



**Alzheimer's Disease  
International**

# **National Alzheimer and Dementia Plans Planned Policies and Activities**

***Early Detection, Access to Diagnosis,  
and Stigma Reduction***

**April 2012**

## **Foreword**

Actual and projected numbers of people with Alzheimer's disease are growing worldwide, and increasing numbers of governments are developing comprehensive public health strategies in response.

Alzheimer's Disease International (ADI) has identified 18 areas of policy on which it has begun the process of analysis to chart and create links to specific plan sections on its website <http://www.alz.co.uk/alzheimer-plans>.

In turn, ADI will be taking policy areas and comparing and contrasting the plans policy directions and commitments and creating a series of policy briefs. This is the first of that series. Ideally over time there will be a series of policy briefs that not only document what policies were promoted in the original government plan but also identify what policies actually moved into implementation and with what impact.

Diagnosis, detection and stigma reduction were chosen because ADI and the existing national plans have documented that a huge gap exists between prevalence estimates and actually numbers of people with a diagnosis. We believe that nothing good can happen for a person with dementia, their family carers or even health systems if it is unidentified or inaccurately assessed. We also believe and have documented a stunning body of evidence about the benefits for each of these stakeholders in our latest World Alzheimer Report <http://www.alz.co.uk/research/world-report-2011>

It is against this backdrop that this first paper is published.



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## **National Alzheimer and Dementia Plans Planned Policies and Activities *Early Detection, Access to Diagnosis, and Stigma Reduction***

Immense growth in the number of individuals with dementia in recent years is a global phenomenon, with nations sharing the challenge to create systematic approaches for dementia prevention, diagnosis and intervention. However, the unique culture and demographics of each nation requires specialised high-level government plans that cannot be addressed through international initiatives. While the timing of implementation of national dementia plans is not ideal during these times of fiscal constraint, the growth of individuals affected by dementia make it essential to get the fundamentals of dementia diagnosis and care correct. Australia, Denmark, England, France, Republic of [South] Korea, Netherlands, Norway, Scotland and Wales have established national dementia plans as of November 2011. These plans are implemented through collaborations between government agencies, legislators, and residential care providers, and community care providers, people with dementia, family members, physicians and researchers. This paper summarises the recommendations for early-detection and access to dementia diagnosis. (The national plan for Denmark is not included in the discussion due to a lack of an English translated version as of November 2011. Northern Ireland's plan was also not available for this analysis at the time it was done)

While each national plan embraces the international aim to improve early-detection and access to a formal diagnosis, variability exists between the plans in terms of implementation and measurement outcomes. Such variability, however, is expected and valuable in order to accommodate international diversity in constructing national dementia plans. Additionally, this paper emphasises stigma as a significant barrier to dementia detection and diagnosis in each of the national plans, and highlights the different tactical approaches to targeting the universal goal of stigma reduction.

### **AUSTRALIA**

The Australian Health Ministers developed the National Framework for Action on Dementia (2006-2010) in collaboration with Australian Community Services and Aged Care Ministers. The framework was developed to create a national policy and implementation plan to improve the quality of life for people with dementia, their family members and care providers through five key priority areas: care and support; access and equity; information and education; research; workforce and training. The National Framework for Action on Dementia was implemented across the Australian states and territories. The Australian Health Ministers

Conference (AHMC) and the Australian Health Ministers Advisory Council (AHMAC) monitored the plan through reports issued by the Health Policy Priorities Principal Committee.

Under the Key Priority Area 1 of “Care and Support” the National Framework for Action on Dementia 2006-2010, two main actions focused on early-detection of dementia. The first key priority for action was to “develop and/or identify effective and appropriate cognitive assessment tools to assess and screen people with dementia or who may develop dementia,” through two central goals. The first goal was to address dementia in a comprehensive assessment process and community care review intake by the Australian Government through the Community Care Review. Second, the Australian Government and States and Territories would review and validate the existing dementia diagnosis and assessment tools.

The second key action under the priority of “Care and Support” was targeted to support primary health care professionals and encourage proficiency among general practitioners for identification, referral and management of individuals age 75 years and up with dementia. Effective immediately in the development stage, the Australian Government and States and Territories were to observe collaborations between divisions of general practitioners and primary care settings to identify opportunities for action.

The Key Priority Area 1 of “Care and Support” also addressed initiatives for access to effective dementia diagnosis through service plan development and community care to meet the needs of individuals with dementia as well as their family members and care providers. Service plan development would be achieved through three primary actions; mapping the service pathways at both a national and state/territory level, assessing service gaps, and incorporating analysis into future plan developments. Under the leadership of the Australian Government and States and Territories, dementia identification and sensitive practices would be incorporated into mainstream services. The priority action in community care would be to identify and promote, through simplified English language, the, “best ways to assist people with dementia, their families and carers to navigate the community care system.”

Key Priority Area 2, “Access and Equity”, further provided recommendations through the lead agency of the Australian Government and States and Territories in accessing dementia diagnoses by addressing specific barriers in care access including: Aboriginal and Torres Strait Islander people, younger people, people who are homeless, people who are financially disadvantaged, people lacking carers, people with dual diagnosis of cognitive impairment, people living in rural/remote locations, people from culturally/linguistically diverse backgrounds and people living alone. Specific barriers to access would be identified and information would be shared across jurisdictions to ensure individuals who are disadvantaged in accessing care

would be provided additional attention. Diverse service models would be developed to address the unique needs of each subpopulation and specific plans were to be highlighted in dementia policies informed by the Australian Health Ministers' Advisory Council's Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009. Progress on “Access and Equity” initiatives was to be reported to AHMAC (Australian Health Ministers Advocacy Council).

## **ENGLAND**

England's National Dementia Strategy was developed under the Department of Health Programme Board. Upon establishment of the strategy, there were 700,000 people living with dementia in the United Kingdom, with approximately 570,000 living in England. Seventeen objectives focused on the three key areas of England's national plan; improved awareness, earlier diagnosis and intervention, and a higher quality of care. The broad range of objectives allowed for greater attention to be placed on care providers. Objective 7, “Implementing the Carers' Strategy” was particularly focused on the important resource caregivers are to individuals with dementia. Personalised “breaks”, for example, were included in the strategy to alleviate caregiver burden. Additionally, greater attention to diverse settings for individuals with dementia was found in England's plan. Objective 8, “Improved quality of care for people with dementia in general hospitals,” Objective 9, “Improved intermediate care for people with dementia,” and Objective 11, “Living well with dementia in care homes” demonstrated a post-diagnosis focus on differences of care settings. In general, England's National Dementia Strategy provided an in depth initiative with each objective composed of primary points, ways to implement change and arguments to support suggested changes in the strategy.

Objective 2 provided, “good-quality early diagnosis and intervention for all,” under the goal of, “early diagnosis and support,” with the goal of earlier detection of dementia. It stated that, “all people with dementia [are] to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.” In the prior models, detection of dementia was often made during a time of crisis. Had earlier detections been made such critical events could have been avoided. Nationwide services to address early detection were to be implemented and be cost-effective.

Objective 2, “good-quality early diagnosis and intervention for all,” under the goal of, “early diagnosis and support,” also created recommendations for increased access to diagnosis.

A pathway of care that delivered rapid and accurate diagnosis with sensitive communication, as well as additional follow-up information, was a primary goal in providing quality care to individuals with dementia and carers. As of February 2009, approximately one-third of people with dementia actually received a formal diagnosis at the time of their illness. One constraint in accessing diagnosis was the existing ambiguity in who should make the formal diagnosis of dementia among general practitioners, old-age psychiatric community teams, geriatric medicine, and neurology services. From review of pilot programmes and consultations for the national plan, emerged the need for a new specialist service to be commissioned to deliver diagnosis and interventions. This new service would be structured to receive referrals from primary care physicians and work locally with other specialists. A core set of assessment tools, agreed upon for regional and national monitoring, would be used in the diagnostic process. Further simplification of the healthcare process would be established through use of third sector organisations. Rather than being hospital-based, services could be provided at private residences and primary care settings, monitored using the same standards.

## **FRANCE**

France's national plan for Alzheimer's disease and related diseases (2008-2012) was outlined in eleven key objectives: increasing support for carers; strengthening coordination between all actors involved; enabling patients and their families to choose support at home; improving access to diagnosis and care pathways; improving residential care for better quality of life for Alzheimer's disease sufferers; recognising skills and developing training for health professionals; making unprecedented efforts in research; organising epidemiological surveillance and follow up; providing information for general public awareness; promoting ethical consideration and an ethical approach; and making Alzheimer's disease a European priority. Each objective had corresponding measurements for implementation, as well as an outlined budget. The detailed budgetary outlines of France's national plan provided greater specificity in the implementation process compared to the other national initiatives. A total of 1.6 billion Euros would be allocated over a span of 5 years for the national plan, with 300 million Euros funded in 2008 alone, with the health insurance system providing a large portion of the funding. Additionally, the national plan for Alzheimer's disease and related diseases (2008-2012) established an annual timeline for each progressive step in the measurement.

Under Objective 5, "improving residential care for better quality of life for Alzheimer's disease sufferers," Measure 19 focused on identifying a national reference centre for the vulnerable population of young Alzheimer's disease patients. Little was known about the exact

prevalence of early-onset Alzheimer's disease in France, however roughly 2 out of 3 times, early-onset Alzheimer's disease was diagnosed late as the public misconception that Alzheimer's is a disease of the elderly meant Alzheimer's was often unconsidered.

Measure 19 was also aimed at improving the quality and coordination of increased access and earlier diagnosis for people with early-onset Alzheimer's disease. A fund of 600,000 Euros was to be issued by the health insurance system from 2008-2012 specifically for Measure 19. Measure 19 of the national plan included creation of a "care strategy" that improved access to diagnosis and quality of care coordination for younger patients. The care strategy was to be built upon existing developed knowledge, would reinforce the importance of research and would produce standards for good practice and tools in the clinical setting.

Thus, because the overall measure did not solely emphasise early-detection, it is hard to assess exactly how much spending is planned on these activities.

For Measure 8, "preparing and implementing a system for giving the diagnosis and providing counselling," a total of 100,000 Euros would be funded by the state budget (Ministry of Health) with full allocation in 2008. As outlined in Measure 8, dementia diagnosis would take place during a specialist memory consultation, either through a neurologist or private hospital. The diagnosis process would also have involved a specific treatment plan for the patient, a structured secondary stage as well as provide possible social support. The secondary consultation should have included the primary care physician. It is also noted that information provided should mobilise healthcare professionals, particularly the future case coordinator. Compared to other national plans, France placed a greater emphasis on the communication during the session of diagnosis, with terms such as "actor" and "role" used.

## **REPUBLIC OF [SOUTH] KOREA**

In the past ten years, Korea worked to implement several key policies. A focus had been on increasing eligibility for long-term care insurance and the declared "War on Dementia" with the aim of controlling the issue before it became unmanageable. The national plan was developed through the collaboration of the Ministry of Health and Welfare, Alzheimer's Association Korea, neurology/psychiatry associations, nurses' associations and the media. The National Steering Committee established two main branches for policy. The first branch spanned from 2008-2010 and focused on early diagnosis/prevention, treatment, infrastructure building and public awareness. The second branch, from 2011-2013, focused on expansion of outreach services, upgrading long-term care insurance, establishment of a "dementia service network" and management of "dementia law".

Early diagnosis was one of the key three objectives in the Republic of Korea national plan. One action that addressed that objective was expanding public health centres from 50% to national coverage. Access to diagnosis was also addressed through the Republic of Korea national plan. A comprehensive National Dementia Centre was to be built and replicated in the four primary regional hospitals to increase access to appropriate physicians and potential dementia diagnoses. The number of trained dementia specialists would also increase, with the goal of 6,000 trained specialists by 2012.

## **NETHERLANDS**

The national plan for the Netherlands was informally structured, written in a letter format by Dr J Bussemaker, The State Secretary of Health, Welfare and Sports. The plan was developed from the National Dementia Programme (LDP), which ran from 2004 to 2008, as well as in conjunction with the Dementia Delta Plan. The LDP was launched in 57 regions, and each region searched for solutions to the problems that were most prevalent in their particular region. The national plan outlined by Dr Bussemaker focused on three key aims: creating a coordinated range of care options that meet the client's needs and wishes; delivering sufficient guidance and support for people with dementia and their carers; and measuring the quality of dementia care annually.

In the prior system, detection of dementia usually surfaced after years of struggle and accumulation of symptoms in an individual. Therefore, the national dementia plan for the Netherlands called for targeted, easily available information to help individuals with dementia onset, as well as family, identify symptoms of dementia. Special emphasis was placed on differences in normative ageing symptoms compared to dementia symptoms. Alzheimer Nederland and the municipalities under the Social Support Act would play a crucial role in policy development for early-detection. In order to achieve earlier diagnosis, general practitioners (GPs) were to be knowledgeable about dementia-like symptoms so early detection could be made at general visits. Additionally, the GPs should know when and where to send patients symptomatic of dementia for secondary care, using professional standards (NHG Dementia Standard) and the Regional Support Structure.

To improve access to a diagnosis of dementia, Netherlands' national plan looked towards a multidisciplinary approach. General practitioners have often viewed a dementia diagnosis as "there is nothing you can do about it," a reflection of the limited pharmacological interventions for dementia as well as the lack of specialised training among practitioners. Interagency collaborations were to use opportunities created by the outlined programme for



research and experiments in the area of dementia. By gaining new knowledge, a more efficient diagnosis process was to occur across healthcare professions.

## **NORWAY**

Norway's Dementia Plan 2015, a sub plan within Care Plan 2015, was centred on the primary goal of avoiding institutionalisation through programme development. The research of the initiative was tailored towards improvements in programs, settings and treatments as opposed to early detection and diagnosis. This was largely due to the consistent emphasis on care quality throughout the main plan. Still, despite emphasis on post-diagnostic care, recommendations for early-detection and access to diagnosis were present in the Norway Dementia Plan 2015.

The Norway Dementia Plan 2015 incorporated a few recommendations to target early-detection of dementia from an earlier government initiative. The 2008 Initiative 4.1.3, a continued initiative from 2007, worked on the "development of evaluation tools for diagnosing persons with developmental disabilities who develop dementia." Additionally, initiative 4.1.3 aimed to gather data on driving skills and dementia that could be very beneficial in determining patterns that help serve as early-detection signs. Initiative 4.3.3 from 2008, another continued initiative from 2007, focused on early-detection through training and implementing diagnostic tools among Norway's primary care doctors and local authorities. The initiative was to develop an ICT-based (Information and Communication Technologies) evaluation as well as diagnostic tools.

Recommendations to access a formal diagnosis were also incorporated throughout the Norway Dementia Plan 2015. Initiative 3.2 targeted the missing links in the care chain that could lead to improved diagnosis. Studies showed that approximately 50% of all users in nursing homes with definitive signs of dementia were not diagnosed. Proper diagnosis was an essential component for a realistic treatment plan to be provided. Therefore, interaction between the "specialist health service and municipal health and care services" would aim to ensure effective collaboration and standardisations for diagnosis, in Norway's dementia plan.

A long-term strategy and outcome targeted for 2015 was mapped in initiative 4.3.1. in which the importance of training for health professionals was discussed, as well as a particular governmental strategy. The government would plan a national strategy to enhance the specialist health services, which were obligated to provide guidance to the municipal health service and have a key role in evaluating, diagnosing and assessing function in people with dementia. Specifically, as outlined in initiative 4.3.2, a four-year action programme would take effect. In the

four-year programme regional health authorities were to develop regional action plans to improve specialist health services. They would issue annual reports to the Ministry of Health and Care Services to assess implementation and effectiveness measures under the national strategy. The Norwegian Quality Improvement of Primary Care Laboratories (NOKLUS) would also be extended to the municipalities to get more reliable diagnosis and reduce treatment error.

## **SCOTLAND**

Scotland's National Dementia Strategy was established in 2010, building upon previously established work in areas of early-diagnosis, improving care pathways and public awareness. The plan had an immediate 3-year change structure, however it was formatted towards long-term objectives. A Dementia Strategy Implementation and Monitoring Group was in charge of programme oversight. The monitoring group was established through the key partners of the Scottish Government, local government, the National Health Service (NHS) the private sector, and the volunteer sector. The national dementia strategy was one of three pillars that compile the larger reform agenda of Scotland, the other two pillars being a carer's strategy and self-directed support. The dementia plan focused on five main work-streams at the national and local level: treatment and improving the response to behaviours that carers and staff find challenging; assessment, diagnosis and the patient pathway; improving the general service response to dementia; rights, dignity and personalisation; and health improvement, public attitudes and stigma.

In Scotland's national plan, the stigma attached to dementia was rooted in the delay of detection and limited access to diagnosis. One of the five key challenges the plan addressed to improve care outcomes was overcoming the fear of dementia, which could lead to a delay in the detection process. Some individuals waited more than 2 years to see their general practitioner for fear of a dementia diagnosis. In addition to affecting the timing, the key challenge to overcome the fear of dementia had implications for accessing a diagnosis. General practitioners may have been reluctant to diagnose, or even conduct assessments, in potential cases of dementia, an issue the NHS Boards had been approaching in recent years to acquire more formal diagnoses. A 2008 trial in Dundee and Perth demonstrated that individuals were more likely to seek help if they felt supportive services would be readily available post-diagnosis. Therefore, increased post-diagnostic support and information provisions were a central goal of Scotland's national plan.

The 2008 publication, *Facing Dementia - How to Live Well With Your Diagnosis*, was issued by NHS Health Scotland through funding by the Scottish Government and has been a

strong template of information in the general practice setting. The Scottish Government also established three post-diagnostic support pilots to determine the ideal model of support: Lothian Post-Diagnostic Support Pilot, Renfrewshire and East Renfrewshire Post-Diagnostic Support Pilot, and the Shetland Post-Diagnostic Support Pilot. Access to diagnosis was also addressed through the NHS Boards' local delivery that aimed to increase the number of formal diagnoses as only approximately one-half of individuals with dementia in Scotland had a formal diagnosis. Increases in local diagnostic clinics and secondary specialist services, in collaboration with an increased willingness of individuals to receive a diagnosis and general practitioners to give a formal diagnosis, was aimed to target and provide support to the undiagnosed in Scotland's national dementia plan.

## **WALES**

By 2021 the number of individuals with dementia across Wales is anticipated to increase by 31% calling the need for a national strategy. Compared to the other national plans formerly discussed, the Wales plan was presented more as an informative template, addressing facts and figures for the nation with broad goals on the national level. Details on how to carry out such plans, in terms of organisational structure and budgetary plans, were not specified in the Wales national plan. The emphasis was placed on creation of "Dementia Supportive Communities," networks of groups and organisations with the aim of creating a national dementia community.

The broad goals of the national plan touched upon the need for early-diagnosis and improvements in access to diagnosis. Among the four priority areas for improvement in dementia policy, "improved early diagnosis and timely interventions" was addressed as a top priority. As of July 2010, the Welsh Assembly Government declared an annual fund of 1.5 million Euros towards improvement of dementia services through such goal implementation. While not articulated to be specific for diagnosis, one of the commitments by the Welsh Assembly Government was to develop training packages for social and health care professionals, as well as local authorities, on dementia. Because detection and accurate diagnosis are such key issues, it would be hoped that in such packets, symptom identification training and appropriate diagnosis procedures were to be included. Leadership to advance this vision was in the process of being explored by the Welsh Assembly Government. The Mental Health Programme Board, established by the Minister for Health and Social Services, would serve to review the progress of the national plan and ensure service coordination.

## **NATIONAL COMPARISONS OF STIGMA REDUCTION**

Alzheimer's disease and related dementias elicit feelings of fear and anxiety among the public. The stigma surrounding dementia can ultimately cause further isolation felt by the person with dementia as well as their family and carers. In England, it was noted in the national plan that roughly three years passed before a symptomatic patient reported dementia-like symptoms to their physician. Similar patterns of behaviour and concerns were noted in every one of the national plans. Across cultures, each national plan recognised stigma as a significant barrier to access diagnosis and treatment for dementia and a factor that lead to social isolation. While the overall goal of stigma reduction presented across national plans, variability existed in how to translate the goal into action.

To attain a baseline understanding of the general public's knowledge, both France and Australia's national plans to reduce stigma began with administration of a public survey. For Australia's Community Awareness Programme, a "dementia literacy" survey would be administered to attain a baseline understanding of the public awareness of dementia. Measure 37 of France's national dementia plan, "studying disease knowledge and attitudes," was issued through state funding, approximately 100,000 Euros, by the Ministry of Health. The objective was to "raise the public's awareness of Alzheimer's disease, the patients' cause and that of their families, in collaboration with the patients' associations." A qualitative study was to be conducted, through use of a survey, to evaluate non-specialists' level of knowledge and attitudes about Alzheimer's disease. Further surveys would be issued throughout the implementation of France's national plan to monitor the development of the general public's attitudes and knowledge. The data would then be released with the goal of both increasing awareness and acceptance of dementia in the general population as well as inspiring regional initiatives.

The most significant commitment was made in Australia's Key Priority Area 3, "Information and Education", structured a Community Awareness Programme that is based upon key messages promoted by the Australian Government and States and Territories. Stigma reduction was addressed in France's national plan in Measure 42, "making the fight against Alzheimer's disease a priority for the European Union during the French presidency." However, no specific budget was given towards Measurement 42. Nonetheless, it provided a strong opportunity to establish Alzheimer's disease as a priority on the national agenda while carrying the unique media pull of its term as president of the European Union.

Conveying key messages and increasing community awareness, via programmes and campaigns, was the most common approach to stigma reduction across the national initiatives

of France, England, Australia, Norway and Wales. Ignorance, stemming from a lack of knowledge about dementia, often translated into feelings of shame and guilt for individuals and carers of dementia patients. Informational campaigns and programmes would help target those uninformed about dementia and ultimately, ideally, reduce the social withdrawal associated with diagnosis.

In the Welsh national plan, the Welsh Assembly Government aimed to raise awareness through inclusion of dementia in health campaigns, communication of dementia issues through professional, paraprofessional and lay led networks and bulletins to health colleagues as well by updating voluntary organisations the government funded.

Under Initiative 4.5.2, Norway's national dementia plan constructed a 4-year action plan for informational and educational campaigns aimed to increase openness in dialogue and social settings about the reality and challenges of dementia. Informational measures would be developed from the plan to make information provisions to the local government more accessible.

England's National Dementia Strategy, under Objective 1, "improving public and professional awareness and understanding of dementia," called for development and delivery of a general public informational campaign, done in phases. The key messages of England's national campaign were to promote preventative decisions, stress the benefits of timely diagnosis, reduce social exclusion and discrimination, reduce anxiety while promoting understanding and to stress that dementia is a disease not a normative process of ageing. Further, 'what's good for your heart is good for your head,' would be utilised as a strong prevention slogan throughout the campaign.

Scotland's national initiative made distinctive recommendations to conquer negative stigma associated with dementia through research and publications. In 2008, the Scottish Government established the Dementia Clinical Research network, with over 1 million Euros in funding. The continuation of the research network in educating the general public helped negate the stigma associated with dementia. In addition to research initiatives, the Scottish Parliament's Cross-Party Group on Alzheimer's disease published, *Charter of Rights for People with Dementia and their Carers in Scotland*. The document was based on the recognition that a great stigma existed about individuals with dementia and that people with dementia and carers often experience discrimination and isolation. The document established that individuals with dementia and their care providers have the right to participate in the decision making process, are accountable for human rights and freedoms, can be free from discrimination, and should consider themselves empowered to access all levels of care and have the full range of legal

*Early Detection, Access to Diagnosis, and Stigma Reduction*

human rights regardless of diagnosis. The central messages to the publication were similar to that of the other national campaigns; however Scotland's production of a "framework" document could be a strong template for disseminating information in other national plans.

**TABLES:**

TABLE 1: National Dementia Plan Recommendations for Early-Detection and Access to Diagnosis

National Plan	Early-Detection	Access to Diagnosis
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Develop and validate effective cognitive screening/assessment tools.</li> <li>• Development and training in the primary care setting.</li> </ul>	<ul style="list-style-type: none"> <li>• Service plan development: mapping service pathways, assessing service gaps and future analysis.</li> <li>• Assistance in community care setting.</li> <li>• Address specific barriers and target vulnerable populations for diverse service models.</li> </ul>
<b>England</b>	<ul style="list-style-type: none"> <li>• Nationwide access to pathway of care with specialist assessment.</li> <li>• Emphasis on detection before crisis.</li> </ul>	<ul style="list-style-type: none"> <li>• Rapid, accurate and sensitive communication with diagnosis.</li> <li>• Rid ambiguity in who makes formal diagnosis.</li> <li>• Delivery of new specialised service.</li> </ul>
<b>France</b>	<ul style="list-style-type: none"> <li>• National reference center targeting early-onset Alzheimer's disease patients.</li> <li>• Care strategy to improve access.</li> </ul>	<ul style="list-style-type: none"> <li>• Diagnosis at specialist memory consultation with specific treatment plan.</li> <li>• Secondary consultation service.</li> </ul>
<b>Republic of [South] Korea</b>	<ul style="list-style-type: none"> <li>• National coverage for public health centers.</li> </ul>	<ul style="list-style-type: none"> <li>• National Dementia Centre.</li> <li>• Increase number of trained dementia specialists.</li> </ul>
<b>Netherlands</b>	<ul style="list-style-type: none"> <li>• General practitioners (GPs) have knowledge to make a formal diagnosis.</li> <li>• GPs aware of secondary services.</li> <li>• Increased public accessibility to information.</li> </ul>	<ul style="list-style-type: none"> <li>• Offset limited known pharmacological interventions.</li> <li>• Interagency collaborations.</li> </ul>
<b>Norway</b>	<ul style="list-style-type: none"> <li>• Development of effective evaluation tools.</li> <li>• ICT-based evaluation and diagnostic tool.</li> </ul>	<ul style="list-style-type: none"> <li>• Interdisciplinary approach to diagnosis.</li> <li>• Fill missing links in care chain.</li> <li>• 4-year action programmed for specialist health services.</li> </ul>

<b>Scotland</b>	<ul style="list-style-type: none"> <li>• Patient and family carers overcome fear associated with stigma to increase access to diagnoses.</li> </ul>	<ul style="list-style-type: none"> <li>• Overcome GPs reluctance to diagnose dementia.</li> <li>• Increase the number of formal diagnoses.</li> </ul>
<b>Wales</b>	<ul style="list-style-type: none"> <li>• Early detection and diagnosis included in top 4 priority areas.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop training packages.</li> </ul>

Table 2: National Dementia Plan Recommendations for Stigma Reduction

<b>National Plan</b>	<b>Stigma – Reduction</b>
<b>Australia</b>	<ul style="list-style-type: none"> <li>• Administer dementia literacy survey.</li> <li>• Community awareness programmes with key messages.</li> </ul>
<b>England</b>	<ul style="list-style-type: none"> <li>• “What is good for your heart is good for your head” Campaign.</li> <li>• Develop and deliver general public information campaign.</li> </ul>
<b>France</b>	<ul style="list-style-type: none"> <li>• Conduct qualitative study/survey to assess knowledge and attitudes.</li> </ul>
<b>Republic of [South] Korea</b>	<ul style="list-style-type: none"> <li>• Public awareness.</li> <li>• Media cooperation.</li> </ul>
<b>Netherlands</b>	<ul style="list-style-type: none"> <li>• Information easily accessible.</li> <li>• Make dementia easier to discuss, less taboo.</li> </ul>
<b>Norway</b>	<ul style="list-style-type: none"> <li>• Development of information measures.</li> <li>• Informational campaign.</li> </ul>
<b>Scotland</b>	<ul style="list-style-type: none"> <li>• Issued publication.</li> <li>• Research network and information dissemination network.</li> </ul>
<b>Wales</b>	<ul style="list-style-type: none"> <li>• Inclusion of dementia in health campaigns and increased communication.</li> <li>• One of four priority areas.</li> </ul>