China

Research conducted in 01/10/2025

China is modernizing its dementia care through the National Action Plan (2024-2030), aiming to standardize diagnosis and train 15 million workers to support its 16 million residents living with the condition. While urban tertiary clinics are expanding rapidly, rural areas face significant gaps in access and diagnostic tools due to the hukou registration system and fragmented care pathways. Families currently provide over 80% of care, bearing heavy financial and social burdens as advanced treatments often remain out-of-pocket. To address this, China is rolling out Long-Term Care Insurance (LTCI) to fund community-based support, though legal standards for mental capacity and advance directives are still being developed.

Highlights

Health system **Universal healthcare with mixed funding and mixed provisions**
ADI member association(s): **Alzheimer's Disease Chinese Hong Kong Alzheimer's Disease Association and Macau Alzheimer's Disease Association**
National dementia plan: **National Action Plan for Coping with Dementia in the Elderly (2024–2030)**
Dementia plan funding: **Funded plan**
Dementia prevalence rate: **1194**
Dementia incidence rate: **205**
Population: **1415083973**
Median age: **40**
Health expenditure (% of GDP): **5**

Diagnosis

In China, dementia diagnosis typically begins in primary care or specialist clinics, progressing to tertiary hospital memory centres for comprehensive assessments. Routine cognitive screening uses Mandarin MoCA, MMSE, and Clock-Drawing tasks, while CT and MRI are standard imaging. Amyloid-PET and genetic testing are limited to select cases, and CSF biomarkers clarify difficult diagnoses. Emerging blood biomarkers are being validated but not yet routine. Basic insurance covers standard visits and imaging, but advanced diagnostics are largely out-of-pocket, making cutting-edge tests and long-term care primarily accessible in large urban centres, with rural patients facing longer waits and travel burdens.

Diagnosis pathway

Urban patients in China usually move from primary-care or specialist clinics to hospital-based memory centres for comprehensive assessments. These centres are increasingly part of large academic hospitals, while rural areas face variable access and longer travel for diagnosis.

In major cities, most people begin with community or primary-care clinics or a general neurology and psychiatry visit, then move to hospital-based memory clinics at tertiary centres for a full cognitive work-up and imaging. These memory clinics have expanded quickly in recent years and are increasingly embedded in large academic hospitals, which makes referral smoother and concentrates expertise. In smaller cities and rural areas, access is more variable as families may cycle through several outpatient visits before reaching a dementia service, and some travel to provincial capitals or national centres for definitive diagnosis. Informal pathways also appear, especially where awareness is low, such as repeated general outpatient visits without targeted cognitive testing, or reliance on family observation until functional decline forces evaluation.

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Wait times

China lacks a national dataset for dementia wait times. Tertiary centres with integrated memory clinics, imaging, and labs enable quicker diagnoses. Rural and smaller-city patients face longer waits due to fewer local services, referral approvals, travel logistics, and inter-provincial appointments for advanced diagnostics.

There is no single national dataset for dementia waiting times, but patterns are consistent with broader specialty care. For example top tertiary hospitals that co-locate memory clinics, neuro imaging, and laboratories tend to deliver faster, more predictable work-ups, while under-resourced settings see longer or staggered waits across multiple visits. Urban-rural disparities matter since a person in a county town might face delays due to referral approvals, travel logistics, and fewer local appointment slots. Inter-provincial travel for complex cases also

stretches the total time to diagnosis, less because of minutes in a waiting room and more due to the steps required to reach the right clinic with the right tools.

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Diagnosis cost

Status: Partially covered
Most Chinese residents have basic insurance covering routine visits, imaging, and labs, but advanced diagnostics such as amyloid-PET or specialized biomarkers are often excluded. With dementia-related costs vastly exceeding typical incomes, many families cannot afford long-term care, leaving innovative diagnostics largely accessible only in large urban tertiary centres.

China's basic medical insurance schemes cover most residents and reimburse a defined share of outpatient visits, imaging, and laboratory tests according to local policy and the national catalogues. In practice, CT and MRI are commonly reimbursed to some degree, while advanced diagnostics such as amyloid-PET and some biomarker assays fall outside standard coverage in many locales and therefore involve out-of-pocket payment, commercial insurance, or research pathways. According to a study from 2015, the estimated annual cost per person living with Alzheimer's disease was 19,144.36 USD, while the average per capita household income in China in 2015 was about 3542.93 USD. This gap illustrates the extreme financial strain dementia places on families, making long-term care and advanced diagnostics unaffordable for most households without insurance support or government subsidies. The net result is that core clinical evaluation is usually insurable, but add-on, cutting-edge tests are unevenly financed, with affordability and uptake highest in big-city tertiary centres.

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Cognitive tests

Status: Available
In routine practice, clinicians in China use validated screens, most commonly the Chinese or Mandarin versions of the Montreal Cognitive Assessment (MoCA) and the Mini-Mental State Examination (MMSE). It is often combined with simple add-ons like a Clock-Drawing task to sample executive and visuospatial skills. Recent large Chinese datasets now provide age- and education-adjusted normative values for MoCA, which improves triage accuracy and helps avoid misclassification in people with lower schooling. In memory-clinic settings, these brief tools determine who needs fuller neuropsychological testing, imaging, or biomarker work-ups.

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Imaging tests

Status: Commonly used

Computed tomography (CT) and magnetic resonance imaging (MRI) are standard parts of the dementia work-up in tertiary hospitals and are used to exclude structural causes and support etiologic diagnosis. Amyloid-positron emission tomography (PET) is available in major centres and has been shown in Chinese memory-clinic cohorts to change diagnoses and treatment plans, particularly in early-onset or diagnostically uncertain cases. However, amyloid-PET is not reimbursed by China's basic medical insurance and remains costly, so its routine use is limited outside large urban hospitals and research networks. In general, CT and MRI are widely obtainable in tertiary care, but amyloid-PET utilization is still constrained by coverage and price.

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Genetic tests

Clinical genetic testing is targeted rather than routine. Apolipoprotein E (APOE) genotyping and monogenic panels (APP, PSEN1/PSEN2) are typically ordered for early-onset, familial, or atypical presentations in academic centres or via reference laboratories. China maintains organized research efforts and registries focused on familial and early-onset Alzheimer's disease, and multi-centre reports describe the mutation spectrum in hundreds of Chinese families. In everyday clinical pathways, however, genetics is not a population screen and is generally confined to selected cases where results will change counselling or management.

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Biomarker tests

Status: Commonly used

Cerebrospinal fluid (CSF) biomarkers (Aβ42/40, total-tau, phospho-tau) are used in tertiary memory clinics to clarify difficult or atypical cases. Recent work from Chinese centres shows that adding CSF improves diagnostic confidence and classification when routine clinical and imaging data are inconclusive. In parallel, blood-based biomarkers, such as notably plasma p-tau217 (and related ratios such as p-tau217/Aβ42), panels including Aβ42, p-tau181, and NfL, are showing high diagnostic and prognostic performance in Chinese research studies. Several studies have established reference intervals and evaluated accuracy against PET and CSF. These blood tests are moving from

research toward staged clinical adoption but are not yet a nationwide routine, whereas CSF testing is already embedded at many tertiary sites.

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Treatment & care

In China, memory clinics and dedicated dementia units integrate neurology, psychiatry, geriatrics, and rehabilitation, mainly in urban centres. The 2024–2030 National Action Plan aims to expand capacity, standardize care, and train the workforce. Basic insurance covers older Alzheimer's drugs and clinic visits, but new anti-amyloid therapies and repeated MRIs often require out-of-pocket payment. Families provide most day-to-day care, while formal support is limited while NGOs and hospitals offer helplines, education, and limited respite. Expanding social support and PAC services could reduce caregiver burden and improve care.

Specialized facilities and services

Memory clinics and dedicated dementia units in China integrate neurology, psychiatry, geriatrics, and rehabilitation, concentrated in urban centres. The 2024–2030 National Action Plan seeks to expand capacity, standardize diagnosis and treatment, and develop the workforce.

China has rapidly expanded dementia-capable services in tertiary hospitals, building out memory clinics and dedicated inpatient units that bring neurology, psychiatry, geriatrics, neuropsychology, and rehabilitation under one roof. Still, coverage of such services is strongest in major cities, with referral upward still common from smaller cities and counties. Moreover, the government's new National Action Plan for Coping with Dementia in the Elderly (2024–2030) tasks 15 ministries with standardizing diagnosis and treatment, scaling dementia care units within elder-care institutions, and training the workforce through 2030. These steps are expected to push capacity beyond top hospitals over the next few years.

Approved medication

Generic Name	Trade Name	Used for
Donepezil	Aricept, Aricept ODT, Adlarity, Eranz, Memac, Alzepil, Davia, Donecept, Donep, Donepex, Donesyn, Dopezil, Yasnal, Memorit, Pezale, Redumas, Zolpezil, Namzaric*	Donepezil is indicated for the symptomatic treatment of mild to moderately severe Alzheimer's dementia. Official UK medicine details (MHRA SPC) link
Rivastigmine	Exelon, Exelon Patch, Prometax, Rivastach, Nimvastid	Symptomatic treatment of mild to moderately severe Alzheimer's dementia. Symptomatic treatment of mild to moderately severe dementia in patients with idiopathic Parkinson's disease. Official UK medicine details (MHRA SPC) link

Generic Name	Trade Name	Used for
Galantamine	Razadyne, Razadyne ER, Reminyl, Reminyl XL, Nivalin, Lycoremine, Galsya	Galantamine is indicated for the symptomatic treatment of mild to moderately severe dementia of the Alzheimer type. Official UK medicine details (MHRA SPC) link
Memantine	Namenda, Namenda XR, Ebixa, Memary, Axura, Akatinol, Maruxa, Nemdatine, Namzaric*	Treatment of adult patients with moderate to severe Alzheimer's disease. Official UK medicine details (MHRA SPC) link
Lecanemab	Leqembi	Lecanemab is indicated for the treatment of mild cognitive impairment and mild dementia due to Alzheimer's disease in adult patients that are apolipoprotein E ε4 (ApoE ε4) heterozygotes or non-carriers. Official UK medicine details (MHRA SPC) link
Donanemab	Kisunla	Donanemab is indicated for the treatment of mild cognitive impairment and mild dementia due to Alzheimer's disease (AD) in adult patients that are apolipoprotein Eε4 (ApoE ε4) heterozygotes or non-carriers. Official UK medicine details (MHRA SPC) link

*Namzaric = combination of Donepezil and Memantine

** MHRA: Medicines and Healthcare products Regulatory Agency - UK medicines regulator;

SPC: Summary of Product Characteristics - detailed product information

Treatment cost

China's basic medical insurance covers older Alzheimer's medications and clinic visits, yet anti-amyloid drugs and repeated MRIs or infusions are mostly uninsured. Patients often face high out-of-pocket costs, limiting access to cutting-edge therapies despite insurance coverage for standard care.

Most clinic visits and the older Alzheimer's disease drugs (donepezil, rivastigmine, galantamine, memantine) are covered to some extent by China's basic medical insurance, based on what each province implements from National Reimbursement Drug List. However, the new anti-amyloid drugs are not yet broadly reimbursed, so people typically pay out-of-pocket unless a hospital or insurer has a special deal with the manufacturer. On top of the drug price, people often need repeated MRI scans and infusion visits which is often not covered by the insurance and makes a significant additional cost.

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Caregiver support

Family care remains central for most Chinese dementia patients, yet formal support is inconsistent. NGOs and hospital programs offer helplines, education, and occasional respite initiatives, but cash allowances and standardized home or day care are lacking. Caregiver stress rises with severe cognitive decline and limited community services. Strengthening social support networks and expanding PAC, home, and day-care services, alongside training from ADC and CAAD, can alleviate family burden and improve patient care.

Family care remains the backbone of day-to-day support with more than 84% of people living with dementia being taken care of by their families. At the same time, national NGOs and hospital programs provide helplines, caregiver education, and periodic respite or skills-training pilots. However, no unified national cash allowance exists specifically for dementia caregiving. Also, the availability of day care, home-based support, and navigation services varies by city and program maturity. One cross-section research shows that caregiver burden in China is strongly shaped by several intersecting factors, including the cognitive status of the person living with dementia, post-acute care (PAC) availability, levels of social support, and the accessibility of community-based services. When cognitive impairment is more severe and community services are limited or fragmented, families carry a heavier load, often without adequate respite, training, or professional guidance. Strengthening formal social support networks, expanding high-quality home-care and day-care services, and scaling PAC facilities can significantly reduce this burden by distributing care responsibilities across trained providers rather than leaving them almost entirely to families. Alzheimer's Disease Chinese (ADC) and the China Association for Alzheimer's Disease (CAAD) help fill gaps with public education, carer resources, and professional training.

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Policy

China's 2025 National Action Plan for Dementia (2024–2030) frames dementia as a public-health and elder-care priority, targeting prevention, early screening, standardized diagnosis, rehabilitation, and expanded care. The LTCI Pilot Programme supports home, community, and institutional services, with national rollout planned to harmonize coverage, quality, and provider supply. Policy gaps include inconsistent legal protections, lack of nationwide advance directive enforcement, and cultural barriers such as stigma, family expectations, and hukou restrictions. Memory clinics are expanding but unevenly distributed, particularly in rural areas, leaving families reliant on informal support and local variation in care quality.

National dementia plan

China's 2025 National Action Plan for Dementia (2024–2030) frames dementia as a major public-health and elder-care challenge, and aims for prevention, early screening, standardized diagnosis and treatment, rehabilitation, and expanded care. According to the plan, half of large elder-care institutions will have dedicated dementia units, and 15 million dementia-care workers will be trained by 2030. It addresses the aging population, rising prevalence, and urban-rural service gaps, and aims to integrate dementia care into broader health system planning and social inclusion strategies.

In January 2025, the Chinese government launched the "National Action Plan for Coping with Dementia in the Elderly (2024–2030)" (sometimes called the National Action Plan on Response to Dementia), a major policy document co-led by the State Council of the People's Republic of China and multiple ministries. This plan places dementia firmly within the broader Healthy China 2030 strategy, recognizing dementia as not simply a clinical condition but a large-scale public-health and elder-care challenge. The document sets the ambition of building a full lifecycle system that covers prevention, population-level screening and early intervention, standardized diagnosis and treatment, rehabilitation and care expansion. It also involves workforce training, and creation of dementia-friendly environments. For example, one element proposes that 50% of elderly-care institutions with more than 100 beds and sufficient capability will establish dedicated dementia units, while approximately 15 million dementia-care personnel will be trained by 2030.
The Action Plan arises in the context of China's rapidly aging population, rising life-expectancy, and a corresponding rise in dementia prevalence. It was estimated that China had more than 16 million people living with dementia by 2021, accounting for nearly 30 % of the global total. The plan emphasizes that screening and early intervention will help "effectively control the growth rate" of dementia prevalence, while improved access to care and standardization are central to narrowing the urban-rural and regional service gap. The significance of this plan is that dementia is elevated from a disease-specific clinical policy into the realm of health system planning, elder care policy, workforce development and social inclusion.

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Upcoming plans

The LTCI Pilot Programme provides a financing and organizational framework for dementia care in China, covering home, community, and institutional services. Since 2016, 15 cities have tested eligibility, benefits, and provider payment mechanisms with mixed results. LTCI is central to the Dementia Action Plan, and national expansion will harmonize coverage, boost provider supply, integrate quality monitoring, and ensure equitable, structured long-term care beyond hospitals for older adults with cognitive impairment.

Alongside the Action Plan, China has been pursuing a Long-Term Care Insurance (LTCI) Pilot Programme that is the backbone for financing and organizing non-acute (home, community, institutional) care for older people living with disabilities and chronic conditions, including dementia. The LTCI initiative began with fifteen pilot cities selected around 2016 and expanded over subsequent years. The LTCI system is intended to cover eligibility benefits and provider payment mechanisms. Evaluations of the pilots show promising outcomes but substantial heterogeneity. Across cities there are very different eligibility thresholds, service-coverage scopes, financing channels and quality of care. For example, some cities only covered people living with severe disability, while others began to include mild or moderate cognitive impairment. The LTCI system is seen as the principal mechanism through which the dementia Action Plan's goals for expanding home and community services and "care beyond hospitals" will be funded and organized.
Looking forward, the strategy foresees the national-scale rollout of LTCI beyond pilot cities, harmonization of assessment tools and benefit design, integration with the dementia Action Plan. In that case, the services for people living with dementia are explicitly supported through LTCI. It will also strengthen provider supply of community and home care, while also building data monitoring and quality assurance systems. These efforts aim to ensure equitable access across regions, improve service quality, and move from ad hoc to systematized long-term dementia care support.

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Policy gaps

Legal barriers

While China's laws protect mental health and older adults broadly, they lack dementia-specific standards. Guardianship, decision-making, and capacity standards are inconsistent, and no national framework defines capacity, supported decision-making, or advance directives nationwide. Fitness-to-drive rules are general, and living-will enforcement exists only in select areas like Shenzhen. Families and providers must often manage care, interventions, and end-of-life decisions without standardized, enforceable dementia-specific legal protections.

China's 2012 Mental Health Law establishes rights protections and regulates involuntary care for "mental disorders", but it does not set dementia-specific capacity standards or a pathway for supported decision-making in progressive cognitive decline. The 2020 Civil Code formalizes adult guardianship, including agreements on "voluntary guardianship", but the implementation relies on general clauses and local notarization practices rather than specific dementia criteria, leaving variability across jurisdictions. When it comes to fitness-to-drive rules, there is no single mention of dementia. Recent licensing changes allow older adults to qualify or extend eligibility with tests of memory, judgment, and reaction, which indicates a shift toward functional assessment. However, there is no single national clinical protocol that links a dementia diagnosis to clear licensing outcomes or reporting duties for clinicians. Moreover, the Law on the Protection of the Rights and Interests of the Elderly guarantees general protections, such as right to health and material assistance, but does not define dementia-specific rights or due-process safeguards. The lack of capacity assessment standards, supported decision-making, or appeal routes leaves families of people living with dementia and Alzheimer's disease and healthcare providers to rely on variable local practices.

Moreover, China's long-term care (LTC) insurance is still a pilot patchwork with different eligibility rules, benefit levels, and assessment tools that vary by the city. As a result, the national evaluations and surveys consistently find services fall short of the needs of people living with disabilities. Finally, China still lacks a single, nationwide law that clearly recognizes and enforces advance directives (living wills). In practice, doctors and families often handle end-of-life and treatment-planning decisions case by case, guided by hospital policy, local custom, and clinical judgment rather than a uniform legal rule. One local exception is Shenzhen, which has implemented elements of living-will policy into its Special Economic Zone medical regulations. Experts point out gaps and ambiguities, and the rules do not apply outside the city. For dementia, this creates a real problem: people need to record their wishes early, while they still have capacity, yet without a clear national framework the validity, scope, and enforcement of those wishes can vary widely between hospitals and regions.

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Cultural barriers

Stigma and social expectations create significant barriers to dementia care in China. Stigma delays help-seeking, while traditional family caregiving norms clash with smaller households and urban migration. Hukou restrictions limit access to services for non-local residents. Memory clinics are expanding but remain unevenly distributed, especially in rural areas, where higher prevalence and fewer resources lead to later diagnosis, fragmented care, and reliance on informal family support.

Local surveys and research continue to identify moderate to high stigma among family carers of people living with dementia in mainland China. Sometimes, this significantly delays timely diagnosis and help-seeking, further increasing caregiver load and undermining early diagnosis goals. At the same time, strong expectations of family caregiving collide with shrinking household size and migration. Older adults who migrate to cities face barriers to services and social benefits. This complicates continuity of dementia care and increasing reliance on informal

support. China's household registration system, which ties access to public services to one's registered locality, is called hukou. For people living with dementia, lacking local hukou in the city where they live can mean reduced eligibility for clinics, long-term care, and social benefits, which also leads to delays, out-of-pocket costs, and fragmented care. National surveys show rapid growth of memory clinics but still uneven distribution, with a small share of hospitals operating dementia-specific clinics or inpatient units. Rural areas have higher prevalence and fewer resources, reinforcing later presentation and inconsistent care quality outside top urban hospitals.

Research

China advances dementia detection using plasma p-tau, Aβ biomarkers, CSF, and amyloid-PET, while ML-enhanced AD8 screening improves accuracy. Longitudinal studies like CHARLS provide representative cognitive and socioeconomic data, supporting scalable early detection, risk prediction, and evidence-based planning for the aging population.

Selected academic institutions

Peking University Sixth Hospital (Institute of Mental Health) Xuanwu Hospital (Capital Medical University) Huashan Hospital (Fudan University) Beijing Tiantan Hospital Shanghai Mental Health Centre (SMHC) West China Hospital, Sichuan University (Chengdu) Beijing Tiantan Hospital (Capital Medical University) Sun Yat-sen University Institute of Neuroscience & CAS Centre for Excellence in Brain Science and Intelligence Technology (Shanghai) Tsinghua University — IDG/McGovern Institute for Brain Research (Beijing) Nanjing Medical University

Clinical trials and registries

Chinese Clinical Trial Register (https://www.chictr.org.cn/) is the official public registry and a primary registry of the World Health Organization's international network. Patients and families can search this database (available in both Chinese and English) to find actively recruiting interventional and observational studies across the country. The National Medical Products Administration is the paramount regulatory body in China.

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Selected innovative methods

In China, plasma p-tau and Aβ ratios, alongside CSF and amyloid-PET studies, are refining dementia diagnosis, while MoCA normative data enhance early detection. The SHARE project shows that machine learning combining AD8 items with simple health metrics outperforms standard screening. Longitudinal studies like CHARLS offer nationally representative, globally harmonized insights into cognitive aging, biomarkers, and socioeconomic factors. These efforts provide practical tools for scalable community dementia screening, inform risk prediction, and support evidence-based strategies for early intervention and resource allocation amid China's growing elderly population.

Large Chinese study populations are advancing blood-based biomarkers, especially plasma p-tau and Aβ ratios, and

evaluating clinical utility against PET and CSF, while tertiary clinics continue to refine how CSF and amyloid-PET change diagnosis and management in complex cases. At the same time, teams are producing Chinese normative data and education-adjusted cut-offs for MoCA, improving fairness and scalability of early detection beyond top hospitals.

One research conducted by Shenzhen Healthy Ageing Research (SHARE) project, tested whether machine learning (ML) models combining selected AD8 items with routinely collected health and demographic data could outperform the traditional AD8 ≥2 threshold for detecting cognitive impairment. Using five ML algorithms and feature selection via permutation importance, researchers identified key predictors, including two specific AD8 items (judgment problems and difficulty with financial transactions), sex, age, body mass index, waist circumference, platelets, serum uric acid, white blood cells, heart rate, carcinoembryonic antigen, and abnormal electrocardiography (ECG). The multilayer perceptron (MLP) achieved the highest accuracy (AUC 0.83), substantially exceeding the baseline AD8 score (AUC 0.65), with AdaBoost, SVM, and GBDT also performing well. SHAP analysis showed female sex, older age, and lower waist circumference were the strongest contributors to cognitive impairment predictions. The findings demonstrate that integrating brief informant items with simple health parameters and ML techniques can greatly improve community dementia screening efficiency in China, offering a practical approach for early identification while minimizing resource demands.

China Health and Retirement Longitudinal Study (CHARLS) participates in the international project the Health and Retirement Study (HRS), which collects nationally representative, longitudinal, and harmonized data that align with global standards to enable cross-national research on aging. These studies integrate rich cognitive assessments, biomarker collection, and repeated health and socioeconomic interviews, offering a multidimensional picture of aging in China that is directly comparable to data from the United States and other countries. CHARLS and related harmonized datasets, accessible through the NIA-supported Gateway to Global Aging, are essential for understanding cognitive aging patterns, dementia risk, and the social and economic determinants of late-life health within China's rapidly aging population.

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Support

China promotes dementia awareness through World Alzheimer's Month campaigns and the ADI Asia-Pacific Regional Conference, while information is disseminated via health portals, hospital websites, ADC/CAAD channels, and mainstream media, as no dedicated national dementia media exists.

Organizations are listed for informational purposes based on publicly available sources. Inclusion does not necessarily indicate affiliation with or endorsement by Alzheimer's Disease International (ADI).

Selected national associations, patient family associations, NGOs:

Alzheimer's Disease Chinese (ADC) China Association for Alzheimer's Disease (CAAD) China Foundation for Poverty Alleviation (CFPA) Shanghai Jinmei Care for the Elderly

Selected initiatives

Each September, World Alzheimer's Month promotes public education and screenings, coordinated by ADC, CAAD, and hospitals. The ADI Asia-Pacific Regional Conference, held annually with ADC, fosters knowledge exchange among professionals and caregivers, focusing on policy, care services, research updates, and regional collaboration for dementia-friendly systems.

World Alzheimer's Month

Each September, World Alzheimer's Month drives public awareness through campaigns, lectures, screenings, and media engagement, often coordinated by ADC and CAAD in partnership with numerous hospitals.

Alzheimer's Disease International (ADI)'s Asia-Pacific Regional Conference

Alzheimer's Disease International (ADI)'s Asia-Pacific Regional Conference is organized annually for more than two decades in partnership with the Annual Conference of ADC and it serves as a regional meeting point where policymakers, clinicians, researchers, care providers, and caregiver groups share evidence and practical know-how. In 2024, the conference title was "Participation, Collaboration, Progress" and it was focused on advancing dementia policy, scaling community and social-care services, updating research and clinical practice. One of its main goals is strengthening cross-border collaboration to build more integrated, dementia-friendly systems across the Asia-Pacific.

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Dedicated media outlets

There is no dementia-only national media channel. Authoritative information flows through national and municipal

health portals, hospital websites, and the communication channels of ADC, CAAD, and university hospitals, supplemented by mainstream media coverage when new policies, approvals, or large studies are announced.