review and changes, arising out of new developments, changes in the infrastructure, staffing or patient complaints or suggestions. It requires a person who can pay constant attention and be responsible – one of the roles of the hospital administrator or manager. For this role to be effective, it is necessary that this person is trained in hospital management and, ideally, does not have a dual clinical role. However, the person needs to work closely with clinical staff to reduce the length of stay, eliminate unnecessary investigations, drugs and therapies, and bring about economies in the use of supplies, facilities and human resources. He or she has to devote enough time and attention in reviewing and improving systems and procedures, such as planning for services and facilities, and scheduling of staff and patients for optimum utilisation of resources to enable cost containment.

Conclusion

Cost containment is a continuous organisational process. A narrow and too simple approach will not necessarily be of benefit. It is a complex interaction of technical, organisational and human factors, which needs committed leadership, good attitudes of staff and a system approach. Higher expenses per surgery do not necessarily mean higher quality. Hospitals that provide quality service, and in large volume relative to their size, tend to have lower unit costs through better systems. On the whole, cost containment should be viewed as one of the strategies to enhance efficiency in eye care delivery.

References

1 R D Thulasiraj, R Priya, S Saravanan. High Volume, High Quality Cataract Surgery. *Indian Journal of Community Ophthalmology* 1997; **3(2)**: 24–32.
2 R D Thulasiraj, S Saravanan. Productivity: Getting Cataract Patients Through and Out. *J CommEye Health*, 2000; **13**: 22–23.
3 R D Thulasiraj. Social Marketing for Effective Eye Care Delivery. NPCB Course Material for Training in District Programme Managers, 1995, pp 79–86.
4 Raymond J Cisneros. Practical Pointers Most Institutions Have a Wealth of Potential Cost Saving Areas. HFM, Oct 1979, pp 47–51.
5 V K Sahney. Managing Variability in Demand, A Strategy for Productivity Improvement in Health Care Services. *Health Care Management Review* 1982; 37–41.

☆ ☆ ☆

Scholarship

London School of Hygiene & Tropical Medicine
Lt Col Henry Kirkpatrick Scholarship

Applications are invited for the above Scholarship to be awarded for October 2001 for studies in tropical ophthalmology and is available for study towards either Masters or Research studies. The scholarship will provide tuition fees and a contribution towards living expenses. In order to be considered, candidates will need to hold an offer of admission from the School for postgraduate study and will not already be in attendance on a research course of study.

We are looking for graduates who have or will have a first or upper second class honours degree, or equivalent. For research studies, applicants will also need to have an MSc, or equivalent.

For more information contact **The Registry, London School Hygiene & Tropical Medicine, 50 Bedford Square, London WC1B 3DP. Telephone: +44 (0) 20 7299 4646, Fax: +44 (0) 20 7323 0638, E-mail: registry@lshtm.ac.uk.** Quoting reference kirk.ceh.

Or visit our web site at **www.lshtm.ac.uk/prospectus** for further details.

Application should be made by no later than 30 April 2001.

Abstract

Rates of Hospital Admissions for Primary Angle Closure Glaucoma among Chinese, Malays and Indians in Singapore

Tien Yin Wong
Paul J Foster
Steve K L Seah
Paul T K Chew

Aim:

To estimate the rates of hospital admissions for primary angle closure glaucoma (PACG) in Chinese, Malays and Indians in Singapore.

Methods:

A population-wide hospital discharge database in Singapore was used to identify all hospital admissions with a primary discharge diagnosis of PACG (International Classification of Disease-CM code: 365.2). The Singapore census was used for denominator data.

Results:

Between 1993 and 1997 there were 894 hospital admissions for PACG. The mean annual rate of PACG admissions was 11.1 per 100 000 (95% confidence interval (CI), 10.4, 11.8) among people aged 30 years and over. The annual rate was highest for Chinese (age and sex adjusted rate: 12.2 per 100 000), which was twice that of Malays (6.0 per 100 000) and Indians (6.3 per 100 000). Females had two times higher rates than males in all three races (age adjusted relative risk: 2.0, 95% CI: 1.7, 2.3).

Conclusion:

Malay and Indian people had identical rates of hospital admissions for PACG, which were only half the rates compared with Chinese.

Published courtesy of :
Br J Ophthalmol 2000; **84:** 990–92.

☆ ☆ ☆