based solely on student numbers but also takes account of proxy measures of research activity to reflect the impact of both teaching and research on service costs. This is precisely what SIFTR is intended to do—that is, to compensate for these justifiable excess costs and make prices in teaching and non-teaching hospitals comparable within the internal market.

The subsequent weighting of the distribution by the excess costs of specialties is done to identify where there are discrepancies. This then enables the school and its provider unit to investigate these costs, in consultation with care group directors, to highlight excess costs that are arising outside teaching and research—for example, due to complex case mix—which should be recouped through service contracts, and inefficiencies that can be dealt with managerially. This is seen by King's and its provider unit as being the considerable advantage attached to this model.

Sheldon is right to highlight the importance of monitoring the quantity and quality of teaching undertaken by NHS teachers. In the case of King's this is covered in the terms of the SIFTR contract that the regional health authority has taken out with the provider unit, but this was not the subject of our paper, which instead concentrated on the process of allocating resources.

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Tobacco advertising

EDITOR,—John Belloch¹ does little to answer the concerns expressed by Selena Gray and colleagues.² Although there is a commitment in last year's renegotiated voluntary agreement on tobacco advertising to reduce the number of advertisements on retailers' premises evenly by time and by type of material, the tobacco industry is at liberty to replace many shoddy small stickers and signs with fewer large, high impact advertisements. Even reduction across geographical base remains vague. There is a well documented tendency for tobacco advertising to be concentrated in poorer areas,^{3,4} so audit by sufficiently small area will be required to ensure a genuine reduction for all sections of the population.

Taking appropriate action will presumably reflect the committee's current approach: to ask the tobacco company concerned to investigate itself; to report back eventually; to adhere to the letter but not the spirit of the agreement, except where it is to the industry's advantage to ignore the strict letter; and to take no action except to remove the particular example of an advertisement that breaches the agreement.

The most telling indictment of the present system of monitoring is the answer to a recent parliamentary question: for 1989-90 and 1990-1 official government figures show that 35% and 77%, respectively, of all breaches of the voluntary agreement in Britain occurred in Oxford.⁴ This is obviously unlikely and reflects a lack of monitoring, making nonsense of Belloch's assertions regarding his committee's arrangements. It also exposes the government's complacent endorsement of the voluntary agreements "to control tobacco advertising... in an effective... way" (R Greig, Department of Health, personal communication) for the sham it is. Anyone with any intelligence knows that tobacco promotion reaches children, yet "the Government believes that the best way to control tobacco advertising and promotion is

through the voluntary agreements" (B Mawhinney, personal communication). These cosy arrangements are best for the tobacco industry.

Every day 450 more children start smoking,⁵ encouraged to a considerable extent by the exciting and intriguing promotion they see all around them. It is time for the government to ban tobacco advertising instead of sacrificing children's future health to current political expediency.

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- 2 Gray S, Bolger G, Ong G. Tobacco advertising on post offices. *BMJ* 1992;305:223-4. (25 July.)
- 3 Matthews P. Medicine and the media. *BMJ* 1986;293:442.
- 4 Mawhinney B. Tobacco advertising. *House of Commons official report*. (Hansard) p 514 col b, 1992 July 13:211-514. (No 49.)
- 5 Royal College of Physicians. *Smoking and the young*. London: RCP, 1992.

Developing a district diabetic register

EDITOR,—S D Burnett and colleagues provide a useful account of data sources available for developing a diabetic register.¹ What they describe, however, is a "hospital catchment area" register, not a district register, which is what they refer to in their introduction. The problem with a hospital catchment area register is that it has no definable population denominator, and, as Liam Donaldson states in his editorial in the same issue, registers without a natural population base have limited applicability.²

Establishing a district diabetic register is an even more difficult task: not only would cases identified from the data sources described by Burnett and colleagues need further sorting by postcode (which would have to be done manually for the Prescription Pricing Authority returns), but a wider net would need to be cast to include all hospitals and practices serving the district's population. As clinicians and general practitioners would have few incentives to update and maintain a register not designed to suit their purposes a district health authority would probably want to derive its data from the hospital and general practitioner registers.

As Donaldson states, a district diabetic register would be invaluable for assessing needs and monitoring outcomes²; purchasing district health authorities should consider rising to the challenge.

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- 1 Burnett SD, Woolf CM, Yudkin JS. Developing a district diabetic register. *BMJ* 1992;305:627-30. (12 September.)
- 2 Donaldson L. Registering a need. *BMJ* 1992;305:597-8. (12 September.)

EDITOR,—We agree with S D Burnett and colleagues that identifying all diabetic patients registered with a practice is an essential starting point for structured care.¹ We have reservations, however, about such a register being held by a district general hospital.

We believe that obtaining names of patients from the Prescription Pricing Authority and the family health services authority exemption certificates could breach confidentiality. We acknowledge that the use of exemption certificates was agreed in principle by the family health services authorities concerned but we question whether this release of information to the authors was covered by their registration under the Data Protection Act. We believe that in these circumstances patients' consent must be first obtained.

Burnett and colleagues do not discuss confi-

dentiality in the context of a centrally held register in any great depth. The BMA's policy is that "A patient's general authority may be assumed for the necessary sharing of information with other health professionals concerned with his health care, both for any particular episode and, where essential, for his continuing care. However, beyond this the patient's express consent must be obtained before any disclosure is made."² We believe that patients who are not treated by, or who have not been referred to, a hospital should not have their names included on the hospital register without their informed consent.

We support programmes established for audit and to encourage standards of excellence. The data, held with explicit safeguards to prevent the identification of patients if their informed consent has not been gained, will also serve as epidemiological data for research purposes.

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- 1 Burnett SD, Woolf CM, Yudkin JS. Developing a district diabetic register. *BMJ* 1992;305:627-30.
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Applying for disability living allowance

EDITOR,—An astonishing half of the disabled people questioned in a survey by the Automobile Association avoided claiming the mobility allowance (now called the disability living allowance) because they did not want a physical examination or were concerned about being humiliated or unfairly judged by the examining doctor.¹ These concerns are known to the Department of Social Security, and its procedures were modified with the introduction of the disability living allowance. This has introduced the idea of self assessment, whereby most claims are decided mainly on the customers' own assessment of how their disability or illness affects them, rather than relying on an examining medical practitioner's report. A visit by a doctor working for the Department of Social Security is now the exception rather than the norm. In the department's manual the instructions for examining doctors say:²

(1) Your assessment of the customer's walking ability should be based on informal observation not by a formal walking test.

(2) If a person's walking ability varies, take account of their overall ability over a period of time not just their ability on the day of the examination.

(3) In general you should always ask to examine the customer, but if they decline, their wishes should be respected.

(4) When carrying out an examination, the dignity and feelings of the customer must always be respected and at no time should they be asked to perform any action they would find distressing or painful.

I am concerned that so many disabled people are not applying for this allowance owing to anxieties about the medical examination. As a profession we need to be alert to this and to do what we can to ease these fears; we need to increase the rate of applications for the benefit and uptake by those who qualify.

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- 1 Godlee F. Disabled drivers not getting advice from doctors. *BMJ* 1992;305:670. (19 September.)
- 2 Department of Social Security Benefits Agency. *Guidance for examining medical practitioners*. London: Benefits Agency, 1992.