Prepare for more changes in diabetes care

In the UK, a general election is imminent, and with it, the potential for change. Whichever party is in power after the election will have to make challenging decisions about NHS funding. The current administration oversaw real increases in NHS funding of almost 7% in England. Already, organisations such as the King's Fund are modelling future reduced-funding scenarios and their possible impact. Unsurprisingly, in the worst economic climate for a generation, no-one is suggesting that funding can be maintained at current levels (Appleby et al, 2009). The Republic of Ireland, faced with similar decisions, has already made cuts in civil services, including healthcare professionals' salaries.

Government-led change

In this sea of perpetual change, it is to be hoped that one legacy of the current government will be the 2004 General Medical Services contract for GPs and the QOF payment-by-results system that it introduced, which has undoubtedly benefited people with diabetes (Campbell et al, 2007). A strong primary care system underpins successful health care (Starfield, 2009), and in times of change we should constantly bring this to the attention of our elected (or potentially elected representatives) lest in their shroud-waving about "hospital closures and hospital waiting times" they forget where much of the real work of care takes place.

In 1997, Labour instituted a process of devolution within the four nations, including their health services, and this journal examined the impact of this in 2008 (Hall, 2008; Kenny, 2008; Millar-Jones, 2008; Quigley, 2008). Change in the ensuing years has resulted in several significant differences between the four nations and their healthcare systems. The QOF for diabetes is currently the same across the four nations and ensures uniformity of diabetes care. This issue of *Diabetes & Primary Care* features diabetes care in Scotland as the Scottish Intercollegiate Guidelines Network publish their updated guidance for the management of type 2 diabetes.

Encouraged by the Government, each of the four nations produced National Service Frameworks (NSFs) in diabetes. Six years on, the Department of Health (2010) in England has reviewed the progress of the implementation of the diabetes NSF. The document describes one year of NHS Diabetes and how it is establishing itself as a new organisation. It goes on to describe a number of future or planned projects.

Research-led change

Likewise, other events are challenging us to change our perspective on the world of primary care diabetes. The safety of a low HbA_{1c} indicator has been debated over the past 18 months as new evidence has emerged. In this issue, Brian Frier makes the case for caution and to avoid aiming for an HbA_{1c} level below 7% (53 mmol/mol), based on the recent meta analysis proposing a "U-shaped" curve for HbA_{1c} (Currie et al, 2010). A general practice-based prospective study outlining the linear relationship between HbA_{1c} and mortality is timely but does not answer the question about safety at lower levels of HbA_{1c} for carefully selected people with diabetes (Landman et al, 2010). These studies look at populations with diabetes, whereas primary care teams deal only with individuals and the need to tailor their management to their specific circumstances.

Should we change how we diagnose diabetes? Such a fundamental question needs thoughtful consideration and unanimity in approach, both nationally and internationally. The American Diabetes Association (2010) proposes to use an HbA_{1c} level of 6.5% (48 mmol/mol) or more for diagnosis but this is far from clear; the case is debated further in this issue (see pages 74 and 87). We await a definitive answer from the World Health Organization.

Churchill said: "there is nothing wrong with change, if it is in the right direction". Over the past few years, for many of us, it has seemed like change is the only thing we can be certain of. However, many of the changes in the way diabetes care has been financed and delivered have promoted high-quality care. We should all recognise this and defend what we have achieved as we face a time of further change and fiscal tightening. ■

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