

EDITORIAL

Health inequities in health and social care in geriatric psychiatry: from healthy aging to subjective cognitive decline and dementia

Accessing health and social care services can be subject to multiple barriers for older adults and people with dementia. Living location, socio-economic and cultural background, age and gender, service availability, workforce knowledge, and inter-service communication can all hinder people from receiving a relevant diagnosis or from accessing the care they need (i.e. Kerpershoek *et al.*, 2019; Stephan *et al.*, 2018).

This special issue sought to highlight some of the diverse inequities that older adults and their families can experience when trying to access health and social care services. Across one systematic review and four studies, findings from this special issue cumulatively highlight some of the breadth of issues facing older adults in relation to service use and mental health outcomes, including the impact of socio-economic position on cognitive decline and dementia risk (Heger *et al.*, 2024), increased difficulties for people from South Asian backgrounds in accessing dementia care services (James *et al.*, 2024), as well as higher prevalence of depressive symptoms in rural compared to urban areas (Yuang *et al.*, 2024) and impact of multi-morbidity on suicidal outcomes (Cations *et al.*, 2024).

Synthesizing the existing evidence on inequalities in accessing community-based social care services for people living with dementia and their family carers, evidence from 23 countries showed barriers in five categories: situational, psychological, interpersonal, structural, and cultural (Giebel *et al.*, 2024). Including evidence from 39 papers, we reported how people with dementia and their family carers can be subject to systematic difficulties, such as lack of workforce knowledge and communication, as well as service suitability, when trying to access care including day care, home care, or support groups. Being from a minority ethnic background can also cause substantial difficulties in accessing culturally appropriate care, whilst unpaid (family) carers themselves can put up their own barriers. Oftentimes, unpaid carers may not wish to seek external support for feeling dutiful to provide the care to their relative themselves. However,

carers and people with the condition wishing to access support can be impeded by a lack of knowledge and information provided by care professionals.

The cultural barriers to accessing care were corroborated in a recent study by James *et al.* (2024) focusing on people with dementia from South Asian backgrounds living in the UK. Having interviewed over 60 people living with dementia, unpaid carers, and health care professionals from either a South Asian or White British background, James *et al.* (2024), showed that previously thought cultural preferences of providing care within the family were mostly held by clinicians. In contrast, people with dementia and unpaid carers from either South Asian or White British backgrounds had different preferences of who provided care, regardless of their ethnicity. Overall, having the financial means and speaking English were both facilitators to accessing the care they needed, which was thus impeded for some.

The fact that clinicians were of the belief that culture decides what type of care people with dementia wish to receive (informal or formal) might indicate a barrier to care in itself. Clinicians may cause a lack of referral to support services after a diagnosis for those from minority ethnic backgrounds due to this held belief. Whilst further research needs to explore the issue of clinicians' knowledge and experience of dementia in people from different cultural backgrounds, James *et al.* (2024), provide further evidence that health care professionals, as well as social care professionals, require further knowledge and training about dementia. Lack of workforce knowledge and training is a key barrier for dementia diagnosis and care (Polacsek *et al.*, 2020), which can be overcome by adequate and continued training and support. One recent training tool to raise knowledge not only about dementia but also dementia-related inequalities for example is the Dementia Inequalities Game (Giebel *et al.*, 2024). Having shown significant improvements in knowledge in the general public and health care students (Giebel *et al.*, 2024;

under review), the board game shows promising signs for a short, social, and engaging intervention for the health and social care professional workforce.

However, even before people receive a diagnosis and try to access care can inequalities arise. Utilizing data from the Maastricht Aging Study cohort, *Heger and colleagues* showed that older adults from lower socio-economic backgrounds showed faster deteriorations in cognition, including processing speed and verbal memory, than those from mid and high socio-economic backgrounds. This was shown when comparing baseline performance to six years follow-up. Unhealthier lifestyle and higher modifiable dementia risk was also linked to poorer levels of cognition at follow-up six and 12 years after baseline, whilst socio-economic background did not affect the relationship between dementia risk and cognitive deterioration. Regardless of this, the fact that socio-economic status (SES) is linked to poorer cognitive performance across aging shows that SES needs to be taken into consideration when developing cognitive and public health interventions to support older adults better and achieve more equitable outcomes in health.

As identified in the systematic review (*Giebel et al. 2024*), inequities are not restricted to cultural factors or SES though, as living location can also contribute to unequal outcomes in health and well-being for older adults. *Yuan et al. (2024)* evidenced that older adults in China living in rural regions showed higher depressive symptoms than those residing in urban areas. Whilst factors such as differences in education, annual income, living status, and age, besides others, explained over 70 percent of the variation in depressive symptoms, it remains unclear as to whether service availability (or a lack thereof) in rural areas may have also been linked to these variations in geographic residency. Service availability is often more limited in rural regions, with public transport to reach services subject to limitations also (i.e. *Bayly et al., 2020*). Considering an increase in digital service provision, especially since the COVID-19 pandemic (*Hepo-niemi et al., 2022*), this may be one solution to increase access to those living in rural areas. However, digital infrastructure can often be poor in more remote regions, so that a hybrid approach to care needs to be taken whilst also expanding in-person care provision where possible.

Experiencing depressive symptoms has been linked to poorer levels of cognition in older adults (*Voros et al., 2020*). Thus, considering higher levels of depression in older adults living in rural areas, there may also be a greater risk for cognitive deterioration. The final included study in this special collection does not specifically focus on

individual inequalities as such, but extends the narrative of depression and mental health outcomes in older adults, which can be linked to previous evidence in this collection. Specifically, *Cations et al. (2024)* reported increased suicidal ideation in older military veterans who experiences both subjective cognitive decline and post-traumatic stress disorder. This was six times higher than in the main sample, suggesting the importance of supporting older adults' cognitive functioning as much as their mental health.

In summary, the five papers included in this special collection paint a diverse picture of some of the many inequities which older adults can experience. What is missing from this perspective here is a greater focus on inequities in lower- and middle-income countries, where service infrastructure and stigma of mental health and dementia are often particularly pronounced and causing barriers to access to care (i.e. *Hurzuk et al., 2022*). To ensure that the highlighted, and additional, inequities in health and social care for older adults are relevant and being addressed across the globe, cross-country collaboration is an important step. There may be good practice solutions from some regions or countries which may be suitable, after cultural and system modification, to other countries also, so that older adults regardless of their backgrounds can access, use, and benefit from care more equitably.

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