DRN-5422933

The complaint

Mr H complains that Vitality Health Limited hasn't agreed to cover the costs of cancer treatment under his personal private medical insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Mr H holds a personal private medical insurance policy, which includes advanced cancer cover.

Unfortunately, in May 2024, Mr H was diagnosed with cancer. He underwent treatment on both the NHS and some treatment which was covered by Vitality. Mr H's treating team also recommended that he receive tumour treating fields (TTF) treatment. So Mr H asked Vitality to cover the cost of TTF treatment.

Initially, Vitality turned down the claim because it concluded that TTF treatment wasn't established treatment in the UK. Mr H went on to provide Vitality with additional evidence, which its Medical Affairs Team (MAT) considered in December 2024. Based on the MAT's review, Vitality agreed to pay a discretionary £20,000 contribution towards the cost of TTF treatment. And Vitality also paid Mr H £500 compensation to recognise the delays in the MAT fully reviewing the additional evidence he'd provided.

Mr H was unhappy with Vitality's decision and he asked us to look into his complaint. He told us that he's self-funded TTF at a monthly cost of £17,500.

Our investigator didn't think Vitality needed to cover the cost of Mr H's TTF treatment. She considered the National Institute for Health and Care Excellence's (NICE) guidance relating to the treatment of Mr H's type of cancer. She noted that NICE's guidance stated TTF treatment shouldn't be offered. So she felt it had been fair for Vitality to conclude that TTF treatment wasn't established treatment in the UK. And she also felt it had been for Vitality to decide what discretionary contribution it should make towards the cost of Mr H's treatment.

Mr H disagreed and I've summarised his detailed response to our investigator:

- Vitality acknowledged that it hadn't asked its MAT to conduct a clinical review of Mr H's claim in August 2024, based upon additional evidence. He felt this had been a serious procedural failure, as it had impacted on the fairness of Vitality's assessment of his claim;
- The MAT had concluded that there was compelling clinical evidence that TTF treatment was effective and there was an unmet clinical need for the treatment. But Vitality had arbitrarily set its contribution amount at £20,000, without providing any transparent criteria or justification for it. He requested a review into how this figure was determined;
- Other insurers covered TTF treatment in certain circumstances. So he questioned whether Vitality's refusal to pay for TTF treatment aligned with industry standards.

> And he questioned whether Vitality's lack of transparency on its voluntary contributions made it difficult for consumers to make an informed choice about cover.

The complaint's been passed to me to decide.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, whilst I'm very sorry to disappoint Mr H, I don't think Vitality has treated him unfairly and I'll explain why.

First, I'd like to say how sorry I was to read about Mr H's diagnosis. I don't doubt what a worrying and stressful time this has been for Mr H and his family. I'd like to reassure him that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I believe to be the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, together with other relevant considerations, such as industry principles and guidance, the contract terms, and the available evidence, to decide whether I think Vitality handled this claim fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr H and Vitality. In common with most private medical insurance policies, Vitality only covers what it considers to be eligible treatment. It isn't obliged to cover any and all treatment a policyholder might need and it's not required to provide the same cover as other private medical insurers. Each insurer is entitled to decide what risks it will cover and which it's chosen to exclude, so long as it sets out cover clearly.

Page 26 of the policy handbook sets out Vitality's approach to 'Treatment that is not established medical practice in the UK'. This states:

'The plan does not generally cover drugs and treatment that is not considered to be established medical practice in the UK, or where there is insufficient evidence of safety or effectiveness. This includes drugs that are used outside the terms of their UK or European licence or treatment that has not been reviewed and approved for general use in the NHS.

However, we may consider a contribution towards the costs of such treatment where this is part of a properly controlled UK clinical trial or where we believe there is adequate evidence that the treatment is safe and effective. We would expect any treatment to be recommended by an appropriate multidisciplinary team (MDT). An MDT is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. You must contact us before undergoing treatment to check what we will cover.'

In my view, the contract terms make it sufficiently clear that Vitality won't generally cover treatment which isn't established medical practice in the UK or which hasn't been approved for general use in the NHS. The terms say that Vitality *may* consider a contribution to these costs in specific situations. But there's no contractual obligation for it to do so.

It's clear that when Vitality assessed this claim, it referred the evidence to its MAT for a

clinical review. In my opinion, that was a reasonable and appropriate response from Vitality. It's unfortunate that there was a delay in the MAT reassessing Mr H's claim and evidence between August and December 2023 and Vitality accepts this was an error. But I don't think I could fairly or reasonably find that any delay in clinically reassessing the claim impacted on the MAT's ability to review the evidence or meant that the reassessment process was unfair. And I think the £500 compensation Vitality's already paid to reflect the trouble and upset this error caused Mr H was fair, reasonable and proportionate in the circumstances.

Vitality's MAT considered the NICE guidance relating to treatment of the type of cancer Mr H unfortunately has. I've looked at that guidance and I can see that it specifically states that TTF treatment *shouldn't* be offered for either new diagnoses or recurrent diagnoses of Mr H's condition. As such then, I don't think it was unfair for Vitality to conclude that the treatment wasn't established medical practice in the UK because it seems it wouldn't be offered on the NHS.

Mr H provided Vitality with additional evidence and I can see this was reviewed by the MAT. I understand Mr H has also seen a copy of the MAT's comments. In brief, the MAT took into account studies which hadn't been available to NICE at the time the guidance was drafted which did show that the efficacy of TTF treatment was promising. The review notes stated:

'Nonetheless, considering the rarity of the condition and the great unmet clinical need, the cumulative evidence of potential effectiveness in the treatment of newly diagnosed (tumour) across clinical trials is compelling. The group therefore felt that a contribution towards the cost of treatment would be appropriate.'

I acknowledge that the MAT commented there was an unmet clinical need for treatment of Mr H's condition and there was evidence of its potential effectiveness. But it remains the case that the MAT concluded TTF treatment wasn't approved for use in the NHS. And therefore, I don't think it was unfair for Vitality to conclude that Mr H's overall claim for treatment wasn't covered.

Nonetheless, Vitality's MAT concluded that given the above factors, a contribution of £20,000 towards the cost of the treatment would be appropriate. I appreciate Mr H feels this level of contribution hasn't been properly explained and that Vitality hasn't set out clear and transparent criteria for such payments. I also appreciate why he'd like to see this information given the clear difference between the amount he's paying for TTF treatment and the amount Vitality's agreed to cover.

But, fundamentally, as the investigator explained, this contribution was made at Vitality's discretion. There was no obligation for it to pay such a contribution – that was a commercial decision it was reasonably entitled to make. And so it wouldn't be reasonable or appropriate for me to interfere with that discretionary decision and to tell Vitality to increase its contribution.

I understand too that Mr H feels Vitality should make its cover levels clearer in relation to conditions and treatments. I wouldn't generally expect an insurer to list each condition a policyholder might develop and the corresponding treatments it will go on to pay for. And I think the policy terms and conditions are sufficiently clear about the risks Vitality's chosen to insure.

I entirely appreciate that Mr H's treating team felt that the TTF treatment was best for him and it isn't my role to interfere in clinical opinion or decide on the most appropriate form of treatment. My role is to decide whether I think Vitality has handled this claim fairly. For the reasons I've given, I think it has.

Overall, despite my natural sympathy with Mr H's position and while I'm very sorry to cause him further upset, I don't find Vitality has treated him unfairly. I'm satisfied that it's paid fair compensation of £500 for its delay in carrying out the full clinical review of Mr H's claim. And I'm not telling Vitality to pay anything more for the costs of Mr H's TTF treatment.

My final decision

For the reasons I've given above, my final decision is that Vitality Health Limited has already settled Mr H's complaint fairly.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr H to accept or reject my decision before 24 April 2025.

Lisa Barham
Ombudsman