Private medical insurance and alcohol treatment

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Alcohol misuse causes serious problems in the working environment for example in my own profession, the law.[1] Misuse often results in permanent damage to people's health and career, to family life and to the business and reputation of the firms and companies they work for. So many, although perhaps not most, professional and commercial organisations providing private medical insurance (PMI) choose policies which cover this condition.

The additional expense may pay for itself several times over. Waiting times for treatment on the NHS for common conditions such as cancer, hypertension and heart disease have reduced significantly. Insurance for these conditions is mostly a convenience or luxury rather than a necessity.

By contrast, although alcohol misuse and dependence are also common conditions, arranging appropriate treatment on the NHS is often much more difficult. Yet within the working environment such treatment is often needed, in the interests of the organisation as well as the individual, at very short notice.

In November 2006, Heather, Raistrick and Godfrey published a review of the effectiveness of treatment for alcohol problems commissioned by the National Treatment Agency.[2] The extent of the current demand and need for alcohol treatment may be illustrated by their finding that **'overall, for every £1 spent on treatment, £5 is saved elsewhere'**.

It seems surprising, then, that there has been so little focus within the government's alcohol strategy on the role of private finance in providing treatment needs. On the one hand it may be unfair that some, mostly affluent, people with PMI should be able to jump the queue. On the other hand, the insurance industry is unquestionably making a major contribution towards treatment resources and supporting private hospitals, some of which might otherwise go out of business. As with private education, those resources are sometimes manipulated to help a wider range of people and there is scope to extend that process.

The case for using PMI to support workplace alcohol policies is not being made as strongly as perhaps it might be. Some insurers, such as **BUPA**, offer cover for alcohol treatment in their more expensive policies as part of their cover for psychiatric treatment. **AXA** excludes alcohol treatment in policies purchased by individuals, although it may be included in policies taken out by employers (often referred to as 'group policies') for the benefit of their workforce. Other insurers exclude treatment for alcohol problems under all options. Some insurers go further and exclude treatment for any condition arising from alcohol misuse, such as cardiomyopathy or liver cirrhosis.

It is often a difficult exercise to find out what is and is not covered. BUPA and AXA, for example, do not make coverage of alcohol treatment a selling point for their policies. You only discover that it is included by checking that it is not excluded.

The regulator of the UK insurance industry is the Financial Services Authority (FSA). Its guidance provides for insurers and intermediaries to provide summaries or key facts for the insurance cover which they offer.[3] The FSA has advised that exclusions for alcohol treatment need not be included in the summary or key facts.[4] This suggests that it may have little conception of how important this issue is within the PMI market. At least one insurer, AXA (which, as noted above, excludes alcohol treatment in policies sold to individuals, rather than employing organisations), has followed this FSA advice on its website, which includes an incomplete list of medical exclusions and refers people to the full policy conditions (which are not online) for other exclusions. So when comparing cover from different insurers, it is essential to insist on seeing the full policy conditions. These are sometimes poorly composed.

What happens when an individual has a number of psychiatric problems including alcohol dependence? Their alcohol problem may be, and according to Heather *et al* often is, co-morbid with depression, bipolar affective disorder or schizophrenia. Do they then get private treatment for the condition that is covered and not for the alcoholism, or does it depend on which is the primary condition?

One might expect this issue to have come up in the courts or in the practice of the Financial Ombudsman Service (FOS). FOS provides an informal service resolving disputes between insurers and their policyholders. Emma Parker (FOS press office) argues that it has not yet arisen. This may possibly be (my analysis not hers) because people in urgent need of psychiatric treatment are even less equipped to take on the insurance industry than the average consumer.

About 20 years ago, I heard anecdotal evidence that some psychiatrists avoided this problem by diagnosing alcoholic patients with PMI as suffering from depression. Ten years ago another psychiatrist told me that PMI insurers had tightened up their practices making it more difficult for people with dual diagnosis to get appropriate private treatment. More recently I have been unable to get any psychiatrist to comment on the question at all.

Heather *et al* comment:

People with complex problems, such as co-morbidity, challenge the organisational effectiveness of and communication between provider agencies. Typically, there is a need to deliver integrated psychosocial interventions and integrated pharmacotherapies for both substance misuse and mental illness, and to access wraparound services. Service models need to be geared to these objectives. The management of severe and enduring mental illness and the neuropsychological complications of alcohol misuse are the province of specialists in psychiatry, clinical psychology and neurology...[2]

It is not unusual, or particularly surprising, that an important legal issue such as this has remained unresolved.

This finding surely has a significant bearing on what should be covered under a PMI policy. Insurers should be, and usually are, interested in designing PMI policies that truly meet market needs and are in line with clinical practice, provided that they can make a commercial profit. On that basis they should consider finding a more satisfactory and workable basis for limiting their liability than by excluding cover for alcohol treatment within a policy which otherwise covers psychiatric treatment. If psychiatrists agree with this view they might consider saying so to the insurance industry, which can be expected to be interested in hearing their views.

It is difficult to predict how a judge in the commercial court might approach a challenge to an insurer's reliance on an exclusion for alcohol treatment. Despite the views of the FSA, an insurer might have difficulty relying on the exclusion if it supplied a policy summary or key facts, which did not mention that exclusion. A co-morbid insured might also argue that depression can only be treated in conjunction with treatment for alcohol dependency and rely on regulation 7(2) of the Unfair Terms in Consumer Contracts Regulations 1999: **'if there is doubt about the meaning of a written term, the interpretation which is most favourable to the consumer shall prevail'**.

An insured might go further and argue that the exclusion was in any event unfair within the meaning of the regulations. The insurer would doubtless respond that a group policy is not a consumer contract.[5] That is an issue on which the European Court itself might ultimately have to rule.

It is to be hoped that, before that happens, the medical profession will take an interest, and that a dialogue with the insurance industry will emerge. The objective should be to develop PMI products that are fully consistent with medical practice and public policy objectives. In particular, it is surely undesirable that medical exclusions should target conditions, such as alcoholism, where NHS resources are inadequate.

References

1 Goodliffe J, Brooke D. Alcoholism in the legal profession. *New Law Journal*, January 1996.

2 Raistrick D, Heather N, Godfrey C. *Review of the effectiveness of treatment for alcohol problems*. London: National Treatment Agency for Substance Misuse, 2006.

3 Since January 2008 policy summaries and key facts are no longer compulsory for general insurance products such as PMI. They are still likely to be used, however. See paragraph 6.1.10G of the FSA's Insurance Conduct of Business Sourcebook (ICOBS).

4 Review of general insurance documentation, 2 December 2005.

5 Whittaker S. Unfair contract terms, public services and the construction of a European conception of contract. *Law Quarterly Review* 2000;116:95–120.

Services for individuals suffering from alcohol dependence and also those who misuse alcohol: an historical introduction

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In the UK after the second world war, individuals who were regarded as alcoholics were regarded as having a psychiatric diagnosis and their drinking led them to attempt to deal with that diagnosis. In other words, the excessive drinking was symptomatic of a psychiatric illness. At Warlingham Park Hospital in 1951, a group of patients, who were alcoholics under the care of Dr Max Glatt, requested an opportunity to share their experiences in a group and not spend their time with mentally ill patients. This led to the first regional alcoholism treatment unit, a residential unit in a hospital, which had inpatient and outpatient facilities.

In the 1960/70s, such units were replicated throughout England and Wales, each city having one or two units. Patients attending such units were usually severely alcohol dependent, aged around 40–50 years and predominately male.

Various studies in the 1970s suggested firstly that this approach, ie regional units, did not reach the much larger number of alcohol misusers compared with those who were dependent and that emphasis should be switched to a greater participation by primary care. The above was started