DRN-5688449

The complaint

Mr G complains that AXA PPP Healthcare Limited hasn't fully settled a claim he made on a personal Global Health Plan.

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 key events.

Mr G holds a personal Global Health Plan, which provides private medical insurance, amongst other benefits.

In November 2024, Mr G was unfortunately diagnosed with prostate cancer. His treating specialist recommended that he should undergo Irreversible electroporation (IRE) surgery. So he made a claim on the policy.

Initially, AXA turned down the claim. That's because it said that the policy terms required a policyholder's treatment to be 'conventional treatment'. It didn't consider IRE surgery to be conventional treatment in line with relevant guidance from the National Institute of Health and Care Excellence (NICE).

However, AXA later agreed to make a contribution to the costs of Mr G's claim in line with what it would have paid for him to undergo what it considered to be conventional surgery – around £17,400 - less the policy excess.

Mr G was unhappy with AXA's decision and he complained. He didn't agree that AXA had interpreted its policy terms fairly. In brief, that's because his treating specialist stated that the IRE surgery was widely practiced in the NHS – and across the world - to treat Mr G's condition. He subsequently complained about delays in the settlement of AXA's contribution to the surgical costs and shortfalls in the amounts he'd expected to be paid. AXA paid him £300 compensation to acknowledge errors it had made in the handling of Mr G's invoices, but it maintained the claim had been settled correctly.

Remaining unhappy with AXA's stance, Mr G asked us to look into his complaint.

Our investigator didn't think AXA had handled Mr G's claim unfairly. He felt it had been fair for AXA to consider that IRE surgery wasn't conventional treatment in line with the policy terms. So he thought it had been reasonable for AXA to limit settlement to what it would have paid for Mr G to undergo conventional treatment. He was satisfied too that AXA had settled Mr G's claim in line with the policy terms.

And while Mr G hadn't specifically complained about the handling of his claim, the investigator considered this point in line with our inquisitorial remit. He felt the £300 compensation AXA had paid Mr G was fair and reasonable to reflect the impact of the errors it had made during the settlement process.

Mr G disagreed and so 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 G, I don't think AXA has treated him unfairly and I'll explain why.

First, I'd like to say how sorry I was to read about Mr G's diagnosis. I don't doubt what a worrying and stressful time this has been for Mr G. I understand that he underwent the IRE surgery as planned and I do hope he's making a good recovery.

It's also important to explain that I'm not a medical expert. This means I can't make clinical decisions or substitute clinical opinion with my own – and it would be inappropriate for me to do so. Instead, my role is to independently and impartially assess the evidence that both parties have provided to decide whether I think AXA fairly relied on the available evidence to conclude that the IRE surgery wasn't covered by the policy terms.

I'd like to reassure Mr G that while I've summarised the background to his complaint and the detailed submissions he's sent 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, alongside other regulatory principles and guidance, the contract terms, and the available evidence, to decide whether I think AXA handled this claim fairly.

I've first considered the policy terms and conditions, as these form the basis of Mr P's contract with AXA. Page 24 of the contract says:

'Your policy covers you for established medical treatments. We call these conventional treatments.

There is no cover for any treatment or procedure that is experimental or that has not been established as being effective.'

The policy goes on to say:

'What do you mean by conventional treatment?

We define conventional treatment as treatment that:

- *is established as best medical practice in the country where the treatment is taking place: and*
- *is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility where the treatment is provided: and*
- *has been proven to be effective and safe for the treatment of your medical condition through high quality clinical trial evidence (full criteria available on request).*

Conventional treatment does not cost more than an equivalent treatment that delivers similar therapeutic or diagnostic outcomes. It must not be provided or used primarily for the convenience or financial or other advantage of you or your medical practitioner or health professional.'

The contract adds:

'What happens if my medical practitioner says I need surgery that is not conventional treatment?

We will also pay for surgery not listed in our Schedule of Procedures and Fees if before the treatment begins, it is established that the treatment is recognised as appropriate by an authoritative medical body. This means procedures and practices must have undergone appropriate clinical trial and assessment and be sufficiently evidenced in published medical journals.'

And page 25 of the policy states:

'What is not covered?

We will not pay for treatment that is not conventional treatment or which is experimental.'

I think the policy terms and conditions clearly explain that AXA only generally pays for conventional treatment. And in my view, it's explained what it considers conventional treatment to be. I find too that it's clearly set out the criteria which need to be satisfied before it will consider and pay for treatment it doesn't consider to be conventional.

Mr G has provided evidence from his treating doctor in support of his claim. I can see he also passed on some of the specialist's comments to AXA when it considered the claim. The specialist said that AXA's claims decision was *'quite surprising as it is available on the NHS as standard treatment and has been for several years, is NICE approved and is supported by AXA UK. I have been using it for 14 years, so it is hardly new. The results have been duplicated by many investigators in many countries around the world.'*

And Mr G also referred to a leaflet, dated October 2024, from an NHS hospital, which concerns IRE surgery. The leaflet says:

'IRE is a newer treatment for prostate cancer. So, we do not yet have the data to tell us how effective it is at controlling cancer in the long term…

IRE is being offered at (hospital) as a normal NHS treatment, not as part of a clinical trial. However, we are going to analyse our IRE prostate cancer treatment and publish the anonymised results. We want to help doctors and patients understand more about IRE. This is in line with NICE guidance on IRE.'

I've carefully considered the treating specialist's evidence, along with the other medical evidence Mr G has referred to. And I've also taken into account the applicable NICE guidance for IRE surgery, which is dated July 2023, but currently remains in place. This says:

'Irreversible electroporation for treating prostate cancer should only be used with special arrangements for clinical governance, consent, and audit or research.

1.2 Clinicians wanting to do irreversible electroporation for treating prostate cancer should:

- *Inform the clinical governance leads in their healthcare organisation.*
- *Ensure that people (and their families and carers as appropriate) understand the procedure's safety and efficacy, and any uncertainties about these.*

- *Take account of NICE's advice on shared decision making, including NICE's information for the public.*
- *Audit and review clinical outcomes of everyone having the procedure. The main efficacy and safety outcomes identified in this guidance can be entered into NICE's interventional procedure outcomes audit tool (for use at local discretion).*
- *Discuss the outcomes of the procedure during their annual appraisal to reflect, learn and improve.*

1.3 Healthcare organisations should:

- *Ensure systems are in place that support clinicians to collect and report data on outcomes and safety for everyone having this procedure.*
- *Regularly review data on outcomes and safety for this procedure.*

1.4 Further research should ideally be randomised controlled trials with an appropriate comparator. Further research could also include analysis of registry data or research databases. It should include details of patient selection, details of the procedure (including imaging) and short- and long-term outcomes.'

Why the committee made these recommendations

There is enough evidence to suggest that the procedure works and does not raise any major safety concerns in the short- and medium term. The procedure can have complications and it is uncertain how well it works in the long term. It is also uncertain who would benefit most from the procedure and at what stage of their prostate cancer treatment it would be most effective. So, it can be used with special arrangements, and further data collection is needed.'

I entirely appreciate that Mr G and his treating team felt that the IRE surgery was best for him and, as I've said, it isn't my role to interfere in clinical opinion or decide on the most appropriate form of treatment.

But, in my view, the NICE guidance indicates that IRE surgery can only be carried out under special arrangements and that further research into the procedure is necessary to assess how well it would work in the long-term and who it would most benefit from it. The NHS hospital leaflet also echoes that the IRE surgery is new and there isn't enough data to show it works in the long term.

Based on the NICE guidance, I don't think it was unfair or unreasonable for AXA to find that IRE surgery wasn't established as best medical practice for Mr G's condition in the UK nor that it hadn't been proven to be safe and effective through high-quality clinical research. On that basis, I don't think AXA unreasonably concluded that Mr G's proposed treatment wasn't conventional treatment in line with the policy terms. So I'm satisfied it was reasonable for AXA to conclude that IRE surgery wasn't covered by the contract.

However, AXA did agree to pay a contribution towards the costs of Mr G's surgery which was equal to the costs of what it considered to be conventional treatment. I find this to be fair and reasonable in the circumstances. From my research, I'm satisfied the surgery AXA deemed as conventional treatment of prostate cancer is one of the main treatments for it. So I think it was reasonable for AXA to use this particular type of treatment as a comparable conventional treatment and accordingly calculate its contribution on that basis.

The policy explains that AXA will pay a provider's usual and customary charges for treatment, unless it's reached a special arrangement with a policyholder prior to surgery. In this case, while Mr G has been paid less than he believes he should have been, AXA has

provided him with a breakdown of the costs it's paid and explained that these are in line with the usual and customary charges it would pay the provider for conventional treatment of Mr G's surgery. I'm satisfied that it was reasonably entitled by the policy terms to limit its contribution to what the provider would have charged it – in particular, because AXA has paid a contribution towards Mr G's surgery outside a strict application of the policy terms.

It's clear that following Mr G's surgery, there were some shortfalls in the service AXA provided when it handled his invoices. AXA paid Mr G £300 compensation to reflect these errors. Mr G didn't specifically ask us to comment on this issue in the complaint he made to us. But, like the investigator, I'm satisfied my inquisitorial remit allows me to make a finding on whether AXA has already paid fair compensation for these errors.

Given Mr G had just been through surgery for cancer and given he was out of pocket for the full costs he'd incurred, I think AXA's errors would have caused him additional unnecessary frustration and upset at an already difficult time. But in my view, the £300 compensation AXA has already paid Mr G is a fair, reasonable and proportionate award to recognise a broadly six week delay in paying its contribution to Mr G's claim.

In summary then, whilst I'm very sorry to cause Mr G further upset, I'm not directing AXA to pay him anything more.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G to accept or reject my decision before 3 November 2025.

Lisa Barham
Ombudsman