World Dementia Council
Leading the Global Action Against Dementia



Virtual Dialogue

Brain health advocacy

Transcript

27 January 2026

Supported by

Alzheimer's Society

Brain health advocacy

Meeting transcript



Lenny Shallcross, *Executive Director World Dementia Council*

Thank you very much for joining. Happy New Year. I hope everyone here had a good Christmas and New Year. I realize many of you have participated in these meetings before. And we've heard me introduce, both myself and the Council. For those of you who are new here, I'm Lenny Shallcross, the Executive Director of the World Dementia Council. The Council was established by the UK government following the G7 Dementia Summit, that was held here in London. The Council brings together global leaders from across the dementia field and beyond. It works both as a convening platform and a strategic think tank. With the aim of ensuring that the scientific progress that's being made in the field translates into meaningful change.

As you will have seen from the invitation, we're running a number of dialogues focused on the future of advocacy as we move into an era of diagnosis and treatment of Alzheimer's and, in the future, other dementias. This is the first of a number this year. This project is supported by the Alzheimer's Society here in the UK, the largest not-for-profit patient organisation here. I'm grateful to Rob, who you can see there on the screen, Chief Public Policy Officer at the Alzheimer's Association, for chairing this session, and to our speakers, who he will introduce. For those of you who have participated before, you'll know the setup, it's designed as a dialogue. It works when you share your perspectives. This is a group of people who are advocating and doing, and with different takes on this question of brain health, and we want to hear from you. Afterwards, we will publish a transcript. We also publish a write-up in the journal, *Alzheimer's & Dementia*.

Before turning over the meeting to Rob, I just want to say something briefly on the topic. What we want to explore today is this concept of brain health — where it works, and how it helps to advance Alzheimer's disease and related dementias. Is it the right framing, the right language, the right concept to help advance the cause?

Policy ideas have their moment in the sun, and there is a lot of talk and focus on brain health right now. But here we are in the UK, and we know something about attractive policy ideas that get taken up by policymakers, endorsed by the public, and all the rest of it — Brexit being an obvious example — and that didn't turn out particularly well for us. An idea having its moment in the sun isn't necessarily a great idea. The road to bad policy is definitely paved with good intentions — although, actually, with Brexit, I'm not sure there were good intentions, but that's by the by.

So is brain health the right framing, the right language, the right concept to help advance the cause? It may well be. You can see how it works from an individual perspective, from a policymaker perspective, and how it can be extended into business and finance ministries around building economic value. But at the same time, does it dilute the salience of disease? In the US, they've just secured another $100 million for Alzheimer's research, and everything that has happened with that huge increase in funding has been built around the salience of a disease. So do you dilute that by emphasising the concept of brain health?

That's what we want to explore. I'm not going to try to answer my own question at the outset — I might come back to it later if Rob lets me — but with that, I'll turn it over to Rob. Thank you again, and over to you.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

I sure can, and thank you very much for the invitation to do so. Thank you to our panellists, whom I'll introduce in order as we come to the opening comments, and thanks to each of you for joining this webinar. I'm really looking forward to it.

This is the kind of webinar that, if I weren't asked to be hosting, I'd probably prefer to be attending, because I could just listen to a question that I've been thinking a lot about personally and am very curious about. I come at this with some biases, which I'll be up-front about, but also, I hope — and I think — with an open mind about what I might need to adjust in my thinking. Some of the frameworks or mental models I've had over the last 10 years may not be the best ones for the future. That, in a sense, is our job today.

As Lenny said, the premise of this conversation is not whether brain health is valuable in general for a range of different ideas. I think we can all agree that it absolutely is, and that hardly needs discussion. More specifically for this webinar the question is whether it is a useful framework for advancing an advocacy agenda for dementia, and for Alzheimer's disease as one cause of dementia. I'm sure we'll arrive at a more nuanced answer than yes or no, but in what context can it be helpful, and under what circumstances?

One thing I've been observing recently — I actually looked this up this morning to see what it's called — is something I think we've all experienced, and which is referred to as the "frequency illusion." That's the idea that you hear a new word, or perhaps you're shopping for a certain car, and suddenly you see it everywhere, or hear that word everywhere, and you wonder whether it just started or whether it's been there all along and you simply weren't noticing it. That's very much how brain health has felt to me over the last five years, increasingly so.

At this point, sitting where I am in the Washington, D.C. policy community, I see brain health crossing my inbox all the time in terms of how it's being framed as a concept. So I have that question in my mind: is this just taking off, or is it that I haven't been paying attention until recently? What's the combination? And who is it taking off with, and why are they gravitating towards this construct as a way to frame discussions? That's where I'm coming at this from.

When I mentioned my biases, Lenny may have anticipated that they come from my experience in advocacy work with colleagues and advocates across the United States. My conclusion from that experience is that framing our agenda around specific diseases — specifically Alzheimer's disease and dementia — has been very effective for us. It's hard for me to imagine our agenda having succeeded if, 10 years ago, we had tried to pursue it primarily through a brain health construct.

On the other hand, this doesn't have to be an all-or-nothing proposition. We can think about when it might be the right time to pivot, and where using that terminology more than I personally have might help advance different concepts. That's what I'm hoping to get a better handle on over the next hour and a half.

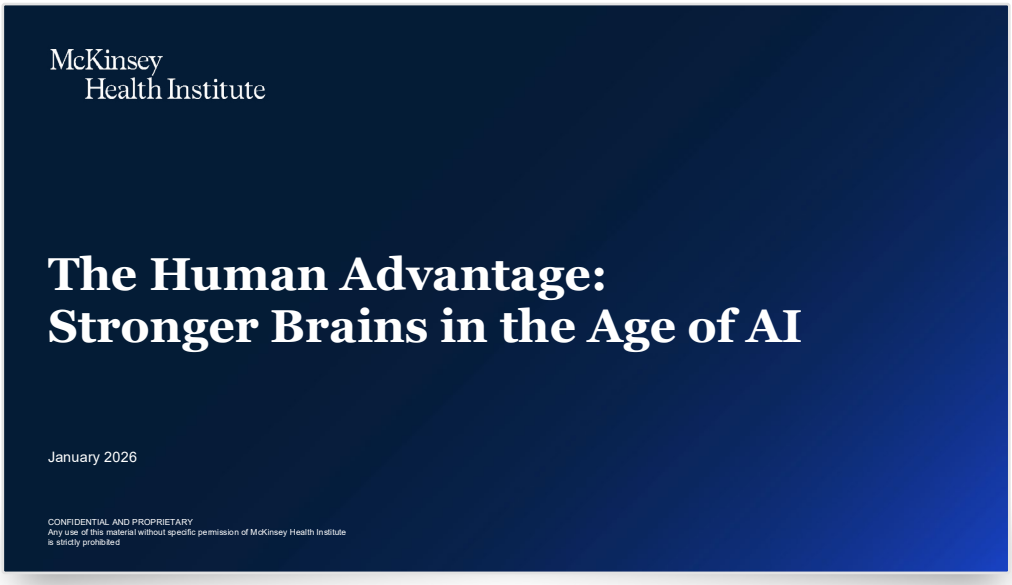
And as we do so, we have some fantastic panellists to help us think this through — not to arrive at a simplistic answer, but to unpack some of the more important nuances, and to understand the different settings in which concepts like this might be appropriate. Fundamentally, we also want to better understand what people actually mean by the term "brain health," because my own experience is that it varies quite a lot depending on who is speaking.

With that, we have an outstanding panellist to start us off, someone who has been thinking about and advancing this concept very effectively. That's Harris Eyre. He is the Executive Director of the Global Brain Economy Initiative and co-lead of the Brain and Society Initiative at the Rice Brain Institute. He's a physician, a neuroscientist, and a strategist who pioneered the concept of brain capital — the idea, as I understand it, that we should measure brain health and brain skills as economic assets. His work has spanned the World Economic Forum, Brookings and McKinsey. So, Harris, I'll turn it over to you to frame this up in the way you've been thinking about and advancing the concept. Thank you for joining us.



Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*

Wonderful. Thank you, Rob, and good to see everyone. Thank you, Lenny. It's good to see some colleagues, and also some new friends.



I'm going to kick things off and frame brain health in the context of the brain economy transition. I've just returned from the World Economic Forum, where the brain economy featured in a flagship report produced with the World Economic Forum and the McKinsey Health Institute, and Kana Enomoto from MHI is on the call today. We had a big week last week which I can talk more about if that's useful to people.

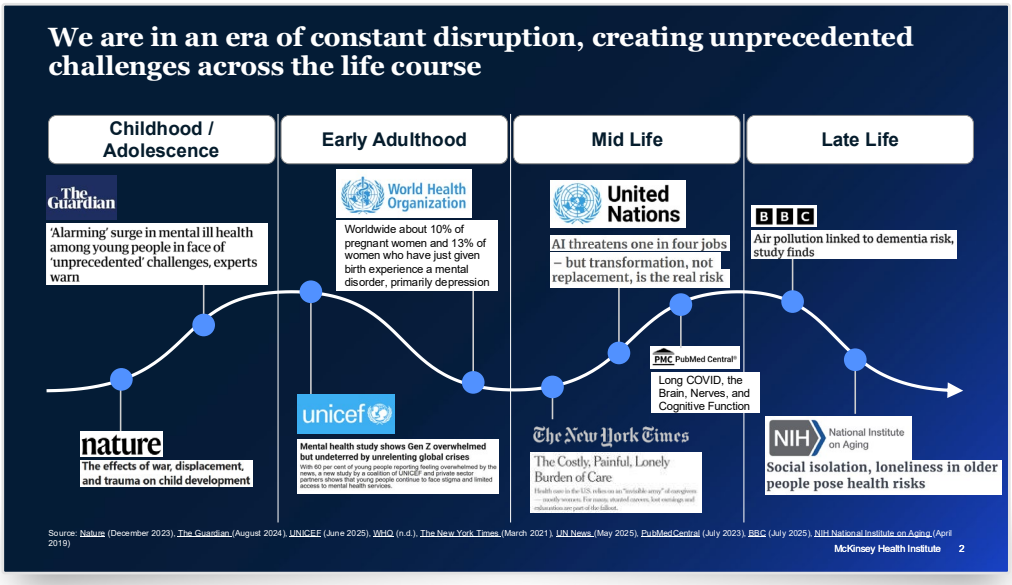
I'm a professor at Rice University and the University of Texas Medical Branch, and I should say that I'm speaking to these slides in a personal capacity.

By way of background, as I get into this, I'm originally from Australia and now live in the United States between California and Texas. The brain economy is something we developed about five years ago in the spirit of looking for impact: how do we grow the size of the pie and increase the impact for the entire brain and mind field? I come from rural Australia, from the northeast, and trained as a physician in psychiatry, neurology, and health system management. I then moved to the United States to study neuroscience, and I also have a background in business and entrepreneurship.

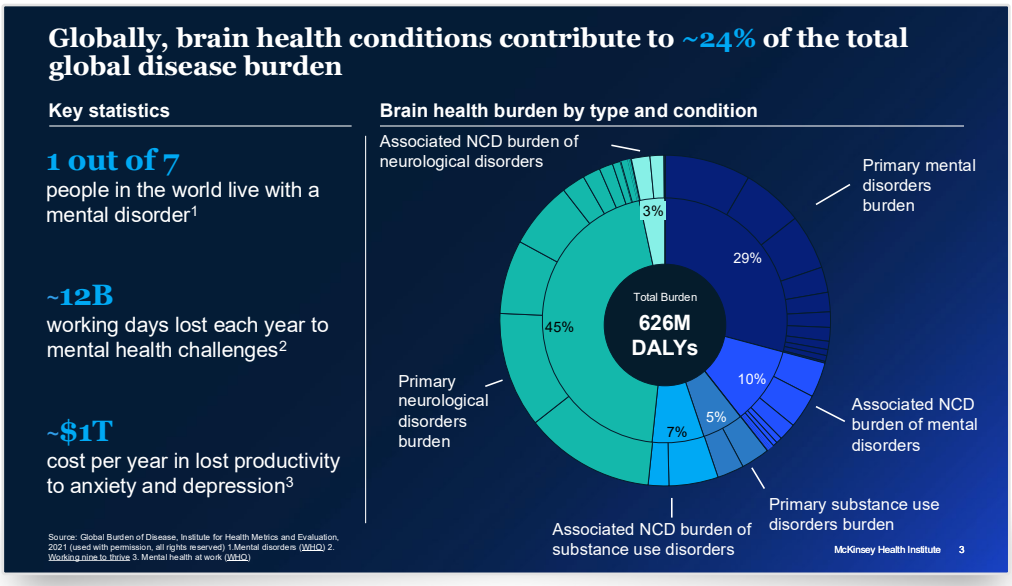
What you see in the brain economy transition is really a manifestation of my personal journey to try to build a big platform and put brain and mind stakeholders — people like all of you — into the engine room of the economy, rather than having them seen primarily as a cost centre for nation-states, particularly a rising health care cost centre. I want neuroscientists, neurologists, advocates, and others working in this space to be seen as core to the productivity of a nation-state, and as something that finance ministers and heads of state should be actively focused on. This work can reduce costs through prevention, value-based care, and better management of health issues, but it can also drive productivity. The human brain is the seat of productivity.

Hopefully that gives you some context. The report we published last week — perhaps I can share a link later — was called *The Human Advantage: Stronger Brains in the Age of AI*. Framing brain health is especially important in the age of AI, and that was really the big unlock in Davos last week. The key question is: how do we try to get the same amount of money that's going into AI to also flow into brain health? How do we redirect at least some of those trillions of dollars currently going into data centres towards brain health?

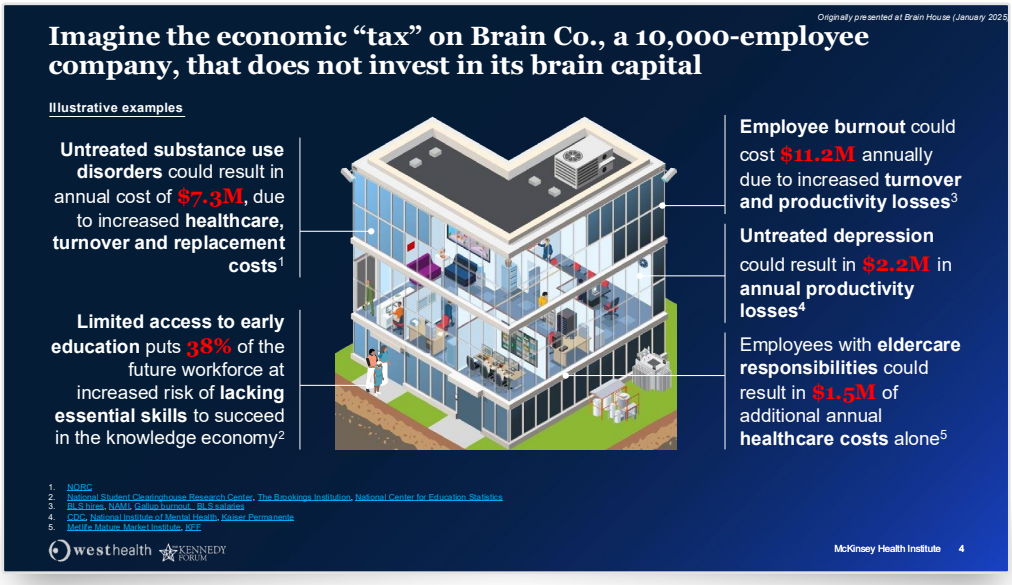
To Lenny's point, this work is not meant to take away from the dementia field. It's meant to grow the overall pool of funding and resources that go to dementia, just as it does for the mental health field and for psychiatry, including treatment-resistant disorders.



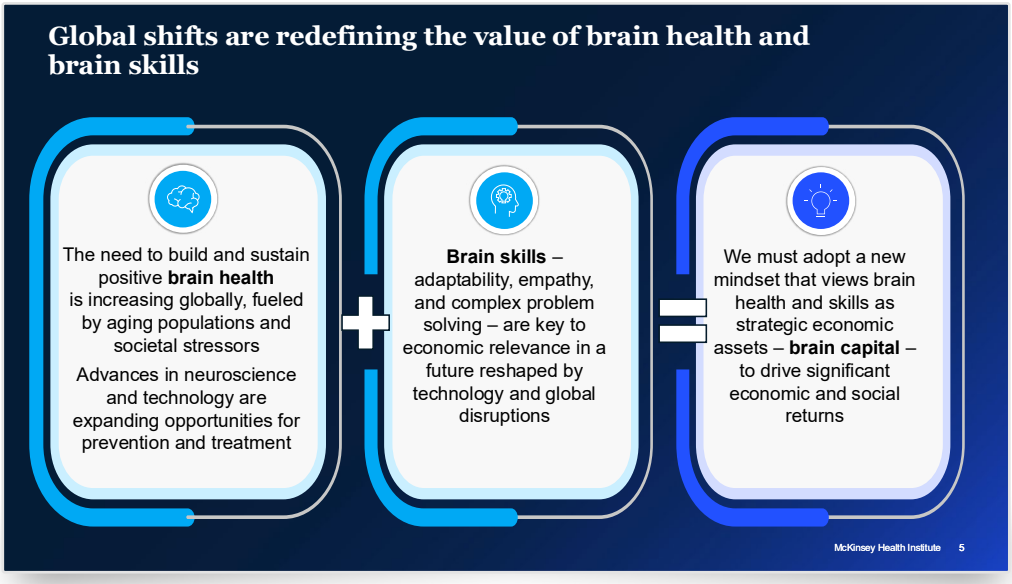
I'm going to move fairly quickly through the next part, because I don't have much time. We're living in an era of unprecedented change and challenges across the lifespan — whether that's malnutrition and food insecurity in children that stunt brain development, youth mental health challenges, AI changing the world of work and making work increasingly stressful, or dementia, which we all know so well.



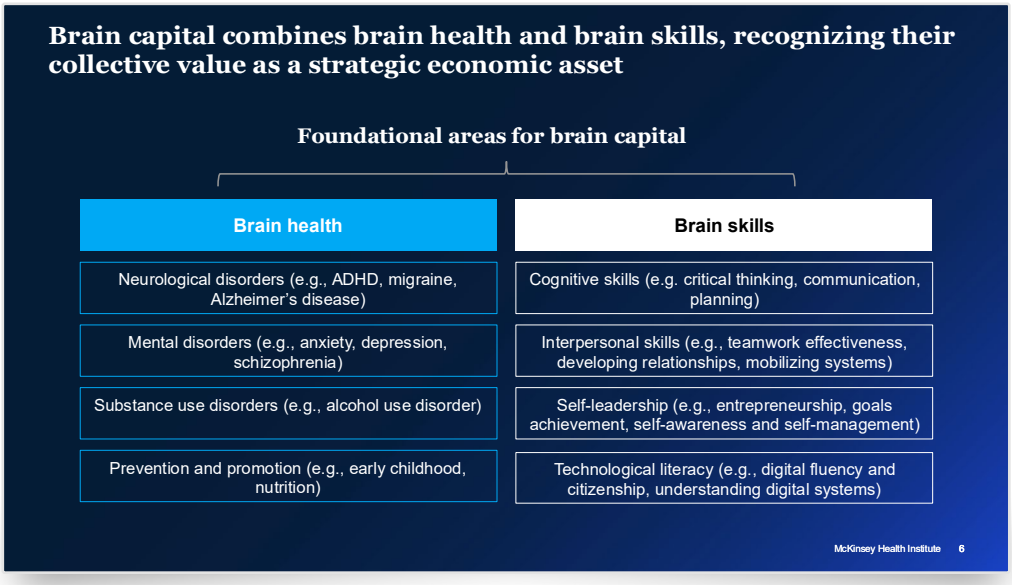
The cost of brain health disorders — which we define as including neurodevelopmental, mental health, neurological, and substance use disorders — is enormous. There are a lot of big numbers here, and these slides are public, so I can share them with anyone who's interested. If you add these disorders together, using data from the Institute for Health Metrics and Evaluation's Brain Health Atlas, the cost is around $3.5 trillion a year, and it's rising at about 3% annually. I won't go into all the details here, but I'm happy to share the material.



This represents a real tax on businesses. If you want to make this tangible for business leaders, you can ask: what would the "brain tax" be for a company with 10,000 employees if it didn't effectively manage these issues, including access to education and other supports. That framing makes the cost very clear.



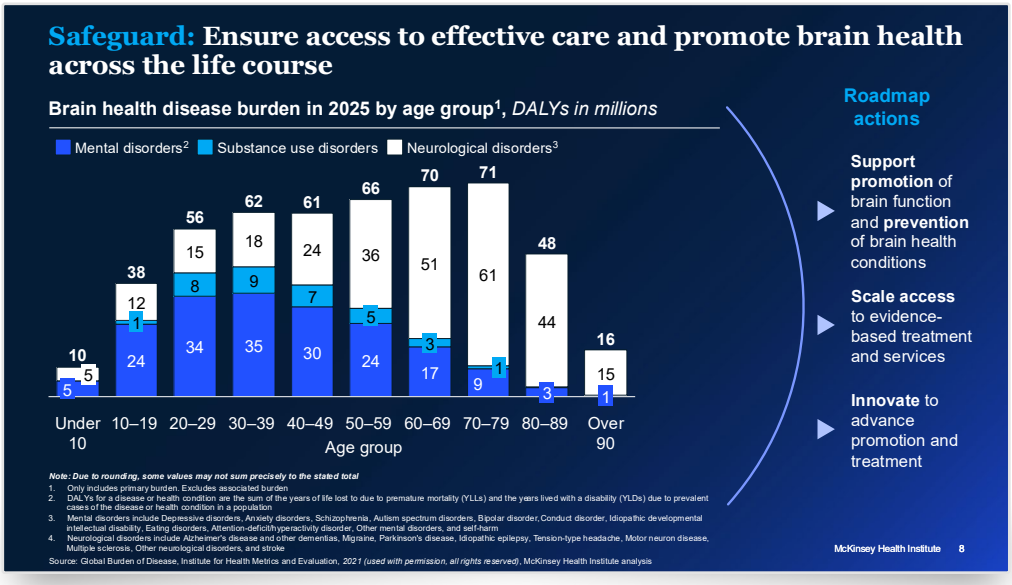
A key concept Rob mentioned is brain capital, which has two components: brain health and brain skills. On brain health, we work closely to align our definition with the World Health Organization and with other stakeholders, such as the Global Brain Health Institute at UCSF and Trinity College Dublin. I won't go into the definition in detail here. Brain skills are the other component: the skills needed to survive and thrive in the modern economy — creativity; AI literacy; resilience; adaptability. That's what brain capital is. We want brain capital to be understood as a national asset, as important as financial capital or physical capital, such as roads and bridges.



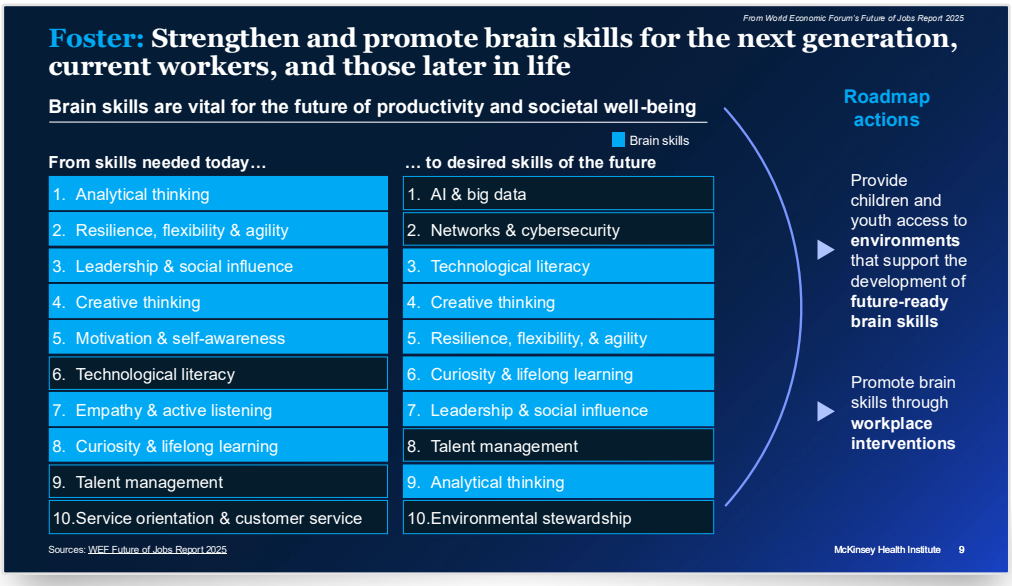
This is an economic transition. I lead the Global Brain Economy Initiative, which is an action platform designed to drive this transition in a sustainable way through public-private-philanthropic collaboration. We engage stakeholders across the private sector, health systems, the public sector, civil society, and human services.



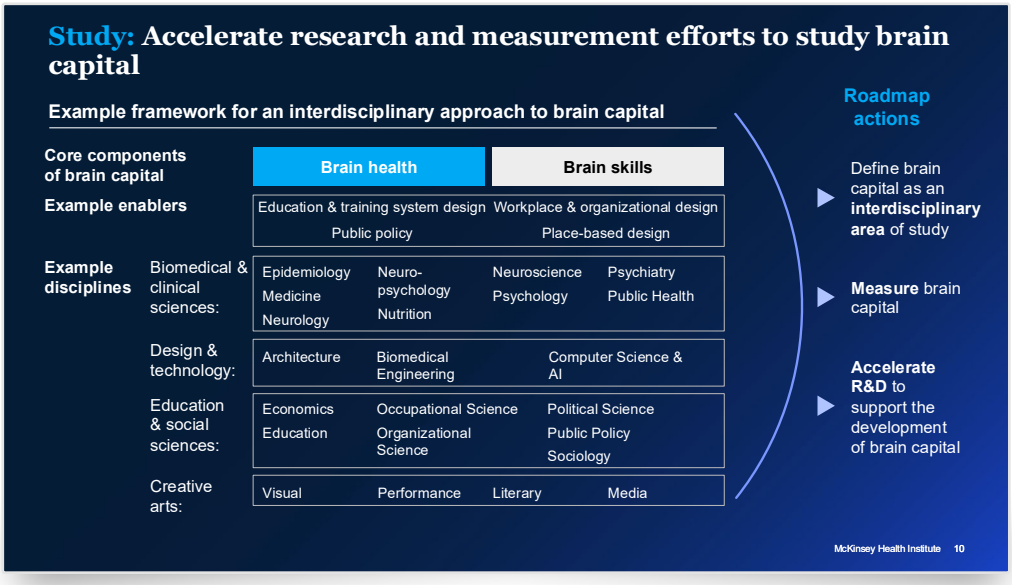
We focus on driving action through a set of levers, and the outcomes we care about are productivity — what heads of state and governments tend to prioritise — but also well-being and human flourishing. In that sense, this is comparable in scale and ambition to something like the energy transition, but it is focused on the human brain.



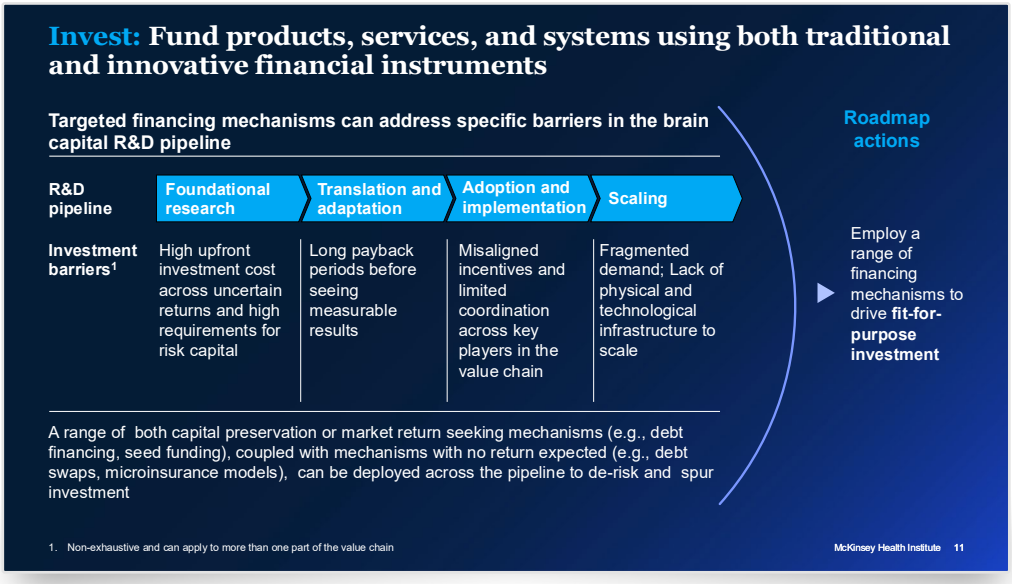
The first lever is safeguarding brain health: what are we doing in value-based care, clinical pathways, public health, and population health?



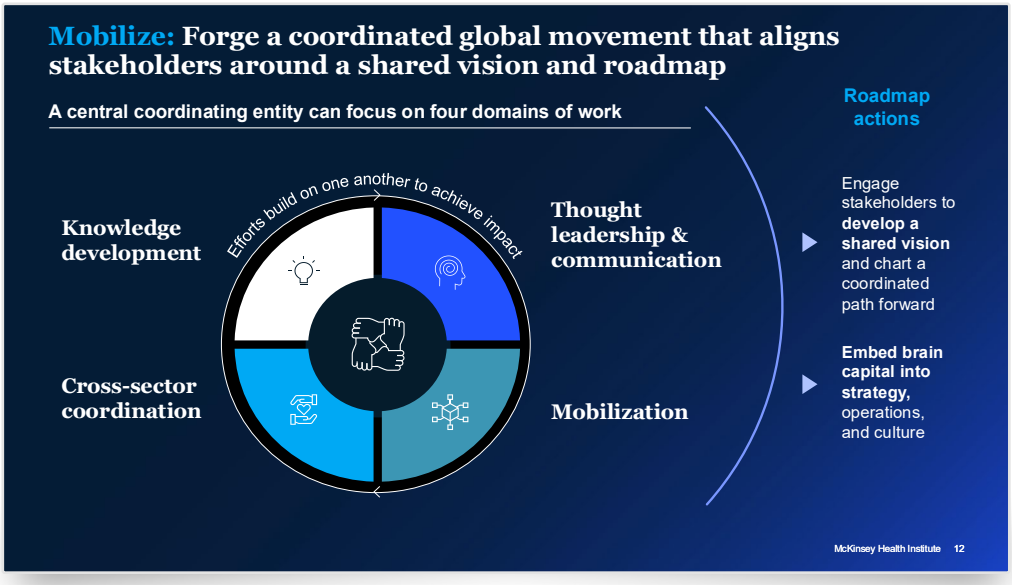
The second lever is fostering brain skills — social and emotional learning, K-12 education, vocational training, upskilling and reskilling in the workplace, and brain skill development in later life to help prevent dementia and support caregivers to remain in the workforce if they wish to.



Research is also critical. We focus on measurement, modelling, and interventions, and on building a pioneering brain economy science. That includes working with leading dementia researchers, but also with experts in areas such as neuroscience in real estate — neuro-design and neuro-architecture — and the neuroscience of food systems. We're asking how we change every sector and industry in the economy to build brain capital and brain health. We have several initiatives launching publicly in the coming weeks. We're also hosting a major science summit at Rice University in March, with another at UCLA later in March.



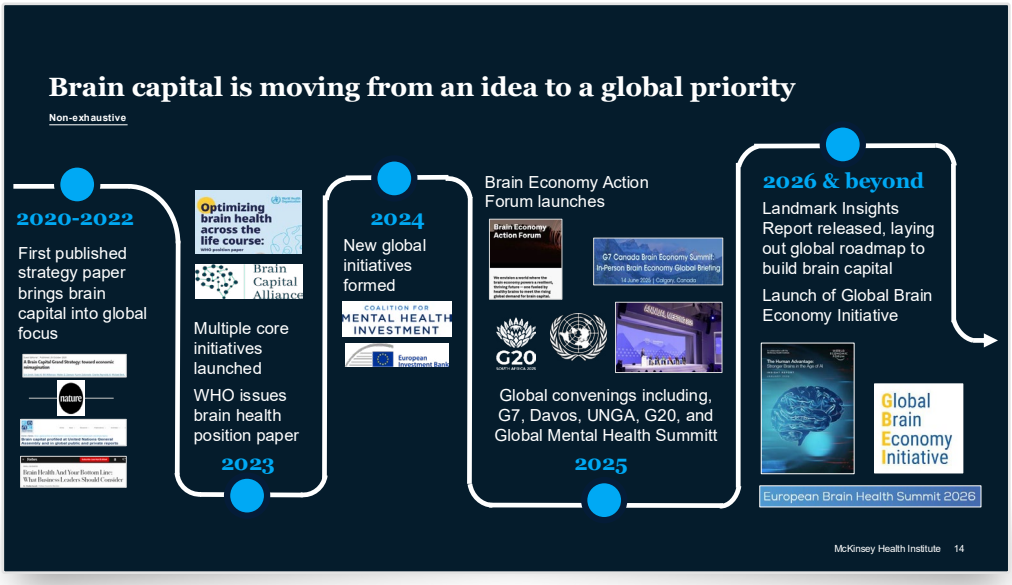
Investing is another key lever. We're looking at how to mobilise capital — public pension funds, sovereign wealth funds, and other sources — into the brain economy to grow the overall pool of funding so that dementia, in particular, receives more resources. We work closely with venture capital funds, civic organisations, and philanthropies around the world that are focused on dementia.



Mobilisation is also essential. That's about coordination: what does a city-level brain economy initiative look like? We now have one in Houston, Texas, and another in Geneva, which was announced last week. We're also working at the state level, including in California and Texas. Last week we met with the Lieutenant Governor of Texas, who is behind the $3 billion Dementia Prevention Research Institute of Texas (DPRIT) legislative package that has now passed.



We're working across all these scales, from cities to states to nation-states. We also have an action forum run by the World Economic Forum and the McKinsey Health Institute, of which the World Dementia Council is a part — thank you, Lenny — and also the Alzheimer's Association — thank you, Rob. Kana Enomoto runs this forum on behalf of MHI and may want to say more about it. We have participants from around the world, many connected to dementia, and we are very deliberately bringing the dementia field along on this journey.



This work is moving from an idea to a global priority. Our ambition is for brain health and brain capital to become one of the top three issues for heads of state, political leaders, and civic leaders globally in the coming years. We're engaging across everything from technical papers to global and regional platforms.



So thank you — that was a flyover. I'll leave these QR codes up for anyone who's interested. With that, back to you Rob.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you, I appreciate that very much. I took a few things away from that — more questions, not answers yet — but in the right sense. I don't think it's time, personally, for me to have all the answers yet.

I heard your theme very clearly around the idea that this is a construct that — using my language, not yours — could potentially lift all boats within this broader concept of brain health. And that leaves me with a question about where we start to adapt that. For an organisation like the Association, which works across many different areas, maybe it belongs in

public policy, or maybe it doesn't. Maybe it's more about how we engage with businesses and other sectors. That will be interesting to explore together with all of you who've joined us this morning as we move forward.

We'll now move on in our opening comments to our next panellist. I'm pleased to introduce Frédéric Destrebecq, Executive Director of the European Brain Council. He leads efforts to develop a European brain health strategy and brings a perspective from a system where public health has a stronger role for government than, I would imagine, is the case here in the United States. So it will be interesting to hear about comparisons across regions and your experience with that, Fred, among other topics. With that, I'm very happy to turn it over to you.



Fred Destrebecq, *Executive Director, European Brain Council*

Thank you, thank you very much, Rob. I'll try to avoid information overload by simply sharing a few thoughts with you orally. I was invited to comment on some of the developments that Harris has just shared, but from the perspective of the European Brain Council, where I've had the pleasure of serving as Executive Director for more than ten years now.

The EBC brings together patient organisations, professional and scientific societies, as well as the private sector, to help generate consensus across the community and promote brain research. Over time, our agenda has really expanded. We were set up a little more than 25 years ago with the ambition of increasing public investment in neuroscience, which at that time was relatively limited in scope.

To achieve that, we had to work very hard to demonstrate the societal impact of brain disorders — and of the brain more generally. That led us to focus on the cost and burden of brain disorders. Some of you may be familiar with that work, although the original study dates back to 2010 and is now relatively old.

What we see as a real source of energy and encouragement today is the extent to which the concept of brain health has been taken up over recent years. As Harris has just shown, it is now also expanding into other areas of advocacy, theory, and work with major institutions. Where I'd like to focus in particular, however, is on brain health through the lens of the World Health Organization.

We are working under the umbrella of several WHO global action plans issued in recent years, particularly the Global Action Plan on Epilepsy and Neurological Disorders, but also the Global Action Plan on Mental Health and the Global Action Plan on Dementia. There is still a great deal of work to be done to implement the objectives and key performance indicators of these plans. But at the very least — and this is what the EBC has chosen to prioritise — we now have clear momentum and clearly articulated goals for every country to begin developing its own national strategies.

Given the level of integration in decision-making within the European Union, we've decided to place strong emphasis on this approach, encouraging countries to develop national strategies towards 2030, and in parallel prompting EU institutions to prioritise a coordination plan, as we've called it. This is about creating synergy and complementarity across different policies that have already been adopted, or that now need to be reactivated and better aligned.

We're working very closely with Harris and other partners on this agenda. I'd also like to highlight the work of the Institute for Health Metrics and Evaluation, which has reinforced and confirmed the burden-of-disease evidence we've been building over many years. This work shows that brain disorders are the leading cause of disability and the second leading cause of mortality. As such, they need to be at the very core of action, both at national and international levels. This explains why brain health has become such a central component of the agenda presented in Davos and within the World Economic Forum Action Forum on the Brain Economy, led by the McKinsey Health Institute.

Alongside brain health, there are of course other important pillars — innovation, investment and others. With the emergence of the Global Brain Economy Initiative, we now see a real wave of momentum and support around this agenda. In Davos last week alone, there were more than 30 events dedicated to brain health, compared with just two or three events two years ago.

This clearly represents a window of opportunity to secure the recognition our field needs, and to attract greater levels of support and investment. Harris mentioned the example of Texas, which is now investing $3 billion in Alzheimer's disease research. That investment has acted as a catalyst, with private-sector actors following public funding to position themselves within this agenda.

As I've said to Lenny and others within the World Dementia Council, Alzheimer's disease and dementia have always been a strong priority for the EBC, but they are also sometimes a tree that hides the forest. Whatever we do for dementia will generate spillover effects across other brain disorders. And prioritising brain health is certainly not to the detriment of dementia — if anything, I would argue the opposite is also true.

To conclude, one reflection I shared on panels in Davos last week is that while the economic impact of brain health, brain skills, and brain capital is undeniable, we would be limiting ourselves if we adopted a purely productivist approach. Social cohesion must also be part of this agenda, as Harris hinted in his slides. In an era where skills such as social interaction, leadership, and critical thinking are increasingly important, this dimension deserves far greater emphasis.

So, I'll stop there and very much look forward to the discussion. Thank you.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you very much, Fred — and as you said, don't go anywhere as we continue the conversation.

Our final panellist, whom I'm pleased to introduce, is Giovanni Frisoni. He is a Full Professor of Clinical Neuroscience at the University of Geneva and Director of the Memory Clinic at Geneva University Hospital. He has authored more than 800 papers on the clinical use of biomarkers.

Giovanni, let me put a simple question to you and then invite you to take it wherever you'd like: where do you see brain health framing helping us to move our agenda forward, and where might it potentially get in the way?



Giovanni Frisoni, *Full Professor of Clinical Neuroscience, University of Geneva; Director, Memory Clinic, Geneva University Hospital*

Thanks, Rob, and thank you, Lenny, for inviting me to share a few thoughts with you.

To understand my point of view, it's important to know that I'm a neurologist — a clinical neurologist and researcher — and my everyday work involves a struggle on two fronts. One front is with patients, who ask me to provide actionable solutions, whether in terms of information, diagnosis, prognosis, risk, or treatment, including drugs. The other front is with funders — decisionmakers who determine funding for research, for clinical activities, and for care.

When the concept of brain health emerged — and the European Academy of Neurology was one of the early champions of this idea — I reacted like many of you probably did. I thought, *wow, this is great*. We've always talked about taking care of the body: vascular health, the heart, the lungs, the gut — but what about the brain? Of course, this seemed like a very positive development.

But then the practical questions began. How should I use this concept to persuade decisionmakers to fund projects? How can it help me secure more resources to improve care for my patients? And, just as importantly, what more should I actually be able to offer my patients as a result of this concept? That's where the difficulty emerged. People quite reasonably asked: *what is really behind this, in practical terms?* And that forced me to step back and undertake a careful review of what we currently offer patients.

Within dementia care, you can identify three broad levels.

The first is primary care, at the level of the general practitioner. There is already some brain health work happening there. When GPs treat vascular risk factors, they are indirectly supporting brain health. When they give advice on healthy lifestyles, they are also indirectly supporting brain health.

At the other end of the spectrum is tertiary care, in memory clinics. Here we focus on tertiary prevention: delaying or preventing the complications of dementia and cognitive impairment. We do this through early diagnosis — and more recently molecular diagnosis—through drugs such as donepezil and rivastigmine, now more recently monoclonal antibodies, as well as psychosocial interventions, rehabilitation, and other approaches.

But what is notably absent from this picture is secondary prevention.

What do I mean by secondary prevention? Let me give an example. I'm 65 years old. Let's imagine my mother had Alzheimer's disease, and perhaps another relative did as well. Let's imagine I have amyloid positivity, or I carry one or two APOE ε4 alleles, or I have elevated p-tau217. I am at high risk of developing Alzheimer's MCI or dementia in the coming years, but what does medicine have to offer me today? Nothing. Zero. This is the missing piece in care today: secondary prevention for people who are cognitively unimpaired but at high risk of developing cognitive impairment/dementia.

Based on this recognition, a few years ago, together with a European group, we began to think about how a new patient journey might address the needs and demands of cognitively unimpaired individuals at high risk of cognitive impairment/dementia. We developed a model consisting of four pillars: risk assessment, risk communication, risk reduction, and cognitive enhancement.

These four activities are not systematically delivered anywhere in clinical medicine today. They are not part of standard GP practice, and they are not part of tertiary care of memory clinics either. We currently have a network of more than 40 centres piloting this approach across Europe and beyond. The future we envision is one in which these activities — risk assessment, communication, risk reduction, and cognitive enhancement — move beyond pilot services and become properly integrated with both tertiary care, through memory clinics, and primary care. This is not something that will happen tomorrow. It's a process that may unfold over the next ten years. It's not just a patient journey — it's a long journey for medicine itself. But it's one that we believe could yield significant benefits, both for patients and for society, in the years ahead.

In conclusion, in the field of cognitive impairment/dementia, the new angle the brain health concept brings is this secondary prevention for people who are cognitively unimpaired but at high risk of developing cognitive impairment/dementia.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you so much for those comments — I really appreciate them. We're now moving into the discussion, and I want to open this up to everyone participating. In particular, I'd be very interested in hearing not just your questions, but your experiences. If you've already used *brain health* as a concept or as a label to advance an agenda focused on helping people with dementia, and you've had positive, negative, or mixed responses, I think it would be extremely valuable for all of us to hear about those concrete cases. And if you haven't yet used that framing, but you're considering whether you should, this is a great opportunity to get some free consultation from our panellists — consultation that might otherwise be hard to come by. So please jump in and tell us what brought you to this webinar, and what you're thinking about exploring.

I'll come to you in the order in which hands were raised in a moment, but before that, I want to tee up a question of my own. I'll be fully transparent here, because this really gets to both the intrigue for me and — if not worries — then at least some open questions about how this plays out in practice, particularly in the United States. I'll frame this around what we've been calling the Texas initiative, which several of you have already mentioned and which I think

all of us should be genuinely excited about. Internally, we refer to it as DPRIT— the Dementia Prevention Research Institute of Texas. For those who may not know, it was modelled on a very successful cancer initiative in Texas — often referred to as CPRIT.

This was a voter referendum, and many of us — including our Alzheimer's Association Texas team and advocates within the state — made the case for its funding through the ballot initiative. The framing was very explicitly around dementia and Alzheimer's disease, and that intuition appears to have been correct, at least insofar as it generated strong support at the ballot box among Texas residents.

When I hear you, Harris, talk about going in and discussing DPRIT in broader terms, that makes a great deal of sense to me, and I can see the appeal of a framing that lifts all boats. At the same time, part of me — drawing on that experience — wonders whether this could dilute the original purpose of DPRIT. Could something that was advanced specifically to address dementia end up drifting into a more nebulous space if it's absorbed into a broader brain health or brain economy framework?

So my question to you — and to the other panellists — is this: what would you say to reassure someone like me, coming at this as a dementia advocate? How does this work in practice? Do I need to be cautious about this or is there a way to ensure that the salience of dementia is preserved while still benefiting from a broader framing?



Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*

If I take the specific example of DPRIT, it's very clear that the legislation itself is written around Alzheimer's disease, dementia and Parkinson's disease prevention. It's also pretty clear that the funding mix is something like 95% biological and translational research, and maybe 5% implementation and innovation. So when I think about my role — particularly coming at this from the brain economy perspective — I see it as asking how we use economic levers to increase that $3 billion and turn it into $6 billion, by bringing in private-sector capital and philanthropic funding. That requires a broader narrative: one that says $3 billion is not only good for patients and families, but also good for the economy of Texas. And then you can start to point to concrete examples — Eli Lilly has already invested $5 billion in a manufacturing facility in Texas. The question becomes: how do we use economic strategy and storytelling to build on that momentum and double the overall level of investment? That's where the brain economy framing comes in. And I see it as something that helps rather than dilutes the agenda — it expands it and makes it bigger.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you — that is really interesting, and I appreciate it. It also reminds me of one important feature of this initiative, which is that Texas puts in money for grants, but those funds have to be fully matched by other partners for the money to move forward. So thank you for that, Harris. Let's now turn to those who've raised their hands. Diane, I will start with you.



Diane Bovenkamp, *Vice President of Scientific Affairs, BrightFocus Foundation*

Yes, good to see you too, and this is just an amazing conversation. I'm Diane Bovenkamp from the BrightFocus Foundation. We've been around for 52 years, and we have awarded about $315 million in research funding across 28 countries. So while we're based in the United States, we very much have a global outlook.

We have used brain health as a concept in the past. We partnered — way back when — with UsAgainstAlzheimer's and others using brain health framing, and I think one of the reasons it resonated is that we're also connected to about 630,000 people affected by these conditions and their families. We fund research in Alzheimer's disease, glaucoma, and macular degeneration.

One of the key things this framing offers is a sense of empowerment. Taking control of your health is a powerful idea. As one of the speakers mentioned earlier, in primary care settings, if something is good for your heart, it's usually good for your brain as well.

I do think this framing has been successful in raising awareness. Robert, as you know, through the Alzheimer's Association and other groups — and through initiatives like LEAD — we've signed many letters to educate Congress on how important this issue is, and then at the global level, to work together to fund research.

I want to raise two points. First, building on what Harris said, I applaud the Texas initiative and others like it. I just hope that, while Alzheimer's disease is rightly central, other conditions aren't left behind — Lewy body dementia, vascular dementia, and others — especially given that many people present with mixed or multi-etiology conditions.

The second point I wanted to raise is that I was one of the organisers of a National Academy of Sciences virtual workshop on the bidirectionality of brain–body interactions. I can share a link in the chat. One of the big takeaways was that researchers and clinicians really need to think about the body as a whole, with the brain as part of that system. So, I come back to the question Lenny raised earlier: is brain health the right framing, or do we need to more explicitly put the brain back into the body when we talk about health and care?

When you think about the microbiome, for example — these organisms in the gut influencing the brain — it's clearly bidirectional. That's just one illustration, but it's something I think is important for us to reflect on. I'd really welcome your comments.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you. I will gather a few comments first and then ask the panellists to respond to several together. Diane, thank you — those were great comments. Henry, I'll turn to you next.



Henry Simmons, *Chief Executive, Alzheimer Scotland*

I'm Henry Simmons, Chief Executive of Alzheimer Scotland. What I wanted to share is that, back in around 2018, we developed an initiative called Brain Health Scotland. The purpose behind it was essentially to start developing brain health memory clinics and to engage communities through education programmes focused on prevention. We've worked very closely over the past several years to do that.

We did wrestle for quite a long time with how this sat alongside our role as an Alzheimer's-focused dementia organisation and campaigning body. And what we ultimately decided was that trying to merge everything together did not really work that well. Instead, we opted for a co-branded approach.

So we established Brain Health Scotland as our prevention arm, and we've used that approach for the past four or five years. It's allowed us to develop new initiatives across primary schools, education for children, youth sports, athletes — really across the public health and public engagement space. Importantly, it's opened doors that we probably would never have opened simply by approaching communities as Alzheimer Scotland alone.

We've supported many thousands of primary schools to help them understand how to look after their brain, supported families, and from our perspective, it's worked extremely well. Having a dedicated prevention arm has allowed us to engage with mainstream parts of communities that we wouldn't normally reach, and that's proven to be very successful.

Alongside that, we're also going through a gradual transition in which our centres — our resource centres — are becoming not just dementia resource centres, but *brain health and dementia* resource centres. Working from the principle of 'it's never too early, never too late,' we're seeing a real sense of change within the movement, and the two strands are coexisting quite well.

Looking ahead, I don't think we'll lose our strong influence or our campaigning role around Alzheimer's and dementia. In fact, we've gained a great deal by engaging a broader set of

communities, businesses, and the public. For us, this has grown into a substantial programme, now largely self-funded through Alzheimer Scotland's resources, while also attracting significant support from corporate partners and others who want to engage with us. I think we've found a sweet spot.

We've also run a very strong brain health clinic, with two years of evaluation — a walk-in brain health clinic in the centre of a large Scottish city, Aberdeen. Around 200 people walked in off the street not seeking a diagnosis, but presenting with secondary care concerns and needing significant time and support just to work through risk assessments.

We now have a model that we'd like to roll out and develop further. So I think it *can* be done. I don't think we should try to squeeze everything together. By being strategic, we can balance two brands without too much difficulty. And I don't think that's a bad place for Alzheimer's organisations to be over the next five to 10 years.

I hope that's helpful.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Absolutely, I really appreciate those comments. I'll just add a brief reflection as I turn back to the panel. What you've shared aligns, in an informal sense, with what I've been hearing from colleagues working in communities across the United States: that *brain health* can be a label that resonates strongly and opens doors that might otherwise be difficult to open — particularly across different generations — if Alzheimer's alone is the label placed front and centre.

So thank you for those perspectives. Let me turn back to the panellists now. Any reactions so far to what you've heard?



Giovanni Frisoni, *Full Professor of Clinical Neuroscience, University of Geneva; Director, Memory Clinic, Geneva University Hospital*

If I may say, I hear what's being said. Some of us use this brain health concept — this is what we did ourselves — as a flagship concept, as you said, Rob, to open doors. But once you've opened the door, you have to propose something concrete, something that actually makes a difference. And that's exactly what we've done. In Geneva, we were fortunate enough to engage with politicians who were sensitive to prevention.

We proposed a patient journey for secondary prevention, using brain health as an umbrella concept. But we did not "sell" brain health itself. The Ministry of Health was not funding a brain health concept — it was funding a patient journey — one that includes activities not already covered by insurance. It was something additional. So we used brain health to open the door, and then to introduce new activities, a new project, and in this case a new clinical programme. That is very much in line with what I'm hearing from others as well.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

And I also see comments in the chat, and I appreciate you having that dialogue there as well.



Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*

Just to respond to Diane's point about the brain and the body — it's a very well-taken point, as I mentioned in the chat. The brain economy, which I've been speaking about, is really about bringing a new narrative and refreshing and reinvigorating conversations with political and business leaders. That's the point of it.

It's not meant to suggest that our brains are disconnected from our bodies. It's meant to be holistic, including spirituality. Last week in Davos, for example, we were having brain economy conversations with First Nations spiritual community leaders and with East–West traditions, including people drawing on Confucian traditions. So body, spirit and soul are absolutely all part of this.

What we're really trying to do — something Lenny is perhaps particularly expert in — is developing new narratives that cut through the noise and refresh debates. And that raises interesting questions about how you create organisational change around brain health and the brain economy.

I mentioned in the chat that the University of Texas Medical Branch Academic Medical Center has announced itself as the first brain economy organisation in the world, so it's worth looking at how they're approaching this. We're also seeing companies like JLL, the world's largest real estate firm, engaging with the brain economy at an organisational level, as well as companies like BP. So there's a broader question here about organisational transformation — how institutions engage with these ideas in a way that respects their history and core mission while also leveraging this new economic transition. That's something Kana Enomoto could speak to in more detail, as she's an expert in this area, but I wanted to add those points to the discussion.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you. I appreciate that. Seb?



Seb Walsh, *Researcher, University of Cambridge*

Thanks, I wanted to make two quick points. Your first question, Robert, was about whether anyone has done any empirical work to look at this. We have done some work on that — albeit with a small sample — through interviews with policymakers in England about their views on dementia prevention.

We included a section where we asked specifically about their views on the terms *dementia prevention, dementia risk reduction*, and *brain health*. What we found was a rather pleasing non-consensus: we had roughly equal numbers of policymakers liking and disliking each of the terms. There was, however, a general sense that *brain health* might be a more accessible term particularly for younger audiences. It's positive and empowering — something people feel they can improve.

We also heard some interesting reflections about the distinction between *risk reduction* and *prevention*, and what people understand those terms to mean. Taken together, this supports what we've been hearing today: that different terms can be useful for engaging different audiences, and that this can be a coherent strategy.

The one note of caution I'd add, speaking as a dementia researcher, is that if we seek to claim the term *brain health*, we need to do so with some humility. Neurological health and brain health can mean many different things. I don't think it always reads well when a paper or policy document labels itself as being about brain health, and then turns out to be solely about dementia.

There's a risk in using these terms synonymously. We can use them strategically and advantageously, but we should also remain epidemiologically coherent and honest in our language. Otherwise, it would be a bit like someone in the epilepsy field talking about *all* of brain health purely through an epileptic lens — we'd probably baulk at that.

So yes, there's a strategic use here, but it needs to be applied carefully. Thanks.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

I've been wondering about the same thing, particularly in picking up on your last point about labels. In our space, we're used to talking about broader concepts — chronic care, for example — and about how we work alongside others who share overlapping concerns. At the same time, I've also been wondering — and I don't have strong personal answers to this yet — about how much this becomes a contested space versus a collaborative one, especially when people approach it from quite different starting points, such as mental health or other areas. So I'm really glad you raised that issue, and I'm interested in hearing more thoughts on it.



Sylvain Piquet, *General Manager, Five Lives*

Yes, thank you very much. I'm very happy to be here — thank you, Lenny, for the invitation. These are great discussion points. I'm Sylvain Piquet, General Manager at Five Lives. We're a digital therapeutics company, and we've been operating for about six years now. We work in both the UK and France, and we partner with organisations such as Oxford University and the FINGERS network — we've been a FINGERS partner since 2022. What we do is build FINGERS-inspired applications for the prevention and remediation of cognitive decline and dementia.

Our first app is *Five Lives Brain Health*, which focuses on dementia risk prediction for the 50-plus population. More recently, we launched *Five Lives Care* for MCI remediation.

The point I'd like to make to this group is that, as a company, we're trying to leverage anything related to brain health economics. We work with clients in the insurance sector in the UK and France, as well as with pharmaceutical companies such as Lilly and Servier. We're also actively pursuing reimbursement pathways, particularly in France, where there is a new and evolving framework. One of the main challenges we see is that Europe is not yet as advanced as the United States — particularly Texas and California — when it comes to the broader concept of brain health economics. What we've learned over time is that our clinical investigations need to focus on more than just patient outcomes, which are obviously critical. We also need to demonstrate health care value creation — value-based health care.

In prevention, for example, we can show reductions in health care consumption. The brain and the body are a single entity, and when people engage in dementia prevention, we can measure reduced health care usage, because the prevalence of age-related chronic conditions decreases slightly, as demonstrated by FINGERS and other studies. In effect, you can postpone the onset of clinical conditions by a couple of years. Another example is MCI remediation, where you can improve quality of life for carers and enable remote patient monitoring — so people only need to return to care settings when necessary.

So the core point I want to make is that it's critically important for initiatives like the Texas Brain Health Economy Initiative to spread, so that we can build robust frameworks to measure health care value creation.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Okay, great. Thank you very much. That point on measurements is well taken. Timothy.



Timothy Daly, *Public Health Researcher Bioethics Program, FLACSO*

Thank you, good afternoon, and thank you very much for a very stimulating panel. I have a comment, and then a question for each of the panellists.

I'll start with the comment. Words are not neutral — and to pick up on your point, Robert, about whether a concept like brain health distracts from disease silos, I'd argue that this really matters because of how language shapes where research money goes and how policy is made. If we look at brain health in the dementia and Alzheimer's space, it's currently framed very much through a high-risk approach — antibodies, biomarkers, and increasingly lifestyle interventions.

But the question I want to put to the panellists relates to health inequalities. If we look at the epidemiology of dementia, we see that in high-income countries there are clearly positive trends — trends we might want to export to the rest of the world, if we could. Even though societies are ageing and the overall "cake" of dementia burden is getting bigger, the slice represented by the age-adjusted prevalence of dementia is actually shrinking in those high-income countries.

That seems to be the result not so much of specific actions like the availability of anti-amyloid antibodies or even individual lifestyle changes, but rather something we could understand through a WHO lens of health inequalities. That's an aspect I don't think we've discussed very much today, and I'll share some relevant literature on this point (Walsh et al. 2022; Daly et al. 2026).

So my question is: how does each of the panellists see the issue of health inequalities? To use a metaphor, if we think about the triangle Giovanni presented around the high-risk approach, beneath that there is also the issue of primordial prevention — the invisible part of the iceberg which consists of health inequalities. Who gets access to memory clinics? Who has access to good brain health across the life course?

I would be very interested to hear how each panellist thinks their approach can help address health inequalities more broadly, and brain health inequalities in particular. Thank you.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you. I believe that Fred had to unexpectedly jump off, with his apologies. So, Lenny, I might call on you as well, effectively as a stand-in panellist for that. With that, are there any reactions from the panellists to Timothy's comments?



Giovanni Frisoni, *Full Professor of Clinical Neuroscience, University of Geneva; Director, Memory Clinic, Geneva University Hospital*

I believe that in the long term dementia prevention will rely on a range of interventions. These will span from lifestyle approaches, including primordial prevention based on societal and environmental changes, to more targeted interventions such as monoclonal antibodies.

And when it comes to interventions like monoclonal antibodies, the risk of inequalities is clearly very high.

However, in low-income countries, lifestyle-related interventions are critically important. The 14 modifiable risk factors account, in principle, for about half of dementia cases. If we were able to implement effective interventions focused only on lifestyle factors — many of which are relatively straightforward to implement even in low-income settings — we could already prevent millions of cases.

The challenge in high-income countries will be different. If and when monoclonal antibodies become available for prevention the risk will be that we focus the entire prevention narrative on those therapies and forget that there is something else that is at least as important and as effective: addressing vascular risk factors, metabolic risk factors, and lifestyle and primordial interventions.

I therefore believe that dementia prevention, and this multi-risk-factor model in particular, lends itself well to being exported to low-income countries. It does not necessarily require the resources of high-income health systems to be effective.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you for that reaction. I'm really pleased to see that a number of people have comments. By my count, we have time for roughly four minutes per comment or reaction, so let's move through them. I'm looking forward to the discussion. Steven.



Steven Lewis, *Clinical Neurologist; President, World Federation of Neurology*

Thank you so much. I'm Steve Lewis. I'm a clinical neurologist, and for the last 27 days I've had the honour of serving as President of the World Federation of Neurology. I've also been a trustee for more than 10 years.

For those who may not know the organisation, very briefly: the World Federation of Neurology is a consortium — a federation — of neurological societies, with 126 member societies as of today. For at least the past 15 years, brain health has been an explicit part of our mission.

The mission of the WFN is, quote, *"to foster quality neurology and brain health worldwide"*, a goal we seek to achieve by promoting global neurological education and training, particularly in under-resourced parts of the world.

So I just want to emphasise that brain health has been a really important part of our mission for a long time. Although we address all neurological diseases — whether or not they affect behaviour or cognition — when we use the term brain health, we probably also include the peripheral nervous system. That said, there's no question that disorders affecting behaviour and cognition are often what both professionals and the public think of first when they hear the term brain health. In summary, I see brain health as a very useful construct, particularly when it relates to disorders that affect behaviour and cognition. And with that, thank you again for the invitation.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you, Steve, I really appreciate that comment. And to the panellists, please do feel free to jump in with reactions as you have them to what we're hearing. Gustavo?



Gustavo Sevlever, *Director of Education and Research and Head of Neuropathology, FLENI*

Thank you, and thank you for including me in this very interesting discussion. I'd like to briefly raise a couple of points.

First, in Latin American low- and middle-income countries, we are facing what I would describe as a demographic bomb. Birth rates have fallen by around 40% over the last four years, while life expectancy in the general population is now close to 80 years. Societies are becoming older and older, and this trend—at different speeds — is happening across Latin America.

In that context, I want to highlight the experience of *LatAm FINGERS*, which has been mentioned earlier. This project is now coming to an end. It has involved 12 countries and 13 centres across Latin America, working together for the first time ever using the same protocol. We are now completing data collection and analysing the results, and I think this represents a very important initiative.

We are not explicitly using the term *brain health* in this project, but the philosophy is very much aligned with it. Brain health serves as an umbrella concept, and in that sense it is extremely useful. The programme focuses on people at risk of developing dementia or Alzheimer's disease, using an intensive, immersive intervention model that many of you will be familiar with.

I think this kind of innovation is clearly feasible in Latin American low- and middle-income countries, particularly in terms of behavioural change. The real challenge now is how to implement these approaches at the population level.

So the challenge ahead is how we take all the evidence and funding generated through the various FINGERS initiatives around the world, and translate that into large-scale population approaches that support behaviour change and deliver a real, concrete brain health strategy.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you very much, that was very interesting. I'm also noting the robust conversation happening in the chat, so thank you for that as well. Oscar, good to see you — over to you for our next comment.



Oscar Lopez, *Professor of Neurology, University of Pittsburgh*

I think all these comments are very useful, and I'm glad to see that the concept of brain health is moving forward. But I assume that most of these interventions need to be done when people are in mid-life.

The most receptive population for changing lifestyles tends to be people with higher socioeconomic status. People in lower socioeconomic groups often do not receive — or do not connect with — the message that changing lifestyle now will lead to better outcomes in the future.

Another issue, at least in the United States, is that people tend to retire at age 65. Many have had very productive working lives, and then at 65 they retire. Those with resources can continue to stay cognitively engaged and adopt lifestyles that support brain health.

There is, however, another group — people who need to continue working to supplement their pension. They are active, but often for the wrong reasons.

All of these complexities need to be taken into account when we talk about brain health. The concept is right, but there are social and structural complexities that we need to address.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Oscar, just reflecting on your comments — and knowing that, in addition to your research work, you've remained very active in community settings and clinical care — do you have an instinct about what kind of framing resonates most with people we want to motivate to think about their brain health, in part to prevent dementia? Put very simply, is it more effective to appeal to fear — *you don't want dementia* — or to use a more positive framing around brain health?



Oscar Lopez, *Professor of Neurology, University of Pittsburgh*

Just two points. First, in the Cardiovascular Health Study, where we followed people up to age 100, after age 93 only about 12% were cognitively normal. So clearly, we have to do something. What seems to resonate most with people is when we talk about the brain–heart axis. That framing opens the door to lifestyle changes and other preventive actions. As has been mentioned today, the brain–heart connection seems to trigger motivation.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Appreciate the insight. Lucy, thank you.



Lucy Wilson, *Chief Communications Officer, UK Dementia Research Institute*

Thanks everyone for the conversation. This is very pertinent for us, not least because we updated our vision to *healthy brain ageing for all* about 18 months ago. We went through a substantial process to get there, including extensive focus groups with our stakeholders. So I just wanted to share a few reflections from our perspective.

One of the key strengths of this narrative for us has been the ability to reframe dementia away from being seen as an inevitable outcome of ageing, and instead as something that is influenced across the life course. That was a major driver behind the update to our mission. In the UK context, this framing has been particularly helpful in our engagement with policymakers, because it allows us to speak more directly about prevention, productivity, and the growth agenda. That has been very valuable.

It's also been important internally. As an institute that is distributed across multiple universities around the UK, having a unifying concept like *healthy brain ageing for all* has really helped with identity and community building. When we host internal events, we frame them around this idea, and we see strong engagement. Researchers at all career stages can articulate it and understand the bigger picture they are contributing to.

In terms of drawbacks — if that's the right word — we do find that we often need to move quite quickly into a second layer of explanation. That's because of the challenges others have mentioned today: questions about where brain health begins and ends, and what the UK Dementia Research Institute's specific role is within that space. As a result, we rely quite heavily on supporting and secondary messaging—about the breadth of conditions we cover and the parts of the research pipeline we focus on. We're conscious not to oversell or imply that we're trying to address the entirety of brain health.

So those are just some reflections from our point of view.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

You actually got to the question that was forming for me in your last comment. In particular, I was wondering whether, when people come to you — metaphorically — hearing *brain health*, they're expecting a broader conversation than dementia. In other words, have you had to expand what you're talking about to meet people's broader conception of what brain health incorporates?



Lucy Wilson, *Chief Communications Officer, UK Dementia Research Institute*

A bit of both. We always frame it clearly in relation to dementia, so it's not misleading up front. But of course, we have sleep researchers, people working on DNA repair, virology, and so on. So we are genuinely building knowledge that extends beyond a single neurodegenerative disease, and that breadth is real. In that sense, the framing does open things up for us as well.



Sandy Gleysteen, *Executive Producer, Women's Alzheimer's Movement, Cleveland Clinic*

Thank you so much for having me. I'm really excited to be here—this has been a great conversation. I work with the Women's Alzheimer's Movement, which is now part of the Cleveland Clinic and was started many years ago by Maria Shriver.

I wanted to raise a couple of points. First, picking up on Harris's emphasis on narrative and the need to change it: Maria helped change the narrative around women and Alzheimer's back in 2010, working with the Alzheimer's Association — Rob, I know you were part of that — by highlighting the fact that two out of three people living with Alzheimer's are women. We've really seen the power of narrative change take hold through our work. One of the reasons we talk a lot about the narrative around brain health is that, as many people have said today, it offers a sense of empowerment. It's not framed as a terrifying, dark neurological disease, one people can't see. Talking about brain health allows us to talk about tangible things — diet, sleep, lifestyle — issues people feel they can engage with.

In addition to focusing on narrative change through communication and public education, I also wanted to pick up on the point about secondary prevention. We've opened the only Alzheimer's prevention centre designed specifically for women, at the Lou Ruvo Center for Brain Health, which is part of the Cleveland Clinic in Las Vegas. The naming there is deliberate as well, calling it more neutrally a center for brain health rather than one dedicated to Alzheimer's or neurological diseases in general. Again, that's aimed to make the center feel less disease oriented and more like a place you might actually want to visit. Also, to Oscar's point about needing to intervene early to prevent Alzeheime's, this centre focuses on women aged 30 to 60 who are at increased risk for the disease. As we know, once you're over 60, the opportunity for prevention is much more limited. So this is about providing not just education, but also a place, the means, and the information to be proactive in the quest to delay or prevent Alzheimer's. One of the financial challenges we've encountered is that the centre relies heavily on philanthropy. Insurance reimbursement is not currently friendly to prevention — including for Alzheimer's — so insurance reimbursement is an important structural issue to keep in mind as we work on affecting policy. Alongside that, we clearly need much stronger education in medical schools around brain health and dementia prevention–and pretty much anything to do around women's health.

Finally, after attending JPMorgan and hearing extensively from technology companies working on AI and data collection, I want to emphasise the importance of data quality. As we move into this new world of large-scale data and AI-driven models, we need to ensure that the data being used is accurate and truly representative of what's happening.

This has been a major issue for us at the Women's Alzheimer's Movement, as we've highlighted the historical lack of research into women's brain health and women's health more broadly. We need to be careful that new AI models don't simply reinforce the same old biases and narratives by feeding in old and biased data for researchers to work with.

So my plea would be that, as we shape new narratives, we do so deliberately and responsibly—not just around sex differences, but also around social and economic factors. I know everyone on this call is sensitive to these issues, and anyone brought together by Lenny certainly is. We remain focused on women at high risk, and it's been great to be part of this discussion. Thank you.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you, I appreciate that. We'll wrap up with a brief comment from Giovanna, then we'll come back to the two panellists who are still with us, and Lenny will close us out.



Giovanna Lalli, *Head of Neurodegeneration Biology, LifeArc*

Yes, thank you so much. This has been a very interesting conversation. I work for LifeArc, an independent medical research organisation that supports translational research, particularly in rare diseases.

We were actually in Davos last week together with Harris and colleagues, and very much part of the brain health discussions there. From our perspective, this is especially relevant in the context of early detection, which clearly sits within the broader brain health agenda.

That's why we are sponsoring finger-prick blood tests for Alzheimer's disease, as well as other early-detection projects aimed at achieving more accurate and earlier diagnosis of different forms of dementia — not just Alzheimer's disease.

Our ambition is to combine health data with advanced data science and new technologies, to enable multimodal data integration and improve differential diagnosis at an early stage.

I also wanted to highlight that the UK is quite active in the brain health space. You've already heard about Brain Health Scotland, but there are also initiatives such as the network of brain health clinics led by Vanessa Raymont in the UK. She has extensive first-hand experience with patient and public engagement through brain health clinics, and would be another valuable person to speak with.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you, I really appreciate that. Giovanna, thank you as well. And Harris, thank you so much for being active in the chat throughout and for engaging so thoughtfully with people there. Any final closing comments you'd like to make?



Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*

This has been a wonderful conversation. Thank you, everyone, for the debate and for really getting into the weeds — thinking about actionable models, pitfalls, and practicalities. I suppose the only thing I'd add, Rob, is something very practical. We don't have all the answers, and that's precisely why Lenny has been so smart in bringing all of us together. If anyone wants to join any of the platforms I mentioned earlier, you'd be very welcome. At least from my side, this is a big community movement, and we really value bringing new people in.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you so much for spending your time with us today, Harris — we really appreciate it. And the same to you, Giovanni. Thank you for joining us. I'd love to hear your closing thoughts.



Giovanni Frisoni, *Full Professor of Clinical Neuroscience, University of Geneva; Director, Memory Clinic, Geneva University Hospital*

Yes, what I hear is a general enthusiasm around the concept of brain health, which has really put its finger on something we perhaps took for granted as a society, but shouldn't have. The challenge, as I've heard from all of you, is that each of us comes to this with a different perspective and therefore gives different content to the concept of brain health. Its interpretation varies across organisations and actors. But I actually think that is how it should be. Brain health is not a unidimensional concept—it cannot be addressed in a unidimensional way. It is a multidimensional space. So I think this has been a very good and productive discussion.



Robert Egge, *Chief Public Policy Officer, Alzheimer's Association; President, Alzheimer's Impact Movement (AIM)*

Thank you so much—I really appreciate that. And Lenny, I know I speak for everyone in thanking you for your leadership of the World Dementia Council and for convening us around this topic. I'll turn to you to close us out.



Lenny Shallcross, *Executive Director, World Dementia Council*

Thanks, Rob, and thank you, everyone. As I haven't said much on the substance of brain health until now, I'll use the last few minutes to offer some concluding reflections.

A couple of observations. I was struck by Seb's point about how you make brain health something genuinely new, rather than simply Alzheimer's rebranded. Seeing it not as a tactical way of achieving what you were already doing, but as something that has value in its own right, something that is genuinely different and broader than a single disease.

Also, as we have covered today, as a concept, there is clearly a lot of power in brain health. But there is also a lot of risk. Here in the UK the last government, just before they effectively fell apart, launched what they called a *major conditions strategy*, which bundled together a number of diseases. In practice, it was more a strategy to not do much about a lot. Joining things together doesn't necessarily make them the sum of their parts even.

And there's also a history in the dementia field that we need to be mindful of. Dementia-friendly communities took off, were copied and replicated, and absorbed a great deal of political energy. But in the end, there was little to show for it. I live in Hackney, which is apparently a dementia-friendly community, but the one thing I can't access is treatment. My bus driver may be dementia-aware, but my health system isn't paying for treatments. The risk here is that one horse advances while the other is left behind: the need to diagnose people, treat people, fund research, improve care, and respond to a rapidly changing treatment landscape. Brain health can easily become the attractive concept that politicians talk about, and then feel they've done their bit. That is the caution.

So, my conclusion is this: there is huge potential in brain health as something new and distinct, and many people on this call have articulated what that could mean. But there is also a real risk that it leaves behind the equally critical work of diagnosis, treatment, research funding, and care. How we ride both horses — how we advance both agendas together — is the challenge ahead.

Thank you very much, Rob, for chairing this discussion. Thank you to everyone for joining. We'll be in touch about the transcript. Thanks to everyone who spoke. Wherever you are — morning, afternoon, or evening — I hope you have a good rest of the day. Thank you very much for joining.

Brain health advocacy

Meeting chat

Kana Enomoto, *Partner, McKinsey Health Institute*
https://www.mckinsey.com/mhi/our-insights/the-human-advantage-stronger-brains-in-the-age-of-ai
We're honored to have WDC and Alzheimer's Association as Pathfinders of the WEF Brain Economy Action Forum
https://initiatives.weforum.org/brain-health-action-forum/community
The Global Brain Economy Initiative is live, and you can get connected here:
https://www.globalbraineconomy.org/

Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*
If useful, you can join the Rice University DeLange Brains in Society Conference in March in Houston.
https://www.linkedin.com/feed/update/urn:li:activity:7421891898262327297/
Also the UCLA Brain Health Summit in late March
https://www.linkedin.com/feed/update/urn:li:activity:7421640782857711616/

Sandy Gleysteen, *Women's Alzheimer's Movement, Cleveland Clinic*
At the Women's Alzheimer's Movement, we run an AD prevention center designed for women around exactly this issue.
https://my.clevelandclinic.org/locations/nevada/specialties/cognitive-disorders/wam-prevention-center

Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*
Dementia researchers cheer Texas voters' approval of $3 billion funding initiative
https://www.science.org/content/article/dementia-researchers-cheer-texas-voters-approval-3-billion-funding-initiative

Frank Gunn-Moore, *Professor of Molecular Neurobiology, University of St Andrews*
I was recently talking to some clinical friends, and they particularly mentioned that we (certainly in the UK) don't teach our current medical students anything on dementia (or it's extremely out of date) and so the concept of brain health doesn't exist medically. Personally, I think students should be taught this as a way to change the narrative.

Ricky Kurzman, *Senior Director, Global Affairs Advocacy, Eisai*
If (Brain Health) + (Brain Skills) = Brain Economy, how much of Brain Health is composed of Alzheimer's? Or another question: how much of the Brain Economy is a function of cognition and function, which are the treatment outcomes measured in Alzheimer's research?

Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*
DPRIT will also inspire California to put more money into dementia prevention. See the emerging California push now being influenced by DPRIT towards dementia prevention.
Researchers Back $23 Billion State Science Fund in Response to Deep Federal Cuts
https://www.sfpublicpress.org/researchers-back-23-billion-state-science-fund-in-response-to-deep-federal-cuts/

Diane Bovenkamp, *Vice President of Scientific Affairs, BrightFocus Foundation*
This is the NASEM "Understanding Brain and Body Bidirectional Interactions for Brain Health and Disease" event:
https://www.nationalacademies.org/projects/HMD-HSP-25-02/event/45148
The brain is not in isolation.

Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*
Totally! We are not brains in jars. The brain health / brain capital / brain economy framing is a new and fresh narrative to re-engage and re-inspire actors, but it is of course linked to spirituality, body (gut, immune, cardiovascular, etc.).

Diane Bovenkamp, *Vice President of Scientific Affairs, BrightFocus Foundation*
Excellent. This concept could be incorporated in research funding as well as care. Looking forward to partnering globally as funders—there is no geopolitical border to finding the next treatment or prevention.

Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*
Agree! You may like to see how UTMB is linking brain economy to their science and clinical care platforms as one anecdote.
https://www.utmb.edu/news/article/utmb-news/2026/01/19/the-university-of-texas-medical-branch-adopts-the-world-s-first-brain-economy-institutional-model
Kana Enomoto can speak to this too.

Seb Walsh, *Researcher, University of Cambridge*
Qualitative study with English policymakers, including views on language:
Exploring English policymakers' attitudes towards dementia risk reduction: A qualitative study - PubMed

Diane Bovenkamp, *Vice President of Scientific Affairs, BrightFocus Foundation*
Good point. Many affected individuals resonate with their diagnosed disease. It will be important in communications to help people understand that improving brain health in general could help many conditions. This also applies to funders and clinicians/scientists who are disease-focused. Looking forward to ideas from this group on integration.

Wiesje van der Flier, *Executive Director, Alzheimer Nederland*
I resonate with Diane's point. Brain health is a very helpful concept and clearly the direction we are heading. Nonetheless, it is important to keep dedicated budgets to solve the challenges of Alzheimer's disease and other dementias. The risk is that brain health dilutes these budgets — not only toward other neurodegenerative diseases like Parkinson's or ALS, but also toward the very broad spectrum of mental disorders.

Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*
For the purpose of Lenny's paper, I'd like to flag some major brain health initiatives emerging:
– Paris Brain Institute World Brain Health Forum that took place in January
– Scottish Brain Science International Brain Health Forum in May in Edinburgh, Scotland
– Lancet Brain Health Commission (Andrea Winkler, Claudio Bassetti)
– Atria Health World Brain Health Forum
– Davos Alzheimer's Collaborative African Brain Health Strategy

Timothy Daly, *Public Health Researcher Bioethics Program, FLACSO*
Some reading on health inequalities in brain health and dementia:
Walsh et al. (2022). A whole-population approach is required for dementia risk reduction.
The Lancet Healthy Longevity, 3(1), e6–e8.
https://doi.org/10.1016/S2666-7568(21)00301-9
WHO Bulletin article:
https://cdn.who.int/media/docs/default-source/bulletin/online-first/blt.25.293220.pdf

Giovanni Frisoni, *Full Professor of Clinical Neuroscience, University of Geneva; Director, Memory Clinic, Geneva University Hospital*
You may be interested in this conference:
https://www.icopad.ch/en/ in February in Geneva, Switzerland

Suzi Leather, *Chair, Alzheimer's Society*
The Manchester Brain Health Centre, which Alzheimer's Society is funding in partnership, is a great example of Giovanni Frisoni's call for secondary prevention.

Diane Bovenkamp, *Vice President of Scientific Affairs, BrightFocus Foundation*
WAM is doing amazing work to promote women's brain health. BrightFocus is a founding member of WHAM (Women's Health Access Matters), making the economic case for funding women's research, including brain health. The latest report is in partnership with financial entities, nonprofits, and academic organisations.
https://whamnow.org/wp-content/uploads/2025/01/WHAM-report-011525.pdf

Lucy Wilson, *Chief Communications Officer, UK Dementia Research Institute*
At the UK Dementia Research Institute, we break down "Healthy brain ageing for all" into Predict, Prevent, and Personalise, alongside public participation.
https://www.ukdri.ac.uk/our-story/about-us/vision

Diane Bovenkamp, *Vice President of Scientific Affairs, BrightFocus Foundation*
https://thewhamreport.org/

Sandy Gleysteen, *Women's Alzheimer's Movement, Cleveland Clinic*
Harris, see you at UCLA in March! I'm working with Helen to sort out what WAM will be doing.

Suzi Leather, *Chair, Alzheimer's Society*
Great session, Lenny. Thank you.

Harris Eyre, *Executive Director, Global Brain Economy Initiative; Co-lead, Brain and Society Initiative, Rice Brain Institute*
Reacted with ❤️😃

Diane Bovenkamp, *Vice President of Scientific Affairs, BrightFocus Foundation*
Agreed, great session. Looking forward to the transcript and potential action items.

Anne Pastuszak, *Senior Director, Research and KTE, Alzheimer Society of Canada*
Alzheimer Society Canada is weighing the brain health narrative for advocacy. This conversation has been stimulating and very helpful. Grateful for the shared experience and caution.

Giovanna Lalli
Thank you for a very insightful discussion—Sandy and Diane, I'd love to connect with you.

Giovanni Frisoni, *Full Professor of Clinical Neuroscience, University of Geneva; Director, Memory Clinic, Geneva University Hospital*
I LOVE this conclusion.

Seb Walsh, *Researcher, University of Cambridge*
Reacted with

Emily Hindle, *Head of Policy, Alzheimer's Society*
Thanks very much for a helpful meeting.

Sandy Gleysteen, *Women's Alzheimer's Movement, Cleveland Clinic*
Thank you so much, Lenny. Brilliant as always.