Trani and colleagues report the results of a cross-sectional study on the association of multidimensional poverty with dementia among older adults in South Africa. Their results were intended to help direct population-level interventions and public policies to improve dementia-related outcomes. Their consideration of multidimensional poverty also underscores the 2 roles of well-being in Alzheimer disease and related dementias research.

Dementia prevalence in low- and middle-income countries (LMICs) is expected to more than triple in the coming decades to reach 152 million individuals by 2050. Most of the world’s affected older adults, 60% or more, will live in LMICs. It is essential to simultaneously develop programs to mitigate population-level dementia risk and build the infrastructure that is needed to support these affected individuals and their families. The investigation of multidimensional poverty in LMICs, as performed in the study conducted by Trani and colleagues, is a core component of developing the knowledge needed to accomplish these goals.

Little is known about the association of multidimensional poverty with outcomes among individuals with Alzheimer disease and related dementias. Outside of a few studies, including the one by Trani and colleagues, what is currently known is largely from studies conducted in high-income countries using data samples often representing some of the most socially and economically privileged in those countries. These studies also typically use a single economic metric to define poverty.

Multidimensional poverty indices capture nonmonetary contributions toward well-being. In their study, Trani and colleagues focused on education, health, economic activity, living standards, social participation, fair treatment, and psychological wellness. Multidimensional poverty indices can identify the poorest individuals and those who fall along a continuum of deprivations. The number and type of subthreshold indicators can help characterize vulnerabilities and enable policy makers to target resources and design strategies to intervene on the factors that are preventing well-being and that are associated with dementia-related outcomes.

Another conceptualization of well-being that is more common in research on Alzheimer disease and related dementias is quality of life, which conceptualizes well-being as a clinical outcome, rather than a precipitant of outcomes. Quality-of-life measures often capture domains related to depression, self-esteem, feelings of exclusion, and relationship satisfaction, among others. Like multidimensional poverty indices, quality-of-life measures are most concerned with individuals who are faring or functioning least well. Quality of life is a foundational care outcome focused on potentially interventional aspects of a person’s life that may be impinged on as a consequence of living with dementia.

Both applications of well-being—multidimensional poverty indices and quality of life—define well-being via functioning. They ask a question of equity: does a person have the independence to lead a life they value and have reason to value? Both applications also appraise well-being as multilevel, comprising personal and situational factors that build the individual’s context. Within these shared elements, however, the 2 methods often differ in the value they place on appraising psychological welfare.

Although psychological experiences are often a main focus of well-being as defined in quality-of-life measures, this domain is all too often not included in multidimensional poverty indices. Much of the research has focused on the economic factors that contribute to well-being, but psychological well-being is also a critical component.
to their credit, Trani and colleagues included a dimension of psychological well-being and assessed it through depression and self-esteem, which are particularly relevant in older adults. Psychological welfare is an essential element of well-being, whether at the individual level to inform clinical outcomes or the population level to inform policy.

The character of well-being as multifactorial and dependent on personal and situational context is useful because it facilitates setting-specific classifications. It also raises questions to be explored in future studies that build on and expand the foundational work of Trani and colleagues. First, research is needed to understand how, if at all, the meaning of well-being and its axioms is different or invariant across contexts. Could differing levels of an experience lead to similar health consequences, depending on context? This knowledge has substantive implications for understanding the generalizability of research results across settings and populations as well as for addressing issues that may emerge when an instrument’s performance and meaning change when the surrounding conditions change.

Two ways relative deprivations can be evident in well-being are via social participation and structural forces. Social participation, also referred to as social isolation, captures an individual’s social position relative to the broader society. Social participation recognizes that an individual’s relationship or degree of integration with social institutions and structures may influence well-being. The dimension that Trani and colleagues used for social participation was defined as “involvement in any group,” which was consistent with the standard of the local community where their research took place. Given that social participation depends on ideas about customary social activities, does an impingement on social participation produce similar effects across subgroups defined by social role?

Structural forces—including those related to society’s treatment of age, race and ethnicity, and gender—define the context in which individuals live, may determine an individual’s social position, and may be associated with deprivations in well-being. Although Trani and colleagues did not include gender equity in their multidimensional poverty indices, they did conduct comparisons based on gender and, in turn, reported multiple gender differences. Their findings stress how men and women are so often differentially affected across contextual factors. Gender warrants further study for its associations with well-being and dementia-related outcomes. Trani and colleagues could not assess age or race and ethnicity in their homogeneously sample of older Black adults, underscoring how relative deprivations can be affected, even quashed, by contextual factors.

A second issue to be undertaken in future studies is the development of methods to directly measure the severity and cause of dementia in LMICs. Trani and colleagues characterize dementia using the 8-item Interview to Differentiate Aging and Dementia and the Rowland Universal Dementia Assessment Scale. Given that these are screening tools, they lack usefulness in establishing a formal diagnosis of dementia. In Soweto, Johannesburg, South Africa, where their study was set, as well as in many other LMICs, access to primary care practitioners and specialists (neurologists and neuropsychologists) is limited, and routine collection of data on conventional biomarkers of Alzheimer disease and related dementias (eg, cognitive testing, imaging, and biofluids) is also not yet available. Advances in infrastructure and cognitive measures, such as cognitive testing, proxy measures, and biomarkers, are needed to move this field forward. Ongoing efforts associated with the Harmonized Cognitive Assessment Protocol may play an instrumental role in achieving these goals.

The study by Trani and colleagues moves the field closer to understanding the social and structural factors associated with dementia-related outcomes. More research is needed to explicate the ways in which deprivations in well-being are associated with dementia outcomes, particularly in LMICs. In addition, the parallels between well-being as defined in their study and well-being as defined as a clinical outcome highlight the roles of psychological welfare, social inclusion, and structural forces in understanding the determinants of dementia-related outcomes. Advancing knowledge of well-being in research on Alzheimer disease and related dementias requires studies to understand how context shifts its meaning and, in turn, its consequences.
REFERENCES


