it will generate immeasurable awareness and put strong pressure on signatory governments to comply with their obligations.

Until a human rights treaty is drafted for older persons, the rights of persons with dementia may be addressed, although not comprehensively, under existing conventions. The socio-economic right to the enjoyment of the highest attainable standard of physical and mental health is recognised in Article 12 of the International Covenant on Economic, Social and Cultural Rights (United Nations, 1966). Further, persons of any age with dementia fall within the protection of the International Convention on the Promotion and Protection of the Rights and Dignity of Persons with Disabilities (CPRD) (United Nations, 2006).

The CPRD can serve as a springboard for the development of a global response to dementia. The treaty not only delineates human rights as they apply specifically to persons with disabilities, but also describes broad measures for the realisation of those rights, to which signatory states are committed. The measures include: 1) Ensuring necessary legislation to protect the rights of persons with disabilities (specifically in the areas of assisted decision-making, and exploitation and abuse); 2) Undertaking or promoting research; 3) Improving access to information for persons with disabilities; 4) Promoting the training of professionals and laypersons who work with persons with disabilities; 5) Raising public awareness about persons with disabilities; 6) Providing health and rehabilitation services including early diagnosis and intervention to maintain independence; 7) Providing an adequate standard of living for persons with disabilities including social protection and poverty reduction programmes; and 8) Ensuring their right to choose from a range of housing options and providing services to maintain residence in the community.

Most, if not all, of the issues embodied in the CPRD measures apply to and should be incorporated in responses to the care and support needs of persons with dementia. The CPRD is not, however, a proxy for a treaty on the rights of older persons, and neither do older persons and persons with disabilities constitute a homogenous group for policy makers. The CPRD neither addresses the situation and rights of older persons with dementia sufficiently, nor does it adequately address the issues and needs of the family and carers of a person with a disability. It is, however, a critical and applicable dementia advocacy tool in countries that have ratified this convention.

The United Nations system with its human rights framework and through its agencies such as the World Health Organization is in a unique position to influence the generation of apposite global and national responses to dementia. Although its human rights treaties may lack strong accountability and enforcement mechanisms, the UN plays an unparalleled leadership role in the development of human rights norms, including those around health issues such as dementia. Regional organisations play a similar role to that of the UN and, currently, both the African Union and the Organization of American States are giving consideration to binding instruments to enhance the human rights of older persons in these regions. These efforts increase awareness about the situation of older persons and would impose culturally specific obligations on signatory states. As binding instruments are drafted and debated, it is imperative that dementia stakeholders advocate for inclusion of the issues faced by persons with dementia in the regions.
A rights based approach to dementia is a legal approach, defined by the creation of duties and mechanisms for accountability. Dementia policies and plans can provide comprehensive recommendations, but their implementation ultimately lies at the discretion of government officials. In the end, it is national law (informed by international and regional human rights standards) that serves as the backbone to ensuring that dementia rhetoric translates into action – *inter alia*, by creating enforceable rights, funding research, establishing advisory councils, and developing plans and mechanisms which serve the needs of persons and families coping with dementia.

**A Special Issue on Dementia**

The globalisation of dementia, the implications and impact of the present and future burden, and the manifold issues that arise and the variety of responses that are needed to address the condition comprehensively are fairly self-evident. For such cogent reasons, the International Longevity Center Global Alliance convened a symposium with the theme “The Globalisation of Dementia: Issues and Responses” towards understanding the global dementia situation, and fostering debate on measures and steps to be taken to advance a global response to the pandemic. International Longevity Center (ILC) is a global policy, research and education organisation with centres in 12 countries. The mission of its centres is to study the impact of longevity on society and its institutions, and to promote healthy and productive ageing ([www.ilc-alliance.org](http://www.ilc-alliance.org)).

The symposium on the globalisation of dementia was held in Cape Town, South Africa on October 26, 2010, with input provided by representatives of nine ILCs, and members of an international and national audience. This special issue of *Global Ageing* includes three of the papers presented in the symposium, while panellists’ input in which they described responses to dementia in their country is integrated in a Forum article. The three articles review the dementia situation in two industrialised countries – France and the United Kingdom, and in South Africa – a middle income country with a large third world economy, which latter article reviews dementia in LDCs broadly. The articles identify key issues relating to dementia in the countries (and regions), and contribute to inter-disciplinary discourse on various responses aimed at curbing escalating costs, stemming the rising incidence of dementia, providing comprehensive care, and enhancing the quality of life of persons with dementia and their carers.

In the first article in the issue, Françoise Forette and Marie-Anne Brieu at ILC–France describe their country’s progressive National Plan for Alzheimer and Related Disorders (the plan dates from 2008), and evaluate achievements thus far and areas in need of strengthening. The authors suggest that France’s plan may well offer insight and guidance to other countries contemplating the design and implementation of a national dementia plan, based on 44 measures which comprise France’s plan, and suggest conditions under which the implementation of new national plans may be successful. The conditions include optimal access to treatment, the development of novel therapies, the advancement of research on dementia, and the design and implementation of care methods that enhance the quality of life of persons with dementia and their caregivers.

In their article, Sally-Marie Bamford and Baroness Sally Greengross at ILC–UK outline the development of various policy responses to dementia in the United Kingdom, against a background of the country’s political and policy landscape. The authors contend that the UK is not fully equipped to respond to the burgeoning demand for care of people with dementia, and make out a case for earlier and improved diagnosis of the condition – an objective of the country’s National Dementia Strategy. They concede that achievement of this objective will increase a demand for care services substantially, and they consider measures to overcome real and potential obstacles to the development of a comprehensive policy response.

In an article on dementia in countries in the developing world, with a special focus on South Africa, Sebastiana Kalula and George Petros at ILC–South Africa explore responses to dementia in selected LDCs: from India to Brazil, China to Nigeria and others. The authors highlight the rapid pace of population ageing and sharp increases in life expectancy in developing countries which are contributing to increases in the prevalence of dementia and associated care demands in these countries. However, the countries are far less equipped than their more developed counterparts to meet the challenges of the dementia burden. The majority of the countries, including South Africa, have no
policy on dementia, and responses, as such, to effects of dementia are largely executed by the NGO sector without support from the government.

Input made by panellists in the symposium, who represented International Longevity Centres in six countries – Argentina, India, Israel, Japan, Singapore and The Netherlands, in response to paper presentations and audience discussion, is integrated in a Forum article. The input comprises brief overviews of the dementia situation and care practices in the panellists' own country, and views they share on appropriate future policy, planning and intervention.

Finally, an outcome of the symposium was the drafting of the “ILC Cape Town Declaration on a Global Response to Dementia – A Call to Action.” The draft declaration, a consensus document of all ILC partners and the symposium audience, was subsequently submitted for online consultation to inter-governmental agencies, and professional and civil society dementia organisations worldwide. Feedback from the organisations was incorporated in the draft and the Declaration revised accordingly. The Declaration is published for the first time in this special issue. However, it remains a work in progress, and plans for continuing consultation and its revision, as well as promotion of its adoption by global agencies, are outlined in a preamble to the Declaration.

Without prospects of intervention that will halt a rising incidence of the disease, the global prevalence of dementia is set to grow virtually unabatedly in the coming decades. The impact of population ageing and the accompanying increase in non-communicable diseases, such as dementia, has even caught the attention of the World Bank which supports efforts to promote healthy ageing and to prevent these diseases to the extent possible, while simultaneously planning for their ramifications (Adeyi, Smith & Robles, 2007). Failure of governments and society to recognise, and to plan to manage and mitigate the effects of the disease will not only leave persons with dementia and their families without appropriate care management and support, but present inexorable challenges to healthcare systems, and put growing strain on professionals and agencies to meet the demands for care. The quality of life of persons with dementia and families’ capability to cope as informal carers to these persons are key issues for which responses must be tailored and executed, in co-ordinated and policy driven ways. The globalisation of dementia and challenges of related issues call for global solutions. An exploration of some of these issues and possible viable solutions is our objective with this special issue.

In tribute to Robert Butler

The guest editors of this special issue of Global Ageing and partners in the ILC Global Alliance dedicate the issue to the memory of the late Robert Neil Butler. Dr Butler, with Mr Shigeo Morioka of ILC-Japan, was a co-founder of International Longevity Center® and Co-President of the Global Alliance at the time of his death, at the age of 83, on July 4, 2010 – some four months before the symposium was held in Cape Town. Bob, as he was affectionately known to all, was scheduled to participate in the symposium, and would have contributed his characteristically incisive insight and expertise with the same circumspection and passion that were hallmarks of his long and extraordinarily distinguished career aimed at improving the human condition, specifically the health and wellbeing of older people. Dr Butler was a geriatrician, an old age psychiatrist, a researcher and an advocate, and the world’s doyen gerontologist. Throughout his career he paid particular attention to dementia: He helped to start and led the American Association of Geriatric Psychiatry and the Alzheimer’s Disease Association. He was the first director of the US National Institute of Ageing, where he established Alzheimer’s disease as a national research priority. This special issue on dementia honours his memory, in gratitude of his leadership and the legacy he left behind, not only International Longevity Center but the global “ageing” community.

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