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Addressing Dementia in Canada: The Current State, Challenges and Opportunities for Improving Care for People Living with Dementia

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Executive Summary

The need to improve dementia care systems in Canada is now more critical than ever. This report, the second in a three-part annual series, examines the current state of Canada's dementia care systems from diagnosis to death, exploring their strengths, weaknesses and opportunities for improvement. It also presents findings from a policy analysis of current government strategic plans and priorities related to the provision of dementia care across Canada, with a focus on identifying strategic priorities aimed at strengthening Canada's dementia care systems.

Dementia is on the rise in Canada. While estimates vary, the Public Health Agency of Canada (PHAC) reports that nearly half a million Canadians aged 65 and older, or approximately 6% of this population, have been diagnosed with dementia,[1] while the Alzheimer Society of Canada (ASC) has estimated that closer to 772,000 Canadians of all ages, or 8.7% of the older adult population, are living with dementia in 2025.[2,3] Looking ahead, ASC has estimated that nearly 1.7 million Canadians, equivalent to 13.2% of the older adult population, could be living with dementia by 2050, representing a 187% increase from 2021.[2,3a]

However, these figures likely severely underestimate the true prevalence of dementia in Canada. Why? Because it is currently estimated that nearly 61.7% of people living with dementia globally remain undiagnosed,[4] meaning there could actually be between 1.3 and 2 million people currently living with dementia in Canada.

Dementia is a very complex disease that often takes years to diagnose. However, the early detection and diagnosis of dementia is essential for improving the lives of people living with dementia. A timely diagnosis enables people living with dementia and their caregivers to begin receiving pharmacological and non-pharmacological treatments, prepare for the future, seek help and support and ultimately focus on what matters most to them.

Despite this, many people living with dementia in Canada may not be able to receive a timely diagnosis. Barriers to receiving a dementia diagnosis include limited public awareness of the signs and symptoms of dementia, as well as the fear and stigma associated with receiving a diagnosis.[5–9] These challenges often mean that people living with dementia do not seek a diagnosis and do not receive care that acknowledges their needs, and that their caregivers are left to provide an increasing

[a] The ASC estimation is based on their Landmark Study, a microsimulation model that developed projections from the data available at the time (e.g., the 2016 Canadian census).[2] Accordingly, these numbers should be interpreted with caution.

level of support that is invisible to the health and social care system. There are systemic challenges too, including the fact that 60% of primary care providers in Canada report limited confidence in their ability to both diagnose and manage the care of a person living with dementia, while people living with dementia face lengthy waitlists to access specialist care, hospitals and their care providers have not been designed to be dementia-friendly or to provide appropriate care for people living with dementia. Finally, the long-term care (LTC) sector, spanning both community and institutional settings, is unprepared and severely under-resourced to provide ongoing community-based dementia care and support.

In recent decades, several nations around the world have worked to better prepare for their anticipated increases in dementia cases through the development of national dementia strategies and policy frameworks. Government dementia strategies typically describe a plan or framework that identifies critical strategic areas and goals and outlines how governments will be responsible for achieving these objectives. Canada joined these efforts in 2017, when it became the last G7 country to develop a national dementia strategy, which came into effect in 2019.[10,11]

To understand the roles governments at the federal, provincial and territorial levels have played in addressing and strengthening the provision of dementia care, this report presents the findings of a document policy analysis of government strategic plans and priorities aimed specifically at improving Canada's dementia care systems.

While the national dementia strategy and its accompanying annual progress reports acknowledge goals around improving care, its commitments remain high-level and not care systems focused.[10,12–18] Given that the delivery of health care is primarily a provincial or territorial responsibility, Canada's national dementia strategy has played a limited role, both in scope and in time, in directly shaping the delivery of care. Nonetheless, there remains a compelling opportunity to develop a national dementia care standard, including a care pathway, to provide greater consistency and accountability across Canada's 13 jurisdictions for Canadians living with dementia and their caregivers.

The NIA found that over the last 15 years, the federal government and nearly all provincial and territorial governments have identified dementia as a key priority. However, the focus, extent and impact of their plans have varied considerably across the country. Only seven of Canada's 10 provinces have developed a dementia strategy since 2010, with the most recent being released by New Brunswick in 2026.[19–26] None of the territories has a dementia strategy, though the Yukon has indicated that the development of one is underway.[27] Additionally, Ontario is currently developing a dementia framework.[28] Eight provinces and all three territories have also developed seniors strategies, though the depth of their dementia-specific care commitments has varied within these.[29–44] Several provinces have provided progress reports or subsequent action plans on their seniors or dementia strategies, which have allowed the NIA to develop an understanding of how care and support are being advanced.[27,45–57]

All dementia strategies identified in the NIA's analysis have included objectives related to improving the care systems for people living with dementia, though care systems priorities varied considerably across provinces. Canada's three territories and eight provinces have released seniors strategies, with the majority including at least one strategic objective related to strengthening their dementia care systems.

For this report, the NIA also expanded its search beyond dementia and seniors strategies to capture dementia care initiatives prioritized within other care systems strategies. This included ministerial annual reports (from

ministries related to seniors or the provision of health and LTC), the most recent health care strategic plans, LTC strategies and frameworks and documents related to end-of-life or palliative care. From this, the NIA identified 15 series of provincial and territorial ministerial annual reports;[58–69] 13 health system strategies;[70–83] six LTC strategies or frameworks;[84–89] eight end-of-life or palliative care frameworks with three progress reports;[90–100] and four other types of government reports to include in this analysis.[101–105]

In total, every province and territory has announced at least one strategy or initiative associated with improving dementia care; however, the type, scope and distribution of these supports have varied greatly across Canada.

The NIA's analysis found that federal, provincial and territorial governments across Canada can do more to establish clear, yearly metrics of success tied to their strategic goals related to the provision of dementia care, and to ensure that this data is made publicly available and easily accessible. Furthermore, while governments have undertaken numerous initiatives aimed at improving their dementia care systems, additional efforts are needed to move toward more cohesive, comprehensive and sustained dementia-focused care systems, including the creation of a national dementia care standard and a formalized care pathway. These initiatives would better support people living with dementia and their caregivers in Canada across all stages of their dementia care journeys.

To further contextualize the current state of Canada's dementia care systems on an international basis, this report also examines the efforts of three other countries: England, Scotland and Denmark. These countries have each demonstrated excellence in distinct aspects of providing dementia care. England has stood out for its achievement of exceptionally high dementia diagnosis rates, driven by proactive assessment. Scotland has become internationally recognized for its pioneering post-diagnostic support standard, which aims to ensure all people living with dementia have access to structured, person-centred support following a diagnosis. Finally, Denmark has become recognized for its strong emphasis on the provision of community-based care coordination, rehabilitation and dementia-friendly communities and care environments. Taken together, these international examples demonstrate that meaningful, system-wide progress in dementia care is achievable, offering clear lessons for how Canada might strengthen its own dementia care systems from diagnosis through to the provision of end-of-life care.

In response to these gaps, this report concludes by presenting four key recommendations:

1. Create a national set of dementia care standards that can strengthen and improve provincial and territorial dementia care systems to provide the best possible evidence-based care and support for all Canadians and their caregivers.

2. Enable and empower Canada's care providers to adopt best care practices across the continuum of dementia care.

3. Improve equity and inclusivity in the provision of culturally safe and appropriate dementia care.

4. Create common metrics that can be monitored to measure Canada's progress in delivering high quality dementia care across each of its provincial and territorial dementia care systems.

Introduction

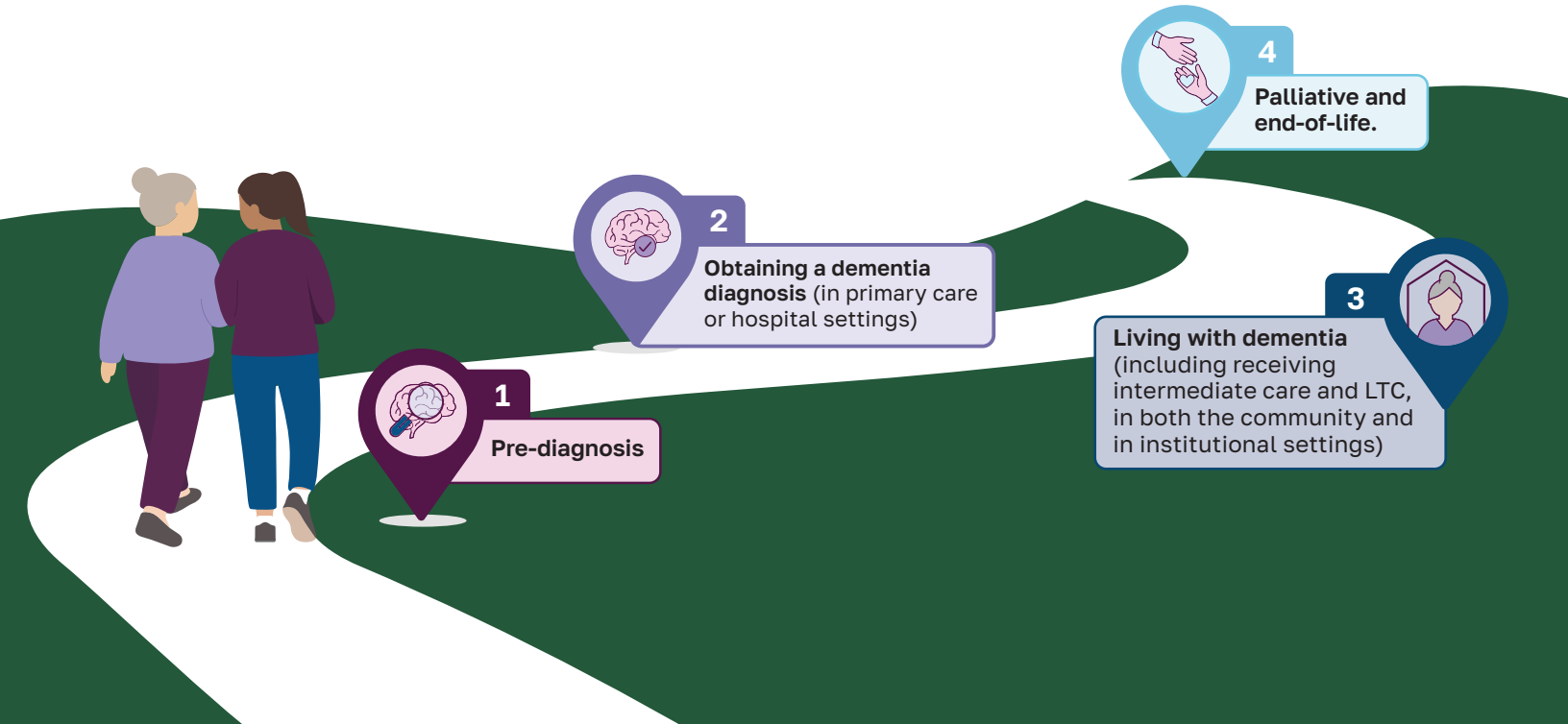
The Dementia Care Journey and Report Overview

People living with dementia in Canada are likely to interact with the health and social care systems multiple times throughout their dementia care journey to access and receive a variety of services. Dementia care consists of several key pillars of support, including primary care, intermediate care (including specialist and hospital-based care for those who may require it over time), long-term care (LTC) in the community (including home and community-based care) and in institutional settings (including LTC and retirement homes), palliative care and end-of-life care. These pillars of support and the frequency with which they are accessed will vary from person to person.

This report is part of a three-year annual series examining the state of dementia in Canada. The first report explored dementia awareness, stigma and prevention, setting a foundational understanding of Canadians' awareness and perceptions of dementia, and how they can reduce their risk.

This year's report shifts focus to the care systems and care providers that shape the experiences of people living with dementia, recognizing the crucial role that formal health and social care services play throughout individual dementia care journeys. The NIA equally acknowledges the essential contributions of unpaid caregivers, and thus their experiences will be the central focus of the third and final report in this series, along with an exploration of what's needed to create more dementia-inclusive communities across Canada.

The following sections of this report will explore the current state and experience of Canada's care systems for people living with dementia. The NIA will first provide an overview describing the general state of dementia in Canada. Then, the NIA will discuss which care systems and paid care providers people living with dementia are likely to interact with during the various stages of their dementia care journeys. This will include an exploration of both similar and different care practices and experiences across Canada, and innovative practices and emerging issues in the following stages that characterize dementia care journeys:



The NIA will then examine the current dementia care policy landscape across Canada to identify actions being taken to improve the dementia care experiences of Canadians living with dementia. The NIA will further analyze international dementia care strategies, highlighting three specific countries that exemplify effective approaches that Canada's dementia care systems could learn from. Finally, the NIA will discuss current gaps and challenges and highlight best practices observed across Canada's dementia care systems. Specifically, issues such as the overall fragmented nature of Canada's dementia care systems, the longstanding history of under-funding and under-development of care for older adults and people living with dementia, the challenges faced by Canadian health care providers and the lack of inclusive dementia care will be explored.

The NIA's Definition of Long-Term Care (LTC): For this report, the NIA specifically uses its broader definition of LTC rather than what is traditionally considered in Canada. The NIA's definition, in line with other common international definitions, encompasses a continuum of care and support ranging from home care and community support services to those being provided in designated care settings like LTC homes, nursing homes or retirement homes.

The NIA defines LTC as a range of preventive and responsive care and supports, primarily for older adults, that may include assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (iADLs) provided by either not-for-profit or for-profit providers, or unpaid caregivers in settings that are not location specific and thus include designated buildings, or in home and community-based settings.

An Overview of Dementia in Canada

"Dementia" is a broad term encompassing various conditions that can cause an often progressive and irreversible decline in a person's cognitive functioning, enough to interfere with their daily life and activities.[106] There are many factors which can impact a person's risk of developing dementia. Some of these factors cannot be controlled and these non-modifiable risk factors include a person's increasing age, genetics and their sex assigned at birth.[107,108] Although dementia does not occur in all older adults, increasing age is the most substantial known risk factor for developing dementia.[109,110]

Independent of but prior to developing dementia, some people can experience a prodromal stage of cognitive impairment known as Mild Cognitive Impairment (MCI). With this condition, a person experiences cognitive decline beyond that expected for their age and level of education, but not to the extent that it significantly impairs their daily life and performance of their daily activities.[111] Although 25% of MCI cases are potentially reversible,[112] MCI may represent a prodromal stage of some diseases, like Alzheimer's, and progress further into dementia. Indeed, people with MCI are at an increased risk of experiencing dementia, with 15% of people developing dementia within two years, and over 33% develop dementia due to Alzheimer's disease within five years.[113,114] However, there is growing evidence that the progression of MCI towards dementia can be prevented or delayed by addressing certain risk factors.[115,116] It is currently estimated that just under 25% of the older adult population globally may be living with MCI as opposed to dementia.[117]

While dementia significantly impacts the lives of many Canadians, most are older adults. According to the Public Health Agency of Canada (PHAC), the majority of people living with dementia are over the age of 65, with only 3% of Canadians living with dementia being under the age of 65.[106]

In 2023-2024, approximately 6% of Canadians aged 65 years and older had been diagnosed with dementia, with the total number of estimated cases among this age group around half a million, according to PHAC.[1]

This low overall prevalence rate, however, belies the fact that the current prevalence rates of dementia double with every five-year age group from ages 65-69 until 85-89, with a prevalence of around 1% among adults 65 to 69, increasing to around 20% among those aged 85 to 89.[1] Further, it is also currently estimated that almost 30% of Canadians older than 90 years of age are living with some form of dementia.[1] As Canada is currently a "super-aged" nation, with 20% of its population being 65 years and older,[118,119] dementia must be treated as a core strategic priority for its care systems — especially as Canada's older population will, over the coming decades, consistently represent close to 25% of its overall population.

Alzheimer's Disease

- Makes up about **60-80%** of dementia cases
- Characterized by the presence of amyloid plaques and tau tangles in the brain
- Symptoms include memory loss; difficulty with language and communication; impaired visual and spatial abilities; problems with reasoning and judgment; and challenges with complex tasks, planning, and organization

Vascular Dementia

- Makes up about **15-25%** of dementia cases
- Characterized by vascular diseases or injuries interfering with the brain's blood supply
- Symptoms include problems with thinking speed, problem-solving and judgement; executive functions like planning and organizing; impaired motor skills; and difficulty with language and communication

Frontotemporal Dementia

- Makes up about **10%** of dementia cases
- Characterized by deterioration to the frontal and temporal lobes of the brain
- Symptoms include personality and behaviour changes; problems with movement; and language/speech difficulties

Lewy Body Dementia

- Makes up about **5-10%** of dementia cases
- Characterized by the presence of alpha-synuclein protein deposits ("Lewy bodies") in the brain's nerve cells
- Symptoms include fluctuations in thinking and alertness; visual hallucinations; and movement and sleep problems similar to Parkinson's disease

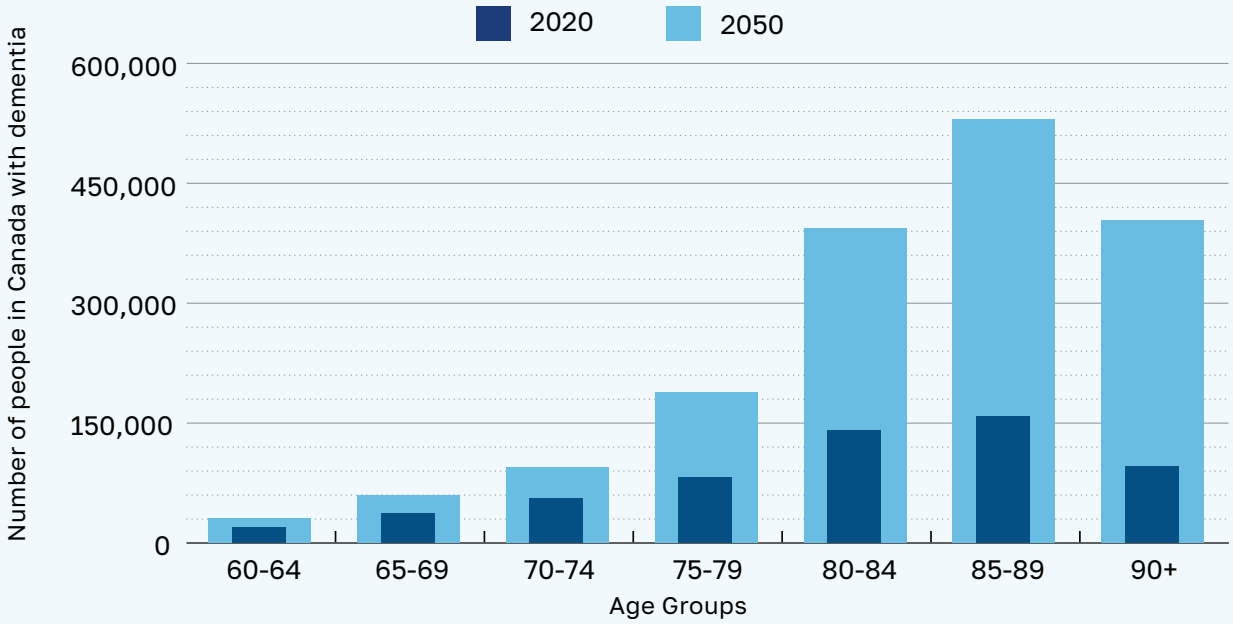
Other Dementias

- Include dementias related to Creutzfeldt -Jakob disease, HIV, Huntington's disease, Wernicke-Korsakoff syndrome, Parkinson's disease and other conditions

Mixed Dementia

- Two or more types of dementia affecting a person at the same time, such as a person having both Alzheimer's disease and vascular dementia (the most common form of mixed dementia)

Figure 1: The Number of People in Canada Living with Dementia by Age Group, for 2020 and 2050.[2]



	2020	2050
Total number of people living with dementia	**597,300**	**1,712,400**

From "Alzheimer Society of Canada. (2022). Navigating the path forward for dementia in Canada: The Landmark Study, Report 1."[2]

The Alzheimer Society of Canada's (ASC) Landmark Study used data modelling methods to estimate the impact of dementia in Canada between 2020 and 2050.[2] According to this study, close to 772,000 Canadians of all ages, equivalent to 8.7% of the older adult population, are expected to be living with dementia in 2025.[2,3] The number of Canadians expected to be living with dementia is expected to reach nearly 1 million by 2030,[2,3,109] which is the year the youngest and oldest members of Canada's baby boom generation will be turning 65 and 85 years of age, respectively. The ASC further estimates that nearly 1.7 million Canadians, equivalent to 13.2% of the older adult population, could be living with dementia by 2050 (an 187% increase from 2021; see Figure 1), and the number of caregivers of people living with dementia will rise to over 1 million, nearly tripling the number of caregivers in a 30-year period.[2,3]

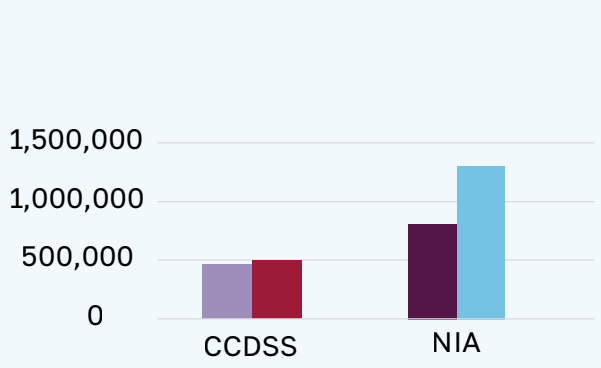
The early detection and diagnosis of dementia is essential for improving the lives of people living with dementia. However, what is more concerning than the currently reported and estimated numbers is that the actual number of people living with dementia in Canada is likely much higher than what PHAC or the ASC's Landmark Study suggest.[120]

While there are no precise, universally agreed-upon current estimates of Canadians currently living with undiagnosed dementia, research indicates it is likely significant and remains a largely hidden issue. Current global estimates of the proportions of people living with dementia who do not have a diagnosis range between 61.7% to 75%.[4,5] These estimates vary among countries and regions, with the United Kingdom (UK) having some of the best reported diagnosis rates, which is why its estimated rate of undiagnosed dementia is 43.1%; the rate stands at 58.2% in Europe (excluding the UK) and 60.7% in the United States.[4] Concerningly, Canada's rates of undiagnosed dementia have been estimated to be as high as 70.7%;[4] however, this figure should be interpreted with caution, as it was based on two regional studies published in 1993 and 2013 and may not be representative of the current overall population in Canada.[4] In the coming years, data from the Canadian Longitudinal Study on Aging (CLSA), a national, stratified longitudinal cohort study of more than 51,000 Canadians aged 45 to 85, with data collection ongoing since 2011,[121] are expected to provide more robust, population-representative estimates of dementia prevalence and the proportion of undiagnosed cases across Canada.[122]

Therefore, when applying the overall estimated global rate of undetected dementia of 61.7%, which was largely estimated among other OECD (Organization for Economic Cooperation and Development) countries, there could be between 1.3 and 2 million people living with dementia in Canada currently, with and without a diagnosis. As previously noted, given that just under 25% of the older adult population globally may have MCI,[117] a potentially sizeable portion of Canada's current older population may be living with a significant level of cognitive impairment and not receiving the medical attention they need. See Figure 2 for a comparison between the current existing population estimates and the detected and undetected dementia cases in Canada.

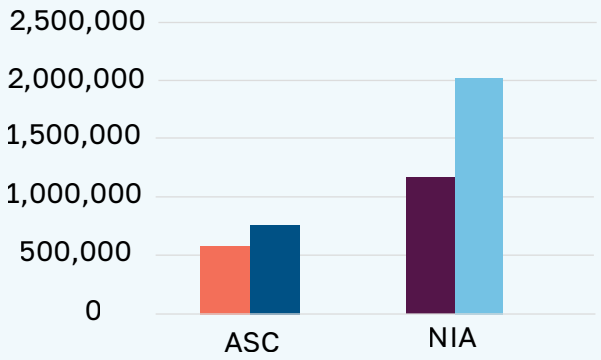
Figure 2 A & B: Comparison of Estimated Numbers of Canadians Living with Diagnosed and Undiagnosed Dementia, based on data from the Canadian Chronic Disease Surveillance System (CCDSS)[1] and the Alzheimer Society of Canada (ASC).[2]

A) Current Estimates of Diagnosed Dementia and Calculated Undiagnosed Cases, based on CCDSS data



- Population Estimates (2020)
- Population Estimates (Most Recent Estimates)
- NIA Calculated Undetected Dementia (Using Most Recent Estimates)
- NIA Recalculated Total Dementia Cases in Canada (Diagnosed and Undiagnosed)

B) Current Estimates of Diagnosed Dementia and Calculated Undiagnosed Cases, based on ASC data



- Population Estimates (2020)
- Population Estimates (Most Recent Estimates)
- NIA Calculated Undetected Dementia (Using Most Recent Estimates)
- NIA Recalculated Total Dementia Cases in Canada (Diagnosed and Undiagnosed)

* Canadian Chronic Disease Surveillance System (CCDSS) estimates based on 2019-2020 and 2023-2024 surveillance data;*[2] ASC estimates were as of January 1, 2025.[3b]

[b] CCDSS estimates are derived from administrative health data;[123] ASC estimates are based on modelling simulations from the Landmark Study Report #1.[2] Undetected dementia was calculated with the following formula: $\frac{\text{Most recent estimate} * 100}{38.3}$

Why Dementia Diagnosis Rates Are Estimated to Be So Low for Canada

There are numerous reasons why many people across Canada struggle to receive a timely diagnosis of dementia, stemming from a variety of complex factors, including:

- gaps in public awareness (e.g., knowledge of signs and symptoms);[6,7]
- anosognosia, the inability to recognize one's own illness;[124]
- ageist attitudes amongst the general public and also embedded in training, clinical guidelines and care norms of health care providers, which further reduce the quality of care provided for people living with dementia;[125]
- fear and stigma associated with dementia that delay help-seeking;[5–8]
- geographic factors that can impact access to care, such as living in rural or remote areas and experiencing transportation challenges;[6]
- structural barriers within current care systems, including a lack of culturally safe screening tools, language interpretation and provider training, that produce unequal access to diagnosis (particularly for underserved and equity-deserving populations) and overall poor care equity;
- differences in provincial/territorial health care systems that create care gaps, including access to primary care, specialized health services and/or tests to receive a diagnosis, gaps that compound for racialized, immigrant and other populations already facing systemic barriers to care;[6,126] and
- the complex nature of diagnosing dementia, as it may take years to conduct multiple assessments or tests to rule out other potential causes of cognitive impairment.[5]

A lack of public awareness may contribute to people not understanding the signs and symptoms of dementia. For example, many people believe that serious declines in their cognition are a normal part of ageing.[5–7] Furthermore, certain personality and behavioural changes may not be recognized as potential signs of dementia. Thus, if a person is in the early stages of dementia, they or their family members and friends may not seek help until the symptoms become more noticeable or challenging to manage.

Some individuals living with dementia may also experience anosognosia during the course of their illness, a condition in which they are unaware of their neurological or psychiatric deficits.[124] Anosognosia may affect anywhere from 20% to 80% of people with dementia, highlighting its widespread impact.[127] This lack of awareness can significantly affect one's ability to recognize symptoms and seek help, ultimately delaying diagnosis and treatment.

Ageism involves stereotypes, discrimination and prejudices based on age.[128] Like members of the general public, health care providers without adequate awareness about what constitutes both normal and abnormal ageing may view health and cognitive changes in an older adult as a normal part of ageing and thus dismiss certain symptoms or neglect to provide adequate care.[125] Indeed, health care providers with better knowledge or training about ageing tend to show fewer ageist attitudes.[129] Thus, like the general public, care providers with a poor understanding of ageing can delay or reduce the quality of care people living with dementia receive. The NIA provides a more thorough discussion of this in the first report of this series.[130]

Fear and stigma around dementia may prevent the person with suspected dementia or their family from getting a diagnosis, and additionally, doctors may be reluctant to give such a diagnosis.[5–9] Public opinion surveys suggest that dementia is feared almost equally or more than cancer.[131,132] Results across multiple Canadian surveys demonstrate the following: 9% of respondents would not be comfortable having a discussion with a health care provider about their personal risk of developing dementia;[133] 7% were not comfortable asking a health care provider for information about dementia leading to a diagnosis;[134] and 24% would not want to know if they had Alzheimer's disease or another form of dementia.[ci] Surveys conducted by the NIA suggest that 6% of people would not be comfortable obtaining an assessment and diagnosis for dementia, and 9% indicated they were unsure about their comfort levels.[d] Commonly reported fears or concerns included the fear of the diagnosis, worry about the future, being treated differently by others, losing independence, losing their sense of self, becoming a burden on others, feeling there is nothing that can be done or being embarrassed.[134E] Furthermore, these findings and barriers are not evenly distributed. Box 1 further explores how to challenge the stigmatizing discourse around dementia.

Box 1: Challenging the Stigmatizing Discourse Around Dementia

One notable challenge with providing dementia care is the common lens through which dementia is viewed. Dementia is a highly stigmatized condition, with much of the language surrounding it being strong and negative,[135,136] and some accounts even describing living with dementia as being "worse than death."[137]

This mindset is pervasive throughout the health care system, which uses a biomedical, loss-focused approach. Thus, health care professionals often provide little hope and support following a dementia diagnosis and may even decide to forgo a diagnosis as they do not see the point in giving one.[5,6,8] If they do give the diagnosis, the message they send can be described as "prescribed disengagement."[138] In other words, people diagnosed with dementia are told to simply "give up."

Kate Swaffer, a person living with dementia, coined the term "prescribed disengagement" based on her experience being diagnosed with dementia:

> Dementia is the only disease or condition and the only terminal illness that I know of where patients are told to go home and give up their pre-diagnosis lives, rather than to 'fight for their lives'.[138]

These beliefs surrounding dementia have contributed to what is known as the "tragedy discourse." While people without cognitive impairment may view the loss of cognition as the loss of self,[139] it is people's stigmatizing behaviour towards those living with dementia, rather than the dementia itself, that takes away their personhood.[140]

[c] All data derived from a Canadian online survey via Leger's LEO panel, with n = 1,606 Canadian residents aged 18+.

[d] National Institute on Ageing, unpublished data from the 2025 NIA Ageing in Canada Survey, 2026.

Following a dementia diagnosis, people living with dementia reportedly felt they were encouraged to become dependent on others and were not encouraged to be actively engaged in their own health care decisions.[141] They may have been forced to give up their jobs by employers, rather than receive workplace accommodations.[141] These responses to a dementia diagnosis have resulted in people living with dementia feeling that the social consequences of their diagnosis were more detrimental to their lives than the disease itself.[136] It is important to recognize that these responses stem from ingrained and pervasive societal narratives about dementia rather than from a deliberate intent to cause harm. Nonetheless, defaulting to a loss-focused, tragedy discourse perpetuates a negative approach to dementia care and risks undermining the well-being and agency of people living with dementia.

Instead, there exists an alternative emerging discourse that focuses on "living well" with dementia. Living well reflects the "best achievable state of health that encompasses all dimensions of physical, mental and social well-being," and is shaped by the physical, social, and cultural surroundings as well as the effects of the chronic disease.[142] Ultimately, the living well discourse focuses on the capabilities and personhood of people living with dementia. One limitation of the living-well discourse is that it does not allow room for "living-poorly."[143] As dementia is a progressive, neurodegenerative condition, people living with dementia will have good and bad days. Thus, while it is important to focus on what it means to live well with dementia, it is also important to account for the real challenges people living with dementia experience, so as not to negate their negative experiences while ensuring continued effort and investment in their wellbeing.[143] What it means to live well should be regularly recalibrated based on where the person living with dementia is on their dementia journey, and on other factors that might impact their lives, such as physical, social or financial issues.

In the context of care systems, the living well discourse may encourage a greater focus on providing person-centred care and can help people living with dementia remain involved in their health care decisions, as well as facilitate authentic care partnerships.[136,140,144] It is important for all care providers working with people living with dementia to reflect on their own perceptions, and to recognize bias and how negative attitudes and resulting behaviours may be counterproductively impacting a person living with dementia. In all, finding a way to adopt the "living well" discourse into dementia care journeys may help promote better dementia care and support across Canada.

There are also several demographic factors impacting obtaining a dementia diagnosis. Individual characteristics, such as being younger (<70 years of age), being a man, being unmarried, experiencing language barriers and having a lower education or socioeconomic status, have been associated with being less likely to receive a dementia diagnosis.[4,6,145,146]

A primary care provider (PCP) refers to a regulated health professional who serves as the first point of contact within the health care system and provides ongoing, comprehensive care across lifespan. In this report, a PCP includes family physicians and nurse practitioners, both of whom are authorized to assess patients, diagnose conditions, initiate and manage treatment, prescribe medications and coordinate referrals to specialist and community-based services.

Culture can shape how one interacts with and understands dementia. For example, some cultures and languages don't have a word or term for dementia, or the available terminology is negative or has stigmatizing connotations (e.g., terms relating to "madness" or "losing one's mind").[147] Some cultural groups may be more likely to view dementia as a normal part of ageing, while others may attribute dementia to witchcraft, the will of a God or karma for something bad the person had done in the past. These are explanatory frameworks which reflect distinct cultural understandings of illness and causation.[148–151] Explanatory frameworks, alongside shame and stigma, expectations around familial responsibilities and poor awareness of dementia or the normalization of symptoms, may also impact the willingness of individuals to engage with the care system, particularly where the care system itself has not earned trust as a safe or responsive place to seek help.[148–150] While there have been efforts to increase dementia awareness and reduce stigma,[152–154] these efforts have often fallen short of providing professional interpretation, culturally safe assessments, trusted community navigation methods or accessible post-diagnostic support. Stigma reduction has been sporadic, education-oriented and aimed at changing communities rather than integrated into service design, provider accountability, community-led outreach and accessible care pathways. Raising awareness alone, without ensuring safe, trusted and culturally appropriate places for assistance and care, can sustain underlying shame and stigma.

Additionally, systemic failures within care systems can create further barriers. First, nearly half of Canada's care providers report lacking the capacity to deliver culturally appropriate care.[155] This lack of capacity and knowledge trickles through care systems, and many diagnostic tools are not adapted to linguistic and cultural differences.[156,157] Medical communication may not be delivered in a way that meets the patient's language, knowledge and other communication needs.[157,158] Finally, the presence of structural, systemic and interpersonal racism affects how people engage with care systems.[149,159] Thus, non-equitable design of care systems can exacerbate cultural and linguistic barriers, making it difficult for immigrant and racialized communities to access proper dementia care.

While over two-thirds of dementia diagnoses are made in primary care settings,[160] Canadians are currently facing a major crisis in accessing primary care. Almost 18% of all Canadians, and specifically 7% of older adults in Canada aged 65 and older, reported not having a regular PCP in 2024, according to the Canadian Institute for Health Information (CIHI).[161,162] However, surveys conducted by the NIA suggest that as many as 29% of Canadians aged 65-79 and 23% of Canadians aged 80 and older do not have a PCP.[163] As a result, limited access to primary care may further explain why many people living with dementia in Canada remain undiagnosed.

However, even when a person connects with a PCP, their PCP may not feel confident enough to give a diagnosis, or may doubt the usefulness of doing so.[6] Some PCPs may prefer to send their patients with suspected dementia to a specialist for further testing and to obtain a definitive diagnosis, which can be a lengthy process. As a result, it has been previously estimated that 50% of dementia diagnoses in Canada are not made early enough.[6,164] People living with dementia may miss out on the opportunity to proactively develop a comprehensive care plan early in their dementia care journey to support their needs, and their caregivers may fail to receive support before a crisis occurs. Instead, a dementia diagnosis may happen in hospital settings after a major incident has occurred, which could have potentially been avoided with earlier diagnosis and intervention.

Geographical factors impact the ability of many Canadians to get a timely diagnosis of dementia. Generally, people living in rural or remote areas tend to have greater barriers related to accessing care for obtaining a dementia diagnosis.[5,6,9] Additionally, as health care services are organized at a provincial/territorial level in Canada, a person's health care jurisdiction may impact their access to health care services and, consequently, a timely dementia diagnosis. Looking across Canada's provinces and territories (see Table 1), it is interesting to note that while Canada's Atlantic provinces have the oldest populations in Canada,[165] they tend to have lower reported dementia incidence rates compared to other provinces and territories whose populations are relatively younger. Findings from the NIA's 2026 Ageing in Canada Survey on access to health care may help to explain this: Canada's Atlantic provinces, like Newfoundland and Labrador and New Brunswick, had the lowest proportion of residents reporting regular access to a PCP, with less than two-thirds reporting they could access needed health care services most of the time.[166]

Across Canada, Saskatchewan had the lowest reported dementia incidence rate, whereas Manitoba had the highest reported rate (Table 1).[1] These stark differences between these two neighbouring prairie provinces may reflect regional variations in the organization of their health care services, dementia care planning, screening and care practices.

For example: in 2024, while Manitoba and Saskatchewan reportedly had considerably different family physician-to-population ratios, Saskatchewan also had fewer people attached to a family physician, as well as those who were attached having greater difficulty accessing their family physician.[167,168] Additionally, while both provinces had comparable specialist-to-population ratios for neurologists and geriatricians, historically, Manitoba has had greater numbers of geriatricians than Saskatchewan.[168] In fact, there was only 1 geriatrician working in Saskatchewan until 2017, whereas Manitoba has steadily had an average of six physicians consistently practicing geriatric medicine since 2002.[168] However, progress has been made in these two provinces, as both provinces now have nine geriatricians registered with their respective provincial Colleges of Physicians and Surgeons.[169,170] Saskatchewan has fewer psychiatrists overall and a poorer psychiatrist-to-older adult ratio than Manitoba. Finally, Saskatchewan remains Canada's only province or territory that has not developed a dementia or seniors' strategy since 2010, which may further contribute to low diagnosis rates.[130] Furthermore, these high-level comparisons may not capture dementia-focused initiatives within these care systems, including those that have completed the College of Family Physicians of Canada's accredited "care of the elderly" training,[171] which supports the provision of better dementia care in primary care settings,[172] and may reduce the need for specialist referrals. See Table 1 for provincial comparisons.

Similarly, while there have been no reports of geriatricians or neurologists based in any of the Canadian territories, the Yukon had more family physicians per population than the Northwest Territories. Additionally, both the Yukon and the Northwest Territories had two psychiatrists for their entire population in 2025.[168] This variability in the provincial and territorial distribution of health care providers and organization of health care services could explain the observed differences in incidence rates, ultimately contributing to Canada's high estimated rates of undiagnosed cases of dementia.

Obtaining a diagnosis of dementia in Canada is also a lengthy process. Globally, it takes on average 3.5 years for a person living with dementia to receive a diagnosis.[145] In addition to the challenges already discussed in obtaining a diagnosis, diagnosing dementia is a complex process, with no single test that can make a diagnosis of dementia definitively.[173] Often, assessments and testing (e.g. blood tests, neuroimaging, cognitive assessments) need to be conducted to eliminate other possible causes of cognitive impairment (e.g., anemia, depression, vitamin deficiencies). Additionally, certain tests are not culturally appropriate and need to be adapted for the appropriate population being served, such as the Canadian Indigenous Cognitive Assessment (CICA) for Canada's Indigenous population.[174] Specialist referrals may also be needed to help make a diagnosis where uncertainty may exist,[173] although access to a specialist is not equally accessible, especially for immigrants who have reported greater difficulties accessing specialists than Canadian-born individuals.[175]

Ultimately, a timely diagnosis is critical for people living with dementia to get support for their dementia care journey. Delays in diagnosis can have profound consequences, as they often postpone access to available treatments and support services, and planning around a person's future care needs.

Globally, it takes on average **3.5 years** for a person living with dementia to receive a diagnosis.[145]

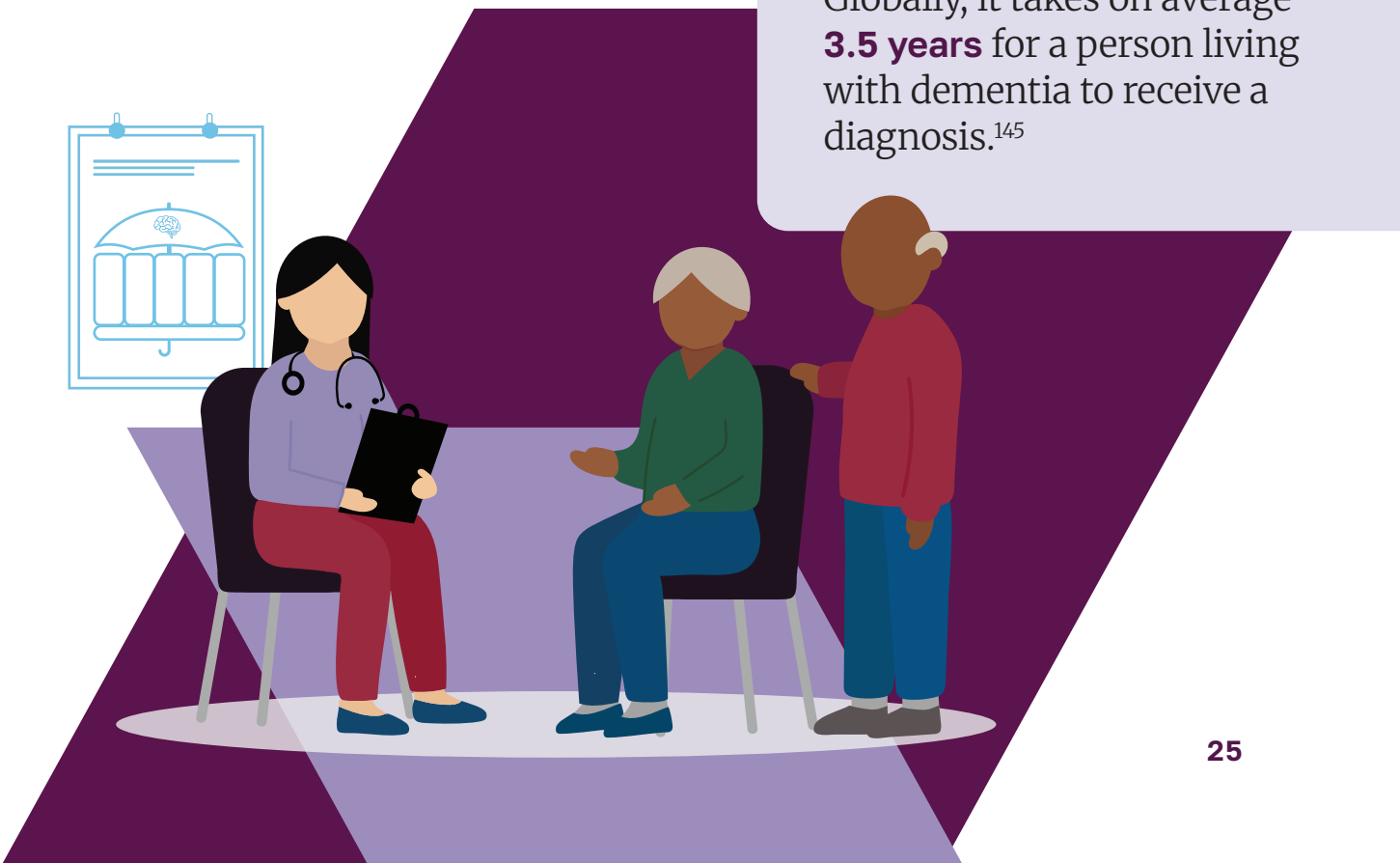


Table 1. Comparison of Dementia Incidence, Population and Number of Health Care Providers Across Canadian Provinces and Territories

	Dementia Age-Standardized Incidence Rate per 100,000 Population (95% CI), 2023–2024[1]	Older Adult Population Aged 65 and Older, 2024[176]	Family Physicians Who Feel Prepared to Manage the Care of People Living with Dementia (%), Commonwealth Fund, 2015[177,178]	Older Adults Attachment to a PCP (%), Across Three National Surveys*[163,179–181]	Family Physicians, 2024[168]		Geriatricians, 2024[168]**		Psychiatrists, 2024[168]		Neurologists, 2024[168]	
					Number Practicing	Older Adults per Provider	Number Practicing	Older Adults per Provider	Number Practicing	Older Adults per Provider	Number of Practicing	Older Adults per Provider
Canada	1329 (1,321–1,338)	7,835,726	40	71-86	36,511	215	421	18,612	5,930	1,321	1,380	5,678
AB	1313 (1,287–1,340)	742,451	36	72-90	4,214	176	36	20,624	679	1,093	206	3,604
BC	1348 (1,327–1,370)	1,129,229	48	73-88	7,320	154	62	18,213	973	1,161	233	4,847
MB	1398 (1,352–1,446)	251,817	43	76-90	1,369	184	7	35,974	192	1,312	43	5,856
NB	Not available	197,263	50	65-83	734	269	10	19,726	97	2,034	23	8,577
NL	1193 (1,131–1,258)	134,891	46	56-76	499	270	3	44,964	85	1,587	12	11,241
NS	1243 (1,198–1,288)	239,758	52	80-83	1,014	236	14	17,126	202	1,187	33	7,265
ON	1332 (1,319–1,345)	2,964,438	36	71-90	13,140	226	154	19,250	2,220	1,335	502	5,905
PE	1153 (1,042–1,273)	36,849	34	60-80	150	246	1	36,849	15	2,457	3	12,283
QC	1367 (1,350–1,384)	1,906,357	41	68-79	7,197	265	129	14,778	1,350	1,412	290	6,574
SK	1085 (1,041–1,130)	218,531	39	72-82	777	281	6	36,422	113	1,934	35	6,244
NT	1122 (767–1,614)	5,024	19	28***	29	173	0		2	2,512	0	
NU	Not available	2,017	19	12***	16	126	0		0		0	
YT	1550 (1,213–1,966)	7,101	19	82***	52	137	0		2	3,551	0	

* Survey sources are the NIA Ageing in Canada Survey (2025), the OurCare Survey (2025) and the Commonwealth Fund survey (2024).
** Does not include geriatric psychiatry.

*** Data only available from the OurCare Survey (2025).

Note: Dates indicate the year in which data were collected, or the survey was conducted, and may not reflect the year of publication.

The Significant Impact of Dementia on Canada's Care Systems

While there are actions individuals can take to reduce their risk of developing dementia (see Box 2), the reality is, dementia isn't entirely preventable and some Canadians will still develop dementia.

The focus of this report will be a discussion of how to better support people living with dementia, from obtaining a diagnosis to receiving timely and appropriate care.

Box 2: Dementia Rates in Canada and the Impact of Prevention

While the number of older adults in Canada living with dementia continues to increase, principally due to Canada's rapidly ageing population,[2] PHAC has also found that the age-standardized incidence rate of older adults who have been diagnosed with dementia each year in Canada has generally decreased over the past two decades.[106] This trend is also observed globally, with incidence rates declining by 13% per decade between 1988 and 2015 in Europe and the United States of America.[182] As a result, fewer people are living with dementia today than was previously predicted; this is likely due to a growing recognition of and efforts to address potentially modifiable risk factors, meaning factors that increase the risk of developing dementia but that individuals may be able to change.

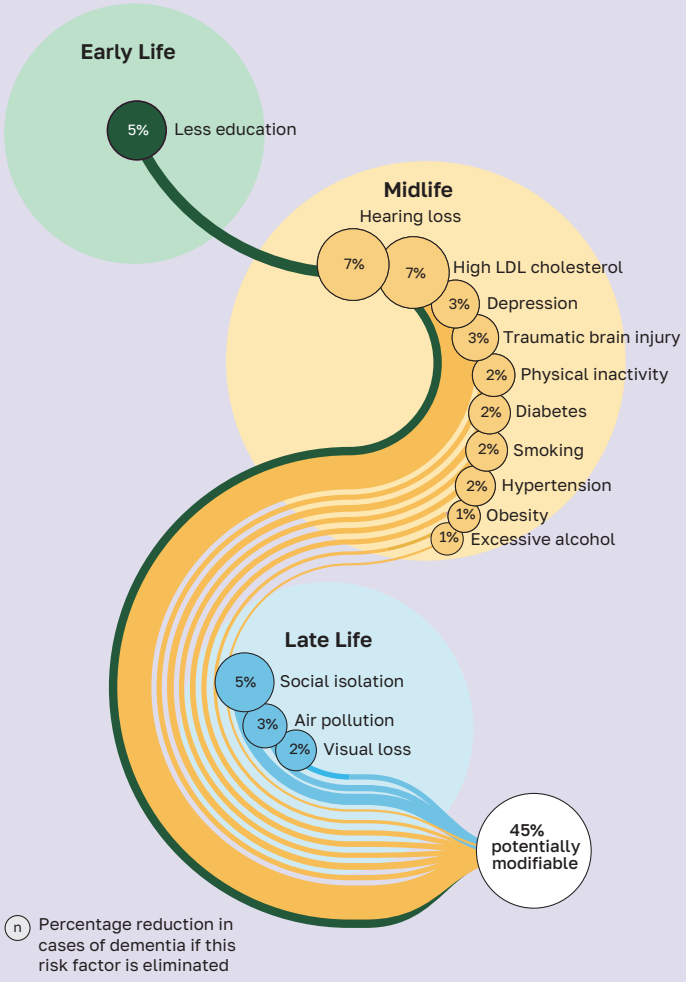
The NIA's first report in this series highlighted the ongoing work of the Lancet Commission on dementia, a global resource developed by experts that comprehensively reviews the latest evidence to identify and quantify potentially modifiable risk factors for dementia.[107] The most recent 2024 update identified a total of 14 potentially modifiable risk factors that are supported by high quality, consistent evidence. These factors are categorized by the life stages where the association with dementia is most prominent:

- early life: lower educational attainment;
- mid life: hearing loss, depression, traumatic brain injury, physical inactivity, diabetes, smoking, obesity, excessive alcohol consumption, hypertension and high low-density lipoprotein [LDL] cholesterol (added in 2024); and
- later life: social isolation, air pollution and untreated vision impairment (added in 2024) (See Figure 3).

The Lancet Commission reports that these potentially modifiable risk factors are thought to be attributable to 45.3% of dementia cases globally,[107] and addressing these factors can reduce the risk of developing dementia even in those with increased genetic risk factors.[107] This means that if all 14 of the risk factors were eliminated, 45.3% of global dementia cases could theoretically be prevented. In Canada specifically, the greatest risk factors for developing dementia have been found to be physical inactivity, hearing loss, obesity and hypertension.[183]

If all four of these lifestyle factors were completely eliminated, this could potentially reduce dementia cases by 29.3%; while addressing all 12 risk factors included in the analysis (i.e., physical inactivity, hearing loss, obesity, hypertension, education, social isolation, excessive alcohol consumption, traumatic brain injury, smoking, depression, diabetes and sleep disturbance) would potentially reduce dementia cases in Canada by nearly 50%.[183]

Figure 3: A Life-Course Visualization of the Population Attributable Fraction of 14 Potentially Modifiable Risk Factors Related to Dementia Identified in the 2024 Lancet Commission Report.[107]



From "Dementia Prevention, Intervention and Care: 2024 Report of the Lancet Standing Commission," by G. Livingston, J. Huntley, K. Y. Liu, S. G. Costafreda, G. Selbæk, S. Alladi, D. Ames, S. Banerjee, A. Burns, C. Brayne, N. C. Fox, C. P. Ferri, L. N. Gitlin, R. Howard, H. C. Kales, M. Kivimäki, E. B. Larson, N. Nakasujja, K. Rockwood, ... and N. Mukadam, 2024, The Lancet, 404(10452), 572–628, (https://doi.org/10.1016/S0140- 6736(24)01296-0). Copyright 2024 by Elsevier. Reprinted with permission.[107]

The care implications and their associated economic impact related to dementia are substantial, as dementia is currently considered to be one of the costliest long-term illnesses.[184] The health care costs and out-of-pocket costs of people living with dementia have been found to be nearly 5.5 times greater compared to those not living with dementia.[185] However, the true costs of dementia are difficult to calculate precisely, and thus estimates must be interpreted with caution.

In 2020, it was estimated that the total economic burden of dementia in Canada was $40.1 billion, with over $15 billion being associated with direct health care costs (Figure 4).[186] Given current trends, this could increase by 275% over the next 30 years.[186]

While dementia-related costs will vary across each individual dementia care journey, overall health care cost estimates remain significantly higher for people living with dementia compared to those not living with dementia (Table 2 and Figure 5). While there is some evidence that health care use increases the year before and after a dementia diagnosis is made,[186] people living with dementia, in general, tend to utilize health care services at greater levels compared to others. This increased utilization includes more PCP visits;[187] more emergency department (ED) visits that are on average 2.5 hours longer;[187,188] hospitalization rates that are 65% higher and hospital stays that are up to two times (100%) longer;[188] and more frequent transitions to, and use of, care in LTC home settings towards the end of dementia care journeys.[185,186,189,190] While upwards of 61% of people living with dementia live outside LTC home settings (often depending on the support of home and community care services, family and friends or private care providers) it is estimated that upwards of 70% of those who end up living in Canada's LTC homes are living with dementia.[189,191]

Figure 4: The Indirect and Direct Costs of Dementia Care in Canada.[186]

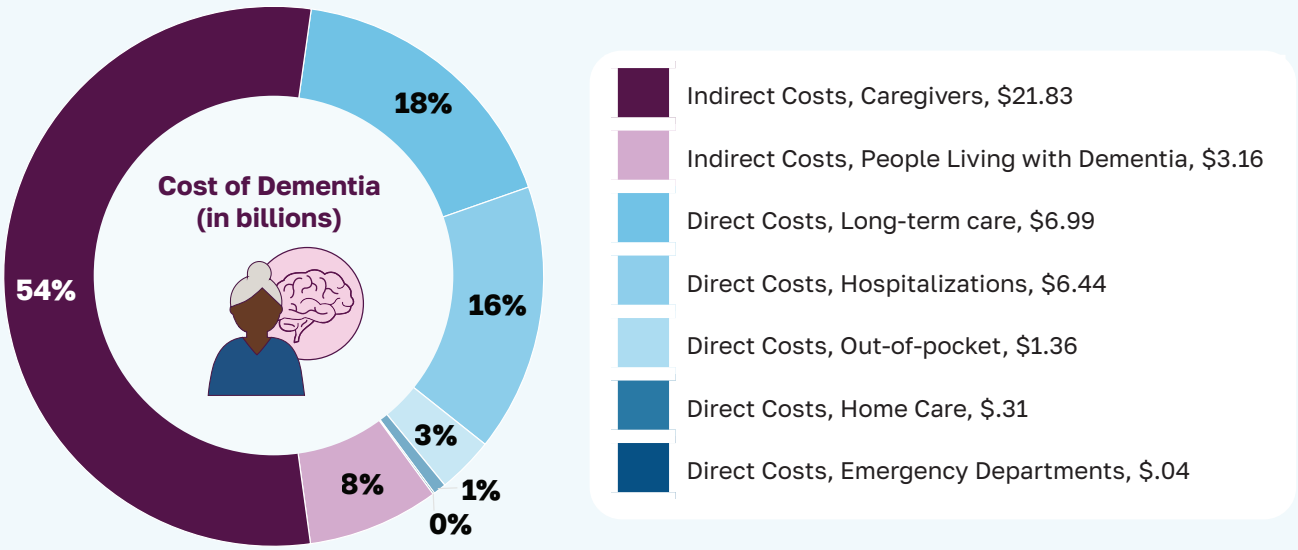
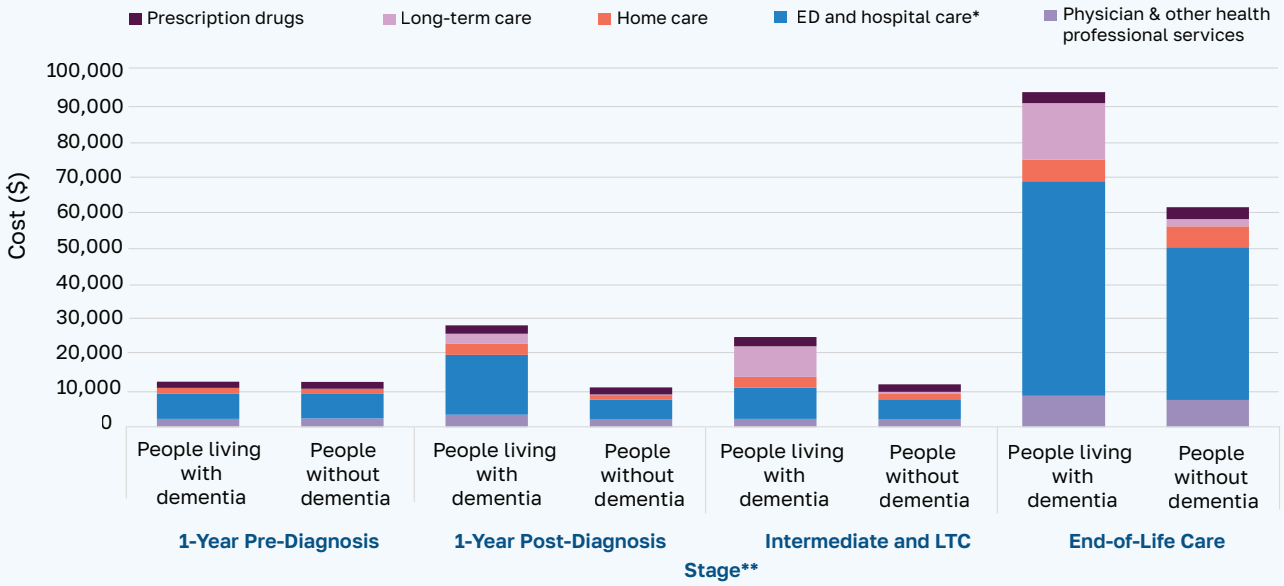


Table 2. Phase-Based Health Costs for People Living with Dementia Compared with People Without Dementia Throughout the Dementia Journey. Data provided by Bronskill et al. (2025).[190]

Sector	1-Year Pre-Diagnosis		1-Year Post-Diagnosis		Intermediate and Long-Term Care		End-of-Life Care	
	People living with dementia	People without dementia	People living with dementia	People without dementia	People living with dementia	People without dementia	People living with dementia	People without dementia
Physician & other health professional services	2,344	2,467	3,535	2,179	2,345	2,154	8,933	7,742
Prescription drugs	1,738	1,950	2,411	1,973	2,622	2,161	3,121	3,362
Ambulatory care	1,307	1,925	1,565	1,663	1,118	1,704	3,305	5,334
Home care	1,666	1,325	3,135	1,296	3,068	1,484	6,109	5,909
Rehabilitation services	690	506	1,239	402	515	433	1,366	1,621
Complex continuing care	648	545	2,684	485	1,706	485	6,741	4,659
Long-term care	0	0	2,858	157	8,707	601	16,096	2,091
Emergency departments	521	399	637	339	441	357	2,253	1,756
Inpatient hospital care	3,779	3,655	10,068	2,684	4,505	2,718	46,272	29,948
Psychiatric inpatient hospital care	195	97	788	85	576	84	965	61
Total*	**13,041**	**13,078**	**29,079**	**11,456**	**25,774**	**12,367**	**95,147**	**62,799**

*Selected sector-specific costs are shown and may not sum to the total health system cost.

Figure 5: Phase-Specific Mean Annual Health System Costs in 2018 Canadian Dollars, Adapted from Bronskill et al. (2025).[190]



* ED and hospital care includes inpatient hospital and psychiatric inpatient hospital care, ambulatory hospital care, hospital-based rehabilitation services and complex continuing care.

** Pre-diagnosis represents the one year before diagnosis; diagnosis represents the one year after diagnosis; end-of-life phase represents the one year approaching death.

Much of the economic impact related to dementia comes at the cost of unpaid caregivers for the person living with dementia. In Canada, the economic impact of unpaid care is valued at $25 billion, or 62.5% of the total costs associated with dementia care (Figure 4).[186] Similar proportions are found in high-income countries in Europe at €126 billion [CAD $205 billion], or 58%.[192] For unpaid caregivers and people living with dementia, much of the cost arises from direct out-of-pocket expenses and lost economic productivity. Nationwide, direct out-of-pocket expenses were estimated to be $1.36 billion alone in 2020, but are expected to rise to $2.25 billion in 2030 and $3.81 billion by 2050.[186] The indirect costs of dementia related to unpaid caregiving are far more significant and have also been quantified to represent nearly $21.83 billion in reduced or lost annual productivity (i.e., absenteeism, presenteeism and early retirement) amongst caregivers in the labour force.

Another $3.16 billion has been attributed to the reduced or lost annual productivity by people living with dementia who were in the workforce and were either forced to retire early or remained employed but had higher rates of absenteeism and presenteeism.[186]

Critically, it has been estimated that reducing the onset of dementia by 10 years could decrease the overall economic costs of dementia in Canada by $77 billion annually by 2050, representing a 70% reduction compared with the anticipated costs based on current trends.[186] This reinforces the need to do much more in Canada to reduce the risk and delay the onset of dementia amongst its rapidly ageing population.

It is also clear that despite Canada's best attempts to reduce the onset of dementia and overall future cases, a timely diagnosis remains important to ensure people living with dementia get the help and support they need early on to live meaningful and fulfilling lives post-diagnosis. Critically, it is necessary to ensure that the right care systems are in place to support a dementia care journey — something Canada's current care systems struggle to do.

The State of Dementia Care Practices and Policies in Canada

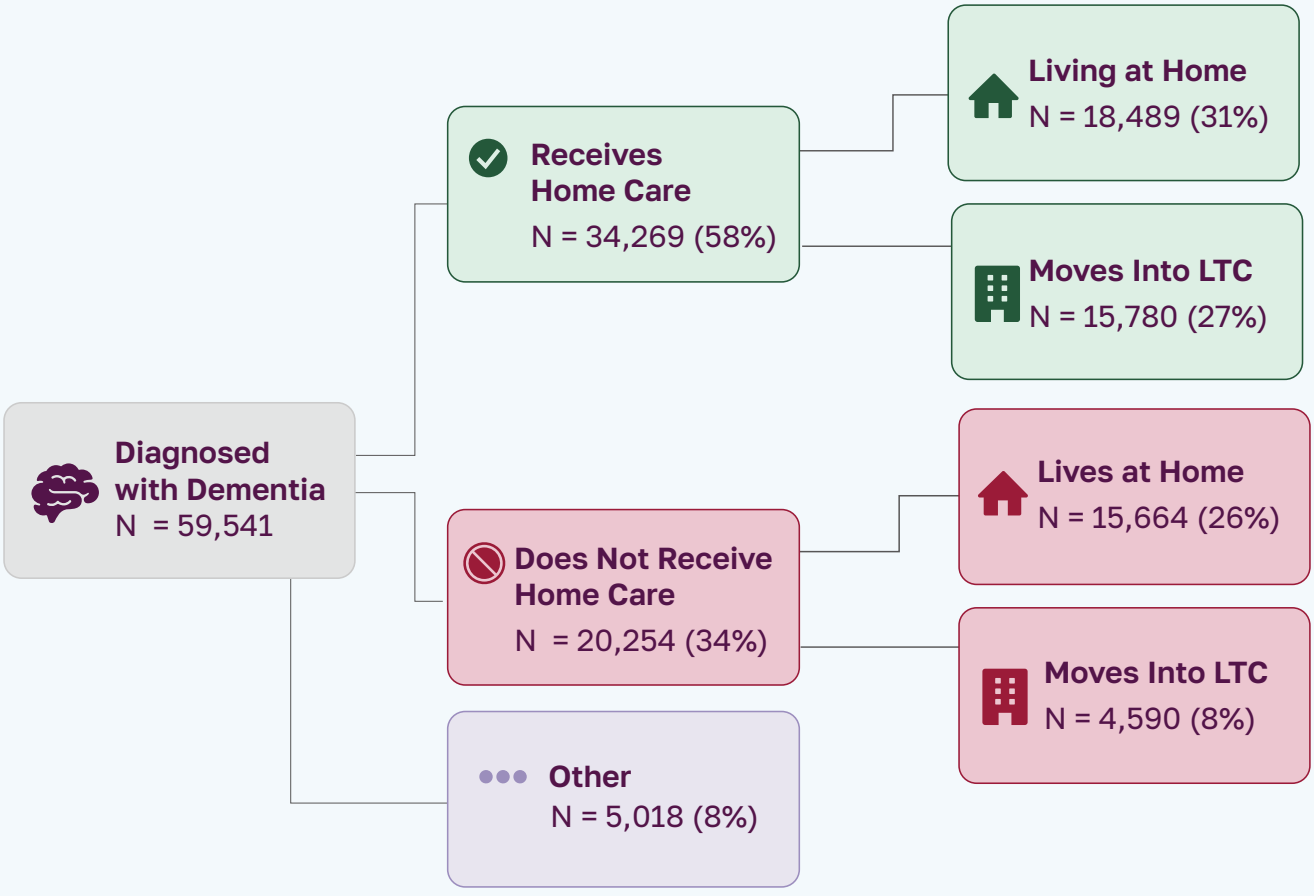
Dementia Care Systems and Practices in Canada

Understanding Dementia Care Patterns and Trajectories

While each person living with dementia will experience their own unique dementia care journey based on their care needs, preferences, values and circumstances, there are some common patterns.

A 2024 study by CIHI identified four common trajectories that 92% of Canadians living with dementia, residing in Alberta, British Columbia, Newfoundland and Labrador and Ontario, experienced within five years of their first health care record related to living with dementia (Figure 6).[160]

Figure 6: Health Care Trajectories for People Living with Dementia in Canada.[160]



These health care trajectories were grouped as follows:

- Received publicly funded home care (58%):
  - Group A: Lives at Home with Home Care — People who lived at home and were only supported by home care (31%).
  - Group B: Moves to an LTC Home after Receiving Home Care — People who originally lived at home and were supported by home care but subsequently moved to a LTC home (27%).
- Did not receive publicly funded home care (34%):
  - Group C: Lives at Home Without Home Care — People who lived at home and were not supported by publicly funded home care and who did not move to an LTC home during the study period (26%). "At home" refers to any setting where people live other than an LTC home. It is typically represented by private homes.
  - Group D: Moves to an LTC Home without Previously Receiving Home Care — People who moved to an LTC home without receiving publicly funded home care (8%); however, it is likely that this group received care from unpaid caregivers and/or private care services not captured by CIHI.
- Others (8%): This includes people who were already living in an LTC home at the time of diagnosis (5%) or were already receiving publicly funded home care prior to their diagnosis (3%).

Notably, over half were still living at home during the first five years of their dementia care journeys. Furthermore, CIHI was unable to capture the levels of both unpaid and privately paid care services that were being provided amongst this overall cohort and how this may have influenced health care trajectories.

Like many people's health care trajectories, one's life expectancy after a dementia diagnosis can vary. While many people living with dementia will die within five years of a diagnosis,[193,194] this has also been found to be impacted by the person's gender and age at their time of diagnosis. Women aged 65 years tended to live about two years longer than men (8.0 years versus 5.7 years, respectively), and women aged 85 years lived twice as long as men of a similar age (4.5 years versus 2.2 years, respectively).[194] Life expectancy post-diagnosis is also dependent on the type of dementia a person has, as people with Alzheimer's disease have longer reported survival rates compared with all causes of dementia in general.[194]

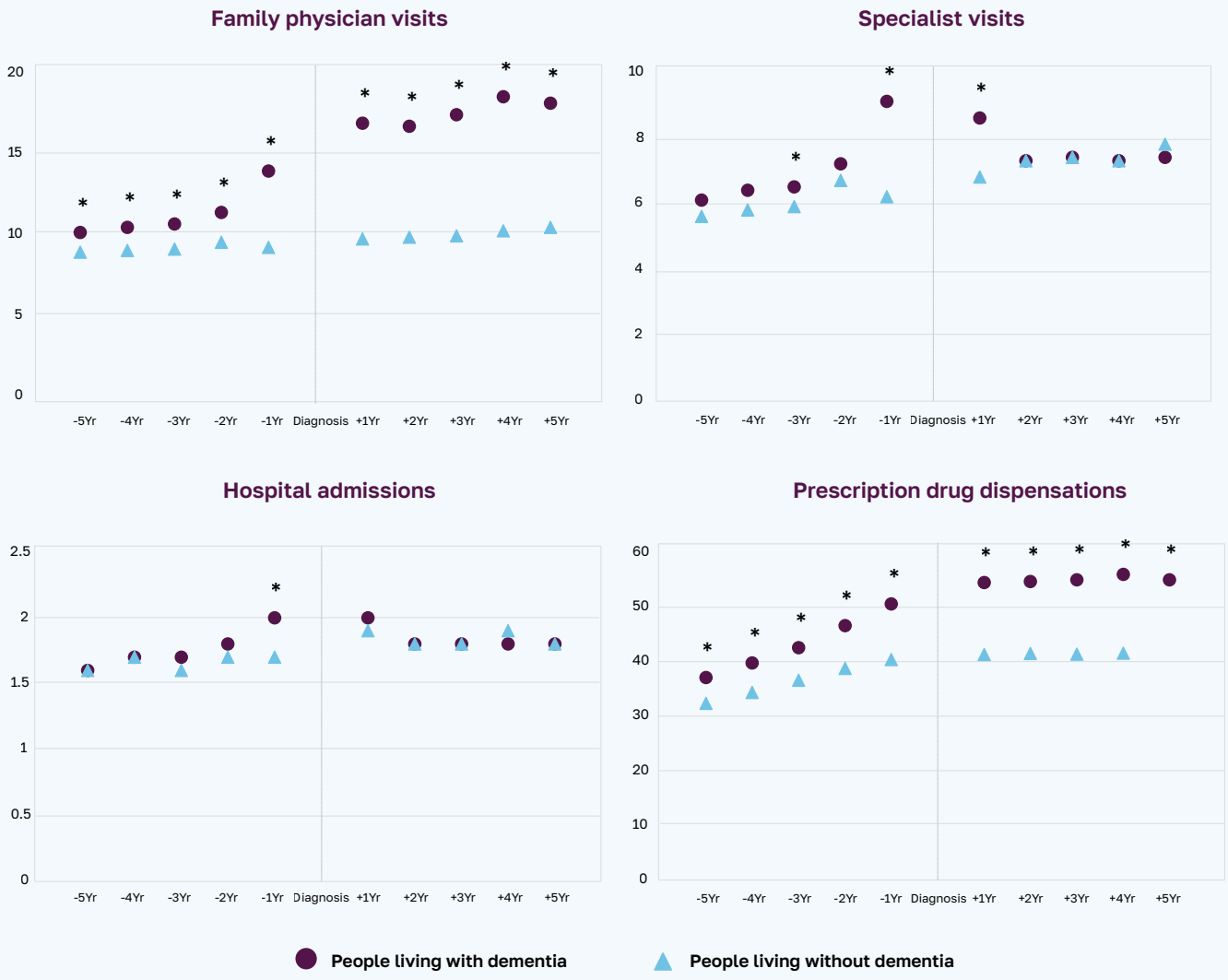
Throughout a person's dementia care journey, there are notable changes in health care utilization, particularly leading up to their dementia diagnosis (Figure 7)[195] and in the year before death.[196] Compared with people without dementia, persons who develop dementia reportedly had a 49.3% and 59.7% greater number of visits to family physicians and specialists, respectively, as well as 90.5% higher rates of hospital admissions in the year leading up to their dementia diagnosis.[195]

In the year following a diagnosis, health care utilization reportedly remained higher in people living with dementia for visiting family physicians (70%), specialists (23.1%), hospital admissions (37.7%) and prescription drug use (29.1%), compared with matched controls without dementia. Family physician visits and prescription drug dispensations remained higher for the five years following a diagnosis (27% and 9%, respectively), while specialist visits and hospitalizations decreased compared with people without dementia (-21% and -18%, respectively).[195]

In the year leading up to death, people living with dementia experienced an increase in hospitalizations, particularly those residing in the community. Critically, better coordination and continuity of care were associated with fewer overall care transitions.[196]

Together, these trajectories and patterns of health care utilization highlight the central role of community-based care throughout the dementia care journey. As many people living with dementia continue to live at home for several years following diagnosis and have steady contact with PCPs, dementia care systems must be equipped to support people earlier, longer and more intensively in community settings.

Figure 7: Unadjusted Mean Number of Health Services for People Living with Dementia, Adapted from Kosteniuk et al. (2022).[195]



*Significantly different between people living with dementia and people without dementia (p <.05).

Dementia Prevention and Risk Reduction

The Essential Role of Primary Care Providers (PCPs) and Public Health in Enabling Dementia Prevention and Risk Reduction

Prior to a dementia diagnosis, PCPs play a critical role in risk reduction and dementia prevention. PCPs are often the main point of contact for individuals to manage and support their health-related issues, and regular access to a PCP is associated with timelier management of health issues overall. Regular access to a PCP has also been associated with reduced hospitalizations and ED visits and overall better health outcomes.[8–10]

PCPs play an important role in wellness and prevention as well as chronic disease management. Critically, several chronic diseases are considered modifiable risk factors for dementia, including obesity, high cholesterol, depression, diabetes, hypertension and hearing and vision loss.[107] Thus, PCPs should be aware of how these chronic conditions relate to dementia. Currently, the outcome of the fifth Canadian Consensus Conference on the Diagnosis and Treatment of Dementia (CCCDTD5) has been to encourage physicians to particularly address hypertension, vision impairment and hearing loss in persons at risk for dementia.[197] Helping patients manage these conditions may help reduce their risk of developing dementia, as well as promote an overall better quality of life.

Additionally, certain behaviours are associated with dementia risk, specifically, physical inactivity, smoking and alcohol consumption, and thus may be appropriate targets for intervention for risk reduction.[107,198] In a primary care setting, family physicians, nurse practitioners or other members of a primary care team can provide coaching and counselling to help modify these behaviours. The CCCDTD5 currently suggests that health care providers should encourage a healthy diet (e.g., the Mediterranean diet), physical exercise, social engagement and education (e.g., support for educational attainment and ongoing education experiences).[197] Furthermore, in people at risk for dementia, health care providers are encouraged to examine possible sleep disorders (e.g., sleep apnea) and promote cognitive training.[197]

PCPs play a significant role in dementia prevention, as they can continuously monitor and manage the health of their patients and address their modifiable risk factors for dementia longitudinally.

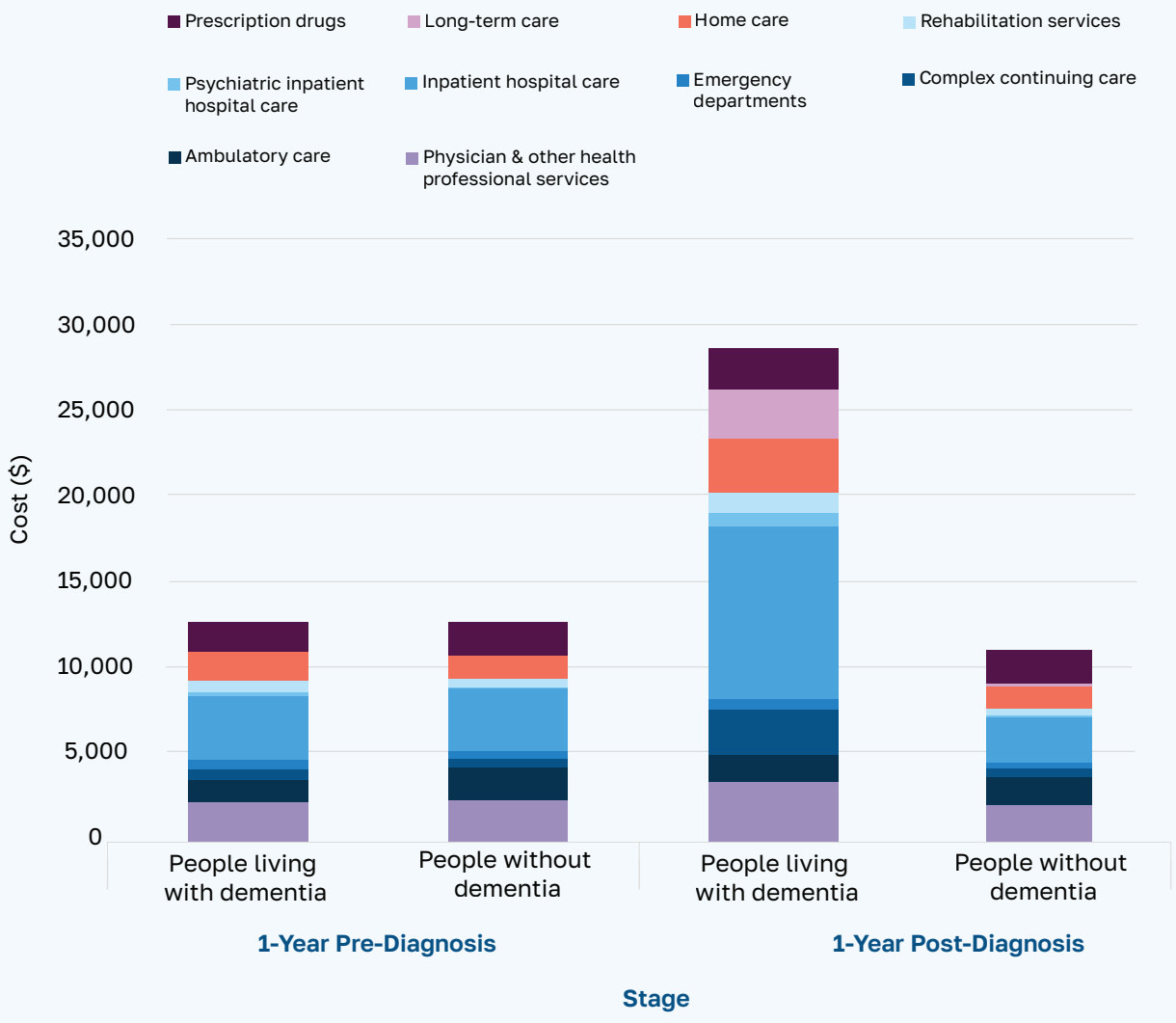
The Dementia Diagnosis

Often, dementia is diagnosed in one of two settings: primary care settings or hospitals. While about 70% of Canadians living with dementia in the community had their condition recorded for the first time in community-based office settings, 30% received their diagnosis in hospital settings.[160] Of the people who were diagnosed in the community, the majority (83%) received a diagnosis from a PCP, whereas 7% received it from a geriatrician, 4% from a neurologist and 3% from a psychiatrist.[160] The diagnosis phase of a dementia care journey is when the first increases in health care costs arise, often associated with increased PCP visits, specialist care and hospital use (Figure 8).[190,195]

As discussed earlier, it is possible that as many as 61.7% of people living with dementia in Canada remain undiagnosed,[4] which may be partially caused by the stigma around dementia.[5–9] Stigma may prevent people living with dementia or their families from seeking out a diagnosis. In turn, health care professionals may be reluctant to give a diagnosis due to wanting to avoid distressing the patient with this information. However, there are many benefits to receiving a timely diagnosis, as is explained in Box 3.

An additional reason may be that Canadian PCPs have reportedly felt ill-prepared for a number of reasons, including the complex nature of dementia, difficulty with providing a diagnosis, challenges coordinating both patient and family needs, a lack of access to specialists, little to no knowledge of the community-based resources available and a lack of time.[199,200] This may help explain why approximately 61.7% of people living with dementia in Canada could be undiagnosed.[4]

Figure 8: Mean Annual Health System Costs in 2018 Canadian Dollars, the Year Prior to and the Year Following a Dementia Diagnosis, Adapted from Bronskill et al. (2025).[190]



Box 3. The Benefits of Obtaining a Timely Dementia Diagnosis

While some studies show that both the person living with dementia and their caregiver may experience short-term distress around the time of a dementia diagnosis,[8] most people living with dementia do not generally experience long-term distress due to having received a diagnosis.[201] Regardless, it is the right of people living with dementia to be told about their diagnosis.

Receiving a timely diagnosis is beneficial for people living with dementia and those providing care and support to them. An early diagnosis may offer relief to a person living with dementia and their caregivers, as it allows them to identify and understand any observed changes in memory, thinking and/or mood.[146,202,203] Moreover, it enables them to learn what to expect as their disease progresses,[146,202,203] which allows people living with dementia and their caregivers to make arrangements for the right supports to be in place early in their dementia journeys.[202,204] This can include integrating non-pharmacological interventions into their lives and routines that may slow the progression of their disease, improve their overall quality of life and help them remain healthy and independent in their own homes and communities for as long as possible.[146,202] It may also include getting support from specialist care providers such as occupational therapists or physical therapists to identify how best to work within the person with dementia's capabilities and support their continued independence.[204] Similarly, pharmacological interventions can alleviate some of the symptoms associated with dementia, such as anxiety, depression and hallucinations, while others may also be able to slow the progression of the disease.[202,205]

For example, addressing hearing loss has been found to improve cognitive functioning in older adults with hearing loss who were at a higher risk of cognitive decline.[206] Another study found that people who were prescribed hearing aids experienced a 33% reduction in dementia risk and a 15% reduction in cognitive impairment seven years later, compared with those who were never prescribed them.[207] Critically, this effect was also directly linked to hearing aid use, as those who wore their hearing aids often or always had greater cognitive protection than those who wore them sometimes or rarely.[207] Additionally, lifestyle factors like engaging in physical activity or having greater social connections have been shown to slow the rate of cognitive decline.[107,208,209]

Finally, a timely diagnosis may validate some of the challenges a person living with dementia has been noticing and allow them to better understand what to expect as the disease progresses. A diagnosis gives the person time to make important decisions about future living situations, care and estate planning and to focus on how they want to prioritize their day-to-day life in the meantime.[202,204]

In addition to the stigma surrounding dementia, PCPs also may not feel comfortable giving a dementia diagnosis. In a 2021 survey by PHAC, 42% of health care providers reported needing much more training to feel comfortable making a dementia diagnosis, while 21% indicated needing a moderate amount of additional training.[155]

Critically, a PCP's under-preparedness is felt by people living with dementia. There is no shortage of stories in the media about patients feeling lost, confused, dissatisfied and hopeless because of their diagnosis process.[210–212] People living with dementia and their caregivers often report feeling they lacked a "prescription of care" or a dementia care road map. Many felt their primary issue was a lack of information, especially relating to how the dementia may progress and how to manage everyday challenges that may arise.[5]

While PCPs may refer a patient to a specialist physician such as a geriatrician or neurologist for a formal assessment and diagnosis, as noted earlier, 83% of diagnoses in the community still occur in primary care settings.[160]

The role of PCPs in providing dementia care is critical, as regular access to PCPs reduces the risk of hospitalization. Nevertheless, hospital settings are the second most common place where 30% of dementia diagnoses are made in Canada and often during a health-related crisis.[160] In the months leading up to a diagnosis, over one-third of people living with dementia were hospitalized.[160] Critically, people who are diagnosed in a hospital are 5.6 times more likely to enter an LTC home than those diagnosed elsewhere.[189] It is likely that these incidents would have been avoidable if detected early. Given that hospitalizations are an expensive part of the dementia care journey, especially for receiving an initial diagnosis,[160] early detection and continuous care and support from a PCP are crucial.

If a PCP is not confident providing care for someone living with dementia or the person's care needs are complex, the person may be referred to a specialist, such as a geriatrician or a neurologist, for further assessment and management. While a geriatrician can provide more specialized care, Canada also has a critical shortage of geriatricians and other specialists, leading to long wait times.[213] This can significantly delay diagnosis and subsequent care, which may mean missing the critical window to receive newly emerging therapies.

This highlights the need for new and innovative approaches towards the provision of dementia care in primary care settings. An emerging Canadian-made approach over the past two decades has been the Multispecialty INnterprofessional Team (MINT®) Memory Clinic model for providing primary care-led dementia care, which has demonstrated its ability to deliver timelier, high quality dementia care while significantly reducing health care costs. See Box 4 for more details about the MINT Memory Clinic Model.

Box 4. MINT Memory Clinics

MINT Memory Clinics are a publicly funded Canadian primary care-led model which uses an interprofessional health team with training in dementia care — including family physicians, nurse practitioners, nurses, pharmacists and occupational therapists — to assess and help manage the care of persons with concerns about their memory or cognition. MINT clinics collaborate with specialists and local community partners like Alzheimer's Societies to enhance the care and support for people living with dementia and their caregivers.

First established within a primary care team in southern Ontario nearly two decades ago, there are currently 130 MINT Memory Clinics across seven provinces in Canada. MINT Memory Clinics can be offered in urban, rural and remote regions and modified to adapt to local contexts.

From 2022-2024, MINT Memory Clinics received federal funding through the National Dementia Strategy's Dementia Community Investment fund to improve access to equitable, person-centred care for people living with dementia and their care partners, with a focus on those facing cultural, geographic or systemic barriers to care.[214,215] This led to the development of 11 new MINT Clinics offering dementia care services in Alberta, British Columbia, New Brunswick, Nova Scotia and Saskatchewan to support diverse and underserved African Nova Scotian, Chinese, Francophone, Indigenous, South Asian and Northern communities.[214,215]

Using this model, if a PCP suspects dementia or another form of cognitive impairment, they can refer their patient to a local primary care-led MINT clinic. The wait time to access a MINT Clinic can vary widely based on local capacity: a fully operational clinic may only have a wait time of 1-2 months, as opposed to the typical 6-12 months to see a specialist.[216] From here, the MINT Memory Clinic can provide a diagnosis and ongoing support to the person living with dementia, their caregivers and their PCP. Usually, only the most complex cases are referred to a specialist, reducing the need for specialist referrals to just 10% of cases.[216] This allows for a quick and efficient diagnostic process with the immediate provision of comprehensive care and system navigation support, helping people living with dementia get the support they need as they embark on their dementia care journeys.

MINT Memory Clinics have also demonstrated remarkable improvements in health outcomes for people living with dementia while reducing overall health care costs. In an independent review commissioned by the Government of Ontario in 2019, receiving care from MINT Memory Clinics was associated with fewer ED visits, with the first ED visit occurring later in a person's dementia care journey.[216,217] Hospitalizations also tended to occur later and be shorter, with fewer alternate level of care (ALC) days and higher home discharge rates.[216,217] This translated into an overall 54% reduction in inpatient hospital care costs and a 51% reduction in ED care costs.[216,217] Additionally, MINT Memory Clinics were found to be associated with a 90% reduction in specialist referrals and a delay in LTC home placements by nearly six months.[216,217] Overall, MINT Memory Clinics were found to reduce total health care system costs by approximately 38% from diagnosis to death, thus saving more than an estimated average of $50,000 per patient over the course of their dementia care journey.[217,218] It was further estimated that if every eligible Ontarian received care from a MINT Memory Clinic, Ontario's health care system would realize nearly $3.5 billion in annual savings.[217]

Critically, MINT Memory Clinics have also demonstrated a significant positive impact on people living with dementia, who have reported significant improvements in their overall quality of life.[73] 96% of people living with dementia and their caregivers reported that they would recommend MINT Memory Clinics to others, while 94% reported they were satisfied with their care.[217]

MINT Memory Clinics have also been demonstrated to have a positive impact on health care providers. Those who underwent MINT Memory Clinic training, to either open a new MINT Memory Clinic or join an existing one, experienced an increased sense of competency around challenging aspects of dementia care; more energy and better attitudes regarding the provision of dementia care; and better collaboration with other health practitioners.[219] This collaborative aspect is greatly appreciated by both PCPs and specialists. Specialists appreciated being included as part of the care team, as well as opportunities to learn from their PCP colleagues; they also benefitted from having less complex cases managed by the care team and receiving comprehensive notes when patients were referred to them.[220] Conversely, PCPs felt they were able to get feedback and respond to referrals from specialists in a much timelier manner, and received consultations and support for their more complex cases.[220]

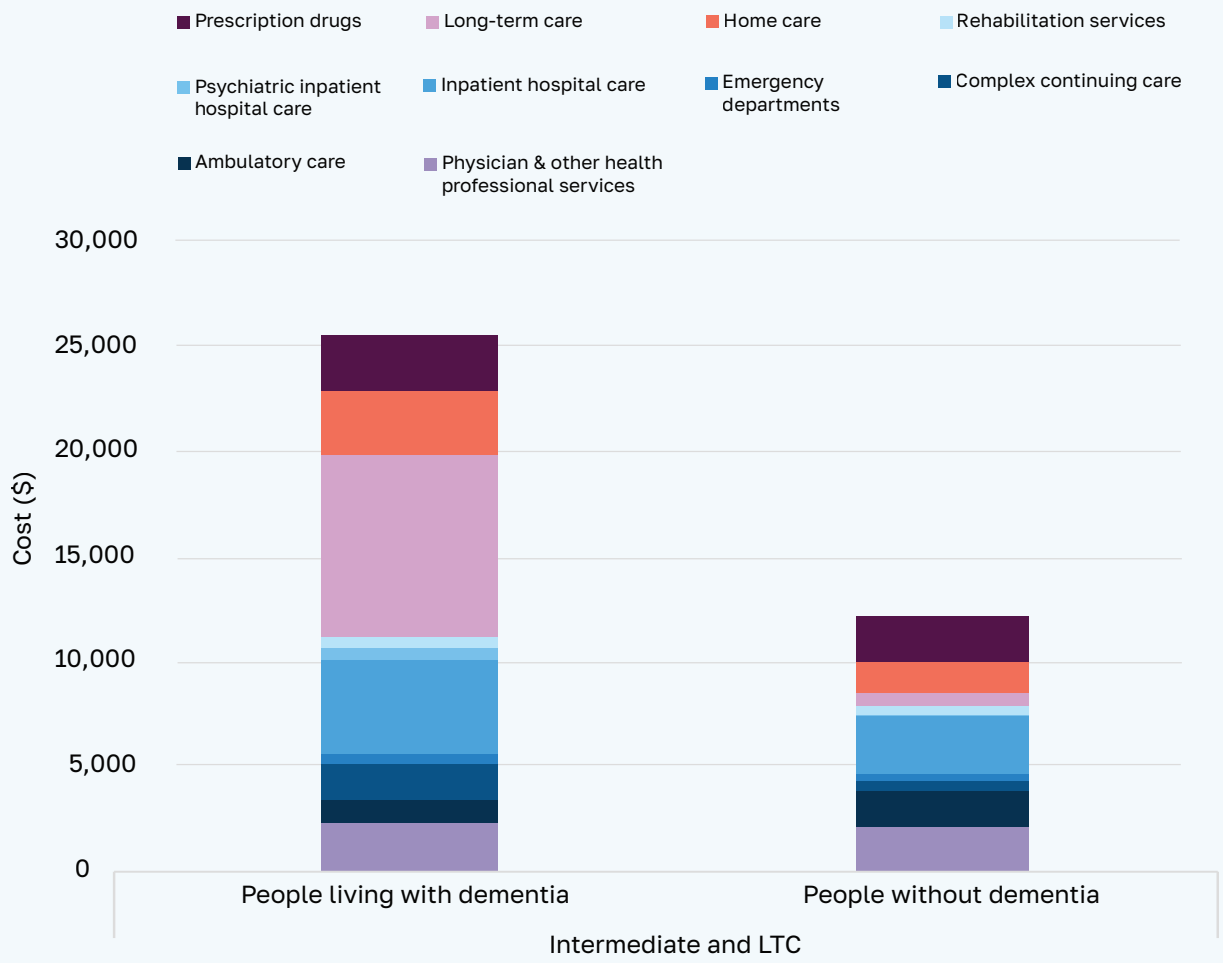
Scaling the MINT Memory Clinic Model across all of Canada to increase its overall reach could improve the care and quality of life for Canadians living with dementia and their caregivers, while also significantly reducing the overall economic impact of providing dementia care.

Despite compelling evidence supporting this model's gradual spread across Canada, to date, only one provincial jurisdiction has made an overall commitment to scale, spread and support the expansion of this model of care. New Brunswick recently introduced a billing code which could help PCPs working in MINT Memory Clinics be more appropriately compensated for their time working in this model of care, versus delivering traditional office-based primary care.

Intermediate and Long-Term Care

After a diagnosis of dementia, there are many points at which a person living with dementia and their caregivers may interact with the health care system. While the continuing costs for dementia care are often less than the diagnosis and end-of-life care stages, the mean annual costs associated with this stage of a dementia care journey have still been found to be double that of people not living with dementia ($25,774 versus $12,367, respectively; Figure 9).

Figure 9: Mean Annual Health System Costs in 2018 Canadian Dollars Associated with Continuing Dementia Care Post-Diagnosis and Prior to End-of-Life, Adapted from Bronskill et al. (2025).[190]



Post-Diagnosis Dementia Care Pathways and Coordination

When and where people access Canada's care systems throughout their dementia care journeys will vary considerably. One of the most notable challenges in the provision of dementia care in Canada is the lack of clear dementia care pathways and poor post-diagnosis care coordination.

A care pathway is defined as a "complex intervention for the mutual decision-making and organization of care processes for a well-defined group of patients during a well-defined period. Therefore, the aim of a care pathway is to enhance the overall quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimizing the use of resources."[221] Care pathways include the provision of care coordination, which is the process of coordinating the roles and sequences of activities of a multidisciplinary care team made up of care providers, the person living with dementia and their caregivers.[222]

While health conditions like cancer and stroke have clear and well-established care pathways and coordinated care networks across most, if not all, parts of Canada, dementia care in Canada lacks any clearly established care pathways.[223]

Canada does have the First Link® program, which is offered by a number of Alzheimer's Societies and is currently available to some extent in every Canadian province and territory, except for Nunavut.[224] First Link helps people living with dementia and their caregivers navigate care systems by facilitating early access to relevant supports and services. Through this program, people can be connected to health care and community resources, receive individual or group-based supports, learn from others with shared experiences and obtain guidance on planning for the future and managing the condition.[224]

One of the objectives of First Link is to improve the coordination of care and linkages to community services to support the non-medical management of issues, from the time of diagnosis through the duration of the disease.[225] Engagement with the First Link program has been shown to both increase the capacity of health care professionals and caregivers to manage dementia and improve their awareness of available community services and resources.[225,226] Critically, most caregivers and people living with dementia were satisfied with their involvement with First Link and their local Alzheimer Society, and caregivers overall feel that First Link improved their dementia care journey.[225,227]

While First Link provides the initial support for caregivers, it does have several limitations. For doctors sending a referral, there is no option to indicate if someone needs unique ethnocultural supports. Furthermore, the services and resources offered by the First Link program vary by province and even regions within a province. The variability of services also includes language options, where services may not be provided in both of Canada's official languages, let alone in non-official languages. Finally, the First Link program is neither situated within nor readily integrated into health care systems, making proper referrals and care difficult to coordinate. Greater investment, development and integration of these services have thus been called for to provide better and more consistent post-diagnosis dementia care support and coordination across Canada.

Ongoing Primary and Specialist Care

A person's ongoing dementia care primarily falls within the scope of their PCP, with the support of specialist care providers as needed. As noted earlier, PCPs play a crucial role in initiating assessments, treatments and care management, connecting their diagnosed patients with dementia to community supports and services and engaging specialists as needed. PCPs and specialists also help manage common symptoms and complications of dementia, such as behavioural and psychological symptoms of dementia (BPSD), falls and the eventual need for more help with ADLs.

It is important to note that major health conversations, such as advance care planning, are initiated by PCPs and specialist care providers who can guide future decision-making, especially around the time a diagnosis of dementia is made. They can further help facilitate care transitions across different care settings as a person's care needs and circumstances evolve. People living with dementia who receive greater continuity of care from their PCPs have been found to experience fewer ED visits and hospitalizations, and a reduced number of transitions between care settings, which reaffirms why access to high quality primary care is so critical for people living with dementia.[228]

However, much like giving a diagnosis of dementia, most PCPs also appear to be uncomfortable providing ongoing dementia care. In 2018, only about 40% of Canadian PCPs reported feeling well-prepared to manage care for people living with dementia.[178] Comfort managing dementia care varies by jurisdiction. In New Brunswick and Nova Scotia, 50-52% or more of PCPs reported feeling comfortable managing the care of patients with dementia, whereas only 19% of physicians reported the same in the Yukon, Northwest Territories and Nunavut.[178] Even in the most confident provinces, only half of PCPs reported feeling well-prepared to support the care of a patient living with dementia. In PHAC's 2021 survey, similar gaps were reported for treating and caring for someone living with dementia (40% needing much more training; 26% needing a moderate amount) and for advance care planning (41% requiring much more training; 22% requiring a moderate amount).[155] Taken together, these findings indicate that approximately 60% of Canadian health care providers do not feel adequately prepared to provide comprehensive dementia care.

The previously mentioned findings highlight the importance of supporting PCPs in delivering care and exploring alternative care delivery models. While education and training are critical, promoting team-based care within primary care settings could be an effective strategy to provide better dementia care. In such models, various care providers, such as social workers, physical and occupational therapists, pharmacists and dietitians, assist PCPs in the delivery of patient care. For instance, Saskatchewan's Rural Dementia Action Research (RaDAR) team employs an interprofessional care delivery model that may include an Alzheimer Society First Link Coordinator.[229,230] They conduct one-day memory clinics every 1-2 months or as needed, integrated with the provision of community services.[230,231] By December 31, 2025, they had hosted 146 clinics serving a total of 242 patients, improving access to quality care in rural areas.[231] Other approaches include Ontario's Primary Care Integrated Geriatric Teams, where health professionals, including PCPs and specialists, collaborate to enhance the provision of primary care for people facing geriatric care-related issues.[232] The key aspect of these approaches is that, like the MINT Memory Clinic model, specialized care is integrated into the overall care provided by the primary care team, allowing for greater continuity.

The Experience of Care Within Hospital Settings

Hospitals are another care setting that need to be well-prepared to provide dementia-related care, as nearly one in five people living with dementia were hospitalized in 2015-2016.[188] Overall, hospitalization rates are 65% higher in people living with dementia compared to older adults not living with dementia, while hospital stays for people living with dementia are also reportedly up to two times longer.[188]

Hospital stays can be difficult experiences for most people and can be especially distressing for people living with dementia and their caregivers. People living with dementia and their caregivers have reported a number of challenges when seeking care in EDs, including experiencing long waiting times and being physically uncomfortable.[233] Furthermore, crowded EDs are often described as being overstimulating, unfamiliar and frightening for people living with dementia — so much so that caregivers have reported feeling they cannot leave the person they are caring for alone in these settings.[233,234] A number of people living with dementia and their caregivers reported feeling they had to wait a long time to be discharged from EDs; were concerned about not getting the right follow-up care; had trouble accessing follow-up care; and were concerned about experiencing continued mobility issues upon returning home.[233]

There are, however, ways to improve the experience of people living with dementia and their caregivers in ED settings. First of all, communication is key.[234–236] Patients have reported wanting to be regularly informed of their results, wait times and what to expect in a way that is accessible to them.[234,235] Communication must be culturally and linguistically suitable, as some may experience challenges using interpreters, and any support documents (such as discharge papers or pamphlets) may only be available in English or French.[235] Additionally, patients felt it was important for their health care providers to identify who they are and what their role will be in their care.[235] People reported wanting to be treated pleasantly, with respect and dignity, and to not feel dismissed or overlooked. It is also important for hospital care providers to communicate in a manner that accounts for the sensory and cognitive needs of people living with dementia, such as using simple, one-step commands, repeating information as needed and speaking at an appropriate pace.[236] The following were also identified as valuable when being discharged from an ED: clear discharge instructions, including transportation options for those with mobility limitations; efficient sharing of information to their PCP; access to respite care; and access to a care coordinator.[233,234]

There are several other initiatives that hospitals and EDs can take to be more dementia inclusive, identified in Box 5.[237]

Box 5: Making Care in Hospitals More Dementia-Inclusive

There are several built-environment interventions that can help improve the experience of people living with dementia and reduce distress during their time in a hospital. These include providing clear signage with high-contrast colours to support wayfinding, as well as visible clocks and calendars to aid orientation.[237–240] Attention to sensory and environmental modifications is also critical. This may involve avoiding shiny or highly patterned flooring that can create glare or visual confusion, using high-contrast tape or paint to clearly mark stairs and ramps and ensuring adequate lighting to minimize shadows and glare.[238–241]

In addition, efforts to reduce noise and excessive sensory stimulation, such as lowering alarm volumes, closing doors quietly and providing private or low-stimulus spaces, can further support comfort, safety and promote restful sleep.[236,238,239,241] Continuity of care can be improved within the hospital setting itself, for example, by performing diagnostic procedures and treatments in the patient's room and minimizing transfers between hospitals and care units.[240] As well, designated spaces for socially and cognitively stimulating activities may lead to greater comfort and familiarity, with the ultimate goal of maintaining calm and accessible environments for patients living with dementia.[240] Some hospitals have developed dedicated Acute Care for Elders (ACE) units focused on providing care for older adults in general and dementia care in particular, designed specifically to better accommodate these needs.[236] While more evidence is required, there is some evidence that geriatric and dementia care-focused units may provide a better patient experience and have better outcomes for patients, such as improved cognitive function, independence and mobility, reduced falls, lower mortality and greater likelihood of returning home rather than moving into residential care.[242–244]

Supporting hospital care providers with the right knowledge and skills is also vital to improving the overall care people living with dementia receive. Targeted education and training around delirium prevention, managing responsive behaviours and communication strategies for people living with dementia can increase care providers' confidence and competence, leading to more person- or emotion-centred care and fewer adverse events.[236–238,240] Training that emphasizes understanding behaviours as expressions of unmet need rather than symptoms to be managed may further reduce the reliance on physical or chemical restraints in the care of people living with dementia.[238]

Ensuring that family and friend caregivers of people living with dementia are meaningfully involved throughout a hospital stay is another critical component of high quality dementia care.[237,238,240] Caregivers are not always well integrated into the care of people living with dementia during hospitalization,[245] and at times can be viewed as a nuisance by hospital staff. However, caregivers often know the person living with dementia best and can provide important baseline information and other contextual insights to support the provision of person-centred care, and should be involved in care planning.[238,240] Caregivers can also provide comfort, support and reassurance to the person living with dementia, helping them stay calm and reducing responsive behaviours.[246] Modifications to hospital policies, such as allowing caregivers to remain present beyond standard visiting hours, can help reduce distress and improve patient outcomes.[238,240] Ensuring that care staff are supportive and empathetic towards caregivers and their needs, actively listen to and integrate their feedback, goals and concerns and create a comfortable physical environment can help support caregivers during their time at the hospital, which is integral to providing good dementia care.[247] In addition, involving caregivers in discharge planning and providing them with information about community resources can better equip them to support the person living with dementia upon returning home.

There are several reasons why people living with dementia require hospitalization more frequently than people without dementia. People living with dementia are at higher risk for falling in both community and institutional care settings, with 15% of ED visits by people living with dementia reportedly related to falls.[248] Conditions such as pneumonia, urinary tract infections and cardiac concerns are also some of the most common reasons for hospitalization.[160,249–251] While there is no clear pattern for health conditions related to repeated ED visits,[252] a number of demographic factors, such as a prior history of ED use, living in rural or low-income areas or a high usage of certain medications (anticonvulsants, antipsychotics and benzodiazepines) have been associated with recurrent ED visits.[253]

An additional contributor to hospitalization among people living with dementia is caregiver well-being. When caregivers face high levels of demand with inadequate supports, they may be less able to identify and address emerging health concerns (e.g., falls, dehydration or improper medication use) before they escalate to a point requiring hospitalization.[254,255] Furthermore, caregivers experiencing significant stress or burnout may bring their person living with dementia to the ED when they have reached a breaking point, not knowing what else to do or needing urgent respite.[254,255]

As previously discussed, when admitted to a hospital, people living with dementia, compared to people without dementia, experience longer hospital stays, particularly as ALC-designated patients, and are 1.5 times more likely to experience hospital harms, such as dehydration, urinary tract infections and delirium.[188] These harms can arise in part from inadequate dementia-specific training among hospital care providers, who may not have been equipped to deliver care in accessible and appropriate ways, causing them to rely on chemical or physical restraints to manage BPSD.[256] Experiencing hospital harms has also been tied to increased lengths of stay, as patients with dementia who stayed for more than one week were found to have a seven times higher odds of experiencing hospital harms than patients without dementia.[188]

People living with dementia also have higher mortality rates upon admission to the hospital and one year later.[249,257] Although these higher mortality rates could be related to their hospital care experiences, it may also be influenced by the possibility that people living with dementia are less likely to receive adequate palliative and end-of-life care at the end of their dementia care journeys,[258] which may lead to avoidable hospital admissions. For example, about one in five older adults (cognitive status not indicated) died within a day of being admitted to a hospital.[259] Regardless of the reason, both facts highlight the glaring gap in end-of-life care for people living with dementia, which will be discussed further in the following section.

According to CIHI, hospitalization often preceded the start of home care and transition into LTC homes for people living with dementia.[160] Critically, individuals whose first dementia assessment occurred in a hospital setting were found to be 6.4 times more likely to be admitted to an LTC home after their hospitalization compared to those first assessed in the community.[160]

Home and Community Care Experiences

While this report focuses on the provision of publicly funded home care services, the NIA would also like to acknowledge the monumental time and effort spent by unpaid caregivers, often family members and friends, in providing care for people living with dementia, especially those who are living at home. These invaluable efforts will be explored in depth in the third and final report of this series. The NIA also acknowledges that many people and their families engage privately paid home care providers in addition to or instead of accessing publicly funded home care, whose contributions are also not usually accounted for in the data that CIHI collects.

The majority (61%) of people currently living with dementia are still living at home,[189] and according to CIHI, around 57% of people living with dementia remain living in their own homes within five years of their first record of a diagnosis.

Of those living with dementia in the community, only a minority were also found to be receiving publicly funded home care, meaning that most of their care needs were addressed by family and friend caregivers. In fact, 95% of all home care clients (with and without dementia) have an unpaid caregiver involved in supporting their care.[260] While people living with dementia should be receiving home care, only about 43% received a home care assessment completed within the first six months of receiving their diagnosis, and only 58% ended up receiving any type of home care at all within five years of their diagnosis.[160] Of the 58% of people living with dementia receiving publicly funded home care, less than one-third (31%) continue to live at home, while 27% eventually moved into LTC homes within five years of their diagnosis.[160]

The type and intensity of home care that individuals receive can vary widely. Many people living with dementia rely on home care services, most commonly through the support of personal support workers (PSWs) or care aides. PSWs can assist with essential ADLs such as bathing, dressing, meal preparation, and medication administration, and access to paid home care support may help to reduce caregiver stress.[261–263] Ideally, the respite that home care provides should be viewed as a preventative measure against increasing caregiver stress, as accessing home care services when a caregiver is already at a point of crisis may limit their ability to benefit from a PSW's support.[264]

Despite their central role in providing dementia care, PSWs are not regulated professionals in many jurisdictions. Some provinces (Alberta, British Columbia and Nova Scotia) have mandatory registries for public sector PSWs, while Ontario has a voluntary PSW registry.[265] However, none of these registries provides the regulatory oversight, professional accountability mechanisms or consistent standards of practice associated with regulated health professions. The registries also do not provide protections for the care providers themselves, as PSWs may face challenging working conditions, including health and safety risks, harassment, discrimination and violence on the job; all while earning low wages, receiving minimal employment benefits and experiencing unstable working hours.[266]

There is considerable variability in PSWs' training, scope of practice and knowledge and skills related specifically to providing dementia care.[267] Additionally, PSWs may often be asked to perform tasks outside their scope of duties, such as addressing acute medical issues, assisting with chronic disease management and promoting general health by advocating to address unmet needs or promoting healthy behaviours like physical activity.[268]

Many PSWs receive limited formal education specific to dementia, including communication strategies, recognizing changes in cognition or function and managing responsive behaviours.[269] This lack of standardized regulation and training may affect care quality and continuity, as well as worker confidence,[269] highlighting the need for greater investment in workforce development, dementia-specific education and more system-level supports for PSWs to provide care at home.

Adult day programs (ADPs) are an important component of community-based dementia care. These programs provide people living with dementia with opportunities for social interaction and recreational activities in a safe environment outside their own homes, for half or full-day sessions.[270] ADPs may offer psychological benefits for participants, such as improved mental health and reduced loneliness, as well as improvements in their overall quality of life, physical health and functional abilities.[271] In addition, participation in day programs has been associated with a 24% reduction in hospitalizations and a 40% reduced risk of transition to living in an LTC home.[271–274] Perhaps more critically, participation in ADPs also affords caregivers much-needed respite,[271,275] as they can leave their person with dementia for an extended period of time knowing they are safe and well-supported. ADPs have been shown to improve caregiver well-being by reducing stress and worry, alleviating pressures associated with caring and continuing to work and increasing feelings of confidence and competency.[271,275,276] These benefits from ADPs are even greater when they provide active supports to caregivers, such as dementia training and education, support and validation, strategies for dementia care and self-care, and social engagement.[277–279]

Multiple barriers limit access to community-based programs, such as ADPs, for people living with dementia and their caregivers. These barriers include limited awareness of available services; insufficient information about programs and services at the time of diagnosis; misperceptions about program suitability or cost; and discomfort with receiving care from individuals who are not family members.[280,281] Additional structural challenges, such as inaccessible program locations and financial constraints, further reduce program uptake.[280,281] Language barriers, cultural biases and a lack of culturally inclusive care options also disproportionately affect equity-deserving populations.[280]

In Canada, insufficient public funding of ADPs leads to understaffing and increased waitlists, and limited transportation capacity means programs are held in places that are difficult to access.[282] Additionally, poor health system organization contributes to access challenges. For example, limited home care and community support services may reduce a caregiver's capacity to prepare a person living with dementia to attend a day program, while system inefficiencies, such as referrals of ineligible clients, can create additional administrative burdens.[282] These challenges underscore the need to improve public awareness of high quality community-based programs and ensure that these services are accessible, inclusive and adequately funded and organized.

The Role of Rehabilitation in Dementia Care

Rehabilitation services can also support "re-ablement" opportunities for those living with dementia. Broadly, re-ablement focuses on strategies that maintain or improve functional ability and independence by maximizing an individual's own capacity and use of their living environments.[283] Focusing on re-ablement can then be used to support people living with dementia by aiming to maintain function as long as possible, regain lost function and finding ways to adapt to functions that cannot be regained.[283]

For example, occupational therapists can help people living with dementia develop schedules or routines and make modifications in their homes to ensure they remain a safe and secure

environment. This ultimately helps the person living with dementia maintain a greater overall level of independence.[284] This increased engagement, involving working with the strengths of the person living with dementia, may partly explain why occupational therapy has been shown to improve the ability of a person living with dementia to conduct their activities of daily living, reduce responsive behaviours and improve their overall quality of life. Additionally, occupational therapists may collaborate with caregivers of people living with dementia to help them recognize, adjust and adapt to the needs of the person they are caring for. This has been associated with improved caregiver outcomes, including decreased hours providing care, an improved quality of life and increased self-efficacy.[285,286]

Physiotherapy and physical exercise have been found to improve functional mobility, ADL performance and reduce falls. They also have potential cognitive benefits.[287] Speech-language pathologists also play a key role in providing dementia care by assessing, diagnosing and treating cognitive-communication and swallowing (dysphagia) disorders associated with the disease.[288] Speech-language pathologists develop and deliver individualized treatment plans to maintain communication, language and swallowing abilities at the highest possible level, while continuously monitoring changes over the course of the disease to ensure timely, appropriate intervention and support.[288]

There are several non-pharmacological approaches to support the provision of dementia care, including cognitive stimulation therapy, physical activity, reminiscence therapy and art therapies.

Cognitive stimulation therapy is one of the most effective approaches and involves engaging in cognitively stimulating tasks and activities (e.g., completing puzzles, discussing a news article), often in social settings. Cognitive stimulation therapy has been shown to improve cognitive functioning as well as reduce BPSD.[289] Physical activity has also demonstrated considerable benefits for people living with dementia, as it can improve cognition, reduce falls, promote physical functioning and improve mood, ultimately supporting independence and quality of life.[208,290,291] Reminiscence therapy involves having the person living with dementia recall past events or memories by using memory aids like photographs or other familiar items of the past, such as music and movies. While the benefits of reminiscence therapy for cognition are limited, it shows promising effects on improving mood and reducing depressive symptoms.[289] Finally, art therapies, which can include music, dance, visual arts and drama, have been shown to improve cognition and mood in people living with dementia.[292–294]

Re-ablement methods show that focusing on what abilities remain or can be restored and maintained, and creatively working around the challenges associated with dementia, can improve the capabilities and well-being of people living with dementia and support their caregivers in turn. However, re-ablement remains an underused resource in dementia care because many people are unaware of it as a care option, and health care providers fail to recognize its value.[295]

Institutional Care Options and Experiences

People living with dementia may require more intensive care and support than what can be provided in their own homes and communities. In these cases, people may move into LTC settings such as assisted living or retirement residences and/or LTC homes.

Retirement and assisted living residences can provide support for people with varying levels of need. This can range from independent living to assisted living to “memory care” for those living with dementia, whose care needs become similar to those residing in a LTC home. However, retirement and assisted living residences are often only available on a private pay basis, unlike LTC homes, which are generally publicly funded and subsidized care settings. Having dementia-

specific programming available in assisted living residences can significantly impact the health trajectories of people living with dementia. In Ontario, assisted living residences with dementia care programs are regulated under the Retirement Homes Regulatory Act. Retirement homes that provide a dementia care program should include the following components: therapies, techniques and activities to maximize functioning and independence, therapies, techniques and activities to promote quality of life and wellbeing; strategies for communicating with the resident if the resident has compromised communication and verbalization skills; and strategies for identifying and addressing triggers for responsive behaviours if the resident exhibits responsive behaviours.[296(§ 41)] For people living with dementia, residing in an assisted living residence with a dementia care program is associated with a 40% lower likelihood of eventually transitioning to an LTC home.[297]

Some people living with dementia may require access to 24-hour care and supervision. If this cannot be provided at home or in a retirement home or assisted living residence, people often need to move into an LTC home. As previously noted, people who are diagnosed with dementia in hospital settings are much more likely to be moved into an LTC home upon their discharge from acute care settings.[160] However, there are other factors that contribute to the increased likelihood of moving into LTC homes, such as living alone (without a primary caregiver), having a caregiver who is unable to provide care, a recent history of wandering behaviour and other significant BPSD, the severity of cognitive impairments and the need for assistance with ADLs.[189,298] However, it is estimated that about one in 10 new residents admitted to an LTC home (regardless of their cognitive status) could have been cared for at home if formal supports were in place.[299] About one-third of people living with dementia move into an LTC home within three years of their diagnosis, and more than half within five years, although transition periods to living in LTC homes tend to shorten with increasing age.[194] In all, about 40% of people currently living with dementia in Canada are estimated to be living in LTC homes,[189] while 60% of LTC home residents have a formal diagnosis of dementia.[300]

In some cases, transitioning to living in LTC homes can be beneficial for both the well-being of the person living with dementia and their caregiver(s). LTC homes provide people living with dementia with continuous care and support as their care needs become more complex. This can allow people living with dementia to have a more consistent routine, more regular medication administration, better access to food and more socialization.[160] To this end, there is evidence that approximately 33% of persons who moved into an LTC home after receiving publicly funded home care experienced improvements in their cognition.[160] It has also been observed that hospitalization rates decrease after individuals with dementia are admitted to LTC homes, regardless of whether they received publicly funded home care prior to admission.[160] However, this is not necessarily true across all LTC settings, as some residents living with dementia experienced greater harms and higher mortality risks in LTC homes compared with those receiving home care.[301,302]

While transitioning a person living with dementia into an LTC home may be a beneficial and necessary step in their dementia care journey, their caregiver(s) may have many mixed, complex feelings, such as guilt, loss, sadness, anger, shame or defeat. These feelings can persist, as levels of emotional distress can remain as high as they were pre-placement.[303,304]

The public perception of LTC homes in Canada is still generally negative. In a survey of Canadians conducted by the NIA between November and December 2020 and within the first year of the COVID-19 pandemic, 85% of participants of all ages, and 96% of participants aged 65 years and older, reported that they would do everything

they could to avoid moving into an LTC home as they get older.[305] This overwhelming sentiment was likely related to the catastrophic outcomes being experienced by LTC home residents during the COVID-19 pandemic.[306] In July 2020, another survey by the NIA revealed that 60% of Canadians, including nearly 70% of adults aged 65 years and older, felt that COVID-19 changed their opinion on whether or not they'd arrange for themselves or an older loved one to live in an LTC or retirement home.[307] In the NIA's latest Ageing in Canada Survey, only 3% of its respondents aged 50 years and older stated that they wanted to move into an LTC home or residence as they aged.[163]

Many of the PSWs who provide direct care for people living with dementia in LTC home settings are not appropriately trained nor sufficiently paid to provide high quality dementia care.[308,309] PSWs have identified needing more support in understanding dementia, responsive behaviour and person-centred communication, and in recognizing delirium.[269] During the COVID-19 pandemic, the chronic poor working conditions of PSWs within LTC homes were highlighted; many PSWs still remain poorly paid, receive few work benefits and continue to work multiple jobs to earn enough income.[310,311] This results in high levels of burnout and ongoing staffing problems, as staffing turnover rates for PSWs currently remain high. In fact, as many as 40% of PSWs left the health care sector within a year of completing their training, while 25% of PSWs with more than two years of training leave annually.[312]

Poor organizational practices in institutionalized settings can lead to poor delivery of care.[313,314] At times, management can be removed from care practices and fail to communicate with care staff. Organizations may create policies without truly accounting for staff needs and conditions, or dismiss staff safety and concerns.[313,314] Other factors include shortage of health care and social care providers, low provider-to-resident ratios, increased workload, restrictive scheduling and a focus on basic physical tasks such as eating, toileting and bathing.[313,314] These poor working conditions, combined with stigma against dementia (where people with dementia are dehumanized or regarded as being less than persons), may contribute to inadequate or harmful care practices.[315] These circumstances undermine the dignity and human rights of people with dementia, adversely affecting their quality of life and well-being.

Understanding and Addressing Responsive Behaviors in the Provision of Dementia Care

Most people living with dementia will experience responsive behaviours (also referred to as behavioural and psychological symptoms of dementia, or BPSD), meaning words, actions or reactions that communicate an unmet need or response to changes in their health, environment or social circumstances. In some cases, these behaviours may place the person or others in their environment at risk. These individuals benefit from specialized behavioural support programs that provide assessment, treatment, care planning and capacity-building support across care settings. One example is Behavioural Supports Ontario (BSO), described in Box 6. BSO has helped educate and support care providers in LTC homes, as well as those providing home and community care, to provide safe and high quality dementia care.

Box 6: Improving Dementia Care Practices Through Behavioural Supports Ontario (BSO)

BSO was launched by the Ontario Ministry of Health and Long-Term Care in 2010 as a project supported by an original annual investment of $40.4 million. It has since expanded into an ongoing province-wide initiative that supports older adults living with, or at risk of, responsive behaviours associated with dementia, mental illness, substance use and/or other neurological conditions, as well as their caregivers.[316] In its current form, it reports to Ontario's Ministries of Health and Long-Term Care as well as Ontario Health.

BSO currently receives over $110 million in annual funding ($95 million for BSO services in LTC homes, $15 million for BSO services in the community and in hospital settings) and employs approximately 1,500 full-time equivalent care providers in a range of disciplines and roles, such as nurses, social workers, recreation therapists and PSWs.[317] The majority of BSO funding supports the salaries and benefits of BSO health care providers. A smaller portion also supports specialized education and training, primarily through the Behavioural Supports 5 Specialized Training and Resources (STaR) Programs, as well as the purchase of therapeutic equipment and supplies used to support care delivery. The BSO Provincial Coordinating Office, which was created in 2015, provides provincial leadership and coordination for BSO by supporting governance and collaboration, monitoring performance and impact, promoting accountability, developing and spreading best practices and resources and serving as a central source of information and connection for partners across Ontario.[318]

There are three core pillars to BSO's current provincial framework of care: 1) System Coordination and Management; 2) Integrated Service Delivery – Intersectoral and Interdisciplinary; and 3) Knowledgeable Care Team and Capacity Building.[319] BSO also operates under seven value-based principles rooted in person and family-partnered care: behaviour is communication; respect; diversity; collaborative care; safety, system coordination & integration; and accountability & sustainability.

BSO teams conduct comprehensive assessments, document behavioural patterns and develop individualized support plans to address the frequency, severity and risk associated with responsive behaviours and to improve quality of life for people living with dementia. These plans are implemented collaboratively with clinical partners and are continuously monitored and adjusted based on the individual's response.[320,321] Through this approach, BSO offers a broad range of services and supports designed to meet the needs of people living with dementia and older adults with complex behavioural needs across the care continuum.

BSO Services in the Community: BSO community-based teams support older adults with behavioural health needs who are living in private dwellings, supportive housing and retirement homes, alongside their families and other community-based care providers. This stream focuses on providing proactive outreach, assessment and care planning to help people living with dementia remain in their homes and communities for as long as possible, while also building the capacity of unpaid caregivers and community-based care providers to manage complex behavioural needs safely and effectively.

BSO Services in LTC Homes: All LTC homes in Ontario have access to BSO services. Depending on the local model, support may be provided by BSO team members embedded within a home itself or by mobile BSO teams that serve multiple LTC homes within a geographic area. BSO teams work alongside residents, LTC home staff and care providers and caregivers to assess responsive behaviours, identify contributing factors and unmet needs, develop individualized care approaches and strengthen team knowledge and skills by providing education, coaching and practical supports.

BSO Services in Hospital Settings: In some areas of Ontario, BSO team members are embedded within a hospital or are part of a mobile care team, making BSO services available to people receiving care in hospital EDs and/or inpatient care units. These services support early identification of delirium and behavioural health needs, help prevent avoidable hospital admissions, reduce barriers to discharge and support timely, coordinated transitions between hospitals and other care settings.

Supporting Transitions across Settings: BSO supports smooth transitions across care settings by preparing individuals, providers from both sending and receiving care settings, families and unpaid caregivers for moves. It also facilitates behavioural care conferences and helps ensure that behavioural support plans and relevant documentation accompany the person changing setting. In 2024-2025, they helped transition 3,700 people from hospitals back into the community; transitioning 6,700 people into LTC homes from hospital settings and 5,700 people from the community. In 2024-2025, BSO accepted 53,800 new referrals, mostly from LTC homes (30,700 individuals, or 57%) but also from the community (13,400, or 25%) and hospitals (9,700, or 28%).[322]

Partnerships with Behavioural Support Units: BSO teams across all sectors work in partnership with several inpatient care units that also serve the BSO population across the province. One example is LTC home based Behavioural Support Units (BSUs). BSUs are specialized units within LTC homes that provide care for people living with dementia or complex mental health conditions whose behavioural health needs exceed what can be supported in a typical LTC home setting. Rooted in emotion-based and person-centred care, BSUs offer enhanced and specialized staffing ratios, multidisciplinary expertise, tailored environments, focused behavioural assessment and enhanced care planning.[323]

Admissions to BSUs are meant to be temporary, with the goal of stabilizing behavioural symptoms and developing care approaches that support a successful transition to another area of the same LTC home, another LTC home, or, in very rare cases, a community setting. In 2024–2025, Ontario had 21 BSUs with 395 spaces, receiving 941 applications, with 602 people added to a waitlist and a 64% acceptance rate. Prior to admission, 46% of residents came directly from acute care settings, 31% from community settings and 14% from another LTC home. Of those who were discharged from a BSU, the average length of stay was 349 days, with most transitioning to the same LTC home as the BSU (37%) or to another LTC home (8%). 45% of residents died during their stay, with an average length of stay of 394 days for this group.[320]

Recognizing the growing demand for this specialized care, the Ontario government committed $10.2 million in new funding in 2024–2025 for the continued operation of 51 BSU beds established in 2023–2024, and to increase BSU bed capacity by 210 beds over three years to help alleviate pressure on hospitals. This investment recognized the essential role BSUs have played as an entry point into LTC homes for people with complex behavioural health needs who may otherwise face significant barriers to admission to a typical LTC home setting.[317]

Finally, a core function of BSO is capacity building: BSO offers coaching and training supports to care providers to ensure care teams have the knowledge and skills needed to care for people with responsive behaviours.[320] For example, in 2024-2025, they provided more than 14,700 formal education sessions, training over 130,000 health care professionals.[322] BSO also supports family caregivers by providing education on dementia and responsive behaviours, practical strategies for prevention and response and guidance on community resources.[320]

A key offering are the 5 STaR Programs, which are designed to help health care providers better understand and respond to responsive behaviours.[324] The 5 STaR program includes PIECES, U-First!, Gentle Persuasive Approaches, DementiAbility and a BSO Foundations course reserved for BSO team members. To complement and build upon the 5 STaR Programs, the BSO Provincial Coordinating Office also develops additional education and training programs on a variety of behavioural health topics, including sexual expression, dementia care in acute care settings and personality disorders. The BSO Provincial Coordinating Office also develops practical clinical tools to support care teams in identifying potential causes of responsive behaviours, implementing preventative strategies and responding effectively in the moment, including the BSO-DOS©, My Personhood Summary© and My Transitional Care Plan©.[325]

BSO has been associated with improvements in care provider competency and quality of care in LTC homes, with respondents indicating that they felt more confident keeping residents safe while supporting their daily routines (78%), were able to provide accessible and comprehensive resident assessments that the care team could implement (84%) and actively sought input from residents and families when collecting assessments (89%).[326] There were also indicators of improved outcomes for people living with dementia, including fewer residents with severe behaviours (declining from 7.2% to 5.8%), lower rates of physical restraint use (from approximately 10% of residents to less than 5%), reduced reliance on antipsychotic medications (from more than 30% of residents to nearly 25%) and better development and implementation of individualized care interventions.[326,327]

In the early years of its implementation, BSO had significant impacts on dementia care systems. In four Local Health Integration Networks that were early adopters (Hamilton-Niagara-Haldimand-Brant, Central East, South East and North Simcoe Muskoka), BSO programs were estimated to have collectively saved nearly $6.7 million in 2012-13.[327] This was driven by lower rates of acute care hospitalizations of LTC home residents located in BSO early adopting regions, including a 22.3% reduction in ALC days, and an 11.5% reduction in total inpatient hospital days.[328]

The benefits of the BSO initiative can be seen at the individual, organizational and system levels. At the individual level, people receiving help from BSO were reportedly less agitated, more willing to accept care and more likely to return to or remain at home.[329] Caregivers described feeling less fearful and more confident in their ability to continue providing care, with some reporting an improved sense of self-worth, enhanced well-being and better quality of life.[329] At the organizational level, BSO was associated with positive outcomes for care providers, including increased confidence, knowledge, comfort and perceptions of safety when supporting individuals with complex needs.[329] Care providers reported a greater willingness to try new approaches, improved ability to manage challenging situations, and stronger teamwork and collaboration.[329] These benefits translated into positive workforce outcomes such as fewer sick days, higher job satisfaction and reduced staff turnover.[329] At the system level, BSO was found to reduce avoidable health system use, such as reduced hospitalizations, fewer crisis placements into LTC homes and fewer emergency (911) calls.[329]

However, the majority of BSO evaluations to date have been conducted in LTC home settings, and thus, their broader impact in community-based care remains largely underinvestigated.[327]

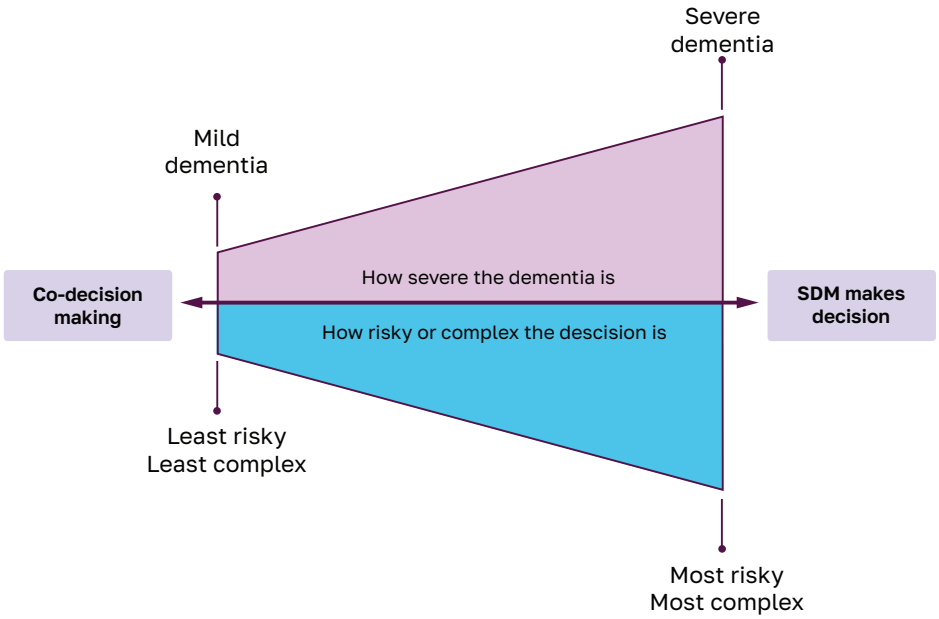
While the BSO initiative delivers high quality and impactful services with its current resources, additional investments will still be needed to support broader uptake and reach across Ontario. At present, BSO can meet the needs of only about 30% of the population it serves, meaning that too many Ontarians who could potentially benefit from this vital service are still unable to access it.[ii]

Substitute Decision-Making in LTC Home Settings

Although residential care settings can address some of the basic care needs of people living with more advanced stages of dementia, they can create new situations that families and caregivers may not be prepared for.

People living with dementia will often eventually require a substitute decision-maker (i.e., a designated person who is legally authorized to make decisions for someone who cannot make decisions for themselves) as their capacity to make decisions becomes further impaired with the progression of their dementia.[330] There are many nuanced social and ethical considerations for substitute decision-makers (Figure 10). This can involve making decisions in the "best interests" of the individual (considering the harms/benefits, previous/current circumstances, and the values, wishes and needs of the person) or using a "past preference standard" (making decisions based on the person's past wishes, values, beliefs and behaviours).[330] This can be particularly challenging around aspects of a person's well-being like sexual expression, which can become a more active issue as their dementia progresses, and their capacity to consent and the risk or complexity of a decision vary.[330] It may be difficult to know what someone's sexual history and past and current preferences are. Additionally, adult children may not like the idea of their parent having sexual partners, or spouses may not be comfortable with changes in sexual expression by their partner living with dementia. Resources to support substitute decision-making regarding sexual expression in people living with dementia have been created and are available online.[331,332]

Figure 10: A Diagram Showing the Trade-Offs Between Co-Decision Making and Substitution Decision Making, Based on the Riskiness or Complexity of the Decision and the Severity of the Dementia.[330]

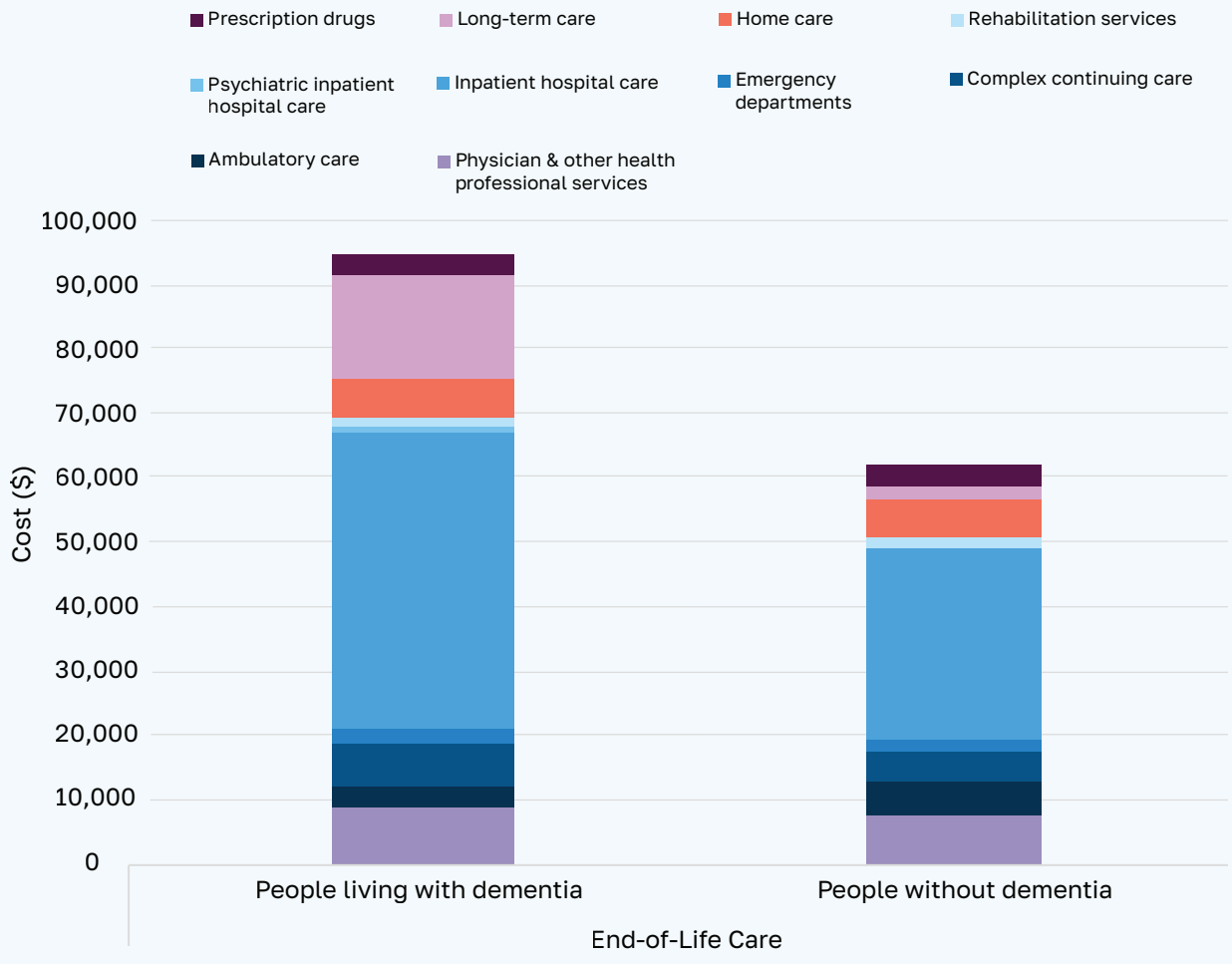


From "Manduca-Barone, A., Brassolotto, J., Grigorovich, A., Colobong, R., & Kontos, P. (2025). Substitute Decision-Makers & Sexual Expression of People Living with Dementia in Long-Term Care Homes." Reprinted with permission.[330]

Palliative and End-of-Life Dementia Care

End-of-life care is arguably the most underdeveloped area of care for people living with dementia, despite being the most expensive phase of care experienced in general and for people living with dementia in particular (Figure 11).[190] Additionally, end-of-life care may come sooner than people anticipate, as over 50% of people living with dementia in Ontario were found to die within five years of their diagnosis.[193]

Figure 11: Mean Annual Health System Costs in 2018 Canadian Dollars Associated with End-of-Life Dementia Care in the Year Preceding Death, Adapted from Bronskill et al. (2025).[190]



Palliative Care

End-of-life care often includes palliative care, which aims to relieve suffering and improve the quality of life for those living with a serious illness and their families.[333] An important aspect of palliative care is pain and symptom management, as well as social, psychological, emotional, spiritual and caregiver support.[333]

While palliative care originated as a care approach for cancer patients,[334] it has expanded to other terminal health conditions. However, people living with dementia have been found to be the least likely group with a common disease to receive palliative care in their last year of life.[258] In fact, people living with dementia are half as likely to receive palliative care compared with cancer patients in hospital and home care settings.[258,335] Older adults without dementia are also more likely to receive palliative care in home care settings, although there appears to be no difference between older adults with and without dementia in the likelihood of receiving palliative care in LTC homes and hospital settings.[335]

There may be several reasons why people living with dementia are not receiving adequate palliative care. Some may relate to the prognosis of dementia itself. Dementia has an unpredictable and highly variable trajectory, which can make it difficult for care providers and caregivers to anticipate changing palliative care needs and determine the appropriate level of support at different stages of the illness. A palliative approach to care can help address this challenge by focusing on quality of life, pain and symptom management and physical, psychological and spiritual needs throughout a person's dementia care journey, with care adapted as needs, preferences and goals change. Communication challenges in late-stage dementia further contribute to this uncertainty, as people living with dementia often have difficulty expressing pain or discomfort. This then requires both their care providers and caregivers to be vigilant and identify non-verbal indicators of pain, such as body language and non-verbal signs, behavioural changes or physiological responses (e.g., swelling, pale or flushed skin). These factors can make it challenging to predict end-of-life timing and to know when to initiate palliative care.[336] This reinforces the importance of a palliative approach that responds to evolving needs, preferences and goals of care rather than solely on prognosis or proximity to death.

Often in health care, a "more life" approach is used, which focuses on the quantity of life and tries to overcome decline. This approach inadvertently often pushes palliative and end-of-life care out of the conversation,[337] as the focus may remain on treatment, stabilization and the prolongation of life, with less attention given to quality of life, comfort and other palliative care needs. As an example, people living with dementia often die from secondary complications of their dementia (e.g., urinary tract infections, pneumonia), and therefore, health care providers may focus on managing these secondary conditions and overlook the potential underlying need for a person living with dementia to receive a more palliative approach to their care.

Some care providers may lack dementia-specific palliative care education, training, tools or experience to respond to the needs and circumstances of people living with dementia. This includes addressing changes in communication abilities, especially around pain, where people living with dementia may not be able to communicate what they are experiencing as clearly to their care providers and caregivers, who thus must be attuned to non-verbal cues.

Finally, given the progressive nature of dementia, advance care planning is particularly important and extends beyond end-of-life conversations. Earlier and ongoing advance care planning can help people living with dementia communicate their values, wishes and preferences for future care, while supporting families, caregivers and care providers in preparing for decisions that

may arise as dementia progresses. However, advance care planning and end-of-life conversations may not be discussed between people living with dementia and their caregivers, families and care providers after a diagnosis. Thus, when it comes time for family members to make significant health care decisions, caregivers may be left unprepared for this final stage of the dementia care journey.

Recent work by Canadian researchers aims to promote end-of-life care specifically for people living with dementia.[338]

Together, they have created an end-of-life dementia care framework presented in Box 7.

Overall, there is limited information available about where people living with dementia die. For people living with dementia already residing in LTC homes, 75% will die in these settings, while about 21.6% will die in a hospital.[339] Given that the majority of people living with dementia in LTC homes will remain in these settings through the end-of-life, it is important to ensure LTC homes can support a palliative approach to care and provide high quality end-of-life care.

Box 7: Dying on Our Own Terms: A Relational Caring End-of-Life Dementia Framework[338]

Canadian researchers have created a comprehensive end-of-life dementia framework. This was based on extensive research of policy and practice documents about end-of-life dementia care, as well as conversations with stakeholders including: people living with dementia (both in the community and in LTC home settings); family members of people living with dementia (both in the community and in LTC home settings) and bereaved family members; and dementia care providers,

This framework emphasizes the provision of compassionate relational care, which focuses on all relationship types (e.g., with humans, nature, pets, the environment) and their interconnected components and supports.

Compassionate relational caring at end-of-life involves:

- Learning about and respecting people living with dementia;
- Supporting quality of life and meaningful engagement;
- Supporting family and relational connections;
- Creating a comforting environment for people living with dementia and their families; and
- Nurturing a supportive and caring health care culture.

The ingredients to support and sustain compassionate relational caring at end-of-life include:

- Addressing stigma, prejudice, misunderstanding and discrimination;
- Nurturing strong relational connections between all individuals involved;
- Maintaining open, honest and transparent communications; and
- Supporting relational caring practices and policies over the dementia journey.

Medical Assistance in Dying (MAiD) and Dementia Care

Medical Assistance in Dying (MAiD) has been allowed in Canada since 2016. In 2024, 16,499 people received MAiD, accounting for 5.1% of all deaths in Canada.[340] However, only 2.2% of all people who received MAiD also had a diagnosis of dementia.[340] The Criminal Code requires a person to have the capacity to provide final consent to MAiD (except in limited circumstances, when the person has entered a waiver of final consent with their practitioner). This may create a legal bind for people living with dementia. Those who have the capacity to consent may be at a stage in their dementia care journey where they feel they are still experiencing a reasonable quality of life, but they may anticipate wanting to receive MAiD in the future when they no longer have the capacity to make this health care decision. Thus, there have been concerns that people with a diagnosis of dementia may opt for MAiD earlier than they would have otherwise preferred, to avoid losing their chance to choose when they want to die.

Recently, there have been more conversations about making advance requests possible. In this scenario, a person could outline when they would want to receive MAiD before they are close to dying, even if they have lost their capacity by that point to actively express their consent. In 2024, the Canadian Ministers of Health and Justice launched a national conversation to hear what Canadians had to say about this issue.[341] While many people (67%) support advance requests for MAiD for people with an incurable medical condition that will lead to a loss of decision-making capacity, those not in support have raised some concerns. These concerns include whether people can truly provide informed consent when they cannot know for certain what they will experience in the future, and that being able to provide final consent right before MAiD is provided thus remains crucial.[341] The ASC supports the notion of advance requests, as it believes people living with dementia have the right to participate in decisions about their lives and care; however, the ASC recognizes the need for informed choice and the need for safeguards to support vulnerable persons.[342,343]

Advance requests for people living with dementia have long been available in the Netherlands and are referred to as "advance euthanasia directives", However, Dutch physicians have expressed ethical concerns about honouring advance euthanasia directives and thus do not necessarily proceed with these requests.[344,345] One notable case study from the Netherlands arose in 2019, which at the time was the first case to result in a criminal investigation since the legalization of MAiD in 2002.[346] In this case, a woman diagnosed with Alzheimer's disease repeatedly expressed a strong desire not to live in a nursing home and completed an advance euthanasia directive while deemed competent, requesting euthanasia should her quality of life decline significantly. As her dementia progressed, she was eventually admitted to a nursing home, where, after a period of adjustment, her physicians concluded that she was suffering and decided to proceed with her advance euthanasia directive. Before the procedure, the physician providing MAiD placed a sedative in the patient's coffee without her knowledge, potentially impairing her judgment and capacity. The patient later became physically resistant during the administration of MAiD medications and needed to be restrained, raising concerns that she may not have been ready or willing to die at that moment. Significant ethical concerns were subsequently raised regarding the clarity and interpretation of the advance euthanasia directive, the patient's capacity at the time it was written, the use of undisclosed sedation, and the patient's apparent resistance during the procedure. This highlights the challenges with writing advance requests for people living with cognitive impairments, especially if they are written with some ambiguity, along with the manner in which they are carried out.[347]

Québec is Canada's first and only province to allow advance requests for MAiD. To qualify for an advance request, a person must have been diagnosed with a serious and incurable illness that will lead to their eventual inability to give consent to their personal care decisions. Although not required, they may choose a "trusted third person" who will make sure the wishes of the person with dementia expressed in their advance request for MAiD are known and respected.[348] Since being allowed in Québec, over 2,100 people have had their advance requests for MAiD approved, although it is unknown how many of these requests have since been carried out.[349] Notably, while advance requests for MAiD are allowed in Québec, it is not yet considered legal under Canada's Criminal Code; however, the federal government has not indicated that it plans to contest Québec's advance request regime, but has also not yet amended the Criminal Code to authorize advance requests.[350] The Québec Minister of Justice and Director of Criminal and Penal Prosecutions has also issued prosecutorial guidelines and directives stating that it is not in the public interest to file criminal charges related to a death that occurs as a result of MAiD provided in compliance with a person's free and informed wishes, in accordance with Québec's current legislation. For now, Québec serves as a case study for the introduction of advance requests for MAiD in Canada; time will tell if Canada's other provinces and territories follow suit, and what the federal government will do as a result of their 2024 consultation.

Dementia Policy and Strategic Government Priorities in Canada Around Improving Dementia Care Systems

The goal of the following analysis is to examine what Canadian governments have done to improve their care systems for people living with dementia, to identify critical gaps and future opportunities.

Research Approach

The goal of the NIA's first report in this series was to identify publicly available strategies and priorities to improve public awareness, reduce dementia risk and challenge the stigmatization of dementia. In preparing the report, authors carried out a web-based search examining provincial/territorial and federal seniors and dementia strategies that were published between 2010 and 2025.

Given the need to strengthen Canada's care systems for people living with dementia, for this report, the NIA similarly examined publicly available dementia and seniors strategies and progress reports from Canada's provincial and territorial governments published between 2010 and 2026. This report used the same search methods outlined in the first report to identify new strategies, progress reports and action plans. The search strategy was also extended to examine any general health care strategies or frameworks, as well as documents relating to the provision of end-of-life care, for each province and territory. See Appendix A for the description of the analysis methods used in the first report and the present report.

At the federal level, the analysis drew primarily on Canada's 2019 national dementia strategy and its associated annual reports from 2020 through 2025, as well as relevant government webpages (e.g., PHAC, Library and Archives Canada). The review focused specifically on themes related to improving dementia care systems in Canada.

To understand provincial and territorial approaches, the NIA revisited the articles initially identified in its first report. In the first report, the NIA conducted an environmental scan of strategic documents (such as dementia strategies, seniors strategies, action plans and related frameworks) intended either to support people living with dementia or to guide broader ageing-related policy. Documents were included if they were currently active or had been published since 2010 and were available in English (see Appendix A for the full methodology). Where available, progress updates or status reports were also incorporated. As most of Québec's reports were presented only in French, to ensure accuracy, the NIA validated findings with a Québec government official in the Ministry of Health and Social Services (Ministère de la Santé et des services sociaux) who was knowledgeable of Quebec's dementia strategy. This methodology was repeated to identify any new provincial or territorial strategies that had been released since publishing the first report of this series. An additional search of provincial and territorial health care strategies was also included.

For this report, the NIA re-examined the 20 provincial and territorial dementia or seniors strategies,[19–21,23–26,29–32,34–37,39,41–44] and three associated progress reports,[27,49,52] that were identified in the first report of this series. Since the release of the first report, New Brunswick has released its new dementia and seniors strategies, which were included in this analysis.[22,33] Additionally, progress reports or action plans from Alberta,[46] British Columbia,[47,48] Newfoundland and Labrador,[50,51] Québec,[45,53,54] Nunavut[55] and the Yukon,[56,57] as well as a 2018 seniors initiative from Prince Edward Island that was not originally included in the previous report,[38] were included in this analysis. In total, there were seven dementia strategies with three progress reports and one action plan,[19–26,45,46,49–51] and 15 seniors strategies with seven progress reports and two action plans included in this

analysis.[27,29–44,47,48,52–57] The status of each strategy as either active, inactive or completed was confirmed through verification with members of the PHAC-supported Federal/Provincial/Territorial Coordinating Committee on Dementia or by contacting government representatives from that jurisdiction.

For this second report, the NIA also expanded the search beyond dementia and seniors strategies to include dementia care initiatives prioritized within other health care strategies or initiatives. This included ministerial annual reports (from ministries related to health, seniors or LTC), the most recent health care strategic plans, LTC strategies and frameworks and documents related to end-of-life or palliative care. To avoid duplication, only information not already captured through the dementia or seniors strategy analysis was included. From this, the NIA identified 15 series of provincial and territorial ministerial annual reports;[58–69] 13 health system strategies;[70–83] six LTC strategies or frameworks;[84–89] eight end-of-life or palliative care frameworks and three progress reports;[90–100] and four other types of government reports to include in this analysis.[101–105]

For dementia-specific care strategies, the NIA extracted each jurisdiction's core objectives. For broader ageing-focused or general health care system documents, the analysis centred on objectives related to dementia, cognitive health, or brain health (see Appendix B). For the purposes of this report, emphasis was placed on objectives linked to care systems and the provision of paid care for people living with dementia (policies related to unpaid caregiving will be explored in the next report of this series).

Finally, the NIA conducted an additional scan of government websites to identify current information on dementia-related programs, care supports and public resources (Appendix C). Programs operated at the level of regional health authorities or by non-government organizations were not included.

Research Findings

Updates from the First Report

The first report in this three-year series examined federal, provincial and territorial dementia strategies, with a focus on public awareness, dementia risk reduction and stigma. Since the publication of that report, New Brunswick has released its new provincial dementia strategy.[22] This strategy includes objectives related to brain health promotion and dementia risk reduction, emphasizing the role of healthy lifestyles in supporting brain health and reducing dementia risk. New Brunswick also aimed to advance risk-reduction initiatives by aligning dementia prevention efforts with broader chronic disease prevention strategies. In addition, the strategy prioritized public education and awareness through provincial campaigns intended to connect residents with relevant information and resources. However, it did not include clear or explicit objectives related to reducing dementia-related stigma.[22]

Federal Government Strategic Priorities and Actions

Canada released its first national dementia strategy in 2019, A Dementia Strategy for Canada: Together We Aspire.[10] Since then, seven annual progress reports have been submitted to Parliament, covering activities from 2019 through 2025.[12–18] The strategy is designed to be implemented collaboratively across federal, provincial, territorial and local governments, as well as in partnership with other organizations and individuals.

PHAC serves as the federal lead on the strategy, supporting implementation of some key elements through its leadership and funding of several targeted initiatives (Table 3). This includes creating three funding programs (the Dementia Community Investment (DCI), the Dementia Strategic Fund (DSF) and the Enhanced Dementia Surveillance Initiative (EDSI)) and providing additional funding to the Centre for

Aging + Brain Health Innovation (CABHI) to fund other projects and innovations.[351] Further, the Canadian Institutes of Health Research (CIHR), Canada's health research funding agency, funds research and innovation to help prevent dementia through risk reduction, advance therapies and improve the quality of life of people living with dementia and their caregivers.

The national dementia strategy is organized around three overarching objectives. Each objective includes several areas of focus, paired with corresponding "aspirations" that describe the intended long-term outcomes.

The national objectives are:

- Prevent dementia
- Advance therapies and find a cure
- Improve the quality of life of people living with dementia and for their caregivers

The present analysis focuses on the national strategy's pillars and areas of focus relating to improving care systems for people living with dementia across their dementia care journeys.

Canada's national dementia strategy is built on several pillars, including a focus on cultivating a skilled workforce. A well-trained and ample workforce will enhance dementia research and ensure evidence-based care, thereby improving the quality of life for those living with dementia and their caregivers. Key priorities in strengthening this workforce involve encouraging recruitment to dementia-related training programs, thus increasing the supply of trained dementia care providers; supporting strategies to lower injury and turnover rates, especially among personal care providers; integrating a dementia lens within existing curricula; developing and sharing information on non-pharmacological, evidence-informed interventions, best practices and therapies for dementia with professional care providers; and exploring what additional tools (e.g. training webinars, workshops) are necessary to support professional care providers in providing quality dementia care.

Canada's dementia strategy also emphasizes the provision of equitable care, with special considerations for higher-risk populations (e.g., individuals with existing health issues, older adults, women), populations facing barriers to equitable care (including ethnic and cultural minority communities, Two-Spirit, lesbian, gay, bisexual, trans, queer, and intersex (2SLGBTQI+) individuals, official language minority communities, rural and remote communities and young onset individuals), and populations who face barriers to accessing equitable care and are at higher risk of developing dementia (e.g., Indigenous people, individuals with intellectual disabilities). Initiatives supporting these groups include the DCI, which funds community-based projects, and cross-sector collaborations that promote healthy living and prevent chronic disease, especially among those experiencing health disparities. Additionally, targeted funding and research efforts, such as the Canadian Consortium on Neurodegeneration in Aging (CCNA), incorporate Sex and Gender-Based Analysis Plus (SGBA Plus) to advance health equity.

With the dementia strategy's first national objective being to prevent dementia, one of its four focus areas is to "expand awareness of modifiable risk and protective factors and effective interventions." Within this objective, it was recommended that care providers incorporate brain health and dementia prevention information into their care practices, including providing information about other chronic conditions with similar risk and protective factors.

The dementia strategy's second national objective, advancing therapies and finding a cure, includes five focus areas: setting and reviewing strategic dementia research priorities; increasing research efforts; developing innovative therapies; involving people with dementia and their caregivers in therapy development; and promoting the adoption of research results in clinical practice and community supports.

This section highlights several CIHR initiatives, notably the Brain Health and Cognitive Impairment in Aging (BHCIA) Research Initiative. BHCIA is a Canadian research hub uniting over 350 researchers and partners to accelerate the development of dementia treatments and care. Through BHCIA, CIHR has funded 16 strategic opportunities aligned with the national dementia strategy, the Dementia Research and Innovation Funders Alliance (which includes 30 organizations), and the CCNA national dementia research hub. Since 2014, the CCNA has focused on prevention, treatment and quality of life. It has contributed significantly to the development of dementia therapies (including developing an antibody for treatment of early Alzheimer's disease), conducting trials for apathy and agitation management and supporting non-drug interventions for people with dementia. The CCNA has generated over 800 knowledge products related to the development of advanced dementia therapies.

The dementia strategy's third national objective focuses on improving the quality of life for people living with dementia and their caregivers. Within this objective, there are five areas of focus, which include promoting and enabling early diagnosis, addressing the importance of access to quality care throughout the dementia care journey and building the capacity of care providers to provide quality dementia care.

The annual reports outline the progress made under the national dementia strategy's primary objectives, providing updates on key initiatives, research and relevant data points.[12–18] They also highlight the advancement of projects funded through PHAC and efforts led by other organizations, including some that do not receive federal funding.[12–18] The content of the annual reports reflects the broad range of stakeholders and partners involved in supporting the strategy, with sections of the report detailing the initiatives of these groups as they relate to the national objectives.[12–18]

The reports note new research or programs related to changing and improving dementia care systems, including initiatives funded by PHAC (e.g., projects funded by the DSF), CIHR (as discussed above) and, in some cases, initiatives undertaken by other organizations. Since 2015, the federal government has invested more than $600 million to support the objectives of the federal dementia strategy. As of June 2025, the DSF, the DCI, and the EDSI have collectively funded 86 projects, with 11 projects related to improving access to high quality dementia guidance, two projects to enhance provincial and territorial online dementia information resources and 30 projects to improve the health and well-being of people living with dementia and dementia caregivers.[18]

In particular, the DSF funded the Dementia Guidelines and Best Practices Initiative, which undertook various activities, such as funding projects to enhance access to high quality dementia guidance.[352] This initiative unfolded in three phases.[14] Phase I involved assessing the quality of dementia guidance available in Canada and internationally, examining development methodologies, and identifying gaps. Phase II centered on consulting guidance users to understand their experiences, usage and barriers. The insights from these first two phases led to Phase III, which provided funding opportunities to create guidelines and best practice resources for Indigenous-centred dementia care; individuals with both intellectual disabilities and dementia; identification, assessment and management of BPSD; culturally appropriate person-centred dementia care; training for first responders; and the establishment of dementia care resource hubs.[352]

As part of the national dementia strategy's goal to address and eliminate stigma and improve the quality of life of people living with dementia and caregivers, several public opinion research projects were conducted for PHAC.[351] In 2021, three projects involved paid care providers as respondents. One survey investigated dementia

care guidance and Indigenous populations, and was highlighted in the 2022 annual report.[15,353] Through a survey and in-depth interviews, the second examined the knowledge, perspectives and experience of dementia care providers, with its preliminary results discussed in the 2021 annual report and further discussion in the 2022 annual report.[14,15,155] A third investigated priorities for creating an information portal on dementia through focus groups.[354] Another public opinion research project, using interviews and a survey, asked people living with dementia and their caregivers about their quality of life, which touched on their experiences receiving health care, the types of paid care providers they have and their paid care providers' knowledge of dementia and tasks performed.[355]

The latest dementia strategy annual report also highlighted the work of other government departments and non-governmental organizations.[18] In 2023-2024, the Government of Canada finalized Aging with Dignity bilateral funding agreements with its provincial and territorial governments to support the goal of helping Canadians stay at home with access to home care (2023-2024 to 2026-2027) or safe LTC homes (2023-2024 to 2027-2028). Its Age Well at Home initiative has supported the Scaling Up Support Services for Seniors Living with Dementia and their Caregivers project, which has allowed the ASC to expand its First Link programs. Additionally, the First Nations and Inuit Home and Community Care program offers a range of basic home and community care services, which allows Indigenous people living with dementia to receive care in their homes and age in place within their communities for as long as possible.

It is important to acknowledge the limitations of this review. The NIA focused its analysis on the publicly available annual reports, with the most recent report providing information only up to June 2025. The NIA did not specifically analyze projects and funding that received non-direct federal government support (e.g., additional dementia-related research spending by the National Research Council, CIHR and the other national tri-council research agencies). Additionally, it is possible that some of the projects funded, such as those within the DCI, included a focus on care systems or a related topic but were not captured as part of the analysis due to the limitations of the search strategy. Furthermore, some initiatives may have received multi-year funding announced prior to but continuing past 2019.

Additionally, it is worth noting that the provision of health care in Canada is a provincial/territorial responsibility. Each province and territory determines which services are medically necessary and will be covered for residents. While the federal government may set standards for health care, provide funds to each province and territory and offer other supports (such as research funding or disease monitoring),[356] it ultimately has limited power over the delivery of care. Thus, it is understandable that the federal dementia strategy has been limited in creating objectives around improving dementia care systems.

Table 3: Components/Projects Across Federal Government Initiatives with Initiatives Related to Dementia Care Providers and Systems (2019-2025)

Initiative	Care Providers	Care Systems
Dementia Strategic Fund	Yes	Yes
Dementia Community Investment	No	No
Enhanced Dementia Surveillance Initiative (2019-2024)	No	Yes
Canadian Institutes of Health Research Brain Health and Cognitive Impairment in Aging Research Initiative	Yes	Yes
Centre for Aging + Brain Health Innovation	Yes	Yes
Public Opinion Surveys	Yes	Yes
National Public Education Campaign (2021-2024)	No	No

Data Sources: [215,351,357–360]

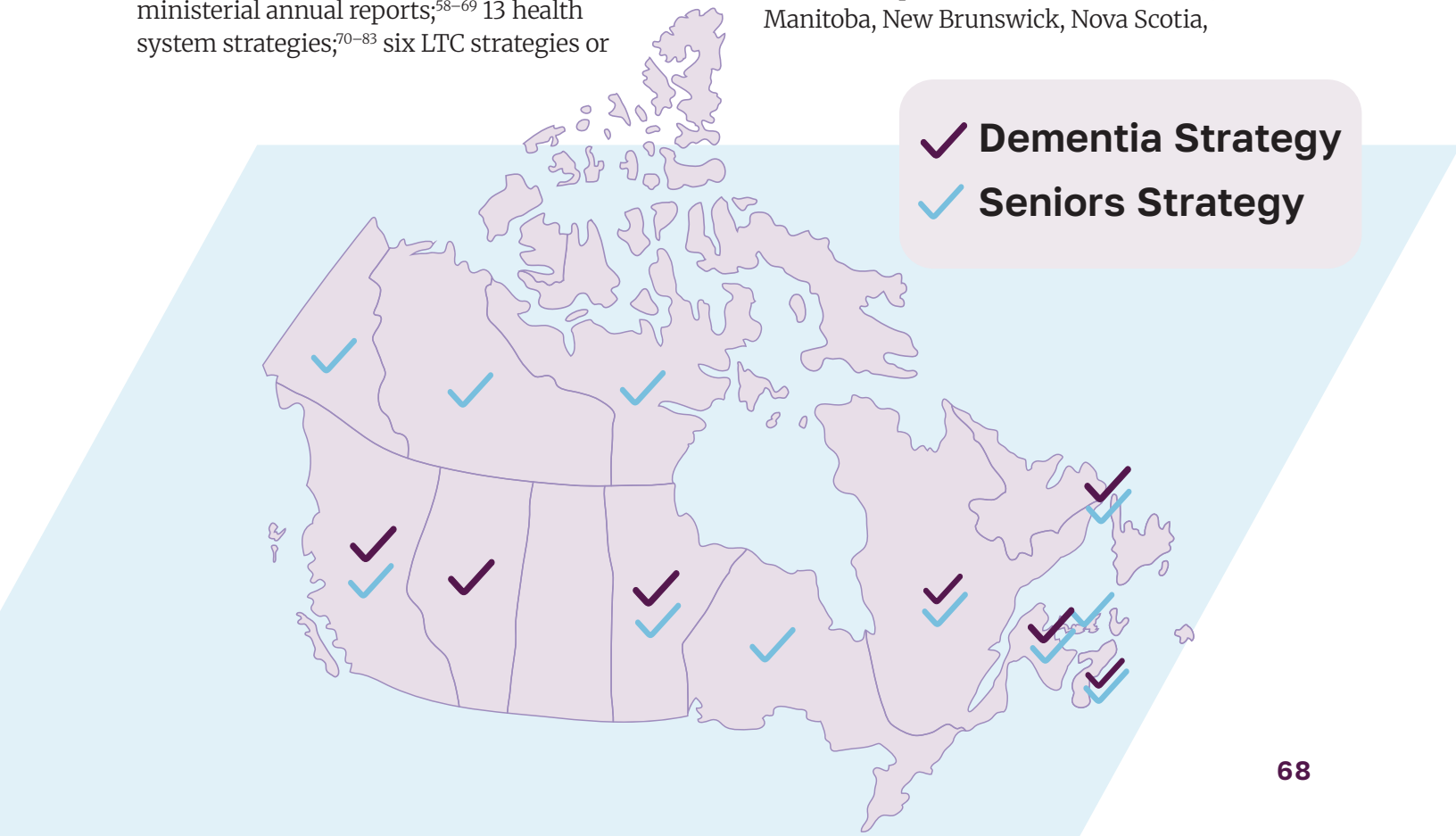
Provincial and Territorial Government Priorities Identified for Improving Their Dementia Care Systems

Since 2010, seven of Canada's 10 provinces (Alberta, British Columbia, Manitoba, Newfoundland and Labrador, Nova Scotia, Québec and, as of January 2026, New Brunswick) have published dementia strategies or action plans, as well as follow-up reports.[19–26,45,46,49–51] Currently, none of the territories has a dementia strategy, although the Yukon has indicated that the development of one is underway.[27] Additionally, Ontario is currently developing a dementia framework.[28] Since 2010, all three territories and eight of Canada's 10 provinces have published seniors strategies, including several follow-up reports and action plans.[27,29–44,47,48,52–57] Saskatchewan remains the only province to have developed neither a seniors nor a dementia strategy.

After expanding the search to include other health policy-related documents, an additional 15 series of provincial and territorial ministerial annual reports;[58–69] 13 health system strategies;[70–83] six LTC strategies or frameworks;[84–89] (two of which were identified through consultations with a representative of Quebec's Ministry of Health and Social Services (Ministère de la Santé et des services sociaux));[84,85] eight end-of-life or palliative care frameworks and three progress reports;[90–98,100] and four other report types to include in this analysis.[101–105]

Of the dementia strategic plans the NIA analyzed, three were reported to be actively used by the current government (British Columbia,[49] New Brunswick[22] and Québec),[26] and five (Alberta,[19] British Columbia,[20] Manitoba,[21] Newfoundland and Labrador and Nova Scotia)[23] were reported to be inactive (Appendix B). Only Newfoundland and Labrador (in 2023),[23] New Brunswick (in 2026)[22] and Québec (in 2025)[26] released their plans after the launch of the national dementia strategy in 2019. British Columbia was the only province to have two dementia strategies published since 2010, with the first released in 2012 and a follow-up action plan in 2016.[20,49]

Since 2010, all three territories and eight of Canada's 10 provinces (British Columbia, Manitoba, New Brunswick, Nova Scotia,



Newfoundland and Labrador, Ontario, Prince Edward Island and Québec) have published a strategy dedicated to supporting older adults. Furthermore, British Columbia (2012, 2024),[29,30] Ontario (2013, 2017),[36,37] Prince Edward Island (2018, 2021, 2026)[38–40] and Québec (2012, 2018, 2024)[41,53,54] each published multiple strategies or actions focused on older adults during this period. Seven jurisdictional strategies (British Columbia,[30] New Brunswick,[33] Newfoundland and Labrador,[34] Prince Edward Island,[40] Québec,[54] the Northwest Territories[42] and Nunavut)[43] were reported to be active by the current government, and eight strategies (British Columbia,[29] Manitoba,[31] New Brunswick,[32] Nova Scotia,[35] Ontario (2013, 2017),[36,37] and Prince Edward Island (2018, 2021))[38,39] were reported to be inactive.

Analysis of Dementia Strategies, Seniors Strategies and Health Strategies related to Improving Dementia Care Systems

When the NIA examined provincial and territorial strategies and frameworks relating to dementia, seniors, general health care and end-of-life care, the analysis identified numerous dementia-focused objectives or initiatives focused on improving access to the different areas of health care (i.e., primary care, specialist care, hospital settings, home and community care, care in LTC homes or end-of-life care; see Table 4) that span dementia care journeys. Alberta and Newfoundland and Labrador were the only jurisdictions with dementia-focused objectives or initiatives across their care systems.

Table 4: Provincial and Territorial Government Strategic Objectives or Initiatives Related to Improving Dementia Care Systems

P/T	Primary Care	Specialist Care	Hospital Care	Home and Community Care	LTC Homes	End-of-Life/ Palliative Care
AB	✓	✓	✓	✓	✓	✓
BC	✓		✓	✓	✓	✓ ✓
MB	✓			✓	✓	✓
NB	✓		✓	✓		✓
NL	✓	✓	✓	✓ ✓	✓	✓
NS	✓		✓	✓	✓	✓
ON			✓	✓	✓	
PE				✓		
QC	✓	✓		✓	✓	✓
SK	✓				✓	
NT					✓	
NU					✓	
YT				✓	✓	✓
Total	8	3	6	10	11	8

✓ = Dementia Strategy, ✓ = Seniors Strategy, ✓ = Other

Eight jurisdictions had objectives or initiatives around improving primary care.[19–24,26,46,49,101] Of these jurisdictions, five (Alberta, Manitoba, Nova Scotia, Québec and Saskatchewan) made commitments around adopting new models of care, which often focused on providing people living with dementia coordinated team-based primary care.[19,21,24,26,41,46,101] Four provinces (Alberta, British Columbia, Newfoundland and Labrador and Saskatchewan) had additional actions to support PCPs through additional dementia training, educational opportunities or improved tools and resources.[19,20,23,24,26,46,49] Four provinces (Alberta, New Brunswick, Nova Scotia and Saskatchewan) made commitments to create a better and more timely dementia diagnosis process,[19,22,24,46,101] and three (Manitoba, Québec and Saskatchewan) aimed to improve access to PCPs overall.[21,26,101]

Beyond primary care, three provinces had made commitments to improving access to specialists for people living with dementia and were the only provinces to have any initiatives related to the provision of specialist care.[19,23,41,46]

Six jurisdictions were found to have made commitments to improve hospital care for people living with dementia.[19,20,23,24,32,46,47,49,361] These initiatives were often focused on supporting better training for hospital care providers to care for people living with dementia, promoting the creation and use of best acute care practices.

Regarding the provision of home and community care, ten jurisdictions had made commitments around improving community-based dementia care by increasing home care capacity and community programs and services.[19–21,23,24,27,31,32,34,39,44,46,49,53,102,104,105]

For the provision of LTC in institutional settings, eleven jurisdictions made commitments aimed at strengthening the provision of dementia care.[19,21,23,24,36,37,43,46,49,54,86,105,362,363] The most common focus was on improved workforce training. For example, British Columbia, Manitoba, the Northwest Territories and Saskatchewan referenced the implementation of the PIECES approach to care for LTC home care providers. The PIECES approach is an evidence-informed care framework that emphasizes understanding the multiple, interconnected factors contributing to responsive behaviours, avoiding assumptions and considering all domains of the person.[21,32,86,364,365] Similarly, other commitments included improving the management of dementia-related health conditions, such as depression and delirium, as well as responsive behaviours.[21,32,36,37,49,86] Alberta, British Columbia, Ontario and Saskatchewan also made commitments related to medication monitoring, with the aim of reducing the inappropriate use of antipsychotics to manage responsive behaviours.[19,37,49,53,365] In addition, Alberta, British Columbia and Manitoba made commitments to review, enhance, develop or promote standards and measures of quality dementia care.[19,21,46,49] Finally, Alberta, Manitoba, Ontario and Saskatchewan made funding commitments to expand LTC home capacity, including increasing the number of beds, constructing new homes or hiring additional care providers.[19,21,46,362,363]

Finally, six provinces have all made commitments broadly focused on improving end-of-life and palliative care for people living with dementia within their dementia strategies.[20–24,26,49] Québec was the only province to explicitly include MAiD as part of its palliative and end-of-life care approach.[26] While eight jurisdictions had general frameworks relating to the provision of end-of-life care,[90,91,94–100] only Alberta, British Columbia, Nova Scotia and the Yukon made any mention of dementia within these frameworks. However, for most of these frameworks, there was little elaboration on how they would address the needs of people living with dementia apart from those living with other chronic conditions.

Analysis of Dementia Strategies, Seniors Strategies and Health Strategies Related to the Provision of Dementia Care

While there were over 25 identified commitments across Canada's provinces and territories aimed at generally improving the provision of care for people living with dementia, the 10 most common, which were implemented in at least three provinces, will be discussed below (Table 5).

Table 5: Provincial and Territorial Government Strategic Objectives Related to Improving the Provision of Dementia Care

P/T	Advanced Care Planning	Care Pathways	Health Care Provider Training	Management of BPSD	Access and Support in Rural Areas	Care Coordination	Care Transitions	Improve, Add or Support First Link	ADPs	Research
AB	✓		✓	✓	✓	✓	✓	✓	✓	✓
BC	✓	✓	✓	✓✓		✓	✓	✓✓		✓
MB					✓			✓	✓	✓
NB			✓✓	✓		✓			✓	
NL	✓	✓	✓✓	✓		✓		✓		
NS		✓	✓		✓		✓	✓	✓	
ON				✓		✓	✓		✓	
PE			✓	✓		✓			✓	
QC			✓	✓✓	✓	✓	✓			✓
SK			✓	✓	✓			✓	✓	✓
NT			✓	✓					✓	
NU										
YT			✓					✓	✓	
Total	3	3	10	9	5	7	5	7	9	5

✓ = Dementia Strategy, ✓ = Seniors Strategy, ✓ = Other
BPSD = Behavioural and Psychological Symptoms of Dementia ; ADP = Adult Day Programs

Three jurisdictions made commitments related to improving advanced care planning by promoting a proactive approach to care planning, which may include future decision-making and desires regarding end-of-life care.[19,20,23,49]

Three jurisdictions made commitments around improving their dementia care pathways, to help with the management and care of people living with dementia from the time of diagnosis and throughout their entire dementia care journeys.[23,24,49]

Ten jurisdictions made commitments or had initiatives related to increasing dementia training for health care professionals across all settings, including those currently in the workforce, as well as in entry-to-practice education programs.[19,20,22–24,32,34,46,49,54,86,102,366–370]

Nine jurisdictions made commitments around improving the management of BPSD in a variety of different care settings.[19,20,22,23,26,37,39,41,45–47,49,53,86,371] For example, British Columbia planned to develop and implement clinical guidelines for the effective use of medications in order to reduce the use of antipsychotic medication in treating behavioural symptoms.[20,47,49] Other provinces included commitments to support training on the management of BPSD or for the creation of specialized services to help health care providers, and in some cases, caregivers, with BPSD management in a variety of care settings.

Five jurisdictions made commitments or had active initiatives to improve access or support for dementia care in rural areas.[19,21,24,41,101]

Seven jurisdictions made commitments or recommendations to support better care coordination, which could involve ensuring people living with dementia have access to an interdisciplinary health team, as well as having a case manager to help people living with dementia and their families navigate the system and access supports.[19,20,22,23,26,40,46]

Five jurisdictions made commitments to improve care transitions (such as the transition between receiving community and institutional-based care), focusing on either reducing the number of transitions, ensuring these transitions are happening at the appropriate time or making the process more seamless.[19,24,26,37,46,49]

Seven jurisdictions reported having initiatives to add, improve or support their regional Alzheimer Society First Link programs.[19–21,24,29,34,47,49,105,224,372] As noted earlier in this report, First Link is a referral program designed to help newly diagnosed people living with dementia and their families and caregivers get the help they need as soon as possible. It is currently offered in every province and territory except for Nunavut.

Nine jurisdictions made commitments or had initiatives underway related to improving the accessibility and availability of ADPs.[19,21,24,27,32,44,46,86,102–104,361,363,373]

Finally, five jurisdictions made commitments to allocate dedicated funding towards research projects, or had designated dementia research teams that were aimed at improving health care or health systems for people living with dementia.[19–21,26,46,49,101] This included research to promote better health care outcomes or to improve clinical practices through knowledge transfer and mobilization. While other provinces also committed funding for dementia research, it was unclear if this funding would be directed to improve their care systems and practices.

Only Nunavut did not have any publicly identifiable initiatives specifically related to improving the provision of care for people living with dementia.

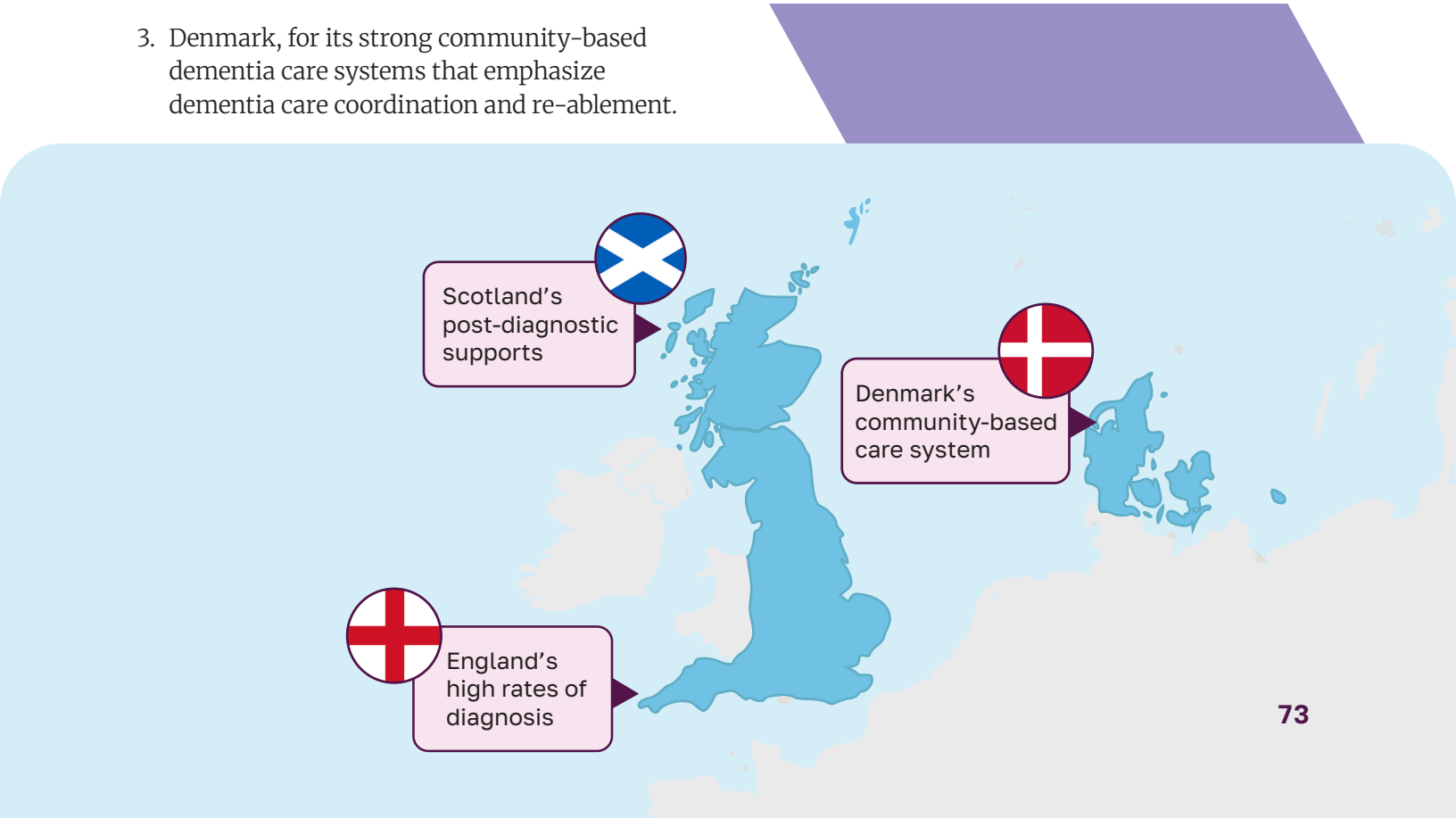
Learning from Other Jurisdictions Beyond Canada

An Exploration of Some International Best Practices

While Canada's dementia care systems still offer considerable room for improvement, promising international examples show that meaningful progress is achievable. Many countries have implemented high quality and innovative approaches to supporting people living with dementia across the care continuum, and the following three stand out for their unique innovations or approaches to providing dementia care. Notably, all of these countries were among the first 10 in the world to develop a national dementia strategy:[374]

1. England, for achieving the highest known dementia diagnosis rates;
2. Scotland, for its strong commitment to providing post-diagnostic supports for people living with dementia; and
3. Denmark, for its strong community-based dementia care systems that emphasize dementia care coordination and re-ablement.

Although these countries share many common principles and goals, such as the provision of person-centred care, strong community supports, and greater system integration, each also demonstrates distinct strengths in how dementia care is organized, delivered and experienced. By examining these leading international approaches, Canada can identify practical lessons and opportunities to strengthen its own dementia care systems across all stages of the dementia journey.



How England Achieved the World's Highest Known Dementia Diagnosis Rates

England has become a global leader in achieving the highest dementia diagnosis rates, partially due to its proactive approach to identifying people living with dementia.

England's 2015 National Dementia Strategy, titled "Prime Minister's challenge on dementia 2020," set out a bold vision: for England to be "the best country in the world for dementia care and support and for people living with dementia, their caregivers and families to live; and the best place in the world to undertake research into dementia and other neurodegenerative diseases."[375] This was to be achieved through targeted actions across three themes: improving health and social care; promoting awareness, understanding, and social action by individuals, communities, and businesses; and research. England set an ambitious goal for two-thirds of people living with dementia to be identified and given appropriate support.[375,376]

Today, England is best known internationally for having achieved the highest reported dementia diagnosis rates in the world, with 66.2% of the estimated number of people living with dementia in the UK having received a diagnosis as of June 30th, 2026, nearly meeting its national target of 66.7%.[377] By comparison, other high-income countries typically range between 20 to 50%.[4,204] Among the UK's countries, England leads, followed by Northern Ireland at 62% in 2022–2023, Wales at 53.9% in 2021–2022, and Scotland at 46.5% in July 2025.[377]

England's achievement of the highest dementia diagnosis rate has been driven in part by a national effort to proactively identify undiagnosed cases. The National Health Service of England launched pilot projects in which health professionals go into LTC homes to assess older adults who may have missed being diagnosed, and in at least 14 areas of the country, LTC home residents are now being proactively assessed by specialist nurses and other health care professionals.[378,379] The proactive assessment of LTC home residents is effectively closing the diagnosis gap, ensuring that people living with dementia who might otherwise go undiagnosed are identified and supported. While there has been much success towards improving diagnosis rates overall, some regions within England have higher diagnosis rates than others,[380,381] while most of those who remain undiagnosed are people living with dementia outside of LTC settings.

In addition to their high diagnostic rates, England also provides strong guidelines around the provision of dementia care. This has been done through England's National Institute for Health and Care Excellence (NICE), an independent public body that provides national guidance and advice to improve the provision of health and social care. Although NICE primarily operates in England, its guidance is frequently referenced by health systems internationally. NICE's dementia quality standard, most recently updated in 2019 (see Table 6), covers the prevention of dementia and the assessment, management and health and social care support for people living with dementia, describing high-priority areas for quality improvement.[382]

The standard identifies several quality goals relevant to the provision of dementia care, spanning diagnosis, advance care planning, care coordination, activities to promote well-being and managing distress (e.g., reducing antipsychotic medication use; see Table 6).[382] Each goal is accompanied by clear quality measures, data sources and guidance on how to calculate performance against those measures. As such, the NICE dementia quality standard could serve as a valuable foundation for developing and measuring the impact of dementia care initiatives in the Canadian context.

However, in recent years, England has taken a step back in its approach to dementia care. Currently, England does not have an active dementia strategy, although there exists a 2025 10-year Health Plan with dementia-specific initiatives.[383] In 2025, England's National Health Service removed the 66.7% diagnosis rate target from its Operational Planning Guidance for 2025-2026.[384] These changes may undermine the progress England has made in improving its dementia detection rates and may ultimately delay the future diagnosis and earlier treatment of people living with dementia.

Table 6. An Overview of the NICE Dementia Quality Standards

Quality Statement	Quality Measures		
	Structure	Process	Outcomes
People accessing behaviour change interventions and programmes in mid-life are advised that the risk of developing dementia can be reduced by making lifestyle changes.	a) Evidence that service specifications for behaviour change interventions and programmes include actions to raise awareness of lifestyle changes that could reduce the risk of developing dementia. b) Evidence that training for practitioners delivering behaviour change interventions and programmes includes how to advise and support people to reduce the risk of developing dementia. c) Evidence that information about the link between unhealthy behaviours and the risk of developing dementia is included in local health promotion materials.	Proportion of people attending behaviour change interventions and programmes in mid-life who are advised that dementia risk can be reduced through lifestyle changes.	a) Public awareness of the link between dementia and lifestyle. b) Uptake of healthy lifestyle choices.
People with suspected dementia are referred to a specialist dementia diagnostic service if reversible causes of cognitive decline have been investigated.	Evidence of local referral criteria and pathways to ensure that people with suspected dementia are referred to a specialist dementia diagnostic service.	Proportion of people living with dementia who have a record of attending a specialist dementia diagnostic service up to 12 months before entering the PCP practice register.	Self-reported or caregiver-reported quality of life of people with dementia.

People living with dementia are given the opportunity to discuss advance care planning at diagnosis and at each health and social care review.	Evidence of local arrangements to ensure that people living with dementia and people involved in their care have early and ongoing opportunities to discuss advance care planning.	a) Proportion of people living with dementia who are given information about advance care planning at diagnosis. b) Proportion of people living with dementia having a health or social care review who have a documented discussion about advance care planning.	a) Proportion of people living with dementia who feel encouraged to make decisions about their future care. b) Proportion of people living with dementia who are aware they can update their advance care plan at each care review.
People living with dementia have a single named practitioner to coordinate their care.	a) Evidence of local arrangements to ensure that people living with dementia have a single named health or social care practitioner to coordinate their care. b) Evidence of local agreement of the role and functions of the named practitioner.	a) Proportion of people living with dementia who have a named practitioner responsible for coordinating their care. b) Proportion of people living with dementia who have a care and support plan.	a) Self-reported or caregiver-reported quality of life of people with dementia. b) Caregiver-reported quality of life of caregivers of people with dementia.
People living with dementia are supported to choose from a range of activities to promote well-being that are tailored to their preferences.	a) Evidence of local arrangements to ensure that a range of activities are available that promote well-being for people with dementia. b) Evidence of local arrangements to ensure that people offering activities to promote well-being to people living with dementia discuss the person's preferences with them and tailor the activities to these. c) Evidence of local arrangements to support access to a range of activities that promote well-being for people with dementia, such as transport options.	a) Proportion of people living with dementia who discuss activities to promote well-being at a review of their care plan. b) Proportion of people living with dementia who take part in activities to promote well-being that are tailored to their preferences.	a) Self-reported or caregiver-reported level of satisfaction with activities to promote well-being. b) Self-reported or caregiver-reported quality of life of people with dementia. c) Level of independence of people with dementia.

People living with dementia have a structured assessment before starting non-pharmacological or pharmacological treatment for distress.	Evidence of local arrangements to ensure that people living with dementia have a structured assessment before starting non-pharmacological or pharmacological treatment for distress.	Proportion of people living with dementia who have started non-pharmacological or pharmacological treatment for distress who had a structured assessment before starting treatment.	a) Antipsychotic prescribing rates for people with dementia. b) Self-reported or caregiver-reported quality of life of people with dementia.
Caregivers of people living with dementia are offered education and skills training.	a) Evidence that education and skills training are available for caregivers of people with dementia. b) Evidence that education and skills training are tailored to the needs and preferences of caregivers of people with dementia. c) Evidence that support is available for caregivers to be able to attend training, knowing that the person they care for will be safe and cared for.	a) Proportion of caregivers of people living with dementia who have a discussion about education and skills training. b) Proportion of caregivers of people living with dementia who take part in education and skills training.	a) Caregiver-reported quality of life of caregivers of people with dementia. b) Caregiver-reported level of satisfaction with the tailoring of the support to their needs and preferences. c) Self-reported or caregiver-reported quality of life of people with dementia.

How Scotland Developed Strong Post-Diagnostic Supports for People Living with Dementia

Scotland has demonstrated excellence in what to do following a dementia diagnosis by offering a compelling model of post-diagnostic supports (PDS) for people living with dementia and their caregivers.

In its most recent 2023 National Dementia Strategy entitled "Dementia in Scotland: Everyone's Story," Scotland has taken a human rights approach, prioritizing people living with dementia who face barriers to realizing their rights and working to ensure all forms of discrimination are prohibited, prevented and eliminated. It also incorporates a person-centred approach to dementia care across all settings and stages and is built around five core ambitions: recognizing dementia as a brain condition affecting the whole person; addressing stigma and promoting inclusion; ensuring timely, person-centred diagnosis; upholding human rights throughout the dementia journey; and supporting a skilled, trauma-informed workforce.

Scotland has placed strong emphasis on its overall approach towards the provision of dementia care by trying to ensure that all people diagnosed as living with dementia have access to PDS for a minimum of one year, regardless of their age or geographic location.[385] The PDS model is structured around five core pillars (see Figure 12): planning for future decision-making; understanding the illness and managing symptoms; supporting community connections; peer support; and planning for future care.[386] PDS can be delivered by Alzheimer Scotland Link Workers, health care providers or other community-based supports. There is also a strong emphasis on self-management, which seeks to empower people living with dementia to manage their health and well-being as effectively as possible, including through the provision of peer support where appropriate.[385]

Figure 12: Alzheimer Scotland's 5 Pillars Model of Post-Diagnostic Support (PDS).[386]

Evaluations from the piloting of Scotland's PDS programme indicate that many participants have reported positive experiences with it.[387] [387] People living with dementia who received PDS reported that it helped them come to terms with their diagnosis, navigate government financial supports such as benefit claims and put legal arrangements in place.[387] Participants valued receiving individualized information and support tailored to their current needs and preferences, including the ability to decide how much information they wanted at different points in their dementia journey.[387] Many PDS recipients also highlighted maintaining a sense of independence and the positive impact of social opportunities associated with PDS (such as dementia cafés, peer groups and day trips), which fostered a sense of connection and reduced isolation.[387] However, the PDS system is not perfect. While acknowledging it offers a useful framework, some have highlighted that the five-pillar model could limit the scope of PDS.[iii] Finally, while persons diagnosed with dementia are supposed to have co-developed their personal management plans, this has not been reported as a universal experience; some also find that they are left without the ongoing support they need after the PDS programme's initial year of support.

Despite being established in 2013, Scotland's PDS programme has yet to undergo an independent evaluation; to rectify this, Scotland has committed to commissioning one as part of its latest strategy in 2023.[388] Alongside this, Scotland has committed to strengthening its monitoring of dementia care through both quantitative and qualitative data, tracking diagnosis rates, PDS access and wait times, duration of support and the outcomes PDS delivers for people living with dementia and their caregivers.[385]

Current tracking data show that while referral rates have increased over time, only 49.6% of newly diagnosed people living with dementia were referred to PDS in 2023, and the median waiting time has risen from 69 days in 2022 to 86 days in 2024.[389] These findings highlight that even within a well-designed and internationally recognized system, challenges remain in ensuring timely and equitable access to PDS. To address this, Scotland's latest dementia strategy aims to close gaps in both diagnosis and PDS by improving data collection, promoting implementation of dementia guidelines across a broad workforce and scaling innovative approaches.[388]

How Denmark Has Established a Person-Centred Approach to Dementia Care Across the Health and LTC Systems

Denmark is widely recognized for its person-centred approach to dementia care, embedded across its health and LTC systems. Central to Denmark's 2017 Danish National Action Plan on Dementia 2025 was the belief that people living with dementia should be supported to maintain their independence, function and quality of life for as long as possible, with care tailored to individual needs and preferences at every stage of the dementia journey.[390] This philosophy was reflected in Denmark's ambitious national goals, integrated care pathways and strong emphasis on rehabilitation rather than decline-oriented care.

Denmark's plan was built around three national goals: that all of its 98 municipalities become dementia-friendly; that 80% of people living with dementia receive a formal diagnosis; and that care and treatment be improved to reduce the use of antipsychotic medications by 50% before 2025.[391]

Currently, an analysis is being completed to evaluate the overall impact of the 2017 Dementia Action Plan and to inform Denmark's next Dementia Action Plan.[iv] Nevertheless, the Danish Health Authority has shared that while all 98 municipalities have made efforts to become more dementia-friendly, no standardized method currently exists to assess and measure the degree to which a municipality can be considered dementia-friendly. With respect

to achieving improved diagnosis rates, while specialist dementia clinics have approached the 80% formal diagnosis target, this has been much harder to achieve in primary care settings. Finally, while progress has been achieved in reducing the use of antipsychotic medications by people living with dementia, there is no standardized method for assessing the reduction in prescribing antipsychotics for these individuals, especially given that many people do not have a diagnosis.

A defining feature of Denmark's dementia care systems is its strong emphasis on providing rehabilitation and active living services.[390,391] Danish policy explicitly supports people living with dementia in maintaining independence and the highest possible level of functional ability for as long as possible. At earlier stages of dementia care journeys, this may include counselling, rehabilitation and psychosocial activities, while later stages involve more comprehensive assistance, adapted activities and the provision of palliative and end-of-life care.[390] Physical activity is strongly promoted, including structured exercise programs, as well as community-based socially and cognitively stimulating activities.

Care coordination is another defining strength of Denmark's dementia care systems, built on formalized collaboration across sectors. The primary framework consists of regional health care agreements between hospitals, municipalities and PCPs, disease management programmes and national planning of medical specialties by the Danish Health Authority.[390] These agreements promote continuous and coordinated care pathways, while disease management programmes provide standardized, evidence-based frameworks that clearly outline interdisciplinary roles and responsibilities across the care continuum for people living with dementia.[390]

Hospital-based memory clinics have played a central coordinating role and have been strengthened to promote greater multidisciplinary expertise, more consistent diagnostic practices and faster diagnosis and treatment initiation, while expanding outreach and consultation services to community care providers.[390] Digitalization and the use of e-health solutions further support communication, information sharing and continuity of care across settings, with ongoing innovation expected to strengthen early detection and coordination between the health care system and people living with dementia.[390] This extensive digitalization has allowed for interconnected medical records, which facilitates clinical data sharing, care coordination and continuity between health and LTC providers to ultimately better enable the provision of care and support.[392]

Furthermore, there are primary care-based dementia care coordinators who are now employed across all municipalities and focus exclusively on providing and supporting dementia care. Dementia care coordinators typically have professional backgrounds such as nursing, occupational therapy or other related fields, and usually have additional specialized training in dementia. While not a nationally standardized role with consistent roles and responsibilities, they typically provide a range of supports, including counselling, dementia education, information services and support groups, and often take on case management roles. Similar roles also exist within LTC services, where dementia care coordinators help organize the provision of post-diagnostic services, support and advise community-based care providers and caregivers and deliver local training initiatives to strengthen overall dementia care capacity.

Denmark has also invested in creating more dementia-friendly hospital environments.[390] In some settings, geriatric nurses meet people living with dementia at the time of admission, helping to orient them, reduce distress and guide them through the hospital experience. One aim is that individuals living with dementia are typically offered a consultation within 48 hours of

admission to discuss the goals of hospitalization and to support planning for discharge and transition back to the community.[390]

Taken together, Denmark's dementia care systems demonstrate what is possible when rehabilitation, coordination, and community inclusion are embedded within the foundation of its LTC policies. Through initiatives such as creating more dementia-friendly municipalities, dedicated primary care-based dementia coordinators and structured hospital navigation supports, Denmark offers a compelling model of person-centred, integrated dementia care across the care continuum and dementia care journeys.

Lessons for Canada from the NIA's International Examples of Dementia Care Best Practices

The three international examples explored each offer distinct and instructive lessons for Canada's dementia care systems. While the NIA has not been able to yet identify a country that has developed an ideal and comprehensive dementia strategy or care system that would serve as a model for Canada, England, Scotland and Denmark have collectively demonstrated that meaningful, system-wide progress in advancing their dementia care systems is achievable through intentional design, sustained investment and a commitment to placing people living with dementia at the centre of their own care journeys.

England's approach demonstrates that proactive outreach efforts by local care providers are essential to closing dementia diagnosis and care gaps, evidenced by its achievement of one of the highest known dementia diagnosis rates in the world. For Canada, this underscores the importance of moving beyond patient-led health inquiries toward proactive, population-level identification strategies: particularly for older adults living in underserved communities and LTC homes and other residential care settings, where according to CIHI, potentially upwards of 87% of residents are currently estimated to be living with a form of cognitive impairment.[191] Having a diagnosis is essential, as it is otherwise hard to proactively identify care gaps that need to be addressed.

Scotland's PDS model aims to provide at least one year of formalized structured support following a dementia diagnosis, alongside clear accountabilities for delivery and outcomes. Scotland's commitment to provide each newly diagnosed person with a named Link Worker, a minimum period of support and ongoing monitoring reflects what is possible when post-diagnostic care is treated as a right rather than an afterthought. However, despite the strong policy foundation, Scotland has not yet fully realized this vision in practice. Persistent implementation challenges, such as constrained public funding, workforce shortages inconsistent access across regions (particularly rural and remote communities) and no clear care pathway, mean that less than half of newly diagnosed persons living with dementia in Scotland who are entitled to PDS are currently receiving it.[393,394] For Canada, Scotland's experience offers two key lessons: the importance of establishing national standards for timely access to PDS, and the recognition that strong policy commitments must be supported by ongoing and adequate investments and accountability to ensure PDS are accessible for people living with dementia and their caregivers across all regions.

Finally, Denmark's approach demonstrates that meaningful improvements in dementia care require system-wide care coordination and strength-based care. Denmark's creation of community-based dementia care coordinators offers a practical model for improving care coordination across care systems and settings, while also prioritizing rehabilitative approaches to restore and maintain function and independence. This better enables people living with dementia and their caregivers to be supported in their own homes and communities for as long as possible.

Together, these approaches highlight opportunities for Canada to advance its dementia care systems by prioritizing coordination and, ultimately, better care and system outcomes.

England, Scotland and Denmark have developed high quality dementia care approaches, demonstrating that strong dementia care systems do not emerge by accident: they require intentional policies, sustained funding and quality standards and accountability measures, as well as strong cross-sector collaborations.

For Canada, these international examples offer clear and actionable lessons. Improving dementia care will require moving beyond the current varied, fragmented and reactive models toward more proactive, consistent and integrated systems of dementia care that support people living with dementia and their caregivers from early and timely diagnosis through to the end-of-life. This will, however, require greater investments in the creation of appropriately resourced dementia care systems and coordination pathways.

Central to this needed transformation is the question of national leadership. Given that the provision of health care and LTC, which largely encompasses the current provision of dementia care, is managed provincially and territorially, a coordinated national approach would be helpful as well. A national coordinating body could be used to establish shared care and quality standards, monitor and report annually on the progress being made towards achieving them and foster meaningful collaboration and communication between Canada's provinces and territories to strengthen and improve their dementia care systems.

One established organization, PHAC, may be well-positioned to fill this role. PHAC led the creation of Canada's National Dementia Strategy, oversees its implementation, monitors progress and reports on outcomes. PHAC also drives targeted initiatives aligned with its mandate to support the strategy. Additionally, it supports the Ministerial Advisory Board on Dementia and co-leads the Federal/Provincial/Territorial (FPT) Coordinating Committee on Dementia, which offers FPT governments a platform to collaborate, exchange information and address programs, policies and issues related to dementia. Furthermore, PHAC leads the Director General Interdepartmental Committee on Dementia.

Thus, PHAC may be best positioned to spearhead efforts towards the collective further development and strengthening of Canada's dementia care systems. PHAC, for example, could help support the development of national standards of care for people living with dementia and their caregivers, shared outcome measures and indicators to monitor progress and mechanisms to support provinces and territories in sharing, adopting and adapting evidence-informed practices that further advance their dementia care systems. Adapting lessons from leading international models to the Canadian context, accounting for its geographic diversity, federal structure and the distinct needs of older adults across communities, can help build more effective, equitable and compassionate dementia care systems that enable people living with dementia to live well in dementia friendly communities, for as long as possible.

Discussion

Since 2010, the Canadian federal government and all provinces and territories have made commitments to improve the care of people living with dementia. However, the focus, extent and successful implementation of these proposed improvements have varied significantly across the country, and there are still major gaps and challenges that need to be addressed around the provision of care for people living with dementia.

As noted earlier, a significant proportion of dementia cases remain undiagnosed in Canada, with estimates indicating that up to 61.7% of people living with dementia have not received a formal diagnosis.[4] Addressing this diagnostic gap, therefore, needs to be a care systems priority.

While some provinces have made investments in training and clinical resources to support physicians and other health care providers in diagnosing and managing dementia, these efforts must also be complemented by strategies that address stigma and ageism within both the health system and the broader public, which also prevent people with suspected dementia and their families from seeking out a diagnosis. Care provider training should emphasize the value of early diagnosis, including their role in care planning, providing access to supports and supporting improved quality of life, while challenging the perception that a dementia diagnosis offers limited benefit.

Concurrently, public-facing policies and education campaigns are needed to reduce stigma and ageism, and encourage timely help-seeking, as fear and misunderstanding continue to delay seeking a diagnosis. Public education initiatives should also focus on improving awareness of dementia symptoms and clearly distinguishing between normal cognitive ageing and cognitive decline, as well as BPSD, enabling individuals and families to recognize when a medical assessment is needed. A coordinated approach to address stigma and ageism, improve awareness and knowledge around dementia and strengthen primary care capacity to better provide care for patients with cognitive and BPSD concerns is essential to increasing diagnosis rates and ensuring people living with dementia and their caregivers receive timely and appropriate supports as early as possible in their dementia care journeys.

As we have learned from England, focusing on a single goal, such as high diagnostic rates, and directing a focused effort towards achieving it with appropriate data records can be an effective approach. England has demonstrated that proactive efforts by local care providers are essential to closing the dementia diagnosis and care gap. Furthermore, England supports these efforts through its national dementia quality standard, which covers the prevention of dementia and the assessment, management and health and social care support for people living with dementia, describing priority areas for improving care quality.[382] However, it is critical not only to increase the number of diagnoses but also to support PCPs in making the diagnosis and delivering care, as many feel unprepared,[155] and many people living with dementia have had a negative experience with the delivery of a dementia diagnosis.[210–212]

Once someone is diagnosed with dementia, having access to ongoing care and support is integral to their dementia care journey. While Canada offers various post-diagnostic care options, there is significant variability in the types of assistance available, accessibility and financial barriers to receiving care. Scotland has made intentional efforts to provide people living with dementia one year of PDS to assist

in navigating their dementia care journeys. However, since dementia is a progressive condition with evolving changes and needs, offering only a single year of guaranteed support is insufficient. Continuous, adaptive efforts are essential to effectively meet the ongoing needs of people living with dementia and their caregivers.

Although there is potential to enhance the provision of dementia care and support in all areas of the health care system, the NIA's jurisdictional scan particularly highlighted the urgent need for significant changes in how care is provided in hospital settings. People living with dementia are three times more likely to become ALC patients compared to other older adults. 63% of ALC patients have a diagnosis of dementia, and according to CIHI, people living with dementia account for approximately half of all reported ALC days.[188,395] ALC days represent one of the most costly components of the Canadian health care system, with current estimates of per-day hospital costs for ALC patients ranging from $730 to $1,200, compared with $225 to $253 per day in LTC home settings.[396] As the average length of stay for ALC patients living with dementia is about 7.7-7.9 days, across nearly 15,000 annual cases, this adds up.[397]

As such, hospital-based dementia care represents a critical opportunity for intervention, especially as people living with dementia experienced 65% higher hospitalization rates and twice as long hospital stays, and were more likely to experience worse outcomes compared with people without dementia.[188] Strategies aimed at preventing avoidable hospital admissions for people living with dementia, improving inpatient dementia care and facilitating timely and effective discharges could generate substantial system-level cost savings while alleviating hospital capacity pressures.[396] While five provinces (Alberta, British Columbia, New Brunswick, Newfoundland and Labrador and Nova Scotia) had strategies to improve overall hospital care, support training for hospital care providers and create best acute care practices for people living with dementia, New Brunswick is the only province to have explicitly acknowledged the challenges of ALC days for people living with dementia within its seniors strategy.[19,20,23,24,32,46,47,49]

While there are several multifaceted challenges to improving Canada's dementia care systems, the NIA will focus on three:

1. Varied and fragmented dementia care systems;
2. A lack of well-trained and supported health care providers; and
3. A lack of inclusive and equitable dementia care for equity-deserving groups.

Improving the Delivery of More Coordinated Dementia Care in Canada

A major challenge highlighted in the NIA's jurisdictional analysis pertains to how varied and fragmented Canada's care systems remain for people living with dementia and their caregivers. As highlighted by the Brainwell Institute's recent report Mind the Gap: Closing the Care Divide for Canadians with Dementia, the provision of dementia care falls under multiple provincial and territorial ministries, such as the Ministries of Health, Long-Term Care, Seniors, Accessibility, Municipal Affairs and Housing.[223] Upon receiving a dementia diagnosis, people living with dementia, their families and caregivers and health care providers alike too often do not know where to turn to access additional care and supports. Programs like local Alzheimer Society First Link have been shown to help people living with dementia and their caregivers better understand and connect with additional available services.[398] However, as evidenced throughout this report, across Canada's provinces and territories, there is considerable variability in the types of services and supports that are actually made available and how they are delivered.[223]

Critically, delayed and disorganized dementia diagnoses and care may cause people to miss the limited window to access new dementia treatments that might be appropriate for them to pursue (Box 8) or other treatments and supports that could better support their dementia care journey.

In the NIA's current policy scan, only seven provinces or territories have made commitments related to either improving system navigation or care coordination. However, it is possible to create a more unified dementia care system. Canada, for example, has already successfully created strong coordination pathways for cancer care. For dementia care, there are some initiatives in Canada currently aimed at improving dementia care pathways, such as the Phased Dementia Pathway by Interior Health in British Columbia,[399] the Dementia Care Pathways Project in Alberta[400] and the Ontario Dementia Task Force, which aim to improve the coordination of dementia care pathways across the care systems.[401]

While these individual efforts will likely help improve dementia care in their respective provinces, it is necessary to expand these systems Canada-wide, so that all Canadians living with dementia can have a clearer, more organized and better-coordinated dementia care journey. The NIA adds its voice to the calls for action put forward by the Alzheimer Society of Ontario and the Brainwell Institute to create dementia care coordination bodies across Canada, similar to how Canada's cancer care systems have been established, developed and organized over time.[223,402]

Canada could also greatly benefit from adopting Denmark's approach, which employs dedicated dementia care navigators to guide individuals through the complexities of their dementia care journeys. These navigators, drawing on diverse professional backgrounds, offer comprehensive services such as case management and personalized support. Critically, they support people living with dementia throughout the dementia care journey, providing continued support beyond one year, as opposed to Scotland's PDS programme. Establishing specialized dementia coordinator roles within communities could significantly enhance care system responsiveness, ensuring that people living with dementia receive timely assistance and ongoing support tailored to their needs. By integrating such specialized roles, Canada can improve the overall coordination of care and ultimately improve quality of life for those affected by dementia and their caregivers.

Addressing the Lack of Well-Trained and Supported Health Care Providers

Across entire care systems, Canada's health care providers have not been well-trained to understand what dementia is, how to diagnose and manage it and how to engage in more dementia-friendly care practices.

Canada is grappling with a well-documented shortage of family physicians, and an increasing number of older Canadians are without a regular PCP. This leaves many people living with dementia or at risk of developing dementia without a consistent point of contact to discuss their health concerns, monitor their condition, coordinate care or connect them to appropriate supports. This is compounded by the fact that approximately 60% of family physicians do not feel comfortable managing the care of a person living with dementia,[178] meaning that even those who do have access to a family physician may not be receiving the dementia-informed care they need. As a result, family physicians may unnecessarily refer people living with dementia to specialists like geriatricians, neurologists or geriatric psychiatrists. As wait times to access these specialists can stretch to months or years in many parts of the country, this can delay early care and intervention. Without timely access and continued care from a knowledgeable PCP, people

living with dementia are likely not receiving early or accurate diagnoses and are less likely to be connected to PDS; thus, they are more likely to visit the ED or be hospitalized, and are more likely to turn to EDs and acute care hospitals.[228]

The lack of dementia-trained care providers extends across the care continuum. In hospital settings, care providers may not be equipped to provide dementia-informed care. Dementia-informed care includes clear and timely communication with people living with dementia and their caregivers about wait times and clinical roles; adopting a patient and respectful approach that avoids dismissiveness; and adapting communication to account for sensory and cognitive needs.[234–236] Additionally, hospital care providers may not provide people living with dementia and their caregivers with the information and support needed to plan for a safe discharge and transition back into the community, referrals to rehabilitation resources, care coordination with their PCP or follow-up care.[233,234]

The lack of adequate training around dementia is perhaps most evident at end-of-life. Compared to other common diseases, people living with dementia are some of the least likely to receive palliative care.[258] Although dementia has an unpredictable and highly variable trajectory, and thus it may be difficult to determine when someone is entering the late stages of the disease, limited dementia-specific training reduces the likelihood that people living with dementia will receive good end-of-life care. People living with late-stage dementia are often unable to express their pain and discomfort through the verbal cues that care providers may traditionally rely on. Instead, care providers must be equipped to identify and respond to non-verbal indicators of pain and distress. Without proper training, there is a significant risk that the pain, discomfort and distress of people living with dementia go unrecognized and unaddressed in their final weeks and months of life, undermining the goal of a dignified and comfortable end-of-life.

Beyond primary, hospital and end-of-life care, Canada's LTC sector represents another critically underfunded and under-supported pillar of the dementia care system.

While the provision of LTC is a critical part of dementia care systems, there are several challenges, particularly related to both current funding models and levels. These challenges arise from the fact that the provision of care in both LTC homes and home and community-based settings is not covered by the Canada Health Act, and thus budget allocations and resources can vary greatly by province.[403]

Publicly funded LTC homes, home care programs and community support services have a longstanding legacy of being unable to appropriately meet the care needs of their residents and clients, and Canada's ageing population in general, due to lack of funding.[309]

Funded at a lower level compared to other parts of the health care system, front-line care providers in LTC home and community settings have often been overlooked.[309] Many care providers in Canada earn less providing publicly funded LTC than they would providing publicly funded hospital care.[155] For example, registered nurses in Ontario make $11 less per hour on average by working in LTC homes versus hospital settings, equating to 32% less.[309,404] 90% of the direct care workforce in LTC homes are health care aides or PSWs, and are generally women, over the age of 40, who speak English as a second language.[266,310,311] These care aides are often some of the lowest-paid care providers, and may hold multiple jobs to support themselves, with nearly a quarter working at more than one LTC home. Many work in unsafe conditions, experiencing harassment and violence on the job, as well as other health and safety risks (e.g., injuries associated with care provision).[266] Burnout among care aides in LTC homes and other settings is high. Burnout rates were already rising pre-pandemic, but significantly increased during the pandemic and had not returned to pre-pandemic

levels by 2024. Critically, "the conditions of work are the conditions of care," and therefore, quality working conditions are an important factor in supporting the delivery of high quality dementia care.[405] These circumstances in LTC homes and broader communities highlight some of the challenges throughout the dementia care system, which need to be urgently addressed to support the growing number of people who will be living with dementia and needing care in the coming years.

Optimistically, this may change, as many provinces and territories have made commitments related to hiring and recruiting more care providers in general, training present and future health care providers and providing increased support for addressing dementia-related health conditions and responsive behaviours. Further, Canada's national dementia strategy recognized having a skilled workforce as one of the pillars of better dementia care in Canada.[10] Health Canada has made considerable investments that support and strengthen Canada's health workforce.[406–408]

Improving the Provision of More Equitable, Inclusive, Culturally Safe and Appropriate Dementia Care

A third challenge facing Canada's dementia care systems is ensuring that care is equitable, inclusive, culturally safe, culturally appropriate and responsive to the populations served. Canadian health care systems have been shaped by longstanding structures of systemic racism, ageism, ableism, colonialism, heterosexism and cisnormativity. These intersecting systems continue to create inequities in access to, experiences of, and the quality of dementia care for racialized, Indigenous and 2SLGBTQI+ populations. While the NIA acknowledges that many groups are being underserved by existing dementia care systems, this report focuses on these three populations. These communities are discussed individually but are not mutually exclusive, as individuals may hold multiple identities and face compounding barriers, which may impact access to care or create distinct care experiences.[409] Despite being presented here as a distinct challenge area, equity considerations are in fact relevant across the other two challenges identified above and should inform how each is addressed.

Cultural safety and culturally appropriate care are related but distinct: culturally appropriate care adapts services to reflect cultural preferences, whereas cultural safety also requires addressing power imbalances, racism and discrimination, and is ultimately defined by the person receiving care rather than the provider.[410–412]

Canada is an incredibly diverse country, with a long history of immigration by people from all parts of the world, bringing a rich variety of languages and cultural practices. Currently, almost a quarter of people living in Canada are landed immigrants or permanent residents,[413] nearly a quarter speak a first language other than English or French[414] and overall, nearly 30% of the Canadian population speaks a non-official language.[415] This diversity in language and culture can create a number of barriers to receiving adequate health care, particularly for people living with dementia.

Discussions about health care can be challenging for most people, but the discomfort may be exacerbated for someone conversing about health care issues in a language that is not their first. Additionally, around 60% of Canadian adults and 88% of older adults are not currently considered appropriately health literate. Poor health literacy has been found to negatively impact one's ability to manage their own health, access health services and make informed health care decisions.[416] Health care providers and

systems often fail to support people in improving their health literacy or to meet them at their level of understanding. For example, health care providers may use medical jargon without proper explanation, which can cause confusion, misunderstanding and misinterpretation of a person's health status.[158] Health care systems need to ensure plain language communication about health conditions is available in accessible formats and in appropriate, diverse languages.

Racialized communities, including both immigrants and Canadian-born people, often experience inequitable care. Within immigrant and racialized communities, social, cultural and structural factors may also shape how dementia is understood, disclosed and responded to. As discussed, some cultural groups may view dementia as a normal part of ageing or attribute it to mystical causes.[148–151] Experiences of racism, both systemically (e.g., culturally inappropriate assessment tools, lack of interpreters) and interpersonally (e.g., dismissal of concerns, receiving little empathy), has resulted in some racialized communities fearing racism or discrimination when seeking health care or feeling uncertain about where to get help and how to navigate Canada's care systems. Negative experiences with care systems can further disproportionally impact people from cultural groups when seeking dementia care.[7,149,150,159]

Canada also needs to provide more inclusive dementia care for Indigenous populations, who experience dementia at rates higher than non-Indigenous populations.[417] Many dementia-related risk factors are rooted in the ongoing impacts of colonization, including the residential school system (which caused significant trauma and impacted educational attainment) and socioeconomic disadvantages (which limit access to healthy choices, stable housing and culturally safe and appropriate health care), while increasing exposure to chronic stress and poor mental and physical health.[109] There is also anti-Indigenous racism present within the care system, which can impact health care access and outcomes,[109,418,419] as well as Westernized assessments of dementia, which may not be culturally appropriate for use in some Indigenous populations.[109] Dementia care in Indigenous populations must also recognize diverse ways of knowing, confront the legacy of systemic mistreatment and colonization and actively address racism to ensure more culturally safe, appropriate and dignified care is provided.

Finally, inclusive dementia care also falls short for people with diverse gender identities and sexual orientations. An estimated 1.3 million Canadians identify as 2SLGBTQI+ individuals.[420] 2SLGBTQI+ communities continue to face significant barriers and discrimination within the health care system, including refusal of care by practitioners, misgendering, lack of cultural safety and appropriateness or limited recognition of partners and chosen family members. Participants in the NIA and Egale Study, Coming Out and Coming In To Living with Dementia, described this last issue directly, recounting care providers repeatedly assuming a heteronormative relationship, i.e., presuming a same-sex partner was a parent or sibling rather than recognizing them as a spouse.[421] These conditions can make it unsafe for 2SLGBTQI+ people to fully disclose their health concerns or engage in open discussion with care providers.[422,423] In the same study, participants described deciding whether to access, avoid or refuse services based on anticipated discrimination, with some adopting strategies such as calling ahead of appointments to disclose their identity or relationship in advance to manage that risk themselves. When dementia is added to this context, 2SLGBTQI+ people living with dementia may experience intersecting stigmas, where stigma related to their gender identity or sexual orientation compounds with stigma related to dementia, further impacting their relationships and connections with others.[421,424] The intersection of dementia and 2SLGBTQI+ identity can further exacerbate barriers to obtaining a timely

diagnosis and appropriate care, demonstrating the need for dementia care systems that are 2SLGBTQI+ friendly.

Critically, a 2021 PHAC survey found that care providers (including developmental services workers, health care professionals, PSWs and first responders) reported significant gaps in their capacity to deliver culturally appropriate dementia care.[155] 45–51% of care providers reported not having the tools to provide culturally appropriate dementia care for ethnic and cultural minority communities. Similarly, 45–56% reported lacking the tools to provide culturally appropriate dementia care for Indigenous peoples, while 42–48% reported the same for 2SLGBTQI+ communities.[155] These findings highlighted that a substantial proportion of care providers across Canada lacked the foundational tools and knowledge needed to deliver equitable, culturally appropriate dementia care to some of the most underserved communities. While tools and cultural awareness training may support care providers and thus can support culturally appropriate care, they do not ensure culturally safe care. There needs to be larger systemic change, which requires organizational policies, interpretation services, inclusive data and documentation practices, community partnership, accountability and action on systemic racism and discrimination.

Canada, nevertheless, has made a lot of progress towards providing more inclusive dementia care. Several projects funded through the national dementia strategy's DCI and DSF have aimed to support the more equitable provision of dementia care in a variety of populations.[215] More and more organizations are taking steps towards encouraging equity and inclusivity, such as translating their resources into different languages to reflect Canada's diverse populations or developing Indigenous-specific resources and tools. Some LTC homes have been developed to serve particular groups, including religious, ethnic or linguistic communities.[425] Others have been developed specifically to better serve members of 2SLGBTQI+ communities.[426] However, to have safe and appropriate person-centred dementia care, there needs to be greater effort to understand, address and ensure accountability for the structures and systems that prevent or limit the health care needs of people of all identities.

Box 8. The Risk of Failing to Act: The New Era of Disease-Modifying Therapies for Addressing Alzheimer's Disease and Their Small Window of Opportunity

While there is currently no known cure for Alzheimer's disease, there has been progress in the development of novel treatments in recent years. One promising advancement has been the emergence of new disease-modifying therapies. Unlike traditional treatments that primarily focus on improving symptom management, disease-modifying therapies aim to alter the underlying disease pathology of Alzheimer's disease, the most common cause of dementia. Clinical trials have demonstrated that by significantly reducing the accumulation of amyloid-β plaques in the brain, new infusion therapies can also reduce the rate of cognitive decline, potentially improving a person's ability to perform their ADLs and reducing caregiver stress.[427]

Health Canada recently approved the use of two of these disease-modifying therapies, lecanemab in 2025 and donanemab in 2026, for the treatment of early Alzheimer's disease.[428,429] However, these disease-modifying therapies pose a small but potentially significant risk to some patients, while questions remain about the magnitude of their overall effectiveness. These drugs are not currently covered by provincial governments and are only available at a substantial cost.

For example, lecanemab must be administered intravenously every two weeks for at least 18 months.[430] One of the most significant adverse effects associated with it is the development of amyloid-related imaging abnormalities (ARIA), which can involve swelling or bleeding in the brain, especially amongst individuals who have two copies of the apolipoprotein E ε4 gene. As a result, individuals receiving treatment require regular brain monitoring with magnetic resonance imaging (MRI) to assess treatment response and detect potential complications. The risk of ARIA is higher in individuals with certain genetic risk factors, so genetic testing is required prior to treatment initiation. Furthermore, Health Canada has only approved the use of lecanemab and donanemab for people who are apolipoprotein E ε4 non-carriers or who have only one copy of the gene. This medication costs approximately US$26,000 (about C$34,000) per year, excluding additional expenses related to intravenous administration, genetic testing and having to undergo repeated MRI scans. Ultimately, this treatment is currently both time and resource-intensive, requiring enhanced engagement with the health care system over an extended period.

There are also questions about the effectiveness of these drugs. A recent Cochrane review of disease-modifying therapies targeting amyloid-β plaques found a trivial effect in improving cognitive function and dementia severity at 18 months.[431] Although amyloid-β plaques were effectively removed with this treatment, patients continued to experience decline, albeit at a slower pace. Given a long history of underwhelming results of medications targeting amyloid-β plaques, it has been questioned whether amyloid-β plaques should continue to be the main target of pharmacological treatments.[432] It is possible that amyloid-β plaques are the result of an upstream physiological process,[432] such as inflammation, and thus a different therapeutic target may be better suited for more robust and clinically meaningful treatment results.

In July 2026, Canada's Drug Agency (CDA) released a draft of its updated reimbursement recommendations for lecanemab suggesting that it should be reimbursed with conditions, overturning its initial decision in February 2026 recommending it not be covered.[433,434]

They recommend lecanemab be reimbursed for the treatment of patients with a clinical diagnosis of MCI or mild dementia due to Alzheimer's disease who are apolipoprotein E ε4 non-carriers or heterozygotes, and who have confirmed amyloid pathology.[434] They further suggested a 90% list price reduction in Canada to justify the incremental cost-effectiveness ratio that the current outcomes data supports.[434] In the United States of America, Medicare currently provides 80% coverage for these drugs for people with MCI or mild dementia due to Alzheimer's disease, meeting the similar coverage criteria that the CDA has proposed.[435,436] In contrast, the Institut national d'excellence en santé et services sociaux in Québec still does not recommend providing public health coverage for these drugs.[437] Similarly, while the European Medicines Agency approved the use of lecanemab in 2025,[438] it is not covered by most European public health systems, including the UK and Denmark.[439] This hesitancy for approval stems from the considerable clinical risks associated with this therapy, combined with the unclear evidence of clinically meaningful improvements in cognition and quality of life, especially beyond 18 months of treatment; however, a recent preliminary report has demonstrated that lecanemab-treated participants continued to show benefits and delay progression after 48 months.[440] Additional research may generate sufficient evidence to better determine if these new disease-modifying therapies are worth funding.

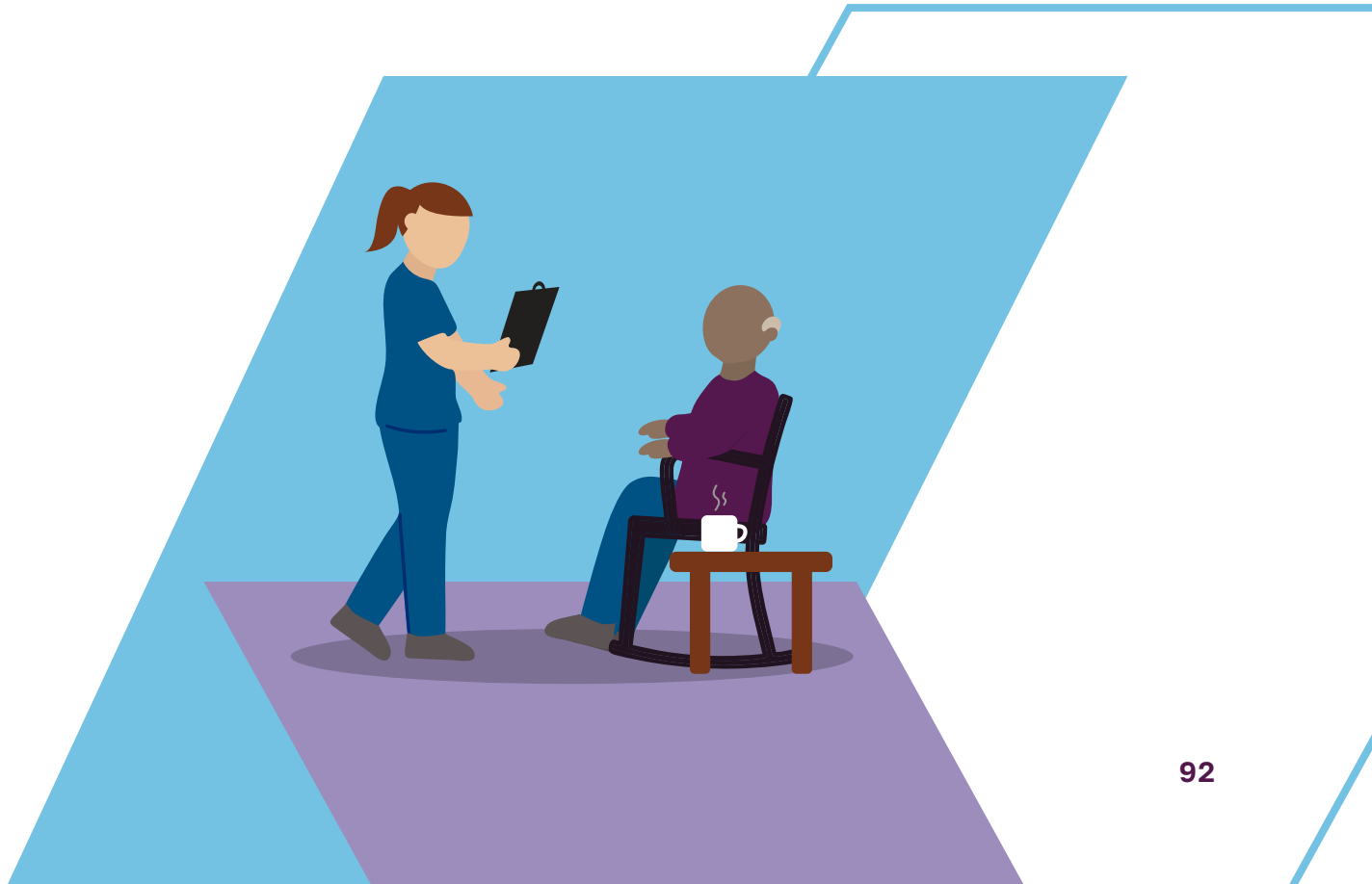
A critical aspect when considering the use of lecanemab and other disease-modifying therapies for Alzheimer's disease has been the narrow therapeutic window. Eligible individuals must be in the early stages of Alzheimer's disease, specifically those experiencing MCI or mild dementia. As a result, timely detection and accurate diagnosis are essential for initiating treatment. Given the significant risks, monitoring requirements and resource demands associated with the use of disease-modifying therapies, specialist consultations are required to determine eligibility as well as to administer and monitor response to these treatments;[402] however, with so few specialists and long wait times, it can be challenging to receive care within the narrow window when people living with dementia are eligible for disease-modifying therapies.

This raises the critical question of whether Canada is currently prepared to deliver these types of disease-modifying therapies. A 2019 report estimated that between 166,000 and 485,000 Canadians could progress from living with MCI to Alzheimer's disease between 2021 and 2050 while waiting for a diagnosis, testing and treatment.[441] Furthermore, without targeted efforts to expand current diagnostic and treatment capacity, it was projected that wait times for access to infusion-based therapies could peak at 28 months.[441] Therefore, without substantial changes to Canada's health care infrastructure, workforce capacity and dementia care pathways, many Canadians will miss the narrow window of opportunity to benefit from these sorts of disease-modifying treatments.

The CDA has also examined Canada's health system readiness for infusion-based therapies and has concluded that new care pathways are required to ensure timely, effective and equitable treatment.[442] This is where novel dementia care models, such as MINT Memory Clinics or Primary Care Integrated Geriatric Teams, could potentially help bridge Canada's current dementia care gaps. Indeed, leveraging highly trained, interprofessional primary care-led teams that have access to specialist supports could increasingly provide timely, high quality dementia care to more Canadians. As noted earlier, MINT Memory Clinics can significantly reduce demands on a limited number of specialists by as much as 90% by ensuring that referrals to them are made only when necessary for complex cases, and that the accompanying clinical information is clear,

comprehensive and well-documented.[216,217] In the context of lecanemab and donanemab, MINT Memory Clinics currently provide the preliminary screening for eligibility before being referred for ongoing care to a specialist. If a person living with dementia is determined to be eligible for treatment with one of the new disease-modifying infusion therapies, MINT clinics could function as treatment hubs for low-risk patients after completing an initial period of specialist treatment and monitoring. This approach could allow specialists to focus their efforts on more complex or high-risk cases while their stable patients can be transitioned back to MINT Memory Clinics for ongoing monitoring and support.

Novel disease-modifying infusion therapies such as lecanemab and donanemab mark a turning point in the treatment of Alzheimer's disease, but without timely diagnosis and access, their future potential could be lost to many Canadians. Current wait times, system capacity constraints and unclear care pathways risk allowing thousands of individuals to progress beyond the narrow therapeutic window in which current treatments could be effective. Therefore, the development and adoption of new care models will be required to ensure these sorts of therapies can be delivered safely, efficiently and equitably.



Conclusions and Future Directions

In this second report in the NIA's ongoing Addressing Dementia in Canada series, the NIA examined the current state of dementia care in Canada, including the different care journeys of people living with dementia and their caregivers. In particular, this report has examined how Canadians experience dementia care across the continuum, from diagnosis to end-of-life, and where system gaps continue to create care delays, inequities and fragmentation. Drawing on emerging evidence, a Canadian jurisdictional policy analysis and international best practices examples, this report highlights both persistent challenges and promising opportunities for delivering more timely, coordinated and high quality dementia care across Canada.

While Canada's provinces and territories have demonstrated growing commitments towards improving their dementia care systems, significant work remains to be done to ensure that care pathways are responsive to population needs, sustainable for future anticipated demands, and aligned with emerging treatments and other care and support opportunities.

To address these gaps, the NIA recommends the following:

1. Create a National Set of Care Standards that can Strengthen and Improve Provincial and Territorial Dementia Care Systems

While provincial and territorial governments are primarily responsible for delivering care and support for people living with dementia, current dementia care pathways remain varied and highly fragmented across Canada's provinces and territories. A national coordinating body may be needed to establish shared care and quality standards, monitor and report annually on the progress being made towards achieving them and foster meaningful collaboration between Canada's provinces and territories to strengthen and improve their dementia care systems. This coordinating body's work could build on the jurisdictional care and quality standards already developed in Canada by Alberta, British Columbia and Ontario, as well as England's NICE dementia guidelines, and accompanying quality standards which also offer clear, evidence-based guidance across key areas of dementia care.[382,443–448]

Canada has demonstrated that this kind of coordinated national approach is achievable through its development of pan-Canadian frameworks for cancer and stroke care, which offer example approaches that dementia care may follow.[223] Common standards with corresponding supported care frameworks would help ensure that all Canadians, regardless of where they live, receive high quality dementia care, and that clear, consistent pathways exist to guide individuals, their families and their caregivers as their needs evolve over time.

2. Enable and Empower Canada's Care Providers to Adopt Best Care Practices Across the Continuum of Dementia Care

Care providers supporting people living with dementia across the continuum perform vital, skilled, and emotionally demanding work that is often undervalued and undercompensated compared with other parts of Canada's health care systems. It is essential to ensure adequate staffing of appropriately paid care providers across primary care, hospital, LTC and end-of-life care settings. Additionally, we must improve training, resources and support for current and future care providers to ensure the delivery of high quality, person-centered dementia care.

Therefore, all provinces and territories in Canada must make deliberate efforts to develop and promote best practices in dementia care. Establishing standardized guidelines will help ensure that individuals living with dementia receive consistent, high quality care regardless of their location or stage of the disease. However, best practices should go beyond creating care pathways to also address the challenges faced by Canada's dementia care providers.

This approach also necessitates supporting Canada's care providers through targeted training and education. Care providers entering care systems should receive comprehensive geriatric and dementia education and training. Current care providers must be equipped to deliver dementia-friendly care, including addressing the cognitive and sensory needs of people living with dementia; effective communication styles and approaches to understanding and managing responsive behaviors; and recognizing the value and wisdom of caregivers. These initiatives should be supported by organizational policy reforms that promote better dementia care practices and foster the development of dementia-friendly care environments.

Further efforts could include promoting interdisciplinary, older adult-focused team-based care to enhance dementia care within primary care. Efforts to create systems for care coordination are essential, which could include creating dementia care coordinator roles as well as supporting systems to facilitate communication between care providers, people living with dementia and their caregivers. Increasing funding and raising awareness of Alzheimer Society First Link programs, especially by positioning them as the initial step following a dementia diagnosis, could enhance care coordination, resource accessibility and support services and facilitate better disease management. Hospitals need to improve staff training in the provision of person-centred care and responding to responsive behaviours, which can reduce harm and elevate quality of care. However, training alone is not enough: staff must be supported as individuals. This requires better pay and working conditions, particularly for PSWs and care aides across Canada.

3. Improve Equity and Inclusivity in the Provision of Culturally Safe and Appropriate Dementia Care

As Canada's population becomes increasingly diverse, its dementia care systems must evolve to reflect and respond to the diverse needs of people living with dementia. Providing equitable care is not simply a matter of improving access: it requires that services be genuinely inclusive, culturally safe, appropriate and responsive to the distinct needs of all communities. Publicly available dementia resources, information and tools should be made accessible across language and cultural contexts. Health care providers need to be supported with training that explicitly addresses biases and systemic barriers affecting racialized communities, Indigenous people and 2SLGBTQI+ communities. For Indigenous communities in particular, culturally safe and appropriate dementia care must be grounded in an understanding of the legacy of colonialism and its ongoing impacts on health and well-being. Furthermore, culturally safe dementia care should recognize and support Indigenous ways of knowing, cultural practices and community strengths. Ultimately, delivering more equitable, inclusive, and culturally safe dementia care is essential to closing the equity gaps that currently prevent racialized, Indigenous and 2SLGBTQI+ communities from receiving high quality dementia care.

4. Create Common Metrics that Can Be Monitored to Measure Canada's Progress in Delivering High Quality Dementia Care

Dementia care across Canada will not only benefit from the creation of national standards, but also from accountability measures that ensure these standards are being met. Federal, provincial and territorial governments should work together to develop a core set of common, nationally consistent metrics to track progress across key domains, including: dementia diagnosis rates; time to being linked to a post-diagnosis support provider; time to home care assessments; time to initiation of home care; caregiver well-being; quality of life; hospitalization rates; restraint use; antipsychotic drug use; care provider confidence in diagnosing and managing dementia; and caregiver distress. These metrics should be developed and collected consistently across Canada's provinces and territories to enable meaningful comparisons, and to identify where care gaps and opportunities persist.

In developing such a measurement framework, Canada does not need to start from scratch. England's NICE dementia guidelines and accompanying quality standards provide a well-established model, offering clear, evidence-based recommendations across key areas of dementia care.[382]

The International Consortium for Health Outcomes Measurement developed the Patient-Centred Outcomes Measures for Dementia, a resource that outlines patient-centred outcomes across six domains: symptoms, functioning and quality of life, caregiver quality of life, sustainability of care, safety and clinical status.[449] Adapting this established measurement framework to the Canadian context could provide a practical and credible foundation for a national dementia measurement system, reducing the time and resources needed to develop metrics from scratch while drawing on internationally recognized standards. Without a comprehensive and unified measurement system, it will be difficult to hold care systems accountable, allocate resources more effectively or demonstrate whether meaningful progress is being made towards improving Canada's dementia care systems.

Appendix A: Document Analysis Method

The research informing this report consists of a document analysis of federal, provincial and territorial strategic planning documents related to dementia. The NIA focused its analysis at the federal government level on the national dementia strategy (2019) and its annual reports (2019 to 2024), identified through the Government of Canada website.[351] Where relevant, the NIA sourced additional information about various programs or outputs related to the strategy from various government websites (e.g., PHAC, Library and Archives Canada).

In the first report, to identify provincial and territorial strategies, the NIA conducted a web-based search from February to April 2025 of publicly available provincial and territorial strategic planning documents, action plans or other frameworks specific to addressing dementia as their sole focus, or plans focused on older adults (often called a "seniors strategy"). The NIA included only publicly available documents, such as strategic plans, action plans and yearly progress reports, published between 2010 and April 1, 2025. For plans focused on older adults to be included in the analysis, the entirety of the plan had to be focused on ageing-related issues and/or older adults in the province or territory. The primary search strategy used Google, and a secondary search was conducted of provincial or territorial websites. The present report expanded this search to June 1, 2026.

In the first report and in the present report, the NIA used the following search terms to identify seniors strategies: [province or territory] + [seniors strategy] OR + [seniors action plan] OR [healthy ageing/aging]. To find strategic plans specific to the topic of dementia, the NIA conducted two web-based searches, the first using Google and the following search terms: [province or territory] + dementia + strategy. Three jurisdictions published multiple strategic plans focused on older adults during this period (British Columbia, Ontario and Québec), and the NIA included both plans in the analysis. However, at times, the NIA focused its analysis on the most recently published plan. In the first report, the NIA identified 23 provincial or territorial strategy documents for the analysis (21 strategies and 2 progress reports). Upon review of the original strategies, one seniors strategy was reclassified as a continuing care strategy.[86] In the present report, an additional 13 strategies/progress reports/action plans were identified. Several seniors strategies and action plans for Québec were only published in French, and the NIA supported the analysis of this plan by having it reviewed by a Québec government official knowledgeable of the strategy.

In the present report, an additional search query was conducted to identify general health care and end-of-life strategies. The NIA used the following search terms to identify health strategies: [province or territory] + [health strategy] OR [health action plan] or [health annual report]. To look at end-of-life care, the NIA used the following search terms: [province or territory] + [palliative care framework] OR [end of life framework]. AI tools were also used for a supplementary jurisdictional scan to identify publicly available government reports, with all sources independently verified by this report's authors.

To triangulate the search strategy, the NIA conducted a secondary search using the term "dementia" in the search function of each territorial or provincial government website. This search also yielded information about current government programs, government funding announcements and other programs or initiatives, such as those provided by regional or provincial/territorial health authorities. For the purposes of this report, the NIA excluded programs or services offered by health authorities.

Content Analysis

A content analysis of the identified documents was conducted with several aims:

- Dementia strategies: To identify key priorities, objectives and action items, and to conduct a secondary analysis determining which objectives addressed any aspect of the dementia care system.
- Seniors strategies: To identify strategic planning documents relevant to older adults and to determine whether they contained primary or secondary objectives, priorities and/or action items specifically related to dementia. Primary objectives were defined as those where a strategic goal or objective in the plan was explicitly and directly related to dementia. Secondary objectives were defined as sub-targets or sub-objectives that explicitly mentioned dementia, cognitive health or brain health, even where dementia was not the primary focus of the objective. For the identified seniors strategies, additional analyses were conducted to determine which objectives addressed the dementia care system. Initiatives related to reducing the use of antipsychotic medications in people without a diagnosis of psychosis were included even when dementia was not explicitly mentioned, given that antipsychotic medications are commonly prescribed to people living with dementia.
- Other documents: To identify strategic planning documents, frameworks, annual reports, action plans or progress reports highlighting initiatives or outcomes related to improving care for people living with dementia. Inclusion was determined by examining whether an objective, strategic goal or initiative in the plan was explicitly related to dementia or to reducing the use of antipsychotic medications in people without a diagnosis of psychosis.

Appendix B: Extended Results of an Analysis of Federal, Provincial and Territorial Strategic Planning Documents

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
CA	Dementia Strategy Status: Active	A Dementia Strategy for Canada: Together We Aspire (2019)[10] Progress reports (2020 through 2026)[12–18]	Three national objectives: 1. "Prevent dementia 2. Advance therapies and find a cure 3. Improve the quality of life of people living with dementia and caregivers"	The 2025 annual progress report[18] outlined the following achievements: ▪ From 2019 to 2025, more than $400 million were invested through CIHR ($256 million) and PHAC ($150 million) to support progress on the strategy's objectives. 86 projects were funded through the DCI, DSF and the EDSI. ▪ Across 62 DCI and DSF projects, more than 5,400 resources have been produced, directly reaching at least 56 million individuals. ▪ CIHR dementia-related research has resulted in more than 1,500 peer-reviewed publications. ▪ A national public education campaign received 144.5 million impressions during the "risk reduction" phase and 83.2 million impressions during the "reducing stigma" and "enabling communities to be more dementia-inclusive" phases.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
AB	Dementia Strategy Status: Inactive	Alberta Dementia Strategy and Action Plan (2017)[19] Alberta Dementia Strategy and Action Plan Progress Report (2019)[46]	Four strategic objectives (2016-2021): 1. "Albertans understand the impact of dementia and actively work towards optimal brain health; 2. Albertans living with dementia and their caregivers are supported in communities; 3. Albertans living with dementia and their caregivers receive timely recognition, diagnosis and clinical management through primary health care, supported by specialized services; 4. Albertans living with dementia and their caregivers experience timely, accessible, integrated and high quality care and services."[19(p. 3)]	The Alberta Dementia Strategy and Action Plan Progress Report[46] outlined progress on the 2017 strategy: ▪ Investment in community partners to reduce stigma and support people living with dementia and their caregivers. This includes eight Community Innovation Grants to better integrate people living with dementia into their communities and reduce stigma. ▪ Investment in partners who actively promote timely recognition and diagnosis of dementia, and who are changing current medical and health-care practice. ▪ Efforts to ensure people living with dementia receive timely and accessible care and services across the care continuum. ▪ Investments into research and supporting the workforce.
	Other: End-of-Life Care Plan or Palliative Care Framework Status: Active	Palliative and End of Life Care Alberta Provincial Framework (2014)[91] Palliative and End of Life Care Alberta Provincial Framework Addendum (2021)[93] Advancing Palliative and End-Of-Life Care in Alberta: Final Report (2021)[92]	Several objectives or initiatives to support palliative and end-of-life care for people living with dementia, including: ▪ "Identify[ing] current local best practices, design[ing] a provincial standard, and implement[ing] practice standards, guidelines and protocols to assess and manage [palliative and end-of-life care] symptoms (including dementia) for primary and secondary level care providers"[91(p. 28)] ▪ Enhancing education, in general, and addressing the needs of dementia-specific issues through a workshop titled "Death, Dying and Dementia"	The 2021 addendum recognizes people living with dementia as a group of interest to help understand and address their end-of-life and palliative care needs.[93] The final report provides recommendations that health care professionals should adopt a palliative approach to care upon diagnosis of a life-limiting condition (such as dementia), supported by clear quality and practice standards.[92] Funded a grant to create the *Canadian Atlas of Palliative Care: Alberta Edition*, which provides an overview of how palliative care is delivered and accessed across the province.[450]

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Other: Annual Report	Health annual reports (2012-2013 through 2024-2025)[59]	-	The annual reports outline the following progress by year: **2013-2014:** ▪ Highlighted concerns regarding antipsychotic use among persons living with dementia in LTC homes. **2014-2015:** ▪ Created a website and online learning environment to support individuals impacted by Alzheimer's disease and related dementias. **2015-2016:** ▪ Developed the Alberta Dementia Strategy and Action Plan. ▪ Expanded dementia care capacity, including new specialized spaces in long-care and supportive living. **2016-2017:** ▪ Launched the Dementia Advice Service through Health Link. ▪ Created approximately 2,000 LTC and dementia spaces. ▪ Expanded First Link program. ▪ Funded projects to improve the quality of life for people living with dementia. ▪ Collaborated with community partners (e.g., the Alzheimer Society). ▪ Launched the Appropriate Use of Antipsychotics Initiative, significantly reducing inappropriate use in LTC homes to 18.1% (below the national average at the time). **2017-2018:** ▪ Established an Implementation and

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				Monitoring Committee for the dementia strategy. ▪ Launched community innovation pilot programs supporting people living with dementia to remain at home with integrated care. ▪ Introduced the Elder-Friendly Toolkit for acute care settings, which includes dementia specific considerations. ▪ Expanded Health Link dementia supports and designated supportive living dementia beds. **2018-2019:** ▪ Ongoing implementation and continuation of the Alberta Dementia Strategy. **2019-2020:** ▪ Added 611 new continuing care spaces, including 179 dementia-specific spaces. ▪ Strengthened partnerships with community organizations to expand support for special populations, including people living with dementia. ▪ Enhanced home care options and expanded continuing care infrastructure. **2020-2021:** ▪ Increased support for people living with dementia and caregivers, including strengthening home care services and caregiver supports; funding community-based dementia projects; and expanding dementia services in rural and remote communities. ▪ Acknowledged the need to address pandemic-related challenges for people living with dementia.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				▪ Redeveloped and expanded older adult housing with specialized dementia care. **2021-2022:** ▪ Supported projects through palliative and end-of-life care initiatives benefiting caregivers of people living with dementia. **2022-2023:** ▪ Continued modernization of Alberta's continuing care system. ▪ Advanced dementia care innovation through Community-Based Innovations for Dementia Care initiative (15 community projects) and ongoing collaboration with the Alzheimer Society of Alberta and Northwest Territories.
	Other: General Health Systems Strategy	Alberta Health Services 2024-2027 Health Plan (2024)[71]	This strategy did not highlight any dementia-specific items.	-
BC	Dementia Strategy Status: Inactive	The Provincial Dementia Action Plan for British Columbia (2012)[20]	Three strategic objectives (2012-2014): 1. "Support prevention and early intervention 2. Ensure quality person-centred dementia care 3. Strengthen system capacity and accountability"[20(pp. 18–19f)]	The Provincial Guide to Dementia Care in BC outlined progress on the 2012 dementia strategy:[49] ▪ Support prevention and early intervention: all four objectives completed. ▪ Ensure quality person-centred dementia care: two objectives completed, two in progress. ▪ Strengthen system capacity and accountability: two objectives completed, two in progress.
	Dementia Strategy	Provincial Guide to Dementia Care in British Columbia	Four priority areas focused on: 1. Public awareness, brain health and early diagnosis	In 2024, the Ministry of Health undertook an evidence review of the dementia plan and concluded

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Status: Active	(2016)[49]	2. Aging in place 3. Quality of care in residential care 4. Increasing health system supports	that its existing goals and priorities continued to align with current frameworks and did not require updating at that time.[v]
	Seniors Strategy Status: Active	Age Forward: British Columbia's 50+ Health Strategy and 3-Year Action Plan (2024)[30]	While the plan primarily focuses on frailty and falls, it also describes how the initiatives in the plan will support cognitive health. One objective outlines the role of preventative screening and assessments that consider cognition as a factor. In addition, the plan identifies key factors that inform it, including risk factors such as the effect of alcohol on the brain. It also describes the impact of physical activity, nutrition and social isolation on cognitive function.	-
	Seniors Strategy Status: Inactive	Improving Care for BC Seniors: An Action Plan (2012)[29] Report on Progress (2013)[47] Final Report on Progress (2014)[48]	▪ Improve information for those living with dementia and their families, including access to the Alzheimer Society's First Link program. ▪ Create dementia care guidelines for care settings.	These objectives were completed, and information on dementia, including the dementia care guidelines, is available on a government webpage.[446]
	Other: End-of-Life Care Plan or Palliative Care Framework Status: Inactive	Provincial End-of-Life Care Action Plan for British Columbia (2013)[90]	One priority related to providing palliative care information, education, tools and resources to health care providers: ▪ "Provide awareness and education on the unique end-of-life care needs of specialized populations, including [...] individuals with dementia [...] who may require special consideration for planning and care delivery to improve health outcomes."[90]	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Other: Annual Report	Ministry of Health Annual Reports (2010-2011 through 2024-2025)[58]	-	The annual reports outline the following progress by year: **2012-2013:** ▪ Implemented priority strategies for community-based health services, including care for people living with dementia. **2014-2015 – 2015-2016:** ▪ Developed residential care models and established care standards for people living with dementia. **2016-2017:** ▪ Renewed PIECES licence for a three-year period to support dementia care approaches. **2019-2020 – 2021-2022:** ▪ Contributed to work related to dementia care and antipsychotic use. **2022-2023:** ▪ Delivered and supported dementia education initiatives. **2023-2024:** ▪ Continued work on dementia care and antipsychotic use. **2024-2025:** ▪ Created a dementia care guide. Renewed PIECES licence to support ongoing dementia care practices. ▪ Expanded dementia education efforts.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Other: Continuing Care Strategy or Framework	Home and Community Care - Policy Manual (2026)[87]	Manual 6 describes the responsibilities of health authorities in planning and delivering publicly subsidized LTC home services. This includes Subsection L (Use of Medications to Manage or Modify Behaviors), which discussed dementia care.	
	Other: General Health Systems Strategy	B.C.'s Health Human Resource Strategy (2022)[70]	This strategy did not highlight any dementia-specific items.	-
MB	Dementia Strategy Status: Inactive	Manitoba's Framework for Alzheimer's Disease and Other Dementias (2015)[21]	This five-year plan outlines five strategic "Responses": 1. "Raising Awareness and Understanding 2. Early Recognition and Initial Assessment and Diagnosis 3. Management, Care and Support 4. End of Life Care 5. Research and Evaluation"[21(p. 3)]	-
	Seniors Strategy Status: Inactive	Manitoba, A Great Place to Age: Provincial Seniors Strategy (2023)[31]	One strategic objective is improved community inclusion and support for those living with dementia and their families. Another objective, related to home care, describes the unique needs of those living with dementia in receiving home care services.	The government provided funding for a number of community dementia initiatives in 2023.[451]
	Other: Annual Report	Manitoba Health Annual Reports Manitoba Health, Seniors and Long-Term Care Annual Reports (2018-2019 through 2023-2024)[62]	-	The annual reports outline the following progress by year: **2018-2019:** ▪ Provided oversight to dementia education initiatives across Manitoba. ▪ Funded Regional Health Authorities to deliver dementia education to personal care home staff. ▪ Improved care environments in patient care areas for people living with dementia.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				2019-2020: ▪ Demonstrated improved care outcomes in Dementia Care Areas through DementiAbility-focused care approaches. ▪ Achieved a 47.65% reduction in aggressive behaviours, linked to enhanced sensory stimulation, relaxation, reminiscence and cognitive supports. ▪ Continued to recognize supports for Alzheimer's disease, related dementias and caregivers as a departmental priority. **2024-2025:** ▪ Invested $650,000 to support nine organizations in delivering programs and services that improve health and wellness for older adults, including people living with dementia, across the continuum of care.
	Other: General Health Systems Strategy	Shared Health Strategic Plan 2025-2030 (2025)[73]	This strategy did not highlight any dementia-specific items.	-
NB	Dementia Strategy Status: Active	Strategy and Action Plan for Alzheimer's Disease and Dementia (2026)[22]	This strategy contains five priority areas: 1. Risk reduction 2. Public education and awareness 3. Supports for people living with dementia and their care partners 4. Trained and supported workforce 5. Time diagnosis and care delivery	-
	Seniors Strategy Status: Inactive	We Are All in This Together: An Aging Strategy for	▪ Implement community-based dementia care	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
		New Brunswick (2017)[32]	▪ Increase dementia education in post-secondary education ▪ Create mobile crisis intervention education and support ▪ Develop a provincial dementia strategy ▪ Improve the quality of care for people living with dementia who are staying in hospital while waiting for other living settings to become available The plan also discusses federal work to align the concept of age-friendly communities with dementia-friendly communities.	
	Seniors Strategy Status: Active	Stronger Care for Seniors: A Long-Term Care Plan for New Brunswick (2026)[33]	This plan acknowledges that it aligns with New Brunswick's current dementia strategy and does not provide any additional dementia-specific considerations.	-
	Other: End-of-Life Care Plan or Palliative Care Framework Status: Active	Palliative Care in New Brunswick: A Person-Centred Care and Integrated Services Framework (2018)[98]	This framework did not highlight any dementia-specific considerations.	-
	Other: Annual Report	Department of Health Annual Reports (2019-2020 through 2024-2025)[67]	-	**2019-2020:** ▪ Acknowledged the development of the provincial dementia strategy and action plan.
	Other: General Health Systems Strategy	Caring for New Brunswick: Putting People at the Heart of Health Care (2025)[78]	This strategy acknowledges the release of the Strategy and Action Plan for Alzheimer's Disease and Dementia. It aims to support people living with dementia and their caregivers with timely diagnosis, navigation assistance and care delivery, but does not provide any further detail or elaboration around dementia.	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
NL	Dementia Strategy Status: Inactive	Dementia Care Action Plan, 2023-2026 (2023)[23] Government of Newfoundland and Labrador Dementia Care Action Plan Progress Reports (2024, 2025)[50,51]	Four strategic objectives: 1. "Increase Awareness, Reduce Risk of Dementia and Address Stigma 2. Diagnosis and Coordination of Care 3. Supports and Services for Individuals Living With Dementia, their Care Partners and Families 4. Professional Learning and Development"[23(pp. 6–10)] The Dementia Care Action Plan will be implemented over a three-year timeframe with short-, medium- and long-term actions: ▪ Short-term: 10 actions to be substantially completed in year one (by March 2024) ▪ Medium-term: 13 actions to be substantially completed in year two (by March 2025) ▪ Long-term: 13 actions to be substantially completed in year three (by March 2026)	In the 2024 progress report:[50] ▪ 3/10 of the short-term actions were fully implemented, with seven partially implemented. ▪ 4/13 of the medium-term actions were fully implemented, with nine partially implemented. ▪ 2/13 long-term actions were fully implemented, with nine partially implemented and two not started. In the 2025 progress report:[51] ▪ 8/10 of the short-term actions were fully implemented, with two partially implemented. ▪ 9/13 of the medium-term actions were fully implemented, with four partially implemented. ▪ 3/13 long-term actions were fully implemented, with eight partially implemented and two not started.
	Seniors Strategy Status: Active	Seniors' Health and Well-Being Plan (2024)[34]	▪ Investment in dementia-friendly community initiatives ▪ Expansion of Provincial Home Care Dementia Program services The plan also describes improvements to care for those living with dementia through the Aging with Dignity Plan. Objectives specific to the Dementia Care Action Plan were discussed above.	**2023:** ▪ Distributed funding for dementia-inclusive communities, including supporting eight communities to create dementia-friendly action plans. This initiative aimed to reduce stigma and increase awareness of dementia.[452] **2024:** ▪ Provided funding for the Dementia Care Action Plan in Budget 2024.[453] ▪ Launched Dementia-Friendly Communities website.[454]

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Other: Annual Report	Department of Health and Community Services Annual Reports (2010-2011 through 2024-2025)[65]	-	The annual reports outline the following progress by year: **2012-2013:** ▪ Continued planning and construction of a Dementia Care Bungalow in Bonavista, expanding dementia-specific infrastructure. **2013-2014**: ▪ Opened North Haven Manor at Lewisporte Health Centre, a 12-room protective community residence for individuals with mild to moderate dementia. **2014-2015:** ▪ Opened new care homes in St. John's and Bonavista, increasing capacity for individuals requiring specialized dementia care. **2016-2017:** ▪ Provided $240,000 in funding over three years to the Alzheimer Society of Newfoundland and Labrador to support the First Link program. **2017-2018:** ▪ Secured approximately $72 million in federal funding over five years to improve access to home and community care, support the development of a Home First Integrated Network, enhance home care services for people living with dementia and advance a province-wide palliative care approach.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				2019-2020: ▪ Advanced the Home First initiative, which provides a nurse practitioner to help people living with dementia remain at home. ▪ Established the Home First Integrated Network. ▪ Initiated development of a Dementia Care Action Plan. **2020-2021:** ▪ Continued development of the Dementia Care Action Plan (delayed due to COVID-19). ▪ Expanded First Link supports. ▪ Introduced online dementia training for home support workers and PSWs. ▪ Expanded the Home Dementia Care Program (nurse practitioner home visit model). **2021-2022:** ▪ Continued progress on initiatives from 2020-21, including the Dementia Care Action Plan development and expanding home-based dementia supports and training. **2022-2023:** ▪ Officially launched the Dementia Care Action Plan and further expanded the Home Dementia Care Program. **2023-2024:** ▪ Increased funding and support to create more dementia-friendly communities. ▪ Expanded the Home Dementia Care Program, reaching 546 clients over five years.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				▪ Launched the Enhanced Dementia Care Program. **2024-2025:** ▪ Fully implemented the Enhanced Dementia Care Program, which provides secure, community-based care and accommodation for individuals with moderate to advanced dementia. This program served 27 participants by fiscal year-end. ▪ Launched the Rehabilitation and Restorative Care Program, which provides low-level rehabilitation and restorative care in a community setting. Delivered services across two sites, serving 78 clients. ▪ Evaluated an ADP. ▪ Increased options for ADPs and launched an evaluation to inform future expansion.
	Other: General Health Systems Strategy	Our Province. Our Health. Our Future. A 10-Year Health Transformation (2022)[76]	▪ Objectives related to updating curriculum content: Ensure that the health care provider curricula prepare the graduate to become an entry-level practitioner with competencies, skills, and confidence to provide a defined scope of practice focused on the patient/client/resident" ▪ Ensure that health care providers "demonstrate knowledge and competences in age-related health factors including multi-dimensional care, frailty, mental health, aging, and dementia."[76(p. 176)]	-
NS	Dementia Strategy Status: Inactive	Towards Understanding: A Dementia Strategy for Nova Scotia (2015)[24] and	The plans' three-year objectives include: 1. "Ensuring access to timely, accurate diagnosis and appropriate care and support	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
		Action Plan[25]	for people living with dementia, their families and caregivers 2. Enhancing health system capacity to provide coordinated dementia care and support that is person-centred and culturally specific 3. Increasing awareness and understanding through evidence informed information and education"[24(p. 8)]	
	Seniors Strategy Status: Inactive	Shift: Nova Scotia's Action Plan for an Aging Population (2017)[35] Shift Progress Report (2019)[52]	Discusses three potentially modifiable risk factors for dementia: promoting physical exercise, addressing social isolation and supporting social networks.	**Progress Report:**[52] ▪ Implemented a range of objectives to support physical exercise among older adults and to address social isolation.
	Other: End-of-Life Care Plan or Palliative Care Framework Status: Active	A Framework for Palliative Care: A Vision and Direction for the Delivery of High-Quality Palliative Care in Nova Scotia (2025)[97]	This framework provides the foundation to support the palliative care needs of Nova Scotians with life-limiting illnesses. Although the framework does not provide specific guidance for people living with dementia, it recognizes dementia as a chronic illness.	-
	Other: Annual Report	Department of Health and Wellness Accountability Reports (2020-2021 through 2024-2025)[66]	These reports did not highlight any dementia-specific items.	-
	Other: General Health Systems Strategy	Action for Health: A Strategic Plan 2022–2026 (2023)[77]	This strategy did not highlight any dementia-specific items.	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
ON	Seniors Strategy Status: Inactive	Ontario's Action Plan for Seniors (2013)[36]	The plan's primary objective of "safety and security" includes a goal related to expanding a program aimed at preventing people living with dementia from going missing in the community	-
	Seniors Strategy Status: Inactive	Aging with Confidence: Ontario's Action Plan for Seniors (2017)[37]	▪ Helping people with dementia, including improving the quality of care and expanding community dementia programs ▪ Improving engagement and funding for art-based activities and art therapy for cognitive conditions associated with ageing	Increased investment in BSO to help those living in LTC with dementia.
	Other: End-of-Life Care Plan or Palliative Care Framework Status: Active	Ontario Provincial Framework for Palliative Care (2021)[94] Progress on Ontario's Provincial Framework for Palliative Care (2025)[95]	This framework did not highlight any dementia-specific considerations.	-
	Other: Annual Report	Ministry of Long-Term Care Annual Reports (2021-2022 through 2025-2026)[63]	-	The annual reports outline the following progress by year: **2021-2022:** ▪ Monitored antipsychotic use, including use among people living with dementia. **2023-2024:** ▪ Provided funding for BSO's BSUs and supported local initiatives to meet the needs of older adults, including people living with dementia. **2024-2025**: ▪ Continued funding for BSUs.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				2025-2026: ▪ Continued funding for BSUs. ▪ Introduced emotion-based dementia training through a three-year pilot program. ▪ Invested $3.1 million into Centres for Learning, Research and Innovation for care quality improvements; $1 million into end-of-life care skill development; and up to $5 million into dementia care planning.
	Other: Annual Report	Ministry of Health Annual Reports (2020-2021 through 2025-2026)[63]	-	The annual reports outline the following progress by year: **2020-2021:** ▪ Invested $35 million through the Local Priorities Fund for dementia and bariatric care in LTC homes. ▪ Provided continued support for BSO. **2021-2022:** ▪ Expanded transitional care capacity in hospitals (including reactivation care centres), indirectly supporting people living with dementia.[455] **2022-2023:** ▪ Committed to supporting 6,500 additional people living with dementia to live independently. **2025-2026:** ▪ Expanded the GeriMedRisk program for dementia care and complex older adult needs ($4.1 million over two years).

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				Other: ▪ Bill 121, the Improving Dementia Care in Ontario Act (2024), received Royal Assent in December 2024.[28] The bill requires that the Minister of Health create a provincial framework to improve access to dementia care and that the Ministry of Colleges and Universities review the "Personal Support Worker Standard" to examine if changes should be made, particularly related to person-centred dementia care.
	Other: Annual Report	Ministry of Health and Long-Term Care Annual Reports (2015-2016 through 2017-2018)[63]	-	The annual reports outline the following progress by year: **2015-2016:** ▪ Provided funding to BSO. ▪ Provided drug coverage for Alzheimer's disease. ▪ Supported Regional Geriatric Programs. **2016-2017:** ▪ Identified dementia as a priority focus within a new community care capacity plan. ▪ Began development of a comprehensive dementia strategy. **2017-2018:** ▪ Continued development of the Dementia Strategy.
	Other: Annual Report	Ontario Health Annual Reports (2019-2020 through 2024-2025)[64]	-	The annual reports outline the following progress by year: **2022-2023:** ▪ Launched the Dementia PET Registry, which enables access to specialized amyloid

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				PET scans to support diagnosis and clinical decision-making for people with early dementia or MCI. **2023-2024:** ▪ Expanded community and hospital-based dementia supports by growing ADPs, expanding the Let's Go Home (LEGHO) and implementing dementia resource teams across 11 hospital sites.[361] **2024-2025:** ▪ Released provincial quality standards for dementia care, which are applicable across hospitals, LTC homes and community settings.[456]
	Other: General Health Systems Strategy	Your Health: A Plan for Connected and Convenient Care (2023)[74]	This strategy did not highlight any dementia-specific considerations.	
	Other: Continuing Care Strategy or Framework	A Better Place to Live, A Better Place to Work: Long-Term Care Staffing Plan (2021-2025)[88]	This strategy did not highlight any dementia-specific considerations.	
	Other: Continuing Care Strategy or Framework	Fixing Long-Term Care Act (2021)[89]	This Act establishes the legislative framework governing the operation, licensing, accountability and quality of care standards across Ontario's LTC homes. Regarding training, it states that "Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents […], training in […] Mental health issues, including caring for persons with dementia."	

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
PE	Seniors Strategy Status: Inactive	Promoting Wellness, Preserving Health: A Provincial Action Plan for Seniors, Near Seniors, and Caregivers Living on Prince Edward Island (2018)[38]	Several dementia-specific recommendations are made across multiple priority pillars: ▪ "Strengthen health system understanding of the particular requirements of dementia care and identify opportunities to support the growing population of people with dementia and their caregivers. ▪ Continue to engage in the development and subsequent implementation of the National Dementia Strategy to ensure that Islander's needs are addressed."[38(p. 18)] ▪ "Enhance specialized geriatric and dementia training for health care providers who support seniors and their caregivers."[38(p. 19)] ▪ "Initiate public campaign to increase awareness of the risk factors and early signs of dementia."[38(p. 21)]	-
	Seniors Strategy Status: Inactive	Seniors Health Services Plan: Aging well 2021 (2021)[39]	Objectives include: ▪ Provide access to home and community-based services for older adults living with complex health conditions, such as dementia ▪ Address behavioural symptoms related to dementia through the Seniors Mental Health Resource Team initiative, which supports the strategic priority to improve the quality and safety of care ▪ Ensure that health care providers have access to continuing education programs and training that includes content specific to older adults, including those living with dementia	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Seniors Strategy Status: Active	Seniors Action Plan 2026-2031 (2026)[40]	Several dementia-specific recommendations are made across multiple priority pillars: ▪ "Recommendation #20: Enhance coordination of existing dementia care supports and services. This includes conducting an assessment of additional tactics required to address anticipated needs, both in facility and community settings."[40(p. 17)] ▪ "Recommendation #33: Expand the number of available beds within the health care continuum to reflect current and future needs of seniors. These may include community care, LTC homes, dementia, restorative, bariatric, complex continuing cares, and palliative care beds."[40(p. 18)]	-
	Other: Annual Report	Department of Health and Wellness Annual Report (2010-2011 through 2020-2021)[68]	These reports did not highlight any dementia-specific items.	-
	Other: Annual Report	Health PEI Annual Reports (2022-2023 through 2024-2025)[68]	-	The annual reports outline the following progress by year: **2022-2023:**[370] ▪ Launched a partnership with the Alzheimer Society to deliver formalized dementia training for all staff. **2023-2024 – 2024-2025:**[367,368] ▪ Established and operationalized a Dementia Specialty Team Program, which supports health care providers caring for older adults with complex cognitive needs and responsive behaviours.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				This team provides education, consultation and system-wide capacity building across LTC settings, hospitals and community services. ▪ Expanded dementia training for clinical care providers (including Clinical Resource Nurses and Registered Nurses), with wider rollout ongoing. **Other:** ▪ Budget 2025-2026 includes funding for ADPs, including those that offer dementia-friendly environments.[373]
	Other: General Health Systems Strategy	Health PEI 2025-2028 Strategic Plan (2025)[79]	This strategy did not highlight any dementia-specific items.	-
QC	Seniors Strategy Status: Active	Vieillir et vivre ensemble - Chez soi, dans sa communauté, au Québec (2012)[41] Follow-up action plans (2018, 2024)[53,54] (English translation: Aging and living together: at home, in one's community, in Québec)	The plan describes government objectives related to improving access to assessment and treatments for individuals living with cognitive impairment or dementia and supporting caregivers. It includes several examples of programs for individuals living with Alzheimer's disease and dementia, including caregiver supports, training for caregivers, in-home respite care and funding for caregiver support groups.	2018-2023 action plan:[53] Describes and highlights several plans and initiatives to support people living with Alzheimer's disease and dementia, including caregiver supports, implementation of best practices for the provision of dementia care and expanded assistance for home care. 2024-2029 action plan:[54] Discusses ongoing goals and plans related to major neurocognitive disorders (including dementia), such as: ▪ Aiming for 80% of staff in assisted living settings to be trained and supported to identify major neurocognitive disorders. ▪ Developing a National Policy and Action Plan on Major Neurocognitive Disorders. ▪ Disseminating awareness and prevention tools regarding the risk of wandering.

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Dementia Strategy Status: Active	Politique québécoise sur la maladie d'Alzheimer et les autres troubles neurocognitifs - Relever les défis d'aujourd'hui et de demain (2025)[26] and action plan[45] (English translation: Québec Policy on Alzheimer's Disease and Other Neurocognitive Disorders - Meeting the Challenges of Today and Tomorrow)	Five primary objectives: 1. Cognitive health promotion and prevention 2. Living with dignity 3. Fair and appropriate access 4. Service quality 5. Research and innovation	Since the 2009 Bergman report and the ministerial decision and actions since 2011, the following has been accomplished:[26] ▪ Increased skills and knowledge related to neurocognitive disorders reported by PCPs. ▪ Increased patient and clinician contacts. ▪ Reduced referrals to memory clinics, indicating better management in primary care. ▪ Stronger sense of competence by PCPs. ▪ Reduction in antipsychotic use from 25% to 20%.
	Other: End-of-Life Care Plan or Palliative Care Framework	Respecting the End-of-Life Care Act (2025)[96]	This act outlines the conditions to receive advanced MAiD requests, including people with neurocognitive disorders, which would apply to people living with dementia.	-
	Other: General Health Systems Strategy	Plan pour mettre en œuvre les changements nécessaires en santé (2022)[75] (English translation: Plan for implementing necessary changes in health care)	This strategy did not highlight any dementia-specific items.	-
	Other: Continuing Care Strategy or Framework	Cadre de référence des centres de jour pour aînés (2023)[84] (English translation: Framework for day centres for older people)	Although people living with dementia were identified as key end-users, this strategy did not highlight any dementia-specific items.	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Other: Continuing Care Strategy or Framework	Politique nationale de soutien à domicile: Mieux chez soi (2026)[85] (English translation: National policy on home care: Better at Home)	Although people living with dementia were identified as key end-users, this strategy did not highlight any dementia-specific items.	-
SK	Other: Annual Report	Saskatchewan Health Authority Annual Reports (2018-2019 through 2024-2025)[61]	-	The annual reports outline the following progress by year: **2018-2019:** ▪ Mention of initiatives to reduce antipsychotic use in people without psychosis, including care approaches specific to people living with dementia.[365] **2023-2024 – 2024-2025:** ▪ Building a specialized LTC home in Regina to support people living with dementia, with the anticipated date of completion in 2027.[362,363] ▪ Discusses investment into the La Ronge LTC project, which will add an ADP for people living with dementia.[363]
	Other: General Report	Sask Health (2019)[101]	-	This report provides information about the Rural Primary Health Care Memory Clinics and research conducted by the Rural Dementia Action Research Team. In 2019, this program was available in Kipling, Weyburn, Radville and Bengough.
	Other: Annual Report	Ministry of Health Annual Reports (2010-2011 through 2024-2025)[60]	-	The annual reports outline the following progress by year: **2013-2014:** ▪ Expanded funding for the First Link program.[372]

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
				2014-2015: ▪ Provided targeted funding for care provider training to improve dementia care, with a focus on managing behaviours of people living with dementia.[369] **2016-2017:** ▪ Established dedicated behavioural assessment units across several health regions to better support individuals with complex dementia-related behaviours.[371] **2024-2025:** ▪ Reported data on patient deaths and serious harm among older adults related to transportation, including people living with dementia.
	Other: General Health Systems Strategy	Patients First Health Care Plan (2026)[72]	-	Describes building a new 240-bed specialist LTC home in Regina, serving special patient populations like people living with dementia.
NT	Seniors Strategy Status: Active	Government of the Northwest Territories Seniors' Strategic Framework (2023)[42]	While there are no strategic priorities that specifically mention dementia, there is a discussion of cognitive impairment in relation to the increased risk of abuse or neglect, and as a factor when considering inclusive ways to provide information to residents about services.	-
	Other: End-of-Life Care Plan or Palliative Care Framework Status: Active	Palliative Approach to Care Service Delivery Model for the NWT (2018)[99]	This framework did not highlight any dementia-specific considerations.	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
	Other: Annual Report	Health and Social Services System Annual Reports (2016-2017 through 2024-2025)[69]	-	**2022-2023:**[366] ▪ Introduced dementia training for home support workers, representing the primary documented initiative to strengthen care capacity.
	Other: General Health Systems Strategy	Northwest Territories Health and Social Services System People Strategy 2025-2028 (2025)[80]	This strategy did not highlight any dementia-specific items.	-
	Other: Continuing Care Strategy or Framework Status: Inactive	Continuing Care Services Action Plan 2017/2018 – 2021/2022 (2017)[86]	Dementia-specific recommendations are made across three out of five objectives: ▪ Under objective one, focused on healthy ageing, the plan describes the Alzheimer's Champions partnership between the Alzheimer Societies of Alberta and the Northwest Territories, which improves community awareness and advocacy. ▪ Under objective two, focused on family and caregiver supports, the plan describes increasing caregiver supports for those assisting someone living with dementia. ▪ Under the third objective, focused on LTC, the plan describes providing training for health care providers related to dementia care, as well as implementing person-centred dementia care.	-

F/P/T	Strategy Type, Status	Strategy Title, Publication Year	Dementia Strategic Objectives	Progress or Achievements
NU	Seniors Strategy Status: Active	Aging with Dignity: Elders and Seniors Strategy (2024)[43] Aging With Dignity: Elders and Seniors Strategy. February 2025 Progress Report (2025)[55]	Objectives include: ▪ Deliver an awareness campaign for dementia and ensure content is available in Inuktut ▪ Provide public education on the impact of substance use on the brain and other physical effects The plan explains that Nunavummiut living with dementia who are in need of the highest level of care (level 5) in an LTC home must leave Nunavut and receive care in Ottawa, Ontario. The plan discusses building an LTC home within Nunavut with the capability to provide level 5 care.	▪ Nunavummi Disabilities Makinnasuaqtiit Society to develop a series of resources as part of an awareness campaign for dementia and Alzheimer's disease.[55] ▪ Working with Piruqatigiit Resource Centre to develop programming in relation to caregiver support.[55]Contract signed in 2024 to operate the Kivalliq Long-Term Care Centre, which has the potential to provide level 5 care to people living with dementia.[457] The LTC home was completed in 2025.[458]
	Other: General Health Systems Strategy	2026-2030 Business Plan (2026)[81]	This strategy did not highlight any dementia-specific items.	-
YT	Seniors Strategy Status: Reporting complete (Inactive)	Yukon Aging in Place Action Plan (2020)[44] Yukon Aging in Place Annual Report (2020-2021 through 2022-2023)[27,56,57]	Objectives include: ▪ Offer the "Shine a Light on Dementia" program to support training and education for caregivers ▪ Challenge the stigma associated with dementia and promote prevention awareness through a public education campaign ▪ Improve access to housing for older adults with complex needs (e.g., cognitive disabilities) ▪ Build collaborations with organizations that support older adults, such as the Center for Aging and Brain Health Innovation The plan also discusses the Yukon's health and social system strategic plan, which has several dementia-related objectives. These objectives include expanding support to help people living with	The annual reports outline the following progress by year: **2020-2021:**[56] ▪ Implemented the "Shine a Light on Dementia" program to provide education and training to support caregivers. The English version was made available to the public online. ▪ Plan underway to launch a public education campaign to reduce stigma associated with dementia, as well as to provide information about dementia prevention and treatment. **2021-2022:**[57] ▪ Implemented the "Shine a Light on Dementia" program to provide education and training to support caregivers. In addition to the

			dementia age in place, improving training and education for caregivers and expanding a day program for older adults living with dementia.	English version, a French version was made publicly available online. ▪ Public education campaign still in progress. **2022-2023:**[27] ▪ Created online dementia resources. ▪ Offered the "Shine a Light on Dementia" program to the public and expanded access through an online course. ▪ Public awareness campaign launched in 2023. ▪ Articulated plans to create a Yukon Dementia Strategy. **Other:** ▪ Finalized agreement with the Alzheimer Society of BC to expand the First Link Dementia Helpline, create caregiver support groups and provide access to online education and webinars.[459]
	Other: Review health and social systems Status: Unknown	Putting People First (2020)[102] Annual Reports (2022 through 2024)[103–105]	This report provides a comprehensive review of Yukon's Health and social services programs. There are several recommendations related to dementia care: ▪ "Expand support for Yukoners with dementia and their families to allow client-owners to remain in their own homes as long as possible. ▪ a. Expand the Whistle Bend Place day program for Yukoners with dementia to a daily capacity of 16 clients and provide support for transportation. ▪ b. provide dementia training for formal and informal caregivers to support Yukoners to remain at home longer."[102(p. 79)]	Several initiatives are shared with the Yukon Aging in Place Action Plan. One initiative not previously mentioned was to expand the already successful Whistle Bend Place day program for people living with dementia.[103,104]

	Other: End-of-Life Care Plan or Palliative Care Framework Status: Unknown	Yukon Palliative Care Framework (2015)[100]	Acknowledges dementia as a chronic disease that would benefit from early palliative care.	-
	Other: General Health Systems Strategy	The Yukon's Health Human Resources Strategy (2023)[82] The Yukon's Health Human Resources Strategy Year 1 Report (2024)[83]	This strategy did not highlight any dementia-specific items.	-

Appendix C: Provincial and Territorial Government Dementia Programs or Resources

P/T	Active Provincial or Territorial Government Programs or Resources
AB	**Online resources:** ▪ Web-based resources on dementia[460] and Alzheimer's disease[461] that span a variety of topics, including what dementia is, symptoms of dementia, when to seek medical care and caring for someone with dementia. ▪ Advancing Dementia Care & Support in Alberta (from the Dementia Resources Toolkit for Health Professionals): Government website with a comprehensive list of resources for health professionals to provide care for people living with dementia, covering a range of topics like assessment, behavioural management and palliative care.[462] ▪ Appropriate Use of Antipsychotics Toolkit (from Provincial Seniors Health & Continuing Care): Resource providing guidance on the assessment and management of responsive behaviours associated with cognitive impairment (including dementia) and appropriate use of medications in older adults.[443] ▪ Alberta Interprofessional Palliative Care Competency Framework (2023): Outlines the minimum skills, knowledge and attitudes required of health care providers when delivering palliative care, supporting consistent interprofessional practice standards across Alberta. It can be used to inform academic curricula, professional development, continuing education, accreditation and employer standards.[463]

P/T	Active Provincial or Territorial Government Programs or Resources
BC	**Online resources for care providers:** ▪ Dementia Guidelines and Dementia Information webpages (2021): Government webpages providing information about a range of topics related to dementia care, including care in residential settings, care in EDs and hospitals, mental health care and use of antipsychotic medications.[448] ▪ Residential care improvements (2021): Improved dementia training for care providers in residential care settings and improved oversight practices.[464] ▪ Provincial guidelines for PCPs to recognize, diagnose and manage patients with cognitive impairment (2023).[465] ▪ Information for medical professionals related to driver medical fitness and dementia care.[466] ▪ Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care (2012).[447] **Online resources for residents:** ▪ Information for families, caregivers and patients includes resources from HealthLink BC[467] and the First Link program (Alzheimer Society of BC).[468] ▪ Brain Health and Injuries: Government webpage providing information and resources about brain health and brain injuries for residents.[469] ▪ Mental Health: Government webpage providing information on mental health resources, including information about Alzheimer's disease and dementia.[470] **Other:** ▪ The government of BC's Lifetime Prevention Schedule Practice Guide for health practitioners includes several items relevant to dementia prevention, including screening and management for obesity, high blood pressure, alcohol use, type 2 diabetes, falls and cardiovascular disease. This guide does not explicitly mention dementia, nor does it cover all of the potentially modifiable risk factors for dementia.[471]
MB	**Online resources:** ▪ Government webpage with information on resources from the Alzheimer Society of Manitoba, such as the First Link program.[472]
NB	**Online resources:** ▪ Webpage dedicated to dementia, including information about living with dementia, information for caregivers, risk reduction, community resources and planning for the future.[473] ▪ Webpage about dementia from Social Supports NB, a Department of Social Development initiative to provide information about government and community programs.[474]

P/T	Active Provincial or Territorial Government Programs or Resources
NL	**Online resources:** ▪ Dementia-Friendly Communities dedicated website: Contains information about dementia, dementia-friendly communities, reducing one's risk of dementia and the types of care and support.[454]
NS	**Online resources:** ▪ Webpage with information about young-onset Alzheimer's disease,[475] Alzheimer's disease,[476] cognitive decline and brain health.[476]
ON	**Online resources:** ▪ Guide to Programs and Services for Seniors in Ontario (2024): Web-based guide for older adults including a section on the supports available for people living with dementia, such as medical alert devices and programs offered by the Alzheimer Society of Ontario.[477] ▪ Information on accessing community support services for Alzheimer's disease and dementia.[478] ▪ Information on extreme heat, including those at high risk, such as people living with dementia.[479] ▪ The Alzheimer Society of Ontario's Finding Your Way Program, which receives funding from Ontario's Ministry for Seniors and Accessibility, provides resources for people living with dementia, as well as their families and caregivers, to help them live safely in the community.[480] **Other:** ▪ Quality Standards for Behavioural Symptoms of Dementia Care for People in Hospitals and Long-Term Care Homes (2024 update): 14 quality statements providing guidance on high quality care, with accompanying measurement indicators. Each statement also includes details on how its successful delivery impacts people with dementia, their caregivers, clinicians and health care services at large.[444] ▪ Quality Standards for Dementia Care for People Living in the Community (2024 update): 10 quality statements providing guidance on high quality care, with accompanying measurement indicators. Each statement also includes details on how its delivery impacts people living with dementia and their caregivers, clinicians, health care team, health care services and community support services at large.[445]
PE	**Online resources:** ▪ Webpage describing resources provided by the provincial health authority, Health PEI, such as the Dementia Specialty Team[481] and the Seniors Mental Health Resource Teams.[482]

P/T	Active Provincial or Territorial Government Programs or Resources
QC	**Online resources:** ▪ Government webpage on Alzheimer's and other neurocognitive disorders.[483] ▪ Information on improving the safety of living at home.[484] **Other** ▪ Guide for families on supporting people who are no longer able to take care of themselves.[485]
SK	**Online resources:** ▪ Web-based information and resources on a dedicated webpage, as well as programs provided by organizations such as the Alzheimer Society and regional health authorities.[486]
NT	**Other:** ▪ Government Disability Strategic Framework (2017–2027) that includes people living with dementia in the definition of disability.[487]
NU	**Online resources:** ▪ Webpage with information about LTC services for residents living with dementia who need significant medical or nursing care.[488]
YT	**Online resources:** ▪ Webpage about dementia, including resources for those living with dementia, their caregivers and health providers and information about the First Link Dementia Helpline.[489] ▪ Webpage providing information about the Seniors and Elders Community Day Program, designed for people living with mild to moderate cognitive decline.[490] ▪ Information about dementia services in LTC in the Continuing Care resident handbook[491] ▪ Palliative Care Clinical tools and Resources for Health Care Providers.[492]

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