Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

4 Reus VI, Fochtmann LJ, Eyler AE, et al. The American Psychiatric Association practice guideline on the use of antipsychotics to treat agitation or psychosis in patients with dementia. *Am J Psychiatry* 2016; **173:** 543–46.
5 Ballard C, Banister C, Khan Z, et al. Evaluation of the safety, tolerability, and efficacy of pimavanserin versus placebo in patients with Alzheimer's disease psychosis: a phase 2, randomised, placebo-controlled, double-blind study. *Lancet Neurol* 2018; **17:** 213–22.

The need for a better global dementia response

The COVID-19 pandemic continues to take a heavy toll on our society. As rightly pointed out in *The Lancet Neurology's* Editorial,[1] COVID-19 has made brutally visible the gaps and weaknesses of health and social care systems for people with dementia. This pandemic has amplified inequalities regarding access to dementia diagnosis, treatment, and care, and has left people with dementia, particularly those living in institutional care, at increased risk of severe outcomes, deterioration in their symptoms, and mortality.[2]

In September 2021, WHO released the global dementia status report[3] to measure progress made since the adoption of the global dementia action plan in 2017.[4] Notwithstanding some encouraging efforts, we are far from reaching the global dementia targets by 2025.

Despite steady increases in dementia prevalence globally and associated social and economic costs, dementia is still not seen as a priority by much of the world. This lack of prioritisation is especially concerning for low-income and middle-income countries (LMICs), where more than 60% of people with dementia live.[3] With only 26% of WHO Member States currently having a standalone or integrated dementia plan and, as such, meeting criteria for the first target of the global dementia action plan,[4] too many countries still do not have comprehensive policy responses to address dementia.[3]

Across all WHO regions, too many people do not have equitable access to community-based integrated dementia services (including risk reduction, diagnosis, treatment, rehabilitation, and long-term care), particularly in low-resource settings and rural or remote areas.[3] Approximately 50% of global dementia costs are covered by informal care, most of which is provided by women.[3] Yet, access to training and support for carers remains limited, particularly in LMICs and rural or remote areas. Carer programmes, such as the WHO iSupport programme, need to be funded and implemented at scale to reduce the burden of informal caregiving. Likewise, if we are to address dementia comprehensively and equitably, risk-reduction strategies need to be integrated at the primary care level and across sectors using innovative approaches, such as the WHO mobile health intervention, mDementia.[5] Finally, strong health information systems and collaborative well coordinated research are integral to our dementia response, for which continued funding and involvement of LMICs are essential components to success.

Building back better services and systems to prevent, delay, and mitigate the effects of dementia, providing quality care for people with dementia and their families, is essential now and for the future in our ageing world.[3]

We declare no competing interests. The authors are staff members and consultants of WHO. The authors alone are responsible for the views expressed in this letter, and they do not necessarily represent the decisions, policy, or views of WHO.

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1 The Lancet Neurology. Amid competing priorities, dementia must not be forgotten. *Lancet Neurol* 2021; **20:** 699.
2 WHO. Neurology and COVID-19: scientific brief, 29 September 2021. Geneva: World Health Organization, 2021.
3 WHO. Global status report on the public health response to dementia. Geneva: World Health Organization, 2021.
4 WHO. Global action plan on the public health response to dementia 2017–2025. Geneva: World Health Organization, 2017.
5 WHO and ITU. Be he@lthy, be mobile: a handbook on how to implement mDementia. Geneva: World Health Organization and International Telecommunication Union, 2021.

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For the **WHO iSupport programme** see http://www.iSupportforDementia.org

We agree with many of the points made in *The Lancet Neurology's* Editorial[1] on the latest From Plan to Impact IV report from Alzheimer's Disease International[2] on the progress of the WHO global dementia action plan.[3] However, we feel that a crucial aspect of dementia knowledge has been missed; specifically, that dementia incidence has declined in many countries[4] without any widespread adoption of individualised approaches to risk reduction.

The emphasis on individualised approaches to risk reduction in the action plan[3] and report[2] misses this key societal change, and fails to incorporate evidence that investment in societal health and wellbeing at a structural level provides tremendous return. The failure to recognise this evidence is a blind spot of the dementia research field. Instead, a mantra of risk reduction through individualised messaging to promote behavioural change, as well as early detection, is promoted across the globe, including to countries where individualised approaches might worsen inequalities.

Population-based approaches are likely to be the most impactful, cost-effective, and meaningful ways to reduce the global burden of dementia. First, structural or socio-cultural approaches to dementia risk reduction can be far-reaching and can address inequality. For example, an individualised approach to dementia risk reduction might be to counsel individuals on healthy