Executive summary
2014 Annual report

Chargeable complaints received
5 104

Full cases finalised
3 822

Percentage of cases finalised within six months
74%

Percentage of cases resolved wholly/ partially in favour of complainants
29.7%

Total expenses for the year
R17.9m

Cost per standard case
R2 950

Recovered for complainants (in lump sums)
R147.1m

Compensation awarded
R452 025

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Some of the features that emerged in 2014 are:

- The office received 9 246 written requests for assistance during 2014, almost 8% fewer than in 2013. Of these 5 104 were chargeable complaints (page 12).
- The number of cases finalised was 3 822, lower than the 4 496 of the previous year. This decline is largely attributable to the changes brought about by the new business model, as the relatively straightforward "Poor service" or "Claims declined" complaints are now settled on transfer to the insurer (page 14).
- Complaints in which the complainants were wholly or partially successful (in office and industry parlance, the "W/P percentage") was 29.7%, compared to 33% in 2013 (page 17). However, if the Transfers settled by insurers are included in this figure, as they would probably have resulted in the same outcome if handled by the office, the W/P percentage would be 38% (36.4% in 2013).
- There was an increase in the percentage of complicated cases to 18%, compared to 15.7% in 2013 (page 15).
- The percentage of complaints about health policies reduced in 2014, reversing the trend which had manifested prior to that. This reduction is mostly due to fewer complaints about hospital cash plans. Although the office is still receiving a number of these complaints at least one insurer had a reduction of 232 in complaints (page 20).

As mentioned in previous Annual Reports it is extremely difficult to forecast complaint volumes and there does not appear to be a single defining reason why a decrease occurred in 2014. The historic pattern of complaints received by the office shows periodic declines, usually about every six or seven years.

The reduction in the number of complaints, a reducing W/P percentage and fewer "Incompetent Cases" suggest that there may be improvements in the complaints handling procedures of at least some insurers, if not all.

Statistical summary of cases finalised

	Totals				Percentage to total	
Nature of complaint	**2013**	**W/P***	**2014**	**W/P***	**2013**	**2014**
Poor communications/documents or information not supplied/poor service	1 319	47%	1 115	38%	30%	29%
Claims declined (policy terms or conditions not recognised or met)	2 166	31%	1 924	28%	48%	50%
Claims declined (non-disclosure)	246	13%	181	21%	5%	5%
Dissatisfaction with policy performance and maturity values	152	13%	132	22%	4%	4%
Dissatisfaction with surrender or paid-up values	63	18%	73	14%	1%	2%
Misselling	33	27%	12	17%	1%	1%
Lapsing	147	37%	170	36%	3%	4%
Miscellaneous	370	17%	215	16%	8%	5%
Total	**4 496**	**33.0%**	**3 822**	**29.7%**	**100%**	**100%**

Surveys

Results of the surveys which were conducted amongst complainants and insurers are encouraging (pages 18 and 19).

The new business model

The essence of our new business model is its requirement that any complaint not previously considered by a subscribing member will be forwarded to it in the first instance with a view to resolving it. The model was incrementally and successfully implemented during 2014 and by the end of the year it applied to all but two subscribing members.

The following effects of the new business model have already been observed:

- The less complicated "Transfers" are resolved by insurers, with the result that the majority of "Reviews" and "Full Cases" which are dealt with by the office, tend to be the more complex complaints.
- The inevitable consequence of the aforegoing is an increase in the time it takes to resolve those more complicated complaints.
- There is an additional administrative burden on the office as well.

2 582 Complaints were transferred to insurers during 2014.

Analysis of Transfers

Settled in favour of the complainant by the insurer	632
Returned to the office and taken up as Reviews	1 115
Required no further action or the complainant did not respond further	282
Awaiting response from the insurer or the complainant	553
	2 582

Publication of complaints data

The office annually publishes individual insurer complaints data. For the period 1 January 2014 to 31 December 2014 the data has been published on its website, www.ombud.co.za and in the Annual Report.

The information published on the website and in the Annual Report shows the number of complaints received, the number of cases considered, the number of cases finalised and the number of cases resolved in favour of the complainant or the insurer, i.e. the W/P (Wholly or Partially) percentage. In addition, Table 2 on our website reflects the nature of the complaints.

Included for the first time this year are the names of the insurers that received more than five second reminders and the number of reminders received by them.

Regulation of the Financial Sector

2014 was a year when the introduction of the Twin Peaks Model of Financial Regulation resulted in extensive draft legislation and policy statements. The Financial Sector Regulation Bill, 2014 included a section affecting the financial services ombudsman, both voluntary and statutory. Significant changes are contained in the draft legislation in accordance with National Treasury's stated objective to "strengthen the Ombud system by creating a stronger central co-ordinating role for the Financial Services Ombuds Council".

Appointment of a new Independent External Assessor ("IEA")

A new IEA, Judge Roger Cleaver, has been appointed in 2014.

The function of the IEA is to take an independent view whether the office provides a reasonable service in its complaints resolution process. The IEA receives and considers service complaints against the office by complainants and subscribing members. A service complaint is about the practical handling of a complaint and it does not relate to the outcome of a complaint. The role of the IEA is thus to consider complaints about the way in which we handle cases – disagreements about the merits of decisions are excluded from his jurisdiction.

Amongst the changes are the following:

- the FSOS Act will be repealed;
- the FSOS Council will continue to exist;
- all the existing recognised ombudsman schemes will continue to exist in accordance with their provisions until the expiry of a period of 18 months from the date on which the new legislation comes into operation;
- section 176 bestows exhaustive powers on the FSOS Council;
- "all financial institutions are required to participate in a recognised scheme appropriate to their business"; and
- that currently recognised schemes, like ours, will be obliged to apply for recognition.

Independent Review of Ombudsman's office

In her Foreword to the Annual Report Judge Leona Theron, the Chairperson of the Ombudsman's Council said that, in accordance with accepted best practice standards, the Council had approved the appointment of and the terms of reference for Dr E de la Rey to conduct an external review which would entail an in-depth investigation and qualitative assessment of key aspects of the office's business. Dr De la Rey released the report of her Independent Review of the office on 16 April 2015. Dr De la Rey used the International Network of Financial Services Ombudsman Schemes (INFO Network) document "Effective approaches to fundamental principles" as a measure to test the way in which the office works and said the following in the concluding paragraph of her report:

> "OLTI complies with and exceeds international standards and expectations for a financial ombud scheme...."

The report, Dr De la Rey's recommendations and the response of the office to those recommendations appear on our website, www.ombud.co.za.

Treating Customers Fairly

In the office our experience of TCF has been the following:

- There is a growing awareness amongst complainants of TCF.
- Some insurers advised us that they are implementing TCF.
- TCF may be one of the factors which contributed to the reduction in the number of complaints to the office.
- Changes to our system are being considered in order to submit to the Financial Service Board complaints categorised according to the TCF outcomes.
- There is no clear manifestation of TCF in the complaints management processes of all subscribing members. On the contrary, there is a discernible failure on the part of some insurers to apply TCF.

Policyholder expectations

We had a number of complaints in 2014 which showed a divergence between the expectations of policyholders and what their insurance policies actually delivered. Even if an insurer acts in terms of the policy wording this divergence can occur for the following reasons:

- the marketing was not appropriate;
- the policy wording was not as clear as it should be;
- the design of the policy is either unusual or out of date or not appropriate for the potential buyers;
- the insurer's ongoing communication during the term of the policy has not been adequate or was non-existent.

Some examples of complaints that demonstrate this divergence are covered in the Annual Report (page 23).

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