SHORT-TERM INSURANCE OMBUD SCHEME

The Need for Governing Rules

The non-life insurance industry plays a vital and, due to its size, an impactful role in protecting and safeguarding against unforeseen loss or damage. This, in turn, enhances the stability of the financial system overall. It is in the interests of consumers of financial products and services that the financial system is stable, balanced and grows in a sustainable way. An integral part of such a financial system is an independent, impartial and effective ombud system that consumers can approach, should their complaints not be resolved by their financial service providers. As a consumer, knowing that there is such an alternative dispute resolution forum available brings comfort and boosts confidence in the financial system.

The non-life, then the short-term, insurance industry recognised the need for the establishment of an ombud scheme and, 33 years ago, in 1989, the industry established a voluntary association called the Ombudsman for Short-Term Insurance. The industry proactively acknowledged, before it became a regulatory requirement for financial ombud schemes, the important self-regulatory role that such a scheme would play in the industry.

The purpose of the scheme had always been, amongst others, to improve the reputation of the industry and to provide greater trust and confidence to financial customers by offering a dispute resolution authority that acts independently from their insurers and ensures that the principles of fairness, equity, efficiency, and impartiality apply.

Apart from a few limitations, which are set out in the scheme's governing rules, the scheme can deal with any dispute by an insured relating to short- term / non-life insurance against his / her own insurer. The scheme decides whether a complaint is within its jurisdiction to deal with. The board of directors, based on the Ombudsman's recommendations, has the power to make changes to the scheme's governing rules, including monetary jurisdictional limits.

The scheme has always offered consumers a no risk mechanism to resolve disputes with insurers. A complainant is not bound by a finding or ruling of the Ombudsman and is free to approach a court of law at any time during the complaint handling process. On the other hand, members of the scheme have agreed to be bound by any ruling made by the Ombudsman, except where an appeal against a ruling has been noted in terms of clause 8 of the governing rules. Where a member is the appellant and is unsuccessful, then the member is bound by the terms of the order of the appeal tribunal.

The scheme also provides members with a cost-effective dispute resolution mechanism that is an alternative to litigation which is formalistic, costly and time consuming. The scheme levies a fixed rate fee per complaint registered against a member. This fee is currently R4 500,00.

The scheme is free to decide how to resolve a complaint, whether by mediation, conciliation, agreement, making a ruling or any other means that are expedient. This is set out in clauses 1.3 and 3.1.3 of the governing rules.

The scheme is a member of the International Network of Financial Services Ombudsman Schemes and subscribes to the fundamental principles for financial ombud schemes of:

- independence to secure impartiality – visibly objective, impartial and unbiased,
- clarity of scope and powers – openness,
- accessibility – well known, easy to use and free for consumers,
- effectiveness and efficiency – consistent redress in all appropriate sectors of financial services,

• good quality of service and value for money,
• fairness – processes and decisions visibly fair and equitable, and
• transparency and accountability – clear, and open to scrutiny, about its work and lessons that can be drawn from it.

In exercising its equity and fairness jurisdiction, the scheme brings some balance of power between the consumer and the financial service provider, which is otherwise unbalanced.

Trends arising from the resolution of complaints by the scheme become learning opportunities for members, whether in relation to how a product is sold, information is communicated, advice is given, or services are provided. From these learning opportunities, members have been able to adapt their services, including how they manage their own customers' complaints internally, and adapt their products. Complaint trends also provide the scheme with an opportunity to educate consumers and the public, and to alert the regulators to unsound business practices or products that do not perform as expected. All of this speaks to the role the scheme plays in strengthening and improving market conduct in the financial sector.

The scheme develops an annual public relations plan setting out the activities it will undertake to fulfil its mandate in terms of creating public awareness and understanding of the scheme and its services, as well as customer and industry education and training. Information about the scheme, including representative case studies and consumer tips, can be found on the scheme's websites, www.osti.co.za and www.insuranceombudsman.co.za, the press, television, radio and on the scheme's social media flatforms, including Facebook, Twitter, LinkedIn and YouTube. The scheme also conducts consumer and industry workshops.

Apart from reporting on the office's statistics in the annual reports, the scheme has been reporting on its members' individual complaint statistics since 2012.

These statistics, as advised by the Financial Sector Conduct Authority (FSCA), are closely considered by the regulator, and are used to inform its thematic reviews of the industry.

The scheme's adjudicative staff / ombuds either come from the legal profession or the industry, many of them having worked in both. This combination of experience provides the office with a strong skill set and the expertise required to resolve complaints, especially complex ones.

Steps taken to enhance user confidence and trust in the scheme include, but are not limited to:

- the inclusion of clause 11 in the governing rules dealing with confidentiality which states that "*the Ombudsman shall as far as possible, maintain confidentiality unless the parties concerned expressly exempt him or her from that duty and the duty shall continue after the termination of his or her services*."
- all staff, on signing contracts of employment with the scheme, agree to be bound by the scheme's Code of Ethics and Code of Conduct.
- in compliance with the provisions of the Protection of Personal Information Act, 2013, and the Promotion of Access to Information Act, 2000 (PAIA), the scheme has published its Privacy Notice and PAIA Manual on its website. Clause 6.1 of the Privacy Notice reads "*only the people who need to know will have access to your personal information*" and clause 6.2 reads "*we have security measures in place to prevent unauthorised or unlawful processing of personal information or access to personal information, including accidental loss, destruction, or damage to personal information data.*"

From 2016 to 2020, the scheme registered 50 513 formal complaints, resolved 48 039 complaints, 80% of which were resolved within six months on average, and recorded a

monetary benefit to consumers of around R475 385 900,00. However, this figure does not represent the full impact of the scheme's governing rules or the scheme itself. This is expanded on more fully below, under the sub-heading "intended operation" of the governing rules.

The scheme has always been open to learning and implementing new ways to improve its operations. It does this by analysing and reporting to the board on a quarterly basis on the outcome of user / customer experience surveys and by continuously benchmarking itself against national and international financial ombud schemes' best practices and adopting these into its operations. The scheme continues to be a member of the International Network of Financial Services Ombudsman Schemes.

The South Africa Financial Ombud System Diagnostic Report by the World Bank Group, published on 29 July 2021, states that the current financial ombud system in South Africa provides an important alternative dispute resolution mechanism for many consumers of financial services. Some of the other "upsides" key findings on page XIX of the report include, that the system "*is generally seen by stakeholders as independent, professional, expertise based, and engaged; and has rules and processes that incorporate fair and equitable principles.*"

Intended Operation of the Scheme

The scheme currently has 53 members with half of its membership base constituting around 80% of the total short-term / non-life market. The top 10 insurers in terms of asset value and premium income are members of the scheme. Its membership therefore represents a significant number of the relevant financial institutions.

The scheme's governing rules give the scheme a wide jurisdiction to deal with complaints pertaining to short-term / non-life insurance by insured persons against their own insurers, subject to a few limitations. The scheme determines which complaints are within its jurisdiction.

The scheme's monetary jurisdictional limits are regularly reviewed and adjusted for inflation. The governing rules also make provision for a member to consent to the scheme's jurisdiction even when the complaint exceeds its jurisdiction. (Clause 4.3)

Clause 1.2 of the scheme's governing rules states that the Ombudsman resolves disputes using the criteria of law, equity and fairness and clause 7.2, dealing with rulings, states that rulings must be based on the law and equity. These rules have been in place for many years, long before the treating customers fairly outcomes were formalised in the financial sector.

The rules allow the scheme to condone, on good cause shown, the late filing of a complaint or appeal against one of its rulings, and, once a complaint is received by the scheme, both prescription and time barring are interrupted while the complaint is in the scheme and until it is finally resolved.

The scheme is easy to access with many ports of entry for complaints, including two websites one of which it shares with the Ombudsman for Long-term Insurance, and it resolves disputes with minimum formality and technicality, whether by mediation, conciliation, agreement, making a ruling or any other means that are expedient.

Apart from the scheme offering consumers a no risk mechanism to resolve disputes with insurers, the scheme also offers members a dispute resolution mechanism that does not set

precedents and its rulings against members are less in the public domain than court judgments.

Complainants may withdraw their complainants at any time during the complaints handling process, are not bound by the scheme's findings and rulings and may pursue their complaints further in a court of law. Members have agreed to be bound by the scheme's findings and rulings, except when an appeal against a ruling is noted, and then they are bound by the order of the appeal tribunal.

The scheme handles all types of short-term / non-life complaints, both in relation to personal lines' insurance and commercial insurance, the latter with certain self-imposed limits. Based on the Annual Report for 2020, the scheme registered the following types of the complaints related to:

• Motor vehicle insurance (36.3
• Other types of insurance, such as mobile device insurance, travel insurance, legal expenses insurance, pet insurance, medical and hospital gap cover insurance, and non-claim-related types of complaints, such as policy-related complaints (23.8%)
• Homeowners' insurance (20.5%)
• Commercial insurance (14.0%) and
• Household contents insurance (5.4%).

The majority of complaints to the scheme emanate from claims that have been rejected by the members.

The complaints handling process allows for the resolution of easily resolvable complaints in an average turnaround time of around two months. More complex complaints or those requiring more information are resolved in the standard complaints handling process.

In terms of the complaints handling process, if the complainant had not complained to his / her insurer before approaching the scheme for assistance, then the insurer is given the opportunity to resolve the complaint directly with the complainant / its insured and, if it is resolved within three weeks and to the satisfaction of the complainant, the scheme refunds half of the fixed rate fee to the member.

Should either the complainant or the member be dissatisfied with the decision made on a complaint, they can have the matter escalated for reconsideration in terms of the escalation process, which is documented in the Complaints Handling Process and published on the scheme's website. The appeal mechanism is also available to either party who is dissatisfied with a ruling made by the Ombudsman.

In line with international best practices, the scheme has developed a vulnerable consumers policy and is in the process of implementing ICT system enhancements to better facilitate and service these consumers and their complaints.

From 2016 to 2020, the scheme registered 50 513 formal complaints, resolved 48 039 complaints, 80% of which were resolved within a period of six months on average, and recorded a monetary benefit to complainants of around R475 385 900,00.

It must be noted, however, that some of the benefits afforded to complainants by the scheme cannot be quantified, such as having a member reinstate a policy, providing the policy documents to a complainant, having a member change the policy cancellation reason or rejection reason, or providing the complainant with a better understanding of the reason(s) for the rejection of his / her claim.

The benefit to consumers therefore exceeds the monetary benefit recorded in the scheme's annual reports. The benefit to one complainant can also have a far-reaching benefit for other consumers who have not approached the scheme for assistance, for example, when the scheme resolves a complaint and the member modifies its sales script, or makes a policy provision simpler and clearer, or changes the way it services a claim. All these outcomes are not just beneficial for the complainant who lodged a complaint with the scheme but are beneficial for all other customers of the member and its future customers.

User surveys are conducted at every touchpoint in the complaints handling process with the users of the scheme and customer experience reports are submitted quarterly to the board. In relation to the complaints that were finalised in 2020, the scheme scored 76 / 80, in other words 95% of the users of the scheme were satisfied with the scheme's service, process and communications. There is room for improvement and the scheme is continually looking for ways to improve its service execution.

Trends arising from the resolution of complaints by the scheme are also shared with the regulator and are used to inform its thematic reviews of the industry. The governing rules create exceptions to the confidentiality provision in the rules and permit the Ombudsman to publish rulings and share statistical information in connection with its work with the regulator, National Treasury, South African Insurance Association, and any other body that is entitled to receive such information. (Clauses 11.1.1, 11.1.2 and 11.1.3)

The scheme's quality assurance programme takes the form of audits conducted by the escalation committee members on all complaints that are escalated for reconsideration to the escalation committee. A quality assurance checklist is completed on each escalated complaint, feedback is provided to the case owner and the results of the quality check form part of the appraisal of performance.

When the scheme's head of customer experience, a senior assistant ombud, deals with service-related complaints about the scheme, she conducts a full case review, including a review of the process and procedures. An externally appointed independent auditing firm, that performs the function of internal audit at the scheme, also conducts quality assurance control reviews on the scheme's dispute resolution processes and procedures.

Impact of the Scheme

As already mentioned, between 2016 and 2020, the scheme registered 50 513 formal complaints, resolved 48 039 complaints, 80% of which were resolved within six months on average, and recorded a monetary benefit to consumers of around R475 385 900,00.

Since the appeal mechanism was introduced in 2013, the scheme has not been taken on appeal. The scheme enjoys a high level of cooperation from its members and no member has voluntarily existed the scheme in, at least, the last 20 years.

Although the scheme is not empowered to make compensatory awards for poor service against a member, it has, in appropriate circumstances, awarded mora interest when a member has unreasonably delayed the payment of a claim to its customer.

The members of the scheme have adopted the Didcott principle, which is based on fairness, whereby they reconstruct the policy instead of cancelling the policy when there has been a misrepresentation or non-disclosure by the insured.

The scheme's role in identifying and mitigating risks of unfair consumer outcomes is set out more fully above.

The scheme published for its members a Handbook in 2010, which was updated in 2013, setting out its approach to certain types of complaints. This Handbook is widely used by the industry and is due to be updated this year. In 2017, the scheme produced a Process Manual for the industry on its complaints handling process and standards on how complaints should be addressed and handled by its members.

Expected Changes:

An increase in the scheme's membership base is anticipated as a result of the implementation of section 211(3) of the FSR Act in terms of which all financial institutions must be a member of a relevant industry ombud scheme. Changes are also anticipated when the Ombud Council sets rules for the ombud schemes in terms of section 201 of the FSR Act.

However, the scheme believes that it is well positioned to accommodate these changes and has access to sufficient resources, whether human, financial or operational, to ensure that it complies with its obligations in terms of chapter 14 of the FSR Act, should its application for recognition be granted.