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The perceived role and relevance of South African optometric professional and regulatory bodies

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Background: Healthcare professions in South Africa are regulated through legislative bodies such as the Health Professions Council of South Africa (HPCSA) towards the protection of the public. Professional associations, on the other hand, enhance professional practice aspirations and advocate for recognition of their profession and membership that is voluntary in nature. These specific mandates are sometimes confused or conflated by the profession.

Aim: To assess practitioner perceptions on the role and relevance of optometric professional and regulatory bodies in South Africa.

Setting: The study was conducted amongst practicing optometrists and dispensing opticians in South Africa.

Methods: A cross-sectional, descriptive study that used a quantitative approach involving 208 optometric professionals was conducted via an online survey.

Results: Approximately two-thirds (65.5%) of the 208 respondents, 65.0% of whom were members of the South African Optometric Association (SAOA), believed that the SAOA is relevant. However, more respondents (72.9%) in the sample believed that the HPCSA was relevant, the majority (56.1%) of whom were also SAOA members. Most respondents did not believe that either the SAOA (68.0%) or the HPCSA (61.0%) protects the practice of optometry. A lack of action against perceived negative practices of optometry networks and violations by registered and unregistered individuals emerged as strong reasons for dissatisfaction amongst respondents. High membership fees were cited as a membership deterrent by 67.0% of non-SAOA members. Despite reporting adequate knowledge of the SAOA (84.7%) and HPCSA (94.6%), factual assessment revealed only 42.4% and 69.5% were accurate on the respective mandates of the two organisations.

Conclusion: Although many practitioners were unclear of the actual mandates of both the SAOA and HPCSA, they believed that both bodies were relevant and should improve advocacy and sanctioning of errant practitioners within the optometric arena in South Africa.

Keywords: advocacy; regulatory bodies; professional associations; HPCSA; SAOA; optometrist; dispensing opticians.

Introduction

Practising a healthcare profession requires mandatory registration and licensure by a relevant regulatory authority in many countries, including South Africa,[1,2] deeming unlicensed practising illegal and a criminal offence.[3,4] To practise their profession, optometrists and dispensing opticians are required, in terms of the *Health Professions Act No. 56* of 1974, to register with the regulator: the Health Professions Council of South Africa (HPCSA).[3,4] Registration through professional boards offers healthcare practitioners professional status aligned with their respective qualifications.[5] Additionally, by preventing unqualified persons from conducting services that fall within the regulated professional scope, the HPCSA protects the public and the profession and endorses the credibility of professionals to both offer and charge fees for professional services rendered.[6]

The medical profession began self-regulation in the mid–19th century with the introduction of licensing laws that enabled the profession to define the scope of practice, education and practice standards, clinical guidelines and ethical standards. The regulatory authority had the responsibility of ensuring that these standards were met, and they had an obligation to address unethical, immoral or incompetent practice.[7] According to White,[2] the rationale for professional regulation

in medicine is primarily patient safety, as patients generally lack the knowledge, skills or judgement required in the diagnosis and treatment of diseases. This vulnerability makes patients reliant on physicians to protect them through the implementation of proper protocols and enforcement of recognised standards for safe and effective practice. In addition to health professionals, other professionals such as auditors and lawyers are also regulated in most parts of the world, including South Africa.[8,9]

A regulatory system that is sanctioned by the government, the custodian of democratic powers, is generally acceded to and respected by the public, especially if the regulator has the necessary powers to determine the degree to which rules and standards are statutorily enforceable and to enforce compliance.[8] Public interest is best protected by having multiple professional bodies acting competitively, particularly given that in many jurisdictions the regulation of a profession is, to some extent, in the hands of the members of the profession itself.[9] However, policy tensions and conflicts between public and professional interests, transparency and privacy, as well as accountability and autonomy, remain challenges of regulating health professions.[10]

The regulatory body is tasked with monitoring the discipline of registered professionals, with a mandate to act against members violating their professional scope and ethical framework.[2,11,12] The absence of such a body and performance of regulatory duties by professional associations with voluntary registration poses various challenges. Until recently, in some regions regulation of optometrists had been the quasi-duty of various professional associations, such as the Ghana Optometric Association (GOA), which found it very difficult to regulate the nonmembers over whom they had no legal jurisdiction.[6]

An argument put forth against discipline-specific professional regulation is that it may hinder the use of multidisciplinary medical teams, where maldistribution of human resources demands innovative use of various professionals.[2] This notion was reinforced in a recent Health Market Inquiry report into the cost of private healthcare in South Africa, which also suggested that the HPCSA regulation prevented the use of multidisciplinary teams in delivering healthcare.[13]

In contrast to regulatory bodies, professional associations are, at their core, voluntary societies that promote and advocate for the profession and support their registered members.[4] The primary roles of a professional association are the following: promoting the profession through advocacy, creating opportunities for continued professional development, promoting and improving the standard of practice and providing professional indemnity insurance, whilst periodically arranging conferences and supplying academic resources as fringe membership benefits.[4] Although professional associations advocate for higher standards of clinical practice, the regulatory body is legally mandated to define and monitor minimum standards for professional education, training and clinical practice. Furthermore, central to the functioning of regulatory bodies is the protection of communities served, whilst being accountable to their registered members and communicating their positions to professionals and key stakeholders, including the public.[4]

Professional associations came into existence with the prime purpose of serving members of the profession concerned. As such, the South African Optometric Association (SAOA) is a voluntary organisation that, as with others such as the American Optometric Association (AOA), conducts advocacy and professional development on behalf of its members to inform and influence national policy directions.[14,15,16] Registration with the HPCSA is mandatory,[3] whilst affiliation to the SAOA is voluntary.[14]

Education played a pivotal role in the historical development of the SAOA, which was formed in the early 20th century with the aim of creating education and training institutions and eventually to facilitate legislation prohibiting unqualified people from practising optometry.[6,15,16] Such education via the SAOA commenced by offering a 6-month optometry course in late 1931, and in 1949, the course evolved into a 2-year part-time course with 2-hour classes attended three times per week at the Johannesburg Technical College as part of the Department of Pharmacy.[17] On successful completion of the course, the title 'Fellow of Optometric Association (FOA)' was conferred upon the candidate, providing them the right to affix FOA behind their names.

The first optometry degree to be offered in South Africa was at the University of the North in 1975, followed by one at the University of Durban-Westville (UDW) in 1979,[6,18] which under the then-apartheid laws were developed for black and Indian students, respectively, whilst white students only attended the Witwatersrand Technikon (Wits Tech). This separation consequently resulted in white graduates qualifying with diplomas, whilst black and Indian graduates qualified with bachelor's degrees – creating a perception that white students had an inferior education and qualification compared to those of black and Indian students.[18] This did not bode well for the then-apartheid government, leading to the SAOA investigating the possibility of having optometry degrees offered at the University of the Witwatersrand (Wits) and Pretoria University. However, that did not materialise, as the two universities already had Faculties of Medicine, which would have placed optometry under the direct control of ophthalmology. The possible option was considered problematic by some within the profession at the time, eventually resulting in the Faculty of Science at Rand Afrikaans University (RAU) being chosen to offer an optometry degree programme for white South African students.[18] Later, as an outcome for higher education institutional rationalisation, mergers of some institutions occurred, which resulted in RAU and Wits Tech being merged into the University of Johannesburg and another degree in optometry starting at the University of the Free State.

The reconfiguration in South Africa created the four optometry degree programmes and, at the Cape Peninsula University of Technology, a diploma programme in optical dispensing.

In pursuit of quality clinical standards, both professional regulatory bodies and associations take a keen interest in matters of education and training of membership, a concept widely recognised.[19] Hence, professional associations and societies provide clinical guidelines, highlight and promote ethical practices and offer unbiased continuing education and services to members. These are complimented by public education messages, as they also serve as the public face of their collective membership.[20] The regulator requires compulsory registration for students in the profession, sets training standards, audits institutions for compliance, defines continuous professional education rules and defines ethical norms and standards for the protection of the public.[15,19]

As optometrists generally interact with different bodies that both regulate and promote their professional practice, the expectation would be that they will be knowledgeable of the specific functions and authority of the respective bodies. However, there is often confusion amongst practitioners about the respective roles of the SAOA and the HPCSA in South Africa. Perceptions and opinions of each professional body and knowledge as to which of the two has relevance to their specific professional practice needs seem inconsistent amongst practitioners. The impact of this may deprive practitioners of gaining optimal benefits from the respective bodies. Therefore, this study assessed the practitioner perceptions of the roles and relevance of the regulatory body (HPCSA) and professional association (SAOA) in South Africa.

Methods

This study was a cross-sectional, descriptive study that used a quantitative research approach. The study tool was a semistructured questionnaire consisting of three sections: section 1 collected demographic information of the respondents, section 2 assessed the knowledge of the two respective optometric bodies and section 3 explored the perceived roles and relevance of the optometric bodies concerned. Although largely closed-ended, there were some instances where respondents were required to justify and explain their responses to open-ended questions.[20,21,22,23,24,25] The questionnaire was piloted amongst 10 optometric professionals across different practice settings, who were excluded from the main study. The survey was made available to all registered practitioners. An online link to a Google Form was created and distributed through various social media platforms utilised by registered practitioners. Of the calculated sample size of 277 practitioners, a total of 208 practitioners completed the survey by the end of the data collection period. Data were captured, processed, coded and analysed using the Stata version 14.2 software. A confidence interval of 95% and a 5% margin of error applied.[23,26,27,28] Responses from open-ended questions were captured, coded and analysed using thematic content analysis, where key themes that commonly appeared in the responses were extracted.[24,25,26]

Ethical considerations

Prior to developing the data collection instrument and the actual collection of data, ethical clearance was obtained from the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee (ref. no. HSS/0228/018M).

Informed consent was obtained from participants before they proceeded to participate in the survey. They were also assured that participation was voluntary and anonymity as well as confidentiality would be maintained.[24,26,27,28,29] In this letter it was made clear that no personal information of respondents would be collected and that all information collected would be confidential and kept anonymous at all times.

Results

Of the 208 respondents, 50.3% were men and 49.7% were women, with 40.9% in the modal age group of 41–50 years and a minority (2.5%) being 71 years or older. The mean age of the respondents was 42.79 years (standard deviation [s.d.] = 9.34 years) and the median age was 42.86 years. The majority of practitioners (98%) confirmed their discipline as optometry, with only a few (2.0%) being dispensing opticians. An overwhelming majority (91.6%) of practitioners practise within the private sector, of which 83.7% are in independent practice, 6.3% in group practice and the remaining 10.0% in franchised practice. Respondents who practised in the cities constituted 40.0%, those in towns constituted 36.0%, those in townships constituted 16.0% and the remaining 8.0% practised in rural settings.

Gauteng province had the highest number of respondents at 47.3%, followed by Limpopo and KwaZulu-Natal provinces with 16.3% and 14.3%, respectively. The Northern Cape had the least number of respondents at 1.5%, as depicted in Figure 1.

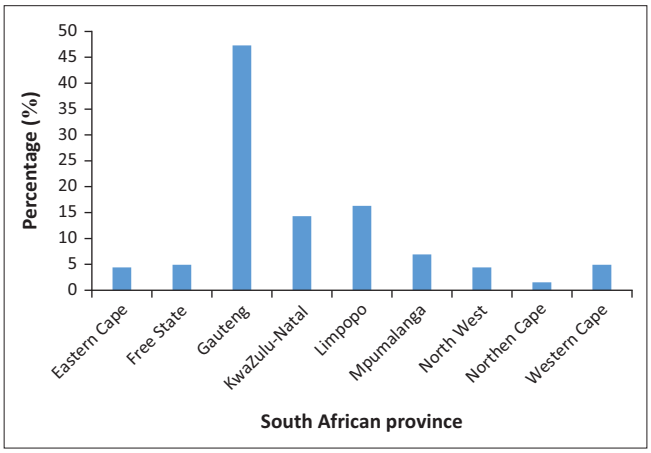


FIGURE 1: Distribution of respondents per province of South Africa.

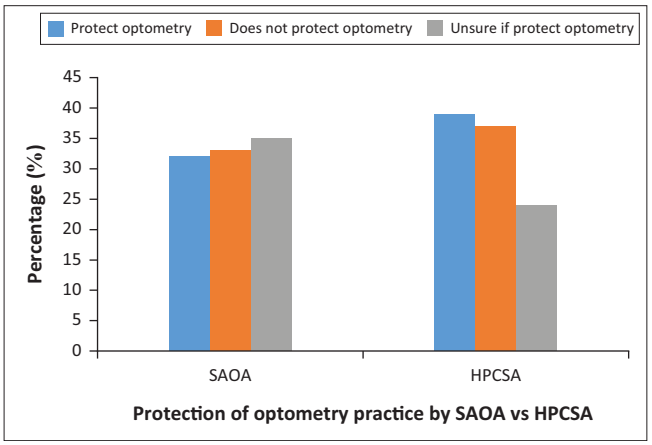
Most of the respondents stated that they had adequate knowledge of the SAOA (84.7%) and the HPCSA (94.6%), with 90.0% and 93.2% highlighting that the information on the SAOA and the HPCSA, respectively, was acquired during their university studies. There was a significant correlation (p = 0.005) between the stated knowledge of the roles of the HPCSA (88.3%) and SAOA (71.2%). However, when probed further to define and select specific mandates of the SAOA and HPCSA, only 42.4% of respondents selected accurate responses on the role of the SAOA, whilst the majority (69.5%) selected accurate responses on the role of the HPCSA.

High membership fees were cited as a deterrent to joining the SAOA for 42.9% of respondents, the majority (67.8%) of them being non-SAOA members, whilst 24.6% were undecided whether fees deterred their SAOA membership. The remaining 32.5% of respondents were not deterred by membership fees, 82.0% of whom were SAOA members. Activities hosted by the SAOA were attended by 63.5% of respondents, who were mainly their own members (62.0%). Similarly, 62.0% of the remaining 36.5% of respondents who did not participate in SAOA activities were non-SAOA members.

Figure 2 shows that most of the respondents were either unsure or believed that the SAOA (68.0%) and HPCSA (61.0%) did not, respectively, protect the practice of optometry. Slightly more respondents thought that the HPCSA (39.0%) protects the practice of optometry as opposed to the SAOA (32.0%), of whom 72.3% were SAOA members.

Half of the respondents indicated that the SAOA is engaging in visible advocacy activities and programmes to fight off the threat of deregulation of the profession and has improved both their communication updates regarding industry activities and their participation in regulatory and legislative work.

There was no significant difference between the opinions of members and nonmembers on the role that the SAOA should play in negotiating medical aid benefits, codes and tariffs, as well as making price lists and tariff guidelines available (Table 1). The only two significant differences of opinion between SAOA members and nonmembers were as follows: more SAOA members felt that the SAOA should negotiate on their behalf for professional indemnity insurance (p = 0.001) and be involved in billing or tariff coding development (p = 0.033).



SAOA, South African Optometric Association; HPSCA, Health Professions Council of South Africa.

FIGURE 2: Protection of the practice of optometry by the South African Optometric Association versus the Health Professions Council of South Africa.

Most of the respondents (75.0%) stated that SAOA should negotiate medical aid tariffs and prices, whilst 17.0% disagreed and 8.0% were unsure about this. Similarly, 75.0% of respondents stated that SAOA must make available price lists and tariff guidelines to the profession, and 84.0% wanted the SAOA to be involved in negotiating medical aid benefits with medical aid schemes on their behalf. Those who thought that the SAOA must develop and maintain tariff codes constituted 93.0%, with only 1.5% not wanting the SAOA to be involved in the development of codes. An overwhelming majority of respondents wanted the SAOA to continue the advocacy through involvement in legislative and policy formulation (94.0%) and to assist the practitioners by negotiating professional indemnity insurance (92.0%).

Figure 3 shows that the majority (73.0%) of respondents, of whom more than half (56.0%) were SAOA members, believed that the HPCSA was relevant and fewer (66.0%) of the respondents believed that the SAOA was relevant in eyecare in South Africa. Only 12.0% and 11.0% of respondents did not believe that the SAOA and the HPCSA were relevant, respectively. Of the 66.0% who believed that the SAOA was relevant, 65.0% were SAOA members.

Analysis of the additional comments revealed that they were mainly related to the SAOA and highlighted two major themes: the first related to a perceived lack of or inadequate action being taken against those who transgress the ethical rules, and the second related specifically to the perceived

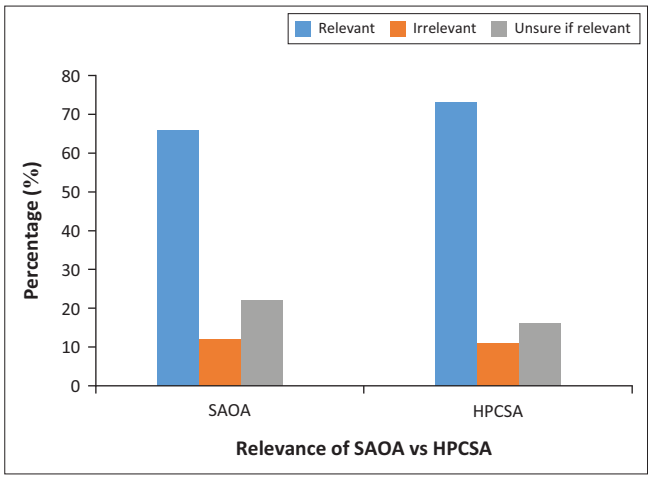
TABLE 1: Respondents' opinions on the role of the South African Optometric Association in advocacy activities.

Activity	Respondents	No (%)	Not sure (%)	Yes (%)	p
Should the SAOA negotiate medical aid tariffs and prices?	Nonmember	8.0	4.0	35.0	**0.876**
	Member	9.0	4.0	40.0	
Should the SAOA negotiate medical aid benefits?	Nonmember	3.0	6.0	38.0	**0.460**
	Member	3.0	4.0	46.0	
Should the SAOA be involved in billing or tariff coding development?	Nonmember	1.5	4.0	41.0	**0.033***
	Member	0.0	1.5	52.0	
Should the SAOA be involved in making the price list (for lenses, frames, etc.)?	Nonmember	8.0	4.0	35.0	**0.876**
	Member	9.0	4.0	40.0	
Should the SAOA be involved in policy formulation?	Nonmember	0.5	3.0	43.0	**0.186**
	Member	1.5	1.0	51.0	
Should the SAOA be negotiating on your behalf for professional indemnity insurance?	Nonmember	1.5	6.0	40.0	**0.001***
	Member	0.0	0.5	52.0	

Note: The opinions of SAOA members and nonmembers were statistically significant on whether the SAOA should negotiate the indemnity insurance as well as getting involved in the billing or tariff coding development as they had p-values of less than 0.005 (data in bold).

SAOA, South African Optometric Association.

*, Significance was accepted using chi-squared tests with $p < 0.05$.



SAOA, South African Optometric Association; HPSCA, Health Professions Council of South Africa.

FIGURE 3: Relevance of the South African Optometric Association versus the Health Professions Council of South Africa.

inaction of the SAOA in relation to network formation and their resultant impact on the industry at large. Some respondents leveled criticism against the SAOA citing that they have lost relevance due to their failure or inability to act against individuals and entities that violate ethical practice and code of conduct of the profession, thereby describing them as being a toothless institution.

There were specific comments directed at the SAOA in relation to managed care organisations or networks within the optometry industry by 10.5% of responding practicing optometric professionals were that the SAOA 'lacked action to stop both the irregular activities of the networks and enabled and allowed the formation of networks and allowing the networks to occupy the optometric space'. Further they laid blame on the SAOA suggesting that it has not intervened to deal with the networks and their exploitative tendencies and is unable to protect the practitioners from exploitation by these networks who act without consequences as they operate unregulated. Only 2.9% blamed the SAOA for the growing incidents of online sales of spectacles and contact lenses.

Practitioners further cited billing and coding, in their engagements with medical aid schemes and networks, as a major problem encountered, with 37.0% stating that the SAOA has not invested time and effort into training members on ethical, accurate billing practices and coding procedures. Further comments included the following: 'the SAOA has not done sufficient lobbying and advocacy work to educate the various stakeholders, in particular the practitioners, about their roles in the industry'.

In responding to the question on what they thought the SAOA should do to regain their confidence and relevance, 65.5% of respondents cited correction of the same issues that they identified as shortcomings of the SAOA. Suggestions were that the SAOA must improve their communication with the industry and intensify their interventions when needed, in particular, on the issue of networks. Many called for the SAOA to fight against the network 'bullying' and 'exploitation' by ensuring their complete elimination from the optical industry and some claimed to be subjected to these actions daily in their respective businesses. They also suggested that the SAOA must find ways to unite the profession and intensify advocacy to raise the profile of the profession with specific reference to the expansion and recognition of the current full scope of optometry.

There were fewer additional comments related to the HPCSA, with some respondents (12.0%) suggesting that the HPCSA must deal effectively with sale of contact lenses and spectacles online especially by lay persons including beauty salons and flea markets and protect the the practice of optometry and improve its credibility.

There were also others who cited a regulatory failure by the HPCSA as 'mobile practices continuing to operate with impunity and without licensure from the HPCSA'.

Discussion

Literature reveals that there is a need for regulatory authorities in healthcare to protect the public from harm and to set and determine standards of practice and training, whilst also emphasising the advocacy role played by professional associations within a regulatory framework.[1,4] This study highlights that most optometrists and dispensing opticians believed that both the HPCSA (73.0%) and the SAOA (66.0%) were relevant to the profession. However, there was still confusion on the specific roles of both the HPCSA and SAOA, as many cited that the SAOA did not take 'action' against those violating the ethical rules. The *Health Professions Act* of 1974 mandates the HPCSA through the Professional Board for Optometry and Dispensing Opticians to charge and take relevant action against practitioners transgressing the ethical rules, a mandate not afforded to the SAOA.

This confusion on this critical role is of concern, as a practitioner wishing to lodge a complaint may erroneously lodge it with the SAOA, resulting in no appropriate legal action being taken against the errant practitioner. Respondents' lack of understanding of the absence of a legal mandate of the SAOA to take disciplinary action against practitioners violating the ethical rules may have influenced the repeated comments referring to the SAOA as being a 'toothless' body. Despite both the HPCSA and the SAOA undertaking engagements and/or education through continuous professional development activities, there is a need for more emphasis to be made on their respective organisational mandates.

Carter et al.[30] stated that professional associations have been a means for members to have collective representation to various external entities at a political level. Governments can be lobbied for changes to public policies and for government to consider and favour the interests of their members in decisions that they make. Most of the respondents (94.0%),

irrespective of their membership of the SAOA, aspired for the SAOA to represent them at different levels within the healthcare sector. This declared aspiration should serve as encouragement to the SAOA to strengthen its strategic health sector interventions on behalf of the profession at large.

Respondents highlighted the need for more effective advocacy and continuous professional education by the respective bodies. Professional associations offer members means and avenues to interact by providing valuable training and professional development through free or discounted seminars, webinars, workshops and conferences.[30,31] As a strategy to improve practitioner knowledge of the respective bodies, combined SAOA and the HPCSA engagements with practitioners may provide a useful common platform for discussion and role clarifications. These may be conducted in the form of regular online briefings, periodic newsletters and question and answer (Q&A) real-time platforms. Apart from highlighting the specific professional issues that fall within their respective mandates, practitioners can be advised on optimal methods of engagement with the respective bodies to enhance general understanding and seek individual assistance and guidance when faced with ethical or professional practice dilemmas.

As shown in Table 1, most of the practitioners (92.0%) aspired for the SAOA to be involved in negotiating for their indemnity insurance, with 40.0% of the respondents being non-SAOA members. The SAOA considers this offering as a service to their membership as well as a strategy to increase SAOA membership. The Psychologist Society of South Africa (PsySSA) is another professional society or association that does the negotiating and obtaining of indemnity insurance for their members.[32]

Most practitioners want to see the SAOA being involved in tariff and price negotiation (75.0%), coding development and maintenance (92.0%), as well as medical aid benefit negotiation (84.0%). However, this is unlawful, as the Competitions Commission considers it anti-competitive behaviour and outlawed that activity in 2004.[33,34] An inquiry into the cost of private healthcare conducted by the Health Market Inquiry in 2019 recommended that a pricing regulator should be established to include practitioner groups and associations representation in the tariff and price negotiation.[13] The Psychologist Society of South Africa recommended commissioning a researcher to determine tariffs and went further to play a role of informing its members on the issue.

The general and very strong sentiments expressed by respondents in relation to perceived inaction against ethical violations, such as fraudulent business practices resulting from billing and coding, are indeed a serious indictment on the optometric profession at large. Compromised practitioner ethics and fraudulent business practices in the optometric industry have been supported by the findings of Nortjé et al., which highlighted that medical practitioners are at top of the list of HPCSA offenders, followed by psychologists and optometrists.[11] The call by respondents to the SAOA for assistance with coding and billing may not purely be a cry to aid in the administrative processes but perhaps also to help in the prevention of widespread ethical transgressions. The training institutions, SAOA and HPCSA, have a shared responsibility to acknowledge the seriousness of the issue and to help contribute to the prevention of ethical contraventions. Emphasis will need to be placed on the broader social impact of the individual practitioner's transgressions, which cause a huge burden on the already strained health fiscus, ultimately threatening the access to and quality of care that patients need. Focused seminars on topics such as medical and financial ethics, coding and billing should be provided as part of the continuous professional development programmes. The role of a professional association is to educate its members on the moral and ethical principles of the profession and seek to influence policies, decisions on resource allocation and promotion of a healthcare profession.[14,15,16] The American Nurses Association highlighted the importance of upholding high ethical values and standards by a declaration of a code of ethics for a profession which demands ethical standards that are not negotiable in any setting.[31] Other associations like the PsySSA corroborate this and suggest that proactive engagements help to address ethical issues that can lead to compromise before they are exposed to such issues.[32]

The second issue raised by respondents in the open-ended question related to perceived 'bullying and exploitation' by networks. Networks form a part of managed care organisations. Managed care is defined as a system of delivering healthcare services where care is delivered by a specified network of providers who agree to comply with the care approaches established through a case management process.[35] In the South African context, managed care is defined by the Regulations 15 of the *Medical Schemes Act*, 131 of 1998, as:

> [*A*] clinical and financial risk assessment and management of health care, with the view to facilitating appropriateness and cost-effectiveness of relevant health care services within the constraints of what is affordable, through the use of rule-based and clinical management-based programmes.[36,37]

Managed care rose to prominence in the 1970s in the United States of America, with a realisation that the cost of healthcare was escalating uncontrollably.[35,38] In South Africa, it was first introduced in the 1990s as a cost reduction mechanism and the *Medical Schemes Act* (MSA) incorporated managed care for the first time in 2000.[38]

It is of concern that there appears to be an acrimonious relationship between practitioners and networks and no evidence of attempts by relevant professional bodies to meaningfully deal with the issue. This current impasse is of concern as it may have a negative impact on both the practice of optometry and the quality of care received by the patient. There is an apparent need for the profession to address the role and impact of networks in relation to optometry.

Although it is accepted that, through its stated mission, the HPCSA protects the public from harm by practitioners,

respondents lamented that the HPCSA failed to protect the profession and public from persons who practise illegally or without relevant qualifications.[32] However, the mandate of the HPCSA is to 'protect the public and regulate and guide the healthcare professions'. As shown in Figure 2, most of the respondents were either unsure or stated that the SAOA (68.0%) and HPCSA (61.0%) did not protect the practice of optometry. This again highlighted the confusion by respondents of the specific mandate of the HPCSA, whose role is to guide the practitioner and protect the public, versus the SAOA, whose primary role it is to protect the practice of its membership.

The higher perceived relevance of the HPCSA by respondents may result from the fact that in order to practise, registration with the regulatory body is mandatory. Additionally, it may be influenced by the frustration with the SAOA on the issue of networks and the slightly better HPCSA role awareness, enhanced by the regular regional roadshows conducted in recent years, where presentations on the various roles of the HPCSA were highlighted for practitioners.

Conclusion

Responding practitioners consider both the SAOA and HPCSA to be relevant bodies for the profession of optometry. Regulatory bodies and professional associations have distinct duties and obligations.[4] Both bodies in South Africa have a vital role to play in fostering best clinical and ethical practice standards for the benefit and protection of the patient, the practitioner and the healthcare system as a whole. Ethics are the responsibility of all and should be transparently and meaningfully addressed by all role-players within the eye health sector. The two key professional bodies that optometrists and dispensing opticians engage with, especially the SAOA, are not well understood by most practitioners. It is recommended that the SAOA and HPCSA develop strategies to enlighten practitioners on their respective roles, thus enabling practitioners to effectively judge their relevance from an informed position.

Some of the specific grievances articulated by respondents and directed at the association, the SAOA, namely, negotiating medical aid benefits and tariffs, paying professional indemnity insurance on their behalf, are in conflict with the prevailing competition laws. This requires further engagement by the SAOA, keeping its membership adequately informed throughout these engagements.

Networks were established because of the rising costs of healthcare services in order to ensure cost-effective and sustainable delivery of quality healthcare services. The role and impact of networks within the industry warrants attention by all stakeholders. It is recommended that multistakeholder engagements facilitated by the association should be conducted towards better professional cohesion amongst all relevant sectors. There is a need for more scholarly research within the area of ethics, business practice and regulation. The authors recommend that further studies should be undertaken within this field to empirically inform policy and guide the general practice of optometry.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

S.A.M. as the principal researcher was involved in the conceptualisation of the study, conducted the study and collected, analysed and presented the data. He was also responsible for the writing of the original article and subsequent review. V.R.M. was involved in the supervision of the project from the beginning, provided guidance in the entire process and informed the structure and look of the article up to the end.

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Data availability

Data used in this study are available from the corresponding author, S.A.M., upon reasonable request.

Disclaimer

This is an original research work conducted by the authors. The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any affiliated agency of the authors.

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