Ombudsman news

essential reading for people interested in financial complaints
– and how to prevent or settle them

Walter Merricks, chief ombudsman

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Financial Ombudsman Service

A fair and reasonable assessment

Back in June 2000, in my first *annual review* as financial ombudsman, I set out our main aims as a new organisation:

to provide consumers with a one-stop service for dealing with financial disputes
At that time complaints about mortgage and insurance brokers and consumer credit providers were outside our remit, let alone complaints about payment services providers. We have now largely achieved the comprehensive coverage we aimed for – something consumers and the industry can now happily take for granted.

to resolve disputes quickly and with minimum formality
In creating the new single ombudsman service, we anticipated delays due to the effects of transferring staff from our seven predecessor ombudsman schemes, and due to the new location and introduction of new systems and processes. What I did not anticipate was that, within a year, mortgage endowment complaints would constitute a third, and then a half, and then two-thirds of our increasing caseload.

This and other surges of 'single-issue' complaints have affected our service timescales, but we have largely managed to avoid an overly formal and legalistic process – and have still dealt with a four-fold increase in our workload.

to offer user-friendly information
We committed ourselves to dealing in as helpful way as possible with the large number of enquiries we would receive from people who had not completed the firm's own internal complaint procedure. In addition, we said we would provide advice and help for complaints-handling staff within firms. Last year half of the consumers who contacted our helpline were subsequently able to resolve their complaint by themselves, 94% of them saying our involvement had helped them sort things out.

to make consistent, fair and reasonable decisions
In the early days, consistency meant harmonising the sometimes different approaches of the former schemes. But we also undertook to make the industry aware of how we would approach commonly-encountered situations. Our website now includes a wealth of information, and our transparency plans envisage significant expansion in this area.

to be accessible for disadvantaged and vulnerable people
We regularly provide information about our service in over 40 languages, and check with all consumers whether they would like us to adapt the way we communicate with them. Our accessibility offering matches, and in some ways exceeds, that of many other public services.

to be cost-effective and efficient; to be seen as good value
Over the last seven years, our unit cost of resolving complaints has averaged out at under three-quarters of the unit cost we inherited from our predecessor ombudsman schemes.

to be trusted and respected by consumers, the industry and other interested parties
Two-thirds of businesses we surveyed last year think we provide a good dispute-resolution service – despite the fact that we upheld 60% of complaints in favour of consumers. Even 42% of the consumers who felt that they had 'lost' their complaint were satisfied with the way we handled it.

I leave the Financial Ombudsman Service conscious of the many challenges that lie ahead, but confident that these aims provide a sound set of objectives against which this organisation can judge itself in the years to come.

Walter Merricks, chief ombudsman

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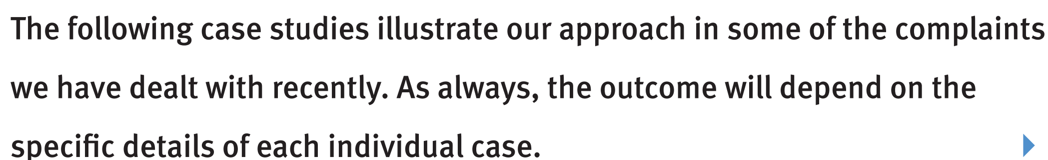
Ombudsman news is not a definitive statement of the law, our approach or our procedure. It gives general information on the position at the date of publication.

The illustrative case studies are based broadly on real-life cases, but are not precedents. We decide individual cases on their own facts.

Insurance disputes involving claims for unemployment or sickness benefit

A number of different insurance products offer benefits in the event of an accident, sickness or unemployment – and we see a significant number of complaints involving claims made under policies of this type. Sometimes, the consumer is unhappy because of delays in processing and paying a claim. But more often, in the cases brought to us, the insurer has turned down a claim for reasons that the consumer thinks unfair or unreasonable.

Consumers who have claimed under policies of this type will generally be experiencing difficult circumstances, so a considerable amount of sensitivity is called for when dealing with these issues.



The following case studies illustrate our approach in some of the complaints we have dealt with recently. As always, the outcome will depend on the specific details of each individual case.

80/1

insurer rejects claim for unemployment benefit when policyholder loses her job through redundancy

When Miss J, who worked for a large high street retailer, obtained a credit card she also took out payment protection insurance (PPI). This covered her monthly repayments, should she become unemployed because of sickness, disability or redundancy.

Around the time she applied for the credit card and insurance, there was some comment in the media about her employer facing a difficult period. The retailer had recently published very disappointing financial results and there was much speculation among her colleagues about its future prospects. Miss J had therefore thought the redundancy cover offered by the policy might prove useful. However, at that stage she had no particular reason to think she would lose her job.

A few weeks after she had obtained her credit card and policy, Miss J's employer announced that it would be consulting staff about possible job losses throughout the company. Three months later, Miss J was told that her own job was one of those at risk of redundancy. And ten weeks after that, Miss J was selected for redundancy and left the company.

Shortly afterwards, Miss J submitted a claim under her payment protection policy for unemployment benefit. This was turned down, on the grounds that the policy terms excluded unemployment claims if the policyholder became '*aware of any increase in the risk of unemployment*' within 90 days of the policy's start date.

After complaining unsuccessfully to the insurer about what she thought was '*a very unfair decision*', Miss J referred her complaint to us.

complaint upheld

We accepted that the insurer needed to limit the scope of its policy, as a safeguard against people applying for cover at a stage when they already knew they were very likely to lose their jobs. However, we took the view in this case that the exclusion was so broad that it was unfair.

... when she applied for the policy she had no particular reason to think she would lose her job.

On a strict reading of the exclusion, if, for example, there was any deterioration in the UK's economic environment during the first three months of the policy, then this might result in policyholders losing all unemployment cover under the policy.

If the insurer wished to exclude cover because a policyholder's knowledge or circumstances changed within the first three months of a policy, then it needed to word its exclusion very clearly – setting out what change or changes had to take place for the exclusion to apply. This had not happened in this case. The insurer also needed to ensure that consumers were made aware of the exclusion, at the time they bought the policy. Again, this had not happened here.

We considered that Miss J had acted honestly and in good faith. At the time she took out the policy she had no particular reason to believe she was at risk of redundancy. So we said it was neither fair nor reasonable for the insurer to reject the claim.

80/2
insurer stops payment of sickness benefit on grounds that policyholder is well enough to return to work

Mr C, who was in his early 40s, worked full-time as a messenger at a large transport company. After being diagnosed with anxiety and stress-related conditions, he put in a claim for sickness benefit under his income protection policy.

The insurer accepted his claim and – as his condition did not improve sufficiently for him to return to work – it continued paying him benefit over the next four years.

In line with the policy terms, at the end of that period the insurer carried out a detailed review of Mr C's situation. The assessment that his consultant provided, as part of this review, suggested there was some doubt about whether Mr C was '*truly fit to return to work*'. However, this opinion did not appear to be based on any clear medical grounds. The insurer therefore asked Mr C to undergo an independent medical examination.

... the specialist concluded that he *was* fit enough to return to work – and that this would be beneficial for him.

The specialist who conducted this examination concluded that Mr C *was* fit enough to return to work – and that returning to work would be beneficial for him. So the insurer told Mr C there was '*insufficient medical evidence*' to support his '*continued inability to work as a result of a medical condition*'.

... he complained that it was '*unfair and unreasonable*' to stop his benefits.

Mr C complained that it was '*unfair and unreasonable*' to stop his benefits. He said that as well as suffering from '*ongoing mental illness*', he now had '*a number of physical disorders*' that prevented him from working. Mr C was unable to provide any evidence of these '*disorders*', so the insurer said it was unable to reconsider the matter. Mr C then brought his complaint to us.

complaint not upheld

The issue for us to determine was whether the insurer had adequately established that Mr C's condition no longer fell within the policy's definition of '*incapacity for employment*'.

... he was not eligible for sickness benefit as he had been diagnosed before the policy's start date.

We found that the medical evidence tended to support the insurer's stance. Mr C's symptoms were not consistent with a disabling mental illness. And we noted that the independent consultant had said Mr C would benefit from returning to work.

We considered what Mr C had said about his '*physical disorders*', but we found that the medical evidence did not suggest he had any physical symptoms that would result in his meeting the policy definition of '*incapacity for employment*'.

We concluded that the insurer had been entitled to terminate the claim, so we did not uphold the complaint.

80/3

insurer refuses to pay sickness benefits on grounds that policyholder's illness was a '*pre-existing condition*'

Mr G, who was in his early 50s, was diagnosed with a serious respiratory condition. As this prevented him from working, he made a claim for sickness benefit under his payment protection insurance policy (PPI).

The insurer turned down the claim. It told Mr G he was not eligible for benefit as he had been diagnosed with respiratory problems before the policy's start date. It said he therefore '*would have been aware, or should reasonably have been aware*' that he already had this condition when he took out the policy.

... No definite diagnosis had been made before the policy was taken out.

The insurer said Mr G's medical records showed that, before the policy's start date, his GP had referred him to a consultant because of a problem that would have caused the shortness of breath. This problem was known to be linked to his now more serious condition. The insurer added that the medical records showed that Mr G might already have acquired the more serious respiratory condition before he took out the policy.

Mr G disputed the insurer's conclusion. He said his GP had confirmed there were references in his medical records to the more serious condition – and these dated from *before* Mr G applied for the policy. However, the GP had not told him that he had – or might have – the more serious condition. The GP had simply noted, for his own reference, some possible causes for the problems Mr G was experiencing. Mr G had only known he had the more serious condition when the actual diagnosis was made – after the policy had started.

When the insurer said it was unable to reconsider the matter, Mr G complained to us.

complaint upheld

After examining the evidence in this case, we were satisfied that – at the time he took out the policy – Mr G had not known he was suffering from a serious respiratory condition. We were also satisfied that he had not known that the seemingly minor symptoms he was experiencing suggested he had an illness of this nature.

No definite diagnosis had been made before the policy was taken out. And the notes made by the GP – which included speculation about several possible causes for Mr G's symptoms – had not been shown to Mr G or discussed with him.

We told the insurer that it was not appropriate in this case for it to cite the exclusion relating to '*pre-existing medical conditions*' in order to reject the claim. We said it should pay the claim, in accordance with the terms of the policy.

... the insurer said his condition did not fall within the definition of 'multiple sclerosis', as set out in the policy.

80/4

insurer turns down claim because consultant's description of policyholder's illness does not fall within the policy definition for that particular condition

After his GP referred him to a consultant neurologist, Mr B was diagnosed with multiple sclerosis. He put in a claim under his critical illness policy, which was designed to pay out a lump sum if he was diagnosed with one of the serious illnesses listed in the policy – and met the qualifying circumstances.

The insurer told Mr B that his condition did not fall within the definition of 'multiple sclerosis', as set out in the policy, as no definite diagnosis had yet been made. In a letter sent to Mr B's GP, the consultant had referred only to '*probable*' multiple sclerosis.

A few months later the consultant saw Mr B again and gave him a definite diagnosis. The insurer had said it would review the claim if this happened, and on the basis of the medical evidence it received at this stage, it agreed to meet the claim.

The insurer said it would pay the claim from the date of the definite diagnosis. Mr B said payment should be back-dated to when he first saw the consultant. He said that if the insurer had investigated his original claim more thoroughly – and had contacted the consultant direct – then the diagnosis would have been confirmed at that point.

Unable to reach agreement with the insurer, Mr B referred his complaint to us.

... The issue for us to determine was whether the insurer had acted reasonably in turning down the claim.

complaint not upheld

Generally speaking, the descriptions and definitions of the illnesses covered in policies of this type have been standardised across the insurance industry. We did not, therefore, need to look into this aspect of the case. The issue for us to determine was whether the insurer had acted reasonably in turning down Mr B's initial claim.

... It was not until some time later that the diagnostic test confirmed the disease as '*definite*'.

At the time he made his first claim for multiple sclerosis, there was a widely-accepted diagnostic approach within the medical profession for establishing if a patient had this condition.
The diagnostic test the consultant carried out, in accordance with this approach, showed that Mr B's multiple sclerosis was only '*probable*' at that stage. It was not until some time later that the diagnostic test confirmed the disease as '*definite*'.

We did not uphold Mr B's complaint and we explained to him why, in the circumstances, we did not think the insurer had acted unfairly in refusing to meet his initial claim.

In situations involving illnesses where such a widely-accepted diagnostic approach does not exist, we would expect insurers to use the best available medical evidence in order to establish whether a condition meets the criteria set out in the policy. ■

80/5

insurer refuses to pay benefits to policyholder who becomes too ill to work

Miss M, who worked full-time in a garden centre, took out a payment protection policy (PPI) when she got a loan from her bank. The policy was designed to ensure her monthly loan repayments would still be paid if she lost her job through redundancy – or developed a serious illness or disability that prevented her from working.

Some time after taking out the policy, Miss M became unwell. It was soon evident that hers was a chronic condition and she became very anxious about the effect it would have on her ability to continue in her job.

She tried to book an appointment with her GP to discuss the situation but was told she would be unable to see him for some while. He was shortly going on holiday and had no free appointments before he went.

Feeling desperate about her worsening state of health, Miss M then contacted her employer. She said she was resigning, as she saw no prospect of being well enough to return to work. Two weeks later, Miss M was able to see her GP, who gave her a medical certificate confirming her inability to work. She then put in a claim under her payment protection policy.

The insurer refused to pay the claim. It did not doubt the state of her health but it pointed out that the policy was designed to cover people who were in employment. At the time she put in her claim she had already resigned from her job, so she was not eligible for cover.

complaint upheld

We were satisfied from the evidence that – at the point at which she resigned from her job – Miss M's state of health met the policy definition of '*disability*'. She would therefore have qualified for benefit under the policy if she had been able to get an appointment with her GP within a reasonable time.

We did not think it appropriate for the insurer to take advantage of the fact that she was unable to do this. We said that the fair and reasonable outcome in this case was for it to meet her claim.

... it was clear that her state of health met the policy definition of '*disability*'.

Chief Ombudsman's Final Decision

This month's *ombudsman focus* features an interview with Walter Merricks, conducted shortly after he announced he would be stepping down in October after ten years as chief ombudsman. Walter Merricks spoke to Neasa MacErlean, a journalist with 20 years' experience of writing about business, the law and consumer finance.

Neasa MacErlean: Your last *annual review* showed you received a record 127,000 new complaints last year – over four times the level you were getting when you first became chief ombudsman. Has the ombudsman service now become a complaints 'factory' – and what needs to happen to stop complaints soaring?

Walter Merricks: In terms of complaints volumes, I certainly hope the next ten years might be less of a rollercoaster ride than the last ten. We've had to deal with some enormous surges in caseload – including floods of complaints about mortgage endowments, split-capital investment trusts, 'precipice' bonds, Equitable Life, bank charges and more recently, of course, payment protection insurance (PPI).

These surges of complaints have all been symptomatic of much wider problems. I very much hope that if similar widespread problems emerged in future, the ombudsman service would not have to be centre-stage in dealing with the fall-out.

Whether in financial services, or in any other mass consumer market, there's the potential for large numbers of consumers to all be affected adversely by the same problem or detriment. But those consumers don't have the power in law to work together to get redress collectively.

I don't believe it's right that the legal system should effectively allow a company responsible for causing consumer detriment to hold on to profits they have made – leaving individual consumers to have to take action, one by one, to get rightful redress.

There's clearly a gap in the legal system here – something I focused on in our last *annual review*. It's this gap in the system that's given rise to the claims-management industry – with a quarter of the cases we deal with at the ombudsman service now referred by claims-management companies.

The government white paper published by the Treasury in July (*Reforming Financial Markets*) makes some strong recommendations in this area. The white paper says that more can be

done to improve the standards of complaints-handling by financial firms, to reduce the number of cases referred to us, and to use the complaints system to identify and deal with emerging problems before they become widespread. The Treasury has also floated the idea of '*collective redress*' through the courts – for groups of consumers who have suffered widespread detriment.

The Civil Justice Council and the European Commission, too, have been looking at ideas involving 'collective redress' for consumers – rather than requiring consumers to pursue individual complaints where there's a wider problem. And in its recent white paper (*A better deal for consumers*), the Department of Business, Innovation and Skills has recommended setting up a Consumer Advocate – with powers to take legal action on behalf of a group of consumers where consumer law has been broken.

What all this shows is that complaints-handling – and the question of redress for groups of consumers collectively suffering the same losses – is now at the top of the agenda. I'm pleased that the Financial Services Authority (FSA) and the government have said this is an area that needs greater focus.

NM: How has the ombudsman service changed over the ten years since you became its first chief ombudsman?

WM: It's really been a process of ongoing evolution. At the start, ten years ago now, it was actually quite a disjointed picture. Seven separate ombudsman and complaints schemes – covering different sectors of the financial services industry – coming together to form the new single Financial Ombudsman Service, literally under one roof for the first time.

Then our jurisdiction started to grow, to cover complaints in other key areas: insurance-broking; mortgage-broking; consumer credit – from store cards to payday loans; travel insurance sold with holidays; 'sale and rent-back' housing transactions – and from November 2009, payment services including money-transfer operators. Pretty much all the pieces of a complicated jigsaw are now in place.

And that has to be better for everyone. I don't think anyone can doubt that this is the right way to do things – the right approach to give consumers confidence that unresolved disputes will be handled fairly. Imagine – of the 114,000 cases we resolved last year – what would have happened, how much would it have cost, how many would have fallen by the wayside, and how much inconsistency would there have been, if these complaints had each had to go through the courts instead?

NM: Your last *annual review* shows that the proportion of complaints upheld in favour of consumers has risen from a historic level of about 30 per cent to almost 60 per cent. What's happening here?

WM: The proportion of complaints we uphold is a pretty accurate reflection of the quality of complaints handling by financial businesses. It's clear that over the last 12 months, many businesses have been under financial pressure. Senior management focus at some businesses has evidently been on riding out the financial turmoil – not on providing top-quality customer service.

This has led to patchy services and under-resourced complaints handling at some businesses. We've seen a significant increase in businesses failing to address their customers' complaints fairly and properly. This does surprise me – bearing in mind we gave notice over a year ago that we would be moving towards publishing complaints data on individual businesses – which we did for the first time last month.

NM: As well as chief ombudsman, you're the founding chairman of the International Network of Financial Ombudsman Schemes. How does the UK Financial Ombudsman Service square up internationally?

WM: We're actually the largest ombudsman scheme in the world. And I think it should be a real source of pride that we have become the model to follow internationally.

The ombudsman model, particularly in financial services, now operates across most of Europe and in virtually every Commonwealth country – as well as in North and South America. With our strong influence in Europe – through FIN-NET (the European Commission-sponsored network of financial dispute-resolution schemes that we helped to set up) – we've provided assistance to the newer EU members. And we're currently giving the benefit of our experience to new ombudsman schemes being set up – for example – in Kazakhstan and Armenia.

Japan and Hong Kong have also consulted us recently on the role of an ombudsman in retail financial markets. Given that the Hong Kong region of China wouldn't be permitted to set up an ombudsman without the approval of the Chinese government, I suspect this could mean that China, too, may have a real interest in this area.

NM: Do you actually deal with complaints yourself?

WM: I rarely deal with individual complaints in terms of handling them from start to finish. But I'm certainly in touch with all of the difficult issues – and I'm in very close contact with our ombudsmen on a wide range of complaints-policy matters.

NM: Have consumers altered over the last ten years?

WM: I think many consumers have certainly become more confident and empowered. They're more prepared to ask questions, shop around, assert their rights – and complain when they're not happy. This is clearly a result of the internet revolution – enabling people to research and share information freely on everything from what travel insurance to buy, to how to make a mis-selling complaint.

Just as great a challenge for us, though, is to make sure we provide an accessible service for those consumers who aren't wired up to the internet. There are a lot of less fortunate, less enabled consumers being left behind by all the new technology. We're just as concerned to make sure that they, too, know about their consumer rights – and their right to come to the ombudsman.

NM: So how do you see the development of financial literacy?

WM: It's going to be a very long-term project – a generational issue. It isn't a question of change overnight. In the past, most people have struggled to take an interest in financial matters – but I think that's now starting to change. One possible silver lining to the current recession is that tighter budgets are making us all more interested in how we save and spend our money. Pensions and mortgages are now regularly front-page news stories.

NM: What message do you have for financial businesses?

WM: Well, as I mentioned earlier – if businesses have been using the recent economic difficulties as a reason for not dealing with customer complaints as fairly or thoroughly as they ought, then this could well turn out to be very short-sighted. When the economy gets back into shape, consumers will remember who dealt fairly with them and who didn't.

NM: What's the future in the UK for the style of dispute resolution that you've developed at the ombudsman service?

WM: It's not just overseas where there's interest being shown in our ombudsman model. Here in the UK, researchers and officials from government, academia and the justice system take a very close interest in our approach to resolving disputes.

This approach involves resolving the vast majority of complaints at the earliest possible opportunity. We prefer to settle complaints informally – getting both sides to agree at an early stage to any recommendations or informal settlement that our adjudicators may suggest. Fewer than 10 per cent of cases include an appeal to one of our ombudsmen for a final decision. And only a tiny number of cases involve a face-to-face hearing.