tory tract infection: this possible link to stroke now needs to be investigated. This theory is supported by data from the Newcastle Heart Project showing that plasma concentrations of IgG and staphylococcal toxin are significantly higher in South Asian than European white populations.^{12 13}

Although smoking is common in Bangladeshi men and almost certainly contributes to explaining some of the high risk, it is uncommon in Bangladeshi women.^{2 6} Chewing tobacco as paan (betel leaf) is common in both sexes, however, and in future epidemiological studies researchers should ascertain total tobacco consumption, as well as using more stringent methods than hitherto for collecting accurate data.¹⁴

We propose that the explanation for high rates of stroke in Bangladeshis lies in their heavier burden of some established risk factors, their socioeconomic deprivation, and some novel risk factors that are yet to be characterised. Pending deeper understanding of the causes, doctors should be aware of the high risk of stroke and stroke fatality in Bangladeshis even in the absence of raised blood pressure.

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Diabetes and the quality and outcomes framework

Successful UK initiative highlights inequity of investments between sectors

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The rapidly rising prevalence of diabetes in the United Kingdom demands an effective response from healthcare services.¹ British general practitioners were among the first doctors in primary care worldwide to manage many aspects of diabetes care in their own practices,² and by the millennium were providing systematic diabetes care.³ Primary care based interventions are cost effective—countries with strong primary healthcare systems have lower healthcare costs and healthier populations.⁴ The 2003 general medical services contract signalled the government's determination to invest in evidence based interventions in primary care and to encourage further expansion of chronic disease management, including diabetes care, into general practice.⁵ The contract introduced a quality and outcomes framework, designed to monitor the quality of the delivery of primary care.

In this week's *BMJ* Campbell and colleagues report that general practitioners were already improving effective care for three of the diseases covered by the

framework.⁶ One of these was diabetes, which is assessed by 18 clinical indicators in the general medical services contract.⁷ Contract data shows the prevalence of diabetes is 3.3% in England and Scotland, 3.8% in Wales, and 2.8% in Northern Ireland, and in England more than 93% of general practices achieved the maximum points for diabetes care.^{w1} Most participating practices have set up active patient registers to facilitate call and recall for consultations.

The new general medical services contract built on the rigorous analyses undertaken to develop the four national service frameworks for diabetes—one for each country in the United Kingdom.⁸ The contract negotiators insisted that the new contract would be the same throughout the UK and largely ignored the patient focused elements such as information, education, and empowerment in the frameworks. The contract focuses on pharmaceutical interventions

Extra references w1-w4 appear on bmj.com

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which are easily measured, and primary care organisations have reported that, concurring with Campbell and colleagues,⁶ prescribing in diabetes and cardiovascular prevention was increasing and increased after the new contract,⁹ reflecting both a rising diabetes incidence and more intensive management.

Although participation in the quality and outcomes framework was not a compulsory component of the new general medical services contract, practices soon realised that non-involvement would mean a loss of about a third of their income, potentially making them non-viable. The financial rewards from the contract have enabled practices to invest in staff and resources. Although the substantial investment in managing diabetes in primary care has been welcomed and has prompted considerable change, it has left those working in secondary diabetes care feeling beleaguered since there has been no similar investment in secondary care.¹⁰ Intensive micromanagement of staff in hospital trusts is further weakening morale.^{w2}

Moving resources to primary care may be more about containing costs than attempting to improve global patient care, and it has resurrected the debate about who has primacy in diabetes care.¹¹ The multifaceted interventions in the new general medical services contract have proved effective in both primary and secondary care,^{12 w3} and have yielded similar outcomes.^{w4} Given that the quality and outcomes framework has encouraged such uniform management of diabetes in primary care, this debate has become sterile.

An epidemic of diabetes demands a concerted approach across primary and secondary care, with active investment in both sectors. Research, guidelines, teaching, and training should be common between both sectors, with the opportunity for secondary care providers to spend some time working in the community. Although much care for people with diabetes will be in primary care, many patients will develop complications requiring the expertise of those in secondary care. The providers in this sector should be nurtured and rewarded as well, and services should have access to better information systems to manage and monitor the delivery and quality of care, although this may stretch limited resources.

While general practices have been implementing the contract and framework, some general practition-

ers have gone further, developing a special interest in diabetes, seeking further training, and providing additional services to primary care organisations.¹³ These initiatives have been poorly resourced, however, lacking a model job description or agreed remuneration, and are still evolving.^{w5}

Though an effective response to the emerging epidemic of diabetes will be centred on primary care, ensuring that patients are empowered to play a key role in the management of their condition, secondary care has a role to play too. Over time, most patients will move between primary and secondary care according to their needs and the complexity of their complications, and it is essential that the service interfaces they traverse should be seamless. The mechanism of rewarding those who provide high quality diabetes care through the system of clinical indicators is proving effective and should now be extended to include all those providing care for diabetes patients.

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