DRN-4853760

The complaint

Mrs B is unhappy with the way Vitality Health Limited has handled a claim made on her private health insurance policy ('the policy').

Although Mrs B is being represented in this complaint, she is the named policyholder and sole beneficiary of the policy. So, I've referred to her throughout.

What happened

Mrs B was admitted to an NHS hospital in July 2023 and was treated for pneumonia. Mrs B's husband (Mr B) contacted Vitality to request she be transferred to the private ward in the hospital – the costs of which to be covered under the policy.

Vitality ultimately declined that request as it concluded that Mrs B's symptoms were related to – and are known symptoms of - a pre-existing chronic condition she had.
Mrs B disagreed and brought a complaint to the Financial Ombudsman Service.

One of our investigators looked into her complaint. He concluded that Mrs B's symptoms and the treatment she received at the NHS hospital were entirely separate to her chronic condition.

Ultimately our investigator recommended that Vitality should:

- reassess the claim in line with the remaining policy terms;
- consider whether Mrs B was entitled to the NHS hospital cash benefit provided by the policy terms; and
- pay £300 compensation for the distress and inconvenience caused to Mrs B by declining the claim.

Vitality said:

- it agreed that the condition Mrs B was being treated for was acute. However, it maintained that it was in relation to her chronic condition.
- it accepted the claim needed further review and said it would request further medical information from Mrs B's consultant. It offered Mrs B "£300 for the inconvenience of not doing this sooner" and "once we have further details of Mrs B's hospital stay, we can assess the claim and provide a decision to her…"
- in view of Mrs B's admission to hospital being an emergency via A&E she was not eligible for the NHS cash benefit as per the terms and conditions.

Mrs B didn't think £300 compensation fairly reflected the impact of Vitality's error. She said £1,000 was more appropriate.

Our investigator didn't agree and said:

> When we award compensation, we look at the impact on the person concerned. I don't doubt that the impact on Mrs B of not be able to access private treatment was considerable. But, as the claim hasn't yet been assessed, there remains the possibility that Mrs B's claim might be legitimately declined.
>
> This would mean that if Vitality had assessed the claim correctly in the first place, Mrs B still would have been unable to use the policy to access private care. I don't therefore think it's appropriate to award compensation for the impact of Mrs B not being able to use her policy when I can't be certain that her inability to do so was the result of an error by Vitality.

Mrs B accepted our investigator's view. She said, once the claim had been reassessed, if Vitality reaffirmed its decision to decline the claim or didn't offer a satisfactory outcome, a further complaint would be raised.

The complaint was then closed.

At the end of September 2023, Vitality contacted Mrs B's consultant haematologist with further questions to better understand Mrs B's respiratory history.

Having not received a reply, Vitality chased for an answer at the end of October 2023 and the consultant haematologist promptly replied with information about Mrs B's recent medical history to do with her chest and lungs.

Vitality accepts that it didn't act quickly enough after receiving the consultant's response. It says it was filed as "completed work". It apologised for the unacceptable delay and offered £150 compensation.

It also said it accepted a claim for the maximum NHS benefit under the policy terms in the sum of £2,000 which would be paid to Mrs B.

Unhappy with that response, Mrs B brought a further complaint to the Financial Ombudsman Service.

A different investigator looked into what happened and recommended Vitality pay Mrs B further compnesation in the sum of £100 – making the total compnesation amount £250.

Mrs B didn't think this adequately compensated her for the impact of Vitality's errors. She also said our investigator should take into account that now the claim had been accepted in light of the further medical evidence, the distress and inconvenience she experienced of not being transferred to a private ward - and having her claim initially declined - should be considered.

Our investigator felt this had already been addressed in the first complaint Mrs B brought to the Financial Service. She'd ultimately accepted the investigator's view at that stage and the £300 compensation recommended. That case had closed, and he didn't think that issue should be considered as part of this complaint. Mrs B disagreed.

Vitality initially disagreed with the increase in compensation recommended by our investigator but subsequently said it would agree to pay this. However, it didn't agree to issues already determined by the Financial Ombudsman being decided as part of this complaint.

This complaint was then passed to me to consider everything afresh to decide.

I issued my provisional decision in May 2024 explaining why I was intending to partially uphold this complaint. An extract of my provisional decision is set out below.

……

Vitality has an obligation to handle claims fairly and promptly. And it mustn't unreasonably decline a claim.

The complaint for me to decide

When providing its summary to the Financial Ombudsman about this complaint, Vitality says Mrs B's "claim has now been accepted".

So, I'm satisfied I can consider as part of this complaint the overall impact declining the claim had on Mrs B from the outset.

I know after investigating the initial complaint brought the Financial Ombudsman Service, our investigator recommended £300 compensation caused to Mrs B for declining the claim.

However, I'm satisfied he made it clear that he was recommending the claim be reassessed in line with the remaining terms of the policy and wasn't recommending the claim to be accepted. The claim was to be reviewed in light of further medical evidence Vitality agreed to obtain.

As our investigator said in his letter dated 7 September 2023 Vitality has "agreed with my recommendation to reassess Mrs B's claim and, it it's accepted, to consider her losses. If you're unhappy with Vitality's decision on the reassessment, including their eventual settlement offer, it's open to Mr and Mrs B to bring a fresh complaint".

I'm satisfied that any settlement offer referred to includes compensation for distress and inconvenience if the claim was later accepted. And that, I'm satisfied, should include the delays caused by the claim not being accepted initially.

As our investigator only recommended the claim be reconsidered, I'm satisfied he wasn't giving an opinion that the claim should've been accepted and therefore, wasn't in a position to consider the reasonable level of compnesation for distress and inconvenience as the claim might not have been accepted by Vitality subsequently.

I'm satisfied the parties understood that to be the case and Vitality acknowledged that it would agree to pay Mrs B £300 compensation at the time for the inconvenience of not requesting the information from the consultant haematologist sooner.

Accepting the claim

The policy terms provide payment of a NHS hospital cash benefit in certain circumstances:
Eligible in-patient treatment that you choose to have as a non-paying NHS patient even though you could have had the treatment in a private facility

But not if:

You are admitted to an NHS hospital in an emergency, no benefit will be payable for any part of the admission.

Further, under the section relation to eligible treatment covered under the policy, it says at page 19 of the policy terms:

> We will not pay for the following treatments:
>
> Emergency treatment by which we mean:
>
> - Treatment in an Accident & Emergency unit or other urgent care centre.
> - Any admission to hospital that was scheduled less than 24 hours in advance.

The schedule of insurance reflects that the NHS hospital cash benefit is £250 each night to a maximum of £2,000.

Vitality has now accepted a claim for the NHS hospital cash benefit. So, I think it's fair to assume that Vitality has departed from its earlier stance that as Mrs B's admission to hospital was an emergency, she wasn't eligible to claim this benefit.

Now that the hospital cash benefit has been paid, I assume that Vitality also accepts that Mrs B's claim should've been accepted in July 2023 if it had obtained the relevant medical information then to enable it to make that decision promptly.

So, I've considered what is likely to have happened then.

If given the option, Mrs B may have decided to accept the NHS benefit and not be admitted to the private ward.

However, given that Mr B specifically requested she be transferred to the private ward at the outset, that she was immunocompromised (as confirmed by the consultant haematologist's letter dated October 2023) and that she was having trouble sleeping due to be on a ward with other patients in the circumstances she describes, I think it's likely that she would've still opted to have been transferred.

Had this happened, unnecessary upset, worry and inconvenience would've been avoided (assuming the private ward had space to accommodate Mrs B). There's nothing to suggest that Mrs B would've received better treatment for her conditions had she been transferred to the private ward although I appreciate what Mrs B says about it being more likely that she would've received a better sleep (by being on a smaller ward or in a private room) and would've been less worried as a result (and, most likely, more comfortable as a result).

Mrs B has said that Vitality has ended up saving thousands of pounds by not agreeing to transfer her to the private ward, at a time when she was still paying over £1,000 per month for the policy. That may be the case. But I've focussed on the impact Vitality's error had on Mrs B. That's because when something goes wrong, I have the power to direct Vitality to put things right and that includes compensation for distress and inconvenience. Our awards are not punitive and when thinking about fair compensation, I don't think the amount Vitality may have saved by not accepting the claim initially is a relevant consideration.

I do, however, think it's a relevant that Mrs B has now received the NHS benefit, which she wouldn't have received if she'd been transferred to the private ward at the time. That's £2,000.

I think this sum fairly and reasonably reflects the distress and inconvenience Mrs B experienced because of Vitality not promptly requesting the information it needed to assess

the claim properly at the time and when Mrs B was still in hospital.

I have no power to direct Vitality to award any compensation to Mr B for any distress and inconvenience he personally experienced in this case because he isn't a policyholder and nor does benefit from the policy. Mrs B says that Mr B cared for her in hospital and submissions have been made about the worry, frustration and inconvenience he experienced. However, I do think the toll on Mrs B is likely to have further worried and impacted Mrs B, at an already difficult time for her. I've taken this into account when concluding that £2,000 fairly reflects the distress and inconvenience Mrs B experienced.

Further delays

Vitality accepts that it should've acted more quickly on the information received from the consultant haematologist dated October 2023. And if it had done so, it would've been able to reassess the claim more quickly in light of this information.

I think this delay did cause further distress and inconvenience to Mrs B which would've been made worse by having already declined her claim whilst in hospital without having all the necessary information before doing so.

I'm satisfied that £250 compensation is a fair reflection of the distress and inconvenience she experienced because of this further delay. That includes the £150 compensation offered in its final response letter dated January 2024 if this sum has already been paid.

……

I invited both parties to provide any further information in response to my provisional decision.

Vitality accepted the view. Mrs B replied, disagreeing with my provisional decision. She set out more details about her medical conditions and relating to specific merits of the complaint I'm deciding she said, in summary:

- Mrs B accepted the sum of £2,000 from Vitality as an interim payment and informed it of such.

- The £2,000 offered by Vitality was if the beneficiary agrees to have NHS treatment instead of private treatment to which they are entitled. Mrs B didn't agree to that course of action. She wasn't presented with this option because Vitality erroneously deprived her of it (by not even looking to cover the claim when first notified of Mrs B's admission to hospital).

- Mrs B contracted sepsis whilst in hospital, which Mrs B believes wouldn't have happened if she'd been isolated. There were no individual rooms available on the NHS ward at the time.

- Vitality should've accepted the claim under the terms of the policy from the outset.

- Mrs B has been psychologically harmed by her experience on ward. She's explained the impact on her, and says she should receive compensation.

- There has been a breach of contract and Mrs B should have her policy premiums refunded going back to at least 2019 and should receive a monetary sum equivalent

to the cost of private care that Vitality saved in this case. The payment made by Vitality in the sum of £2,000 represents around two months' worth of premiums.

- She has been a policyholder for many years and this experience has led her to end the policy.

- Vitality never said it would decline the claim on the basis of admission to hospital was through A & E.

- No attempt has been made to address issues which occurred in 2021.

- Vitality didn't chase the haematologist. It was Mr B who did this, after Vitality had said it hadn't been able to get hold of them. Mr B was able to get in touch within a few minutes.

- The Ombudsman doesn't understand the extent of the difficulties suffered because of Vitality's errors.

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.

That includes the points raised in response to my provisional decision.

I'll explain why the further points raised don't change my mind.

- I appreciate Mr B confirming that it was he who chased the consultant haematologist for their report towards the end of 2023, rather than Vitality. I accept that the information should've reasonably been obtained sooner by Vitality, and I took this into account when directing Vitality to make a further compensation payment of £250 (less the £150 it's already offered if that had been paid by it).

- Having looked at the correspondence form the time, I'm satisfied that the claim to transfer Mrs B to private care for her treatment was initially declined by Vitality. Its initial final response letter dated July 2023 confirms that. In my provisional decision, I explained that our investigator didn't think the reason given by Vitality to do so was fair. And he recommended Vitality to pay £300 compnesation and to, ultimately, reassess that claim. Nothing I've received in response to my provisional decision convinces me that wasn't the case.

- In my provisional decision, I also set out why I assumed that Vitality now accepts that Mrs B's claim should've been accepted in July 2023 if it had obtained the relevant medical information then to enable it to make that decision promptly. Vitality hasn't disagreed in response to my provisional decision. So, I'm satisfied it does accept that. So, it isn't in dispute that this was an error.

- I'm not persuaded that because of this, it would be fair and reasonable to direct Vitality to refund Mrs B's monthly premiums going back to at least 2019 or to pay her the amount equivalent to what Vitality saved in private medical costs had she been transferred to a private ward at the time.

- As I explained in my provisional decision, I've focussed on the impact Vitality's error had on Mrs B. That's because when something goes wrong, I have the power to

direct Vitality to put things right and that includes compensation for distress and inconvenience. Our awards are not punitive and when thinking about fair compensation, I don't think the amount Vitality may have saved by not accepting the claim initially is a relevant consideration. Further, Mrs B was capable of benefiting from the policy and Vitality had the risk under the policy of a successful claim being made on the policy since 2019, and before.

- So, I've considered the impact on Mrs B and the distress and inconvenience this caused Mrs B which for reasons set out in my provisional decision, I think was considerable. However, Mrs B has received £2,000 from Vitality which she wouldn't have received had the claim been accepted and she had been transferred to a private ward (if space was available at the time).

- I can understand why Mrs B views this as an interim payment and I accept that she didn't request the NHS benefit at the time; her choice would've been to be transferred to the private ward. But as this is a payment she wouldn't have received or been entitled to, I think it's fair and reasonable to take this into account when determining the level of fair compensation should be awarded to reflect the impact Vitality's errors had on Mrs B.

- Mrs B has explained the impact remaining on the ward has had on her. I have a lot of empathy for the situation she was in but I haven't seen persuasive evidence that it's more likely than not that Mrs B wouldn't have contracted sepsis had she moved to a private ward. I am also mindful that she still did have access to medical care, and she was receiving treatment. But I do accept that she would've been less worried having a private room particularly given her medical history and vulnerabilities, and more comfortable as a result.

- Overall, I'm satisfied the £2,000 she received from Vitality fairly and reasonably reflects the distress and inconvenience Mrs B experienced because of Vitality not requesting the information it needed to assess the claim properly at the time, when Mrs B was still in hospital. I think this also reflects what happened whilst she was in hospital – part of the impact of which could've been avoided if the claim was accepted earlier.

The complaint I'm determining is about what happened in 2023 when a claim made was on the policy and the subsequent delays getting information, not what happened in 2021.

If Mrs B is unhappy with the way in which private medical insurance policies operate more widely, she is free to raise those concerns with the Financial Conduct Authority, the regulator.

For the above reasons and for reasons set out in my provisional decision (an extract of which is set out above and forms part of this final decision), I partially uphold Ms B's complaint and direct Vitality to pay Mrs B £250 compensation for distress and inconvenience (less £150 if this has already been paid).

Putting things right

I direct Vitality to pay Mrs B £250 compensation for distress and inconvenience (less £150 if this has already been paid).

My final decision

I partially uphold this complaint and direct Vitality Health Limited to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B to accept or reject my decision before 15 July 2024.

David Curtis-Johnson
Ombudsman