Encouraging early diagnosis of dementia is a good thing

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Widespread criticism followed the announcement in October 2014 of an NHS England scheme to increase dementia diagnosis by paying general practices £55 for each patient added to their dementia register over the next six months.1 Commentators expressed varying levels of alarm; GP Martin Brunet was concerned that it jeopardised the ‘trust inherent in the doctor-patient relationship’.2 Katherine Murphy, chief executive of the Patients Association, described the payments as ‘a bounty on the head of certain patients’.3 Internet searches revealed anonymous suspicions that the scheme was motivated by governmental lust for inheritance tax, housing shortages necessitating elderly people to be removed from their homes, or pharmaceutical companies requiring swathes of new dementia diagnoses in order to test new medications. There were fears that diagnosis would be made on the basis of a 10-minute consultation insufficient to fully explore differential diagnoses and even that GPs would be incentivised to generate spurious diagnoses.

Unsurprisingly the Dementia Identification Scheme4 is not motivated by such nefarious objectives. In fact it aims to improve dementia detection and recording of diagnosis to enable care and support for patients and their families, provide treatments and enable people to plan their own future care.5 Participation is optional but payment will be provided to enrolled practices, rather than individual GPs, at the end of a six-month period according to the differential between practices’ dementia registers at the scheme’s start and end. At the scheme’s announcement, it was planned as a six-month project, and this has recently been confirmed by NHS chief executive Simon Stevens, no doubt partly in response to criticism.

Assessment of those with cognitive problems is beneficial. Remediable causes of cognitive decline can be identified and treated and the ‘worried-well’ can be reassured. Most people with early dementia want to know of their diagnosis,4 and they and their family are relieved when diagnosis is reached.5 Too often, however, we diagnose dementia late.8 Diagnosis facilitates access to efficacious pharmacological7 and psychological8 interventions, informs the provision of appropriate social care and reduces the likelihood of crises and institutionalisation in a cost-effective manner.9 Seeking to increase the rate of diagnosis is a laudable aim.

Practices will pursue a variety of strategies to meet the scheme’s aim, including reviewing existing clinical documentation for unrecorded diagnoses, referring suspected cases to memory services, or making the referral in primary care in cases where diagnosis is clear or referral inappropriate. It seems unlikely that already busy GPs will arrange hundreds of consultations with at-risk individuals; they are more likely to look for those already diagnosed with dementia whose diagnosis has not been accurately recorded. Maintaining a dementia register is already an indicator under the Quality and Outcomes Framework10 in recognition that accurately recorded diagnosis allows timely medical care for patients at risk of late presentation with physical ill-health and information sharing between health and social care agencies to promote active care.

We do not know whether this scheme will work, as financial incentives in healthcare settings have shown mixed results.11,12 However, if the scheme’s outcome data are successfully collected and analysed, we will learn more. The sensationalist responses to this scheme reveal mistrust of the motives of government and GPs, and paternalistic efforts to protect the vulnerable from the clutches of a health and social care system that is perceived by many to be inadequate. Although improved care for dementia is certainly needed, concerns about dementia diagnosis are misguided and do not serve the needs or wishes of people with dementia and their families.

References

Declaration of interest
None to declare.

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