A Global View on Output and Outcomes of Cataract Surgery With National Indices of Socioeconomic Development

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PURPOSE. Cataract blindness accounts for a substantial proportion of blindness worldwide. Understanding the correlations between national levels of socioeconomic development with the quantity and quality of cataract surgery may provide insight for the prioritization and resource allocation for blindness prevention programs.

METHODS. The relationships between human development index (HDI), gross domestic product (GDP) per capita, and cataract surgical coverage (CSC) and visual outcome of cataract surgery were examined in a multinational study utilizing secondary data from the repository for Rapid Assessment of Avoidable Blindness (RAAB), World Health Organization, Global Burden of Disease, United Nations, and the World Bank.

RESULTS. A total of 266 RAAB studies across 73 countries/territories were retrieved. Linear regression model results revealed strong associations of HDI with prevalence of cataract blindness ($\beta = -7.056, P < 0.001$), CSC ($\beta = 60.808, P = 0.004$), proportion of intraocular lens (IOL) implantation ($\beta = 87.040, P = 0.001$), and proportion of cases with good vision outcomes among operated eyes ($\beta = 73.351, P < 0.001$) in studies performed between 1995 and 2009. Similar associations were observed for studies performed between 2010 and 2015. In addition, countries with lower GDP per capita showed a higher rate of cataract blindness ($\beta = -0.527, P = 0.001$), lower CSC ($\beta = 9.800, P < 0.001$), lower percentage of IOL implantation ($\beta = 6.871, P = 0.001$), and fewer patients with good vision outcomes after surgery ($\beta = 7.959, P < 0.001$). After controlling survey year, country, and other factors, GDP per capita and HDI were also found to be significantly associated with CSC and visual outcomes after cataract surgery (all $P < 0.05$).

CONCLUSIONS. We documented the strong associations of socioeconomic indices with quantity and quality of cataract surgery. These socioeconomic indicators should be considered as important factors for developing strategies aimed to improve worldwide cataract surgery service delivery.

Keywords: cataract surgical coverage, outcome, human development index, socioeconomic, gross domestic product

The current World Health Organization (WHO) global action plan (GAP), “Universal eye health: a global action plan 2014–2019,” requests countries to strengthen national initiatives for the elimination of avoidable visual impairment. The global target is a reduction in the prevalence of avoidable visual impairment by 25% in 2020, compared to 2010.1 Globally, unoperated cataract remains the leading cause of blindness (51% in 2010), even though cataract surgery is one of the most cost-effective medical procedures.2,3 Cataract surgical rate (CSR) and coverage (CSC) are recommended in the GAP as key indicators for delivering eye care. The visual outcome after cataract surgery is an indicator of the quality of cataract surgery, which is just as important as output indicators.4 At a population level, low socioeconomic status is likely to be correlated with care inequality.5,6 The gross domestic product (GDP) per capita is a single indicator of economic wealth, while the human development index (HDI) is a composite indicator appraising both social and economic status. Both indicators were commonly used for the comparisons of development across countries.7

In our previous analysis, we found a close correlation between CSR and GDP per capita globally.8 Socioeconomic factors play a key role in the access to high-quality health care, but also as a determinant of long-term health outcomes following treatment.8–11 When evaluated against the output and quality of cataract surgery, socioeconomic indicators such as the HDI and GDP present considerations for health policy and implications for target setting in public health. Although it
was previously reported that 90% of blindness was in
developing countries, and that access and quality of health
services may be closely linked to socioeconomic factors.\(^\text{2,3,15}\)
no standard socioeconomic indicators were specifically inves-
tigated. At present, the nature of these associations is not well
understood. The aim of this study was to quantify the
correlations of levels of socioeconomic development with
the quantity and quality of cataract surgery performed in
countries of interest.

**METHODS**

**Sources of Data**

The Rapid Assessment of Avoidable Blindness (RAAB) is a
standardized, population-based methodology and was designed
to assess the prevalence of blindness and its main causes in a
population aged 50 years and above, living in a district
environment. The study provides further information about
CSC, cataract surgical outcomes, and barriers to cataract
surgery access.\(^\text{16}\) An online repository for RAABs (http://raab
data.info/repository/; in the public domain) has documented
the salient findings of all RAAB studies completed to date.
Information fields including survey year, location, prevalence
and cause of blindness, rate of cataract blindness, CSC, and
outcomes of cataract surgery were extracted from this
repository for the present study.

The HDIs of countries were obtained from the Human
in the public domain). HDI is a product informed by social
and economic factors across three domains (health, educa-
tion, living standard) released by the United Nations
Development Programme (UNDP). Before 2010, it was
calculated by values of life expectancy, education attainment,
and GDP per capita. In 2010, the UNDP changed the formula
for calculating HDI to four indicators (life expectancy, mean
years of schooling, expected year of schooling, and gross
national income [GNI] per capita). The HDI is scored
between 0 and 1 based on quartiles, with the lowest,
second-lowest, second-highest, and highest quartiles consid-
ered as low, medium, high, and very high human develop-
ment for specific years. The values of GDP per capita in the
corresponding year and country were obtained from the
World Bank repository (http://data.worldbank.org/; in the
public domain). To minimize effects of economic inflation,
the GDP per capita was calculated based on 2011 constant
international dollars using the purchasing power parity (PPP)
method. The levels of solar ultraviolet (UV) radiation and age-
standardized mean body mass index were obtained from the
WHO Global Health Observatory data repository (http://apps.
who.int/gho/data/node.imr; in the public domain). The age-
standardized prevalence of cataract was retrieved from the
Global Burden of Diseases, Injuries and Risk Factors Study
2015 (GBD 2015) Results Tool (http://ghdx.healthdata.org/
gbd-results-tool; in the public domain).\(^\text{17,18}\) The proportion of
people aged 50 years or older was obtained from the United
Nations World Population Prospects, the 2015 Revision
(https://esa.un.org/unpd/wpp/Download/Standard/Popula-
tion/; in the public domain).

**Definition of Variables**

The prevalence of blindness and low vision (% in persons 50
years and older) in the sample was calculated based on
bilateral presenting visual acuity of less than 3/60 and ranging
from 3/60 to 6/18 (20/60), respectively. The rate of cataract
blindness was defined as a percentage of all blindness caused
by cataract, and prevalence of cataract blindness was defined
as the percentage of cataract blindness in a population. CSC is
usually reported both by eye and by person, and at different
levels of presenting visual acuity. Previous research has
presented a strong association with various measures of CSC
among RAAB studies. Only the CSC by person at the 3/60 level
(blindness) was used for all analyses in this study because this
variable was available for all RAAB studies. Visual outcome
after cataract surgery measured in RAAB studies was
expressed as the percentage of all operated eyes with “good
outcomes,” “poor outcomes,” or “borderline outcomes.” A
good outcome was defined as ability to see 6/18 and better
following surgery. Proportion of intraocular lens (IOL %) was
defined as the percent of eyes with IOL correction among all
operated eyes. The mean UV radiation was defined as the
average daily ambient UV levels in J/m². Furthermore, GDP
per capita was defined as the total market value of all
recognized final goods and services produced within a
country, in a given period of time, divided by the population
at annual measurement.

**Statistical Analysis**

All statistical analyses were performed using the STATA 12.0SE
statistical software package (Stata Corp., College Station, TX,
USA). Scattergrams were constructed to explore the relation-
ship between HDI, GDP per capita, and cataract surgery
indices. Because changes were made to the definition of HDI
before and after 2010, two sets of analyses were performed
HDI. GDP per capita was transformed to logarithmic value
due to an evidently exponential relationship in scattergrams.
Simple linear regression was used to evaluate the correlations
between HDI, logarithm scale of GDP per capita, and cataract
surgical metrics. Comparisons of cataract surgery indices
among different quartiles of GDP per capita were assessed by
ANOVA test, followed by post hoc Turkey test. The
association of percent of IOL implantation with proportion
of good outcome was assessed as well. The generalized
estimation equation (GEE) linear regression model with an
exchangeable working correlation matrix was used to assess
the effect of HDI or GDP per capita on CSC and proportion
of good surgical outcome after accounting for survey year,
country, the mean UV radiation, prevalence of cataract,
the proportion of people aged 50 years or older, and mean body
mass index for each country. These regressions modeled CSC/
outcome as a function of HDI/per capita GDP via a linear link,
and robustly accounted for the above factors within each
country. A P value <0.05 was considered to be statistically
significant.

**RESULTS**

There were 266 RAAB studies performed in 73 countries/territories (Fig. 1). Among these, 135 (50.8%) were conducted
from 1995 to 2009, and 131 (49.2%) were conducted after
2010. The majority of studies were performed in East Asian
and Pacific countries. Most studies were conducted in middle-
and low-income countries (97.0%), while high-income areas were
underrepresented (3.0%). Table 1 presents the characteristics
of the sample population from these studies, including a total
of 612,000 people aged 50 and older. The mean prevalence
rates of blindness and low vision in the examined population
were 3.8% and 15.6%, respectively. The majority of cases of
blindness were attributed to cataract, ranging from 21.2% to
91.1% of all blindness. For persons with cataract blindness, the
CSC values ranged from 10% to 100%. Among the operated eyes, 7.0% to 100% were corrected by IOL implantation. Approximately half of the operated eyes (range from 6.0% to 86%) had good vision outcomes.

For studies performed between 1995 and 2009, linear regression model results revealed a strong direct correlation between HDI and CSC ($\beta = 60.808$, $P = 0.004$; Fig. 2) as well as a direct correlation between HDI and good vision outcomes in operated eyes ($\beta = 73.351$, $P < 0.001$; Fig. 2). Similar associations were seen for studies performed from 2010 to present (Fig. 2). Table 2 summarizes the linear regression analyses of cataract surgical indices with HDI. For studies performed between 1995 and 2009, HDI was found to be closely related to the rate of cataract blindness ($\beta = -7.506$, $P < 0.001$) and proportion of IOL implantation ($\beta = 87.040$, $P = 0.001$). For studies performed in 2010 or later, the same trends were detected, with lower-HDI countries having higher odds of small CSC and poor visual outcomes compared to higher-HDI countries.

Cataract surgery indices differed significantly among countries with different quartiles of GDP per capita (Fig. 3). Countries with lower GDP per capita showed a higher rate of cataract blindness ($\beta = -0.527$, $P = 0.001$), lower CSC ($\beta = 9.800$, $P < 0.001$), and lower percentage of IOL implantation ($\beta = 0.871$, $P = 0.001$), with fewer patients with good vision outcomes ($\beta = 7.959$, $P < 0.001$) (Table 3). Among the included studies, the proportion of patients with good vision outcomes was lowest in Pakistan (6%) and highest in Malaysia (86%). Higher rates of IOL implantation were associated with a significant increase in the odds of good visual outcomes after cataract surgery ($\beta = 0.825$, $P < 0.001$).

### Table 1. Characteristics of Sample Population of Included Studies

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean</th>
<th>Median</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>2758</td>
<td>2500</td>
<td>1150</td>
<td>7500</td>
</tr>
<tr>
<td>Coverage, %</td>
<td>94.4</td>
<td>96.1</td>
<td>69.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Rate of blindness, %</td>
<td>3.8</td>
<td>3.2</td>
<td>0.4</td>
<td>11.1</td>
</tr>
<tr>
<td>Rate of low vision, %</td>
<td>13.6</td>
<td>13.1</td>
<td>2.3</td>
<td>40.9</td>
</tr>
<tr>
<td>Rate of functional low vision, %</td>
<td>2.2</td>
<td>2.0</td>
<td>0.0</td>
<td>5.7</td>
</tr>
<tr>
<td>Cataract as cause, % of all blindness</td>
<td>62.7</td>
<td>65.3</td>
<td>21.2</td>
<td>91.1</td>
</tr>
<tr>
<td>Rate of cataract blindness, %</td>
<td>2.3</td>
<td>1.9</td>
<td>0.2</td>
<td>8.2</td>
</tr>
<tr>
<td>CSC at blind level, %, person</td>
<td>63.5</td>
<td>64.5</td>
<td>10.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Rate of IOL implantation, %</td>
<td>79.1</td>
<td>86.0</td>
<td>7.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Good outcome after surgery, %</td>
<td>53.2</td>
<td>55.0</td>
<td>6.0</td>
<td>86.0</td>
</tr>
</tbody>
</table>

### Figure 1. Distribution of studies using methodology of assessment of avoidable blindness (RAAB).
Table 4 shows the results of GEE linear regression controlling for survey year, country, and other factors. The results showed that the higher CSC was significantly associated with the increase in HDI (coefficient = 60.307, $R^2 = 0.270$, $P = 0.047$) after adjusting other factors. The CSC was also significantly associated with logarithm value of GDP per capita (coefficient = 10.558, $R^2 = 0.210$, $P = 0.004$). With regard to the proportion of good visual outcome, the HDI (coefficient = 117.441, $R^2 = 0.356$, $P < 0.001$) and GDP per capita (coefficient = 14.186, $R^2 = 0.315$, $P < 0.001$) were also significantly correlated after controlling year, country, and other factors.

**DISCUSSION**

The information on output and quality of cataract surgery is essential for monitoring the progress of surgical services, and

**TABLE 2.** Association of Quantity and Quality of Cataract Surgery With Human Development Index

<table>
<thead>
<tr>
<th>Indices</th>
<th>Regression Coefficient, 95%CI</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\beta$</td>
<td>Low</td>
</tr>
<tr>
<td>Year 1995–2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of cataract blindness, %</td>
<td>–7.506</td>
<td>–11.155</td>
</tr>
<tr>
<td>CSC at blind level, %</td>
<td>60.808</td>
<td>20.792</td>
</tr>
<tr>
<td>Rate of IOL implantation, %</td>
<td>87.040</td>
<td>39.212</td>
</tr>
<tr>
<td>Good outcome after surgery, %</td>
<td>73.351</td>
<td>42.012</td>
</tr>
<tr>
<td>Year 2010–2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of cataract blindness, %</td>
<td>–4.249</td>
<td>–6.891</td>
</tr>
<tr>
<td>CSC at blind level, %</td>
<td>88.309</td>
<td>50.771</td>
</tr>
<tr>
<td>Rate of IOL implantation, %</td>
<td>44.882</td>
<td>19.813</td>
</tr>
<tr>
<td>Good outcome after surgery, %</td>
<td>60.519</td>
<td>30.140</td>
</tr>
</tbody>
</table>

95%CI, 95% confidence interval.
provides a valuable proxy measure of eye care and burden of blindness. This study documented statistically significant associations of HDI and GDP per capita with quantity and quality of cataract surgery. The countries with highest HDI had the best cataract surgery outcomes, which should be reached by a large number of countries, and identification of the key determinant of these variations was essential. The proportion of good visual outcomes following cataract surgery was higher in Latin America and the Caribbean than in Sub-Saharan Africa (63.0% vs. 43.1%, respectively), which may be partly explained by different proportions of IOL implantation (90.5% vs. 75.6%, respectively). We also confirmed the statistically significant associations between IOL implantation and proportion with good vision outcomes following surgery.

Economic factors have been linked to resource availability for eye health and its service delivery. We found that CSC increases when GDP per capita grows, raising the possibility that important factors such as increased resources for health care, improved infrastructure and technology, efficiency of providers, and better affordability of patients may accompany increasing wealth. In China, only 35.7% of patients with cataract blindness received cataract extraction, and lower CSC was correlated with older age, being female, lower educational level, and geographic rurality. Of 21 countries in Sub-Saharan Africa and in Brazil, a higher density of ophthalmologists was located in areas with higher GDP per capita. In China, a study of the GDP for 13 cities in Jiangsu Province also found a positive correlation between GDP and CSR.

Socioeconomic level is a multidimensional concept with several indicators. Although GDP per capita is the most commonly used indicator, it has been criticized for overemphasizing economic factors. HDI is a more comprehensive indicator, reflecting social and economic domains. Comparing between countries with similar economic size and wealth by GDP per capita, there are differences in standard of living, education, and health, which are reflected by HDI. Our findings are consistent with previous questionnaire and descriptive studies, which demonstrated that lower HDI was

### Table 3. Association of Quantity and Quality of Cataract Surgery With Gross Domestic Product per Capita

<table>
<thead>
<tr>
<th>Indices</th>
<th>Regression Coefficient, 95%CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of cataract blindness, %</td>
<td>$\beta$ $\pm$ CI</td>
</tr>
<tr>
<td>Rate of IOL implantation, %</td>
<td>$\beta$ $\pm$ CI</td>
</tr>
<tr>
<td>Good outcome after surgery, %</td>
<td>$\beta$ $\pm$ CI</td>
</tr>
<tr>
<td>CSC at blind level, %</td>
<td>$\beta$ $\pm$ CI</td>
</tr>
<tr>
<td>Rate of cataract blindness, %</td>
<td>$-0.527 \pm -0.822 \text{ to } -0.231 \text{ (0.001)} \text{ (0.110)}$</td>
</tr>
<tr>
<td>Rate of IOL implantation, %</td>
<td>$9.800 \pm 6.329 \text{ to } 13.272 \text{ (0.001)} \text{ (0.226)}$</td>
</tr>
<tr>
<td>Good outcome after surgery, %</td>
<td>$7.959 \pm 4.844 \text{ to } 11.074 \text{ (0.001)} \text{ (0.210)}$</td>
</tr>
<tr>
<td>CSC at blind level, %</td>
<td>$-0.822 \text{ to } -0.231 \text{ (0.001)} \text{ (0.110)}$</td>
</tr>
<tr>
<td>Rate of IOL implantation, %</td>
<td>$6.871 \pm 2.734 \text{ to } 11.007 \text{ (0.001)} \text{ (0.105)}$</td>
</tr>
<tr>
<td>Good outcome after surgery, %</td>
<td>$7.959 \pm 4.844 \text{ to } 11.074 \text{ (0.001)} \text{ (0.210)}$</td>
</tr>
</tbody>
</table>

95%CI, 95% confidence interval.
correlated with a low preoperative visual acuity and increased prevalence of cataract blindness.23,24 Lou et al.25 recently demonstrated that socioeconomic disparity in cataract burden has been deteriorated even global health progress in cataract, with heavier burden in less developed countries. These results indicate that health policymakers should pay more attention to socioeconomic-related inequality in quantity and quality of cataract surgery.

The WHO recommends that at least 80% of patients have good visual outcomes following surgery as an indication of adequate quality of service.26 Unfortunately, outcomes of cataract surgery in many countries do not meet this recommended level. For example, the China Nine-Province Survey revealed that only 46.5% of postoperative cataract eyes had presenting visual acuity of 20/63 and better, and 23.5% remain blind after cataract surgery in rural China.19 Our findings of positive associations between cataract surgical outcomes and HDI were also consistent with other ecologic findings of positive associations between cataract surgical outcomes and HDI, despite many barriers. In these countries, there are often unequal distribution of the data. Secondly, the RAAB studies examined individuals who had had surgery recently and many years prior to the date of the study, which may introduce bias especially for visual outcomes. Thirdly, most data were derived from middle- and low-income countries; thus the conclusions should not apply directly to other areas. Fourthly, using HDI and GDP per capita has limitations in that HDI is an average value of socioeconomic development for a country, and significant variations in development levels may exist within a country. Fifthly, subgroup analyses were not performed by sex, ethnicity, and education because corresponding data for these fields were inadequate. Reassessment of the relationship between cataract indices and socioeconomic factors in specific populations may produce more comprehensive findings in the future. Finally, only data at country level were available; for example, exposure is the average HDI/per capita GDP of a country, outcome is CSC/proportion of good visual outcome in a country. Fifthly, subgroup analyses were not performed by sex, ethnicity, and education because corresponding data for these fields were inadequate. Reassessment of the relationship between cataract indices and socioeconomic factors in specific populations may produce more comprehensive findings in the future. Finally, only data at country level were available; for example, exposure is the average HDI/per capita GDP of a country, outcome is CSC/proportion of good visual outcome in a country. Because no individual data were available, ecologic fallacy and bias may arise from aggregation of data.52–54 For example, different provinces in China have significantly different development levels. Different populations in a region might have different prevalence of cataract, educational level, and awareness of cataract surgery. Even in the United States, high geographic variations in the rate and timing of cataract surgery were observed in recent years.55 However, we could not perform subgroup analysis according to sex, ethnicity, or region because of inadequate data. Furthermore, the aggregated data did not take into account inequalities within countries. Future prospective study examining the individual characteristics of patients and cataract surgery outcomes could provide better insight into the impact of socioeconomic development on the progress of blindness prevention. In addition, longitudinal studies could provide better insight into the return on investment in cataract surgical programs.

In conclusion, this ecologic analysis provides a worldwide overview of the quantity and quality of cataract services according to socioeconomic development indices. We demonstrated a strong association between HDI, GDP per capita, and the quantity and quality of cataract surgery. These socioeco-

| Table 4. Generalized Estimating Equations Using Linear Regression Model for Assessing Relationship Between Socioeconomic Factors and Cataract Surgical Indices |
|---------------------------------|------------------|-------------|
| Model 1‡                        | Model 2†         |
| Coefficient (95%CI)             | Coefficient (95%CI) |
| **CSC**                        | **P**            | **R²**    |
| HDI 79.957 (47.996–111.917)     | <0.001           | 0.198      |
| Per capita GDP‡ 11.737 (7.370–16.105) | <0.001     | 0.148      |
| Proportion of good visual outcome |                 |            |
| HDI 114.381 (97.955–130.807)    | <0.001           | 0.250      |
| Per capita GDP‡ 18.352 (16.017–20.688) | <0.001    | 0.028      |

95%CI, 95% confidence interval.
‡ Model 1 controlled for the country and survey year.
† Model 2 further adjusted for the prevalence of cataract vision loss, proportion of people aged 50 years and older, mean body mass index, and the daily ambient ultraviolet radiation.
‡ Logarithmic scale.

where inadequate quality of postoperative care is highly prevalent.52

The limitations of this study should not be ignored. Firstly, the accuracy of each RAAB study depends on sample sizes at a given time. The RAAB studies include only the population 50 years and older; thus cataract indices in people under 50 cannot be estimated. Some RAAB studies were performed in subnational regions or single provinces, which leads to unequal distribution of the data. Secondly, the RAAB studies examined individuals who had had surgery recently and many years prior to the date of the study, which may introduce bias especially for visual outcomes. Thirdly, most data were derived from middle- and low-income countries; thus the conclusions should not apply directly to other areas. Fourthly, using HDI and GDP per capita has limitations in that HDI is an average value of socioeconomic development for a country, and significant variations in development levels may exist within a country. Fifthly, subgroup analyses were not performed by sex, ethnicity, and education because corresponding data for these fields were inadequate. Reassessment of the relationship between cataract indices and socioeconomic factors in specific populations may produce more comprehensive findings in the future.
nomics indicators should be considered when developing strategies aimed to enhance cataract surgical services worldwide.

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Disclosure: W. Wang, None; W. Yan, None; A. Müller, None; M. He, None

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