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Abstract

Across the OECD, on average, 61 people per 1 000 population aged 65 and over were estimated to be living with dementia in 2023. This policy review provides an overview of the most recent dementia policies across OECD countries and changes in the past decade. The analysis suggests that national dementia policies increasingly emphasise prevention through modifiable risks, early diagnosis, and non-pharmaceutical treatment approaches. The paper summarises approaches towards improving awareness while pointing to limited efforts to improve diagnostics. Developments in managing behavioural and psychological symptoms of dementia, along with related workforce training, are more prominent. Additionally, services and support for dementia carers and progress towards more coordinated and inclusive care pathways are present in most national strategies and plans.

Résumé

Dans l'ensemble des pays de l'OCDE, en moyenne, 61 personnes pour 1 000 habitants âgés de 65 ans et plus souffrent de démence en 2023. Cette analyse donne un aperçu des politiques les plus récentes en matière de démence dans les pays de l'OCDE et des changements intervenus au cours de la dernière décennie. L'analyse suggère que les politiques nationales en matière de démence mettent de plus en plus l'accent sur la prévention par le biais des risques modifiables, du diagnostic précoce et des approches thérapeutiques non pharmaceutiques. Le document résume les approches visant à améliorer la sensibilisation tout en soulignant les efforts limités déployés pour améliorer les diagnostics. Les progrès réalisés dans la prise en charge des symptômes comportementaux et psychologiques de la démence, ainsi que la formation du personnel concerné, sont plus importants. En outre, la plupart des stratégies et plans nationaux prévoient des services et un soutien aux aidants des personnes atteintes de démence, ainsi que des progrès envers des parcours de soins plus coordonnés et plus inclusifs.

Acknowledgements

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Executive summary

Encompassing a range of health conditions, *dementia* refers to symptoms of memory and cognitive difficulties that can eventually interfere with the everyday life and activities of people living with dementia. While Alzheimer's disease is the most common form of dementia, other diseases exhibit similar symptoms, including vascular dementia, dementia with Lewy Body's, and Parkinson's disease. Population ageing will likely lead to an increase of people with dementia and could reach almost 32 million by 2040 across OECD countries.

Dementia is a policy priority as governments recognise the scope of the challenge ahead linked to a growing number of people living with dementia as populations age. As many as 30 of the 38 OECD countries have national plans and strategies for addressing dementia and 63% of countries have updated their national strategies in the past decade. Czechia, Germany, Greece and Switzerland are expecting to publish new policy documents. Prevention of dementia is one of the most important aspects emphasised in 79% of the strategies. Some countries integrate prevention of dementia among general preventive policies, while nine OECD countries have specific strategies such as multidomain interventions. In addition, 74% of strategies and plans put a strong emphasis on addressing stigma and promoting awareness, and 90% include supportive actions for carers of people living with dementia.

Progress on diagnosis rates has been slow due to bottlenecks both in primary care and specialists. GPs remain the first point of contact in 38 OECD countries and can perform diagnosis in 13% of the countries. Yet, they often lack the time and skills to perform an initial accurate diagnosis. At the same time, diagnostic guidelines are available in 30 countries, helping to standardise the diagnostic process and improve timeliness. A few countries like Australia and the United Kingdom have introduced national training standards, while Ireland and Japan have developed continuous education training to improve dementia diagnosis. Several incentives have been implemented to improve diagnostic rates such as financial incentives in Denmark, the United States and the United Kingdom and have shown that such incentives as well as having targets have resulted in improvements, although there are concerns about overdiagnosis. Diagnosis is also hampered by bottlenecks in diagnostic technology and access to specialists. Some countries, like Austria, have rolled out diagnosis to other professionals to partly address such bottlenecks.

Changes to the diagnostic process have resulted in limited improvements in the ability to diagnose in the past decade in most countries but the outlook appears promising. Incidence has increased in absolute terms (counts), but incidence rates per population have remained constant or declined in some OECD countries, like Denmark and Canada. It is not clear whether these observations can be attributed to prevention measures slowing down incidence rates, or whether they point at an increasing diagnostic gap, with diagnostic capacities not keeping up with increased demand due to population ageing. Steady progress in blood-based biomarkers show that they will soon be able to address some bottlenecks in diagnosis. Biomarkers appear to have high accuracy, do not require invasive procedure, are affordable and possible require less evaluations from specialists.

Professionals, people living with dementia and their families might have little incentive to improve diagnosis as long as suitable care options are not available. Despite dementia research featuring prominently in almost 72% of countries' strategies and plans, there has been only a slight improvement in pharmacological treatment options. Four medications to ease the symptoms of people living with dementia are available and are reimbursable in 14 OECD countries so far. However, in 2018, France stopped reimbursement due to the lack of evidence on cost-effectiveness. Although two new treatments have recently emerged, they are not necessarily considered to be cost-effective and have limited impact on the symptoms of dementia, while only being available for a fraction of the people living with dementia. By comparison, progress has been made on non-pharmacological treatments, with increasing evidence of effectiveness. In 29 out of 33 guidelines, countries provide advice on the use of non-pharmacological interventions. Cognitive stimulation therapy, physical exercise, occupational therapy and music therapy have evidence of positive outcomes on cognitive function. Nevertheless, their coverage and use in care settings is not widespread. Currently, only 13 OECD countries report providing reimbursement or subsidies for such interventions.

Progress remains slow in reducing the use of chemical (antipsychotics) and physical restraints, although guidelines for the behavioural and psychological symptoms of dementia (BPSD) strongly recommend against their use. Data on antipsychotic use across OECD countries show no sign of a decline across the board, with large variations across countries, ranging from a prevalence of 16 to 96 per 1 000 people 65 and over. National BPSD guidelines are available in 20 countries (67%), with subnational and sector-specific guidelines available in 3 (10%) and 11 (37%) countries respectively. Most guidelines were published in the past decade. Antipsychotic treatment is recommended to be limited for a short-term use, and with close and frequent reviews, and it is strongly recommended to combine it with non-pharmacological approaches. Regulations on restraint use are still lacking across the OECD, as only 10 countries have established explicit restrictions or bans.

Care co-ordination has improved but still requires a more structured approach to further ensure access to post-diagnostic care. As dementia care services spread out across health and social care sectors, care co-ordination can help people with dementia and their carers navigate available services, improve the overall care experience, and alleviate carers' burden. A coordinated care model has been increasingly adopted, with care coordinators available in 16 countries and special case management available in 16 countries as well. Only a few countries perform adequate evaluation or have a structured approach to post-diagnostic services. Scotland has developed targeted post-diagnostic services, while in Germany and Finland, follow-up care is embedded in networked and integrated care systems.

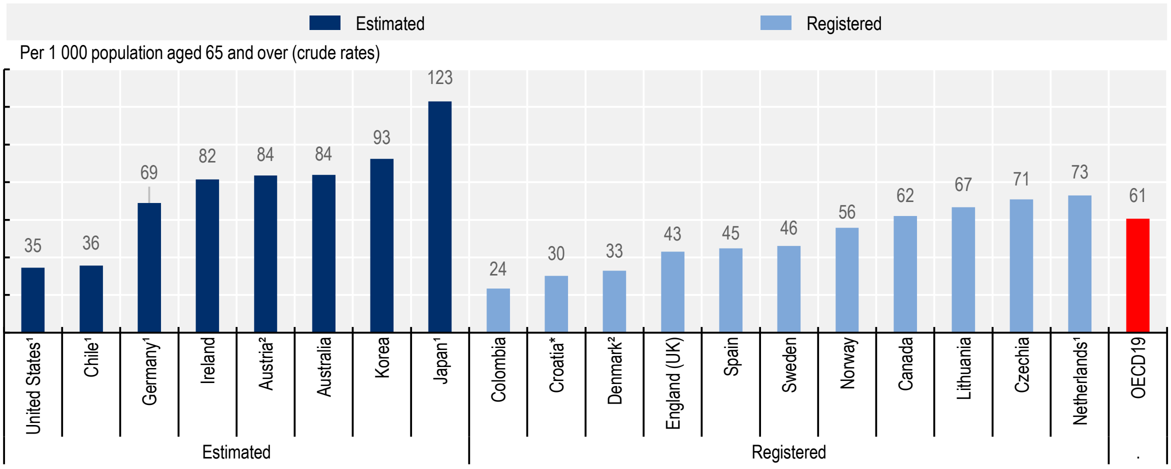
Many people with dementia rely on their families and friends for care and countries are increasingly supporting them, given awareness of the toll that caregiving can take and the importance of improving care quality among this group. Efforts have been made in training and counselling of caregivers, and in targeting these policies towards people with dementia: 26 countries have training while counselling is available in 21 countries. Austria provides a cash allowance for courses, while Spain has hands-on training and other countries like Australia have developed flexible e-learning options. Counselling efforts have expanded through the use of self-help groups or helplines as in Korea, and the more widespread free and online counselling options, as in Estonia. Respite care appears to be widely available, with 27 countries having such services. It remains limited in time in most countries, not always having nation-wide availability and not well-targeted towards the needs of people with dementia. Japan has day services, short-term stays, and peer support tailored to dementia care, while Iceland offers up to eight weeks of respite per year.

Family caregivers of people with dementia rely on general provisions for caregivers which are widely available but heterogeneous. 25 out of 29 countries offer leave permits, 20 of which are unpaid leave measures and 17 are paid leave schemes. Such entitlements are not specific for caring for people with dementia and vary widely in generosity across countries. Some countries, like Canada, provide up to 15 weeks of income support at 55% up to a maximum of USD 695 a week for 2025, for those providing care for a critically ill or injured adult, as well as up to 26 weeks for those providing care for someone with a significant risk of death in the following 26 weeks or end-of-life care, while certain countries in Europe like Spain provide only a limited number of days (5 days). Unpaid leave tends to be longer but also varies across countries from two years for spouses or registered partners in Spain to only one week of unpaid leave every 12 months in Scotland. Similarly, cash benefits are available in 24 out 29 OECD countries. In 15 of them are directed towards the caregiver, while in nine countries the benefits target the care recipients. Benefits, as observed in 2025, range from small, targeted transfers of around USD 30 per month to payments exceeding USD 2 000 per month, depending on the scheme, intensity of care, and eligibility criteria.

1 Dementia is a policy priority for countries

1. Across 19 OECD countries, on average, 61 people per 1 000 population aged 65 and over were living with dementia in 2023 (OECD, 2025[1]) ranging from 24 per 1 000 population in Colombia to 122 per 1 000 in Japan – although differences in diagnostic rates, definitions and measurements hamper international comparability as some of the data is based on patient-registered data, while others are based on estimated prevalence rates (Figure 1.1). The term 'dementia' refers to a set of symptoms of cognitive decline, such as memory loss, that interferes in one's daily life and social activities and affects behaviour and relationship. Dementia is a progressive condition that often begins with cognitive impairment which can worsen over time and Alzheimer is a prominent form of dementia. Its prevalence increases with age, affecting a growing proportion of older adults.

Figure 1.1 Estimated and registered prevalence of dementia across 19 OECD and accession countries, 2023 or latest year available



Note: 1. 2022 data. 2. 2024-25 data. Definitions vary across countries (see the "Definition and comparability" box). *Accession/partner country.

Source: Pilot data collection from OECD Healthcare Quality and Outcomes. National sources include: GÖG (Hg.) (2025), Österreichischer Demenzbericht 2025 (Austria); Canadian Chronic Disease Surveillance System (CCDSS) (2025), Dementia, including Alzheimer's disease; Observatorio Social (2022), Encuesta Discapacidad y Dependencia (Chile); Danish Dementia Reserch Centre (2025), Incidence and prevalence of dementia in Denmark; Rommel, A. et al. (2025), "Dementia – Prevalence, trends and regional patterns in Germany. An analysis based on routine data from the statutory health insurance", Journal of Health Monitoring, Vol. 10/1; Ninomiya, T. et al. (2024), A Study on the Prevalence and Future Projections of Dementia and Mild Cognitive Impairment (Japan); Ministry of Health and Welfare (2025), 2023 National Survey on Dementia Epidemiology and Prevalence (Korea); Ministerio de Salud (2023), Base de Datos Clínicos de Atención Primaria (Spain); and Kramarow, E. (2024), "Diagnosed dementia in adults age 65 and older: United States", National Health Statistics Reports, no. 203.

Definition and comparability

Dementia prevalence data are collected from national sources. Some countries provide data based on estimates, while others use patient-registered data. These two approaches differ significantly. Estimated data may overestimate prevalence, as they include projections based on population characteristics and assumptions. In contrast, registered data includes only officially diagnosed cases, which may understate the true number due to underdiagnosis or gaps in reporting.

The OECD is currently performing a pilot data collection on dementia to better understand variations in data reporting across OECD member and accession countries and to move towards internationally comparable data. Several OECD countries have built nationwide patient registries (e.g. England (United Kingdom) and Norway) and dementia registries (e.g. Sweden, forthcoming in Ireland) that facilitate identification of people that have been diagnosed with dementia.

1.1 A growing number of OECD countries have developed national strategies and plan for dementia

2. Although dementia remains a prominent issue on the international policy agenda, it is often underdiagnosed as persistent stigma continues to hinder its early diagnosis and effective care provision. The creation and implementation of national plans and strategies is key to producing change in the recognition and management of dementia. Collaboration between the government, local-level authorities, civil society organisations, and families is also important for raising awareness about dementia and improving the services and support available, not only for people living with dementia, but also their families and carers, and improving the working conditions of professional caregivers.

3. Over the past decade, OECD countries have set up and updated new dementia strategies and plans. Currently, **more than three-fourths (30 out of 38**) have implemented stand-alone national strategies and plans focusing on dementia. Most countries have one national strategy or plan addressing dementia, however, some countries in Table 1 report having more than one dementia framework. This is because, in addition to a national dementia strategy, they have implemented national norms regulating dementia (Costa Rica, Finland, Italy, Japan, Korea, Norway). In Spain and Portugal, dementia plans are implemented at both the national and regional levels. Consequently, 24% (8 of 38) of OECD countries have more than one dementia framework in place, resulting in 43 dementia policies collected in total.

4. In contrast to the widespread adoption of dedicated dementia strategies, some countries present different approaches. Conversely, Hungary, Estonia, Colombia, the Slovak Republic, Lithuania, Türkiye, and Latvia have not implemented stand-alone national dementia policies. Despite this, three of these countries have integrated dementia-related objectives into broader policy frameworks, for example targeting long-term care (Hungary) or neurodegenerative diseases (France). France, for instance, previously implemented specific national Alzheimer plans (in 2001, 2004, and 2008) but, since 2013, has regulated dementia through a broader national neurodegenerative diseases plan. For its part, Estonia despite lacking a national policy, they have the Dementia Competence Centre’s (DKK) strategic plan which serves as planning tool for the DKK day-to-day activities and longer-term development work. However, the rest of countries mentioned appear to have neither a dedicated national dementia policy nor a broader strategy that explicitly addresses dementia.

5. Since 2018, progress in updating and establishing national dementia strategies and plans has been uneven across countries. While 36% have not revised their initial strategy established before 2018, 63% of OECD countries have implemented updates. In addition, Czechia, Germany, Iceland, Mexico and

Poland which lacked a strategy prior to 2018, have since implemented at least one. Looking ahead, Czechia, Germany, Greece and Switzerland are expecting to publish new policy documents. Switzerland's and Greece's new action plan, and Germany's updated strategy are scheduled for release within the next few years. The strategy for dementia in Czechia will be updated in 2026.

6. Dementia-specific policies, as well as broader strategies that include dementia, are primarily the responsibility of the Ministry of Health, in approximately 76% (33/43) of the countries examined, sometimes in collaboration with the Ministry of Social Affairs. In contrast, in other countries the responsibility lies in different ministries or health-related institutions: for example, the National Institute of Geriatrics in Mexico, National Council for Older Persons (CONAPAM) in Costa Rica; the Social Care Ministry in Scotland, and the Ministry of Elderly and Social Security in Sweden.

1.2 Prevention, caregiver support, stigma reduction and research feature prominently in the dementia policies and plans

7. Dementia is an illness with no clear nor unique cure because it is caused by different diseases. However, research has found that there are a number of ways to decrease the risk of dementia and to extend the quality of life of those who suffer it. Recent evidence from the Lancet Commission has revealed new evidence on 14 modifiable risk factors, indicating their potential to prevent or significantly delay nearly half of all dementia cases (Livingston et al., 2024[2]). Among them are policies to improve physical activity, to reduce obesity, to better manage diabetes and hypertension (OECD, 2019[3]; OECD, 2023[4]; OECD/WHO, 2023[5]). These reduce risk factors that directly cause damage to the brain. In addition, treating hearing impairment, fighting social isolation, and improving education helps people to increase and maintain cognitive capacities. The research highlighted that around 45% of all cases are associated with 'modifiable' risk factors countries can address throughout the life course and could be prevented. This is particularly relevant, as the risk of being diagnosed with dementia is set to increase considering current ageing population trends.

8. Table 1.1 shows that national dementia strategies frequently organise policy measures around five common themes: caregiver support, awareness-raising and destigmatization, prevention, diagnosis, and research and development (R&D) investment. These themes reflect the need for comprehensive approaches to reduce risk, improve diagnosis, and enhance the quality of life for those affected.

9. **Measures aimed for caregivers** are the most frequently included component, present in approximately 90% of measures (39 out of 43) which aim to support and empower them in their roles. In some countries, strategies provide in-depth action plans focused on improving caregiver well-being, while in others, the strategies are more general and not dementia specific. In Scotland's (UK) dementia strategy, initiatives such as the Alzheimer Scotland Centre for Policy and Practice Carers' Academy supports family carers of people living with dementia by enhancing their understanding of dementia, developing practical care skills, and providing peer-to-peer learning and emotional support (University of West Scotland, 2023[6]). In contrast, Finland's measures for informal caregivers are not dementia-specific but offer various support services, such as service vouchers, home care, and respite options. Additionally, caregivers can balance work with caregiving through part-time and remote work, and temporary care leave is supported.

10. A common element between the different strategies of the support available to dementia caregivers is counselling services. A nationwide network of counselling centres, known as memory centres, is being established in Czechia. In Korea, to reduce the care burden on family caregivers they offer online psychological self-screening and counselling (since 2017) and outbound case management through the National Dementia Helpline (1899-9988). Other measures available is the provision of travel vouchers and leisure services for family caregivers. Similarly, Germany's national dementia strategy also includes counselling services to help relatives access support, reduce caregiver stress, and enable longer home

care for people with dementia. The goal is to create a culture where the first contact takes responsibility for addressing issues and arranging further support. Furthermore, another feature in Germany's strategy is the strengthening of new forms of cooperation: local networks of care and support services. This is useful for people with dementia and their carers/family as it helps them stay informed about the support services available to them.

11. To decrease the incidence and prevalence of dementia is a shared goal for many OECD countries which have incorporated dementia prevention into their national strategies. Out of the 43 plans and strategies in Table 1.1, nearly four-fifths (34/43) explicitly include **prevention as a key component**. Countries aim to prevent dementia and increase its early detection through different initiatives, however, most of them lack a national prevention program. A common approach involves widespread public health campaigns promoting healthy living. These campaigns are included in the plans of Germany, Canada, Iceland or Norway. In Germany, initiatives like the national action plan "IN FORM" promote physical activity, alongside campaigns like "Alcohol? Know your limits" to address risk factors. Other countries focus on information and awareness like Sweden or Australia. For example, Swedish Dementia Centre, offers free online training for the public, guiding them on simple lifestyle changes for brain health. Similarly, Dementia Australia provides comprehensive tips on lifestyle modifications to reduce dementia risk, covering areas such as physical exercise, heart health, mental stimulation, and social engagement in its webpage and social media.

12. Dementia prevention also includes initiatives raising awareness of specific modifiable risk factors. For instance, Costa Rica prioritises cardiovascular health, targeting factors like smoking, alcohol, obesity, and chronic disease management. Canada, Iceland and Norway highlight social well-being, with initiatives addressing loneliness and social isolation and fall prevention among older people. Beyond this, countries such as the Netherlands or Canada, are also investing significantly in research into modifiable risk factors, with the aim of uncovering new knowledge and optimizing future interventions. The Netherlands, for instance, has launched a dedicated "risk reduction" theme within its dementia research program, managed by *ZorgOnderzoek Nederland Medical Sciences* (ZonMw). Similarly, Canada's Brain Health and Cognitive Impairment in Aging (BHCIA) Research Initiative, led by the Canadian Institutes of Health Research's Institute of Aging, funds research on brain health and dementia risk reduction. It also supports the Canadian Consortium on Neurodegeneration in Aging (CCNA), a national network where primary prevention is a core research theme.

13. A step forward in this context are prevention measures that address multiple lifestyle factors at once. Recent research using Randomised Control Trials (RCTs) has shown its positive effects on cognitive function. There are three large ongoing RCTs: the Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER), the Multidomain Alzheimer Preventive Trial (MAPT), and the Prevention of Dementia by Intensive Vascular Care (PreDIVA) study. Out of these three RCTs, the FINGER trial showed that a multidomain lifestyle intervention can benefit cognition in older people with an elevated risk of dementia. The other two did not show a statistically significant benefit of preventive interventions but additional analyses among participants at risk of dementia showed beneficial effects of intervention. Overall, these results suggest that the targeting of preventive interventions to at-risk individuals is an effective prevention strategy (Kivipelto, Mangialasche and Ngandu, 2018[7]). In addition, targeting several risk factors may contribute to enhance overall health status in advanced age because dementia-related risk factors are shared with other pressing public health problems (Mangialasche et al., 2012[8]).

14. These positive results have inspired the implementation of the FINGER model in other settings. For example, various OECD countries have formed part of FINGER network groups. One of these groups is EU-FINGERS, including Sweden, Finland, Germany, Hungary, Luxembourg, the Netherlands and Spain; and the other group is LatAm-FINGERS including OECD member and accession countries such as Chile, Costa Rica, Mexico, Brazil, Argentina and Peru (Crivelli et al., 2023[9]).

15. Another initiative addressing multiple lifestyle factors is Luxembourg's Programme for Dementia Prevention (PDP). The program aims to prevent or delay dementia by reducing modifiable risk factors through personalized multi-domain interventions. It targets people with Mild Cognitive Impairment (MCI) or Subjective Cognitive Decline (SCD) to help them stay cognitively and physically active. Participants follow a structured pathway that includes initial referral, neuropsychological assessment, thorough risk factor profiling, communication of results, and provision of vouchers granting access to tailored interventions (Schröder et al., 2024[10]).

16. Parallelly, other dementia prevention initiatives specifically target vulnerable groups. For instance, Australia's National Dementia Action Plan (2024–34) identifies opportunities to partner with relevant communities to develop targeted strategies and messages for diverse or high-risk populations, such as First Nations communities, while Germany funds targeted interventions for people with disabilities or impairments. Similarly, Italy's Prevention Plan focuses on early identification and management of individuals at increased risk for or affected by Non-Communicable Chronic Diseases (NCNTs), aligning with its National Chronic Disease Plan. Furthermore, countries are increasingly focusing on educating the workforce in contact with patients or those suspected of dementia. This includes training healthcare professionals, such as GPs and allied health staff in Australia or to integrate brain health and prevention into chronic disease management in Canada. Furthermore, Czechia and Spain, in their national plans, focus on capacity building, professional qualification, and specialised training for primary care providers to improve diagnosis and support along the dementia journey.

17. Looking at countries with no dedicated dementia strategy, like Hungary or Estonia, their prevention approaches vary. While Hungary's long-term care (LTC) policy includes general prevention programs not specific to dementia, Estonia's DKK strategy directly encourages local governments to offer specific dementia-preventive activities, such as dance therapy and memory cafes, and facilitate access through healthcare.

18. Prevention efforts appear to pay off, but more could be done. The incidence rate of dementia in Europe and North America has declined by 13% per decade over the past 25 years, which could lead 15 million fewer people developing dementia by 2040 (Wolters and al, 2020[11]). At the same time, countries have not made enough efforts to reduce a number of risk factors. While smoking has declined and countries have made efforts to make mental health treatment more accessible, not enough has been done to improve physical activity and to reduce obesity (OECD, 2019[3]; OECD, 2023[4]; OECD/WHO, 2023[5]).

19. Furthermore, 76% of the measures address measures to improve the **diagnosis of dementia** (33/43). For example, Australia and Mexico share a commitment to improving early diagnosis, coordinated care, and training for healthcare providers. Australia's approach includes broader system reforms, such as regularly reviewing and updating clinical practice guidelines, clarifying national pathways for screening and diagnosis, and reassessing funding models for memory clinics. In addition, it includes embedding memory clinics within Aboriginal Community Controlled Health Organisations to improve access and ensure culturally appropriate care for First Nations people. Mexico's National Dementia Plan focuses on improving dementia diagnosis and management within healthcare institutions. The strategy emphasizes coordinating care across all levels to optimize diagnosis and follow-up, reorganizing existing services instead of creating new ones to prevent overburdening the system.

20. Other countries, such as Denmark or Finland, have recently implemented initiatives to promote earlier dementia diagnoses. As part of the Finance Act for 2025, Denmark has allocated DKK 15 million for 2025 and DKK 20 million for 2026 to strengthen regional dementia assessments by expanding capacity and reducing waiting times. This reflects Denmark's ongoing commitment, as shown by the 2024 SSA agreement, which earmarked over DKK 123 million to upgrade assessment units, upskill staff, and support safe prescribing, including antipsychotics (Ministry of the Interior and Health, 2025[12]). In Finland, the National Memory Care Pathway promotes early dementia diagnosis by lowering barriers to entry into assessment and care. A key component of the pathway is the systematic integration of lifestyle counselling

across all stages of care, supported through the implementation of the FINGER model within wellbeing services counties. The FINGER model supports risk factor management and early intervention, encouraging earlier help-seeking and recognition of cognitive impairment in primary and community care settings (Pennanen et al., 2023[13]).

21. When it comes to **de-stigmatisation efforts**, 74% of the measures (32/43) include actions to raise awareness and reduce stigma around dementia. In 2016, in Germany, the federal government launched a national awareness campaign and promoting ‘Dementia Friends’ training across various occupational groups to help build a dementia-friendly environment. The campaign is not a one-off event, but an ongoing initiative that is also part of the National Dementia Strategy adopted in 2020.There are also materials and approaches to educate children and young people about dementia in an age-appropriate manner. Similarly, Japan’s Basic Act on Dementia also highlights the importance of promoting public understanding by ensuring people have accurate knowledge about dementia, with the aim of fostering a more inclusive society. This includes promoting dementia awareness through education and supporting people with dementia to share their experiences, such as via Dementia Hope Ambassadors.

22. Lastly, with **72% (31/43) of policies incorporating R&D,** countries are increasingly investing in innovation to drive forward dementia research and improve dementia’s prevention, diagnostic and treatment. Norway’s Brain Health Strategy includes a government allocation of NOK 20 million through the Norwegian Research Council to establish new clinical research centres for serious central nervous system diseases, including dementia. Other plans, for example Switzerland’s, include a scope of action focused on improving data collection on current and future dementia care at the cantonal level (Objective 8) and enhancing the exchange between researchers and care providers (Objective 9). This includes projects such as the development of a national monitoring system to track dementia prevalence and care needs across the entire care pathway, and the scientific evaluation of innovative care models to ensure quality and safety. Moreover, a national online platform is proposed to catalogue dementia research and support knowledge transfer through networking and targeted events.

23. Beyond these priorities, some strategies also focus on integrating community-based initiatives. Community-based services are essential as they provide accessible care and ensure continuity across various stages of dementia. In Canada and Costa Rica, dementia strategies include an objective on the importance of care co-ordination and strengthening community-based care services. Similarly, in Korea and Japan, both national dementia plans include a network of local dementia centres to provide community-based diagnostic and care (Legislative Council Secretariat, 2023[14]). In Czechia, efforts are underway to improve the planning and coordination of health and social services in individual regions through meetings of interdisciplinary working groups.

24. In parallel, countries have incorporated measures to improve the quality of care through workforce development. For example, Korea focuses on enhancing the expertise of dementia-related health professionals, targeting doctors, nurses, occupational therapists, social workers, and care workers. Furthermore, Korea has implemented the Dementia Education Program Graduate Database (since 2015) to manage educational histories and enhance the capabilities of dementia care providers. In this line, Costa Rica also includes as an objective the development of training for healthcare professionals. This is achieved through specialized curricular programs in neurocognitive diseases, collaboration with universities to integrate the topic into curricula, and promoting courses, workshops, and seminars related to dementia.

Table 1.1. National dementia strategies are implemented across the majority of 38 OECD countries

OECD country	National Strategy	Policy		Contents				
		Stand- alone	Broader	Prevention	Caregivers	R+D	Diagnosis	De-stigma / awareness
Australia	National Dementia Action Plan 2024-2034.	●		●	●	●	●	●
Austria	Dementia Strategy - Living well with dementia, 2015.	●			●	●	●	●
Belgium (Flanders)	Flanders' dementia plan 2021-2025.	●		●	●			●
Canada	A Dementia Strategy for Canada: Together we Aspire, 2019.	●		●	●	●	●	●
Chile	Dementia National Plan 2017-2025.	●		●		●		●
Costa Rica	National plan for Alzheimer's disease and related dementias: shared effort 2014-2024.	●			●	●	●	●
	National Norm for Care of Adults with Cognitive Impairment and Dementia, 2017.		●	●	●		●	
Czechia	National Action Plan for Alzheimer’s Disease and Related Illnesses 2020-2030.	●		●	●	●	●	●
Denmark	A Safe and Dignified Life with Dementia: National Action Plan on Dementia (2017-2025).	●			●	●	●	●
Estonia	Dementia Competence Center 's Strategic Plan 2023 2027.		●	●	●		●	●
Finland	Finland National Memory Programme 2012-2020.	●		●	●	●		●
	Programme: A strong and committed Finland of Prime Minister Petteri Orpo's Government, [Supports Older Peoples Coping at Home], 2024.		●	●	●			
	Quality recommendations to guarantee active and functional ageing and sustainable services in 2024-2027.		●	●	●			
France	National Strategy for Neurodegenerative Diseases 2024-2028.		●			●		
Germany	National Dementia Strategy, 2020-2026.	●		●	●	●		●
Greece	Dementia action plan, 2016-2020.	●		●	●	●	●	●
Hungary	Strategy for long-term care 2023-2030.		●		●			●
Iceland	National Dementia Action Plan 2020-2025.	●		●	●	●	●	●
Ireland	National dementia strategy, 2014.	●		●	●	●	●	●
Israel	Addressing Alzheimer’s and Other Types of Dementia: Israeli National Strategy (2013).	●			●			●
Italy	National Plan on Dementia, 2014.	●		●			●	●
	Italian National Prevention Plan 2020-2025.		●	●				
Japan	National Framework for Promotion of Dementia Policies, 2019.	●		●	●	●	●	●
	Basic Act on Dementia to Promote an Inclusive Society, 2024.		●	●	●	●	●	●
Korea	National Responsibility for Dementia, 2017.		●	●	●		●	●
	Fourth General Measures for Overall Dementia Management (2021-2025).	●		●	●	●	●	●
Luxembourg	National Action Plan for Dementia Diseases, 2013.	●		●	●		●	●
Mexico	National Plan Dementia Care, 2024.	●		●	●	●	●	●
Netherlands	National Dementia Strategy 2021-2030.	●		●	●	●	●	●
New Zealand	Dementia Mate Wareware Action Plan 2026-2031.	●		●	●	●	●	
Norway	Dementia Plan, 2025.	●		●	●	●	●	●
	The National Brain Health Strategy, 2018-2024.		●	●	●	●	●	
Poland	National Action Programme on Dementia Diseases, Public Policy until 2030.	●		●	●	●	●	
Portugal	Dementia Health Strategy (Despacho n.° 5988/2018)	●			●	●	●	●
	Regional health plan for dementia Lisbon and Tagus valley region, 2019.		●		●		●	●

Slovenia	Dementia Management Strategy until 2030.	●		●	●	●	●	●
Spain	Alzheimer and other dementias plan for 2019-2023.	●		●	●	●	●	●
	Alzheimer and other dementias: strategy on neurodegenerative disorders of the national health system, 2022.		●	●	●	●	●	
	Comprehensive Plan for Alzheimer's and Other Dementias in Andalusia, 2021.		●	●	●	●	●	●
Sweden	Everyday Counts: National Dementia Strategy 2025-2028.	●		●	●	●	●	
Switzerland	National Dementia Platform, 2021.	●			●	●	●	
United Kingdom (Scotland)	Dementia strategy: Everyone's Story.	●		●	●	●	●	●
United States	National Plan to Address Alzheimer's Disease, 2024.	●		●	●	●	●	●
Total¹		30	13	34	39	31	33	32

Note: The “Policy” column distinguishes between two types of strategies: (1) stand-alone policies which represent the national dementia policy, and (2) policies that are not stand-alone but are embedded within broader strategic frameworks, correspond to regional strategies or related to dementia. The “Contents” columns refer to the most common topics included in these strategies and plans. 1. The total number of policies, strategies and plans is of 43.
Source: OECD questionnaire/interviews.

1.3 Raising awareness and reducing stigma is a preliminary step to encourage people to get diagnosed for dementia

25. Stigma against people with dementia can be perpetuated by individuals living with dementia, their families, society, and even healthcare professionals. It stems from a lack of public awareness and understanding and influences people with dementia and their families to delay diagnosis and remain unaware of available support (Aboseif and Woo, 2020[15]). Misconceptions about dementia have led to associated negative attitudes and these misconceptions significantly undermine efforts toward early detection and diagnosis.

26. The two most common types of stigmas are at the public and individual level. Public-level stigma refers to society’s negative stereotypes, prejudice, and discrimination toward people with dementia. Common perceived stereotypes toward people with dementia include being seen as dangerous, less competent, or being closer to death (Nguyen and Li, 2020[16]). When people with dementia internalize these negative views, it leads to individual-level stigma. This can cause them to feel shame, reduced self-esteem, and social withdrawal. As a result, they may avoid being diagnosed to protect their independence, or prevent feeling like a burden to their family (Harper, Dobbs and Buckwalter, 2018[17]). Cultural misconceptions add to the problem as in some communities, dementia is seen as a normal part of aging rather than a medical condition requiring treatment and support (Cations et al., 2018[18]). In such contexts, families may hide symptoms or hesitate to seek medical help due to frustration, fear of social discrimination, or lack of understanding (Siette, Meka and Antoniades, 2023[19]).

27. Furthermore, stigma is also present at the structural level, although often overlooked. It is embedded in policies, professional routines, and diagnostic practices that reinforce negative associations with dementia. Legal, healthcare, and social systems often place responsibility for care onto families, which can result in people with dementia receiving inadequate support, fragmented care, and being treated as manageable cases rather than individuals with rights. A study in the United Kingdom found that GPs’ awareness of both public stigma and structural discrimination surrounding dementia can make them reluctant to make an early diagnosis, as they may wish to avoid labelling patients with a condition associated with negative perceptions (Gove et al., 2015[20]).

28. Many countries have implemented various measures and strategies to reduce stigma and promote more inclusive attitudes toward dementia within their societies. Table 1.2 presents a summary of the main

efforts implemented by countries, grouped into three categories: raising awareness, promoting inclusion, and providing training and guidance (See Table A.1, for more information).

29. The first category, **raising awareness**, focuses on increasing public understanding of dementia. One of the most common approaches adopted by countries is the launch of national awareness campaigns. These campaigns aim to educate the public and reduce misinformation towards the condition. For example, Italy launched the campaign “Do not forget to love me” in 2019 and Australia promotes Dementia Action Week each year alongside a website offering practical tips to support people living with dementia. Evidence on campaign effectiveness is mixed. In Flanders (Belgium) a public health campaign increased awareness of dementia risk reduction (Van Asbroeck et al., 2021[21]) , while other studies in the Netherlands and Denmark concluded similarly that mass-media campaigns had overall limited effect but improved knowledge and willingness to act among those exposed (Heger et al., 2020[22]; Paauw et al., 2024[23]).

30. In addition to nationwide campaigns, other initiatives have emerged to raise awareness and combat stigma around dementia. These include Czechia’s activities as 7th Unforgettable Evening Concert, the Demetrix escape game focused on understanding the experiences of people with dementia and communication or discussions connected with the screening of the film "Waltzing, Matilda.", Scotland’s Pluto Play Productions using drama to challenge stigma, the Spanish Alzheimer Foundation’s escape room experience, and Austria’s late-night talk show “Welcoming Alzheimer”. In Canada, several non-governmental organisations received support through the Dementia Strategic Fund to lead awareness initiatives focused on reducing stigma and fostering dementia-inclusive communities. Examples include the Dancer not Dementia campaign, which highlighted the creativity, playfulness, and imagination of people living with dementia, while helping communities to provide welcoming, dementia-inclusive dance activities or the *Open Minds, Open Hearts* project, which fostered social cohesion and a sense of belonging through guided intergenerational group activities between post-secondary students and people living with dementia. Similarly, the Austrian Dementia Strategy supports and promotes a wide range of awareness-raising activities, including initiatives delivered through non-profit sponsoring organisations within the Austrian welfare system, self-help organisations, and dementia-friendly community projects.

31. The second category, **promoting inclusion**, consists of actions that create new structures or make use of existing community infrastructure. A widespread activity in many countries (France, Hungary, United Kingdom, Czechia, etc) is the establishment of Dementia Cafés, informal community spaces where people living with dementia, their families, and caregivers can meet, share experiences, and access support in a relaxed and welcoming environment. In the United Kingdom, the Touchstone Black and Minority Ethnic Dementia Service organises Dementia Cafes targeted to Southeast Asian community, run in their native language.

32. Beyond cafés, other initiatives promote community-based support systems. In Czechia, for example, the city-level pilot “Let’s Be Dementia Friendly” (2022–2024) aims to raise awareness about public guardianship and promote the use of existing informational materials targeted at public and private guardians, people living with dementia, informal carers, and the general public. In Japan, the Dementia Ambassadors of Hope initiative empowers individuals to act as community advocates, while Korea’s Dementia Safe Village program fosters supportive local environments where people with dementia can live safely and with dignity.

33. The third category, **training and guidance**, groups training program by audience: family, public servants or other specific group professions and wider public. Most countries (22) have implemented training programs targeted at **people with dementia’s family**. These diverse training programs aim to enhance caregiver support and aid decision-making. For example, the United States National Family Caregiver Support Program provides caregivers with information on available services and assistance in accessing them. Similarly, Iceland included in its national plan a service centre for individuals with dementia and their families. This centre will offer regular courses, including those for newly diagnosed individuals,

and provide ongoing support, advice, and education for both patients and their families. In parallel, other initiatives include the Native Women's Association of Canada's ‘Supporting a Circle of Care: A Culturally Informed Support Group and Toolkit for Indigenous Caregivers of People Living with Dementia’, a more culturally tailored support that acknowledges Indigenous values, beliefs, and traditions (Native Women Association of Canada, 2023[24]).

34. Trainings for **specific group professions** can be found in 16 countries. Some of these initiatives often aim to raise awareness and improve the competence of professionals who interact with individuals with dementia. For example, Estonia organizes training and information days for local government sector managers and social work specialists to enhance their counseling skills. Estonia also extends training to employees of agencies that frequently encounter people with dementia, such as police, rescue services, cultural workers, and service staff. Similarly, Austria focuses on informing and training for sectors such as emergency services (fire brigade, rescue, ambulance transport), service and trade industries (public transport, banks), and both medical and non-medical staff. Additionally, Austria has developed a code of good practice for media reporting on dementia and organized several workshops offering concrete formulation suggestions, alternatives and recommendations for dealing with language and images. Activities focused on training other professions, such as police officers, civil servants, and railway employees, are also beginning in Czechia.

35. Beyond professional sectors, other countries are integrating dementia education into broader public awareness and youth programs. For instance, Ireland's 'Creating a Dementia Inclusive Generation' Transition Year Programme aims to educate teenagers about Alzheimer's disease and combat its stigma. Czechia also extends its offerings with programs in the field of aging and dementia, such as 'We Age Successfully' or virtual reality projects, for inclusion in primary and secondary school education. Further workshops at schools are appearing in various plans of interdisciplinary groups, both at primary and secondary schools. School representatives participate in interdisciplinary working groups in the regions.

36. Lastly, 19 countries also offer training and information **to the wider public**. Canada, for example, launched funding opportunities for projects on awareness raising and improving dementia guidance through its Dementia Strategic Fund, complementing its broader national public education campaign. Through funded projects a diverse range of organizations such as academic institutions, community organizations, and advocacy groups delivered activities related to prevention, stigma reduction, and dementia-inclusive communities. Similarly, Estonia provides extensive online resources through DKKs website (https://dementsus.ee), which hosts numerous instructional and educational videos and regularly organises public events such as charitable fundraising campaigns on dementia related subjects.

Table 1.2. Many countries include actions to raise awareness, promote inclusion and provide dementia training and guidance across OECD countries

OECD country	**Awareness raising**		**Promoting inclusion***		**Dementia training and guidance**		
	Campaigns, social media	Culture, TV, Podcast…	Policy / Institutional Framework	Community and Social Programs	Family carers	Specific group profession	Wider audience
Australia	●	●	●	●	●	●	●
Austria	●	●	●		●	●	
Canada	●	●	●	●	●	●	●
Costa Rica	●	●			●	●	●
Czechia	●	●	●	●		●	●
Estonia	●	●	●	●	●	●	●
Finland	●	●	●	●	●	●	●
France	●			●	●		

Germany	●	●	●	●	●	●	●
Greece	●	●		●	●		●
Hungary	●		●	●	●		
Iceland	●				●	●	●
Ireland	●			●	●	●	
Israel	●	●			●	●	●
Italy	●	●			●		
Japan			●	●			●
Korea	●		●	●	●		
Latvia							●
Mexico				●			●
Netherlands	●	●	●	●	●	●	●
Norway	●	●		●		●	
Poland	●	●			●		
Portugal					●		●
Slovenia	●			●			●
Spain	●	●	●	●	●	●	●
Sweden			●		●	●	
Switzerland	●	●		●	●	●	
UK (Scotland)	●	●		●			●
United States	●	●		●	●		●
Total	24	18	13	20	22	16	19

Note: * Policy / Institutional Framework refers to formal programs, policies, or networks at national, municipal, or organizational level that create structures to support people with dementia. Community & Social Programs refers to practical, on-the-ground initiatives, activities, or services that directly engage people with dementia, carers, or the public. A more detailed table is available in Annex A (Table A.1).
Source: OECD's own analysis/questionnaire.

1.4 Progress has been made in measuring dementia

37. More OECD countries are undertaking efforts to better understand the prevalence of dementia in their countries. This is done through the creation of dementia registries or other means to record data on dementia (Table 1.3). It allows countries to better plan resources, to understand within-country differences, and to estimate the diagnostic gap.

Table 1.3 More countries in the past decade have developed dementia registries and data investigations

OECD country	Name	Entity in charge	Description
Australia	National Centre for Monitoring Dementia (NCMD)	Australian Institute of Health and Welfare	Data on prevalence, mortality, burden of disease, care needs of people and carers of people with dementia, prescriptions, primary, hospital and aged care, dementia support services and initiatives, cost of dementia, behavioural and psychological symptoms, and dementia among subgroups (e.g., young onset, First Nation)
	Australian Dementia Network Registry	Monash University	Key variables include diagnoses, demographics, clinical parameters, diagnostic processes, dementia medication, time between referral and diagnosis
Canada	Canadian Chronic Disease Surveillance System and Dementia in Canada	Public Health Agency of Canada and Canadian Institute for Health Information	Incidence, prevalence, and all-cause mortality for dementia (by jurisdiction, age group and sex); dementia in home and community care, hospitals and long-term care, dementia and falls, young onset dementia
Czechia	Alzheimer's disease and	Institute of Health	Prevalence

	unspecified dementias	Information and Statistics (UZIS)	
Denmark	Dementia in Denmark	Danish Dementia Research Centre	Data on prevalence, incidence, mortality, medication
England	Primary Care Dementia Data	NHS England	Estimated and recorded rate of dementia, care plan and care review, medication review, young unset dementia
France	National Alzheimer Database	Banque Nationale Alzheimer	Contains 31 items, amongst others demographic data on the patient, diagnostic details, the type of care carried out during the patient's visit to the centre and clinical measures such as the MMSE
Germany	Public Health Reporting Germany	Robert Koch Institute, Scientific Institute of AOK (WIdO)	Prevalence
Ireland	National Dementia Registry	National Office of Clinical Audit	*Forthcoming*
Israel	National Dementia Dataset	Geriatric Division, Israel Center for Disease Control, four health funds	Prevalence, incidence, dementia medication
Japan	Study on the Prevalence and Future Projections of Dementia and Mild Cognitive Impairment	University of Kyushu	Prevalence, projections
Korea	2023 National Survey on Dementia Epidemiology and Prevalence	Ministry of Health and Welfare	Prevalence, care provision, expenditures
Netherlands	Nivel Primary Care Database / National Medical Registry	Netherlands Institute for Health Services Research (Nivel)	Prevalence, incidence, medication
	Dementie in Kaart (https://dementieinkaart.nl)	Multiple data sources: CBS, Vektis, CIZ, CAK, Nivel, Dementia Monitor Informal Care, Alzheimer Nederland	Data on care and support for people with dementia and their carers, at national and regional levels.
	VZinfo.nl (Dementie)	National Institute of Public Health and the Environment (RIVM), with input from experts, research institutes, and universities	Data on health, risk factors, care, and prevention related to dementia..
Norway	Demenskaret	Norwegian National Centre for Ageing and Health	Prevalence, incidence, forecast
Slovak Republic	Healthcare utilization by patients with Alzheimer's disease	Institute of Health Analyses (IZA)	Prevalence, medication, hospitalisations
Spain	Registry of Dementia of Girona (ReDeGi)	Department of Health of the Generalitat de Catalunya	Prevalence, incidence, family history, medication
Sweden	Swedish Dementia Registry (SveDem)	Uppsala Clinical Research Center (financed by Swedish Association of Local Authorities and Regions)	Prevalence, number of clinical parameters (e.g., age, sex, BMI, diagnoses), medical treatment, community support, time between referral and diagnosis
Switzerland	*Not applicable*	Swiss Health Observatory (Obsan)	Medication, care pathways
United States	National Health Statistics Report	Centers for Disease Control and Prevention (CDC)	Prevalence

Source: OECD questionnaire/interviews.

38. A number of OECD countries have implemented dementia registries to monitor the quality of care delivered to patients with dementia on a national level, such as Denmark (Danish Dementia Registry, DanDem, since 2005), Norway (Norwegian Dementia Registry NorCog, since 2013) and Sweden (Swedish Dementia Registry, SveDem, since 2007). Other registries collecting epidemiological data complement these efforts, such as the French National Alzheimer Database (since 2009), and the Registry of Dementia of Girona in Spain (ReDeGi, since 2007) (Krysinska et al., 2017[25]). Spain has no integrated national dementia registry. Hence, national estimates rely on diverse sources (Instituto Nacional de Estadística and Conjunto Mínimo Básico de Datos, regional registries, and cohort studies). Ireland is joining the number of OECD countries with a dementia registry and is in the process of setting up a dementia registry, which is being developed by the National Office of Clinical Audit. Both Chile and Greece have incorporated dementia registries into their national dementia plans, with Chile emphasising a professionalized system for comprehensive data collection and analysis, and in Greece to systematically record and classify dementia cases to improve diagnosis, treatment, and care.

39. In addition to building dedicated registries, OECD countries are using data to better understand the prevalence and incidence of people with dementia, to monitor their pathways, and to assess whether care delivered to them is of good quality. Australia has introduced its National Data Improvement Plan 2023-2033 to improve dementia data over the next ten years (Australian Institute of Health and Welfare, 2023[26]). In Canada, the Public Health Agency of Canada (PHAC) conducts routine surveillance using health administrative data through the Canadian Chronic Disease Surveillance System (Government of Canada, 2025[27]). Further, through the Enhanced Dementia Surveillance Initiative, PHAC funded CIHI to examine the health care trajectories of people living with dementia, building on their previous report from 2018 (Canadian Institute for Health Information, 2018[28]; Canadian Institute for Health Information, 2025[29]; Public Health Agency of Canada, 2025[30]). Switzerland has just published the results of an investigation of the prescription of antipsychotics to people with dementia in 2024 (Swiss Health Observatory, 2024[31]) and Germany makes sure, that people with cognitive limitations are included in the sample for the legally mandated inspections in long-term care facilities.

2 Despite promising developments, gaps remain in dementia diagnosis

40. A dementia diagnosis is a crucial step in accessing care and support, and receiving a timely diagnosis is important to take advantage of available treatment and care. A diagnosis allows people living with dementia and their families towards the services that will be most beneficial to them. Those with early dementia may be offered medications or non-pharmacological interventions that improve symptoms, even if only temporarily. Families and carers can be trained to provide better care for people with dementia and manage the impact of caring on themselves more effectively. Despite these benefits, diagnosis rates remain low in many countries but renewed efforts in diagnosis offer good prospects.

2.1 General Practitioners often initiate a dementia diagnosis, yet they often lack the capacity to formalise the diagnosis

41. In most OECD countries, **General Practitioners (GPs) pose the initial diagnosis, which is confirmed by a specialist**. GPs are the first point of contact for people with dementia in most countries. The role of primary care in dementia detection is often formalised or highlighted in national dementia plans and strategies and is often linked with goals to promote timelier diagnosis. In nearly all countries, GPs perform at least a basic cognitive assessment and provide people with an indicative diagnosis. Across all countries, for which information is available, there appears to be no change in the past decade (Table 2.1).

42. In addition, nurses also support the role of GPs, for example assisting with early identification of suspected dementia cases or facilitating referrals. Nurses sometimes are part of the teams working in memory clinics in Israel, Greece, England (United Kingdom), Finland, hence, are involved in the diagnosis process. In Australia, Canada, Denmark, Ireland, Sweden nurses support GPs in primary care settings. A systematic review highlighted potential benefits such as improved patient access, earlier detection and management of cognitive decline and enhanced care co-ordination. However, some limitations discussed are unclear role definition, insufficient dementia-specific training, time pressures, and weak communication with GPs (Gibson, Goeman and Pond, 2020[32]).

Table 2.1 Across OECD countries, while GPs are the main contact point, specialists perform the formal diagnosis

	2018	**2025**
GPs as first contact point[1]	Australia, Austria, Belgium, Canada (British Columbia), Chile, Czechia, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Israel, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Portugal, Slovak Republic, Slovenia, Sweden, Switzerland, United Kingdom (England), United States.	Australia, Austria, Belgium, Canada, Chile, Colombia, Costa Rica, Czechia, Denmark Estonia, Germany, Greece, Finland, France, Hungary, Ireland, Iceland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, Slovenia, Slovak Republic, Spain, Sweden, Switzerland, Türkiye, United Kingdom, United States.
	2018	**2025**
Specialists performing formal diagnosis	Austria, Belgium Czechia, Estonia Finland, France, Germany, Greece, Hungary, Ireland, Israel, Luxembourg, Mexico Portugal, Slovak Republic, Slovenia, United States.	Australia, Austria, Belgium, Chile, Colombia, Costa Rica, Czechia, Denmark Estonia, Germany, Greece, France, Finland, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, the Netherlands, New Zealand, Norway Poland, Portugal, Slovenia, Slovak Republic, Spain, Sweden, Switzerland, Türkiye, United Kingdom, United States.

Note: 1. In Germany, Greece, Japan, Ireland, Korea, Latvia the first contact point can be done by other professionals .
Source: Care needed report for 2018 (OECD, 2018[33]) and for 2025 OECD own analysis/questionnaires.

43. Parallelly, in 13% of them (5/38) **the GP can perform the formal diagnosis**: Canada, Finland, Ireland, Korea, and Norway. In these countries, GPs can provide official dementia diagnosis usually for more common forms of dementia. While a specialists like neurologist or psychologist (Canada, Norway) or geriatrician or a psychiatrist (Ireland) are referred to for more complex or unclear cases, for younger-onset dementia, those with minority backgrounds, or intellectual disabilities. In Korea, at medical institutions (including hospitals affiliated with Dementia Care Centres), GPs, family medicine specialists, neurologists, and psychiatrists provide consultations, index diagnosis, formal diagnosis (diagnostic tests), and drug treatments. In Finland, for older persons who are already home-care clients or in service housing with 24-hour assistance, the diagnosis can, in some cases, also be made by a primary health care physician.

44. Evidence suggests that primary-care diagnosis of dementia can be accurate and faster for straightforward cases, but specialist pathways still add value for complex presentations. Ronner et al. (2024[34]) find that many GP referral letters already contain clear diagnostic information and that many patients are diagnosed at the memory clinic without extra investigations; implying some referrals may be avoidable and that empowering GPs could shorten time to diagnosis. Nevertheless, several studies indicate that GPs were better at ruling in dementia than ruling it out (Creavin et al., 2021[35]). A systematic review documents substantial delays caused by complex referral criteria and limited memory clinic capacity. Simplifying referral pathways, or allowing direct GP diagnosis for typical cases, can speed up diagnosis; however, risks remain for underdiagnosis or misclassification of atypical or early cases without specialist input (Kusoro et al., 2025[36]). To address these challenges, new diagnostic tools (for example, plasma biomarkers) could further reduce diagnostic errors in primary care settings.

45. The setting where the diagnosis takes place also may vary, although most of it is performed in primary care settings and hospitals. In other countries, such as Iceland, Ireland, Finland, Slovenia, memory clinics[1] are responsible for the formal diagnosis. In Greece, it can take place in memory clinics or day care centres. In Finland, also in home care client and 24/7 care centres, while in Japan and Korea in Dementia Medical centres. In another group of countries (Israel, Italy, Latvia), the range of settings is broader also

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[1] Memory clinics are defined broadly as clinical settings where health professionals deliver advanced diagnostic services. Some memory clinics may focus solely on diagnosis or go beyond it to provide ongoing care and support (OECD, 2018[33]).

including community healthcare, long-term care institutions, long-term care at home, disability services, charities, community associations, or other civil societies.

46. In most OECD countries, GPs are key in launching the overall diagnostic pathway, but access to a GP is uneven across OECD countries and if available, GPs face increasing constraints in their time. Diagnosing dementia competes with other conditions, such as cancer, diabetes, congestive heart failure, for the limited time of General Practitioners. On average, only 38% of primary care practices participating in PaRIS reported that the time scheduled for regular and follow up consultations was 15 minutes or more, ranging from 80% or more in Norway, Portugal and Iceland to less than 10% in the Netherlands, Spain and Wales (OECD, 2025[37]). GPs (family doctors) represented less than one-quarter (23%) of all physicians on average across OECD countries in 2021, ranging from around half in Portugal, Chile and Canada to just 6% in Korea and Greece (OECD, 2023[38]). Many countries since the pandemic face shortages of healthcare workers as the number of doctors is not increasing as fast as the ageing of the population. Countries such as Austria, Czechia, Finland, Italy, Latvia, Portugal, Slovenia and Spain reported a shortage of GPs (OECD, 2024[39]).

47. Dementia remains underdiagnosed, diagnosis happens late, or it is misdiagnosed. A metareview estimated the rate of undetected dementia cases to be at 62.9% in North America and 53.7% in Europe, highlighting that rates of undiagnosed people tend to be higher in the community (63.6%) compared with people in nursing homes (50.9%) and diagnosis rates are lower if detection is undertaken by general practitioners (Lang et al., 2017[40]). Misdiagnosis can also be common in primary practice. Misdiagnosis in dementia means receiving an incorrect non-dementia diagnosis or receiving an initial incorrect dementia subtype diagnosis. A systematic review of studies highlighted that clinicians knowledge impacts misdiagnosis, that early symptoms of dementia were frequently not recognised or misattributed to other factors such as depression or burnout, and that existing evidence from 12 countries indicates that misdiagnosis is a frequent issue in rare dementias (Giebel et al., 2024[41]).

48. GPs often do not have sufficient initial training to provide effective diagnosis, but countries are trying to equip them with new dementia modules and continuous education. Previous studies identified that dementia training in medical school was often comprising a low number of hours, just 12 hours (Jacinto and al., 2015[42]). Dementia training is included in GP curriculum, though covered broadly. In Mexico, the curriculum covers dementia-related topics as part of geriatrics. In Finland, basic education in social and healthcare includes contents on the care of memory-related diseases, with additional opportunities for supplementary and continuing education. Similarly, in Austria, dementia training is integrated into the standard medical school curriculum and offered as part of elective courses. In addition, in some hospital's dementia training is mandatory for all staff, from health professionals to janitors, cooks and others. In Switzerland, however, non-mandatory dementia training is included in nurses' curriculum.

49. There is growing recognition of the need for dementia training, particularly among GPs and primary care physicians, across OECD countries. Still, direct financial or formal incentives remain inconsistent and are often limited to specific contexts. Some countries provide incentives to increase the uptake of GPs through subsidising their training programmes. In Australia and Ireland, dementia training is free for GPs supported by allocated funding, and GPs themselves can be involved in curriculum development. Non-financial incentives, such as offering Continuing Medical Education (CME) credits, can also appeal to primary care physicians when financial support for continuing education and training is already available (Perales-Puchalt et al., 2023[43]).

2.2 Inequitable access to specialists and equipment hampers the formal diagnosis

50. Formal diagnosis is often the competency of specialists but a referral from a GP is usually required. Generally, once a person is suspected of having dementia, they first go to a GP who use some simple diagnostic tests to detect dementia before they refer the person suspected of dementia to specialists for more comprehensive assessment. Across the 38 OECD countries, the formal diagnosis is often performed by different specialists which may vary depending on the OECD country (e.g., neurologists, geriatricians, psychiatrists, neuropsychologists). In many countries, a formal diagnosis by a specialist is necessary for people living with the disease being reimbursed fully or partially for a range of social and clinical support services, including medications and home care. However, for a limited number of countries, primary care physicians and sometimes even non-physician health professionals are also allowed to initiate and follow up the prescription of medications to relieve the symptoms of people with dementia. In Australia, Denmark, Korea, Mexico, Sweden, Mexico and Korea and the United Kingdom, GPs are allowed to prescribe medications to relieve the symptoms of people with dementia, while in Spain they can follow up but not initiate it (Danish Ministry of Health, 2017[44]; Australian Institute of Health and Welfare, 2019[45]; NHS, 2024[46]). In Australia, GPs can prescribe medication, but a specialist must confirm an Alzheimer's disease diagnosis for the medications to be subsidised. Moreover, in the Netherlands, nurse practitioners are allowed to start the prescription of medications for people with dementia (Aho et al., 2025[47]).

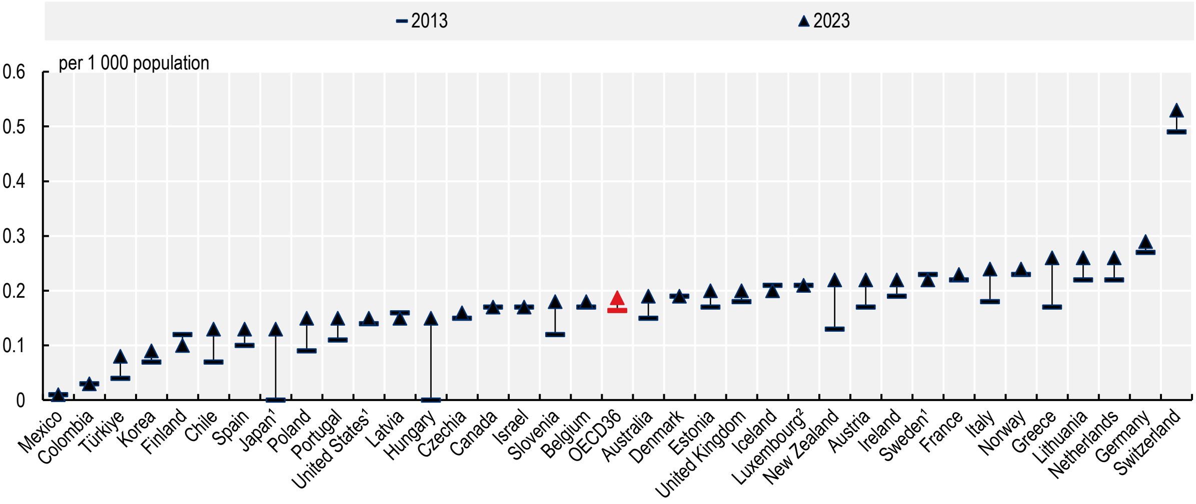
51. While GPs are the most common contact point, in other countries, patients can directly go to the specialist. **In a few countries** – Germany, Greece, Ireland, Japan, Korea, and Latvia- **an initial consultation with GPs is not always necessary** for dementia diagnosis. In Germany, people can directly access a specialist when symptoms of dementia are present, which reflects the general health system design as Germany does not have a gatekeeping system in general. A gatekeeping system already exists as "Hausarztzentrierte Versorgung" within contract-systems of Association of Primary Care doctors with statutory health insurance companies. Insured persons can voluntarily decide whether they want to sign up for such a contract. Around 10 million insured persons are already enrolled in this system. The Japanese health system does not register general practitioners in a separate category from specialists; so insured patients are allowed to go directly to any physician (Kato et al., 2019[48]; Nakanishi and Nakashima, 2013[49]). In Greece, Korea and Latvia patients can bypass the primary care system in favour of going directly to a neurologist or other specialist. In Ireland, older people can also enter the specialist diagnostic pathway through referrals from other medical specialists, particularly if they are already under the care of a psychiatrist or neurologist from regional memory clinics.

52. Most dementia guidelines across OECD countries recommend a similar set of diagnostic procedures. The diagnostic process typically follows a structured pathway initiated by a referral from a GP. This pathway generally includes a clinical interview with the patient (often involving a family member), a physical and neurological examination, cognitive testing, laboratory tests (such as blood work), and neuroimaging techniques (like Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) scans) to assess brain structure and function.

53. Specialists are needed to identify dementia sub-types and may often be more experienced in caring for people with dementia, including identifying the best available treatment options and local services available to a person with dementia and their family. Neurologists, psychiatrists, and geriatricians, are often needed to diagnose specific sub-types of dementia, including Alzheimer's disease, dementia with Lewy Bodies, and vascular dementia. Receiving a differential (sub-type) dementia diagnosis is important to ensure the best treatment pathways can be adopted. Different dementia sub-types have been found to respond differently to existing dementia treatment options, including memantine and anti-cholinesterase inhibitors (Livingston et al., 2024[2]).

54. The availability of specialists varies significantly across OECD countries. While the OECD averages 0.18 psychiatrists per 1 000 people, the range of psychiatrists varies considerably with Germany having 0.27 and Switzerland 0.52 while this rate stands at0.05 in Turkey and even less in Mexico.

Figure 2.1. Psychiatrists per 1 000 population, 2013 and 2023



Note: 1. Latest data from 2022. 2. Latest data from 2017.
Source: OECD Health Statistics 2025.

55. There are also differences between countries regarding the diagnostic infrastructure. In addition to the overall availability in the country, there are also wide regional differences in access to CT, MRI and PET scans within countries. Previous OECD analysis shows large increases in CT and MRI exams per 1 000 population in a number of countries up to 2019. For example, the number of CT exams more than doubled in Korea, and the number of MRI exams more than doubled in Australia, Korea and Slovenia (OECD, 2023[38]). However, there are large variations in the use of CT scanners and MRI units across countries, which can prompt to delays in some countries in diagnosis.

2.3 Diagnostic rates have improved in absolute, but not in relative terms

56. Countries are undertaking efforts to increase diagnostic rates of people with dementia and to shorten the diagnostic process by (i) increasing diagnostic capacities and by (ii) easing, harmonising and speeding up the diagnostic pathway.

57. A number of OECD countries have seen an increase in dementia diagnoses in absolute terms, but the ageing of the population aged 65 and above also increases the demand for diagnoses. The picture looks rather mixed for incidence rate per 100 000 population. In some countries, like Denmark, the rate of new diagnoses per people aged 65 and above has remained somewhat stable at has fluctuated between 8 000 and 8 750 diagnoses per people aged 65 and above in between 2010 and 2022 but increased to 9 675 diagnoses in 2023 (Danish Dementia Research Centre, 2025[50]), Other countries, like Canada, and Germany, have been experiencing a decrease in diagnoses As a result, diagnostic rates among people aged 65 and above have often remained constant over time and not managed to close diagnostic gaps For example, in Canada, the incidence count has increased by around 40% from 73 730 new diagnoses in 2010 to 101 265 in 2023, but the crude incidence rate has decreased from 1 544 per 100 000 inhabitants in 2010-11 to 1 309 per 100 000 inhabitants aged 65 and above in 2023-24 (Government of Canada,

2025[51]). Similarly, Germany recorded a reduction in dementia incidence by 26% over the course from 2015 to 2022 in the outpatient sector (Michalowsky et al., 2025[52]). So far, it is not clear whether reductions in incidence rates per population can be attributed to an actual reduction in individual risks, for example thanks to preventative measures, or whether the ageing of the population outpaces increases in dementia, and to which extent differences in diagnostic patterns are at play. It is unclear whether the reduction in incidence per population is a positive sign for a reduction in dementia incidence, or a concerning sign about diagnostic capacities not keeping up with the ageing of the population.

58. Countries are undertaking a set of efforts to increase the diagnostic capacities through rolling out **diagnostic roles to other professions to increase the workforce available**. A few countries have broadened diagnosis to other professionals. In Austria, because of the challenge to access memory clinics which tend to be concentrated in the capital and major cities, psychologists are allowed to perform a diagnosis. NHS England launched a national pilot in 2022 across 14 sites to enhance dementia diagnosis in nursing homes using the Diagnosed Advanced Dementia (DiADeM) framework. DiADeM was designed to improve early diagnosis of people in nursing homes by designing a tool for GPs to perform the diagnosis without referring older people to memory clinics. In addition, better training, diagnostic guidelines, and financial incentives are helping GPs to improve diagnosis.

2.4 Diagnostic guidelines support GPs in improving diagnosis

59. A number of countries have taken steps to promote high quality dementia diagnosis and care through the **development of guidelines**. Diagnostic guidelines are currently available in 30 OECD countries (Table 2.2), with 8 countries having implemented more than one (Australia, Canada, Chile, Germany, Latvia, Mexico, Switzerland, or the United States). In Canada, they have an additional guideline that focuses on disclosing and communicating the disease, while Australia has a guideline dedicated to Aboriginal People with Dementia in Remote Communities. In the case of Mexico, one guideline is from 2009 and focuses on dementia diagnosis at the primary care level while the other is from 2017 and tackles vascular dementia at the three care levels. In Germany, an additional guideline focuses on consent to medical measures for people with dementia; in Switzerland, one guideline focuses on the ethical aspects of the care and treatment of people with dementia, while the other addresses diagnostic recommendations, while in Latvia, one guideline focuses on clinical pathways and algorithms, while another addresses clinical guidelines for Alzheimer’s disease, vascular dementia, Lewy body dementia, and frontotemporal dementia. As a result, Table 2.2 shows the availability of 38 dementia diagnostic guidelines.

60. Among the 38 dementia guidelines available across OECD countries, there is considerable variation in how often they are updated, their scope, target audiences, and how they assess evidence quality. To begin with, only 65% of the guidelines (25/38) have been updated in or after 2018. Regular updates are essential to ensure guidelines reflect the latest evidence, medical advancements, and evolving best practices. In the US, diagnostic criteria were updated to reflect new science and technologies, such as the use of plasma biomarkers, alongside validated CSF and imaging markers from the 2018 framework. In Germany, one of the guidelines is designed as a living guideline and is revised annually. In Czechia, a recommended procedure for the diagnosis and treatment of dementia was developed in 2025. In Australia, their Clinical Practice Guidelines and Principles of Care for people with dementia (2016) is currently being updated and will be published in late 2026. In contrast, 8 countries (Belgium, Greece, Lithuania, Luxembourg, Poland, Portugal, Slovak Republic and Slovenia) do not currently have a guideline in place. Although Costa Rica does not have a diagnostic guideline for dementia per se, relevant content typically found in such guidelines is incorporated into national legislation.

61. Diagnostic guidelines contribute to standardising diagnostic processes, ensuring consistency and timeliness in clinical decision-making. Guidelines mitigate the lack of specific dementia knowledge of

primary care physicians and other health and social workers by incorporating standardized diagnostic tools, subtype-specific diagnostic criteria, principles of communication and care, ethical considerations and post-diagnostic care pathways. While all guidelines are aimed at healthcare professionals, some also address other groups, including social and long-term care workers, patients, informal carers, and, to a lesser extent, researchers and policymakers. For example, some guidelines contain sections in an accessible language to offer support for families and carers. In this way they know what to expect before and after receiving a diagnosis, their rights across the whole process and the treatment they should or could be receiving. One example in Canada is the ‘Dementia, Your Companion Guide’ produced by McGill University, which is available in multiple languages and helps people living with dementia and caregivers understand their diagnosis, validates their experiences, and informs them of what to expect (Mc Gill University, 2025[53]). Israel has a section on the rights of the patient suffering from dementia, outlining entitlements across key areas such as tax exemptions, nursing care benefits, and insurance-related allowances.

62. Guidelines serve as a useful tool for GPs to deliver more consistent, evidence-based care tailored to dementia patients. Some guidelines grade the quality of evidence and strength of recommendations, such as Australia, Czechia, Denmark, Estonia, Germany, Hungary, Iceland, Italy, Japan, Korea, and Latvia. For example, Germany uses the GRADE approach, a four-level system that rates the quality of evidence as High, Moderate, Low, or Very Low. In addition, they include two-stage recommendation grading: a strong recommendation is expressed as 'we recommend' or 'do not recommend' (⇑⇑ / ⇓⇓), while a weaker recommendation is expressed as 'we suggest' or 'do not suggest' (⇑ / ⇓). Similarly, Australia recommendations are classed differently as ‘evidence-based recommendations’ developed from systematic reviews with supporting references; ‘consensus-based recommendations’ issued when no quality evidence is available despite a systematic review or ‘practice points’ which offer guidance outside the scope of the evidence review. Thanks to this, users can trust the evaluated information and whether adherence to the recommendations will yield more benefits than harm. Moreover, access to this information is useful for the other health and social care professionals supporting GPs in the diagnosis, leading to earlier diagnosis and timely intervention.

63. Primary care doctors use a range of standardised tools and tests to assess people with suspected dementia which are often recommended in clinical guidelines. The most common is the Mini Mental State Examination (MMSE), with the clock test and the Montreal Cognitive Assessment (MOCA), a screening tool for mild cognitive impairment also frequently administered at the primary care level (See Box 2-1). This consistency supports international comparability and a strong consensus on best practices in dementia diagnosis. In France, both tests are recommended; however, it is noted that these tests alone are not sufficient to make a diagnosis of a neurocognitive disorder or to determine its cause. Among diagnostic guidelines, 28 countries recommend the MMSE, with 16 of them recommending it alongside the Clock Drawing Test. In addition, the MoCA (Montreal Cognitive Assessment) test is recommended by 22 countries for detecting mild cognitive decline, as it is considered more accurate in early stages. Other tests included in these guidelines are Mini-Cog, General Practitioner Assessment of Cognition (GPCog), Memory Impairment Screen (MIS), Consortium to Establish a Registry for Alzheimer’s Disease (CERAD), Six-item Cognitive Impairment Test (6-CIT), Addenbrooke’s Cognitive Examination 3 (ACE3). Mini-Cog, GPCog, MIS and 6-CIT are brief and easy to administer in primary care, whereas ACE3 and CERAD offer a more comprehensive evaluation for specialized settings.

Box 2-1. Types of dementia diagnostic tools

As the role of general practitioners in assessment and diagnosis of dementia has grown, a range of cognitive assessment tools have been developed to assist physicians in determining whether their patients have become cognitively impaired. The most widely used cognitive impairment screening tools share a number of common characteristics: they are short (intended to be used within a regular doctor's visit), easy to administer, and easy to score. The design of different screening tools nevertheless introduces different biases into the assessment, including related to level of education, cultural background, and how symptoms of dementia or cognitive impairment manifest in different people.

Mini mental state exam (MMSE)

The MMSE is a 30-point, 11-question assessment that tests cognitive function in the areas of orientation, registration, attention and calculation, recall, language, and visual construction. Originally proposed in 1975, it is the most frequently used cognitive assessment tool for dementia. While easy to administer, it is judged to be less effective for detecting mild cognitive impairment, while its structure – notably its use of verbal responses and written questions – may contribute to performance biases based on education level and language fluency. Unlike most cognitive assessment tools, the MMSE is copyrighted, somewhat limiting its use. Because of its copyright, the MMSE is somewhat less frequently recommended as an assessment tool in clinical guidelines.

Montreal cognitive exam

The Montreal Cognitive Exam (MoCA) is a 10-minute, 30-point exam designed to screen for cognitive impairment. Scores from MoCA and the MMSE have found to be similar, particularly for people with dementia, though a number of studies indicate that MoCA may be more sensitive in detecting cases of earlier (mild) cognitive impairment (Nasreddine et al., 2005, Zadikoff et al., 2008, Dong et al., 2010, Trzepacz et al., 2015).

Mini cognitive assessment instrument

The mini-cognitive assessment ("mini-cog") is a three-minute, three-part test that incorporates recall and delayed recall exercises with a clock test drawing. Its simplicity and brevity may be advantageous compared with longer assessment tools, such as the MMSE, given the short appointment times primary care practitioners often have with their patients. The mini-cog has been found to be as sensitive as the MMSE and other assessment tools in detecting cognitive impairment (Borson et al., 2003).

Source: OECD Secretariat.

64. Several countries have taken steps to make their diagnostic approaches more inclusive and culturally sensitive. For instance, Canada recognises the importance of adapting approaches for Indigenous and minority populations. In Australia, the KICA-Cog is a validated cognitive assessment tool developed specifically for use with Aboriginal and Torres Strait Islander Australians, available for urban and regional, or remote settings (Western Australia University, 2025[54]). Meanwhile, Norway provides the MMSE-NR3 in both Norwegian and Northern Sami, enabling more accessible cognitive assessments for individuals from the Sami population. Another example is the Rowland Universal Dementia Assessment Scale (RUDAS) which is a short cognitive screening test designed to minimise cultural and language bias by using gestures, imitation, and visual-spatial tasks that do not require reading, writing, arithmetic, or

culture-specific knowledge. It is recommended in Australia, the Netherlands, Norway, Sweden and the United Kingdom (Scotland), among others.

Table 2.2. OECD countries have made efforts to promote early dementia detection through the implementation of diagnostic guidelines

OECD country	Policy	Year	Audience
Australia	Clinical Practice Guidelines and Principles of Care for people with dementia	2016	Health and aged care staff: doctors, nurses, allied health and care workers (community, residential, hospital), people with dementia & carers.
	Guidelines for Diagnosis and Care of Aboriginal People with Dementia in Remote Communities	2012	Health professionals and aged care coordinators.
Austria	Medical Guideline - Living Better with Dementia	2019	Primary care and specialist physicians
Canada	Recommendations of the 5th Canadian Consensus Conference on the diagnosis and treatment of dementia	2020	Clinicians and researchers.
	National Dementia Guidelines: Disclosing and Communicating a Diagnosis of Dementia	2024	Family physicians, and health care providers/professionals.
Chile	Clinical Guidelines for the Diagnosis and Treatment of Dementias	2017	Not specified
	Technical Guidelines for the Implementation of Explicit Health Guarantees (GES) No. 85 for Alzheimer's Disease and Other Dementias	2022	Primary and specialized healthcare teams for the care of individuals with dementia and their surrounding environment
Colombia	Clinical Practice Guideline for the Diagnosis and Treatment of Major Neurocognitive Disorder (Dementia)	2017	Healthcare professionals
Costa Rica	National Norm for Care of Adults with Cognitive Impairment and Dementia	2017	Not specified.
Czechia	Alzheimer's disease and other cognitive disorders - interdisciplinary recommendations for clinical practice	2025	Doctors, especially neurologists, psychiatrists, geriatricians, internists and family doctors and other healthcare professionals
Denmark	National clinical guideline for diagnosis of mild cognitive impairment and dementia	2017-2020	Not specified
Estonia	Alzheimer's Disease Diagnosis and Treatment	2017	Healthcare professionals: family physicians, specialists, clinical psychologists, speech therapists, occupational therapists, nurses, etc.
Finland	Memory Disorders. Current Care Guidelines	2023	Doctors, healthcare professionals, social workers, pharmacists, students, decision-makers in social welfare and healthcare, and, where applicable, memory patients and their families.
France	Guide care pathway for Alzheimer's disease or a related disorder.	2018	Health professionals
Germany	S3 living guideline on dementia	2025	Specialist doctors, neuropsychologists, occupational therapists, physiotherapists, art therapists, music and dance therapists, speech therapists, nursing staff, social workers, affected individuals & relatives.
	S2k Guideline: Consent of People with Dementia to Medical Measures	2019	Doctors, psychologists, and nurses from the participating professional associations and organizations, serves to inform other individuals (e.g., doctors from other professional associations, other therapeutic professions, and social workers).
Hungary	Diagnosis, Treatment, and Care of Dementia	2022	Physicians, psychologists, physiotherapists, dieticians, nursing staff, caregivers.
Iceland	Dementia. Diagnosis and treatment	2007	Healthcare professionals
Ireland	Dementia Diagnosis & Management in General Practice:	2019	GPs, public health nurses, occupational therapists, physiotherapists, speech language therapists, dieticians, social workers.
Israel	Dementia treatment and its prevention	2022	Physicians

Italy	National guideline “Diagnosis and treatment of dementia and Mild Cognitive Impairment” 2024	2024	All health and social care professionals involved in caring for people with dementia or MCI in any setting.
Japan	Clinical Practice Guideline for Dementia	2017	Doctors, but also other professionals
Korea	Dementia Clinical Treatment Guidelines.	2021	Psychiatrists and neurologists as well as internists, family medicine doctors, and primary care physicians who may encounter dementia patients.
Latvia	Clinical pathways and algorithms: “Diagnosis and Treatment of Dementia”	2019	GPs, psychiatrists, neurologist, other specialised doctors, specialists from diagnostic offices, patients and their relatives, support persons.
	Clinical guidelines for Alzheimer's disease, vascular dementia, Lewy body dementia, and frontotemporal dementia	2017	Neurologists, psychiatrists, internists, family (general practice) doctors, residents of the relevant specialties, and medical faculty students for training purposes
Mexico	Diagnosis and Treatment of Dementia in Older Adults at the Primary Care Level	2009	General practitioner, family doctors and psychologists.
Mexico	Updated for vascular dementia for 3 care levels	2017	Specialist Doctors, General Practitioner, Family Doctors, students
Netherlands	Dementia Diagnostics	2024	All care providers involved in primary, secondary and third line care of patients with dementia or suspected dementia.
New Zealand	New Zealand guidance on recognising and managing early dementia	2020	Not specified
Norway	National professional guideline	2022	Primary and secondary healthcare professionals, social care professionals, community, care home and care at home staff, people living with dementia and their families and carers
Spain	Diagnostic and therapeutic guidelines of the Spanish Society of Neurology.	2018	Not specified.
Sweden	National guidelines for care in dementia	2018	Patients
Switzerland	Medical Ethical Guidelines. Care and treatment of people with dementia.	2017	Physicians, nurses and therapists caring for patients with a persistent disease-related loss of cognitive abilities.
	Diagnostic recommendations for dementia by Swiss Memory Clinics	2024	Professionals in primary care and memory clinics.
Türkiye	Clinical protocol for Alzheimer's and other dementia diseases	2025	All physicians involved in the diagnosis and treatment of diseases causing dementia, especially Alzheimer’s disease.
United Kingdom (Scotland)	Assessment, diagnosis, care and support for people with dementia and their carers	2023	Doctors, especially neurologists, psychiatrists, geriatricians, internists and family doctors and other healthcare professionals
United States	Physician Guidelines for the Screening, Evaluation, and Management of Alzheimer’s Disease and Related Dementias - San Diego Region	2024	Primary care physicians, internists, psychiatrists, nurse practitioners, and physician assistants caring for older adults in their practices
	Revised Criteria for Diagnosis and Staging of Alzheimer's Disease” Alzheimer Association	2024	Not specified

Source: OECD’s own analysis/questionnaire.

2.5 Efforts have been made in a few countries to improve diagnosis through training and financial incentives

65. A few countries have taken steps ahead with the introduction of national training standards, to improve diagnosis knowledge among GPs. In Australia and the UK there is a national training standards framework for dementia which includes a specific module for diagnosis (Dementia Training Australia, 2025[55]) (Skills for Health, Health Education England and Skills for Care, 2018[56]). In the case of Australia, GPs can access free trainings on dementia. In Slovenia two regulations[2] define training standards for LTC sector professionals, including personnel requirements, such as training. The continuous training for formal LTC workers includes contents related to diagnostics such as communication with users and families, ethical dilemmas and decision-making, encouraging healthy lifestyles among users, and preventive care and early detection of health issues. In Korea there are two frameworks,[3] one is for professionals working within the national dementia care system, including staff at Dementia Care Centers, while the other is targeting doctors, nurses, nursing assistants, social workers, occupational therapists, clinical psychologists who are working on dementia care. In Spain, a national training strategy is in place as part of the requirements for accreditation in LTC centers.

66. Countries like Ireland and Japan have developed continuous education training to improve diagnosis. In Ireland, there are practice-based GP dementia workshops part of the PREPARED project (PRimary care, Education, PAthways and REsearch of Dementia). One of these was focused on diagnosis and post diagnostic care (Health Service Executive (HSE), 2024[57]). In Japan, there are programs for primary care physicians, dentists, pharmacists, or nurses, covering basic knowledge of dementia symptoms and characteristics, ways to support people with dementia and their families, the importance of multidisciplinary collaboration, and related systems.

67. Hungary and Israel are two examples of countries showing a commitment to improving dementia-related training among primary care providers. Hungary has expressed willingness to enhance training for GPs on dementia symptoms within its long-term care plan. Similarly, Israel’s National Dementia Strategy (2013) aims to broaden education and clinical experience in dementia across the curricula for physicians, nurses, and social workers, while also developing potentially mandatory training for family physicians on dementia diagnosis and care management.

68. Physicians often have little incentive to strengthen their dementia skills, even where programs are available as most of them are not mandatory. Financial incentives can help to boost skills such as Denmark’s program to compensate physicians for the time spent away from practice in dementia training, can be a motivating tool for upskilling, but are rare for dementia. In Japan, those trained in dementia are eligible for additional LTC insurance compensation. Similarly, the United Kingdom implements through the Quality and Outcomes Framework a pay-for-performance scheme for GP practices, which includes dementia-related indicators. The financial incentive for achieving the targets can prompt to invest in training, however studies analysing the effects of such pay-for-performance programmes state that its implications are mixed and limited (Roland and Guthrie, 2016[58]; Gillam, Siriwardena and Steel, 2012[59]). Other type of incentives, performance-based, are available in Spain, and Korea. In Spain, the training is required for the accreditation of the LTC facility. Similarly, in Korea, dementia training is an evaluation item for Dementia Care Centres. Also, it is recognised as continuous education, or a requirement for maintaining qualifications or licenses.

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[2] Regulations on Services, Personnel Requirements, Training, and Supervision in Long-Term Care, and the Regulations on the Content, Scope of Training, and Skill Catalogue for Long-Term Care Consultants and External Experts.

[3] Training of Workforce on Specialized Dementia Care (2022~Current) Training of Specialized Dementia Care by Job Type (2007~Current)

69. A number of countries have set goals around improving diagnosis rates and have designed different policies to support this. To improve timely dementia diagnosis, Denmark has allocated DKK 35 million (around USD 5.08 million) in 2025 and 2026 to increase the capacity of regional diagnostic units and also support increasing the number of diagnostic procedures outside hospitals. In England, there was a national ambition for at least two-thirds (66.7%) of people living with dementia to have received a formal diagnostic rate by 2025 was put into place in 2015. Diagnostic rates were tracked throughout the country and significantly improved, reaching the target. With the COVID-19 pandemic, diagnosis rates declined by 5.4% between March 2020 and February 2023 (Hazan et al., 2023[60]) and the dementia diagnostic target was included in the NHS operational plan for 2024-25, although it has been removed for 2025-26. Denmark has included a target of 80% diagnostic rates in its dementia strategy. In Hungary, to promote early diagnosis of dementia, occasional screening tests can be used to help 'case detection' in the GPs practice.

70. Other countries are trying to increase diagnostic rates in regions with currently limited healthcare access. In Australia, ADNeT (Australian Dementia Network) are trialling a virtual memory clinic for regional locations that have limited access to dementia specialists. In Austria, outpatient gerontopsychiatric care and memory clinics are another example that aims to improve access to closer-to-home contact points where multi-professional teams offer information, early diagnostic support and follow-up care. However, these services are regionally organised and heterogeneous in structure.

71. Financial incentives have proved to boost diagnostic rates but need to be considered carefully to avoid the risk of "overdiagnosis". England introduced two temporary financial incentive schemes for primary care to tackle underdiagnosis in dementia: the 3-year Directed Enhanced Service 18 (DES18) 2013 to 2016 and the 6-month Dementia Identification Scheme (DIS) between 2013 and 2014. The schemes encouraged a proactive approach towards diagnosis and were facilitated by a separate pay-for-performance scheme whereby GPs were paid GBP 55 per additional diagnosis. The schemes appear to have been effective in boosting GP dementia registers nationally by around 40 000 cases (Mason et al., 2018[61]), although the schemes were associated with some negative effects on patient experience (Liu et al., 2019[62]). In the United States, Medicare reintroduced risk adjustment for Alzheimer disease and related dementias (ADRD) to its to its risk-adjustment payment model 'Medicare Advantage (MA)'. This generated an incentive to improve dementia detection and reduce missed diagnoses and this resulted in increased diagnosis (Zissimopoulos, Joyce and Jacobson, 2023[63]). In Czechia, a new annual reimbursement for cognitive screening or assessment provides a financial incentive for GPs to evaluate patients and make referrals for potential dementia diagnoses (OECD questionnaire on dementia, 2024).

2.6 National screening programmes are uncommon

72. **National screening programs** for dementia remain limited. Population screening has proven to be a popular approach in OECD countries when detection rates for various diseases are suboptimal. However, unlike screening programmes for cancers, where the evidence relating to improved outcomes from early detection and treatment is more developed, the effectiveness of screening programmes for dementia is much less clear. While screening can enable early diagnosis and support timely treatment and decision-making, it may also pose potential harms. Concerns about developing population screening programmes for dementia rest largely on the insufficient evidence of effect they have demonstrated, and the lack of cure for the disease. Screening programmes also run the risk of mistakenly identifying people without dementia as having the disease. The additional costs of screening, lack of preparedness of primary care physicians to undertake such screening programmes, and the additional time burden have further been identified as arguments against implementing broader screening programmes for dementia.

73. Existing literature generally advises against widespread screening. Screening itself is not harmful, but problems can arise from the conditions it detects or from misinterpreting or misusing the information it provides (Borson et al., 2013[64]). In this line, countries have largely refrained from or actively rejected

implementing population screening programmes to detect dementia, despite persistently low diagnosis rates. Currently three countries (United Kingdom, United States and Australia) recommend not implementing routine screening for asymptomatic individuals (UK National Screening Committee, 2018[65]; U.S. Preventive Services Task Force, 2020[66]; Royal Australian College of General Practitioners, 2022[67])

74. At the same time, only three countries (Japan, Spain, South Korea) have established national/local dementia screening programs. In Spain, some regions offer early detection of genetic neurodegenerative diseases, such as Andalucia's Alzheimer Strategic Plan (Junta de Andalucia, 2021[68]). About 50% of regions provide genetic analysis to identify specific types of dementia, although fast referral protocols remain rare. In Japan, local governments screen individuals aged 65 and older, and a recent survey reported that 276 municipalities run early detection programs for dementia. In South Korea, people aged 66 and older undergo the National Health Insurance Service's cognitive test every two years. In addition, Dementia Care Centers provide free screenings every two years for all adults, with annual tests for those aged 75+ living alone.

75. Other countries, including Chile, the United States, and South Korea, have developed dementia screening programs in the past, but most have since not followed them, with the exception of South Korea.

2.7 Future developments might further improve diagnosis and monitoring

76. To improve diagnosis and monitoring future development must focus on transforming the care pathway and enhancing early detection. This includes integrating digital cognitive tools and AI-driven assessments into primary care to identify subtle cognitive changes earlier and more accurately (Snider et al., 2025[69]).

77. In recent years, self-diagnostic tools have developed and have the potential to help speeding up diagnosis but many caveats remain. There are several online tests as well apps to test memory with varying degrees of accuracy. Recently, attention has been drawn to the Self-Administered Gerocognitive Exam (SAGE), which is a brief self-administered cognitive screening instrument used to identify mild cognitive impairment (MCI) from any cause and early dementia. Studies have shown that SAGE relates favourably as SAGE detects MCI conversion to dementia at least 6 months sooner than MMSE (Scharre et al., 2021[70]). While the hope is that this test removes some bottlenecks in performing cognitive assessments by GPs, there are still strong limitations to make this effective. First, a number of people might still not want to perform a self-diagnosis for fear of the results and might not be aware of the test. Second, there might still be limited accuracy or the results difficult to understand or be misleading (David and Deeley, 2024[71]). Third, without any promising breakthrough in treatment, people might not wish to perform the test or follow up with their medical practitioner to record their dementia diagnosis.

78. Another innovative diagnostic tool is DiADeM, which supports timely and accurate dementia identification in care home settings. NHS England launched a national pilot in 2022 across 14 pilot sites to enhance dementia diagnosis in care homes using the DiADeM framework. DiADeM supports GPs in diagnosing dementia for people with advanced dementia in care homes who do not have a formal diagnosis, where referral to memory services may be unfeasible or distressing. Across 13 pilot sites, 76% of people assessed were diagnosed with dementia, highlighting the high prevalence of undiagnosed dementia in care homes. Nine sites recommended systematic integration of DiADeM into mainstream Memory Assessment Service (MAS) pathways, and staff reported the tool was effective for diagnosing advanced dementia. Where assessments aligned with MAS, capacity increased and waiting lists reduced. In addition, 86% of sites reported improvements in person-centred care planning, advance care planning, and post-diagnostic support. Finally, GP-led pilots demonstrated that leveraging existing primary and community care expertise can successfully extend dementia care beyond MAS (NHS England, 2025[72]).

79. Despite these results, challenges remain, including embedding DiADeM into care pathways, ensuring sustainable funding, improving staff awareness and training, enhancing data sharing, managing administrative burden, increasing referral quality, supporting workforce recruitment and supervision, and strengthening cross-system collaboration. Looking ahead, DiADeM has the potential to address inequalities in care, ensure person-centred assessments, and extend support to those living at home through tailored interventions and services (NHS England, 2025[72])..

80. Blood-based biomarkers have recently emerged as promising predictive tools for dementia. Such predictive tools are less invasive than other diagnostics methods (such as cerebrospinal fluid) and require less advanced technology which has the advantage of being easy to access throughout the country, cheaper and scalable. Emerging evidence suggests that they are good at predicting dementia. Biomarker tests can detect in the blood two proteins which build up in the brain when someone has Alzheimer's disease. Concentrations in blood of these two proteins associate with the corresponding concentrations in imaging techniques in PET scans (Teunissen and al., 2021[73]). A study concluded that a biomarker had high diagnostic accuracy (range, 88%-92%) for detecting Alzheimer disease in both primary and secondary care (Palmqvist et al., 2024[74]). P-tau217 considered to have the most utility as a biomarker for Alzheimer and commercially available plasma with p-tau217 shows comparable results than with using Cerebral Spinal fluid (Ashton and Brum, 2024[75]). Other biomarkers appear to be reliable in detecting multiple types of dementia (NIH, 2022[76]).

81. A number of studies are underway piloting how the tests can best be rolled out into day-to-day clinical practice to help enable early and accurate diagnosis of dementia. This is the case, for instance of the MIRIADE (Multi-omics Interdisciplinary Research Integration to Address DEmentia diagnosis) project, which is that findings on the biomarkers are implemented in initial clinical trials so that they can be available in the near future for diagnostics. Germany, Spain, Latvia, Sweden and the United States mention the potential use of blood biomarkers in their diagnostic guidelines. Spain has done clinical trials of the diagnostic performance of pTau217 (Martínez-Dubarbie and al, 2025[77]) and these efforts are supported by the Behaviour and Dementia Study Group of the Spanish Society of Neurology, which has published a consensus position and recommendations on the use of blood-based biomarkers for Alzheimer's disease diagnosis (Suárez-Calvet et al., 2025[78]). In May 2025, the United States Food and Drug Administration cleared for marketing the first in vitro diagnostic device that tests blood to aid in diagnosing Alzheimer's disease, Lumipulse G pTau217/β-Amyloid 1-42 Plasma Ratio, for people aged 50 and above. Such blood tests are not meant to be standalone tests for anybody to study genetic risks of dementia, but they are part a larger assessment, in people who already have signs and symptoms of dementia. Clinical guidelines and pathways for the diagnostic practice will be needed as biomarkers become more widely adopted and more precise. At the moment, to receive amyloid therapy, a PET scan is still required (Rubin, 2025[79]), but, in the future, PET scans and cerebral spinal fluid tests might become optional. With improved diagnosis accuracy of biomarkers, it is estimated that this could lead to a reduction in specialist evaluations from 36% to 14%, leading to substantial cost saving (Dumas et al., 2023[80]).

82. When it comes to monitoring, real-world evidence is a useful tool for tracking treatment outcomes and guiding clinical decisions. It helps understand how new treatments work in everyday practice, particularly among diverse populations over extended periods Registries such as ALZ-NET can streamline data collection, support insurance coverage, and monitor patient-centred outcomes, including independence and quality of life. However, collecting high-quality real-world evidence poses challenges such as incomplete data, delays, and dependence on clinicians, and overcoming these is essential to optimise patient outcomes and support the effective use of new therapies (Snider et al., 2025[69]).

3 Advancements in dementia treatment remain modest

3.1 Clinical guidelines for treating dementia have evolved over the past decade

83. Countries have established clinical guidelines for dementia care to provide standardised recommendations based on evidence and ensure quality care throughout the progression of the illness across all care settings. Currently, at least 36 clinical guidelines for dementia care are available across 27 countries, identified through by OECD dementia interview and questionnaire, and supplementary desk research. 20 countries (74%) have nationally applicable care guidelines that are either published or endorsed by the government, one country (4%) has a subnational level guideline, and nine countries (33%) have sector-specific guidelines published by relevant medical associations or dementia-oriented non-governmental organizations (NGOs) (overlaps permitting). Australia, Estonia, France, Ireland, Japan, and Sweden have more than one guideline by different authorities. Most of the guidelines identified were released in 2018 or later, while the national treatment guidelines from Australia, Austria, Estonia, Iceland, Japan, Mexico, Slovenia, and Sweden have not yet been updated. While Czechia and Estonia are developing clinical treatment guidelines, Costa Rica, Greece, and Poland lack a single dementia-specific guideline.

84. These clinical guidelines for dementia commonly address non-pharmacological interventions, pharmacological approaches, care pathways or models of care, support for carers and families, management of hospital and acute care, ethical and legal considerations, along with public health and prevention, and diagnosis and assessment (Table 3.1). Non-pharmacological interventions are among the most frequently addressed (29 out of 33) whereas ethical and legal considerations were the least (20 out of 33). Across the guidelines cover non-pharmacological interventions, care pathways, and carer support with greater detail than other areas.

Table 3.1. The latest guidelines for dementia treatment strongly emphasise non-pharmacological treatment

OECD country	Year	Pharmacological approaches	Non-pharmacological interventions	Care pathways	Support for carers and families	Hospital and acute care management	Ethical and legal considerations
Australia	2015/2016	Medium	High	High	High	High	Medium
Austria	2011	Medium	Medium	Medium	Medium	Low	Low
Canada	2020	Medium	High	Medium	Medium	Low	Low
Denmark	2018	High	Medium	Medium	Medium	Low	Medium
Estonia	2017	Medium	Medium	Medium	Medium	Low	Low
Finland	2024	High	High	High	High	Low	High
France	2018	Medium	High	High	High	Medium	High

Germany	2023	High	High	Medium	Medium	Medium	Medium
Hungary	2022	Medium	Medium	Medium	Medium	Low	Medium
Iceland	2007	Medium	Medium	Medium	Medium	Low	Medium
Ireland	2023	Medium	High	High	High	High	Medium
Israel	2023	Medium	Medium	Medium	Medium	Low	Low
Italy	2024	High	High	High	Medium	Medium	Medium
Japan	2017	Medium	Medium	Medium	Medium	Low	Medium
Korea	2022	Medium	Medium	Medium	Low	Low	Low
Latvia	2017	High	Medium	Medium	High	Low	Low
Mexico	2017	Medium	Low	Low	Medium	Low	Low
Netherlands	2024	Medium	High	High	High	Medium	Medium
Norway	2024	Medium	High	High	High	Medium	High
Portugal	2023	Medium	Medium	Medium	Medium	Low	High
Scotland	2023	Medium	High	High	High	Medium	Medium
Slovenia	2013	Medium	Medium	Medium	Medium	Low	Medium
Spain	2018	Medium	Medium	Medium	Medium	Low	Low
Sweden	2017	Medium	High	High	High	Medium	Medium
Switzerland	2024	High	High	High	High	Medium	Medium
United Kingdom	2018	Medium	High	High	High	Medium	Medium
United States	2018	Medium	High	High	High	Medium	Medium

Note: Each treatment guideline is evaluated using a 5-level scale of “Strongly emphasised”, “Emphasised”, “Less emphasised”, “Not emphasised”, and “Not covered” based on the level of detail and tone of each recurring theme. However, due to space limitations in the table, “Strongly emphasised”, “Emphasised”, and “Less emphasised” are displayed as High, Medium, and Low, respectively, with rare cases (“Not emphasised” and “Not covered”) also categorised as Low. Content related to Diagnosis and Assessment, and Public Health and Prevention is not included in the analysis.

85. Several key changes and advancements have emerged from the focus areas across the countries’ guidelines over the past decade. A notable change is the attitude towards pharmacological treatments and non-pharmacological interventions. The latest treatment guidelines have expanded non-pharmacological therapies while underscoring the cautious use of pharmacological treatments. This contrasts with the fact that, in 2018, non-drug approaches had been integrated only to a limited extent, despite their recognised value (OECD, 2018[33]). Guidelines from Australia, Canada, and the United Kingdom prioritise non-pharmacological approaches such as cognitive stimulation, music therapy, and environmental design. Together, many countries (e.g., Denmark, Germany, Ireland) have updated their guidelines to limit antipsychotic use, promote deprescribing, and emphasise non-drug alternatives for behavioural symptoms (see section 3.4).

86. Another improvement involves efforts to create a better environment for managing dementia in hospitals and the community. Current guidelines (e.g. Australia’s Safety and Quality Pathway, Ireland’s Integrated Care Pathways) include hospital-specific protocols for managing delirium and dementia, and promote dementia-friendly environments, as hospitals were identified as high-risk environments for people with dementia in 2018 (OECD, 2018[33]). Australia’s approach is guided by the Australian Commission on Safety and Quality in Health Care, particularly through the Safety and Quality Pathway for Patients with Cognitive Impairment and Action 5.29 of the National Safety and Quality Health Service (NSQHS) Standards (Australian Commission on Safety and Quality in Health Care, n.d.[81]). Action 5.29 helps hospitals become more dementia-friendly by promoting early identification of cognitive impairment and individualised care planning. It encourages non-pharmacological approaches and dementia-friendly environments to reduce distress and improve patient outcomes. Ireland’s Health Service Executive (HSE) developed integrated care pathways and updated delirium algorithms to guide the care of people with dementia in acute hospital settings, based on learnings from three pilot hospital projects (Health Service

Executive, n.d.[82]). The Czech Republic is testing the use of an information sheet for patients with cognitive impairment during hospitalisation. These pathways support continuity of care from community to hospital, and include tailored protocols for Emergency Departments (ED) and Acute Medical Assessment Units (AMAU). Once admitted to wards, patients follow nationally endorsed algorithms and care bundles that can be locally adapted, ensuring consistent, person-centred care for those with known or suspected dementia.

87. Lastly, most updated guidelines (e.g. National Institute for Health and Care Excellence [NICE], Alzheimer's Association, French Haute Autorité de Santé [HAS], German Association for Psychiatry and Psychotherapy [DGPPN]) explicitly embed person-centred care as a foundational principle, with structured care planning and shared decision-making involving people with dementia and their carers. Previously, although countries had started to emphasise home and community-based care, dementia-specific care that takes a person-centred approach was inadequate (Marulappa et al., 2022[83]). In many cases, services remain fragmented, and care models do not fully reflect the needs and preferences of people living with dementia (OECD, 2018[33]). In response, for example, the HAS 2018 dementia care guideline in France embeds person-centred care by emphasising respect for individual preferences, autonomy, and daily routines (Haute Autorité de Santé, 2018[84]). It promotes shared decision-making and personalised care planning that evolves with the person's condition and wishes. The guideline also highlights the importance of maintaining communication, social connection, and adapting the environment to support safety and independence.

3.2 Non-pharmacological interventions are considered the first-line treatment, but are not yet widely integrated into dementia care systems

88. Non-pharmacological interventions have seen considerable development over the past decade. With limited pharmacological options to treat dementia, non-pharmacological approaches have become the standard and preferred interventions for improving the quality of life for persons with mild cognitive symptoms, along with their carers (OECD, 2018[33]). Compared to a decade ago, increasing evidence indicates that non-pharmacological interventions are effective in supporting or improving cognitive function in people with mild to moderate dementia, although the degree of benefit varies by intervention type and individual factors (Bahar-Fuchs et al., 2019[85]).

89. The treatment guidelines identified recommend 14 types of non-pharmacological interventions. Included are cognitive stimulation therapy, reminiscence therapy, music therapy, physical activity or exercise, occupational therapy, environmental modifications, validation therapy, psychosocial interventions, caregiver support and education, structured routines, person-centred care, multicomponent interventions, assistive technology, and social engagement activities. Cognitive stimulation therapy (CST), occupational therapy, and caregiver support are the most consistently recommended across the guidelines. Particularly, multicomponent interventions (combining physical, cognitive, and social activities) are emphasised in newer guidelines (e.g., Australia, Germany). In practice, physical exercise was the most used non-pharmacological intervention, followed by cognitive stimulation therapy, psychological therapy, and social activities, according to the 2024 OECD dementia interviews and questionnaire.

90. **CST** is now more widely recognised as a core non-pharmacological intervention for people with mild to moderate dementia than in 2018, when it was recognised as promising but not universally adopted (OECD, 2018[33]). CST is consistently described as improving cognition, non-cognitive symptoms, communication, confidence, and quality of life (Holden, Stoner and Spector, 2021[86]; Paggetti et al., 2024[87]), and as being the most cost-effective approach (Eaglestone et al., 2023[88]). International organisations working on dementia (e.g., WHO, Alzheimer's Disease International) have endorsed CST as evidence-based (Kelly et al., 2025[89]), and even some national health systems (e.g., NHS in the United Kingdom, HSE in Ireland) have integrated CST into memory clinics and dementia pathways (Holden,

Stoner and Spector, 2021[86]). Nevertheless, limited and variable implementation has remained largely unchanged over the past decade. Only 55% of trained professionals perform CST in practice due to resource constraints, lack of awareness, and staffing challenges, even though 95% of them recognise the efficacy of CST (Kelly et al., 2025[89]). This variation might result from unstandardised inclusion criteria, intervention structure, and evaluation measurement (Holden, Stoner and Spector, 2021[86]).

91. **Physical exercise** has also gained increasing support in guidelines. It is recommended as an important intervention for both the prevention and management of dementia, not only for physical health but also for maintaining cognition and reducing disability in people with moderate dementia. Interventions like walking (including nature walks and walking-based exercises), dance and music-based movement, strength and balance training are the most commonly recommended physical activities across the guidelines (e.g., Australia, Germany, Ireland, Netherlands, Norway, United States). Physical activity shows consistent benefits for cognition, daily function, and neuropsychiatric symptoms. Particularly, resistance and multicomponent exercises (aerobic, strength, balance) are effective for slowing cognitive decline and maintaining executive function, as well as reducing depression, agitation, and behavioural disturbances (Demurtas et al., 2020[90]; Veronese et al., 2023[91]). Although the scientific certainty remains low to moderate (Veronese et al., 2023[91]), multimodal interventions that combine physical activity with cognitive or social components may yield larger effects on cognition and activities of daily living (ADLs) (Sharew, 2022[92]; Vu, Nguyen and Nguyen, 2024[93]). Guidelines emphasise implementation based on holistic health benefits, even if cognitive outcomes are not definitively proven.

92. Other non-pharmacological interventions increasingly mentioned include **occupational therapy (OT)** and **music therapy**. Focusing on reablement, OT supports independence, dignity, and engagement of people with dementia, leading to positive outcomes for both people with dementia and their carers (Bennett et al., 2019[94]). It has already been recognised as a core intervention in the NICE guideline for people with dementia who are experiencing difficulties with ADLs (National Institute for Health and Care Excellence, 2018[95]). Currently, more national guidelines recommend OT as an essential component of dementia care (e.g. Italy, Scotland). Yet, in some countries, OT is not explicitly labelled but is included under broader terms, such as functional support, multidisciplinary care, or rehabilitation/reablement (e.g. Germany, Netherlands, Norway), while its implementation rates vary across the regions (National Board of Health and Welfare, 2018[96]). Music therapy is also gaining growing attention across OECD countries, particularly in Italy and Spain (OECD questionnaire, 2024). Recent research shows music-based therapy has potential non-cognitive benefits for people with mild to moderate dementia, although its cognitive benefits remain inconclusive (Bleibel et al., 2023[97]; Gassner, Geretsegger and Mayer-Ferbas, 2022[98]; van der Steen et al., 2025[99]). The latest Cochrane review (2025[99]) finds that music therapy may improve depression, overall behavioural problems, and social behaviour in the short term. However, its effects on emotional well-being, agitation, or cognition of people with dementia and its long-term impact on outcomes are uncertain.

93. When implementing non-pharmacological interventions, guidelines emphasise individualised and structured care plans combining multiple components. The most appropriate approaches can differ from person to person, as the numbers, types, and severity of symptoms vary at all stages of dementia (NICE, 2018[100]). Therefore, multicomponent approaches are more advantageous than single-component approaches. Australia encourages structured, person-centred care plans that incorporate cognitive stimulation, physical activity, and caregiver support, while Ireland advocates for integrated care pathways that include environmental modifications, psychosocial interventions, and caregiver education. Germany and the United Kingdom detail step-by-step recommendations for multicomponent interventions, including occupational therapy, music therapy, and structured routines, tailored to individual preferences and needs. In several countries, ongoing non-pharmacological interventions alongside pharmacological treatment are recommended (e.g. Canada, Scotland in the United Kingdom).

94. Despite growing evidence and attention, non-pharmacological interventions are not yet widely adopted in care practices. Countries presented that the implementation rates of non-pharmacological interventions were much lower than the awareness levels. In Spain, 86% of geriatricians, 92% of neurologists, 90% of primary care physicians, and 97% of pharmacists believe cognitive stimulation benefits and improves the quality of life for patients and carers. However, when caregivers are asked about memory maintenance workshops or programmes, only 46% have used them at some point, 15% claim they are not available in their area, and up to 36% are unaware that these types of therapies exist (Spanish Ministry of Health, Consumer Affairs and Social Welfare, 2019[101]). This suggests that clinicians' knowledge of the value of CST has not necessarily translated into prescribing it for treating dementia, to say nothing of other non-pharmacological interventions. This gap in awareness and practice among professionals can further limit access to information and the chance to explore these intervention options without using medications among people with dementia and their carers. Data on access and use of non-pharmacological interventions are not yet available.

95. Similarly, the full integration and reimbursement of non-pharmacological interventions into health and long-term care systems remains limited (Table 3.2). Of the 29 OECD countries with available data, 11 countries (38%) reported not reimbursing non-pharmacological interventions through their national health insurance or long-term care insurance. These countries commonly highlight the uncertainty surrounding the effectiveness of psychosocial interventions without medication and the lack of reliable clinical research evidence. Meanwhile, 14 countries (48%) reported providing reimbursement or subsidies, with nine countries (31%) offering full support and five countries (17%) providing partial support. However, the reimbursement status was unclear in Czechia and Portugal (7%) and unknown in Canada and Finland (7%).

96. In Germany, Section 45c of the eleventh book of the German Social Code allows for reimbursement of community-based non-pharmacological services, including development and expansion of services to provide support in everyday life (this also includes neighbourly assistance), counselling, and support networks for people with dementia (German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2020[102]). Japan covers cognitive stimulation, physical exercise, and psychological and psychosocial interventions through public long-term care insurance (OECD questionnaire, 2024). Greece provides extensive coverage for all types of non-pharmacological interventions, from cognition-enhancing programmes, physical therapy, to speech therapy (OECD questionnaire, 2024). In the United Kingdom, NHS-funded dementia care, including non-pharmacological interventions, is reimbursed under the national payment framework (NHS England, 2023[103]), while in Norway, non-pharmacological interventions for dementia treatment are reimbursed if they are part of psychosocial and therapeutic services delivered by authorised professionals covered by the National Insurance Act (Norwegian Directorate of Health, 2025[104]). In Sweden, non-pharmacological interventions are financed through municipal budgets and national subsidies, consistent with Sweden's universal care framework (Swedish National Board of Health and Welfare, 2019[105]).

97. Australia subsidises some non-pharmacological dementia care through the Support at Home Programme (Australian Government Department of Health and Aged Care, n.d.[106]). Specifically, the Australian Government funds free specialist behaviour support programs to provide personalised support and non-pharmaceutical strategies to help carers and aged care providers care for individuals experiencing behavioural and psychological symptoms of dementia. In the Netherlands, dementia care is covered under the Health Insurance Act (Zorgverzekeringswet), and non-pharmacological interventions (e.g., OT, physiotherapy, speech therapy) can be reimbursed at least partially if medically indicated and included in the basic insurance package. Austria, Spain, and the United States tend to partially reimburse non-pharmacological interventions conducted in group homes or nursing homes under certain conditions. In Spain, coverage depends on the type of service and setting (e.g., residential care or locally funded specific programs). This finding aligns with previous observations on OT that it is often underfunded and not reimbursed, especially in home and community-based care settings (WHO, 2017[107]).

Table 3.2. OECD countries have mixed approaches on coverage for non-pharmacological interventions

Not reimbursed (11 countries)	Reimbursed (14 countries)	Maybe (3 countries)
Estonia, France, Hungary, Iceland, Ireland, Korea, Latvia, Mexico, Poland, Scotland, Slovenia	Australia*, Austria*, Costa Rica, Germany, Greece, Israel, Italy, Japan, Netherlands*, Norway, Spain*, Sweden, United Kingdom, United States*	Czechia, Portugal

Note: The reimbursed status for non-pharmacological interventions is defined by the existence of financial coverage through the national health insurance or long-term care insurance. Countries with an asterisk (*) indicate the countries providing partial reimbursement. Other indirect reimbursement schemes through social care benefits or local government initiatives may exist, but have not been identified by desk research.
Source: OECD questionnaire/interviews and publicly available data identified by desk research.

3.3 While treatment options for dementia remain limited, there are questions of the benefits of emerging innovations relative to their cost

98. Several medications to relieve the symptoms of dementia are available and frequently initiated after a diagnosis. These include memantine, which is applicable for people with Alzheimer's dementia, dementia with Lewy bodies, and Parkinson's disease, and cholinesterase inhibitors, such as donepezil, galantamine, and rivastigmine. These four drugs have been found to have moderate effects on cognition for people with specific dementia subtypes, with the potential risk of side effects. Memantine is reported to have beneficial but minor effects on cognition for people with moderate to severe Alzheimer's disease (McShane and al., 2019[108]). In clinical trials, patients taking donepezil or galantamine had higher scores on memory and thinking tests than those taking a placebo, although these benefits were modest and may not be large enough to be evident in daily life. Their side effects include nausea and diarrhoea, while there was no evidence of a difference in side-effects for rivastigmine (Battle et al., 2021[109]). The effects of rivastigmine, like those of other cholinesterase inhibitors, are found to be temporary and do not stop the global clinical deterioration (Birks, Chong and Grimley Evans, 2015[110]).

99. With limited treatment options, there is a broad consensus across clinical guidelines that pharmacological interventions should be accompanied by non-pharmacological approaches. Nonetheless, countries vary in their attitudes towards and implementation of pharmacological treatment. Australia, Norway, and the United Kingdom adopt a cautious and evidence-guided approach to pharmacological treatment. For example, Australia advises clinicians to carefully weigh the risks and benefits of medications, particularly in older adults, and to prioritise safety and person-centred care. In contrast, 10 countries (Denmark, France, Germany, Hungary, Israel, Italy, Japan, Korea, Mexico, Portugal) follow a structured and specialist-led model, where pharmacological interventions are detailed and often central to clinical management. Germany provides comprehensive protocols for prescribing cholinesterase inhibitors and memantine, including dosage, indications, and monitoring requirements. Korea emphasises the role of neurologists and psychiatrists in managing dementia pharmacologically, underscoring the importance of specialist oversight. Meanwhile, nine countries (Austria, Canada, Estonia, Finland, Ireland, Netherlands, Scotland, Switzerland, United States) promote an integrated and person-centred philosophy, where pharmacological treatment is embedded within broader care pathways. Ireland outlines models of care that combine medication with psychosocial support, caregiver education, and environmental adjustments, ensuring that treatment aligns with individual needs and preferences (Health Service Executive, 2023[111]). These diverse approaches reflect varying healthcare priorities, from safety and regulation to clinical precision and holistic care.

100. The existing medications to relieve the symptoms for people with dementia are widely registered across OECD countries, but their reimbursement status varies by country. With generic versions of the aforementioned anti-cholinesterase drugs available, donepezil is the most commonly approved and reimbursed, while galantamine is the least. Within the European Union, most countries provide 75% or higher reimbursement of these types of medications, although Belgium, Croatia, and Finland provide partial reimbursement (below 75%) (Alzheimer Europe, 2023[112]). France withdrew reimbursement for all four medications under a recommendation by the Haute Autorité de Santé in 2018, stating minimal treatment effects compared to the side effects. The cancellation of reimbursement for drugs for dementia symptoms raised concerns about potentially reducing dementia specialist and related care and increasing psychotropic drug use and polypharmacy risks. However, it was found to have little impact because prescriptions had already decreased before the policy change, related to their modest scientific evidence (Couret et al., 2024[113]). A few other countries consider revising the reimbursement rule for medications to relieve the symptoms for people with dementia, as they account for a considerable portion of national medicinal reimbursement. In 2019, the National Institute for Health and Disability Insurance (RIZIV) in Belgium reportedly considered revising the reimbursement status of Alzheimer's medications, including donepezil, rivastigmine, galantamine, and memantine, due to questions about their long-term effectiveness and cost-effectiveness (Alzheimer Europe, 2019[114]). Ireland included drugs for dementia symptoms as a high-cost area and has performed regular pharmaeconomic assessments (Barry, 2008[115]).

101. Meanwhile, the recent pharmaceutical innovations (lecanemab and donanemab) have brought new hope to dementia treatment but also present new challenges. Previously, the first anti-amyloid monoclonal antibody, aducanumab, was approved by the FDA in 2021, but it was discontinued by the pharmaceutical producer due to its controversial results from randomised controlled trials and infrequent prescriptions (Smith et al., 2025[116]). The new drugs are authorised for a small group of patients with a specific genetic predisposition in early-stage Alzheimer's (mild cognitive impairment or mild dementia), aiming to slow disease progression by clearing amyloid plaque in the brain (Sims et al., 2023[117]). They differ from the existing drugs that are used across mild to moderate stages of Alzheimer's disease, primarily to manage symptoms. Despite potential benefits, a significant share of people in clinical trials reportedly experienced mild brain swelling and bleeding side effects (Woloshin and Kesselheim, 2022[118]).

102. Currently, only a few OECD countries and regions have approved the new medications, with inconsistency surrounding their approval decisions. As of January 2026, marketing authorisation of lecanemab (Leqembi, marketed by Eisai and Biogen) has been granted in Australia, Canada, the European Union, Israel, Japan, Korea, Mexico, the United Kingdom and the United States (Australian Department of Health, Disability and Ageing, 2025[119]; Eisai, 2025[120]; EMA, 2024[121]) and it is currently under review in 9other countries (Eisai, 2025[122]). Donanemab (Kisunla, marketed by Eli Lilly) is authorised in Australia, Brazil, the European Union, Japan, Mexico, the United Kingdom, and the United States (Eli Lilly and Company, 2025[123]; EMA, 2025[124]).

103. In various countries, authorisation was contingent upon the treatment of certain older adults with early-stage Alzheimer's disease, and the process leading up to approval involved several reversals. In Australia, the Therapeutic Goods Administration (TGA) approved donanemab in May 2025 and lecanemab for specific indications in September 2025. Before its approval, however, the TGA rejected the approval of lecanemab in March 2025, confirming its decision in October 2024 (Australian Department of Health, Disability and Ageing, 2025[119]). In the European Union, the European Medicines Agency (EMA) granted EU marketing authorisation for lecanemab in April 2025 and donanemab in September 2025 (EMA, 2025[124]; EMA, 2025[125]). The decision was made after a series of evaluations, initial rejections, formal appeals, and ultimately overturning the original negative decision, sparking controversy over its favouritism and impartiality (De Strooper et al., 2025[126]). Although lecanemab received central authorisation at the EU level, so far it has only been registered in a few national registers without reimbursement. In the United Kingdom, the Medicines and Healthcare products Regulatory Agency (MHRA) approved both lecanemab and donanemab in 2024. However, neither of them is recommended by the National Institute for Health

and Care Excellence (NICE) for NHS use, only available through private access with a prescription. In Canada, Health Canada authorised lecanemab in November 2025 and Cadana's Drug Agency is reviewing its reimbursement status (Health Canada, 2025[127]; CDA-AMC, 2025[128]), whereas it was rejected in Quebec in December 2025 (INESSS, 2025[129]).

104. While the regulatory approval decision only considers the benefit-risk (efficacy-safety) profile of the product, post-approval considerations related to cost-benefit of the new medications beyond their effectiveness is an important element. Lecanemab and donanemab are anticipated to demand considerable healthcare resources for early diagnosis, infusion services, and neuroimaging. Since they are intended for a specific group of patients in the very early stage of Alzheimer's disease, comprehensive diagnostic assessments are necessary before prescription, even though the percentage of people eligible for the treatments is relatively low. Administering these treatments requires adequate workforce capacity, as they need to be infused intravenously regularly, for about an hour per infusion (Smith et al., 2025[116]). Finally, intensive monitoring for potential side effects is also required, such as regular MRI scans to detect brain bleeding. In the European Union, the initial negative opinion in July 2024 related to lecanemab in July 2024 stated that the risks of brain swelling outweighed the benefits. However, EMA later concluded that the benefits of a slowdown in progression due to the drug outweighed the risks for the restricted population of patients with only one or no copy of *ApoE4*, who were less likely to experience amyloid-related imaging abnormalities (ARIA) than people with two *ApoE4* copies. In the United Kingdom, the NICE issued draft guidance rejecting donanemab, citing modest clinical benefit compared to high cost that substantially exceeds the thresholds considered acceptable for NHS funding, estimated by per quality-adjusted life year (QALY) (NICE, 2025[130]). Also in Canada, as a condition of authorisation, the manufacturer committed to conduct an additional study to confirm the treatment benefit of lecanemab in the indicated population, and by extension, to support the demonstration of a favourable benefit-risk profile. The results for the confirmatory study are expected in 2030. This underscores the need for healthcare systems to manage expectations and address the robust infrastructure requirements for the new medications before adopting these therapies at scale.

3.4 Limited treatment choices mean that treatment of people with dementia often rely on chemical and physical restraints

105. Managing behavioural and psychological symptoms of dementia (BPSD) is an integral part of dementia treatment. Dementia can be accompanied by non-cognitive symptoms as the illness progresses, such as distress, agitation, aggression, and delusions, and are found among up to 32% of people with dementia living in the community, with higher rates for Alzheimer's patients (Kwon and Lee, 2021[131]). These symptoms lower the quality of life among people with dementia, complicate treatment and extend hospitalisation, while worsening the caregiving burden and well-being of their carers (Anantapong et al., 2025[132]). The management of BPSD is a subject of widespread debate, mainly because of the lack of data from robust, well-controlled studies and the fact that most available agents are associated with serious adverse drug reactions (Oxford Health NHS Foundation Trust, 2019[133]).

106. Chemical and physical restraints have long been used to inhibit intense behavioural and psychological symptoms of dementia. Antipsychotics, such as risperidone, benzodiazepines, and antidepressants have long been used as chemical restraints, and their estimated prevalence in LTC facilities was 32% across North America, Europe, Asia, and Australia between 2000 and 2020 (Lee et al., 2021[134]).[4] While antipsychotics can decrease the severity and frequency of severe distress and potentially

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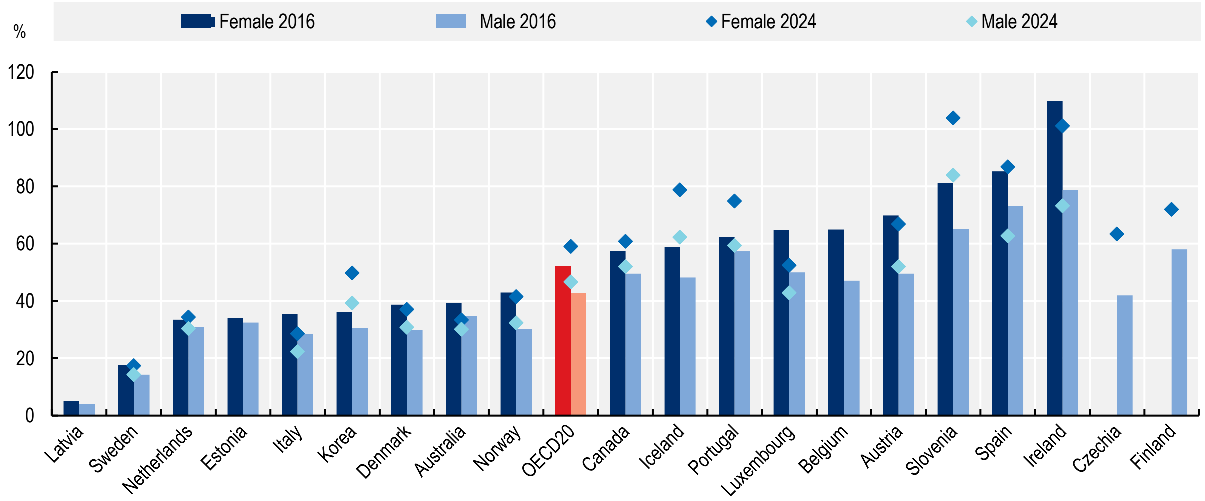
[4] The countries included in the meta-analyses are the United States, Canada, the Netherlands, Germany, Norway, Spain, Sweden, Italy, Romania, Switzerland, Finland, Austria, China, Taiwan, Singapore, Australia, and European and Middle Eastern countries.

harmful behaviours in people with dementia, their use is linked to a higher risk of functional and cognitive decline, strokes, cerebrovascular events, and increased mortality (Rogowska et al., 2023[135]). Country recommendations agree upon the restricted use of antipsychotics in specific circumstances, particularly in severe cases of agitation or psychosis. In France and the United Kingdom, antipsychotics are third-line and require specialist consultation, electrocardiogram monitoring, and close follow-up. It is consistently recommended that antipsychotics should be used only for the short term with great caution, to be accompanied by specialist-caregiver cooperation, low starting doses, regular evaluation, and progressive withdrawal if discontinued. Benzodiazepines are discouraged due to risks, especially in older adults, while certain antipsychotics are to be avoided for Lewy body dementia.

107. However, gaps still exist between policy and practice, with care involving restraints remaining widespread in LTC facilities (Moens, Donback and Ascensão, 2025[136]). Antipsychotic prescribing for people aged 65 or over serves as a useful proxy for that among people with dementia, since antipsychotic prescribing for those with dementia makes up a significant proportion of the total prescribing for older people (OECD, 2018[33]). The antipsychotic prescription rate is also an indicator of the quality of care received by people with advanced dementia (Barnes et al., 2012[137]). The rates of antipsychotic prescription among people aged 65 and above have shown a slight increase from 52.5% to 53.7% between 2016 and 2024, with substantial variation across OECD countries with available data. Antipsychotic prescriptions are influenced by age, care setting, comorbidities, and socioeconomic factors, in addition to gender (Maclagan et al., 2020[138]; Mar et al., 2024[139]). Particularly, psychotropic medication use is higher in women than in men, to the extent that women were 25% more likely to be prescribed antipsychotic medication than men at any given age in all 20 OECD countries (Figure 3.1) (OECD, 2023[38]). This higher prescription rate in women is related to the tendency that women with dementia in community settings receive more antipsychotics than men, whereas men with dementia are more likely to be prescribed these medications in nursing homes and hospitals (Trenaman, Rideout and Andrew, 2019[140]). This could raise concerns about the overuse of these drugs to manage challenging behaviour in older people.

Figure 3.1. Antipsychotic use among older people have remained constant over the past years

Proportion of people 65 and over prescribed antipsychotics, 2016 vs 2024 (or nearest)



Note: The earliest and latest reference years may vary depending on data availability by country.
Source: OECD Health Data Statistics 2025 OECD Data Explorer • Prescribing in primary care

108. Currently, the use of physical restraints is strongly discouraged in dementia care. Physical restraint refers to the use of physical force to prevent, restrict, or subdue movement of a person's body for the primary purpose of influencing behaviour, including various methods, such as bedrails, belts, and other restraints. Approximately one in three LTC facilities in North America, Europe, Asia, and Australia used physical restraints between 2000 and 2020, with bedrails being the most prevalent form (44%) (Lee et al., 2021[134]). Using physical restraints in long-term care has been justified by the prevention of falls or fall-related injuries or controlling specific behaviours, such as aggression or wandering. However, contrary to this belief, physical restraint use actually raises the risk of falls, reduces psychological well-being (Möhler et al., 2023[141]) and can worsen clinical and behavioural outcomes (Singh et al., 2023[142]). People with dementia are reported as being more likely to be subjected to the inappropriate use of restrictive practices. A few country BPSD guidelines state that physical restraints may be considered only as a last resort, and only when there is an immediate risk of serious harm to the person with dementia and others, and all other interventions (non-pharmacological and pharmacological) have failed. The decision to use physical restraints is made by a multidisciplinary team, with input from caregivers and legal representatives, and must comply with legal frameworks and ethical standards.

109. Although a few OECD countries have explicitly banned or regulated the use of restraints in institutional care settings, regulatory measures against restraints remain uncommon and often absent. To date, only 10 countries (Australia, Canada (Ontario), Denmark, France, Germany, Japan, Norway, Spain, Sweden, the United Kingdom) have limited or banned the use of restraints (Table 3.3). Ireland published a proposal for the regulations on restraint use in 2019 (Health Service Executive, 2019[143]), but the development of legal frameworks was pending (Houses of the Oireachtas, 2023[144]). In Estonia, a draft Act amending the Health Services Organisation Act with regard to the use of restraint measures ("Tervishoiuteenuste korraldamise seaduse täiendamise seadus (ohjeldusmeetmete rakendamine)") has recently been submitted to the government and is planned to enter into force on 1 July 2026 (Government of Estonia, 2025[145]).

Table 3.3. Legal restrictions on restraint use in dementia care remain uncommon in the OECD

OECD country	Year	Legal restricti regulations	Restraint type
Australia	2021	*Aged Care Act 2024'*	1, 2, 3, 4, 5
Canada (Ontario)	2007	*Long-Term Care Homes Act*	1, 2, 4
Denmark	2018	*Consolidation Act on Social Services*	1, 2, 4
France	2016	*Code de l'action sociale et des familles*	1, 2, 4
Germany	2009	*Civil Code (BGB)* and *Guardianship Law*	1, 2, 3, 4
Japan	2006	*Long-Term Care Insurance Act*	1, 2, 3, 4
Norway	1999	*Patient and User Rights Act*	1, 2, 3, 4, 5
Spain	2022	*Instruction 1/2022 (BOE-A-2022-2221) of the Attorney General's Office*	1, 2, 3
Sweden	2010	*Health and Medical Services Act* and *Social Services Act*	1, 2, 3, 4
United Kingdom	2005	*Mental Capacity Act 2005* and *Deprivation of Liberty Safeguards (DoLS)*	1, 2, 3, 4, 5

Note: Year refers to the year of the latest update or amendment of the regulations. Types of restraints covered by the regulations include 1) physical restraints, 2) chemical restraints, 3) mechanical restraints, 4) environmental restraints, and 5) seclusion.

110. The current legal frameworks cover different types of restraints, from physical restraints to seclusion, and emphasise that restraints should only be used when absolutely necessary, usually to prevent immediate harm. Legal or informed consent from the patient or their legal representative is required before restraints are applied. Use of restraints must be documented and subject to regular review to assess necessity and safety. Decisions often involve a team of professionals, including medical staff, caregivers, and legal representatives. Countries encourage non-pharmacological interventions, environmental modifications, and staff training as preferred alternatives. Restraint use is framed within ethical care

principles, emphasising dignity, autonomy, and human rights. Laws and regulations on restraints in Australia, Canada (Ontario), Denmark, Sweden, and the United Kingdom specifically address restraint use in dementia care. In contrast, in France, Germany, Japan, Norway, and Spain, these laws generally cover care of older people more broadly.

111. In parallel, across OECD countries, guidelines for BPSD management have been developed by governments and relevant medical associations to inform clinicians about the symptoms of dementia and recommend treatment options based on the latest evidence. Currently, 38 BPSD management guidelines are identified across 30 OECD countries. The national BPSD guideline is available in 20 countries (67%), with subnational and sector-specific guidelines available in 3 (10%) and 11 (37%) countries, respectively (overlaps permitting). Australia, Japan, the Netherlands, Scotland, Spain, Sweden, and the United Kingdom have multiple guidelines published by different authorities. 16 guidelines in 13 countries were standalone ones for managing BPSD, while the remaining 22 in 17 countries had information about BPSD integrated as part of dementia treatment guidelines. Most BPSD-dedicated guidelines were released in 2018 or later, except for the one from the United States (2016). The guidelines from Korea and the United States focus only on pharmacological treatment. However, five countries (Czechia, Costa Rica, Greece, Latvia) do not yet have any guidelines for managing BPSD.[5]

112. Diagnosing BPSD is recommended to be based on an established framework for analysis, structured assessment tools, and personalised assessment, grounded in a person-centred approach. The guidelines provide general and symptom-specific recommendations, along with good practices for assessing and managing BPSD. A multidisciplinary assessment involving input from general practitioners, specialists, nurses, social workers, and family members is highly recommended to ensure a comprehensive understanding of the behaviours and the needs of the person with dementia and individualised. The Polish guideline emphasises the central role of primary care physicians in identifying and managing BPSD.

113. Non-pharmacological interventions are again recommended as a first-line treatment for BPSD. Each intervention was suggested corresponding to specific dementia symptoms, with the broadest support for environmental adaptation and design. The BPSD guidelines recommend multiple non-pharmacological interventions for all symptoms, ranging from agitation to vocal disruption. Among others, depressive symptoms of people with mild-to-moderate Alzheimer’s disease and other dementias and apathy are strongly recommended to be treated using various psychosocial interventions. Cognitive stimulation therapy is consistently recommended for managing depression and anxiety across countries. Music therapy is strongly recommended to reduce agitation, along with anxiety, apathy, depression, and behavioural problems. A safe and structured environment is recommended throughout symptom management. Education and support for caregivers are also emphasised as crucial non-pharmacological interventions.

114. As in overall dementia care, pharmacological treatment is considered second-line in managing the behavioural and psychological symptoms, recommended only when non-pharmacological interventions are ineffective, and the symptoms are severe and pose a risk to the patient and their carers’ safety. Severe agitation, psychosis, and sexual disinhibition are likely to be treated with medications among other BPSD. Recommendations on pharmacological treatments vary between Alzheimer’s disease and other types of dementia. In any case, pharmacological treatment is recommended for the short term with close and frequent review. Canada follows this approach for managing severe agitation or psychosis, while recommending deprescribing antipsychotics, as well as antidepressants and benzodiazepines, for those

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[5] Although Latvia does not have a national guideline for BPSD management, its TSI project material for training medical and medical support personnel on dementia (Ministry of Health, 2019) is structured in a guideline format. Likewise, Poland published information equivalent to a guideline for the public online (Ministry of Health and the National Health Fund, 2022).

without a history of severe agitation or psychosis or severe mental illnesses. In Australia, medicinal treatment mainly relies on a combination of medications for dementia symptoms, while avoiding polypharmacy, because Risperidone is the only antipsychotic approved under the Australian Pharmaceutical Benefits Schemes (PBS) for BPSD. France recommends prescribing antidepressants primarily in combination with mood stabilisers. Sweden (Stockholm) displays a relatively strong negative attitude towards pharmacological treatment, considering it only as a complement to proper care and environmental adjustments, and only if non-drug measures are insufficient. Most BPSD guidelines recommend using pharmacological treatments in conjunction with non-pharmacological approaches (Australia, Canada, Spain, United Kingdom).

3.5 More harmonised and systematic dementia-specific training across care settings may help bridge the gap between policy and practice

115. Dementia-specific education and training increase staff knowledge, improve attitudes toward people with dementia, and boost confidence in care delivery across healthcare and long-term care settings (Parveen et al., 2021[146]; Schneider et al., 2020[147]; Wehry and Wihry, 2022[148]). Some evidence suggests that well-structured training can also enhance care practices, including lowering the inappropriate use of psychotropic drugs and improving agitation management (Bielderman et al., 2021[149]; Shier et al., 2024[150]; Zabihi et al., 2025[151]). Recently, at least 25 OECD countries have developed national plans that include workforce training components. 18 countries explicitly include dementia training for health and long-term care staff in their national dementia strategies, six countries (Austria, Finland, Mexico, Portugal, Spain, Switzerland) partially or indirectly reference training, while only Türkiye does not have a national strategy and thus does not explicitly mention training provision. In Estonia, this is integrated into broader LTC policy.

116. Dementia education and training vary across OECD countries in terms of target trainees, content, and delivery. Currently, only nine countries (Australia, Hungary, Ireland, Israel, Korea, Norway, Slovenia, Spain, United Kingdom) have established national training standards on dementia, targeting different groups of practitioners. Most focus on healthcare professionals and long-term care staff, while some include informal carers and community members. Focussing on the dementia training standards in Australia, Ireland, the United Kingdom, and the United States, the most common content across these standards includes basic dementia awareness, communication in dementia care, community care, recognition and care for memory problems, and basic knowledge of legal issues (Pit et al., 2024[152]).

117. With or without national standards, dementia education and training are primarily delivered through educational pathways, including as part of medical school curricula or as continuing professional development for healthcare and social care staff. In Austria, dementia training is included in the regular curriculum at medical schools, alongside elective courses specific to dementia. Likewise, dementia-specific elective courses are available at medical schools for doctors and nurses in many countries. In Finland, the Finnish Medical Association offers a special qualification in the treatment of memory disorders for GPs. In Estonia, occupational therapy students complete a dedicated subject focusing on dementia in their final year. Some countries offer dementia education as degree programmes or certification programmes. In Ireland, dementia education and training are offered as a master's degree course for healthcare professionals, including GPs and nurses, by the University College Cork (OECD questionnaire, 2024). In Spain, postgraduate programmes on dementia exist in different provinces. In Salamanca, master's degree programmes on dementia (research) have been offered since 2012 On average, 60 people register for this programme annually and receive 3 500 hours of training over four years. Dementia education and training can also take place outside educational institutions for community members and the public. Large hospitals or long-term care facilities may provide their own dementia education and training. In Tirol and Styria in Austria, large hospitals require dementia training for all staff, from health professionals to janitors, cooks,

and other hospital employees, initiatives part of their national dementia strategy recommendations (OECD questionnaire, 2024).

118. However, dementia education and training remain non-mandatory in most countries, except for seven countries. This situation has persisted for nearly a decade, during which comprehensive dementia training was rarely a standard part of the minimum requirements for care staff. Australia's new aged care legislation and regulatory framework have an increased focus on dementia and incorporate provisions to support dementia training. It requires care workers to receive regular competency-based training in core topics, including dementia, and obliges care providers to demonstrate that staff meet these training requirements. As of 2025, six more countries (Estonia, Germany, Japan, Korea, Slovenia, United States) have made dementia training for health and long-term care staff mandatory. Estonia has a 12-day voluntary training programme for care homes to train two staff members in each care institution to become an internal trainer. By 2024, 86 of just over 200 institutions had completed the programme in its six years. Germany has incorporated mandatory modules on dementia care in the generalist nursing education programme since 2020 under the Nursing Professions Act. Japan's national dementia strategy mandates standardised training for nurses and GPs, while the Japanese Nursing Association requires dementia care training for nurses working with people with dementia, especially in hospitals, aligned with national reimbursement policies (Dementia Care Add-on 2 and 3) (Japanese Nursing Association, 2025[153]). Korea offers structured dementia training, including mandatory smart e-learning for staff in specialised long-term care and home care facilities (Korean National Medical Center, n.d.[154]). Slovenia's 2024 Long-Term Care Act regulations set minimum standards for staff qualifications, making dementia care a required competency (Box 3.1). In the United States, 13 states require dementia training at the organisational level in long-term care, home health, and hospice settings, but there are no federal requirements (MedBridge, 2023[155]). To facilitate dementia training for health and long-term care practitioners, countries can provide various incentives, including paid training time, certificates/badges, accredited qualifications, as well as national policy/standards, although only a few countries currently do so (Sass et al., 2019[156]; Surr et al., 2020[157]). More attention is needed to tackle a lack of funding, organisational support, and staff literacy, as well as high staff turnover and inconsistent service delivery, which continue to hinder training uptake (Pit et al., 2024[152]).

Box 3.1. Slovenia's regulations on mandatory dementia training

As part of the establishment of Slovenia's long-term care system, two key regulations were adopted in early 2024 to define the scope and content of training for professionals in the sector. These include the *Regulations on Services, Personnel Requirements, Training, and Supervision in Long-Term Care*, and the *Regulations on the Content, Scope of Training, and Skill Catalog for Long-Term Care Consultants and External Experts*. Both regulations mandate that knowledge and skills related to dementia care be included as essential content, ensuring a consistent standard across all long-term care settings. In accordance with these rules, minimum dementia-specific training applies to long-term care consultants (such as nurses, physiotherapists, occupational therapists, and social workers) who assess eligibility for care; long-term care coordinators (health and social professionals); and service providers focused on strengthening and maintaining independence (including kinesiologists and social gerontologists). Long-term care consultants are required to complete 35 hours of initial training and 15 hours of refresher training every three years. Service providers must complete 30 hours of basic training, while coordinators undergo 50 hours of initial training and 20 hours of refresher training every three years. Dementia-related content is integrated into all these training programs, reflecting Slovenia's commitment to person-centred, dementia-aware long-term care.

Source: OECD Questionnaire on dementia, 2024.

119. Emerging areas for improvement include training on non-pharmacological interventions and, increasingly, on the management of BPSD for both professional and informal carers. Although national dementia strategies and dementia care pathways now recognise non-pharmacological approaches as a substantial part of care, their use in actual care settings is still low. A shortage of staff to implement non-pharmacological interventions is a significant barrier to increasing the availability of these interventions across various care settings, as reported in Spain, Sweden, and Switzerland (OECD questionnaire, 2024). However, there is little consensus or guidance on how these trainings should be delivered or what constitutes effective support, leading to significant variability in practice across countries and regions (Felstead et al., 2023[158]; Lobo, Lobo and De-la-Cámara, 2019[159]). Particularly, there is a notable gap in tailored training for severe BPSD, especially in hospital and palliative care settings (Gallop et al., 2025[160]), with a lack of accessible and timely training options about BPSD targeting caregivers (Ramirez et al., 2021[161]). To overcome these barriers to training, Ireland launched a dedicated Occupational Therapy Practice in Dementia Care Modules for therapists at all levels within its dementia care pathways in 2023 (Health Service Executive, 2023[162]), while providing free dementia care training for home care workers and home care support providers to deal with BPSD (OECD questionnaire, 2024). The Modules cover assessments, interventions, communication strategies, ADLs, seating, transfers, and carer support. Ireland significantly expanded in training and professional development, reflecting a shift toward standardised, evidence-based occupational therapy practice.

4 Care co-ordination for people with dementia has been given more emphasis

4.1 Care co-ordination is improving, but not yet meeting the full needs of people with dementia

120. Coordinated post-diagnostic services help people with dementia and their carers better navigate and access care services available for them. Care co-ordination, some form of referral to other services, resources, or care (Abrams et al., 2024[163]), can strengthen post-diagnostic support by reducing the navigation and access challenge of people with dementia and their carers. Care co-ordination can include connecting to community resources and services based on the socioeconomic situation and residency of a person diagnosed with dementia, assisting with how best to use these services to meet their needs, and contacting service agencies for the person diagnosed with dementia and carers (Abrams et al., 2024[163]). While care co-ordination refers to broad, system-level integration of services, case management refers to more individualised, treatment-focused ones (OECD, 2018[33]).

121. Coordinated care models are seen as essential for improving outcomes for both people with dementia and their carers. Care co-ordination and case management in dementia care consistently improve quality of life for people with dementia and their carers, with benefits including better well-being, reduced hospitalisations, and lower emergency department use (Possin et al., 2019[164]; Possin et al., 2025[165]; Saragih et al., 2021[166]). Early and structured involvement of case managers increases timely diagnosis, regular screening, and adherence to care guidelines (Carey et al., 2025[167]). Care co-ordination is linked to decreased carer burden and depression, as well as improved preparedness and satisfaction with care (Possin et al., 2025[165]; Saragih et al., 2021[166]). Personalised care planning and support from care navigators can further help address their unique needs (Cha et al., 2021[168]; Millenbah et al., 2022[169]). Case management-based collaborative care models are associated with better management of BPSD, reducing the risk of symptom deterioration (Saragih et al., 2021[166]). Personalised care plans increase the involvement of people with dementia and carers in decision-making, improve communication, and support more holistic, person-centred care (Britt et al., 2024[170]; Spencer et al., 2024[171]).

122. Strengthening access to post-diagnostic care and support through a coordinated care approach is a key policy goal in many national plans. In Australia, improving treatment, co-ordination and support for people living with dementia is a priority action of the National Dementia Action Plan 2024–2034 (Australian Government Department of Health and Aged Care, Department of Social Services, & Dementia Australia, 2023[172]), while in Norway the Dementia Plan 2025 Priority area 1: references ensuring that individuals with dementia who need additional and coordinated services, are offered an Individual Plan and a coordinator (Norwegian Ministry of Health and Care Services, 2022[173]). Similarly, strengthening co-ordination of care and case management is a central goal of Chile's dementia strategy. Achieving optimal quality care for people with dementia and their families requires collaboration across professionals,

services, care levels, and social sectors. The national action plan highlights this approach through its component on better co-ordination of care and support programs, aiming to ensure that care is seamless, integrated, and responsive to the needs of both individuals with dementia and their family environments (Ministerio de Salud. Gobierno de Chile, 2017[174]). In Finland, memory coordinators operate to help people with memory disorders and their families in organising everyday life and services immediately after diagnosis (Pennanen et al., 2023[13]).

123. Sectoral collaboration is also highlighted in national plans. The Spanish Comprehensive Plan for Alzheimer's Disease and Other Dementias (2019–2023) recognises a deficit and fragmentation in the social and health response to the needs for prevention, treatment, and care. The guiding principles of the Comprehensive Plan for Alzheimer's and other Dementias include providing care through adequate social and health co-ordination centred on both the person with Alzheimer's and their family caregiver, promoting co-ordination and collaboration across multiple sectors, and ensuring coordinated and continuous care that takes into account the specific needs of each individual as a key priority (Spanish Ministry of Health, Consumer Affairs and Social Welfare, 2019[101]). In Costa Rica, the National Dementia Plan (2014–2024) has set out objectives to strengthen co-ordination across health providers, community organisations and social protection systems, with a focus on supporting people to remain at home for as long as possible. The country's primary care model, delivered through integrated primary care teams (Equipos Básicos de Atención Integral de Salud EBAIS) teams, provides a potential backbone for continuity of care by linking general practitioners, nurses and social workers at the community level (Ministerio de Salud (Costa Rica), 2014[175]). While the Plan calls for intersectoral collaboration and improved caregiver support, formalised roles such as dedicated dementia case managers—shown in OECD countries such as Germany, France and Japan to reduce unmet needs and ease transitions across services are not yet fully established.

124. Several national strategies and plans discuss specific ways to enhance co-ordination through workforce strategies. The Scotland National Dementia Strategy highlights that effective care co-ordination improves outcomes for people with dementia and their care partners. Multidisciplinary teams, clear communication, and regular GP follow-ups are central, supported by the developing Integrated Health and Care Record. People with advanced dementia in care homes receive the same coordinated support as those at home. Workforce development will focus on strengthening post-diagnostic support and care co-ordination skills (Scottish Government & COSLA, 2023[176]). Similarly, the United Kingdom National Institute for Health and Care Excellence quality standard on dementia specifically states on coordinating care, that people with dementia should have a single named practitioner responsible for coordinating their care (National institute for Health and Care Excellence, 2019[177]). Additionally, the Swedish National Dementia Strategy 2025–2028 recognises that people with dementia often need coordinated care from multiple healthcare and social service providers. It emphasises the importance of a designated care contact to ensure person-centred, coordinated, and needs-based support (Swedish Government., 2025[178]). The government intends to amend legislation so that, from 1 July 2026, persons living in special housing under the Social Services Act will also be offered the opportunity to have a designated care contact. Similarly, the Irish National Dementia Strategy recommends that within primary care services, a named key worker will be appointed to play a key role in co-ordinating each patient's care and promoting continuity, and ensuring that the patient knows who to access for information and advice (Department of Health, 2014[179]).

125. Care co-ordination services have become more prominent but are not yet available across all countries. Special Case Management (SCM) appears to be more common than care coordinators across OECD countries. SCM exists in 16 countries (including regions of a country), an increase from 12 countries and regions in 2018 (Table 4.1).[6] SCM involves assigning a dedicated professional, such as a nurse, social worker, or occupational therapist with dementia-specific training, to develop personalised care plans,

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[6] 12 countries and regions count those with general dementia case management and those with dementia case management for specific populations, from Table 3.1. in the OECD (2018[33]).

coordinate multidisciplinary teams, and monitor patient progress. Care coordinators are present at either regional or national level in 16 of the 28 OECD countries that responded to the survey.

Table 4.1. More than two-thirds of the responding OECD countries have coordinated care mechanisms for dementia care

	OECD countries
Both Care Coordinator and Special Case Management	Austria*, Canada*, Costa Rica, Finland, France, Japan, Korea, Spain*, Sweden, United Kingdom (Scotland), USA
Care Coordinator only	Estonia, Ireland, Netherlands, Norway, Switzerland
Special Case Management only	Australia, Germany, Latvia, Mexico, Slovenia
Neither identified	Czechia, Greece, Hungary, Iceland, Israel, Italy, Poland, Portugal

Note: *: Only in some regions.
Source: OECD’s own analysis/questionnaire.

4.2 Case management and personalised care plans are now being integrated into dementia care

126. Special case management systems and personalised care plans are increasingly used to address the complex needs of people with dementia. This often involves multidisciplinary teams and professional care coordinators. In Korea, Dementia Care Centers provide case managers who are licensed nurses, social workers, or occupational therapists trained specifically in dementia care. These managers deliver tailored interventions for early-stage patients, following structured implementation plans. Spain illustrates a regional approach, with Castilla y León designating case managers to develop individualised care plans (Junta de Castilla y León, 2025[180]), while in France, *Centres Locaux d’Information et de Coordination* (CLIC) and Alzheimer trams offer structured rehabilitation, including 15-session ergotherapy programmes and housing adaptations. In Czechia, some regions are developing and testing a concept whereby care coordination is handled by Memory Center advisors, who are available to family caregivers, municipalities, and services. How to set up care, how to deal with specific situations, selecting appropriate services, and involving the wider family; they also perform screening tests and collaborate with general practitioners and specialists. These initiatives emphasise the usefulness of individualised care pathways and co-ordinated follow-up to assist people with dementia to access all services available to them. In Slovenia, psychiatrists and neurologists within hospital and outpatient settings coordinate teams including dementia-trained nurses, physiotherapists, psychologists, social workers, and dietitians. Norway grants individuals with long-term care needs a coordinator and an individual plan, independent of diagnosis, implemented through cross-disciplinary teams. Since 2013, the province of Vorarlberg has operated a region-wide case management system for care and support in Austria, funded by the *Bundespflegefonds* and organised through municipal and regional service points, providing coordinated support for people with dementia and their families. In Finland, local health/municipal services organise coordination roles according to regional needs. Memory coordinators are found in Geriatric Outpatient Clinics and support people with memory disorders and their families by assessing functional ability, monitoring cognitive status, updating care plans, and referring to appropriate services, with appointments available at clinics, remotely, or at home (City of Helsinki, 2025[181]).

127. Some countries incorporate case management for people with early dementia into a general case management system. In Estonia, case management is based on general principles for all individuals in need of assistance. The case manager role is in the local government, who assesses the person's need for help and determines what kind of help the person needs. Most hospitals have social workers who are case managers on the hospital side and are partners of local government social workers. In some regions there are care coordinators in the social sector, whose role is to support individuals with both social and

healthcare needs. This pilot project was launched in 2018, aiming to contribute to the development of a more integrated and person-centred provision of social and health services to people with complex support needs. In case of a need for 24-hour care in a care home, a care plan is created, which also involves an assessment by a healthcare professional. Family members should be involved in creating the care plan when their relative lives in a care home. The care home must prepare a care plan in cooperation with the service recipient or, if the recipient is not able, with the person financing the service. This plan must be completed within 30 days of the service starting. The care provider must review the plan at least every six months, or more frequently if needed. In Australia, people with dementia can access care management services through various programs that, while not dementia-specific, ensure the delivery of approved, funded aged care services aligns with individual needs, preferences, and culturally appropriate practices.

128. Offering both dementia-specific and more general care support is similarly the model in Japan, where case management is an integral part of national goals to support elderly citizens to age in the community, through the Integrated Community Care System (Ministry of Health, Labour and Welfare, 2017). The country's 'Orange Plan' dementia strategy further calls for the development of dementia care pathways to be implemented at the municipal level throughout Japan. In addition to services offered through integrated community support centres. Japan recently developed integrated care teams for early dementia. Teams are located in integrated community support centres, but also offer home visits, assessments, and support to family members of people with early onset dementia. Life support coordinators transition to dementia community support coordinators when patients develop dementia, working closely with community general support centres and dementia medical centres. These arrangements ensure care is personalised and coordinated across professional domains. To ensure that people with early-stage dementia have access to appropriate medical and care services, 'dementia community support coordinators', appointed by municipalities, work in collaboration with a multidisciplinary 'Initial-Phase Intensive Support Team'. This team visits the homes of people with dementia to provide support. If the person is certified for long-term care, a care plan is developed by a care manager to facilitate access to care services. In local governments, a 'life support coordinator' primarily supports the older adults, and when someone develops dementia, a 'dementia community support coordinator' takes on the role. They work in co-ordination with relevant institutions such as 'community general support centres' and 'dementia disease medical centres'.

129. An example where initiatives have supported care-co-ordination outside of what is provided by the country is in Ireland. The Alzheimer Society of Ireland (ASI) rolled out a Dementia Advisor programme in July 2014, initially employing seven Dementia Advisors across the country (Department of Health, 2014[179]). In late 2020 ASI received funding from the *Health Service Executive/Slaintecare* to expand the Dementia Advisor Service, which now includes over 20 Dementia Advisors (The Alzheimer Society of Ireland, 2025[182]).. ASI is working collaboratively with the National Dementia Office to deliver a nationwide Dementia Advisor service. The specific mandate of the Dementia Advisors is to provide support and information to people with dementia and their carers living in the community. They have a strong presence on the ground and work closely with Primary Care Teams, key health and social care professionals and service providers locally to signpost people to the resources that are available locally as well as providing timely information and social support.

4.3 Integrating health and social services for dementia enhances coordinated care

130. Integration of health and social services can facilitate coordinating care for dementia, as in most countries, post-diagnostic dementia care is often fragmented, with services delivered by a mix of health (e.g., diagnosis, medication, clinical follow-up) and social care (e.g., daily living support, home care, caregiver assistance). This leads to inconsistent service provision, duplication, and gaps in care,

particularly with varying access and quality by location (Frost et al., 2020[183]). Lack of shared information systems, unclear roles, insufficient training, and limited collaboration between sectors are the barriers to integration (Smith et al., 2021[184]). Fragmentation particularly affects minority, rural, and underserved populations, who may have even less access to coordinated post-diagnostic support (Frost et al., 2020[183]; Giebel, 2024[185]).

131. Countries recognise that integrating health and social care is essential for enhancing post-diagnostic care and are making efforts to overcome the challenge. In Estonia, the Ministry of Social Affairs is working towards full integration of health and social care within five years, although data protection regulations present challenges for information sharing. Estonia's Viljandi Hospital Memory Clinic is another good example of a comprehensive care pathway for people with memory disorders. The clinic aims to integrate the medical and social systems so that all information regarding the medical management of memory disorders, as well as available support services, is accessible to patients and their relatives from a single source. Similarly, Icelandic municipalities manage social services while the state oversees healthcare, with integration prioritised at a national level. In Finland, multiprofessional counselling and client guidance systems coordinate health and social services, ensuring that people with dementia and their families receive comprehensive, continuous care. Sweden has made legislative improvements to align health and social care at the municipal level, with further proposals pending.

132. Community-based networks enhance access and co-ordination for people with dementia. Germany has developed extensive regional networks linking all relevant players such as hospitals, GPs, long-term care facilities, informal carers, and community organisations. Building upon this successful framework, the promotion of community-based networks is currently being further expanded through legislative changes. To this end, funding of the networks will be improved and an office will be established to support the developments of new networks. In Austria, the province of Oberösterreich operates dementia service points that provide prevention, diagnosis, and carer support. These services are co-financed by Social Security to incentivise replication in other provinces, recognising the role of regional autonomy in service delivery. In addition, some provinces have implemented coordination models, including Memory Clinics in Vienna, the Dementia Network of Styria, and regional care coordination programs in Tyrol.

133. In addition to more systemic networks, efforts to coordinate care have occurred at a more local level. An example of a local level effort to coordinate care was Peterborough City Council in the United Kingdom, which sought to ensure that, during NHS Health Checks, individuals identified as at risk of or diagnosed with dementia were connected with the appropriate services (Department of Health, 2015[186]).. The Health Check provided an opportunity to highlight Peterborough's investment in dementia care, including the new Dementia Resource Centre, and to address gaps in professional knowledge and skills. A GP referral pathway was established to link those with memory concerns from the NHS Health Check to relevant dementia services. This pathway included signposting to the Dementia Resource Centre, which offered advice and information from the Alzheimer's Society, assessment and diagnosis via the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Memory Clinic, and post-diagnostic support groups and activities for people with dementia and their carers. To support practices in implementing the dementia component of the NHS Health Check, clinical nurse lead employed by Peterborough's Public Health department provided guidance and support in the role of a "clinical coach".

4.4 Post-diagnostic dementia care hinges on better integration and stakeholder collaboration to ensure care continuity and address system gaps

134. Effective dementia care requires integrated and structured co-ordination across health and social care services. While many countries have made policy commitments, implementation remains uneven, and formal roles like care coordinators or case managers are not universally established. For instance,

Latvia and Mexico rely primarily on general multidisciplinary teams or referral-based models, while Portugal's home care services are fragmented, with limited co-ordination between shifts. Some countries, including Israel, Italy, and Hungary, report minimal or unclear systems. Even where structured programmes exist, implementation often varies regionally. As seen in Spain and Austria, the influence of local governance, resource allocation, and service infrastructure on care delivery is highlighted. In many cases there is a reliance on community-based leadership or more general care co-ordination that is not specific to people with dementia.

135. The effective implementation of coordinated dementia care depends on better co-ordination between stakeholders. Strong collaboration among public services organisations and key stakeholders in the not-for-profit sector, for instance, can enhance dementia care co-ordination (Abrams et al., 2024[163]). The success of such programmes depends on the shared commitment of organisers, carers, and partner institutions to actively engage and support the initiative. Clear communication among all team members, along with strong co-ordination between primary care providers and the rest of the team, is especially important. A delivery model that is both adaptable and responsive, fostering regular and open communication with people with dementia, is crucial. Additionally, coordinators who demonstrate empathy, strong listening skills, and the ability to build trusting relationships with clients play a vital role in facilitating effective care. At the same time, support for managing burnout and stress among care co-ordinators should be implemented as part of the coordinated care model, as they are major barriers to the successful and continuous realisation of the care model (Abrams et al., 2024[163]).

136. Sustained support for both people with dementia and their carers is also an essential element of the co-ordination of person-centred dementia care. Providing hands-on support and guidance to carers strengthens the care process and reduces carers' burden (Abrams et al., 2024[163]). Scotland has developed targeted post-diagnostic services, including informal respite, peer support, and continuous engagement campaigns. In Germany and Finland, follow-up care is embedded in integrated care and support systems. In countries with structured case management, such as Korea and France, carers actively participate in personalised care planning and intervention, ensuring continuity and enhancing patient outcomes.

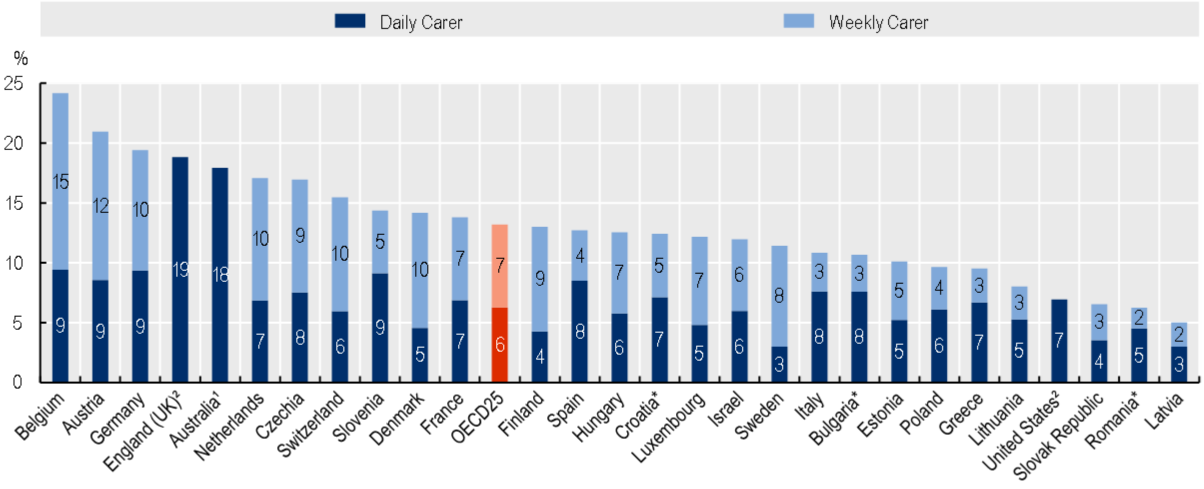
137. Effective care co-ordination and special case management is a cornerstone of post-diagnostic dementia support, and countries increasingly rely on both care coordinators and special case management to ensure continuity and quality of care. Primary care providers, particularly GPs, often act as the first point of contact, while care coordinators help patients and families navigate health and social services. Examples of effective implementation include Germany's "*Pflegestützpunkte*" (LTC service points), and Estonia's Viljandi Hospital Memory Clinic, which integrates medical and social care under a single coordinated system. Integration of health and social services, as seen in Iceland and Finland, further strengthens the role of care coordinators and special case managers by enabling seamless communication and reducing service duplication. Active involvement of family members in planning and monitoring care is also a critical component, which must be well supported (Chapter 5). Across these diverse systems, evidence suggests that well-defined care co-ordination roles, supported by structured pathways, multidisciplinary collaboration, and targeted special case management, are essential for meeting the complex needs of people living with dementia.

5 Caregiver support is improving but it is not dementia-focused

138. Informal caregivers are essential in supporting individuals who require care, providing significant assistance that complements or extends beyond formal health and social services. Data from 19 OECD countries show the societal reliance on informal care, with approximately 60% of older people reporting they receive only this kind of assistance (Rocard and Llena-Nozal, 2022[187]). This widespread commitment is further underscored by recent data showing that, on average, 13% of people aged 50 and above in OECD countries are informal caregivers (Figure 5.1).

139. The widespread reliance on unpaid caregivers underscores the burden they carry, which is particularly acute for those caring for people with dementia. The caregiving role is time-intensive, and caring for someone with dementia brings additional challenges due to the progressive nature of the disease, particularly in managing neuropsychiatric symptoms and functional decline. This often leads dementia caregivers to consistently report higher levels of depressive symptoms and a reduced quality of life than non-dementia caregivers (Karg et al., 2018[188]). Studies consistently show that an increase in caregiving intensity, measured by the hours dedicated per day, is directly linked to a greater caregiver burden (Xu et al., 2021[189]). The demanding nature of dementia care often forces caregivers to withdraw from their social support systems, increasing their risk of negative health outcomes. Research from the United Kingdom indicates that caregivers of people with dementia frequently experience feelings of loneliness, which is exacerbated by factors such as social isolation, caregiving stress, and a decline in the quality of their relationship with the care recipient (Victor et al., 2020[190]).

Figure 5.1. People aged 50 and above providing informal care, 2021-2022 (or nearest year)



Note: The definition of informal carers differs between surveys. Data for the United Kingdom, Australia, United States refer to informal carers in general. Data for Canada are based on the population aged 15 and over and are not directly comparable with the indicator shown in the figure (population aged 50 and above). In 2022, 13.4 million Canadians aged 15 and over reported having provided unpaid care to children or care-dependent adults in the previous 12 months (Wray, 2024[191]). 1. 2022 data. 2. 2018-2019 data. *Accession/partner country.

Source: SHARE wave 9 (2021-2022); SDAC (2022) for Australia; Census-based statistics (2021) for United Kingdom; HRS wave 14 (2018-19) for United States.

140. To address these challenges, policy intervention can make a difference by providing caregivers with relief tools and resources. OECD countries have implemented policies that offer different support instruments available for dementia caregivers and caregivers in general, in the form of financial assistance, flexible work arrangements, respite services, and access to training and counselling (Table 5.1). Despite the significant burden on carers of people with dementia, most existing support across countries is not tailored to them, reducing its adequacy and effectiveness.

Table 5.1. Policies across 29 OECD countries provide dementia carers with cash benefits, leave, respite, training, and counselling services

OECD countries	Cash Transfer	Leave		Respite	Training	Counselling
		Paid	Unpaid			
Australia	●	●	●	●	●	●
Austria	●	●	●	●	●	●
Canada		●	●	●	●	●
Costa Rica	●			●	●	●
Czechia	●	●				●
Estonia	●	●		●	●	●
Finland	●		●	●	●	●
France	●	●	●	●	●	●
Germany	●		●	●	●	●
Greece	●			●	●	
Hungary	●		●			
Iceland				●	●	●
Ireland	●	●	●	●	●	●
Israel	●		●	●		●
Italy	●	●		●	●	
Japan		●	●	●	●	●
Korea	●		●	●	●	●
Latvia			●	●	●	●
Mexico	●			●	●	
Netherlands	●	●	●	●	●	●
Norway	●	●	●	●	●	●
Poland	●	●	●	●	●	●
Portugal	●		●	●	●	●
Slovenia		●	●	●	●	
Spain	●	●	●	●	●	●
Sweden	●	●		●	●	
Switzerland	●	●		●	●	
United Kingdom	●		●	●	●	●
United States	●	●	●	●	●	
Total	24	17	20	27	26	21

Source: OECD's own analysis / questionnaire. See Annex B for further information.

5.1 Most countries provide cash transfers and tax relief to ease financial pressures on carers – but few are specific to carers of people with dementia

141. Caregiving often leads to a financial strain due to lost wages, out-of-pocket expenses for care services and equipment. In 2019, the global burden of dementia was estimated to amount to USD 972.3 billion in high-income countries (Wimo et al., 2023[192]). Around half of these costs result from informal care. Family members are often first in line to care for people with dementia, especially in countries that rely largely on informal care. Across 11 European countries, the average annual hours of informal care due to dementia ranged from 163 hours in Sweden to 1 051 hours in Czechia. The financial burden to households varied accordingly between almost EUR 2 700 in Sweden and around EUR 15 500 in Germany resulting from out-of-pocket costs and informal care costs (Meijer et al., 2022[193]). In line with this, countries have tried to alleviate this through policies providing financial assistance such as cash transfers and tax reliefs.

142. One type of direct financial assistance are cash transfers. About 24 of the 29 OECD countries provide at least one cash benefit (see Annex B, Table B.1). These benefits can either be paid directly to carers through a carer allowance or to care recipients, a portion of which may be used to compensate formal carers. 16 countries provide direct payments to the carer, while nine countries provide cash benefits to the care recipient. In Mexico and Austria, both carers and recipients can apply. Although these cash transfers target care recipients rather than people with dementia or their carers specifically, they are generally aimed at individuals with certain dependency levels or disabilities or their carers, which typically includes people with dementia.

143. The criteria for determining eligibility for cash benefits typically include means-testing, which limits access to people with low incomes, as well as factors such as the caregiver's relationship to the care recipient and the recipient's level of dependency. Many countries adopt a broad definition of family caregiver, including not only relatives but also non-related individuals such as neighbours, friends, or acquaintances. Some countries, however, take a narrower approach including only those with a direct personal or household relationship with the carer. This is the case of Estonia, as they state that the care allowance is for nursing a sick family member at home (Estonian Health Insurance Fund, 2025[194]). By contrast, in Hungary, eligible carers include a wide range of relatives by blood, marriage, adoption, or fostering, as well as cohabiting partners and certain in-laws.

144. Across OECD countries, cash transfers for informal carers offer different degrees of economic aid. In most cases, the amount of the benefit depends on the recipients' level of care required and the target group. Generally, those cash transfers directed to the person in need of care tend to be more generous than those given directly to the carer. This is because these transfers are designed to cover the full costs of care and ensure the care recipient has adequate support, whereas transfers to carers are often more narrowly focused on compensating for lost income or mitigating poverty risks.

145. Among the schemes available, they can be classified according to their level of generosity and purpose into three groups. In the first group there are cash transfers that provide minimal financial support, typically intended as a supplement to other income or as vouchers for small expenses. Some schemes provide small monthly allowances, typically under USD 150, such as Estonia's Care Allowance (USD 32.61– 108.7 /month), Hungary's Cash for Care (USD 132.37 /month), Korea's Family Care Allowance (USD 161.05 /month), and Poland's Care Allowance (USD 54.23 /month) and Care Supplement (USD 64.43 /month). Others offer bimonthly transfers, such as Mexico's Jalisco caregiver support programme (USD 109.29 /month), while the Netherlands' *Mantelzorgcompliment* provides vouchers or cash ranging from USD 81.52 to USD 108.7. Most of them are eligible for carers except Korea's and Poland's Care Allowance and Care Supplement.

146. The second group of cash transfers offers moderate support, providing partial coverage of care expenses for recipients or carers. Within this group, monthly support typically ranges from around USD 140

to over USD 500, depending on the country and type of care. Some schemes such as Sweden's Home Care Allowance provide between USD 140.02 and USD 560.08 per month, depending on the level of care provided. Mid-range transfers include Greece's Severe Disability Allowance (USD 367.39 /month). At the higher end, carers may receive over USD 500 per month, as seen in Italy's Indennità di accompagnamento (USD 573 /month), Portugal's Subsídio Cuidador Informal (USD 509.26 minus household income), and Poland's Caregiving Benefit for those who give up work to care for a disabled family member (USD 617.59 /month). Some schemes, like Australia's Carer Allowance (USD 106.97 every two weeks) and France's Accueil familial (USD 32.66 per day including a paid leave allowance equal to 10% of the remuneration for services rendered), provide support either as frequent payments or through a combination of daily remuneration and additional benefits.

147. Finally, the third group includes benefits typically designed to provide significant financial relief, often linked to the intensity of care required or to income replacement. In some countries, support is provided as income-based replacement, such as Australia's Carer Payment, which provides up to USD 710.33 per fortnight for single carers. The United States' Cash and Counselling Programs offer flexible payments ranging from USD 12–USD 20 per hour, depending on state regulations. In the United Kingdom, carers can receive the Carer's Allowance (USD 106.79/week). Moreover, in Scotland, the Carer Support Payment gives USD 105 per week to unpaid carers providing 35 hours or more of care. Switzerland (Fribourg) offers daily payments of up to USD 39.77, and Norway provides hourly compensation for care of USD 21.12. Ireland's Carer's Benefit and Carer's Allowance provide up to USD 283.7 – USD 323.91 per week depending on the age and the number of care recipients.

148. Moreover, in some of the countries mentioned, carers receive additional grants on top of regular benefits to further support them in managing the costs and demands of caregiving. For example, in Ireland, the Carer's Support Grant is an annual payment for those receiving the Carer's Allowance or Carer's Benefit, amounting to USD 2 173.91 for each person cared for. In the United Kingdom, carers can receive the Carer Premium worth USD 59.49 per week (2025/26). In Australia, those receiving the Carer Payment are eligible for an annual Carer Supplement of USD 394.74.

149. In Europe, several schemes offer substantial monthly payments tied to the level of dependency, such as France's *Allocation Personnalisée d'Autonomie (*APA) which ranges from USD 2 223.43 per month for the highest care level (GIR 1) to USD 867.35 for the lowest one (GIR 4). Other examples include Austria's Long-term Care Allowance (USD 218.26– 2 344.13 per month), Czechia's and Germany's care allowances paid to the care recipient (USD 55.99–1 234 per month, and USD 377.17 – 1 076.09 per month; respectively). In contrast, Spain and Finland offer benefits for family members/informal carers providing daily care. In Spain the support ranges from USD 195.65 – 494.57 while in Finland is of USD 513.04 - 1 026.09.

150. Tax relief schemes have been introduced in several countries, providing indirect compensation for care responsibilities. In Czechia, these include a wastable tax credit that can be claimed by a taxpayer whose spouse's annual income does not exceed USD 2 928.51. However, this credit is not targeted exclusively at taxpayers with dependent family members. Similarly, in Canada, carers of infirm dependents can benefit from the Canada Caregiver Credit, which reduces their taxable income in recognition of their caregiving duties (Government of Canada, 2025[195]). In France, carers of young children or relatives can receive Pension or Carer Credits (Crédits de parent-aidant), providing pension contributions for periods spent providing care. Finally, in Japan, families supporting elderly or non-resident relatives may claim Dependent Deductions for Elderly and Non-Resident Relatives, offering tax relief for dependents living abroad.

5.2 Leave entitlements vary in duration and generosity

151. Paid and unpaid leave policies are another common measure designed to support informal carers. These policies allow carers to take time off from paid employment to provide necessary care for family members or dependents, which can be temporary or for a longer period of time, without losing their job security or access to social benefits. Paid leave helps carers maintain some income, while unpaid leave offers flexibility for LTC, together easing the financial and practical burdens of informal caregiving. Leave entitlements for informal carers vary widely across countries in both duration and the generosity of compensation, with paid leave generally shorter than unpaid leave. Across OECD countries, leave schemes are available in 86% of countries (25 out of 29) (see Annex B, Table B.2). Approximately 68% countries (20 of 29) offer unpaid leave measures, from which five offer the possibility of benefitting from a carers' benefit, while around 58% (17 of 29) provide paid leave.

152. The majority of leave schemes are designed to care for sick or temporarily ill family members, while a smaller number specifically cover dependents, and only one addresses explicitly long-term care for dementia (Austria's *Pflegekarenz)*. Leave schemes for sick family members and dependents may implicitly target dementia, because individuals with dementia often require ongoing care due to illness or loss of independence, even if the condition is not explicitly mentioned in the legislation. For example, France's *Congé de proche aidant* implicitly includes care for people with dementia as it allows leave for caring for disabled or elderly persons who are losing independence.

153. Some of the most generous leave policies, in terms of both duration and benefit amount, include Canada's Compassionate Care Leave, which provides up to 28 weeks of leave, the related EI Compassionate Care Benefits can provide 26 weeks of temporary income support for claimants providing care for individuals with a significant risk of death in the following 26 weeks or in need of end-of-life care. Eligible carers can receive Compassionate Care Benefits, replacing 55% of earnings up to a maximum of USD 507.3 per week in 2025. Austria offers unpaid leave (*Pflegekarenz*) of three to six months with a care allowance (*Pflegekarenzgeld*) for up to three months (generally replacing 55% of daily net income), with the possibility of extending the leave unpaid for up to six months and the benefit for three more months under certain conditions. In France, carers on unpaid leave under *Congé de solidarité familiale* can access the *Allocation journalière d'accompagnement*, which allows up to six months of leave with a three-week financial benefit for end-of-life care, amounting to USD 70.01 per day.

154. Shorter paid leave entitlements include Switzerland's *Congé payé pour la prise en charge d'un membre de la famille*, which offers only up to 10 days per year, taken in instalments of a maximum of 3 days per episode. In countries such as Italy and Spain, paid leave exists but is limited to specific situations. Italy's *Permessi giornalieri per legge* allows three days per month for carers of individuals with severe disabilities, while Spain's *Permiso especial por fuerza mayor* provides four days of paid leave for urgent family emergencies, including illness or accidents involving cohabiting relatives. Although these provisions may apply to carers of people with dementia, they do not fully accommodate the continuous and long-term nature of such care needs.

155. Regarding unpaid leave, some of the most generous measures in terms of duration include Spain's *Excedencia por cuidado de familiares*, which allows up to two years of unpaid leave to care for family members; Austria's long-term *Pflegekarenz*, where unpaid extensions beyond the paid care allowance can reach up to 6 months despite limited employment protection; and the United States' Family and Medical Leave Act (FMLA), which provides 12 weeks of unpaid leave with job protection for eligible employees in businesses with 50 or more employees and in the public sector. By contrast, Scotland's unpaid carer's leave allows only one week of leave every 12 months, with additional time off for emergencies but no clear maximum, while Latvia's *Aprūpētāja atvaļinājums* offers just one week of unpaid leave per year, representing minimal support for carers. A similar approach is also followed by Israel, Poland, Slovenia or

Finland. In the case of Estonia, unpaid leave is available only by mutual agreement between the employer and the employee, since they do not have a specific statutory scheme for unpaid caregiver leave.

5.3 Respite care is often limited in scope and its quality varies greatly across OECD countries

156. Across OECD countries, respite care exists in nearly all countries (see Annex B, Table B.3) but remains insufficient, with low uptake due to limited compensation, uneven service availability, and organisational challenges. Respite care provides temporary relief for carers, allowing them to take a break from their duties and focus on their own health and wellbeing. Respite care provisions for carers of older adults vary widely in the type of service offered, access and availability, duration, and dementia-specific support. Significant care burden and lack of structured support have been recognised as ongoing issues and most guidelines now include formal caregiver support, such as education, respite care, and psychological services (e.g. NICE NG97, Alzheimer's Association recommendations).

157. Respite care is offered in a variety of settings, including day care centres (Ireland, Costa Rica, Finland, Mexico, Spain, the Netherlands), in-home support (Canada, Finland, Korea, Portugal, Spain), short-term residential stays (Finland, Germany, Italy and Spain), and emergency or rapid-response services (Finland, Netherlands, Scotland, United States). One of the most studied forms of respite care is day care, which reduces caregiver burden especially when caregiver support is included and behavioural problems in people with dementia. However, it may lead to earlier placement in a nursing home. Evidence for temporary residential and community-based respite is mixed or limited. (Vandepitte et al., 2016[196])

158. Access to respite and day care services for people with dementia varies widely across countries due to differing funding systems, costs, and eligibility rules, resulting in regional disparities in service use and barriers to care. Most services are financed through municipalities. Countries such as Norway, Ireland, Sweden, and Korea provide nationally organised or municipality-backed programmes, while in others, services may be more localised or limited. A study in Ireland highlights this variation, showing that 18% of people with dementia live more than 15 km from their nearest day care centre, and many centres lack the capacity to serve those within their catchment areas (Pierse et al., 2020[197]).

159. Cost and eligibility can also limit access to respite care. Respite care is funded through municipal budgets (Finland, Norway, Netherlands, Portugal, Sweden), national programmes or insurance schemes (Germany, Iceland, Japan, Korea), or carer-specific allowances (Australia, Austria). Even when national programmes, insurance schemes, or carer allowances exist, coverage may not fully cover all respite services, leaving carers to bear extra costs. These variations in funding and out-of-pocket expenses can make respite care less accessible, particularly for lower-income families or those in areas with limited municipal support.

160. Moreover, access to day care may depend on whether a formal diagnosis is required. A study across European countries found that carers reported that a diagnosis was not required in Germany, Italy, Norway, the Netherlands and Sweden whereas in Portugal, one carer suggested that having a diagnosis could hinder access to day care or nursing home services (The Actifcare Consortium, 2019[198]).

161. When it comes to duration, some countries guarantee a set number of days per year, while others offer flexible programmes with local discretion. The number of respite days varies widely, from 2-3 days per month in Finland, up to 6 weeks per year in Germany, 8 weeks per year in Iceland, and up to 63 days per year in Australia.

162. Dementia-specific respite care is explicitly offered in Australia, France, Greece, Iceland, Ireland, Japan, Korea and the Netherlands, though in many countries respite is broader for older adults or people with disabilities. In Australia, dementia-specific respite care is limited in some jurisdictions; however, the

Australian Government funds a number of dementia-specific respite care programs aimed at improving the quality of dementia respite care, with a national footprint that includes education and support for family carers, as well as day and overnight respite care (Department of Health, Disability and Ageing, 2024[199]). In France, informal carers can access day or night care for the person with loss of autonomy, temporary stays in care facilities or with host families, and in-home relief services – some of these services are targeted for carers of people with dementia. In Japan, dementia cafés and multifunctional small group homes provide day services, short-term stays, and peer support tailored to dementia care. Iceland offers up to eight weeks of respite per year, combined with dementia-specific training and evaluation, while Greece has a limited number of dementia-focused day centres. In Korea, carers can use the Long-Term Care Family Leave System to access Short-Term Care (12 days/year) or All-Day Visiting Care (24 times/year), and they can take a break while patients participate in "healing programmes" at Dementia Care Centres, including art, exercise, gardening, outings, and outdoor therapy linked to forests, agriculture, and marine environments.

163. By contrast, in Hungary and Czechia respite programmes are insufficient. In the case of Czechia, they have only minimal provision, with services dependent on local providers and often unsustainable due to low demand and limited funding. Even in countries with well-developed general respite care, dementia-specific options remain scarce. In countries like Australia, Germany, and the United States, a broad range of respite options exists, such as in-home care, day care, and short-term residential care, but not all of them are tailored to the complex, long-term needs of people with dementia, requiring carers to adapt general services to meet these challenges.

5.4 Countries provide training and counselling to strengthen carers' knowledge and skills

164. Training interventions and counselling can empower carers with the skills and knowledge they need to manage the complex and progressive nature of dementia. In total, 26 countries offer training programmes for family carers of people with dementia, amounting to 36 programmes overall, while 21 countries offer counselling services for them (see Annex B, Table B.4 and Table B.5). In most OECD countries, training and counselling still rely heavily on the voluntary sector through Alzheimer organisations. When it comes to training, 16 programmes are organised by NGOs, while 20 are run by public institutions. Regarding counselling services, 12 programmes are organised by NGOs, while 9 are run by public administrations.

165. Training programmes vary in format (online, in-person, or residential), duration, and target audience, but all aim to equip carers with knowledge, practical skills, and psychosocial support to improve care for people living with dementia (see Table B.4). Most programmes are individual, short, and often online, tailored to carers' specific needs. Online and flexible dementia training makes education accessible regardless of location. These programmes allow carers to learn at their own pace and revisit material as needed, offering a flexible solution for busy schedules. Flexibility is important, as longer programmes may increase dropout (Sousa et al., 2016[200]). In Australia, the Understanding Dementia MOOC and the Preventing Dementia MOOC offer digital courses on dementia prevention and management. Furthermore, the Dementia Carer Respite and Education (Staying at Home) program aims to improve the wellbeing of carers of people living with dementia in the community, while providing opportunistic education and peer support. Estonia's Dementia Competence Centre complements this with instructional videos, webinars, and regular seminars, providing practical guidance and real-life scenarios to help carers better support their loved ones. In Finland, the Alzheimer Society (Muistiliitto) also offers training, guidance, information, and support for people with memory disorders, their relatives, and professionals. In addition, Pasqual Maragall Foundation in Spain provides online dementia training for family members. Since 2021, 87 online groups have been organised, with more than 800 carers participating.

166. In a few countries, family caregiver training is supported through subsidies or grants. For example, in Austria, a grant of up to USD 217.39 per year per care recipient is available to support home care by close relatives. It can be used for care courses, professional guidance, or online nursing training.

167. Hands-on training programmes provide practical experience alongside educational content. In Spain, the CRE Alzheimer (Imserso) School for Families runs two-day courses each year, delivered in two annual editions with around 40 participants per edition, helping participants develop skills in dementia care and understanding the condition. Italy offers a combination of e-learning and residential courses through the Italian National Fund for Alzheimer's and the *Corso per familiari delle persone con demenza*, complementing theoretical knowledge with practical caregiving techniques. Finally, Mexico's ISSTE courses certify family carers and emphasize both practical care skills and emotional support.

168. Fewer training programmes are community-based and aimed to promote dementia friendly communities. Group programmes encourage peer support and social interaction but may not fully address each caregiver's individual needs (Sousa et al., 2016[200]). In Japan, the community-based Dementia Supporter Training Programme offers a single 60–90-minute session led by a trained "dementia caravan mate." It covers dementia types, symptoms, and support strategies, with participants receiving an orange bracelet as certification (Aihara and Maeda, 2020[201]). In Korea, Dementia Partner Training provides individuals, starting from elementary school age, with the knowledge and skills to support dementia patients and their families through offline or online programmes. Building on this foundation, Dementia Partner Plus Training prepares these partners to take a more active role in your community by engaging in dementia-related volunteer activities and promoting dementia-friendly environments.

169. Nevertheless, these training programmes often lack systematic evaluation, meaning there is no measurement of their effectiveness or follow-up to assess ongoing caregiver needs. Additionally, most programmes are designed primarily for family carers and do not include the person with dementia, limiting the potential for joint learning or shared strategies. A major issue in caregiver-only programmes is what happens to the person with dementia during training sessions. The lack of support or supervision for the person with dementia can prevent carers from participating (Sousa et al., 2016[200]). Among the training programmes mentioned, Australian Government–funded dementia respite programmes are evaluated to assess effectiveness and inform continuation, and the Dementia Carer Respite and Education (Staying at Home) program delivers integrated respite care for both the carer and the person with dementia.

170. Counselling services for people with dementia and their carers are available across 17 OECD countries and are most often free and confidential, ensuring accessibility for carers regardless of income or location (see Table B.5). Counselling services also present benefits for both carers and people with dementia. For people with dementia can reduce depression and anxiety, improve quality of life, and support identity and coping strategies. For carers, it alleviates burden, enhances resilience, and improves psychological well-being. Tailored and remote interventions, as well as dyadic sessions involving both caregiver and person with dementia, can further support coping and relationship dynamics (Shoesmith et al., 2020[202]).

171. Since the COVID-19 pandemic, there has been a notable increase in digital and remote service delivery, including online, telephone, and hybrid counselling formats. Several OECD countries have developed good practices that can be adapted to different contexts. In Austria, the Relatives' Talk programme offers up to ten psychologist-led counselling sessions, available at home, at external locations, by phone, or online. Estonia offers free social counselling, where trained counsellors guide and advise informal care families, share up-to-date service information, provide training for new carers, and facilitate caregiver-to-family groups for those whose loved ones have moved to a nursing home.

172. Self-help and peer support represent another form of counselling, as seen in Korea, where trained family carers can join self-help groups supported through online platforms, mobile apps, and phone calls. These groups are also connected to the National Dementia Helpline and paired with five Dementia Partners and a dedicated counsellor, providing both professional guidance and peer-to-peer support.

173. France, Spain, and Norway, among other countries focus specifically on psychological and emotional wellbeing, providing therapeutic or psychosocial support. In France, individual counselling sessions are offered through France Alzheimer to help carers manage stress and emotional challenges. In Spain, the Pasqual Maragall Foundation facilitates therapeutic group sessions that encourage peer support and emotional resilience. Similarly, Norway's Psychosocial Support for Carers programme provides structured emotional guidance and counselling within the public health system.

174. Current counselling practices for people with dementia and their carers face some limitations. Many interventions are not adapted to the varying levels of cognitive impairment, emphasizing the need for customised materials and strategies. Follow-up assessments and evaluation of long-term impact are often inconsistent, which limits understanding of the sustainability of benefits. However, as previously mentioned, online options have become increasingly available. While face-to-face sessions are generally more effective in detecting subtle emotional and behavioural cues, remote interventions such as telephone or online sessions offer greater accessibility (Shoesmith et al., 2020[202]).

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Annex A. Additional information on policies aimed at raising awareness and addressing stigma against dementia

Table A.1. Policies aimed to raising awareness and addressing stigma across 29 OECD countries

OECD country	Awareness Raising		Promoting inclusion		Dementia training and guidance		
	Campaigns, social media	Culture, TV, Podcast…	Policy & Institutional Frameworks	Community & Social Programs	Family / Carers	Public Servants / Specific Professions	Wider Audience / Public
Australia	Dementia Australia – Dementia Action Week (annual); govt campaigns promoting healthy, active lifestyles.	Moving Pictures (multimedia project).	Dementia Friendly Communities initiatives.	National Dementia Support Program and Dementia Friendly Communities initiatives.	Short courses for families (Dementia Australia, Carers Australia). MOOCs delivered by the Wicking Dementia Research and Education Centre.	Australian Government–funded: the Dementia Training Program and Equip Aged Care Learning modules, the Dementia Respite Education and Mentoring (DREAM) project. University of Tasmania tertiary dementia education, and TAFE vocational training for the health, aged care, emergency services, and legal sectors.	Dementia-inclusive Communities Guide funded by the Victorian State Government, Understanding Dementia and Preventing Dementia MOOCs by the Wicking Dementia Research and Education Centre, and national information and support resources provided by Dementia Australia.
Austria	Personal Assistance for People with Dementia; World Alzheimer's Month; Self-Help	Joint Logo for all activities; Brochures; Conferences; Outreach and Awareness Programs; Caregiver	Dementia-friendly urban design, mobility planning, accessible housing;		"3b: Strengthening competences of families and friends".	Fire brigade, rescue, transport, banks, medical/non-medical staff, mayors, councilors.	Code of good practice for media reporting.

	Works; Broad Media & PR Campaigns.	Magazine; Late Night Talk Show “Welcoming Alzheimer”.	sports & singing clubs, hairdressers, restaurants.				
Canada	Dementia Strategic Fund, Early Diagnosis & Risk Reduction Campaign (Saskatchewan); Dementia Helpline (Rural Support); PEI Let’s Talk Memory.	Dementia Strategic Fund: Baycrest’s Defy Dementia Podcast, Women’s Brain Health Initiatives Mind Over Matter expansion, and Lucilab,);	Dementia-Friendly Canada Initiative	Inuvialuit Settlement Region Dementia Awareness and Intervention.	Supporting a Circle of Care (Native Women's Association of Canada); My Tools 4 Care-In Care (University of Alberta).	Dementia Strategic Fund supports the Dementia Guidance and Best Practices Initiative, which targeted specific groups/professions. For example, the Guidelines for communicating a dementia diagnosis was targeted to family physicians, specialists and nurse practitioners.	Dementia-inclusive community training; national public education campaign (Dementia Strategic Fund and civil organizations).
Costa Rica	Sigo Siendo Yo Campaign (JPS & UNAFUT);	Discussion Forums; Information Guides.			Health education for families/carers (healthcare settings)	Courses/workshops for professional healthcare workers	Informational guides for dementia care
Czechia	National Public & Media Campaign	7th Unforgettable Evening Concert, the Demetrix escape game focused on understanding the experiences of people with dementia and communication or discussions connected with the screening of the film "Waltzing, Matilda	“Let’s be dementia friendly” city pilot 2022–2024; public/private guardianship awareness; corporate social responsibility programs. Dementia-friendly society" (2024-2027), covering one-third of the Czechia's regions. Memory counseling centers, interdisciplinary coordination working groups, regular meetings of all coordinators – transfer of best practices across the country.	Alzheimer Cafés; 4 support groups for people with dementia; 20+ self-help groups for carers; 30+ family meeting places.		Training for professionals (transport, government agencies, emergency services, etc.).	Programmes for schools & aging/dementia awareness (We Age Successfully, VR projects)
Estonia	Information Hotline; Newsletter; regional conferences across the country	Information desks at senior fairs and exhibitions (Pärnu, Paunvere, 60+ Festival, Klooga Info Days) DKK	Dementia Friends Movement	4 museum programs for people with dementia; dementia-friendly badge for care institutions	Training/support groups for family carers; e-learning (Dementia Competence Centre)	Training for social workers, police, rescue board, service workers, local government managers (DKK)	Website resources, instructional videos, seminars (Dementia Competence Centre)

Finland	Memory Friendly Finland campaign	YouTube Channel (Alzheimer Society of Finland); Online memory portal (www.muisti.fi)	Housing & age-friendly living environments.	Voluntary work participation	Training/counselling for informal carers (local organisations & municipalities)	Brain health training for professionals in sports, culture, education (local authorities)	Brain health in schools; volunteer support (wellbeing services counties)
France	France Alzheimer’s campaign, ‘Building an inclusive society’			Memory Cafés France Alzheimer; Caring City Marie de Paris	Training for carers (France Alzheimer)		
Germany	Joint publicity campaign for the National Dementia Strategy; National Dementia Week; school-age awareness initiative	Week for Life Event on Dementia (Churches); Awareness in culture, art, and music by German Cultural Council	Municipal framework for dementia-friendly public spaces; public transport employee training	Dementia-sensitive public meetings; informal neighbor support networks; digital participation	Free training for relatives/volunteers	Dementia Friends training; multipliers for migrant-background contacts (DAlzG)	Youth awareness
Greece	Carers day. Screening and prevention campaign	Factsheet and booklets		Factsheets and booklets	Training program & practical advice for carers (Alzheimer Association)		Dementia awareness for wider community
Hungary	Let’s Make Dementia a Public Issue! Campaign; Health Day		Open-Air Ethnographic Museum (Szentendre Skanzen)	Dementia program for elderly; Alzheimer Café Sopron; Dementia-friendly Mosonmagyaróvár initiative; municipal events & dementia backpack	“Dementia Information Hours (DIO)” – 12-month family programme (Catholic Charity)		
Iceland	Campaign on ageism and loneliness				Courses for newly diagnosed & families (Service centre for dementia)	Training for municipalities & service providers (Heilsuvera)	Educational materials for public awareness (NGOs & Heilsuvera)
Ireland	Dementia understand together” – radio and TV			Memory Cafés	Training for PwD & families (basic education, Understand Together campaign)	Teenagers’ dementia education (Alzheimer Society of Ireland)	
Israel	Campaign (national plan)	EMDA Dementia Friends sessions; public materials and campaigns with municipalities; community outreach.			Caregiver workshops and training by EMDA and partner NGOs; counselling services; hotlines.	Primary care nurse/clinician training modules under national programme; professional education on dementia.	Community awareness programmes and Dementia Friends activities aiming to educate general public

Italy	Do Not Forget to Love Me Campaign; national/regional awareness campaigns to reduce stigma and promote respect for people with dementia	Website "Inclusion Objective"			Supporting families/carers; promoting informal support		
Japan			Dementia Ambassadors of Hope, Integrated Support Project (Netherlands model)	Dementia cafés; Restaurant Mistaken Orders			Dementia Supporters Training
Korea	Dementia Awareness Day; National Walkathon for Overcoming Dementia; Dementia Management Workshop, community engagement with schools, hospitals, and senior centers		Namwon City Dementia Safety Market & Village	Dementia-Safe Franchise Stores; Gyeongju Kkokkomu Memory Café; Seoul "Caring Again" Safety Net	Dementia Partner & Partner Plus; online self-help groups (NID, MDC/PDC)		
Latvia							Seminars & training
Mexico				Alzheimer Association initiatves			Alzheimer Association initiatives
Netherlands	Assess your Assumptions campaign , Alzheimer association of the Nederland campaigns (Samen Dementievriendelijk, Stop Dementie, targeted risk campaigns), training videos, World Alzheimer's Month engagement.	Podcast: Door met Dementie (Alzheimer Nederland), Podcast: Alzheimer voor beginners (Stichting Participatie met Dementie)	Dementia networks, ("regionale dementienetwerken"), Dementia-Friendly Municipality Certificate (Certificaat Dementievriendelijke Gemeente), awarded by Alzheimer Nederland.	Alzheimer Café and Trefpunt, The Unforgettable Cooking Club	Workshops via Local Mantelzorg Support Centres (e.g., Tandem), Alzheimer Nederland Workshops and Training	Dementia-Friendly Together, professional & private training	Dementia-Friendly Together, youth & community
Norway	All moments count – Talk to your GP Campaign	The Hunt for Good Moments – Film		Dementia-friendly society; municipal training for public & private service employees (shops, pharmacies, libraries, transport, cafés)		Education for non-healthcare public sector	
Poland	National educational campaign titled "Stay Longer	TV/radio spots, online videos, animations, banners,			"A Caregiver Tailored" handbook (Foundation for		

	on the Stage of Life", ‘Help Me Find My Way Home’ campaign (police and local authorities), Jestem Tu CZEKAM social campaign by Polish Police.	podcasts, infographics, website, press ads.			Standards of Care in Dementia)		
Portugal					Family support (Alzheimer Association)		Public awareness strategy (National strategy)
Slovenia	National campaigns by Spomincica – Alzheimer Slovenia to reduce stigma and educate on dementia			Dementia-Friendly Communities; safe inclusive environments for people with dementia & families			Dementia-Friendly Communities activities
Spain	Alzheimer awareness campaigns; IMSERSO social media awareness; Andalucía regional awareness campaign	Escape Room – Spanish Alzheimer Foundation; Alzheimer info materials	IMSERSO “Comunidades Amigables”; CEAFA “Ayuntamientos Solidarios”; Andalusia Entornos Amigables	CRE Alzheimer (Imserso) School of Families 2024	Orientation, training, and capacity building for family carers (Red de Escuelas de Salud)	Dementia training is provided to social and health professionals by specialised centres (CRE Alzheimer), scientific societies and universities, with uneven coverage and updating across regions and training levels.	Dementia training is provided by specialised centres (CRE Alzheimer), scientific societies and universities, with uneven coverage and updating across regions and training levels.
Sweden			Varied municipal approaches; civil society support groups; telehealth in rural areas, in-person consultation in cities		Basic dementia training for carers (Swedish Dementia Centre)	Municipal worker training (Swedish Dementia Centre)	
Switzerland	Information content must be adapted to the everyday lives of the various target groups and the diversity of the support services	Anti-Stigma Award; Documentary Film «Alzheimer mit 56 – Das Familienleben nach der Diagnose» on Swiss TV. Several short documentaries on young people with dementia have aired in recent years, and in		Local dementia-friendly community initiatives, memory cafés, and caregiver support groups implemented at cantonal and municipal level.	Training for relatives and volunteers	Hospital/domestic workers, disabled services, opticians, hairdressers, bank staff	

		2021 documentary Tiger and Buffalo – The Journey of Bruno Sensei by Fabian Biasio was released.					
United Kingdom (Scotland)	Public awareness campaigns on brain health and dementia to change perceptions	Touchstone's BME Dementia Service; BME Dementia Forum; Pluto Play Productions – Drama addressing stigma		Weekly South Asian Dementia Café; Carer Walking Group; employer awareness programs (Carer Positive, Dementia Friends)			Brain Health Scotland – public awareness, prevention
United States	Alzheimer's commercial and social media campaigns in Spanish & English, National Institute on Aging #AlzScience Twitter Chat.	Videos "How Alzheimer's Changes the Brain" & "What is Dementia?"; Webinars.		Dementia-Friendly America initiatives, NGO-driven	Family Caregiver Support Programs; care planning tool (National Family Caregiver Support Program, CDC)		National dementia call line & awareness

Source: OECD's own analysis/ questionnaires.

Annex B. Additional information on caregiver support mechanisms available for people with dementia and their carers

Table B.1. Cash benefits schemes vary depending on their purpose, the target recipients, and the amount provided.

OECD country	Scheme	Definition/ purpose	Target	Amount
Australia	Carer Payment	A payment for providing regular care to a disabled, ill, or frail adult, based on the care recipient's income and assets.	Carer	Depends on your status: USD 710.33 if single, plus USD 394.74 annual Carer Supplement.
	Carer Allowance	A supplementary payment if you care for someone who needs daily support.	Carer	USD 106.97 each fortnight.
Austria	Long-term care allowance	Earmarked benefit that is independent of income and is intended to cover additional care-related expenses only and is therefore not designed to create a general increase in income. It should be regarded as a lumpsum contribution to the costs of the care required.	Both	Broad scale (USD 218.26–2 344.13); varies by care level.
Costa Rica	Care Transfer (Transferencia por cuidados)	It is aimed at supporting households in poverty or extreme poverty in which one of the members requires assistance from a third party in their environment due to severe dependency.	Carer	Small, targeted, means-tested transfer for poor women carers (USD 141).
Czechia	Care allowance	This allowance helps cover care costs, whether provided by a professional service or a family member who may need to reduce work to provide care.	Recipient	USD 55.99–1 234 /month; varies by dependency.
Estonia (Tallin)	Care allowance	Monetary support for a carer for up to seven days looking after a family member at home.	Carer	USD 32.61– 108.7 per month.
Finland	Care allowance for informal care	They grant informal care support when an older person needs daily care and attendance from a family member to be able to live at home.	Carer	USD 513.04 - 1 026.09; varies by care intensity.
France	Personalised Autonomy Allowance (APA - Allocation personnalisée d'autonomie)	Financial allowance used to help older people who are partially or fully dependent cover the costs of care (in full or in part), either at home or in a care facility.	Recipient	USD 2 223.43 (GIR 1), USD 1 580.63 (GIR 2), USD 1 299.64 (GIR 3) and USD 867.35 (GIR 4) per month.
	Family-Based Care (Accueil familial)	It allows an older people and/or disabled person to be accommodated in the home of a family caregiver. The hosted person pays the caregiver and may receive financial assistance under certain conditions.	Recipient	The minimum gross daily remuneration of USD 32.66 is increased by a 10% paid leave allowance, resulting in an approximate monthly total of USD 1 065.65.
Germany	Care allowance	Provides support if people in need for care decide to be cared for by relatives, friends or other volunteers instead of an outpatient care service.	Recipient	USD 377.17 – 1 076.09; depends on care level.
Greece	Severe disability	Provides regular monetary assistance to	Recipient	USD 367.39/month.

	allowance	individuals whose degree of disability substantially limits their autonomy and ability to perform daily activities. These programmes aim to help cover essential expenses, support independent living, and reduce the financial burden associated with disability care.		
Hungary	Cash for care - Ápolási díj	Financial contribution provided to an adult relative who provides home care for a person in need of long-term care.	Carer	USD 132.37 per month.
Ireland	Carer’s Support Grant	Annual payment made to carers who get Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance (DCA).	Carer	USD 2 173.91 once each year.
	Carer's Benefit	Payment available to insured people who may need to leave work or reduce their hours to care for a person or people in need of full-time care. It can be paid for a period of 2 years (104 weeks) for each person being cared for and may be claimed over separate periods up to a total of 2 years (104 weeks).	Carer	USD 283.7 per week for 1 care recipient or USD 425.54 per week for 2+ recipients, paid up to 2 years (104 weeks) per person.
	Carer’s Allowance	A payment for people on low incomes who are caring for a person who needs full-time care and attention because of age, disability, or illness (including mental illness).	Carer	Maximum weekly payment of USD 282.61 for carers under 66 and USD 323.91 for those aged 66 or over
Israel	Long-term care benefit	Allows eligible individuals to receive all or part of their benefit in cash instead of in-kind nursing services. The amount and available options depend on the assessed level of care required.	Recipient	USD 14.05 per month average.
Italy	Care Attendance Allowance (Indennità di accompagnamento)	Granted if, due to physical or mental disability, the disabled person is unable to walk without the permanent help of a companion or, being unable to perform the daily acts of life, needs continuous assistance.	Carer	USD 573 per month, paid for 12 months.
Korea	Family Care Allowance	Designed to alleviate the financial burden on families and encourage them to take on caregiving responsibilities.	Recipient	USD 161.05 per month; very limited eligibility.
Mexico (Jalisco)	Caregiver support transfers	It helps primary carers and people with disabilities, chronic kidney disease, or cancer recognising and supporting the caregiving work and the specialized care they require.	Both	USD 109.29 per month paid on a bimonthly basis.
Netherlands	Informal Caregiver Recognition Benefit (Mantelzorgcompliment)	As a caregiver reward, you can select one of three options to acknowledge your efforts: a EUR 100 Samen Vaals voucher, a EUR 100 personalized VVV voucher, or a fixed cash amount of EUR 75.	Carer	USD 81.52 – 108.7 voucher.
Norway	Care benefit	Provided to individuals who perform demanding or burdensome caregiving tasks for a relative or another person in need of care. It compensates private carers for duties that would otherwise be the responsibility of the municipality, with the goal of helping them continue providing care at home.	Carer	Hourly payment of USD 21.12.
Poland	Care allowance	Granted to persons with disabilities—specifically, children up to 16 years of age and adults holding a significant disability certificate. It is intended to help cover part of the expenses related to care and assistance.	Recipient	USD 54.23 per month.
	Caregiving benefit	Granted to individuals who resign from employment or refrain from taking up work in order to provide care for a disabled family member. Its purpose is to compensate the caregiver for the loss of income resulting from their caregiving duties.	Carer	USD 617.59 per month.
	Special Care Allowance	Provided to individuals who must give up employment in order to care for a disabled family	Carer	USD 155.78 per month.

		member. It is intended to provide partial compensation for lost income resulting from the necessity of caregiving.		
	Care Supplement	Granted to individuals over 75 years of age and to persons who are completely unable to work and live independently. It is intended to help cover additional expenses related to the care and support of seniors or persons with disabilities.	Recipient	USD 64.43 per month.
Portugal	Informal Caregiver Allowance (Subsídio cuidador informal)	Granted to the main informal caregiver who dedicates most of their time to caring for a dependent person and, as a result, is unable to engage in professional activity or has a reduced income.	Carer	Equals the Social Support Index (USD 509.26) minus the household's reference income.
Spain	Cash Benefit for Care in the Family Environment (Prestación Económica Para Cuidados En El Entorno Familiar, PECEF)	Contributes to the expenses related to caring for a dependent person at home.	Carer	USD 195.65 – 494.57 depending on care intensity.
Sweden	Home care allowance	Family allowance, home care allowance, care allowance or paid family care can be given to a person who cares for a family member at home Its purpose is to give a stimulus grant to those people whose relatives perform a significant additional work that would otherwise be carried out within the framework of home care.	Recipient	USD 140.02 – 560.08 per month.
Switzerland (Fribourg)	Lump-Sum Benefit for Informal Caregivers (Idemnité forfaitaire proche aidants)	Granted to parents and close relatives who provide regular, substantial, and long-term support to a dependent person, enabling them to live at home. The objective is to strengthen the involvement of informal carers so that individuals in need of care and support can remain in their familiar environment for as long as possible.	Carer	Daily payment (USD 39.77 per day maximum).
United Kingdom	Attendance Allowance	Benefit that helps cover extra costs for individuals with a disability or health condition severe enough that they need assistance or supervision from another person to look after themselves.	Recipient	USD 94.74 or USD 141.54 per week, depending on the level of assistance required to people of State Pension age.
	Carer Support Payment (Scotland)	For unpaid carers who provide 35 or more hours of care per week to someone receiving disability benefits.	Carer	USD 105 per week paid by Social Security Scotland
	Carer Allowance + Carer Premium and Carer addition	Carer's Allowance is the main state benefit for carers, when caring for someone for at least 35 hours a week. Carer premium is an additional amount added to certain means-tested benefits to support individuals who provide regular care to someone with a disability or health condition.	Carer	Carer allowance: USD 106.79 a week. Carer Premium: USD 59.49 per week (2025/26)
United States	Cash & Counseling Programs	Instead of only using home care agencies, recipients can hire and pay family members or other individuals as carers, allowing relatives to become paid carers for tasks like bathing, dressing, and cooking.	Carer	USD 12 and USD 20 per hour, up to USD 3 500 per month. There is variation across states.

Source: OECD's own analysis/ questionnaires.

Table B.2. Leave schemes are available across OECD countries but few are for people caring people with dementia

OECD country	Leave Scheme	Duration	Paid	Who is eligible
Australia	Unpaid Carer's Leave	2 days per episode	No	Employees caring for or supporting an immediate family or household member who is sick, injured, or in an emergency
	Paid Sick and Carer's Leave	10 days per year	Yes	Employees caring for or supporting an immediate family or household member who is sick, injured, or in an emergency
Austria	Pflegekarenz / Part-time Care Leave	3–6 months	No but can request Care benefit (55% of daily net income, up to 3 months)	Employees supporting close relatives with care level 3+, dementia, or minors at care level 1
	Allgemeine Pflegefreistellung	1 week	Yes	Employees caring for sick close relatives
Canada	Employment Insurance benefits	Up to 15 weeks	Yes	Offers partial income replacement for to individuals who take leave from work to provide care or support to a critically ill or injured adult (aged 18 or older). Includes income replacement at 55% of earnings up to a maximum of USD 507.3 a week for 2025.
	Compassionate Care Leave	Up to 28 weeks within a 52-week period	No (but eligible for 26 weeks of benefits at 55% income replacement)	Employees caring for a severely ill family member
	Critical Illness Leave (adult)	17 weeks	No	Employees caring for an adult family member with critical illness
Czechia	Long-term Caregiver Leave (Dlouhodobé ošetrovné)	Up to 90 days	Yes (60% of reduced daily income)	Employees caring for a family member after hospital discharge requiring full-time care
Estonia	Hoolduspuhkus (Additional Carer's Leave)	Up to 5 working days/ year	Yes (national minimum wage)	An employee who is a close family member, legal guardian or local-government-appointed caregiver of an adult with a severe disability
	Nursing Leave	Up to 7 days	Yes	Employees nursing a sick family member at home
Finland	Informal Caregiver Leave	2-3 days off per month	No	Employees providing assistance to a seriously ill or injured family member
France	Carer Leave (Congé de proche aidant)	Up to 3 months (renewable, max 1 year total)	No (respite benefit available)	Employees caring for a disabled, older people, or dependent relative
	Family solidarity leave (*Congé de solidarité familiale*)	3–6 months	Partly (3-week allowance - (*allocation journaliere d'accompagnement*))	Employees assisting a seriously ill relative
Germany	Pflegezeit (Caregiver Leave)	Up to 6 months	No	Employees caring for close relatives needing home care
	Familienpflegezeit (Family Care Leave)	Up to 24 months (partial leave)	No	Employees caring for close relatives needing home care
Hungary	Unpaid Family Care Leave (Fizets nlkli szabadsg)	Up to 2 years	No	Employees providing personal care for a relative (medical certificate required)
Ireland	Carer's Leave	13–104 weeks	No (but can request Carer's Benefit)	Employees providing full-time care for a person in need of constant supervision
Israel	Family Medical Leave	6 days/year (spouse or parent)	No	Employees caring for a sick spouse or parent
Italy	Paid Family Care Leave	3 working days/ month (short term)	Yes	Employees caring for a disabled or dependent relative
	Extended Disability Care Leave	Up to 2 years	Yes	Employees caring for a seriously disabled child or relative.
Japan	Short term leave for caregivers (介護休暇)	5–10 days	No	Employees caring for a family member (extended if caring for more than two care recipients)
	Caregiver leave (介護休業)	A total of 93 days per family member / the 93 days can	No, but they can be eligible for Nursing Care Leave Benefits (up to 67% of their	Employees who are covered by unemployment insurance are eligible, if their family member's long-term care

		be split into up to three installments	wage).	needs are officially assessed and classified into Care Levels 1 to 5.
Korea	Family Care Leave (가족돌봄휴직)	Up to 90 days/year. Extra 5 days for single parents or carers of disabled spouse	No	Employees caring for family members in need of care.
	Family Care Vacation (가족돌봄휴가)	10 days/year.	No	Employees providing temporary care for family members
Latvia	Carer's Leave (Aprupetaja atvalinajums)	1 week (5 days)	No	Employees caring for family members
Netherlands	Langdurend Zorgverlof (Long-term Care Leave)	A maximum of six times the number of hours you work per week	No, unless CAO or company policy says otherwise.	Employees caring for a critically ill person or someone needing extended care
	Kortdurend Zorgverlof (Short-term Care Leave)	Short-term	Yes (70% of wage)	Employees caring for a sick person in their household
Norway	Family Care Leave	10 days/year	No	Employees caring for a family member
	Pleiepenger i livets sluttfase	Varies (weeks, months)	Yes	Employees providing end-of-life care for a loved one
Poland	Care Leave (Urlop opiekunczy)	5 days	No	Employees caring for a family member
	Care Allowance (Zasilek opiekunczy)	14 days	Yes	Employees providing care for a sick family member
Portugal	Family Assistance Leave (*Falta para assistencia a membro do agregado familiar*)	15 days (30 for spouse)	No	Employees assisting a household member or spouse
Slovenia	Family Care Leave	5 days	No	Employees providing care for a family member or a person with whom the worker lives in the same household and who needs "substantial care for health reasons.
	Paid Care Leave	10 days for each episode of illness per family member in need of care	Yes (80% of the individual's average earnings in the preceding calendar year)	Employees caring for close relatives (extendable for partner/child)
Spain	Care-related leave of absence (excedencia por cuidado)	Up to 2 years	No	Employees caring for a spouse or registered partner, or a relative up to the second degree by consanguinity or affinity (including relatives of the partner) who, due to age, accident, illness, or disability, cannot care for themselves and is not engaged in paid employment.
	Paid Leave for Illness/Urgent Care. (Royal Decree-Law 5/2023)	Up to 5 days	Yes	Employees caring for a spouse or registered partner, relatives up to the second degree by consanguinity or affinity (including relatives of the partner), or any other person living in the same household.
Sweden	Carer's Benefit Leave	Up to 100 days per episode	Yes (up to 80% of income)	Employees caring for a loved one with a life-threatening illness
Switzerland	Family Care Leave	Up to 3 days/incident; max. 10 days/year.	Yes	Employees caring for a family member
United Kingdom (Scotland)	Carer's Leave	1 week/year. Depends on the situation; no fixed duration is set	No	Employees caring for a dependent (no fixed duration for emergencies)
United States	Family and Medical Leave Act (FMLA)	Up to 12 weeks	No (some state programs pay 60–70%)	Employees caring for family members with serious health conditions

Source: OECD's own analysis/ questionnaires.

Table B.3. Respite services options for carers of people with dementia are scarce

OECD country	Programme	Type of respite	Duration	Funding / eligibility / other details
Australia	Carer Payment Respite	In-home replacement, holiday/personal breaks	Up to 63 days/year	Linked to Carer Payment; flexible use for rest/holiday/personal time
Austria	Federal Long-Term Care Act — Support Fund for People with Disabilities	Substitute care when carer unavailable	Short-term / variable	Financial support; eligibility typically requires 1 year caregiving
Canada (BC)	British Columbia Respite Services	At-home, adult day centres, long-term care, hospice	Short-term (hours/days)	Publicly subsidized home and community care; supports acute, chronic, palliative or rehabilitative needs
Costa Rica	Day Care Centres	Day-centre respite for older adults	Variable	Social/day centre provision for older adults
Estonia	Municipal Services	Day care, short stays, in-home care, respite holidays	Variable; +5 paid care leave days/year for relatives of adults with profound disabilities	Municipal delivery; statutory extra leave for some relatives
Finland	Act on informal care allowance	Carer leave days (formal respite allowance)	3 days/month (high/medium needs), 2 days/month (low)	Part of informal care allowance; discretionary support
France	Le droit au répit	Day/night care, short stays, home assistance — dementia focus	Day or short-term stays; variable	Platform of options, strong dementia-specific supports and day care
Germany	National respite provisions	Holiday stand-ins, short-term care, day/night institutional care	Up to 6 weeks/year	Funded by long-term care insurance
Greece	Help at Home Programme and Day care	Home support, day centres (some dementia services)	Day-time / short stays	Public programme delivering personal and home support services
Iceland	National Respite Programme	Day care, short stays, training and support for carers	Up to 8 weeks/year	Includes dementia carer training, evaluation, support
Ireland	National Respite Programmes	In-home, residential, day care, overnight, hospice respite	Variable (hours, overnight, short stays)	National programmes across settings; eligibility varies by programme.
Israel	National Support Services	Adult day care, carer support groups, respite programmes	Day and short-term	National support with caregiver groups and day services
Italy	Adult Day Care / Integrated Home Care / Open RSA	Day services, home-based support, short residential options	Variable; days to short stays	Mix of home and residential; Open RSA supports professional care at home
Japan	Long-Term Care Insurance Benefits	Day services, short stays, small group homes, dementia cafés	Day to short stays; frequent day programmes	Funded by LTC insurance; strong dementia/community supports
Korea	Long-Term Care Insurance	Facility/home care, short-term care, all-day visiting care; special leave	Short-term and day services; special leave provisions	Funded by LTC insurance; includes special leave for dementia carers
Latvia	Municipal Services	Some day care centres; short stays/in-home options	Limited / variable	Municipal provision; respite not widely dementia-specific
Mexico	Day care centres	Day-centre respite for older adults	Day-time	Day centre provision for older adults.
Netherlands	Social Support Act (Wmo 2015)	Day care, home help, emergency respite, tech supports	Flexible (day, night, 24/7, emergency)	Municipal responsibility; includes e-health, guided activities, emergency cover
Norway	Avlastningstiltak (Respite care)	Home help, day care, respite at nursing home	Variable (short stays / day support)	Nationally funded and organized; for family carers

				of older adults
Poland	National Respite Services	Short-term stays, family care homes, home care	Short stays / variable	National services; not always dementia-specific
Portugal	Centres for Vacations and Leisure; Day Centres; Home Support	Day centres, meals, leisure, home help, vacation breaks	Day to short stays / vacation programmes	Social and recreational activities plus personal care; municipal/regional support
Slovenia	National Caregiver Support	Education, respite care, financial support	Short-term / variable	National plan includes training and financial supports for informal carers
Spain (Andalucía)	Respite care programme	Day care or residential respite	24 hours to 1 month (extendable)	For rest, emergencies, hospitalization or carer illness
Sweden	Municipal Respite Services	Day care, short-term institutional care, in-home respite, carer counsellors	Day to short stays	Municipal delivery; carer counsellors and support groups common
Switzerland (Fribourg)	Annuaire des institutions et services	Directory of respite services; short paid respite	Up to 10 days/year (instalments; max 3 days per case)	Canton-level services; paid respite in small instalments
United Kingdom (Scotland)	Short Breaks and Emergency Respite Care	Holidays, overnight stays, brief time off, emergency respite	Short breaks; emergency cover when carer unavailable	Local council provision; may include financial support
United States (NY state)	Respite Program (NY)	Adult day, in-home care, temporary overnight stays, case management	Short-term / variable	State-level programs: case management, counselling, training, support groups

Source: OECD's own analysis/ questionnaires.

Table B.4. Training courses for family carers are available across 26 OECD countries – most being dementia-specific

OECD country	Programme	Ministry / Institution	More details	Dementia-specific
Australia	Preventing Dementia MOOC	University of Tasmania	Online course, self-paced	Yes
	Staying at Home program	Dementia Support Australia	carer education and peer support	Yes
	Care of People with Dementia in their Environments (COPE)	COPE Australia	Structured intervention, caregiver support included	Yes
Austria	Subsidised education and training	Federal Ministry of Social Affairs, Health, Care and Consumer Protection	Varies; funding for multiple training sessions	General
	Outpatient gerontopsychiatric care	Connexia	Individualized counselling, outpatient setting	General
Canada	Dementia Community Investment (DCI) and Dementia Strategic Fund project resources	Public Health Agency of Canada	Community-based projects, variable duration	Yes
Costa Rica	Cuidadores de Personas Adultas Mayores con Demencia Tipo Alzheimer	Cuidar.cr	Workshops and talks, group-based	Yes
Estonia	Educational videos, real-life scenarios, seminars	Dementia Competence Centre	Mixed format; workshops and seminars	Yes
Finland	Former carers trained to support current carers	Alzheimer Society of Finland, dementia and other associations, wellbeing services counties	Peer-support model, training duration varies	Yes
France	Training for Caregivers of a Relative with Alzheimer's Disease - Formation pour les aidants d'un proche atteint de la maladie d'Alzheimer	National Portal for Information and Support Services - Portail national d'information et d'orientation	Professional counselling sessions, individual format	Yes
Germany	Care courses for caring relatives	LTC Insurance Fund	Varies; includes practical and	General

	and carers		theoretical sessions	
Greece	Training programmes and practical advice	Alzheimer Associations	Workshops and seminars, in-person	Yes
	Online training platform	Alzheimer Athens – Greek Municipal Network of Healthy Cities	Online training modules	Yes
Iceland	Training, evaluation, memory, nutrition, and medical support	Government	Mixed format; practical and theoretical components	Yes
Ireland	Engaging Dementia	HSE Health Service Executive	Multi-session programme, community-based	Yes
Italy	E-learning and residential course	Italian National Fund for Alzheimer's	Online and in-person, blended learning	Yes
	Course for family members of people with dementia / Corso per familiari delle persone con demenza	Dementia Observatory	Short courses, workshops for family carers	Yes
Japan	Dementia Supporter Caravan 2024	Ministry of Health, Labour and Welfare	Nationwide programme, volunteer-based	Yes
Korea	Dementia Partner Training	Ministry of Health and Welfare	Short-term courses, includes practical exercises	Yes
	Dementia Partner Plus Training	Ministry of Health and Welfare	Extended programme, includes follow-up support	Yes
Latvia	Training	Government	Duration varies; partially subsidized	General
Mexico	Courses for informal carers of older adults, including frail and dementia patients	ISSTE (Institute for Social Security and Services for State Workers)	Workshops and training sessions; group-based	Yes
Netherlands	Online training options and workshops	Netherlands' Alzheimer Association	Online self-paced courses	Yes
	Short online courses; five-day course for couples; evening courses for family and dementia carers	Laurens	Mix of online and in-person; multi-day courses	Yes
Norway	Education, Caregiver Schools, and Discussion Groups	Municipalities	Knowledge on dementia, practical caregiving skills, emotional support, and peer interaction for family members.	Yes
Poland	Dementia Care Training	Polish Alzheimer's Association	Workshop-based; practical caregiving skills	Yes
Portugal	Training and workshops for carers of people with dementia	Alzheimer Portugal Association	Group-based; includes practical and emotional skills	Yes
Slovenia	Training and support for practical and emotional caregiving skills	Slovenian Ministry of Health	Workshop-based; practical and emotional support	Yes
Spain	IMSERSO School for Families	CRE Alzheimer (Imserso)	2-day course, 40–50 participants/year	Yes
	Free Course for Carers of Dependent Older Adults	Spanish Society of Geriatrics and Gerontology - SEGG	Short courses, group-based	General
	Dementia Trainings	CRE Alzheimer (Imserso)	Seminars and online training	Yes
	Online programme "Learn to Care and to Care for Yourself".	Foundation Pasqual Maragall	Provides emotional support and training from a practical perspective, tailored to their needs. Since 2021, 87 online groups have been organised, with more than 800 carers participating.	Yes
Sweden	Programmes on understanding dementia and care strategies	Swedish National Board of Health and Welfare	Multi-session programmes; theoretical and practical focus	Yes
Switzerland	iSupport Swiss	Institute of Public Health (IPH) & eLearning Lab, Università della Svizzera italiana	Online self-paced course for informal carers	Yes

United Kingdom (Scotland)	Workshops and training	Age Scotland	Short courses and workshops for carers	Yes
United States	Dementia care training programs	Alzheimer Association	Various programs: duration and format vary. Most are online	Yes

Source: OECD's own analysis/ questionnaires.

Table B.5. Counselling for family carers of people with dementia is present in 21 OECD countries

OECD country	Programme	Organisation	Details
Australia	National Dementia Helpline	Dementia Australia	Offers free, confidential counselling and emotional support for individuals, families, and carers at all stages of dementia.
Austria	Relatives' Talk (Angehörigengespräch)	Federal Ministry of Social Affairs	Up to 10 psychological counselling sessions for informal carers, available at home, online, or by phone.
Canada	First Link®Dementia Support Services	Alzheimer Society of Canada Dementia Society of Ottawa and Renfrew County	Connects people to dementia-focused health services, support and information. Provides counselling, care coaching, education, and activity programmes for people with dementia and their carers.
Costa Rica	Workshops and Talks	FundAlzheimer Costa Rica	Offers educational workshops and support sessions for carers and families of people with dementia.
Czechia	Alzheimer Point	Alzheimer Nadacní Fond	Free counselling centre for carers and people with cognitive impairment, offering advice and support activities.
Estonia	Support groups for caregivers	Dementia Competence Centre	Provides information, guidance, and counselling on dementia care and available social benefits.
Finland	National Memory Advice helpline, family suppot groups, Muistiluotsi Expert and Support Centres.	The Alzheimer Society of Finland	Offers free,timely and confidential counselling, advice and emotional support for individuals, families and carers, offers educational workgroups and peer support groups
France	Individual Counselling Sessions (Entretiens individuels)	France Alzheimer	Provides professional psychological support to help carers manage stress and emotional challenges.
Germany	Case and Care Management	LTC Insurance Fund and LTC Service Points (Pflegestützpunkte)	Provides counselling and advice for persons in need of long-term care and their informal carers.
Iceland	Advice Phone Number	Alzheimer's Association in Iceland	Information and counselling services available for individuals with dementia and their relatives. Free of charge.
Ireland	Alzheimer National Helpline, Dementia Adviser Service, Family Support Groups	Alzheimer Society of Ireland	Free and confidential advice, emotional support, and family support groups for carers and people with dementia.
Israel	Psychogeriatric Clinic and Hotline	Israeli Alzheimer's Medical Centre	Provides assistance and counselling to family members of people with dementia.
Japan	Counselling Services	Local Governments	Local governments provide counselling services for carers, including guidance on caregiving techniques, legal matters, and emotional support.
Korea	Dementia Partner Programme	National Dementia Centre	Provides online and in-person support groups, counselling, and helpline (1899-9988) for family carers.
Latvia	24/7 Crisis Helpline	Latvian Samaritan Association / Skalbes	Free, confidential counselling and emotional support for carers and people in crisis, including dementia carers.
Netherlands	Meeting Centres Support Programme (MCSP)	Developed by Amsterdam UMC (Vrije Universiteit Medical Centre); implemented by municipalities in collaboration with welfare and care organisations	offer structured social and therapeutic activities, individual consultations, and group counselling for carers in accessible community locations.
Norway	Psychosocial Support for Carers	Norwegian Health Directorate	Provides emotional support, guidance, and counselling for family carers of older adults and people with

			dementia.
Poland	Counselling Services	Polish Alzheimer's Association	Offers support and counselling for carers and families of people with dementia.
Portugal	Memory Café, Music Stimulation Activity, Support Groups	Alzheimer Algarve	Activities for people with dementia and their carers/relatives (currently in Portuguese only).
Spain	Therapeutic Groups for Carers	Fundació Pasqual Maragall Also, family associations (asociaciones de familiares, AFA)	Facilitates therapeutic group sessions offering psychological support for family carers.
United Kingdom	Local Support Groups and Talking Therapies	Alzheimer's Society UK	Offers local peer-support groups, emotional counselling, and therapy for carers.

Source: OECD's own analysis/ questionnaires