ISSN No:-2456-2165

Reckoning Frauds in Tanzania's Insurance Services: An Ethical Perspective*

Emmanuel Selemani Shindika,
Principal and Chief Executive Officer,
Tanzania Public Service College (TPSC)
Dar es salaam, Tanzania

Francis Daudi,
PhD Candidate,
University of Basel
Basel, Switzerland

Abstract:- Fraudulent claims have been growing within the insurance sector despite strategies innovated every day as internal mechanisms to control. Surprisingly, automated internal control and services provisions attributed to the increase of fraudulent claims rather than serving the purpose. Some scholars argue that the lack of a code of ethics and professionalism has greatly contributed to an increase in fraudulent claims in the insurance sector. This is an important argument in which this paper attempts to explore fraudulent claims with a view of addressing the challenge and provide an ethical measure for the development of the insurance sector in Tanzania. Also, this paper evaluates efforts that have been done by the Tanzania Insurance Regulatory Authority (TIRA) in a war against frauds and other malpractice in Tanzania's insurance industry.

Keywords:- *Fraudulent, Ethics, Professionalism, Insurance.*

I. INTRODUCTION

It is widely known that fraud and corruption jeopardise insurance services all over the world. The insurance industry, which contributes to the national economies, is more exposed to fraudulent activities, particularly in developing countries. Some of the contributing factors include, but not limited to, weak investigations teams, ungoverned insurance agencies and brokers. For instance, India is one of the largest insurance markets in Asia; however, there is no practical insurance law, and therefore, health insurance fraudulent claims led the insurance companies to lose about 35 per cent of revenue. In Africa, the largest insurance market in the continent, South Africa, which is comprised of 70.59 per cent of Africa's premiums income, is vulnerable to frauds claims. More than 20 per cent paid out as short term insurance claims were fraudulent in 2019 alone (Insurance Crime Bureau, 2019). The fraudulent insurance claims said to have been attributed to 'Unprecedented financial pressure'. In Tanzania, little is known about the magnitude of the problem. Additionally, Tanzania's insurance industry is not immune to fraud and corruption; however, this topic remains a 'sensitive issue'. Therefore, this paper intends to analyse the problem and provide solutions from an ethical point of view. It should be noted that money lost through fraudulent claims compromises the ability of insurance companies to indemnity or make good claims of those who have loyalty paid their premiums for years and genuinely when suffered loss. Insurers might find themselves in increasing premiums and excess in an attempt to rectify loss, making portfolios if the fraudulent claims become unchecked.

II. LITERATURE REVIEW

Fraud has been highly studied among scholars who proposed various methods of dealing with it owing to profound impacts emerges across financial sectors. Indeed, notwithstanding strategies employed over the years to prevent fraudulent claims yet, insurance service has been victimised more than any economic sector worldwide. In 2012, the Association of Certified Fraud Examiners (ACFE) approved a universal meaning of fraud. It states, "Any illegal action characterised by deceit, secrecy, and breach of trust is a fraud. These actions do not require violence and physical coercion. Frauds are committed by people and organisations with the aim of acquiring money, assets, or services, avoiding payments or loss of services, or obtaining commercial or personal benefits". However, before a universal definition of fraud, the International Association of Insurance Supervisors in 2007 defined fraud as an omission or act intended to gain an advantage that is undeserved. This is strategically achieved by concealing, suppressing, misrepresenting or non-disclosure of material facts pertinent to transactions of financial decisions.

Insurance fraud has been a key point of discussion among scholars and insurance stakeholders across all nations. Insurance Outlook Report 2019/2020, East Africa reveals that fraud in the insurance sector is a 'constant threat'. The report proposed the use of big data to establish trends based on historical data, which would eventually allow insurers to develop possible indicators for fraud. Furthermore, this report recommended the setting up of a strong internal mechanism that can be used to determine employee's behaviour patterns which would be helpful in detecting fraudulent activity. Copious literature has focused on factors that influence the fraudulent claims in different countries (Bolton and David 2002: Duffied and Grabosky 2011), other studies defined and contextualise this challenge (Doig and Wells 1999), and other scholars have categorised fraudulent claims within insurance business (Clarke 1990; Albrech 2004). This paper sort of addressing this challenge in the context of Tanzania's insurance market and provide solutions from an ethical point of view.

This paper offers a new perspective through provide recommendations on ethical grounds. Fraudulent claims remains a 'sensitive issue' in insurance which is one among the small public sector which big potentialities. There is no considerable attention on this topic, and only annual reports published by Tanzania Insurance Regulatory Authority (TIRA) have highlighted frauds and other malpractices within the insurance sector. However, pieces of literature drawn from other countries are useful to understand the problem in its totality.

Abramson and Hollings (1999) linked fraudulent claims with age, level of education and income. They clearly pointed out that younger people with average education and income are likely to engage more on fraudulent claims demographically compares to adults with both higher level of education and income. Kilemi, R. (2018) focused on filling gaps in the same studies by analysing ways in which financial stress influences the increase of fraudulent claims in Nairobi, Kenya. Based on levels, Albrecht (2004) identifies two major factors which cause fraud in the insurance sector. One is the Organisational environment, and two is personal characteristics (perpetuators). The study is relevant as it brings in personal characteristics such as behaviours, age, gender, educational background and income. This paper focused on perpetrators to give ethical solutions to the problem.

Furthermore, Weisberg and Dering (1991) connected moral standards of both policyholders and staffs within insurance companies as the factor which leads to the increase of fraud in the insurance sector worldwide. They state that fraud is normally planned activity that involved insured clients with the assistance of employees. In his work, Clarke (2005) categorised "Fraudsters" into three major groups;

i. The opportunist
ii. The Amateur
iii. The Professional

The opportunist always takes advantage of a genuine loss to commit fraud by claiming, together with genuine losses, for items that were not stolen. On the other hand, the amateur often starts by committing opportunistic fraud and thereafter take a step ahead by submitting a claim for items stolen that never took place. The most common and very serious fraudster in the insurance business is professional. This kind of fraudster engages in systematic frauds in organised networks or individually.

Finally, in their study, Dalal and Murdoch (2010) attempt to give a solution to the increase in fraudulent claims. They recommended the adoption of a relationship between insurance companies and community structures where the policyholders are sensitised on the importance of making genuine claims. This can be a practical strategy for combating and preventing frauds. However, this study extends the strategy to the context of Tanzania's insurance sector.

III. ETHICAL CONSIDERATIONS IN TANZANIA'S INSURANCE SECTOR

According to Solomon S. Huebner, who is considered the “father of insurance education” notes that any insurance industry needs people who are both knowledgeable and ethical as a precondition to prosperity. To him, high ethical standards allow a professional relationship between an agent and a client. With the same view, various systems have been in place to ensure Tanzania's insurance sector is growing on the basis of sound ethical principles. Insurance regulations provide for the code of ethics and practice for Tanzania's insurance sector. The second schedule advocates what is known as 'inter alia', which is adherence to the principles of 'Utmost good faith', which binds all insurance practitioners to provide service above self with a view of achieving a legitimate objective. Additionally, the second schedule on insurance regulations of 1998 consists of groups of rules under six general categories of doctrines- cum legal principle. These principles impose a duty to all insurance providers to ensure a duty of confidentiality within the sector, the principle of disclosure and misinterpretation of material information and the duty to practice fair trading with ethical consideration and provide for professional practice. Commissioner of Insurance is empowered by these regulations to regulate insurance, both ethical and professional issues.

(Kanywanyi, J.1998) noted that insurance is a profession on its own and therefore bound to have its own stamp of professionalism. With a shared view, Muruke (2002) proposed in her study that the insurance sector in Tanzania has to be administered along the ethical and professional line. To ensure this, the Commissioner of Insurance in Tanzania, among other duties, is responsible for ensuring that all practitioners adhere to the code of ethics and practice.

However, not everyone within the industry is adhering to professional standards and ethics. This can be seen through fraudulent claims and other malpractice in recent years. To curb this, Kanywanyi strongly proposed both institutional and organisational self-regulatory and central state regulatory systems to ensure that the business of insurance is conducted in an ethical and professional manner. One of the well-established systems is the Tanzania Insurance Regulatory Authority (TIRA) which is working in collaboration with other stakeholders in the prevention of frauds and other malpractice in Tanzania's insurance sector.

Generally, Fraudulent claims and other malpractice has been known for threatening the health of insurance markets across the world. Tanzania's code of ethics and practice in the insurance sector tend to focus more on practitioners, with no considerable attention given to policyholders. This is a loophole that often allows some policyholders in collaboration with professionals within the sector to receive a huge amount of money as compensation out of frauds. Therefore, Ethics should be part of our curriculum, and policyholders need to be educated on the impacts of fraudulent claims on others, the insurance sector and the national economy at large.

IV. TIRA IN A WAR AGAINST INSURANCE FRAUDS

Tanzania Insurance Regulatory Authority is the government agency established by the Insurance Act No 10 of 2009 with a duty of overseeing insurance services in the country. TIRA is under the Ministry of Finance and Planning. Studies show that Tanzania's insurance sector is not immune from fraudulent and other malpractices activities though the sector is relatively small. The Tanzania Insurance Regulatory Authority (TIRA) report of 2011 shows that auditing in accordance with International Standards on Auditing (ISA) and the International Standards of Supreme Audit Institutions (ISSAI) as means of identifying frauds through the assessment of the risks of material misstatements of the financial statements. Though this report does not show the magnitude of the problem but it gives a strategy for identifying the existence of it.

Tanzania Insurance Regulatory Authority (TIRA) report of 2015 sheds light on the criminal cases which were filed by the authority in courts. TIRA carried out activities that gear towards dealing with fraud in the insurance markets. The report shows that a total of fifteen (15) criminal cases were filed by TIRA in different courts to prosecute relevant culprits. In addition to that, fraudulent activities in Tanzania is contrary to section 161 of the Insurance Act.

Apart from that, The Tanzania Insurance Regulatory Authority (TIRA) is a member of the East African Insurance Supervisors Association (EAISA), which was established in December 2008. Other members are Agence de Regulation et de Controle des Assurances (ARCA), Burundi; the Insurance Regulatory Authority (IRA), Kenya; the National Bank of Rwanda (NBR) and the Insurance Regulatory Authority (IRA), Uganda. One among major issue during the signing of the Memorandum of Understanding (MOU) was fraudulent activities in the region and therefore established mutual assistance in that area among others by detection and reporting to the respective organs of fraudulent practices and money laundering in the insurance market.

V. RESEARCH METHODOLOGY

This paper employed both quantitative and qualitative approaches. The quantitative approach is relevant to the paper as it involved some statistical data. The qualitative approach found to be the most appropriate for this study the reason that it yields data that provide depth and detail to create an understanding of phenomena and lived experience. Both approaches allowed researchers to use multiple sources of data. This section, therefore, illustrates the research design, the targeted population, data collection methods and data analysis plan which was used for conducting this study.

a. Research Design

This study used a descriptive cross-sectional survey design, which enabled researchers to make a comparison between fraudulent claims and malpractices, which involved various insurance companies, brokers and agencies. This design allowed researchers to collect data from brokers, agencies and companies without bias. Furthermore, a descriptive cross-sectional survey design was appropriate because of categorical comparisons on ages and sizes. It also assisted researchers to describe the nature of fraudulent claims and malpractices in the insurance industry of Tanzania and responses proposed to counter them in ethical ways. Thematically analysis was used to describe fraudulent acts.

b. Target Population

The study involved 17 registered Insurance Companies, 61 Insurance Brokers, 72 Insurance agencies, 11 forensic investigators and 11 Loss Assessors in Tanzania. However, the study involved 92 policyholders and six officers from the Tanzania Insurance Regulatory Authority. This size of the population validated sampling procedures and allowed researchers to achieve specific objectives stated in this study.

VI. DATA COLLECTION

This study used primary data which both qualitative and quantitative. Primary data was collected using both structured and semi-structured questionnaires to various insurance stakeholders such as policyholders and executives in all Insurance companies, agencies and brokers. Questionnaires were distributed to loss adjusters, loss assessors, customers and executive employees of insurance companies. It was also important to involve private and forensic investigators in this study so as to understand fraud in the insurance sector—a total of 270 questionnaires distributed to a targeted population. The questionnaire was divided into three sections with a view of addressing research questions. The questionnaire consists of both open and closed-ended questions. The researchers used Google Forms which provided a fast way to distribute online questionnaires amidst the pandemic crisis. Thus, some questionnaires were distributed as Google Forms and responses collected in an online spreadsheet. Researchers conducted Key Informants Interviews which allowed them to enter into researcher to enter into respondents' perspectives. Focal persons were identified and selected purposively to act as key informants who did not participate in the filling questionnaires.

a. Data Analysis

The data obtained through Key Informants Interviews and the questionnaires were coded and categorised based on research objectives after being checked. Analysis of data based on descriptive statistics and all the data entered into statistical package for social sciences. Statistical descriptions presented mean scores and percentages. Mean scores revealed the magnitude of fraud claims, while percentages used to analyse strategies employed to eliminate fraud claims and corruptions in the insurance industry.

b. Data presentation

Data collection tools allowed researchers to obtained sufficient data, which were coded and categorised based on research objectives. Then, these data were entered into the Statistical Package for Social Sciences (SPSS). Findings from SPSS were described by using tables to give an understanding as to how frauds rooted in the insurance sector. As it is a sensitive issue, most responded opted not to disclose their

companies' names. A total of 270 questionnaires distributed to a targeted population, and 210 were returned. Therefore, the response is nearly 78% of all respondents involved. Key Informants Interviews gave more information that could not be available in questionnaires.

VII. DATA ANALYSIS

a. Table 1.1 Challenges that hinder the spread of Insurance in Tanzania.

The respondents were provided with spaces to outline the challenges that dwindle the spread of insurance in Tanzania. Results are as follows:

Challenges	No of Respondents	Percentages
Lack of insurance knowledge by the majority of Tanzanians	52	24.8
Informal insurance schemes	33	15.7
Shortage of expertise and well-trained professionals in the sector	31	14.7
Insufficient technology and markets innovations.	35	16.6
Fraudulent claims and corruption	51	24.4
Poor economic conditions among ordinary Tanzanians.	8	3.8
TOTAL	210	100

The results in Table 1.1 indicates that major problems which impede the growth of the insurance industry in Tanzania are lack of insurance knowledge by the majority of Tanzanians and Fraudulent claims, and corruption. Other challenges include poor economic conditions among ordinary Tanzanians, Shortage of expertise and well-trained professionals in the sector and informal insurance schemes such as family-safety nets and mutuality among co-workers.

b. Table 1.2 Factors that lead to the increase of frauds claims in Tanzania's insurance industry.

The respondents were requested to indicate factors that attributed to the rise of frauds claims in the insurance industry in Tanzania (open-ended question). The findings are as follows:

Factors	No of Respondents	Percentages
Financial difficulties	63	30%
Managers' failure to abide by the internal	34	16.1%
Inadequacy of Information Technology equipment	46	21.9%
Delay in dealing with genuine claims	67	32%
TOTAL	210	100%

The results in Table 1.2 indicates that policyholders perceived the delaying in dealing with genuine claims as a major cause of the rise of frauds claims. Hypothetically, The frauds claims in Tanzania largely contributed by opportunist by taking advantage of a genuine loss to commit fraud by claiming, together with genuine losses, for items that were not stolen. On the other hands, forensic investigators, insurance brokers and agencies believed that financial difficulties among Tanzanians attributed to the rise of fraud claims within the industry.

c. Table 1.3 Impacts of fraudulent claims on the insurance sector and economy of Tanzania.

The respondents were asked to indicate the extent they agreed that fraudulent claims affect the insurance sector and economy of the country. The statements generally touched on various possible effects such as increases premiums as an attempt to rectify loss-making portfolios, weakening insurance companies financially and shifting foreign insurance's investment to another country subsequently leads to unemployment and loss of revenue. The results are as follows;

Factors	No of Respondents	Percentages
Weakening insurance companies financially	69	41.1%
shifting of foreign insurance's investment to another country	43	25.6%
Increase of premiums	56	33.3%
TOTAL	168	100%

The results in Table 1.3 indicates that respondents from insurance companies are direct affected by fraudulent claims. However, respondents from customers/policyholders believe if the problems escalated, then premiums price will be raised, and that would subsequently affect their budgets.

d. Table 1.4 Possible measures to minimise fraudulent claims in Tanzania's insurance sector.

The respondents were provided with an open-ended question to suggest possible solutions to reduce or fight fraudulent claims in Tanzania. The question was addressed intentionally to get relevant suggestions from the stakeholders.

Possible solutions	No of Respondents	Percentages
Fraudulent claims on Social ethics subjects/courses	68	32.4%
Imposed strong internal mechanisms to detect any frauds	61	29.1%
Easing procedures for compensation	53	25.2%
Comprehensive management of agencies, brokers and assessors	12	5.7%
Preparation of curriculum on insurance and frauds	10	4.8%
Others	6	2.8%
TOTAL	210	100%

The results in Table 1.4 indicates that there are some possible solutions for minimising fraudulent claims. 32.4 per cent suggested the introduction of fraudulent claims on Social ethics subjects/courses, 29.1 per cent of respondents believed that set up of internal mechanisms to detect any frauds should reduce the menace of fraudulent claims, while 25.2 per cent of respondents proposed easing procedures for compensation. Additionally, 5.7 per cent believes fraudulent claims have mainly occurred on the level of agencies or brokers; therefore suggested comprehensive management of agencies, brokers and assessors. 4.8 per cent feel like insurance is still alien to Tanzanians; thus, there is a need to prepare a curriculum on insurance and frauds.

VIII.INTERPRETATION OF FINDINGS

From the findings, fraudulent claims is one among the leading challenge which facing the insurance sector in Tanzania and therefore, insurance stakeholders and government should take steps to minimise them. Generally, some possible solutions such as including fraudulent topic claims in ethics subjects in all levels, comprehensive management of agencies, brokers and assessors and Imposed strong internal mechanisms to detect any frauds. Furthermore, the findings of this study are consistent with the objectives as ethical measures have been proposed throughout data collections. While, it is clear that fraudulent claims have effects on insurance sectors such as raise of premiums to committed policyholders as an attempt to rectify loss-making portfolios, weakening insurance companies financially and shifting of foreign insurance's investments to another country subsequently due to ramparts frauds within the sector.

It is evident that the majority of Tanzanians are not aware of the importance of insurance as a service. Additionally, some people are aware, but still, they cannot afford premiums due to financial constraints. Some of those who managed to buy insurance products such as health and vehicles insurance as mandatory required by law tempted to use that opportunity to make money through fraudulent claims. There are some cases whereby fraudster, by the support of unprofessional brokers or agents, take advantage of a genuine loss to commit fraud by claiming together with a genuine loss of items. It is often due to weakness in an internal mechanism within insurance companies because of fraudulent claims in organised networks or individually. Though the Insurance sector remains an important economic sector, however, there is no enough investment in innovation and technology which can be used to detect fraudulent claims.

IX. CONCLUSION AND RECOMMENDATION

a. Conclusion

Therefore, this paper intends to analyse the problem and provide solutions from an ethical point of view. It should be noted that money lost through fraudulent claims compromises the ability of insurance companies to indemnity or make good claims of those who have loyalty paid their premiums for years and genuinely when suffered loss. Insurers might find themselves in increasing premiums and excess in an attempt to rectify loss, making portfolios if the fraudulent claims become unchecked. In that way, it is obvious, both insurance companies and policyholders are affected by frauds within the sector.

b. Recommendations

i. TIRA, in collaboration with other stakeholders, should continuously conduct staff training to improve knowledge on detecting frauds.
ii. Insurance companies should constantly evaluate their internal control systems.
iii. Insurance companies and agencies should set clear and standardised rules of behaviour that will be adopted in day-to-day business with well-defined responsibilities.
iv. Documents, reports, and data concerning decision-making should be made available on the website for anyone interested.
v. Decisions must be verifiable and reproducible. In order to minimise the risk of fraud, correct accounting is crucial: receipts and bills must be checked, and expenses, where possible
vi. The government, through its arm, TIRA, work hand in hand with the Prevention and Combating of Corruption Bureau to ensure that the public is educated on the impacts of fraudulent claims or any misconducts.
vii. The government needs to adopt risks management topics in the secondary curriculum and basic insurance in the university curriculum.

REFERENCES

[1]. Abramson, F. & Hollings, H. "Fraud Examination". Mason, OH: South Western, Cengage, Learning, 1999.
[2]. Albrecht, W. S., & Albrecht, C. O. "Fraud examination & prevention". Mason, OH: Thomson/South-Western, 2004.
[3]. Association of Certified Fraud Examiners (ACFE), 2012
[4]. Bolton, R., & Hand, D. "Statistical Fraud Detection": A Review. Statistical Science, 17(3), 235-249, 2002. Retrieved February 23, 2021, from http://www.jstor.org/stable/3182781
[5]. Clarke, M. "The control of insurance fraud: a comparative view. The British Journal of Criminology, volume 30, number 1, winter, pp. 1–22, 1990.
[6]. Doig, A., Jones, B. & Wait, B. "The Insurance Industry Response to Fraud". Secur J 12, 19–30 (1999). https://doi.org/10.1057/palgrave.sj.8340027
[7]. Duffield, G. and P. Grabosky, "The Psychology of Fraud, In Trends and Issues in Crime and Criminal Justice", Australian Institute of Criminology, 2001.
[8]. Insurance Act No 10, 2009
[9]. Insurance Crime Bureau of South Africa, 2019.
[10]. Insurance Outlook Report 2019/2020, East Africa
[11]. Kanywanyi, J. "Ethics and Professionalism in a competitive Insurance Market- the Case of Tanzania," a paper presented at 2nd Tanzanian Annual Insurance Day Seminar, Dar es salaam, 1998.
[12]. _____ "Challenges in Insurance Industry in Eastern and Southern Africa sub-region in a view of Liberalisation and Privatisation" a paper presented at the O.E.S.A.I's 18th Annual General Meeting and Seminar, Dar es salaam, 9th May 1995.
[13]. Kilemi, R. "Factors Influencing Fraudulent Claims by Employees in Selected Main Insurance Companies in Nairobi",(Unpublished Master's thesis 2018).
[14]. Schiller, Joerg. (2006). The Impact of Insurance Fraud Detection Systems. Journal of Risk & Insurance. 73. 421-438. 10.2139/ssrn.377740.
[15]. Tanzania Insurance Regulatory Authority (TIRA) report of 2011
[16]. Tanzania Insurance Regulatory Authority (TIRA) report of 2015
[17]. Weisberg, H. I. and R. A. Derrig, 1991, Fraud and Automobile Insurance: A Report on Bodily Injury Liability Claims in Massachusetts, Journal of Insurance Regulation, 9(4):497–541
[18]. Zainab Muruke, "Challenges and effects of liberalisation of the insurance industry in Tanzania: Law and practice"(Master's thesis, University of Dar es Salaam…, 2002) 21-26