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Strengthening Alzheimer's Disease Policy and Management in Asia Pacific: Pathways to Progress

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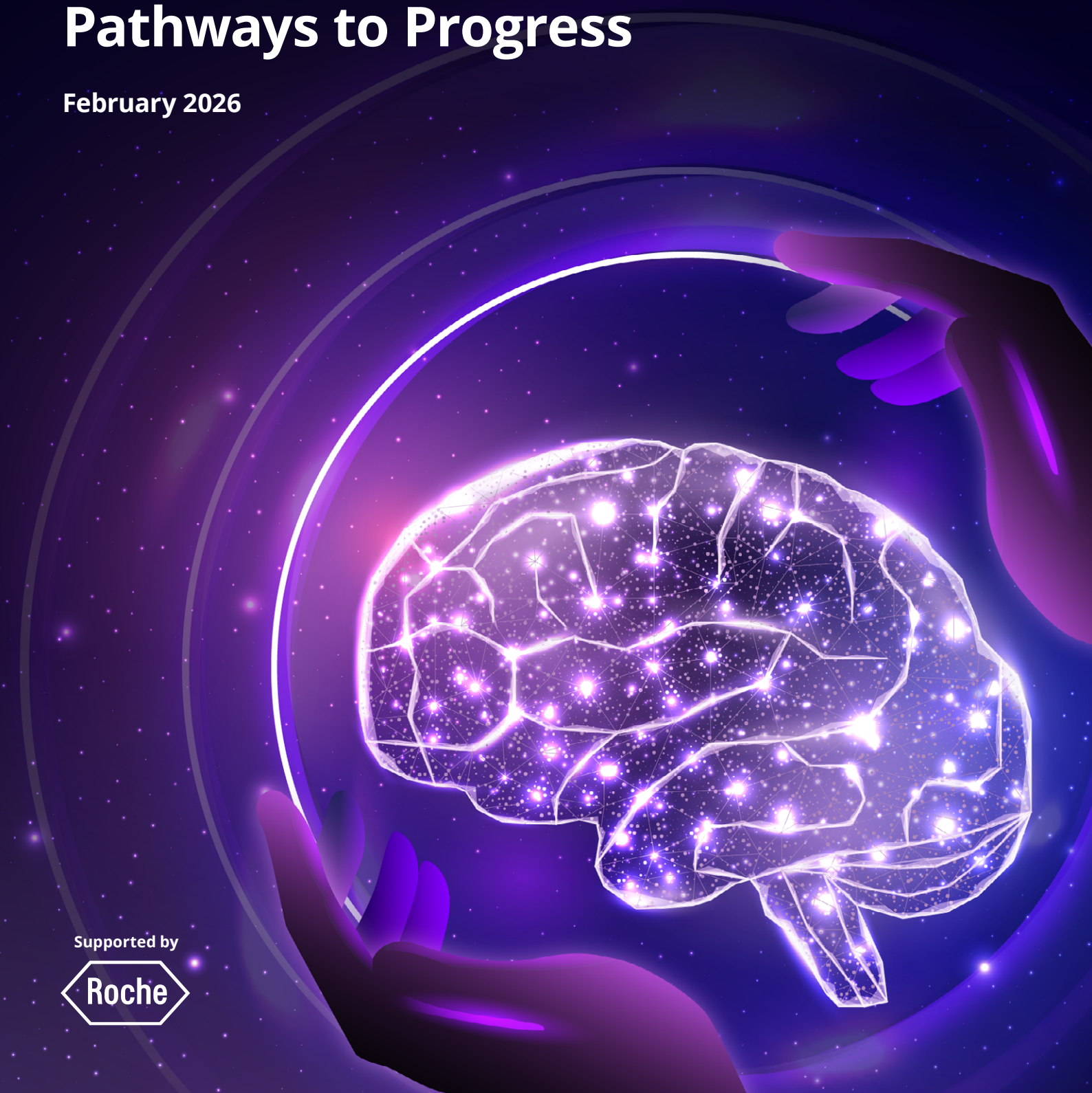

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Abbreviations & acronyms

Organisation & programme names	
Abbreviation / Acronym	**Full term**
AAIC	Alzheimer's Association International Conference
ACO	Accountable Care Organization
ADI	Alzheimer's Disease International
ADNeT	Australian Dementia Network
AMED	Japan Agency for Medical Research and Development
ASEAN	Association of Southeast Asian Nations
CHeBA	Centre for Healthy Brain Ageing
CMS	Centers for Medicare & Medicaid Services (United States)
CRE-VCD	Centre of Research Excellence in Vascular Contributions to Dementia
CUHK	The Chinese University of Hong Kong
DAAC	Dementia Australia Advisory Committee
DICC	Dementia Integrated Care Center (Taiwan)
DREAMT	Dementia, Regional and Remote, Empowering Aboriginal and Torres Strait Islander Medicine & Telehealth Project
FDA	Food and Drug Administration (United States)
GUIDE	Guiding an Improved Dementia Experience Model (CMS)
HAICDDS	Hospital-Associated Integrated Care for Dementia System (Taiwan)
HKGS	Hong Kong Geriatrics Society
IWG	International Working Group (AD diagnostic criteria)
JCCPA	Jockey Club Centre for Positive Ageing
JOYALZ	JOint Alzheimer's Disease Registry (South Korea)
JSDR	Japanese Society for Dementia Research
KBASE	Korean Brain Aging Study for the Early Diagnosis and Prediction of Alzheimer's Disease
KDA	Korean Dementia Association

KDRC	Korea Dementia Research Center
KNA	Korean Neurological Association
K-DReaMS	Korean Dementia Registry and Monitoring System
MOH	Ministry of Health
NCMD	National Centre for Monitoring Dementia (Australia)
NHIS	National Health Insurance Service (South Korea)
NHMRC	National Health and Medical Research Council (Australia)
NHS	National Health Service (United Kingdom)
NIA-AA	National Institute on Aging – Alzheimer's Association
OECD	Organisation for Economic Co-operation and Development
SEARO	WHO South-East Asia Regional Office
UNSW	University of New South Wales
WHO	World Health Organization
WPR	WHO Western Pacific Region
WiSE	Well-being of the Singapore Elderly Study

Others	
Aβ	Amyloid beta
Aβ42/40	Amyloid beta 42/40 ratio
AD	Alzheimer's disease
AMT	Abbreviated Mental Test
APAC	Asia Pacific
BBBM	Blood-Based Biomarker
CALD	Culturally and Linguistically Diverse
CBR	Community-Based Rehabilitation
CHW	Community Health Worker
CME	Continuing Medical Education
CSF	Cerebrospinal Fluid
CT	Computed Tomography
DALY	Disability-Adjusted Life Year
DMT	Disease-Modifying Therapy
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
Dx	Diagnosis
Dx + Tx	Diagnosis plus Treatment
EAP	East Asia and the Pacific
EEG	Electroencephalography
EHR	Electronic Health Record
GDP	Gross Domestic Product
GPCOG	General Practitioner Assessment of Cognition
HTA	Health Technology Assessment
ICER	Incremental Cost-Effectiveness Ratio
INT$	International Dollar
KR	Republic of Korea (South Korea)
LMIC	Low- and Middle-Income Country
LMICs	Low- and Middle-Income Countries

mHealth	Mobile Health
MCI	Mild Cognitive Impairment
MEDLINE	Medical Literature Analysis and Retrieval System Online
MMSE	Mini-Mental State Examination
MoCA	Montreal Cognitive Assessment
MRI	Magnetic Resonance Imaging
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NZ	New Zealand
PBPM	Per-Beneficiary-Per-Month
PCP	Primary Care Physician
PET	Positron Emission Tomography
PLWD	People Living With Dementia
PPP	Public–Private Partnership
QALY	Quality-Adjusted Life Year
QALYs	Quality-Adjusted Life Years
SMS	Short Message Service
Tx	Treatment
UHC	Universal Health Coverage
UI	Uncertainty Interval
USD	United States Dollar

1. Foreword

"This co-publication brings together complementary perspectives from clinical leadership and health system strategy. Together, we seek to bridge the gap between scientific progress and policy action, supporting practical solutions that can be adapted across diverse healthcare contexts in the region."

Seung Hyun Kim, M.D. PhD.
President
Korean Neurological Association

Dementia stands among the most pressing public health challenges facing the Asia-Pacific (APAC) region, and Alzheimer's disease is its leading contributor. As populations age rapidly across the region, the growing burden of Alzheimer's disease is already placing significant pressure on individuals, families, health systems, and economies. Addressing this challenge requires not only strong dementia strategies, but also clearer focus on Alzheimer's disease itself.

While Alzheimer's disease is commonly addressed within broader dementia frameworks, there are compelling policy and system level reasons to examine it more directly. Alzheimer's disease accounts for the majority of dementia cases, drives long term care demand, and increasingly shapes future treatment and financing considerations. Without specific attention, Alzheimer's disease risks being diluted within broader ageing or dementia agendas, resulting in delayed diagnosis, fragmented care pathways, and insufficient system readiness for emerging therapeutic and diagnostic advances.

Recognising Alzheimer's disease as a policy priority in its own right allows governments and health systems to plan more effectively across the full care continuum, from earlier identification and timely diagnosis to treatment readiness, long term care, and data driven system oversight. It also strengthens accountability, supports more targeted investment, and helps ensure that systems are prepared to respond to future clinical and societal demands.

It is within this context that the Korean Neurological Association (KNA) and Deloitte have jointly developed this White Paper, Strengthening Alzheimer's Disease Policy and Management in APAC: Pathways to Progress. The report provides a structured, comparative assessment of Alzheimer's disease readiness across nine Asia–Pacific economies, examining policies, care pathways, system capacity, financing mechanisms, data infrastructure, and the roles of clinical and civil society stakeholders. By placing Alzheimer's disease explicitly at the centre of analysis, the White Paper aims to support more focused, forward looking decision making.

This co-publication brings together complementary perspectives from clinical leadership and health system strategy. Together, we seek to bridge the gap between scientific progress and policy action, supporting practical solutions that can be adapted across diverse healthcare contexts in the region.

We would like to express our sincere appreciation to the Advisory Panel of regional experts who provided invaluable technical guidance throughout the development of this White Paper. Their clinical, policy, and system level insights were instrumental in shaping the analytical framework, validating key findings, and ensuring that the recommendations are both evidence based and grounded in real world practice across APAC.

The findings of this White Paper are clear: while many APAC economies have made progress through dementia strategies, important gaps remain in Alzheimer's disease prioritisation, early diagnosis, data integration, and system preparedness. Addressing these gaps will require deliberate policy choices, sustained leadership, and collaboration across government, healthcare providers, and society.

We hope this White Paper will serve as a useful reference for policymakers, clinicians, and stakeholders seeking to strengthen Alzheimer's disease policy and management in a timely, equitable, and sustainable manner.

The opportunity for action is clear. Decisions made in the coming years will determine how effectively health systems across the Asia-Pacific region respond to the rising impact of Alzheimer's disease. Through this co-publication, we call on stakeholders to act with clarity, coordination, and purpose to strengthen Alzheimer's disease policy and care for the decades ahead.

2. About the white paper

Strengthening Alzheimer's Disease Policy and Management in Asia Pacific: Pathways to Progress is a regional White Paper developed to assess the current state of Alzheimer's disease policy, diagnostic pathways, and care delivery across 9 APAC economies: Australia, China, Hong Kong, Japan, New Zealand, Singapore, South Korea, Taiwan, and Thailand. The report aims to identify priority system gaps, examine variations in service readiness, and highlight opportunities for strengthened policy action. By providing a structured, comparative view of Alzheimer's disease preparedness across the region, the White Paper supports governments, payers, clinicians, and other relevant healthcare system stakeholders in advancing more resilient, equitable, and sustainable approaches to Alzheimer's disease management.

To ensure a rigorous and well-rounded evaluation, the White Paper draws on both clinical expertise and policy analysis. KNA contributed scientific and practice-based insights, while Deloitte, as the knowledge partner, conducted the policy review, benchmarking, and findings synthesis. The Advisory Panel and contributor including 27 experts from the 9 APAC territories played an instrumental role in shaping the direction and depth of the work. Bringing together diverse clinical, policy, research, and civil-society perspectives, the panel contributed directly to defining priority issues, validating the analytical framework, and refining the cross-territory assessments. Its members - including neurologists, psychiatrists, geriatricians, neuropsychologists, molecular genetics specialists, senior policymakers, public-health leaders, and representatives from Alzheimer's disease and Dementia organisations and advocacy groups - ensured the analysis was grounded in frontline realities, informed by national policy contexts, and responsive to community needs. Their multidisciplinary and regionally varied expertise was central to enhancing the relevance, robustness, and practical value of the findings and recommendations presented in this White Paper.

A key feature of this White Paper is its structured scorecard, which applies a consistent set of clinical and policy-related domains, subdomains and indicators to evaluate Alzheimer's disease care and management across the region. While informed by global references e.g. broader health-system assessment tools by World Health Organisation (WHO) and World Bank, WHO Global Plan of Action on the Public Health Response to Dementia Innovation Readiness Index, etc., the scorecard is tailored specifically to Alzheimer's disease and the APAC context, enabling a more nuanced understanding of regional strengths, system gaps, and improvement priorities. By introducing this standardized, multi-domain assessment, the report provides a practical, disease-specific instrument for assessing policy progress, identifying strategic opportunities, and guiding forward planning.

We express our deep appreciation to the 27 experts who contributed insights throughout this process.

South Korea

Prof. Dr. Seung Hyun Kim – South Korea
President, Korean Neurological Association
Professor, Department of Neurology, Hanyang University Medical Center, Seoul Hospital
Director, Lou Gehrig Clinic of Hanyang University Hospital
Director, Cell Therapy Center of HUMC

Prof. Ho Jin Choi
Head of the Department of Neurology, Hanyang University Guri Hospital; Policy director, Korea Dementia Association

Dr. Hanna Cho
Associate Professor, Gangnam Severance Hospital;
Chair, Research Director, Korean Dementia Association

South Korea

Prof. Bon D Ku
Professor, Dean of College of Medicine
Director of Neuroscience Center & Institute for Cognitive Intervention
Department of Neurology, International St. Mary's Hospital, Institute for Cognitive Intervention
Catholic Kwandong University College of Medicine

Prof. Hyun Kook Lim
Professor, Department of Psychiatry, Yeouido St. Mary's Hospital
The Catholic University of Korea
Director, The Catholic Brain Health Center, The Catholic University of Korea

Prof. So Young Moon
Professor, Department of Neurology, School of Medicine,
Ajou University
Academic Director (Managing) at the Korean Dementia Association

Australia

Ann Pietsch
Chair, Dementia Australia Advisory Committee (DAAC)

Dr. Kaele Stokes
Executive Director Services, Advocacy & Research
Dementia Australia

Prof. Lee-Fay Low
Professor in Ageing and Health
Sydney School of Health Sciences, Faculty of Medicine and Health

Prof. Ralph Martins
Professor of Neurobiology, Macquarie Medical School, Centre for Ageing, Cognition, and Wellbeing
Foundation Chair of Aging and Alzheimer's disease, Edith Cowan University's School of Medical and Health Science
Research Leader, Alzheimer's Research Australia

Prof. Sharon Naismith
Clinical Neuropsychologist, Charles Perkins Centre, The University of Sydney
Member, Australian Psychological Society

Prof. Perminder Sachdev
Scientia Professor of Neuropsychiatry, UNSW Sydney
NHMRC Leadership Fellow
Co-director, Centre for Healthy Brain Ageing (CHeBA),
Discipline of Psychiatry & Mental Health, School of Clinical Medicine, UNSW Sydney
Director, Neuropsychiatric Institute, The Prince of Wales Hospital, Randwick NSW 2031
Co-director, Australian Dementia Network (ADNeT)
Director, Centre of Research Excellence in Vascular Contributions to Dementia (CRE-VCD)

China

Dr. Jun Xu
Deputy Director, Cognitive Disorders Department, Beijing Tiantan Hospital
Vice President, Cognitive Disorders Branch of the Chinese Geriatrics Society

Dr. Ling Yue
Chief Physician, Geriatric Psychiatry Department, Shanghai Mental Health Center

Hong Kong

Dr. Au Yeung Tung Wai
Research Associate, Jockey Club Institute of Ageing,
The Chinese University of Hong Kong
Honorary Clinical Associate Professor, Faculty of Medicine, The Chinese University of Hong Kong

Ms. Florence Ho
General Manager, Jockey Club Centre for Positive Ageing (JCCPA)

Japan

Prof. Takeshi Ikeuchi
Professor, Department of Molecular Genetics, Brain Research Institute Niigata University

Assoc. Prof. Dr. Atsushi Iwata
Vice President, Tokyo Metropolitan Institute for Geriatrics and Gerontology

New Zealand

Dr. Makarena Dudley (Contributor)
Clinical Neuropsychologist, Senior Lecturer, School of Psychology
Deputy Director Māori, Centre for Brain Research, University of Auckland

Singapore

Assoc. Prof. Dr. Iris Rawtaer
Director, Research Office
Head & Senior Consultant, Psychiatry, Sengkang General Hospital

Dr Zhao Yi Jing
Medical Director, Zhao Neurology and Headache Clinic
Neurologist, Mount Elizabeth (Orchard) Hospital

Assoc. Prof. Dr. Adeline Ng
Head of Dementia Program, Senior Consultant Neurologist and Director, Special Projects, Office of Academic Affairs, National Neuroscience Institute

Dr. Melanie Tan
Geriatrician, Gleneagles Hospital; The Straits Geriatrics Centre

Taiwan

Dr. Shu-Ti Chiou
Founder & President, Health & Sustainable Development Foundation
Vice Chair, Taiwan Parliamentary Commission on Strong-Generation Policies and Economic Development
Elected Member of the Global Executive Board, International Union for Health Promotion & Education
Chair, International Task Force on Health Promoting Hospitals & Age-friendly Health Care
Adjunct Professor, College of Medicine, National Yang Ming Chiao Tung University, Taiwan
Former Director-General, Health Promotion Administration, Ministry of Health and Welfare, Taiwan

Dr. Chaur-Jong, Hu
Dean, College of Medicine, Taipei Medical University

Thailand

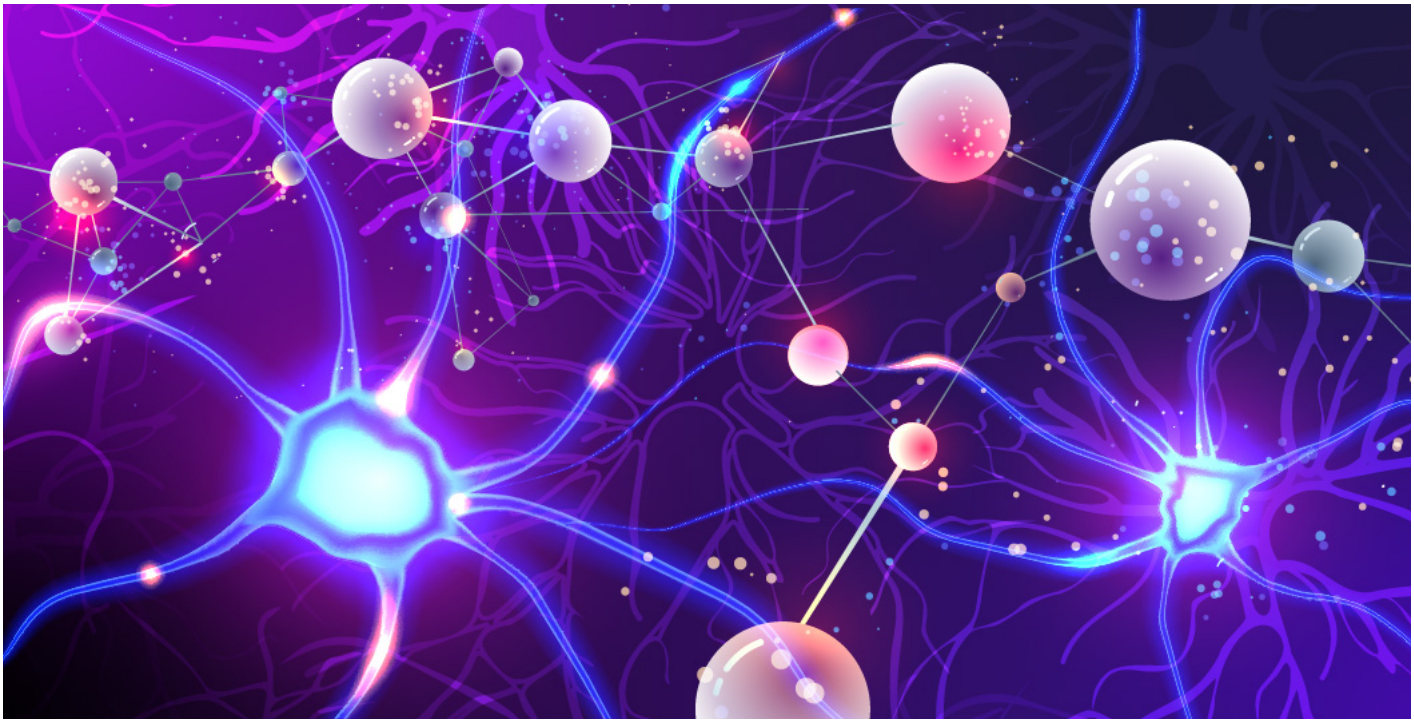
Dr. Bootsakorn Loharjun
Director, Institute of Geriatric Medicine,
Department of Medical Services,
Ministry of Public Health, Thailand

Dr. Natthiya Siritham
Deputy Director, Public Health Administration Division,
Ministry of Public Health, Thailand

This publication represents an independent assessment. The views and recommendations do not necessarily reflect those of the sponsor or the institutions of the Advisory Panel members. Some elements of our assessment reflected differing perspectives from these stakeholders.

3.

Executive summary



3. Executive summary

3.1. Overview

Alzheimer's disease and other dementias have become a fast-escalating public-health, economic, and social challenge worldwide, and especially across APAC. Globally, an estimated **55 million** people are living with dementia, a figure expected to rise to **139 million by 2050**[1]. In APAC alone, the burden is projected to surge from roughly **26 million in 2025** to nearly **71 million by 2050** as the region continues to age at unprecedented speed[2,3]. Recent modelling further underscores the scale of this challenge: a 2024 Lancet study projects that dementia cases in China alone could reach up to **66 million by 2050** (95% uncertainty interval (UI) 64.7-68.0 million) under upper-bound scenarios[4] . This trajectory may be even steeper when considering multimorbidity, as more than **80%** of people with dementia live with at least 2 additional chronic conditions, driving higher complication rates, longer hospital stays, and rising care costs[5] . Alzheimer's disease is the predominant cause of dementia, accounting for **60 - 80%** of all cases[6]. Many more are affected earlier in the disease continuum: global evidence suggests roughly **315 million people carry preclinical Alzheimer's disease pathology** without symptoms, reinforcing the need to shift from late detection to earlier, biologically guided intervention[7].

The economic impact is already profound. In 2019, dementia generated an estimated **USD 1.3 trillion** in societal costs worldwide - half of which came from informal, unpaid caregiving[8] . Across the globe, this burden falls disproportionately on women, who provide around 70% of all dementia care hours. These costs are expected to more than double to USD 2.8 trillion by 2030[9] and to 9.1 trillion by 2050[10]. For APAC, the financial trajectory is even sharper than the global average: In China, total dementia-related costs were estimated at around USD 233 billion in 2020 under the opportunity-cost approach and are projected to rise to USD 494 billion by 2030 - equivalent to almost 2% of Gross Domestic Product (GDP)[11] - exceeding the worldwide average of roughly 1.1% of GDP[12] Japan and Australia show similarly heavy long-term care, productivity loss, and informal-care burdens[13,14] .

Given Alzheimer's disease makes up the most significant proportion of all dementias, **without decisive action across the full spectrum of Alzheimer's disease care, these costs will escalate at an even faster pace**. In China, informal caregiving value using the opportunity-cost method is projected to more than **double** over a single decade, increasing from approximately **USD 130 billion in 2020 to around USD 277 billion by 2030**. This alone represents the majority of the economy's total dementia expenditure, underscoring how delaying action today will lock families and the health system into rapidly escalating costs driven by uncompensated caregiver time[15] . As individuals progress to more advanced stages of disease, care needs rise sharply. Evidence from Taiwan shows that total dementia care costs increase substantially with severity: costs for moderate dementia are **1.4 times higher** than for mild cases, while severe dementia costs are almost **double** those for mild disease. This escalation reflects higher supervision needs, increased functional dependency, and greater likelihood of

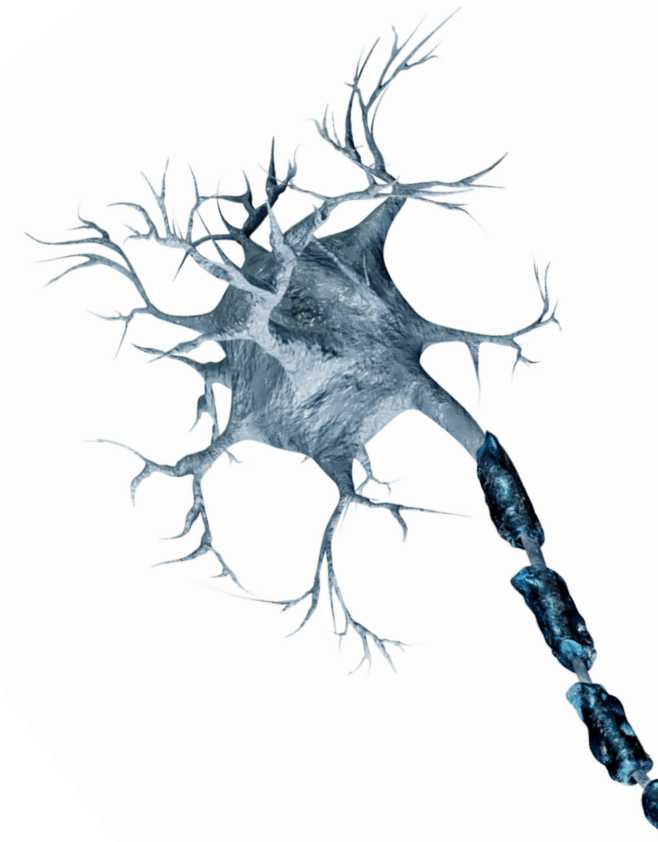
institutionalisation - factors that will further strain families and health systems across APAC[16]. Yet global economic modelling consistently shows that **earlier detection and treatment can significantly reduce future spending**. UK analyses indicate that diagnosing and treating Alzheimer's disease earlier can save £8,800 - £44,900 per person, largely by delaying progression and reducing long-term care needs[17]. These savings depend on identifying patients at the mild, biomarker-confirmed stage - the population where disease-modifying treatments (DMTs) demonstrate cost-effective value. Encouragingly, building this diagnostic readiness is feasible and cost-efficient: in China, Cerebrospinal Fluid (CSF)-based biomarker testing reduces diagnostic costs by 33 - 37% compared with Amyloid beta Positron Emission Tomography (Aβ-PET) while maintaining equivalent accuracy, lowering diagnostic-pathway spending by ¥1,900 - 2,100 per patient[18] . Investing now in scalable biomarker infrastructure, timely diagnosis, and early-stage treatment is therefore not only a clinical imperative but an economic one.

Despite these pressures, critical gaps persist. Data remains fragmented or incomplete, making it difficult for policymakers to accurately track prevalence, model future demand, or plan financing for diagnostics, long-term care, and emerging DMTs. Late diagnosis delays access to both symptomatic and biomarker-guided DMTs, and may ultimately render patients ineligible for DMT altogether, increasing long-term dependency. Most economies lack dedicated Alzheimer's disease strategies, robust registries, structured biomarker pathways, or cost financing plans to prepare for early-stage detection and treatment.

As APAC continues to urbanise and populations age, the region urgently needs tailored strategies to strengthen prevention, early detection, and long-term management of Alzheimer's disease. Improving access to cognitive assessment, biomarker-based diagnosis, specialist capacity, and caregiver support will be essential to mitigate rising clinical and economic burdens. This White Paper evaluates the current Alzheimer's disease policy and management landscape across 9 APAC territories, identifies system-wide gaps, and proposes targeted actions focused on early detection, biomarker integration, DMT access, stronger data and monitoring systems, multidisciplinary care capacity, and sustainable financing.

By **aligning national strategies with scientific advances, expanding diagnostic readiness**, and **leveraging structural reforms** - such as **bundled financing for Diagnosis (Dx) + DMT + Monitoring** and **task-shifting to primary care** - the recommendations outlined in this report aim to help APAC health systems reduce delays, improve access to evidence-based treatment, and safeguard long-term sustainability.

Acting early can avert tens of billions in future costs, while inaction will lock health systems into exponentially rising expenditure driven by late-stage disease



3.2. Key findings

01. Alzheimer's disease lacks dedicated policy prioritisation

Despite the scale of Alzheimer's disease, most economies do not treat it as a distinct policy priority. Instead, Alzheimer's disease is typically embedded within general dementia agendas, ageing strategies, or wider Non-Communicable Disease (NCD) frameworks. This creates diffuse accountability, limited transparency in budget allocation, and slow translation of scientific gains -especially in diagnostics and DMTs - into practice. Only a subset of higher-maturity systems feature structured dementia plans with measurable deliverables; even fewer outline Alzheimer's disease-specific goals, cost operational pathways, timelines, or evaluation targets. The result is misalignment between disease burden and policy action, particularly in emerging systems where resource constraints, competing health priorities, and limited cross-sector coordination further weaken attention to Alzheimer's disease. In addition, policy updates are slow or outdated in several territories, limiting responsiveness to rapid advances in Alzheimer's disease research and care.

02. Clinical guidelines exist, but system-level adoption is uneven

While most territories reference international diagnostic and treatment standards, these are not consistently embedded across the health system due to limited primary care integration, delays in updating guidelines to reflect biomarker advances or DMT eligibility, and unclear referral pathways. Beyond adoption gaps, structural constraints further hinder implementation: limited funding and diagnostic reimbursement restrict access to advanced testing, and workforce shortages (neurologists, geriatricians, psychiatrists, dementia-capable primary physicians) reduce service capacity - collectively impeding timely diagnosis, treatment initiation, and readiness for DMT.

03. Major gaps in diagnostic access and biomarker infrastructure

While tertiary centres in mature economies are beginning to scale imaging and biomarker-based diagnostics, availability remains highly uneven across the region. CSF testing remains heavily concentrated within tertiary hospitals, with access uneven across the region and limited by self-pay costs and scarce reimbursement. Most economies have not formally embedded CSF biomarkers into Alzheimer's disease diagnostic pathways, despite their importance for confirming diagnosis, determining eligibility for DMTs, and improving clinical confidence.

Blood-based biomarkers (BBBM) are the only scalable operational mechanism capable of protecting specialist capacity, reducing unnecessary downstream diagnostics, and ensuring cost-effective system performance[19 20 21] . E.g., pTau181's high negative predictive value enables safe and effective rule-out triage, ensuring that only patients with a high likelihood of Alzheimer's disease proceed to confirmatory CSF or Positron Emission Tomography (PET) testing. When integrated into a structured pathway, **BBBMs reduce avoidable specialist referrals, minimise reliance on invasive or costly diagnostic procedures, and accelerate accurate diagnosis across populations.** They also provide momentum to connect individuals who may not be eligible for DMTs to appropriate non-pharmacological services and support, ensuring earlier intervention across the full spectrum of patient needs. As BBBMs move from research to routine care, their responsible adoption requires governments to pair reimbursement with investment in real-world trials and implementation studies to validate performance, optimise diagnostic pathways, and build clinician confidence.

Earlier BBBM-enabled identification also supports timelier DMT initiation, more appropriate management of mild cognitive impairment (MCI) due to Alzheimer's disease, and delays progression to high-cost institutional care. Yet regional adoption remains nascent: coverage is uneven, clinical protocols are still emerging, and reimbursement pathways are scarce.

The fiscal implications are substantial. Without investment in the early diagnostic pathway-including blood-based biomarkers for triage and CSF or PET for confirmation, APAC governments face a high risk of inefficient DMT spending, with therapies directed to patients who are ineligible or too advanced to derive meaningful clinical benefit. Investment in early diagnostics is therefore a fiscal imperative, not a discretionary option. These gaps undermine early detection, weaken health-system preparedness, and jeopardize the scalable and sustainable introduction of DMTs across the region. Addressing them is both a clinical necessity and a fiscal obligation.

04. Data gaps limit evidence-based decision-making

Registries dedicated to dementia or Alzheimer's disease remain uncommon. Existing data systems tend to be hospital-based, incomplete, or project-driven, limiting real-world tracking of diagnostic timelines, biomarker testing uptake, treatment eligibility, or long-term outcomes. Weak interoperability between registries, electronic health records (EHRs), payer systems, and clinical datasets constrains systematic analysis. The absence of reliable national evidence hampers health-technology assessment, forecasting of long-term care demand, capacity planning for treatment pathways, and evaluation of financing models for diagnostics and DMT adoption.

05. Public, caregiver, and provider awareness remain limited

Low recognition of cognitive impairment among the public - particularly in rural, lower-income, and ageing populations - leads to delayed care-seeking. Stigma remains persistent, suppressing screening, help-seeking, and family disclosure. Advocacy efforts specific to Alzheimer's disease are generally limited, limiting visibility of emerging diagnostic and therapeutic advances. Caregiver programmes are uneven in scale and often underfunded, despite representing a crucial pillar of Alzheimer's disease care. At the provider level, capability to conduct cognitive assessments, counsel families, and interpret biomarkers remains inconsistent, particularly in primary care.

3.3. Key recommendation areas

Based on the key findings, the White Paper sets out 10 evidence-based recommendations across 5 domains: policy and planning; prevention and screening; diagnosis and capacity; treatment and access; and education and awareness - and classifies each action by **level of impact (high, medium)** and **feasibility (short-, medium-, long-term time horizon)** to guide national policymakers and regional stakeholders in prioritisation and sequencing.

Actions are tailored to 2 system archetypes: high-income economies[22] with mature systems (Australia, Hong Kong, Japan, New Zealand, Singapore, South Korea, Taiwan), focused on equitable access, financing, and DMT readiness; and upper-middle-income economies[23] with **emerging systems** (China, Thailand), where diagnostic capacity, policy prioritisation, and data integration require urgent acceleration. Together, these actions provide a practical policy roadmap to elevate Alzheimer's disease as a national health priority, enable earlier detection and intervention, and build sustainable system capacity for the future.

Within these recommendations, the high-impact actions proposed for short- to medium-term implementation are concentrated into 5 key areas:

01 Prioritise Alzheimer's disease within national health strategies and transition toward comprehensive end-to-end Alzheimer's disease programmes

Reflecting their respective levels of Alzheimer's disease policy maturity, governments should strengthen national prioritisation of Alzheimer's disease with the long-term aim of guiding all economies toward fully costed, comprehensive Alzheimer's disease programmes covering the full patient journey, from early screening and diagnosis through to treatment and long-term care by 2027. Before implementing new policies or revising existing ones, relevant local evidence should be provided to governments wherever feasible to inform decision-making.

1 Group 1: with no Alzheimer's disease/ Dementia action plans

Secure the development and rollout of initial national dementia/ Alzheimer's disease strategies, elevating Alzheimer's disease from a secondary concern to a top-tier public health issue through foundational policy frameworks and awareness initiatives.

2 Group 2: with existing dementia action plans

Elevate Alzheimer's disease within these plans by advocating for Alzheimer's disease-specific emphases, while helping governments expand focus to the total patient journey including screening, diagnosis, and access to DMTs to ensure comprehensive coverage beyond general dementia care.

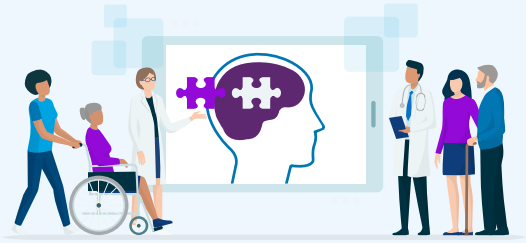
3 Group 3: with existing Alzheimer's disease-specific plans:

Advocate for enhanced focus on the complete patient journey, including screening, diagnosis, and treatment, to optimise existing plans for end-to-end support and improved outcomes.

Mandating comprehensive costed National Alzheimer's disease programmes

Across all territories assessed, **no government currently earmarks a dedicated budget for Alzheimer's disease-specific programmes**, representing a critical structural gap in system preparedness. Although economies such as Australia, Japan, South Korea, and Taiwan invest substantially in dementia more broadly - supporting care delivery, research, and innovation - these commitments **do not translate into ring-fenced, costed Alzheimer's disease programmes with disease-specific accountability**.

To address this gap, governments should **mandate standalone, costed Alzheimer's disease programmes and action plans**, rather than subsuming Alzheimer's disease under broad "Dementia" or "Ageing" frameworks. **Broader frameworks dilute disease-specific priorities, making it difficult to set clear targets, allocate dedicated budgets, or prepare for innovations unique to Alzheimer's disease. Without a standalone plan, Alzheimer's disease often competes with other conditions for attention and resources, resulting in fragmented pathways and inadequate system readiness.**



Moving toward comprehensive, end-to-end Alzheimer's disease programmes will then require clear investment priorities to operationalise national strategies and strengthen system readiness:

- **Commit to multi-year, costed national Alzheimer's disease programmes** that cover the full patient journey -from early screening and risk assessment to diagnosis, treatment readiness, and long-term care
- **Allocate dedicated budgets** for critical system enablers, including biomarker and imaging capacity, workforce training, and digital infrastructure to support timely and accurate diagnosis
- **Prepare for equitable access to DMTs** by strengthening referral pathways, eligibility criteria, and treatment delivery models
- **Integrate community-based and long-term care supports** to ensure continuity of care and reduce reliance on high-cost institutional services
- **Embed monitoring and evaluation mechanisms** to track implementation progress, patient outcomes, and system performance over time

02 Introduce a dementia care redirection policy to shift resources toward early detection and treatment preparedness

Although global studies consistently show that late-stage dementia care is one of the most significant cost drivers in aging societies and modelled data shows the value of early intervention[24], most governments lack concrete, territory-level quantification of these costs and do not track how much spending could be avoided through earlier detection and intervention. This absence of localised data makes it difficult to set priorities, justify investment in early Alzheimer's disease pathways, or plan for DMT readiness. A Dementia Care Redirection Policy is therefore essential to create fiscal visibility and guide evidence-based resource allocation.

Ministries of Finance should mandate a Dementia Care Redirection Policy that systematically quantifies the escalating fiscal burden of late-stage, institutional long-term care and **reallocates a defined portion of this expenditure toward upstream interventions** - specifically early Alzheimer's disease screening, biomarker-confirmed diagnosis, and full system readiness for DMTs.

Such a policy mechanism enables governments to:

Align fiscal incentives with early detection, where interventions generate substantially higher long-term returns

Protect future DMT budgets by ensuring that only biomarker-confirmed, clinically appropriate patients enter treatment pathways

Stabilise health and social care budgets by shifting funding from high-cost, late-stage care to earlier, more cost-effective stages of disease management, and

Embed Alzheimer's disease sustainability within national financing frameworks, ensuring governments can scale early detection and therapeutic access without creating new fiscal pressures.

By redirecting even a modest share of late-stage care spending, governments can unlock meaningful resources to build early detection infrastructure, strengthen diagnostic capacity, and prepare for the responsible, equitable rollout of DMTs.

03 Strengthen early detection and diagnostic pathways (from screening → diagnosis → confirmation)

Across APAC, dementia remains largely undetected - up to 90% in some settings -due to stigma, limited screening, insufficient biomarker access, and inconsistent national guidelines. Fragmented pathways delay diagnosis by 1-3 years, reducing treatment effectiveness and increasing long-term care costs. To address this readiness gap, APAC health systems need a unified, stepwise early detection and diagnostic pathway that enables timely, accurate, and affordable diagnosis across diverse settings, ensuring patients enter care earlier and are appropriately prepared for DMTs and long-term disease management.

Scope of key actions include:

Establish national screening and triage frameworks

- Integrate cognitive screening into primary care for older adults (age cutoff to be determined based on specific context)
- Integrate Montreal Cognitive Assessment/Mini-Mental State Examination (MoCA/MMSE) into universal health coverage (UHC) health checks and community outreach programmes
- Introduce BBBM as the first-line "rule-out" test to stratify patients before referral
- Scale BBBMs screening - Mature systems should initiate health technology assessments (HTAs) and pilots within 12 months to evaluate and adopt Japan's BBBMs p-tau217 screening model as a best-practice approach
- .Define clear screening thresholds and triage triggers

Standardise diagnostic pathways and clinical guidelines

- Harmonise national criteria for MCI and prodromal Alzheimer's disease using cognitive + biomarker criteria
- Develop stepwise decision trees for screening → BBBM triage → confirmatory testing
- Implement national quality assurance (QA) and competency standards for pathway adherence

Mandate workforce task-shifting to execute the pathway

- Train primary care physicians (PCPs) to conduct Tier 1 cognitive screening and BBBM triage
- Empower nurses and community health workers to conduct basic assessments and referrals
- Address neurologist/geriatrician shortages with structured skill transfer

Build coordinated referral pathways

- Map screening, triage, and referral flows aligned to existing facilities
- Use standard referral templates and digital guidance tools
- Ensure patient follow-up and feedback loops between care levels

Pilot early detection pathways using existing infrastructure

- Leverage community clinics, geriatric centres, district hospitals, and Puskesmas-like networks (government-mandated community health clinics located across Indonesia) to pilot pathway implementation
- Demonstrate feasibility across both mature and emerging systems before national scaling

04 Expand and modernise diagnostic infrastructure and workforce capacity

Diagnostic capacity across APAC remains heavily concentrated in tertiary centres, with many systems lacking PET / magnetic resonance imaging (MRI) / computed tomography (CT) availability, CSF laboratory capacity, biomarker testing infrastructure, and sufficient numbers of trained specialists. These gaps create inequitable access, long wait times, and bottlenecks that undermine timely diagnosis and readiness for DMTs. To close this system-level deficit, countries must build robust, scalable diagnostic infrastructure that enables confirmatory Alzheimer's disease diagnosis across regions and develop the specialist and technical workforce needed to operate and interpret these tools, ensuring the entire health system can meet DMT eligibility requirements and support an effective early detection pathway.

Modernise confirmatory diagnostic infrastructure

- Expand MRI, CT, PET availability; upgrade equipment and throughput
- Establish or scale CSF testing facilities with QA systems in regional hospitals
- Establish regional CSF reference labs
- Pilot BBBM studies with regulatory oversight
- Mobilize global partners (e.g., Davos Alzheimer's Collaborative, Brain Health Initiative) for system design and setting up BBBMs work flow for Ministry of Health (MOH)

Strengthen digital systems and diagnostic data infrastructure

- Build interoperable national Alzheimer's disease data platforms capturing cognitive scores, biomarker results, imaging, and diagnostic timelines.
- Develop Alzheimer's disease-specific registries linked to EHRs and payer datasets
- Standardise national data definitions, metadata structures, and digital monitoring frameworks
- In emerging systems, expand existing dementia registries with Alzheimer's disease modules, and pilot digital data-collection systems in tertiary centres
- Support real-time monitoring of diagnostic speed, biomarker uptake, regional equity, and pathway adherence

Build hub-and-spoke diagnostic networks

- Designate regional diagnostic hubs offering confirmatory imaging and CSF testing
- Connect primary and secondary facilities via teleconsultation and structured e-referral flows
- Standardise reporting times and quality benchmarks

Mobilise and optimise existing physical infrastructure

- Convert district hospitals into diagnostic access points for basic imaging and biomarker sample collection
- Optimise existing tertiary centres rather than constructing new facilities where feasible
- Use public–private partnerships and pooled procurement mechanisms to expand diagnostic capacity efficient

Build specialist and technical workforce capacity

- Launch foundational training programmes in which the first year focuses exclusively on BBBM interpretation, post-result patient counselling, and referral criteria for DMT eligibility; subsequent modules can expand to palliative and rehabilitation skills for long-term dementia care
- Upskill radiologists, neurologists, nuclear medicine specialists, and laboratory professionals in advanced imaging protocols, CSF handling, and biomarker interpretation to ensure high-quality diagnostic services
- Establish certification programmes and regional centres of excellence
- Partner with global health organisations (e.g., Davos Alzheimer's Collaborative, Brain Health Initiative) to support infrastructure planning and specialised skills transfer

05 Establish conditional, biomarker-linked reimbursement frameworks for Alzheimer's disease diagnosis and DMTs

Across the region, reimbursement mechanisms for Alzheimer's disease remain fragmented and poorly aligned with the diagnostic and treatment requirements of the DMT era. Most economies do not reimburse biomarker confirmation, CSF testing, or emerging blood-based biomarkers, limiting equitable access to early diagnosis. In addition, current reimbursement frameworks typically treat dementia broadly - without recognising Alzheimer's disease as a distinct, biologically defined condition - resulting in outdated eligibility criteria and fiscal models that do not support precision diagnosis or DMT delivery. Existing budget allocations lean heavily toward long-term social care, while medical diagnosis, biomarker infrastructure, and therapeutic readiness remain largely unfunded.

Policymakers should create reimbursement frameworks that are clinically aligned, fiscally sustainable, and explicitly tied to Alzheimer's disease pathology. This includes ensuring that all reimbursed DMT use is grounded in biomarker-confirmed eligibility, expanding reimbursement for diagnostic modalities, and building financing mechanisms that support early detection and treatment preparedness. As the clinical and economic evidence base for DMT continues to evolve, reimbursement approaches should remain adaptive, with provisions for ongoing monitoring and periodic review to reflect emerging real-world data.

Scope of key actions include:

Demand conditional reimbursement tied to biomarker confirmation

- Mandate that **payers adopt biomarker-confirmed eligibility as a non-negotiable prerequisite** for DMT reimbursement, ensuring fiscal efficiency by only funding treatments for patients with proven amyloid pathology
- Link reimbursement to diagnostic pathways established under national guidelines, ensuring alignment between financing decisions, clinical criteria, and treatment initiation

Expand reimbursement to cover foundational diagnostic infrastructure

- Reimburse MRI, CSF biomarkers, and validated blood-based biomarker assays within a structured diagnostic–treatment pathway, ensuring patients can realistically access the diagnostic prerequisites required for DMT eligibility
- Introduce **diagnostic bundles** that combine cognitive assessment, biomarker confirmation, and referral follow-up into a single reimbursed package to prevent financial barriers and improve diagnostic completeness

Build sustainable financing models for DMT delivery

- Mandate bundled payment models for diagnostics + DMT + monitoring, requiring that any newly approved DMT be financed as an integrated package; This ensures diagnostic confirmation is funded, eliminates siloed costs, and transfers the risk of poor patient selection and inadequate monitoring to providers and payers
- Develop and pilot diverse reimbursement models (e.g., shared-cost, outcome-linked, or bundled payment schemes) to balance early adoption with long-term fiscal sustainability
- Establish HTA fast-tracks for DMTs and companion diagnostics, ensuring reimbursement decisions evolve with emerging clinical evidence, rather than lagging years behind scientific progress

Prioritise Alzheimer's disease within national financing and budget-setting processes

- Train radiologists, neurologists, nuclear medicine specialists, and laboratory professionals in advanced imaging protocols, CSF handling, and biomarker interpretation
- Establish certification programmes and regional centres of excellence
- Partner with global health organisations (e.g. Davos Alzheimer's Collaborative, Brain Health Initiative) to support infrastructure planning and specialised skills transfer

3.4. Implementation direction: Strengthen policy mechanisms & governance for accountability

Effective implementation of these recommendations will require coordinated action across governments, clinical stakeholders, payers, and industry partners. While specific execution pathways will differ by health-system maturity, the structural components below aim to guide national adaptation, policymaking, and operational planning across the APAC region.

a.Key stakeholders

Successful delivery depends on cross-sector collaboration. Core actors include:

Governmental authorities

Ministries of Health, Finance, and Social Welfare; national payers and insurance authorities responsible for budgeting, reimbursement, UHC schemes, and Alzheimer's disease strategy implementation

Clinical and scientific bodies

Neurology, geriatrics, dementia and Alzheimer's disease societies, academic and research institutions responsible for guideline development, training, and evaluation of biomarker and DMT evidence

Providers and delivery networks

Tertiary hospitals, memory centres, secondary and community health facilities that drive screening, diagnosis, CSF/BBBM testing, and DMT delivery

Data and digital agencies

National digital-health offices, EHR authorities, and registry custodians tasked with interoperability, privacy standards, and monitoring

Industry partners

Diagnostics, pharmaceutical, tele-neurology and digital health companies supporting biomarker testing infrastructure, capacity building, and DMT implementation models

Civil society and patient groups

Advocacy bodies, caregivers' associations, and NGOs essential to public awareness, caregiver support, and policy accountability

b. Strategic enablers

Delivering the recommendations outlined in this White Paper will require system-level enablers that ensure feasibility, scalability, and sustainability across diverse health contexts in Asia Pacific. In addition to governance, stakeholder engagement, and regional collaboration, several policy and financing mechanisms must be embedded as structural enablers of Alzheimer's disease system readiness.

Governance and policy coordination

Clear institutional ownership and inter-ministerial coordination (across Health, Finance, Social Welfare, Digital, and Insurance) to oversee planning, resource allocation, stakeholder engagement, and progress monitoring. This includes aligning reimbursement, diagnostic standards, and data governance under a unified national Alzheimer's disease framework.

Public and stakeholder engagement channels

Mechanisms to involve patient and caregiver groups, academic societies, community organisations, and civil society in awareness, service design, communication strategies, and feedback loops to strengthen uptake and sustainability.

Regional and global collaboration

Cross-territory platforms that connect governments, research institutions, registries, HTA agencies, and multilateral partners to:

- share implementation evidence
- harmonise biomarker standards
- co-develop data governance models
- benchmark policy progress, and
- support emerging economies in building diagnostic and registry capacity

Such collaboration enables territory-appropriate adoption pathways, shared learning on DMT financing, and coordinated Alzheimer's disease system readiness across the region.

c. Phased implementations

While health-system starting points vary, the following sequence provides a reference framework for adoption.

Short-term (1-3 years)
Build foundations

Focus on high-impact, low-barrier interventions:

- Prioritise Alzheimer's disease in national strategies and dedicate funding streams
- Launch early-detection pilots combining cognitive assessment and BBBM
- Expand secondary/tertiary diagnostic capacity and referral networks
- Begin biomarker guideline updates and initiate HTA reviews
- Initiate registry development or enhance existing dementia modules

Output
operational pilots, foundational policy alignment, biomarker testing routes in place, early data streams established.

Medium term (3-5 years)
Institutionalise and scale

Scale infrastructure and harmonise standards:

- Standardise diagnostic pathways integrating CSF ratios and BBBMs
- Introduce reimbursement mechanisms and bundled diagnosis and treatment (Dx+Tx) payment models
- Fully operationalise national Alzheimer's disease registries linked to EHRs
- Embed biomarker literacy, rehabilitation, and palliative-care skills into workforce curricula
- Establish multisite DMT eligibility and administration pathways

Output
consistent national protocols, equitable diagnostic access, HTA-linked financing, measurable DMT readiness

Long-term (5-10 years)
Consolidate and transform

Build self-sustaining national Alzheimer's disease programs:

- Integrate DMT pathways into UHC benefit schemes
- Scale tele-neurology, remote monitoring, and home-based dementia care
- Formalise cross-territory collaborations and data-sharing platforms
- Anchor comprehensive caregiver support and long-term care into national budgets
- Fully harmonise Alzheimer's disease policy renewal cycles with national ageing and NCD strategies

Output
system-level resilience, optimised diagnostic costs, durable treatment access, equitable service delivery

d. Monitoring and evaluation: Institutionalize monitoring and evaluation with mandatory KPIs

A structured governance model is essential to track progress and drive accountability over time. Governments should elevate Monitoring & Evaluation from a passive reporting function to a **core accountability instrument** enabling transparent oversight, quality improvement, and meaningful system readiness for DMT rollout. Key elements:

1. National oversight mechanisms:

- Ministry-led steering committees monitoring delivery against strategic plans
- Annual policy reviews with mandatory reporting on biomarker uptake, diagnostic timelines, and DMT readiness
- Routine assessment of adherence to diagnostic and reimbursement criteria, enabling continuous improvement and financial risk protection

2. Key performance indicators:

- Time-to-diagnosis reduction, with a system-level target of reducing current delays of 1- 3 years to less than 6 months
- Coverage of cognitive or BBBM screening among ≥60 populations
- Diagnostic capacities at secondary-level hospitals
- Registry completeness for biomarker and treatment datasets
- Biomarker reimbursement rates and HTA progression milestones
- DMT eligibility and treatment initiation timelines
- Rural-to-urban equity ratios in diagnosis and treatment access

3. Transparent public reporting:

- Annual dashboards summarising biomarker access, diagnostic accuracy, regional equity, and payer utilisation - shared with patient groups, clinicians, and policymakers
- Integration of Alzheimer's disease KPIs into national Alzheimer's disease registries, linked with payer datasets to support real-time monitoring

4. Regional benchmarking:

Collaboration through WHO, ASEAN Health, or other platforms to compare metrics, share best practices, and inform evidence-based adjustment of reforms.

3.5 Call to action

Alzheimer's disease management in APAC has reached a critical inflection point. Without urgent, coordinated action, rising prevalence, late diagnosis, and growing care costs will outpace system capacity, deepen inequities, and erode economic resilience. At the same time, validated biomarkers and emerging DMT offer a historic chance to shift Alzheimer's disease from late-stage response to proactive, early intervention. If leveraged now, early detection and treatment readiness could help governments avoid more than at least US 100 billion in late-stage care costs across APAC over the next decade; every US $1 invested today in early diagnosis and system preparedness can save an estimated US $5 in future institutional-care spending.

This White Paper outlines a practical roadmap to elevate Alzheimer's disease as a health priority, strengthen early detection, expand biomarker-supported diagnosis, and prepare systems for safe, equitable access to new treatments. Achieving this requires aligned leadership: governments to set strategy and financing; health providers to expand diagnostic and referral capacity; and academic, civil society and industry partners to drive evidence, innovation, and awareness.

With **targeted investment, robust data systems, and cross-territory collaboration**, APAC can build an Alzheimer's disease care model that is earlier, fairer, and more sustainable - delaying progression, reducing long-term care pressures, and improving quality of life. **The window for action is now; decisions made in the next few years will determine whether the region can strengthen existing foundations for Alzheimer's disease care or continue to face the disease with suboptimal preparedness**.

4.

Introduction

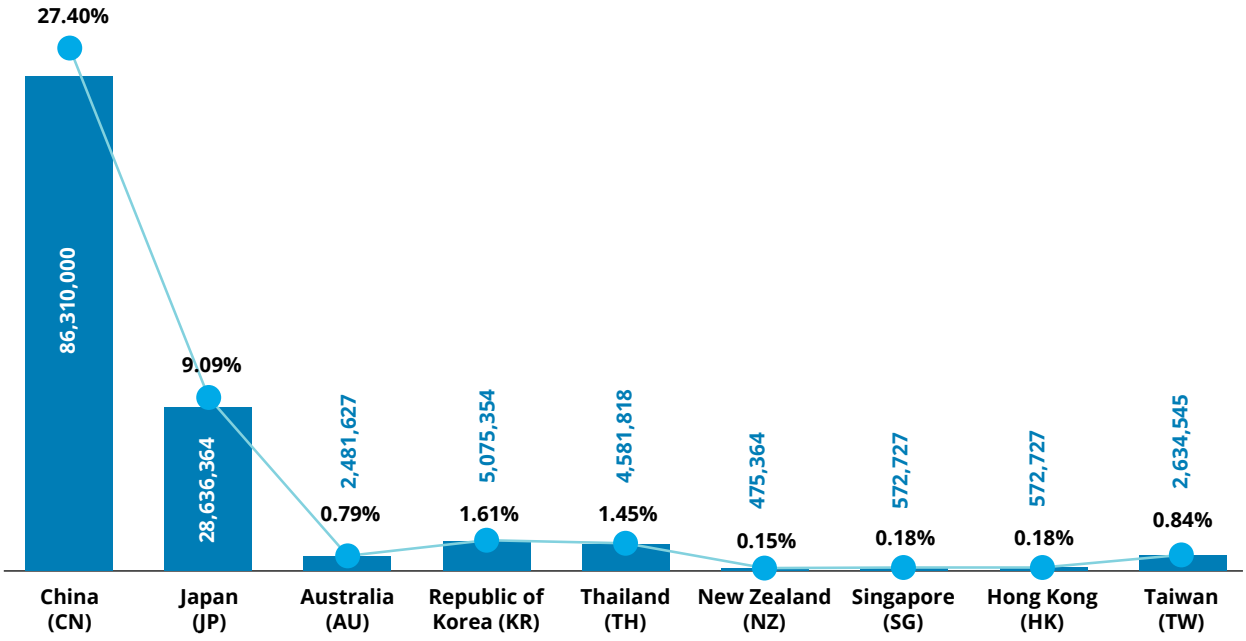
4. Introduction

4.1. Why Alzheimer's disease requires urgent policy attention

Alzheimer's disease and other dementias have become a critical and rapidly escalating public health challenge across the APAC region, requiring immediate attention and coordinated action from Ministries of Health and other relevant healthcare system stakeholders. Globally, **55 million** people are living with dementia, a figure projected to nearly triple to **139 million** by 2050 as populations age[25]. APAC will be disproportionately affected: cases in the region are expected to rise from around **26 million** in 2025 to nearly **71 million by 2050**, by which time more than half of all people with dementia worldwide will reside in APAC[26 27 28] . Dementia, including Alzheimer's disease, is already the **7th leading cause of mortality worldwide** and **a major contributor to disability and dependency among older adults**[29] . As the predominant cause of dementia, accounting for **60-80% of cases**, Alzheimer's disease drives most associated clinical, economic, and societal burden[30].

Alzheimer's disease itself **is a chronic, progressive, and currently irreversible neurodegenerative disorder that impairs both cognitive and behavioral functioning**[31 32]. Crucially, Alzheimer's disease pathology begins long before dementia is diagnosed. Global estimates suggest that approximately **315 million people** currently have preclinical Alzheimer's disease, meaning they carry underlying biological disease without dementia symptoms[33]. Across the region, this translates into an estimated **preclinical Alzheimer's disease pool of more than 130 million people** in the target economies alone, far exceeding the number of individuals with clinical symptoms today. This vast reservoir of early, asymptomatic disease represents an enormous therapeutic window that health systems must urgently prioritize if they aim to meaningfully alter the trajectory of Alzheimer's disease.

Figure 1: Estimated share of the global preclinical Alzheimer's disease pool (315M people) contributed by the economies under review



In other words, most people with Alzheimer's disease are not yet living with dementia, but are instead in earlier biological stages that precede cognitive decline. This reinforces the modern understanding of **Alzheimer's disease as a progressive continuum** rather than a sudden clinical event[38]: from an asymptomatic preclinical phase, to mild cognitive impairment due to Alzheimer's disease, and eventually to Alzheimer's dementia, during which functional independence gradually deteriorates and full dependency becomes inevitable in advanced stages[39].

Figure 2: Stages of Alzheimer's disease

	Key features	Functional impacts
 **Preclinical Alzheimer's disease**	Pathological amyloid and tau changes begin many years before symptoms	No noticeable symptoms; daily function unaffected
 **Mild Cognitive Impairment (MCI)**	Early cognitive difficulties; represents a symptomatic but non-dementia phase; not all progress to Alzheimer's disease dementia	Independent; mild deficits that do not interfere with daily life
 **Early-Stage Alzheimer's disease (Mild)**	A person functions independently; may experience memory lapses. Difficulties include word-finding, remembering names, performing tasks, forgetting recently read material, misplacing items, planning/ organizing	Mostly independent; symptoms noticeable but person can still work, drive, and engage socially
 **Middle-Stage Alzheimer's disease (Moderate)**	Longest stage; more pronounced symptoms e.g., forgetfulness, moodiness, confusion, needing help with dressing, bladder/bowel issues, sleep changes, wandering, behavioral changes	Needs assistance with daily activities; supervision often required
 **Advanced Alzheimer's disease (Severe)**	Profound cognitive decline; limited response to surroundings; very restricted speech; major loss of physical abilities (mobility, sitting, swallowing); increased susceptibility to infections (e.g., pneumonia)	Requires continuous personal care; fully dependent for daily activities; little awareness of recent events or environment; severe communication impairment; high medical vulnerability

Alzheimer's disease rarely occurs in isolation; it sits at the intersection of aging and multimorbidity. Recent analyses suggest that **more than 80% of people living with dementia have at least two additional chronic conditions**, such as hypertension, diabetes, cardiovascular disease or chronic kidney disease, with many living with three or more[40]. This multimorbidity is associated with higher hospitalisation rates, increased risk of complications, longer lengths of stay and substantially higher care costs over time. Studies also show that multimorbidity with onset in midlife is strongly associated with subsequent dementia[41]. In APAC, this burden is magnified by very high rates of metabolic disease, particularly diabetes. In China, about 12% of adults - nearly 148 million people - are living with diabetes[42], while in Thailand roughly 10% of adults (over 6.3 million people) are affected[43], with prevalence and undiagnosed rates continuing to rise. A recent study on older Chinese adults shows a strong relationship between multimorbidity and dementia, with risk rising as additional conditions accumulate and diabetes-hyperlipidaemia combinations exert an especially strong adverse effect. Thai cohort data likewise indicate that over half of older adults with diabetes exhibit measurable cognitive impairment, suggesting how poorly controlled type 2 diabetes can accelerate cognitive decline and dementia risk[44]. These patterns reinforce that public-health planning should prioritise early identification and management of these treatable conditions, alongside population-level cardiometabolic risk-reduction campaigns, to slow progression of metabolic multimorbidity and mitigate its compounding effects on Alzheimer's disease and other dementias burdens in APAC.

In addition to its heavy clinical toll, Alzheimer's disease and other dementias impose profound and compounding burdens across patients, families, society, and healthcare systems. In 2019, the global societal cost of dementia reached approximately **US $1.3 trillion**, with about **50% attributable to informal, unpaid care** provided by family members or other caregivers[45]. The remainder comprised direct social sector spending on services such as long-term care (around 34%) and direct medical costs associated with diagnosis, treatment, and care delivery (about 16%)[46]. As populations age and the number of people living with dementia continues to rise, all components of this economic burden are projected to increase substantially to approximately **US $2.8 trillion** by 2030[47]. A recent macroeconomic analysis further estimates that Alzheimer's disease and other dementias will reduce global GDP by about **INT$14.5 trillion between 2020 and 2050**, equivalent to **0.42% of annual global GDP**[48].

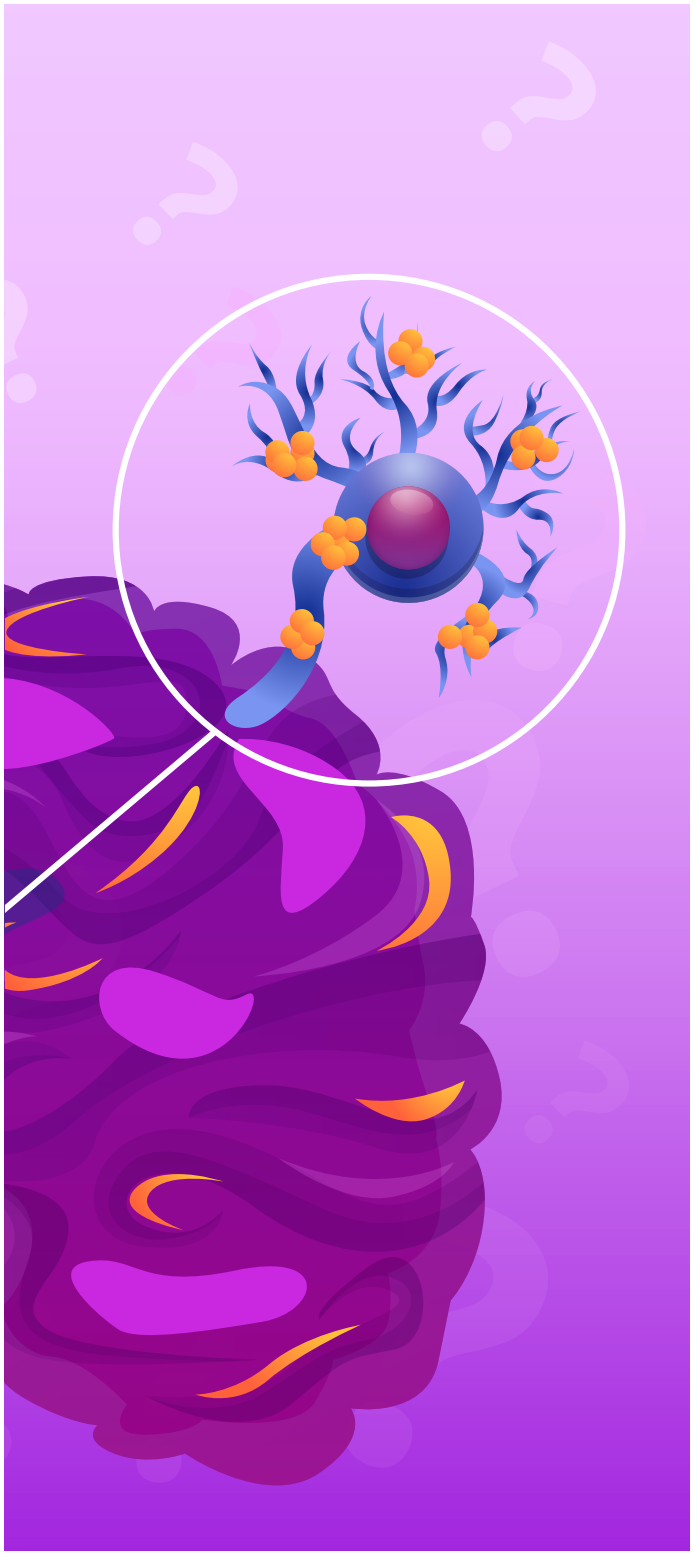
APAC examples illustrate how this burden plays out at system level. Regional dementia care costs are estimated at **US $185 billion**, with around **70% of this spending occurring in more advanced economies**, yet low- and middle-income countries (LMICs) face the fastest growth in cases with far fewer formal services[49]. In 2020, dementia-related spending in China was estimated at **USD 233 billion** using the opportunity-cost approach and **USD 257 billion** using the proxy-cost approach. These figures were projected to reach approximately USD 332 billion and USD 366 billion by 2025, respectively. Looking ahead to 2030, national dementia expenditures are expected to escalate to **USD 494 - 545 billion**, representing **1.98 - 2.12% of the country's GDP** - an increase of more than twofold compared with 2020[50]. In Japan, the societal cost of Alzheimer's disease dementia alone has been estimated at around US $6.9 billion, with long-term care and informal caregiving representing the bulk of expenditures rather than acute medical care[51]. Public long-term care added about US $30.9 billion, while informal and productivity losses for family caregivers reached approximately US $54 billion, accounting for the overwhelming majority of total costs[52]. In Australia, dementia has become a major cause of mortality and represents a significant financial burden. In 2022-23, total spending on aged care, healthcare, and dedicated dementia support for people living with the condition was estimated at approximately US $3.0 billion[53]. Across the region and globally, women disproportionately bear this load: they provide around 70% of dementia care hours, averaging 5 hours of unpaid care per day, while also experiencing higher dementia-related disability and mortality[54].

While several diseases can lead to dementia, Alzheimer's disease warrants particular clinical and policy attention because **early and accurate Alzheimer's disease diagnosis fundamentally changes the trajectory of care and outcomes[55].** Unlike most other dementias, Alzheimer's disease has validated biomarkers that can detect the disease years before symptoms appear, creating a meaningful therapeutic window in which intervention is most effective. Early identification enables access to symptomatic treatments and emerging DMTs, which provide the greatest long-term benefits for People Living With Dementia (PLWD) when initiated early in the disease continuum[56]. For families, it provides clarity early enough to support informed medical, financial, legal, and life-planning decisions before the disease becomes debilitating[57] [58]. At the system level, earlier Alzheimer's disease diagnosis strengthens preparedness by enabling more accurate forecasting of care needs, guiding budget allocation and workforce planning, informing long-term care capacity, and ensuring appropriate referral and care pathways.

Taken together, these trends make clear that Alzheimer's disease is not only a growing clinical crisis, but a **structural health-system and economic imperative for the APAC region.** Acting early, prioritising Alzheimer's disease in national strategies, and making targeted, cost investments in diagnosis, care capacity, and treatment access offer the most realistic pathway to prevent the growing burden from overwhelming health and social systems.

APAC needs a dedicated Alzheimer's disease policy response now

The scale of preclinical Alzheimer's disease, the strong association between multimorbidity and dementia risk, and the accelerating societal and fiscal costs all signal that current approaches are insufficient. For APAC governments and health authorities, Alzheimer's disease requires dedicated, forward-looking, and cost strategies that prioritise earlier detection supported by biomarker-based diagnostics, DMT access, strengthening specialist and long-term care capacity, expanding caregiver support, and ensuring sustainable financing mechanisms. Without decisive policy action, Alzheimer's disease and other dementias will continue to outpace system readiness, widen inequalities - particularly in LMICs - and place mounting pressure on national budgets, labour markets, and economic growth across the region.



4.2. White paper design and methodological approach

a. Literature review

This White Paper is grounded in a systematic benchmarking exercise designed to assess the current Alzheimer's disease landscape, policy environment, diagnostic readiness, clinical standards, and care models across APAC.

A structured evidence review was conducted covering both international and national sources. Indexed literature databases (e.g., MEDLINE, Embase, Cochrane Library) were complemented by grey literature, including government policy papers, clinical guidelines, strategic frameworks, programme evaluations, and published registry data.

More than 150 publications from the last 25 years (2000 - 2025) were reviewed and thematically organised into core areas most relevant for Alzheimer's disease system readiness: (1) Epidemiology and disease burden, (2) Societal and economic impact, and (3) Policy, infrastructure, and pathway effectiveness.

This review served as the analytical foundation for identifying policy gaps, variability across territories, and opportunities to strengthen early detection, equitable access to biomarkers, and system preparation for DMT.

b. Scorecard

Insights from the literature review informed the development of an Alzheimer's disease policy and system-readiness scorecard, designed to provide a structured, comparable assessment across the region. The framework consists of **5 domains**, **26 sub-domains** and **76 indicators**, reflecting critical components of effective Alzheimer's disease management:

1. **National policy and planning**: Reviewing the extent to which Alzheimer's disease is reflected in national strategies, including dedicated policy or action plans, governance structures, financing commitments, and national registries; This domain also assesses whether policies are designed inclusively, supported by clinical guidelines, aligned with preventive-care priorities, and accompanied by research, innovation, and implementation mechanisms
2. **Prevention and early identification**: Evaluating the presence and quality of screening policies for high-risk populations, including clinical guidance, coverage arrangements, and funding mechanisms that support cognitive assessment and early biomarker-based identification of Alzheimer's disease
3. **Diagnosis and system capacity**: Assessing availability and implementation of Alzheimer's disease diagnostic guidelines, the strength of diagnostic infrastructure (neuroimaging, CSF and blood-based biomarkers), specialist and workforce capacity, referral timeframes, rates of diagnostic testing, and financial support for Alzheimer's disease diagnostics
4. **Treatment, monitoring, and access**: Reviewing policies and protocols governing Alzheimer's disease treatment and monitoring, including use of multidisciplinary care models, integration with supportive and palliative services, availability and affordability of symptomatic therapies, preparedness for DMTs, adoption of home-based and remote monitoring models, and reimbursement or coverage schemes
5. **Advocacy, awareness, and education**: Examining the role and engagement of patient organisations, professional societies, and research institutes in national dialogue; availability of education, support tools, and capacity-building resources; and the visibility of Alzheimer's disease within national campaigns to reduce stigma, strengthen caregiver support, and enhance clinician capability

Each indicator was scored using publicly available information, with tiered scales illustrating maturity levels from low to high. Ratings were derived through structured literature review, policy document analysis, and publicly accessible datasets. All scoring judgements reflect Deloitte's independent analysis and may not capture every nuance within national regulatory or delivery systems.

c. Advisory panel

To reinforce technical robustness and contextual accuracy, the research was guided by an Advisory Panel of regional experts in neurology, geriatrics, dementia care, public health policy, and health-system design from across APAC.

Advisors contributed through structured consultations, written feedback, and virtual roundtable discussions. Their input helped refine the assessment framework, validate findings, interpret policy variation, and ensure recommendations are clinically grounded, regionally relevant, and aligned with global Alzheimer's disease best practices. While the insights of these experts informed the work, the conclusions presented in this White Paper represent Deloitte's independent assessment and do not necessarily reflect the views or recommendations of the experts or their respective organisations. Some elements of our assessment reflected differing perspectives from these stakeholders.

5.

Disease landscape and burdens of Dementia and Alzheimer's disease in Asia Pacific

5. Disease landscape and burdens of Dementia and Alzheimer's disease in Asia Pacific

5.1 Disease overview

a.Dementia and Alzheimer's disease in the regional NCD landscape

Dementia is a clinical syndrome marked by progressive decline in one or more cognitive domains, memory, language, executive function, and visuospatial skills, severe enough to impair everyday functioning. Although risk rises with age, dementia is not a normal consequence of ageing. Globally, over 55 million people lived with dementia in 2021; trajectories indicate ~78 million by 2030 and ~139 million by 2050. More than 60% of cases already occur in low- and middle-income countries (LMICs), and the LMIC share is projected to reach ~71% by 2050. These realities make dementia a leading driver of disability, dependency and costs across Asia–Pacific. [59 60 61]

Alzheimer's disease is the most common cause of dementia, typically ~60–70% of cases. Biologically, Alzheimer's disease is defined by amyloid-β plaques and tau neurofibrillary tangles and is conceptualized as a continuum from preclinical AD through MCI due to AD to AD dementia. Diagnostic confirmation increasingly relies on biomarkers, CSF ratios or emerging blood-based assays, and, selectively, amyloid/tau PET. Biomarker-enabled pathways help differentiate Alzheimer's disease from non-Alzheimer's disease dementias and target DMTs appropriately. [62 63 64]

Table 1: The subtypes of dementia and Alzheimer's disease

Dementia type	Typical clinical features	Primary pathology/mechanism
Alzheimer's disease (AD)	Progressive episodic memory loss → multidomain decline; gradual course	Amyloid-β plaques; tau tangles; synaptic and neuronal loss
Vascular cognitive impairment/ dementia (VCI)	Executive dysfunction, slowed processing, attention deficits; gait change; stepwise decline post-stroke or insidious with small-vessel disease	Large-vessel ischemic stroke or small-vessel disease (white-matter injury)
Lewy body dementias (DLB/PDD)	DLB: fluctuations, visual hallucinations, parkinsonism, REM sleep behaviour disorder; PDD: dementia after established Parkinson's disease	α-synuclein (Lewy bodies); cortical/ subcortical network disruption; cholinergic deficits
Frontotemporal dementias (FTD)	Often <65 years; bvFTD (disinhibition, apathy, loss of empathy) or language variants (primary progressive aphasia)	Tau or TDP-43 proteinopathies; focal frontal/temporal degeneration
Mixed dementias	Mixed memory + executive + visuoperceptual deficits depending on combined pathologies	Co-occurrence of AD with vascular and/or Lewy body changes

AD type	Clinical presentation	Key biology/biomarkers
Typical amnestic AD	Insidious episodic memory impairment → multidomain decline	Amyloid+/tau+; medial temporal and posterior cortical involvement
Young onset AD (<65 years) incl. Autosomal Dominant Alzheimer's Disease (ADAD)	Earlier onset; frequent non-amnestic features; strong family history	Pathogenic APP/PSEN1/PSEN2 variants; high amyloid positivity
Posterior cortical atrophy (PCA)	Early visuoperceptual/visuospatial symptoms (reading/navigation) with relative memory sparing initially	AD pathology posteriorly; tau burden occipito-parietal
Logopenic variant Primary Progressive Aphasia (PPA) (lvPPA)	Word-finding pauses; impaired sentence repetition; phonologic short-term memory (STM) deficits	AD pathology with left temporoparietal involvement; amyloid+/tau+
Behavioral/dysexecutive variant AD	Early apathy/disinhibition; executive dysfunction; resembles bvFTD	AD biomarkers positive; posterior or mixed frontal–posterior patterns

b. Risk factors

Dementia's causes are heterogeneous and often mixed; AD remains the most common aetiology (typically ~60–80% of cases), biologically defined by amyloid-β deposition and tau pathology and staged across a continuum from preclinical AD through MCI due to AD to AD dementia under the A/T/N framework.[65 66]

Age is the strongest overall risk correlated for AD, yet dementia is not inevitable with ageing, as shown by population cohorts in which many individuals reach advanced age without dementia.

Clinical factors

From a clinical vantage point, Alzheimer's risk accumulates through a constellation of conditions that interact over the life course. Age remains the strongest correlation of AD incidence; however, dementia is not an inevitable consequence of aging, as many people reach advanced age without cognitive impairment. Vascular comorbidities play a central role: sustained midlife hypertension, diabetes, dyslipidaemia, and cerebrovascular disease (including small-vessel disease and prior stroke) are consistently associated with later cognitive decline and increased dementia risk, and their optimal management reduces downstream AD burden. In addition, midlife hearing impairment has emerged as one of the largest single contributors to population-level dementia risk, and routine screening, hearing-aid fitting, and rehabilitation are pragmatic levers to mitigate this pathway.[8] Clinical depression, especially when persistent or recurrent, is also associated with higher dementia risk, with timely treatment and social support improving trajectories.[8] Emerging signals indicate that vision loss may contribute meaningfully to risk in certain regions and populations, underscoring the broader importance of sensory health within dementia prevention portfolios.[9] Finally, because mixed etiologies are common in older adults, clinical pathways should recognise the compounding effects of vascular brain injury and other co-pathologies when assessing risk and designing follow-up.[3 4]

Modifiable risk factors

Lifestyle exposures shape risk across decades and are amenable to policy and clinical intervention. Tobacco smoking increases vascular and neurodegenerative risk, and cessation lowers risk even in later life; physical inactivity and unhealthy dietary patterns that drive obesity and metabolic syndrome are linked to cognitive decline, while regular activity and healthy weight maintenance are protective.[8] Harmful alcohol consumption elevates risk and responds to standard harm-reduction approaches.[8] Social participation matters as well: low social contact and loneliness are associated with higher dementia risk, and programmes that enhance engagement and community ties can reduce isolation-mediated pathways.[8] These levers frequently co-benefit broader noncommunicable disease (NCD) goals in cardiovascular and metabolic health, strengthening the cost-effectiveness case for investment.[2 8]

Genetic factors

Genetic influences on AD span common alleles and rare, highly penetrant mutations. The APOE ε4 allele is associated with increased risk and earlier average age at onset in sporadic, biomarker-defined AD cohorts, making it the most studied common genetic risk factor.[5] At the rare end of the spectrum, autosomal-dominant AD (ADAD) due to pathogenic variants in APP, PSEN1, or PSEN2 causes early-onset familial disease with relatively predictable ages at symptom onset, a pattern well documented in the Dominantly Inherited Alzheimer Network and subsequent genetic screening studies.[6 7] In addition, Down syndrome confers markedly elevated AD risk because the APP gene resides on chromosome 21, increasing amyloid-β production and accelerating underlying pathology.[7] While genetic status is non-modifiable, its recognition is vital for counselling, surveillance, and eligibility for targeted trials and interventions.[5 6]

Environmental factors

Environmental exposures, particularly air pollution (fine particulate matter, PM2.5), are associated with increased dementia risk, and clean-air policies therefore function as upstream dementia-prevention levers alongside their cardiopulmonary benefits.[8] Evidence synthesised in the Lancet Commission and updated in global population-attributable fraction analyses indicates that air-quality improvements can meaningfully reduce aggregate risk, with the largest gains in lower-resource settings where pollutant exposures are higher.[8 9] Although environmental noise can contribute to hearing loss—thereby indirectly affecting dementia risk—the most robust dementia-specific evidence to date centres on particulates and broader pollution control.[8 9]

Other factors (socio-structural, injury, and care-system determinants)

Several additional domains warrant inclusion because they shape risk environments and modify individual trajectories. First, education, particularly access to quality schooling in early life, increases cognitive reserve and is consistently associated with lower dementia risk across cohorts; expanding educational opportunity is therefore a cornerstone of long-horizon prevention.[8] Second, traumatic brain injury (TBI)—including repetitive head impacts—is linked to higher dementia risk, making road safety, occupational protections, and sport concussion protocols relevant for NCD strategies that include AD.[8] Third, health-system and social determinants—captured by indices such as the sociodemographic index (SDI), gross national income (GNI), and the Health Access and Quality Index (HAQI)—correlate with the share of dementia attributable to modifiable factors, suggesting that tailored whole-population approaches should be prioritised where baseline risk exposure is highest and service access is most constrained.[9] In aggregate, these socio-structural and injury-related determinants complement clinical, lifestyle, genetic, and environmental domains, and they emphasise that AD risk reduction is both a medical and a policy endeavour.

c. Treatment landscape

The modern AD care pathway is shifting from late, syndromal recognition toward earlier, biomarker-enabled intervention and real-time safety monitoring. This transformation is shaped by (i) life-course prevention with demonstrable population-level impact, (ii) diagnostic precision using the NIA–AA A/T/N biomarker framework, (iii) a two-tier treatment model (symptomatic + disease-modifying therapies in appropriately selected patients), and (iv) active pharmacovigilance/registry tracking to ensure safety, equity, and measurable outcomes.

Prevention

Prevention acts across the life course and remains the highest-value lever for health systems. Large evidence syntheses show that addressing twelve modifiable risk factors, education, hypertension, hearing loss, smoking, obesity, depression, physical inactivity, diabetes, low social contact, harmful alcohol use, traumatic brain injury (TBI), and air pollution, could prevent or delay a substantial share of future dementia cases (up to ~40% in pooled models), with newer global analyses estimating ~34% and highlighting regional variation (for example, a prominent signal for vision loss in some settings). These data justify upstream investment in midlife cardiovascular/metabolic control, sensory health, tobacco control, active mobility, and clean-air policy, alongside structural actions that expand access to education and injury prevention. [70]

As the burden rises—57 million people with dementia in 2021, nearly 10 million new cases annually—the WHO Global Action Plan on Dementia (2017–2025) calls for integrated risk reduction, diagnosis, treatment, caregiver support, data systems, and innovation, providing a blueprint for national and regional programmes (including APAC).[71]

Diagnosis

Diagnosis now combines clinical assessment, structural imaging, and biomarkers to distinguish AD from non-AD dementias and to identify mixed disease (common in older adults). The NIA–AA Research Framework (2018) defines AD biologically using A/T/N measures: β-amyloid (A), pathologic tau (T), and neurodegeneration (N), enabling diagnosis across the continuum from preclinical disease to MCI due to AD and AD dementia. This approach standardizes eligibility and timing for disease-modifying therapies and supports consistent care pathways. [63]

Access to biomarkers is expanding. In June 2023, the FDA granted 510(k) clearance to CSF assays providing t-tau/Abeta42 and p-tau181/Abeta42 ratios, which are concordant with amyloid PET and help confirm AD pathology in adults ≥55 undergoing evaluation. These assays can be run on widely available automated analyzers, offering scalable confirmation of amyloid status as part of diagnostic work-ups.[72]

In October 2024, the WHO published Preferred Product Characteristics (PPC) for blood-based AD diagnostics, guiding developers, funders, and regulators on analytic performance and equitable adoption, particularly in LMICs where CSF/PET access is limited. The PPC reflects the rapid progress of BBBMs p-tau217 and related assays and anticipates validation in diverse, real-world populations. [73]

Treatment

Treatment has two layers: symptomatic therapies and disease-modifying anti-amyloid monoclonal antibodies. Symptomatic agents, cholinesterase inhibitors (donepezil, rivastigmine, galantamine) and memantine, offer modest improvements in cognition or global function for many patients; recommendations differ by stage and tolerance, and discontinuation strategies may be considered to reduce treatment burden when memantine is initiated, without worsening institutionalization risk in some cohorts. These are not disease-altering therapies but remain foundational to comprehensive care. [74 75]

Disease-modifying anti-amyloid therapies are now available in several markets for early symptomatic AD with confirmed amyloid pathology. AD drug was launched in Japan in December 2023 with NHI pricing ~¥2.98M/year (~US$20,500) and appropriate-use guidance; China launched AD drug in June 2024, initially in the private market, with CNY 2,508 per 200 mg vial and pilot insurance solutions, both signalling integration of diagnostic confirmation and post-marketing surveillance.[76 77 78]

In the United States, another AD drug received FDA approval in July 2024 for adults with early symptomatic AD (MCI or mild dementia) and confirmed amyloid pathology. The approval highlights monthly infusions, limited-duration therapy tied to plaque clearance, and boxed warnings for ARIA (amyloid-related imaging abnormalities), mandating careful eligibility selection and MRI-based monitoring.[79]

Monitoring

Monitoring spans safety, effectiveness, and system performance. At the patient-level, anti-amyloid therapies require ARIA surveillance: consensus guidance emphasizes key MRI sequences (including GRE/SWI for microbleeds) at baseline and at defined intervals during treatment, with escalation pathways for symptomatic ARIA-E/ARIA-H and standardized reporting to support multidisciplinary decision-making.[80]

At the programme-level, national dashboards and registries track uptake, outcomes, and equity. The WHO Global Dementia Observatory provides a monitoring mechanism across seven action areas (risk reduction, diagnosis, treatment/care, carers, data, research/innovation), while Australia's National Dementia Action Plan (2024–2034) publishes annual indicator dashboards - including measures for diagnosis and post-diagnostic support - to assess progress and guide improvement cycles.[81 82]

5.2 Dementia & Alzheimer's disease epidemiology in Asia Pacific

Prevention

Across APAC, point prevalence of all-cause dementia ranges from ~7-12% in high-resource country surveys to >25% in some LMIC community studies using the 10/66 algorithm, with AD typically comprising ~60–70% of cases. For example, Singapore's WiSE-2 found 8.8% dementia among adults ≥60 (2022–2023), with absolute numbers rising due to population ageing and a shrinking treatment gap (from 70.6% to 51.5%).[83]

In South Korea, the 2023 Ministry of Health and Welfare survey recorded 9.25% dementia among ≥65 and 28.42% MCI, with >1 million people projected by 2026. [76]

In Japan, updated projections show ~4.43 million people with dementia in 2022 and ~6.45 million (17.7% of ≥65) by 2060, a downward revision linked to improved risk-factor control. [76]

In Aotearoa New Zealand, capture-recapture analysis correcting for cases missing from routine datasets raised dementia prevalence to ~7.1% (≥60) and ~9.2% (≥65), with ~48% of cases not captured, highlighting under-diagnosis across ethnic groups. Australia estimates ~425,000 people living with dementia (2024) and projects ~1.1 million by 2065, with dementia the leading cause of death in 2023. India's LASI/LASI-DAD modelling indicates 7.4% dementia among ≥60, ~8.8 million people, with large urban–rural and sex gradients. Malaysia reports ~330,000 people living with dementia (2023) and launched national action plans to strengthen detection and care. Indonesia's STRiDE study (two provinces; 10/66) found ~27.9% (≥65) and <1% formally diagnosed, underscoring hidden burden. China reports a very large early-AD pool: ~17 million people with MCI or mild AD dementia (2024), reflecting demographic scale and the need for scalable blood-based biomarkers to support diagnosis.[84]

Table 2: Dementia prevalence and AD-specific signal

Territory	Dementia prevalence	AD-specific signal	Burden level
China [92]	— (early-AD pool reported)	Early-AD pool ~17M (MCI/mild AD, 2024)	High–Very high
South Korea[86 87]	9.25% (≥65, 2023); MCI 28.42%; >1M by 2026	AD predominates; rising vs vascular over time	High
Japan [88]	12.3% (≥65, 2022); 17.7% (≥65) ≈6.45M by 2060	AD ≈ ~70%; Basic Act/Plan emphasises early detection	High
Australia [89 90]	~425,000 (2024); ~1.1M by 2065; leading cause of death (2023)	CSF biomarker ratios expanding; therapy eligibility rising	High
Taiwan	7.99% (≥65, 2025) [93]	AD the most common subtype (56.88%) [94]	High
Hong Kong	7.2% (≥65)[95]	AD the most common subtype (63%) [96]	High
New Zealand [91]	7.1% (≥60) / 9.2% (≥65) (capture–recapture)	AD share assumed ~60–70%; access uneven	Moderate
Thailand	7.2% (≥65) [97]	AD the most common subtype (54.3%) [98]	Moderate
Singapore [85]	8.8% (≥60, 2023); ~73,918	AD ≈ 60–70%; biomarker adoption growing; usage of novel therapeutics growing	Moderate

Incidence

Incidence data are sparser but confirm growing inflow to caseloads. A 2024 NZ study estimated dementia incidence 19.2/1,000 person-years (≥60) after capture–recapture correction, with ~36% of incident cases missing from datasets; rates rose with age and showed ethnic differences. Japan's recent multi-site work (2022–2023) suggests lower dementia morbidity rates than earlier estimates, consistent with risk-factor improvements, yet absolute numbers will increase with ageing. In South Korea, MCI prevalence (a precursor state) has grown to 28.42% (≥65), portending higher future incidence even as dementia prevalence has plateaued.[99]

Many LMICs (e.g., Indonesia, India) lack robust national incidence series, emphasising the need for routine registries and biomarker-enabled diagnostic pathways to quantify inflow.

Comorbidities and mixed pathologies relevant to AD

Older adults frequently show mixed etiologies, AD plus vascular brain injury, Lewy body pathology, or TDP-43, complicating diagnosis and care. Comorbid cerebral amyloid angiopathy (CAA) is important for systems considering anti-amyloid therapies: recent work links Lewy body co-pathology to higher CAA risk, and CAA increases susceptibility to ARIA (amyloid-related imaging abnormalities), necessitating careful eligibility and MRI monitoring. Under-diagnosis is itself a co-determinant of burden; NZ and Indonesia demonstrate large fractions of undetected cases, especially in minority or rural populations. Finally, vascular risk control (hypertension, diabetes) and sensory health (hearing/vision) materially influence dementia trajectories, reinforcing the prevention section of this chapter.

5.3 Social and economic burdens of Dementia & Alzheimer's disease in Asia Pacific

a. AD patients' quality of life

AD progressively erodes autonomy and everyday functioning, beginning with episodic memory and extending to language, visuospatial, and behavior domains, reducing quality of life (QoL) for patients and families. Atypical phenotypes (PCA; lvPPA) can produce earlier disability in reading/navigation or communication even when memory is relatively spared. Early recognition and service expansion (e.g., reduced treatment gap in Singapore) may improve QoL and caregiver outcomes.[100]

b. Gender-specific burden

Across APAC, women bear a disproportionate burden - as patients and caregivers. In Australia, more women live with dementia than men and dementia is the leading cause of death; in South Korea, female prevalence exceeds male prevalence (9.57% vs 8.85%). These differences reflect longevity, biological risk, and social caregiving roles that translate into greater financial, health, and time costs for women.[101] [102]

c. Caregiving dynamics

Informal caregiving remains central. In South Korea, non-cohabiting kin provide ~18 hours/week and facility care costs exceed community care (KRW 31.38M vs 17.34M annually). Singapore has expanded polyclinic memory services and day care capacity to ease burden; in New Zealand, capture–recapture (~48% cases missing) implies hidden family burden in official statistics. [103] [104] [105] [106]

d. Economic burdens

1. **National burden relative to AD/dementia spending**

   Australia projects ~1.1M people by 2065 and reported ~AUD 3.7B direct health & aged-care costs in 2020–21 (49% residential aged care). China's early-AD pool (~17M) is prompting payer pilots to manage access and fiscal risk. [107] [108]

2. **Direct vs indirect cost balance**

   Direct costs (medical care, long-term care, diagnostics) and indirect costs (caregiver time, productivity loss, transport, home modifications) both rise in APAC, but their balance differs by system maturity. In Australia, direct spending is well-documented, residential aged care is the single biggest cost component—while indirect costs are high but harder to quantify.

   In South Korea, per-patient costs highlight the split: facility/hospital care averages KRW 31.38 million/year, vs KRW 17.34 million/year in the community, with care expenses the largest share, yet families still absorb substantial indirect costs (time and out-of-pocket), especially before institutionalization.

   In New Zealand, under-ascertainment (nearly half of cases missing) implies that indirect costs borne by families—unpaid care and lost earnings—are significantly bigger than what routine data capture, inflating the true societal bill. [109]

3. **Patient-level spending and efficiency**
   Households face sharp increases when institutionalizing. Efficiency gains come from diagnostic pathways (CSF; emerging blood-based tests) that reduce PET dependence and help target early-AD therapies; community services can delay institutionalization and reduce hospitalizations. [110] [111] [112] [113]

   In China, AD drug launched first in the private market with a listed vial price of CNY 2,508 (200 mg); payer pilots aim to share cost risk while building diagnostic pathways—including blood biomarkers—to target treatment efficiently at early-AD. While therapy pricing is significant, diagnostic efficiency (see d-4) can lower per-patient system costs compared with PET-dependent routes.

4. **Cost efficiency & sustainability (diagnosis, care models, therapy)**
   Diagnostic efficiency is a major sustainability lever. FDA-cleared CSF assays (e.g., t-tau/Aβ42, p-tau181/Aβ42) offer high concordance with amyloid PET and can be deployed on existing immunoassay platforms, reducing reliance on costly PET and speeding A/T/N confirmation for therapy eligibility.

   In October 2024, WHO issued Preferred Product Characteristics (PPC) for blood-based AD diagnostics to guide product performance and equitable adoption, especially in LMICs, signalling a pathway to lower-cost, scalable triage and follow-up.
   On the care delivery side, community services (day care, carer respite, integrated primary care) can reduce hospitalizations and delay institutionalization, e.g., Singapore's expansion of polyclinic dementia services and day-care capacity—improving caregiver retention and system efficiency.

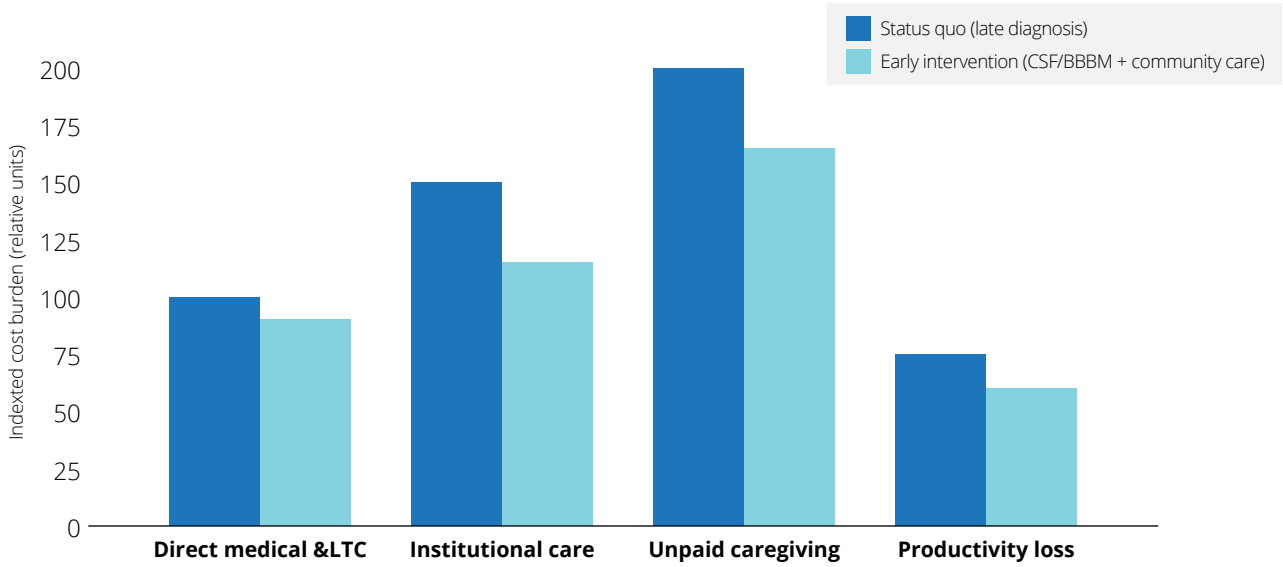
   For therapy programmes, safety monitoring (e.g., ARIA risk with anti-amyloid therapies) requires MRI protocols and careful eligibility (e.g., CAA, APOE-ε4), which add upfront costs but protect long-term sustainability by avoiding severe adverse events and inappropriate use.

5. **Cost of inaction: immediate and future burdens of late diagnosis**
   Late diagnosis shifts care to crisis settings (A&E/inpatient) and accelerates institutionalisation, raising total cost and depressing quality of life. Global cost trajectories show current dementia costs >US$1.3T, rising to ~US$2.8T by 2030; macro models project a cumulative global AD/ADRD burden of ~US$14.5T by 2050. [114] [115]

   UK real-world analyses show undiagnosed dementia patients attend A&E more often and that delaying nursing home admission can save £8,800–£44,900 per person. [116]

6. **Baseline late-stage diagnosis vs early programmatic intervention (chart)**
   Illustrative indexed comparison: status quo late diagnosis increases institutional care and unpaid caregiving; early intervention using CSF and blood-based biomarkers (BBBM) plus community support reduces crisis care. [117] [118]

Figure 3: Baseline late-stage diagnosis vs early programmatic intervention



7. **Macroeconomic impact on GDP and economy**
   U.S. microsimulation places the 2025 burden at US$781B, of which only ~30% is medical/LTC; QoL losses (~US$302B), unpaid caregiving (~US$233B) and lost earnings (~US$8.2B) dominate—translating into GDP opportunity costs. Global macro modelling indicates multi-trillion losses by 2050. [119] [120] [121]

8. **Boost from investments: diagnostics, DMTs, and growth**
   Accelerating biomarker-enabled diagnostics and DMTs can add up to ~0.5% to regional GDP by 2030 via productivity gains; Europe modelling shows savings of €33.7–€85B (25–50% progression reduction) and €84.7B for a 3-year halt at mild stage; U.S. acceleration of DMT R&D reduces per-drug development cost (from ~US$5.7B to ~US$2.0B), averts ~7M cases (2025–2040), and saves US$74–100B in care costs. [122] [123] [124]

   DMT market outlook suggests a CAGR ~67.8% to 2030 (from early base), stimulating pharma innovation and jobs. [125]

9. **Indirect benefits: QALY gains and productivity**
   Early CSF/BBBM detection adds ~0.02–0.54 QALYs per patient; DMTs deferring onset by 1–5 years can reduce incidence by 24–39%. U.S. indirect costs are ~US$832B annually (including ~US$599B unpaid caregiving and ~US$233B productivity losses), and rise steeply with severity—underscoring the value of early detection and support. [126] [127] [128]

   LMIC systematic reviews indicate indirect costs average ~58% of total dementia burden vs ~42% direct—important for APAC LMIC planning. [129]

10. **ROI for diagnostics & therapies (CSF, BBBMs, DMTs)**
    CSF biomarkers (t-tau/Aβ42; p-tau181/Aβ42) provide high diagnostic certainty (PET-concordant), improving staging and reducing misdiagnosis. Economically, focus should shift from "test cost" to "value of early certainty": avoiding unnecessary treatments, targeted DMT eligibility, delayed institutionalisation, and fewer crisis admissions. [130] [131]

    BBBM (e.g., p-tau217): WHO PPC (Oct 23, 2024) sets analytic and adoption targets, enabling primary-care triage and CSF confirmation, reducing PET dependence and widening equity. [132]

    European/UK/US savings: €33.7–€72.7B at 25–50% progression reduction; €84.7B for 3-year halt at mild stage; £0.7–£3.3B annual net savings in UK scenarios; and U.S. R&D acceleration reducing per-drug costs to ~US$2.0B with ~7M cases averted and US$74–100B in care savings. [133] [134] [135]

    APAC program design: BBBM triage in primary care → CSF confirmation in memory clinics → eligibility vetting (CAA/APOE, MRI capacity) → registries/dashboards (outcomes, equity, ARIA safety). [136]

Table 3: Dementia / AD social and economic burden signals

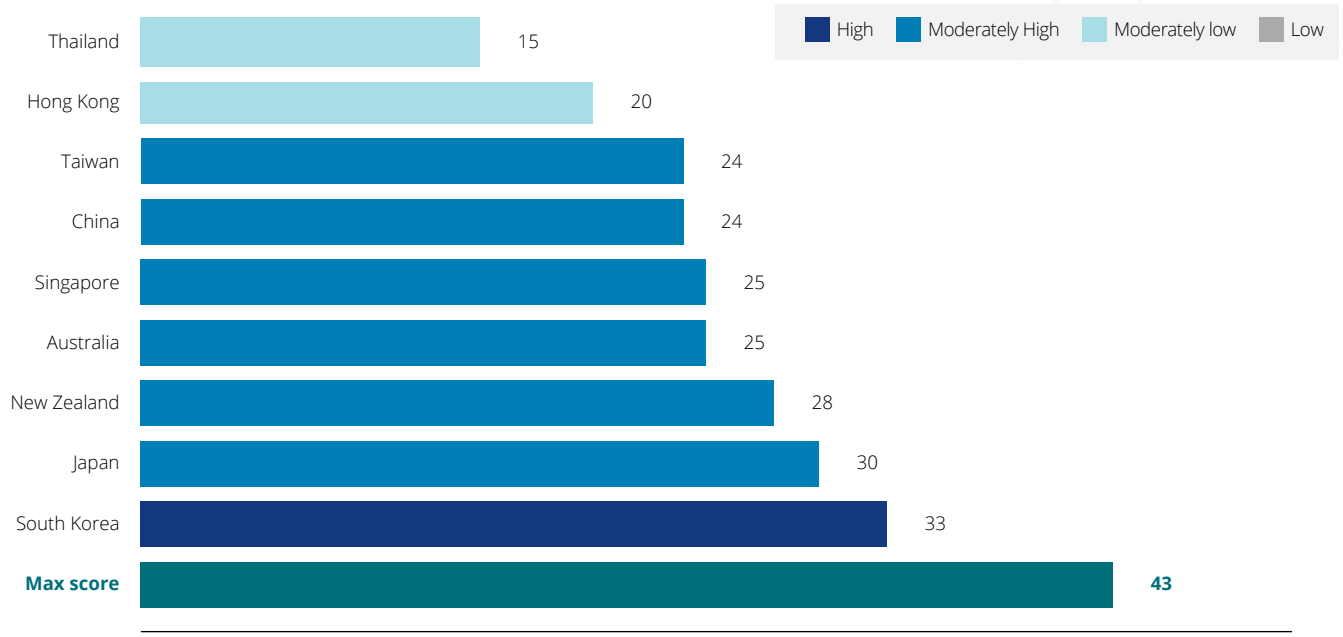
Territory	Social burden signals	Economic burden signals
Australia	>102,000 informal carers; dementia = leading cause of death (2023)[137]	Direct health & aged-care costs ~AUD 3.7B (2020–21); 49% residential aged care; ~1.1M projected by 2065
China	Early-AD ~17M (2024) requires scalable patient & caregiver support[139]	Private-market therapy launch with CNY 2,508/vial; insurance pilots to share risk; blood biomarkers for efficient case-finding[142]
Hong Kong	High system and caregiving needs implied by cost escalations; gaps in early diagnosis reflected in hidden care costs[140]	Annual per-person cost for older adults with neurocognitive disorders incl. dementia: US$5,677 (mild), ~US$12,841 (major)
Japan	Morbidity revised downward (risk-factor improvements), but absolute numbers rise[142]	Inclusive policy (Basic Act/Plan) aims to manage social & fiscal burden via prevention and early detection[143]
New Zealand	~48% of cases missing (capture–recapture); equity gaps for Māori, Pacific, Asian[143]	Under-ascertainment implies indirect costs underestimated; incidence ~19.2/1,000 py (≥60)[136]
Singapore	Treatment gap reduced to 51.5%; expanded day care & polyclinic services[144]	Community investment reduces hospital use and caregiver strain (ongoing)[135]
South Korea	Female prevalence higher; families give ~18 hrs/week; high caregiver burden[145 146]	Facility care KRW 31.38M/year vs community KRW 17.34M/year; >1M by 2026 [147 148]
Taiwan	Physical, psychological, and social stresses experienced by caregivers, reflecting broader societal impact beyond direct medical issues[149]	Annual cost per dementia patient: NT$310,018 - 710,737 (~US$9,000 - 20,000)[150]
Thailand	High caregiver burden (~40%) drives poorer quality of life, especially for women and those with financial strain, illness, and long care hours[150]	Dementia care creates significant household financial burden, especially in rural areas (≈THB 90,644 / US$ 2,684 per year)[152]

6.

Assessment of Alzheimer's disease management in Asia Pacific

6. Assessment of Alzheimer's disease management in Asia Pacific

6.1. Domain 1: National / regional disease policy and planning landscape



Comparative summary

- **Overall strengths**
  - **Dedicated national dementia strategies:** 7/9 territories (except Hong Kong and Thailand) have dedicated dementia strategies, demonstrating a clear policy focus to addressing dementia as a distinct priority rather than as part of broader aging or noncommunicable disease agendas
  - **Preventive and community orientation:** Policies increasingly emphasise early detection, risk reduction, and community-based care, aligning with WHO and regional ageing priorities
  - **Evidence-based policy making:** Several plans (e.g., Australia, Japan, South Korea, Taiwan) link policy with research, data, or registry development, supporting evidence-based decision-making
  - **Integrated care systems:** Integration of healthcare-welfare systems (e.g., Hong Kong, Taiwan, South Korea) strengthens continuity of care and carer support
  - **Long-term commitment:** Multi-year plans (e.g., Australia's 10-year, Japan's Basic Plan 2024, Taiwan's 2018-2025) demonstrate policy stability and long-term government commitment

- **Common gaps**
  - **Limited Alzheimer's disease-specific focus:** While Alzheimer's disease is often addressed within broader dementia frameworks, most economies lack **dedicated Alzheimer's disease-specific objectives and costed implementation plans**. In the DMT era, this gap is no longer a technical omission - it is a **system-level risk; The absence of clear, costed national Alzheimer's disease action plans threatens the fiscal viability of DMT introduction**, as payers cannot justify reimbursement without assurance that early-stage patient identification, biomarker confirmation, and monitoring pathways will be properly funded; Dedicated Alzheimer's disease planning is therefore essential to ensure that diagnostic prerequisites are in place, financial exposure is controlled, and access pathways for emerging Alzheimer's disease diagnostics and therapies are sustainable
  - **Weak data and monitoring system:** Few economies have operational dementia registries and Alzheimer's disease-specific registries are rare, existing only in select high-income economies (Japan, Korea); The absence of systematic Alzheimer's disease data collection hampers evidence-based planning, monitoring of therapeutic access, and evaluation of Alzheimer's disease-specific policy impacts; Establishing robust national dementia and Alzheimer's disease registries should form part of these operational plans
  - **Delayed policy renewal:** Policy updates are slow or outdated in several territories (e.g., Singapore, Thailand), limiting responsiveness to rapid advances in Alzheimer's disease research and care

- **Disparities across economy archetypes**
  - **High maturity:** South Korea demonstrates institutionalised and sustained policy framework through a legislated Dementia Management Act and four successive National Dementia Plans with defined implementation cycles and measurable KPIs
  - **Moderately high:** Australia, Japan, New Zealand, Singapore, Taiwan, and China have formal national dementia frameworks with multi-sector coordination. They emphasise early detection, integrated care, and alignment with global dementia priorities, though varying in legal status and implementation strength
  - **Moderately low:** Hong Kong and Thailand address dementia within broader ageing or public-health frameworks rather than through dedicated national dementia plans, indicating limited policy specificity and lower institutional prioritisation
- **Best practices**
  - **Australia:** Integration of ADNeT Registry and National Centre for Monitoring Dementia to inform national planning
  - **Japan:** Basic Act on Dementia mandates inclusion, awareness, and inter-ministerial coordination
  - **South Korea:** Dementia Management Act ensures five-year policy renewal and national performance targets
  - **Taiwan:** Dementia Plan 2.0 aligns with WHO framework and scales community care infrastructure
  - **New Zealand:** Co-development of Dementia Mate Wareware Action Plan with Alzheimer's and dementia organisations promotes equity and inclusion

Table 4: High-level summary of Dementia and Alzheimer' s disease policies in Asia Pacific

Territory	Standalone Dementia / Alzheimer's disease policy	Key highlights	Dementia / Alzheimer's disease registries	Dedicated Dementia / Alzheimer's disease research & innovation funding	Equity & inclusivity provisions
Australia	Yes - ***National Dementia Action Plan 2024–2034***	✓ Establish a 10-year national roadmap to strengthen diagnosis, care coordination, and support for people living with dementia, including Alzheimer's disease ✓ Recognise emerging Alzheimer's disease treatments that may slow disease progression but are not yet approved in Australia ✓ Promote innovative and inclusive clinical trials supported by national research institutions	Yes - ADNeT Registry functions as a national clinical quality registry for dementia and MCI; NCMD provides national monitoring and data linkage	Strong - Multiple dementia-specific allocations in 2024–25 Federal Budget supporting care, research, and training	Yes - First Nations and CALD programs
Hong Kong	No, under Elderly Health framework - ***Elderly Services Programme Plan (2017); Preventive Care for Older Adults in Primary Care Settings (2023)***	✓ Guide long-term elderly service development and improve early detection and multidisciplinary support for dementia, including Alzheimer's disease ✓ Integrate healthcare and welfare services through neighbourhood elderly centres and primary care for early screening and intervention ✓ Strengthen carer training and preventive health education to enhance quality of life and build dementia-friendly communities	No - CUHK Early-Onset Dementia Registry is research-only and not part of national surveillance	Weak - No dementia or Alzheimer's disease-specific budget	Limited

Territory	Standalone Dementia / Alzheimer's disease policy	Key highlights	Dementia / Alzheimer's disease registries	Dedicated Dementia / Alzheimer's disease research & innovation funding	Equity & inclusivity provisions
Japan	Yes - ***Framework for Promoting Dementia Policies (2019); Basic Plan for Promotion of Dementia Measures (2024); The Basic Act on Dementia to Promote an Inclusive Society (2024)***	✓ Establish inclusion and risk reduction as national guiding principles for dementia and Alzheimer's disease policy ✓ Mandate inter-ministerial coordination, awareness campaigns, and patient/ family engagement under statutory frameworks ✓ Support research, innovation, and collaboration across ministries to advance dementia policy implementation	Yes (Alzheimer's disease specific) - AMED-funded DMT Registry enrolls Alzheimer's patients treated with anti-Aβ drugs	Strong - - ¥16.1 B allocated for National Dementia Strategy under FY2025 social security budget	Yes - legal equity guarantees
New Zealand	Yes - ***Dementia Mate Wareware Action Plan (2026-2031); New Zealand Health Plan | Te Pae Waenga (2024-2027)***	✓ Address the national challenge of dementia through a refreshed five-year roadmap focused on prevention and timely care ✓ Prioritise equitable access and collaboration across government and community health systems ✓ Align dementia within broader national health planning to reduce health loss and inequities	No - No formal or national registry for dementia or Alzheimer's disease	Moderate - NZ $12 M pilot funding and limited aged-care budget use for dementia; additional funding request unapproved	Yes - Māori and Pacific inclusion
Singapore	Yes - ***National Dementia Strategy (2017)***	✓ Provide a national framework to guide MOH, healthcare institutions, and community providers in dementia and caregiver support ✓ Coordinate service delivery and long-term planning for dementia care and ageing populations ✓ The updated version to be released in the near-term future	No - Relies on periodic WiSE studies, not a continuous registry	Moderate - Grants to Dementia Singapore (S$9.7M in 2023, S$11.8M in 2024) and ageing-care programs	Yes - multicultural care model
South Korea	Yes - ***National Dementia Plan (2008 - Revised 2012, 2016, 2020)***	✓ Establish a legislated framework for prevention, early detection, and comprehensive dementia management ✓ Integrate digital tools such as the Check Dementia app and monitor progress through 14 KPIs ✓ Transition from provider-centered to user- and community-based dementia care systems	Yes (Alzheimer's disease specific) - K-DReaMS national registry covers 45% of adults 65+, with JOYALZ focused on Alzheimer's disease therapies	Strong - ₩239 B allocated for dementia programs and ₩1 T national pledge for dementia care expansion	Yes - universal coverage and rural equity

Territory	Standalone Dementia / Alzheimer's disease policy	Key highlights	Dementia / Alzheimer's disease registries	Dedicated Dementia / Alzheimer's disease research & innovation funding	Equity & inclusivity provisions
Taiwan	Yes - ***Taiwan Dementia Plan 2.0 (2018-2025)***	✓ Implement 19 action plans aligned with the WHO Global Action Plan on Dementia ✓ Strengthen hospital- and community-based services to ensure a full continuum of care for dementia patients ✓ Expand national day-care infrastructure with 1,048 centres, including 31 dementia-specific facilities	Yes - Regional HAICDDS registry (>14,000 cases) exists; national registry planned under Dementia Plan 2.0	Strong - Over US$134.5 M funded for Taiwan Dementia Plan 2.0	Yes
China	Yes - ***National Action Plan for Senile Dementia's Disease (2024-2030); Action Plan for the Prevention and Control of Senile Dementia (2023-2025); Silver Economy Strategy (2023)***	✓ Enhance prevention, screening, diagnosis, and care for individuals affected by dementia, including Alzheimer's disease ✓ Mandate cognitive screening for citizens aged 65+, targeted follow-up, and public awareness campaigns ✓ Promote healthy ageing and geriatric care industries through the Silver Economy initiative	No - Provincial registry	Moderate - The Science and Technology Innovation 2030 initiative includes clinical cohort studies on Alzheimer's disease and other dementias, with funding exceeding US$30 million since 2022	Yes
Thailand	No, under public health framework - ***20-Year National Strategic Plan for Public Health (2017-2036)***	✓ Structure long-term health system reforms across four phases toward sustainability and performance excellence ✓ Drive implementation through strategies on promotion, prevention, service quality, and governance ✓ Include dementia as a target for intermediate care, requiring 40% of facilities to expand coverage	No - Limited research-based registry	Weak - No national dementia or Alzheimer's disease-specific funding; only scattered local initiatives	Limited

Selected observation and evaluation

- **Standalone vs. integrated policies**
  - **Standalone dementia strategies:** 07 territories (Australia, Japan, South Korea, Taiwan, China, Singapore, and New Zealand) have formal national dementia strategies or legal frameworks; While these include dementia-focused objectives, they do not set Alzheimer's disease-specific targets, creating a policy gap for disease-specific action
  - **Integrated approaches:** Hong Kong and Thailand integrate dementia under broader ageing or public health strategies, such as the Elderly Services Programme Plan and the 20-Year National Strategic Plan, with limited Alzheimer's-specific focus

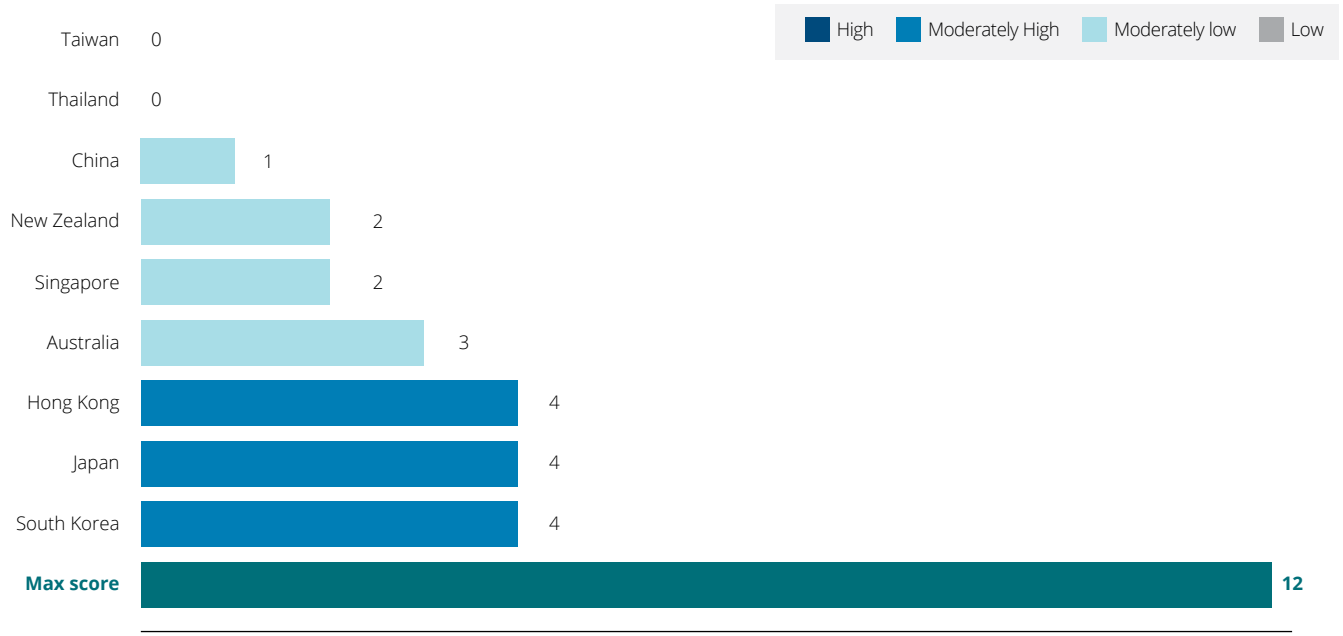
- **Specific targets and timelines**
  - **Defined policy cycles:** Australia (2024-2034), Japan (2019-2025; 2024 onward), South Korea (2021-2025), Taiwan (2018-2025), China (2024-2030), and New Zealand (2026-2031) specify time-bound frameworks and renewal cycles for policy continuity
  - **Limited quantitative targets:** Few plans set measurable dementia outcomes or Alzheimer's disease-specific goals. Hong Kong and Thailand lack defined timelines or performance indicators for dementia care

- **Population-based registries**
  - **Comprehensive national systems:** Australia operates two key data infrastructures - the ADNeT Registry, a national clinical quality registry for dementia and MCI, and the National Centre for Monitoring Dementia (NCMD), which links national datasets to track dementia trends and outcomes
  - **Alzheimer's disease-specific registries:** Japan maintains the AMED-funded DMT Registry enrolling Alzheimer's patients treated with anti-Aβ therapies, while South Korea operates the large-scale K-DReaMS national registry alongside the JOYALZ registry focused on new Alzheimer's disease drug use and outcomes
  - **Regional or partial systems:** Taiwan runs the HAICDDS regional registry (over 14,000 cases) with plans for national expansion under Dementia Plan 2.0; China supports cohort-based monitoring through the HOPE Study, functioning as a long-term registry prototype
  - **Research-based or limited coverage:** Hong Kong's CUHK Early-Onset Dementia Registry serves research purposes only, while Thailand has fragmented hospital-based datasets. New Zealand and Singapore rely on periodic epidemiological studies (e.g., WiSE) rather than continuous national registries

- **Funding and financing mechanisms**
  - **Strong investment in Dementia including Alzheimer's disease:** While no territory currently earmarks a budget exclusively for Alzheimer's disease programs, several economies, notably Australia, Japan, South Korea, and Taiwan, show strong financial commitment to dementia (encompassing Alzheimer's disease) through substantial investments in care delivery, research, and innovation
  - **Moderate investment models:** New Zealand and Singapore maintain moderate funding through pilot programs or targeted grants
  - **Limited or weak funding:** Hong Kong, China, and Thailand lack dedicated national dementia or Alzheimer's disease funding, relying mainly on general elderly-care or long-term care budgets and scattered local initiatives rather than structured dementia financing frameworks
  - **Uneven public reimbursement / insurance coverage for dementia and Alzheimer's disease care:** Most territories provide partial public reimbursement for anti-dementia or Alzheimer's drugs and diagnostic services; Access to advanced diagnostics (e.g., amyloid PET, CSF testing) and new DTM (e.g., lecanemab) is improving in Japan but remains limited elsewhere
  - **Emerging private insurance products for Alzheimer's disease:** Especially in Japan, South Korea, China, Singapore, and Thailand; These include critical illness or long-term care plans offering Alzheimer's disease-specific payouts or reimbursement for new drug treatments, reflecting growing market recognition of dementia-related needs

- **Inclusivity and equity**
  - **Policy commitment to equity:** 5/9 territories (Australia, Japan, New Zealand, South Korea, and Taiwan) explicitly integrate equity within their dementia frameworks; These policies emphasise accessibility, inclusion, and protection of rights. Australia's plan prioritises equity and human rights, Japan and South Korea embed barrier-free and income-based access, New Zealand targets Māori, Pacific, and rural populations, and Taiwan expands nationwide care networks and legal protections
  - **Policy recognition of preclinical Dementia / Alzheimer's disease and at-risk populations:** 4/9 territories (Australia, Japan, South Korea, and China) include early detection and risk-reduction measures; Australia focuses on high-risk and First Nations groups, Japan promotes early intervention through Team Orange, South Korea provides nationwide free cognitive screening for adults 60+, and China integrates cognitive checks for people aged 65+ within routine health services
  - **Patient navigation and community care:** Across APAC, diverse programs enhance dementia and Alzheimer's disease support through navigation and community-based services; For instance, Australia, Japan, New Zealand, and South Korea operate structured systems such as helplines, volunteer networks, and home-care programs, while Singapore, Taiwan, China, and Thailand promote dementia-friendly communities and integrated local care
- **Translation of research into practice**
  - **Rapid translation:** Japan rapidly translates clinical evidence into practice, e.g., with lecanemab approved and reimbursed within 12 months (2022-2023); South Korea similarly maintains an estimated 3-year adoption timeframe for new Alzheimer's disease drugs
  - **Moderate or slow adoption:** Singapore has an average adoption lag of over 3 years for new dementia technologies and guidelines
  - **Unpredictable or unstandardised timelines:** Australia, Hong Kong, New Zealand, Taiwan, China, Thailand have no standardised or predictable timeframe for adoption; new guidelines and therapies are integrated inconsistently or with certain delays

6.2. Domain 2: Alzheimer's disease prevention and screening



Comparative summary

- **Overall strengths**
  - **Growing policy recognition of dementia and Alzheimer's disease:** All economies include some level of clinical guidance or professional practice addressing early cognitive assessment for older adults, reflecting rising policy recognition of dementia and Alzheimer's disease within ageing and primary care agendas
  - **Structured cognitive screening:** Several territories (e.g., Hong Kong, Japan, New Zealand, South Korea, China) explicitly reference validated tools such as MMSE, MoCA, GPCOG, and Clock Drawing Test in national or professional guidelines, supporting greater standardisation in cognitive evaluation
  - **Expanding screening access:** Public access to screening is improving through funding models such as South Korea's free nationwide dementia screening via Dementia Care Centers and Hong Kong's tiered Cognitive Health Assessment Subsidy Scheme

- **Overall gaps**
  - **Absence of organised screening for high-risk population:** No economy operates a formal, population-based Alzheimer's disease screening program targeting high-risk groups; most rely on case-finding or opportunistic assessment in clinical settings
  - **Limited biomarker integration in screening:** Although clinical pilots and adoption are emerging in several markets, BBBM and CSF biomarkers are largely absent from national screening guidelines, resulting in fragmented implementation and missed opportunities for early detection; Japan is the only economy where BBBMs p-tau217 and p-tau217/Aβ42 are included as screening tests under national fluid biomarker guidelines
  - **Fragmented screening funding:** Financial support for cognitive screening is inconsistent - partial or pilot-based in Australia, Hong Kong, Japan, and South Korea, with limited or no reimbursement in Singapore, Taiwan, China, and Thailand

Scale the Japanese BBBMs screening model across mature health systems

Japan's adoption of **BBBMs p-tau217 as a frontline screening test** represents a global best practice in accelerating early Alzheimer's disease detection, reducing dependence on high-cost confirmatory testing, and strengthening system readiness for DMTs. This model should be positioned as a benchmark for mature health systems across the region.

All mature systems should:

- **Initiate HTAs and pilot programmes within 12 months** to evaluate, adapt, and integrate Janpan's model into national diagnostic pathways
- **Prioritise BBBM adoption as a core enabler of scalable, equitable, and cost-efficient Alzheimer's disease diagnosis,** ensuring seamless linkage from screening to confirmatory testing and treatment planning

- **Disparities across economy archetypes**
  - Across all 9 territories, prevention and screening maturity remains limited. No economy currently demonstrates high readiness or comprehensive system-level screening.

Moderately low:

- Hong Kong and South Korea show the presence of professional guidelines and selective public initiatives but retain gaps in biomarker inclusion and reimbursement for screening
- Japan, despite lacking explicit recommendations for screening high-risk individuals in national guidelines, demonstrates relatively stronger financing mechanisms with cognitive function tests included in basic medical fees and CSF biomarker testing partially reimbursed by public insurance

Low:

- In Australia, New Zealand, Taiwan, China, and Thailand, screening remains largely opportunistic or research-based, with no inclusion of screening and biomarker-based screening in the guidelines
- Singapore has established screening guidelines, but these are limited by low reimbursement levels and constrained financing mechanisms

- **Best practices**
  - South Korea's free dementia screening program through public health centers represents an accessible and scalable screening model
  - Japan's comprehensive inclusion of validated tools and periodic follow-up for individuals with subjective cognitive decline demonstrates a structured, evidence-based approach to early detection
  - Hong Kong's community screening and subsidy scheme offers a replicable model for expanding early cognitive assessment access via public - charity collaboration

The cost-effectiveness of screening in mainland China for Alzheimer's disease patients aged over 60[153]

01. Target population: All individuals aged >60 years in mainland China were eligible for screening.

02. Two-step screening process

- Step 1 - Initial Screening: Conducted using the MMSE under general GP guidance
- Step 2 - Diagnostic Confirmation: Individuals with suspicious MMSE scores were referred to tertiary hospitals for specialist evaluation. Diagnostic tests included:
  - Physician evaluation
  - Laboratory tests: blood biochemistry, folic acid, serum vitamin B12, serum amylopsin, syphilis antibodies, thyroid function, and CSF analysis
  - Imaging and neurophysiological tests: MRI, EEG

03. Model framework: A 9-state Markov model simulated disease progression and cost-effectiveness outcomes from ages 60 to 80, comparing screening versus no screening

04. Key results:

- **ICER (Incremental Cost-Effectiveness Ratio): USD 26,413.77 per QALY gained** (vs. no screening)
- **Cost-Effectiveness Probability:**
  - **18% at 1× GDP per capita** threshold
  - **77% at 3× GDP per capita** threshold
- **Health Impact:**
  - **Deaths averted:** 0.076% of total population
  - **Severe Alzheimer's disease cases averted:** 0.006%
- **Net monetary benefit:** USD 128.29 per capita

Sensitivity Findings:

- **ICER decreased (better)** when drug effects lasted longer
- **ICER increased (worse)** with more frequent screening; later screening start age; higher comorbidity levels
- Higher screening frequency reduced deaths and severe Alzheimer's disease cases despite higher costs

05. Conclusion:

- **Screening for Alzheimer's disease in adults ≥60** can reduce severe cases and deaths
- **Cost-effectiveness** depends on program design - timing, frequency, and drug durability
- **MCI** detection offers the best opportunity to delay progression and improve economic value

Policy implications

Strengthening early detection systems is critical, as structured screening for cognitive impairment remains limited despite strong evidence of cost-effectiveness in reducing severe cases and deaths. Health systems should focus on developing and testing integrated cognitive and biomarker-based screening models that are scalable and adapted to local resource contexts. To enable sound policy decisions, governments should seek relevant local evidence wherever feasible before introducing new policies or updating existing ones. In this context, generating robust implementation evidence through ***pilot programmes, data-sharing networks, and multi-stakeholder partnerships*** *involving governments, clinical societies, and diagnostic stakeholders will be essential to establish sustainable national screening pathways.*

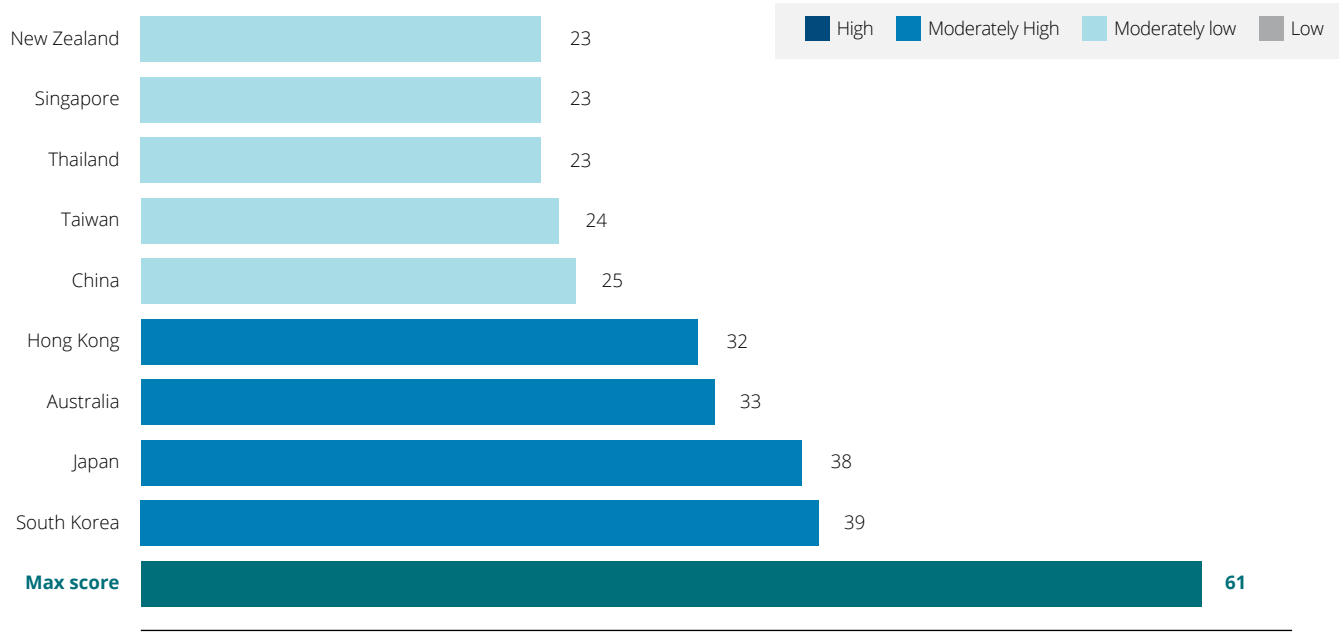
Selected observation and evaluation

- **Screening coverage in clinical guidelines**
  - **Moderately low coverage:** Hong Kong, Singapore, and South Korea have partial frameworks supporting dementia screening for high-risk population; Hong Kong lists validated tools (AMT, Alzheimer's disease, MoCA), Singapore promotes community-based detection, and South Korea integrates MMSE and MoCA with free screening via Dementia Care Centers, though biomarker use remains absent
  - **Low coverage:** Australia, Japan, New Zealand, Taiwan, China, and Thailand show limited or opportunistic screening; Australia and New Zealand rely on clinician vigilance, Japan uses validated tools without population-level screening, and Taiwan, China, and Thailand lack high-risk screening or biomarker inclusion

- **Reimbursement for cognitive screening**
  - South Korea offers the most extensive public funding through free screening at Dementia Care Centers under the NHIS; Hong Kong provides tiered subsidies through its Cognitive Health Assessment Scheme, and Japan incorporates cognitive function tests into its routine basic medical fee structure
  - Australia partially funds cognitive assessments but lacks universal coverage. Singapore, Taiwan, China, and Thailand have no dedicated reimbursement schemes, with patients relying on general health coverage such as MediSave withdrawals or universal healthcare visits that do not specifically include dementia screening benefits

- **Reimbursement for biomarkers in screening**
  - Across APAC, no economy publicly reimburses BBBM testing, largely because these assays have not yet been introduced into routine clinical practice; In territories where it is available, reimbursement mechanisms remain absent
  - CSF biomarker testing shows only limited public coverage; A notable exception is observed in Australia: a financing mechanism for CSF testing exists in New South Wales, where the service is publicly funded and conducted at Concord Hospital; Nationally, CSF testing was under review as part of the Kisunla reimbursement application, however, following the drug's initial rejection, the associated CSF reimbursement request is unlikely to advance; Japan also offers limited CSF biomarker coverage through public insurance, while in all other territories, biomarker testing remains research-based or fully out-of-pocket

6.3. Domain 3: Alzheimer's disease diagnosis and resource capacity



Comparative summary

- **Overall strengths**
  - **Universal recognition of Alzheimer's disease:** All 9 economies reference Alzheimer's disease in their clinical guidelines, though the specificity and depth of diagnostic guidance vary; Australia, Hong Kong, Japan, and South Korea have structured Alzheimer's disease diagnostic criteria aligned with international standards such as DSM-5, NIA-AA, or IWG
  - **Growing diagnostic infrastructure:** Japan and South Korea demonstrate high MRI, CT, and PET capacity; Hong Kong and Taiwan leverage private or tertiary-center networks for biomarker testing
  - **Emerging multimodal approaches:** Increasing integration of cognitive tests, neuroimaging, and biomarker validation supports transition toward precision diagnosis and readiness for disease-modifying treatments

- **Overall gaps**
  - **Limited biomarker inclusion for diagnosis in guidelines:** Only 3/9 economies (Japan, South Korea, and Hong Kong) explicitly mention CSF biomarkers for Alzheimer's disease diagnosis; Japan uniquely includes BBBM (p-tau217 and p-tau217/Aβ42) in its national guideline; Other economies do not mention BBBM and CSF biomarkers, underscoring the need for stronger policy alignment to enable early and equitable diagnosis
  - **Limited access and reimbursement:** Most economies lack reimbursement for CSF (except for Australia and Japan) and BBBM, leaving diagnosis heavily dependent on out-of-pocket or research access
  - **Uneven diagnostic capacity:** High-income economies maintain broad access to advanced imaging, while middle-income economies (China, Thailand) show concentration mainly in tertiary centers; Even economies with world-class imaging capacity e.g., South Korea, which maintains some of the highest PET and MRI availability in APAC - still face persistent early-detection barriers; Advanced imaging alone has not translated into faster or more equitable Alzheimer's disease diagnosis because BBBM integration, biomarker reimbursement, and policy readiness remain incomplete; Without BBBM-enabled triage, high-capacity systems continue to experience unnecessary specialist referrals, diagnostic bottlenecks, and delayed identification of DMT-eligible patients
  - **Delayed diagnosis and data gaps:** Diagnostic delay remains common, with most economies lacking coordinated national tracking; Existing data show prolonged timelines, often exceeding a year from symptom onset; E.g., Australia's ADNeT Registry (2023) shows only partial coverage, with 13% diagnosed within 1 year and 30% after 3 years; Only China systematically monitors diagnosis timing through national "Blue Book" reports

- **Disparities across economy archetypes:**
  - **Moderately high:** Australia, Hong Kong, Japan, South Korea - strong diagnostic frameworks, cognitive tool integration, and imaging infrastructure, but gaps in biomarker recognition (Australia) and funding
  - **Moderately low:** New Zealand, Singapore, Taiwan, China, Thailand - baseline diagnostic systems with limited biomarker access, uneven workforce distribution, and fragmented financing

- **Best practices**
  - **Japan:** Full integration of DSM-5/NIA-AA/IWG-2 criteria with CSF confirmation and partial reimbursement for CSF biomarkers
  - **Australia & China:** National registries (Alzheimer's diseaseNeT, "Blue Book") tracking time-to-diagnosis
  - **South Korea:** Exceptional imaging capacity supporting early and accurate diagnosis

Delayed diagnosis - a critical system gap

"Since April 2023, the ADNeT Registry has collected information on the time from participant symptom onset to their initial appointment with diagnostic services. In 2023, 13% of participants with dementia had their initial appointment within 1 year of symptom onset and 30% had their initial appointment more than 3 years from symptom onset" - *Australian Dementia Network (ADNeT) Registry, 2023*

Such prolonged delays are **concerning in an era where Alzheimer's disease is becoming increasingly treatable**. A three-year delay is long enough for approximately 30% of individuals with MCI due to Alzheimer's disease to progress to dementia, meaning that a substantial proportion of those who would have been DMT-eligible at symptom onset will have already progressed beyond the therapeutic window by the time they reach specialist care . This represents both a clinical loss and a fiscal inefficiency, as delayed diagnosis erodes the potential impact of DMT reimbursement and readiness investments.

Policy Implications

There is an urgent need to strengthen early detection and diagnosis through routine cognitive screening for high-risk adults aged 60 and above, integrated into national health checks or universal health coverage schemes. Expanding access to biomarker testing and introducing reimbursement pilots will be essential to enable timely, evidence-based diagnosis and appropriate planning for DMT. In parallel, national data systems should be enhanced to monitor diagnostic timeliness, coverage, and equity, ensuring consistent evaluation and improvement of early detection programs.

Selected observation and evaluation

• Diagnosis coverage in clinical guidelines

- **Moderately high:** Hong Kong, Japan, and South Korea provide the most structured diagnostic guidance, explicitly covering Alzheimer's disease within national or dementia guidelines. These frameworks reference internationally recognised diagnostic standards and emphasise multidisciplinary evaluation for differential diagnosis
- **Moderately low coverage:** Australia, Singapore, China, and Thailand outline diagnostic protocols for dementia but with limited Alzheimer's disease-specific guidance; While they acknowledge subtype differentiation, most rely on general dementia criteria without detailed biomarker or subtype-specific diagnostic pathways
- **Low:** New Zealand and Taiwan show limited Alzheimer's disease-specific inclusion in national guidance, with available references focusing mainly on general dementia assessment and clinical judgment rather than standardised national protocols

• Diagnostic infrastructure and service capacity

- Japan and South Korea demonstrate the most advanced diagnostic infrastructure in the region, with the highest availability of MRI, CT, and PET scanners; South Korea ranks among the global leaders in imaging utilisation, though the widespread reliance on PET scans has delayed the adoption of BBBM testing - underscoring the need for a comprehensive evaluation of all diagnostic modalities
- Australia, Hong Kong, New Zealand, and Singapore have moderate MRI and CT density but face constraints in tracer access and Alzheimer's disease-specific imaging expertise; while Taiwan, China, and Thailand continue to experience limited distribution of MRI and PET scanners beyond tertiary hospitals
- CSF biomarker capacity remains tertiary center driven: 6/9 economies (Australia, Hong Kong, Japan, Singapore, South Korea, and Thailand) provide CSF testing in select specialist or tertiary hospitals; Japan shows the most formalised approach, with CSF Aβ42/40 and pTau181/Aβ42 explicitly recommended; However, regional uptake in general is constrained by invasiveness, clinician confidence, and self-paid costs
- Except Japan, BBBM testing is expanding but remains pilot-stage, concentrated in tertiary or research settings: economies such as South Korea, Taiwan, China have introduced p-tau assays through clinical pilots or multicentre studies (e.g., KBASE/Asan, Taiwan-Alzheimer's diseaseNI, etc.), though none are integrated into standardised national diagnostic pathways; Australia, New Zealand, and Singapore remain research-focused, validation with limited or outsourced testing, leading to restricted clinical access and uneven readiness for scale-up; These gaps highlight the need for policy action and system-level readiness to enable broader implementation and equitable adoption

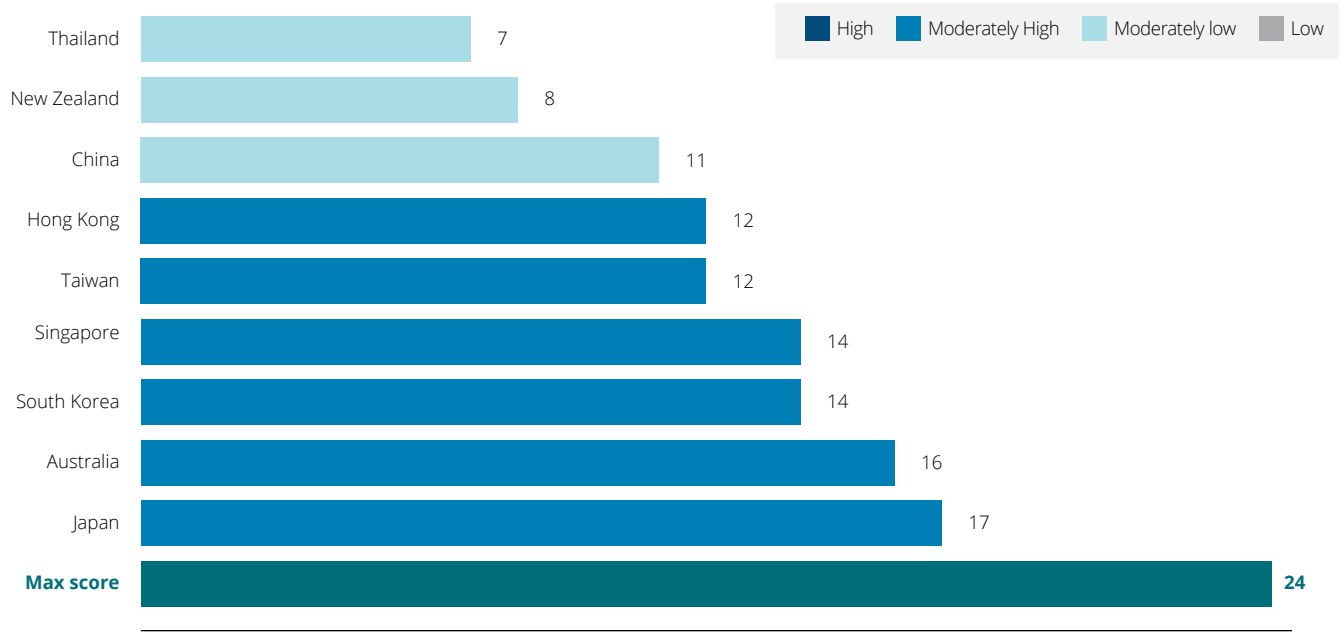
• Workforce capacity and specialist availability

- **Geriatricians/Psychogeriatricians:** Need strengthening in Japan [155], New Zealand[156], and South Korea[157], where density remains moderately low (≤2 per 100k)
- **Neurologists:** Limited availability in Australia[158], New Zealand[159], and Singapore[160] (≤3 per 100k), constraining diagnostic capacity beyond tertiary centers
- **Psychiatrists:** Lower ratios observed in Singapore[161], China[162], and Thailand[163] (<6 per 100k), indicating mental health workforce gaps
- **Mental health social workers:** Significant shortages in New Zealand[164], China[165], and Thailand[166] (≤1 per 100k)

• Reimbursement for biomarkers in diagnosis:

- Cognitive assessments receive partial or selective funding across most economies, reflecting gradual integration into public health programs through a mix of subsidies, pilot schemes, or free screening in selected facilities
- CSF biomarker testing receives partial reimbursement only in select settings in 2 territories:
  + Japan: CSF pTau181 - reimbursed when used for the purpose of diagnosis; CSF Aβ42/40 and pTau181/Aβ42 - reimbursed when used to confirm Aβ pathology for the prescription of DMTs
  + New South Wales (Australia) funds CSF testing at Concord Hospital, highlighting uneven clinical adoption and financial support
- Public reimbursement for BBBM testing remains limited across most economies, resulting in uneven access and delayed early detection; Few systems have established frameworks for diagnostic integration, reimbursement, or clinical infrastructure, indicating a significant policy gap in supporting routine adoption within national health systems; As many health systems face constraints in specialist availability - particularly geriatricians and neurologists - BBBM reimbursement offers a practical pathway for task-shifting; By enabling primary-care providers to perform early triage using low-cost BBBM tests, systems can reduce unnecessary referrals and reliance on PET imaging; Reimbursing BBBMs is therefore a cost-efficient strategy: it is more affordable to support scalable biomarker screening than to expand specialist capacity or invest in additional high-cost diagnostic equipment

6.4. Domain 4: Alzheimer's disease treatment and access



Comparative summary

• Overall strengths

- **Comprehensive pharmacological treatment for Alzheimer's disease:** All 9 economies include pharmacological treatment protocols in clinical guidelines
- **Regulatory readiness for DMTs:** 7/9 territories (Australia, Japan, South Korea, Singapore, Hong Kong, Taiwan, China) have approved lecanemab and/or donanemab with defined eligibility requiring amyloid confirmation through PET or CSF testing, signaling growing regulatory agility and openness to innovative DTMs
- **Emerging digital monitoring systems:** Telemedicine and home-based monitoring are widely adopted, particularly in Australia, Japan, South Korea, and Taiwan, improving accessibility for rural or aging populations, showing progress toward continuous, accessible monitoring for patients and caregivers
- **Multidisciplinary and integrated care models:** Developed economies such as Japan, Singapore, and Taiwan demonstrate strong examples of integrated dementia centers and cross-specialty collaboration

• Overall gaps

- **Biomarker-therapy alignment gap in clinical guidelines:** Although 7 economies have approved DMTs requiring amyloid confirmation via PET or CSF, most have not yet reflected this in treatment guidelines. South Korea is a partial exception, where KDA recommends CSF or PET testing to confirm amyloid pathology before lecanemab use - signaling early steps toward aligning biomarker guidelines with DMT implementation.
- **Funding shortfalls:** Biomarker tests remain fully out-of-pocket; symptomatic drug reimbursement is only partial in most countries except for Australia, Hong Kong, Japan; There is a need for bundled financing (diagnostics + DMT + monitoring), which can reduce out-of-pocket exposure and align expenditure with outcomes

• Disparities across economy archetypes

- **Moderately high:** Australia, Hong Kong, Japan, Singapore, South Korea, Taiwan demonstrate relatively advanced Alzheimer's disease treatment and monitoring systems, characterised by broad access to symptomatic drugs, regulatory approval of DMTs, and multidisciplinary care frameworks; Gaps remain in biomarker integration and formalised reimbursement for advanced diagnostics
- **Moderately low economies:** New Zealand, China, Thailand provide basic access to symptomatic therapies but lag in treatment monitoring infrastructure and/or DMT readiness, and palliative care linkages

• Best practices

- **Australia:** Integrated pharmacological and non-pharmacological care, strong palliative pathways, and telehealth expansion (e.g., Dementia, Regional and remote, Empowering, Aboriginal and Torres Strait, Medicine and Telemedicine and telehealth – "DREAMT" project)
- **Japan:** Clear national linkage between biomarker confirmation and DMT eligibility, with comprehensive Alzheimer's treatment guidelines
- **South Korea:** Mandatory amyloid confirmation for DMT use and an advanced hybrid telemedicine model for dementia care
- **Taiwan:** National Dementia Integrated Care Centers (DICC) with multidisciplinary teams and insurance-funded palliative care for dementia

Selected observation and evaluation

- **Treatment & monitoring coverage in clinical guidelines**
  - **Moderately high:** South Korea stands out for integrating biomarker-based eligibility criteria in its Lecanemab Appropriate Use Recommendations, marking an early example of linking treatment monitoring to DMT implementation
  - **Moderately low (Australia, Hong Kong, Japan, Singapore, Taiwan, China, Thailand):** Most economies include pharmacological and non-pharmacological interventions for symptomatic management but lack structured monitoring protocols or biomarker integration, reflecting limited adaptation to emerging DMT requirements
  - **Low (New Zealand):** Treatment guidance is framed broadly under dementia management without Alzheimer's disease-specific provisions or defined monitoring mechanisms

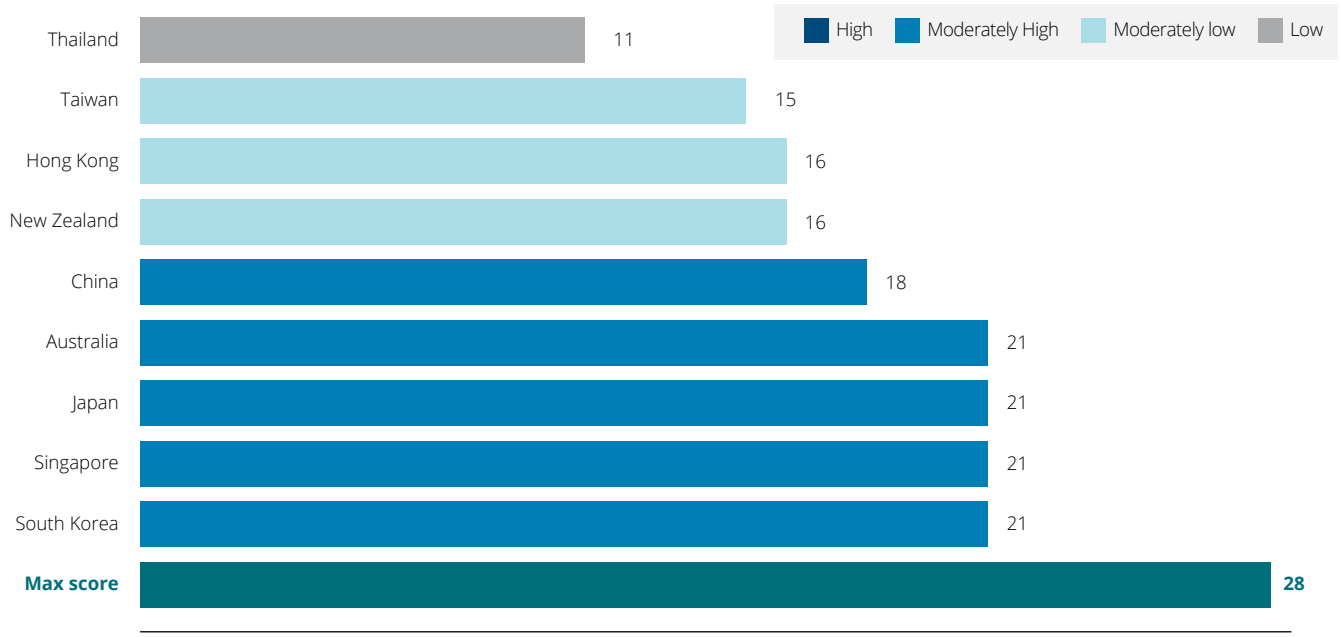
- **Reimbursement for biomarkers in treatment & monitoring**
  - Across all economies, BBBM testing lacks any public or private reimbursement, while CSF biomarkers are only partially covered in Japan (CSF Aβ42/40 and pTau181/Aβ42) when used for the purpose of confirming Aβ pathology for the prescription of DMTs
  - The lack of reimbursement for biomarker testing represents a critical bottleneck for real-world DMT implementation. Without sustainable financing mechanisms, equitable access to precision Alzheimer's disease care remains limited, particularly as new therapies increasingly require biomarker-based eligibility and ongoing monitoring to guide treatment response and safety

Economic imperative for early diagnosis and biomarker-guided DMT adoption

- **Earlier intervention yields major savings:** Multiple economic evaluations demonstrate that **earlier diagnosis and treatment of Alzheimer's disease can generate substantial lifetime and system-wide savings** by delaying progression, institutionalisation, and caregiver burdens. UK modelling (2024) shows that early diagnosis and treatment could **save between £8,800** and **£44,900 per person**, depending on disease stage and care setting[167]. Pan-European modelling found that slowing disease progression by 25–50% through DMTs could save **€33.7 - €72.7 billion**, while halting progression for three years at the mild stage could generate **€84.7 billion** in cumulative savings[168]. US analysis (2014) projected that accelerating the arrival of DMTs could **reduce R&D costs from $5.7 billion to $2 billion per drug and avoid 7 million dementia case-years (2025–2040)**, saving **$74 - $100 billion** in future care costs. Together, these findings show that earlier diagnosis and treatment not only preserve quality of life but also deliver multibillion-dollar returns to health systems and economies.
- **DMT adoption depends on biomarker-confirmed diagnosis:** With the emergence of DMTs such as *lecanemab* and *donanemab*, health-technology assessments confirm that these treatments are **cost-effective at $8,900 - $21,500 per year in the US** only when targeted to **biomarker-confirmed early-stage Alzheimer's disease** - the population with proven amyloid pathology[169]. In practice, this means that biomarker testing is a prerequisite for ensuring both clinical precision and fiscal efficiency, as treating individuals without confirmed amyloid would add cost without benefit.
- **Biomarker-based confirmation is cost-efficient and scalable:** Health-economic studies show that confirmatory biomarker testing can match diagnostic accuracy at far lower cost. In China, a 2025 multicentre evaluation found that **CSF biomarkers achieved equivalent outcomes to Aβ-PET while reducing diagnostic costs by 33 - 37%**, driven by lower test prices and reduced indirect expenses such as travel and productivity loss[170]. Overall, CSF testing lowered total pathway costs by **¥1,900 - ¥2,100 per patient** without compromising quality-adjusted life-years[171]. With far greater accessibility than PET, CSF testing offers a practical and cost-saving approach for nationwide early-diagnosis expansion. Recent simulation data from Japan indicate that **adding BBBM testing to diagnostic pathways shortens wait times and increases treatment eligibility** compared with PET/CSF-only strategies[172]

Policy Implications: *As the body of evidence for DMTs expands, health systems across APAC are expected to* ***evaluate early diagnostic and biomarker strategies*** *to ensure sustainable Alzheimer's disease management. Integrating CFS / blood-based* ***biomarker-guided early diagnosis*** *together with* ***cost-effective DMT implementation*** *will be critical to advancing clinical precision, promoting equitable access, and maintaining long-term economic sustainability for aging populations.*

6.5. Domain 5: Alzheimer's disease advocacy, awareness and education



Comparative summary

- **Overall strengths**
  - **Strong civil society engagement:** All economies have at least one Alzheimer's or dementia-focused patient/caregiver organisation actively providing education, advocacy, and support
  - **Multi-stakeholder collaboration:** Many economies demonstrate collaboration between government, patient organisations, and professional societies (e.g., Australia's National Dementia Action Plan 2024-2034, Japan's Public-Private Council on Dementia, Singapore's Dementia-Friendly Singapore initiative)
  - **Comprehensive awareness efforts:** National or annual awareness campaigns (e.g., Dementia Action Week in Australia, Dementia Supporter Caravan in Japan, World Alzheimer's Month in New Zealand, Forget Us Not in Singapore) are widely used to combat stigma and promote dementia-friendly communities

- **Overall gaps**
  - **Uneven policy participation:** Patient organisations in some economies (e.g., Thailand, Hong Kong) show limited or no formal participation in national dementia policy planning
  - **Variable government-led education**: Direct government-run Alzheimer's disease or dementia education programs are present in only a subset of economies (notably Australia, Japan, Singapore, South Korea), with limited evidence in Taiwan, China, and Thailand
  - **Limited Alzheimer's-specific focus:** While dementia education and support are common, Alzheimer's disease-specific initiatives are less frequent, particularly in lower-resource settings
  - **Inconsistent caregiver access:** While caregiver support programs exist, their accessibility and standardization vary - strongest in Australia, Japan, Singapore, South Korea, and Taiwan, weaker in China and Thailand
  - **Gaps in healthcare provider training:** Specialist dementia training is well-established in Australia, Japan, Singapore, and Taiwan but remains fragmented or short-term in South Korea, China, and Thailand

- **Disparities across economy archetypes**
  - **High:** Australia, Japan, Singapore, and South Korea demonstrate the most comprehensive dementia / Alzheimer's disease advocacy, awareness, and education ecosystems - featuring active national patient organisations, direct participation in policy development, large-scale public awareness campaigns, caregiver training, and professional education frameworks
  - **Moderately high economies:** Hong Kong, New Zealand, Taiwan and China have well-established patient organisations, strong community-based awareness programs, and partial involvement in national dementia planning. Alzheimer's disease education and formal patient support programs remain limited
  - **Moderately low economies:** Thailand shows emerging but less coordinated advocacy and education structures. While national or community organisations actively conduct awareness campaigns, caregiver services and government education programs remain limited and fragmented

- **Best practices**
  - **Australia:** Dementia Australia leads advocacy and runs the National Dementia Support program, offering integrated support services, 24/7 helplines, and accredited dementia training programs
  - **Japan:** The Dementia Supporter Caravan (with over 10 million trained supporters) and strong public-private partnerships exemplify a mature, scalable model for awareness and community support, with potential for digital adaptation in remote areas
  - **Singapore:** Dementia Singapore functions as a national centre for training, consultancy, and advocacy, backed by Ministry of Health initiatives under Dementia-Friendly Singapore
  - **New Zealand:** Alzheimers NZ co-authored the Dementia Mate Wareware Action Plan and runs sustained national awareness and advocacy campaigns through lived-experience groups
  - **Taiwan:** Taiwan Alzheimer's Disease Association (TADA) operates over 500 support centres and "Schools of Wisdom," showing strong community-based care and inclusion of dementia rights in organisational bylaws
  - **South Korea:** National Dementia Centers and Dementia Counselling Centers provide structured caregiver education, outreach to at-risk populations, and a nationwide dementia helpline

Selected observation and evaluation

- **Patient & caregiver organisation engagement and advocacy**
  - All economies have at least one Dementia/Alzheimer's disease-focused patient organisation; Engagement is strong in Australia, New Zealand, Hong Kong, Japan, Singapore, South Korea, and Taiwan, where groups actively shape national plans and deliver structured support services (e.g., Dementia Australia; Hong Kong Jockey Club; Hong Kong Alzheimer's Disease Association (HKADA); Alzheimer's Association Japan (AAJ); Alzheimers NZ; Dementia Singapore; Alzheimer's Association Korea; Taiwan Alzheimer's Disease Association (TADA); Alzheimer's Disease Chinese (ADC). Thailand shows strong community awareness but limited policy influence
  - Advanced systems combine advocacy, service delivery, and policy engagement; others focus mainly on awareness and caregiver support

- **Professional medical and scientific societies / research Institutes engagement and advocacy**
  - Australia, New Zealand, Japan, South Korea, Taiwan feature specialised entities actively engaged in dementia research, policy, and guideline development (e.g., Australian Dementia Network (ADNeT); Alzheimer's Research Australia; New Zealand's Dementia Prevention Research Clinics; Japanese Society for Dementia Care; Japanese Society for Dementia Research (JSDR); Japan Agency for Medical Research and Development (AMED); Japanese Society of Neurology; Korean Dementia Association (KDA); Korea Dementia Research Centre (KDRC); Taiwan Society of Geriatric Emergency & Critical Care Medicine)
  - Hong Kong, Singapore, China, Thailand: professional groups mainly cover geriatrics or neurology with dementia included as part of broader mandates (Hong Kong Geriatrics Society (HKGS); National Neuroscience Institute (NNI); China Association of the Universities for the Aged (CAUA); China National Clinical Research Center for Geriatric Diseases; Thai Society of Gerontology and Geriatric Medicine; Foundation of Thai Gerontology Research and Development Institute; Neurological Society of Thailand)
  - More advanced economies integrate scientific networks into dementia policy, research funding, and national guideline development, reflecting strong institutional collaboration; Lower-scoring economies maintain relevant geriatric or neurological bodies but with limited Alzheimer's disease-specific focus or formal policy contribution

- **Educational programs and support resources**
  - Patient education: Sustained support for patient education is key to improving disease understanding and reducing stigma; Most programs are dementia-wide rather than Alzheimer's disease-specific; Coverage is broader in high-income economies, while China and Thailand remain limited to awareness activities
  - Caregiver education and support: Training and helplines are available across most economies, mainly through patient and caregiver organisations; Alzheimer's disease-specific curricula are rare, with Thailand and China offering only basic caregiver support; There is a further need to educate caregivers on different dementia types, and to improve awareness of early diagnostic tools and potential DMTs to enhance timely care decisions
  - Healthcare provider education: National dementia training frameworks for both primary care and specialists are established across the economies; Embedding Alzheimer's disease-specific modules in clinical and continuing education will be essential to prepare providers for new diagnostic and treatment advances

7.

Regional recommendations on Alzheimer's disease management

7. Regional recommendations on Alzheimer's disease management

Alzheimer's disease represents a growing public health crisis in APAC, driven by rapid population ageing, underdiagnosis, and emerging access challenges as new DMTs enter the clinical landscape. While advances in dementia care and Alzheimer's treatment offer new opportunities, rising system-level costs (financial, medical, and social burden) threaten to deepen inequalities between low- and middle-income and high-income countries, underscoring the need for coordinated policy responses[173].Building on the evidence and gaps identified in this white paper - including fragmented policy frameworks, limited access to biomarker testing, outdated clinical guidelines with slow updates to incorporate new therapies, insufficient data infrastructure, and uneven public education and awareness - this section proposes a prioritised, evidence-based framework to strengthen Alzheimer's disease management across the region. Recommendations cover 5 key domains relevant to health system and patient care continuum: (1) Policy and planning, (2) Prevention and screening, (3) Diagnosis and resource capacity, (4) Treatment and access, and (5) Education and awareness.

These actions are tailored to 2 regional healthcare archetypes:

- Mature healthcare systems (Australia, Japan, South Korea, Taiwan, Hong Kong, Singapore, New Zealand) with advances in clinical infrastructure and research translation but facing challenges in DMT readiness, financing, and equitable access
- Emerging healthcare systems (China, Thailand) with growing system capacity but limited data integration, diagnostic access, and policy prioritisation

Technological innovations such as biomarker testing, and tele-neurology are highlighted for their potential to accelerate early detection, enhance care coordination, and promote scalable, equitable dementia care models across APAC.

Prioritisation by impact and feasibility

Recommendations are classified along two key dimensions: **Impact** and **Feasibility (Time horizon)**, to guide national policymakers and regional stakeholders in prioritisation and sequencing

High impact: *Actions with transformative potential to improve early detection, treatment access, and patient outcomes*	1 Prioritise Alzheimer's disease within national health strategies 2 Pilot and expand early cognitive and biomarker-based screening 3 Strengthen diagnostic infrastructure and capacity across care levels	4 Standardise diagnostic pathways and integrate validated biomarkers 5 Build national Alzheimer's disease registries and data platforms 6 Ensure health-system readiness for disease-modifying therapies	7 Scale digital and home-based care models
Medium impact: *Actions that incrementally enhance system efficiency or complement high-impact reforms*	8 Strengthen advocacy and education ecosystem	9 Invest in workforce training for early detection	10 Promote cross-territory collaboration and data sharing
Regional recommendations	**Short term (1-3 years):** Implementable using existing programs or infrastructure; enables early gains and momentum-building	**Mid term (3-5 years):** Require more coordination, moderate investment, or policy adaptations for scale-up	**Long term (5-10 years):** Dependent on structural reforms, legislative change, sustained investment, or system transformation

While these recommendations are designed to be concrete and actionable, they are intentionally framed at a strategic, system-wide level rather than prescribing detailed interventions for each territory. To translate them into meaningful national action, individual countries should:

- Localise outcome targets in alignment with their national dementia action plans and broader ageing strategies
- Establish clear institutional ownership for implementation, coordination, and progress monitoring across relevant ministries and agencies
- Embed inclusivity and equity, ensuring that rural, low-income, and minority populations are not left behind

Collectively, this framework provides a comprehensive roadmap to accelerate dementia and Alzheimer's disease management across the APAC region through integrated policy reform, sustainable financing mechanisms, and innovation-driven health system strengthening.

7.1. High impact, short-term recommendations (1 - 3 years)

01 Prioritise Alzheimer's disease within national health strategies (Domain 1: Policy and planning)

- **Challenges:** 7/9 economies have dementia frameworks but lack Alzheimer's disease-specific objectives, cost operational plans, and dedicated financing; Existing budgets are largely directed toward managing dementia symptoms - such as community care and caregiver support - rather than investing in medical diagnosis and treatment of Alzheimer's disease; Funding commitments rarely include specific allocations for diagnostic infrastructure, biomarker testing, or access to DMTs; In addition, policy renewal is often slow and disconnected from advances in Alzheimer's disease diagnostics and therapies, leaving health systems underprepared for the DMT era
- **Objectives of recommendations:** Secure political commitment, sustainable funding, and measurable accountability for Alzheimer's disease policy development and implementation; Expand budget allocations beyond long-term care to include diagnosis, early intervention, and DMT preparedness; Strengthen policy responsiveness through structured review, HTA, and financing mechanisms that link Alzheimer's disease to Healthy Ageing and broader economic agendas
- **Recommendations:**

  Mature systems:
  - Renew national dementia strategies (e.g., South Korea's National Dementia Plan, Singapore's National Dementia Strategy, Japan's Framework for Promoting Dementia Policies, etc.) by embedding clear Alzheimer's disease-specific action plans with measurable goals, costed implementation frameworks, and DMT-readiness milestones aligned with WHO's global dementia and NCD action plans
  - Introduce mandatory annual policy reviews and HTA processes for CSF and BBBM to support timely reimbursement and diagnostic access, ensuring alignment between policy renewal and evolving scientific evidence
  - Operationalise through inter-ministerial working groups (Health, Finance, Social Welfare) conducting 12-24-month pilots that test financing models such as public grants, insurance coverage, and value-based reimbursement, adjusted by GDP per capita feasibility
  - Establish cross-domain accountability frameworks linking policy updates with measurable progress on biomarker integration, DMT eligibility coverage, and workforce training indicators

  Emerging systems:
  - Develop a standalone National Alzheimer's disease Action Plan and cost operational roadmap where dementia strategies are not yet in place (e.g., Thailand); Position Alzheimer's disease as a specific national priority within national health planning to ensure visibility, dedicated funding, and accountability, rather than subsuming it under broader ageing or NCD frameworks
  - Establish multisectoral taskforces - bringing together Health Ministries, NGOs, academic institutions, and social organisations - to coordinate policy development, financing, and workforce capacity, drawing on China's Healthy China 2030 plan as a reference model for national action, including pilot programs targeting 80% elderly screening coverage
- **Illustrative outcome targets:** Embed Alzheimer's disease-specific objectives and indicators into existing national dementia or Healthy Ageing strategies by 2026; Propose a standalone National Alzheimer's disease Strategy with a costed operational roadmap by 2028, ensuring alignment with WHO's Decade of Healthy Ageing (2021–2030) framework; Allocate ≥5 % of dementia or ageing budgets to Alzheimer's disease diagnostics, biomarker access, and DMT readiness by 2027; Complete the first annual HTA reviews for DMTs and CSF/BBBM reimbursement by 2027; Launch pilot Alzheimer's disease programs through multisectoral taskforces involving ministries, NGOs, and academia by 2027
- **Target stakeholders for driving actions:** Health Ministries; Finance and Social Welfare Agencies; National Dementia Taskforces; Dementia, Neurology and Geriatrics Societies; Academic Institutions

The case for dedicated, costed action plans

Alzheimer's disease and other dementias represent not only a public health crisis but a growing **macroeconomic threat** - particularly across East Asia and the Pacific (EAP). As the region's population ages rapidly, Alzheimer's disease' and other dementias' prevalence and their associated costs are expected to surge. Between 2020 and 2050, EAP will shoulder **nearly 40% of the global Alzheimer's disease' and other dementias'-related economic burden**, totaling **INT$5.76 trillion** - an estimated **0.50% of regional GDP**, disproportionately higher than its 36.6% share of global output. Over the same period, the region is projected to lose **9,953 million disability-adjusted life years (DALYs)** to Alzheimer's disease - 40.1% of global DALYs, despite comprising just 27% of the global population[174].

These figures highlight a critical policy mismatch: the rThese figures highlight a critical policy mismatch: the region bears a disproportionate share of disease burden and economic loss but lacks proportional planning and investment. Without intervention, national health systems will face spiraling long-term care costs, widening health inequities, and mounting strain on families and caregivers. Cross-country evidence also demonstrates that dedicated, cost strategies can deliver measurable fiscal returns. For example, the case from England demonstrates that **early-diagnosis memory services can generate major public savings**. A nationwide rollout costing approximately **£220 million per year** would, by preventing just **10% of care home admissions**, deliver **£120 million in annual public expenditure savings** and nearly offset total costs within a decade. Under a 20% reduction scenario, **public-sector savings alone fully repay the investment in about six years**. Even modest gains in quality of life (0.01-0.02 QALYs per person-year) render such programmes cost-effective, while caregiver-support interventions can delay institutionalisation by 53-557 days and reduce placement risk by 6-28%[175].

With the advent of DMTs and scalable biomarker diagnostics, Alzheimer's disease now follows a distinct, treatable pathway that demands disease-specific national planning. **As science redefines what's possible in Alzheimer's disease care, policy and budgets must keep pace**.

Establishing **ring-fenced, cost Alzheimer's disease strategies** - whether integrated into existing dementia frameworks or as standalone national plans is now essential. These plans should set measurable goals, secure multiyear funding, and focus on five fiscal and clinical pillars:

- Early and accurate diagnosis
- Scalable biomarker testing infrastructure
- Equitable access to DMTs
- Strengthened health and care workforce
- Comprehensive caregiver and long-term care support

Together, these components not only improve patient outcomes but also enable governments to manage the growing fiscal pressure of ageing societies.

02 Pilot and expand early cognitive and biomarker-based screening (Domain 2: Prevention and screening)

- **Challenges:** A large proportion of dementia cases remain undiagnosed; in some low-income countries, up to 90% go unrecognised due to self-stigma and cultural barriers to seeking care[176]; Organised screening programs are rare; most countries rely on opportunistic, or case-finding approaches in clinical settings
- **Objectives of recommendations:** Enable earlier detection and triage to specialist evaluation by piloting scalable cognitive and biomarker-based screening models appropriate to different resource contexts; It is critical that, before introducing new health system interventions or updating existing clinical protocols, relevant local evidence is provided to governments wherever feasible to support informed decision-making
- **Recommendations:**

  Mature systems:

  – Mandate routine cognitive screening for high-risk groups (e.g., adults ≥ 60 years), incorporating validated tools such as the MoCA or MMSE into national health-check programs or universal health-coverage (UHC) benefit packages, accompanied by incentives for primary-care adoption and reporting

  – Leverage existing national dementia networks (e.g., South Korea's 256 Dementia Relief Centres) to pilot stepwise screening models combining cognitive testing with BBBM "rule-out" assays for individuals with mild cognitive impairment, followed by confirmatory CSF or PET testing at specialist centres

  – Replicate Japan's BBBMs screening model by initiating HTAs and national pilot programmes within 12 months to evaluate, adapt, and integrate BBBM screening into routine triage pathways for MCI and early Alzheimer's disease, informing national thresholds, referral criteria, and reimbursement pathways

- Conduct multicentre clinical and implementation studies to assess the accuracy, cost-effectiveness, and workflow integration of BBBM testing in primary and community care
- Engage primary care practitioners and geriatric networks in awareness and pilot programs to determine how biomarker information can be used meaningfully and ethically in community settings
- Introduce pilot reimbursement schemes for BBBM and cognitive screening to support data collection and equity monitoring
- Mobilise private payers to expand early screening access: Governments should offer targeted tax incentives or regulatory fast-track pathways for private insurers that agree to cover the cost of BBBM screening for asymptomatic but high-risk adults aged 55+; This is a low-cost, high-impact lever that can rapidly expand screening coverage beyond publicly funded programs while reducing out-of-pocket barriers and accelerating early detection

Emerging systems:

- Initiate phased rollouts starting with district-level implementations in emerging systems, combining cognitive screening with biomarker sampling at district or provincial hospitals, supported by regional laboratory partnerships for confirmatory testing
- Strengthen training for primary-care physicians and community health workers on dementia recognition, risk factors, and referral pathways - drawing on Indonesia's existing Puskesmas (government-mandated community health clinics located across the country)[77] network and community-based rehabilitation (CBR) programs, which already integrate trained health cadres (kader) to deliver home- and community-level care for chronic conditions[178]; Leveraging these structures can build frontline capacity and ensure system readiness for future biomarker integration once screening and reimbursement pathways are fully established
- Participate in regional collaborations to share data, protocols, and lessons from pilots

- **Illustrative outcome targets:** By 2028, initiate national or regional pilot studies integrating cognitive and biomarker screening; ≥50% of adults ≥60 in pilot areas receive cognitive assessments; by 2030, ≥20% increase in confirmed early-stage (MCI due to Alzheimer's disease) diagnoses
- **Target stakeholders for driving actions:** Health Ministries; Dementia, Neurology and Geriatrics Societies; Academic Institutions; Diagnostic Industry Partners; Regional and Global Research Collaboratives

Integrating BBBM into routine practice: a game changer for early and cost-effective Alzheimer's disease diagnosis

Optimised, cost-saving diagnosis: A high-performing BBBM (with 88% sensitivity, 89% specificity) used in primary care could reduce CSF/PET testing by 86% and 47% respectively[179]

Efficient resource use & accuracy: BBBMs pTau181 as a rule out test for Alzheimer's disease before confirmatory CSF/PET improved diagnostic accuracy and reduced resource use[180]

- **True positives ↑ 98.5%, false negatives ↓ 83.9%** in primary care (10–23% prevalence)
- **True negatives ↑ 22.4%, false positives ↓ 32.5%** in secondary care
- **Clinic visits ↓ 1.8–5.3%, procedures ↓ 1.5–3.6%**, and timely accurate diagnoses ↑ 7%

Earlier detection, lasting impact: Incorporating **BBBM** into primary care not only reduced costs **(€1,062 saved per patient)** but also improved patient outcomes, adding **+0.033 QALYs** over 20 years. Most savings stemmed from lower Alzheimer's disease-related expenditures, including medical, social, and informal care costs[181]. Improving the accuracy and timing of Alzheimer's disease diagnosis provides intrinsic value, independent of the availability of DMTs, by facilitating earlier access to symptomatic treatments and delivering measurable benefits to both patients and society.

03 Strengthen diagnostic infrastructure and capacity across care levels (Domain 3: Diagnosis and resource capacity)

- **Challenges:** High-income economies maintain broad access to advanced imaging (e.g., PET, MRI, CT) and emerging biomarker testing, while middle-income economies rely mainly on tertiary centres with limited reach to secondary and community care levels
- **Objectives of recommendations:** Expand equitable access to dementia and Alzheimer's disease diagnosis through scalable imaging, laboratory, and referral infrastructure suited to different resource contexts
- **Recommendations:**

  Mature systems:
  - Modernise and optimise diagnostic infrastructure across care levels by expanding MRI, CT, and PET access and maintenance programs
  - Integrate CSF testing capacity into secondary and regional hospitals to support timely amyloid confirmation, while continuing to assess feasibility and phase BBBM integration
  - Institutionalise integrated hub-and-spoke referral networks, linking community and primary-care providers to specialised memory centres through digital reporting, standardised referral protocols, and multidisciplinary review mechanisms
  - Establish national quality-assurance standards and digital data-exchange systems to ensure consistency of diagnostic results

  Emerging systems:
  - Develop flexible regional diagnostic hubs that serve as extensions of tertiary facilities - equipped with basic neuroimaging, cognitive-testing, and tele-consultation capacity - to extend access into underserved and rural provinces
  - Mobilise global health implementer organisations (e.g., Davos Alzheimer's Collaborative, Brain Health Initiative), to support Ministries of Health in developing Alzheimer's disease-specific hub-and-spoke models, workforce training programs, establishing the BBBMs work flow and end-to-end patient-journey models
  - Establish PPPs and cost-sharing models to expand shared imaging infrastructure and mobile diagnostic units, reducing government fiscal burden while accelerating reach
  - Build training programs for primary-care and neurology teams to interpret imaging and cognitive data and refer patients for biomarker confirmation when indicated
  - Explore stepwise diagnostic models: using cognitive testing and MRI at local levels, escalating to CSF or PET in specialised centres to align patient needs with available resources
- **Illustrative outcome targets:** ≥30 % of secondary hospitals networked for dementia diagnostics by 2027; ≥10 % increase in access to imaging and confirmatory testing by 2028
- **Target stakeholders for driving actions:** Health Ministries; Hospital Networks; Diagnostic Laboratories; Radiology and Neurology Societies; Dementia, Neurology and Geriatrics Societies; Diagnostics Industry Partners

7.2. High impact, mid-term recommendations (3-5 years)

04 Standardise diagnostic pathways and integrate validated biomarkers (Domain 3: Diagnosis and resource capacity)

- **Challenges:** Diagnosis of Alzheimer's disease remains largely symptom-based across APAC; While both CSF biomarkers and BBBM are validated and increasingly adopted in clinical practice, access and reimbursement remain limited; Most economies lack standardised national guidelines, quality assurance systems, and reimbursement frameworks to ensure accuracy, equity, and clinical reliability
- **Objectives of recommendations:** Establish standardised diagnostic pathways that embed biomarkers within clinical and reimbursement systems, ensuring diagnostic accuracy, governance, affordability and equitable access
- **Recommendations:**

  Mature systems:
  - Update national diagnostic guidelines to include CSF biomarker ratios (Aβ and p-Tau) as confirmatory tests for early Alzheimer's disease, with defined use criteria, interpretation protocols, and patient communication standards
  - Include BBBMs (e.g., pTau-181) in national diagnostic algorithms as minimally invasive rule-out tests to identify patients who may not require confirmatory CSF or PET testing, ensuring alignment with emerging FDA-designated standards for clinical use
  - Establish quality assurance frameworks and accreditation systems for laboratories performing Alzheimer's disease biomarker assays, linked to digital reporting and registry integration

  - Develop commercial and reimbursement models for CSF testing to enable sustainable access and prepare for future integration of validated BBBM assays
  - Encourage joint health tech assessment and payer-industry evidence generation to demonstrate cost-effectiveness and system value

  Emerging systems:
  - Designate regional reference laboratories for CSF testing and establish collaborative networks for quality control, training, and data harmonisation
  - Conduct BBBM pilot studies with regulatory oversight to build local evidence for future diagnostic inclusion
  - Develop national cost-effectiveness analyses and reimbursement dossiers to support adoption once validated

- **Illustrative outcome targets:** ≥30 % of specialist centers using standardised biomarker criteria by 2030; ≥50 % reduction in diagnostic wait times

- **Target stakeholders for driving actions:** Health Ministries; National Health Insurance; Dementia, Neurology and Geriatrics Societies; Academic Institutions; Laboratory Networks; Diagnostic Industry Partners

05 Build national Alzheimer's disease registries and data platforms (Domain 1: Policy and planning)

- **Challenges:** Across APAC, fragmented data systems limit governments' ability to track biomarker uptake, diagnostic timeliness, and treatment outcomes; Few economies maintain national dementia registries with Alzheimer's disease-specific modules, and linkages between biomarker datasets, EHRs, and treatment records remain inconsistent. This constrains health-system readiness for DMT adoption and evidence-based policymaking

- **Objectives of recommendations:** Establish robust, interoperable national data systems that capture real-world evidence on Alzheimer's disease diagnosis, treatment, and outcomes - supporting policy design, financing, HTA analysis, and equitable access

- **Recommendations:**

  Mature systems:
  - Develop or expand dedicated Alzheimer's disease registries that capture CSF and BBBM testing, DMT eligibility, treatment uptake, and outcomes; link them with payer datasets to support health-economic analyses and inform evidence-based decisions on diagnosis and treatment investment
  - Integrate Alzheimer's disease registries with national EHR systems to enable longitudinal tracking of the full patient pathway from diagnosis to post-treatment monitoring; implement standardised pathways in line with AAIC 2025 BBBMs guidelines and national policies
  - Establish digital data-exchange and monitoring frameworks, including wait-time guarantees for DMT eligibility and standardised data definitions across laboratories, hospitals, and research centers
  - Publish annual registry reports on diagnostic access, biomarker adoption, and treatment equity to inform payer, clinical, and policy decisions

  Emerging system:
  - Establish or strengthen national dementia registries that incorporate Alzheimer's disease-specific modules (biomarker, diagnosis, and treatment fields)
  - Pilot digital data-collection tools in tertiary hospitals to track biomarker testing, diagnosis-to-treatment intervals, and care outcomes
  - Collaborate with academic institutions and regional laboratories to build analytic capacity and ensure data standardisation for future Alzheimer's disease-specific expansion

- **Illustrative outcome targets:** By 2028, ≥15 % improvement Alzheimer's disease data completeness and registry-payer linkages; by 2030, ≥5 economies maintain operational interoperable national or multicentre registries integrating Alzheimer's disease and biomarker datasets with monitoring frameworks for HTA and policy evaluation

- **Target stakeholders for driving actions:** Health Ministries; Digital Health and Data Agencies; National Dementia and Alzheimer's disease Registries; Academic and Research Institutions; Hospital Networks

06 Ensure health-system readiness for disease-modifying therapies (Domain 4: Treatment and access)

- **Challenges:** With the introduction of disease-modifying therapies such as lecanemab and donanemab, health systems must adapt to new clinical, diagnostic, and financial requirements; DMT eligibility depends on biomarker-confirmed amyloid pathology, but most economies face limited testing capacity, fragmented diagnostic pathways, and inadequate reimbursement mechanisms; Without proactive planning, access to DMTs may exacerbate existing inequities in dementia and Alzheimer's disease care
- **Objectives of recommendations:** Ensure that health systems are equipped to deliver DMTs safely, efficiently, and equitably through aligned diagnostic–treatment pathways, financing models, and patient navigation mechanisms
- **Recommendations:**

  Mature systems:
  - Define eligibility and treatment pathways requiring biomarker confirmation via CSF testing with standardised referral and monitoring protocols
  - Integrate DMTs into clinical guidelines and specify multidisciplinary coordination between neurologists, geriatricians, imaging, and biomarker laboratories
  - Mandate bundled payment models for diagnostics + DMT + monitoring: Ministries of Finance should require that any newly approved DMT be financed through a bundled payment model, in which diagnostic confirmation (BBBM/CSF/PET), drug administration, and safety monitoring are reimbursed as a single integrated package; This approach solves the siloed cost problem, ensures that the diagnostic step is fully funded, and transfers the risk of poor patient selection and inadequate monitoring to providers and payers, promoting appropriate, evidence-based use of DMTs
  - Develop financing and reimbursement frameworks that bundle diagnostic and treatment costs to ensure affordability, e.g., bundled payment or shared-cost models covering confirmatory testing, drug, and follow-up monitoring
  - Develop HTA fast-track mechanisms for DMTs and companion diagnostics to shorten adoption timelines and enable earlier patient access while maintaining safety and cost-effectiveness standards
  - Develop "DMT-ready" checklists and implementation protocols to ensure diagnostic pathways (Recommendation #4) are systematically connected to treatment initiation and patient monitoring systems
  - Integrate patient registries to track DMT utilisation, safety, and outcomes across tertiary and community settings.
  - Launch foundational workforce training programmes in which the first year focuses exclusively on BBBM interpretation, post-result patient counselling, and referral criteria for DMT eligibility

  Emerging systems:
  - Embed DMT readiness planning within national / regional dementia frameworks, outlining phased introduction once regulatory approval are achieved
  - Launch phased Diagnostics-DMT pilots in urban tertiary hospitals, beginning with CSF / BBBM testing linked to limited-scale DMT administration, to build operational and clinical evidence for national scale-up
  - Conduct feasibility and cost-effectiveness studies on DMT implementation to inform payer dialogue, budget impact analysis, and future HTA submissions
  - Invest in capacity-building, including specialist training, data systems, and referral mechanisms, to prepare for eventual DMT adoption
  - Leverage public-private partnerships (PPPs) to support financing pilots, registry establishment, and patient education on eligibility and safety monitoring
- **Illustrative outcomes targets:** Establish diagnostics/ biomarker-based eligibility frameworks to enable future DMT pathway implementation by 2028; Mandate that payers adopt biomarker-confirmed eligibility as a non-negotiable prerequisite for DMT reimbursement by 2028, ≥20% reduction in out-of-pocket diagnostic costs; ≥50% of tertiary hospitals establish DMT coordination and patient-tracking systems
- **Target stakeholders for driving actions:** Health Ministries; National Health Insurance; Dementia, Neurology and Geriatrics Societies; Academic Institutions; Hospital and Laboratory Networks; Diagnostic and Pharma Industry Partners

Reference model for bundling diagnostics & treatment payment

Across public models such as the Centres for Medicare & Medicaid Services (CMS) GUIDE Model in the United States and the National Health Service (NHS) England dementia pathway framework, as well as private models like Isaac Health in the United States, bundled or capitated dementia payments already support coordinated, end-to-end care. These precedents can serve **as references for developing an Alzheimer's disease-specific Diagnostics and Treatment (Dx + Tx) bundle -integrating biomarker-confirmed diagnosis, DMT initiation, and safety monitoring -** to establish reimbursement mechanisms that **ensure both affordability and equitable access.**

Case study / Source	Model & design	Indicative suggestions for Alzheimer's disease Dx + Tx bundling
Centers for Medicare & Medicaid Services (CMS), United States - GUIDE Model (2024-2030)[182]	A national **alternative payment model** launched by CMS to improve dementia care; Provide a **per-beneficiary-per-month (PBPM) Dementia Care Management Payment** for an integrated service package including individualised care plans, care coordination, caregiver support, 24/7 helpline access, and respite benefits. Aims to enhance quality of life and reduce hospital and emergency utilisation	Develop an Alzheimer's disease-specific bundled episode to include **biomarker confirmation, DMT initiation, and follow-up monitoring** under one accountable payment
National Health Service (NHS) England, United Kingdom – Models of Dementia Assessment and Diagnosis: Indicative Cost Review (2019)[183]	Official NHS England report detailing **3 standardised diagnostic pathways** - community-based, specialist-led, and hybrid models - with associated **staffing patterns and indicative cost structures** for end-to-end dementia assessment and diagnosis; Provide a transparent costing basis for commissioners. Focus is on the diagnostic pathway (assessment + diagnosis) rather than treatment bundle	**Use pathway-based costing**. Apply NHS methodology to design a **diagnostic sub-bundle** for Alzheimer's disease that covers **BBBM triage and confirmatory CSF/PET testing**, forming the diagnostic foundation of an integrated Dx + Tx payment model
Isaac Health, United States - Virtual Memory - Care Model[184]	A **virtual-first memory-care provider** partnering with **Medicare Advantage plans**; Offer **bundled or risk-sharing payment arrangements** covering screening, specialist diagnosis, and longitudinal dementia management	**Leverage provider-led contracting.** Pilot **Dx + Tx bundles with risk-sharing** through memory-clinic networks that integrate **diagnostics, DMT initiation, and follow-up monitoring** under one payment contract

7.3 High impact, long-term recommendations (5 - 10 years)

07 Scale digital and home-based care models (Domain 4: Treatment and access)

- **Challenges:** Limited access to dementia and Alzheimer's disease specialists in rural and underserved areas; Fragmented digital infrastructure and lack of reimbursement for tele-health and remote monitoring
- **Objectives of recommendations:** Expand digital and home-based models to improve care continuity, monitoring, and equity of access; Integrate technology into existing dementia and Alzheimer's disease pathways for sustainable, patient-centered care
- **Recommendations:**

  Mature systems:
  - Integrate tele-neurology and digital cognitive-monitoring tools into national care pathways, linked with EHRs and registries
  - Develop longitudinal dashboards combining biomarker, cognitive-function, and treatment data to support remote case management and adherence tracking
  - Introduce reimbursement codes for digital follow-up visits and home-based monitoring to sustain hybrid care delivery
  - Partner with telecom and technology companies to ensure secure, interoperable platforms for cross-institutional data exchange

  Emerging systems:
  - Pilot tele-dementia clinics connecting provincial hospitals with tertiary specialists via low-cost digital platforms
  - Deploy mobile health (mHealth) including SMS-based tracking and reminders - to enable long-term digital care scaling, drawing on successful rural models such as community SMS follow-up programs in China[175]
  - Train CHWs to assist elderly patients with technology use and remote symptom reporting
  - Collaborate with telecom operators to subsidise data access for dementia and caregiver support programs.
- **Illustrative outcome targets:** 25% reduction in rural diagnostic delays by 2032; ≥50% of tertiary hospitals adopt digital follow-up models by 2035
- **Target stakeholders for driving actions:** Health Ministries; Telehealth Providers; Technology and Telecom Companies; Hospital Networks; Community-Health Agencies

7.4. Medium impact, short-term recommendations (1 - 3 years)

08 Strengthen advocacy and education ecosystem (Domain 5: Education and awareness)

- **Challenges:** Persistent stigma and low public understanding delay diagnosis and care-seeking; Need to keep current momentum and further enhance coordination among patient groups, clinicians, and policymakers to promote disease and therapy awareness and education
- **Objectives of recommendations:** Strengthen national advocacy and education frameworks to embed dementia and Alzheimer's disease awareness, caregiver support, and therapy literacy in public health priorities
- Recommendations:

  Mature systems:
  - Establish national Alzheimer's disease and dementia advocacy alliances uniting patient organisations, scientific societies, and policymakers to promote early diagnosis, biomarker literacy, and stigma reduction
  - Formalise the role of civil society as Patient Navigation Hubs: Governments should officially designate accredited patient organisations (e.g., Dementia Australia, Alzheimer's Association Korea) as patient navigation hubs within national dementia and Alzheimer's disease strategies; These organisations should receive government funding and mandates to provide follow-up support after screening or diagnosis, guide patients through referral pathways, and address access and equity barriers in rural and underserved communities
  - Embed policies mandating patient-organisation participation in national Alzheimer's disease and dementia planning committees, ensuring that lived-experience perspectives shape awareness campaigns, service design, and policy priorities
  - Integrate public education campaigns into national health communication strategies (TV, digital, and workplace platforms)
  - Launch caregiver-training certifications and peer-support platforms, supported by digital content and tele-learning modules
  - Collaborate with regional and global groups (e.g., Alzheimer's diseaseI, OECD, WHO) to harmonise messaging and evidence dissemination

Emerging systems:
- Build grassroots dementia-awareness networks anchored in community centers, primary-care clinics, and local NGOs
- Train CHWs and volunteers to deliver culturally adapted dementia education and caregiver support
- Leverage radio, SMS, and local-language campaigns to address stigma and promote care-seeking behavior
- Establish small-scale patient-led advocacy groups to represent dementia and Alzheimer's disease needs in national planning processes

- **Illustrative outcome targets:** 30% increase in public awareness and 25% rise in caregiver-training participation by 2028
- **Target stakeholders for driving actions:** Patient and caregiver organisations; Health Ministries; Media Partners; Dementia, Neurology and Geriatrics Societies

7.5. Medium impact, mid-term recommendations (3 - 5 years)

09 Invest in workforce training for early detection and rehabilitation (Domain 3: Diagnosis and resource capacity)

- **Challenges:** Limited clinical and laboratory awareness and expertise in CSF and BBBMs; uneven access to specialist and allied-health training, particularly outside urban centers; In addition, rehabilitation and palliative-care competencies remain under-developed in most dementia training pathways, resulting in fragmented patient management across the disease continuum;
- **Objectives of recommendations:** Strengthen workforce capacity for early dementia and Alzheimer's detection, rehabilitation, and palliative care through standardised curricula, certification, and digital learning; Promote multidisciplinary skill development spanning diagnostics, counselling, functional support, and end-of-life care - ensuring alignment with WHO's Rehabilitation Competency Framework (2021) and global dementia workforce priorities
- **Recommendations:**

  Mature systems:
  - Develop national / regional certification programs for neurologists, geriatricians, and laboratory scientists on CSF and BBBM use, interpretation, patient counselling, cognitive-function support, and end-of-life management
  - Integrate dementia and biomarker modules into continuing-medical-education (CME) and specialist fellowship curricula
  - Partner with academic institutions and professional societies to develop AI-enabled simulation tools for diagnostic training, multidisciplinary case management, rehabilitation planning, and palliative-care pathways

  Emerging systems:
  - Incorporate dementia-screening and referral skills, rehabilitation and palliative-care basics into undergraduate and general-practice training
  - Provide short-term upskilling courses for nurses, general physicians, and lab technicians on cognitive-screening protocols and sample handling
  - Use tele-education platforms and regional digital learning hubs to deliver remote training, mentorship, and peer learning from centers of excellence - supporting scalable workforce upskilling across geographies
  - Mitigate clinician confidence issues through structured task-shifting and capacity-building guided by WHO's Rehabilitation Competency Framework (2021)[186], ensuring that general practitioners, nurses, and allied health professionals can safely and confidently conduct dementia screening and rehabilitation activities in line with global competency standards

- **Illustrative outcome targets:** By 2028, establish national training frameworks on Alzheimer's disease diagnostics / rehabilitation / palliative care; ≥500 specialists and CHWs certified in early detection / functional rehabilitation / end-of-life support
- **Target stakeholders for driving actions:** Health Ministries; Medical Universities; Dementia, Neurology and Geriatrics Societies; Hospital Networks

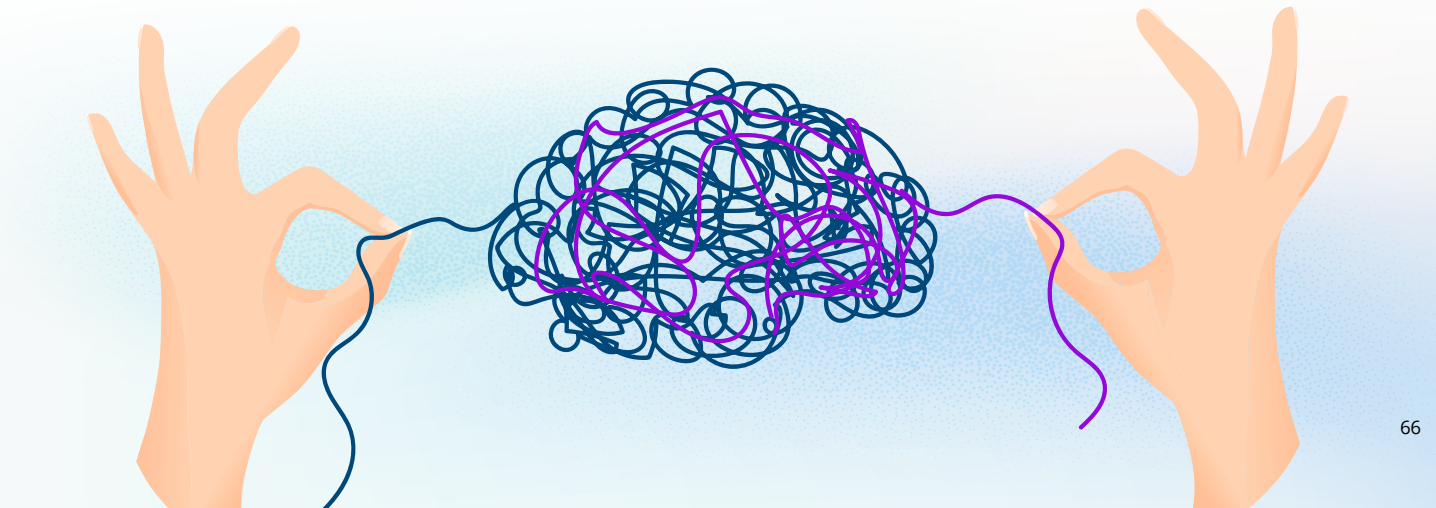
7.6. Medium impact, long-term recommendations (5 - 10 years)

10 Promote cross-territory collaboration and data sharing (Domain 5: Education and awareness)

- **Challenges:** Fragmented policies and limited data-sharing slow biomarker adoption and DMT preparedness across the region; No unified regional platform links governments, researchers, and advocacy groups to coordinate Alzheimer's disease and dementia strategies
- **Objectives of recommendations:** Establish regional mechanisms to align policies, harmonise data, and exchange best practices; Strengthen collaboration between mature and emerging systems to accelerate equitable access to therapeutic innovations
- **Recommendations:**

  Mature systems:
  - Lead the formation of a regional Alzheimer's disease and dementia policy network under WHO WPR/SEARO or ASEAN Health Division, in close partnership with Alzheimer's Disease International (Alzheimer's diseaseI), to share best practices on biomarker integration, HTA evidence, and DMT financing
  - Host annual regional roundtables and policy dialogues (e.g., co-convened with Alzheimer's diseaseI) to exchange experiences and best practices on diagnostic governance, reimbursement, and data interoperability
  - Collaborate with Alzheimer's diseaseI to produce regional policy toolkits and advocacy briefs on early detection, biomarker adoption, and DMT readiness
  - Provide technical mentorship and open-access toolkits for emerging economies developing national biomarker or dementia frameworks

  Emerging systems:
  - Participate actively in the regional policy network, contributing data and insights from national dementia and Alzheimer's disease initiatives
  - Join multi-territory pilot projects focused on biomarker validation, registry interoperability, and financing models for DMT readiness
  - Share local data through regional repositories aligned with dementia initiatives to enhance transparency, comparability, and policy benchmarking
  - Seek donor and development partner support (e.g., WHO, Alzheimer's diseaseB, OECD) to co-fund cross-border registry, HTA, and workforce research
- **Illustrative outcome targets:** By 2030, ≥3 regional pilot projects on biomarker validation, data sharing, or DMT readiness initiated; by 2035, establishment of a regional Alzheimer's disease and dementia policy network
- **Target stakeholders for driving actions:** Health Ministries; Alzheimer's diseaseI; WHO; ASEAN Health Division; Donor and Development Organisations; Dementia, Neurology and Geriatrics Societies; Patient and Caregiver organisation



8.

Conclusion

8. Conclusion

Seizing the window for system reform

Alzheimer's disease is reshaping the health, social, and economic landscape of APAC. With rapidly ageing populations, high levels of multimorbidity, and large numbers of people in preclinical and prodromal stages of disease, the region is moving towards a tipping point where dementia and Alzheimer's disease-related needs risk outstripping system capacity. At the same time, scientific advances in biomarkers and DMTs have created a historic opportunity to shift from late-stage crisis response to earlier, more proactive, and more equitable models of care.

This White Paper has highlighted both sides of that equation. The burden of Alzheimer's disease is profound and growing: rising prevalence, escalating long-term care needs, heavy reliance on unpaid caregiving - especially by women - and mounting fiscal pressures on health and social systems. Yet our assessment across 09 APAC territories shows that Alzheimer's disease still lacks explicit policy prioritisation, early-detection programmes remain underdeveloped, diagnostic and biomarker capacity is unevenly distributed, and data systems are not yet fit for purpose to inform financing, planning, and evaluation.

At the same time, there are clear foundations on which to build. Many territories have dementia strategies, UHC platforms, and emerging digital health infrastructure. Clinical expertise in neurology, geriatrics, psychiatry, and public health is strong in several settings, and civil society is increasingly vocal in advocating for people living with dementia and their caregivers. The policy and system-readiness scorecard developed for this White Paper provides a structured baseline that can help governments and partners understand where they stand today, benchmark progress over time, and target interventions where they will have the greatest impact.

The recommendations set out in this report focus on 6 core levers: prioritising Alzheimer's disease within national health strategies; piloting and scaling early cognitive and biomarker-based screening; strengthening diagnostic infrastructure and capacity; standardising diagnostic pathways and integrating validated biomarkers; building national Alzheimer's disease registries and data platforms; and ensuring health-system readiness for DMTs. Taken together, these actions provide a practical roadmap for both mature and emerging systems, recognising that pathways and pace will differ, but that the direction of travel must be shared: earlier detection, more accurate diagnosis, better-supported families, and sustainable access to effective treatments.

Delivering on this agenda will require sustained, coordinated leadership. Ministries of Health cannot act alone; finance and social welfare authorities, payers, regulators, digital agencies, academic institutions, providers, industry partners, and civil society all have distinct and complementary roles to play. Governance mechanisms that clarify accountability, mobilise cross-sector taskforces, and embed transparent monitoring and evaluation will be critical to ensure that commitments translate into measurable change in people's lives.

Ultimately, the test of success will not be the number of policies written or pilots launched, but whether people at risk of or living with Alzheimer's disease in APAC receive earlier, more accurate diagnoses; have real options for treatment and support; and can live with dignity, independence, and connection for as long as possible. If governments and partners use this White Paper as a catalyst - to inform national strategies, guide investment decisions, and shape implementation plans - APAC can move from fragmented, reactive responses towards a coherent, future-ready model of Alzheimer's disease care.

The window for decisive action is narrow but open. Choices made in the coming years will determine whether the region is prepared for the next era of Alzheimer's disease science and care, or left to confront its consequences unprepared. By acting now - strategically, collaboratively, and with a clear focus on equity and sustainability - APAC can lead a global shift towards earlier, fairer, and more resilient Alzheimer's disease management.

9.

Appendices

9. Appendices

Detailed methodology & scorecard

This research consisted of a benchmarking exercise that assessed the current landscape of Dementia and Alzheimer's disease care in the APAC region, with a specific focus on 09 territories. A targeted literature review was conducted using indexed databases (including MEDLINE, Embase, and the Cochrane Library) and grey literature sources (such as policy documents and reports) to identify existing policy frameworks, clinical guidelines, and programmatic approaches related to Dementia and Alzheimer's disease. The review included over 150 studies published between 2000 and 2025, which were screened for relevance and thematically categorised into three areas: epidemiological trends, social and economic impacts, and policy and program effectiveness. From this analysis, we developed a draft set of indicators and sub-domains, ultimately organised across 05 domains designed to benchmark Dementia and Alzheimer's disease care to eventually identify opportunities for improvement. These domains included: National / Regional disease policy and planning landscape; Dementia and Alzheimer's disease prevention and screening; Dementia and Alzheimer's disease diagnosis and healthcare system capacity; Dementia and Alzheimer's disease treatment monitoring and access; Dementia and Alzheimer's disease advocacy, awareness, and education. In total, the scorecard comprised 5 domains, 26 sub-domains, and 76 indicators.

A scoring structure was then developed for each indicator, with defined scoring ranges (e.g. 0–2, 0–4) used to classify performance levels from low to moderately low, moderately high, and high. Territories were assessed based on the best available publicly accessible information, and the evaluation drew on a range of both primary and secondary research sources. The scoring process inevitably involves simplifying complex realities, and as such, we acknowledge that not all readers may agree with every individual score. In several instances, supporting data were unavailable or incomplete in the public domain. The purpose of the exercise was not to rank territories but to support evidence-informed policy dialogue and highlight areas where targeted interventions may improve Dementia and Alzheimer's disease care outcomes.

Deloitte retained full editorial independence throughout the research process. The research was led by Yongho Yi, conducted by Chi Tran. Seong Jin Lee and Kavita Rekhraj oversaw the research project. An Expert Advisory Panel composed of local and regional leaders in Dementia and Alzheimer's disease care provided critical guidance, reviewing the indicator framework and contributing insights via interviews, email correspondence, and virtual meetings. Their input ensured scientific rigor and helped ground the findings in current clinical best practices and the regional context.

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
Overall national policy and planning landscape	**1**	**Existence and operational status of national Alzheimer's disease policies / strategies / plans**	**1**	**Existence and operational status of national Alzheimer's disease policies / strategies / plans** 3 = Standalone national policies, strategies, or plans on dementia are in place and specifically mention Alzheimer's disease 2 = Standalone national policies, strategies, or plans on dementia are in place, but do not specifically mention Alzheimer's disease 1 = Dementia and/or Alzheimer's disease are included within broader national NCD policies, strategies, or plans, but not as standalone priorities 0 = No national policy, strategy, or plan addresses dementia or Alzheimer's disease
			2	**Currency of the national policies / strategies / plans** 1 = Policies, strategies, or plans were launched or updated in 2020 or later (e.g., within the past 5 years) 0 = Policies, strategies, or plans were launched or last updated before 2020

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	2	**Priority & specificity of Alzheimer's disease in national policies / strategies / plans**	**3**	**Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)** 2 = Policies, strategies, or plans include Alzheimer's disease-specific targets 1 = Policies, strategies, or plans include Dementia-specific targets, but not specific to Alzheimer's disease 0 = Policies, strategies, or plans do not include any specific targets related to Dementia or Alzheimer's disease
	3	**Coordinating mechanism for implementation**	**4**	**Dedicated national Alzheimer's disease programmes / initiatives** 2 = Policies, strategies, or plans include Alzheimer's disease-specific programmes or initiatives 1 = Policies, strategies, or plans include Dementia-specific programmes or initiatives, but not specific to Alzheimer's disease 0 = Policies, strategies, or plans do not include any Dementia / Alzheimer's disease initiatives
			5	**Joint national and regional Alzheimer's disease coordination mechanisms** 2 = There is Alzheimer's-specific coordination between national and subnational governments 1 = There is coordination on Dementia more broadly, but not specific to Alzheimer's 0 = There is no coordination between national and subnational governments specific to Dementia or Alzheimer's
	4	**Alzheimer's disease financing**	**6**	**Dedicated budget to Alzheimer's disease programmes** 2 = A dedicated budget is allocated specifically for Alzheimer's disease programmes 1 = A dedicated budget exists for broader Dementia and Alzheimer's disease programmes, but not specific to Alzheimer's disease 0 = No dedicated budget is allocated to Dementia or Alzheimer's disease programmes
			7	**Funding / insurance coverage for Dementia / Alzheimer's disease Care (Public)** 2 = Dementia / Alzheimer's disease care is fully funded or reimbursed 1 = Dementia / Alzheimer's disease care is partially funded or reimbursed 0 = Dementia / Alzheimer's disease care is not funded or reimbursed
			8	**Funding / insurance coverage for Dementia / Alzheimer's disease (Private & Alternatives)** 2 = Dementia / Alzheimer's disease care is fully funded or reimbursed 1 = Dementia / Alzheimer's disease care is partially funded or reimbursed 0 = Dementia / Alzheimer's disease care is not funded or reimbursed

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	5	**Existence of registries established for Alzheimer's disease**	**9**	**Existence of registries established for Alzheimer's disease** 2 = Alzheimer's disease-specific national registries exist 1 = National Dementia and Alzheimer's disease registries exist, but not specific to Alzheimer's disease 0 = No national registries exist for Dementia or Alzheimer's disease
			10	**Integration of Dementia-specific tracking in EMR systems** 3 = Advanced/Integrated EMRs: Dementia data are routinely and structurally captured in EMRs across care settings; includes diagnosis, assessments, and care planning. National systems may support data exchange/interoperability. 2 = Developing/Moderate EMRs: EMRs include structured dementia diagnosis fields and some cognitive or functional assessments, used in some settings (e.g., hospitals, memory clinics). Limited data sharing or coordination. 1 = Emerging/Basic EMRs: EMRs capture only Dementia diagnosis (often inconsistently or as free text). No structured assessments or care plans. No interoperability. 0 = No EMR Capture: No electronic medical record system is in use, or if one exists, it does not capture any Dementia-specific information

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	6	**Inclusivity and equitable policy formulation**	**11**	**Policies / strategies / plans / programmes addressing equitable access to care to Alzheimer's** 2 = Policies, strategies, plans, or programmes specifically address equitable access to care for Alzheimer's disease patients 1 = Policies, strategies, plans, or programmes address equitable access to care for Dementia and Alzheimer's disease in general, but not Alzheimer's disease-specific 0 = No policies or programmes address equitable access to care for Dementia or Alzheimer's disease
			12	**Policy recognition of preclinical Alzheimer's disease / Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring** 2 = National Alzheimer's/dementia strategies or policies explicitly address preclinical Alzheimer's disease / Dementia or at-risk populations, including individuals with genetic risk, biomarker positivity, or family history. Policies may include guidelines for early detection, monitoring, or preventive interventions (e.g., lifestyle programmes, registries, or surveillance). 1 = At-risk populations are indirectly acknowledged in national policies (e.g., mention of early-stage or high-risk groups), but no specific strategies or plans for preclinical Alzheimer's disease / Dementia are in place 0 = No mention of preclinical Alzheimer's disease / Dementia or at-risk populations is found in national Alzheimer's or dementia policies or strategies
			13	**Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up** 2 = Alzheimer's disease-specific patient navigation programmes exist for underserved communities 1 = General Dementia and Alzheimer's disease patient navigation programmes exist for underserved communities 0 = No patient navigation programmes exist for underserved Dementia or Alzheimer's disease populations
			14	**Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)** 2 = Community-based care programmes specifically for Alzheimer's disease patients exist 1 = Community-based care programmes for Dementia and Alzheimer's disease patients in general exist 0 = No community-based care programmes exist for at-risk Dementia or Alzheimer's disease populations

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	7	**National Alzheimer's disease clinical guidelines availability and implementation**	**15**	**Availability of clinical guidelines on Alzheimer's disease** 3 = National Dementia clinical guidelines are available and include a dedicated section with specific clinical protocols for Alzheimer's disease 2 = National Dementia clinical guidelines are available; Alzheimer's disease is mentioned, but not in a dedicated section with specific clinical protocols 1 = No Dementia-specific guidelines are available; Dementia or Alzheimer's disease is addressed only within broader aged care or general cognitive health frameworks 0 = No national clinical guidelines are available for either Dementia or Alzheimer's disease
			16	**Currency of clinical guidelines** 2 = Clinical guidelines were updated within the last 2 years (e.g., latest update in 2023 or later) 1 = Clinical guidelines were updated within the last 5 years (e.g., latest update in 2020–2022) 0 = The latest update was before 2020
			17	**Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care** 2 = 50% or more healthcare regions or facilities implementing national clinical guidelines 1 =< 50% healthcare regions or facilities implementing national clinical guidelines
	8	**Policy support for preventive care**	**18**	**National policies focused on primary prevention / modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels** 1 = Country has targets for upstream risk factors such as physical activity, obesity, hypertension, alcohol consumption, smoking, air pollution, depression, healthy diets, etc. 0 = Country has no target for upstream risk factors
			19	**National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health / cognitive screening or monitoring)** 1 = National policies, strategies, or plans include strategies for brain health / cognitive screening or monitoring (e.g., in primary care, aging populations, or at-risk groups) 0 = National policies, strategies, or plans do not include any formal strategies for brain health / cognitive screening or monitoring

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	9	**Alzheimer's disease research and innovation**	**20**	**Funding for Alzheimer's disease research: Investment in / funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research** 2 = Investment / funding is dedicated specifically to Alzheimer's disease research (e.g., clinical trials, basic science, public health) 1 = Investment / funding is dedicated to broader dementia and Alzheimer's disease-related research 0 = No investment / funding is dedicated to dementia or Alzheimer's disease-related research
			21	**Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices** 2 = Eligible patients with Alzheimer's disease are enrolled in clinical trials specifically focused on Alzheimer's disease therapies or medical devices 1 = Eligible patients with Dementia, including those with Alzheimer's disease, are enrolled in broader dementia-related clinical trials without specific emphasis on Alzheimer's disease 0 = No evidence of eligible Dementia or Alzheimer's disease patients being enrolled in clinical trials for therapies or medical devices
			22	**Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice** 2 = Typical time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice is from 1 to 3 years 1 = Typical time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice is more than 3 years 0 = Unpredicted and no standardised adoption timeframe

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
Prevention & screening (early detection)	**10**	**Alzheimer's disease screening guidelines (for high-risk population)**	**23**	**National clinical guidelines screening coverage for high-risk population** **For example:** **Older adults (e.g. ≥65 years)** **Individuals with subjective cognitive decline (SCD)** **People with family history of dementia** **Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression** 1 = Guidelines **recommend or include screening for individuals at high risk** of Dementia / Alzheimer's disease 0 = Guidelines **do not recommend or include screening for individuals at high risk** of Dementia / Alzheimer's disease
			24	**National clinical guidelines screening coverage for high-risk population** **For example:** **Older adults (e.g. ≥65 years)** **Individuals with subjective cognitive decline (SCD)** **People with family history of dementia** **Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression** 1 = National **screening guidelines** for Dementia / Alzheimer's disease explicitly recommend one or more validated cognitive assessment tools 0 = National **screening guidelines** do not include or recommend any specific cognitive assessment tools
			25	**Inclusion of BBBMs in screening guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)** 2 = Three or more BBBMs recommended **for screening** (e.g. pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP) 1 = One or two BBBMs recommended **for screening** 0 = No BBBMs recommended or mentioned **for screening**
			26	**Inclusion of CSF biomarkers in screening guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)** 2 = Three or more CSF biomarkers recommended **for screening** (e.g. Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL) 1 = One or two CSF biomarkers recommended **for screening** 0 = No CSF biomarkers recommended or mentioned **for screening**

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	11	**Alzheimer's disease screening funding**	**27**	**Funding for validated cognitive assessment tools in screening (public and/or private)** **For example:** **MMSE (Mini-Mental State Examination)** **MoCA (Montreal Cognitive Assessment)** **Mini-Cog** **GPCOG (General Practitioner Assessment of Cognition)** **CASI (Cognitive Abilities Screening Instrument)** **Clock Drawing Test** 2 = Cognitive screening for Dementia / Alzheimer's disease is fully funded or reimbursed (e.g., through national insurance, public health programmes, private insurance) 1 = Cognitive screening is partially funded or reimbursed 0 = Cognitive screening is not publicly funded or reimbursed
			28	**Financing mechanism for BBBMs in Alzheimer's disease screening** 2 = BBBMs tests for screening (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL) are fully funded or reimbursed by public health insurance, national programmes, or private insurance 1 = BBBMs tests for screening are partially funded or reimbursed (e.g., only for certain populations, settings, or under limited plans) 0 = BBBMs tests for screening are not publicly or privately funded and are fully out-of-pocket
			29	**Financing mechanism for CSF biomarkers Alzheimer's disease screening** 2 = CSF biomarker tests for screening (e.g., Aβ42, Aβ42/40, total tau, pTau181) are fully funded or reimbursed by public or private payers 1 = CSF biomarker tests for screening are partially funded or reimbursed 0 = CSF biomarker tests for screening are not funded and patients must pay fully out-of-pocket

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
Diagnosis & healthcare system capacity	**12**	**Alzheimer's disease diagnosis guidelines**	**30**	**National clinical guidelines diagnosis coverage** 2 = Guidelines explicitly cover diagnosis of Alzheimer's 1 = Guidelines explicitly cover diagnosis of Dementia, but not specifically Alzheimer's 0 = Guidelines do not include diagnostic protocols for Dementia / Alzheimer's
			31	**Inclusion of validated cognitive assessment tools in diagnostic guidelines** **For example:** **MMSE (Mini-Mental State Examination)** **MoCA (Montreal Cognitive Assessment)** **Mini-Cog** **GPCOG (General Practitioner Assessment of Cognition)** **CASI (Cognitive Abilities Screening Instrument)** **Clock Drawing Test** 1 = National diagnostic guidelines for Dementia / Alzheimer's explicitly recommend one or more validated cognitive assessment tools 0 = National diagnostic guidelines do not include or recommend any specific cognitive assessment tools
			32	**Inclusion of BBBMs in diagnostic guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)** 2 = Three or more BBBMs recommended for diagnosis (e.g. pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP) 1 = One or two BBBMs recommended for diagnosis 0 = No BBBMs recommended or mentioned for diagnosis
			33	**Inclusion of CSF biomarkers diagnostic guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)** 2 = Three or more CSF biomarkers recommended for diagnosis (e.g. Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL) 1 = One or two CSF biomarkers recommended for diagnosis 0 = No CSF biomarkers recommended or mentioned for diagnosis

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	13	**Capacity of / Availability of/ access to diagnostic infrastructure and services**	**34**	**MRI** 4 = High (>0.43 machines per ten thousands of population) 3 = Moderately high (>0.28-0.43 machines per ten thousands of population) 2 = Moderately low (>0.14-0.28 machines per ten thousands of population) 1 = Low (0-0.14 machines per ten thousands of population)
			35	**CT** 4 = High (>0.87 machines per ten thousands of population) 3 = Moderately high (>0.58-0.87 machines per ten thousands of population) 2 = Moderately low (>0.30-0.58 machines per ten thousands of population) 1 = Low (0-0.30 machines per ten thousands of population
			36	**PET** 4 = High (>4.0 machines per 1 million population) 3 = Moderately high (>2.0 - 4.0 machines per 1 million population) 2 = Moderately low (>0.5 - 2.0 machines per 1 million population) 1 = Low (<=0.5 machines per per 1 million population)
			37	**CSF Biomarker testing** 3 = CSF biomarker testing (e.g., Aβ42/40, total-tau, p-tau) is regulatorily approved and routinely available nationwide in any clinical settings for Alzheimer's diagnosis 2 = CSF biomarker testing is available in select tertiary or neuro-specialty centres and used in clinical practice, but it is not yet integrated into standardised national diagnostic pathways 1 = CSF testing is only available through research protocols, clinical trials, or by sending samples abroad; not approved for routine clinical use 0 = No domestic capacity for CSF biomarker testing - neither in clinical settings nor research infrastructure
			38	**BBBMs testing** 3 = At least one BBBMs assay (e.g., p-tau217/181, Aβ42/40 ratio, NfL) has regulatory clearance and is routinely used across the country in clinical Alzheimer's diagnostic practice 2 = BBBMs testing is used clinically in select centres or available as validated lab-developed tests or pilots, but not integrated into standard national diagnostic pathways 1 = BBBMs are limited to research use, validation studies, or investigational pilots, with no regulatory approval for clinical implementation 0 = No domestic availability of BBBMs testing - neither clinical nor research-level access

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	14	**Tracking of time to diagnosis for Alzheimer's disease**	**39**	**Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms** 2 = The country systematically tracks time to diagnosis for Alzheimer's disease / dementia through official mechanisms such as national datasets, health registries, or structured surveys 1 = There is some tracking of time to diagnosis, but efforts are fragmented, local, or led by non-governmental stakeholders, rather than part of a coordinated national approach 0 = There is no evidence that the country or relevant stakeholders track or report time to diagnosis for Alzheimer's disease / dementia
	15	**Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)**	**40**	**% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary public institutions** 3 = >80% 2 = 50–80% 1 = <50%
			41	**% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary private institutions** 3 = >80% 2 = 50–80% 1 = <50%
			42	**% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting** 3 = >80% 2 = 50–80% 1 = <50%
			43	**% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at public primary care setting** 3 = >80% 2 = 50–80% 1 = <50%

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	16	**Capacity of workforce**	**44**	**Geriatricians / Psychogeriatricians** 4 = High (>3 staffs per 100k of population) 3 = Moderately high (>2-3 staffs per 100k of population) 2 = Moderately low (>1.5-2staffs per 100k of population) 1 = Low (<=1.5 staffs per 100k of population)
			45	**Neurologists** 4 = High (>6 staffs per 100k of population) 3 = Moderately high (>3-6 staffs per 100k of population) 2 = Moderately low (>1.5-3.0 staffs per 100k of population) 1 = Low (<=1.5 staffs per 100k of population)
			46	**Psychiatrist working in mental health sector** 3 = High (>12 staffs per 100k of population) 3 = Moderately high (>6-12 staffs per 100k of population) 2 = Moderately low (>2-6 staffs per 100k of population) 1 = Low (<2 staffs per 100k of population)
			47	**Social workers working in mental health sector** 4 = High (>20 staffs per 100k of population) 3 = Moderately high (>10-20 staffs per 100k of population) 2 = Moderately low (>1-9 staffs per 100k of population) 1 = Low (<=1 staffs per 100k of population)
	17	**Alzheimer's disease diagnostics funding coverage**	**48**	**Funding for validated cognitive assessment tools in Alzheimer's disease / Dementia diagnosis (public and/or private)** **For example:** **MMSE (Mini-Mental State Examination)** **MoCA (Montreal Cognitive Assessment)** **Mini-Cog** **GPCOG (General Practitioner Assessment of Cognition)** **CASI (Cognitive Abilities Screening Instrument)** **Clock Drawing Test** 2 = Cognitive assessment for Alzheimer's / Dementia diagnosis is fully funded or reimbursed (e.g., through national insurance, public health programmes, private insurance) 1 = Cognitive assessment for Alzheimer's / Dementia diagnosis is partially funded or reimbursed 0 = Cognitive assessment for Alzheimer's / Dementia diagnosis is not publicly funded or reimbursed
			49	**Financing mechanism for BBBMs in Alzheimer's disease diagnosis** 2 = BBBMs tests for diagnosis (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL) are fully funded or reimbursed by public health insurance, national programmes, or private insurance 1 = BBBMs tests for diagnosis are partially funded or reimbursed (e.g., only for certain populations, settings, or under limited plans) 0 = BBBMs tests for diagnosis are not publicly or privately funded and are fully out-of-pocket
			50	**Financing mechanism for CSF biomarkers in Alzheimer's disease diagnosis** 2 = CSF biomarker tests for diagnosis (e.g., Aβ42, Aβ42/40, total tau, pTau181) are fully funded or reimbursed by public or private payers 1 = CSF biomarker tests for diagnosis are partially funded or reimbursed 0 = CSF biomarker tests for diagnosis are not funded and patients must pay fully out-of-pocket

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
Treatment monitoring and access	**18**	**Alzheimer's disease treatment monitoring guidelines**	**51**	**National clinical guidelines treatment & monitoring coverage (e.g., periodic cognitive assessment, adverse event checks, medication reviews)** 2 = Guidelines explicitly cover treatment of Alzheimer's disease 1 = Guidelines explicitly cover treatment of Dementia, but not specifically Alzheimer's disease 0 = Guidelines do not include treatment protocols for Dementia / Alzheimer's disease
			52	**Inclusion of BBBMs in treatment & monitoring guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)** 2 = Three or more BBBMs recommended for treatment & monitoring (e.g. pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP) 1 = One or two BBBMs recommended for treatment & monitoring 0 = No BBBMs recommended or mentioned for treatment & monitoring
			53	**Inclusion of CSF biomarkers in treatment & monitoring guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)** 2 = Three or more CSF biomarkers recommended **for treatment & monitoring** (e.g. Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL) 1 = One or two CSF biomarkers recommended **for treatment & monitoring** 0 = No CSF biomarkers recommended or mentioned for treatment & monitoring
	19	**Involvement of multi-disciplinary team**	**54**	**Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)** 1 = Guidelines recommend shared decision-making or treatment with a multidisciplinary team 0 = No mention of multidisciplinary care
			55	**Hospitals and clinics offer care by a multidisciplinary team including geriatricians/neurologists, psychologists, social workers, occupational therapists, etc. for Dementia / Alzheimers** 1 = Available 0 = Not available
	20	**Linkage to supportive/ palliative care**	**56**	**Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines** 1 = Guidelines include referral pathway to supportive / palliative care services 0 = Guidelines don't include referral pathway to supportive / palliative care services
			57	**Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)** 1 = Available 0 = Not available / very limited

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	21	**DMT access pathway readiness**	**58**	**Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)** 3 = At least one DMT for Alzheimer's disease (e.g., lecanemab, donanemab) has received full regulatory approval and is authorized for use at the national level 2 = At least one DMT has received conditional or accelerated approval or is available through named-patient/compassionate use programmes 1 = At least one DMT has been submitted for regulatory review, but approval is pending 0 = No DMT has been approved, submitted for review, or made available through any regulatory pathway
			59	**Eligibility criteria for DMT access - Assesses whether clear, formalized eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)** 2 = Eligibility criteria for DMT access are clearly defined e.g., in national guidelines, clinical protocols, or reimbursement frameworks. These criteria explicitly include amyloid confirmation as a prerequisite for treatment. 1 = Eligibility criteria for DMT access exist but are unclear, informal, or not standardised nationally (e.g., based on clinical discretion). Amyloid confirmation may be mentioned but not required or not uniformly applied. 0 = No defined eligibility criteria for accessing DMTs are available, and no requirement for amyloid confirmation is outlined in policy or clinical practice
	22	**Home health medication monitoring and remote patient monitoring:**	**60**	**Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients** 1 = Medication monitoring and/or remote clinical follow-up (e.g., home visits, telemedicine consultations, remote patient monitoring technologies, etc.) are available for Dementia and Alzheimer's disease patients 0 = Such services are not available for Dementia and Alzheimer's disease patients

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	23	**Alzheimer's treatment & monitoring funding coverage**	**61**	**Existence of funded / reimbursed drug therapy for Alzheimer's disease** 2 = All drugs included in the NEDL for Dementia / Alzheimer's disease are fully funded/reimbursed 1 = Some drugs included in the NEDL for Dementia / Alzheimer's disease are funded/reimbursed 0 = No drug included in the NEDL for Dementia / Alzheimer's disease is funded/reimbursed
			62	**Financing mechanism for BBBMs in Alzheimer's disease treatment & monitoring (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)** 2 = BBBMs tests for treatment & monitoring (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL) are fully funded or reimbursed by public health insurance, national programmes, or private insurance 1 = BBBMs tests for treatment & monitoring are partially funded or reimbursed (e.g., only for certain populations, settings, or under limited plans) 0 = BBBMs tests for treatment & monitoring are not publicly or privately funded and are fully out-of-pocket
			63	**Financing mechanism for CSF biomarkers in Alzheimer's disease treatment & monitoring (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)** 2 = CSF biomarker tests for treatment & monitoring (e.g., Aβ42, Aβ42/40, total tau, pTau181) are fully funded or reimbursed by public or private payers 1 = CSF biomarker tests for treatment & monitoring are partially funded or reimbursed 0 = CSF biomarker tests for treatment & monitoring are not funded and patients must pay fully out-of-pocket
			64	**Existence of patient / caregiver organizations** 1 = At least one patient / caregiver organization or advocacy group focused on Dementia / Alzheimer's disease exists 0 = No patient / caregiver organization or advocacy group focused on Dementia / Alzheimer's disease exists
			65	**Participation in national policy & plan development, and/or joint programmes with government** 1 = At least one patient / caregiver organization focused on Dementia and/or Alzheimer's disease actively participates in national policy & plan development, and/or joint programmes with government 0 = No patient / caregiver organization focused on Dementia and/or Alzheimer's disease participates in national policy & plan development, and/or joint programmes with government
			66	**Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease** 1 = Available 0 = Unavailable

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	25	**Dementia/ Alzheimer's disease professional medical and scientific societies / associations, research institutes engagement and advocacy**	**67**	**Existence of professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease** 2 = At least one professional medical or scientific society, association, or research institute specifically focused on Dementia / Alzheimer's disease exists 1 = Only professional medical or scientific societies, associations, or research institutes covering general cognitive health or geriatrics including Dementia / Alzheimer's disease exist 0 = no professional medical or scientific societies, associations, or research institutes covering Dementia or Alzheimer's disease exist
			68	**Participation in national policy & plan development, and/or joint programmes or initiatives with government agencies on Dementia / Alzheimer's disease** 1 = One or more medical or scientific society, association, or research institute participate in developing national Dementia and/or Alzheimer's disease policies or plans 0 = No medical or scientific society, association, or research institute participate in such policy or plan development
			69	**Contributions towards clinical guidelines development** 1 = One or more medical or scientific society, association, or research institute are listed as contributors to national Dementia and/or Alzheimer's disease clinical guidelines 0 = No medical or scientific society, association, or research institute is listed as a contributor in national clinical guidelines

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
	26	**Dementia / Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)**	**70**	**[PATIENT] Availability of patient education programmes and support resources initiated / driven by patient / caregiver organizations** 3 = Alzheimer's disease-specific educative programmes or resources are run by patient organizations 2 = Broader Dementia and Alzheimer's disease-specific programmes or resources are run by patient organizations (but not Alzheimer's-only) 1 = Only general aging or brain health programmes/resources are provided by patient organizations, with some relevance to Dementia / Alzheimer's disease 0 = No educative programmes or resources related to Dementia or Alzheimer's disease are run by patient organizations
			71	**[PATIENT] Availability of patient education programmes and support resources initiated / driven by the professional medical and scientific societies / associations, research Institutes focused on Dementia / Alzheimer's disease** 3 = Alzheimer's disease-specific educative programmes or resources are driven by the professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease 2 = Broader Dementia and Alzheimer's disease–specific programmes or resources are driven by the professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease (but not Alzheimer's disease-only) 1 = Only general aging or brain health programmes/resources are driven by the professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease, with some relevance to Dementia / Alzheimer's disease 0 = No educative programmes or resources related to Dementia or Alzheimer's disease are driven by the professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease
			72	**[PATIENT] Availability of patient education programmes and support resources initiated / driven by the government** 3 = Alzheimer's disease-specific educative programmes or resources are run by the government 2 = Broader Dementia and Alzheimer's disease-specific programmes or resources are run by the government (but not Alzheimer's disease-only) 1 = Only general aging or brain health programmes/resources are provided by the government, with some relevance to Dementia / Alzheimer's disease 0 = No educative programmes or resources related to Dementia or Alzheimer's disease are run by the government

Domains	No.	Sub-domains	No.	Indicators & scoring criteria
			73	**[CAREGIVER] Availability of caregiver-focused education, training, and support services on Dementia / Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines)** **Can be driven by:** – **Patient or caregiver organization** – **Professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease** – **The government** 3 = At least one Alzheimer's disease-specific education, awareness, training, or support service for caregivers is available 2 = At least one Dementia (including but not Alzheimer's disease-specific) caregiver education, awareness, training, or support service exists 1 = Only general aging or brain health–related caregiver programmes/ services are available (not dementia-specific) 0 = No relevant programmes or services related to aging, brain health, dementia, or Alzheimer's disease are available for caregivers
			74	**[ALL] Existence and implementation of Dementia and Alzheimer's awareness programmes** 3 = At least one Alzheimer's-specific community-based outreach programme or public awareness campaign exists 2 = At least one Dementia and Alzheimer's–specific awareness programme exists (but not Alzheimer's-only) 1 = At least one general brain health or aging-related awareness programme exists (not dementia-specific) 0 = No awareness or outreach programmes related to brain health, Dementia, or Alzheimer's exist
			75	**[HEALTHCARE PROVIDERS] Availability of clinical education for primary care providers** 3 = At least one Alzheimer's disease-specific clinical education or training programme is available and targeted at primary care providers (e.g., GPs, family doctors, community health workers) 2 = At least one Dementia- and Alzheimer's disease–specific education/training programme exists for primary care providers, but not Alzheimer's disease-only 1 = Only general aging or brain health–related clinical education programmes are available (not dementia-specific) for primary care providers 0 = No relevant clinical education programme is available for primary care providers
			76	**[HEALTHCARE PROVIDERS] Availability of specialist training in Dementia/Alzheimer's care** 3 = At least one Alzheimer's-specific training or subspecialty programme exists for relevant specialists (e.g., neurologists, psychiatrists, geriatricians) 2 = At least one Dementia- and Alzheimer's–specific specialist training programme exists, but not focused exclusively on Alzheimer's 1 = Only general aging, neurodegenerative, or brain health–related content is included in broader specialist education programmes 0 = No dedicated dementia- or Alzheimer's-related specialist training programmes are available

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10. References

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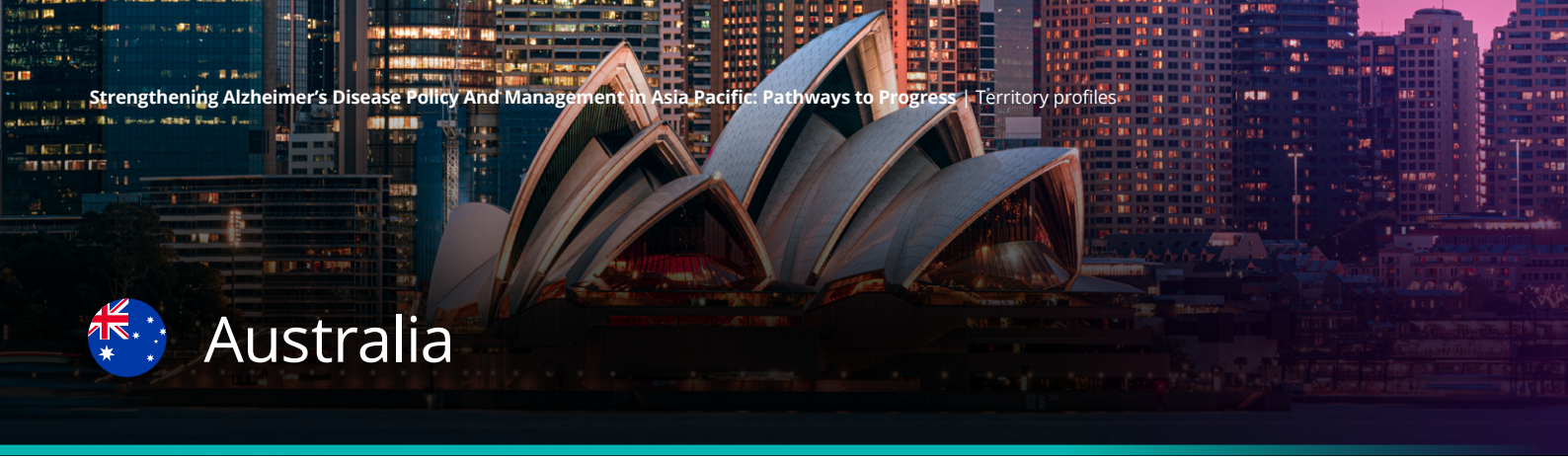
11.

Territory profiles



Australia

11. Territory Profiles

11.1. High-income territories

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
Australia	Moderately high	Low	Moderately high	Moderately high	High

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	**Existence and operational status of national Alzheimer's disease policies/strategies/ plans**	**0-4**	**3**	Existence and operational status of national Alzheimer's disease policies/ strategies/plans	**2**	National Dementia Action Plan 2024 - 2034[187] – Year of publication: 2024 – Author/Issuing Body: Australian Government Department of Health and Aged Care – Overall description: A 10-year national roadmap to enhance diagnosis, care coordination, support for people living with dementia (including Alzheimer's specifically mentioned), and carers – The policy notes emerging Alzheimer's treatments that may slow progression. It calls for innovative, inclusive clinical trials, with support from national research bodies
				Currency of the national policies/strategies/plans	**1**	National Dementia Action Plan 2024 - 2034[188]: Year of publication - 2025

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
2	**Priority & specificity of Alzheimer's disease in national policies/strategies/ plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	Policies, strategies, or plans include Dementia-specific targets, but not specific to Alzheimer's National Dementia Action Plan 2024–2034[189] Action 1: Promote equity and human rights Action 2: Tackle stigma, improve awareness and promote inclusivity Action 3: Empower individuals and communities to minimise risk where they can, and delay onset and progression Action 4: Improve dementia diagnosis and post-diagnostic care and support Action 5: Improve treatment, coordination and support for people living with dementia Action 6: Support carers of people living with dementia Action 7: Build capability of the workforce to care for and support people living with dementia Action 8: Improve dementia data, maximise the impact of dementia research and promote innovation

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
3	**Coordinating mechanism for implementation**	**0-4**	**2**	Dedicated national Alzheimer's disease programmes/initiatives	**1**	Australia has several dementia-focused programmes, though none are specific to Alzheimer's disease. These initiatives cover clinical support, workforce training, community awareness, respite and transitional care, specialist behaviour management, and research funding. Examples include the Dementia and Aged Care Services Fund, the Dementia Behaviour Management Advisory Service, the Dementia Training Programme, Dementia-Friendly Communities, the Dementia, Ageing and Aged Care Mission, the Hospital to Aged Care Dementia Support Programme, dementia-specific respite services, the National Dementia Support Programme, the Severe Behaviour Response Teams, specialist dementia care units in residential aged care, and the Advance Project for advance care and palliative planning[190].
				Joint national and regional Alzheimer's disease coordination mechanisms	**1**	Coordination is most often associated with individual projects or initiatives. In contrast, system-wide coordination remains limited, including in areas such as models of care, standardised services, and care pathways. Example: The Australian Institute of Health and Welfare (AIHW) collaborated with 17 Primary Health Networks (PHNs) on a dementia-focused general practice data demonstration project[191]. This initiative showcased coordination between national and subnational levels to explore data governance, analytics platforms, and the feasibility of establishing a National Primary Health Care Data Collection (NPHCDC). It highlighted both challenges (e.g. inconsistent data standards, governance differences) and opportunities for improving nationwide dementia data quality and consistency.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
4	**Alzheimer's disease financing**	0-6	3	Dedicated budget to Alzheimer's disease programmes	1	In the health sector, funding is more commonly allocated to specific initiatives or time-limited projects rather than to broader, permanent programmes. Multiple dementia-specific measures are included in the 2024 - 25 Federal Budget,including: $56.8M for the Acute to Residential Care Transition dementia programme; $30.4M for Specialist Dementia Care programme; $1.7M for the Australian Dementia Network (AdNeT)[192]. These initiatives address dementia broadly, not Alzheimer's specifically, and are linked to overall dementia system readiness and care improvements.
				Funding/insurance coverage for Dementia/ Alzheimer's disease Care (Public)	1	Expert interview: Funding support from both aged care and the National Disability Insurance Scheme (NDIS) may not fully cover all costs, and access to Alzheimer's disease-specific diagnostics remains uneven. For example, in New South Wales, cerebrospinal fluid (CSF) testing is available at no charge for public patients, but this is not routinely offered in other states. Similarly, amyloid PET scans are very limited, and clinicians often have to rely on less specific imaging such as MRI or FDG PET. (Source: Expert interview)
				Funding/insurance coverage for Dementia/ Alzheimer's disease (Private & alternatives)	1	Partially funded under Dementia - Various private insurance products are available, such as hospital cover, trauma insurance, and total permanent disability (TPD) insurance, which may assist in care needs related to Dementia. However, these are general policies and not specifically designed for Alzheimer's care.[193]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
5	**Existence of registries established for Alzheimer's disease**	**0-5**	**3**	Existence of registries established for Alzheimer's disease	**1**	(1) National Centre for Monitoring Dementia (NCMD):[194] Australia's National Dementia Action Plan (2024–2034) prioritises improving dementia data and research. To support this, the Australian Institute of Health and Welfare (AIHW) established the National Centre for Monitoring Dementia (NCMD) in 2021. The NCMD tracks dementia trends, addresses data gaps, and provides evidence for policymaking through an annual online dashboard of 50 indicators. While not a formal registry, this system functions as a national monitoring tool to ensure transparency, evaluate progress, and guide dementia-related initiatives. (2) Clinical Quality Registry: ADNeT Registry:[195] The Australian Dementia Network (ADNet) Registry, managed by Monash University, is a clinical quality registry for individuals newly diagnosed with dementia or mild cognitive impairment. It collects clinical data and patient-reported outcomes to benchmark care quality across participating sites. The registry links with government datasets to assess long-term outcomes and supports recruitment for research trials. By integrating patient, caregiver, and service-level data, ADNeT helps drive quality improvement and evidence-based dementia care in Australia.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Integration of Dementia-specific tracking in EMR systems	**2**	My Health Record (MHR) is a national, opt-out digital summary of allergies, medications, diagnoses, care plans, and advance directives, widely accessible across GP, hospital, and aged-care settings - including for Dementia. Structured capture of diagnosis and care plan documents is standard, and MHR supports interoperability across sectors[196 197 198]. Current status (not Dementia-specific): – Over 24.2 million Australians (out of 27.2 million population) are registered for My Health Record, with over 99% of records containing data – More than 1.6 billion documents have been uploaded, including: clinical documents, medicine documents, pathology reports, diagnostic imaging reports – 99% of GPs, pharmacies, and public hospitals are now registered and actively using the system – Specialist participation is growing: 59% are registered, 34% have actively used My Health Record

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
6	**Inclusivity and equitable policy formulation**	0-8	5	Policies/strategies/plans/ programmes addressing equitable access to care to Alzheimer's	1	The National Dementia Action Plan includes Action 1: Promote equity and human rights, indicating a focus on equitable care for people with dementia broadly, not Alzheimer's-specific[199]
				Policy recognition of preclinical Alzheimer's disease/Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	2	At-risk populations are indirectly acknowledged in national policies (e.g., mention of early-stage or high-risk groups), but no specific strategies or plans for preclinical Alzheimer's disease/ Dementia are in place. (Source: Expert interview)
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	1	Dementia-focused navigation and case management programmes exist and are being expanded under the National Dementia Plan. Services like the National Dementia Helpline[200] and the Dementia Behaviour Management Advisory Service offer personalised guidance[201]. Specific efforts target underserved groups including First Nations communities, culturally and linguistically diverse (CALD) populations, and younger-onset dementia cases.
				Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	1	Numerous community-based dementia initiatives are supported by public funding through Primary Health Networks and local health services, including Dementia-Friendly Communities projects, memory cafés, and CALD/First Nations pilot programmes. While these programmes include Alzheimer's patients, they are not Alzheimer's-specific, and funding is for broader dementia care.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
7	**National Alzheimer's disease clinical guidelines availability and implementation**	**0-6**	**3**	Availability of clinical guidelines on Alzheimer's disease	**2**	– Guideline: Clinical practice guidelines and principles of care for people with dementia[202] – Author: National Health and Medical Research Council (NHMRC) – Issue year: 2016 – The guideline includes Alzheimer's-specific information where relevant, for example, outlining medications subsidised through the Pharmaceutical Benefits Scheme (PBS) for individuals diagnosed with Alzheimer's disease, but does not contain a dedicated section with Alzheimer's disease clinical protocols. Instead, it adopts a comprehensive approach informed by a public health and aged care perspective that extends beyond a purely neurological, disease-specific focus.
				Currency of clinical guidelines	**0**	2016[203] - Updates in progress (Source: Expert interview)
				Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care	**1**	< 50% healthcare regions or facilities implementing national clinical guidelines (Source: Expert interview)
				National policies focused on primary prevention/ modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	Australia has set ambitious targets related to risk factors of heart diseases but are also relevant to dementia[204]: – Smoking: Reduce to ≤5% by 2030 – Alcohol: 10% reduction in harmful consumption by 2028 – Salt Intake: Reduce by 30% by 2030 – HT: Increase control rate from 32% to 70% by 2030 – Physical Activity: Reduce insufficient activity by 15% by 2030 – Obesity: Halt rise and reduce childhood obesity by 5% by 2030

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health/ cognitive screening or monitoring)	**1**	Australia's National Dementia Action Plan (2025) mentions screening and recommends expanding the use of culturally safe, evidence-based screening and diagnostic tools. Current tools are not always fit for purpose and may lack sensitivity, with results often unclear or open to interpretation. Many tools are not appropriate or accessible for people with low literacy or those living in remote areas. First Nations communities and people from Culturally and Linguistically Diverse (CALD) backgrounds face additional barriers due to the limited availability of culturally appropriate, validated tools. Some tools like the Kimberley Indigenous Cognitive Assessment (KICA) are in use and have been adapted for regional and urban settings, but broader adoption is still limited[205].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	0-6	3	Funding for Alzheimer's disease research: Investment in/funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	1	– Dementia Australia Research Foundation has awarded more than AU$31 million in dementia research funding over the past 25 years, with a deliberate focus on supporting early- and mid-career researchers - over 70% of whom remain active in the dementia field (Source: Expert interview) – Alzheimer's Research Australia is a significant funder of Alzheimer's disease research, funding Alzheimer's researchers, PhD scholarships, and providing world-class research facilities and services Dementia[206] – Since 2015, National Health and Medical Research Council's (NHMRC) has invested over AU$458 million across 447 dementia research projects (43% basic science, 39% clinical, 10% public health, 8% health services)[207] – The Australian Government's Boosting Dementia Research Initiative (BDRI) invested $200 million over five years from 2014 to 2019[208] – 2022: The NHMRC-Japan Agency for Medical Research and Development (AMED) - total investment of $1.5 million[209] – Centre of Research Excellence (CRE) grants, e.g., $3 million in 2024 to MIND-Alzheimer's disease CRE focusing specifically on Alzheimer's basic science[210]
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	2	The Australian Dementia Network (ADNet) Screening for Trials Initiative provides a nationally coordinated platform for trial participation, specifically including Alzheimer's patients[211]. Participants access to the latest potential therapies through participation in trials.
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	0	Unpredicted and no standardised adoption timeframe (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 2: Prevention & screening (early detection)						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**0**	National clinical guidelines screening coverage for high-risk population For example: Older adults (e.g. ≥65 years) Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression	**0**	"Medical practitioners working with older people should be alert to cognitive decline, especially in those aged 75 years and older"[212] While practitioners are advised to be alert to cognitive decline in older adults, this is a recommendation for clinical vigilance or case-finding based on observed symptoms or concerns, not a formal screening programme for high-risk groups
				Inclusion of validated cognitive assessment tools in screening guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	No direct mention of validated cognitive assessment tools in the screening context in the guideline[213]. But in practice, multiple cognitive assessment tools are used, with the choice varying by care setting and clinical pathway (Source: Expert interview).
				Inclusion of BBBMs in **screening guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarker is mentioned for screening[214]
				Inclusion of CSF biomarkers in **screening guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening[215]. But in practice, cerebrospinal fluid (CSF) biomarker testing-such as the amyloid/tau ratio-is provided at no cost to public patients in New South Wales (NSW) hospitals and in at least one specialist centre in Queensland. In addition, biomarker testing is also available through certain research projects. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
11	**Alzheimer's disease screening funding**	**0-6**	**2**	Funding for **validated cognitive assessment tools in screening** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Organisations such as Dementia Australia identify tools like the MMSE, GPCOG, and RUDAS as commonly used in the diagnostic assessment of cognitive impairment and dementia. Assessments are implicitly funded through reimbursement for clinician consultations. In practice, however, most clinicians outside public hospital clinics charge fees that exceed the scheduled Medicare reimbursement, meaning services are only partially subsidised and patients incur out-of-pocket costs. In contrast, services delivered through public hospital clinics (such as memory clinics) are provided to patients at no direct charge. (Source: Expert interview)
				Financing mechanism for **BBBMs in Alzheimer's disease screening**	**0**	Unavailable in general, possibly available through research projects in some settings. (Source: Expert interview)
				Financing mechanism for **CSF biomarkers Alzheimer's disease screening**	**1**	Public funding for both CSF testing and Amyloid-specific PET scanning was not supported as a part of the Kisunla reimbursement application. Exception - In New South Wales, this service is publicly funded, with testing conducted at Concord Hospital - not nationwide. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
12	**Alzheimer's disease diagnosis guidelines**	**0-7**	**3**	**National clinical guidelines diagnosis coverage**	**2**	– The guidelines explicitly address diagnosis of dementia with a comprehensive assessment protocol described – Subtype diagnosis (which includes Alzheimer's disease) is explicitly stated: "34 PP A diagnosis of subtype of dementia should be made by healthcare professionals with expertise in differential diagnosis using international standardised criteria (see Appendix 2)."[216]
				Inclusion of validated cognitive assessment tools in **diagnostic guidelines** For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	The guidelines explicitly require the use of validated cognitive assessment tools as part of diagnosis[217] Specific tools are mentioned: – Kimberley Indigenous Cognitive Assessment (KICA-Cog and KICA-Screen) for Indigenous Australians – Modified KICA (mKICA) as an alternative to MMSE – Mini Mental State Exam (MMSE) – Rowland Universal Dementia Assessment Scale (RUDAS) for culturally and linguistically diverse (CALD) populations There is an emphasis on considering various factors affecting test performance (age, education, language, etc.) Formal neuropsychological testing is also recommended when diagnosis is uncertain.
				Inclusion of BBBMs in **diagnostic guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	"Many diagnostic technologies including biomarkers for β-amyloid or neuronal injury (e.g., 18F-fluorodeoxyglucose Positron Emission Tomography [FDG-PET] or CSF tau) are currently being evaluated and may prove to be useful in the assessment of dementia in the future. The routine use of these technologies in clinical practice is considered to be premature" [218] No BBBMs (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP) are recommended for routine diagnosis.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Inclusion of CSF biomarkers **diagnostic guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	"Many diagnostic technologies including biomarkers for β-amyloid or neuronal injury (e.g., 18F-fluorodeoxyglucose Positron Emission Tomography [FDG-PET] or CSF tau) are currently being evaluated and may prove to be useful in the assessment of dementia in the future. The routine use of these technologies in clinical practice is considered to be premature" [219] "Cerebrospinal fluid examination should not be performed as a routine investigation for dementia. Cerebrospinal fluid examination may be indicated if Creutzfeldt–Jakob disease is suspected or in rapidly progressive dementia."[220] No recommendation for CSF biomarkers such as Aβ42, tau proteins for routine diagnosis. It is only for very specific, rare cases. Additionally, "biomarkers for β-amyloid or neuronal injury (e.g., CSF tau) are being evaluated but not recommended routinely".

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
13	**Capacity of/ Availability of/ access to diagnostic infrastructure and services**	0-18	11	MRI	**2**	0.15 per ten thousands of population[221]
				CT	**3**	0.68 per ten thousands of population[222]
				PET	**3**	>2.0 - 4.0 machines per 1 million population A major concern is the limited availability of tracers in some regions, along with a shortage of expertise in brain imaging. The availability of PET scanners does not necessarily guarantee routine access to the radiotracers required for Alzheimer's disease-specific imaging. In addition, neuroimaging with PET requires specialised expertise, and not all PET centres are equipped or trained to perform it - many are primarily focused on oncology and solid tumour staging or diagnostics. (Source: Expert interview)
				CSF Biomarker testing	**2**	CSF Alzheimer's disease biomarkers (Aβ42, t-tau, p-tau) are clinically validated and used in practice (mainly in tertiary/specialist centres); uptake is limited outside specialist services: "Despite CSF analysis being a safe and cost-effective diagnostic method, the use of CSF biomarkers in the evaluation of potential Alzheimer's disease remains limited in Australian clinical practice due to a variety of factors, including regional access challenges, concerns over the perceived invasiveness of LP and a lack of confidence among clinicians in interpreting the results."[223]
				BBBMs testing	**1**	BBBMs have so far been limited to research use, with the first clinical biomarker (pTau181) only recently becoming available in Australia (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
14	**Tracking of time to diagnosis for Alzheimer's disease**	**0-2**	**1**	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**1**	– There is some tracking of time to diagnosis, but efforts are fragmented, local, or led by non-governmental stakeholders, rather than part of a coordinated national approach (Source: Expert interview) – Since April 2023, the ADNeT Registry has collected information on the time from participant symptom onset to their initial appointment with diagnostic services[224]. In 2023, 13% of participants with dementia had their initial appointment within 1 year of symptom onset and 30% had their initial appointment more than 3 years from symptom onset. Only a fraction of patients get on to the ADNeT registry.
15	**Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)**	**0-12**	**4**	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary/tertiary public institutions	**1**	<50% (Only one lab was doing it. Now there are two labs by numbers are very limited) (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary/ tertiary private institutions	**1**	<50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting	**1**	<50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at public primary care setting	**1**	<50% (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
16	**Capacity of workforce**	**0-16**	**12**	Geriatricians/ Psychogeriatricians	**3**	(WHO, 2017) Number of geriatricians or psychogeriatricians (per 100,000): 2.24[225]
				Neurologists	**2**	(WHO, 2017) Number of neurologists (per 100,000): 2.1[226]
				Psychiatrist working in mental health sector	**4**	(WHO, 2015) Number of psychiatrists (per 100,000): 13.525[227]
				Social workers working in mental health sector	**3**	(AIHW, 2022) Number of social workers working in mental health sector: 2900; Per 100k (using population data from 30 June 2024): 10.659[228]
17	**Alzheimer's disease diagnostics funding coverage**	**0-6**	**2**	Funding for validated cognitive assessment tools in Alzheimer's disease/Dementia diagnosis (public and/or private) For example: • MMSE (Mini-Mental State Examination) • MoCA (Montreal Cognitive Assessment) • Mini-Cog • GPCOG (General Practitioner Assessment of Cognition) • CASI (Cognitive Abilities Screening Instrument) • Clock Drawing Test	**1**	Organisations such as Dementia Australia identify tools like the MMSE, GPCOG, and RUDAS as commonly used in the diagnostic assessment of cognitive impairment and dementia. Assessments are implicitly funded through reimbursement for clinician consultations. In practice, however, most clinicians outside public hospital clinics charge fees that exceed the scheduled Medicare reimbursement, meaning services are only partially subsidised and patients incur out-of-pocket costs. In contrast, services delivered through public hospital clinics (such as memory clinics) are provided to patients at no direct charge.Access to these assessments is only partially funded in Australia. (Source: Expert interview)
				Financing mechanism for **BBBMs in Alzheimer's disease diagnosis**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers in Alzheimer's disease diagnosis**	**1**	Public funding for both CSF testing and Amyloid-specific PET scanning was not supported as a part of the Kisunla reimbursement application. Exception - In New South Wales, this service is publicly funded, with testing conducted at Concord Hospital - not nationwide. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 4: Treatment monitoring and access						
18	**Alzheimer's disease treatment monitoring guidelines**	**0-6**	**2**	National clinical guidelines **treatment & monitoring** coverage (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**2**	Pharmacological treatments are specifically mentioned for Alzheimer's disease[229]
				Inclusion of BBBMs in **treatment & monitoring** guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarkers recommended or mentioned for treatment & monitoring[230]
				Inclusion of CSF biomarkers in **treatment & monitoring guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarkers recommended or mentioned for treatment & monitoring[231]
19	**Involvement of multi-disciplinary team**	**0-2**	**2**	Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**1**	Guidelines recommend shared decision-making or treatment with a multidisciplinary team[232]
				Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologists, psychologists, social workers, occupational therapists, etc. for Dementia/Alzheimers	**1**	E.g., Australia (Better Health Victoria): The Cognitive Dementia and Memory Service (CDAMS) is a publicly funded specialist multidisciplinary service providing diagnosis, referral, and education for individuals experiencing memory loss or cognitive changes, as well as for their supporters[233]. Memory Disorders (MD) centres of research excellence that fund MD care: e.g. ISLAND Clinic in Tasmania (Source: Expert interview) Additionally, private geriatricians and clinics are available.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
20	**Linkage to supportive/ palliative care**	**0-2**	**2**	Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**1**	Care for people with advanced dementia should be based on a palliative approach and involve a palliative care service if indicated. Treatment and care should be provided as per the person's Advance Care Plans[234]
				Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**1**	In Australia, palliative care is available to anyone living with dementia, regardless of the stage of their condition. But it often supports people in the final stage of dementia to die in comfort and with dignity. Family members, carers and health professionals can all organise palliative care though it may not be dementia-specific. Services can be found through Palliative Care Australia's National Palliative Care Service Directory.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
21	**DMT access pathway readiness**	**0-5**	**5**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**3**	1. Donanemab (Kisunla by Eli Lilly) has received full regulatory approval from the Therapeutic Goods Administration (TGA) for early symptomatic Alzheimer's disease in 2025[235]. 2. Before that, The Advisory Committee on Medicines found aducanumab (Aduhelm)'s benefit–risk profile negative for mild Alzheimer's due to limited efficacy and safety concerns, leading the sponsor to withdraw the submission on 6 May 2022 before a decision[236]. 3. Lecanemab (brand name LEQEMBI) has now been approved by TGA[237] Notes: Donanemab & Lecanemab restriction to APOE4 non-carrier or heterozygous population
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**2**	TGA Approval Materials[238]: Eligibility for donanemab for patients with MCI due to Alzheimer's disease, or mild Alzheimer's disease will require confirmation of evidence of Aß pathology using a validated test where today the tests available are brain Aß PET or CSF Alzheimer's disease biomarker testing. After APOE testing, amyloid PET or CSF biomarkers confirm amyloid pathology. • APOE genotyping: Detects APOE4 allele for treatment eligibility • Amyloid PET: Visualises and quantifies amyloid plaques in the brain • CSF biomarkers: Lumbar puncture measures Aß42, tau, and related ratios, which align closely with PET and are equally effective for detecting Alzheimer's pathology in donanemab's target population

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
22	**Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease/ Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.**	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	Australia is actively using telehealth to address the challenges of providing dementia care in rural and remote areas. The "DREAMT" project (Dementia, Regional and remote, Empowering, Aboriginal and Torres Strait, Medicine and Telemedicine and telehealth) is a notable initiative that uses telehealth to provide specialist dementia services to Indigenous communities[239]. Research has also shown that telehealth for dementia care can be as effective as face-to-face services, with the added benefit of saving on travel time and costs for families and caregivers[240].
23	**Alzheimer's treatment & monitoring funding coverage**	**0-6**	**2**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**2**	All 4 Alzheimer's medications under Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) are subsidised[241] Donanemab & Lecanemab not funded
				Financing mechanism for BBBMs in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 5: Advocacy, awareness and education						
24	**Dementia/ Alzheimer's disease patient organisation engagement and advocacy**	**0-3**	**3**	Existence of patient/ caregiver organisations	**1**	Dementia Australia is the national peak body supporting people living with dementia, their families and carers[242]. With an estimated 433,300 Australians affected and 1.7 million involved in care, it provides trusted information, education and support services, advocates for policy and community change, backs research and the care workforce, promotes dementia-friendly communities, and ensures people with lived experience are central to its work. Its aim is to empower those impacted by dementia and help them live as well as possible.
				Participation in national policy & plan development, and/or joint programmes with government	**1**	Dementia Australia has been actively engaged in the development of Australia's National Dementia Action Plan 2024-2034[243]. As the peak dementia advocacy organisation in Australia, Dementia Australia has contributed to the planning and policy development of The action plan. The plan aims to improve the lives and care of people living with dementia, their carers, and families over the next 10 years. It was developed through extensive consultation with various stakeholders, including people living with dementia, their carers and families, aged care providers and workers, advocates, and peak industry bodies and organisations.
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**1**	E.g., Dementia Australia offers : – A 24 hour National Dementia Helpline which offers phone and webchat – Free, confidential, professional counselling for individuals, families, couples and professional carers at all stages of a dementia journey – Post diagnostic support, counselling, peer support, social support, carer support, day and centre based respite, among others

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
25	**Dementia/ Alzheimer's disease professional medical and scientific societies/ associations, research institutes engagement and advocacy**	**0-4**	**4**	Existence of professional medical and scientific societies/associations, research institutes focused on Dementia/ Alzheimer's disease	**2**	– Dementia Australia Research Foundation is committed to supporting research across AD and other dementias[245] – The Australian Dementia Network (ADNeT) brings together researchers from 21 institutions to improve dementia care through: A national clinical quality registry to track and benchmark care, standardised best practice guidelines for diagnosis and treatment, and a screening programme to identify patients suitable for clinical trials.[246] – Alzheimer's Research Australia is a leading medical research organisation dedicated to Alzheimer's disease and other dementias[247]
				Participation in national policy & plan development, and/ or joint programmes or initiatives with government agencies on Dementia/Alzheimer's disease	**1**	ADNeT is actively involved in the implementation, data-generation, and clinical/registry infrastructure that support the national dementia policy framework[248]. Its role is less about being a policy-authoring body, and more about providing the evidence, services and scale required to deliver on policy goals and track progress.
				Contributions towards clinical guidelines development	**1**	Clinical guidelines (published in 2016) were developed by a consortium led by Professor Sue Kurrle from the University of Sydney, with participation from multiple peak bodies (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
26	**Dementia/ Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)**	**0-21**	**14**	[Patient] Availability of patient education programmes and support resources initiated/driven by patient/caregiver organisations	**2**	Dementia Australia runs dementia-specific helpline, education and support services (Federally funded service) [249]
				[Patient] Availability of patient education programmes and support resources initiated/ driven by the professional medical and scientific societies/associations, research Institutes focused on Dementia/ Alzheimer's disease	**2**	Broader Dementia and Alzheimer's–specific programmes or resources are driven by the Professional Medical and Scientific Societies/ Associations, Research Institutes focused on Dementia/Alzheimer's (but not Alzheimer's-only) (Source: Expert interview)
				[Patient] Availability of patient education programmes and support resources initiated/driven by the government	**2**	The National Dementia Support programme (NDSP), funded by the Australian Government, delivers information and education programmes and resources directly to people living with dementia, their caregivers, and families via Dementia Australia[250]. These are government-sponsored public education initiatives.
				[Caregiver] Availability of caregiver-focused education, training, and support services on Dementia/Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines) Can be driven by: - Patient or caregiver organisation - Professional medical and scientific societies/ associations, research institutes focused on Dementia/Alzheimer's disease - The government	**2**	Dementia Australia provides dedicated information, advice and support specifically for carers, recognising both their caregiving responsibilities and their own individual needs[251]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[All] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	Dementia Action Week is a national annual awareness campaign delivered by Dementia Australia under the National Dementia Support Programme.[252] The 2025 theme was "Nobody can do it alone," emphasising the importance of connection, support networks, and collective action for people living with dementia, their families and carers[253].
				[Healthcare providers] Availability of clinical education for **primary care providers**	**2**	E.g, Dementia Training Australia aims to transform the knowledge and skills of GPs and Practice Nurses involved in diagnosing and supporting people living with dementia and their carers[254]
				[Healthcare providers] Availability of **specialist training** in Dementia/ Alzheimer's care	**2**	E.g., The Dementia Training Programme, run by the Department of Health, Disability and Ageing, provides a national platform for accredited education, upskilling and professional development in dementia care[255]. It offers free accredited courses for eligible care workers, tailored onsite training for aged care providers, and an online training portal. Since July 2022, the programme has expanded to include advanced training for personal care workers, communities of practice to support dementia care leaders, training to manage behavioural and psychological symptoms and reduce restraint use, and national training standards and pathways to improve and standardise dementia education.

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Hong Kong

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
Hong Kong	Moderately high	Low	Moderately high	Moderately high	High

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	**Existence and operational status of national Alzheimer's disease policies/strategies/ plans**	**0-4**	**2**	Existence and operational status of national Alzheimer's disease policies/ strategies/plans	**1**	(1) Elderly Services Programme Plan[256] – Year of publication: 2017, revised periodically (latest 2024) – Author/Issuing Body: Working Group under the Elderly Commission; submitted via the Labour & Welfare Bureau – Overall description: The ESPP is Hong Kong's strategic policy framework to guide the long-term development of elderly services in response to population ageing. Recommendation 10 of the ESPP aims to improve early detection, care quality, and multidisciplinary support for persons with dementia, including Alzheimer's disease. Recognising the burden of dementia, the ESPP calls for closer healthcare-welfare integration, early screening and intervention at neighbourhood elderly centres (NECs), and improved carer and frontline staff training to build a dementia-friendly service model.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
						(2) Preventive Care for Older Adults in Primary Care Settings[257] – Year of publication: revised edition 2021 – Author/Issuing Body: Health Bureau's Primary Healthcare Commission – Overall description: To provide a common evidence-based framework for healthcare professionals to deliver comprehensive, preventive, and person-centred care for older adults. The framework aims to promote health, prevent diseases, detect chronic conditions early, including cognitive decline and dementia, and empower older adults and their carers with knowledge and tools to improve quality of life and reduce healthcare burden. – This framework supports primary care providers in delivering holistic preventive care for older adults, including lifestyle advice, chronic disease risk management, and opportunistic screening for cognitive impairment. For dementia, it promotes early identification, referral, and coordinated follow-up with community and specialist services.
				Currency of the national policies/strategies/plans	**1**	Elderly Services programme Plan – Year of publication: 2017, revised periodically (latest 2024)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
2	**Priority & specificity of Alzheimer's disease in national policies/strategies/ plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	(1) Elderly Services programme Plan[258] – Recommendation 10: Services for elderly persons with dementia should be strengthened. The issue of dementia should be considered as an integral part in the whole spectrum of elderly services and a multidisciplinary approach should be adopted
						– Some directions that could be considered include: i. enhancing workers' knowledge and skills in early detection of dementia (including mild cognitive impairment cases) at elderly centres at neighbourhood level (i.e. NECs) and in making timely referral to appropriate services; ii. strengthening training in early detection, management and care of dementia in elderly service units, in particular CCS; and iii. strengthening education and training for elderly persons and family carers in early detection of dementia.
3	**Coordinating mechanism for implementation**	**0-4**	**2**	Dedicated national Alzheimer's disease programmes/initiatives	**1**	E.g., – Dementia Community Support Scheme (DCSS): Social Welfare Department and Hospital Authority - provides appropriate support services for elderly persons with mild or moderate dementia in the community to help stabilise progression of the disease and alleviate their distress of frequenting hospitals, as well as provides related support to carers[259] – Dementia-Friendly Community Campaign: led by Hong Kong Alzheimer's Disease Association with support from SWD, accomplished in Mar 2023[260 261]
				Joint national and regional Alzheimer's disease coordination mechanisms	**1**	The Dementia Community Support Scheme is a collaborative initiative involving the Hospital Authority, Health Bureau, Social Welfare Department, and community NGOs, including Neighbourhood Elderly Centres (NECs), but there is no formal mechanism to monitor its implementation[262].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
4	**Alzheimer's disease financing**	**0-6**	**2**	Dedicated budget to Alzheimer's disease programmes	**0**	No specific dementia or Alzheimer's budget is mentioned. The government increased elderly care vouchers under the Residential Care and Community Care Service Voucher Schemes, but these are general eldercare supports without focus on dementia or Alzheimer's[263]. (Source: Expert interview)
				Funding/insurance coverage for Dementia/ Alzheimer's disease Care (Public)	**1**	For public healthcare services, 5% of the cost has to be covered by users and the remaining 95% is subsidised by the Government (Food and Health Bureau, 2010)[264]. Individuals with more financial difficulties may apply for medical fee waiver such that there will be no out-of-pocket payments when using public healthcare services (Hospital Authority, 2019d). The service fees for public services provided by the Hospital Authority and commonly used by people with dementia were revised with effect from 1 January 2026. For eligible persons, charges are **HK$250 per attendance** at specialist outpatient clinics with **HK$20 per drug item, HK$150 per attendance at** family medicine clinics with HK$5 per drug item, **HK$100 per attendance** for geriatric day hospital services, and **HK$100 per attendance** for rehabilitation day hospital services (Hospital Authority, 2026)[265].
				Funding/insurance coverage for Dementia/ Alzheimer's disease (Private & alternatives)	**1**	Partially funded, Alzheimer's disease specifically mentioned. E.g., – FWD's Holistic Elderly Care Service provides dedicated support for Alzheimer's patients through in-home cognitive therapy, occupational therapy, and brain health activities[266]. – AXA's LoveAssure Critical Illness Protection offers Dementia (including Alzheimer's) benefits, including a lump-sum payout and an annual caregiver annuity until age 100 upon diagnosis of severe dementia[267].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
5	**Existence of registries established for Alzheimer's disease**	**0-5**	**1**	Existence of registries established for Alzheimer's disease	**0**	Hong Kong does not operate a dedicated national dementia or Alzheimer's registry. However, in 2016, The Chinese University of Hong Kong (CUHK) established the Early-Onset Dementia Registry as a research-focused initiative to study the causes and impacts of dementia in individuals under 65 within the Chinese population[268]. Supported by the Seeds Foundation Limited, the registry serves primarily academic and clinical research purposes rather than national surveillance or policy monitoring.
				Integration of Dementia-specific tracking in EMR systems	**1**	EMRs capture only dementia diagnosis (often inconsistently or as free text). No structured assessments or care plans. No interoperability. (Source: Expert interview)
6	**Inclusivity and equitable policy formulation**	**0-8**	**3**	Policies/strategies/ plans/programmes addressing equitable access to care to Alzheimer's	**0**	There is no specific policy targeting equitable access to dementia or Alzheimer's care. Existing support (e.g., Community Care Service Voucher is elderly-focused and income-based, not dementia-specific[269])
				Policy recognition of preclinical Alzheimer's disease/Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	**2**	Preventive Care for Older Adults in Primary Care Settings (2021) supports early detection of dementia by recommending that primary care providers assess cognitive function whenever impairment is suspected, based on direct observation, patient report, or concerns from family or carers[270]. Opportunistic screening for dementia is also advised if there is clinical suspicion during routine health risk assessments.
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	**0**	No available information on Alzheimer's or dementia-related patient navigation programmes for underserved populations

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Community - based care programmes: availability of community - based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	**1**	The Dementia Community Support Scheme (DCSS) provides community-based services with public funding but does not distinguish Alzheimer's from other types of dementia[271]
7	**National Alzheimer's disease clinical guidelines availability and implementation**	**0-6**	**5**	Availability of clinical guidelines on Alzheimer's disease	**3**	Guideline: Practical Manual of Dementia in Older Adults (Third Edition) [272] – Author: Brain Health Special Interest Group, Hong Kong Geriatrics Society (HKGS) – Issue year: 2022 – Section 2.3 specifically discusses "Alzheimer's Disease (AD) and Dementia due to AD" ➔ A new guideline is expected to be released in January 2026, jointly developed by five professional organisations in Hong Kong. This guidance follows the Alzheimer's Association's July 2025 recommendations on the use of blood-based biomarkers in specialty care settings. The participating organisations include the Chinese Dementia Research Association, the Hong Kong Society of Nuclear Medicine and Molecular Imaging, The Hong Kong Geriatrics Society, The Hong Kong Neurological Society, and The Hong Kong Society of Diagnostic Radiologists.
				Currency of clinical guidelines	**1**	2022[273]
				Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care	**1**	< 50% healthcare regions or facilities implementing national clinical guidelines (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
8	**Policy support for preventive care**	**0-2**	**2**	National policies focused on primary prevention/modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	HK works to achieve the following 9 targets by 2025[274]: 1. A 25% relative reduction in risk of premature mortality from cardiovascular diseases, cancers, diabetes, or chronic respiratory diseases. 2. At least 10% relative reduction in the prevalence of binge drinking and harmful use of alcohol (harmful drinking/alcohol dependence) among adults and in the prevalence of drinking among youth. 3. A 10% relative reduction in the prevalence of insufficient physical activity among adolescents and adults. 4. A 30% relative reduction in mean population daily intake of salt/ sodium. 5. A 30% relative reduction in the prevalence of current tobacco use in persons aged 15+ years. 6. Contain the prevalence of raised blood pressure. 7. Halt the rise in diabetes and obesity. 8. Prevent heart attacks and strokes through drug therapy and counselling. 9. Improve availability of affordable basic technologies and essential medicines to treat major NCDs.
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health/ cognitive screening or monitoring)	**1**	The Preventive Care for Older Adults in Primary Care Settings (2021) explicitly promotes opportunistic cognitive impairment screening and referral pathways, including for dementia[275]. The Elderly Services Programme Plan (ESPP) also supports early screening in community centres[276].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	**0-6**	**3**	Funding for Alzheimer's disease research: Investment in/funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	**2**	**Dementia** 1. The Health and Medical Research Fund (HMRF), managed by the Health Bureau, supports a wide range of investigator-initiated research[277]. Over the past five years, it has funded about HK$80 million for approximately 70 such projects involving clinical trials on areas like cognitive impairment - this includes Dementia/Alzheimer's research though not exclusively focused on it. **Alzheimer's disease specific** 1. CUHK received a grant of HK$5.6 million from the Alzheimer's Drug Discovery Foundation (via a Diagnostics Accelerator programme) to develop machine learning-based digital biomarkers for Alzheimer's disease[278]. 2. Hong Kong Center for Neurodegenerative Diseases (HKCeND) donated research support valued around HK$9.77 million in-kind, covering the development of cognitive profiles, biomarkers, and screening methods related to Alzheimer's disease and mild cognitive impairment[279].
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	**1**	There is no national Alzheimer's-specific trial infrastructure, nor centralised coordination for Alzheimer's disease clinical trials. However, dementia patients, including those with Alzheimer's, participate in clinical studies, particularly non-pharmacological interventions such as music-with-movement therapy (e.g., NCT03575026) (Source: Expert interview)
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	**0**	3. Unpredicted and no standardised adoption timeframe (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 2: Prevention & screening (early detection)						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**2**	National clinical guidelines **screening coverage** for high-risk population For example: Older adults (e.g. ≥65 years) Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression	**1**	Guideline mentions screening for individuals at high risk of Dementia/ Alzheimer's disease[280] Updates are expected with the release of a new guideline in January 2026.
				Inclusion of validated cognitive assessment tools in screening guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	HKGS includes Section 3.1 "Screening Tools for Dementia" listing those five tools: Abbreviated Mental Test (AMT), Alzheimer's disease, Clock Drawing Test (CDT), Montreal Cognitive Assessment (MoCA), and Hong Kong Brief Cognitive Test (HKBC)[281]. The manual treats them as screening tools (i.e. for initial detection/screening) rather than full diagnostic tools. Guideline mentions screening for individuals at high risk of Dementia/ Alzheimer's disease[282]
				Inclusion of BBBMs in **screening guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarker is mentioned for screening[283] Updates are expected with the release of a new guideline in January 2026.
				Inclusion of CSF biomarkers in **screening guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening[284] Updates are expected with the release of a new guideline in January 2026.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
11	**Alzheimer's disease screening funding**	**0-6**	**2**	Funding for **validated cognitive assessment tools in screening** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**2**	Cognitive Health Assessment Subsidy & Community Dementia Screening – Cognitive Health Assessment Subsidy Scheme (CUHK): Provides tiered financial support for cognitive screening and investigations (including neurologist consultation and MoCA 5-Minute HK Version), with Tier 1: free, Tier 2: 60% subsidy, and Tier 3: 30% subsidy, supported by the Lee Heng Charity Foundation[285]. – Community Dementia Screening Funding: The Community Chest funds community-based dementia screening and support, including the "Blissful Care" Community Screening & Support Services for People with Dementia project (approved allocation: HK$1,114,800)[286].
				Financing mechanism for **BBBMs in Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
12	**Alzheimer's disease diagnosis guidelines**	**0-7**	**4**	National clinical guidelines **diagnosis coverage**	**2**	Guidelines explicitly cover diagnosis of Alzheimer's[287] Updates are expected with the release of a new guideline in January 2026.
				Inclusion of validated cognitive assessment tools in **diagnostic guidelines** For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	HKGS includes Section 3.1 "Screening Tools for Dementia" listing those five tools: Abbreviated Mental Test (AMT), Alzheimer's disease, Clock Drawing Test (CDT), Montreal Cognitive Assessment (MoCA), and Hong Kong Brief Cognitive Test (HKBC)[288]. The manual treats them as screening tools (i.e. for initial detection/screening) rather than full diagnostic tools.
				Inclusion of BBBMs in **diagnostic guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No BBBMs recommended or mentioned for diagnosis[289] Updates are expected with the release of a new guideline in January 2026.
				Inclusion of CSF biomarkers **diagnostic guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**2**	CSF biomarkers recommended/ mentioned for diagnosis in section 4.2 of the guideline[290] CSF Aβ42 (or Aβ42/Aβ40 ratio) CSF total tau (T-tau) CSF phosphorylated tau (P-tau)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
13	**Capacity of/ Availability of/ access to diagnostic infrastructure and services**	0-18	8	MRI	**2**	Moderately low (>0.14-0.28 machines per ten thousands of population) (Source: Expert interview)
				CT	**1**	Low (0-0.30 machines per ten thousands of population) (Source: Expert interview)
				PET	**1**	Low (<=0.5 machines per 1 million population) (Source: Expert interview)
				CSF Biomarker testing	**2**	Cerebrospinal fluid biomarkers (including Aβ42 protein, total tau, and phospho-tau) are widely investigated biomarkers of Alzheimer's disease and can be supportive of a diagnosis of Alzheimer's disease but are not yet recommended for routine diagnostic purposes[291]. None of these tests are valid as a standalone diagnostic test. These cerebrospinal fluid biomarkers can be measured only in private laboratory settings on a self-paid basis. Such tests are not well accepted in Hong Kong because of the invasiveness of collecting cerebrospinal fluid. Many private laboratories are reluctant to establish in-house CSF testing because of its limited clinical uptake. Only a small number of institutions or laboratories will send CSF samples overseas when testing is required. (Source: Expert interview)
				BBBMs testing	**2**	BBBMs p-tau assays have been implemented in memory-clinic practice and regional studies; available in specialist settings rather than broad routine use (Source: Expert interview)
14	**Tracking of time to diagnosis for Alzheimer's disease**	0-2	1	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**1**	According to a longitudinal research in a memory clinic in Hong Kong, among 658 people who underwent dementia screening between 2006 and 2013, there was an average of 15-month delay in diagnosis[292].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
15	**Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)**	0-12	4	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary/ tertiary public institutions	1	Very low, as neither CSF nor BBBMs Alzheimer's disease biomarkers are reimbursed in Hospital Authority (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary/ tertiary private institutions	1	Very low, as neither CSF nor BBBMs Alzheimer's disease biomarkers are reimbursed in Hospital Authority (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting	1	Very low, as neither CSF nor BBBMs Alzheimer's disease biomarkers are reimbursed in Hospital Authority (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at public primary care setting	1	Very low, as neither CSF nor BBBMs Alzheimer's disease biomarkers are reimbursed in Hospital Authority (Source: Expert interview)
16	**Capacity of workforce**	0-16	13	Geriatricians/ Psychogeriatricians	3	Number of geriatricians or psychogeriatricians: 165[293] Population (2025 est.): ~7.5 million Geriatricians per 100,000: (165/7,500,000) × 100,000 = 2.2 per 100,000
				Neurologists	3	Number of neurologists (per 100,000): 1.9[294]
				Psychiatrist working in mental health sector	3	Number of psychiatrists (per 100,000)[295]: 7.55
				Social workers working in mental health sector	4	Hong Kong: In 2019, there were 326 social workers per 100,000 population in the social services sector[296]. Assuming 10% work in the mental health sector, the estimated number of mental health social workers is 32.6 per 100,000 population.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
17	**Alzheimer's disease diagnostics funding coverage**	0-6	2	Funding for **validated cognitive assessment tools in Alzheimer's disease/Dementia diagnosis** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**2**	– Cognitive health assessment subsidies: CUHK's Cognitive Health Assessment Subsidy Scheme offers tiered support (free, 60%, or 30% subsidy) for designated assessments, including neurologist consultation, MoCA 5-Minute HK Version, and AccuBrain® AI brain image analysis (supported by the Lee Heng Charity Foundation)[297] – Insurance payout for Alzheimer's diagnosis: FWD Crisis OneMaster/ Crisis OneMaster Pro provides a lifelong annuity following a confirmed Alzheimer's disease diagnosis (in addition to a one-off critical illness payment), subject to policy terms[298] – Community funding for early detection: The Community Chest funds early detection services for Alzheimer's, including a project by the Hong Kong Alzheimer's Disease Association (approved allocation: HK$879,800)[299]
				Financing mechanism for **BBBMs in Alzheimer's disease diagnosis**	**0**	BBBMs tests for diagnosis are not publicly or privately funded and are fully out-of-pocket (Source: Expert interview)
				Financing mechanism for **CSF biomarkers in Alzheimer's disease diagnosis**	**0**	CSF biomarker tests for diagnosis are not funded and patients must pay fully out-of-pocket (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 4: Treatment monitoring and access						
18	**Alzheimer's disease treatment monitoring guidelines**	**0-6**	**2**	National clinical guidelines **treatment & monitoring coverage** (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**2**	Pharmacological treatments are specifically mentioned for Alzheimer's disease[300]
				Inclusion of BBBMs in **treatment & monitoring guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarkers recommended or mentioned for treatment & monitoring[301]
				Inclusion of CSF biomarkers in **treatment & monitoring guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarkers recommended or mentioned for treatment & monitoring[302]
19	**Involvement of multi-disciplinary team**	**0-2**	**2**	Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**1**	Guidelines recommend shared decision-making or treatment with a multidisciplinary team[303]
				Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologists, psychologists, social workers, occupational therapists, etc. for Dementia/Alzheimer's'	**1**	Care staff operate as a multidisciplinary team supported by visiting specialists offering services such as music therapy, podiatry, family counseling, and dietetics on an ad hoc basis[304]. The service has recently expanded to include transitional care for dementia patients who have become deconditioned following hospital stays for acute illnesses.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**0**	Guideline doesn't include referral pathway to supportive/palliative care services[305]
20	**Linkage to supportive/ palliative care**	**0-2**	**1**	Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**1**	1. In Hong Kong, palliative care services under public hospitals were originally only offered to patients with cancer; however, following the provision of palliative care to patients with end-stage renal failure at Caritas Medical Centre in 2008, palliative care services are also available to patients with organ failure. In order to reduce unnecessary hospital admissions and to encourage aging well in the community, several public hospitals collaborated with elderly homes to provide palliative care services to elderly residents, especially for those who are frail and/or suffering from dementia[306]. 2. Advanced dementia should be treated as a terminal illness, requiring end-of-life (EOL) care. In Hong Kong, EOL services for this group - particularly in residential care homes - are limited, with many patients routinely sent to hospitals regardless of wishes or prognosis. Barriers exist to dying in place at home or in care homes. Since 2015, the Hospital Authority has funded programmes to enhance community geriatric teams' EOL support, including advance care planning and non-hospital Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, aiming for full coverage by 2018/19[307]. Hospital initiatives include EOL clinical plans and dedicated wards to improve quality of death. Updated 2015 guidelines address life-sustaining treatment, comfort feeding, and potential legal and care enhancements such as enduring power of attorney and wider use of careful hand feeding in care homes.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
21	**DMT access pathway readiness**	**0-5**	**3**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**3**	On 11 July 2024, Eisai and Biogen announced that Leqembi™ (lecanemab) was approved in Hong Kong for treating Alzheimer's disease in patients with mild cognitive impairment or mild dementia[308]
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**0**	No defined eligibility criteria for accessing DMTs are available, and no requirement for amyloid confirmation is outlined in policy or clinical practice (Source: Expert interview)
22	**Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease/ Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.**	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	The ICT Outreach programme for the Elderly (2021-2023) engaged over 11,000 elderly people, including around 1,700 with dementia, through services in residential care homes, day care centers, and community outreach stations[309]. Funded non-profit organisations introduced digital technology to support elderly care, including: – Remote telehealth consultations with professional nurses. – Use of smart health devices and mobile applications for health monitoring. – Cognitive training and rehabilitation via tablets and gerontechnology products. – Interactive virtual reality and augmented reality exercises for cognitive and physical health. – These efforts highlight ongoing initiatives to provide remote medication monitoring and clinical follow-up for dementia and Alzheimer's patients in Hong Kong.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
23	**Alzheimer's treatment & monitoring funding coverage**	**0-6**	**2**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**2**	All symptomatic therapies are reimbursed, but not valid for DMT (Source: Expert interview)
				Financing mechanism for BBBMs in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 5: Advocacy, awareness and education						
24	**Dementia/ Alzheimer's disease patient organisation engagement and advocacy**	**0-3**	**3**	Existence of patient/ caregiver organisations	**1**	– Hong Kong Jockey Club/JCCPA[310]: The Hong Kong Jockey Club has supported positive ageing initiatives for decades. In 1997, it established the Jockey Club Centre for Positive Ageing (JCCPA) to address the growing need for holistic, professional care for older people living with dementia. – Hong Kong Alzheimer's Disease Association (HKADA)[311]: Founded in 1995 and a member of Alzheimer's Disease International since 1996, HKADA is based in Hong Kong SAR, China. It operates multiple service centres, including the Brain Health Centre, Jean Wei Centre, Tseung Kwan O Integrated Service Centre, and Gene Hwa Lee Centre. HKADA is the first organisation in Hong Kong dedicated to dementia services, and has developed the "6-Arts®" multi-intellectual cognitive stimulation model, drawing on traditional Chinese principles. In collaboration with the Social Welfare Department, it has supported dementia-friendly community initiatives across Hong Kong. Services include day care, caregiver support and training, counselling, helplines, educational events, resources, and community engagement activities.
				Participation in national policy & plan development, and/or joint programmes with government	**1**	The Hong Kong Alzheimer's Disease Association has participated in public consultations, such as the 2008 response to the Healthcare Reform Consultation Document[312]
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**1**	Hong Kong Alzheimer's Disease Association – Gene Hwa Lee Centre[313] Community Care Service Voucher (CCSV) for the Elderly (Centre-based) Community Care Service Voucher (CCSV) for the Elderly (Home-based) Community Care Service Voucher (CCSV) for the Elderly (Home-based) Day Respite Service for Elderly Day Respite Service for Elderly Elderly Day Care Service

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
25	**Dementia/ Alzheimer's disease professional medical and scientific societies/ associations, research institutes engagement and advocacy**	0-4	2	Existence of professional medical and scientific societies/ associations, research institutes focused on Dementia/Alzheimer's disease	**1**	Example: As 5 professional organisations are co-organising the Hong Kong Alzheimer's Disease Symposium 2026 in January 2026, this reflects strong collective interest and engagement in dementia-related topics. The participating organisations include the Chinese Dementia Research Association, the Hong Kong Society of Nuclear Medicine and Molecular Imaging, The Hong Kong Geriatrics Society, The Hong Kong Neurological Society, and The Hong Kong Society of Diagnostic Radiologists.
				Participation in national policy & plan development, and/ or joint programmes or initiatives with government agencies on Dementia/Alzheimer's disease	**0**	Hong Kong Geriatrics Society (HKGS)[314]: Involved in geriatric health advocacy, but limited explicit evidence of direct participation in national dementia policy or plan development
				Contributions towards clinical guidelines development	**1**	A new guideline is expected to be released in January 2026, jointly developed by 5 professional organisations in Hong Kong. The participating organisations include the Chinese Dementia Research Association, the Hong Kong Society of Nuclear Medicine and Molecular Imaging, The Hong Kong Geriatrics Society, The Hong Kong Neurological Society, and The Hong Kong Society of Diagnostic Radiologists. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
26	**Dementia/ Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)**	0-21	12	[Patient] Availability of patient education programmes and support resources initiated/driven by patient/caregiver organisations	**2**	Hong Kong Alzheimer's Disease Association offers patient education through resources (fact sheets, reading materials), seminars/webinars/ workshops, etc.[315]
				[Patient] Availability of patient education programmes and support resources initiated/driven by the professional medical and scientific societies/ associations, research Institutes focused on Dementia/Alzheimer's disease	**0**	Primarily clinician-oriented, with limited direct patient education (Source: Expert interview)
				[Patient] Availability of patient education programmes and support resources initiated/driven by the government	**2**	The Social Welfare Department launched the "Dementia Friendly Community Campaign", a multi-year public education initiative featuring "Dementia Friends" information sessions for the general public[316]
				[Caregiver] Availability of caregiver-focused education, training, and support services on Dementia/Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines) Can be driven by: – Patient or caregiver organisation – Professional medical and scientific societies/associations, research institutes focused on Dementia/ Alzheimer's disease – The government	**2**	The Hong Kong Alzheimer's Disease Association (HKADA) also provides limited training programmes for caregivers and general practitioners (Source: Expert interview) JCCPA - "Inaugurated in June 2000, JCCPA was the first NGO in Hong Kong offering one-stop specialised care for people who have dementia. In addition to providing holistic care services and research, we also offer professional training for caregivers and industry counterparts to advance the quality of care for such cases."[317]
				[All] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	The Social Welfare Department launched the Dementia Friendly Community Campaign and Support for Carers Project in 2022 to raise awareness and support people with dementia, the elderly, and carers. Over 5,500 people have become internationally recognised Dementia Friends after attending information sessions, with a target of 10,000 in three years. 49 property management companies joined the carers' project, training staff to identify elderly needs and provide assistance.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[Healthcare providers] Availability of clinical education for **primary care providers**	**2**	GP Training via the Dementia Screening and Support Project (DSCS) Organized by the Jockey Club Centre for Positive Ageing (JCCPA) along with CUHK and HK geriatrics specialists. A series of four GP-focused training sessions delivered both online and in person, focusing on dementia pathology, prevention of hospital admissions, use of technology for dementia screening and follow-up care.
				[Healthcare providers] Availability of **specialist training** in Dementia/ Alzheimer's care	**2**	E.g., – The Institute of Alzheimer's Education (IAE) was inaugurated in 2013. It aims to build the capacity of the entire community for better care of people with dementia by providing training and education for the general public, professionals, and all other kinds of carers[318]. In line with policy direction, the need for capacity building to support people with dementia at community level has become one of the focuses of Non-Government Organisations (NGOs) and institutions. – With emphasis on human resource development with a 360-degree approach, The Hong Kong Alzheimer's Disease Association has been striving to raise the competency of professionals (including GP training, nurses, allied health professionals and social workers), semi-professionals (e.g. care workers, health workers, informal carers etc.), and any other people who may come into contact with people with dementia in the community[319]. In addition, HKADA has also become the pioneer of a specialised training programme for Certified Dementia Care Planners. By the end of the year 2014, approximately 120 planners will be capable of care planning and the management of people with dementia in either community or residential home settings.

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Japan

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
Japan	Moderately high	Moderately low	Moderately high	Moderately high	High

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	**Existence and operational status of national Alzheimer's disease policies/strategies/ plans**	**0-4**	**3**	Existence and operational status of national Alzheimer's disease policies/ strategies/plans	**2**	(1) The National Framework for Promotion of Dementia Policies[320] – Year of publication: 2019 – Author/Issuing Body: Ministry of Health, Labour and Welfare (MHLW), joint signatories included the Cabinet Secretariat, the Cabinet Office, the National Police Agency, etc. – Overall description: The 2019 Framework is Japan's third national dementia strategy (following the "Orange Plans"), grounded in the philosophies of Inclusion and Risk Reduction (set to be in effect until 2025) (2) Basic Plan for Promotion of Dementia Measures[321] – Year of publication: Dec 2024 – Author/Issuing Body: Ministry of Health, Labour and Welfare (MHLW) – Overall description: legally mandated execution plan following strategic direction of the 2019 Framework, and statutory requirement from the 2023 Basic Act on Dementia (3) The Basic Act on Dementia to Promote an Inclusive Society[322] – Year of publication: Jan 2024 – Author/Issuing Body: National Diet – Overall description: Legal statute mandating government structures, awareness, barrier-free environments, employment initiatives, research, and patient/family involvement

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Currency of the national policies/strategies/plans	**1**	(3) The Basic Act on Dementia to Promote an Inclusive Society[323] - Year of publication: Jan 2024
2	**Priority & specificity of Alzheimer's disease in national policies/strategies/ plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	Policies, strategies, or plans include Dementia-specific targets, but not specific to Alzheimer's (1) The National Framework for Promotion of Dementia Policies (2019)[324] – Public awareness & self-expression support 2. Prevention across stages: primary, secondary, tertiary – Medical/care services & caregiver supports – Dementia-barrier-free infrastructure, support for younger-onset dementia, and social participation – Research & innovation, industrial promotion, international cooperation (2) The Basic Act on Dementia to Promote an Inclusive Society[325] – Ensure individuals with dementia can independently exercise their civil rights and live daily lives by their own decisions – Promote correct knowledge and understanding of dementia across society. – Remove barriers preventing participation; ensure opinions and involvement in social activities. – Guarantee seamless, high-quality health & welfare services. – Support caregivers and families. (3) Basic Plan for Promotion of Dementia Measures – Every citizen understands the "new view of dementia" (reduce stigma, foster inclusion). – The will and intent of persons with dementia are respected in their daily lives. – People with dementia and their families can live confidently in their communities with mutual support. – Society can utilize new knowledge, innovations, and technologies related to dementia

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
3	**Coordinating mechanism for implementation**	**0-4**	**2**	Dedicated national Alzheimer's disease programmes/initiatives	**1**	Multiple programmes/initiatives by national ministries/under national policies for dementia – Ministerial Council on the Promotion of Policies for Dementia Care – Dementia Supporters programme (Dementia Supporter Caravan) – Cognicise - National Center for Geriatrics and Gerontology (NCGG) – Dementia Cafés- Introduced in the original Orange Plan and expanded in New Orange Plan[330] – Orange Innovation Project - Ministry of Economy, Trade and Industry (METI), as part of the Framework for Promoting Dementia Policies – Dementia-Friendly Business Certification Schemes[331]
				Joint national and regional Alzheimer's disease coordination mechanisms	**1**	– Japan has established a robust, legally mandated framework to coordinate dementia policy at the local government level[332]. Under the Basic Plan for Promoting Dementia Measures, all municipalities are required to develop dementia care pathways that outline a standardised process - from pre-diagnosis consultations to end-of-life care. Each municipality must also appoint regional care coordinators -typically healthcare professionals with dementia expertise - to oversee the integration of medical and nursing services. A nationwide study conducted in 2021 found that, as of October 2020, approximately 88% of municipalities had established such care pathways. However, recent updates on the full implementation of these pathways across all municipalities remain limited.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
4	**Alzheimer's disease financing**	0-6	3	Dedicated budget to Alzheimer's disease programmes	1	The Ministry of Health, Labour and Welfare allocated ¥16.1 billion for implementing the National Dementia Strategy as part of its ¥34 trillion social security request in FY2025[333] [334]. Although Alzheimer's may be covered under this umbrella, the budget is not specific to Alzheimer's disease.
				Funding/insurance coverage for Dementia/ Alzheimer's disease Care (Public)	1	All medical and care expenses are reimbursed, subject to a co-payment rate of 10 - 30%, which varies according to individuals' financial circumstances (Source: Expert interview)
				Funding/insurance coverage for Dementia/ Alzheimer's disease (Private & alternatives)	1	Partially funded, Alzheimer's disease specifically mentioned - In Japan, private insurance companies offer dedicated dementia insurance products that specifically include coverage for Alzheimer's disease. One notable example is the "Dementia Insurance 'be'", launched in 2024 through a collaboration between Lifenet Insurance and Eisai[335]. While lifestyle modifications and exercise are commonly recommended for managing mild MCI, the approval of a new pharmaceutical treatment in 2023- specifically indicated for patients with MCI and mild dementia due to Alzheimer's disease - has introduced medication as an additional early intervention option. Although this treatment is covered by Japan's public healthcare system, individuals are still required to make co-payments for medications, diagnostic tests, and related services, making financial preparedness increasingly important.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
5	**Existence of registries established for Alzheimer's disease**	**0-5**	**3**	Existence of registries established for Alzheimer's disease	**2**	In Japan, the AMED-funded DMT Registry is ongoing, enrolling Alzheimer's disease patients treated with anti-Aβ antibody drugs[336 337]
				Integration of Dementia-specific tracking in EMR systems	**1**	Dementia data sharing only occurs for research purposes (Source: Expert interview) The Government of Japan (GOJ) is actively promoting the widespread adoption and interoperability of Electronic Medical Records (EMRs) to accelerate healthcare digitasation. Despite its convenience and accessibility, Japanese patients currently lack the ability to freely access their medical information[338]. While EMRs are being introduced, their use is largely confined to individual medical institutions, with limited interoperability across different medical facilities. This lack of integration complicates patient care and restricts the use of medical information in diagnosis, treatment, health management, medical coordination, and the R&D of medical care and pharmaceuticals.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
6	**Inclusivity and equitable policy formulation**	0-8	4	Policies/strategies/plans/ programmes addressing equitable access to care to Alzheimer's	**1**	Under the Basic Act on Dementia, Article 3 and subsequent articles legally mandate the government to ensure seamless, high-quality care while respecting the will of affected individuals[339]. The 2019 Dementia Framework promotes accessibility through barrier-free infrastructure such as appropriate signage and mobility aids[340]. The Community-based Integrated Care System connects healthcare, social services, and volunteer support[341]. These policies enhance equity for people with dementia, but do not focus specifically on Alzheimer's disease.
				Policy recognition of preclinical Alzheimer's disease/Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	**2**	Basic Plan for Promoting Dementia Measures (2023) includes a community-based early intervention initiative through "Team Orange," a nationwide network of trained volunteers, including people living with dementia and dementia supporters[342]. Established in 2019, the programme promotes wellness among seniors and provides mental and daily life support, with referrals to medical and social services. The government aims to expand this to 1,700 municipal-level groups by 2025.
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	**0**	The Dementia Supporter Caravan has trained over 13 million volunteers to guide people with dementia and their families, providing informal navigation and awareness of resources[343]. Early Intensive Support Teams under the national framework also assist with dementia care, but programmes are not Alzheimer's-specific nor explicitly focused on underserved communities.
				Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	**1**	Japan has widespread dementia community programmes such as over 7988 dementia cafés[344], volunteer care initiatives (e.g., Community Social Workers[345], and Community-Based Integrated Care Centers (CBICS)[346]. These are supported by government policies but are more universal to all dementia, not just dedicated to Alzheimer's patients.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
7	**National Alzheimer's disease clinical guidelines availability and implementation**	**0-6**	**7**	Availability of clinical guidelines on Alzheimer's disease	**3**	1) Guideline: Clinical Practice Guideline for Dementia[347] – Author: collaboratively developed by several prominent academic societies, including the Japanese Society of Neurology and the Japan Society for Dementia Research – Issue year: 2017, version 2026 (issue year/date to be confirmed), is currently in development – The guidelines include a dedicated chapter (Chapter 6) focused specifically on Alzheimer's disease dementia. This chapter comprehensively reviews diagnosis, treatment (both pharmacological and non-pharmacological), care strategies, imaging and biomarker use, and available social support. Each section is structured around clinical questions (CQs) with evidence grading and recommendations, demonstrating a structured and disease-specific approach. 2) Appropriate Use Guidelines for Cerebrospinal Fluid and Blood Biomarkers Related to Dementia[348] 1st Edition: March 31, 2021 2nd Edition: September 30, 2023 3rd Edition: March 31, 2025 Committee Member Supervised by: Japanese Society for Dementia Research; Japanese Society of Geriatric Psychiatry; Japanese Society of Neurology; Japanese Society of Psychiatry and Neurology; Japan Geriatrics Society; Japanese Society of Neurological Therapeutics 3) Appropriate Use Guideline for Amyloid PET Imaging Agents – most recently updated to 4th edition in 2025 and jointly developed by professional societies including the Japanese Society of Nuclear Medicine, Japanese Neurology Society, and others[349]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Currency of clinical guidelines	**2**	Appropriate Use Guidelines for Cerebrospinal Fluid and Blood Biomarkers Related to Dementia[350] 1st Edition: March 31, 2021 2nd Edition: September 30, 2023 3rd Edition: March 31, 2025 Appropriate Use Guideline for Amyloid PET Imaging Agents – most recently updated to 4th edition in 2025[351]
				Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care	**2**	50% or more healthcare regions or facilities implementing national clinical guidelines (Source: Expert interview)
8	**Policy support for preventive care**	**0-2**	**2**	National policies focused on primary prevention/ modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	Health Promotion Targets351F : – Smoking in over 15s Decrease by 3.6% – Physical inactivity Decrease by 1.3% – Alcohol intake Decrease by 5% – Obesity Decrease by 0.63% – HT Decrease to 23.4% – Diet (fruit and vegetable intake) Increase to 88%
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health/ cognitive screening or monitoring)	**1**	The 2019 Framework[353] and 2024 Basic Plan[354] promote risk reduction and early detection, aligning with secondary prevention through screening and monitoring efforts. The Basic Act on Dementia (2024) institutionalizes early-stage efforts across systems[355].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	0-6	5	Funding for Alzheimer's disease research: Investment in/funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	1	– Japan devotes 0.2% of its total research funding to dementia, making Japan's investment into dementia research the smallest among G7 countries[356]. Therefore, Japan is expected to rapidly increase investments into dementia research. Japan is also expected to actively adopt a successful, revolutionary private and public collaboration model like the Dementia Discovery Fund (DDF). – AMED dementia R&D grants[357]: Japan Agency for Medical Research and Development (AMED) administers comprehensive dementia funding under its "R&D Grants for Dementia" programme – In March 2023, AMED and Australia's NHMRC launched a joint dementia research scheme with up to ¥30 million JPY per Japan-led project (~AU$500k)
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	2	The National Clinical Registry of Disease-Modifying Therapies for Alzheimer's Disease (AD-DMT Registry)357F actively supports recruitment and monitoring of Alzheimer's clinical trial participants358F
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	2	Typical time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice is from 1 to 3 years. E.g., ClarityAlzheimer's disease results were announced in December 2022, followed by lecanemab's approval in September 2023 and insurance reimbursement starting in December 2023. TRAILBLAZER-ALZ2 results were released in July 2023, with donanemab approved in September 2024 and reimbursement beginning in November 2024 (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 2: Prevention & screening (early detection)						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**2**	National clinical guidelines **screening coverage** for high-risk population For example: Older adults (e.g. ≥65 years) Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression	**0**	Guidelines do not mention screening for individuals at high risk of Dementia/ Alzheimer's disease[360]
				Inclusion of validated cognitive assessment tools in screening guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	The Mini Mental State Examination (MMSE) is widely used internationally to screen for cognitive impairment, with a maximum score of 30. Scores of 23 or below generally suggest possible dementia. However, MMSE has lower sensitivity in mild dementia, high-functioning individuals, and those with visuospatial impairments[361]. In Japan, the Revised Hasegawa's Dementia Scale (HDS-R) is commonly used alongside MMSE, with a cutoff score of 20 for dementia suspicion. For detecting mild dementia and mild cognitive impairment, more sensitive tools like the Montreal Cognitive Assessment (MoCA-J) and Addenbrooke's Cognitive Examination-Revised (ACE-R) are used. Adding neuropsychological tests (e.g., trail making, logical memory tasks) to MMSE improves mild dementia diagnosis. The Alzheimer's Disease Assessment Scale-Cognitive Subscale (ADAS-Jcog) focuses on memory and visuospatial function to monitor Alzheimer's disease progression.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
						For severe dementia, assessments like the Severe Impairment Battery (SIB) and Severe Cognitive Impairment Rating Scale (SCIRS) are appropriate. Cognitive assessment should consider not only test scores but also the patient's premorbid abilities and current physical and mental state to accurately estimate cognitive decline.
				Inclusion of BBBMs in **screening guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**1**	Plasma pTau217 and pTau217/Aβ42 are recommended as a prescreening test for CSF/PET (Source: Expert interview)
				Inclusion of CSF biomarkers in **screening guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	CSF p-tau181 has been used for differential diagnosis of dementia in clinical practice. CSF Aβ42/40 ratio and pT181/Aβ42 have been clinically used prior to initiation of anti-Aβ antibody therapy. They are used as a confirmatory test rather than as a screening test. (Source: Expert interview)
11	**Alzheimer's disease screening funding**	**0-6**	**2**	Funding for **validated cognitive assessment tools in screening** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Cognitive function tests included in basic medical fees, some specific screening covered but no separate billing allowed[362] : "The simplified items in "A" of "1" of "D285" cognitive function tests and other psychological tests refer to the MAS anxiety scale, MEDE multifaceted early dementia assessment test, AQ Japanese version, Japanese version of LSAS-J, M-CHAT, Hasegawa intelligence scale, and MMSE, and the others... "D285" Cognitive function test and other psychological tests, item "1" (i), shall, in principle, be billed only once per three months... The cost of the National Seiken Dementia Screening Test is included in the basic medical fee and cannot be billed separately."
				Financing mechanism for **BBBMs in Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers Alzheimer's disease screening**	**1**	Partially reimbursed by public insurance (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
12	**Alzheimer's disease diagnosis guidelines**	**0-7**	**6**	National clinical guidelines **diagnosis coverage**	**2**	Guidelines explicitly cover diagnosis of Alzheimer's[363] - "Chapter 6: Alzheimer's Disease Dementia" is a dedicated section for Alzheimer's disease. The diagnostic criteria for Alzheimer's disease dementia are based on three main frameworks: – The DSM-5 (2013) replaced the term "dementia" with "major neurocognitive disorder" and defined Alzheimer's disease dementia based on cognitive decline criteria, gradual onset, exclusion of other causes, and classification as probable or possible. Amyloid PET and CSF Aβ42 are important diagnostic markers, with other tests like genetic analysis and imaging noted for future use. – The 2011 NIA-AA criteria view Alzheimer's disease as brain pathology spanning preclinical, mild cognitive impairment, and dementia stages. Diagnosis centers on progressive cognitive impairment and incorporates biomarkers such as CSF Aβ42, amyloid PET, tau proteins, FDG-PET metabolism, MRI brain atrophy, and genetics, linking clinical symptoms with pathology for research and clinical use. – The 2014 IWG-2 criteria further classify Alzheimer's dementia into typical (memory impairment progressing to other domains) and atypical variants (e.g., posterior cortical atrophy, logopenic aphasia). Diagnosis relies on amyloid PET, CSF biomarkers (Aβ42, total tau, phosphorylated tau), and genetic testing to confirm pathology alongside clinical symptoms.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Inclusion of validated cognitive assessment tools in diagnostic guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	The diagnostic criteria (DSM-5, NIA-AA, IWG) focus mainly on clinical diagnosis supported by biomarkers but do not explicitly mention specific cognitive assessment tools such as MMSE, MoCA, Mini-Cog, etc[364].
				Inclusion of BBBMs in **diagnostic guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**1**	BBBMs p-tau217 and p-tau217/Aβ42 are recommended in Guidelines for the Appropriate Use of Cerebrospinal Fluid and Blood Biomarkers in Dementia[365]
				Inclusion of CSF biomarkers **diagnostic guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**2**	CSF p-tau181, Aβ42/40 ratio, p-tau181/ Aβ42 ratio are recommended in Guidelines for the Appropriate Use of Cerebrospinal Fluid and Blood Biomarkers in Dementia[366]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
13	**Capacity of/ Availability of/ access to diagnostic infrastructure and services**	0-18	15	MRI	**4**	0.6 per ten thousands of population[367]
				CT	**4**	1.16 per ten thousands of population[368]
				PET	**3**	There are 336 facilities certified by the Japanese Society of Nuclear Medicine as amyloid PET imaging facilities (as of Aug, 2025). With Japan's population at approximately 123.3 million, 336/123 = 2.73 machines per 1 million population. (Source: Expert interview)
				CSF Biomarker testing	**2**	CSF biomarker testing (e.g., Aβ42/40, total-tau, p-tau) is regulatorily approved and routinely available nationwide in any clinical setting: – p-Tau 181: AD diagnosis – t-Tau: Creutzfeldt–Jakob disease (CJD) diagnosis – Aβ42/40 & p-Tau 181/Aβ42: confirmation of Aβ pathology Public insurance generally covers only one test per patient (Source: Expert interview)
				BBBMs testing	**2**	Multiple Japanese cohorts and clinical studies demonstrate BBBMs phosphorylated tau (p-tau) in clinical workflows, but not yet integrated into standard national diagnostic pathways[369]
14	**Tracking of time to diagnosis for Alzheimer's disease**	0-2	1	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**1**	A survey of family caregivers found that the median time from first noticing changes to receiving a formal dementia diagnosis in Japan is 12 months[370]. While this suggests some awareness of diagnostic timelines, this data is based on a localised study - not on structured national datasets or coordinated registries.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
15	**Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)**	0-12	4	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary/tertiary public institutions	**1**	According to a medical institution's announcement, among 296 patients who visited a specialized outpatient clinic, only 59 underwent CSF testing. Most patients seeking DMT treatment reportedly opt for PET scans as their Aβ pathology test. BBBMs testing is not covered by insurance and is therefore presumed to be rarely performed (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary/tertiary private institutions	**1**	< 50% According to a medical institution's announcement, among 296 patients who visited a specialized outpatient clinic, only 59 underwent CSF testing. Most patients seeking DMT treatment reportedly opt for PET scans as their Aβ pathology test. BBBMs testing is not covered by insurance and is therefore presumed to be rarely performed (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting	**1**	< 50% BBBMs testing is not covered by insurance and is therefore presumed to be rarely performed (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at public primary care setting	**1**	< 50% BBBMs testing is not covered by insurance and is therefore presumed to be rarely performed (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
16	**Capacity of workforce**	**0-16**	**10**	Geriatricians/ Psychogeriatricians	**2**	(WHO, 2017) Number of geriatricians or psychogeriatricians (per 100,000): 1.87[371]
				Neurologists	**3**	(WHO, 2017) Number of neurologists (per 100,000): 4.38[372]
				Psychiatrist working in mental health sector	**3**	(WHO, 2016) Number of psychiatrists (per 100,000): 11.867[373]
				Social workers working in mental health sector	**2**	(WHO, 2016) Social workers working in mental health sector (per 100,000): 8.328[374]
17	**Alzheimer's disease diagnostics funding coverage**	**0-6**	**2**	Funding for **validated cognitive assessment tools in Alzheimer's disease/Dementia diagnosis** (public and/ or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Only the MMSE and MoCA are eligible for reimbursement. These tests are relatively low-cost, with the MMSE priced at around ¥800. (Source: Expert interview)
				Financing mechanism for **BBBMs in Alzheimer's disease diagnosis**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers in Alzheimer's disease diagnosis**	**1**	P-tau181: reimbursed for AD diagnosis Aβ42/40 and p-Tau 181/Aβ42: reimbursed for the purpose of confirming Aβ pathology (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 4: Treatment monitoring and access						
18	**Alzheimer's disease treatment monitoring guidelines**	**0-6**	**2**	National clinical guidelines **treatment & monitoring coverage** (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**2**	1. Pharmacotherapy for Alzheimer's Disease Dementia[375] Cholinesterase Inhibitors (donepezil, galantamine, rivastigmine): Improve cognition, daily function, and behavior in mild to moderate stages; side effects include nausea and vomiting. Rivastigmine patch has fewer side effects. Memantine (NMDA antagonist): Effective for moderate to severe stages, improves cognition and behavior, generally well tolerated; limited benefit in mild stages. Severe Dementia: Donepezil and memantine maintain cognitive function; treatment benefits modest but present. Combination Therapy: ChEIs plus memantine may offer slight additional benefits in moderate to severe dementia; unclear benefit in mild case 2. Non-Pharmacological Therapies for Alzheimer's Disease Dementia[376] Effectiveness varies by patient and practitioner; combining therapies and patient willingness is key. Preferred for behavioral symptoms but can have risks. Cognitive stimulation, exercise, and music therapy may help, though evidence is limited and mixed. Reminiscence therapy's benefits are unclear.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
18				Inclusion of BBBMs in **treatment & monitoring guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarkers recommended or mentioned for treatment & monitoring[377]
				Inclusion of CSF biomarkers in **treatment & monitoring guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarkers recommended or mentioned for treatment & monitoring[378]
19	**Involvement of multi-disciplinary team**	**0-2**	**2**	Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**1**	Support given by a multidisciplinary team is recommended to enable patients with dementia to receive continuous medical and long-term care[379]
				Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologists, psychologists, social workers, occupational therapists, etc. for Dementia/Alzheimers'	**1**	Japan (National Center for Geriatrics and Gerontology)[380] : In 2010, the Center for Comprehensive Care and Research on Memory Disorders was established at the National Center for Geriatrics and Gerontology (NCGG) as a model medical center for dementia care. The center's multidisciplinary team consists of 24 doctors, 8 nurses, 10 psychologists, 1 psychiatric social worker, and 2 clerks.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
20	**Linkage to supportive/ palliative care**	**0-2**	**2**	Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**1**	Palliative and hospice care improve quality of life[381]
				Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**1**	E.g. The Japanese government promotes home-based palliative and end-of-life care and introduced home-care support clinics in 2006 to provide 24-hour medical and nursing care in patients' homes following hospital discharge[382]. Home-care support clinics play a key role in the provision of home-based end-of-life care for patients with advanced illnesses including dementia.
21	**DMT access pathway readiness**	**0-5**	**5**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**3**	1. September 24, 2024 - Japan's Ministry of Health, Labour and Welfare has approved Kisunla™ (donanemab-azbt, 350 mg/20 mL every four weeks for IV infusion) treatment for adults with early symptomatic Alzheimer's disease, including those with mild cognitive impairment (MCI) or mild dementia, with confirmed amyloid pathology[383] 2. Lecanemab was approved in Japan in September 2023 for the treatment of patients with mild cognitive impairment (MCI) and mild dementia due to Alzheimer's disease[384]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**2**	Pharmaceuticals and Medical Devices Agency (PDMA) Review Documents[385]: Donanemab acts by removing brain Aβ plaques in patients with Alzheimer's disease; therefore, to identify the intended patient population for use of donanemab, brain Aβ pathology needs to be determined. Brain Aβ pathology was assessed by amyloid PET at the time of enrollment of subjects in Study AACI, and the guidelines state that CSF Aβ levels are also highly correlated with brain Aβ pathology as measured by amyloid PET and biopsy (Clinical Guidelines on the Proper Use of Cerebrospinal Fluid and Blood Biomarkers for Dementia, and APOE Testing. [in Japanese] Committee for Preparation of the "Clinical Guidelines on the Proper Use of Cerebrospinal Fluid and Blood Biomarkers for Dementia, and APOE Testing"; 2023: p.6-7). Therefore, prior to the initiation of donanemab treatment, brain Aβ pathology should be assessed using amyloid PET scans, CSF testing, or other testing methods whose results show an established correlation with amyloid pathology.
22	**Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease/ Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.**	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	In Japan, where an ageing population and labour shortages are growing concerns, digital solutions designed with the needs of dementia patients in mind are playing a crucial role385F . These innovations help ease the burden on caregivers and contribute to an environment where patients and caregivers can live with dignity. While traditional telemedicine for remote consultations is a part of this, the focus is also on smart technologies like facial recognition systems to prevent wandering and smartphone apps for brain assessments and medication reminders. The use of telemedicine is often seen as a supplement to in-person care, with guidelines from the Ministry of Health, Labour and Welfare for its proper implementation[387]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
23	**Alzheimer's treatment & monitoring funding coverage**	**0-6**	**3**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**2**	galantamne, rivastigmine, donepezil, memantine, donanemab, lecanemab are all approved and reimbursed (Source: Expert Interview)
				Financing mechanism for BBBMs in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert Interview)
				Financing mechanism for CSF biomarkers in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**1**	CSF biomarker tests (Ab42/40 and pTau181/Ab42) used to support patient selection for DMT are reimbursed under public insurance, whereas tests conducted for treatment monitoring are not covered. (Source: Expert Interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 5: Advocacy, awareness and education						
24	**Dementia/ Alzheimer's disease patient organization engagement and advocacy**	**0-3**	**3**	Existence of patient/ caregiver organizations	**1**	Alzheimer's Association Japan (AAJ) was founded in 1980 and has been a member of Alzheimer's diseaseI since 1992[388]. Support to caregivers provided e.g., toll-free telephone consultations
				Participation in national policy & plan development, and/or joint programmes with government	**1**	The Alzheimer's Association Japan is part of the Japan Public-Private Council on Dementia, collaborating on dementia-related policies[389]. In collaboration with the Japanese government and other stakeholders, the AAJ participates in various activities, including awareness campaigns, policy discussions, and international forums. For instance, in 2023, the AAJ co-hosted a dementia symposium in Hiroshima and participated in the Civil Society 7 (C7) engagement group during the G7 Hiroshima Summit, advocating for dementia-related policies.
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**1**	– Alzheimer Association Japan[390] : telephone consultation service, post-diagnostic peer support gatherings ("Tsudoi"), monthly newsletter pole-pole offering education and guidance – Japan's Ministry of Health, Labour and Welfare's Dementia Supporter programme training ordinary citizens, including students and community members, in dementia awareness and basic caregiving (90-minute sessions)[391]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
25	**Dementia/ Alzheimer's disease professional medical and scientific societies/ associations, research institutes engagement and advocacy**	**0-4**	**4**	Existence of professional medical and scientific societies / associations, research institutes focused on Dementia/Alzheimer's disease	**2**	Japanese Society for Dementia Care[392] Japanese Society for Dementia Research (JSDR)[393] Japan Agency for Medical Research and Development (AMED)[394] Japanese Society of Neurology[395]
				Participation in national policy & plan development, and/ or joint programmes or initiatives with government agencies on Dementia/ Alzheimer's disease	**1**	Japanese Society for Dementia Care[396] Japanese Society for Dementia Research (JSDR)[397] Japan Agency for Medical Research and Development (AMED)[398] Japanese Society of Neurology[399] These groups collectively contribute to national dementia strategies, research funding, and policy advisory roles. AMED is a government agency supporting dementia research initiatives.
				Contributions towards clinical guidelines development	**1**	Supervised by the Japanese Society of Neurology[400] (Cooperating Societies: Japanese Society of Neurological Therapeutics, Japanese Society of Psychiatry and Neurology, Japanese Society of Dementia, Japan Geriatrics Society, Japanese Society of Geriatric Psychiatry)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
26	**Dementia/ Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)**	**0-21**	**14**	[PATIENT] Availability of patient education programmes and support resources initiated/driven by patient/caregiver organizations	**2**	Alzheimer's Association Japan (認知症の人と家族の会) provides toll-free consultations and resources for Alzheimer's/dementia[401]
				[PATIENT] Availability of patient education programmes and support resources initiated/driven by the professional medical and scientific societies / associations, research Institutes focused on Dementia/Alzheimer's disease	**2**	Broader Dementia and Alzheimer's–specific programmes or resources are run by civil society organizations (but not Alzheimer's-only) (Source: Expert Interview)
				[PATIENT] Availability of patient education programmes and support resources initiated/driven by the government	**2**	The National Framework for Promotion of Dementia Policies (2019-2025) emphasizes patient-centered care and public awareness through "inclusion" and "risk reduction."[402] Key initiatives include the Dementia Supporters programme, Team Orange, and Dementia Cafés.
				[CAREGIVER] Availability of caregiver-focused education, training, and support services on Dementia/Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines) Can be driven by: – Patient or caregiver organization – Professional medical and scientific societies/ associations, research institutes focused on Dementia/Alzheimer's disease – The government	**2**	JHPN - "The Dementia Supporters training programme aims to train 12 million Dementia Supporters by 2020."[403]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[ALL] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	Japan has the highest aging rate in the world, and to support the increasing number of people with dementia, campaigns to raise public awareness of dementia and building dementia-friendly communities were launched well in advance. In 2005, the Japanese government pioneered a new community support system for people with dementia and their carers called the 'Japan National Campaign of Dementia Supporter Caravan (Ninchishou supporters)', which also helped in raising public awareness on dementia[404] . As a result of the implementation of this programme in Japan, by the end of 2018, over 10 million dementia supporters had been trained in the country. Specifically, the design of this national dementia strategic plan involves one individual educating a group of dementia supporters, who then support people with dementia in their own communities.
				[HEALTHCARE PROVIDERS] Availability of clinical education for **primary care providers**	**2**	JPHN - "Prefectures and designated cities have implemented training programmes for primary care doctors (who will specialize in various fields in the future) in order to improve their ability to respond to dementia and so that they can become mediators between people seeking healthcare and medical specialists."[405]
				[HEALTHCARE PROVIDERS] Availability of specialist training in Dementia/Alzheimer's care	**2**	Under the 2019 Dementia Policy Framework by MHLW, care staff must complete Dementia Care Basic Training via e-learning (~150 minutes)[406] . This covers core principles, disease understanding, and basic care techniques. Completion is required for dementia care personnel (2021-2024 transition period). For care professionals with ~2 years experience, municipalities offer Dementia Care Practitioner Training: Combines classroom instruction (typically 5-6 days) + workplace practice (2-4 weeks). Examples: Tokyo: 6 days + 4 weeks onsite, free of charge for qualified staff

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New Zealand

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
New Zealand	Moderately high	Low	Moderately low	Moderately low	Moderately high

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	Existence and operational status of national Alzheimer's disease policies/ strategies/plans	0-4	3	Existence and operational status of national Alzheimer's disease policies/ strategies/plans	2	1) The Dementia Mate Wareware Action Plan 2026-2031[407] addresses the urgent challenge of dementia in Aotearoa New Zealand, which significantly affects individuals, whānau, the health system, and the economy. Presented at the Alzheimers NZ Summit in September 2025, the refreshed plan updates the previous version (ending 2025) and provides a five-year roadmap for government and health services. The plan emphasizes five immediate priority areas to: – Prevent dementia where possible – Ensure people receive timely support and care The kaitiaki group- Alzheimers NZ, Dementia NZ, NZ Dementia Foundation, and the Mate Wareware Advisory Rōpū - led its development with broad sector input. Urgent government action is needed to implement the plan effectively, as inaction would be costly and ineffective. Dementia as a key contributor to health loss and inequities. Issued on 1 August 2025, the plan is current and nationally applicable.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
						2) The New Zealand Health Plan[408] | Te Pae Waenga (2024-2027) is a three-year strategic plan for Health New Zealand | Te Whatu Ora, established under the Pae Ora (Healthy Futures) Act 2022. It aims to ensure timely access to quality healthcare nationwide and specifically references
				Currency of the national policies/ strategies/plans	**1**	1) The Dementia Mate Wareware Action Plan 2026-2031 (Sep 2025) [409] 2) The New Zealand Health Plan | Te Pae Waenga (2024-2027) (Aug 2025) [410]
2	**Priority & specificity of Alzheimer's disease in national policies/strategies/ plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	Dementia Mate Wareware Action Plan 2026–2031[411] Vision: Dementia Mate Wareware is prevented as much as possible and people living with dementia mate wareware and their families and whānau get the help and support they need Goal: Improve the wellbeing of people living with dementia mate wareware and their families and whānau, and decrease the impact of dementia mate wareware Purpose: The purpose of this Action Plan is to: – Provide a roadmap for action for government and the health system over the next five years – Highlight the barriers to access – Focus health system action and investment on specific evidence-based priorities that will have a material impact on the lives of people living with dementia mate wareware and their families and whānau, and the health system – Provide a context within which primary, community, specialist, and hospital services can work together toward the same goals – Hold decision-makers accountable for making progress on these priorities

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
3	**Coordinating mechanism for implementation**	**0-4**	**3**	Dedicated national Alzheimer's disease programmes/ initiatives	**1**	The plan establishes national programmes and initiatives for dementia (Mate Wareware Network, Leadership and Advisory Group, pilot programmes, workforce plans)[412] Government's Health Select Committee's inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders. Submissions were made in August 2024, hearings held in 24/25 and a final report delivered in November 2025[413,414]
				Joint national and regional Alzheimer's disease coordination mechanisms	**2**	A Dementia Mate Wareware Leadership and Advisory Group was established under the Dementia Mate Wareware Action Plan 2020–2025[415]. Leadership and oversight are also provided by the kaitiaki group - comprising Alzheimer's NZ, Dementia NZ, the New Zealand Dementia Foundation, and the Mate Wareware Advisory Rōpū.
4	**Alzheimer's disease financing**	**0-6**	**3**	Dedicated budget to Alzheimer's disease programmes	**1**	– Pilot programmes funding: The government allocated $12 million over four years (Budget 2022) to support seven pilot initiatives focused on community-based dementia mate wareware support services.[416] – Aged care budget allocations: Funds within the aged care budget are applied to dementia-related services, including day programmes, community support provided by Alzheimer's organisations, and residential care facilities.[417] – Unapproved funding request: A business case for additional funding to expand community-based dementia services has been submitted, but this request has not yet been approved (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Funding/insurance coverage for Dementia/ Alzheimer's disease Care (Public)	**1**	The government funds the majority of healthcare in New Zealand through public taxes, so references to insurance are not applicable. Dementia (mate wareware) is recognised as a health condition, and related services are publicly funded. However, like other parts of the health system, these services are under pressure, and additional funding will be needed to meet rising demand as the population ages. (Source: Expert interview)
				Funding/insurance coverage for Dementia/ Alzheimer's disease (Private & alternatives)	**1**	Approximately 20% of the population holds life or income insurance, while around 37% have health insurance. Dementia and Alzheimer's disease are explicitly excluded from coverage in some health insurance policies, such as those offered by Southern Cross Health Insurance. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
5	**Existence of registries established for Alzheimer's disease**	**0-5**	**3**	Existence of registries established for Alzheimer's disease	**0**	New Zealand does not possess a formal, dedicated national registry for dementia or Alzheimer's (Source: Expert interview)
				Integration of Dementia-specific tracking in EMR systems	**3**	Compared with other developed nations, New Zealand's use of information technology (IT) in health care is among the highest in the world[418]. All of the country's 1,100 general practices use an electronic medical record system with comprehensive functionality to manage patient's problem lists, enter clinical progress notes, perform electronic prescribing, and order laboratory tests and x-rays, among other tasks. Physicians are also increasingly using information technology to communicate with patients and allow them to schedule appointments. New Zealand also stands out in terms of interoperability, with primary care providers, hospitals, radiology providers, and pathology laboratories, as well as most specialists able to use standard messaging to communicate with each other. Although the available information does not explicitly detail dementia-specific modules within these EMRs, these core functionalities are inherently valuable for tracking and managing dementia.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
6	**Inclusivity and equitable policy formulation**	0-8	4	Policies/strategies/ plans/programmes addressing equitable access to care to Alzheimer's	**1**	The Dementia Mate Wareware Action Plan emphasizes equity for Māori, Pacific peoples, rural, and young-onset dementia patients, using an intersectional framework. It targets dementia, not specifically Alzheimer's[419]
				Policy recognition of preclinical Alzheimer's disease/ Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	**1**	There is no broadly available focus on preclinical recognition of dementia in New Zealand. However, some research-based programmes exist, such as the Dementia Prevention Research Clinics[420]
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	**1**	All 17 local Alzheimers and Dementia organisations provide support to their communities, including underserved populations. In addition, the seven pilot programmes and many other agencies also deliver similar support services. (Source: Expert interview)
				Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	**1**	A co-developed model by Alzheimers NZ and Dementia NZ includes home visits, education, cognitive therapies, and culturally safe programmes (e.g., Te Ao Māori responsiveness, whānau involvement)[421]. Government funding supports implementation via the Auckland District Health Boards. However, these are broadly dementia-focused, not Alzheimer's-specific.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
7	**National Alzheimer's disease clinical guidelines availability and implementation**	**0-6**	**5**	Availability of clinical guidelines on Alzheimer's disease	**2**	1. Several regions currently have pathways that guide general practitioners (GPs) in the assessment of individuals presenting with cognitive impairment[422] . These pathways are in the process of being standardised at the national level to ensure greater consistency. Northland HealthPathways Auckland HealthPathways Midland HealthPathways Hawke's Bay HealthPathways Whanganui & MidCentral HealthPathways Wairarapa, Hutt Valley, Capital and Coast (3D) HealthPathways Nelson-Marlborough HealthPathways Canterbury HealthPathways Aoraki (South Canterbury) HealthPathways Southern HealthPathways 2. BPAC (Best Practice Advocacy Centre)[423]- 2020 also provides guidance on recognising and managing dementia in primary care. Although dated, they are still broadly applicable to current practice
				Currency of clinical guidelines	**1**	2013[424]
				Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care	**2**	50% or more healthcare regions or facilities implementing national clinical guidelines (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
8	**Policy support for preventive care**	**0-2**	**2**	National policies focused on primary prevention/ modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	New Zealand's Government Policy Statement on Health 2024-2027[425] – Daily smokers aged 15+: ≤5% in all groups – % eating 5+ servings of vegetables & 2+ fruit/day: Increase – % meeting physical activity guidelines: Year-on-year increase – Hazardous alcohol consumption (age 15+): Year-on-year decrease – Weekly contact with friends/family: Increase – Social cohesion and culture (GSS): Increase – % lonely most/all of the time (last 4 weeks): decrease – Psychological distress (NZ Health Survey): decrease
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health/ cognitive screening or monitoring)	**1**	The Healthy Ageing Strategy (2016)[426] and Dementia Mate Wareware Action Plan (2020)[427] support early intervention, cognitive assessment, and monitoring across care pathways, especially among Māori and underserved populations

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	**0-6**	**4**	Funding for Alzheimer's disease research: Investment in/funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	**2**	Dementia & Alzheimer's disease Specific 1. New Zealand's health research funding landscape includes government, philanthropic and charity sources that support dementia research. The Health Research Council (HRC) is the government's main vehicle for health research investment - in its 2024 annual report the HRC reports total research spending (across all health areas) of about NZ$127.8 million for the year, and the HRC research repository shows numerous dementia-related project grants in recent years (including multi-million-dollar programme and project grants)[428] 2. There are active, longitudinal dementia research platforms in New Zealand. The Dementia Prevention Research Clinics (DPRC)[429]- a national network led from the University of Auckland and supported by Brain Research New Zealand - run multi-year cohort and intervention studies focused on identifying risk processes and testing prevention strategies for Alzheimer's disease. These clinics are an ongoing national research resource. 3. Philanthropic and mission-driven organisations also play an important role. Brain Research New Zealand (BRNZ) and the New Zealand Brain Research Institute have historically funded targeted grants and strategic awards for Alzheimer's and related neuroscience research, although BRNZ's Centre of Research Excellence funding cycle has faced renewal uncertainty in recent rounds[430]. In recent years the Neurological Foundation has become a significant funder of research related to dementia/Alzheimer's disease. In December, a grant of $1m was announced for a project 'Blood Biomarkers: A New Frontier in Alzheimer's Diagnosis in New Zealand' and a further $1m for 'Mate Wareware-Dementia Prevention Research Platform' which aims to develop a national dementia registry[431]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	**2**	New Zealand participates in international Alzheimer's drug trials (e.g., gantenerumab) with strict eligibility criteria such as age and amyloid levels[432] . Registration in the Australia New Zealand Clinical Trials Registry (ANZCTR) confirms targeted Alzheimer's involvement[433] NZ is also a trial site for the DIAN study using lecanemab in inherited Alzheimer's disease[434]
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	**0**	Unpredicted and no standardised adoption timeframe (Source: Expert interview)
Domain 2: Prevention & screening (early detection)						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**1**	National clinical guidelines **screening coverage** for high-risk population For example: Older adults (e.g. ≥65 years) Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression	**0**	BPAC guidance states that symptoms should be assessed when first reported or noticed, including in older adults and after certain medical events (falls, motor vehicle accidents, safety incidents) [435]. It does not recommend proactive or routine screening for asymptomatic high-risk groups (e.g. family history, vascular risk factors).

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
10				Inclusion of validated cognitive assessment tools in **screening guidelines** For example: – MMSE (Mini-Mental State Examination) – MoCA (Montreal Cognitive Assessment) – Mini-Cog – GPCOG (General Practitioner Assessment of Cognition) – CASI (Cognitive Abilities Screening Instrument) – Clock Drawing Test	**1**	The BPAC guidance specifies tools such as[436]: GPCOG (General Practitioner Assessment of Cognition) as a brief screen Mini-Addenbrooke's Cognitive Examination (Mini-ACE/M-ACE) for comprehensive assessment. IQCODE, Functional Activities Questionnaire (FAQ) for family/whānau informants
				Inclusion of BBBMs in **screening guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No mention of biomarkers in screening
				Inclusion of CSF biomarkers in **screening guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No mention of biomarkers in screening

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
11	**Alzheimer's disease screening funding**	**0-6**	**1**	Funding for **validated cognitive assessment tools in screening** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Mini-ACE screening test is recommended and freely available; no direct funding details but free test usage. NZ Dementia Foundation[437] - "Mini-Addenbrooke's Cognitive Examination (Mini-ACE or M-ACE) is a brief cognitive screening test. It's free, easy to use, and takes around five minutes to complete. The Mini-ACE has replaced the Montreal Cognitive Assessment (MoCA) test as New Zealand's recommended cognitive screening test."
				Financing mechanism for **BBBMs in Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
12	**Alzheimer's disease diagnosis guidelines**	**0-7**	**1**	National clinical guidelines **diagnosis coverage**	**1**	Whilst there is not a single guideline, the BPAC[438] and HealthPathways Guidelines[439] provide guidance for the diagnosis and management of dementia. Note that BPAC guidelines and HealthPathways are applicable to the primary care setting. If a patient is referred to secondary care for a formal diagnosis, the process will depend on geographic location, as composition of the MDT in memory clinics varies and does not usually include a neurologist FTE (Source: Expert interview).
				Inclusion of validated cognitive assessment tools in **diagnostic guidelines** For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	BPAC guidance[440] GPCOG and Mini-ACE are explicitly recommended IQCODE and FAQ are also referenced for informants
				Inclusion of BBBMs in **diagnostic guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No mention of biomarkers in diagnosis
				Inclusion of CSF biomarkers **diagnostic guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No mention of biomarkers in diagnosis

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
13	**Capacity of/ Availability of/ access to diagnostic infrastructure and services**	0-18	8	MRI	**2**	0.17 per ten thousands of population[441]
				CT	**2**	0.44 per ten thousands of population[442]
				PET	**2**	Moderately low (>0.5 - 2.0 machines per 1 million population). Whilst there are PET instruments available for oncology, there are only a few machines conducting amyloid PET. The tracer is made in Wellington and must be transported nationally. For this reason, patients are 'batched' for appointments. (Source: Expert interview)
				CSF Biomarker testing	**1**	There is some private use of CSF and a few samples from the public system, but use is largely for research purposes. Samples are sent to the Florey in Melbourne as, in the absence of funding, the volumes are too low to justify local set-up. (Source: Expert interview)
				BBBMs testing	**1**	BBBMs work exists in national research/ clinic networks (NZ-DPRC) and pilots, but adoption appears mainly research-focused with limited routine clinical deployment[443]
14	**Tracking of time to diagnosis for Alzheimer's disease**	0-2	1	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**1**	Studies by University of Auckland found that on average, it took 3.6 years from the time symptoms began to when the formal diagnosis was made by a doctor[444] . One participant summed up the experience of many when they described their journey to a diagnosis as "long and frustrating"

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
15	**Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)**	0-12	4	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary/tertiary public institutions	**1**	<1% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary/tertiary private institutions	**1**	<1% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting	**1**	<1% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at public primary care setting	**1**	<1% (Source: Expert interview)
16	**Capacity of workforce**	0-16	8	Geriatricians/ Psychogeriatricians	**2**	In 2012, there were 72 geriatricians (public sector) recorded, equating to 1.6 geriatricians per 100,000 population Public hospital memory clinics are largely led by geriatricians, very few have a permanent neurologist FTE (Source: Expert interview)
				Neurologists	**1**	(Atlas of MS, 2020) Number of neurologists (per 100,000): 1[445]
				Psychiatrist working in mental health sector	**4**	(WHO, 2016) Number of psychiatrists (per 100,000): 28.540[446]
				Social workers working in mental health sector	**1**	Low (<=1 staff per 100k of population). Only a couple of memory clinics have social work as part of their teams (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
17	**Alzheimer's disease diagnostics funding coverage**	0-6	1	Funding for **validated cognitive assessment tools in Alzheimer's disease/Dementia diagnosis** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Cognitive assessment for Alzheimer's/ Dementia diagnosis is partially funded or reimbursed (Source: Expert interview)
				Financing mechanism for **BBBMs in Alzheimer's disease diagnosis**	**0**	Funding for biomarkers is anticipated to be through the National Pathology budget. Evaluation will be through the newly developed Health Technology Evaluation Pathway (HTEP) led by Health New Zealand and supported by PHARMAC (Source: Expert interview)
				Financing mechanism for **CSF biomarkers in Alzheimer's disease diagnosis**	**0**	Funding for biomarkers is anticipated to be through the National Pathology budget. Responsibility for evaluation and procurement of medical devices is currently being decided - Health New Zealand or PHARMAC (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 4: Treatment monitoring and access						
18	**Alzheimer's disease treatment monitoring guidelines**	**0-6**	**1**	National clinical guidelines **treatment & monitoring coverage** (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**1**	BPAC guidance[447] : The guidelines cover dementia management, including: – Symptom management (pharmacological and non pharmacological) – Cognitive assessment monitoring (Mini-ACE suggested for follow-up) – Medicine reconciliation and reviews. – Regular 3-6 month reviews Alzheimer's disease is noted as the most common subtype, but treatment recommendations are framed for dementia broadly, not Alzheimer's disease-specific
				Inclusion of BBBMs in **treatment & monitoring guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No inclusion of biomarkers
				Inclusion of CSF biomarkers in **treatment & monitoring guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No inclusion of biomarkers

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
19	**Involvement of multi-disciplinary team**	**0-2**	**2**	Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**1**	BPAC guidance emphasizes primary care management, referral to geriatricians/neurologists if complex, and engagement with Alzheimers NZ/ Dementia NZ[448]
				Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologist, psychologists, social workers, occupational therapists, etc. for Dementia/ Alzheimers'	**1**	Example: The Memory Team was established in mid-2013 to improve services for people with memory problems, cognitive impairment and/ or dementia in the Counties Manukau area[449] . It is a multidisciplinary specialist service comprising staff with physical and mental health expertise, including geriatricians, nurses, occupational therapists, social workers, physiotherapists, and old age psychiatrists. There are a number of public memory teams nationally, with the CM and Canterbury teams catering for the largest volumes of patients[450]. The Canterbury clinic is the only neurologist-led clinic. If presenting symptoms are psychiatric then AD patients may be referred to older persons mental health clinics lead by psychogeriatricians/psychiatrists.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
20	**Linkage to supportive/ palliative care**	**0-2**	**1**	Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**0**	Referrals to supportive or palliative care services may take place within individual memory clinics, but no standardised national pathway exists (Source: Expert interview)
				Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**1**	In New Zealand, palliative care for individuals with dementia and Alzheimer's disease is increasingly recognised as a crucial component of end-of-life care, and efforts are being made to integrate it into the broader healthcare system. E.g., Dementia Care NZ is a leading aged care provider in New Zealand, specializing in person-centred care for elderly people, particularly those with dementia[451] They pioneered the 'Small Homes' and 'Best Friends Approach to Care' models locally and offer a full continuum of residential services, including rest home, dementia, hospital, and dementia hospital care. Their approach emphasizes compassionate, individualised support as a core mission.
21	**DMT access pathway readiness**	**0-5**	**1**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**1**	No DMT has been approved, submitted for review, or made available through any regulatory pathway (Source: Expert interview) At the 73rd Medicines Classification Committee meeting (held in early 2025), the committee recommended that lecanemab be officially added to the New Zealand Medicines Schedule as a prescription medicine[452] -this is a classification decision and not an approval.
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**0**	No DMT has been approved yet (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
22	**Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease/ Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.**	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	New Zealand's approach to dementia care is largely based on personalised, in-home services. While there is a strong focus on community and home-based support, virtual services are becoming more common. The COVID-19 pandemic and Te Pae Tata Interim New Zealand Health Plan 2022 has put the spotlight on the use of remote technologies to support the delivery of healthcare and whānau to manage their health from home using remote patient monitoring technology[453]
23	**Alzheimer's treatment & monitoring funding coverage**	**0-6**	**1**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**1**	Around one-third of patients receive funded anti-dementia drugs such as donepezil and rivastigmine[454] . Only symptomatic treatments are funded. (Source: Expert interview)
				Financing mechanism for BBBMs in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 5: Advocacy, awareness and education						
24	**Dementia/ Alzheimer's disease patient organisation engagement and advocacy**	**0-3**	**3**	Existence of patient/caregiver organisations	**1**	Alzheimers NZ is the national organisation representing people and their whānau living with dementia mate wareware in Aotearoa New Zealand[455]. Its role includes raising awareness of dementia mate wareware, providing information and resources, advocating for high-quality services, supporting research, and offering practical tools to help ensure people are heard, valued, and supported. Alzheimers NZ supports a network of local Alzheimers organisations across Aotearoa New Zealand, all of which are members of Alzheimers NZ. These local organisations deliver services directly within their communities, including information and education on dementia mate wareware, support for whānau and friends in caregiving roles, and support groups and day programmes for people living with dementia mate wareware.
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**1**	Alzheimers NZ and partner organisations are authors of the Dementia Mate Wareware Action Plan and hold leadership roles on the Dementia Mate Wareware Leadership and Advisory Group[456]
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**1**	– Alzheimers NZ National Helpline: Information and support for people living with dementia and carers[457] – Carer Support Subsidy: Financial support to help full-time carers take a break from caring[458] – Support for newly diagnosed individuals and families: Information packs, booklets, advocacy support, and links to local programmes provided by Alzheimers NZ[459] – Education and wellbeing (Dementia Learning Centre): Online courses, webinars, podcasts, etc[460].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
25	**Dementia/ Alzheimer's disease professional medical and scientific societies/ associations, research institutes engagement and advocacy**	0-4	3	Existence of professional medical and scientific societies/associations, research institutes focused on Dementia/ Alzheimer's disease	**2**	Dementia Prevention Research Clinics[461]
				Participation in national policy & plan development, and/ or joint programmes or initiatives with government agencies on Dementia / Alzheimer's disease	**1**	Personnel from the Dementia Prevention Research Clinics are actively involved in broader policy discussions within the dementia sector[462]
				Contributions towards clinical guidelines development	**0**	No medical or scientific society, association, or research institute is listed as a contributor in national clinical guidelines
26	**Dementia / Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)**	0-21	12	[Patient] Availability of patient education programmes and support resources initiated / driven by patient / caregiver organisations	**2**	Alzheimers NZ provides nationwide dementia education/support and e-learning[463]
				[Patient] Availability of patient education programmes and support resources initiated / driven by the professional medical and scientific societies / associations, research Institutes focused on Dementia / Alzheimer's disease	**0**	No educative programmes or resources related to Dementia or Alzheimer's are driven by the Professional Medical and Scientific Societies / Associations, Research Institutes focused on Dementia / Alzheimer's
				[Patient] Availability of patient education programmes and support resources initiated / driven by the government	**2**	The government supports a wide range of community-based education, primarily delivered through local Alzheimers and Dementia organisations. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[Caregiver] Availability of caregiver-focused education, training, and support services on Dementia / Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines) Can be driven by: – Patient or caregiver organisation – Professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease – The government	**2**	Dementia Learning Centre aims to empower health professionals, care providers, and the wider community with the knowledge, attitudes, and understanding needed to improve care and support[464]
				[All] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	World Alzheimer's Month 2025 (NZ)[465]: – National campaign: radio ads, social media videos featuring the Lived Experience Advisory Group – Local initiatives: Memory Walks, library events, Artful Mind Exhibition, awareness workshops – Summit 2025: launch of refreshed Dementia Mate Wareware Action Plan, infographics, and World Alzheimer Report 2025 – Advocacy campaign: "What's our point" promoting government support for people with dementia and their whānau

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[Healthcare providers] Availability of clinical education for **primary care providers**	**2**	Professional Development Education via Dementia New Zealand[466] Dementia care for Māori short course - Goodfellow Unit (2019) - Cultural communication, diagnosis, and long-term dementia care for Māori patients and whānau; free, 1 CPD hour. Recognising and managing early dementia - BPAC (2020) - RNZCGP-endorsed guidance for early dementia recognition and management; 1 CME credit per hour. Living well with dementia - Goodfellow Unit (2020) - Podcast for primary care diagnosis, whānau/community involvement, and practical patient/carer support. Dementia update - Pharmac (2017) - Presentations on screening, management, psychological impact, behavioural symptoms, and late-stage care in general practice. Management of dementia in primary care - BMJ Learning - Covers dementia management and behavioural/ psychological symptoms; free for RNZCGP members (1 hr). Recognising, Diagnosing and Managing Dementia in General Practice - Dementia Training Australia - Four-module online course (4 hrs) on recognition, diagnosis, progression, and management in GPs
				[Healthcare providers] Availability of **specialist training** in Dementia/ Alzheimer's care	**2**	There are courses provided by various universities throughout New Zealand for healthcare workers at every level[467] . For example, BPAC released new guidance on recognising and managing early dementia in February 2020. Reading an article on bpac.org.nz is endorsed by the Royal New Zealand College of General Practitioners (RNZCGP) as a Continuing Professional Development (CPD) activity. Every hour spent reading articles earns one Continuing Medical Education (CME) credit.

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Singapore

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
Singapore	Moderately high	Low	Moderately low	Moderately high	High

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	**Existence and operational status of national Alzheimer's disease policies / strategies / plans**	**0-4**	**3**	Existence and operational status of national Alzheimer's disease policies / strategies / plans	**2**	National Dementia Strategy (NDS)[468] – Year of publication: 2009 (revised 2017) – Issuing body / author: Ministry of Health (MOH), Singapore – Overall description: Guide the MOH, public healthcare institutions (PHIs), and community service providers in developing and implementing services to care for persons with dementia and support their caregivers. – An updated dementia strategy is expected to be released soon (Source: Expert interview)
				Currency of the national policies / strategies / plans	**1**	1) National Dementia Strategy (NDS)[469]: MOH developed the NDS in 2009 in consultation with partners including clinical experts on dementia care. The NDS was reviewed and updated in 2017 to meet the evolving needs of persons with dementia and their caregivers.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
2	**Priority & specificity of Alzheimer's disease in national policies / strategies / plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	National Dementia Strategy (NDS)'s key elements include increasing awareness of dementia and promoting early detection of the condition[470]
3	**Coordinating mechanism for implementation**	**0-4**	**2**	Dedicated national Alzheimer's disease programmes / initiatives	**1**	1) Dementia-Friendly Singapore (DFSG)[471] The Dementia-Friendly Singapore (DFSG) is a national initiative announced by the Ministry of Health (MOH) in 2016 to address dementia prevalence in Singapore. This was spun off from the ground up Forget Us Not campaign by Lien Foundation, KTPH and partners in making Chong Pang dementia-friendly in 2015. Under DFSG, the Agency for Integrated Care (AIC) and community partners aim to build dementia-friendly communities and nations to support persons living with dementia through the 3Es strategy. The desired outcomes are promotion of preventive activities, encouraging early identification and provision of care and support. 2) Day & Home care capacity[472] Since 2015, the Ministry of Health (MOH) has added 4,600 day care places and 3,100 home care places to ensure that we have sufficient capacity of home and day care services to support aging in place in the community. The pilot on night respite care for dementia patients has been extended as it was suspended for a period of time due to the COVID-19 pandemic. 3) Crest - Community outreach teams[473] They add to a host of existing ones that the Government has put in place over the years, as it aims to build a dementia-inclusive Singapore. As part of the 2015 action plan for successful aging, the Government has already established 15 dementia-friendly communities in neighbourhoods such as Yishun, Bedok and Toa Payoh East.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Joint national and regional Alzheimer's disease coordination mechanisms	**1**	Singapore demonstrates coordination between national and subnational levels through the Ministry of Health and the Agency for Integrated Care, which collaborate with community service providers and regional teams to deliver dementia outreach, screening, and care services[474]. This includes the deployment of 48 community outreach teams across regions to identify at-risk seniors and refer them to national healthcare institutions, aligning local implementation with national dementia strategies.
4	**Alzheimer's disease financing**	**0-6**	**3**	Dedicated budget to Alzheimer's disease programmes	**1**	Government grants were provided to Dementia Singapore (S$9.7M in 2023, SGD$11.8M in 2024). Broader funding includes S$3.5B for Age Well SG (supports seniors aging in community), and top-ups to eldercare funds like CST, SMF[475]. Services and funding support dementia and aging populations, but no specific Alzheimer's allocation is detailed.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
4				Funding / insurance coverage for Dementia / Alzheimer's disease Care (Public)	**1**	Government subsidies are available for dementia care at public healthcare institutions[476]. Singaporeans who require inpatient care can receive government subsidies of up to 80% in subsidised wards, and may use MediShield Life and MediSave to help pay hospital bills. For outpatient care, Singaporeans are eligible for subsidies at specialist outpatient clinics in public hospitals, polyclinics, and general practitioner clinics under the Community Health Assist Scheme. Dementia is a qualifying chronic condition under this scheme. Following enhancements in November 2023, all Singaporeans are eligible for chronic condition subsidies regardless of income. The annual subsidy cap for Community Health Assist Scheme Blue and Orange cardholders with complex chronic conditions was increased from S$500 to S$520 and from S$300 to S$320 per year, respectively. Seniors under the Pioneer Generation and Merdeka Generation schemes receive additional subsidies across outpatient settings. Singaporeans may also use MediSave for outpatient dementia treatment under the Chronic Disease Management Programme, with withdrawals of up to S$500 per year, increasing to S$700 per year for patients with complex chronic conditions from 1 January 2021. Those aged 60 years and above may withdraw up to S$200 under Flexi-MediSave. Patients who face financial difficulty may seek additional assistance through MediFund at public healthcare institutions.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Funding / insurance coverage for Dementia / Alzheimer's disease (Private & alternatives)	**1**	Partially funded, Alzheimer's disease specifically mentioned – AIA Centurion PA Plan[477]: Launched August 2023, the first personal accident plan covering neurological diseases, including Alzheimer's and severe dementia. Up to S$100,000 lump-sum upon diagnosis (early to late-stage), reimbursement of up to S$20,000 for home/day-care services over 24 months. – MSIG CriticalCare Plus[478]: Introduced September 2024, a critical illness plan including Alzheimer's/severe dementia among its five major illnesses. offering up to S$100,000 lump-sum payout on first diagnosis
5	**Existence of registries established for Alzheimer's disease**	**0-5**	**2**	Existence of registries established for Alzheimer's disease	**0**	Singapore does not maintain a formal, continuous national registry for dementia or Alzheimer's. Instead, national prevalence data and epidemiological insights are primarily derived from large-scale, comprehensive epidemiological studies, notably the Well-Being of the Singapore Elderly (WiSE) studies conducted by the Institute of Mental Health (IMH)[479]. These studies provide snapshots of prevalence and associated factors. Singapore's approach relies heavily on large-scale, periodic epidemiological studies and advanced research cohorts to generate national prevalence data and insights into dementia types and biomarkers, serving as a robust alternative to a continuous registry. The repeated citation of the WiSE studies as the primary source of national prevalence data, rather than an ongoing registry, is a crucial observation.
				Integration of Dementia-specific tracking in EMR systems	**2**	EMRs include structured dementia diagnosis fields and some cognitive or functional assessments, used in some settings (e.g., hospitals, memory clinics). Limited data sharing or coordination. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
6	**Inclusivity and equitable policy formulation**	**0-8**	**4**	Policies / strategies / plans / programmes addressing equitable access to care to Alzheimer's	**0**	There is no dementia- or Alzheimer's-specific policy on equitable care access. Broader elderly-focused programmes includ[480]: CHAS subsidies for chronic disease (up to S$520/year), MediSave withdrawals (up to S$700/year), and financial assistance via MediFund. The Home Caregiving Grant (S$400/month) and caregiver support programmes ease financial burden but are not dementia-specific.
				Policy recognition of preclinical Alzheimer's disease / Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	**2**	National Dementia Strategy (NDS) (2017) promotes early detection by increasing awareness and establishing community outreach teams[481]. These teams, set up by the Ministry of Health and the Agency for Integrated Care, work with community providers to identify seniors showing signs of dementia and refer them for further assessment at primary healthcare institutions. As of June 2020, 48 teams had reached over 324,000 people, with plans to expand further.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	**1**	General Dementia and Alzheimer's patient navigation programmes exist for underserved communities (Source: Expert interview)
				Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	**1**	Under the Dementia-Friendly Community Framework, SGD $160 million has been committed to enable dementia-friendly neighborhoods and initiatives such as Go-To Points[482], HACK Care home modifications[483], and caregiver social groups. However, this funding spans other mental health conditions and does not specifically target Alzheimer's patients or at-risk groups.
7	**National Alzheimer's disease clinical guidelines availability and implementation**	**0-6**	**4**	Availability of clinical guidelines on Alzheimer's disease	**2**	- Guideline: MOH Clinical Practice Guidelines for Dementia[484] - Author: Ministry of Health - Issue year: 2013 - The guideline includes Alzheimer's-specific information where relevant, for example, Pharmacological management of dementia for individuals diagnosed with Alzheimer's disease, but does not contain a dedicated section with Alzheimer's disease clinical protocols. The Agency for Care Effectiveness (ACE) will be publishing the ACE Clinical Guidelines for Dementia (not just Alzheimer's disease) by the end of 2025 (Source: Expert interview)
				Currency of clinical guidelines	**0**	2013[485]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
8	**Policy support for preventive care**	**0-2**	**1**	National policies focused on primary prevention / modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	Relevant targets include[486 487]: – 30% relative reduction in the mean population intake of salt/sodium by 2025 – 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances – halt the rise in obesity and diabetes – As part of the revised Singapore's Nationally Determined Contribution (NDC) emissions target 2030, Singapore pledged to reduce emissions to around 60 MtCO2e in 2030
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health / cognitive screening or monitoring)	**0**	The National Dementia Strategy (2017) focuses on service development and caregiver support, but does not include cognitive screening or monitoring as a strategic action[488]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	**0-6**	**5**	Funding for Alzheimer's disease research: Investment in / funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	**2**	Alzheimer's disease - specific 1) In 2016-2020, the Alzheimer's disease THErapy with NEuroaid (ATHENE) Study—a randomized controlled trial evaluating Neuroaid II in mild to moderate Alzheimer's patients-received SGD 675,000 in funding[489] 2) Singapore has in place the building blocks of a world-class dementia innovation ecosystem. It is an innovator in dementia management, especially in healthcare system preparedness. However, the country's nascent dementia research efforts could be more developed and coordinated. Singapore's dementia innovation ecosystem could be improved through greater attention to issues of funding, data integration, and support for drugs' clinical development (cohort development and clinical trials support/ partnerships) [490] 3) Singapore actively invests in dementia research through a strong network of public funding, academic institutions, and targeted research initiatives. Under the Healthy and Meaningful Longevity Initiative, the National Medical Research Council (NMRC) launched a Cognition grant, offering up to SGD 4 million per project (inclusive of 30% indirect costs) over four years, specifically targeting prevention, early detection, and scalable community interventions for dementia[491].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
						4) There are numerous institutes and hospitals actively conducting research on MCI and dementia, supported by the National Medical Research Council (NMRC) and other funding bodies. At the National Neuroscience Institute (NNI), multiple NMRC- and externally funded cohort studies and clinical trials are ongoing. In addition, the Geriatric Education & Research Institute (GERI) conducts research focused on ageing and cognition, while the Dementia Research Centre (DRC) at Lee Kong Chian School of Medicine - Nanyang Technological University (LKC-NTU) undertakes complementary work in this field. Collectively, these centres are engaged in cohort studies incorporating MRI, biomarker assessments, digital screening tools, and interventional research. (Source: Expert interview)
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	**2**	Alzheimer's-focused pharmacological trials (e.g., lecanemab, Alzheimer's disease and lifestyle-based RCTs (e.g., SINGER) are actively conducted. Institutions like the Memory Aging and Cognition Centre (MACC)[492] and the National University Health System (NUHS)[493] coordinate infrastructure for both Alzheimer's disease-specific and dementia-related trials. At the National Neuroscience Institute (NNI), the team is actively involved in clinical trials for novel pharmaceutical therapies and medical technology devices. Current and recent studies include the previous TauRx trial, an upcoming anti-tau clinical trial, the NeuroAiD trial, an IRB-approved transcutaneous pulsed stimulation trial for patients with MCI, and an ongoing lymphovenous anastomosis (LVA) trial for Alzheimer's disease (Source: Expert interview))
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	**1**	Typical time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice is more than 3 years (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 2: Prevention & screening (early detection)						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**2**	National clinical guidelines **screening coverage** for high-risk population For example: Older adults (e.g. ≥65 years) Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression	**1**	Individuals who should be evaluated for dementia include those with progressive cognitive or behavioural complaints suggestive of dementia, as well as patients who arouse the physician's or caregiver's suspicion of cognitive impairment despite the absence of complaints[494]
				Inclusion of validated cognitive assessment tools in **screening guidelines** For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	National screening guidelines for Dementia / Alzheimer's explicitly recommend one or more validated cognitive assessment tools (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Inclusion of BBBMs in **screening guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarker is mentioned for screening
				Inclusion of CSF biomarkers in **screening guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening
	Alzheimer's disease screening funding	**0-6**	**0**	Funding for **validated cognitive assessment tools in screening** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	No specific funding for cognitive screening; general dementia treatment subsidies but no specific screening reimbursement
				Financing mechanism for **BBBMs in Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
	Alzheimer's disease diagnosis guidelines	**0-7**	**2**	National clinical guidelines **diagnosis coverage**	**1**	Clinicians should make a diagnosis of a specific type of dementia based on the available criteria. A number of well-validated clinical criteria may be used for the various types of dementia (Alzheimer's disease, vascular dementia, dementia with Lewy bodies, Parkinson's disease dementia, and fronto-temporal dementia)[495]
				Inclusion of validated cognitive assessment tools in **diagnostic guidelines** For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	In individuals with suspected cognitive impairment, diagnosis should be made using the DSM-IV criteria for dementia with history from a reliable informant. This should be supplemented by an objective approach, with bedside cognitive tests and/or neuropsychological assessment[496]
				Inclusion of BBBMs in **diagnostic guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No BBBMs recommended or mentioned for diagnosis

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Inclusion of CSF biomarkers **diagnostic guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No CSF biomarkers recommended or mentioned for diagnosis
	Capacity of / Availability of/ access to diagnostic infrastructure and services	**0-18**	**6**	MRI	**1**	0.078 per ten thousands of population[497]
				CT	**1**	Low (0-0.30 machines per ten thousands of population) (Source: Expert interview)
				PET	**1**	<=0.5 machines per per 1 million population) (Source: Expert interview)
				CSF Biomarker testing	**2**	Major hospitals (e.g., NUH, National Neuroscience Institutes @ Tan Tock Seng Hospital (NNI-TTSH)) list CSF/ Alzheimer evaluation tests; CSF biomarker testing is available in tertiary centres and used clinically[498]
				BBBMs testing	**1**	At the NNI, Simoa p-tau217 testing has been conducted under research protocols for the past two years. In parallel, NNI is actively validating Roche and other p-tau217 assays to support biomarker development and clinical research efforts.(Source: Expert interview)
	Tracking of time to diagnosis for Alzheimer's disease	**0-2**	**0**	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**0**	There is no evidence that the country or relevant stakeholders track or report time to diagnosis for Alzheimer's disease or dementia (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)	**0-12**	**4**	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary public institutions	**1**	<50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting	**1**	<50% (Source: Expert interview)
	Capacity of workforce	**0-16**	**10**	Geriatricians / Psychogeriatricians	**3**	(Statista, 2023) Number of registered geriatric medicine specialists : 2.8[499]
				Neurologists	**2**	(Singapore Medical Council, 2023) 2.32[500]
				Psychiatrist working in mental health sector	**2**	(MOH, 2021) Number of psychiatrists (per 100,000): 4.6[501]
				Social workers working in mental health sector	**3**	Moderately high (>10-20 staffs per 100k of population) (Source: Expert interview)
	Alzheimer's disease diagnostics funding coverage	**0-6**	**1**	Funding for **validated cognitive assessment tools in Alzheimer's disease / Dementia diagnosis** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	AIA[502]- "In response to these findings, AIA Centurion PA plan was developed to provide people with more accessibility to cover themselves for neurological diseases by offering the first-in-market optional rider attached to a personal accident plan, where lump-sum payouts for the diagnosis of early, intermediate, and late stage Alzheimer's Disease/ Severe Dementia and Idiopathic Parkinson's Disease are available for up to S$100,000."

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Financing mechanism for **BBBMs in Alzheimer's disease diagnosis**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers in Alzheimer's disease diagnosis**	**0**	CSF biomarker tests for diagnosis are partially funded or reimbursed (Source: Expert interview)
Domain 4: Treatment monitoring and access						
	Alzheimer's disease treatment monitoring guidelines	**0-6**	**2**	National clinical guidelines **treatment & monitoring coverag**e (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**2**	Pharmacological treatments are specifically mentioned for Alzheimer's disease: Memantine (an N-methyl D-aspartate antagonist) may be used to treat mild to moderate Alzheimer's disease when acetylcholinesterase inhibitors are contraindicated, not tolerated, or ineffective[503]
				Inclusion of BBBMs in treatment & monitoring guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarkers recommended or mentioned for treatment & monitoring
				Inclusion of CSF biomarkers in treatment & monitoring guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarkers recommended or mentioned for treatment & monitoring

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**1**	Patients with young onset dementia should receive specialist multidisciplinary care for the diagnosis and management of their condition[504]
	Involvement of multi-disciplinary team	**0-2**	**2**	Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologists, psychologists, social workers, occupational therapists, etc. for Dementia / Alzheimers'	**1**	1) Singhealth Duke NUS Memory and Cognitive Disorders Centre is a good example of multidisciplinary team care and cutting edge dementia treatments[505]. The SingHealth Duke-NUS Memory and Cognitive Disorder Centre was established in March 2020 to meet this need. The virtual Centre is a network that brings together the strengths and expertise of healthcare professionals from different specialties across SingHealth institutions to help patients access multi-disciplinary treatment and support at all stages of their dementia journey. 2) NNI serves as the major centre for young-onset dementia (YOD) referrals, evaluation, and treatment. Services incorporate neurology expertise, biomarker testing, and YOD-focused interventions. This includes the bespoke NNICE programme (NNI Cognitive Engagement and Rehabilitation Programme), which aims to provide patients with YOD meaningful vocational and employment-related opportunities as part of cognitive rehabilitation. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Linkage to supportive/ palliative care	**0-2**	**2**	Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**1**	Summary of the palliative care guidance for advanced dementi[506]: Patients with advanced dementia should be regularly assessed and treated for pain using a stepped pharmacological protocol, such as the WHO analgesic ladder or American Geriatric Society guidelines. Antibiotic use should be individualised by weighing risks and benefits. Tube feeding decisions should be personalised due to insufficient evidence of benefit. Advance care planning, especially regarding CPR, is recommended because of the poor outcomes of CPR in advanced dementia.
				Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**1**	1) Singapore has a well-developed and evolving system for palliative care that is increasingly extending its focus to include individuals with dementia and Alzheimer's disease. E.g., Organisations like the Singapore Hospice Council (SHC) and its members including HCA Hospice Limited, Assisi Hospice, and Dover Park Hospice, are at the forefront of providing specialist palliative car[507]. 2) All government acute care hospitals in Singapore have established palliative care services. They provide inpatient and outpatient care, and many also collaborate with community partners to ensure a seamless transition for patients moving from acute care to community-based settings. Khoo Teck Puat Hospital (KTPH), for example, has dedicated inpatient wards for patients with dementia and provides palliative care services as part of its integrated geriatric care[508].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	DMT access pathway readiness	**0-5**	**5**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**3**	The Health Sciences Authority (HSA) approved lecanemab (LEQEMBI®) in May 2025[509] , and donanemab (Kisunla) in early 2025[510], classifying them as prescription-only medicines requiring initiation by a physician experienced in Alzheimer's disease diagnosis and treatment
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**2**	Health Sciences Authority (HSA) guide to HCPs: The presence of Aβ pathology must be confirmed using approved methods such as amyloid PositronEmission Tomography (PET) scan or cerebrospinal fluid (CSF) analysis or equivalent validated
	Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease / Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	Singapore has been gradually integrating telemedicine and remote patient care into its dementia support ecosystem. E.g., Telehealth platforms enable patients to access mental health professionals remotely, providing consultations for conditions including dementia[511].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Alzheimer's treatment & monitoring funding coverage	**0-6**	**1**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**1**	Donepezil, rivastigmine, and memantine subsidised up to 75% for citizens[512]
				Financing mechanism for BBBMs in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 5: Advocacy, awareness and education						
	Dementia/ Alzheimer's disease patient organisation engagement and advocacy	**0-3**	**3**	Existence of patient / caregiver organisations	**1**	Dementia Singapore[513] was formed in 1990 as the Alzheimer's Disease Association to support Singapore's growing dementia community, raise awareness, and reduce stigma. It is a leading Social Service Agency specialising in dementia care, advocating for the needs of people living with dementia and their families, building community capability through knowledge and consultancy, and delivering person-centred care innovations.
						Dementia Singapore is registered as a Company Limited by Guarantee (UEN: 202111519K), is a registered Charity, and is recognised as an Institution of a Public Character. It is a member of the National Council of Social Service and Alzheimer's Disease International, has been appointed a Centre of Specialisation by the National Council of Social Service since 2007, and is one of eight Learning Institutes under the Agency for Integrated Care Learning Network.
				Participation in national policy & plan development, and/ or joint programmes with government	**1**	Dementia Singapore participates in the Dementia-Friendly Singapore initiative, a national programme launched by the Ministry of Health to address dementia prevalence[514]
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**1**	Dementia Singapore[515] -"Dementia Helpline: 6377 0700"

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Dementia/ Alzheimer's disease professional medical and scientific societies / associations, research institutes engagement and advocacy	**0-4**	**3**	Existence of professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease	**1**	National Neuroscience Institute (NNI)[516]
				Participation in national policy & plan development, and/or joint programmes or initiatives with government agencies on Dementia / Alzheimer's disease	**1**	Key research and clinical institution actively collaborated with the Ministry of Health on dementia strategy, including the National Dementia Strategy 2021-2030 (Source: Expert interview)
				Contributions towards clinical guidelines development	**1**	Medical or scientific societies, associations, or research institutes contributed to national Dementia and/or Alzheimer's clinical guidelines (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Dementia / Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)	**0-21**	**15**	[Patient] Availability of patient education programmes and support resources initiated / driven by patient / caregiver organisations	**3**	Broader Dementia and Alzheimer's–specific programmes or resources are run by patient organisations (but not Alzheimer's-only) (Source: Expert interview)
				[Patient] Availability of patient education programmes and support resources initiated / driven by the professional medical and scientific societies / associations, research Institutes focused on Dementia / Alzheimer's disease	**2**	Broader Dementia and Alzheimer's–specific programmes or resources are run by civil society organisations (but not Alzheimer's-only) (Source: Expert interview)
				[Patient] Availability of patient education programmes and support resources initiated / driven by the government	**2**	The Ministry of Health, via agencies like AIC, delivers dementia public education programmes and toolkits, caregiver subsidies, and dementia-friendly community initiatives - not limited to Alzheimer's disease but effective for public knowledge[517]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[Caregiver] Availability of caregiver-focused education, training, and support services on Dementia / Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines) Can be driven by: – Patient or caregiver organisation – Professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease - The government	**2**	Dementia Singapore provides caregiver support services to empower caregivers of people living with dementia[518]. These include a national helpline, community support teams (COMIT and CREST) for assessment, therapy, outreach, and awareness, caregiver support groups and networks for education, respite, and self-care, an Elderly home respite service, and Memories Café for social engagement in dementia-friendly settings. Dementia Singapore also offers a fully funded, eight-session caregiver programme designed to help caregivers better understand dementia, respond to behavioural changes, and provide care with confidence and compassion. Programme topics include understanding and managing dementia, handling challenging behaviours, home care for a person with dementia, and the importance of caregiver self-care.
				[All] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	Singapore's Health Promotion Board has commissioned a film that raises awareness of dementia[519]. It has also launched a series of dementia awareness initiatives on social media and TV in different languages. Lien Foundation, Khoo Teck Puat Hospital, and the local Alzheimer's association have collaborated on the Forget Us Not campaign that trains the public to recognise and help people with dementia[520].
				[Healthcare providers] Availability of clinical education for **primary care providers**	**2**	Dementia Singapore[521] - "Dementia Singapore Academy (DSA) is the training and consultancy arm of Dementia Singapore, which provides training programmes for professionals and members of the public, as well as consultancy services for agencies providing dementia care services."
				[Healthcare providers] Availability of **specialist training** in Dementia/ Alzheimer's care	**2**	NNI offers a Cognitive Neurology and Dementia Fellowship for clinical fellows to gain advanced skills in diagnosing and managing cognitive disorders, including dementia, alongside research training in cognitive neurology[522]

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South Korea

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
South Korea	High	Moderately low	Moderately high	Moderately high	High

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	**Existence and operational status of national Alzheimer's disease policies / strategies / plans**	**0-4**	**3**	Existence and operational status of national Alzheimer's disease policies / strategies / plans	**2**	National Dementia Plan[523 524] – Year of publication: 2008 (Revised 2012, 2016, 2020, 2023) – Author/Issuing Body: Ministry of Health and Welfare – Overall description: Focused on prevention, early detection, and early post-diagnosis management of Dementia; integrated digital supports like check Dementia app; extended governance across community, regional, and national coordination systems. The South Korean government has issued four NDPs since 2008, with the latest one spanning from 2021 to 2025 alongside targets for 14 KPIs to be met by 2025. In August 2011, South Korea enacted the Dementia Management Act which became effective from February 2012. This act sets out the statutory obligations for the government to formulate a new NDP once every five years.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
						– 2008 – 1st NDP: Launched as a declaration of a "War against Dementia" – Subsequent plans (2nd, 3rd, and 4th) have pursued a series of strategic shifts: The first two NDPs were provider-centred and focused on building the infrastructure for dementia care. Starting with the 3rd NDP, and continuing into the 4th NDP (2021–2025), the approach became more user- and community-based, integrating existing infrastructures to maximise cost-effectiveness and deliver comprehensive care
				Currency of the national policies / strategies / plans	**1**	National Dementia Plan[525 526] - Year of publication: 2008 (Revised 2012, 2016, 2020)
2	**Priority & specificity of Alzheimer's disease in national policies / strategies / plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	Policies, strategies, or plans include Dementia-specific targets, but not specific to Alzheimer's disease[527 528]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
3	**Coordinating mechanism for implementation**	**0-4**	**2**	Dedicated national Alzheimer's disease programmes / initiatives	**1**	NDP-4 is a dedicated national programme coordinated by the Ministry of Health and Welfare as the lead body and the National Dementia Center, which supports strategic research, data, education, and national-level coordination[529]. (1) Vision: A dementia-friendly society where people with dementia live well with family and neighbours. (2) Goals: Support safe, comfortable living at home and in the community; increase registration and management by local dementia centres from 50% (2019) to 80% (2025)
						(3) Key priorities and 2025 targets – Prevention & early care: Early screening for seniors 75+ living alone (61%); intensive early treatment with insurance-covered caregiver counselling (implemented); service use among mild dementia patients 60+ (90%) – Care capacity & caregiver support: Short-term respite providers (350); family-caregiver leave (12 days/year); Medical Cost of Dementia Support income eligibility (140% of median income) – System & infrastructure: Case managers/ care coordinators (512); trained dementia professionals (70,000); specialised long-term care institutions (310); dementia relief hospitals (22) – Research & society: Integrated dementia data system (implemented); positive public attitudes (68%); "dementia partners" (2 million)
				Joint national and regional Alzheimer's disease coordination mechanisms	**1**	South Korea demonstrates strong coordination between national and subnational levels through its three-tier dementia management system: the National Institute of Dementia leads national strategy and system development, while 17 regional dementia centers and 256 local centers implement services on the ground - including early screening, prevention, and family support - ensuring alignment of national policy with regional and community-level care delivery[530].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
4	**Alzheimer's disease financing**	**0-6**	**3**	Dedicated budget to Alzheimer's disease programmes	**1**	Compared to the comprehensive management plan, the budget component appears somewhat limited relative to other advanced countries. However, it may be more appropriate to consider the overall healthcare budget rather than focusing solely on funds specifically allocated to Alzheimer's disease.(Source: Expert interview) MOHW allocated ₩239.0B in 2023 for dementia-related policies, with ~80% directed to the nationwide dementia management system and 14% for expanding care facilities [531]. In 2019, the government pledged ₩1 trillion after President Moon called for state responsibility in dementia care. However, these allocations target dementia care as a whole, without separating Alzheimer's disease-specific funding.
				Funding / insurance coverage for Dementia / Alzheimer's disease Care (Public)	**1**	Coverage for Dementia, not specific for Alzheimer's disease [532] Early screening and diagnosis: The National Dementia Early Detection Programme (since 2010) provides free screening every two years for residents aged 60+ at local dementia centres. The National Health Insurance Service also offers screening at age 66, with biennial follow-up. Older adults identified with cognitive decline can access in-depth evaluation and differential diagnosis, subsidised for those earning below 120% of median income, up to KRW 150,000 (diagnostic evaluation) and KRW 110,000 (differential diagnosis). In 2021, about 70% (≈407,000) of those identified pursued further assessment. Long-term care insurance: Since 2008, dementia patients co-pay only 15–20% for long-term care benefits. Eligibility was expanded in 2014 to include a special dementia level, and in 2018 with a cognitive assistance level for those with preserved physical function. In 2021, 360,070 dementia patients were approved under the "5+1" structure. Support outside long-term care: Older adults with mild dementia not eligible for long-term care can receive up to 40 hours/month of customised services (e.g. housekeeping, daily living assistance, safety checks), supporting about 130,000 people in 2021. Low-income patients may also receive subsidies for dementia medication and medical expenses, capped at KRW 360,000 per year.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Funding / insurance coverage for Dementia / Alzheimer's disease (Private & alternatives)	**1**	Partially funded, Alzheimer's disease specifically mentioned. E.g., – Insurer: Heungkuk Fire & Marine Insurance – Product: Targeted Dementia Drug Authorised Treatment Cost special rider (renewable every 5 years) – Exclusivity: 9-month exclusive use right granted by the General Insurance Association; similar products cannot be launched during this period – Coverage: Innovative Alzheimer's treatments that remove amyloid beta protein (e.g. Leqembi), including future drugs with the same effect – Eligibility & payout: For patients diagnosed with very mild dementia (CDR 0.5) or mild Alzheimer's dementia, with confirmed amyloid beta accumulation; one-time payout up to KRW 10 million if treatment is given at least seven times
5	**Existence of registries established for Alzheimer's disease**	**0-5**	**4**	Existence of registries established for Alzheimer's disease	**2**	(1) JOYALZ Registry [533]: JOYALZ is a multi-center, real-world registry project launched by the Korean Dementia Association (KDA) to advance both clinical care and basic research in Alzheimer's disease. In response to rapid advancements in Alzheimer's disease treatments and diagnostic technologies, JOYALZ was established to systematically collect and analyse real-world data on new Alzheimer's disease drugs and diagnostic tools approved since 2021. The registry aims to capture prescription patterns, long-term safety and efficacy of treatments, and patient outcomes in clinical settings. It also gathers data on the utilisation and effectiveness of novel diagnostics. By sharing this data, JOYALZ fosters collaboration among clinicians, researchers, and experts, with the vision of improving Alzheimer's disease understanding, enhancing prevention and treatment strategies, and contributing to a world free from the burden of Alzheimer's. (2) Korean Dementia Registry and Management System (K-DReaMS) [534]:

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
						K-DReaMS is South Korea's large-scale registry and management system for dementia, maintained by the Korean National Institute of Dementia. It captures data on older adults nationwide, with nearly 45% of individuals aged 65 and above included. Among them, 8% have a confirmed dementia diagnosis. Beyond collecting diagnostic data, K-DReaMS plays a broader role in standardizing the services provided by local dementia centers and coordinating support for people living with dementia and their families. This comprehensive system not only supports monitoring and early detection but also strengthens the nationwide care infrastructure for dementia. (3) National Brain Biobank of Korea [535]: The National Brain Biobank of Korea is being established as a research platform to advance understanding of brain diseases, including dementia. It collects comprehensive antemortem clinical data - such as neuropsychological test results, blood tests, and imaging - as well as postmortem pathological data from patients. This includes individuals within dementia cohorts. By integrating both clinical and pathological information, the biobank supports high-quality, large-scale research aimed at improving the diagnosis, treatment, and prevention of dementia and related neurodegenerative disorders.
				Integration of Dementia-specific tracking in EMR systems	**2**	A key strength of EMRs in South Korea is their explicit use for retrieving and analysing standardised dementia assessment scores [536]. These include widely recognised tools such as the Mini-Mental State Examination (MMSE), Clinical Dementia Rating (CDR), and Global Deterioration Scale (GDS) for Alzheimer's disease patients. This direct integration of validated assessment tools into the EMR allows for precise and consistent monitoring of cognitive function and disease progression. No specific info on interoperability.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
6	**Inclusivity and equitable policy formulation**	0-8	6	Policies / strategies / plans / programmes addressing equitable access to care to Alzheimer's	1	Policy efforts include the Long-Term Care Insurance scheme, which added dementia-specific eligibility tiers in 2014 and 2018 for people with cognitive decline [537]. Residents aged 60+ with income below 120% of the median qualify for subsidies (150,000 won for cognitive testing; 110,000 won for imaging/ blood tests). Free national cognitive screening is available every two years for those aged 60+, with a transition screen at age 66.
				Policy recognition of preclinical Alzheimer's disease / Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	2	South Korea has implemented the National Dementia Early Detection programme since 2010, offering free cognitive screening every two years to all residents aged 60 and above through local dementia centres [538]. In 2021, over 3.8 million older adults were screened, with 579,000 (15%) diagnosed with cognitive decline. In parallel, the National Health Insurance Service (NHIS) provides additional screenings starting at age 66 - considered a key transition into old age - with follow-up tests every two years. In 2021, 2.5 million elderly underwent NHIS screenings, identifying 281,000 cases (11%) of cognitive decline.
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	2	The 3rd National Dementia Plan introduced community-based services, including a 24-hour short-term visiting care service (up to 6 days per year), offering in-home respite for patients with severe impairment [539]. This expansion of home care aims to address gaps in institutional care, particularly in underserved rural areas.
				Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	1	South Korea funds multiple community-based dementia services, such as mobile visiting services, day/night care expansion, and housing safety support [540]. These services support dementia patients broadly and are not Alzheimer's-specific or designed for targeted at-risk populations.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
7	**National Alzheimer's disease clinical guidelines availability and implementation**	**0-6**	**6**	Availability of clinical guidelines on Alzheimer's disease	**2**	(1) Clinical Practice Guideline for Dementia: Part 1, Diagnosis and Evaluation" (2021 Revised Edition)[541] – Author: Korean Dementia Association – Latest update: 2021 – A cornerstone document, emphasizing evidence-based diagnostic approaches – The Clinical Practice Guideline for Dementia (Diagnosis and Evaluation): 2021 Revised Edition includes only brief references to Alzheimer's disease e.g., Can performing amyloid PET scans in patients with MCI or dementia improve the accuracy of Alzheimer's disease diagnosis, without a dedicated section. (2) Clinical Practice Guidelines for Dementia: Recommendations for the Pharmacological Treatment of Behavioral and Psychological Symptoms[542] – Author: Korean Dementia Association – Issue year: 2025 – A separate guideline specifically addresses the pharmacological treatment of behavioral and psychological symptoms of dementia (BPSD) – The Clinical Practice Guidelines for Dementia: Pharmacological Treatment of BPSD briefly mention Alzheimer's disease, e.g., recommending citalopram for agitation in Alzheimer's disease, but include no dedicated section on Alzheimer's disease
				Currency of clinical guidelines	**2**	(1) Clinical Practice Guideline for Dementia: Part 1, Diagnosis and Evaluation" (2021 Revised Edition)[543] – Author: Korean Dementia Association – Latest update: 2021 (2) Clinical Practice Guidelines for Dementia: Recommendations for the Pharmacological Treatment of Behavioral and Psychological Symptoms[544] – Author: Korean Dementia Association – Issue year: 2025

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care	**2**	50% or more healthcare regions or facilities implementing national clinical guidelines (Source: Expert interview)
8	**Policy support for preventive care**	**0-2**	**2**	National policies focused on primary prevention / modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	Primary Prevention Targets [545]: – Smoking decrease by 11.7% – Physical activity increase by 5.5% – Alcohol intake decrease by 3% – HT decrease by 1% – Diabetes decrease by 1%
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health / cognitive screening or monitoring)	**1**	The 4th National Dementia Plan (2021–2025) and the Dementia Management Act support early detection and include digital tools (e.g., Check Dementia app) for screening and cognitive monitoring [546 547]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	0-6	6	Funding for Alzheimer's disease research: Investment in / funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	2	Alzheimer's disease specific [548] Government agencies including the Ministry of Health and Welfare, Ministry of Science and ICT, National Research Foundation, and Korea Health Industry Development Institute are investing in peer-reviewed Alzheimer's studies focusing on genetics, biomarkers, diagnostic technologies, and care interventions Dementia [549] The South Korean government has devoted much effort to national dementia research and pledged to invest a total of 198.7 billion won (HK$1.3 billion) between 2020 and 2028. In 2023, the government budgeted for 13.4 billion won (HK$84.4 million) to support 82 research projects covering causes and pathogenesis, prediction technologies and diagnostics, prevention and treatment technologies and other areas. To facilitate dementia-related research, MOHW also conducts surveys to determine the current status of dementia and cost burden every five years, and the next survey is scheduled to be conducted within 2023.
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	2	K-ROAD (Korea-Registries to Overcome Alzheimer's Disease) [550]: A hospital-based clinical registry launched in 2023, tracking over 5,800 patients across 16 dementia clinics for early diagnosis, biomarker research, and treatment outcomes. Trial Ready Registry-Dementia Platform Korea (TRR-DPK) [551]: launched to investigate potential Alzheimer's disease therapeutic targets and biomarkers, addressing the need for standardised, high-quality clinical data in Korea. The TRR-DPK system is planned to enroll 3,000 participants in MCD exams, blood tests, and brain imaging by 2028.
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	2	Although it is difficult to determine an exact answer, based on the success of the lecanemab clinical trial and the time required for its introduction into the Korean healthcare market, it is estimated to be within 03 years (Source; Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 2: Prevention & screening (early detection)						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**2**	National clinical guidelines screening coverage for high-risk population For example: Older adults (e.g. ≥65 years) Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression	**1**	The elderly with SCD have a higher risk of progression to dementia (or Alzheimer's disease dementia) in the future compared to those without SCD. Therefore, it is recommended to evaluate their clinical progress through periodic follow-ups every 1 or 2 years [552].
				Inclusion of validated cognitive assessment tools in screening guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	No direct mention of validated cognitive assessment tools in the screening context [553]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Inclusion of BBBMs in screening guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	In South Korea, the widespread use of PET scans has delayed the adoption of BBBMs testing. A comprehensive evaluation of all biomarker testing modalities is therefore needed. (Source: Expert interview)
				Inclusion of CSF biomarkers in screening guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening in the guideline. However, The Lecanemab: Appropriate Use Recommendations by the Korean Dementia Association (KDA) includes mention of CSF biomarker testing [554]. The KDA recommends lecanemab for patients with MCI or mild Alzheimer's disease, requiring confirmation of amyloid pathology via amyloid PET or CSF testing.
	Alzheimer's disease screening funding	**0-6**	**2**	Funding for validated cognitive assessment tools in screening (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**2**	Free dementia screening at public Dementia Care Centers; health insurance reimburses dementia-related expenses and screening (Source: Expert interview)
				Financing mechanism for BBBMs in Alzheimer's disease screening	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers Alzheimer's disease screening	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
	Alzheimer's disease diagnosis guidelines	**0-7**	**5**	National clinical guidelines diagnosis coverage	**2**	Diagnosis coverage [555]: Neurological examination is strongly recommended for differential diagnosis of dementia. CSF tests for Aβ, total tau, and phosphorylated tau can improve Alzheimer's disease diagnosis accuracy and may be considered. APOE genotyping can be considered for diagnosis and prognosis of Alzheimer's disease-related dementia, though evidence is weaker. Structural brain MRI assessing medial temporal lobe (MTL) atrophy is strongly recommended to increase diagnostic accuracy and rule out other causes. Amyloid PET scans can improve Alzheimer's disease diagnosis accuracy and may be considered, but evidence is weaker.
				Inclusion of validated cognitive assessment tools in diagnostic guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	In the process of diagnosing dementia, performing MMSE may be considered to determine whether overall cognitive function of patients has reached the level of dementia [556]
				Inclusion of BBBMs in diagnostic guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	Unavailable. In Korea, the widespread use of PET scans has delayed the adoption of BBBMs testing. A comprehensive evaluation of all biomarker testing modalities is therefore needed. (Source: Expert interview)
				Inclusion of CSF biomarkers diagnostic guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**2**	CSF Aβ, total tau, and phosphorylated tau tests can increase accuracy of Alzheimer's disease diagnosis in MCI or dementia patients and can be considered for differential diagnosis [557]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Capacity of / Availability of/ access to diagnostic infrastructure and services	**0-18**	**16**	MRI	**4**	High (>0.43 machines per ten thousands of population). South Korea is among the highest in the world for utilisation of CT, MRI, and PET scans. Based on the Health Insurance Review & Assessment Service (HIRA) assessment, South Korea demonstrates extremely high utilisation of imaging equipment: 1,694 institutions conducted 3.29 million CT, MRI, and PET scans over just three months, with CT alone accounting for 2.62 million scans. (Source: Expert interview)
				CT	**4**	High (>0.87 machines per ten thousands of population). South Korea is among the highest in the world for utilisation of CT, MRI, and PET scans. Based on the Health Insurance Review & Assessment Service (HIRA) assessment, South Korea demonstrates extremely high utilisation of imaging equipment: 1,694 institutions conducted 3.29 million CT, MRI, and PET scans over just three months, with CT alone accounting for 2.62 million scans. (Source: Expert interview)
				PET	**4**	High (>4.0 machines per 1 million population). South Korea is among the highest in the world for utilisation of CT, MRI, and PET scans. Based on the Health Insurance Review & Assessment Service (HIRA) assessment, South Korea demonstrates extremely high utilisation of imaging equipment: 1,694 institutions conducted 3.29 million CT, MRI, and PET scans over just three months, with CT alone accounting for 2.62 million scans. (Source: Expert interview)
				CSF Biomarker testing	**2**	Korean consensus/protocols and multicentre studies document clinical CSF biomarker use in tertiary (teaching) hospitals [558]
				BBBMs testing	**2**	Korean multicentre cohorts (KBASE/Asan) and recent studies show BBBMs p-tau is in clinical/ research use in tertiary memory clinics [559]
	Tracking of time to diagnosis for Alzheimer's disease	**0-2**	**1**	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**1**	There is some tracking of time to diagnosis, but efforts are fragmented, local, or led by non-governmental stakeholders, rather than part of a coordinated national approach (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)	**0-12**	**4**	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary public institutions	**1**	<50% As mentioned earlier, South Korea is the country where PET scans are the most accessible and widely used, and therefore the proportion of CSF and BBBMs testing is relatively low. (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary private institutions	**1**	<50% As mentioned earlier, South Korea is the country where PET scans are the most accessible and widely used, and therefore the proportion of CSF and BBBMs testing is relatively low. (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting	**1**	<50% As mentioned earlier, South Korea is the country where PET scans are the most accessible and widely used, and therefore the proportion of CSF and BBBMs testing is relatively low. (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at public primary care setting	**1**	<50% As mentioned earlier, South Korea is the country where PET scans are the most accessible and widely used, and therefore the proportion of CSF and BBBMs testing is relatively low. (Source: Expert interview)
	Capacity of workforce	**0-16**	**11**	Geriatricians / Psychogeriatricians	**2**	Moderately low (>1.5-2staffs per 100k of population) (Source: Expert interview)
				Neurologists	**3**	(KOSIS, 2025) Number of neurologists (per 100,000): 4.27 [560]
				Psychiatrist working in mental health sector	**3**	(KOSIS, 2025) Number of psychiatrists (per 100,000): 8.25 [561]
				Social workers working in mental health sector	**3**	(NCMH, 2023) Total number of certified mental health social workers (per 100,000): 12.58 [562]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Alzheimer's disease diagnostics funding coverage	**0-6**	**2**	Funding for validated cognitive assessment tools in Alzheimer's disease / Dementia diagnosis (public and/ or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**2**	South Korea has free cognitive assessment for Alzheimer's and Dementia diagnosis for ages over 60 [563]
				Financing mechanism for BBBMs in Alzheimer's disease diagnosis	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in Alzheimer's disease diagnosis	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 4: Treatment monitoring and access						
	Alzheimer's disease treatment monitoring guidelines	**0-6**	**4**	National clinical guidelines treatment & monitoring coverage (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**2**	Pharmacological treatments are specifically mentioned for Alzheimer's disease [564]
				Inclusion of BBBMs in treatment & monitoring guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarkers recommended or mentioned for treatment & monitoring
				Inclusion of CSF biomarkers in treatment & monitoring guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**2**	No biomarker is mentioned for monitoring in the guideline. However, The Lecanemab: Appropriate Use Recommendations by the Korean Dementia Association includes mention of CSF biomarker testing[565] . The KDA recommends lecanemab for patients with MCI or mild Alzheimer's disease, requiring confirmation of amyloid pathology via amyloid PET or CSF testing.
	Involvement of multi-disciplinary team	**0-2**	**1**	Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**0**	No mention of multidisciplinary care in the guideline. However, in reality, the staffing structure of Dementia Safety Centers and various aspects of dementia-related policies call for a multidisciplinary approach. (Source: Expert interview)
				Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologists, psychologists, social workers, occupational therapists, etc. for Dementia / Alzheimers'	**1**	The country operates a dual medical system integrating Western medicine and Korean traditional medicine, allowing both approaches to be provided to dementia patients within the same institution [566]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Linkage to supportive/ palliative care	**0-2**	**0**	Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**0**	Guidelines don't include referral pathway to supportive / palliative care services
				Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**0**	In Korea, people with dementia (PWD) often receive poor quality end-of-life (EOL) care despite the recognised need for palliative services [567]. Palliative care for PWD is scarcely provided, with no protocols or guidelines for dementia-specific EOL care developed. Although 46% of adults in Korea express a desire to use hospice and palliative care services, available services remain insufficient, and in 2020 only 21.3% of both cancer and non-cancer patients used hospice.
	DMT access pathway readiness	**0-5**	**5**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**3**	Lecanemab (LEQEMBI®) is approved
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**2**	Korean Dementia Association (KDA) recommends the use of lecanemab for patients who meet the diagnostic criteria for MCI due to Alzheimer's disease and mild Alzheimer's disease dementia, confirmed to be amyloid biomarker - positive (via amyloid PET or CSF testing)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease / Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	Telemedicine in South Korea has rapidly expanded in recent years, driven by advances in technology and the need to improve healthcare access, especially during the COVID-19 pandemic [568]. Remote consultations, including for chronic conditions like dementia, have become increasingly integrated into the healthcare system to overcome barriers such as mobility limitations and uneven distribution of medical resources. A notable example is the Gangdong-gu district in Seoul, which launched a pilot remote medical assessment programme for dementia patients after the closure of its Dementia Care Center in early 2020 due to COVID-19. This initiative combined telemedicine with visiting nurse services to fill care gaps and address healthcare inequalities. In 2020, 227 patients received remote dementia evaluations, while over 1,100 benefited from nurse visits at home.
						Gangdong-gu's programme includes an initial home visit by nurses for cognitive assessments, followed by remote clinical evaluations via video consultations with doctors. Staff assist patients with technology during sessions to ensure smooth communication. The district also provides helplines, cognitive stimulation kits, online dementia classes, and tailored case management to support vulnerable populations. Plans are in place to expand one-on-one home visits for those unable to use digital services and to offer outdoor programmes to reduce infection risks. This comprehensive telehealth model highlights South Korea's innovative approach to dementia care, blending technology with community support to enhance accessibility and resilience in healthcare delivery.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Alzheimer's treatment & monitoring funding coverage	**0-6**	**1**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**1**	Donepezil, rivastigmine, galantamine, and memantine reimbursed by NHIS [569]
				Financing mechanism for BBBMs in Alzheimer's disease treatment & monitoring (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in Alzheimer's disease treatment & monitoring (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
Domain 5: Advocacy, awareness and education						
	Dementia/ Alzheimer's disease patient organisation engagement and advocacy	**0-3**	**3**	Existence of patient / caregiver organisations	**1**	Alzheimer's Association Korea (Republic of) [570]
				Participation in national policy & plan development, and/or joint programmes with government	**1**	Patient organisations are actively participating in the policy consultation process (Source: Expert interview)
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**1**	National Responsibility Policy for Dementia Care was implemented in Korea in September 2017 [571]. This policy comprises 04 key elements, including the government expanding nationwide dementia relief centers to provide services, such as dementia prevention, education, early screening, and care

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Dementia/ Alzheimer's disease professional medical and scientific societies / associations, research institutes engagement and advocacy	**0-4**	**4**	Existence of professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease	**2**	(1) Korean Neurological Association [572] (2) Korean Geriatrics Society (3) Korean Association of Gerontology and Geriatrics [573] (4) Korea Dementia Research Centre (KDRC) [574] (5) Korean Dementia Association [575]
				Participation in national policy & plan development, and/ or joint programmes or initiatives with government agencies on Dementia / Alzheimer's disease	**1**	All above listed organisations have roles in national dementia policy and programme development with government cooperation
				Contributions towards clinical guidelines development	**1**	Guideline 1: Clinical Practice Guideline for Dementia: Part 1, Diagnosis and Evaluation (2021 Revised Edition) [576] Guideline 2: Clinical Practice Guidelines for Dementia: Recommendations for Pharmacological Treatment of BPSD [577] Author: Korean Dementia Association - Experts from KDA play a key advisory role not only in developing clinical guidelines and proposing lecanemab AURs, but also in the policymaking process for dementia.
	Dementia / Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)	**0-21**	**14**	[Patient] Availability of patient education programmes and support resources initiated / driven by patient / caregiver organisations	**2**	Broader Dementia and Alzheimer's–specific programmes or resources are run by patient organisations (but not Alzheimer's-only) (Source: Expert interview)
				[Patient] Availability of patient education programmes and support resources initiated / driven by the professional medical and scientific societies / associations, research Institutes focused on Dementia / Alzheimer's disease	**2**	Active educational programmes are being implemented at both the National Dementia Center and Counselling Center (DCC) (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[Patient] Availability of patient education programmes and support resources initiated / driven by the government	**2**	Active educational programmes are being implemented at both the National Dementia Center and Counselling Center (DCC) for patients (Source: Expert interview)
				[Caregiver] Availability of caregiver-focused education, training, and support services on Dementia / Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines) Can be driven by: – Patient or caregiver organisation – Professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease - The government	**2**	Active educational programmes are being implemented at both the National Dementia Center and Counselling Center (DCC) for caregivers (Source: Expert interview)
				[All] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	Active awareness programmes are being implemented at both the National Dementia Center and Counselling Center (DCC) (Source: Expert interview)
				[Healthcare providers] Availability of clinical education for primary care providers	**2**	The Korean Dementia Association AAK makes great efforts in training professionals for early diagnosis of people with dementia and referring them to regions, so that they can be assigned to dementia care specialists at an early stage [578]
				[Healthcare providers] Availability of specialist training in Dementia/ Alzheimer's care	**2**	Korean National Dementia Plans includes dementia specialist education programmes for doctors, nurses, program managers, and care workers to improve dementia care capacity [579]

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Taiwan

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
Taiwan	Moderately high	Low	Moderately low	Moderately high	Moderately high

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	**Existence and operational status of national Alzheimer's disease policies / strategies / plans**	**0-4**	**3**	Existence and operational status of national Alzheimer's disease policies / strategies / plans	**2**	National Dementia Care Strategy 3.0[580] – Year of publication: 2025 (upgraded from Dementia Prevention and Care Policy Framework and Action Plan 2.0 (2018–2025)) – Author/Issuing Body: MOHW's Department of Long-Term Care – Overall description: The strategy is aligned with WHO Global Action Plan on Dementia's 7 strategic pillars, focusing on: The programme will continue to follow the WHO's seven strategic pillars, focusing on: strengthening dementia care service networks, enhancing support for family caregivers, improving public literacy on dementia to further advance the indicators of a dementia-friendly Taiwan
				Currency of the national policies / strategies / plans	**1**	2025

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
2	**Priority & specificity of Alzheimer's disease in national policies / strategies / plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	Policies, strategies, or plans include Dementia-specific targets, but not specific to Alzheimer's [581]
3	**Coordinating mechanism for implementation**	**0-4**	**2**	Dedicated national Alzheimer's disease programmes / initiatives	**1**	Policies, strategies, or plans include Dementia-specific programmes or initiatives, but not specific to Alzheimer's [582]
				Joint national and regional Alzheimer's disease coordination mechanisms	**1**	Taiwan demonstrates active coordination between national and subnational governments in dementia care through regular interdepartmental meetings that bring together central and local stakeholders to align policies and monitor implementation [583]. Regional health bureaus collaborate with local healthcare resources to maintain dementia care networks, with pilot projects in seven public health bureaus by 2016.
4	**Alzheimer's disease financing**	**0-6**	**3**	Dedicated budget to Alzheimer's disease programmes	**1**	The government invested US$315.75M (TW$9B) during 2018-2019 to promote dementia prevention and care [584]. 46% of this was spent on risk reduction, 41% on diagnosis, treatment, care and support, 8% on research, and 4% on caregiver support. The Dementia Plan 2018-2025 also received $134.5M. These funds comprehensively support dementia-related needs but are not specifically earmarked for Alzheimer's programmes.
				Funding / insurance coverage for Dementia / Alzheimer's disease Care (Public)	**1**	Dementia is included in the National Health Insurance Administration's Hospital Patient-centered Integrated Outpatient Service Plan, which provides integrated care through interdisciplinary teams [585]. In 2017, the government considered allowing representatives to see doctors or collect medications for people with dementia, expanded the Post-acute Care Plan to include adults over 75 with dementia and certain chronic conditions, and added coverage for family counseling fees in dementia outpatient care under the Family Physician Integrated Care Plan.
				Funding / insurance coverage for Dementia / Alzheimer's disease (Private & alternatives)	**1**	Partially funded, Alzheimer's disease specifically mentioned. E.g., Special disease insurance" (嚴重特定傷s'c's病險) in Taiwan includes severe Alzheimer's disease (for instance, requiring CDR = 3 etc.) [586]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
5	**Existence of registries established for Alzheimer's disease**	0-5	2	Existence of registries established for Alzheimer's disease	**0**	Regional Dementia Registry: HAICDDS Database (Taiwan) [587]- Taiwan does not yet have a comprehensive national dementia registry, although The action plan for Dementia 2.0 includes the goal of establishing a national registry and surveillance system. At the regional level, a "dementia registry database" is integrated with the History-based Artificial Intelligent Clinical Dementia Diagnosis System (HAICDDS). Currently implemented in three hospitals within the Show Chwan Healthcare System (two in central Taiwan and one in southern Taiwan), the system has collected over 14,000 detailed patient records since January 2016. It incorporates AI and uses the Clinical Dementia Rating (CDR) to assess dementia staging, serving as a valuable model for structured, data-driven dementia diagnosis and monitoring at the regional scale.
				Integration of Dementia-specific tracking in EMR systems	**2**	Taiwan has made significant progress in electronic medical records (EMR) since 2000, when the Ministry of Health and Welfare began digitizing patient records to improve data accuracy, accessibility, and efficiency [588]. In 2011, the Electronic Medical Record Exchange Center (EEC) was launched to enable record sharing across institutions, covering five key medical record types (e.g., outpatient records, medications, lab tests, imaging, and discharge summaries). As of now, over 6,800 healthcare facilities use the system, which relies on the international CDA R2 standard. However, due to the lack of unified national standards for medical data exchange, institutions often rely on customized data formats and interfaces, limiting full interoperability. Plus, NHIA has implemented the National Health Insurance Mobile App for insured since 2014.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
6	**Inclusivity and equitable policy formulation**	0-8	4	Policies / strategies / plans / programmes addressing equitable access to care to Alzheimer's	1	The National Dementia Plan 2.0 focuses on protecting the rights of people with dementia, improving accessibility through services such as a national dementia care helpline and long-term care management centers across all 22 cities and counties. The Ministry of Health and Welfare also organizes public legal education on guardianship and property trusts. While these initiatives demonstrate commitment to equitable dementia care, they do not specifically target individuals with Alzheimer's disease.
				Policy recognition of preclinical Alzheimer's disease / Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	2	Dementia Prevention and Care Policy and Action Plan 2.0 aims to prevent or delay dementia by reducing modifiable non-communicable disease (NCD) risk factors such as obesity, diabetes, and hypertension through public health campaigns, accessible screenings, and targeted counselling [589].City-level dementia screening for at-risk groups is also available; for example, Chiayi City's 2025 Integrated Health Screening programme requires all residents aged 65 and older to complete the Alzheimer's disease dementia screening, with those scoring 2 or higher referred for specialist diagnosis [590].
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	0	Multiple helplines support carers of people with dementia[591] - such as the #1966 Long-term Care Services line, the Dementia Care Helpline, and the Family Carer Helpline - offering consultations, counseling, and referrals. A national dementia case management system is in place, with integrated memory clinics required to employ case managers and maintain a dementia registry. However, these services are not specifically targeted at patients from underserved backgrounds.
				Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	1	Community-based programmes include the Dementia Care Helpline and Family Carer Helpline, counseling for 6,000 carers annually, 30 family carer training sessions yearly, and early-stage mild dementia services supported by local subsidies. While substantial, the programmes are focused on dementia in general and not tailored to Alzheimer's or specific at-risk populations.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
7	**National Alzheimer's disease clinical guidelines availability and implementation**	**0-6**	**4**	Availability of clinical guidelines on Alzheimer's disease	**2**	(1) Guideline: Taiwan Dementia Treatment Guideline[592] – Author: Taiwan Society of Geriatric Emergency & Critical Care Medicine – Issue year: 2021 – This provides extensive recommendations primarily focused on pharmacological and non-pharmacological interventions for dementia. Alzheimer's disease is mentioned but not with a dedicated section (2) Application of blood-based biomarkers of Alzheimer's disease in clinical practice: Recommendations from Taiwan Dementia Society[593] – Author: Taiwan Dementia Society – Issue year: 2024
				Currency of clinical guidelines	**1**	2021
				Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care	**1**	< 50% healthcare regions or facilities implementing national clinical guidelines (Source: Expert interview)
8	**Policy support for preventive care**	**0-2**	**2**	National policies focused on primary prevention / modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	Targets [594]: – Prevalence of overweight and obesity among adults maintained at or below 50.8% – Prevalence of insufficient physical activity among adults maintained at or below 39.3%. HPA Policy Highlights for 2025 KPIs – Prevalence of insufficient physical activity among seniors maintained at or below 52.1% – The adult smoking rate maintained at or below 12.7% – The junior high school student smoking rate maintained at or below 2.4% the average of the available data from the most recent three years – Prevalence of adults daily consuming 3 servings of vegetables and 2 servings of fruits maintained at or higher than 20.0% for vegetables and 14.9% for fruits in 2023 – The recommended daily salt intake for adults maintained at or below 8.2 grams for men and 6.6 grams for women in 2023
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health / cognitive screening or monitoring)	**1**	The Dementia Plan 2.0 (2018-2025) supports timely diagnosis and referral pathways between primary and specialist care, indicating a structured system for screening and monitoring[595]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	0-6	4	Funding for Alzheimer's disease research: Investment in / funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	**2**	(1) Taiwan's Alzheimer's research ecosystem receives sequential and collaborative support from multiple institutions. In the early stages, the Academia Sinica, Ministry of Science and Technology (MOST), National Health Research Institutes (NHRI), and Veterans General Hospitals - including Taipei and Taichung - launched foundational genetic and longitudinal cognitive decline studies [596] (2) Building on this groundwork, the National Science and Technology Council (NSTC) and Chang Gung Memorial Hospital together fund the Taiwan-Alzheimer's diseaseNI project, which integrates BBBMs p-tau217 biomarkers into Alzheimer's risk prediction models [597]
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	**2**	Taiwan's participation in Alzheimer's disease-specific international trials (e.g., donanemab via TRAILBLAZER-ALZ studies [598]) and initiatives like the Taiwan Alzheimer's Disease Neuroimaging Initiative (TW-ADNI [599] - Longitudinal, multicenter study designed to develop clinical, imaging, genetic and biochemical biomarkers for the early detection and tracking of Alzheimer's disease) show integration of Alzheimer's patients in both trial and biomarker research.
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	**0**	Unpredicted and no standardised adoption timeframe (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**0**	National clinical guidelines screening coverage for high-risk population For example: Older adults (e.g. ≥65 years) Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression	**0**	Guidelines do not mention screening for individuals at high risk of Dementia / Alzheimer's disease[600 601]
				Inclusion of validated cognitive assessment tools in screening guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	No direct mention of validated cognitive assessment tools in the screening context
				Inclusion of BBBMs in screening guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarker is mentioned for screening
				Inclusion of CSF biomarkers in screening guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Alzheimer's disease screening funding	**0-6**	**0**	Funding for validated cognitive assessment tools in screening (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for BBBMs in Alzheimer's disease screening	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers Alzheimer's disease screening	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
	Alzheimer's disease diagnosis guidelines	**0-7**	**0**	National clinical guidelines diagnosis coverage	**0**	No single national guideline exists, but an urgent review of DMT eligibility protocols is required, as these serve as the de facto diagnostic criteria (Source: Expert interview)
				Inclusion of validated cognitive assessment tools in diagnostic guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	No single national guideline exists, but an urgent review of DMT eligibility protocols is required, as these serve as the de facto diagnostic criteria (Source: Expert interview)
				Inclusion of BBBMs in diagnostic guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No single national guideline exists, but an urgent review of DMT eligibility protocols is required, as these serve as the de facto diagnostic criteria (Source: Expert interview)
				Inclusion of CSF biomarkers diagnostic guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No single national guideline exists, but an urgent review of DMT eligibility protocols is required, as these serve as the de facto diagnostic criteria (Source: Expert interview)
	Capacity of / Availability of/ access to diagnostic infrastructure and services	**0-18**	**5**	MRI	**1**	0.09 per ten thousands of population [602]
				CT	**1**	0.17 per ten thousands of population [603]
				PET	**1**	Low (<=0.5 machines per per 1 million population) (Source: Expert interview)
				CSF Biomarker testing	**0**	No confirmed regulatory approval specifically for CSF biomarkers as standalone diagnostics - though their clinical importance is acknowledged, especially with emerging DMT options [604]. Unable to find CSF testing in clinical trials.
				BBBMs testing	**2**	Taiwan-ADNI and clinical groups have published integration workflows for BBBMs p-tau217 as a triage/clinical tool; available in tertiary centres as part of practice/pilots [605]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Tracking of time to diagnosis for Alzheimer's disease	**0-2**	**0**	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**0**	There is no evidence that the country or relevant stakeholders track or report time to diagnosis for Alzheimer's disease or dementia
	Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)	**0-12**	**4**	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary public institutions	**1**	<50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary private institutions	**1**	<50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting	**1**	<50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at public primary care setting	**1**	<50% (Source: Expert interview)
	Capacity of workforce	**0-16**	**13**	Geriatricians / Psychogeriatricians	**4**	Number of registered geriatricians: 828 [606] Population (2025 estimate): ~23 million Estimated geriatricians per 100,000: 3.6
				Neurologists	**4**	(Atlas of MS, 2020) Number of neurologists (per 100,000): 4.8 [607]
				Psychiatrist working in mental health sector	**3**	(Psychiatry Research, 2019) Number of psychiatrists (per 100,000): 6.2 [608]
				Social workers working in mental health sector	**2**	Taiwan: Out of 9,817 licensed social workers[609] and a population of ~23 million [610]There are approximately 42.7 social workers per 100,000 population. Assuming 10% work in mental health, this results in an estimated 4.3 mental health social workers per 100,000 population.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Alzheimer's disease diagnostics funding coverage	**0-6**	**1**	Funding for validated cognitive assessment tools in Alzheimer's disease / Dementia diagnosis (public and/ or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Cognitive assessment for Alzheimer's / Dementia diagnosis is partially funded or reimbursed (Source: Expert interview)
				Financing mechanism for BBBMs in Alzheimer's disease diagnosis	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in Alzheimer's disease diagnosis	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 4: Treatment monitoring and access						
	Alzheimer's disease treatment monitoring guidelines	**0-6**	**2**	National clinical guidelines treatment & monitoring coverage (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**2**	Pharmacological treatments are specifically recommended for Alzheimer's disease, focusing on improving cognitive function, daily living, and behavioral symptoms through medications such as donepezil, rivastigmine, galantamine, and memantine [611]
				Inclusion of BBBMs in treatment & monitoring guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarkers recommended or mentioned for treatment & monitoring [612]
				Inclusion of CSF biomarkers in treatment & monitoring guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening [613]
	Involvement of multi-disciplinary team	**0-2**	**1**	Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**0**	No mention of multidisciplinary care [614]
				Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologists, psychologists, social workers, occupational therapists, etc. for Dementia / Alzheimers'	**1**	Since launching the Dementia Action Plan 2.0 in 2017, Taiwan has developed over 114 Dementia Integrated Care Centers (DICC) [615]. These centers incorporate medical, care, and support divisions, staffed by multidisciplinary teams including medical professionals, nurses, nutritionists, pharmacists, physical and occupational therapists, social workers, psychologists, and legal representatives.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Linkage to supportive/ palliative care	**0-2**	**2**	Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**1**	Guidelines don't include referral pathway to supportive / palliative care services [616]
				Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**1**	Taiwan has a strong foundation for end-of-life care that is more inclusive of non-cancer diagnoses [617]. Initially focused on terminal cancer care, palliative services in Taiwan have included eight additional terminal non-cancer illnesses, such as dementia, heart failure, and chronic obstructive lung disease, since 2009. The NHI plays a vital role by reimbursing hospice and palliative care services for eligible patients, including those with advanced dementia. This coverage has helped to make these services more affordable and accessible.
	DMT access pathway readiness	**0-5**	**4**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**3**	Lecanemab (LEQEMBI®) is approved [618] Donanemab (Kisunla) is approved [619]
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**1**	Expert Opinion [620]: Pre-treatment testing and condition confirmation: Amyloid positron emission tomography (PET) or Aβ amyloid protein testing in cerebrospinal fluid must be completed to confirm Aβ positivity. MRI examination is also required to exclude the risk of major brain bleeding.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease / Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	Taiwan developed a Dementia Case Management Information System (DCMIS) [621] to support dementia care case managers and caregivers through remote monitoring and telehealth. Case managers faced challenges such as high caseloads, paperwork, difficulty tracking cases, and lack of accessible health education resources. The DCMIS was designed with features including case management functions (assessments, care plans, reminders), a health education database, and communication tools to improve patient handover and follow-up. The system uses a mobile app via the LINE platform, enabling case managers to conduct assessments, deliver health education, and manage cases in real time. Pilot testing showed the app was user-friendly, improved data accessibility, reduced reliance on paper materials, and facilitated case management. Barriers included lack of integration with government systems, absence of a desktop option, and concerns that some caregivers might find mobile apps challenging or prefer traditional educational materials.
	Alzheimer's treatment & monitoring funding coverage	**0-6**	**1**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**1**	Some drugs included in the NEDL for Dementia / Alzheimer's are funded/reimbursed. NHIA has rejected the reimbursement application of Leqembi. (Source: Expert interview)
				Financing mechanism for BBBMs in Alzheimer's disease treatment & monitoring (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in Alzheimer's disease treatment & monitoring (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 5: Advocacy, awareness and education						
	Dementia/ Alzheimer's disease patient organisation engagement and advocacy	**0-3**	**3**	Existence of patient / caregiver organisations	**1**	TADA [622], founded by Chen Rong-Chi in 2002 and a member of Alzheimer's Disease International since 2005, is based in Chinese Taipei. The organisation has amended its bylaws to include the human rights of people with dementia, established an advisory group, and addressed issues such as financial security, traffic rights and labour rights. It has developed "Schools of Wisdom" for people with mild dementia and created 500 Support Centres for People with Dementia and their Families nationwide. TADA also promotes dementia-friendly communities across sectors. Its services include caregiver meetings, counselling, dementia care training, educational events, a helpline, meaningful activities, memory cafés, newsletters, resource materials, seminars and workshops, support groups and training for carers.
				Participation in national policy & plan development, and/or joint programmes with government	**1**	TADA was commissioned to conduct a survey on the Taiwan Dementia Plan and Action Plan 2.0, indicating involvement in policy development [623]
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**1**	Provided by TADA [624]: Caregiver meetings Counselling Dementia Care Training Educational events Helpline Meaningful engagements/activities Memory Cafes Newsletter Resources (fact sheets, reading materials) Seminars/Webinars/Workshops Support groups Training for carers

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Dementia/ Alzheimer's disease professional medical and scientific societies / associations, research institutes engagement and advocacy	**0-4**	**3**	Existence of professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease	**2**	Taiwan Society of Geriatric Emergency & Critical Care Medicine [625]
				Participation in national policy & plan development, and/ or joint programmes or initiatives with government agencies on Dementia / Alzheimer's disease	**1**	Taiwan Society of Geriatric Emergency & Critical Care Medicine [626] - Engaged in dementia research and clinical practice, with involvement in advisory roles related to dementia care policies
				Contributions towards clinical guidelines development	**0**	Guideline: Taiwan Dementia Treatment Guideline Author: Taiwan Society of Geriatric Emergency & Critical Care Medicine
	Dementia / Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)	**0-21**	**9**	[Patient] Availability of patient education programmes and support resources initiated / driven by patient / caregiver organisations	**2**	TADA developed many 'Schools of Wisdom' (cognitive intervention module designed for people with mild dementia), as well as 500 Support Centres for People with Dementia and their Families (SPDF) across the country [627]
				[Patient] Availability of patient education programmes and support resources initiated / driven by the professional medical and scientific societies / associations, research Institutes focused on Dementia / Alzheimer's disease	**0**	Primarily clinician-oriented, with limited direct patient education
				[Patient] Availability of patient education programmes and support resources initiated / driven by the government	**0**	No educative programmes or resources related to Dementia or Alzheimer's are run by the government

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[Caregiver] Availability of caregiver-focused education, training, and support services on Dementia / Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines) Can be driven by: – Patient or caregiver organisation – Professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease – The government	**2**	TADA developed many 'Schools of Wisdom' (cognitive intervention module designed for people with mild dementia), as well as 500 Support Centres for People with Dementia and their Families (SPDF) across the country [628]
				[All] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	The Health Promotion Administration collaborated with NGOs and local cities to hold World Alzheimer's Month Events every year, to dispel the myth of dementia and create a dementia-friendly Taiwan [629]
				[Healthcare providers] Availability of clinical education for primary care providers	**1**	Only general aging or brain health-related clinical education programmes are available (not dementia-specific) for primary care providers [630]
				[Healthcare providers] Availability of specialist training in Dementia/ Alzheimer's care	**2**	The Taiwan government implemented an 8-hour dementia training programme for healthcare professionals and a 20-hour dementia training programme for long term care workers [631] [632] . All hospitals also have access to advanced training programmes.

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China

11.2 Middle-Income Territories

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
China	Moderately high	Low	Moderately low	Moderately low	Moderately high

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	**Existence and operational status of national Alzheimer's disease policies / strategies / plans**	**0-4**	**3**	Existence and operational status of national Alzheimer's disease policies / strategies / plans	**2**	National plans (2024 - 2030) address "senile dementia" without distinguishing Alzheimer's from other dementias in Chinese context (1) National Action Plan for senile dementia Disease (2024–2030)《应对老年期痴呆国家行动计划(2024 - 2030年)》[633] – Publication year: March 2024 – Issuing body: National Health Commission of the People's Republic of China, jointly with 14 other government agencies – Overall description: To enhance prevention, diagnosis, treatment, care, and support for individuals affected by Alzheimer's disease, while promoting public awareness and reducing stigma. The plan outlines seven core action areas, including strengthening service systems, capacity-building, and early detection.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
						(2) Action Plan for the Prevention and Control of senile dementia (2023 - 2025)《国家卫生健康委办公厅关于开展老年痴呆防治促进行动(2023—2025年)》 – Publication year: September 2023 – Issuing body: National Health Commission of the People's Republic of China [634] – Overall description: To promote early screening, awareness, and management of Alzheimer's disease in response to population ageing. The plan mandates: Routine cognitive screening for citizens aged 65+; Targeted follow-up and referral for individuals at high risk; Community and media campaigns to raise awareness (3) Developing a Silver Economy to Promote the Well-Being of the Elderly [635] [636] [637] – Publication year: January 2024 – Issuing body: General Office of the State Council of the People's Republic of China – Overall description: To build a robust "Silver Economy" to support the growing needs of China's aging population and promote healthy and active aging. The strategy encompasses economic activities and policy reforms aimed at elderly well-being. Key measures include: Expanding geriatric medical services in hospitals; Enhancing elderly-oriented product supply and standards; Fostering industries such as biotechnology, smart health, and home-based care
				Currency of the national policies / strategies / plans	**1**	(1) National Action Plan for Alzheimer's Disease (2024–2030)《应对老年期痴呆国家行动计划(2024—2030年)》[638] – Publication year: March 2024

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
2	**Priority & specificity of Alzheimer's disease in national policies / strategies / plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	Policies, strategies, or plans include Dementia-specific targets, but not specific to Alzheimer's National Action Plan for Alzheimer's Disease (2024 - 2030) [639] – Outlines seven key tasks to combat senile dementia and sets a series of targets to be achieved by 2030 • Key objectives include raising awareness about dementia prevention, implementing cognitive function screening for the elderly, providing early intervention for high-risk groups, enhancing standard diagnosis and treatment systems, and expanding care services. • The action plan also proposes that dedicated care units for seniors with dementia should make up 50 percent of elderly care institutions with over 100 beds and adequate service capabilities, while the cumulative number of trained dementia care personnel should reach 15 million by 2030. The action plan proposes 7 main tasks, including disseminating scientific knowledge on the prevention and control of Alzheimer's disease, carrying out screening and early intervention for Alzheimer's disease, improving the level of standardised diagnosis and treatment services for Alzheimer's disease, increasing the supply of care services for the elderly with dementia, building a friendly social environment for Alzheimer's disease, strengthening the scientific and technological support capacity for coping with Alzheimer's disease and strengthening foreign exchanges and cooperation in response to Alzheimer's disease. Focusing on 7 main tasks, 9 project columns have been set up, including the World Alzheimer's Disease Month theme publicity activity project, cognitive function screening and early intervention ability improvement project, "Guardian Memory" community cognitive training activity station project, senile dementia whole course service collaboration network project, senile dementia related specialist training project, dementia elderly care area (unit) construction project, dementia elderly caregiver training project, "yellow bracelet" dementia elderly care action project, senile dementia information management project.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
3	**Coordinating mechanism for implementation**	0-4	2	Dedicated national Alzheimer's disease programmes / initiatives	1	Policies, strategies, or plans include Dementia-specific programmes or initiatives, but not specific to Alzheimer's 2024 - 2030 National Dementia Action Plan Flagship Projects [640 641] – World Alzheimer's Disease Month theme publicity activity project – Cognitive function screening and early intervention ability improvement project – "Guardian Memory" community cognitive training activity station project – Senile dementia whole course service collaboration network project – Senile dementia related specialist training project – Dementia elderly care area (unit) construction project – Dementia elderly caregiver training project – "Yellow bracelet" dementia elderly care action project – Senile dementia information management project
				Joint national and regional Alzheimer's disease coordination mechanisms	1	China demonstrates evolving coordination between national and subnational governments through its national dementia action plan, which directs grassroots healthcare facilities and local governments to implement cognitive screening, establish memory clinics, and expand stage-specific dementia care services. Cities such as Shanghai, Guangzhou, and Shandong Province have acted on this guidance by launching dementia-friendly initiatives, increasing care capacity, and enhancing early detection. These efforts reflect alignment between central policy direction and local-level implementation, though the consistency and depth of collaboration may differ across regions.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
4	**Alzheimer's disease financing**	**0-6**	**2**	Dedicated budget to Alzheimer's disease programmes	**0**	There is no publicly available national-level funding designated exclusively for Alzheimer's or dementia. Although some local initiatives (e.g., memory cafes, cognitive screening expansions) exist, they are not tied to a formal national dementia or Alzheimer's budget.
				Funding / insurance coverage for Dementia / Alzheimer's disease Care (Public)	**1**	Current antidementia medications are available in the Chinese market. However, dementia is not in the list of special diseases, and therefore, patients have to pay for the treatment [642]. But the out-of-pocket expenses can be reimbursed during hospitalisation. Urban Employee Basic Medical Insurance (UEBMI) and Urban/Rural Residents Basic Medical Insurance (URRBMI) cover inpatient, outpatient, and medication costs broadly, including those related to dementia and Alzheimer's care In urban regions, most dementia patients are covered by the UEBMI scheme or the URBMI scheme, but these two insurance schemes have different benefit designs and levels of financial protection [643]
				Funding / insurance coverage for Dementia / Alzheimer's disease (Private & alternatives)	**1**	Partially funded, Alzheimer's disease specifically mentioned Commercial health insurance supplements public schemes for inpatient and outpatient dementia/ Alzheimer's care: A 2025 study in Hubei reported that Alzheimer's disease patients with commercial insurance had significantly shorter hospital stays than those relying solely on public insurance [644]. In June 2024, Eisai and Biogen launched Leqembi in China at ~CNY 2,508 per dose, collaborating with a major private insurer to secure partial reimbursement [645]. • Alzheimer's-specific therapy reimbursement is emerging through private coverage.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
5	**Existence of registries established for Alzheimer's disease**	**0-5**	**1**	Existence of registries established for Alzheimer's disease	**0**	China does not operate a centralised, government-run national dementia registry. However, the HOPE Study (The CHina registry study on cOgnitive imPairment in the Elderly), led by Sun Yat-sen University, serves as a major long-term research initiative [646]. Since 2020, the study has been recruiting approximately 5,000 older adults to track cognitive decline and associated biological markers over a 20-year period. While not a population-wide registry, HOPE represents a significant effort to generate longitudinal, biomarker-rich data on cognitive impairment and dementia in China.
				Integration of Dementia-specific tracking in EMR systems	**1**	The adoption of the electronic medical record (EMR) is rapidly growing in China [647]. Constantly evolving, Chinese EMRs contain vast amounts of clinical and financial data, providing tremendous potential for research and policy use; however, they are only partially standardised and contain free text or unstructured data. Possible implications: This means that while a vast amount of dementia-related information exists, its structured and standardised capture for consistent tracking, interoperability, and large-scale analysis is a major limitation. This situation suggests a basic maturity level, where the quantity of data collected precedes its quality and standardization for specific conditions, thereby hindering a more systematic and granular approach to dementia tracking.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
6	**Inclusivity and equitable policy formulation**	0-8	4	Policies / strategies / plans / programmes addressing equitable access to care to Alzheimer's	1	National Action Plan for Senile Dementia (2024–2030) focuses on protecting the rights of people with dementia, improving accessibility through services such as a national dementia care helpline and long-term care management centers across all 22 cities and counties. The Ministry of Health and Welfare also organizes public legal education on guardianship and property trusts. While these initiatives demonstrate commitment to equitable dementia care, they do not specifically target individuals with Alzheimer's disease.
				Policy recognition of preclinical Alzheimer's disease / Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	2	The National Action Plan (2024-2030)[648] includes integrating preliminary cognitive screening into routine health services for individuals aged 65 and above. Medical and health facilities with sufficient capacity are also encouraged to conduct in-depth cognitive assessments for those who screen positive during the initial evaluation.
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	0	No structured patient navigation programme for Alzheimer's or dementia populations. Some efforts exist (e.g., Under the National Action Plan, health and social workers guide patients via memory clinic referrals, digital tools, and home-based follow-up) but lack national coverage or underserved subgroup targeting[649].
				Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	1	National plans (2023-2025 and 2024-2030) focus on memory clinic training in community health centers and building multi-sectoral community service networks (involving CDC workers, volunteers, social workers) [650] [651] . These are part of a broader dementia strategy, not Alzheimer's-specific or targeted toward at-risk populations.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
7	**National Alzheimer's disease clinical guidelines availability and implementation**	0-6	5	Availability of clinical guidelines on Alzheimer's disease	**2**	(1) Chinese Guidelines for Early Prevention of Alzheimer's Disease (2024) [652] – This guideline addresses distinctive features of preventive measures and encompasses strategies at the individual, family, and society levels, advocating for proactive lifestyles, social engagement, cognitive training, physical exercise, tobacco cessation and moderate alcohol consumption, nutritional balance, adequate sleep, management of blood pressure, glucose and lipid levels, weight, and other chronic conditions, along with incorporating traditional Chinese medicine (TCM) into primary prevention efforts against Alzheimer's disease. This guideline serves as a reference for individuals, families and communities engaged in Alzheimer's disease prevention initiatives. – No Alzheimers dedicated section (2) Chinese Guidelines for the Diagnosis and Treatment of Alzheimer's Disease 2020 [653] – No Alzheimers dedicated section
				Currency of clinical guidelines	**2**	Chinese Guidelines for Early Prevention of Alzheimer's Disease (2024) [654]
				Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care	**1**	< 50% healthcare regions or facilities implementing national clinical guidelines (Source: Advisory Panel)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
8	**Policy support for preventive care**	0-2	2	National policies focused on primary prevention / modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	Targets for primary prevention [655]: (1) Physical activity: At least 40% of residents participate in regular exercise (2) Salt intake: Reduction of salt intake to below 5g per day (3) HT awareness: Increase awareness rate of high blood pressure among residents ≥30 years old to at least 65% (4) HT management: At least 70% HT management rate of patients (5) Blood lipid testing: Annual blood lipid testing for residents ≥35 years old is at least 35%
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health / cognitive screening or monitoring)	**1**	(1) The action plan for the Prevention and Control (2023-2025) mandates routine cognitive screening for all citizens aged 65+ and follow-up for high-risk individuals [656]. (2) Published in 2022 by China's National Health Commission, the Chinese Expert Consensus on Assessment of Cognitive Impairment in Older Adults has led to pilot programmes in select provinces and municipalities, incorporating cognitive assessments into community health screenings for early detection. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	0-6	4	Funding for Alzheimer's disease research: Investment in / funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	**2**	National Natural Science Foundation of China (NSFC) [657]: Between 2009 and 2018, the National Natural Science Foundation of China (NSFC) rapidly increased its funding projects in the field of pharmacological research on drugs for the prevention and treatment of Alzheimer disease. It was found that the research on Alzheimer's disease prevention and treatment drugs gradually shifted from the related mechanism targets represented by the amyloid β-protein (Aβ)-cascade theory and tau abnormal modification theory to new mechanisms and targets associated with autophagy and inflammation, epigenetic modification, and intestinal flora imbalance.
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	**2**	China has conducted over 90 clinical trials related to Alzheimer's, including 41 since 2019 [658]. These encompass both modern and traditional medicine, demonstrating substantial Alzheimer's-specific research activity.
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	**0**	Unpredicted and no standardised adoption timeframe (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 2: Prevention & screening (early detection)						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**1**	National clinical guidelines screening coverage for high-risk population For example: Older adults (e.g. ≥65 years)	**0**	Guidelines do not mention screening for individuals at high risk of Dementia / Alzheimer's disease [659 660]
				Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression		
				Inclusion of validated cognitive assessment tools in screening guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Chinese Guidelines for the Diagnosis and Treatment of Alzheimer's Disease (Version 2020) recommend MMSE and MoCA for cognitive assessment [661]
				Inclusion of BBBMs in screening guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarker is mentioned for screening [662 663]
				Inclusion of CSF biomarkers in screening guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening [664 665]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Alzheimer's disease screening funding	**0-6**	**0**	Funding for validated cognitive assessment tools in screening (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for BBBMs in Alzheimer's disease screening	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers Alzheimer's disease screening	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
	Alzheimer's disease diagnosis guidelines	**0-7**	**2**	National clinical guidelines diagnosis coverage	**1**	Guidelines explicitly cover diagnosis of Dementia, but not specifically Alzheimer's [666 667]
				Inclusion of validated cognitive assessment tools in diagnostic guidelines For example: MMSE (Mini-Mental State Examination)	**1**	National diagnostic guidelines for Dementia / Alzheimer's explicitly recommend one or more validated cognitive assessment tools [668 669]
				MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test		
				Inclusion of BBBMs in diagnostic guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No BBBMs recommended or mentioned for diagnosis [670 671]
				Inclusion of CSF biomarkers diagnostic guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No CSF biomarkers recommended or mentioned for diagnosis [672 673]
	Capacity of / Availability of/ access to diagnostic infrastructure and services	**0-18**	**6**	MRI	**1**	0.05 per ten thousands of population [674]
				CT	**1**	0.09 per ten thousands of population [675]
				PET	**1**	0.27 per ten thousands of population [676]
				CSF Biomarker testing	**1**	CSF testing (Aβ42/t-tau) is commercially available but limited to ~30 major hospitals (e.g., Peking Union). Not nationally integrated. (Source: Expert interview)
				BBBMs testing	**2**	Large Chinese cohort studies and lab validations (including Lumipulse evaluations and population cutoffs) show BBBMs p-tau assays are available in specialist labs and used clinically in selected centres [677]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Tracking of time to diagnosis for Alzheimer's disease	**0-2**	**2**	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**2**	China publishes detailed national reports ("Blue Books") on Alzheimer's and dementia. The 2023 China Alzheimer's "facts and figures" report notes specific delays: 32.6% of patients saw a doctor within 1 year of symptoms and 71.6% within 2 years [678]. This suggests China gathers nationwide data on diagnostic timing. A government-backed "blue book" and related studies compile such metrics, implying a coordinated national data effort.
	Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)	**0-12**	**4**	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary public institutions	**1**	<50% Although access to PET and CSF testing remains constrained, these diagnostic tools are increasingly utilized in premier medical institutions, and their commercial deployment is steadily widening. (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary private institutions	**1**	<50% Although access to PET and CSF testing remains constrained, these diagnostic tools are increasingly utilized in premier medical institutions, and their commercial deployment is steadily widening. (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at private primary care setting	**1**	<50% Although access to PET and CSF testing remains constrained, these diagnostic tools are increasingly utilized in premier medical institutions, and their commercial deployment is steadily widening. (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) at public primary care setting	**1**	<50% Although access to PET and CSF testing remains constrained, these diagnostic tools are increasingly utilized in premier medical institutions, and their commercial deployment is steadily widening. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Capacity of workforce	**0-16**	**10**	Geriatricians / Psychogeriatricians	**3**	6,877 geriatric institutions (fact) [679] × 5 geriatricians/institution (conservative assumption) = 34,385 geriatricians (estimated). Population (2025): ~1.37 billion Estimated geriatricians per 100,000 = (34,385 / 1,370,000,000) × 100,000 ≈ 2.51
				Neurologists	**4**	(Atlas of MS, 2020) Number of neurologists (per 100,000): 14 [680]
				Psychiatrist working in mental health sector	**2**	(WHO 2015) Number of psychiatrists (per 100,000): 2.199 [681]
				Social workers working in mental health sector	**1**	(The Lancet, 2019) Number of social workers working in mental health sector: 1500; Per 100k (using population data): 0.106 [682]
	Alzheimer's disease diagnostics funding coverage	**0-6**	**1**	Funding for validated cognitive assessment tools in Alzheimer's disease / Dementia diagnosis (public and/ or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Cognitive assessment for Alzheimer's / Dementia diagnosis is partially funded or reimbursed (Source: Expert interview)
				Financing mechanism for BBBMs in Alzheimer's disease diagnosis	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in Alzheimer's disease diagnosis	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 4: Treatment monitoring and access						
	Alzheimer's disease treatment monitoring guidelines	**0-6**	**2**	National clinical guidelines treatment & monitoring coverage (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**2**	Pharmacological treatments are specifically mentioned for Alzheimer's disease. In the Chinese Guidelines for the Diagnosis and Treatment of Alzheimer's Disease published in 2020 [683], there are mainly two types of drugs approved to alleviate cognitive impairment in Alzheimer's disease patients, including cholinesterase inhibitors (donepezil, rivastigmine, and galantamine) and glutamate receptor antagonists (memantine), as well as drugs to treat psychiatric symptoms in Alzheimer's disease patients. All of the above medications treat symptoms only and have limited effects on Alzheimer's disease patients. These medications are far from meeting the needs of the current medical system in light of the increasing prevalence of Alzheimer's disease.
				Inclusion of BBBMs in treatment & monitoring guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarkers recommended or mentioned for treatment & monitoring [684 685]
				Inclusion of CSF biomarkers in treatment & monitoring guidelines (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening [686 687]
	Involvement of multi-disciplinary team	**0-2**	**1**	Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**0**	No mention of multidisciplinary care [688 689]
				Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologists, psychologists, social workers, occupational therapists, etc. for Dementia / Alzheimers'	**1**	Hospitals in major Chinese cities have implemented a multidisciplinary team (MDT) approach involving collaboration among neurology, psychiatry, and rehabilitation departments. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Linkage to supportive/ palliative care	**0-2**	**1**	Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**1**	Guidelines don't include referral pathway to supportive / palliative care services [690] [691]
				Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**0**	Palliative care for individuals with dementia and Alzheimer's in China is still in its early stages of development [692]. The country is grappling with the dual challenges of a rapidly aging population and a healthcare system that has traditionally prioritised curative medicine. While national policies are beginning to address the issue, significant systemic and cultural barriers hinder the widespread availability and acceptance of these services.
	DMT access pathway readiness	**0-5**	**4**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**3**	Lecanemab (LEQEMBI®) is approved [693] Donanemab (Kisunla) is approved [694]
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**1**	Eligibility criteria for DMT access exist but are unclear, informal, or not standardised nationally (e.g., based on clinical discretion). Amyloid confirmation may be mentioned but not required or not uniformly applied. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease / Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	China has explored telemedicine for dementia care, particularly in rural areas [695]. Telemedicine in China has significantly improved healthcare accessibility for rural residents and helped reduce disparities among different demographic groups, supporting the goal of universal health coverage. However, its effectiveness depends on addressing local infrastructure challenges like internet connectivity. Successful telemedicine expansion requires integration with existing systems, such as the family doctor programme and compact medical communities, to enhance collaboration and ensure safe, accessible, and affordable healthcare for local populations.
	Alzheimer's treatment & monitoring funding coverage	**0-6**	**1**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**1**	Pharmaceutical agents including donepezil, rivastigmine, and sodium oligomannate have been incorporated into the national medical insurance formulary. (Source: Expert interview)
				Financing mechanism for BBBMs in Alzheimer's disease treatment & monitoring (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in Alzheimer's disease treatment & monitoring (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 5: Advocacy, awareness and education						
	Dementia/ Alzheimer's disease patient organisation engagement and advocacy	**0-3**	**2**	Existence of patient / caregiver organisations	**1**	Alzheimer's Disease Chinese (ADC) [696] was founded in 2002 and became a member of Alzheimer's diseasel the same year. It is a national branch of the Chinese Geriatric Health Association. The Alzheimer's Disease Committee of the China Association of Geriatric Care (formerly known as the Alzheimer's Disease and Related Diseases Professional Committee of the China Association of Geriatric Care) is a national branch of the China Association of Geriatric Care. It is a non-profit, non-governmental organisation. In 2002, it was officially approved as the only official member organisation of Alzheimer's Disease International (ADI) in mainland China. ADC is composed of a large number of expert volunteers engaged in Alzheimer's disease medical care, people from all walks of life who are enthusiastic about Alzheimer's disease publicity, education and social services, social workers, patients, their families and caregivers. It is committed to carrying out popular science publicity and education to raise public awareness; providing guidance and support in relevant medical care, care and other aspects to patients, families and caregivers to improve their quality of life; organising domestic and international academic exchanges and professional training to improve the clinical skills of medical staff; providing more scientific information and reasonable suggestions to the government to increase the country's attention and concern for Alzheimer's disease and related cognitive disorders, and improve patients' health care and social service conditions. The current ADC committee consists of 227 members from 31 provinces, autonomous regions, and municipalities directly under the central government. Members include professionals in neurology, psychiatry, psychology, traditional Chinese medicine, geriatrics, general practice, nursing, pharmacy, gerontology, social service agencies, volunteers, and patients' families. Each year, the ADC organizes hundreds of public welfare activities, including free clinics and education, benefiting hundreds of thousands of seniors.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Participation in national policy & plan development, and/or joint programmes with government	**1**	The Alzheimer's Disease Chinese is part of the China Association of Geriatric Care and has been involved in public welfare activities and policy advocacy [697]
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**0**	Zhensheng's support group at Peking University Institute of Mental Health (Beijing), established in 2000, brings together caregivers and volunteers to share experiences, vent frustrations, and explore strategies for coping with dementia patients [698]. A Beijing project is investigating if group training and support for family caregivers can reduce caregiver burden and slow patient decline, while also assessing if shifting services from hospitals to community centers improves access and affordability. While China is making progress in developing support services for individuals with Alzheimer's and their caregivers, there is a clear need for more comprehensive and accessible programmes. Continued investment in training, infrastructure, and community-based initiatives will be vital in addressing these needs.
	Dementia/ Alzheimer's disease professional medical and scientific societies / associations, research institutes engagement and advocacy	**0-4**	**2**	Existence of professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease	**1**	(1) China Association of the Universities for the Aged (CAUA) [699] (2) National Clinical Research Center for Geriatric Diseases [700] (3) China Ageing Development Foundation [701]
				Participation in national policy & plan development, and/ or joint programmes or initiatives with government agencies on Dementia / Alzheimer's disease	**1**	The listed organisations work closely with government agencies in aging and dementia policy development and public health initiatives [702] [703] [704]
				Contributions towards clinical guidelines development	**0**	No medical or scientific society, association, or research institute is listed as a contributor in national clinical guidelines

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Dementia / Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)	**0-21**	**14**	[Patient] Availability of patient education programmes and support resources initiated / driven by patient / caregiver organisations	**2**	ADC is committed to carrying out popular science publicity and education to raise public awareness; providing guidance and support in relevant medical care, care and other aspects to patients [705]
				[Patient] Availability of patient education programmes and support resources initiated / driven by the professional medical and scientific societies / associations, research Institutes focused on Dementia / Alzheimer's disease	**2**	Patient education programmes and resources are provided by professional medical and scientific societies / associations, research Institutes focused on Dementia / Alzheimer's disease (Source: Expert interview)
				[Patient] Availability of patient education programmes and support resources initiated / driven by the government	**2**	Patient education programmes and resources are provided government (Source: Expert interview)
				[Caregiver] Availability of caregiver-focused education, training, and support services on Dementia / Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines)	**2**	Caregiver-focused programmes and resources are available (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Can be driven by: – Patient or caregiver organisation – Professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease – The government		
				[All] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	Across China, public awareness initiatives for World Alzheimer's Day are underway, in addition to concerted efforts to foster dementia-friendly communities. (Source: Expert interview)
				[Healthcare providers] Availability of clinical education for primary care providers	**2**	There is dementia-specific (not Alzheimer's-only) clinical training for primary care providers. A cluster-randomised trial in Beijing community health centers trained PCPs with lectures, supervision, online support, and screening toolkits, improving dementia detection knowledge and practice [706].
				[Healthcare providers] Availability of specialist training in Dementia/ Alzheimer's care	**2**	Dementia Quality Care Online Training programme [707] Initiated by the China Alzheimer's Project in collaboration with Peking University Institute of Mental Health, this online training programme aims to: – Provide accessible education on dementia care for both professionals and informal caregivers. – Promote personalised care approaches to improve the quality of life for individuals with dementia. – Recognition: Awarded the MetLife Foundation Award for Best Dementia Care Education Project by Alzheimer's Disease International

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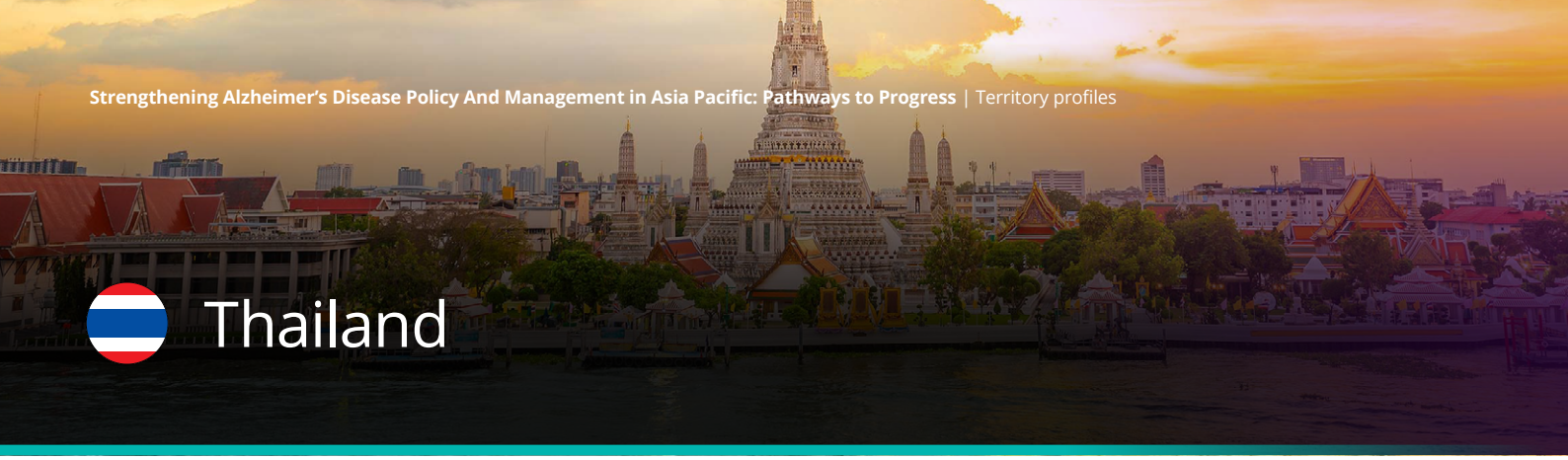

Thailand

Overall assessment

Domains	AD policy and planning landscape	AD prevention & screening	AD diagnosis & healthcare system capacity	AD treatment monitoring and access	AD advocacy, awareness and education
Thailand	Moderately low	Low	Moderately low	Moderately high	Moderately high

High | Moderately High | Moderately Low | Low

scorecard results

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 1: Overall national policy and planning landscape						
1	**Existence and operational status of national Alzheimer's disease policies / strategies / plans**	**0-4**	**1**	Existence and operational status of national Alzheimer's disease policies / strategies / plans	**1**	Twenty-Year National Strategic Plan for Public Health (2017-2036)[708] - Year of publication: 2017 (revised 2018) - Author/Issuing Body: The Ministry of Public Health (MOPH) - Overall description: This policy is structured into four phases-System Reform (2017–2021), System Strengthening (2022–2026), Moving Toward Sustainability (2027–2031), and Becoming a Top-3 Health System in Asia (2032–2036). These are driven by four strategies: Promotion, Prevention and Protection Excellence, Service Excellence, People Excellence, and Governance Excellence, each comprising multiple work plans and projects aligned to the goals of each phase. Dementia is briefly mentioned e.g., Dementia is included as a target group for intermediate care services, with at least 40% of IMC facilities expected to expand services to cover dementia care.
				Currency of the national policies / strategies / plans	**0**	Twenty-Year National Strategic Plan for Public Health (2017-2036)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
2	**Priority & specificity of Alzheimer's disease in national policies / strategies / plans**	**0-2**	**1**	Presence of specific Alzheimer's disease targets (e.g., targets for reducing Alzheimer's disease prevalence, improving early diagnosis, expanding access to Alzheimer's disease treatment and care services)	**1**	Policies, strategies, or plans include Dementia-specific targets, but not specific to Alzheimer's Twenty-Year National Strategic Plan for Public Health (2017-2036) [710] - At least 40% of health facilities providing IMC services are capable of expanding new types of target groups based on the local context, including IMC services for dementia, psychiatric, and paediatric patients. Phase 3 (2027-2031) of the plan will expand IMC to include dementia by integrating early screening, short term rehabilitation, and nursing services across hospital and home settings. The plan aims for 70% of M-level hospitals (120-300 beds) and F-level hospitals (10-120+ beds) to offer IMC, with at least 40% equipped to serve dementia patients through infrastructure upgrades. While specific components of the upgrades are not yet detailed, these likely include enhancements such as cognitive assessments and geriatric training.
3	**Coordinating mechanism for implementation**	**0-4**	**0**	Dedicated national Alzheimer's disease programmes / initiatives	**0**	No formal national dementia programme
				Joint national and regional Alzheimer's disease coordination mechanisms	**0**	Thailand shows limited formal coordination between national and subnational governments in dementia care. Regional initiatives such as the "Relieve Sadness, Tell Stories, Sing Songs" Project in Trang Province are implemented at the provincial level and aim to prevent depression and Alzheimer's dementia among the elderly through social engagement and health educatio[711]. While these efforts loosely align with national elderly and mental health strategies, they are locally driven and lack explicit integration into a national dementia governance framework.

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
4	**Alzheimer's disease financing**	**0-6**	**3**	Dedicated budget to Alzheimer's disease programmes	**1**	No standalone Alzheimer's or dementia budget is reported. However, under Universal Health Coverage, the NHSO expanded the "dependent care" allowance to include people with mid- and end-stage dementia[712]. Additionally, the government allocated ~US$17.4M for LTC for the elderly, and US$19M through NHSO to support local health funds for care provision. These funding streams support dementia care under broader elderly or LTC programmes, without Alzheimer's-specific designation
				Funding / insurance coverage for Dementia / Alzheimer's disease Care (Public)	**1**	[Coverage for Dementia, not specific for Alzheimer's disease] Thailand's Universal Coverage Scheme (UCS), administered by the NHSO, provides health services for dementia care, including Alzheimer's, through a dependent-care allowance[713]: - The NHSO expanded its "dependent care" allowance, from 6,000 THB to 10,442 THB per person per year—specifically to include individuals with middle- and end-stage dementia - Around 600,000 people with dementia are now covered under this allowance, up from ~320,000 previously However, care for chronic conditions such as dementia is rarely insured. Institutional LTC costs more than most Thais can afford to pay, thus most in need of such care continue to depend on family and community care[714].
4				Funding / insurance coverage for Dementia / Alzheimer's disease (Private & alternatives)	**1**	Partially funded, Alzheimer's disease specifically mentioned A collaboration between Eisai Thailand and Thai Life Insurance aims to develop insurance products that specifically cover dementia and Alzheimer's, including future-generation treatments [715]. "Thai Life Insurance" expands Alzheimer's disease coverage to cover all stages of the disease[716].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
5	**Existence of registries established for Alzheimer's disease**	**0-5**	**1**	Existence of registries established for Alzheimer's disease	**0**	(1) Thailand does not maintain a centralised national dementia registry. Instead, it operates a distributed system that combines NHSO inpatient data with academic hospital cohort registries. Analysis of NHSO data from 2015-2019 identified 29,895 dementia cases, providing structured insights into diagnosis rates, regional distribution, mortality, and hospital costs[717] (2) Complementing this, the Collaborative Aging and Dementia Research Society Thailand (CART) registry collected clinical, cognitive, and neuroimaging- including molecular imaging- data from 454 patients, offering detailed diagnostic and etiological insights[718]. The CART cohort found approximately 50% Alzheimer's disease, 24% vascular dementia, with the remaining being other or unspecified type
				Integration of Dementia-specific tracking in EMR systems	**1**	Thailand's EMR maturity for dementia tracking is categorised as basic. This is characterised by foundational internal systems and emerging external technologies, but it lacks explicit, standardised EMR integration for dementia-specific data. (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
66	**Inclusivity and equitable policy formulation**	0-8	1	Policies / strategies / plans / programmes addressing equitable access to care to Alzheimer's	**0**	There is insufficient policy support for long-term care of older adults with dementia in rural areas, indicating a lack of focused efforts on equitable access to care[719]
				Policy recognition of preclinical Alzheimer's disease / Dementia and at-risk populations - Evaluates whether national Alzheimer's disease or dementia policies address preclinical Alzheimer's disease, including asymptomatic individuals with biomarkers, family history, or genetic risk, and whether strategies are in place to guide early detection, risk reduction, or monitoring	**0**	No mention of preclinical Alzheimer's disease / Dementia or at-risk populations is found
				Patient navigation programmes for underserved subgroup: Alzheimer's disease patients from underserved backgrounds enrolled in patient navigation programmes to improve access to care and follow-up	**0**	No information is available indicating the existence of patient navigation programmes for underserved dementia or Alzheimer's populations.
				Community-based care programmes: availability of community-based Alzheimer's disease management programmes designed to support at-risk groups (e.g., community health workers, peer support groups)	**1**	E.g., Community-based dementia care is expanding via the Thai Integrated Care programme for Dementia, developed by Mahidol University and health-promoting hospitals in the northeast[720]. While early evaluation shows positive outcomes, it is in initial stages, not Alzheimer's-specific, and not yet a nationally scaled initiative

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
7	**National Alzheimer's disease clinical guidelines availability and implementation**	**0-6**	**4**	Availability of clinical guidelines on Alzheimer's disease	**2**	- Guideline: Clinical Practice Guidelines for Dementia (Full Version, 2020)[721] - Author: Neurological Institute of Thailand - Issue year: 2020 - No Alzheimers dedicated section → A draft local guideline including AD BBBM is expected to be announced in 2026 (TBC)
				Currency of clinical guidelines	**1**	2020
				Percentage of healthcare regions or facilities implementing national clinical guidelines, such as standardised treatment protocols and follow-up care	**1**	< 50% healthcare regions or facilities implementing national clinical guidelines (Source: Expert interview)
8	**Policy support for preventive care**	**0-2**	**1**	National policies focused on primary prevention / modifiable risk factors reduction of Alzheimer's disease. For example: physical inactivity, smoking, excessive alcohol consumption, air pollution, head injury, infrequent social contact, lower education, obesity, hypertension, diabetes, depression, hearing impairment, untreated vision loss, elevated LDL levels	**1**	Primary prevention targets[722] 1) Tobacco use: Decrease prevalence to less than 15.7% 2) Obesity: Prevent increase in obesity 3) Physical inactivity: Lower prevalence by 24% 4) Hypertension: Decrease prevalence by 12.2% 5) Sodium Intake: Decrease mean population intake by 24% 6) Diabetes: Prevent increase in diabetic cases 7) Harmful use of alcohol: Decrease to <6.7L per person per year
				National policies focused on secondary prevention of Alzheimer's disease (e.g., brain health / cognitive screening or monitoring)	**0**	The 20-Year National Strategic Plan for Public Health (2017-2036) mentions dementia in intermediate care, but does not outline screening or monitoring strategies in national policy [723]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
9	**Alzheimer's disease research and innovation**	0-6	3	Funding for Alzheimer's disease research: Investment in / funding for Alzheimer's disease-specific clinical trials, basic science research, and public health research	**1**	A culturally adapted version of the Reducing Disability in Alzheimer's Disease (RDAD) programme-an intervention aimed at reducing behavioral and psychological symptoms of dementia-has been successfully implemented in Thailand[724] . This adaptation retained the core intervention components, trained family caregivers, and prepared for a randomised trial rollout[725]. The project received NIH extramural funding (grant U19 MH113201). At present, while general dementia research and health technology assessments are supported through broader funding bodies, dedicated Alzheimer's-specific funding in Thailand is limited.
				Clinical trial participation: Eligible Dementia and Alzheimer's disease patients enrolled in clinical trials e.g., for new therapies or medical devices	**2**	Although Thailand does not yet have a nationally coordinated Alzheimer's clinical trial framework, it engages in community-level Alzheimer's and dementia studies. The Thai Clinical Trials Registry (TCTR) lists ongoing dementia-related trials, such as TCTR20240721003, which enrolls adults aged 60+ with subjective cognitive decline or preclinical dementia criteria[726]. Additionally, the Health Intervention and Technology Assessment programme (HITAP) supports the Reducing Disability in Alzheimer's Disease (RDAD) programme[727]- an intervention culturally adapted and piloted in Thai communities. These efforts reflect modest Alzheimer's-specific trial activity at local levels.
				Translation of research into practice: Time-to-adoption for new guidelines, therapies, and technologies from clinical trials to everyday practice	**0**	Unpredicted and no standardised adoption timeframe (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 2: Prevention & screening (early detection)						
10	**Alzheimer's disease screening guidelines (for high-risk population)**	**0-4**	**2**	National clinical guidelines **screening coverage** for high-risk population For example: Older adults (e.g. ≥65 years) Individuals with subjective cognitive decline (SCD) People with family history of dementia Those with prior stroke, traumatic brain injury (TBI), hypertension, diabetes, obesity, or depression	**1**	Guidelines mentions screening for individuals at high risk of Dementia / Alzheimer's disease[728]
				Inclusion of validated cognitive assessment tools in screening guidelines For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Validated cognitive assessment tools are mentioned in the screening context [729]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				Inclusion of BBBMs in **screening guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarker is mentioned for screening[730] → A draft local guideline including AD BBBM is expected to be announced in 2026 (TBC)
				Inclusion of CSF biomarkers in **screening guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening[731]
	Alzheimer's disease screening funding	**0-6**	**0**	Funding for **validated cognitive assessment tools in screening** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for B**BBMs in Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers Alzheimer's disease screening**	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 3: Diagnosis & healthcare system capacity						
	Alzheimer's disease diagnosis guidelines	**0-7**	**3**	National clinical guidelines **diagnosis coverage**	**1**	Guidelines explicitly cover diagnosis of Dementia, but not specifically Alzheimer's[732]
				Inclusion of validated cognitive assessment tools in **diagnostic guidelines** For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	National diagnostic guidelines for Dementia / Alzheimer's explicitly recommend one or more validated cognitive assessment tools[733]
				Inclusion of BBBMs in **diagnostic guidelines** (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No BBBMs recommended or mentioned for diagnosis[734]
				Inclusion of CSF biomarkers **diagnostic guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**1**	The current guideline mentions CSF diagnosis (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Capacity of / Availability of/ access to diagnostic infrastructure and services	**0-18**	**7**	MRI	**1**	0.04 per ten thousands of population[735]
				CT	**1**	0.12 per ten thousands of population[736]
				PET	**1**	0.07 per ten thousands of population[737] PET is available in medical university hospitals, provincial hospitals, and some private hospitals (Source: Expert interview)
				CSF Biomarker testing	**2**	Multiple Thai memory-clinic publications (Siriraj, Chulalongkorn, King Chulalongkorn Memorial Hospital) report CSF biomarker testing in tertiary centres[738]- available clinically but concentrated in a few centres
				BBBMs testing	**2**	Real-world memory-clinic studies (King Chulalongkorn, other centres) have implemented BBBMs p-tau assays and reported clinical-practice evaluation[739] - available in tertiary memory clinics
	Tracking of time to diagnosis for Alzheimer's disease	**0-2**	**0**	Evaluates whether a country is collecting or reporting data on how long it takes for individuals to receive an Alzheimer's disease (or dementia) diagnosis from the onset of symptoms	**0**	There is no evidence that the country or relevant stakeholders track or report time to diagnosis for Alzheimer's disease or dementia

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Biomarker testing rate (Percentage of patients with suspected Alzheimer's disease undergoing biomarkers - CSF or BBBMs - to confirm diagnosis)	**0-12**	**4**	% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary public institutions	**1**	< 50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary private institutions	**1**	< 50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary private institutions	**1**	< 50% (Source: Expert interview)
				% of patients with suspected Alzheimer's disease undergoing biomarker testing (CSF or BBBMs) in secondary / tertiary private institutions	**1**	< 50% (Source: Expert interview)
	Capacity of workforce	**0-16**	**9**	Geriatricians / Psychogeriatricians	**3**	Moderately high (>2-3 staffs per 100k of population) (Source: Expert interview)
				Neurologists	**4**	(MOPH, 2023) Number of neurologists (per 100,000): 8.94[740]
				Psychiatrist working in mental health sector	**1**	(WHO, 2016) Number of psychiatrists (per 100,000): 0.721[741]
				Social workers working in mental health sector	**1**	(WHO, 2016) Social workers working in mental health sector (per 100,000): 0.836[742]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Alzheimer's disease diagnostics funding coverage	**0-6**	**1**	Funding for **validated cognitive assessment tools in Alzheimer's disease / Dementia diagnosis** (public and/or private) For example: MMSE (Mini-Mental State Examination) MoCA (Montreal Cognitive Assessment) Mini-Cog GPCOG (General Practitioner Assessment of Cognition) CASI (Cognitive Abilities Screening Instrument) Clock Drawing Test	**1**	Cognitive assessment for Alzheimer's / Dementia diagnosis is partially funded or reimbursed Asia Advisors Network - "Thailand: Thai Life Insurance launches comprehensive critical illness insurance for seniors. The product covers screening for Alzheimer's disease and long-term monthly benefits for expenses in receiving services from nursing homes that are partners with TLI." [743]
				Financing mechanism for **BBBMs in Alzheimer's disease diagnosis**	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for **CSF biomarkers in Alzheimer's disease diagnosis**	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 4: Treatment monitoring and access						
	Alzheimer's disease treatment monitoring guidelines	**0-6**	**2**	National clinical guidelines **treatment & monitoring coverage** (e.g., periodic cognitive assessment, adverse event checks, medication reviews)	**2**	Pharmacological treatments are specifically mentioned for Alzheimer's disease[744]
				Inclusion of BBBMs in **treatment & monitoring** guidelines (e.g., pTau217, pTau181, Aβ42/40 ratio, NfL, GFAP)	**0**	No biomarkers recommended or mentioned for treatment & monitoring[745]
				Inclusion of CSF biomarkers in **treatment & monitoring guidelines** (e.g., Aβ42, Aβ42/40 ratio, t-tau, p-tau181, p-tau217, NfL)	**0**	No biomarker is mentioned for screening[746]
	Involvement of multi-disciplinary team	**0-2**	**1**	Guidelines recommend multidisciplinary dementia care (e.g., involving geriatricians, neurologists, psychologists, social workers, etc.)	**1**	Guideline mentions multidisciplinary care[747]
				Hospitals and clinics offer care by a multidisciplinary team including geriatricians/ neurologists, psychologists, social workers, occupational therapists, etc. for Dementia / Alzheimer's'	**0**	There is an identified need to develop multidisciplinary dementia care to follow local guidelines. Nurse administrators are encouraged to establish systems where nurse case managers or advanced practice nurses coordinate integrative care collaboration with other health professionals to improve dementia management outcomes[748]

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Linkage to supportive/ palliative care	**0-2**	**1**	Inclusion of referral pathways to supportive or palliative care in dementia clinical guidelines	**0**	A referral pathway exists (Source: Expert interview); however, the scope outlined in current guidelines does not include referral pathways to supportive or palliative care services[749]
				Availability of palliative care services for people with Alzheimer's disease (e.g., home-based comfort care, palliative dementia unit in hospital or care home)	**1**	1) Underutilisation of palliative care[750]: A national survey of tertiary hospitals in 2020 showed that while a substantial percentage of inpatients needed palliative care, a very small number, specifically 1.11% of people with dementia, actually had access to these services. 2) Private and Specialised Palliative Facilities[751 752]: In contrast to this limited availability within the public healthcare system, Thailand has seen the growth of private and specialised palliative facilities including dementia, particularly as the country has become a popular destination for medical tourism. Numerous high-quality private facilities have been established, especially in tourist-friendly areas like Chiang Mai and Pattaya, which cater to both local and international clients. These facilities often offer specialised, person-centered palliative dementia care with a high staff-to-patient ratio, advanced therapies, and hospice care options.
	DMT access pathway readiness	**0-5**	**5**	Regulatory approval status of Alzheimer's disease DMTs (e.g., lecanemab, aducanumab)	**3**	At least one DMT for AD (e.g., lecanemab, donanemab) has received full regulatory approval and is authorised for use at the national level (Source: Expert interview)
				Eligibility criteria for DMT access - Assesses whether clear, formalised eligibility criteria exist for patient access to Alzheimer's disease DMTs, including requirements for amyloid confirmation (e.g., via PET or CSF)	**2**	Eligibility criteria for DMT access are clearly defined e.g., in national guidelines, clinical protocols, or reimbursement frameworks. These criteria explicitly include amyloid confirmation as a prerequisite for treatment (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Home health medication monitoring and remote patient monitoring: Efforts to provide Alzheimer's disease / Dementia patients with regular medication reviews, adjustments, and ongoing remote clinical monitoring through telemedicine or other remote care services.	**0-1**	**1**	Availability of home health medication monitoring or remote care for Dementia and Alzheimer's disease patients	**1**	While there is a push for more integrated care, the full-scale adoption of telemedicine for Alzheimer's disease/ Dementia is still developing and faces challenges related to resource limitations and caregiver education (Source: Expert interview)
	Alzheimer's treatment & monitoring funding coverage	**0-6**	**1**	Existence of funded/ reimbursed drug therapy for Alzheimer's disease	**1**	Donepezil is the only ADD covered by the Universal Coverage Scheme (UCS), Thailand's primary national health insurance scheme, which insures 75 % of Thai population[753]
				Financing mechanism for BBBMs in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)
				Financing mechanism for CSF biomarkers in **Alzheimer's disease treatment & monitoring** (e.g., assist in patient selection for DMT, monitor disease progression and support personalised care plans)	**0**	Unavailable (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
Domain 5: Advocacy, awareness and education						
	Dementia/ Alzheimer's disease patient organisation engagement and advocacy	**0-3**	**1**	Existence of patient / caregiver organisations	**1**	Alzheimer's and Related Disorders Association of Thailand was founded in 1998 and has been a member of Alzheimer's diseasel since 1999 . One of the activities is Caregiver support services.
				Participation in national policy & plan development, and/ or joint programmes with government	**1**	At least one patient / caregiver organisation focused on Dementia and/ or AD actively participates in national policy & plan development, and/or joint programmes with government (Source: Expert interview)
				Availability of direct support services (e.g., respite care, 24/7 hotline services, caregiver training, post-diagnostic support) for people living with Alzheimer's disease	**0**	E.g., Alzheimer's and Related Disorders Association of Thailand provides caregiver support services[755]. However, in general, Alzheimer's support services remain limited. Scarce and not standardised. Caregiver training and post-diagnostic support are emerging but not widely accessible. Some local community initiatives exist to support caregivers and improve care, but broader, more comprehensive programmes are needed.
	Dementia/ Alzheimer's disease professional medical and scientific societies / associations, research institutes engagement and advocacy	**0-4**	**3**	Existence of professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease	**1**	(1) Thai Society of Gerontology and Geriatric Medicine[756] (2) Foundation of Thai Gerontology Research and Development Institute[757] (3) The Neurological Society of Thailand[758]
				Participation in national policy & plan development, and/or joint programmes or initiatives with government agencies on Dementia / Alzheimer's disease	**1**	The Neurological Society of Thailand Actively participate in national dementia policy, research, and programme initiatives with government agencies.
				Contributions towards clinical guidelines development	**1**	One or more medical or scientific society, association, or research institute are listed as contributors to national Dementia and/or AD clinical guidelines (Source: Expert interview)

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
	Dementia / Alzheimer's disease educational programmes and support resources (for patients; for caregivers; for healthcare providers)	**0-21**	**10**	[Patient] Availability of patient education programmes and support resources initiated / driven by patient / caregiver organisations	**2**	Broader Dementia and AD-specific programmes or resources are run by patient organisations (Source: Expert interview)
				[Patient] Availability of patient education programmes and support resources initiated / driven by the professional medical and scientific societies / associations, research Institutes focused on Dementia / Alzheimer's disease	**2**	Broader Dementia and AD–specific programmes or resources are driven by the professional medical and scientific societies / associations, research insitutues focused on Dementia / AD (Source: Expert interview)
				[Patient] Availability of patient education programmes and support resources initiated / driven by the government	**2**	Broader Dementia and AD-specific programmes or resources are run by the government (Source: Expert interview)
				[Caregiver] Availability of caregiver-focused education, training, and support services on Dementia / Alzheimer's disease (e.g., e-learning platforms on symptom recognition and disease management, webinars on new therapies and diagnostics, 24/7 helplines) Can be driven by: - Patient or caregiver organisation - Professional medical and scientific societies / associations, research institutes focused on Dementia / Alzheimer's disease - The government	**2**	Alzheimer's and Related Disorders Association of Thailand was founded in 1998 and has been a member of Alzheimer's diseaseI since 1999. One of the activities are Caregiver support services[759].

No.	Sub-domains	Range	Total score	Indicators	Indicator score	Justification
				[All] Existence and implementation of Dementia and Alzheimer's awareness programmes	**2**	During World Alzheimer's Month, the Alzheimer's and Related Disorders Association of Thailand collaborated with the Thailand Health Promotion Foundation, Ramathibodi Hospital's Faculty of Medicine, and the Manuttangwai Group to organize nationwide awareness activities[760]. These included dementia risk screenings and community workshops designed to promote dementia-friendly environments and strengthen public understanding and support for people living with dementia.
				[Healthcare providers] Availability of clinical education for primary care providers	**2**	An action-research project in central Thailand trained primary care providers and community health volunteers on dementia awareness and screening . They developed a care pathway including: awareness-building, screening, referral, multidisciplinary coordination, cognitive stimulation, and home care.
				[Healthcare providers] Availability of specialist training in Dementia/ Alzheimer's care	**2**	The Alzheimer's Disease and Related Disorders Association-Thailand has had significant input into the training of the healthcare workforce in Thailand . It usually has two types of training workshops/conferences annually. One is for healthcare professionals and the other for family caregivers.

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