

A Comprehensive Inventory of Canadian Databases Supporting Intersectional Health Services Research for Persons with Dementia

Background – why intersectionality?

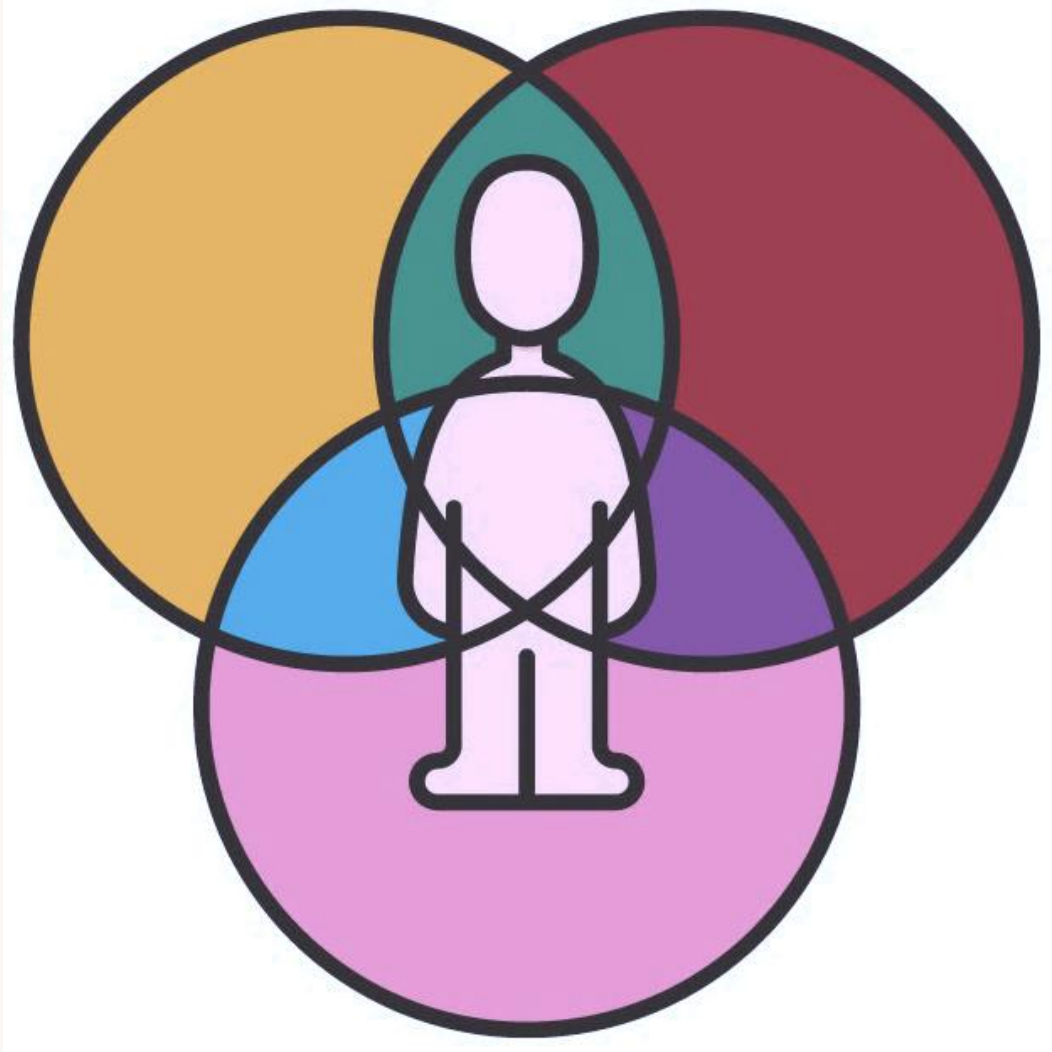
Vulnerable and marginalized subsets of the Canadian population often have worse health outcomes than average, across many measures.

There is already research that investigates **the role of individual social determinants of health** on dementia risk and prevalence. Through this, we know that education, ethnicity, and socioeconomic status hold predictive power. Policymakers may be interested in knowing how access to care and use of health services is correlated with these factors, which has also been investigated to an extent.

By adopting an intersectional research approach, we enable analysis **across social identities and power systems** to better explain the multi-factoral and complex causes of health disparities amongst people living with dementia.

Objectives

- 1 To enable further research on equitable dementia care that takes into account complex and overlapping aspects of social identities, rather than individual social determinants.
- 2 To identify the strength of current data infrastructure, and the missed opportunities in data collection, to improve practices and enhance the data sources available.
- 3 To inform and recommend targeted policy action, that identifies underserved populations and acts on evidence to mitigate health inequities amongst those living with dementia.



Methods

Framework: Mapping Review

Selected for its ability to survey and analyze broad sources of information, not only journal articles. Used in similar studies (Annis et al, 2023). Reporting uses the PRISMA-ScR recommendations, as no formal guidelines exist for mapping reviews.

1. Database Identification

Consultation with expert data users within our broad network, outreach to team members of included databases, and an environmental scan (Tremblay et al., 2026)

2. Screening and selection criteria

Canadian sample; enables dementia identification; ≥1 social determinant of health; tracks health services use; accessible for future research. Two reviewers independently screened every candidate database; disagreements were resolved by the PI.

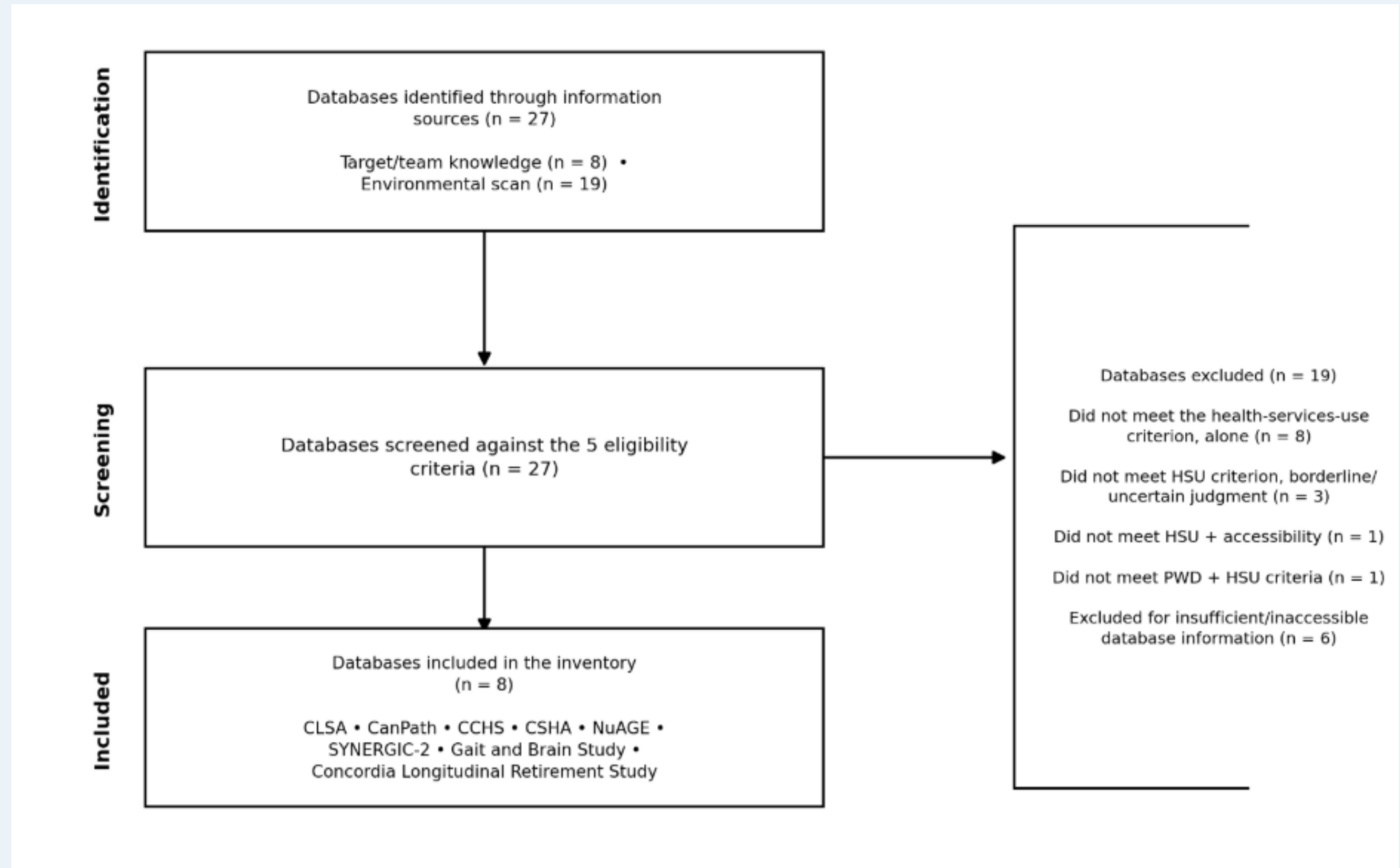
3. Data extraction and analysis

For each included database, study characteristics, dementia identification methods, health services use, and social determinants of health were extracted into a standardized spreadsheet. SDH standards evaluated against the SPARK Toolkit, CIHI, and PHAC recommendations.

4. Reporting and dissemination

Results are reported using the PRISMA-ScR guidelines. Article to be published open access. PDF summary page in development for broad dissemination on Canadian data hosting platforms to enhance accessibility to interested researchers.

Results



Screening decisions:
27 databases were screened for inclusion, 8 included with 13 entries (some databases had several cohorts)
The most restrictive criterion was the lack of ability to track health services usage (n=12 total)

Summary of database characteristics:

- Scope ranges from single city cohorts to pan-Canadian surveys with close to national representativeness
- Sample sizes from 387 to 225,620
- Sampling strategy split between probability-based and convenience/purposive designs, with implications for representativeness
- Different demographic range. Some concentrated on only elderly vs all ages

Intersectionality & Health Services Use

- **No database fully supports intersectional analysis of HSU among persons with dementia.** Standards-aligned SDH, robust HSU, and thorough dementia identification are not fully tracked. CLSA comes the closest to having all three.
- **SDH quality and HSU quality are generally inversely distributed.** Health-services surveys (CLSA, CCHS) measure utilization well, while etiology cohorts (CanPath) measure social position relatively better.
- **Large variety in SDH reporting:** Gender identity is collected in 8 of 13 entries; Wealth is nearly absent. Only CLSA collects it entirely, limiting socioeconomic status granularity across the other databases.

Dementia identification:

- **Diagnosis:** All 13 entries record diagnosis, almost entirely by self-report (exception: physician-identified in Gait and Brain Study), likely underestimating prevalence
- **Functional and cognitive testing:** Algorithm for undiagnosed dementia in development for CLSA; feasible for NuAGE, SYNERGIC-2, and CLRS; not feasible for CCHS or most CanPath cohorts
- CLSA and NuAGE screened out cognitive impairment at baseline, so they capture incident cases only



Next Steps

