



**THE EFFECT OF FRAUDULENT PRACTICES ON THE GROWTH OF THE INSURANCE INDUSTRY IN KENYA: A
CASE OF SELECTED INSURANCE COMPANIES**

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CASE OF SELECTED INSURANCE COMPANIES**

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ABSTRACT

The aim of this report was to investigate the level of fraud in the insurance companies and how it is affecting growth of the industry. CFC Life, Britam and Jubilee Insurance companies are all headquartered in Nairobi with various branch networks all over the country. The research was geared to determine if high levels of fraud among the representatives of the companies and/or clients is the major contributor to the slow growth process of the insurance sector, which has seen litigations, loss of jobs and low public confidence in its importance as a key economic growth factor.

The study sought to analyze the effect of fraudulent practices on the growth of insurance as the background of the problem by following up on the causes of fraud in the insurance companies under the study and how it is affecting their reputation. The report further justified the study and its significance as fraud is one of the major vices that we have in society and no effort should be spared in finding out how best to handle it especially among the major companies and areas that it is prevalent. In the report, limitations of conducting the study were also put on perspective and how the researchers countered the limitations.

A rich review of literature was done by studying materials already done by other people; by reading newspapers, books, internet, comparing this work with fraud activities reported in other regions and analyzing fraud reports that have a particular reference to the study. The study compared insurance fraud in Kenya and the developing countries. It also pursued the impact of fraud on the economy of the country. Causes of fraud in Kenya were also examined and the initiatives the governments should introduce or reinforce to curb this problem.

Survey research design was used in the study and a representative sample size of 290 selected to represent the whole population. Stratified sampling technique was used to get the respondents and questionnaires were employed to gather primary data as well as interviews among the different insurance companies to get the coherent picture on the fraud situation on the ground. Data collected underwent four processes of analysis to make it easy to compare and contrast and also to enhance operation of mathematical manipulation.

This research work is important as the data received helped in recommending the steps to be taken to curb fraud and evaluate the effectiveness of the mechanism put in place to guard against fraudulent incidences in the companies that offer insurance. It will also be used as a measure to determine the level of confidence that the people have in taking up insurance products. Further to these, the report sought to establish if adequate resources and efforts are put in place to fight fraud as well as the recognition and comprehension of the effects of fraud by the insurance company's management teams.

Key Words: Fraud, Industrial Growth, Insurance Sector

INTRODUCTION

Insurance is defined as a contract in which the insured transfers risk of potential loss to the insurer who promises to compensate the former upon suffering loss (Kariuki, 2013). The insured then pays an agreed fee called a premium in consideration for this promise. The promisor is called the Insurer and the promisee is called the Insured, Lowe (2009). Insurance premium is the monetary consideration paid by the Insured to the Insurer for the cover granted by the Insurance policy.

The Insurer takes on a number of clients (Insured) who pay small premiums that form an aggregate fund called the premium fund, Insurance theory Concepts (2010). The likelihood of an event or loss may be mathematically calculated or it may be based on the statistical results of past experience in order to determine the amount of premiums that would be required to accumulate a common fund or pool, to meet the losses upon their arising Grose (2009). Insurance is based on the operation of large numbers or averages, where risks are pooled together through paying small premiums which are a small portion of the insured values and aggregated to form a premium fund out of which those who suffer loss are compensated Young (1994).

The insurance sector plays a key role in economic development since it is an infrastructure pillar of the financial services sector and the economy as a whole (Olima, 2010). The economic importance of the insurance sector has been increasing in most developing countries. Insurance companies form a growing part of the domestic financial sector. They have also become significant players in the international capital markets. Gordon (2013) adds that insurance reduces the economic waste occasioned by destruction of property by works such as fire, floods, storms and other natural calamities. Insurance is a mobilizer of savings for the financial and investment sectors of the economy.

Many consumers may not be aware of the prevalence of insurance fraud nor the trickle

down negative impact it causes. Insurance fraud is the second most costly white collar crime and also one of the most often carried out crimes in the country. Consumers should know that in addition to being wide-spread, insurance fraud also affects everyone.

Principles of Insurance

Insurance is operated on certain conventional principles and according to Elements of Insurance (2012), the timing or occurrence of the loss must be uncertain. The rate of losses must be relatively predictable to enable the insurer to estimate accurately the premiums vis-avis the risks. Ivamy (2011) argues that the larger the number of homogenous exposures considered, the more closely the losses reported will equal the underlying probability of loss. This requires that the insured's' experience must be more or less homogenous and Harrows (2010) argued that if the opposite is true, the insured persons who present fewer or smaller claims will feel that the premiums asked from them are too high considering the benefit they derive from the pool and in comparison with the premiums they would be charged by other pools. This may then lead to the collapse of the pool. According to Sabera (2009) insurers need to know how much they would be required to pay when the insured event occurs.

Statement of the Problem

Despite the uptake of insurance products having registered reasonable growth over the years, the penetration levels as represented by the ratio of Gross Direct Premiums to Gross Domestic Product (GDP) stood at 3.16% as at end of 2012 (Insurance Industry Annual Report, 2012) .This may look comparatively reasonable viewed against similar numbers for Sub-Saharan economies which stand at rates below 1%. However, bench-marked against peer states in the Southern African Region, Kenya is way below.

The low penetration rate was attributable directly to a number of factors including

unhealthy competition, apathy by consumers due to poor image, pervasive fraud and low levels of consumer awareness (T.Gichuhi, Executive Chairman, Association of Kenyan Insurers, 2012) All the reasons given above may be attributable to undesirable behavior by intermediaries. This in turn translated to inadequate profit levels for the insurance sector in Kenya. Kenyan insurance companies generally reported high loss ratios. Between 2010 and 2013, the loss ratios for the industry as a whole ranged between 56% and 60%. Insurers have traditionally relied on investment income to act as a cushion for their underwriting results. (2006-2013, PwC)

It was also a problem to the intermediaries themselves as distrust by the market led to lower sales, lower commissions and lower uptake of insurance sales as a career of choice. A population that is not receptive to insurance in turn suffered the following problems; Inadequate cover against exposure to hazards; insufficient investments/savings for future; Social imbalance occasioned upon the inevitable demise of breadwinners.

The pervasiveness of insurance fraud drove up costs for all consumers and cost the insurance industry millions of shillings each year (Forbes 2010). Detecting insurance fraud was found out to be difficult because of the clandestine nature by which the criminal perpetrates the fraud. The research focused on the general industry as a case in point to come up with ways of solving the problem. Insurance fraud imposed personal costs such as disrupted lives and families, humiliation and depression, lost jobs and bankruptcy.

Dishonest insurance agents pocketed client insurance premium meant to service the clients' policies, leaving the clients dangerously uncovered. The agents also increased a policyholder's premiums by secretly adding unwanted coverage to clients' policies in order to benefit financially (Fraud practices mitigation report 2011). This led to serious integrity issues and reduced the public confidence in insurance companies once a victim found out about the fraud activities.

Objectives of the study

The key objective of the study was to establish the effect of fraudulent practices on growth of insurance industries in Kenya. The Specific Objectives were to find out how misrepresentation of products and misappropriation of premiums affected the growth of insurance companies in Kenya.

Research Questions

1. How did misrepresentation of products affect the growth of insurance companies?
2. What was the effect of misappropriation of premiums to the growth of the insurance companies?

Scope of the study

The study was conducted in three insurance firms namely CFC Life, Jubilee Insurance and Britam and covered human resource departments, risk and compliance departments, finance departments, agency services departments and administration departments as well as internal security organs. All respondents in each of the mentioned areas were of great help in successfully carrying out the exercise. The insurance industry has a high literacy level with the majority of the employees holding degrees. Due to the high literacy level, some employees devise ways of hacking the systems and swindling the company millions of money through their advanced technological knowhow.

Theoretical Review

a) White Collar Crime theory

Edwin Hardin Sutherland (1924) in his leading text *principles of Criminology* first stated the principle of differential association that the development of habitual patterns of criminality arises from association with those who commit crime rather than with those who do not commit crime. The theory also had a structural element positing that conflict and social disorganization

are the underlying causes of crime because they determine the patterns of people associated with them. He remained convinced that social class was a relevant factor, coining the phrase *white-collar criminal* and went ahead to define *White-Collar Crime* as "approximately as a crime committed by a person of respectability and high social status in the course of his occupation." This involves criminal acts of corporations and individuals in corporate capacity. The theory of differential association stated that crime is learnt, not genetic and it is learnt from intimate personal groups.

b) Fraud Triangle theory

Donald R. Cressey (April 27, 1959) developed the fraud scale. Cressey found three offender types which are: Independent businessmen, long term violators, and absconders. Independent businessmen are involved in "Borrowing" and they keep the funds for themselves, while long term violators are involved in "Borrowing" to protect family. The absconders take the money and run and they are usually unmarried, loners who blame "outside influences" or "personal defects for their actions. He created the fraud triangle as below.

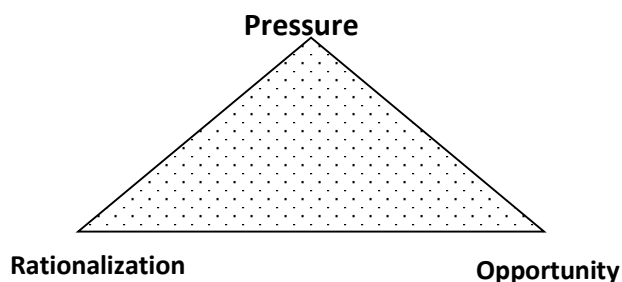


Figure 1. Fraud triangle

(He noted that there are non-sharable Problems which include: Violation of ascribed obligations, personal failures, business reversals, physical isolation, gaining status and employer-employee relations.

Pressure is financial, vice and work related while opportunity is in the controls around the working environment, accounting and procedures. Opportunity also is affected by performance

quality, disciplining perpetrators, access to information, ignorance, apathy, incapacity and the audit trail. Rationalization is enhanced by perceptions that they owe me, nobody will get hurt, I deserve more and it's for a good purpose.

c) Fraud Scale theory

W. Steve Albrecht (1986) came up with nine motivators of fraud which include: Living beyond means, overwhelming desire for personal gain, high personal debt, and close association with customers, pay not commensurate with job, and wheeler-dealing, strong challenge to beat system, excessive gambling and family/peer pressure. He developed the fraud scale which had:

Situational pressures (Immediate problems with environment and usually debts/losses incurred by people), perceived opportunities (brought about by poor controls), Personal integrity (which is influenced by individual code of behavior).

d) Clark Study theory

They unlike Cressey and Albrecht after performing a study of 10,000 american workers concluded that employees steal primarily as a result of workplace conditions and that the true costs of the problem are vastly understated. Hollinger-Clark did conclude however that five separate but interrelated sets of factors were significant in understanding occupational fraud. This factors are: External economic pressures, contemporary employees especially younger ones were not as honest and hardworking as those of prior generations, any employee can be tempted to steal, most employee theft was to some degree a result of job dissatisfaction, theft occurs because of the broadly shared formal and informal structure or norms of the organization. The above theories show that perpetrators of fraud feel justified and this must be countered, morally, legally and the consequences of fraud criminalized. In the concept of wages-in-kind organizations should hire the right people, treat them well and have reasonable expectations from the employees. The controls instituted must pose a visible and highly likely threat of

apprehension because perception of detection is the greatest deterrent. Hidden controls do not deter fraud and the controls cannot be predictable. It is based on this research gaps that this study will be undertaken to bridge the gap as insurance fraud has continued to exist even with the existence of previous studies as gathered in this literature review.

Conceptual Framework

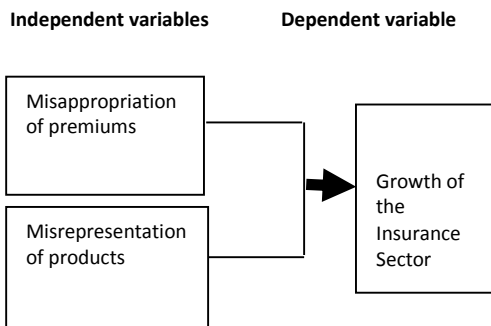


Figure 2. Conceptual Framework

Misappropriation of premiums

According to Njuguna and Arunga (2013), this refers to the use of diversion of clients' payments against cover to unintended use by the agents themselves. It would have the effect of leaving the affected clients exposed to loss even after meeting their obligation. Premium diversion is the embezzlement of insurance premiums and it is the most common type of insurance fraud (FBI 2013). Another common premium diversion scheme involved selling insurance without a license, collecting premiums and then not paying claims

Misrepresentation of products

Consequent to the pressure to earn more and meet set targets by the underwriters, sales people deliberately gave false information to target clients to obtain buy-in. This may also have been caused by poor training, which led to the sales-person themselves unaware of certain crucial details that they needed to pass on to clients. (Healy Scanlon, 2012) Across the spectrum of different insurance products, from life insurance to fire insurance to homeowners' insurance a constant in the underwriting process

was the use of information provided in the application as a means to calculate risk.

Underwriters reviewed the information and determined whether to accept the risk and what premium to assign in large part based on the information submitted by the insured. Once an agent misrepresented the product the underwriter could end up issuing a wrong cover to a client that was not intended for in the first place. Once the client discovered the anomaly they cancelled the cover and multiple cancelations ultimately led to stunted growth of the insurance sector (AKI Report, 2011)

Empirical Review

Insurance dates back, as old as the story of mankind and the instinct which prompts the businessman of today in securing themselves against any incidental occurrences which existed among primitive men back then. There was the need to avert the consequences of these incidental occurrences' to make some sort of sacrifice in order to achieve security. The concept of insurance is a development of the recent past, especially after the industrial era, which dates back almost 6000 years ago (Ivamy,2013).

The essence of the insurance contract lies in the elimination of the uncertain risks of loss by the individuals or business entities through a combination of a large number of similarly exposed individuals and business entities to a common fund premium payment sufficient enough to make good the loss caused to the individual or entity in question (Lowe, 2009). Insurance operates on the principle of pooling risks where the people contribute to a common fund in form of premiums and where the lucky ones who do not suffer loss help the unlucky ones who suffer loss during a defined insurance period (Irukwu, 2006). Modern society is plagued with so many risks in the daily life undertakings such that a system of ensuring that one who suffers loss is duly and adequately compensated became most appropriate.

The Insurance business has accordingly become more necessary than ever before. Insurance seeks to restore an insured to the economic position occupied just before suffering loss (Young,1994). These risks are pooled together and transferred to another person or entity whereby a large number of people faced with similar risk transfer the same to another person, the insurer, who specializes in uncertainty bearing in consideration of those insured persons paying proportionately small amounts of money called premiums. The Insurer promises to compensate the insured when the risk insured against, materializes (Ngobi, 2008). When a large number of people pay these relatively small and affordable sums in the form of premiums, they form an Insurance pool from which the Insurer settles Insurance claims (Clare Chou Chua, 2010).

Critique of Literature

Insurance professionals remain skeptical about industry efforts to combat fraud, according to Insurance Times research (2014). The survey, carried out to mark the launch of the Insurance Times's Fraud Charter initiative, showed that barely one in 20 (6%) respondents believe that existing moves will be sufficient to tackle the issue of insurance fraud. They were overwhelmed by 68% respondents who believe that the initiatives, established by the industry players, will not be enough. The survey also shows that 70% of industry professionals reported an increase in fraud over the past year, while 64% believe many policyholders think it is acceptable to make a fraudulent claim.

Insurance fraud occurs when any act is committed with the intent to fraudulently obtain some benefit or advantage to which they are not otherwise entitled or someone knowingly denies some benefit that is due and to which someone is entitled. According to the United States Federal Bureau of Investigation the most common schemes include: Premium Diversion, Fee Churning, Asset Diversion and Workers Compensation Fraud. The perpetrators in these

schemes can be both insurance company employees and claimants.

Fraudulent claims accounts for a significant portion of all claims received by insurers, and cost billions of shillings annually. Types of insurance fraud are very diverse, and occur in all areas of insurance. Insurance crimes also range in severity, from slightly exaggerating claims to deliberately causing accidents or damage. Fraudulent activities also affect the lives of innocent people, both directly through accidental or purposeful injury or damage, and indirectly as these crimes cause insurance premiums to be higher. Insurance fraud poses a very significant problem, and governments and other organizations are making efforts to deter such activities.

It is because of the persistence of fraud activities and the lack of proper initiatives that have necessitated different studies in different parts of the world. The studies have not conclusively helped sort the problem. This study focused on the solutions that can benefit the local insurance industry to curb fraud activities in order to improve on growth in the insurance industry.

Research Gap

Previous research done by Verma (2013), proved that researchers have continuously focused on the individual fraud arising in the insurance industry without due consideration of the bigger problem this causes to the perceptions held by people about insurance. Research has not clearly shown the link between the fraudulent activities in the insurance industry and the slow uptake of insurance by the masses (Growth Impeded). This study set out to find out the causes of the fraud associated with insurance and it outlines ways of improving the situation in order to ensure confidence among the people as well as explore ways of spurring growth in the companies that deal with insurance.

RESEARCH METHODOLOGY

Research design

The research was a descriptive survey within which the overall research was conducted. It was the blue print for the collection, measurement and analysis of the data collected. There was a need for research design in this project in order to facilitate advance planning of data collection methods and analysis techniques to ensure availability of time, staff and other resources. Research design was also crucial in helping in the organization of ideas and a framework within which the study was conducted and to look for mistakes and other shortages long in advance before they were done. It was also helpful in facilitating smooth production of research within minimum expenditure and maximum value.

Survey research design was used in this project proposal. This design method was used because of the low cost and easy accessibility of information. It is worth to note that conducting accurate and meaningful surveys is one of the most important facets of research. The survey research design was a very valuable tool for assessing opinions and trends. Even on a small scale, such as small businesses, judging opinion with carefully designed surveys dramatically changes strategies.

Target population

The study target population was the insurance companies with their headquarters in Nairobi. There are a total of 49 insurance companies in Kenya. All of these companies in Kenya are regulated, supervised and developed by the Insurance Regulatory authority. The three companies in this case study were the leading diversified financial services providers in the insurance industry. They offer a wide range of insurance and asset management services to individuals, small businesses, corporations and government entities. British-American has a global presence in London, Mauritius, Malta, Kenya, Uganda, Rwanda and South Sudan. Jubilee insurance is the oldest insurance company in Kenya and has offices in Burundi, Mauritius, Tanzania, and Uganda. CFC Life has a presence in eleven countries in Africa. All of the three companies have a large asset base that has

helped their sustenance over the years and the depth of their operations in Kenya made them the most suitable target in providing material for this research work to represent the whole population. In addition to these all the three companies have Anti-Fraud Policies which is an added advantage to the code of business ethics that they operate in.

The study was about the effects of fraud in the growth of the insurance industry. The report sought to find out the extent of fraud, review the security apparatus used around taming fraud and get first hand information on concerns of the company management in light of the problem of fraud.

Sample size and sampling techniques

A sample of 6% of the target population was used which consisted of the staff of CFC Life, Britam and Jubilee Insurance companies. The respondents included women, men, department heads, security staff, subordinate staff as well as agents working for the insurance companies under the study.

According to the 2013 Insurance Regulatory Authority report the approximate number of agents and staff for the three companies under the study; CFC Life, Britam and Jubilee were 4500 people. The sample size that was used in the study was efficient, effective, representative, reliable and flexible to use in covering the many insurance companies in Kenya today.

Table 1. Sample size

Name of the company	Total population	Sample size	Percentage
CFC LIFE	608	36	12
BRITAM	2532	152	52
JUBILEE	1700	102	35
Total	4840	290	100

The sampling technique is the method used to select the items to include in the sample from the population. Stratified sampling technique was used to select each group of respondents to

participate in the study. Stratified sampling is a method of sampling from a population and it is used when the population is heterogeneous, or dissimilar, where certain homogeneous, or similar, sub-populations can be isolated into groups or strata. The sub-populations in the companies under the study vary considerably and each sub-population (stratum) was sampled independently out of which individual elements were randomly selected.

Data collection techniques

Techniques used in the data collection included questionnaire method and abstraction from records. In the Questionnaire Method, a list of standard questions was prepared to fit the inquiry of this study. The questionnaire was sent by post to the selected departments in the respective companies accompanied by a letter explaining the purpose of the study and a self addressed envelope. The letter also contained the time period that the questionnaire was to be re-posted as they were left with the respondents to be picked within a period of time. The method was free from personal bias.

Abstraction from records was used to collect secondary data whose main sources are journals, library books and newspaper commentaries among others. In using this method, attention was focused on the purpose of the data, how the data was collected, how it was summarized and presented, the accuracy of the data and the interpretation to be made. Abstraction method of data collection had advantages which included a cheap collection of information, as the materials were readily available. It took less time to get the required information and a large quantity of data was available on the subject.

Data analysis

The data collected underwent four processes in its analysis.

Data editing was done first. Once the raw data was obtained, editing was done where omissions, cancellations, duplications or any errors were eliminated from the data. Original responses were however not changed. The data was checked for accuracy and logged in; into the

computer; transforming the data; and developing and documenting a database structure that integrated the various measures.

Coding followed the data editing. In coding, absolute values or scores were assigned to some attributes observation or judgment. This is called descriptive statistics which was used to describe the basic features of the data in the study. They provided simple summaries about the sample and the measures. Together with regression model of data presentation and simple graphics analysis, the descriptive statistics formed the basis of virtually every quantitative analysis of data. Classification was then done by data being classified into groups or intervals with similar characteristics. Mass data was condensed through classification. Finally tabulation was done by different variables in the data being put in one table to make it easy to compare and contrast and further to enhance operation of mathematical manipulation.

3.6. Regression analysis

Regression analysis was conducted for prediction and forecasting. It was used to determine the relative impact of factors such as misappropriation of premiums and misrepresentation of products for the same service on the growth of the Insurance Sector. The regression model was as below:

$Y = X_1 + X_2$, where:

Y = Growth of the insurance sector.

X_1 = Misappropriation of premiums.

X_2 = Misrepresentation of products.

The regression analysis also produced a correlation, coefficient of determination and analysis of variance. Correlation sought to show the nature of relationship between dependent and independent variables, while coefficient of determination showed the strength of the relationship. Regression analysis further estimated the conditional expectation of the dependent variable given the independent variables that is, the average value of the dependent variable when the independent variables are fixed.

FINDINGS AND DISCUSSION

Response Rate

The sample of the study comprised of 290 respondents. The research instrument was administered to the respondents who completed the questionnaires on the spot or later returned the completed instrument. Out of the 290 questionnaires administered, 288 were fully filled and returned. This was a response rate of 99% as displayed in Table 4.1 below.

This response rate is adequate and conforms to assertions by Mugenda and Mugenda (2003) that a 50% response rate is adequate for analysis and reporting, a rate of 60% is good while a response rate of 70% and over is excellent. Non-responses were attributed to unavailability of respondents even with persistent follow ups and the respondents considering the information sensitive.

Reliability and Validity

Reliability refers to the extent to which a measuring instrument contains variable errors that appear inconsistency from observation during any one measurement attempt or that vary each time a give unit is measured by the same instruments. Cronbach's alpha of well above 0.7 implies that the instruments were sufficiently reliable for the measurement. As most items total correlation were reasonably high, the construct validity of the instruments was considered reasonable.

Table 2. Reliability and validity

variable	Coefficient Reliability
Misappropriation of premiums	0.952
Misrepresentation of product	0.933

General Information

Gender of the respondent

It was paramount for the study to determine the respondent's gender to ascertain gender parity

in the insurance industry in Kenya. According to the analysis, majority of the respondents were male represented by 80% while 20% were female.

Age of the respondents

According to the findings 51% of the respondents were between 35 to 44 years of age. 17% were 45 to 54 years, 21% were 55-64 years of age and 1% and 10% 18 to 34 years of age.

Marital status

From the findings majority of the respondents were married which was a total of 223; these who were single were 40 respondents while the divorced respondents were 10. Those who were widowed were 4 and 5 respectively for the men and women. While those who were separated were 6 out of the number that responded.

Level of education

According to the finding 68.6% indicated that they had university level of education, 7.3% indicated that they had secondary level 14.6% indicated that they had school dropouts while 3.5% which consisted of one person had primary level of education.

Department

According to the finding the majority of the respondent worked as field staff which was 73% and followed by the underwriters who were 12% of the respondents. Compliance and Administration were 5% each.

Form of insurance fraud

The Respondents were required to state the form of insurance fraudulent activity that the company management or independent auditors have identified within their company and the results are as below.

Insurance Fraudulent Activities Identified by Management

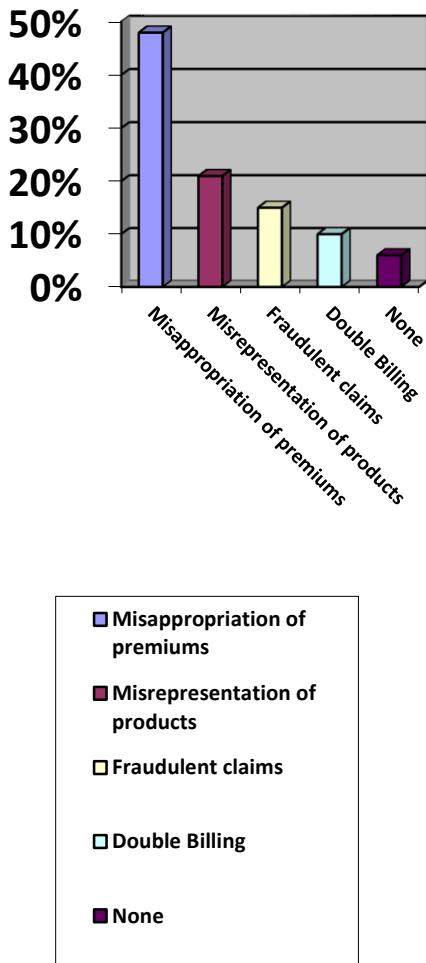


Figure 3. Forms of insurance fraud

From the findings it was clear that the form of fraudulent that had been identified by most of the company management or the independent auditors was Misappropriation of premiums. This was followed by the Misrepresentation of product and then Fraudulent claims. The form that had the list number is the double billing. At the same time there are those who stated that there was none of the forms of the fraudulent was identified in their company.

Study variables

Misappropriation of premiums

The study sought to find out whether there is misappropriation of premiums and the effect of this on the growth of insurance companies. This

is in line with the literature review According to Njuguna and Arunga (2013); this refers to the use of diversion of clients’ payments against cover to unintended use by the agents themselves. It will have the effect of leaving the affected clients exposed to loss even after meeting their obligation.

Extent to which Misappropriation of premiums affected the growth of insurance companies

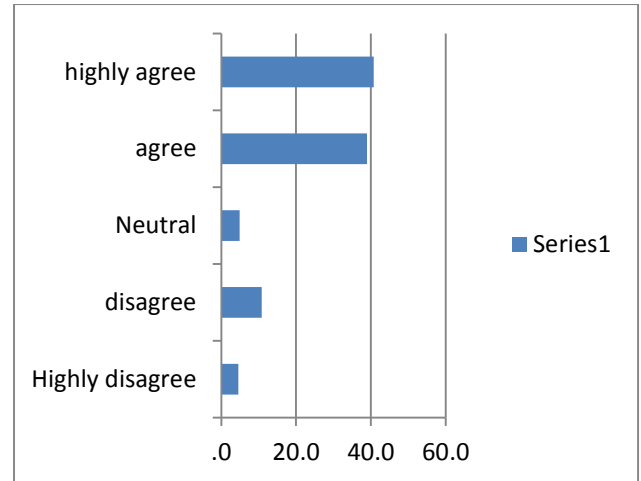


Figure 4 Extent to which Misappropriation of premiums affected the growth of insurance companies

According to the finding ,41% of the respondent stated that they highly agree Misappropriation of premiums affected the growth of insurance companies. 39% of the respondents agree that the Misappropriation of premiums affected the growth of insurance companies. 5% were neutral 11% disagree while 4% highly disagree .

Table 3 position about the effect of misappropriation of premiums on the growth of the insurance companies

Misappropriation of premiums	Highly Disagree	Disagree	Neutral	Agree	Highly agree	Mean	Standard Deviation
My company has put in clear strategy to manage misappropriation of premiums	4.5	10.8	4.9	39.0	40.8	4.01	1.140

My company has risk assessment checks to arrest misappropriation of premiums	6.3	10.5	3.5	35.2	44.2	4.0	1.212
Training policy framework should allow inputs from stakeholders	5.9	11.1	3.8	37.6	41.5	3.9	1.199
I am fully sensitized on misappropriation of the premiums	9.8	4.9	1.7	24.7	58.9	4.1	1.285
I have witnessed a case of an agent engaging in theft of premiums	5.6	10.8	5.6	36.6	41.5	3.9	1.187
Premium misappropriation has affected the performance of the company	7.3	7.0	3.1	28.6	54.0	4.1	1.221
The misappropriation of premium is a common issue in the organisation	8.4	9.8	6.3	32.4	43.2	3.9	1.280
The misappropriation of the premium leaves the affected clients exposed to loss even after meeting their obligation	10.1	6.6	3.8	30.7	48.8	4.0	1.306

From the finding, the respondents indicated that their Companies had put in clear strategy to manage misappropriation of premiums and that their companies had risk assessment checks to arrest misappropriation of premiums indicated by a mean of 4.01 for both. Also it was indicated that misappropriation of the premium leaves the affected clients exposed to loss even after meeting their obligation which has similar mean of 4.01.

It is also clear the companies sensitized clients on misappropriation of the premiums; this was indicated by a mean of 4.18 and a standard deviation of 1.285. The findings also found out that the misappropriation of premium is common and that issue in the organisation and Premium misappropriation has affected the performance of the company, this is represented by the mean of 3.92 and 4.15 and the standard deviations of 1.280 and 1.221 respectively.

Misrepresentation of product

The study sought to find out the effect of Misrepresentation of product on the growth of insurance companies.

The extent to which Misrepresentation of product affected the growth of insurance companies

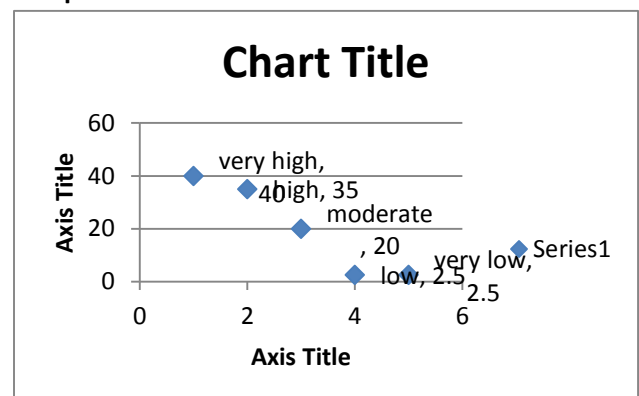


Figure 5. The extent to which Misrepresentation of product affected the growth of insurance

From the finding ,40% of the respondents rated the extend to which Misrepresentation of product affected the growth of insurance as

very high, 35% of the respondents rated the extents to which Misrepresentation of product affected the growth of insurance as high, 20% the respondents rated the extent to which Misrepresentation of product affected the growth of insurance as moderate , while 2.5%of the respondents rated the extents to which which Misrepresentation of product affected the growth of insurance as low and very low respectively.

Table 4 Position about the influence of Misrepresentation of product on the growth of insurance companies.

Misrepresentation of product	Highly Disagree	Disagree	Neutral	Agree	Highly agree	Mean	Standard Deviation
My company has ensured agents and brokers are trained to avoid misrepresentation of products	6.6	10.5	2.4	33.1	47.4	4.04	1.231
My company has ensured that the insured is provided with all the necessary information in writing to avoid misrepresentation of products	5.2	11.5	5.6	41.1	36.6	3.92	1.162
The clients are sensitized on the misrepresentation of the product.	5.6	10.5	5.2	33.4	45.3	4.02	1.196
My company carries out regular customer awareness campaigns	6.3	9.8	4.9	36.6	42.5	3.99	1.197
Sales people deliberately give false information to target clients to obtain buy-in.	5.9	11.1	7.0	35.2	40.8	3.94	1.207
Product misrepresentation is caused by poor training, which leads to the salesperson themselves unaware	6.6	9.4	6.6	38.0	39.4	3.94	1.197
Once an agent misrepresents the product the underwriter can end up issuing a wrong cover to a client that was not intended for in the first place.	7.7	10.5	6.3	31.7	43.9	3.94	1.269
Once the client discovers the anomaly they can cancel the cover and multiple cancellations ultimately lead to stunted growth of the insurance	8.7	9.8	7.7	28.6	45.3	3.92	1.305

Product misrepresentation can be avoided if the company considers the best approach to handle it.	9.4	9.8	5.2	32.4	43.2	3.9	1.311
My company usually sends information to the consumer to ensure they were provided with accurate information and they signed to the same	0	4	26	13	57	4.01	1.33

From the finding the respondents indicated that their companies have ensured agents and brokers are trained to avoid misrepresentation of products as indicated by mean a of 4.04 with 47.4% highly agreeing and a standard deviation of 1.321. It also indicated that the clients are sensitized on the misrepresentation of the product as indicated by a mean of 3.92 and a standard deviation of 1,162 with 36.6 highly agreeing with the statement. The finding also indicated that the clients are sensitized on the misrepresentation of the product and that companies represented by mean of 4.04 and 3.99 respectively. The respondents also indicated that the their company usually sends information to the consumer to ensure they were provided with accurate information and they signed to the same and that Product misrepresentation can be avoided if the company considers the best approach to handle it, this is indicated by the means of 4.01 and 3.9 respectively

Regression analysis

This section presents a discussion of the results of inferential statistics. The researcher conducted a multiple regression analysis so as to investigate the effect of fraudulent practices on the growth of the insurance industry in Kenya; a case of selected insurance companies. The researcher applied the statistical package SPSS to code, enter and compute the measurements of the multiple regressions for the study. Findings are presented in the following tables;

Table 6 Model Summary

Model	R	Adjusted R Square	Std. Error of the Estimate
1	.758 ^a	.575	.562

- a. Predictors: (Constant) Misappropriation of premiums, Misrepresentation of product
- b. Dependent variable: Growth of the insurance industry

Coefficient of determination which is R² explains the extent to which changes in the dependent variable can be explained by the change in the independent variables or the percentage of variation in the dependent variable (Growth of the insurance industry) that is explained by all the 4 independent variables (Misappropriation of premiums, Misrepresentation of product).

The four independent variables that were studied, explain 57.5% (refer to .575 above) of variance in growth of the insurance industry as represented by the R². This therefore means that other factor factors not studied in the research contribute 42.5% of variance in the dependent variable. Therefore, further research should be conducted to investigate into the other factors that influence growth of the insurance industry in Kenya.

Table 4.10. ANOVA (Analysis of variance)

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	28.888	4	7.222	95.718	.000 ^a
	Residual	21.351	283	.158		
Total		50.239	287			

- a. Predictors: (Constant), Misappropriation of premiums, Misrepresentation of product.
- b. Dependent Variable: growth of the insurance industry

The F critical at 5% level of significance was 3.54. Since F calculated is greater than the F critical (value = 95.718), this shows that the overall model was significant. The significance is less than 0.05, thus indicating that the predictor variables, (Misappropriation of premiums and Misrepresentation of product) explain the variation in the dependent variable which is growth of the insurance industry. Subsequently, we reject the hypothesis that all the population values for the regression coefficients are 0. Conversely, if the significance value of F was

larger than 0.05 then the independent variables would not explain the variation in the dependent variable.

Table 4.11: Multiple regression analysis

Model		Unstandardized Coefficients		Standardized Coefficients	
		B	Std. Error	Beta	Sig.
1	(Constant)	3.632	.454		.025
	Misappropriation of premium	-3.254	0.070	-.243	.000
	Misrepresentation of product	-1.132	0.001	-.175	.005

From the regression findings, the substitution of the equation ($Y = \beta_0 + \beta_1X_1 + \beta_2X_2$) becomes:
 $Y = 3.632 - 3.254 X_1 - 1.132X_2$.

Where Y is the dependent variable (growth of the insurance industry), X₁ is misappropriation of premiums, X₂ is misrepresentation of product.

According to the equation, taking all factors (Misappropriation of premiums, Misrepresentation of product) constant at zero, growth of the insurance industry will be 3.632. The data findings also show that a unit increase in misappropriation of premiums variable will lead to a -3.254 increase in growth of the insurance industry; a unit increase in misrepresentation of product will lead to a -1.132 increase in growth of the insurance industry. This means that the most significant factor is misappropriation of premiums.

At 5% level of significance and 95% level of confidence, misappropriation of premiums had a 0.000 level of significance; implying that the most significant factor is misappropriation of premiums.

SUMMARY OF FINDINGS

Misappropriation of premiums

From the findings, majority of the respondents indicated that misappropriation of the premiums affected the growth of the insurance companies by having the majority agreeing that it affected. It was also found out that Companies had put in clear strategy to manage misappropriation of premiums and that their companies had risk assessment checks to arrest misappropriation of

premiums. The findings also found out that the misappropriation of premium are a common issue in most companies and that the organisation and Premium misappropriation has affected the performance of the company. This is in line with the literature review that This requires that the insured's' experience must be more or less homogenous and Harrows (2010) argued that if the opposite is true, the insured persons who present fewer or smaller claims will feel that the premiums asked from them are too high considering the benefit they derive from the pool and in comparison with the premiums they would be charged by other pools. This may then lead to the collapse of the pool. According to Sabera (2009) insurers need to know how much they would be required to pay when the insured event occurs.

Misrepresentation of product

The study further found out that majority of the respondents indicated that Sales people deliberately give false information to target clients to obtain buy-in and that Once an agent misrepresents the product the underwriter can end up issuing a wrong cover to a client that was not intended for in the first place and so affecting the performance of the insurance companies. These statements were supported by the majority of the respondents where they also collate with the literature review that once the client discovers the anomaly they can cancel the cover and multiple cancelations ultimately lead to stunted growth of the insurance sector (AKI Report, 2011).

Conclusion

The research was very successful in connecting the effect of the fraudulent practices on the growth of the insurance industry in Kenya. Both the industry and the management have a broad approach in managing fraud risk. Fraud is managed not only because of its direct financial impact, but also because of integrity aspects. The direct costs of fraud, the reputation risk, supervisory requirements and ethics are all

important reasons. This applies to all the three fraud categories - internal fraud risk, policyholder and claims fraud risk and intermediary fraud risk. However, there are small differences: for policyholder and claims fraud, the direct costs are the most important, whereas for internal fraud the reputation risk is dominant.

Internal problems in insurance companies like misappropriation of premiums and misrepresentation of products serve to deter growth of the insurance industry as all the dissatisfied customers tell other potential customers and hence put off their prospects of taking up insurance.

Recommendations

This report recommends several steps that should be taken in order to ensure a drastic reduction in fraud activities within the insurance companies. The recommendations are as follows; Work environments should be continuously improved to create a sense of belonging for all staff working in the insurance companies and the companies should establish clear responsibilities so that each staff member is held liable for their actions if involved in fraud. There should be elimination of the management of money flows by a single person to avoid temptation to commit fraud as well as the establishment of clear reporting lines and communication procedures to seal loopholes for committing fraud.

The management of the insurance companies should establish efficient physical and procedural safeguards for money use and assets then have this audited from time to time. There should also be elimination of potential conflicts of interest between insurer, management and staff. Each of the companies should establish a transparent and consistent policy of dealing with internal fraud. The human resource departments should offer adequate supervision of staff and management in order to weed out bad elements within the company.

There should also be sound whistle blowing procedures and safeguards in order to deal with internal fraud more effectively.

Areas for further research

These areas include: The emergency of cyber crime as a complex fraud instrument within the

financial sector and initiatives to combat this problem; Effect of government reforms in combating insurance fraud activities; and the efficacy of the Association of Kenya Insurers in providing oversight on insurance companies' activities as opposed to the Insurance regulatory authority.

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