

Gender ratio and hospital admissions

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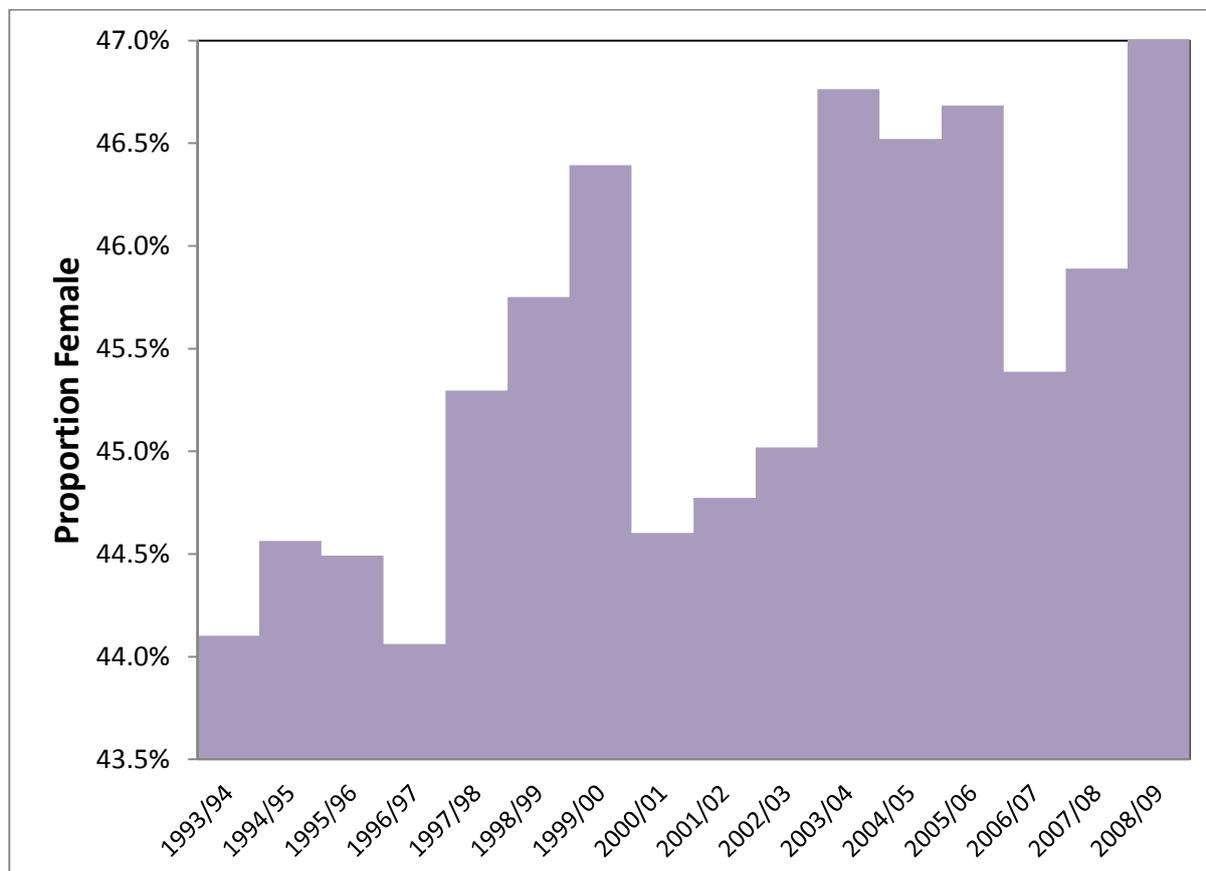
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A series of articles in BJHCM has suggested that the pattern in medical and mental health admissions and A&E attendances can be best understood in the context of a pattern of repeating outbreaks of a new kind of infectious disease (Jones 2009a,b, 2010a-j). It has also been suggested that an increase in the proportion of female admissions is a characteristic signature associated with these outbreaks (Jones 2010a,d,e).

Figure 1: Change in proportion of female admissions for general symptoms in New Zealand



Data kindly supplied by the NZ Ministry for Health

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Figure 1 gives an example from New Zealand relating to admissions for general symptoms (ICD-9 diagnosis code 780). As can be seen three clear shifts can be seen in 1997/98, 2003/04 and 2008/09 which match the dates (for a full year effect) following proposed outbreaks in 1996, 2002 and 2007 seen in the UK. In the UK each outbreak appears to be particularly associated with an increase in general symptoms since clinicians are not looking for a disease which works via general immune function impairment (Jones 2009b, 2010h-j).

The interesting point is that the proportion of female admissions is drifting steadily upward over time and this may offer insight into the cumulative effects of the infectious outbreak and the unexplained increase in medical admissions over the past three decades.

If one may suggest, at the very least, health care is not behaving the way we have been told it is supposed to behave (Jones 2010k). Is it time for a realistic reappraisal of the evidence-base for the basis of the biological factors involved and their knock-on effects in cost behaviour?

References

- Jones R (2009a) Trends in emergency admissions. *BJHCM* 15(4), 188-196.
- Jones R (2009b) Cycles in emergency admissions. *BJHCM* 15(5), 239-246.
- Jones (2010a) Additional studies on the three to six year pattern in medical emergency admission http://www.hcaf.biz/Recent/Additional_Studies.pdf
- Jones R (2010b) Emergency preparedness. *BJHCM* 16 (2), 94-95.
- Jones R (2010c) Forecasting demand. *BJHCM* 16(8), 392-393.
- Jones R (2010d) Nature of health care costs and financial risk in commissioning. *BJHCM* 16(9), 424-430.
- Jones R (2010e) Nature of health care costs and the HRG tariff. *BJHCM* 16(9), 451-452
- Jones R (2010f) Forecasting emergency department attendances. *BJHCM* 16(10), 495-496
- Jones R (2010g) Trends in Programme Budget expenditure. *BJHCM* 16(11), 518-526.
- Jones R (2010h) Unexpected, periodic and permanent increase in medical inpatient care: man-made or new disease. *Medical Hypotheses* 74, 978-83
- Jones R (2010i) Can time-related patterns in diagnosis for hospital admission help identify common root causes for disease expression. *Medical Hypotheses* 75: 148-154.
- Jones R (2010j) The case for recurring outbreaks of a new type of infectious disease across all parts of the United Kingdom. *Medical Hypotheses* 75(5): 452-457.
<http://dx.doi.org/10.1016/j.mehy.2010.04.023>
- Jones R (2010k) Myths of ideal hospital size. *Medical Journal of Australia* 193(5): 298-300.