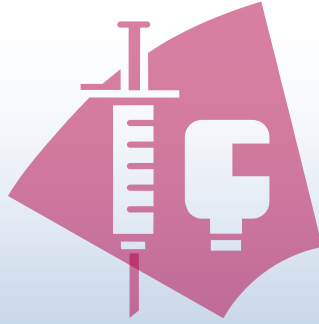


Diagnosis



Treatment



care

August 2009

Beat breast and cervical cancers

August is Women's Month in South Africa. In celebrating the uniqueness of women, *CMScript* takes a closer look at cervical and breast cancers and the provisions in terms of prescribed minimum benefits (PMBs) for the screening of these diseases.

Cervical and breast cancers are the leading cancers in South African women. According to the National Cancer Registry, one in every 27 South African women will be diagnosed with breast cancer in her lifetime and one in every 31 with cervical cancer.

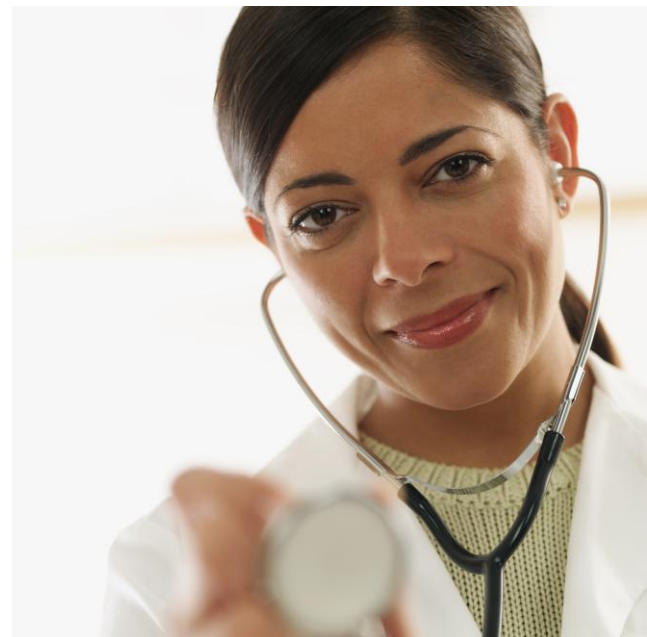
The good news is that both these cancers can be treated successfully if they are detected in their early stages.

The survival rates for breast cancer are:

- Five-year survival rate – 86%
- Ten-year survival rate – 76%

Women with no metastatic breast cancer (i.e. the cancer has not spread to other parts of their bodies) have a five-year survival rate of 96% while those with metastatic breast cancer have a five-year survival rate of 21%. These figures demonstrate the importance of early detection.

Cervical cancer has a five-year survival rate of 90% if it is diagnosed early yet more than 3 400 South African women die every year from this disease.



Diagnosis

Early detection of cervical and breast cancers is of the utmost importance. The Cancer Association of South Africa (CANSA) has published position statements that call for comprehensive health services that are equitable, available, affordable, and accessible to all women in South Africa.

Early detection begins with regular breast self-examination and annual gynaecological examinations.

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In order to acknowledge the importance of access to quality healthcare, the prescribed minimum benefit (PMB) regulations include the screening of certain conditions.

Early detection begins with regular breast self-examination and annual gynaecological examinations. A comprehensive gynaecological examination includes a breast examination

and a pap smear. Due to a lack of screening services and awareness, it is estimated that less than 20% of South African women have ever gone for a pap smear. Yet the current public sector guidelines state that all women from the age of 30 should be screened at 10-yearly intervals, translating into four pap smears per woman per lifetime.

Detailed information on self-examinations and pamphlets on how to perform the tests can be obtained from your healthcare provider or CANSA.

Prescribed minimum benefits and cancer

Prescribed minimum benefit (PMB) regulations make provision for the screening of both breast and cervical cancers. The screening includes cervical smears (a pap smear) and breast examinations by healthcare professionals. The screening tests for breast cancer, however, do not involve mammograms. Mammograms are not used as regular screening tests in the public sector but are performed once a lump has been discovered or if the family history suggests that the woman is at a high risk of developing cancer. Genetic testing is also excluded from the benefit.



Beat breast cancer!

Section 29(1)(o) of the Medical Schemes Act 131 of 1998 states that scheme rules shall provide for the scope and level of minimum benefits to be available to beneficiaries, as may be prescribed.

The following sub-regulation (p) then explains that the benefits may not be less than the services that would have been provided in the public sector.

Using DSPs for screening tests

Medical schemes may use designated service providers (DSPs) and network facilities to provide PMB-related services such as medication, consultations, investigations, and hospitalisation. DSPs can be general practitioners, specialists, and hospitals where you can obtain your PMB-related services without having to co-pay for them.

However, a scheme may never indicate that they do not cover the payment of a PMB condition or that you can only get cover in the public sector.

Only where a medical scheme, on a case-by-case basis, arranged guaranteed access for certain services in the public sector, may it refer you to a state facility. Co-payments may apply if you voluntarily do not want to use a DSP. Schemes cannot refuse to cover screening tests, except in instances of valid co-payments as mentioned above.

If you find yourself in a situation where you are unable to obtain the healthcare services you need from your scheme's DSP or network, and are forced by circumstances to involuntarily use a non-DSP instead, for instance when the closest doctor or hospital is quite a distance away, make alternative arrangements with your scheme to make sure you can obtain your services from a non-DSP without having to incur co-payments.

And remember that where a DSP is available and you voluntarily choose to get your PMB services at a non-DSP facility, the scheme may ask you to foot the bill partially.

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Pictures: courtesy of Microsoft Clip Art online