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Older adults’ perceptions of navigating eye healthcare in Denmark. A qualitative study

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Abstract

Background: Vision impairment can have an impact on cognition, health and social function. Vision loss may be avoided if detected early and treated promptly. Eye health is a minor topic in general practice, but the ongoing relationship between doctor and patient has the potential to assist the patient in navigating the healthcare system and guaranteeing timely healthcare service delivery.

Aim: To explore the attitudes of older members of the public (MOP) of navigating primary sector eye healthcare in Denmark, with a focus on optometrists, practising ophthalmologists (PO), and general practitioners (GP).

Design and Setting: Qualitative study design set in the capital area of Denmark

Method: Focus-group interviews performed in the spring of 2022 with 21 MOP.

Results: Older MOPs perceived optometrists and POs to be the most relevant health professionals to consult about eye health. MOPs identified several opportunities for enhancing the function of general practice that are currently unexplored.

Conclusion: Older MOPs seek help from health professionals who are directly qualified to treat the symptoms of ageing that they are experiencing or expect to face in the near future. However, included MOPs identify relevant potentials for GPs’ to address vision impairment. This includes a focus on the patient’s general health and function, as well as potential comorbidities influencing treatment trajectories. The current denigration of general practice risks missing out on the potential benefits of robust engagement from general practice in eye health.

Where this fit in

In general practice, eye health is a poorly investigated topic. This study unfolds how older members of the public navigate their health-seeking behaviours in primary care for vision and eye health, including their impressions of optometrists, practising ophthalmologists, and general practitioners. The study shows general practice is not the first option for patients and expands on the potential and barriers to engaging general practitioners in vision and eye health. The study adds to the discussion of how to design healthcare services.
Introduction

Vision impairment is a common anxiety of function loss in older adults and can lead to worsened mental health [1,2]. It may also have an impact on cognition and social function [3–8].

Vision impairment can be caused by refractive anomalies, which can be corrected, or by ocular disease, which in many situations can be treated. This study takes place in Denmark, where the majority of the population has access to corrective lenses. As is the availability of healthcare services for the detection and treatment of eye problems. Due to demographic changes the prevalence of diagnosis such as age-related macular degeneration (AMD) is expected to increase [9]. A recent study found that anti-VEGF-medication reduced the prevalence of central vision loss in the Danish population [10], but issues with detection of especially AMD and glaucoma remains [11–14]. Early detection and access to treatment are vital to the disease progression.

Because general practice is the first point of contact with the healthcare system, it may play an important role in detection of vision impairment. General practice takes a person-centred approach to treatment and follows patients over time [15]. Many of their patients have chronic conditions or are elderly. The ongoing relationship could perhaps assist the patient in determining which health professional to contact and when [16]. Increased focus on eye health could help prevent blindness and vision impairment caused by chronic eye diseases [17]. An important component is incorporating patient knowledge into the treatment strategy to ensure timely health-service use and appropriate care – including discarded patient knowledge, which is often key to understanding the complexities that older adults must navigate when living with chronic diseases [18].

In this paper, we wish to unfold, which primary healthcare professionals older members of the public (MOP) consider to be relevant to contact in relation to their vision and eye health. The focus will be on optometrists, practising ophthalmologists (POs) and GPs. The findings may aid in organising eye health services for older adults.

Methods

Design

This study is part of a health intervention aimed at detecting preventable vision loss in general practice [19]. We used a phenomenological approach to unfold experiences with eye health and views of relevant health professionals among MOPs aged 60 and up [20]. This allowed us to
understand and describe the interviewees’ attitudes as they expressed them. Focus-group interviews [21] were conducted using a semi-structured interview guide. This strategy allowed the group to have discussions about culturally and morally acceptable attitudes and behaviours. The MOPs who took part were not included because they had severe vision impairment; rather, the great majority reported good vision function and the ability to perform their daily tasks. Our goal was to spark a discussion about their self-reported vision, future vision expectations, the significance of social relationships and, most importantly, their imagined expedient health-seeking conduct connected to vision.

Setting

This study was conducted in Denmark, a socio-democratic welfare state where general practice coordinates healthcare and performs the majority of diagnostics [22]. Every citizen is assigned a default general practice. Treatment in the primary and secondary sectors is tax-funded, and no out-of-pocket payments are required. The frequency of annual visits to the GP increases with age. In 2022, half of citizens aged 70 to 79 had at least ten encounters with general practitioners within a year [23]. GPs address 90% of all medical cases [22,24] and serve as an entry point into the healthcare system as well as a source of subsequent referrals. Nevertheless, few exceptions are found, one of which is that citizens can book an appointment with a PO without a referral from their GP. POs are tax-exempt organisations that operate independently in the primary sector. GPs and POs can both access patient records and refer patients to hospital-based clinics. Optometrists typically operate in privately owned enterprises that are not part of the public healthcare system, which means they cannot refer to or access patient records. Visual acuity tests are often free of charge in optician shops. Optometrists can also perform diagnostic tests such as fundus photography and tonometry, but they are not permitted to make diagnoses. Before the patient meets the ophthalmologist, POs and hospital-based eye clinics might use optometrists to perform a variety of exams.

Data generation

Data was generated in the Copenhagen Capital Region between March and June 2022. Data consist of four semi-structured focus-group interviews with MOP [21], which were audiotaped and lasted between 58 to 90 minutes.
The interviews followed an interview guide that covered three major themes: (1) the role and significance of one’s vision in everyday life, (2) social relations and identity, and (3) intentional health-seeking behaviours. All interviews began with an explanation of how they were part of a study on general practice detection of vision impairment.

Inclusion criteria: 1) being 55 or older, and 2) residing in the outskirts of the capital city. A total of 21 interviewees aged 60-87 years (mean=72 years) were included after 38 expressed interest in participation. See table 1. The group composition was guided by an ambition of information power in data [25]. Interviewees were recruited through a national NGO that promotes age-related issues [26], and interviews took place in the NGO offices. The interviewees were separated into three interview groups: those with no known eye diseases (n=13), those with cataracts (n=3), and those with known eye diseases (n=5). The first group were split into two focus groups. The themes in the interview guide were the same in all four interviews, but minor changes were made to the questions posed to account for differences in experiences related to health-seeking behaviour in the two interviews with MOPs who had no known eye diagnosis and the two interviews with MOPs who had cataract and other eye-diagnosis, respectively.

Given broad inclusion criteria and differences in diagnostic status across the participant group, we asked into the interviewees’ own perception of their vision using the Visual Function Questionnaire-25 (VFQ-25) [27]. Please see Table 1 in the supplementary material.

[INSERT Table 1. Information on interviewees]

Data analysis

Focus groups were audiotaped and transcribed verbatim. Interviews were analysed using thematic analysis [28]. In the first round, all transcripts were read and coded manually and openly, after which interviews were thematised separately. The authors integrated key themes from the interviews to learn about interviewees’ perceptions of health professionals’ responsibility for age-related eye health. Following conversations, pertinent themes were defined, and transcripts were coded in NVivo 1.7 appropriately. The findings are reported by the standards for reporting qualitative research (SRQR) [29].
Data ethics

The study was carried out following the Helsinki Declaration [30] and the General Data Protection Regulation. All interviewees signed a written informed consent form. Interviewees are kept anonymous, and no specific geographical locations are used.

Results

We present our findings on MOPs attitudes towards optometrists and POs to be the most relevant health professionals to contact in the following section. We then explain how interviewees discovered several possibilities for strengthening the role of general practice, and how these possibilities are currently unexplored. Figure 1 depicts an overview of the analytical themes.

[INSERT figure 1. Analytical Themes]

Perceptions of optometrists

Interviewees described some degree of vision impairment was as a normal part of the ageing process. When experiencing visual changes, the majority of the interviewees saw optometrists as the ‘initial contact’. Overall, the optometrists and their relationships with them were described positively. (1) Accessibility was specifically noted as a factor in deciding which health provider to contact first. (2) Optometrists were perceived as highly qualified and customer-focused. However, as optometrists commercialise eye health, (3) the high service level was by some interviewees viewed as a difficulty.

Accessibility

Optometrists were perceived as highly accessible, owing to extended hours, including Saturdays, and the ability to walk in from the street and book an appointment. Thus, optometrists were reachable in terms of contacting, booking a last-minute appointment, and transportation to the optometrist shop. The interviewees were asked about whom to contact first when experiencing vision changes in the following excerpt:
“Well, I would call an optometrist. (…) it could take maybe six months before I could see a PO. So I’d go see an optometrist and find out if the optometrist said ‘You need to see a PO.’” Here the interviewee perceives the optometrist as the entrance point to the healthcare system which can perform an eye examination and encourage you to contact a PO if relevant, based mainly on accessibility.

**Qualified treatment**

All of the interviewees had their vision checked by an optometrist at some point. Optometrists were viewed favourably. They were described as service-oriented and proficient in general. Interviewees expressed considerable confidence in optometrists' judgements and highlighted their abilities to determine whether additional examinations by a PO were required:

“He [the optometrist] could give you a clue so you can tell the PO ‘I saw the optometrist who told me I have first signs of glaucoma’. Then the PO will see you immediately.” The optometrist is here identified as a gatekeeper who can identify what further treatment could be necessary. More importantly: as someone who can provide you with the necessary keywords to bypass the long waiting list at POs and instead secure you an acute consultation.

**Commercialization**

In addition to accepting the optometrists' judgements and commending them for their qualifications, interviewees problematized their relationship with the optometrists to the point where they became customers rather than patients: “If you go see an optometrist, well that's a service trade where you’re a customer (…).” In respect, the interviewees are aware of the commercialization of optometry shops and felt compelled to be critical. However, the discussions on the commercialization of optometrists were often followed by a slew of stories in which interviewees were advised to not spend money on new glasses just yet or to go see a PO before having new glasses made: “(...) an optometrist needs to make money, but on the other hand, I have to admit that I’ve been to the optometrist where they told me that it did not prove necessary to buy new glasses yet (…) so I guess that’s fair, right? But it’s just that thought that it’s pure business.”

Thus, the experiences are great, but a concern underscores the relationship, because: When is their concern for my health focused on my needs rather than their profit?

**Perceptions of POs**

Next to optometrists, interviewees perceived POs as relevant to be knowledgeable about vision and eye health. Interviewees who had initially contacted a PO based their decision on a family history of eye diseases; they were aware that a consultation with a PO could be booked and expressed a desire
for the most qualified care. Interviewees identified two major barriers to the PO: (1) restricted accessibility and (2) biomedical communication.

**Accessibility**

The PO was regarded to be difficult to reach. The study’s setting in the Capital area of Copenhagen provides optimal access to specialist doctors and POs placed within a fair geographical distance of the patient, hence accessibility was not connected to geography. Rather, the accessibility issue in this data is related to difficulty in establishing contact and booking consultations. POs were difficult to reach by phone, and some interviewees had difficulty booking consultations using online platforms. Waiting lists of more than six months of waiting were cited as making it very difficult to have your eyes examined by a PO.

“You have to book the next consultation immediately [after your visit]” and “(...) I can’t book a consultation a year in advance. I can only book six months in advance. (...) So it’s in my diary: call and book a consultation with the PO.” Overall, it took some effort to book a consultation with the PO, and the interviewees expressed frustrations with the extended wait.

**Biomedical communication**

POs were recognised as experts in performing eye examinations and were described as highly competent. Their medical capabilities were not called into question. What interviewees questioned, was their ability to work with a person-centred approach, understood as providing care that is responsive to the individual’s life circumstances, including other health-related conditions that the patient may encounter. Thus, addressing the entire person rather than just the eyes. Several times, the level of communication was noted as being low and insufficient. As exemplified here:

“So, I choose the PO, because that should basically be where expertise is found. I mean, they are the ones who are medically trained. But it’s funny, because at the same [they] might not be the most communicating members of the medical world. I mean, I’m sure they’re very skilled at looking into the eyes and performing diagnostics, but they are not particularly talkative or empathetic. They’re like, very specific.”

The interviewees reported a lack of patient support and knowledge about their condition(s). The PO identified and expressed their diagnosis, but what this meant for the patient – both in terms of daily life management and disease progression in general – was not felt to be adequately covered. This
was the case when an interviewee shared her experience with a glaucoma diagnosis: “Well he [PO] was not a man of many words, so he says ‘you’ve got glaucoma’. Okay, and you just sit there.”

Perceptions of general practice

The interviewees do not perceive their GP to be a relevant health practitioner to consult with eye health unless the situation is acute. All interviewees identified eye health as a significant part of ageing and related function loss during group discussions. The GP was identified as an important actor in treating patients’ overall health conditions in this perspective. We will elaborate on the role of the GP by addressing the following themes: (1) the GP is not the first choice, (2) the possibilities for engaging the GP in eye health, and (3) barriers relating to engaging the GP in eye health.

General practice is not the first choice

The interview guide asked explicitly which health professional is immediately appropriate to contact when experiencing a vision change, while the next three questions asked about the GP’s current or desired role in eye health. Interviewees had little experience with contacting a GP about eye health; instead, many hypothetical discussions about when to consult a GP were initiated: “Well, for instance, something like an allergy. I mean, the first time you catch something like that you don’t know if it’s one or the other thing going on. And then you can’t stand it – that the eyes are itching or streaming and such. But other than that, I don’t think the GP is particularly interested.” The interviewee here mentions allergy symptoms as factors impacting eye health. However, she concluded by saying that she assumed the GP was only interested in allergy-related eye problems. Her perspective of relevance was thus dual, as she discovered that both patients and GPs regard eye health as unimportant in general practice. This is also expressed in another passage, in which all interviewees initially said ‘no’ when asked if they had ever visited their GP for something related to their eyes, and one interviewee concluded by saying: “I wouldn’t bother him with that.” Overall the interviewees did not perceive that their eyes and vision are concern for their GPs, and the data lacks stories of interviewees discussing their vision with their doctors: “(...) I wouldn’t start with contacting my GP unless it was painful.”

Potentials of engaging the GP in eye health
The GP-related questions in the interview guide asked interviewees if they could conceive ways the GP may participate in monitoring prospective changes in vision. What if their GP asked them about their vision, and if they had any suggestions for how the GP could help them with their eye health. The interviewees agreed to a large extent that general practice offers eye health potential, particularly in detecting early signs of visual impairment, being in charge of further referrals and managing issues affecting life-quality such as dry eyes. This does not imply that GPs should be in charge of the diagnoses, but as one interviewee put it: “Well, they [GPs] can perform a few examinations, but they just need to refer the patient further. Or, ‘just’ is not ‘just’ because you only go see an ophthalmologist if you detect something is wrong, right?” Underlining that patients can only act on symptoms if they can sense them.

Interviewees express a need for a more open and holistic dialogue, such as once a year, to discuss the vision, as illustrated: “[…] well just a short test right? It’s not so dramatic when you’re at this level [primary sector] and then you can be referred to other specialists. I could actually imagine that would work.” In Denmark, GPs can arrange such an annual consultation for those with chronic conditions, and these yearly consultations were popular among the interviewees in our study. They were also recognised as a possible setting to address vision and overall function loss.

**Barriers to involving the GP in eye health**

The interviewees all agreed that inefficient structures guide the GPs’ work: “And I can get so angry because I don’t think its fair working conditions we offer the GP’s”. Interviewees highlight that consultation time is too short and that it is inconvenient for patients because they must book one consultation per concern and thus feel unable to explain their overall health condition. Even when it came to lengthy sessions, one of the interviewees stated: “[…] you don’t get to talk about everything, whether that’s eyes or not eyes. Generally, you’re left with stuff that you could worry about. There’s not always time to discuss it.”

Interviewees expressed concerns about the GP’s vision and eye health competence. Some challenged why a GP should assess one’s vision when optometrists and POs are available: “Well, I have to say that the GP is not nearly as good as a PO. He’s actually not nearly as good as an optometrist.” The interviewee shows that she’s fully aware of the key skills of POs and optometrists in examining the eyes, which is obviously outside the scope of GPs’ expertise. In this respect, further involvement of the GP should be committed to the key competencies of GPs, which include a patient-centred approach and the ability to incorporate patient needs into the treatment plan.
Discussion

We discovered that MOPs consider optometrists and POs to be the most obvious health experts to consult about vision and eye health. When asked directly, the GP is also identified as relevant. As a result, the interviewees seek treatment from health professionals who are directly qualified for the symptoms they are experiencing or expect to face in the near future as part of aging. However, interviewees perceive the GPs’ role and duties in vision and eye health as unclear, and the current denigration of general practice risks missing potential benefits of robust engagement from general practice. This involves a focus on patients’ overall health and function, as well as any comorbidities influencing the care trajectories.

Strengths and limitations

Focus-group discussions provided the opportunity to listen in on MOP’s conversations about primary healthcare providers and their responsibility for eye health and vision. To engage all interviewees’ special emphasis was placed on facilitating conversations around the table. Thus, interviewees’ opinions mirror comments that are considered socially acceptable or common sense [21]. This is seen as a strength in our findings since interviewees’ perceptions were shared in an environment where consensus is sought.

The interviewees in this study face minor difficulties in their daily lives as a result of their vision impairment (see supplementary material). All interviewees, however, had their vision checked by an optometrist and wore glasses. As a result, their interactions with optometrists were more intense than those with POs. The area constituting the study setting is characterized by a close geographical proximity to POs, and therefore interviewees may be more likely to seek specialised doctors than those in more rural areas. The ideal access to specialised doctors may introduce bias. Conversely, it may be strength as the findings are not influenced by geographical access issues. A limitation of this study is the majority of female interviewees, making it difficult to address gender specific practices in health seeking behaviour [31].

We exclusively interviewed ethnic Danes from the capital area. Existing research on disparities in eye health identifies ethnic minority status as indicator of vulnerability and low compliance [32–35]. We are unable to report on this aspect based on our data, but refer to a Danish study that concluded a generally low level of health literacy among patients with retinal diseases [36]. The homogeneity of
the interviewees is a strength because it supports the information power of our findings [25]. The findings are not intended to be generalizable to all MOPs in Denmark, but rather to reveal perspectives from a group that (1) represents a large population group in the elderly population (2) on a specific inquiry (3) with the goal of uncovering which primary healthcare professionals’ MOPs perceive as relevant to contact concerning eye health and gaining an understanding of culturally acceptable health-seeking behaviour.

Diabetic eye diseases are a threat to vision in many countries and are a major focus of eye health research [37,38]. We did not include an emphasis on diabetic eye diseases because general practice is already involved in diabetes treatment management.

**Comparison with existing literature**

Although eye health is a minor topic in general practice, our findings support that the GP, may be a significant stakeholder due to the GPs’ close and regular interaction with patients, ensuring timely disease detection [39]. According to a Canadian study, public knowledge of asymptomatic eye disease is low [16]. This requires health professionals to address eye health, identify subtle vision changes, and know what questions to ask. According to a survey of UK GPs, general practice is not good at identifying red flags concerning eyes [40], and primary care providers are not good at communicating eye-care information to patients [41]. In this regard, the GP may fail to diagnose asymptomatic eye disease, necessitating referral to the secondary sector [42,43]. The GP may act as the initial health professional assessing the eye health of the individual and provide referral for necessary cases [44–47].

Studies on screening programmes predominate in extant literature on the detection of vision impairment in general practice [48,49]. Such courses do not always require heavy equipment [50] and might be carried out, i.e., by administering a simple questionnaire on the patient's appraisal of their vision [44]. However, visual screenings in primary care have shown mixed results; in an intervention reported by Smeeth et al. they were unable to find improved visual outcomes [51], and the US Preventive Services Task Force recently issued a recommendation statement on screening for impaired visual acuity in older adults, finding insufficient evidence to determine the benefits and harms of screening [52]. Given the risk of overdiagnosis, observations on the potential unintended effects of screening programmes must be examined [53]. This includes self-screening, which has been linked to anxiety and excessive use of health resources [54].
Implications for practice and research

Because of their often asymptomatic nature, eye diseases such as AMD and glaucoma can be difficult to identify. MOPs attitudes of relevant health professionals’ responsibilities are significant because they play a pivotal role in citizens’ health-seeking behaviours and can help more citizens preserve their vision longer. According to this study, optometrists, followed by POs, are identified as relevant health providers. Because optometrists and POs are experts in vision and eye health, the MOPs included in the study reported an expediently health-seeking behaviour. This study was carried out in a setting with good geographical access to specialists, and the health-seeking behaviour towards POs is similar. However, the commercial objective of optometrists and the biomedical communication of POs presented challenges to the interviewees. Interviewees demanded more. This study cannot reflect on existing experiences with general practice, but we highlight the potential of general practice based on the interviewees’ statement of increasing focus on their entire health and function. GPs are concerned with the patients’ daily life, including multimorbidity and long-term health. This gives GPs a key role as the patients’ first point of contact in the healthcare system, where they may help manage vision impairment and explain diagnoses given by specialists. General practice is in charge of delivering primary healthcare to all citizens and is frequently in charge of managing chronic conditions like hypertension and diabetes. In this context, age-related loss of function, including vision, is a critical issue to address due to its impact on the patient’s ability to self-care, as well as physical and mental health. This could be accomplished by asking questions about recurring falls or limits in daily activities, as well as making accurate referrals. In this regard, the findings are relevant to a debate on general practice sustainability, because early detection of vision impairment reduces the burden for patients and can reduce workload in general practice and ophthalmology practice.

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Ethical approval

As part of the DETECT project, the study has received ethical approval from local authorities. See the protocol paper [19] for further details.

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Conflicts of interest

The authors have declared no conflicts of interest.

References


Table 1: Information on Interviewees

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Education level defined as: short: 2-2 ½ years, medium length: 3 ½-4 years and long: 5+ years.

17 female and four males. All of Ethnic Danish descent.

One interviewee did not give their age.