

Hospital Services Report

June 1998 Quarter

Notes

This document contains the most up-to-date information available at the time of preparation.

This *Hospital Services Report* is available on the Department of Human Services Internet site located at:
<http://www.dhs.vic.gov.au/ahs/pub.htm>

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Contents

<i>Introduction</i>	1
1. The Year 2000 Dilemma	2
2. Private Health Insurance - June 1998 Quarter	5
3. Hospital Admitted Patient Activity - June 1998 Quarter	6
4. Access to Emergency Services - June 1998 Quarter	9
5. Access to Critical Care Services - June 1998 Quarter	17
6. Access to Elective Surgery - June 1998 Quarter	18
7. Glossary	30

Introduction

Consumers, health care providers and government all need information on the quality of health services. Public access to information assists consumers to understand the health care system, it assists providers of health services in planning and increases the accountability of the Department of Human Services to the people in the state of Victoria, Australia.

The *Hospital Services Report* was introduced in 1995. This edition includes data for two quarters, June and September 1998, which covers the months of April to September.

This edition includes a special feature on the Year 2000 issue as it relates to the Victorian public hospitals.

The information included in this report is often requested from the Department. Since technical information of this nature is very difficult to interpret, each graph and table needs to be carefully considered in the context of the complexity of the health care system. Department staff, hospital staff, general practitioners and other health care professionals may be able to assist you to interpret this report.

Alterations to Elective Surgery Information

A number of figures and tables previously presented in the Hospital Services Report relating to patients treated from the waiting list are presented in a different format in this edition in order to provide consumers with a more accurate picture of patients treated or cancelled from both the waiting list and booking list. Figures 6.2, 6.5, 11.2 and 11.5 and Tables 6.2 and 11.2 in this edition refer.

Hospital Access Program (HAP)

In 1998/99, the Department introduced the Hospital Access Program to bring together the former Emergency Services and Elective Surgery Enhancement Programs and a new program component designed to improve critical care bed availability. This approach recognises the interrelated nature of demand management across these three areas. The HAP is aimed at fostering an integrated approach by Network/hospital management to service delivery, including bed management, in order to attain a balance in meeting the demand for services in these three areas. Information on the provision of elective surgery, emergency and critical care services will be reported in this publication in the same manner as in previous editions.

1. The Year 2000 Dilemma

The Y2k Bomb, or the Year 2000 glitch, or Millennium Bug as it is often called, is a non-reversible computer programming problem with a fixed deadline. Although as a structural problem it may be simple, its potential effects and sheer magnitude makes the delivery of solutions a highly complex and difficult process. The root cause is how most electronic systems have been programmed to record the date in the last two digit "YY" format, the most common item of information recorded.

The early pioneer programmers used a truncated date input format (ie. 99 instead of 1999), limited as they were by very expensive, primitive computer equipment with low memory capacity and hard disk space. In time, this programming "convention" became the norm, despite computers becoming many times more powerful and more impacting in our lives.

Computers behave exactly the way they have been programmed to. When computers move from 1999 to 2000 many will be unable to cope sensibly with a year whose value (00) is apparently less than the previous one (99). They will then presume that 00 stands for 1900, 01 stands for 1901 etc. This can lead to absurd conclusions such as if a person was born in 1945, had a child in 1965 who retires 65 years later (which should be in 2030, but is recorded as 1930), then – according to a computer – the child will retire 15 years before his parent was born, at the age of minus 35.

It is difficult to predict how problems are likely to manifest, particularly as the Y2k problem is exacerbated by additional date-processing dependent computer problems associated with 2000 being a Leap Year and so close to the user default (9/9/99) date (please see list of roll over dates at the end). At best Y2k problems could be simple, like 1900 instead of 2000 being printed on a letter. At worst, essential systems, equipment or processes will malfunction or stop altogether, thus endangering human life, vital infrastructure or machinery. Such system failures may create an

unprecedented havoc. The depth and breadth of the Y2k 2000 dilemma now troubles the minds not only of the IT specialists but more so of enterprise managers, shocked at the possible ramifications posed by the millennium bug.

The Y2k alarm was raised in 1991 when a Canadian named Peter de Jager first drew attention to the potential scale of this problem. He was especially concerned at the extent of the occurrence of two-digit years in the massive COBOL-based, date dependent computer programs, now called 'legacy' systems, used by the huge and complex organisations in the US. De Jager's calculations suggested that there might not be enough COBOL programmers in the world to correct all the Year 2000 problems in time.

We now know that the problem is much bigger than the old legacy systems and not restricted to computers. Tens of millions, possibly hundreds of millions of date dependent embedded chips reside in the variety of electronic equipment now controlling commercial, financial, manufacturing, infrastructure and telecommunications systems. The occurrence of multiple simultaneous failures and domino effect failures is not impossible, with the scale and spread effect of the problem rendering many "traditional" recovery options useless. In health, Y2k failures may impact on hundreds of the small, medium and large information processing systems, causing enormous unpredictable problems ranging from erroneous sequencing of record listings, to miscalculation of medical doses, to deletion of the latest vital records or databases of critical applications. Unless remediated, a number of medical equipment and devices may be affected since there are built-in clock functions in these devices, as will be building equipment (lifts, fire alarms, security/safety systems, etc) and even motor vehicles (chip-based).

The Y2k deadline is a unique event because it is shared by the whole world, cannot be missed or moved and remains the same regardless of the number of affected items. De Jager's view on fixing the problem is that "nobody can tell you how big the problem is, or how much it will cost to solve".

Almost all kinds of systems, IT-related or otherwise, on all sizes of hardware platforms in virtually every organisation are affected. Vendor-provided software, including operating systems, are not immune either. As the problem horizon is not negotiable it has become a race against the clock. At this stage there may already be insufficient time to fix all of the affected systems. At best, some ten months should remain for corrective action. At worst, in those systems that process future-dates, the problem will occur earlier than 1 January 2000. An organisation found that five-year employment contracts could not be renewed; a travel company could not take bookings for the 99/00 season; several health-care providers reported problems with patient management systems and booking systems (eg where patient appointments are made beyond 1999); a local authority found it could not issue licences for beyond 1999, and finance-sector cards with expiry dates in the Year '00' were rejected by automatic teller machines.

The Department of Human Services has developed a number of documents which provide a suggested methodology to assist hospitals in identifying Y2k problems and assess associated risks. The Department's Victorian Public Hospitals Year 2000 Unit have been working with Metropolitan Health Care Networks and Alliances of Rural Hospitals towards effecting Y2k compliance across this sector.

Following the whole-of-government approach in reporting to the State Cabinet, six phases in dealing with the Y2k issue have been broadly identified:

Risk acceptance & management commitment, aimed at developing an overall plan for the hospital, to determine what is involved in addressing the issue, tasks and resources required, as well as critical projects and deadlines. Management commitment is crucial at this stage. Steps within this phase include raising awareness of Y2k issues within the hospital/Network/Alliance; developing a Y2k project team and assign responsibilities; identifying stakeholders and establishing business and technical reporting structures; and setting timelines and deadlines.

Inventory, risk assessment and impact analysis identify what processes are essential to the hospital and what these depend on. Where processes are dependent on external suppliers and other third parties, formally seek and audit information about trading partners' Y2K compliance, as well as their partners' compliance further down the "food chain". Focus on high-risk resources and identify what situations may arise from their failure. Loss scenarios may involve geographic or systemic failures and should extend beyond internal resource categories. Determine the context of risk assessment and set the scope and objectives of the risk management plan with senior management involvement. Develop definitions for risks to include means of assessing risk, description of levels and likelihood of risk (e.g. critical, high, medium, low).

Identify possible failures and their consequences, estimate the cost of managing risks and weigh possible failures against likelihood and remedial magnitude. Prioritise processes, taking into account internal and external risk factors, including any potential leverage from pre-existing internal and external controls and infrastructures that may mitigate risk. Identify systems that will tolerate repair after the event, as opposed to those that must be managed in advance. Set compliance deadlines and focus on critical systems most likely to miss their "failure horizon". Consider issues of legal liability, and revisit insurance policies.

Strategic planning and resource allocation to determine the compliance action to be taken on each inventory item and hospital process, and allocate resources to achieve

these within the timeframes set. Prepare a detailed strategy of remediation/repair approach. Secure a result-oriented budget that includes the cost of personnel required, the replacing or upgrading of software and equipment, and the cost of investigation or change of key applications. Consult and enlist appropriate personnel and resources.

Remedial activity and compliance testing to prepare and implement the option to move towards a compliant environment. Project plans should be tested to ensure that every business process continues to work properly. It is viewed that this process will take 50% of project time.

Manage each remediation strategy using appropriate business and technical staff, ensuring that deadlines are met and appropriate resources allocated. Ensure compliance and sign projects off as completed.

Contingency planning defining and testing 'bridging plans' or possible alternatives for those business and service critical applications most at risk (e.g. to stop the imperiled business process or to identify available Y2K ready replacement alternatives or human or other intervention choices). Ensure appropriate delegation of clear levels of responsibility and authority in the event of failure. Carry out internal and independent testing and validation of contingency plans and update as necessary. Ensure a communications strategy exists aimed at imparting awareness and training about contingency plans

The final stage is Certification and sign off aimed at ensuring all steps have been completed and reviewed to include: reviewing of all contingency plans and test results; budget analysis and process post assessment.

The following key year 2000 example dates are suggested as minimum date sets for use in testing:

31 December 1999 and 1 January 1999, as 31 December 1999 is commonly used as a 'die date' it is likely that on that night some systems will stop altogether, while on 1

January 1999 many forecasting and budgetary systems will seek for the first time the year 2000 date.

29 February 2000 and 31 December 2000. It is widely known that any year exactly divisible by four and not evenly divisible by 100 is a leap year. The other rule not clearly known is that years at the end of the century divisible exactly by 400 are leap years. For example: Years 1880, 1940, 2000 and 2400 are leap years, while 1800, 1900, 1945, 2100, 2200 and 2300 are not. The year 2000 is a leap year, which results in 366 days when some systems will be expecting only 365 days. This will disturb all calculation routines or programs that have not considered the additional day in that year.

Many systems have used 9/9/99 - or simply '99' - to signify 'no expiry date'. On 9/9/99 many computer files on magnetic tapes marked with that date to ensure that they should be kept forever will suddenly become free to be overwritten with new material.

30 June 1999 and 1 July 1999 mark the end of the 98-99 financial year and the beginning of the 99-2000.

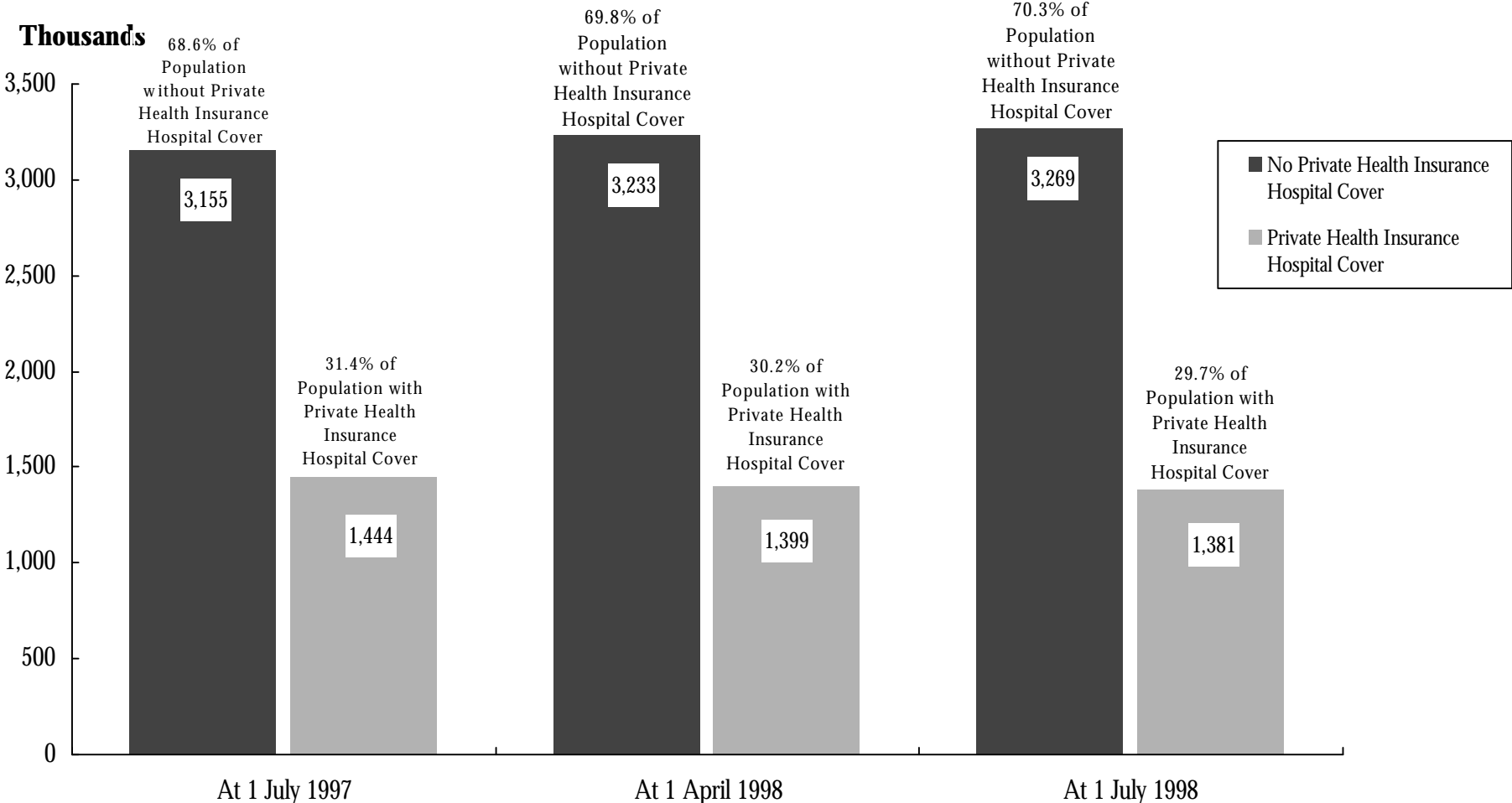
The Business Support & Development Group I2T2 Strategy Team has a listing of websites for building a Business Continuity Plan for those seeking additional information. Contact Chris Papadopoulos on 9616 8625 or e-mail chris.papadopoulos@dhs.vic.gov.au in this regard.

For information on hospital related Y2k issues contact Jim Lizardo, Manager - Victorian Public Health Year 2000 Program, on 9616 7109 or e-mail jim.lizardo@dhs.vic.gov.au.

2. Private Health Insurance

How Many Victorians Have Private Health Insurance Hospital Cover?

Figure 2.1 Health Insurance Status of Victorians ^{1 2 3}



¹ Data is for all people covered by insurance, that is, contributors, partners and dependants.

² Data for current quarter is provisional.

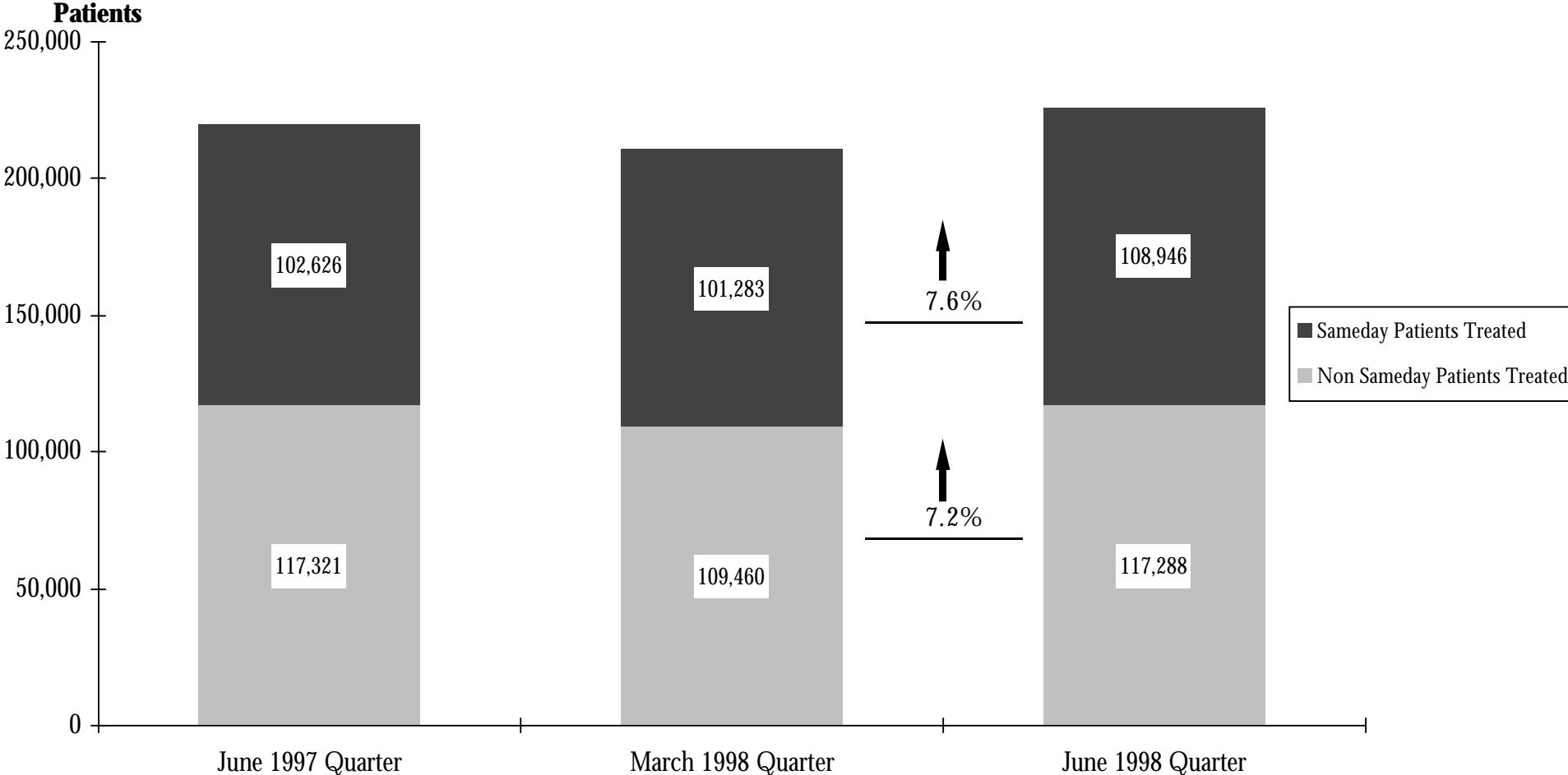
³ Statistics reflect total persons covered by any level of hospital private health insurance.

Source: Private Health Insurance Administration Council

3. Hospital Admitted Patient Activity

How Many Patients Are Treated in Our Public Hospitals?

Figure 3.1 Admitted Patients in Public Hospitals ^{1 2 3}



¹ Data is for casemix-funded acute public hospital patients. The data refers to the number of “separations” (ie. the number of patients that have been discharged from hospital).

² 1997/98 data is provisional.

³ “Sameday” patients are admitted and discharged on the same day.

Source: Victorian Inpatient Minimum Database

Patients Treated in Each of Our Major Public Hospitals

Table 3.1 Admitted Patients by Individual Hospital ^{1 2 3}

Hospital	June 1997 Quarter		March 1998 Quarter		June 1998 Quarter		March 1998 to June 1998		Change (%)
	Non Sameday Only	All	Non Sameday Only	All	Non Sameday Only	All	Non Sameday Only	All	
North Western Health Care Network									
Royal Melbourne Hospital	6,097	14,291	5,952	14,618	6,319	15,360	6.2%	5.1%	
Western Hospital	6,521	11,763	6,439	12,873	6,615	13,377	2.7%	3.9%	
Preston & Northcote Community Hospital ⁴	3,643	5,723	646	3,038	-	-	N/A	N/A	
Northern Hospital ⁵	-	-	1,854	1,045	3,306	5,331	N/A	N/A	
Other Hospitals	2,362	4,626	2,234	4,428	2,381	4,819	6.6%	8.8%	
Inner and Eastern Health Care Network									
The Alfred	4,792	11,226	4,601	8,967	4,646	9,480	1.0%	5.7%	
Angliss Health Services	2,635	3,747	2,701	3,873	2,928	4,355	8.4%	12.4%	
Box Hill Hospital	4,029	6,557	3,895	6,867	4,221	7,668	8.4%	11.7%	
Maroondah Hospital	1,960	3,565	1,769	3,386	1,984	3,745	12.2%	10.6%	
Peter MacCallum Cancer Institute	1,238	2,582	1,242	2,935	1,283	3,007		2.5%	
Royal Victorian Eye and Ear Hospital	1,946	3,436	1,499	2,684	1,630	3,077	8.7%	14.6%	
St. Vincent's Hospital	3,889	9,145	3,683	8,762	4,125	9,353	12.0%	6.7%	
Other Hospitals	2,238	4,419	1,682	3,619	1,464	3,275	-13.0%	-9.5%	
Southern Health Care Network									
Dandenong Hospital	4,327	6,558	4,088	6,035	4,258	6,495	4.2%	7.6%	
Monash Medical Centre	7,541	16,289	7,007	16,155	7,662	17,562	9.3%	8.7%	
Sandringham & District Memorial Hospital	1,225	1,845	1,135	1,612	1,191	1,759	4.9%	9.1%	
Peninsula Health Care Network									
Frankston Hospital	4,944	9,672	4,771	9,446	5,126	10,091	7.4%	6.8%	

¹ Data is for casemix-funded acute public hospital patients. The data refers to the number of 'separations' (ie. the number of patients that have been discharged from hospital).

² 1997/98 data is provisional.

³ 'Non Sameday' patients remain in hospital overnight or longer.

⁴ Preston & Northcote Community Hospital (PANCH) closed on 2 February 1998. The March 1998 data includes all separations from 1 January 1998 to 1 February 1998 and all multiday stays concluding on 2 February 1998.

⁵ Northern Hospital opened on 2 February 1998. The March 1998 data includes all separations from 3 February 1998 to 31 March 1998 and all sameday separations recorded on 2 February.

Table 3.1 Admitted Patients by Individual Hospital (cont'd)

Hospital	June 1997 Quarter		March 1998 Quarter		June 1998 Quarter		March 1998 to June 1998		Change (%)
	Non Sameday Only	All	Non Sameday Only	All	Non Sameday Only	All	Non Sameday Only	All	
Women's and Children's Health Care Network									
Royal Children's Hospital	4,679	7,454	3,988	6,872	4,437	7,535	11.3%	9.6%	
Royal Women's Hospital	3,597	7,930	3,100	6,963	3,040	7,057	-1.9%	1.3%	
Other Metropolitan Hospitals									
Austin & Repatriation Medical Centre	5,917	15,074	5,878	15,188	6,311	16,081	7.4%	5.9%	
Austin & Repatriation Medical Centre - Royal Talbot	169	169	101	102	174	175			
Mercy Public Hospitals Inc., East Melbourne	2,048	3,064	2,147	3,346	2,219	3,680	3.4%	10.0%	
Non Metropolitan Hospitals									
Ballarat Health Services	2,999	5,441	2,716	4,761	2,965	5,440	9.2%	14.3%	
Bendigo Health Care Group	2,672	4,520	2,434	4,173	2,697	4,702	10.8%	12.7%	
Central Wellington Health Service	1,098	1,853	1,001	1,813	1,111	2,007	11.0%	10.7%	
Barwon Health	5,104	9,054	4,861	8,653	5,132	9,241	5.6%	6.8%	
Goulburn Valley Health	2,238	3,250	2,046	2,998	2,400	3,495	17.3%	16.6%	
Hamilton Base Hospital	825	1,408	764	1,397	915	1,637	19.8%	17.2%	
Latrobe Regional Hospital	2,248	4,822	2,161	4,592	2,319	4,880	7.3%	6.3%	
Wangaratta District Base Hospital	1,584	2,436	1,464	2,456	1,459	2,428	-0.3%	-1.1%	
Warrnambool & District Base Hospital	1,800	2,975	1,714	3,001	1,891	3,221	10.3%	7.3%	
West Gippsland Healthcare Group	1,042	2,114	983	1,952	1,087	2,157	10.6%	10.5%	
Wodonga Regional Health Service	1,368	2,717	1,235	2,782	1,316	2,933	6.6%	5.4%	
Other	18,546	30,222	17,669	29,351	18,676	30,811	5.7%	5.0%	
Total All Public Hospitals	117,321	219,947	109,460	210,743	117,288	226,234	7.2%	7.4%	

Source: Victorian Inpatient Minimum Database

4. Access to Emergency Services

How Many Patients Are Treated in Our Hospital Emergency Departments?

Table 4.1: Patients Treated in Hospital Emergency Departments ^{1 2}

	June 1997 Quarter	March 1998 Quarter	June 1998 Quarter	Change (%) March 1998 to June 1998
Patients Treated	160,374	159,125	161,855	1.7%

¹ Data only for hospitals participating in the Emergency Services Enhancement Program. A complete list of these hospitals is given in Table 4.2.

² As the Mercy Hospital and the Royal Women's Hospital are not participants in the 1997-98 Emergency Services Enhancement Program, their figures have been excluded from data prior to July 1997 to enable comparative interpretation of the data.

Source: Victorian Emergency Minimum Dataset

Patients Treated in the Emergency Department of Each of Our Major Public Hospitals

Table 4.2 Patients Treated in Hospital Emergency Departments, by Individual Hospitals ^{1 2 3 4}

Hospital	June 1997 Quarter	March 1998 Quarter	June 1998 Quarter	Change (%) March 1998 to June 1998
North Western Health Care Network				
Preston & Northcote Community Hospital ⁵	8,900	1,900	-	N/A
Northern Hospital ⁶	-	6,311	8,591	N/A
Royal Melbourne Hospital	10,171	10,674	10,154	-4.9%
Western Hospital	15,356	15,130	15,186	0.4%
Inner and Eastern Health Care Network				
The Alfred	9,704	10,180	9,932	-2.4%
Angliss Health Services	7,688	7,915	7,886	-0.4%
Box Hill Hospital	8,166	8,037	8,153	1.4%
Maroondah Hospital	6,370	6,693	6,781	1.3%
St. Vincent's Hospital	5,751	6,158	6,225	1.1%
Southern Health Care Network				
Dandenong Hospital	9,964	9,772	10,146	3.8%
Monash Medical Centre	12,519	11,921	12,123	1.7%
Peninsula Health Care Network				
Frankston Hospital	7,252	7,405	7,808	5.4%

¹ Data only for hospitals participating in the Emergency Services Enhancement Program.

²

Data includes all emergency department patients, that is, they include patients who are subsequently admitted to hospital and patients who are treated in the emergency department without being admitted to hospital.

³ Note that some hospitals have multiple campuses and may operate separate emergency departments on each campus.

⁴ As the Mercy Hospital and the Royal Women's Hospital are not participants in the 1997-98 Emergency Services Enhancement Program, their figures have been excluded from data prior to July 1997 to enable comparative interpretation of the data.

⁵ As the Preston and Northcote Community Hospital (PANCH) closed at the end of January 1998, the March 1998 quarterly data includes figures for January only.

⁶ As the Northern Hospital opened on 2 February 1998, the March 1998 quarterly data includes figures for February and March only.

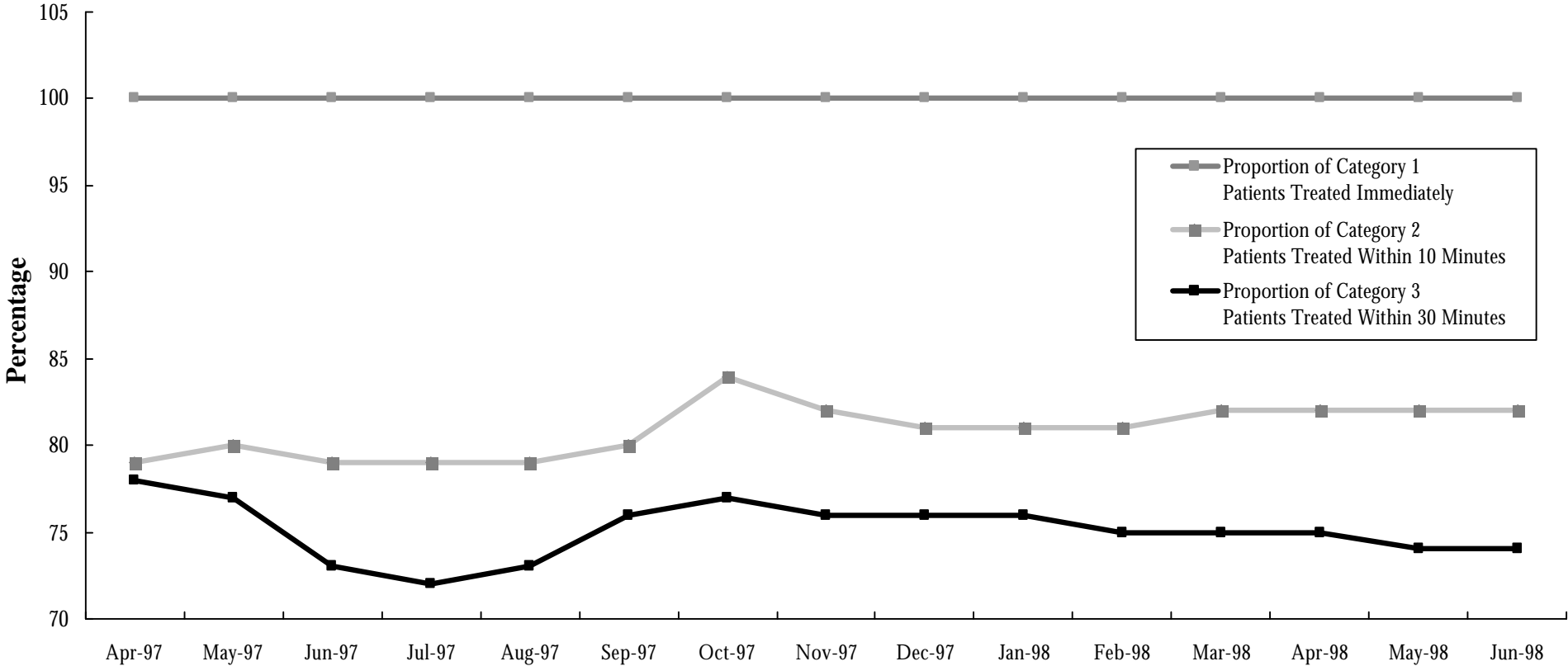
Table 4.2 Patients Treated in Hospital Emergency Departments, by Individual Hospitals (cont'd)

Hospital	June 1997 Quarter	March 1998 Quarter	June 1998 Quarter	Change (%) March 1998 to June 1998
Women's and Children's Health Care Network				
Royal Children's Hospital	15,103	12,248	13,749	12.3%
Metropolitan Non-Network Hospitals				
Austin and Repatriation Medical Centre	8,380	8,753	8,813	0.7%
Non Metropolitan Hospitals				
Ballarat Health Services	7,581	7,115	7,198	1.2%
Bendigo Health Care Group	6,945	7,226	7,336	1.5%
Barwon Health	8,061	8,769	8,616	-1.7%
Goulburn Valley Health	4,916	5,484	5,291	-3.5%
Latrobe Regional Hospital	7,547	7,434	7,867	5.8%
Total All Public Hospitals	160,374	159,125	161,855	1.7%

Source: Victorian Emergency Minimum Dataset

How many Patients, Classified According to Need, Are Treated Within Ideal Times in Our Hospital Emergency Departments?

Figure 4.1: Emergency Department Achievement of ACEM Waiting Times by Triage Category^{1 2 3 4}



¹ Waiting times are calculated as the time between presentation at the emergency department and commencement of treatment. The following Australasian College for Emergency Medicine (ACEM) patient categories and recommended treatment times are used:

- Category 1: Resuscitation case requiring immediate treatment, for example, major trauma, cardiac arrest, unconsciousness, shock.
- Category 2: Emergency case requiring treatment within 10 minutes, for example, severe trauma, chest pain, severe pain, severe breathing difficulty.
- Category 3: Urgent case requiring treatment within 30 minutes, for example, moderate trauma, infection, breathing difficulty.

² Variation in waiting times may reflect delays in clerical data entry rather than delays in clinical response.

³ Data only for hospitals participating in the Emergency Services Enhancement Program.

⁴ As the Mercy Hospital and the Royal Women's Hospital are not participants in the 1997-98 Emergency Services Enhancement Program, their figures have been excluded from data prior to July 1997 to enable comparative interpretation of the data.

Patients, Classified According to Need, Who Are Treated within Ideal Times in Each of Our Hospital Emergency Departments

Table 4.3: Emergency Department Achievement of ACEM Waiting Times by Triage Category, by Individual Hospital: June 1998 Quarter^{1 2}

Hospital	Category 1 Patients		Category 2 Patients		Category 3 Patients	
	Number of Patients	Treated Immediately	Number of Patients	Treated in 10 Minutes	Number of Patients	Treated in 30 Minutes
North Western Health Care Network						
Northern Hospital	54	100%	211	80%	1,861	72%
Royal Melbourne Hospital	130	100%	1,139	83%	3,335	87%
Western Hospital	195	100%	825	85%	3,340	86%
Inner and Eastern Health Care Network						
Alfred Healthcare Group	212	100%	860	84%	2,405	78%
Angliss Hospital	6	100%	74	84%	1,340	76%
Box Hill Hospital	85	100%	341	89%	2,727	76%
Maroondah Hospital	42	100%	263	92%	1,531	86%
St. Vincent's Hospital	90	100%	350	82%	1,567	85%
Southern Health Care Network						
Dandenong Hospital	229	100%	1,011	73%	4,439	66%
Monash Medical Centre	133	100%	1,014	74%	4,463	66%
Peninsula Health Care Network						
Frankston Hospital	68	100%	544	76%	3,392	50%

¹ Data only for hospitals participating in the Emergency Services Enhancement Program (ESEP).

² Australasian College for Emergency Medicine (ACEM).

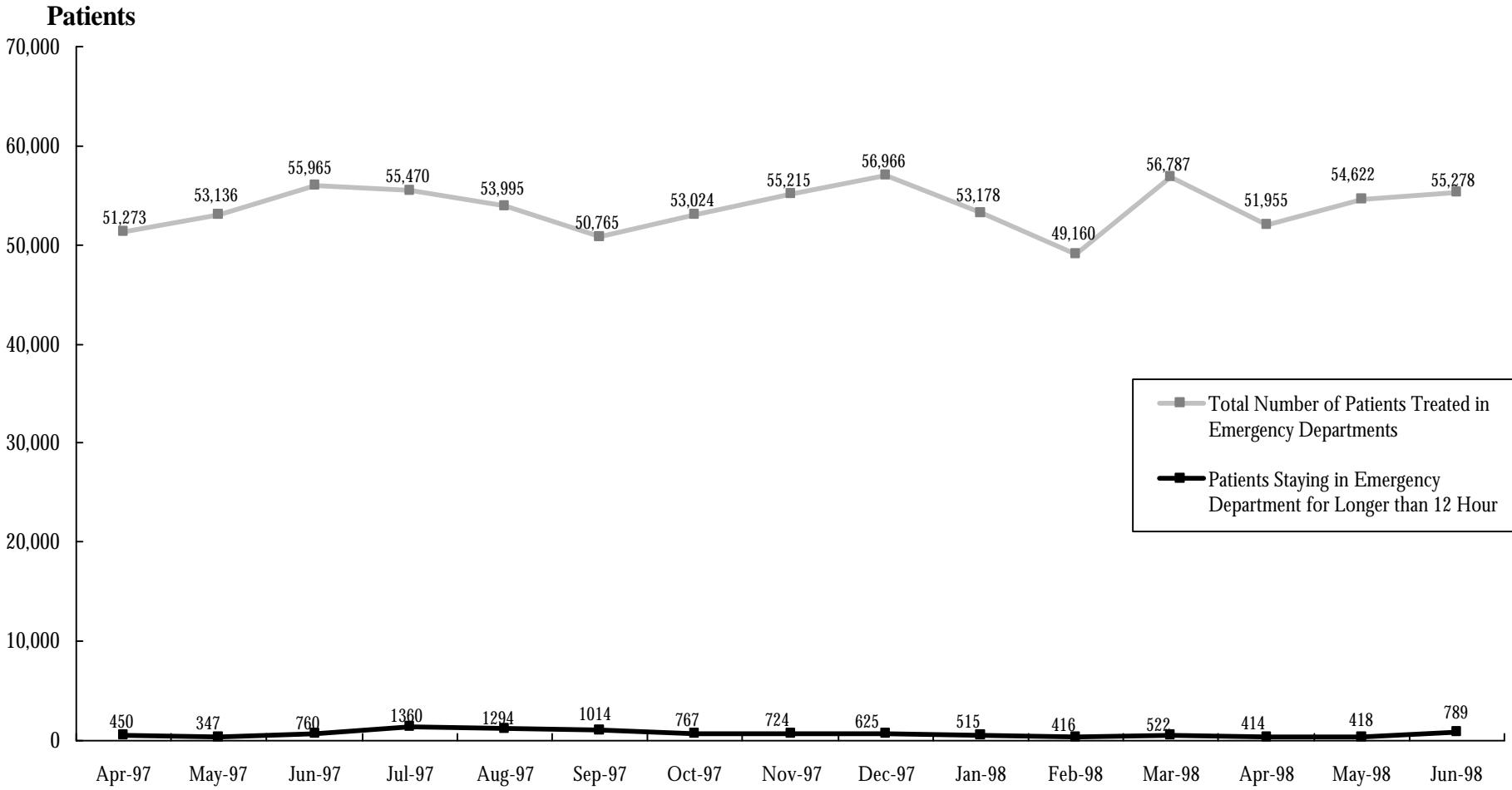
Table 4.3: Emergency Department Achievement of ACEM Waiting Times by Triage Category, by Individual Hospital (cont'd)

Hospital	Category 1 Patients		Category 2 Patients		Category 3 Patients	
	Number of Patients	Treated Immediately	Number of Patients	Treated in 10 Minutes	Number of Patients	Treated in 30 Minutes
Women's and Children's Health Care Network						
Royal Children's Hospital	29	100%	268	90%	3,441	78%
Metropolitan Non-Network Hospitals						
Austin and Repatriation Medical Centre	85	100%	686	79%	2,536	63%
Non Metropolitan Hospitals						
Ballarat Base Hospital	23	100%	150	88%	1,668	81%
Bendigo Health Care Group	12	100%	139	88%	1,092	79%
Barwon Health	85	100%	391	89%	2,218	78%
Goulburn Valley Health	16	100%	297	96%	1,566	79%
Latrobe Regional Hospital	39	100%	386	91%	1,093	86%
All ESEP Hospitals	1,533	100%	8,949	82%	44,014	74%

Source: Victorian Emergency Minimum Dataset

How many Patients Stay for an Extended Period in the Emergency Department?

Figure 4.2: Patients Staying in Emergency Departments for Over 12 Hours While Waiting for a Hospital Bed ^{1 2 3}

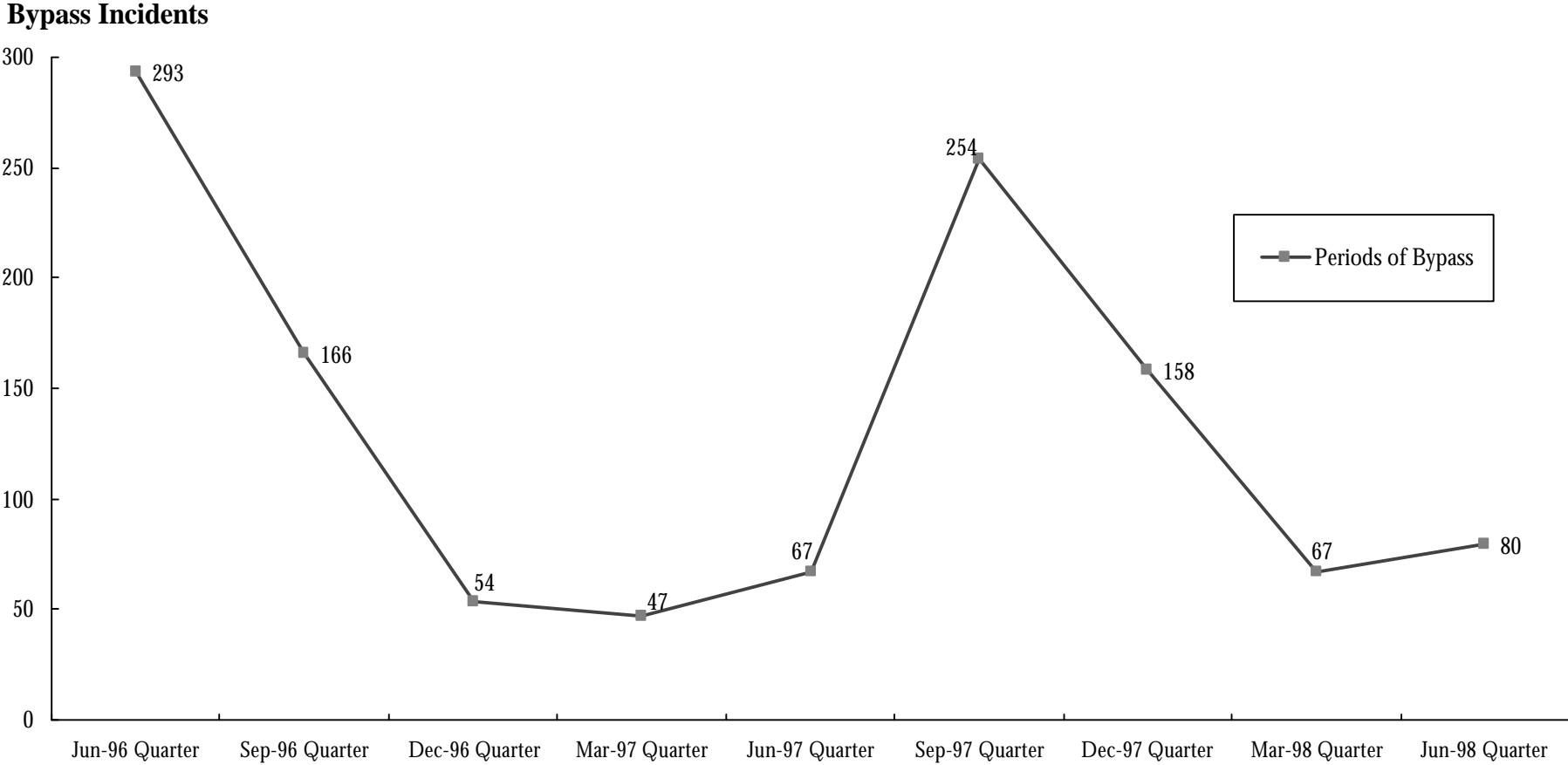


¹ The period of 'stay' is calculated from the time the patient arrives in the emergency department to the time when the patient leaves the emergency department.
² Data only for hospitals participating in the Emergency Services Enhancement Program.
³ As the Mercy Hospital and the Royal Women's Hospital are not participants in the 1997-98 Emergency Services Enhancement Program, their figures have been excluded from data prior to July 1997 to enable comparative interpretation of the data

Source: Victorian Emergency Minimum Dataset.

How Often Are Hospital Emergency Departments Too Busy, and Consequently Go on 'Bypass'?

Figure 4.3: Periods of Ambulance Bypass of Public Hospitals ^{1 2 3}



¹ Hospital emergency departments are bypassed by ambulances when the emergency department has reached maximum capacity and the treatment of patients already in the emergency department could be significantly compromised by the ambulance arrival of an additional patient requiring emergency treatment. Each individual period of ambulance bypass is for two hours or less.

² Data only for hospitals participating in the Emergency Services Enhancement Program.

³ Metropolitan Ambulance Service (MAS) response times are now being reported in MAS Response Report: A Quarterly Statistical Review of MAS, Melbourne. The 1st Issue (Feb 1998) of the Response Report reported on MAS response times for the December 1997 quarter. Copies of the Response Report can be obtained from MAS, Corporate Planning and Corporate Communications Unit, (03) 9840 3648.

5. Access to Critical Care Services

How Many Hospital Beds Are Available for Patients Who Need Intensive Care?

Table 5.1: Average Number of Intensive Care Beds (Excluding Step-down Beds) Available and Open at 9.00a.m., by Month ¹

	Apr-97	May-97	Jun-97	Jul-97	Aug-97	Sep-97	Oct-97	Nov-97	Dec-97	Jan-98	Feb-98	Mar-98	Apr-98	May-98	Jun-98
Available ²	8.3	8.2	5.9	2.4	1.7	3.4	4.2	6.8	6.3	10.0	7.8	4.8	5.9	5.5	3.0
Total Open ³	88.0	89.3	89.8	91.1	90.6	85.9	85.5	84.1	83.7	81.3	85.9	86.5	88.6	89.2	89.6

¹ Based upon hospital census taken at 9.00a.m. daily.

² Available beds are unoccupied beds which are staffed, functional and available to receive new patients.

³ Total open beds are all functioning and staffed beds, regardless of whether they are occupied.

Source: Office of the Coordinator of Emergency and Critical Care Services.

How Many Hospital Beds Are Available for Patients Who Need Coronary Care?

Table 5.2: Average Number of Coronary Care Beds (Excluding Step-down Beds) Available and Open at 9.00a.m., by Month ¹

	Apr-97	May-97	Jun-97	Jul-97	Aug-97	Sep-97	Oct-97	Nov-97	Dec-97	Jan-98	Feb-98	Mar-98	Apr-98	May-98	Jun-98
Available	7.9	6.4	6.4	5.4	6.5	7.3	9.5	10.3	9.1	12.4	10.4	9.7	7.9	8.7	8.1
Total Open	78.2	80.9	78.6	77.9	74.5	78.4	77.6	79.1	77.6	76.5	78.8	80.3	75.8	76.5	74.8

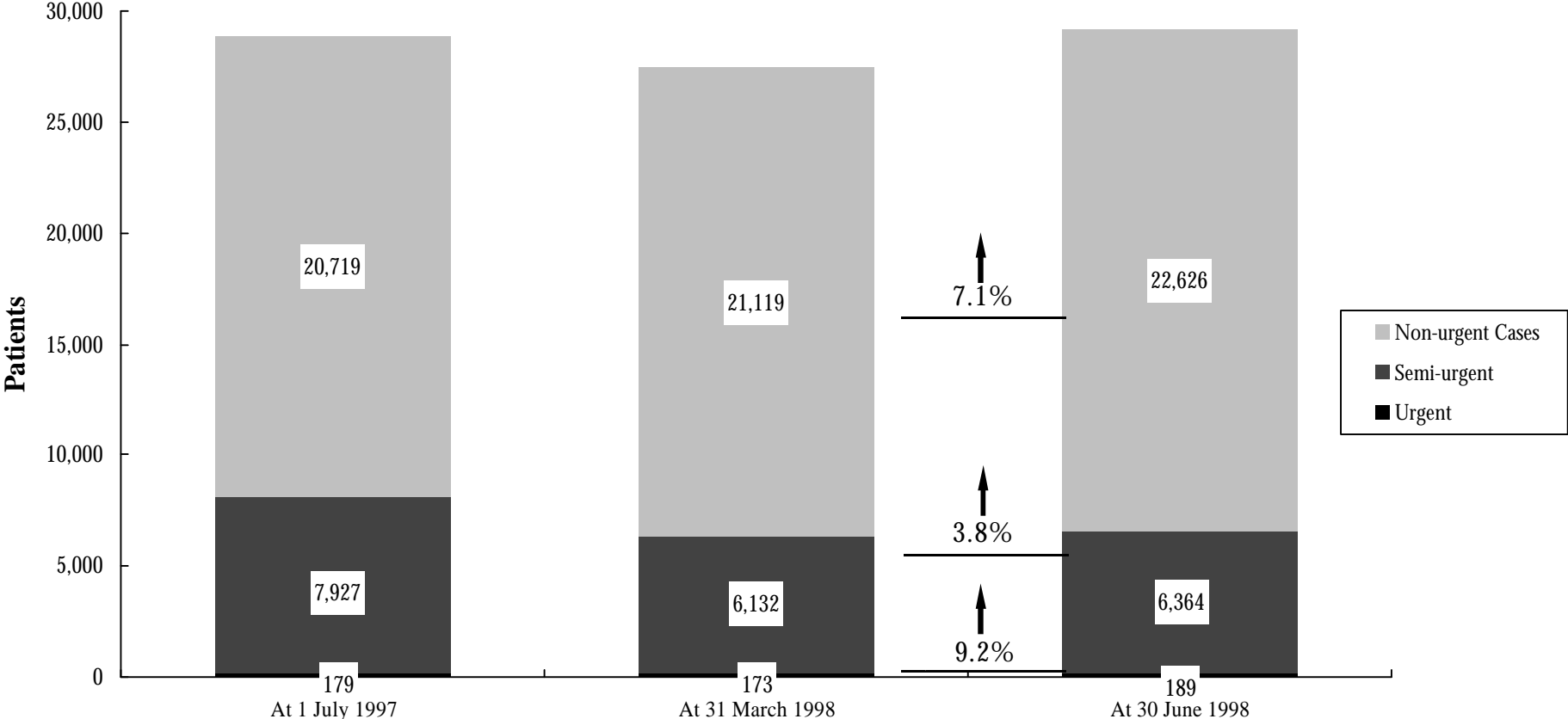
¹ Notes under Table 5.1 apply.

Source: Office of the Coordinator of Emergency and Critical Care Services

6. Access To Elective Surgery

How Many People, Classified According to Need, Are on the Waiting List?

Figure 6.1: Waiting List by Patient Category^{1 2}



¹ The waiting list patient categories are:

- Urgent cases (waiting list Category 1): Very urgent admission desirable for a condition that has the potential to deteriorate quickly, to the point that it may become an emergency. Admission within 30 days is desirable.
- Semi-urgent cases (waiting list Category 2): Admission within 90 days acceptable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency. From 1 January 1998 the definition for Category 2 patients has been changed to conform with national waiting list data definitions as published in the Australian Institute Health & Welfare National Health Data Dictionary Version 6.0 as follows: Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.
- Non-urgent cases (waiting list Category 3): Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability which is very unlikely to deteriorate quickly and which does not have the potential to become an emergency.

² Note that for this and subsequent tables, the numbers involved may be small and therefore small absolute changes may result in large percentage changes.

³ Discrepancies between the total number of urgent, semi-urgent and non-urgent cases in Figure 6.1 & Table 6.1 and total waiting in Figure 6.2 & Table 6.2 are due to some hospitals not providing urgency categories for all patients.

The Waiting List Patient Categories For Major Public Hospitals

Table 6.1 Waiting List by Patient Category, by Individual Hospital^{1 2 3}

Hospital	Urgent Cases			Semi Urgent Cases				Non Urgent Cases			
	1 Jul 1997	31 Mar 1998	30 Jun 1998	1 Jul 1997	31 Mar 1998	30 Jun 1998	Change % Mar 1998 to Jun 1998	1 Jul 1997	31 Mar 1998	30 Jun 1998	Change % Mar 1998 to Jun 1998
North Western Health Care Network											
Preston & Northcote Community Hospital ⁴	0	-	-	201	-	-	N/A	1,819	-	-	N/A
Northern Hospital ⁵	-	13	10	-	264	312		-	1450	1,599	N/A
Royal Melbourne Hospital	58	42	68	587	385	408	6%	1,330	1,510	1,481	-2%
Western Hospital	1	20	20	232	265	255	-4%	1,595	2,144	2,280	6%
Inner and Eastern Health Care Network											
Alfred Healthcare Group	40	7	28	457	241	270	12%	702	1,031	939	-9%
Angliss Health Services	0	1	0	29	22	9	-59%	353	257	243	-5%
Box Hill Hospital	0	3	2	178	189	203	7%	475	431	533	24%
Maroondah Hospital	1	13	14	53	133	163	23%	1,554	1,517	1,441	-5%
Peter MacCallum Cancer Institute	0	-	-	0	-	-	N/A	49	-	-	N/A
Royal Victorian Eye and Ear Hospital	0	1	0	1,681	1,522	1,372	-10%	83	21	13	-38%
St. Vincent's Hospital	10	6	1	658	431	442	3%	722	845	828	-2%
Southern Health Care Network											
Dandenong Hospital	2	4	4	129	123	78	-37%	998	926	1,212	31%
Monash Medical Centre	26	11	2	632	420	431	3%	2,853	2,287	2,569	12%
Sandringham & District Memorial Hospital	1	2	1	23	19	7	-63%	361	493	556	13%
Peninsula Health Care Network											
Frankston Hospital	4	13	11	471	393	465	18%	1,511	1,677	1,770	6%

¹ Note that for this and subsequent tables, the numbers involved may be small and therefore small absolute changes may result in large percentage changes.

² Peter MacCallum Cancer Institute, Central Wellington Health Service, Hamilton Base Hospital and Warrnambool and District Base Hospital no longer participate in the elective surgery enhancement program as of 1 July 1997.

³ Note that ESIS data collection dates are the final day of the month. The previous system measured waiting lists as at the first day of the following month.

⁴ The Preston and Northern Community Hospital closed at the end of January 1998. The data provided is for January 1998 only.

⁵ The Northern Hospital opened on 2 February 1998. The data provided is for February and March 1998 only.

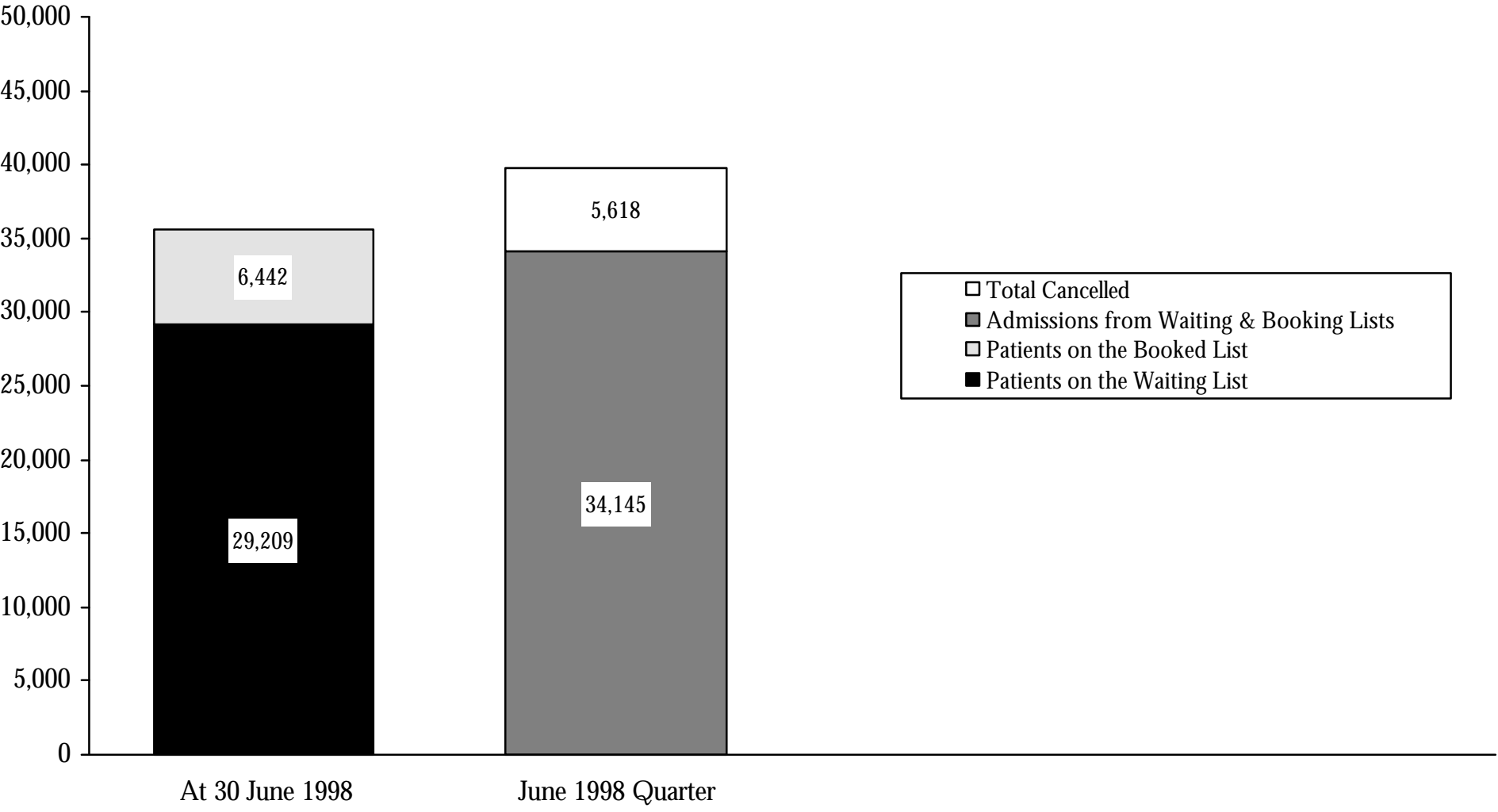
Table 6.1 Waiting List by Patient Category, by Individual Hospital (cont'd)

Hospital	Urgent Cases			Semi Urgent Cases				Non Urgent Cases			
	1 Jul 1997	31 Mar 1998	30 Jun 1998	1 Jul 1997	31 Mar 1998	30 Jun 1998	Change % Mar 1998 to Jun 1998 to	1 Jul 1997	31 Mar 1998	30 Jun 1998	Change % Mar 1998 to Jun 1998 to
Women's and Children's Health Care Network											
Royal Children's Hospital	5	1	0	98	44	59	34%	581	659	676	3%
Royal Women's Hospital	4	3	3	163	188	187	-1%	274	334	352	5%
Metropolitan Non-Network Hospitals											
Austin and Repatriation Medical Centre	16	17	16	1,003	686	590	-14%	1,584	1,487	1,326	-11%
Non Metropolitan Hospitals											
Ballarat Base Hospital	1	0	0	583	312	303	-3%	602	1,069	1,318	6%
Bendigo Health Care Group	9	13	1	139	119	105	-12%	750	890	730	-18%
Central Wellington Health Service	0	—	—	4	—	—	N/A	43	—	—	N/A
Barwon Health	0	0	1	170	100	385	285%	1,058	902	1,470	63%
Goulburn Valley Health	0	1	3	214	180	171	-5%	785	626	564	-10%
Hamilton Base Hospital	0	—	—	2	—	—	N/A	17	—	—	N/A
Latrobe Regional Hospital	1	1	0	70	30	47	57%	299	226	263	16%
Wangaratta District Base Hospital	0	1	2	67	56	27	-52%	144	192	182	-5%
Warrnambool and District Base Hospital	0	—	—	0	—	—	N/A	61	—	—	N/A
West Gippsland Healthcare Group	0	0	2	83	10	75	650%	116	145	281	94%
Total All Waiting List Hospitals	179	173	189	7,927	6,132	6,364	4%	20,719	21,119	22,626	7%

Source: Hospital waiting list returns (until 1 January 1998) and Elective Surgery Information System (after 2 January 1998).

How Many People from the Waiting List and the Booking List Each Quarter?

Figure 6.2: Admissions and Cancellations ¹



¹ In Victoria, the waiting list is used to coordinate patients who have been recommended for elective surgery but who cannot be booked in for admission to hospital because the demand for elective surgery at that hospital exceeds the resources available at that time. Patients are considered to be booked when they have been given a planned date within six weeks to be admitted for their elective surgery. Booked patients are separate to waiting list patients.

People from the Waiting List and Booking List Who No Longer Require Treatment in Each of Our Major Public Hospitals

Table 6.2: Admissions and Cancellations, by Individual Hospital: June 1998 Quarter

Hospital	Patients on the Waiting List at 30 June 1998	Patients on the Booking List at 30 June 1998	Admissions from Waiting List & Booking List During the Quarter	Patients Cancelled from Waiting & Booking Lists	Total Permanent Removals from Waiting & Booking Lists During the Quarter
North Western Health Care Network					
Northern Hospital	1,921	191	986	17	1,003
Royal Melbourne Hospital	1,957	243	2,075	360	2,435
Western Hospital	2,555	411	2,172	438	2,610
Inner and Eastern Health Care Network					
Alfred Healthcare Group	1,237	479	1,629	523	2,152
Angliss Health Services	252	120	419	44	463
Box Hill Hospital	738	321	1,194	133	1,327
Maroondah Hospital	1,618	52	1,029	477	1,506
Royal Victorian Eye and Ear Hospital	1,385	547	2,714	249	2,963
St. Vincent's Hospital	1,271	310	1,361	249	1,610
Southern Health Care Network					
Dandenong Hospital	1,294	200	954	140	1,094
Monash Medical Centre	3,002	686	2,641	506	3,147
Sandringham & District Memorial Hospital	564	76	464	68	532
Peninsula Health Care Network					
Frankston Hospital	2,246	299	1,541	308	1,849

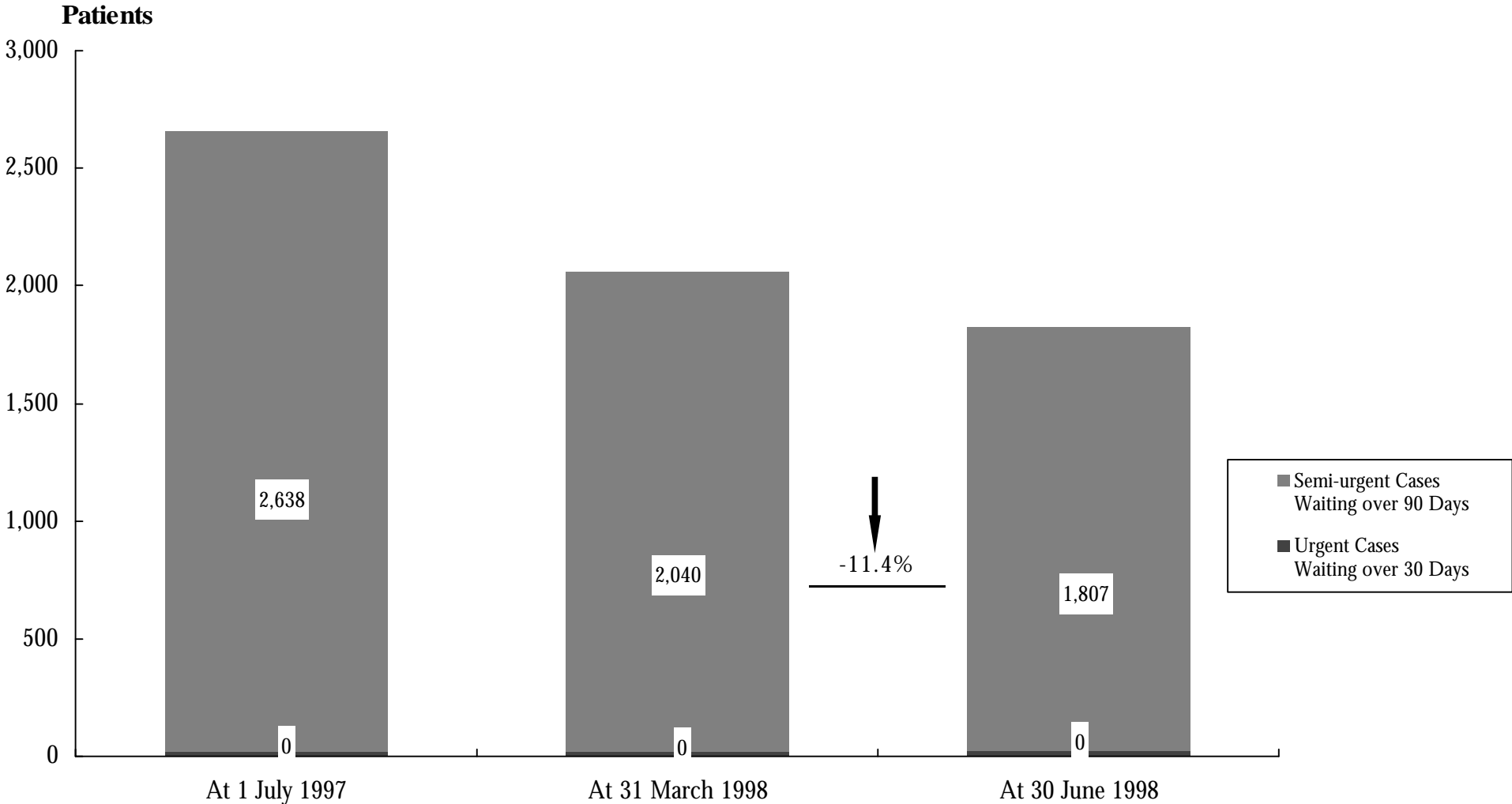
Table 6.2: Admissions and Cancellations, by Individual Hospital: June 1998 Quarter (cont'd)

Hospital	Patients on the Waiting List at 30 June 1998	Patients on the Booking List at 30 June 1998	Admissions from Waiting List & Booking List During the Quarter	Patients Cancelled from Waiting & Booking Lists	Total Permanent Removals from Waiting & Booking Lists During the Quarter
Women's and Children's Health Care Network					
Royal Children's Hospital	735	494	2,675	194	2,869
Royal Women's Hospital	542	357	2,072	251	2,323
Metropolitan Non-Network Hospitals					
Austin and Repatriation Medical Centre	1,932	301	2,582	479	3,061
Non Metropolitan Hospitals					
Ballarat Base Hospital	1,651	351	2,545	648	3,193
Bendigo Health Care Group	836	184	794	179	973
Barwon Health	1,856	328	1,308	65	1,373
Goulburn Valley Health	738	148	734	110	844
Latrobe Regional Hospital	310	134	1,116	93	1,209
Wangaratta District Base Hospital	211	116	530	60	590
West Gippsland Healthcare Group	358	94	610	27	637
Total all Waiting List Hospitals	29,209	6,442	34,145	5,618	39,763

Source: Elective Surgery Information System.

How Many People on the Waiting List and Booking List Wait Longer than the Ideal?

Figure 6.3: Waiting List and Booking List Patients Exceeding Ideal Waiting Times, by Patient Category^{1,2}



¹ Waiting longer than ideal includes semi-urgent patients waiting over 90 days and urgent patients waiting over 30 days.

² Note that for this and subsequent tables, the numbers involved may be small and therefore small absolute changes may result in large percentage changes.

Source: Hospital waiting list returns (until 1 January 1998) and Elective Surgery Information System (after 2 January 1998).

People on the Waiting List and Booking List Waiting Longer than the Ideal For Each of Our Major Public Hospitals

Table 6.3 Waiting List and Booking List Patients Exceeding Ideal Waiting Times by Patient Category, by Individual Hospital ^{1 2}

Hospital	Urgent Cases Waiting over 30 Days				Semi-Urgent Cases Waiting over 90 Days			
	1 Jul 1997	31 Mar 1998	30 Jun 1998	Change % Mar 1998 to Jun 1998	1 Jul 1997	31 Mar 1998	30 Jun 1998	Change % Mar 1998 to Jun 1998
Western Health Care Network								
Preston & Northcote Community Hospital ³	0	0	0	-	0	-	-	N/A
Northern Hospital ⁴		0	0	-		40	54	N/A
Royal Melbourne Hospital	0	0	0	-	177	114	140	22.8%
Western Hospital	0	0	0	-	59	70	59	-15.7%
Inner and Eastern Health Care Network								
Alfred Healthcare Group	0	0	0	-	80	118	87	-26.3%
Angliss Health Services	0	0	0	-	0	4	0	-100.0%
Box Hill Hospital	0	0	0	-	5	6	9	50.0%
Peter MacCallum Cancer Institute	0	-	-	N/A	55	-	-	N/A
Maroondah Hospital	0	0	0	-	0	0	0	-
Royal Victorian Eye and Ear Hospital	0	0	0	-	690	579	518	-10.5%
St. Vincent's Hospital	0	0	0	-	176	120	114	-5.0%
Southern Health Care Network								
Dandenong Hospital	0	0	0	-	0	0	2	N/A
Monash Medical Centre	0	0	0	-	244	202	196	-3.0%
Sandringham & District Memorial Hospital	0	0	0	-	3	2	2	0.0%
Peninsula Health Care Network								
Frankston Hospital	0	0	0	-	150	92	94	2.2%

¹ Peter MacCallum Cancer Institute, Central Wellington Health Service, Hamilton Base Hospital and Warrnambool and District Base Hospital no longer participate in the elective surgery enhancement program as of 1 July 1997.

² Note that ESIS data collection dates are the final day of the month. The previous system measured waiting lists as at the first day of the following month.

³ The Preston and Northern Community Hospital closed at the end of January 1998.

⁴ The Northern Hospital opened on 2 February 1998. The data provided is for February and March 1998 only.

Source: Hospital waiting list returns (until 1 January 1998) and Elective Surgery Information System (after 2 January 1998).

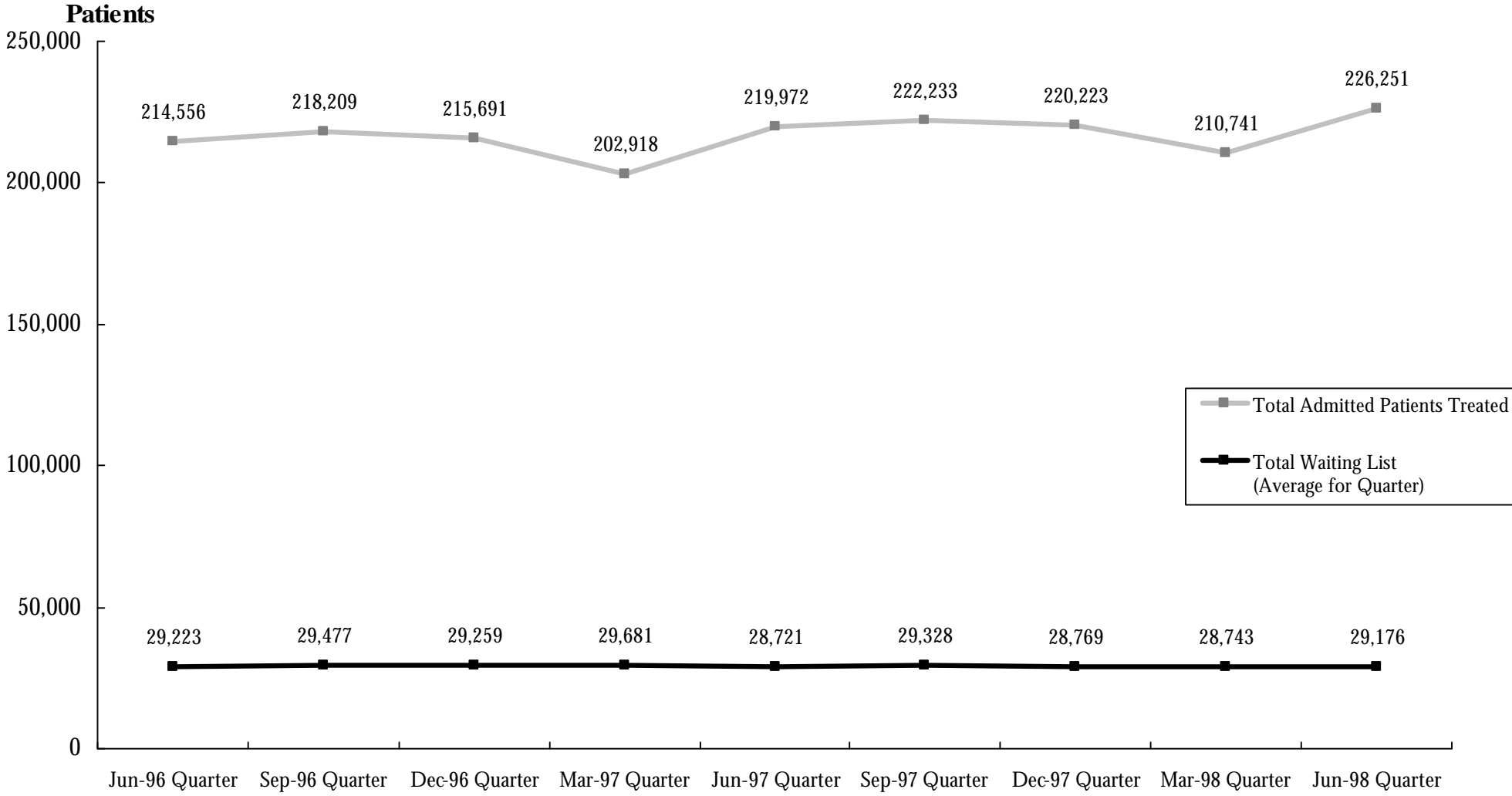
Table 6.3 Waiting List and Booking List Patients Exceeding Ideal Waiting Times by Patient Category, by Individual Hospital (cont'd)

Hospital	Urgent Cases Waiting over 30 Days				Semi-Urgent Cases Waiting over 90 Days			
	1 Jul 1997	31 Mar 1998	30 Jun 1998	Change % Mar 1998 to Jun 1998	1 Jul 1997	31 Mar 1998	30 Jun 1998	Change % Mar 1998 to Jun 1998
Women's and Children's Health Care Network								
Royal Children's Hospital	0	0	0	-	0	0	1	N/A
Royal Women's Hospital	0	0	0	-	30	8	16	100.0%
Metropolitan Non-Network Hospitals								
Austin & Repatriation Medical Centre	0	0	0	-	508	293	162	-44.7%
Non Metropolitan Hospitals								
Ballarat Base Hospital	0	0	0	-	360	260	137	-47.3%
Bendigo Health Care Group	0	0	0	-	18	24	30	25.0%
Central Wellington Health Service	0	-	-	N/A	0	-	-	N/A
Barwon Health	0	0	0	-	45	41	126	207.3%
Goulburn Valley Health	0	0	0	-	16	56	35	-37.5%
Hamilton Base Hospital	0	-	-	N/A	0	-	-	N/A
Latrobe Regional Hospital	0	0	0	-	0	0	0	-
Wangaratta District Base Hospital	0	0	0	-	12	11	16	45.5%
Warrnambool and District Base Hospital	0	-	-	N/A	0	-	-	N/A
West Gippsland Hospital	0	0	0	-	10	0	9	N/A
Total All Waiting List Hospitals	0	0	0	-	2,638	2,040	1,807	-11.4%

Source: Hospital waiting list returns (until 1 January 1998) and Elective Surgery Information System (after 2 January 1998).

How Does the Waiting List Compare to the Total Number of Patients Treated?

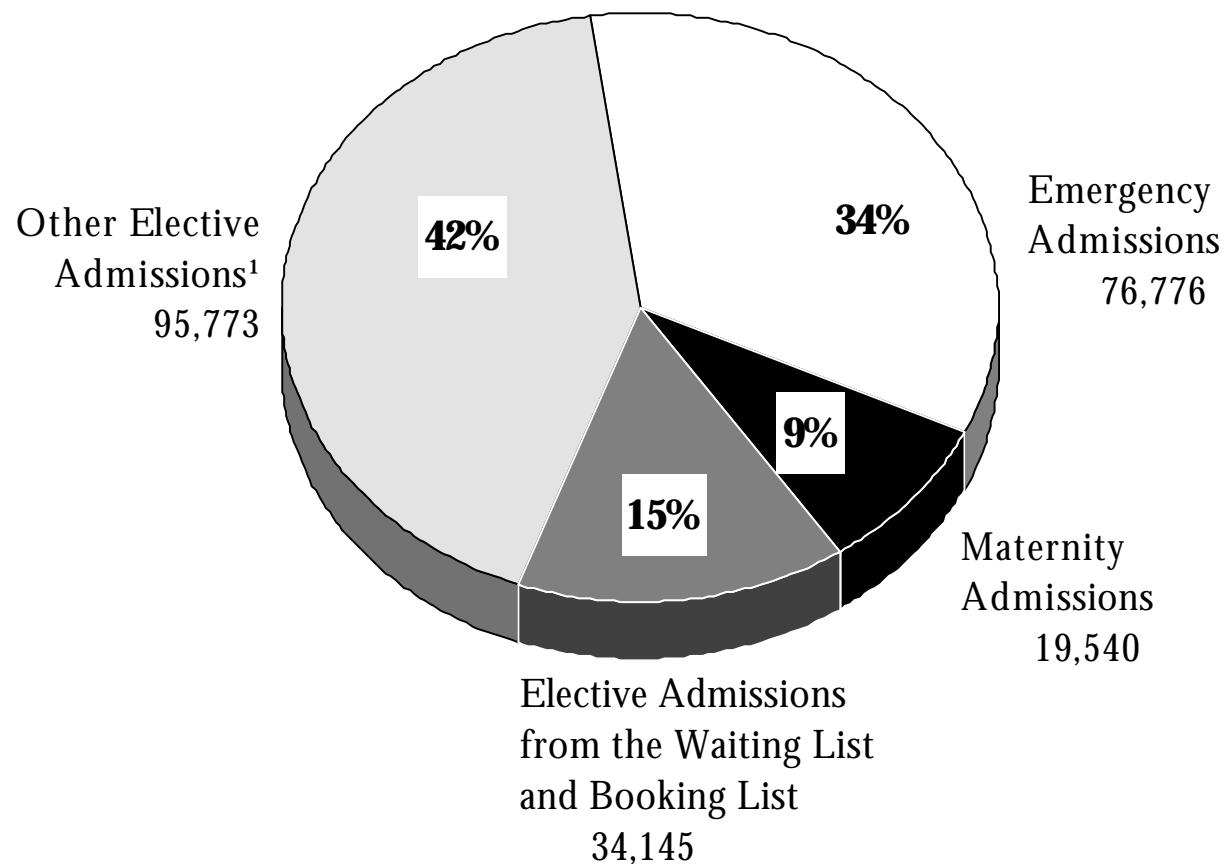
Figure 6.4: Waiting List Compared with Overall Admitted Patient Activity



Source: Victorian Inpatient Minimum Database.
 Hospital waiting list returns (until 1 January 1998) and Elective Surgery Information System (after 2 January 1998).

How Much of Total Hospital Activity Comes from the Waiting List and Booking List?

Figure 6.5: Separations by Admission Type ^{2 3 4}



¹ Includes statistical admissions, which refer to a change in patient care type.

² Patients on the waiting list who are treated during the quarter: see definition of treated patients given in Figure 3.1.

³ Includes maternity and newborns admissions.

⁴ Percentages may not add due to rounding.

Source: Victorian Inpatient Minimum Database.

Hospital waiting list returns (until 1 January 1998) and Elective Surgery Information System (after 2 January 1998).

How Many Patients Are Booked for Elective Surgery?

Table 6.4: Booked Patients at Waiting List Hospitals ^{1 2}

	At 1 July 1997	At 31 March 1998	At 30 June 1998	Change (%) March 1998 to June 1998
Booked Patients		6,003	6,442	7.31%

¹ Note that ESIS data collection dates are the final day of the month. The previous system measured waiting lists as at the first day of the following month.

² In Victoria, the waiting list is used to coordinate patients who have been recommended for elective surgery but who cannot be booked in for admission to hospital because the demand for elective surgery at that hospital exceeds the resources available at that hospital. Patients are considered to be booked when they have been given a planned date within six weeks to be admitted for their elective surgery. Booked patients are separate to waiting list patients.

Note: Patients may be booked immediately at the time that they are referred for elective surgery or they may be booked after having waited on the waiting list. The ability of a hospital to offer bookings depends on a number of factors including (i) the urgency of the patient's condition, (ii) the suitability (fitness) of the patient to undergo surgery, and (iii) availability of resources, including appropriately skilled surgical staff, operating theatre facilities, recovery room facilities, and general ward capacity.

Source: Hospital waiting list returns (until 1 January 1998) and Elective Surgery Information System (after 2 January 1998).

7. Glossary

What Do the Terms Used in this Report Mean?

Admitted Patient

Someone who is an inpatient in a hospital. Sameday patients who are admitted for less than 24 hours are also counted as inpatients but people who attend hospital for outpatient clinics are not.

Cancellation

The permanent removal of a waiting list patient from a booking list or waiting list without admission or booking for the awaited procedure

Casemix Funded

A system of funding hospitals according to the actual number and type of services that they provide. Casemix funding was introduced for most Victorian public hospitals in July 1993.

Coronary Care

A hospital unit with specialised staff and equipment to care for patients with heart disease.

Elective Admission

A planned admission to hospital. Emergency admissions and transfers from other hospitals are not counted as elective admissions.

Elective Surgery

Planned surgery that is not an emergency requiring hospital admission within 24 hours.

Emergency Admission

An unplanned admission to hospital due to unexpected illness or injury that requires urgent care.

Emergency Department

A hospital department that specialises in providing emergency care for people who are in need of urgent care (ambulance cases for example) and people who choose to seek treatment in an emergency department.

Health Care Network

A group of community acute hospitals, psychiatric services, tertiary acute hospitals and aged care services in the metropolitan area that is managed by a single board of directors.

Intensive Care

A hospital unit with specialised staff and equipment to provide continuous care for critically ill, injured or post-operative patients.

Non Sameday Patient

In the context of this report, a non sameday patient is an inpatient who leaves hospital on a later date than when they were admitted.

Separation

When an inpatient leaves a hospital. This is the technical way of counting the number of inpatients treated by a hospital.

Step Down Bed

Hospital beds with specialised staff and equipment to care for patients who no longer need coronary or intensive care but are not yet ready to move to a general hospital ward.

Transfer

When an inpatient is moved from one hospital to another. This might be in order to obtain a specialised treatment not available at the first hospital or because of the patient's preferences.

Waiting List Hospital

A major public hospital that performs elective surgery for public patients and uses a waiting list to properly keep track of people who require elective surgery