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Social determinants of health and health inequalities in Alzheimer's Disease in the United Kingdom: A Systematic Review of the Evidence between 2018 and 2024

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Abstract

Background: Alzheimer's disease (AD) accounts for 60–70% of dementia cases worldwide and remains a leading cause of death in England and Wales (Leahy et al., 2023; WHO, 2021). Its prevalence, progression and management are shaped not only by biological ageing but also by health inequalities and the social determinants of health (SDoH), yet the mechanisms linking these factors to AD outcomes in the UK remain fragmented across the literature.

Aim: This systematic review synthesises evidence on how health inequalities and SDoH influence AD prevalence, progression and management in the UK.

Methods: Following PRISMA 2020 guidance (Page et al., 2021), a systematic literature search was conducted across ProQuest Central, PubMed, Medline and APA PsycINFO (supplemented by Web of Science, Scopus, ScienceDirect and Embase) for studies published between January 2018 and January 2024. Thirteen studies (quantitative n=8, qualitative n=4, mixed-methods n=1) met the eligibility criteria and were appraised using the Mixed Methods Appraisal Tool.

Results: Four themes emerged: (1) demographic, socioeconomic and geographic health inequalities in AD; (2) SDoH – including economic stability, education, healthcare access and social context – as drivers of AD prevalence; (3) the influence of health inequalities on disease progression, institutionalisation and mortality; and (4) the role of health promotion in dementia-risk reduction. Deprivation, social isolation, loneliness and unequal access to healthcare consistently predicted poorer AD outcomes across demographic groups, including older adults, women, and socioeconomically disadvantaged populations.

Conclusion: Health inequalities and SDoH interact across individual, interpersonal, community and societal levels to shape AD outcomes in the UK.

Recommendations: Policy and practice should prioritise equitable healthcare access, health literacy, social-support infrastructure, and multidisciplinary, Theory-of-Change-informed strategies to reduce AD-related health disparities.

Keywords: Alzheimer's Disease; Health Inequalities; Social Determinants of Health; Dementia; United Kingdom; Systematic Review

1. Introduction

Alzheimer's disease (AD) is the most common form of dementia, accounting for 60–70% of global dementia cases and characterised by progressive memory loss, language impairment and functional decline (Leahy et al., 2023). Global projections suggest the number of people living with dementia will rise substantially by 2030, while in the UK dementia

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already ranks among the leading causes of death, imposing a growing burden on individuals, caregivers and health systems (WHO, 2021; Brookes et al., 2018). Although advancing age remains the principal risk factor, AD outcomes are increasingly understood to be shaped by health inequalities and the social determinants of health (SDoH) – the economic, educational, environmental and social conditions in which people are born, live, age and receive care (Alzheimer's Society, 2023).

Health inequalities are defined as unfair and avoidable differences in health status across population groups, driven by factors such as socioeconomic position, ethnicity, disability, and geography (HealthyPeople, 2022; Office for Health Improvement and Disparities, 2022). In the context of AD, socioeconomic deprivation, limited education, poor healthcare access and weak social-support networks have each been implicated in disparities in disease risk, diagnosis and progression (Dorling et al., 2017). Despite two decades of UK policy attention to health inequalities – including the English health inequalities strategy of 1997–2010 – disparities in AD-related outcomes persist, and the mechanisms linking SDoH to AD across the disease course remain incompletely mapped in a single evidence synthesis.

This gap is significant given that welfare-state and economic conditions account for a substantial share of cross-national variation in health inequality, and that the cost-of-living pressures affecting the UK since 2020 have been described as a public health crisis in their own right (Perez et al., 2023). Addressing these gaps is consistent with the WHO's Global Status Report on Dementia (2021) and the Sustainable Development Goals' commitment to equitable health for all. Accordingly, this review had the following aim and objectives.

Aim: To systematically review and synthesise evidence on how health inequalities and SDoH influence the prevalence, progression and management of AD in the United Kingdom.

Objectives: to (i) identify the specific health inequalities associated with AD in the UK, considering demographic, socioeconomic and geographic disparities; (ii) examine how SDoH – education, economic stability, neighbourhood and built environment, healthcare access, and social/community context – influence AD prevalence; (iii) evaluate how these factors shape disease progression; and (iv) appraise how health-promotion strategies can be tailored to reduce AD-related inequalities.

2. Literature Review

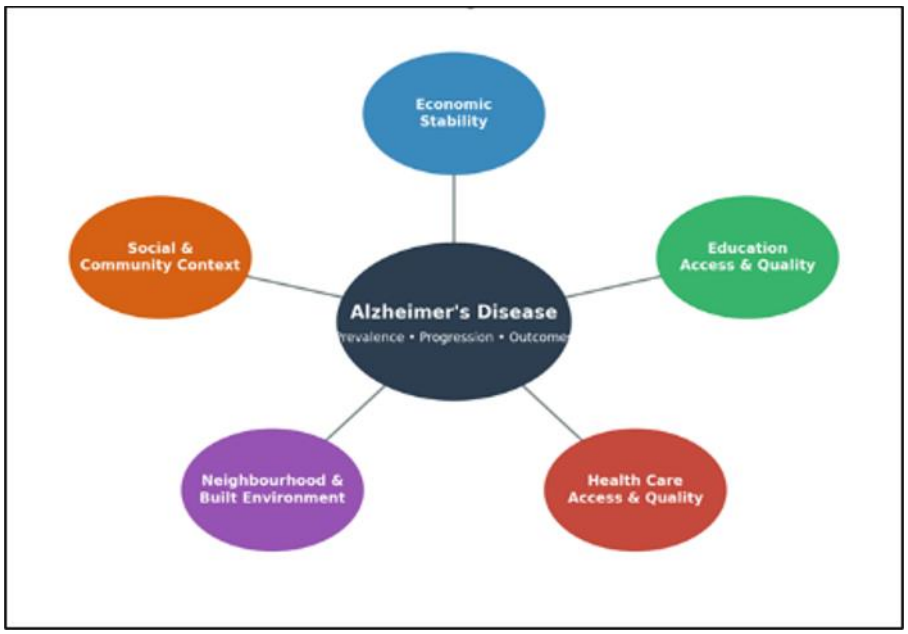

Figure 1 Conceptual framework of SDoH domains influencing AD in the UK (adapted from Office for Health Improvement and Disparities, 2022).

Contemporary public-health theory situates health outcomes within a layered model that spans individual behaviour, interpersonal relationships, community context, and societal structures (Office for Health Improvement and Disparities, 2022). Applied to AD, this model implies that biological risk (age, genetics) interacts with modifiable, socially patterned exposures. Five overlapping SDoH domains are commonly used to organise this evidence: economic stability, education

access and quality, healthcare access and quality, neighbourhood and built environment, and social and community context (Figure 1).

Prior epidemiological work indicates that socioeconomic status, education and healthcare access collectively account for a large share of variation in population health status, reinforcing the case for examining these domains specifically in relation to AD (Prince et al., 2013). Evidence from ageing cohorts further shows that dementia risk is not evenly distributed: lower socioeconomic position, limited educational attainment, and social isolation are consistently associated with higher dementia incidence and poorer quality of life among those living with the condition (Livingston et al., 2017; Prince et al., 2015). However, much of this literature has addressed single determinants or single stages of the disease course in isolation. The present review builds on this foundation by synthesising UK-specific evidence across the full course of AD – from prevalence through progression to health promotion – within a single, integrated framework.

3. Methodology

3.1. Design

A qualitative systematic review design was adopted, following the methodological guidance of Stern et al. (2020) for the conduct of systematic reviews, and reported in accordance with the PRISMA 2020 statement (Page et al., 2021).

3.2. Search Strategy and Data Sources

Literature searches were conducted via the Swansea University library gateway (iFind), with ProQuest Central, PubMed, Medline and APA PsycINFO as primary databases, supplemented by Web of Science, Scopus, ScienceDirect, Embase and BioMed Central. Search terms combined three concept blocks using Boolean operators: (i) “Alzheimer's” OR “Alzheimer's disease”; (ii) “health inequalities” OR “health inequality” OR “social determinants of health” OR “health disparities”; and (iii) “United Kingdom” OR UK OR England OR Scotland OR Wales OR “Northern Ireland” OR Britain, combined with AND. The population, intervention, comparison and outcome (PICO) framework structured the search: population – persons with AD in the UK; intervention – exposure to health inequalities/SDoH; comparison – varied by determinant examined; outcome – impact on AD prevalence, progression or management (Tove Faber et al., 2020).

3.3. Eligibility Criteria

Studies were included or excluded according to the criteria summarised in Table 1.

Table 1 Eligibility criteria applied during study selection.

Criterion	Inclusion	Exclusion
Geographic scope	Studies conducted in the UK (England, Scotland, Wales, Northern Ireland)	Studies conducted outside the UK or with no clear geographic setting
Publication type	Peer-reviewed journal articles, academic theses/dissertations, case studies, primary statistical reports	Grey literature, conference proceedings, editorials, opinion pieces, government reports
Publication period	January 2018 to January 2024	Published before January 2018
Language	English	Non-English publications
Study design	Qualitative, quantitative and mixed-methods primary research (case studies, interviews, cohort studies, focus groups)	Systematic reviews, meta-analyses, and studies not focused on health inequalities/SDoH and AD
Population	Human participants aged ≥60 years, both sexes	Non-human studies; populations aged <60 years

3.4. Study Selection and Quality Appraisal

The search returned 119 records; after removal of six duplicates, 113 abstracts were screened, of which 97 were excluded for not meeting eligibility criteria. Sixteen full-text articles were retrieved and assessed, and three were

subsequently excluded, leaving thirteen studies for inclusion (Figure 2). Included studies comprised eight quantitative, four qualitative and one mixed-methods design, all non-randomised and descriptive in nature. Methodological quality and risk of bias were appraised using the Mixed Methods Appraisal Tool (MMAT), and two reviewers cross-checked data extraction to support reliability and coding consistency.

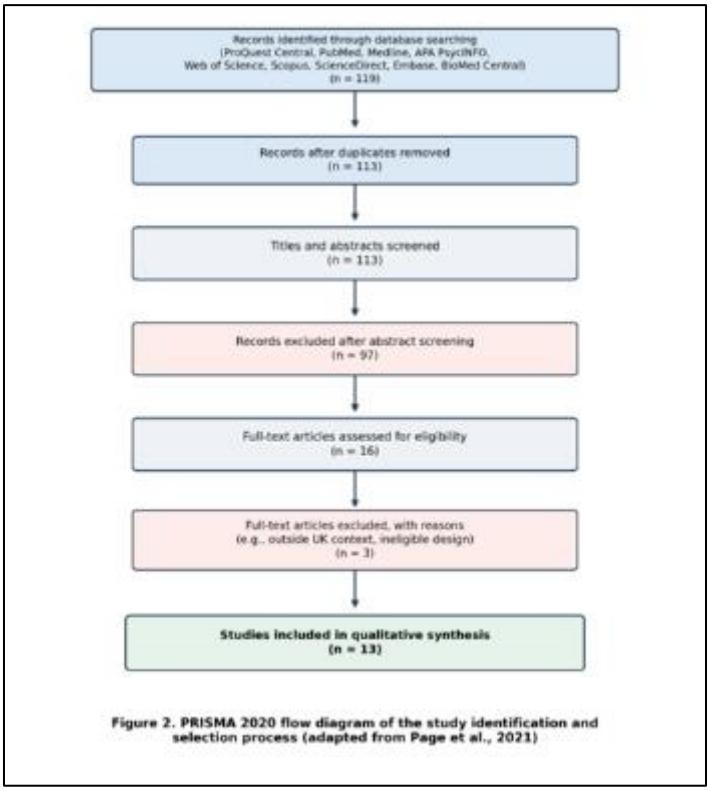

Figure 2 PRISMA 2020 flow diagram of study selection (adapted from Page et al., 2021).

4. Discussion

The thirteen included studies collectively addressed four themes: health inequalities in AD; SDoH and AD prevalence; the influence of inequalities on disease progression; and the role of health promotion. Study characteristics are summarised in Table 2.

Table 2 Characteristics and key findings of included studies (n = 13).

Author(s) & Year	Design	Theme	Key Finding(s)
Leahy et al. (2023)	Quantitative – EHR database (CPRD)	Health inequalities	Diagnosed AD prevalence 378.4/100,000; early AD 292.8/100,000; prevalence rose with age, deprivation, and female sex.
Heising & Angelopoulos (2022)	Quantitative – 2D-CNN model (ADNI dataset)	Health inequalities	Low-cost 2D-CNN detected MCI (73.5% precision) and AD (83.7% precision), supporting equitable early diagnosis.
James Rupert (2021)	Qualitative – interviews (7 patients, 26 carers)	Health inequalities	Informal dementia care is unevenly distributed; women disproportionately assume primary-carer roles.
Belger et al. (2019)	Quantitative – non-interventional cohort (3 countries)	SDoH & prevalence	Disease severity, non-spousal caregiving and functional decline predicted faster institutionalisation and rising cost.

Deckers et al. (2019)	Quantitative – longitudinal cohort (ELSA, n=6,346)	SDoH & prevalence	Lifestyle factors mediated the wealth–dementia risk relationship; education acted as a distal risk factor.
Kimia et al. (2023)	Quantitative – cohort/statistical modelling	SDoH & prevalence	Social isolation was linked with classical AD-related-dementia risk factors, supporting social interventions.
Victor et al. (2020)	Quantitative – IDEAL cohort, regression	SDoH & prevalence	Depressive symptoms, isolation and living alone predicted loneliness among people with dementia.
Antoine et al. (2022)	Quantitative – national cohort, administrative data	Progression	Nearly half of people with AD/related syndromes had unfavourable end-of-life healthcare-utilisation trajectories.
Farina et al. (2020)	Mixed methods – multi-workstream protocol (DETERMIND)	Progression	Inequalities in dementia-care provision, cost and outcome mapped using a Theory-of-Change framework.
Jitlal et al. (2021)	Quantitative – national death-certificate data (2001–2017)	Progression	Dose–response relationship between deprivation and dementia mortality; the gap widened over time.
Wu et al. (2018)	Quantitative – IDEAL cohort	Progression	Greater deprivation and rural/urban context were associated with poorer quality of life and well-being.
Bosco et al. (2020)	Qualitative – secondary analysis of national survey	Health promotion	Family history and trust in evidence motivated lifestyle change; mistrust and competing priorities were barriers.
van der Wardt et al. (2020)	Qualitative – focus groups (patients, carers, professionals)	Health promotion	Capability, opportunity and motivation shaped engagement in physical activity among people with MCI/dementia.

4.1. Health Inequalities in AD: Demographic, Socioeconomic and Geographic Disparities

Using linked primary- and secondary-care records, Leahy et al. (2023) estimated the prevalence of diagnosed AD in England at 378.4 per 100,000 and early-onset AD at 292.8 per 100,000, with prevalence increasing with age, deprivation, and among women – directly implicating socioeconomic position in disease occurrence. Complementing this population-level picture, Heising and Angelopoulos (2022) demonstrated that a low-cost 2D convolutional neural network could detect AD and mild cognitive impairment with 83.7% and 73.5% precision respectively, suggesting that algorithmic tools could narrow diagnostic disparities where specialist resources are limited. At the level of informal care, James Rupert (2021) found that caregiving responsibilities are unevenly distributed, with women disproportionately occupying primary-carer roles shaped by gendered and socio-cultural negotiation rather than by clinical need alone. Together, these studies show that inequalities in AD manifest simultaneously at the levels of disease prevalence, diagnostic access, and the informal-care burden that follows diagnosis.

4.2. Social Determinants and AD Prevalence

A cluster of studies linked specific SDoH to AD and dementia risk. Deckers et al. (2019), following 6,346 participants in the English Longitudinal Study of Ageing, found that lifestyle factors mediated the relationship between household wealth and dementia risk, with education acting as a distal risk factor operating through its association with wealth and healthier lifestyles. Belger et al. (2019) showed that disease severity, the availability of a non-spousal informal carer, and functional decline predicted a faster transition to institutional care and higher societal cost – outcomes with clear implications for families with fewer economic resources. Kimia et al. (2023) and Victor et al. (2020) extended this picture to the social domain: social isolation was associated with classical AD-related-dementia risk factors, while depressive symptoms, isolation and living alone were the strongest predictors of loneliness among people already living with dementia. These findings converge on economic stability, education and social connectedness as modifiable levers for reducing AD prevalence.

4.3. Health Inequalities and AD Progression

Four studies addressed disease progression. Antoine et al. (2022) found that almost half of people with AD or related syndromes experienced unfavourable healthcare-utilisation trajectories in their final year of life, shaped by both individual and contextual determinants. Farina et al. (2020), through the multi-workstream DETERMIND programme, mapped inequalities in the provision, experience and cost of dementia care using a Theory-of-Change framework, providing a causal map for intervention design. Using national death-certificate data spanning 2001–2017, Jitlal et al. (2021) identified a dose–response relationship between socioeconomic deprivation and dementia mortality, with the inequality gap widening over the study period. Consistent with this, Wu et al. (2018) reported that greater area-level deprivation and rural/urban context were associated with poorer quality of life, life satisfaction and well-being among people living with dementia in the community. Collectively, these studies show that inequalities do not only determine who develops AD, but also how the disease is experienced, cared for, and ultimately how it ends.

4.4. The Role of Health Promotion

Two studies examined the modifiable, behavioural side of the equation. Bosco et al. (2020), analysing free-text responses to a national UK survey, found that family history of dementia and trust in evidence-based information motivated lifestyle change, whereas competing health priorities and mistrust of information sources were key barriers. Van der Wardt et al. (2020), using focus groups with patients, carers and professionals, showed that engagement in physical activity among people with mild cognitive impairment or dementia depended on the interaction of capability, opportunity and motivation, and called for individualised, rather than generic, intervention design. Together, these studies suggest that health-promotion strategies for AD risk reduction must combine population-level public-awareness campaigns with individually tailored support.

4.5. Integration of Findings

Read together, the four themes indicate that health inequalities and SDoH operate at every stage of the AD trajectory in the UK – shaping who is diagnosed, how quickly the disease progresses, the burden borne by informal carers, and the individual's capacity to engage in preventive behaviour. This pattern is consistent with a socio-ecological interpretation in which individual, interpersonal, community and societal factors interact rather than operate independently (Chhetri & Zacarias, 2021). A Theory-of-Change approach offers a practical mechanism for translating this multi-level evidence into coordinated action: it requires stakeholders to make explicit the causal assumptions linking a proposed intervention (for example, expanding community dementia-support services) to the intended reduction in inequality, testing these assumptions against the evidence summarised here (Farina et al., 2020). The consistency of the deprivation–AD gradient across prevalence (Leahy et al., 2023), mortality (Jitlal et al., 2021) and quality of life (Wu et al., 2018) strengthens confidence that socioeconomic position is a central, modifiable driver of AD-related health inequality in the UK, rather than an artefact of any single study design.

5. Conclusion

This review synthesised evidence from thirteen UK-focused studies to examine how health inequalities and social determinants of health shape the prevalence, progression and management of Alzheimer's disease. Four interlinked themes emerged: demographic, socioeconomic and geographic disparities in disease occurrence; the contribution of economic, educational, environmental and social determinants to disease prevalence; the influence of inequality on disease progression, institutionalisation and mortality; and the potential of tailored health-promotion strategies to reduce risk. Across themes, socioeconomic deprivation, social isolation and unequal access to healthcare consistently predicted poorer AD outcomes, reinforcing the value of an integrated, socio-ecological understanding of the disease that extends beyond its clinical presentation. These findings underscore that AD in the UK cannot be adequately addressed through clinical care alone; a coordinated response that spans individual, community and policy levels is required to narrow the disparities identified in this review.

Recommendations

Based on the synthesised evidence, the following recommendations are proposed for policy, practice and future research:

- Policy: Prioritise policies that improve economic stability, educational opportunity and healthy-ageing environments, with explicit targets for reducing socioeconomic gradients in AD prevalence and mortality (Chhetri & Zacarias, 2021).

- Healthcare access: Expand equitable access to screening, diagnosis and treatment, including cost-effective AI-supported diagnostic tools, particularly in deprived and under-served areas (Heising & Angelopoulos, 2022).
- Caregiver support: Introduce structured support for informal carers – respite care, training and financial assistance – to offset the disproportionate burden identified among women and non-spousal carers (James Rupert, 2021; Belger et al., 2019).
- Health promotion: Deliver public-awareness campaigns alongside individually tailored behaviour-change interventions that address trust, competing priorities, and capability/opportunity/motivation barriers to healthy lifestyles (Bosco et al., 2020; van der Wardt et al., 2020).
- Multidisciplinary collaboration: Engage healthcare providers, policymakers, researchers and community organisations in Theory-of-Change-informed strategies that make explicit the causal pathways between interventions and reduced AD-related inequality (Farina et al., 2020; Alderwick et al., 2021).
- Research: Future studies should examine the intersectionality of socioeconomic status, ethnicity, gender and geography in AD outcomes, and adopt longitudinal designs capable of establishing causal pathways between SDoH and disease trajectories.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

Limitations

This review was restricted to English-language, UK-focused, descriptive primary studies published between 2018 and 2024; findings should therefore be interpreted as UK-specific and may require adaptation as new evidence, particularly from underrepresented ethnic and regional groups, becomes available.

References

[1] Alderwick, H., Hutchings, A., Briggs, A., & Mays, N. (2021). The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: A systematic review of reviews. BMC Public Health, 21(1), 753. https://doi.org/10.1186/s12889-021-10630-1

[2] Alzheimer's Society. (2023). Risk factors for Alzheimer's disease. Alzheimer's Society, United Kingdom.

[3] Antoine, E., Gardette, V., Renoux, A., Sourdet, S., Nourhashemi, F., Sanou, B., Dutech, M., Muller, P., & Gallini, A. (2022). Potential determinants of unfavourable healthcare utilisation trajectories during the last year of life of people with incident Alzheimer Disease or Related Syndromes: A nationwide cohort study using administrative data. Age and Ageing, 51(3). https://doi.org/10.1093/ageing/afac053

[4] Belger, M., Haro, J. M., Reed, C., Happich, M., Argimon, J. M., Bruno, G., Dodel, R., Jones, R. W., Vellas, B., & Wimo, A. (2019). Determinants of time to institutionalisation and related healthcare and societal costs in a community-based cohort of patients with Alzheimer's disease dementia. The European Journal of Health Economics, 20(3), 343–355. https://doi.org/10.1007/s10198-018-1001-3

[5] Bosco, A., Jones, K. A., Di Lorito, C., Stephan, B. C. M., Orrell, M., & Oliveira, D. (2020). Changing lifestyle for dementia risk reduction: Inductive content analysis of a national UK survey. PLoS ONE, 15(5), e0233039. https://doi.org/10.1371/journal.pone.0233039

[6] Brookes, G., Harvey, K., Chadborn, N., & Dening, T. (2018). 'Our biggest killer': Multimodal discourse representations of dementia in the British press. Social Semiotics, 28(3), 371–395. https://doi.org/10.1080/10350330.2017.1345111

[7] Chhetri, D., & Zacarias, F. (2021). Advocacy for evidence-based policy-making in public health: Experiences and the way forward. Journal of Health Management, 23(1), 85–94. https://doi.org/10.1177/0972063421994948

[8] Deckers, K., Cadar, D., van Boxtel, M. P. J., Verhey, F. R. J., Steptoe, A., & Köhler, S. (2019). Modifiable risk factors explain socioeconomic inequalities in dementia risk: Evidence from a population-based prospective cohort study. Journal of Alzheimer's Disease, 71(2), 549–557. https://doi.org/10.3233/JAD-190541

[9] Dorling, H., Ollerhead, L., & Kidgell, C. (2017). The NIHR public health research programme: Intervention approaches to tackle health inequalities. Journal of Public Health, 39(4), 856–862. https://doi.org/10.1093/pubmed/fdw128

[10] Farina, N., Hicks, B., Baxter, K., Birks, Y., Brayne, C., Dangoor, M., Dixon, J., Harris, P. R., Hu, B., Knapp, M., Miles, E., Perach, R., Read, S., Robinson, L., Rusted, J., Stewart, R., Thomas, A., Wittenberg, R., & Banerjee, S. (2020). DETERMinants of quality of life, care and costs, and consequences of inequalities in people with dementia and their carers (DETERMIND): A protocol paper. International Journal of Geriatric Psychiatry, 35(3), 290–301. https://doi.org/10.1002/gps.5246

[11] HealthyPeople. (2022). Disparities. Healthy People 2020. https://wayback.archive-it.org/5774/20220414003754/https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

[12] Heising, L., & Angelopoulos, S. (2022). Operationalising fairness in medical AI adoption: Detection of early Alzheimer's disease with 2D CNN. BMJ Health & Care Informatics, 29(1). https://doi.org/10.1136/bmjhci-2021-100485

[13] James Rupert, F. (2021). Structuring unequal relations: Role trajectories in informal dementia care. Sociology of Health & Illness, 43(1), 65–81. https://doi.org/10.1111/1467-9566.13194

[14] Jitlal, M., Guru, N. K. A., Karania, T., Parry, E., Neligan, A., Dobson, R., Noyce, A. J., & Marshall, C. R. (2021). The influence of socioeconomic deprivation on dementia mortality, age at death, and quality of diagnosis: A nationwide death records study in England and Wales 2001–2017. Journal of Alzheimer's Disease, 81(1), 321–328. https://doi.org/10.3233/JAD-210089

[15] Kimia, S., Villeneuve, S., Rosa, N. P., Badhwar, A., Poirier, J., Sharma, V., Medina, Y. I., Silveira, P. P., Dube, L., Glahn, D., & Bzdok, D. (2023). Social isolation is linked to classical risk factors of Alzheimer's disease-related dementias. PLoS ONE, 18(2). https://doi.org/10.1371/journal.pone.0280471

[16] Leahy, T. P., Simpson, A., Sammon, C., Ballard, C., & Gsteiger, S. (2023). Estimating the prevalence of diagnosed Alzheimer disease in England across deprivation groups using electronic health records: A clinical practice research datalink study. BMJ Open, 13(10), e075800. https://doi.org/10.1136/bmjopen-2023-075800

[17] Livingston, G., Sommerlad, A., Orgeta, V., Costafreda, S. G., Huntley, J., Ames, D., Ballard, C., Banerjee, S., Burns, A., Cohen-Mansfield, J., Cooper, C., Fox, N., Gitlin, L. N., Howard, R., Kales, H. C., Larson, E. B., Ritchie, K., Rockwood, K., Sampson, E. L., … Mukadam, N. (2017). Dementia prevention, intervention, and care. The Lancet, 390(10113), 2673–2734. https://doi.org/10.1016/S0140-6736(17)31363-6

[18] Office for Health Improvement and Disparities. (2022). Health disparities and health inequalities: Applying All Our Health. GOV.UK. https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health

[19] Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. BMJ, 372, n71. https://doi.org/10.1136/bmj.n71

[20] Perez, F. A., Satherley, P., Farrow, E., & Vohra, J. (2023). The cost-of-living crisis is a public health crisis. Perspectives in Public Health, 143(2), 61–62. https://doi.org/10.1177/17579139231163748

[21] Prince, M., Bryce, R., Albanese, E., Wimo, A., Ribeiro, W., & Ferri, C. P. (2013). The global prevalence of dementia: A systematic review and metaanalysis. Alzheimer's & Dementia, 9(1), 63–75.e2. https://doi.org/10.1016/j.jalz.2012.11.007

[22] Prince, M. J., Wu, F., Guo, Y., Gutierrez Robledo, L. M., O'Donnell, M., Sullivan, R., & Yusuf, S. (2015). The burden of disease in older people and implications for health policy and practice. The Lancet, 385(9967), 549–562. https://doi.org/10.1016/S0140-6736(14)61347-7

[23] Stern, C., Lizarondo, L., Carrier, J., Godfrey, C., Rieger, K., Salmond, S., Apóstolo, J., Kirkpatrick, P., & Loveday, H. (2020). Methodological guidance for the conduct of mixed methods systematic reviews. JBI Evidence Synthesis, 18(10), 2108–2118. https://doi.org/10.11124/jbisrir-d-19-00169

[24] Tove Faber, F., Michael Friberg Bruun, N., Lindhardt, C. L., & Mette Brandt, E. (2020). Using the full PICO model as a search tool for systematic reviews resulted in lower recall for some PICO elements. Journal of Clinical Epidemiology, 127, 69–75. https://doi.org/10.1016/j.jclinepi.2020.07.005

[25] van der Wardt, V., Hancox, J., Pollock, K., Logan, P., Vedhara, K., & Harwood, R. H. (2020). Physical activity engagement strategies in people with mild cognitive impairment or dementia – A focus group study. Aging & Mental Health, 24(8), 1326–1333. https://doi.org/10.1080/13607863.2019.1590308

[26] Victor, C. R., Rippon, I., Nelis, S. M., Martyr, A., Litherland, R., Pickett, J., Hart, N., Henley, J., Matthews, F., & Clare, L. (2020). Prevalence and determinants of loneliness in people living with dementia: Findings from the IDEAL programme. International Journal of Geriatric Psychiatry, 35(8), 851–858. https://doi.org/10.1002/gps.5305

[27] WHO. (2021). Global status report on the public health response to dementia. World Health Organization. https://www.who.int/publications/i/item/9789240033245

[28] Wu, Y. T., Clare, L., Jones, I. R., Martyr, A., Nelis, S. M., Quinn, C., Victor, C. R., Lamont, R. A., Rippon, I., & Matthews, F. E. (2018). Inequalities in living well with dementia – The impact of deprivation on well-being, quality of life and life satisfaction: Results from the IDEAL study. International Journal of Geriatric Psychiatry, 33(12), 1736–1742. https://doi.org/10.1002/gps.4998