Rates of removing patients from general practitioners' lists according to fundholding status and time of becoming a fundholding practice

	No of patients removed from list	Person years	Rate of removal/10 000 person years (95% CI)
Fundholding practices*			
April 1993:			
Prepreparatory period	126	1 066 874	1.2 (1.0 to 1.4)
Preparatory year	21	203 214	1.0 (0.6 to 1.6)
Fundholding	140	762 053	1.8 (1.5 to 2.2)
April 1994:			
Prepreparatory period	218	1 348 525	1.6 (1.4 to 1.8)
Preparatory year	27	215 764	1.3 (0.8 to 1.8)
Fundholding	141	593 351	2.4 (2.0 to 2.8)
April 1995:			
Prepreparatory period	125	493 268	2.5 (2.1 to 3.0)
Preparatory year	26	68 037	3.8 (2.5 to 5.6)
Fundholding	27	119 065	2.3 (1.5 to 3.3)
April 1996:			
Prepreparatory period	440	2 114 203	2.1 (1.9 to 2.3)
Preparatory year	113	256 267	4.4 (3.6 to 5.3)
Fundholding	58	192 200	3.0 (2.3 to 3.9)
Fundholding practices overall:			
Prepreparatory period	909	5 022 870	1.8 (1.7 to 1.9)
Preparatory year	187	743 282	2.5 (2.2 to 2.9)
Fundholding	366	1 666 668	2.2 (2.0 to 2.4)
Non-fundholding practices			
April 1993:			
Before	1415	6 242 994	2.3 (2.2 to 2.4)
After	871	3 745 796	2.3 (2.2 to 2.5)
April 1994:			
Before	1622	7 241 873	2.2 (2.1 to 2.4)
After	664	2 746 917	2.4 (2.2 to 2.6)
April 1995:			
Before	1870	8 240 752	2.3 (2.2 to 2.4)
After	416	1 748 038	2.4 (2.2 to 2.6)
April 1996:			
Before	2117	9 239 631	2.3 (2.2 to 2.4)
After	169	749 159	2.3 (2.0 to 2.6)
Non-fundholding practices overall	2286	9 988 790	2.3 (2.2 to 2.4)

*The prepreparatory period extends from January 1987 until the start of the preparatory year. The preparatory year covers the financial year before fundholding began

economic and demographic characteristics of practice populations arising from a selection bias in practices that became fundholding practices. Other factors, such as the 1990 contract (which substantively altered the terms of service of all general practitioners in the United Kingdom), cannot explain the increase, as similar changes were not found for the non-fundholding practices.

It is unclear why the rate of removing patients has increased but "list cleaning" (removing patients who have died or left the practice area from lists) can be discounted. The database used in this study is maintained separately from the patient registration data within the Central Services Agency and contains only removals made at the request of general practitioners. Trained staff undertake validation checks which include contacting practitioners and writing to patients to inform them of the category of removal. Removals because of death are processed differently, and follow up procedures would identify a misclassification.

The public perception is that financial factors motivate fundholders to remove patients from their lists.[3] In the United States where healthcare systems provide financial incentives "adverse selection" is common; it has been suggested that the reforms in the NHS could stimulate similar effects.[4] Increased rates of removing patient may, however, reflect the additional workload and pressures of fundholding[5] rather than attempts at financial gain.

The decision to remove patients occurs comparatively infrequently and our results suggest that a fundholding practice with a list size of 5000 patients would be making one additional removal decision every five years. Our findings suggest that other areas of health care that experience large increases in workload, or where the potential for adverse selection exists, should be monitored.

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Conflict of interest: None.

1 Dixon J, Glennerester H. What do we know about fundholding in general practice? *BMJ* 1995; 311:727-30.
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Corrections

Will the fudge on equity sustain the NHS into the next millennium?
In the article by Mays and Keen (4 July, pp 66-9) the third sentence in the first paragraph of the section about arguments for changes, contained an error. The sentence should have read: "Although it is difficult to believe when you are on an NHS waiting list, people in the United Kingdom are more satisfied with healthcare arrangements than are people in the United States and Sweden, but less satisfied than people in Canada; these three countries all spend more than the United Kingdom on health care.[9]"

Excess mortality after human albumin administration in critically ill patients
In the editorial by Martin Offringa (25 July, pp 223-4) the reference cited towards the end of the penultimate paragraph should have been reference 4, not 2.

Cardiac arrests outside hospital
The opening sentence of the editorial by Tom Evans (4 April, pp 1031-2) should have read: "Twenty five years after the original epidemiological studies[1 2] two thirds of all patients who die with acute coronary events still do so before reaching a hospital (p 1065).[3]"

Randomised controlled trial comparing effectiveness and acceptability of an early discharge, hospital at home scheme with acute hospital care
An error occurred in this article by Suzanne H Richards and colleagues (13 June, pp 1796-801). In table 6 (p 1800) the difference (95% confidence interval) for "Information on treatment (as much as wanted)" should have been −3.2 (−15.7 to 9.3) (rather than −3.2 (−11.2 to 17.8)). This does not, however, affect the interpretation of the results.