

**FRAUD TOLERANCE LEVEL AS A PREDICTOR OF INSURANCE CLAIMS
BEHAVIOUR: A SOUTH AFRICAN STUDY**

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DECLARATION

I declare "*Fraud tolerance level as a predictor of insurance claims behavior: A South African Study*" submitted in accordance with the requirements for the degree of Doctor of Philosophy in Social Science and Humanities in the subject Criminology is my own work and has not been submitted to another institution of higher education. All sources cited or quoted in this thesis are indicated and acknowledged in the comprehensive list of references.



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ABSTRACT

The insurance sector as a foundation which other sectors depend on is a critical cornerstone of a well-functioning society. An insurer's strength exists in its ability to foresee, assess, price and mitigate current and emerging risks. Despite the value that insurance brings to maintaining and sustaining society there is large scale abuse of the various insurance products on offer. The abuse is predominately committed through the submitting of either false or inflated claims which negatively impacts the entire insurance value chain from underwriting to claims processes.

Insurance claims fraud is classified as opportunistic or organised. Opportunistic claims fraud consists of claims inflation or claims padding for a genuine loss while organised claims fraud involves the lodging a claim for a loss that did not occur and usually involves staging of incidents. Opportunistic fraud is the most common type of fraud experienced by insurers and presents the greatest challenge to the insurance industry.

While there are challenges in accurately determining the true costs of insurance fraud; there is consensus that the costs are significant. In response to incidents of insurance fraud insurers have implemented various measures to curb fraud; these measures range from the establishment of insurance crime bureaus, creation of internal investigation teams and the employment of technology as early warning systems. These measures although useful have not been able to be very effective as insurance fraud still continues to rise.

Studies indicate that consumer attitudes towards insurance fraud play an important role which must be considered when developing fraud prevention strategies. Tolerance has been identified as an important factor which influence consumer

attitudes towards insurance fraud. Previous studies found that factors such as high insurance premiums, excess payments, consumer relationship with insurers, consumer's previous claims experience and societal acceptability of insurance fraud played a role in shaping a consumer's tolerance level.

This study was undertaken to explore the role that policyholder tolerance has on predicting claims behaviour in the South African insurance market. The study also aimed at identifying reasons which motivated policyholder's to commit and deter them from committing insurance fraud. A further aim was to identify the common types of insurance fraud and to measure policyholders' perceptions towards their primary insurer, the insurance industry, brokers and insurance assessors.

The fraud triangle and the theory of planned behaviour were used as theories in support of this study.

Primary data for this study was gather through an online self-administered questionnaire and the sample population consisted of policyholders within the short-term insurance market. A total of 560 completed valid questionnaires were received and analysed.

The study shows that respondents have low levels of tolerance for insurance fraud. Results indicated that financial pressure, greed, financial benefit and opportunity were reasons why policyholders' committed insurance fraud in SA. Factors which deterred policyholders from committing insurance fraud included consumer integrity and honesty, fear of being caught and prosecuted and fairness and value for money.

Respondents indicated that inflated claims were more prevalent than false claims and it was easier to submit an inflated claim than a false claim. Regarding perceptions the study shows that respondents have a more positive view of their own primary insurer than the insurance industry in general, brokers and insurance assessors.

Lastly, the research identified five factors that significantly explain levels of short-term insurance fraud tolerance, namely 'Unfairness/injustice', "Have policyholders' best interest at heart", 'Industry relations', 'Opportunity' and 'Morality'. The findings of this study could be useful to insurers when developing consumer education and awareness programmes.

There exists opportunities for future research regarding several aspects of insurance fraud which was not dealt with in this study.

Key words: Insurance fraud, insurance fraud costs, insurance fraud types, opportunistic fraud, organized fraud, fraud acceptability, fraud tolerance, consumer ethics, fraud attitudes, rationalization, fraud detection, information asymmetry, fraud triangle, planned behavior

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LIST OF ABBREVIATIONS

ABI	Association of British Insurers
BC	Before Christ
CAIF	Coalition Against Insurance Fraud
COIDA	Compensation for Occupational Injuries and Disease Act
€	Euro
EY	Ernst and Young
ICB	Insurance Crime Bureau
IFB	Insurance Fraud Bureau
III	Insurance Information Institute
IT	Information Technology
£	British pound
NT	Taiwan dollar
PwC	PricewaterhouseCoopers
R	South African rand
RAF	Road Accident Fund
SA	South Africa
SAARF	South African Advertising Research Foundation
SAICB	South African Insurance Crime Bureau
SANTAM	South African National Trust and Assurance Company Limited
SAPS	South African Police Services
SEM	Structural Equation Modeling
SIU	Special Investigations Unit
UK	United Kingdom
UNEP	United Nations Environment Programme
US	United States
USD	United States dollar

CHAPTER 1: INTRODUCTION

1.1 BACKGROUND

Businesses, institutions, government departments and individuals worldwide make use of insurance as a means to protect themselves and/or their assets against the risk of some unforeseen future event that could cause loss or damage (Evans, 2013:1; Grant, 2012:1-34). Insurance is thus seen as a mechanism that affords protection to victims of accidents, crime, and natural and/or man-made disasters to the extent that they are insured (Insurance Europe, 2012:5). The insurance sector has been described as a pillar that supports society (Grant, 2012:7).

Short-term insurers¹ who underwrite the various products that offer this protection are regarded as experts at foreseeing, managing and underwriting the various forms of emerging risks (Würmli, 2011:1). Even the United Nations has acknowledged the expertise of short-term insurers as risk managers, and has mobilised insurers at various levels to assist in disaster risk management initiatives (United Nations Environmental Programme [UNEP] Finance Initiative, 2013:1-4). Despite the role of short-term insurance in sustaining the functioning of society, the value of insurance is often underestimated (Grant, 2012:7; Würmli, 2011:2).

Flooding in Limpopo and Western Cape and hailstorms in Gauteng have illustrated the value of short-term insurance (Decker, Tswana & Bezuidenhout, 2013; Dolley, 2013; Sapa, 2013; Jadoo, 2017). Damages caused by these catastrophic events resulted in the short-term insurance industry receiving estimated claims totalling R1.6-

¹ Full definitions of short-term insurance business and short-term insurance products are provided in section 1.7.

billion from individuals and businesses (Santam, 2013:2). This is not unique to South Africa (SA) – in 2013, insured losses due to natural disasters globally amounted to USD 37 billion (UNEP Finance Initiative, 2013:1).

Grant (2012:4) describes insurance as a social protection mechanism that contributes to societal and economic growth by offering a sense of security in mitigating against loss. Insurance is crucial in risk management, especially when dealing with technological and other advances in society and the new and emerging risks that it faces (Würmli, 2011:3).

Due to the importance of insurance, there is concern that the collapse of the insurance industry could be catastrophic on any economy (Vaughan, 2004:258). Vaughan (2004:262) quotes as examples the collapse of HIH Insurance in Australia, which severely affected the construction sector, and the withdrawal of terrorism insurance cover for construction and real estate industries post 9/11. He therefore maintains that all efforts must be made to protect the insurance sector.

The sustainability, affordability and future viability of the insurance sector are dependent on short-term insurers' ability to effectively manage operational costs and the risk of insurance fraud (Ernst & Young [EY], 2011:2; Pešout & Andrle, 2011:613; Viaene & Dedene, 2004:313).

It is reported that the phenomenon of insurance fraud emerged shortly after the concept of insurance had been discovered (Hoyt, 1990:304). Insurance fraud is a common occurrence affecting insurance companies globally, and it is estimated that it costs insurers billions of dollars (Association of British Insurers [ABI], 2012:3; Dionne & Gagné, 2002:213-214; Schiller, 2006:421). A scan of literature on insurance fraud

reveals the magnitude of this problem and how prevalent it is worldwide (Coalition Against Insurance Fraud [CAIF], 1997, 2008; EY, 2011:3; Insurance Europe, 2013:9, 12).

Internationally, various estimates have been used to calculate the cost of insurance (ABI, 2009:1-4). These estimates range from seven to 15% of claims value to 10% to 22% of claims volume, depending on the country. In 2011, insurers in the United Kingdom (UK) exposed fraud totalling £1 billion (Evans, 2013:9).

In SA, the South African Insurance Association estimates that approximately 10% of claims contain an element of fraud, which equates to between R2 billion and R3 billion a year. The South African Insurance Crime Bureau (SAICB)² reports that fraudulent claims pertaining to laptops, cell phones and motor vehicles increased by as much as 10% to 12% during 2010.

Short-term insurers both locally and internationally have implemented various in-house programmes to try and stop the increase in insurance fraud (ABI, 2012:13-15). In their quest to assist, academics also began researching this endemic, hoping that by better understanding insurance fraud, they would be able to formulate better solutions (Dean, 2004; Miyazaki, 2009; Morley, Ball & Ormerod, 2006; Tennyson, 1997, 2002, 2008). These initiatives have, however, done little to reduce insurance fraud incidents as insurance fraud continues to plague short-term insurers (Evans, 2013:9-12; EY, 2011:4). In 2017, the ICB estimated the insurance fraud rate at 12%

² The SAICB changed its name to the Insurance Crime Bureau (ICB) in 2017 (ICB, 2017:3).

and reported that short-term insurers could be losing more than R5 billion per year (ICB, 2017:2).

It is against this background that this research was undertaken. The research proposed an alternative approach to studying insurance fraud within a South African context by looking at the possible link between a policyholder's tolerance for insurance fraud and claims behaviour. The primary focus of this research was to determine whether a policyholder's tolerance for insurance fraud had an impact on claims behaviour.

Several studies have been conducted internationally on consumer tolerance and consumer ethics within the insurance industry (Brinkmann & Lentz, 2006; CAIF, 1997, 2008; Dean, 2004; Lesch & Brinkmann, 2011; Tennyson, 1997, 2002). None of these studies, however, attempted to use the tolerance factor to predict claims behaviour.

1.2 PROBLEM STATEMENT

Insurance fraud poses significant risks to both the insurers and honest policyholders. These risks manifest in the form of high claim costs for insures, reduced profits due to paying out fraudulent claims and delays in claims settlement processes. Several studies on insurance fraud suggest that the catalyst for fraud is driven by consumer behaviour and tolerance for insurance fraud (Brinkmann & Lentz, 2006; CAIF, 1997, 2008; Dean, 2004; Lesch & Brinkmann, 2011; Tennyson, 1997, 2002).

The magnitude of consumers' willingness to accept insurance fraud was illustrated in a study which found that insurance fraud was seen as more acceptable than drinking

a can of cold drink in a supermarket without paying for it or changing the price tag of an item in a retail store (Brinkmann & Lentz, 2006:182-183).

There is thus an urgent need to understand the various aspects related to consumer behaviour and consumer tolerance for insurance fraud in South Africa. This urgency is intensified considering the threat insurance fraud poses to the affordability and sustainability of insurance both to the effective functioning of society and short-term insurers.

There is limited research in South Africa focussing on the problem of consumer behaviour and consumer tolerance for insurance fraud. This study is undertaken to address the problem in understanding the link between consumer behaviour, consumer tolerance for insurance fraud as it relates to insurance fraud in South Africa.

The research was guided by the following questions:

- What is the level of tolerance towards short-term insurance fraud amongst policyholders in SA?
- What are the main reasons for policyholders to commit and not commit insurance fraud in SA?
- What are policyholders' perceptions towards the insurance industry, their own primary insurer, brokers and insurance assessors?
- What is the relationship, if any, between policyholders' perceptions towards the insurance industry, their own primary insurer, their broker and insurance assessors, reasons for committing insurance claims fraud, and levels of tolerance?

1.3 PURPOSE STATEMENT

Given the high incidence of insurance claims fraud, the high levels of acceptance by consumers and the substantial financial impact, very little research has focussed on an ethical perspective (Dean, 2004:68; Lesch & Brinkmann, 2011:18; Miyazaki, 2009:590). There have been calls from practitioners and academics for more research on insurance fraud in general and to better understand consumer attitudes (Miyazaki, 2009:590).

There has been very limited research in SA on consumer attitudes towards insurance fraud. An extensive search of EBSCOhost, Emerald, Google Scholar, Informaworld, ProQuest, SA ePublications, ScienceDirect and SpringerLink did not yield any results to indicate that a study examining the linkage between insurance fraud tolerance and consumer claims behaviour had previously been undertaken in SA.

1.4 RESEARCH AIMS AND OBJECTIVES

The primary aim of this research was to measure policyholders' tolerance towards short-term insurance fraud. Secondary to this was to understand how certain factors, including policyholders' attitudes and perceptions towards the insurance industry, can explain levels of tolerance.

More specifically, the research objectives can be stated as:

- To understand and measure policyholders' tolerance to insurance fraud.
- To identify the main reasons for committing insurance claims fraud and for not committing insurance claims fraud.

- To measure policyholders' perceptions towards the insurance industry, their own primary insurer, brokers and insurance assessors.
- To investigate the relationship between perceptions towards the insurance industry, primary insurer, broker and insurance assessors, levels of tolerance, and reasons for insurance fraud.

1.5 IMPORTANCE AND BENEFITS OF THE STUDY

This research will be beneficial to academic researchers and short-term insurers. Firstly, this research will contribute to the academic literature and help explain policyholder behaviour in perpetrating insurance fraud. It will provide researchers and short-term insurers with a new lens with which to investigate the phenomenon of insurance fraud. This research will further create interest and opportunities for future research on this topic both internationally and, more especially, locally.

Secondly, this research will significantly contribute to short-term insurers by providing a better understanding of why policyholders are tolerant of insurance fraud. Armed with this information, short-term insurers will be able to design awareness and communication programmes to change policyholders' attitudes towards insurance fraud (CAIF, 1997:21, 2008:14-15; Dean, 2004; Tennyson, 2002:53; Viaene & Dedene, 2004:329).

Thirdly, short-term insurers will also be able to identify and either remove or limit those factors that contribute to the enhancement of a policyholder's tolerance levels to insurance fraud (Miyazaki, 2009:597). There is an opportunity for short-term insurers to explore the possibility of segmenting policyholders according to their tolerance levels, thereby ensuring that they understand the policyholders' risk profiles.

Fourthly, understanding the role of tolerance level in insurance fraud could help researchers use this construct to examine other crimes that have become socially acceptable.

Finally, this study will add to the body of knowledge, especially given the lack of research on this topic. This is the first time that this topic has been researched in SA.

1.6 RESEARCH DESIGN AND RESEARCH METHODOLOGY

Research design and research methodology are two different concepts and should not be confused (Babbie & Mouton, 2001:74). Babbie and Mouton (2001:74) describe a research design as a “plan or blue print” indicating the manner in which the research will be conducted. Research design thus involves the setting out of the overall picture on how the research will be done.

Creswell (2009:3) states that there are three types of research designs, namely qualitative, quantitative and mixed methods. He contends that quantitative research involves numbers and “closed ended questions”. Quantitative research is mostly concerned with testing relationships between variables, which is achieved through the use of measuring instruments (Creswell, 2009:4).

A quantitative design was used for this research to test the relationship between two variables, namely policyholder insurance fraud tolerance and claims behaviour. This design was most appropriate for this study.

Research methodology refers to the approach a researcher utilises for data collection, data analysis and interpretation of results for the study (Creswell, 2009:15; Saunders,

Lewis & Thornhill, 2009:3). Research methodology thus refers to the methods used by a researcher for the evidence gathering, evidence analysis and evidence interpretation necessary for the study. Creswell (2009:12) lists experimental and non-experimental as strategies most associated with quantitative studies. He points out that surveys, which are classified as a non-experimental strategy, are useful where the study involves examining trends, attitudes or opinions. Leedy and Ormrod (2010:187) point out that survey research encompasses the gathering of information about people or groups of people by soliciting responses to questions being posed on the topic being studied.

This was a non-experimental study and therefore a questionnaire was used to collect data. To this end, it was necessary to develop and construct an instrument to measure policyholders' insurance fraud tolerance levels within a South African short-term insurance context.

A descriptive study involves the observation and description of a situation or event (Babbie & Mouton, 2001:80-81; Saunders et al., 2009:140). Although Saunders et al. (2009:140) acknowledge the usefulness of descriptive studies in management and business, they argue that a descriptive study on its own provides little value. They confirm that a descriptive study will normally be followed by an explanation, which they term as "descriptive-explanatory studies" (Saunders et al., 2009:140). Welman, Kruger and Mitchell (2005:23) contend that descriptive research aims to "explain and predict behaviour". Explanatory studies seek to explain the relationship between variables (Saunders et al., 2009:140). This study can therefore best be described as a descriptive explanatory study seeking to describe and explain the relationship between policyholder insurance fraud tolerance and insurance claims behaviour.

A cross-sectional study refers to the study of a particular phenomenon at a single point in time (Babbie & Mouton, 2001:93; Leedy & Ormrod, 2010:186). Saunders et al. (2009:155) describe cross-sectional studies as a “snapshot” of the problem being studied at a specific moment in time. This study adopted a cross-sectional design.

There are two types of sampling techniques, namely probability sampling and non-probability sampling (Welman et al., 2005:56-57). In probability sampling, each member of the population has an equal chance of being selected, which is achieved through a method of random selection (Leedy & Ormrod, 2010:205). With probability sampling, the researcher has the ability to determine the sampling error, and by choosing a representative sample, the researcher has the ability to generalise the findings of the study (Babbie & Mouton, 2001:202).

In non-probability sampling, members of the population are selected through a non-random method, which means that there is no assurance of population representation and further there is a risk that some members of the population have minimal or no chance of being included in the sample (Leedy & Ormrod, 2010:211). Despite these shortcomings, non-probability sampling is still useful in research, especially in instances where there is a need to gain “theoretical insights” on a topic being researched, where there are limited resources pertaining to costs or where there is difficulty in identifying the specific sample frame (Babbie & Mouton, 2001:166; Saunders et al., 2009:233).

While it has been posited that probability sampling allows for generalisation, it has also been argued that it is still possible to generalise the findings of a study where non-probability sampling was used, albeit not statistically (Saunders et al., 2009:213).

Details of insurance policyholders are well guarded and well protected by insurers due to competitive advantage this information provides. Further there are regulatory constraints in sharing policyholder details with external parties without consent. This study employed a non-probability sampling technique as there is no sampling frame for policyholders in South Africa. It is recommended that non-probability sampling be used in situations in such situations (Saunders et al., 2009:233). Examples of non-probability sampling techniques include purposive or judgemental sampling, quota sampling and snowball sampling (Babbie & Mouton, 2001:166-167).

Snowball sampling technique was used for this study. There is no list or repository for policyholder information and this therefore poses a challenge in identifying policyholders. Babbie & Mouton, 2001:167 and Saunders et al., 2009:240 recommend the use of snowball sampling technique and argue that this technique is most effective and provide the only solution when it is difficult to locate individuals of a specific population.

Leedy and Ormrod (2010:213) contend that a larger sample is most beneficial when carrying out research, but this offers little guidance in determining the size of a large sample. Gay, Mills and Airasian (cited in Leedy & Ormrod, 2010:213) suggest the following when determining the sample size:

- For smaller samples (100 or fewer), the entire population should be sampled.
- For a population size of about 500, 50% should be sampled.
- For a population size of about 1 500, 20% should be sampled.
- Beyond a certain point, a sample size of 400 should be adequate.

Welman et al. (2005:69) suggest that larger sample sizes reduce the error rate. Saunders et al. (2009:219), basing their calculation on a 95% accuracy level, indicate that 384 participants would be required for a sample population of larger than a million. The South African Advertising Research Foundation (SAARF, 2016) estimated that the total number of policyholders in SA at the time was 1.765 million. Applying the formula proposed by Saunders et al. (2009:219), this would mean that a minimum of 384 participants were required for this study. A final sample of 560 was realised, exceeding this minimum suggested sample size.

1.7 STUDY DELIMITATIONS AND ASSUMPTIONS

The delimitations and assumptions that relate to this study are discussed below.

1.7.1 Delimitations

The study had several delimitations. Firstly, this study was limited to the context of policyholders within the South African short-term insurance industry and included only personal line policyholders.

Secondly, the primary purpose of the study was to explore the linkage between policyholder insurance fraud tolerance and claims behaviour, and therefore did not examine the various fraud prevention initiatives adopted by short-term insurers.

Thirdly, the study focussed on measuring levels of short-term insurance fraud tolerance amongst policyholders in SA. It was therefore limited to identifying and defining the variables needed for such measurement.

Finally, this study was limited only to insurance claims fraud.

1.7.2 Assumptions

The following basic assumptions underlie the research study. It was assumed that:

- The proposed sampling frame would constitute a relevant representation of the diverse population of policyholders in SA.
- Insurance fraud tolerance level is a measurable construct that can be further defined by a qualitative strategy of inquiry and measured through a quantitative strategy of inquiry.
- Measuring the opinions, perceptions and reported behaviours of respondents as representatives of policyholders would provide relevant data for analysis in the context of the research objectives.
- That fraud tolerance level can be used as a construct to segment and better understand policyholders' thought processes and ultimately intended behaviours.

1.8 DEFINITION OF KEY TERMS

Key terms used in this study, related to insurance, fraud and toleration, are defined in below.

1.8.1 Insurance

Smith and Robertson (1971:1166) define an insurance contract as:

a promise by one person (the insurer) to pay a sum of money or to give something of value to another (the insured or a beneficiary) upon the happening of a contingency or fortuitous event, which is beyond the control

of the contracting parties and in which the promise has an interest apart from the contract.

Viaene and Dedene (2004:314) describe insurance as:

a contractual relationship in which the insurer party agrees with an insurance taker party or policyholder, against payment of a premium, to make monetary provision on behalf of an insured party to cover, after a formal claim has been filed by a (first-or third-party) claimant party, the loss of an insurable interest due to one or more future, well-defined, but uncertain events.

Viaene and Dedene (2004:314) further state that the contracting parties must act with utmost good faith. In essence, insurance is a contract of utmost good faith where the insurer undertakes to indemnify a policyholder in the instance of an insured event where the policyholder has suffered loss or damage to an insurable interest against the payment of a specific premium. A policyholder should not make a profit from the loss (Baker, 2000:562).

Insurance contracts are classified as either indemnity or non-indemnity. In various jurisdictions, these contracts are known as general or non-life insurance, and long-term savings and life insurance.

1.8.1.1 Indemnity insurance

In indemnity insurance, the contract between the parties provides that the insurer will indemnify the insured for patrimonial loss or damage suffered as the result of the

occurrence of the event insured against. The purpose of the contract is to return the consumer to the position prior to the occurrence of the event insured against, as well as to ensure that the consumer does not make a profit out of the loss or damage (Reinecke, Van der Merwe, Van Niekerk & Havenga, 2002:4). General or non-life insurance is also referred to as property and casualty insurance, covering motor, property, accident, health, liability and other specialist products (ABI, 2014:4; Grant, 2012:8).

In SA, indemnity insurance is commonly referred to as short-term insurance. For the purposes of this study, the term “short-term insurance” is used. This study was limited to short-term insurance only.

1.8.1.2 *Non-indemnity insurance*

Non-indemnity insurance is also referred to as long-term insurance. Long-term savings and life insurance refer to pensions, annuities, investments and savings and protection policies. These policies are designed to offer financial stability during retirement, or financial compensation to beneficiaries after an accident, illness or death to the policyholder (ABI, 2014:10, Grant, 2012:8).

In SA, non-indemnity insurance is commonly referred to as long-term insurance. For the purposes of this study, the term “long-term insurance” is used.

1.8.2 **Personal lines business**

Personal lines business is defined as “those classes of business used to insure the persons and property of private individuals” (Lindstrom, 2012:134).

1.8.3 Fraud

Snyman (2008:504) defines fraud as “the unlawful and intentional making of a misrepresentation, which causes actual prejudice or which is potentially prejudicial to another”. Derrig (2002:273) defines fraud as “criminal acts, provable beyond reasonable doubt, that violate statutes making the wilful act of obtaining money or value from an insurer under false pretences or material misrepresentations as a crime”. He also notes that some of the definitions of fraud are too narrow to include certain practices associated with opportunistic fraud.

1.8.3.1 Opportunistic fraud

Opportunistic fraud is usually perpetrated by an individual who inflates or exaggerates the value of a valid or legitimate loss suffered; the intention is to obtain a better financial benefit than the actual loss suffered (Haithem, Ayisi & El-Hedhli, 2014:318; Miyazaki, 2009:589; Tennyson, 2002:36). Tennyson (2002:36) further states that opportunistic fraud is characterised by “claims exaggeration or build up” and may be submitted by any claimant who suffers a loss. Crocker and Morgan (1998:356) define “build up” as “entailing the inflation of the damages associated with an otherwise valid claim”. Miyazaki (2009:589) refers to this type of insurance fraud as claims padding, and he describes it as the “purposeful inflation or overstatement of the actual value when making a claim”.

For the purposes of this study, the term “inflated claim” is used to describe opportunistic fraud as this term is commonly used within the South African insurance industry.

1.8.3.2 *Planned or organised fraud*

Planned insurance fraud occurs when a claim is submitted for an insured event or loss that did not materialise, and involves elaborate planning with the aim of gaining financial benefit. It is simply claiming for a loss which did not happen (Haithem et al., 2014:318; Tennyson, 2002:36). Tennyson (2002:36) reports that this type of fraud manifests itself by the falsifying of claims where the insured event did not happen and yet a claim is still submitted. She further states that it is committed by professionals who fabricate the entire loss, and is sometimes referred to as organised fraud. Crocker and Morgan (1998:356) refer to this type of fraud as “outright fraud where claims are filed for losses resulting from non-existent accidents”.

For the purposes of this study, the term “false claim” is used to describe planned or organise fraud as this term is commonly used within the South African insurance industry.

1.8.4 *Toleration*

According to Forst (2017:1), toleration refers to “the conditional acceptance of or non-interference with beliefs actions or practices that one considers to be wrong but still ‘tolerable’ such that they should not be prohibited or constrained”. Toleration consists of three important components, namely objection, acceptance and rejection (Forst, 2004:314; Valdés, 1997:127-128). The objection component requires that the tolerant individual at the outset considers the belief or conduct to be wrong or morally unacceptable (Forst, 2004:314-315, 2014:67). It would not amount to toleration if the objection component was missing, but would amount to “indifference” or “affirmation”

(Valdés, 1997:128). The objection component is harmonised through the acceptance component (Forst, 2017:1).

The acceptance component does not remove the tolerant individual's view that the belief or conduct is wrong or morally unethical, but rather suppresses the view (Forst, 2014:67). According to Valdés (1997:128) and Forst (2004:315; 2014:67), there are positive reasons overriding the initial reasons that formed the basis for the tolerant individual concluding that the belief or conduct was wrong or morally unethical; this therefore results in toleration.

1.9 ETHICAL ISSUES

The research conformed to the ethical standards of the University of Fort Hare. Possible ethical issues pertaining to this study that were considered and addressed are discussed below.

1.9.1 Informed consent and voluntary participation

Respondents were advised at the beginning of the survey that their participation was voluntary and that they had the option to withdraw from the survey at any time during the survey. Survey respondents were afforded the opportunity to withdraw from this survey even after starting by clicking on the "exit and clear survey" button on screen.

No monetary incentives were offered to respondents as reward for their participation in this survey. Respondents' consented to participate in this survey by ticking "I voluntarily consent to participate in this survey" before proceeding with the survey.

1.9.2 Anonymity

The questionnaire was designed so as not to elicit any identifying information from respondents. The respondents were able to access the survey through an online link, where the survey form was hosted on an online platform, thereby removing the risk of any personal information or e-mail addresses being exposed. Further, as this was an online survey, face-to-face contact was not necessary, thus removing any risk of identifying the respondents. Respondents were able to complete the survey in privacy. Respondents were assured that the findings of the survey would be presented from an aggregated group perspective, not an individual level.

1.9.3 Confidentiality

At the introduction of the survey, respondents were advised that all information would be treated confidentially. The collected data are hosted on an external database with strict security protocols and strong encryption. No identifying information was collected during this study. Respondents were advised that the findings of this study would be used for academic and publication purposes.

1.10 STRUCTURE OF THE THESIS

Chapter 1: Introduction

This chapter provided an overview of the study undertaken by providing details on the background, problem statement, purpose statement, research aims and objectives, and importance and benefits of the study. The study delimitations and assumptions were noted, as well as definitions of key terms.

Chapter 2: Literature review

This chapter contains details of literature reviewed for the purposes of this study. It focuses on the history of insurance, the value of insurance, what insurance fraud is, the types of insurance fraud, preventative measures used to curb insurance fraud and how consumers' accepting attitudes influence insurance fraud.

Chapter 3: Theories

In this chapter, a number of relevant theories applicable to this study are discussed.

Chapter 4: Research methodology and design

This chapter provides details on the research methodology and the research design used for this study. The methods to implement the study are also discussed.

Chapter 5: Results of the study

In this chapter, the findings of the study are discussed and presented in relation to the research objectives.

Chapter 6: Conclusion and recommendations

In this chapter, conclusions are drawn based on the research findings. Implications are discussed and recommendations are made. Imperatives for future research are presented.

CHAPTER 2: INSURANCE FRAUD

2.1 INTRODUCTION

Research on insurance and insurance fraud is very limited in SA, thus illustrating the value of this research. An extensive scan of international literature on insurance fraud also yielded limited information. The limited information available demonstrates that the lack of insurance fraud research is not unique to SA, but is also international. There has been an appeal to academics to conduct more research in the area of insurance fraud given the importance of the insurance sector and the devastating effects insurance fraud could have on this sector (Miyazaki, 2009:589-590). This study is therefore aimed at addressing the deficiency of insurance fraud research, especially in SA, and adding to the body of knowledge.

Several authors (most notably: Brinkmann, 2005; Cummins & Tennyson, 1994; Dean, 2004; Lesch & Brinkmann, 2011; Lesch & Byars, 2008; Miyazaki, 2009; Tennyson, 1997, 2002, 2008; Viaene & Dedene, 2004; Weisberg & Derrig, 1991) dominate the field of insurance fraud research internationally and have produced insightful articles on the topic of consumer insurance fraud and tolerance. Recent articles still refer to these authors and cite their articles as important sources (Brokesova & Pastorakova; 2013:297-298; Haithem et al., 2014:316-7; Tseng, 2016:353; Tseng, Kang & Chung, 2014:321). This study was therefore based on the information consulted by the sources currently available.

This chapter reflects on a brief overview of the origin of insurance, defines short-term insurance, discusses the value of insurance to society, examines the phenomenon of

fraud and insurance fraud, and finally discusses consumer behaviour as it relates to insurance fraud.

2.2 ELEMENTS OF INSURANCE

Risk is part of everyday life, which creates insecurity and uneasiness for society (Reinecke, Van der Merwe, Van Niekerk & Havenga, 2002:1). Reinecke et al. (2002:1) define risk as “the possibility of harm which can result in patrimonial or non-patrimonial loss”. The sense of insecurity stems from possible losses society could suffer should risks in fact materialise (Möller, 1975:59; Reinecke et al., 2002:1). This need for peace of mind and protection from the various forms of risks gave birth to the concept of insurance (UNEP Finance Initiative, 2014:1). Risk can manifest itself in different forms, including natural disasters, biological disasters, technological disasters, political risks, economic risks and demographic risks, or a combination of these (Insurance Europe, 2012:3; UNEP Finance Initiative, 2014:1). The value that insurance products offer to society is so overwhelming that not even religious or economic systems opposed the development of insurance (Möller, 1975:59).

Insurance cannot prevent a risk from occurring, but instead enables society to transfer their personal risk to a third party, thereby relieving themselves from the financial or physical burden they may incur when risks materialise (Grant, 2012:3; Insurance Europe, 2012:5; Möller, 1975:59). The concept of insurance in its most basic form occurs when people who are exposed to the same or similar risk transfer such risk to a third party and make a small payment in return for protection from the consequences should the risk happen (Grant, 2012:5; Insurance Europe, 2012:5; Reinecke et al., 2002:2). Insurance is thus the pooling of premiums and the distribution of costs

amongst a number of people with similarly exposed risks, thereby easing the negative financial consequences that one person could face; it is a risk transfer mechanism (Grant, 2012:5; Insurance Europe, 2012:5). It is further contended that insurance involves the management and mitigation of risk, based on the principle of shared responsibility (Grant, 2012:3).

It is difficult to determine the exact beginnings of insurance. However, practices emulating insurance, which consisted of risk transfer, can be traced back to the Phoenicians, Rhodians and Romans (Vance, 1908:1-3). The Great Fire of London in 1666, which cost an estimated £10 million, contributed to the development of fire insurance in the UK when the need for protection against the losses from the risk of fires was realised. This protection was intended to help alleviate the financial burden of individuals as seen after the fire (Buckham, Wahl & Rose, 2010:6). Additionally, the idea of reducing risk amongst merchants when transporting goods gave rise to the development of marine insurance in the UK; the merchants agreed to make contributions to those who suffered losses while transporting goods with boats (Insurance Europe, 2012:7).

These are but some examples that illustrate society's pooling together and transferring of risk to a third party to achieve a common goal of protection and peace of mind. This ultimately gave rise to the concept of insurance and the beginning of the insurance industry, with insurers becoming the third party to whom the risks were transferred.

The growth and development of the insurance industry as we know it today began to evolve in that, as new risks emerged, insurers responded by developing new products to aptly deal with such risks. This trend will continue in future given the growth of the

fourth industrial revolution, with self-driving cars and drone technology as examples (Evans, 2013:40; Swiss Re, 2015b:4).

In SA, an insurance contract was defined in *Lake v Reinsurance Corporation Ltd* as (Reinecke et al., 2002:3):

a contract between an insurer (or assurer) and an insured (or assured), whereby the insurer undertakes in return for the payment of a price or premium to render to the insured a sum of money, or its equivalent, on the happening of a specified uncertain event in which the insured has some interest.

This definition became the basis for both indemnity and non-indemnity insurance or capital insurance (Reinecke et al., 2002:3).

Smith and Robertson (1971:1166) define an insurance contract as:

a promise by one person (the insurer) to pay a sum of money or to give something of value to another (the insured or a beneficiary) upon the happening of a contingency or fortuitous event, which is beyond the control of the contracting parties and in which the promise has an interest apart from the contract.

Viaene and Dedene (2004:314) describe insurance as:

a contractual relationship in which the insurer party agrees with an insurance taker party or policyholder, against payment of a premium, to make monetary provision on behalf of an insured party to cover, after a

formal claim has been filed by a (first-or third-party) claimant party, the loss of an insurable interest due to one or more future, well-defined, but uncertain events.

They further state that the contracting parties must act with utmost good faith.

In essence, insurance is a contract of utmost good faith where the insurer undertakes to indemnify a policyholder upon the occurrence of an insured event where the policyholder has suffered loss or damage to an insurable interest against the payment of a specific premium. A policyholder should not make a profit from the loss (Baker, 2000:562).

Reinecke et al. (2002:4) state that insurance contracts are classified as indemnity and non-indemnity or capital insurance; this differentiation is based on the nature of the interest being protected and on which the insurance contract is based. Reinecke et al. (2002:5,17, 20) add that, in indemnity insurance, the interest must be of a patrimonial nature, for example a person's assets, while in capital insurance, the interest must be non-patrimonial, for example a person's body and limbs.

In indemnity insurance, the contract between the parties provides that the insurer will indemnify the insured for patrimonial loss or damage suffered as the result of the occurrence of the event insured against. The purpose of the contract is to place the policyholder in the position prior to the happening of the event insured against, and to ensure that the consumer does not make a profit out of the loss or damage (Reinecke et al, 2002:4). In SA, indemnity insurance is commonly referred to as short-term insurance.

In other jurisdictions, insurance contracts are classified into two categories, namely general or non-life and long-term savings or life insurance. General or non-life insurance is also referred to as property and casualty insurance, covering motor, property, accident, health, liability and other specialist products (ABI, 2014:4; Grant, 2012:8). This is similar to short-term insurance in SA.

Long-term savings and life insurance refer to pensions, annuities, investments and savings and protection policies. These products are designed to provide income during retirement and financial compensation to beneficiaries after an accident, illness or death (ABI, 2014:10, Grant, 2012:8). This is referred to as long-term insurance in SA.

Literature and case law classify contracts of insurance as contracts of utmost good faith, which implies that parties to the insurance contract display utmost good faith towards one another for the duration of the contract (Reinecke et al., 2002:110; Viaene & Dedene, 2004:314). This entails that parties to the insurance contract must disclose all material information to each other. Reinecke et al. (2002:4) state that the term short-term insurance covers most instances of indemnity insurance, but it must be noted that some forms of capital or non-indemnity cover can be classified as short-term insurance as well.

The above discussion provided some useful background information on the history, development and definition of short-term insurance. This study is limited to indemnity insurance or short-term insurance. The term short-term insurance is commonly used in SA and is understood to relate to insurance for protection of assets. It is for this reason that the term short-term insurance will be used throughout this study.

2.3 VALUE OF INSURANCE

It has been stated that insurance is the cornerstone of modern life and that society and economy would not function without insurance (Insurance Europe, 2012:3). Evans (2013:1) reports that insurance is the “fore front of the changing world”, which is integrated and intertwined in all aspects of a functioning society and economy. Reinecke et al. (2002:3) state that insurance provides a “service to those who are in distress”. The value provided by insurance is so profound that neither Islamism nor socialist countries reject the idea of insurance or its development (Möller, 1975:59). The scope, purpose and availability of insurance have drastically evolved since its commencement from merely affording protection and managing risk, to the arena where insurance now plays a much greater and impactful role in economic growth, development and social enhancement (Buckham et al., 2010:6; UNEP Finance Initiative, 2014:2-3).

The insurance sector worldwide employs millions of people either directly or indirectly, and is responsible for numerous job creation programmes (Grant, 2012:19). Grant (2012:19) further reports that insurers globally control trillions of US dollars in premiums and assets.

Globally in 2013, insurers collected life premiums totalling USD 2 608 billion and non-life premiums totalling USD 2 033 billion, and controlled investments totalling USD 27 000 billion (Swiss Re, 2014:1-3). Over the same period, the premiums collected by life insurers in Africa amounted to USD 50 billion and premiums collected by non-life insurers amounted to USD 22 billion (Swiss Re, 2014:30). In 2016, insurers globally reported life premiums of USD 2 617 billion and non-life premiums of

USD 2 115 billion (Swiss Re, 2017:1-2). During the same period, insurers in Africa collected life premiums to the value of USD 41 billion and non-life premiums totalling USD 20 billion (Swiss Re, 2017:42).

A report compiled by ABI (2016:9) on the state of insurance in Europe in 2016 indicates that the total premiums collected for 2015 was €1 200 billion, of which €976 billion was paid out in claims and benefits. The assets controlled by the insurance industry were valued at €9 800 billion, making it the largest investor in the European Union (ABI, 2016:25). In 2015, there were 3 700 insurance companies operating in Europe, employing more than 975 000 employees (ABI, 2016:29).

The Insurance Information Institute (III, n.d.[b]) reports that the nett premiums for US insurers in 2015 totalled USD 1.2 trillion, with assets and investments worth more than USD 1.5 trillion. There were 5 926 insurers operating in the US in 2015, and it was reported that, in 2016, the insurance sector employed 2.6 million people (III, n.d.[b]).

Buckham et al. (2010:8) argue that the pooling and diversification of risk has become a scientific discipline, thereby creating benefits at micro and macro level. Vaughan (2004:262) goes as far as to state that insurance is critical in “greasing the wheels of commerce”.

In understanding the role that insurance plays within society and the economic sector, it is important to unpack the strengths of an insurer. Würmli (2011:1) mentions that insurers' strengths lie in their ability to assess risk, provide limits to insurable products, create insurance products for new markets, and implement measures and provisions to manage risk exposures. Würmli (2011:1-2) further states that insurers have a more

sustainable business model than banks, and argues that banks regularly fail because of their poor business model as opposed to the model used by insurers.

Insurers are able to provide insurance cover for almost all conceivable assets or activities, thereby providing greater certainty to individuals and organisations (Buckham et al., 2010:7). Buckham et al. (2010:7) acknowledge that measuring the economic value linked to insurance is difficult, but cite a study undertaken by Outreville which showed a positive link between premiums per capita and gross domestic product per capita, thus indicating that insurance played an important role in economic growth. A similar view is echoed by the ABI (2016:8), which advocates that the value of the insurance industry lies in its ability to stimulate economic growth and development.

Grant (2012:3) states that insurance primarily serves a social protection mechanism for individuals. He goes further to mention that there are certain economic activities for which insurance is a prerequisite, and cites the purchasing of home and business expansion as examples. This means that, without insurance, it would be difficult for people to purchase property or motor vehicles, as insurance is a prerequisite when buying assets through bank-obtained loans.

Insurance does not prevent disasters from happening, but when these disasters do occur, insurance plays a critical role in assisting victims to piece back their lives as quickly as possible by speeding up the claims process and making much-needed funds available to these victims (Grant, 2012:12; UNEP Finance Initiative, 2014:1-2). The earthquake in Japan during 2011 is an example where insurance companies sent

about 10 000 staff to assist with relief efforts and ensured that claims were quickly settled, thus assisting victims financially (Grant, 2012:12).

The role insurers play during the occurrence of natural catastrophes and man-made disasters is well-documented. Swiss Re (2015a:1, 13) reports that, during 2014, global losses due to natural catastrophes and man-made disasters totalled USD 110 billion, of which insurers covered losses totalling USD 35 billion. For the same period, Africa's losses totalled USD 1.5 billion, of which insured losses totalled USD 0.8 billion. In 2017, the global total losses were reported to be USD 337 billion, of which insurers covered losses totalling USD 144 billion. In Africa, the total losses were USD 2.9 billion, of which insured losses amounted to USD 0.8 billion (Swiss Re, 2018:1, 17).

Table 1 reports details of the costliest losses incurred by insurers per event worldwide since 1970, as reported by Swiss Re (2018:48).

Table 1: Costliest losses incurred by insurers worldwide from 1970 to date (Swiss Re, 2018:48)

Loss	Year	Value of insured loss
Hurricane Katrina	2005	USD 82 394 million
Earthquake in Japan	2011	USD 38 128 million
Hurricane Maria	2017	USD 32 000 million
Hurricane Sandy	2012	USD 36 079 million
Hurricane Irma	2017	USD 30 000 million
Hurricane Harvey	2017	USD 30 000 million
Hurricane Andrew	1992	USD 27 943 million
Terror attack in US (9/11)	2001	USD 25 991 million

The above examples demonstrate how insurers assist governments in easing financial burdens by contributing for losses during times of crisis. Of the total losses suffered in

2017, almost 42% was covered by insurance (Swiss Re, 2018:48). It has been argued that the gap between the actual losses suffered and the losses covered by insurance indicates a serious shortfall in insurance, thus exposing individuals, organisations and governments to financial ruin in the event of catastrophes (Swiss Re, 2012:1).

Buckham et al. (2010:7-8) and Grant (2012:3-4) list the following as examples where insurance supports economic growth:

- The insurers' willingness to insure new and costly technology resulted in the expansion of the North Sea oil industry.
- Insurance empowers and makes it possible for people to own their own homes; without insurance, people and lending institutions would be afraid to take unmitigated risks.
- Insurance functions as a savings mechanism to assist individuals to plan for future financial commitments, such as retirement.
- Insurance creates a platform for effective risk management.
- While insurance does not prevent losses, insurance reduces the financial impact of losses on the victim.
- Insurance provides assurance by promoting future financial security.
- Insurance reduces the financial burden on state institutions in providing social grants for citizens.
- Insurance promotes trade and commerce, thereby enhancing economic growth.

The ability to understand and manage risk is of paramount importance to an insurer (UNEP Finance Initiative, 2014:1-4). This therefore makes the insurance sector the ideal partner to assist with disaster risk management. It is against this background that

the United Nations has forged alliances with the insurance sector to assist with disaster risk management efforts. The UNEP Finance Initiative (2014:4) has acknowledged that the value of insurers is more than just the payment of claims; the insurers' risk research, models, analytics, past data and future planning contribute significantly to risk management. This is further supported by the initiatives undertaken by reinsurers to document learnings from past man-made and natural disasters with the aim to prevent or minimise loss to life and property (Swiss Re, 2012:1-14, 2015a:14-20).

Insurers also contribute significantly to post-disaster recovery efforts. They have various initiatives aimed at better understanding the causes of natural disasters, such as earthquakes, flooding and storms, and proposing the implementation of preventative measures to protect communities and to better understand the risk for underwriting purposes (Swiss Re, 2011:12, 2012:9-14, 2015a:14-20).

Although much of the above discussion on the value of insurance is equally applicable to SA, it is important to expand on this a bit further.

2.4 VALUE OF THE INSURANCE INDUSTRY IN SOUTH AFRICA

The South African insurance industry is ranked eighteenth globally in terms of premium volume, thus indicating the sector's strength and financial stability (Swiss Re, 2014:36). The short-term insurance industry received gross written premiums totalling R92.1 billion in 2016 (KPMG, 2017:78). The insurance industry paid out claims for weather-related damages totalling R2.5 billion in the last four years (KPMG, 2017:82).

A survey conducted by PricewaterhouseCoopers (PwC, 2012:14) amongst 29 insurers revealed that the short-term and long-term insurance industry employed 73 658 people, and it was estimated that this figure would increase to 78 953 in 2015. This survey also found that the number of brokers and intermediaries operating in the insurance industry were 57 687, and it was estimated that this figure would increase to 65 948 in 2015. The insurance industry as a sector is dependent and utilises the services of a vast array of providers, including motor body repairers, builders, plumbers, loss adjusters, attorneys, doctors and information technology (IT) suppliers to deliver on the promise of indemnifying policyholders. This in turn creates and enhances job opportunities within the economic sector.

In a bid to develop skills, the insurance industry has also partnered with the Insurance Sector Education and Training Authority (2018:15-22) to participate in its internship and work-based experience programme by offering work-based training and skills required for employment within the insurance sector. It can therefore successfully be argued that the insurance industry as a sector contributes towards creating employment and developing skills both within insurance and the related sectors in SA.

The insurance industry also plays an active role in uplifting the communities within which they operate. This has resulted in insurance companies investing millions of rands, both financially and through resources, to numerous community social programmes, which is a welcome relief for communities, charities and welfare organisations in need of upliftment (Hollard, n.d.; Momentum, n.d.; Sanlam, n.d.; Santam, n.d.; Telesure, n.d.).

PwC (2012:14) found that the long-term and short-term insurance industry in SA had a combined policyholder strength of 32.9 million policyholders, and it was estimated that this figure would increase to 41.3 million in 2015. This means that these 32.9 million policyholders enjoyed protection, benefits, or both, from the various insurance products they had purchased.

Storms and flooding in Limpopo and Western Cape and hailstorms in Gauteng have illustrated the value of short-term insurance to these policyholders in SA (Bloomberg News, 2014; Jadoo, 2017; Ross, 2014). Damages caused by these catastrophic events resulted in the short-term insurance industry receiving estimated claims totalling R1.6 billion from individuals and businesses (Santam, 2013:2). Santam paid out claims totalling R19 billion in 2017 compared to R16 billion in 2016 (Santam, 2018).

Insurers played a critical role in 2017 in responding to the catastrophes caused by storms in the Western Cape and fires in Knysna. It has been estimated that insurers' claim costs for these events were more than R4 billion (Jadoo, 2017; Smith, 2017; Vision Brokers, n.d.). In addition, insurers made huge donations to support and assist in rebuilding efforts for the uninsured people living in Knysna after most of the residents lost all their possessions in the fires (Omarjee, 2017).

2.5 COMPENSATION MECHANISMS IN SOUTH AFRICA

SA has a limited compensation model restricted for certain victims. The most popular known compensation mechanisms in SA are the Compensation for Occupational Injuries and Diseases Act (COIDA) and the Road Accident Fund (RAF). These

mechanisms, however, have limited application relating either to the beneficiaries of the schemes or the amounts payable under the scheme.

COIDA (1997:1) was specifically set up to compensate employees or dependents of employees for injuries, diseases or death arising from the scope of their employment. The injury, disease or death must have occurred in the course of employment and not as a result of the employee's own misconduct, unless death or serious disability occurs (COIDA, 1997:16). Domestic workers, members of the South African National Defence Force and members of South African Police Services (SAPS) are excluded from the scheme (COIDA, 1997:5).

The RAF compensates for injury or death resulting from motor vehicle accidents and is based on fault (RAF Act, 1996:8). Thus, to receive compensation from the RAF, the claimant must prove that the injury or death occurred due to the negligence or wrongful conduct of a third party associated with driving a motor vehicle. No compensation is payable if the loss was due to the claimant's own negligence or wrongful conduct, and the claimant must have the details of the driver or owner of the vehicle (RAF Act, 1996:8).

The RAF does not pay compensation for loss or damage to property connected to the accident, and no compensation is payable if the accident occurred outside the borders of SA. In addition, the RAF has certain limitations on amounts payable and there are certain exclusions despite injury or damage sustained (RAF Act, 1996:8-11). It was reported in 2017 that the RAF was under huge financial pressure, with about R11 billion in arrears, which resulted in the RAF being unable to pay out to claimants (RAF, 2017:54-57). This trend of financial constraints continues (RAF Act, 2017:54-

57). Due to the financial constraints experienced by the RAF, there will be delays in claimants receiving their payments, thereby threatening the legitimacy and effectiveness of this model, to the detriment of claimants.

The provisions of the RAF Act (1996) means that, despite RAF compensation, damages or losses caused to property must be claimed separately; this includes damages to motor vehicles. Innocent third parties involved in motor vehicle accidents will have to pursue the legal route of instituting civil litigation at their own cost to recover losses sustained for damage to property; this can be both time-consuming and costly.

The inconvenience that such persons will personally suffer are inconceivable, given the time and cost it takes to legally settle these matters in courts and the administrative burden it places on the justice system. The success of recovery will finally also depend on the offending party's ability to repay the debt. Uninsured people are faced with this harsh reality daily. However, for those with insurance policies in place, there is comfort that the insurance company will indemnify them for their losses to damage to property and person, even if there was an element of own negligence.

South Africans fall victim to crime on a daily basis. The 2014/2015 crime statistics released in September 2015 indicate that 2.206 million crimes were committed in SA during the reporting period (BusinessTech, 2015).

Table 2 reports details of the specific crime categories committed during 2014/2015, which predominantly affect assets or property, thus impacting insurance (BusinessTech, 2015). As can be noted from the information in Table 2, there was an increase in property-related crimes, which directly affects the citizens of SA who are ultimately the crime victims.

Table 2: Specific crime categories committed during 2014/2015

Category	2014	2015	% change
Truck hijacking	991	1279	29.1%
Carjacking	11 180	12 773	14.2%
Robbery with aggravating circumstances	118 963	129 045	8.5%
Robbery at residential premises	19 284	20 281	5.2%
Robbery at non-residential premises	18 573	19 170	3.2%
Common robbery	53 505	54 927	2.7%
Stock theft	24 534	24 965	1.8%
Burglary at non-residential premises	73 464	74 358	1.2%
Theft out of or from motor vehicle	143 801	145 358	1.1%
All theft not mentioned elsewhere	363 517	360 541	-0.8%
Driving under the influence of alcohol or drugs	69 725	68 561	-1.7%
Burglary at residential premises	259 784	253 716	-2.3%
Theft of motor vehicle and motorcycle	56 645	55 090	-2.7%
Arson	5 458	5 127	-6.1%
Commercial crime	76 744	67 830	-11.6%

Compensation for crime victims has the purpose of redressing the harmful effects caused by crime and providing support for the losses incurred by these victims (South African Law Reform Commission, 2004:26). It is interesting to note that SA does not have any compensation scheme for victims of crime (South African Law Reform Commission, 2004:34). It has been reported that the support system for crime victims in SA is ineffective and reactive (South African Law Reform Commission, 2004:3, 34).

Further, in comparison to other countries, crime victims abroad have much more support, both emotionally and financially, than crime victims in SA (South African Law Reform Commission, 2004:27). Crime victims in SA will therefore have to enforce their rights for compensation of their own accord by instituting civil actions against the offender, or alternatively, upon finding the offender guilty, the courts may order restitution in favour for the victim (South African Law Reform Commission, 2004:46-

49). Neither option is viable, and both can become burdensome for crime victims because of the associated costs, time delays and practicalities (South African Law Reform Commission, 2004:49).

However, for those crime victims who have insurance policies in place, insurance is a welcome relief as it relates to compensation when crime occurs. Incidents of burglaries, carjacking, theft of motor vehicle, theft out of motor vehicle and stock theft are insurable events for which insurance cover can be incepted. The contract of insurance attempts to place the crime victim policyholder in the same position as before the occurrence of the event insured against. The insurer does this through indemnification by monetary reimbursement, repair, replacement or any combination of these, and it occurs as soon as possible so as to ensure that the crime victim policyholder is not inconvenienced any further.

The contribution of insurance and the insurance industry to society as a whole, both internationally and in SA, has been discussed above. The discussion that follows examines the phenomenon of insurance fraud, the associated costs, the different types of insurance fraud, the effects of insurance fraud, the victims of insurance fraud and complexities associated with insurance fraud.

2.6 INSURANCE FRAUD

Despite the valuable contribution that insurance brings to societies, especially in mitigating against total financial losses, the reality is that the industry has itself fallen victim to the scourge of crime manifested in the form of insurance fraud (Ericson et al., 2000:540; Morley et al., 2006:163-164; Tennyson & Salsas-Forn, 2002:289). Although

it may be difficult to comprehend this, considering that insurers are supposed to be great at managing risk, insurance fraud is considered a risk.

Insurance fraud was the first fraud type ever recorded in 300 BC when Hegestratos, a Greek merchant, incepted an insurance policy known as bottomry. He then tried to intentionally sink an empty boat and sell the contents (Beattie, n.d.). Not much has changed since then. It has been reported that insurance fraud most probably became commonplace with the development of insurance in the 17th century (Hoyt, 1990:304; Lesch & Brinkmann, 2011:18; SAS, 2008:3). During the late 19th century, railway companies became the victims of insurance fraudsters who claimed USD 500 for falling (Derrig, 2002:271). Derrig (2002:271-2) elaborates that patterns of false claims continued. In the 1870s, the false claims pattern changed to claims for “railway spine”, while in the 1950s, the false claims were for auto “whiplash”; there were trends in attempts to benefit from the insurance companies.

Insurance fraud remains a significant risk plaguing the insurance industry, and the frequency, methods and financial impact of insurance fraud remain a growing concern for insurers all over the world (ABI, 2012:3; Association of Certified Fraud Examiners, 2009:12; CAIF, 1997, 2008; Dionne & Gagné, 2002:213-214; Schiller, 2006:421). In a survey conducted amongst short-term insurers in India, EY (2011:3) found that 40% of the respondents reported increases in insurance fraud, and of these respondents, at least 56% indicated that fraud increased by much as 20%. Dean (2004:67) reports that insurance fraud is the second largest white-collar crime in the US in terms of monetary value.

2.6.1 Challenges with measuring the magnitude of insurance fraud

It is prudent to first determine the actual costs of insurance fraud in order to ascertain just how serious the problem is (Ai, Brockett, Golden & Guillén, 2013:122). This will assist to emphasise the need to understand insurance fraud; it will also assist with resource allocation in managing anti-fraud initiatives and in communicating reliable and accurate information to stakeholders (Derrig, 2002:274; Viaene & Dedene, 2004:319). However, trying to measure insurance fraud is no easy task, which makes any effort to understand the degree of this problem and advocate solutions difficult (CAIF, 2008:1, n.d.[a], n.d.[c]; Derrig, 2002:274; Smith, 2000:137).

Viaene and Dedene (2004:317) state that there were no attempts to measure the rate of insurance fraud until the late 1980s, when the desire for insurance fraud statistics gained momentum as there was a greater need to illustrate the magnitude of the problem. They contend that various quantitative attempts were undertaken to determine the extent and cost of insurance fraud. However, the results of these qualitative exercises were at best estimates because these estimates were based on information gathered from closed claims analysis, crime statistics, fraud detection tools or previous studies, bringing the integrity of the data into question (Ai et al., 2013:122, 123; Viaene & Dedene, 2004:317-318).

The difficulty of measuring insurance fraud is attributed to the fact that there is no single agency or institution that gathers and keeps accurate insurance fraud information (Skiba & Disch, 2014:89). Further, individual insurers are reluctant to disclose their actual exposure to insurance fraud, and are not willing to share information on their fraud costs exposure (Lang & Wambach, 2013:256). Some

insurers accept insurance fraud as the cost of doing business and have therefore factored this into premium rates (Hoyt, 1990:309-310). A further challenge in determining the cost of insurance fraud is ascribed to the absence of suitable methodology to measure criminal or hard fraud, suspected criminal fraud, soft fraud or systematic abuse, and suspected fraud or systematic abuse (Derrig, 2002:274).

Viaene and Dedene (2004:318) explain that the deceptive element of fraud and the lack of understanding thereof further contribute to the obstacles in accurately quantifying insurance fraud. Measuring the rate of insurance fraud with accuracy thus remains a difficult task (Derrig, 2002:274; Tennyson, 2008:1184-1185).

Despite this difficulty to accurately quantify insurance fraud, the view remains that insurance fraud is a serious problem (Crocker & Morgan, 1998:356). Additionally, there is a need to determine insurance fraud costs in order to raise awareness of the problem, prioritise problem areas and communicate the seriousness of the problem to stakeholders (Ai et al., 2013:121; Viaene & Dedene 2004:319). Ai et al. (2013:122) aptly contend that “you cannot manage something you cannot measure”. These authors suggest that an accurate and continuous monitoring of the insurance fraud rate is crucial, and therefore propose using the PRIDIT-based Fraud Rate Estimation as a solution (Ai et al., 2013:123).

2.6.2 Global costs of insurance fraud

The estimated costs of insurance fraud vary from country to country and are dependent on the class or type of insurance; it is estimated that fraud costs in Europe equate to about 10% of all claims expenditure (Insurance Europe, 2013:9; Lesch & Brinkmann, 2011:19).

Based on a review of academic literature and publicly available data, ABI (2009:6) provided international estimates on insurance fraud costs per country and per product type. Table 3 provides details of these estimates per country, product line, estimate and the source as cited in ABI (2009).

Table 3: Estimates per country, product line, estimate and the source (ABI, 2009:6)

Country	Product line	Estimate	Source (as cited in ABI, 2009)
United Kingdom	Retail	7% of claims (by value)	ABI
Australia	General	10% of claims (by value)	ICA
United States (Arizona)	General	10% of claims (by volume)	ABI
United States	General	10% of claims (by volume)	Hoyt
United Kingdom	General	10% of claims (by value)	ABI
Canada	General	10%-15% of premiums	IBoC
United States	Motor	11%-15% of claims (by value)	IRC
Germany	Motor	11% of claims (by volume)	Clarke
United Kingdom	Retail	11% of claims (by volume)	ABI
United Kingdom	General	13% of claims (by volume)	ABI
United States	General	15% of claims (by value)	Hoyt
Spain	Motor	22% of claims (by volume)	Artís et al.

There has been a drive in certain insurance markets to start compiling and keeping accurate data on the prevalence of insurance fraud; these include markets in countries like the UK, Germany, Sweden, France and Finland (Insurance Europe, 2013:9).

In 2011, it was estimated that about £1.9 billion of insurance fraud in the UK went undetected, while the value of detected insurance fraud increased to £983 million; a seven percent increase from 2010 (ABI, 2012:5; Insurance Europe, 2013:9). ABI (2012:5) further revealed that there were about 2 670 fraudulent claims exposed every

week, with most of the fraud detected in home insurance claims. In 2013, ABI reported that in 2012 insurers in the UK noted an increase in insurance fraud by detecting 124 000 cases and saving £1.1 billion (Evans, 2013:9). In 2014, ABI reported an 18% increase in detected fraud in the UK during 2013, totalling £1.3 billion, and it was estimated that about £2.1 billion went undetected (ABI, 2014:9; Insurance Fraud Taskforce, 2016:5).

It has been reported that, in Canada, insurance fraud is the second greatest generator of criminal proceeds, after drug dealing, and that about 10% to 20% of claims are fraudulent (Ericson et al., 2000:539).

A study by an insurance association in Germany revealed that more than half of all claims for loss or damage to smartphones or tablet PCs could not have occurred, thus indicating that there was a fraudulent element in these claims (Insurance Europe, 2013:9).

In Sweden, during 2011, fraud investigators detected insurance fraud totalling €40 million, while in France, insurers detected 32 042 fraudulent claims, resulting in a saving of €168 million (Insurance Europe, 2013:10).

In 2000, fraud in property and casualty insurance was estimated to make up 10% of annual claims, or about USD 20 billion per year in the United States (Smith, 2000:137). The CAIF (n.d.[b]) estimates that insurance fraud costs Americans about USD 80 billion annually.

Hoyt, Mustard and Powell (2004:1) report that insurance fraud is such a serious problem in the US that various states have enacted laws and regulations to mitigate

fraud in the insurance industry. Insurance fraud is reported to be the second largest white-collar crime in the US (Dean, 2004:67; Miyazaki, 2009:589).

In a survey conducted by EY (2011:3) amongst retail insurers in India during 2010 to 2011, it was found that about 40% of those surveyed felt that insurance fraud had increased substantially by between 20% and 40%, and it was estimated that this trend would continually grow.

Insurance fraud in Taiwan related to automobile theft insurance has become a significant problem, and in 2008, insurance fraud was estimated to make up five percent of claims, equating to 150 million NT dollars (Dionne & Wang, 2013:69).

2.6.3 Costs of insurance fraud in South Africa

A review of the sparse literature on insurance fraud in SA indicates that no attempt has yet been made to quantify the costs associated with insurance fraud. The costs are mostly based on estimates, which are reported in various online media articles. Both the ICB and the South African Insurance Association estimate the that short-term insurance fraud costs the industry about 15% of premium costs or about R3 billion to R4 billion (eNCA, 2013; COVER, 2015; Fin24, 2013; Wood, 2017). In 2017, the ICB estimated the insurance fraud rate at 12% and reported that short-term insurers could be losing more than R5 billion per year to insurance fraud (ICB, 2017:2).

There is also no readily available information on insurance fraud cases reported to the SAPS, as these cases are clustered under commercial crime in the police crime statistics (SAPS, 2016:70-72). There is limited information from insurers on number of reported criminal cases to SAPS, with information only available in media reports

(COVER, 2015; eNCA, 2013; Fin24, 2013; Wood, 2017). The Association for Savings and Investments South Africa (2016) reported that the value of fraudulent claims in the long-term insurance industry increased from R755.2 million in 2014 to R870.7 million in 2015.

Irrespective of the methods used or concerns raised about the accuracy of these estimates, there is consensus amongst the various sources that incidents of insurance fraud are widespread and the costs are significant, which will remain a challenge for insurers both locally and internationally to manage (Ai et al., 2013:122; CAIF, n.d.[b]; Dionne & Wang 2013:68; Miyazaki, 2009:589; Ormerod, Ball & Morley, 2012:371; Tennyson, 2008:1184-1186). According to Dionne and Gagné (2002:214), morality, poverty, the behaviour of intermediaries, the attitudes of insurers and the nature of insurance contracts are some of the reasons for insurance fraud.

The methods to measure insurance fraud and the estimated costs associated therewith were discussed above. The different types of insurance fraud are discussed in the next section.

2.6.4 Defining insurance fraud

Snyman (2008:504) defines fraud as “the unlawful and intentional making of a misrepresentation, which causes actual prejudice or which is potentially prejudicial to another”, while Duffield and Grabosky (2001:1) describe fraud as “obtaining something of value or avoiding an obligation by means of deception”. Ramamoorti (2008:522), on the other hand, provides a more comprehensive explanation by defining fraud as “intentional acts and is perpetrated by human beings using deception, trickery, and

cunning that can be broadly classified as comprising two types of misrepresentation: *suggestion falsi* (suggestion of falsehood) or *suppression veri* (suppression of truth)".

Derrig (2002:273) defines insurance fraud as "criminal acts, provable beyond reasonable doubt, that violate statutes making the wilful act of obtaining money or value from an insurer under false pretences or material misrepresentations as a crime". However, he concedes that this definition is narrow and will not cover all the different instances of insurance fraud. Lesch and Byars (2008:412) define insurance fraud as the "deliberate deception perpetrated against an insurance company or agent for the purpose of financial gain and includes illegitimate claims, claims exaggeration and reporting fake incidents". Viaene and Dedene (2004:314) posit that the elements of material misrepresentation (in the form of concealment, falsification or lie), intent to deceive and the aim of gaining unauthorised benefit must be present to constitute fraudulent activity.

As can be noted from the above definitions, the elements of deceit, lying or misrepresentation with the intention of gaining a benefit or advantage to the detriment of someone else must be present for the conduct to constitute a crime of fraud. Viaene and Dedene (2004:314) confirm that insurance fraud consists of material misrepresentation, intention to deceive or to obtain undue benefit, and they correctly argue that a mere lack of good faith does not necessarily amount to fraud within the legal framework.

It has thus been argued, with good reason, that the legal definitions of fraud may be restrictive as they fail to encapsulate the various types of conduct associated with insurance fraud. This is especially true where such conduct may fall short with regard

to proving all the elements of fraud as a crime, despite the presence of an element of deceit or misrepresentation, as observed in cases of opportunistic insurance fraud; the mere lack of good faith is not fraud (Tennyson, 2011:151-155; Viaene & Dedene, 2004:315). Derrig (2002:273) and Weisberg and Derrig (1991:499) indicate that opportunistic fraud as a category of insurance fraud may not necessarily meet the requirements of the legal definition of fraud, and therefore feel that such conduct may be considered as falling in the “grey area”.

Hoyt (1990:304) reflects this same sentiment. Although he cites the definition of fraud from Webster’s dictionary as “... intentional pervasion of truth in order to induce another to part with something of value or to surrender a legal right”, he instead opts to refer to insurance fraud as the “abuse of the insurance mechanism for financial gain” (Hoyt, 1990:304, 305). Abuse of insurance is described as “any practice that uses insurance in a way that is contrary to its intended purpose or the law” (Viaene & Dedene, 2004:315). This term seems most apt, as it is broad enough to include the various types of conduct that would not normally be classified as fraud in the strict legal sense. There is support for this reasoning in the insurance fraud definition provided by Lesch and Byars (2008:412-413). These authors’ definition of insurance fraud is therefore preferred for this study.

Insurance fraud can be committed at any stage of the insurance lifecycle from the policy inception stage up to the claims stage, and in various ways (Insurance Fraud Taskforce, 2016:5; Miyazaki, 2009:589). All insurance product lines, including household, motor vehicle, life, all risks and other commercial insurance products, are susceptible to insurance fraud (Miyazaki, 2009:589).

2.6.5 The various faces of insurance fraud

Insurance fraud manifests itself in various forms, and being able to distinguish between these forms is critical in developing appropriate responses. Having a general anti-fraud programme to remedy the various insurance fraud types is not recommended (Miyazaki, 2009:589; Tennyson, 2011:151-155). This reinforces the argument that different fraud prevention strategies must thus be deployed for the different types of insurance fraud.

Hoyt (1990:305) and Morley et al. (2006:164) list the following types of insurance fraud by describing the different methods in which insurance fraud is committed at the various stages:

- An insurance claim incident is falsely created, for example a staged motor vehicle accident.
- The amount of the loss is overstated; that is, although the loss might be legitimate, the reported amount claimed for is inflated.
- The circumstances of the claim are deliberately misrepresented in order to receive payments under an existing policy, for example where a claim for pre-existing damage is submitted during a current claim.
- Information provided at policy inception stage is deliberately misrepresented in order to obtain an insurance policy or to obtain one at a lower premium.
- A claim is submitted to various insurers for the same loss.

Hoyt (1990:305) suggests that most insurance fraud types can be classified into the first two categories. Although insurance fraud can be perpetrated at any stage in the

insurance lifecycle (Insurance Fraud Taskforce, 2016:5), this study is limited to insurance claims fraud.

There is consensus amongst researchers and academics that insurance claims fraud generally consists of two distinct forms, namely opportunistic and planned (Crocker & Morgan, 1998:356; Haithem et al., 2014:317-318; Insurance Europe 2013:7; Miyazaki, 2009:589; Ormerod et al., 2012:371; Tennyson, 2002:36; Tseng & Su, 2013:38).

These two forms are discussed below.

2.6.5.1 Opportunistic insurance fraud

The first type of insurance fraud is commonly referred to as opportunistic fraud, which is usually perpetrated by an individual who inflates or exaggerates the value of a valid or legitimate loss suffered. The intention of this type of fraud is to obtain a better financial benefit than the actual loss suffered (Haithem et al., 2014:318; Miyazaki, 2009:589; Tennyson, 2002:36). Tennyson (2002:36) further states that opportunistic fraud is characterised by “claims exaggeration or build up”, and may be submitted by any claimant who suffers a valid or genuine loss. Crocker and Morgan (1998:356) define “build up” as “entailing the inflation of the damages associated with an otherwise valid claim”.

In a study on bodily injury liability claims, Weisberg and Derrig (1991:516) define built up claims as “an attempt by the claimant and/or health care provider to inflate the damages for which compensation is being demanded”. They indicate that, in such cases, the injury is genuine but the claim for damages is increased. They found that the payments for the built up claims were moderate and were for minor injuries; this made up about one third of claims in the sample (Weisberg & Derrig, 1991:535).

Miyazaki (2009:589) refers to this type of insurance fraud as claims padding, and describes it as the “purposeful inflation or overstatement of the actual value when making a claim”. Haithem et al. (2014:317) and Viaene and Dedene (2004:316), on the other hand, describe this type of insurance fraud as soft fraud. They report that soft fraud occurs when “claimants seize an opportunity to inflate the damages of an otherwise legitimate claim (claim padding or build up)”. They do agree that the term “soft” and “opportunistic” can be used interchangeably.

For the purposes of this study, the term “inflated claim” is used as it is a term commonly understood in the South African context. This process can thus be illustrated in Figure 1.

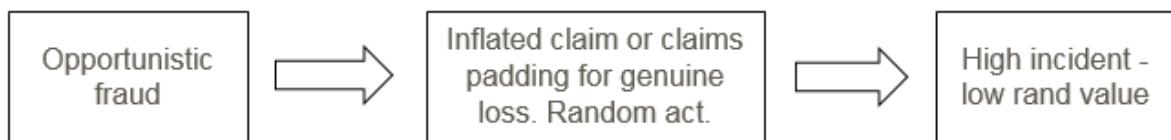


Figure 1: Process relating to opportunistic fraud

2.6.5.2 *Planned insurance fraud*

The second type of insurance fraud is referred to as planned insurance fraud. Planned insurance fraud occurs when a claim is submitted for an insured event or loss that did not occur, and involves elaborate planning with the aim of gaining financial benefit. It is simply a claiming for a loss that did not happen (Haithem et al., 2014:318; Tennyson, 2002:36, 2011:151-155;). Tennyson (2002:36) reports that this type of fraud manifests itself by falsifying of claims where the insured event did not happen, but a claim is still submitted. She further states that it is committed by professionals who fabricate the

entire loss. Crocker and Morgan (1998:356) refer to this type of fraud as “outright fraud where claims are filed for losses resulting from non-existent accidents”.

Weisberg and Derrig (1991:515) list the following as types of fraud encountered in bodily injury liability claims:

- Multiple claims submitted for a single injury.
- Medical accounts submitted for treatment which was not rendered.
- Claims submitted for non-existent or pre-existing conditions unrelated to incident.
- False claim submitted for loss of wages.

Haithem et al. (2014:317) and Viaene and Dedene (2004:316) refer to this type of conduct as “hard” fraud. They describe it as “carefully premeditated and minutely executed scams to rip off insurance”. The authors do agree that the terms “hard” and “planned” have a similar meaning. Claims for bogus or staged injuries, accidents, burglaries and fires are some examples of “hard fraud” listed by these authors.

For the purposes of this study, the term “false claim” is used as it is a term commonly understood within the South African insurance industry. This process can be illustrated in Figure 2.

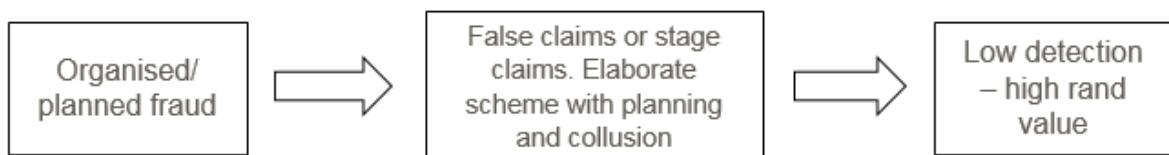


Figure 2: Process relating to organised/planned fraud

2.6.6 Progression of insurance crime

Morley et al. (2006:165) cite Clark's classification of fraudsters into "opportunists", "the amateur" and "the professional". They maintain that opportunists exploit a legitimate loss by claiming for additional items within the confines of this legitimate loss; amateurs start with opportunistic fraud and advance to claiming for staged incidents; and finally, professionals, whom they regard as the most serious type of fraudster, commit insurance fraud either individually or in an organised network (Morley et al., 2006:165). SAS (2015:1) list three types of fraudsters, namely opportunistic individuals who inflate claims to obtain benefit, deliberate fraudsters who target insurers, and organised gangs who believe that insurers are easy targets. A recent report by the Insurance Fraud Taskforce (2016), which was established in the UK to explore the causes of insurance fraud and provide recommendations, also found three categories of insurance fraudsters, namely organised gangs, those who commit pre-mediated fraud without assistance and opportunistic fraudsters.

In considering the above classification of fraudsters, there is a basis to argue that it is possible in certain circumstances that there would be a progression of insurance fraud from opportunistic insurance fraud to planned insurance fraud and ultimately to organised insurance fraud. This will occur where the fraudster who initially committed opportunistic insurance fraud progresses to more planned forms of fraud for greater returns, and thereafter more organised insurance fraud, which yields the greatest returns. This progression could be influenced by the poor control environment, the belief of low detection and the financial gain. A review of the literature did not reveal any attempt to explore such a possible progression. If the argument is accepted that progression of insurance fraud is possible, it then supports the contention that more

effort should be put into reducing opportunistic fraud. The progression can be represented as shown in Figure 3.

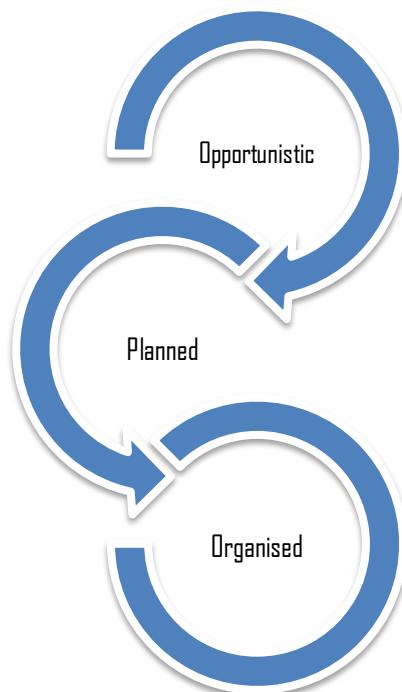


Figure 3: Interrelationship between opportunistic and organised fraud

In SA, the ICB and many short-term insurers have also classified insurance fraud in terms of organised or planned fraud and opportunistic fraud (Serious about fighting insurance crime, 2008:7).

Of the two types of insurance fraud discussed above, various authors (Miyazaki, 2009:589; Tennyson & Salsas-Forn, 2002:289; Weisberg & Derrig, 1991:499) have reported that opportunistic insurance fraud is the most common, widespread and costly type perpetrated by policyholders against insurers. These authors report that the prevalence of opportunistic insurance fraud is related to consumer attitudes because consumers do not perceive the conduct as fraud or unethical. The authors

further state that tolerance and the acceptability play a huge role in reinforcing such consumer belief.

There is support for the views expressed by Miyazaki (2009:589) and Tennyson (2002:36) in CAIF (1997:11, 2008:5) findings, which revealed that a large percentage of consumers in the US considered opportunistic insurance as acceptable. This in-depth study conducted by the CAIF (1997:11, 2008:5) identified four groups of consumers according to their tolerance levels towards insurance fraud. These and other studies are further discussed later in this chapter.

The definitions of fraud, insurance fraud and the two types of insurance fraud were introduced in the paragraphs above. Next, the effects of insurance fraud are discussed.

2.6.7 Consequences of insurance fraud

It has been discussed earlier in section 2.3 that insurance is fundamental to the effective functioning of society at different levels. Therefore, any form of insurance fraud undermines this effective functioning of insurance, which in turn negatively impacts on a functioning society (Hoyt, 1990:315). Viaene and Dedene (2004:313-314) aptly describe insurance as “being the basic pillar of modern society”, and argue that insurance fraud has the potential to destroy this. They explain that insurance fraud has far-reaching consequences in that, aside from negatively affecting insurer profitability, it also has a negative impact on the insurance value chain, the insurance industry and is harmful to society and economic structures.

Hoyt (1990:305) goes as far to suggest that insurance fraud increases moral hazard. He supports this by suggesting that the concept of insurance encourages dishonesty, thus resulting in increased levels of moral hazards. Lesch and Brinkmann (2011:18) point out that, since the dawn of insurance, there has always been the potential for insurance fraud, which in turn increased moral hazard. Ericson et al. (2000:540) argues that insurance fraud is a crime created by concept of insurance.

Insurance fraud costs and the costs of investigating fraudulent claims are costs that insurers normally pass on to policyholders, resulting in higher premiums for honest policyholders (CAIF, 2016b:1; Insurance Europe, 2013:11; Ormerod et al., 2012:371). The continuous increase in premiums has devastating consequences for society at large in that it threatens the sustainability and affordability of insurance. It has been reported that the increase in insurance fraud in certain insurance product types has resulted in premium increases, which in the UK means that, on average, policyholders pay an extra £50 per year due to fraud. This was also confirmed in an Insurance Fraud Taskforce (2016:3) finding.

Premium increases during tough economic times place huge financial pressure on already burdened policyholders. Policyholders, in an attempt to maintain financial survival, opt to cancel insurance cover as the first cost-cutting step and are forced to carry the risk themselves (Hesse, 2017; Hoosen, 2016; Wood, 2017). The payment of fraudulent claims also results in the redistribution of premiums from honest policyholders to pay claims of dishonest policyholders.

In an effort to curb insurance fraud, honest policyholders are subjected to the same stringent and rigorous process to detect fraudulent claims submitted by dishonest

policyholders (ABI, 2012:8). The claims investigation and stricter verification process affect an insurer's ability to settle legitimate claims expeditiously, thus sometimes resulting in delays (Insurance Europe, 2013:11; Ormerod et al., 2012:371). This in turn damages the relationships between the policyholder and the insurer, which can lead to a decline for insurance products or consumers lobbying for more government regulation of insurers (Lesch & Brinkmann, 2011:26). Further, the delay in claims settlement also places a strain on the trust relationship between policyholder and insurer.

The costs of insurance fraud also place financial burdens on insurers in establishing structures and creating processes to curb insurance fraud by purchasing new technology or setting up special investigative units (SIUs). The CAIF (2007:4) reports that the budget for insurance fraud bureaus increased by USD 15 million from 2004 to 2006. There has been a significant increase in the use of technology by insurers in the US to detect and prevent fraud with insurers comfortable in justifying the costs thereof (CAIF, 2016b:1-2). ABI (in Insurance Fraud Taskforce, 2016:7) reports that insurers in the UK spends about £200 million per year on technology to fight insurance fraud. These significant costs in turn place a strain on insurers' profitability targets (Pešout & Andrlé, 2011:613; Viaene & Dedene, 2004:314).

It has been reported that monies obtained from insurance fraud are used to fund other serious crimes (Insurance Europe, 2013:11; Insurance Fraud Taskforce, 2016:15). Furthermore, insurance fraud puts a strain on other governmental institutions like courts and law enforcement agencies (Insurance Fraud Taskforce, 2016:5). Other consequences of insurance fraud include policyholders having a false sense of assurance due to being duped by unscrupulous brokers with regard to the required

insurance cover, death or injury caused to innocent people due to staged accidents, and loss of jobs in the insurance sector due to huge financial losses experienced by insurers (Pešout & Andrle, 2011:613; Tchinnosian & Jay, 2018).

The discussion above provided some insights into the consequences of insurance fraud. In the next section, the discussion focuses on measures employed within the insurance sector to prevent insurance fraud.

2.6.8 Measures to prevent insurance fraud

It has been argued that insurance fraud is a crime created by the insurance industry itself due to the manner in which the industry operates (Ericson et al., 2000:540).

Wilhelm (2004:8-14) proposes the use of the “fraud management lifecycle” as a tool to effectively manage fraud within organisations, irrespective of the nature of business. He contends that the fraud management cycle consists of eight stages, namely deterrence, prevention, detection, mitigation, analysis, policy, investigation and prosecution. Wilhelm (2004:15-16) further states that each stage is a critical building block to the entire fraud management lifecycle, and recommends the integration of information technology systems for optimal effectiveness.

Lees (2012:5) posits that, because there is no one reason for committing fraud, the fraud triangle, which consists of motivation, opportunity and rationalisation, offers a useful solution in developing an anti-fraud programme. He also argues that a combination of detection, prevention, response and deterrence, supported by technology, is a key element to a good anti-fraud strategy, ensuring that the elements of the fraud triangle are aptly covered (Lees, 2012:7-8).

Ramamoorti (2008:530) and Ramamoorti, Morrison and Koletar (2009:7-10) state that, because fraud is committed by human beings, it is important when developing anti-fraud strategies to understand the reasons why the fraud was committed; they stress that exploring other disciplines that focus on understanding human behaviour is a vital component to the success of anti-fraud strategies.

Insurers have been forced to implement anti-fraud measures due to several factors, including the high monetary cost of insurance fraud, the negative impact on profitability and sustainability for insurers, decline in policyholders, government regulations preventing insurers from passing insurance fraud costs to policyholders, and stricter governance of insurers by government legislation (Ai et al., 2013:139; Ericson et al., 2000:540; Hoyt, 1990:310).

Before discussing the various initiatives implemented by insurers to prevent insurance fraud, it is useful to first look at the steps taken by governments to prevent insurance fraud. Governments have recognised and acknowledged the valuable role that the insurance sector plays in maintaining a sustainable economy, and have therefore also responded to prevent insurance fraud (Grant, 2012:4).

2.6.8.1 Government interventions

Hoyt et al. (2004:1), in a study examining the effectiveness of legislation on moral hazards, report that 43 states in the US enacted 124 new anti-fraud statutes between 1988 and 1999 for the insurance industry. This was done in a bid to prevent insurance fraud by mobilising all role players within the insurance industry to collectively act against insurance fraud. These anti-fraud statutes imposed obligations on insurers, law enforcement agencies and regulators to actively address the risk of insurance

fraud. In discussing the most important statutes, Hoyt et al. (2004:7-8) posit that the statutes aimed at insurers required that insurers define insurance fraud and warn claimants that insurance fraud is a crime. The statutes further imposed an obligation on insurers to report incidents of insurance fraud. Finally, the statutes required that insurers establish SIUs.

In analysing statutes aimed at law enforcement and regulators, Hoyt et al. (2004:9-10) found that statutes in 35 states at the time classified insurance fraud as a felony instead of a misdemeanour. Statutes enacted also made it compulsory for states to establish insurance crime bureaus with the purpose to detect, investigate and prosecute insurance fraud at an industry level. This was aimed to ensure collaboration amongst insurers to collectively assume responsibility in tackling insurance fraud. Statutes also created an obligation on prosecutors to report any licenced professional convicted of insurance fraud to the appropriate licensing authority.

All states in the US now have some or other statute dealing with prevention of insurance fraud amongst the various insurance products (III, n.d.[a]).

Governments in the Nordic countries have created cross-border co-operation agreements aimed at information sharing between neighbouring countries due to the ease with which insurance fraud scams are perpetrated between countries (Insurance Europe, 2013:13).

In the UK, the Insurance Fraud Taskforce (2016) was set up to explore the reasons for insurance fraud and provide recommendations. The report, which was finalised in 2016, was favourably received by the UK Government, which has committed to overseeing its implementation (UK Government, 2016). Since 2010, the UK

government has enacted several measures and reforms aimed at minor soft tissue claims. While these legal reforms were not specifically aimed at curbing insurance fraud, they did have an impact on reducing fraud (Insurance Fraud Taskforce, 2016:46). The Insurance Fraud Taskforce also recognises the value of existing legislation in the fight against fraud, the namely Fraud Act 2006, Proceeds of Crime Act 2002 and Contempt of Court. The Independent Sentencing Council guidelines, which were introduced in October 2014, acknowledged the harm of insurance fraud and therefore recommended longer sentences (Insurance Fraud Taskforce, 2016:48). The Insurance Fraud Taskforce (2016:22, 25) recognises the usefulness of legislation in reducing insurance fraud by reporting that the propensity to submit fraudulent personal liability claims in Sweden and France has been reduced due to legal reforms regarding whiplash claims.

2.6.8.2 The situation in South Africa

In SA, a scan of literature or legal provisions did not reveal any special effort or project by the government to tackle insurance fraud. There appears to be an acknowledgement by the Regulator in SA that insurance fraud is becoming a concern. The Financial Services Board, which oversees the activities of insurers in SA, has through Board Notice 158 of 2014 forced insurers to have appropriate policies and strategies to deter, prevent, detect, report and remedy insurance fraud (Financial Services Board, 2014:17). It also prescribes for insurers to participate in industry initiatives aimed at the prevention of insurance fraud and for the reporting of insurance fraud to regulatory authorities.

Insurance fraud cases are currently prosecuted within the confines of the crime of fraud as contained within criminal law. It can be argued that the government has not responded to insurance crime as yet because the insurance industry has been slow to elevate insurance fraud as a priority affecting society. This is supported by the fact that the insurance industry has made no attempt as yet to measure insurance fraud or provide statistics on the number of insurance fraud cases reported to the SAPS.

Viaeene and Dedene (2004:19) state that obtaining accurate and reliable statistics of insurance fraud costs would help elevate the problem through the availability of credible information. The cost of insurance fraud in SA is based on estimates that are mainly available in media reports. The lack of credible sources in SA to prove the costs of insurance fraud is a major obstacle for the insurance industry to convince the government to intervene with regulation to prevent insurance fraud.

As mentioned earlier, most countries only started measuring and keeping statistics on insurance fraud costs in the late 1980s, and the magnitude of the problem then prompted action. Prior to this, there was no focussed effort to curb insurance fraud because the costs were at best only estimates and therefore ignored. Although early methods to measure insurance fraud were criticised due to their inaccuracy, there was agreement that it was a serious problem. These first steps to quantify insurance fraud prompted action.

Insurance research in the South African insurance industry is also severely lacking compared countries like the US, UK, Canada, Australia and Germany. There is also no evidence to indicate the South African insurance industry has lobbied or is lobbying

the government for reforms to prevent insurance fraud. It could again be argued that such a call for action would prove difficult without statistics to support it.

The tobacco industry in SA is plagued by the illicit cigarette trade (Tobacco Institute of Southern Africa, n.d., 2015). In responding to this threat, the Tobacco Institute of Southern Africa was able to demonstrate the detrimental effect of the illicit cigarette trade on the South African economy in terms of harm to smokers and the loss of revenue to government by being able to quantify the losses (Tobacco Institute of Southern Africa, n.d.; Matroos, 2015). Through actively lobbying government, the sector was able to get illicit cigarette trade listed as a national priority crime, which is now being dealt with through a multi-law enforcement strategy (Tobacco Institute of Southern Africa, 2015). A similar approach was adopted to elevate copper theft as a priority crime due to its devastating impact on the economy.

Insurance fraud also has a negative impact on the economy of a country, and if an insurance company had to collapse or if the insurance premiums became unaffordable for citizens, it would have detrimental consequences for growth and stability (Grant, 2012:3; Vaughan, 2004:258-272). In SA, there is merit for the insurance industry to lobby government to treat insurance fraud as a priority crime, but this can only be done once an attempt has been made to quantify the insurance fraud losses.

The insurance sector's collective response to insurance fraud is discussed in the next section.

2.6.8.3 *Insurance fraud bureaus*

In a collaborative response to the common threat of insurance fraud, the insurance industry embarked on establishing centralised bureaus with the purpose of detecting and investigating insurance fraud. This was intended to ease the burden for a single insurer to execute the time-consuming task of identifying multiple incidents of fraud (Derrig, 2002:276). These insurance crime bureaus became the fusion centre of intelligence and information sharing amongst insurers (ABI, 2012:6; CAIF, 2007:1-23).

This collaboration has resulted in insurers in various countries setting up insurance fraud bureaus to join forces in tackling insurance fraud. Some examples of such bureaus are the Insurance Bureau of Canada (n.d.); the Insurance Fraud bureau of Australia (2015); Insurance Ireland (Ireland, 2015), the National Insurance Crime Bureau (n.d.) in the US, the Insurance Fraud Bureau (IFB, n.d.) in the UK, and the Insurance Crime Bureau (ICB, n.d.[a]) in South Africa.

According to the CAIF (2007:7), the budget for insurance fraud bureaus increased from USD 119 million in 2004 to USD 134 million in 2006. The number of employees also increased, from 1 279 in 2004 to 1 561 in 2006 (CAIF, 2007:8). The insurance fraud bureaus further reported a 20% increase in case referrals, receiving 125 000 referrals in 2005.

The IFB and Insurance Fraud Enforcement Department were formed by UK insurers in their efforts to curb organised insurance fraud, and it is reported that they spend more than £200 million annually (Insurance Fraud Taskforce, 2016:7). Since its inception in 2006 the IFB managed 133 complex investigations, issued 1 800 alerts per year and was responsible for 1 180 arrests, which resulted in 442 convictions (IFB,

2016). Insurers in the UK funded the establishment of Insurance Fraud Law Enforcement Department, which is part of City of London's Police, to investigate fraud cases reported by insurers (Insurance Europe, 2013:14).

The SA short-term insurance industry formed the ICB in 2008 to assist the industry in detection, prevention, investigation and awareness initiatives relating to insurance fraud in SA (ICB, 2017:1). The ICB (2017:17) reported in 2017 that it had 64 pending investigations totalling more than R162 million and had saved the insurance industry more than R150 million over a three-year period. Further, between 2015 and 2017, members of the ICB recovered cloned vehicles with a street value of more than R12 million (ICB, 2017:17).

These insurance bureaus support the insurance industry against insurance fraud irrespective of the countries where they operate. Some of their most important functions are discussed below.

Firstly, the insurance bureaus are responsible for collating and facilitating information sharing amongst participant insurers with a view to identifying insurance fraudsters, fraud trends and latest fraud scams across the various insurers (ICB, n.d.[a]; Insurance Europe, 2013:13; Insurance Fraud Taskforce, 2016:7-9; Viaene & Dedene, 2004:328). These bureaus invest heavily in technology to ensure that information is optimally utilised in fraud prevention activities; it is reported that the insurance fraud bureaus in the UK spends more than £200 million annually on technology (Insurance Europe, 2013:14; Insurance Fraud Taskforce, 2016:7). The ICB has deployed several technology solutions to deal with insurance fraud in SA, and in 2017, it invested

approximately R20 million in the development of technology and human resources (ICB, 2017:17).

Secondly, the insurance bureaus conduct investigations on behalf of insurers into organised and complex insurance fraud cases where multiple insurers are involved. The bureaus also co-ordinate the reporting of criminal cases to law enforcement agencies and provide support to ensure the successful prosecution of fraudsters (IFB, 2016). In 2017, the ICB was conducting 64 open investigations totalling R162 million on behalf of its member companies (ICB, 2017:17).

Finally, the insurance fraud bureaus host various reporting mechanisms where people can safely report suspicions of insurance fraud (ICB, n.d.[b]; Insurance Europe, 2013:15, CAIF, 2007:1-23). These bureaus also drive awareness and training projects on behalf of insurers (CAIF, 2007:1-23; Insurance Europe, 2013:14). In 2017, the ICB reported that it had achieved savings in excess of R18 million for member companies due to information received through the fraud line (ICB, 2017:17).

2.6.8.4 Alliance partners to combat insurance fraud

Several other bodies have partnered with insurance fraud bureaus and insurers to also take up the fight against insurance fraud. The Insurance Research Council, ABI, CAIF and Insurance Europe are examples of bodies which, amongst others, play a critical role in commissioning studies and research on the various facets of insurance fraud, thereby enhancing a better understanding of this phenomenon. They also advocate awareness campaigns with the intention to change public perception of insurance fraud and lobby relevant stakeholders to take a tougher stance against insurance fraud (ABI, 2017; CAIF, 2013; Insurance Research Council, n.d.; Insurance Europe, n.d.).

No such bodies exist in SA to support the insurance industry or the ICB with the activities described above. It can be argued that this shortcoming further prevents insurance crime from being listed as a priority for government intervention or action.

2.6.8.5 Insurers' response to combatting insurance fraud

Insurers themselves have also implemented various fraud prevention programmes to deter, prevent and investigate instances of insurance fraud. Research exploring measures employed by insurers to detect and prevent insurance fraud and determining the effectiveness thereof is limited (Morley et al., 2006:164).

There is no one silver-bullet approach to curbing the various types of insurance fraud, and therefore it is important to have a variety of interventions for an effective holistic fraud prevention programme (SAS, 2012:3). Optimal use of anti-fraud technology, supported by experienced staff, is fundamental to the success of a fraud prevention programme. It has been argued that technology and human intervention complement and support each other (CAIF, 2016b:9). These interventions are described below.

(a) Technology in fraud detection and prevention

During the early stages of insurance fraud detection and prevention, insurers began using business rules and red flags to identify suspicious claims (SAS, 2008:3). The red flags and business rules are indicators that individual insurers developed over time from experience of proven fraud, and are therefore suggestive of potential fraud (Morley et al., 2006:165-166; Viaene & Dedene, 2004:326). These red flags and business rules formed the first line of defence for insurers in their fraud prevention programmes (CAIF, 2016b:4). The screening of incoming claims against business

rules and red flags was initially a manual process conducted by claims staff or claims adjusters (Morley et al., 2006:166; Viaene & Dedene, 2004:326).

The growth in technology and software development provided insurers with an opportunity to exploit this technology for both detection and prevention of insurance fraud (Insurance Europe, 2013:14; SAS, 2008:4). The Insurance Fraud Taskforce (2016:7) reports that insurers in the UK spend more than £200 million annually on anti-fraud technology. A CAIF (2016b:3-4) study on insurance fraud technology reports that 76% of respondents stated that detecting claims fraud was primarily being conducted by anti-fraud technology, while 90% reported having automated red flags and business rules.

Insurance fraud is not only limited to claims, but impacts the entire insurance lifecycle, and technology allows insurers to detect and prevent fraud along this lifecycle (CAIF, 2016b:3). In addition to automated red flags and business rules, insurers are using technology to build predictive modelling tools that score claims on the propensity to be fraudulent, informing insurers on how to deal claims efficiently (CAIF, 2016b:4; Ormerod et al., 2012:371-372; SAS, 2008:7). Other technological solutions being used by insurers include:

- social networking analysis, which is used to identify organised crime patterns through linking relationships;
- text mining, which is used to detect similarities in claims descriptions; and
- voice stress analysis, which is used to detect stress levels.

These technological solutions are being deployed with great success in detecting and preventing opportunistic and organised insurance fraud. Insurers using these solutions

report an increase in referrals received from these systems, detection of more fraud and reduction in time to investigate claims (CAIF, 2016b:5; Ormerod et al., 2012:372; SAS, 2008:9; Viaene & Dedene, 2004:327).

Research indicates that insurers will continue to invest more in technology as it provides them with a balance between detecting fraudulent claims earlier and expediting valid claims (CAIF, 2016b:9; Insurance Europe, 2013:14). Additionally, insurers are able to access information hosted by various databases or sources that assist them in underwriting good risk clients, avoiding bad risk clients and validating claims (Insurance Europe, 2013:13; Insurance Fraud Taskforce, 2016:44-45; TransUnion, n.d.[a], n.d.[b]).

(b) Special investigation units

Claims that are flagged as suspicious or fraudulent require further investigation as mere suspicion is not indicative of fraud. Insurers have therefore created SIUs to investigate claims suspected of being fraudulent to determine whether the suspicions are valid or not (Baldock, 1997:3; Client Global Insights, 2004:4; Dionne, Giuliano & Picard, 2009:62; Ericson et al., 2000:540; Insurance Europe, 2013:13).

There are SIU teams with experienced claims staff and fraud investigators who provide advice to claims staff on how to detect and investigate fraud, SIU teams who conduct fraud investigations and also have the ability to assess claims, and SIU teams who are primarily responsible for investigating suspicious claims (Baldock, 1997:3; Client Global Insights, 2004:4; Dionne et al., 2009:62). SIU teams are generally part of insurers' operations, but some insurers have outsourced this function (Client Global Insights, 2004:4). Insurers in the US, Canada, Europe and Australia have fully

established SIU teams as a measure to investigate fraudulent claims (Ericson et al., 2000:540; Insurance Europe, 2013:13).

Ericson et al. (2000:540) report that, in 1997, an estimated 1 200 insurers had SIU teams and that one major insurer had increased the number of investigators from 300 to 1 200. In 2004, Client Global Insights (2004:4) suggested that insurers in the US received a return of USD 3 for every dollar spent by the SIU at the time. Ericson et al. (2000:540) aptly argues that, since insurance fraud is a “self-created” crime, the SIU is the insurers’ “private police” established to respond to this threat. SIU teams thus form an integral part of any insurer’s anti-fraud programme.

Staff within insurance companies are indispensable in the success of any anti-fraud programme. Even with sophisticated technology in place, the success of fraud detection and prevention is still dependent on staff involvement (CAIF, 2016b:9). Training of claims staff is conducted regularly by various anti-fraud experts to upskill them with regard to detecting the latest fraud trends affecting the insurance industry (Insurance Europe, 2013:15; Morley et al., 2006:178).

The above discussion provided an overview of the importance of technology and staff in the detection and prevention of insurance fraud. Some of the other measures used by insurance to detect and prevent insurance fraud are described below.

(c) Other measures

Insurers have used contractual terms to combat insurance fraud. Forfeiture clauses in the insurance policy contract entitle the insurer to reject any claim that is fraudulent or

contains elements of dishonesty. This provides the insurer with additional protection against fraudulent claims (Evans, 2013:15).

Insurers have also implemented various mechanisms to facilitate the reporting of insurance fraud by the general public (CAIF, 2007:11; Insurance Europe, 2013:15). This was done to encourage the public to report cases of insurance fraud in a safe and secure environment.

In SA, literature on anti-fraud programmes by insurers is limited. The available information is found in media reports. South African insurers' response to prevent and detect insurance fraud is similar to that adopted by insurers globally. To prevent insurance fraud in SA, insurers have employed various solutions as part of their anti-fraud programmes, including the following:

- optimal use of technology in the form of predictive analytics to segment claims;
- the use of SIU teams to investigate potential fraudulent claims;
- the implementation of reporting channels allowing people to report suspicions of fraud;
- exploiting external data sources for information to better underwrite risks; and
- the inclusion of forfeiture clauses in policy contracts to reject fraudulent claims according to civil law requirements (Krige, 2013:102-107; TransUnion, n.d.[a], n.d.[b]).

2.6.8.6 The approach adopted by new and emerging insurers to curb insurance fraud

Lemonade, a New York City insurer formed in September 2016, has developed an innovative way to deal with insurance fraud. Lemonade partnered with Dan Ariely, a professor in psychology and behavioural economics, and reinvented the concept of insurance in creating insurance as a charity, thus aiming to reduce fraud. Lemonade has taken technology to new heights by utilising artificial intelligence and chatbots in the insurance processes. Lemonade boasts that it is the first insurer to successfully use technology without any human intervention from insurance application to the claims and settlement process. Lemonade believes that its commitment to being more transparent, providing clients with faster service and improving the reputation of insurers will prevent insurance fraud (Moodie, 2017; Wordsworth, 2017; The Economist, 2017). However, some experts have expressed reservations about this model being the solution to insurance fraud (CAIF, 2016a).

Another insurer that has embarked on a journey of changing the concept of insurance is Pineapple, a newly formed insurer in SA. Pineapple is changing the face of insurance by providing the world's first "decentralised peer to peer" insurance. The insurer is hoping that its innovative insurance model of allowing clients to freely choose which networks they want to belong, returning unused premiums to clients and displaying high degrees of transparency where clients are informed on how premiums are spent will assist in preventing fraudulent claims (BusinessTech, 2017; Timm, 2017).

2.6.8.7 Academic contribution to combatting fraud

Academics and researchers internationally have also weighed in with valuable contribution by researching insurance fraud and proposing strategies to detect and/or prevent this phenomenon (Derrig, 2002:273). Below, the contribution of each researcher is discussed separately as the studies focussed on different aspects of detection and prevention of insurance fraud.

Hoyt (1990:311-312) posits that prevention of insurance fraud should be aimed at reducing what he terms the “utility” of insurance fraud. Hoyt explains that “utility” occurs where individuals seek to make decisions that are most beneficial to them. Hoyt (1990:313) therefore recommends that insurers should limit the probability of paying fraudulent claims and increase sanctions imposed on insurance fraudsters. Hoyt (1990:314) further argues that there is a dire need for insurers to invest in consumer education and continually engage with government and law enforcement as partners in preventing insurance fraud.

Crocker and Tennyson (2002:469-507) explored the effectiveness of optimal claims settlement strategies in automobile accidents, an environment most prone to claims inflation. They found support for the theory that claims underpayment strategies reduced the temptation by claimants to employ costly methods for claims inflation related to injury claims. However, they argue that there must be a balance between the underpayment of claims and possible litigation costs associated with underpayment, and they report that insurers should not employ bad faith tactics in this claims settlement strategy. Crocker and Tennyson (2002:504) thus suggest that, when insurers are developing claims settlement strategies, they must consider ways to

reduce the claimants' motivation to inflate their claim costs. These ways should include a settlement strategy that the claimant finds attractive and deters would-be fraudsters from employing burdensome resources to inflate claim costs.

Hoyt et al. (2004:1-34) conducted a study on the effectiveness of anti-fraud legislation on insurance fraud within the automobile insurance sector. They found support that laws relating to the mandatory formation of SIUs, laws that made insurance fraud a felony and the mandatory reporting of professionals to licencing authorities had the greatest impact on reducing insurance fraud. Strangely, though, the same study found an increase in fraud where states had laws making it compulsory for insurers to report criminal cases to authorities.

Blais and Bacher (2007:337-352), in applying the "deterrence theory", conducted a randomised field experiments at four insurers to understand what impact the threat of legal sanctions would have on claims padding. The authors state that previous literature indicated that the threat of legal sanctions was more effective in cases of white-collar crimes than with other crimes types, and therefore wanted to test this theory at insurance companies.

The study was conducted at four insurers involved a written threat letter being sent to claimants at the moment the claimants had the opportunity to inflate their insurance claims; this exercise was known as the "deterrent-letter project". Blais and Bacher (2007:346-348) concluded after the study that the deterrent letter was successful in deterring claims padding, thus proving that the threat of legal sanction has a positive effect on reducing insurance fraud. However, they argue that the threat must be made when the opportunity to commit the crime arises. Based on this, it can be contended

that, if insurers want to successfully implement the deterrent letter, the letter must be sent to the policyholder at the claims reporting stage so as to remove any opportunity.

Morley et al. (2006:163-180, also see Ormerod et al., 2012:371-381), in an ethnographic study conducted to examine fraud prevention initiatives, concluded that the knowledge and skill held by claims staff were critical for the successful deployment of fraud prevention technology. Their study revealed that the knowledge of the claims staff, which was gained from years of experience, was not optimally utilised in fraud prevention efforts within the companies being studied, and that the skills and knowledge of the claims staff were not considered during anti-fraud technology implementation. They therefore recommend that there must be cohesion between an insurer's claims processes and its fraud detection processes, and that such fraud detection processes must be able to rapidly respond to the changing nature of different insurance fraud scams.

A search for similar types of research conducted by South African academics or researchers yielded no results, once again illustrating the lack of insurance fraud study in SA.

The discussion above provides valuable information for insurers to utilise or consider when developing anti-fraud strategies. It also provides an array of options that insurers can integrate into a holistic anti-fraud strategy instead of focussing on one specific solution.

The information contained above is based on research and studies conducted internationally. It is argued that the recommendations and solutions contained in these studies can also be used by insurers in SA, as they are generic in nature. The

deterrence letter, developing claims settlement strategies that reduce the temptation to commit insurance fraud, using technology and leveraging the skills and knowledge of claims staff in anti-fraud strategies are some of the recommendations that South African insurers can implement.

Much of the discussion thus far focussed on role of insurers, insurer bodies and law enforcement agencies in detecting, preventing and responding to insurance fraud. As consumers of insurance products, policyholders are important stakeholders in the insurance lifecycle, and consideration must be given to them when developing anti-fraud strategies. It is important to understand why policyholders commit insurance fraud and what factors enhance or inhibit a policyholder's propensity to commit insurance fraud. The next section provides some details regarding this aspect.

2.6.9 Consumer attitudes towards insurance fraud

Insurance fraudsters employ their skills even in times of catastrophes, seeking opportunities to commit insurance fraud when restitution from insurers is needed by innocent honest policyholders. During Hurricane Katrina, there were numerous cases of inflated claims and cases of arson committed by policyholders who set fire to their properties after the floods because they did not have flood cover (III, 2017). This resulted in the Department of Justice establishing the Hurricane Katrina Fraud Task Force to investigate insurance fraud cases, which eventually culminated in the permanent establishment of the National Centre for Disaster Fraud, whose mandate it is to investigate, amongst others, insurance fraud cases during catastrophic events (III, 2017). This clearly illustrates the magnitude of insurance fraud and the lengths to

which policyholders will go, committing insurance fraud even during times of human tragedy.

International literature refers to policyholders as consumers, as policyholders are consumers of insurance products. For the purposes of this discussion, the terms policyholders and consumers mean the same thing and are used interchangeably. Understanding consumers' attitudes may be key to explaining their fraudulent insurance behaviour (Tennyson, 2002:36). Furthermore, Tennyson (2002:38) advocates that understanding consumer attitudes is in the public's interest, which will ultimately benefit the insurance industry. A consumer's attitude towards insurance fraud is therefore an important aspect in this research.

A central concept emanating from some of the studies on consumer attitudes is the acceptability of and tolerance for insurance fraud (Tennyson, 1997, 2008). Factors enhancing and inhibiting acceptability and tolerance are thus also discussed in this section.

In cases of opportunistic insurance fraud, policyholders are prepared to exploit the opportunity of a genuine loss to inflate their legitimate claims. This begs the question of what drives honest policyholders to engage in such dishonest behaviour. Tennyson (2002:36) postulates that the answer to this rests in understanding the attitudes of consumers and the factors that influence them as consumers of insurance products to accept insurance fraud. She states the dishonest behaviour is linked to consumer attitudes.

Tennyson (2002:36) further contends that, while planned fraud can be best managed by enhanced detection and stronger sanctions, reducing opportunistic fraud will

require a better understanding of consumer attitudes. Miyazaki (2009:590) argues that an effective strategy can only be developed to curb insurance fraud acceptability if the factors that enhance consumer acceptability of insurance fraud are better understood.

Insurance research on consumer attitudes is limited (Brinkmann & Lentz, 2006:177; Dean, 2004:68; Miyazaki, 2009:589-590). The primary major contributors for researching and writing on the topic of insurance consumer attitudes towards insurance fraud are Cummins and Tennyson (1996), Ericson et al. (2000), Lesch and Brinkmann (2011), Miyazaki (2009) and Tennyson (1997, 2002, 2008). In 2004, Dean (2004:68) commented that research on insurance consumer attitudes was limited; at that point, it was only Tennyson's (1997) research that provided information on this topic.

The most notable surveys on consumer attitudes towards insurance fraud were conducted in America by the CAIF (1997, 2008). The data from these surveys formed the basis of several analytical studies that further provided more insight on consumer attitudes towards insurance fraud (Tennyson, 1997, 2002, 2008). A scan of literary sources in SA indicates that no academic studies of consumer attitudes towards insurance fraud have been conducted in SA.

The various factors influencing consumer attitudes are discussed below.

2.6.9.1 *Moral hazard*

An important aspect emanating from studies on consumer attitudes and insurance fraud is “moral hazard”, which several writers believe plays a role in consumer attitudes toward insurance fraud (Baker, 2000:559-577; Cummins & Tennyson,

1996:29-50; Ericson et al., 2000:532-558; Hoyt, 1990:304-305). It is thus important to begin the discussion by exploring moral hazard and its relevance to consumer attitudes towards insurance fraud. Hoyt (1990:304-305) comments that the potential for insurance fraud and the increase in consumers' moral hazard started with the formation of insurance.

The term moral hazard was initially used to describe risks associated with insured property in fire insurance, but this term was later expanded to describe people's behaviour (Baker, 2000:561). Cummins and Tennyson (1996:29) posit that moral hazard arises when the conduct of the consumer's behaviour is such that it impacts on the probability of an event happening, or on the amount of the damage caused by such an incident. Ericson et al. (2000:537) defines moral hazard as "the ways in which an insurance relationship fosters behaviour by any party in the relationship that immorally increases risk to others". Arrow (1963:961) defines moral hazard as "the effect of insurance on incentives".

Some writers argue that the mere creation of the concept of insurance itself has created moral hazard in the insurance industry (Baker, 2000:565; Ericson et al., 2000:532-558). They support this view by maintaining that insurance is structured in such a manner that it incentivises parties in the insurance relationship to embark on risky behaviour, thereby resulting in immoral consequence. This is because being insured moves the risk from the consumer to the insurer, thus reducing the consumer's risk aversion (Baker, 2000:568; Ericson et al., 2000:537).

Baker (2000:565) cites the Handbook of Adjustment of Loss or Damage by Fire for the Use of Fire Underwriters (1868) and Aetna Insurance Company (1867). He mentions

that, from these writings, it is evident that insurers at that time already realised that insurance posed a threat to morality due to the temptation created and the enticement for rewarding dishonest behaviour. Baker (2000:565) states that insurers, understanding the temptation each claim posed, took it upon themselves to minimise such temptation factors by conducting a moral assessment of the claimant.

Insurance fraud is a crime created by the insurance industry itself because the insurance contractual relationship is based only on the concept of “good faith”, thereby creating an opportunity for dishonesty (Ericson et al., 2000:540; Tennyson 2008:1181). Further, the design of insurance contracts also influences consumers' propensity to be dishonest commit insurance fraud. This is evident from a study conducted by Dionne and Wang (2013:70, 83) who examined the relationship between consumer insurance fraud and the design of insurance contracts specifically regarding two types of insurance contract endorsements, namely replacement cost endorsement and no-deductible endorsement. They found evidence that there was a specific timing pattern linked to automobile theft claims in each of the types of endorsements. In cost replacement policies, automobile theft claims increased during the existence of the contract, while in no-deductible endorsements, automobile theft claims were most prevalent during the initial periods of the contract (Dionne & Wang, 2013:72). They therefore conclude that the insurance contract design creates an inducement for consumers to perpetrate insurance fraud, thus increasing the consumer's moral hazard. This supports an earlier study by Dionne and Gagné (2002), who concluded that the probability of insurance fraud was greater towards the end of replacement cost endorsement policies.

Ericson et al. (2000:539, 543) note that practices by insurers themselves create an environment for moral hazard to flourish. They list mis-selling, over-insurance, selling the wrong products to clients, paying out claims suspected to be fraudulent and condoning dishonesty by keeping dishonest policyholders to collect premiums as some of the insurers practices that increase moral hazards amongst consumers (Ericson et al., 2000:539, 543).

Cummins and Tennyson (1996:29-50) found overwhelming evidence indicating that attitudes towards dishonest behaviour were related to the frequency of bodily injury claims. They argue that their study indicated the role of moral hazard in the automobile bodily claims, and they suggest that this could be attributed to the compensation for pain and suffering (Cummins & Tennyson, 1996:45-46). An interesting feature emanating from of this study is that claims behaviour was determined by the economic and legal environment in which the consumer was situated (Cummins & Tennyson, 1996:31).

In summarising the discussion on moral hazard, the literature also indicates that consumer moral hazard will be enhanced in the following cases:

- if there is a strained relationship between insurer and consumer;
- if there is a disconnect between the sales promise and claims experience;
- if there is a perception of bad faith by the insurer;
- if there is opportunity due to insurer not having effective validating processes;
- if there is a perception of unfairness in settlements; and
- if the consumer has the ability to morally justify the dishonesty (Baker, 2000:559-577; Brinkmann, 2005:186; Cummins & Tennyson; 1996:29-50; Ericson et al.,

2000:532-558; Hoyt, 1990:304-305; Lesch & Brinkmann 2011:19; Viaene & Dedene, 2004:321).

Lesch and Brinkmann (2011:19) aptly conclude that insurance fraud is a product of moral hazard.

2.6.9.2 *Social and ethical environment*

To further understand consumer attitudes, it is also important to analyse the studies focussing on attitudes towards insurance fraud and to identify the characteristics emanating from these studies.

Tennyson is credited for undertaking the first studies on consumer attitudes towards insurance fraud (Dean, 2004:68). Tennyson (1997:247-265) undertook a study to understand what factors influenced a consumer's attitude towards insurance fraud. She conducted her study by interrogating data obtained from a National Insurance Research Council survey of 1 987 adults. In this study, Tennyson (1997:260) found strong evidence indicating that consumers' attitude towards insurance fraud was informed by the social and ethical environment in which they found themselves. She also found that perceptions towards the insurance institution played a role; she concluded that consumers who had a negative perception of the insurance institution would be more inclined to be tolerant towards insurance fraud.

Two important aspects are deduced from Tennyson's (1997) study. Firstly, the social and ethical environment in which the consumer was located, and secondly, the consumer's perception towards the insurance company or the insurance industry, played a role in attitude formation.

2.6.9.3 Cost-benefit analysis

The simple model of rational crime was developed by Gary Becker to explain the “cost-benefit” decision-making process before someone committed a crime (Ariely, 2013:4). Ariely (2013:14) explains that this theory focussed on the benefit that would be derived from the crime, the possibility of getting caught, and the sanction that would be imposed if caught. It is worth mentioning that Ariely (2013:11-29) critically analysed the model through several experiments and did not find support for this model in its entirety. Ariely (2013:11-29) opines that there are other and more compelling factors which this theory fails to consider. These other factors are, however, not relevant to this study.

Lesch and Brinkmann (2011:20) refer to the cost-benefit analysis as “intrapersonal calculation” done by a consumer before proceeding to act fraudulently. Tennyson (1997:248) contends that the cost-benefit theory does have an impact on a consumer’s decision-making process with regard to whether to submit a fraudulent claim or not. She maintains that the actions by insurers who seldom punish consumers who submit fraudulent claims and insurers settling claims which they suspect are fraudulent will create a climate that favours consumers’ attitude for submitting fraudulent insurance claims (Tennyson, 1997:248).

Other writers have echoed similar sentiments, but have also included other aspects, such as lighter sentences being imposed for insurance fraud, insurers paying claims speedily and thus overlooking low-cost fraud in claims to gain competitive advantages, and insurers retaining dishonest consumers with the purpose of collecting premiums, as factors that reinforce consumer attitudes by creating a low risk environment (Dionne

& Wang, 2013:71, Ericson et al., 2000:539-540; Viaene & Dedene, 2004:320).

Insurance fraud is considered by criminals as an industry that is low risk but provides huge returns when compared to other crimes (Viaene & Dedene, 2004:320).

The discussion above focussed on decision-making relating to the possible risk versus the possible reward versus the possible detection versus the possible sanction as a factor in consumer attitudes towards insurance fraud. It is concluded from the discussion above that cost-benefit analysis is an important factor in the formation of consumer attitudes towards insurance fraud.

2.6.9.4 Prevalence of insurance fraud

Cherrington (2008) writes about “social desirability” and “evaluation apprehension”, stating that people will do and say things that are acceptable, or behave in a manner befitting the social norms of their peers.

The prevalence of insurance fraud and the fact that it has become common practice in society creates a more tolerant or accepting attitude towards insurance fraud (Lesch & Brinkmann, 2011:17; Miyazaki, 2009:589). It is argued that this may be so because there is no fear amongst consumers that fraudulent behaviour will be frowned upon or that there is no negative stigma attached to such behaviour, thus creating a climate where people can easily justify their behaviour (CAIF, 1997:7; Dean, 2004:68). Dean (2004:68) states that insurance fraud flourishes in an environment where it is not considered shameful and where the dishonest behaviour can be easily justified.

According to Tseng and Su (2013:39), people model their behaviour according to the response it elicits from their peers or those important to them. If the peers find the

behaviour acceptable, social consensus is reached. This social consensus allows the person to continue with the behaviour even though it might be wrong. Tseng and Su (2013:38-56) found that, due to social consensus from peers, insurance salespersons were more tolerant towards incidents of small fraud because they believed that their peers would find the small fraud acceptable.

A further factor reinforcing the social consensus of insurance fraud is how laws penalise this type of fraud. Tennyson (2008:1191) comments that previously only about 10 states in the US considered insurance fraud as a crime. This position has subsequently changed, as confirmed by Hoyt et al. (2004), who reviewed the various laws that were enacted to prevent insurance fraud. The fact that there were no specific laws dealing with insurance fraud for a long time would have certainly contributed to its prevalence and its acceptance.

In a study conducted by Weisberg and Derrig (1991:529-535) on bodily injury claims in Massachusetts, they focussed particular attention on claims received from consumers in Lawrence City, as the abnormally high claims volumes received prompted the suspicion that fraud was widespread in that area. The authors found several similarities, ranging from the use of attorneys to the type of injuries, in the manner in which claims were filed by the different claimants from Lawrence (Weisberg & Derrig, 1991:530-531). Despite the high incidents of inflated claims in Lawrence and the similarities, these authors did not probe whether community acceptance played a role. It could be contended that the prevalence of inflated bodily injury claims in Lawrence could be attributed to the claims behaviour and acceptance of the claimants, given the similarities noted in the claims patterns.

The pervasive nature and common practice of insurance fraud, or the “everyone is doing it” mentality, can be best explained by Ariely’s (2013:191-235) studies suggesting that cheating is infectious. Ariely (2013:191-235) conducted several experiments to illustrate the concept that cheating is infectious by placing an actor, unbeknown to the group, amongst a group of students, and created an observable condition where the actor was involved in cheating. This resulted in the rest of the group also engaging in cheating, which he concluded was due to the group observing the cheating behaviour and realising that there was no consequence to the cheating, leading them to follow the behaviour of the cheater.

It also emerged from additional experiments that the study group engaged in cheating when they recognised and acknowledged the person pretending to be the cheater as a peer within their own group (Ariely, 2013:204-207). People are able to justify their wrong behaviour when other people with whom they are acquainted with also participate in similar wrong behaviour, thus making their wrong behaviour more acceptable and tolerated (Ariely, 2013:195). Ariely (2013:200) uses the analogy of an “immorality virus” to indicate the infectious nature of dishonesty. He states that, in circumstances where a few people digress from socially accepted norms, they have the ability influence other people within their surroundings. He further states that the mere observation of acts of dishonesty also slowly erodes one’s own ethical beliefs (Ariely, 2013:193).

Ariely (2013:207) concludes that his experiments, which were conducted in various scenarios, confirmed that dishonesty is infectious and even the mere observation of acts of dishonesty can gradually influence behaviour. He theorises that this is what could have happened at Enron and during other major corporate scandals. This means

that, because dishonesty or cheating can easily spread in an environment where dishonesty is pervasive or common practice, this in turn makes a perfect conduit for cheating behaviour to occur. Further, no negative stigma will be attached to the dishonest behaviour as everyone is part of the group where such behaviour is commonplace, thus making it acceptable.

It is argued that, because insurance fraud is considered to be pervasive and common practice, it culminates in justification of, willingness to commit, or tolerance towards insurance fraud (CAIF, 1997, 2008; Miyazaki, 2009:589). Heath (2008:603) posits that the concept of “everyone is doing it” entails widespread acceptability of transgressions, which reduces societal compliance and removes any negative consequences which society attaches to such transgressions.

In consumer studies undertaken in 1997 and 2007 by the CAIF (1997, 2008) to explore the tolerance of insurance fraud in America, respondents indicated that insurance fraud was common and widespread, with an estimated 73% stating that it was very common or fairly common (CAIF, 1997:16). There was a substantial increase in the prevalence of insurance fraud between the first and second survey (CAIF, 2008:6-7).

In the study, cluster analysis was employed, and the respondents were categorised into four groups according to their tolerance levels of insurance fraud (CAIF, 1997:3-4):

- The realists made up 21.6% of the survey sample. They displayed a low level of tolerance towards insurance fraud and indicated that insurance fraud did occur.

- The conformists made up 26.4% of the survey sample. They were fairly tolerant of insurance fraud as they believed that many people perpetrated insurance fraud, thus making it more acceptable.
- The moralists made up 30.7% of the survey sample and displayed the lowest tolerance level towards insurance fraud. They indicated that there was no reason for committing insurance fraud.
- The critics made up 21.2% of the survey sample. They did not believe that insurance fraud was common (CAIF, 1997:16).

The CAIF studies (1997, 2008) on consumer tolerance levels and the clustering of respondents according to their tolerance levels was significant because it highlighted two important issues. Firstly, the study confirmed that the concept of tolerance is a measurable construct. Secondly, it indicated that the concept of tolerance could be used to segment consumers (CAIF, 1997:10-11; 2008:5-6). Brinkmann and Lentz (2006:184-188) successfully employed a similar clustering methodology to the CAIF (1997:10-11; 2008:5-6) to categorise the respondents in their study. This illustrates that clustering according to tolerance levels is possible.

The pervasive nature and common practice of insurance fraud play a role in consumer attitudes by enhancing a more accepting and tolerant attitude towards insurance fraud. This is due to the lack of moral stigma and the ease of justification based on the rationalisation that “everyone is doing it” (Heath, 2008:603). The discussion below briefly provides some context on the concept of tolerance.

2.6.9.5 *Tolerance*

According to Forst (2017:1), toleration refers to “the conditional acceptance of or non-interference with beliefs actions or practices that one considers to be wrong but still “tolerable” such that they should not be prohibited or constrained”. While toleration refers to a practice, tolerance refers to attitude (Forst, 2004:315).

Toleration consists of three important components, namely objection, acceptance and rejection (Forst, 2004:314; Valdés, 1997:127-128). The objection component requires that the tolerant individual at the outset considers the belief or conduct to be wrong or morally unacceptable (Forst, 2004:314-315, 2014:67). It would not amount to toleration if the objection component was missing, but would amount to “indifference” or “affirmation” (Valdés, 1997:128).

The objection component is harmonised through the acceptance component (Forst, 2017:1). The acceptance component does not remove the tolerant individual’s view that the belief or conduct is wrong or morally unacceptable, but rather suppresses that view (Forst, 2014:67). According to Valdés (1997:128) and Forst (2004:315; 2014:67), there are positive reasons overriding the initial reasons that formed the basis for the tolerant individual concluding that the belief or conduct was wrong or morally unethical; this therefore results in toleration.

Toleration has a limit, which is referred to as the “limit of rejection” or the “rejection component” (Forst, 2017:1, Valdés, 1997:128). This refers to the point where the reasons for rejection are more overwhelming than the reasons for acceptance, thus ending the toleration. Forst (2004:315, 2014:67-68) and Valdés (1997:128) posit that

toleration must be intentional and voluntary; the individual must have reason for the acceptance and the individual must act repetitively.

Tolerance has been successfully used as a measurable construct in several studies on consumer attitudes toward insurance fraud (CAIF, 1997, 2008; Tseng & Su, 2013). The CAIF (1997, 2008) used cluster analysis to categorise four groups of respondents according to their tolerance levels for insurance fraud. This study also highlighted the specific strategy required to change behaviour for each group of respondents identified (CAIF, 1997:20, 2008:14).

Several studies (Brinkmann & Lentz, 2006; Dean, 2004; Miyazaki, 2009; Tennyson, 1997, 2002; Tseng & Su, 2013) on insurance fraud, focussing on consumer behaviour, identified reasons such as relationship with insurers, recent claims experience, consumer education, consumer ethics and claims deductibles as influencing consumer behaviour toward towards insurance fraud. It is argued that these reasons will have an impact on a consumer's tolerance level towards insurance fraud, especially as it relates to the acceptance component where the reason to accept trumps the negative belief that the behaviour is morally unacceptable.

2.6.9.6 *Situational ethics*

Brinkmann and Lentz (2006:177) define consumer ethics as "describing, understanding and criticising consumers and their behaviour from a moral perspective". Ethical attitudes refer to the manner in which a consumer views a certain conduct or action as either being right or wrong (Tseng et al., 2014:325).

Consumers no longer only consider the rightfulness or wrongfulness in deciding whether a behaviour is acceptable or not; there is a greater tendency to consider other factors as well (CAIF, 2008:7). This is referred to as “situational ethics”, where the concept of only right and wrong is stretched to include other factors such as “no one is getting hurt” or “everyone is doing it” in the ethical decision-making process. Ericson, Barry and Doyle (2000:538) write about “situational opportunities”, which they state are caused by ineffective claims processes or inadequate underwriting processes, and term these as examples of “bureaucratic inefficiencies”.

Brinkmann (2005:183) writes about “situational handling”, where he states that the decision on consumer ethicality is based on factors relevant to a specific situation (also see Miyazaki, 2009:590). It is during this process that consumer ethics are important. Dionne and Wang (2013:69, 74, 83) found that insurance fraud increased during a recession, indicating that financial difficulties cause low consumer morality.

Various writers on the topic have summarised consumer ethical decision-making philosophies as moralism, utilitarianism and justice theory (Brinkmann, 2005:183-197; Dean, 2004:68-69; Lesch & Brinkmann, 2011:17-32; Miyazaki, 2009:590-591; Tennyson, 2011:151-155). Moralists will argue that insurance fraud is wrong and unethical without exception; their view is that no reason exists for such conduct. The supporters of utilitarianism or justice theory believe that the decision to commit insurance fraud will be premised on the fairness of the outcome or the extent to which others will be impacted by such action (CAIF, 2008:7; Miyazaki, 2009:590). The CAIF (2008:7) found that 67% of respondents indicated insurance fraud was acceptable with the proviso that no one got hurt. More startling was that 64% indicated that insurance

fraud was acceptable if there were “extenuating circumstances”; the actual description of what “extenuating circumstances” entailed was not provided (CAIF, 2008:7).

Dean (2004:68-69) posits that individual consumers will use moralism (“rules based judgements”), utilitarianism (judgements based on “consequences of the outcome”) or judgements based on “fairness of the outcome” when making ethics-related decisions. In his study on consumer ethics with regard to insurance fraud, Dean (2004:67-79) found that females found “claims padding” to be more unethical than males (Dean, 2004:77). Dean (2004:77) cites Dawson’s socialisation theory to explain the difference in ethical judgements between male and female. This theory suggests that the differences that shape male and female personalities during childhood development also shape their interests, values and concerns. Dean (2004:77) did not find support for the hypothesis that the interactions between the policyholder and the insurance agent or the insurance company had an effect on the ethical perceptions of claims padding when controlling for several factors.

Miyazaki (2009:589-598) contends that “situational factors” will affect a consumer’s ethical perception on claims padding. While agreeing with the ethical decision-making process as outlined by Dean (2004:68-69), Miyazaki’s (2009:590-591) study focussed specifically on justice and fairness. Miyazaki’s (2009:590-592) study used insurance deductibles as the situational factor in considering the fairness and justice aspect to determine whether it would affect a consumer’s ethicality towards claims padding. The study found that the insurance deductible did have a bearing on the ethicality of claims padding. There was a greater acceptance of claims padding in situations where there were higher deductibles, and respondents proposed higher settlements (Miyazaki, 2009:595). Interestingly, though, this finding was only relevant to respondents who

displayed low levels of ethicality. Respondents who displayed a high degree of ethicality were unmoved by the high deductibles (Miyazaki, 2009:595).

During Brinkmann and Lentz's (2006) study on insurance consumer dishonesty, they collected data from business students in Norway and Germany. They found that the respondents from Germany were more tolerant to insurance fraud than the respondents from Norway (Brinkmann & Lentz, 2006:184). When comparing insurance consumer dishonesty and dishonesty in other environments, they found that respondents displayed a more accepting attitude towards insurance dishonesty than drinking a can of cola without paying and swapping the price tag of an item (Brinkmann & Lentz, 2006:185).

Several studies have been conducted (Brinkmann, 2005; Dean, 2004; Miyazaki, 2009) to explore the effect of fairness on the consumer's attitude towards insurance fraud, but Tseng et al. (2014:321) found no study exploring the relationship between loss-premium comparison and a consumer's acceptance of insurance fraud. In an effort to address this shortcoming, Tseng et al. (2014) undertook the first study to examine the effect of fairness and loss-premium differences on a consumer's acceptance of insurance fraud. They define loss as the actual damages suffered by the consumer during an event and premium as the cost of insurance cover or the insurance product (Tseng et al., 2014:322). These concepts have a huge impact on consumers' acceptance of insurance fraud (Tseng et al., 2014:322). Tseng et al. (2014:323-333) used the equity theory, distributive justice and attribution theory, and concluded that loss-premium comparisons did play a role in the consumer's acceptance of insurance fraud. They also found that perception of fairness and the perception of comparative

fairness influenced a consumer's ethical decision-making process regarding insurance fraud (Tseng et al., 2014:332).

Consumers contemplating to commit acts of dishonesty are confronted with an internal conflict with their own value system of always doing the right thing against the act violating their value system by doing something knowing that it is wrong (Ariely, 2013:27, Heath, 2008:602). This internal conflict is managed through a "technique of neutralisation", which seeks to harmonise the value system and the violation thereof (Brinkman, 2005:186-187; Duffield & Graboski, 2001:1-6; Sykes & Matza, 1957:666-667). The technique of neutralisation or rationalisation is a process whereby the dishonest consumer attempts to preserve his or her self-image by justifying the wrongful behaviour with plausible excuses to explain the wrongful behaviour away; this is done to remove feelings of guilt (Tennyson, 2011:151-155; Viaene & Dedene, 2004:321).

Sykes and Matza (1957:667-669) studied juvenile delinquency, and identified and categorised five neutralisation techniques used in cases of dishonesty to remove feelings of guilt. They summarise these techniques as follows:

- **Denial of responsibility:** the individual shifts the blame for the dishonest behaviour to someone else or to certain circumstances. In the case of insurance fraud, the consumer could state that he or she was advised by the broker or family members to act in a dishonest manner.
- **Denial of injury:** the individual minimises the impact of the dishonest behaviour or totally rejects that any harm was caused. In the case of insurance fraud, the

consumer could argue that the financial impact of the dishonest behaviour was minimal or that insurance fraud is a “victimless crime”.

- **Denial of victim:** the individual appreciates the wrongfulness of their dishonest conduct but contends that the victim “deserved it”. In the case of insurance fraud, the consumer could argue that the insurer unfairly rejected a previous claim or that the insurer is always looking for reasons to reject claims.
- **Condemnation of the condemners:** the individual attacks the credibility, the rules or processes of the victim, contending that this was the cause for the dishonest behaviour. In the case of insurance fraud, the consumer could assert that the insurer’s policy conditions unfairly impacted on him or her receiving a fair settlement for the loss suffered; therefore, he or she inflated the claim.
- **Appeal to higher loyalties:** the individual argues that he or she did not personally benefit from the dishonest act, but performed it for the benefit of others. In the case of insurance fraud, a consumer could argue that he or she submitted a false insurance claim to use the monies to pay a medical bill for a sick family member.

Heath (2008:603) posits that there are two other categories of neutralisation techniques, namely “everyone else is doing it” and “claim to entitlement”, which have been identified by other authors. He states that the concept of “everyone else is doing it” allows the individual to escape guilt due to social acceptance of the specific dishonest behaviour. He further advances the argument that, in such an environment, compliance will be difficult to achieve as there is a social rejection of any negative consequences attached to non-compliance. In the case of insurance fraud, a consumer who submits an inflated claim argues that there is nothing wrong with the behaviour because “everyone is doing it”.

In “claim to entitlement”, the individual may claim that he or she was fully within his or her rights to act or that there was injustice committed by the victim. In the case of insurance fraud, a consumer who submits a false claim could argue that it was done to recoup previous years’ premiums when no claims were submitted, or that the insurer was sanctioned by the regulator for bad customer service.

Ariely (2013:27) posits that people want to feel good about themselves while at the same time profiting from cheating. He maintains that people are able to harmonise these conflicting goals through the “fudge factor theory”. The “fudge factor theory” operates on the basis that people have an appetite for a certain cheating limit, meaning that, as long as people cheat a little and are within their desired cheating threshold, they are able to justify their action and still able to feel good about themselves (Ariely, 2013:29).

Jones (1991:374) asserts that ethical decisions are taken on the basis of the amount of harm caused to victims or the benefit accruing to beneficiaries; he refers to this as the “magnitude of consequences”. Tseng and Su (2013:40) argue that there is a link between the fraud size and the fraud tolerance displayed by insurance salespersons in Taiwan. Tseng and Su (2013:38-56) found evidence to support that a relationship exists between social consensus, the perceived fraud sizes related to opportunistic and planned insurance fraud, and the insurance salesperson’s insurance fraud tolerance level. They found that, for both opportunistic and planned insurance fraud, salespersons would be more accepting of the fraudulent behaviour if the fraud size was small, believing that there would be high social consensus among their peers.

In relation to insurance fraud, it could be argued that dishonest consumers may also have an amount or percentage which they are able to justify as acceptable for inflated claims. No record exists of research exploring what a possible acceptable amount for an inflated claim would be.

The CAIF's (1997:16-17, 2008:11-12) studies on consumer tolerance for insurance fraud conducted in the US found that neutralisation techniques provided a justification for respondents to be more accepting of insurance fraud. Studies by Ericson et al. (2000:537), Miyazaki (2009) and Tennyson (1997, 2002) found that factors such as perception of the insurance industry, previous claims history, deductibles and fairness played a role in justifying accepting attitudes towards insurance fraud. Neutralisation techniques are strategically employed by consumers as a tool to evade feelings of guilt. It is argued that neutralisation techniques will definitely have an influential impact on consumer attitudes towards insurance fraud, as noted from the discussions above.

2.6.9.7 Perceptions of the insurance industry

The perception of the insurance industry is an important factor in determining a consumer's attitude towards insurance fraud, and this perception is informed by issues such as trust, the insurer's financial stability, fairness and an insurer's premium rates (Tennyson, 1997:251-260).

An EY (2014:9) global consumer insurance survey found that consumers' trust in insurance companies was the lowest when compared to the banking sector, supermarkets, car manufacturing and online shopping. These results were surprising considering all the financial scandals within the banking sector and scandals within the car manufacturing industry. The survey found that individuals with lower income

displayed low levels of trust, and that there were low levels of trust in mature insurance markets compared to developing insurance markets (EY, 2014:10). Consumers listed “value for money”, “brand reputation”, “easy to understand, clear communications and “being easy to deal with” as important for them when dealing with insurance companies (EY, 2014:10). Consumers further indicated that other factors that were significant for them as per insurance product were “financial stability” for life products, and “being easy to deal with” and “being responsive” for non-life products (EY, 2014:10). This survey underpins the findings from several studies (CAIF, 1997, 2008; Dean, 2004:78; Tennyson, 1997, 2002) illustrating the importance consumers attach to the reputation of the insurance industry.

The finding that low levels of trust will have an impact on consumer attitudes towards fraud supports the findings of the CAIF (1997, 2008) and Tennyson (1997, 2002). It is argued that low levels of trust will increase consumers’ accepting attitudes toward insurance fraud. Insurers are therefore presented with a challenge to rebuild trust with their consumers, not only to attract more consumers, but more importantly to realise that high trust levels will lower consumers’ accepting attitudes towards insurance fraud.

Tennyson (2002:35-55) conducted a study based on an analysis of data from a CAIF survey conducted in 1997. This study also involved the examination of consumer attitudes towards insurance fraud by exploring consumers’ claims experience and consumers’ understanding of insurance processes. Tennyson (2002:37) wanted to determine whether these factors played a role in shaping consumers’ attitudes towards insurance fraud. Tennyson (2002:52) found a direct link between a consumer’s attitude towards insurance fraud, the number of insurance products a consumer had and the

claims experience. It was found that consumers with positive claims experiences and more insurance products were less likely to find insurance fraud acceptable. The study also highlighted the importance of educating consumers because there was evidence in the study to support the view that consumers who understood insurance processes would have a lower tolerance for insurance fraud (Tennyson, 2002:53).

In a consumer survey conducted by Accenture (2010:4), 55% of respondents indicated that poor service from an insurance company may most likely prompt a person to commit fraud against the insurance company. Ericson et al. (2000:537) also point out that, if the insurer does not maintain a relationship with the consumer or if there is a disconnect between the sales promise and the claims experience, the relationship becomes strained and creates an environment of unethical behaviour. This finding highlights the importance of the relationship between the insurer and the consumer.

Viaeene and Dedene (2004:321) state that insurers cannot merely assume that consumers have an understanding of how the insurance process works. They argue that this lack of understanding could lead to either unintentional insurance fraud by consumers or greater accepting attitudes of consumers towards insurance fraud because they do not understand the impact of the said fraud.

Würmli (2011:1-4) comments that the value and success the insurance industry has achieved in building a sustainable society has been well demonstrated. Würmli also notes that there was a severe lack of public trust displayed towards insurers despite the important role of the insurance sector. He argues that the lack of trust was caused by the lack of transparency on the part of insurers. He argues that insurers must be more transparent about their insurance processes if they want to improve the trust

relationship with consumers. There is also support for this in the EY (2014:11) survey, where consumers listed “easy to understand, clear communication” as second most important in their relationship with insurers.

The image of the insurance industry will dictate how consumers will respond towards insurance fraud. Studies have confirmed that there is a relationship between consumers’ attitude towards insurance fraud and their perception of the insurance industry. The more positive the perception, the less likely it is that consumers will be accepting of insurance fraud. Lesch and Baker (2011:107) aptly point out that, if the insurance industry acted in a manner perceived to be unethical or unfair, then those affected will feel justified in also behaving unethically.

2.6.9.8 Information asymmetry as an opportunity to commit insurance fraud

This section examines asymmetry of information as a factor that creates opportunities for consumers to commit insurance fraud. Consumers most likely commit fraud when an opportunity exists and when they believe they can get away with it. An Accenture (2010:7) survey found that 68% of respondents felt that people committed insurance fraud because they believed they could get away with it; this was up from 49% in a similar survey conducted in 2003. These findings indicate that the belief is rife that there are opportunities to commit insurance fraud and that there is a low detection rate.

It has been suggested that insurance is vulnerable to insurance fraud and abuse due to the mere nature of its business operations (Lesch & Brinkmann, 2011:18). The insurance model, which is primarily structured around information exchange, has created opportunities and incentives to prevent consumers from fully disclosing all

material information (Derrig, 2002:275; Outreville, 2010:488). Schiller (2006:421) posits that insurance fraud takes place due to the private information a consumer has about the incident regarding the claim.

Cressey (1953) has been credited with developing the “fraud triangle”, a model used to explain the reasons why people commit fraud. Cressey postulates that the fraud triangle consists of three elements, namely:

- perceived need or pressure, referring to financial or other benefit to be gained from the fraud;
- perceived opportunity, referring to the great ease and low detection in committing the fraud; and
- perceived rationalisation, referring to the individual's ability to justify the act of committing fraud.

Insurance is a contractual relationship between the insurer and the consumer based on good faith (Lesch & Brinkmann, 2011:17). The contract places a reciprocal duty on the consumer to pay a specific premium amount and, in return, the insurer will indemnify the consumer on the occurrence of an insured peril (Lesch & Brinkmann, 2011:18; Reinecke et al., 2002:3).

The concept of good faith rests on the premise that both insurer and consumer will at all times disclose all material information to each other for the duration of the contract (Viaene & Dedene, 2004:314). This means that information exchange between consumer and insurer is a vital component to good faith. Several researchers assert that the opportunity to commit insurance fraud is created by information asymmetry

during the various information exchange interactions (Dionne, 2012:8-14; Lesch & Brinkmann, 2011:18; Schiller, 2006:422; Tseng & Shih, 2012:164).

Information asymmetry exists when one contracting party is privy to more information than the other party (Outreville, 2010:485; Shi & Zhang, 2014:557; Tseng & Shih, 2012:164). Information asymmetry is particularly relevant to the insurance industry as the insurer would require private information to which only the consumer has access. This information is required for premium calculation, risk classification and claims evaluation (Dionne, 2012:8). Therefore, the insurer would require the consumer to disclose all material information at the underwriting stage for premium calculation and for the validity of insurance contract, as well as to disclose material information regarding the circumstances of loss at the claims stage for the claim to be settled.

This does pose a challenge for insurers and, in order to overcome information asymmetry during the claims process, insurers have employed claims adjusting processes, which are aimed at limiting information asymmetry. However, such processes are costly and places a strain on resources (Crocker & Tennyson, 2002; Lang & Wambach, 2013).

Van Wolferen, Inbar and Zeelenberg (2013:15-16) state that information asymmetry leads to the insurer's inability to verify critical health information, and even suggest that it creates an opportunity for the consumer to fake doctor's visits. They also highlight the fact that the insurer is not able to observe the consumer's risky behaviour, which could have an impact on contractual terms. They further contend that insurance fraud due to information asymmetry is more specifically a result of the insurer's inability to directly observe when claims are lodged (Van Wolferen et al., 2013:19).

This information asymmetry thus places the consumer in an advantageous position in deciding which information to disclose, considering the harm or benefits that could accrue to the consumer based on the information supplied. According to Viaene and Dedene (2004:320), because the insurer is dependent on information provided by the consumer, the insurer has no option but to trust the consumer – this is where the opportunity for manipulation of information exists. Stiglitz (2009:67) contends that a consumer has better information than the insurer about his or her health, specifically regarding smoking and drinking habits; he indicates that this has resulted in consumers acting in bad faith by not furnishing correct information.

A consumer's knowledge that he or she has the private information advantage and can benefit from this is a good enough motivation for committing insurance fraud (Lesch & Brinkmann, 2011:18). There is therefore sufficient incentive for a consumer to omit or misrepresent information provided to the insurer, since the consumer understands that there is a lack of perfect information and that he or she is the only person privy to the said information. Tseng and Shih (2012:164) assert that information asymmetry is one of the reasons why consumers claim for losses not covered in the insurance contract. They state that this is evident in car insurance products where a consumer incepts insurance cover and thereafter claims for losses not covered.

Baker (2000:565) aptly concludes that "even good people had to be protected from the temptation that insurance could create". He therefore posits that claims must be validated that because of the temptation factor involved during the submission of a claim. It has also been suggested that claims adjusting processes employed by the insurer, albeit costly, are aimed at limiting information asymmetry (Crocker & Tennyson, 2002; Lang & Wambach, 2013).

The insurance industry is an information-intensive business, which is dependent on the consumer's discretion to furnish what information he or she wants to, realising the harms and benefits that could accrue given the nature of the information supplied by the consumer. The lack of accurate information has forced insurers to place trust in the information received from the consumer, yet it has been noted that consumers are not very trusting of the insurance industry (EY, 2014:9; Lesch & Brinkmann, 2011:25-26). It follows that information asymmetry places the consumer as the owner of the private information in a dominant position to manipulate this trust and provide information for own benefit.

The insurer also has access to private information, namely information regarding policy conditions, underwriting guidelines, risk segmentation rules and claims processes (Ericson et al., 2000:535; Viaene & Dedene, 2004:315). Tennyson (2011:151-155) illustrated this by explaining the difference in consumer experience where care is demonstrated during the sale of insurance products, while during the claims stage the same consumer experiences insensitive treatment by use of technical and legal policy wordings. In not disclosing or explaining all material information to the consumer, an opportunity is created for the insurer to be unethical and act in bad faith (Crocker & Tennyson, 2002:470; Lesch & Brinkmann, 2011:26).

Dionne (1984:304-321) went further and explored the opportunities for fraud that information asymmetry presented for insurance service providers, namely garage owners, surgeons and doctors. He argues that garage owners, surgeons and doctors possess information of a technical nature about which the consumer has no knowledge. This imbalance of information creates an opportunity for fraud on the part of insurance service providers.

This section illustrated that, because the insurance contract and the related insurance process are information-sensitive and based on good faith by the consumer, service provider and insurer, information asymmetry creates an opportunity for any of these parties to undermine the element of good faith. The owner of the information wields the dominance and exploits the opportunity by considering the benefit that may be gained when deciding what information to disclose whenever a need arises for information disclosure.

2.6.9.9 Perception that insurance fraud is a victimless crime

This section scrutinises reality of consumers' perception that "insurance fraud is a victimless crime" (Insurance Europe, 2012:5). Tennyson (2011:151-155) contends that a consumer's willingness to cheat is decided based on the harm caused to others; a consumer will be more willing to cheat if the harm to others is minimum or non-existent. Accordingly, Tennyson (2011:151-155) states that consumers will more readily perpetrate insurance fraud because there is seemingly no visible victim or noticeable harm.

A victimology analysis needs to be undertaken to determine the veracity of the perception that insurance fraud is a victimless crime. Kirchhoff (2005:54) defines victimology as "a scientific study of the victim of human rights violations (including crime), of victimisations and of the reactions to both of these". In essence, it is a scientific study that pays particular attention to the plight of the victim. Victimology considers both primary victimisation, where the harm is caused through direct interaction with the victimiser, and secondary victimisation, which refers to the harm caused to the social environment (Kirchhoff, 2005:55). Kirchhoff (2005) further

elaborates that harm or damage caused by victimisation can manifest itself in emotional, physical or material form.

Insurance literature focussing on an in-depth analysis of identifying the actual victims and the type of victimisation they suffer is limited. The available literature makes brief references to honest policyholders paying higher premiums, insurers experiencing financial burdens due to implementation of costly anti-fraud measure and impact on society (Insurance Europe, 2012:9-11; Insurance Fraud Taskforce, 2016:15-16, Pešout & Andrle, 2011:613; Viaene & Dedene, 2004:314).

Below, an attempt is made to identify most of the victims and determine the type of victimisation they experience based on the limited literature.

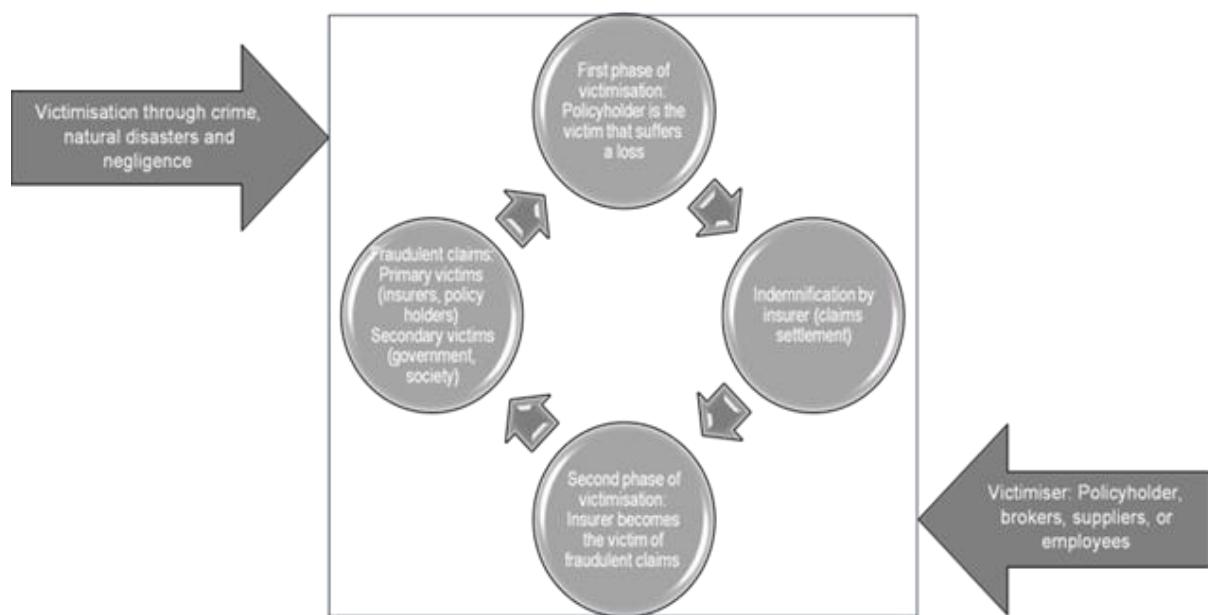


Figure 4: Insurance fraud and victimisation model (Chetty, 2014)

The model in Figure 4 above suggests that there are two possible phases to insurance fraud victimisation, and it is thus important to discuss both.

(a) First phase of victimisation

In the first phase of victimisation, the consumer is the victim and experiences loss or damage. It is contended that this form of victimisation occurs when the specific insured event materialises and the consumer suffers a loss or damage. Here, the consumer becomes the primary victim and friends or family who were also affected by the event could be secondary victims. An example of this is the case of a motor vehicle accident where the motor vehicle is damaged and a family member is injured. This is the essence of what an insurance contract promises to deliver on – restoring the policyholder to the position he or she was in prior to the loss.

The damage or harm suffered by these victims is normally financial, due to loss or damage of possession, and emotional, relating to stress caused by the harm and the concern of replacing, repairing or restoring. In more serious cases, there could be physical injury or emotional trauma.

(b) Second phase of victimisation

In the second phase of victimisation, the insurance value chain is the victim. This section attempts to identify all possible victims in the insurance value chain who are victimised or suffer harm through insurance fraud, as well as to understand the type of victimisation experienced. This section uses as much information as possible from the (limited) available literature.

An example of the second phase of victimisation is when a consumer submits an inflated or false claim to the insurer, which is paid out. Victimisation causes primary

harm to shareholders, insurers, employees and the honest consumers and secondary harm to the government and society.

According to Viaene and Dedene (2004:314), insurance fraud poses a threat to the entire insurance value chain. Shareholders experience both financial and emotional harm. Financial harm includes, amongst others, increase in operating costs, reduction in profits, additional costs to implement anti-fraud measures, decrease in return on investments, loss or reduction of bonuses and possible downgrading. Emotional harm experienced by shareholders will include anxiety about the state of business, embarrassment, and fear for loss of trust and confidence by consumers.

Honest consumers are also primary victims of insurance fraud. The policyholder will experience financial harm due to an increase in insurance premiums, increase in excess payments and delay in receiving claim payments due to lengthy claims processes (ABI, 2012:5; Insurance Europe, 2012:11). It is estimated that, in the UK, consumers have to pay an extra £50 per year due to insurance fraud (Insurance Europe, 2012:11). In a CAIF (1997:9, 2008:9) survey, respondents believed that premiums would increase due to insurance fraud.

Emotional harm suffered by consumers will be concern about insurers' ability to honour claims, honest consumers being subjected to stringent and rigorous anti-fraud processes, and concern about the affordability of insurance premiums (ABI, 2012:8; Insurance Europe, 2012:11). The financial stability of insurers is an important factor for consumers so that they have assurance that the insurer will be able to pay out claims (Tennyson, 1997:251). In an EY (2014:11) survey, respondents indicated the

financial stability of an insurance company as an important characteristic in the relationship.

Insurers are also victims in that they have to implement costly anti-fraud processes and technology. This will result in reduced profits and negatively affect client service due to time-consuming claims settling strategies (Pešout & Andrlé, 2011:613). In the UK, insurers spend more than £200 million per year on insurance fraud prevention initiatives (Insurance Fraud Taskforce, 2016:7). The CAIF (2007:7) indicates that about USD 134 million was spent in 2006 in the US to tackle insurance fraud.

Financial harm experienced by employees will include no or reduced bonuses, no or reduced increases, reduced benefits due to cost-cutting initiatives and higher insurance premiums. An EY (2011:10) study found that insurers in India lost more than eight percent of their total revenue due to fraud. Emotional harm manifests itself in the form of anxiety about job security, increased work pressure to increase profitability, and loss of confidence and trust in management structures. Further, employees are subjected to aggressive behaviour by insurance fraudsters after the claims have been found to be fraudulent (Morley et al., 2006:166). Employees are also overburdened and under pressure to detect and prevent fraudulent claims (Derrig, 2002:276; Morley et al., 2006:166).

The government as a secondary victim experiences both financial and emotional harm. The financial harm suffered by the government will be the financial burden it will have to carry, especially in cases of natural disasters where there is no insurance cover (Vaughan, 2004:262). Governments are also consumers of insurance products, so they will also experience premium increases. The emotional harm relates to their

concern regarding economic growth should the insurance sector collapse. The insurance industry has been described as the foundation of society, and it has been argued that, without insurance, an economy would be dysfunctional (Insurance Europe, 2012:3).

The other secondary victim is society at large, which will suffer both financial and emotional harm. The financial harm relates to society's response to higher premiums, which threaten the sustainability of the insurance sector. If the premiums are extremely high or there is a collapse in the insurance sector, society will have to self-insure, which is very costly. The emotional harm relates to the concern for assurance about possessions. Law enforcement agencies are also victims of insurance fraud, due to the extra burden placed on them to prosecute insurance fraud cases (Derrig, 2002:276; Insurance Fraud Taskforce, 2016:15).

The above discussion examined and dispelled the myth that insurance fraud is a victimless crime. As can be noted, several primary and secondary victims are affected by insurance fraud. There is limited literature on victims of insurance fraud; this discussion attempted to identify possible victims and provide some context on the topic.

2.6.9.10 Demographic factors

The impact of demographic factors on consumer acceptability of insurance fraud has been under-researched (Brokesova & Pastorakova, 2013:298). However, Dean (2004) and Tennyson (1997, 2002) considered demographic factors such as age, gender, education and income, as well as their influence on a consumer's acceptance of insurance fraud.

In Tennyson's (1997, 2002) analysis of insurance consumer data, she found that there was a relationship between certain demographic factors and a consumer's tolerance towards insurance fraud. She found that women displayed a lower tolerance of insurance fraud than men; this was confirmed by Dean's (2004:77) finding that women displayed a much lower level of insurance fraud acceptance when compared to men.

Brinkmann and Lesch (2006) found that Norwegians were less accepting of claims exaggerations and misrepresentations in the insurance sector than Germans,

Brokesova and Pastorakova (2013:297-304) conducted a study in Slovakia to determine whether demographic factors consisting of gender, age, income, education and religion played a role in consumers' insurance fraud acceptance, considering the previous studies done on this topic. They found that men, low educated and younger individuals were more accepting of insurance fraud (Brokesova & Pastorakova, 2013:300). Upon analysing data on income, they found that respondents with a monthly gross income of less than €300 were more likely to accept insurance fraud than those whose income exceeded €1 500. Their findings regarding gender, age, education and income are aligned to the previous studies of Tennyson (1997, 2002) and Dean (2004).

Brokesova and Pastorakova's (2013:301) results regarding religion indicated that non-believers were more accepting of insurance fraud than strong believers and believers. They did find that the scores between non-believers and strong believers were relatively close, which they found strange. They had assumed that there would have been a greater score difference between non-believers and strong believers given the high morality of strong believers.

Brokesova and Pastorakova's (2013:302) study indicates that demographic factors have an impact on a consumer's tolerance towards insurance fraud, and a better understanding and use of this information could allow insurers to effectively segment consumers according to their tolerance and propensity to commit insurance fraud. Insurers do have access to the demographic information of consumers.

In summarising the discussion above and noting its relevance to consumer insurance fraud, it would be apt to quote Jones (1991:372), who eloquently states that the following characteristics influence a person's morality towards fraud:

- the magnitude of the consequences of the act;
- the degree of social consensus about the ethicality of the act;
- the probability that the act will take place and will cause an effect;
- the temporal immediacy of the consequences;
- the proximity of the victims to the actor; and
- the concentration of the effect or number of people impacted.

2.7 CHAPTER SUMMARY

This chapter dealt with the findings from an extensive literature review. There is a notable gap in the available of fraud related research in the context of SA focussing specifically on understanding insurance fraud tolerance.

This chapter started by considering the various elements of insurance. This covered aspects related to risk and risk management. The value of insurance was next discussed by providing reference to statistics aiming to illustrate the size of the industry. Attention was given to the compensation mechanisms in SA.

Lastly, the chapter focussed on insurance fraud. Here, the challenges in measuring fraud were explored, along with the global cost as well as the effect on cost of insurance in SA. The definition of insurance fraud was discussed. The role of consumer acceptance towards insurance fraud and the factors influencing this behaviour were also discussed.

Chapter 3 focusses on the theories involved in consumer insurance fraud. Two theories, namely the fraud triangle and theory of planned behaviour, are discussed.

CHAPTER 3: THEORIES

3.1 INTRODUCTION

When designing effective anti-fraud strategies, organisations need to understand the profile of the fraudster perpetrating fraud against them as well as the reasons why fraud is perpetrated against them (Murdock, 2008:81; Skiba, 2015:14). Fraudster profiling and reasons for committing fraud are best dealt within the criminology realm. According to Ramamoorti (2008:523), criminology is “the study of crime, the causes of crime (etiology), crime typology, the meaning of crime in terms of law, rates, or incidences of crime, and community reaction to crime”, while Skiba (2015:14) defines criminology as “the scientific study of criminal behaviour”.

In this chapter, two theoretical models, namely the fraud triangle and the theory of planned behaviour, are explored with regard to their application on a policyholder’s tolerance to insurance fraud. The discussion also considers the combined model of the fraud triangle and the theory of planned behaviour to provide insights on consumer insurance fraud. This combined model has been successfully used in other studies to predict behaviour (Cohen, Ding, Lesage & Stowey, 2010; Haithem et al., 2014).

According to Skiba (2015:14), theories focussing on examining criminal behaviour regarding insurance fraud have been lacking compared to crimes such as robberies and homicide. While Skiba (2015:15-18) acknowledges that no attempt has been made to apply the various available theories to insurance fraud, he postulates that it is possible for these theories to be applied to insurance crime. Skiba (2015:15) mentions that the “strain theory” is most applicable to opportunistic insurance fraud

where the fraud is mostly committed to relieve social strain. According to Skiba (2015:16-18), other useful theories that could be applicable for insurance fraud are “rational choice theory”, “routine-activities theory” and “deterrence theory”.

The lack of studies on theories applicable to insurance fraud has created a vacuum in proposing a specific theory or theories most suitable for insurance fraud. It is against this background that there is an argument for considering the fraud triangle (Cressey, 1953) and the theory of planned behaviour (Ajzen, 1991) as possible options for application in insurance fraud. These theories also offer an opportunity to be used together, as has been done in other studies (Brown, Hays & Stuebs, 2017; Haithem et al., 2014). The discussion in the next section provides some background on the fraud triangle.

3.2 FRAUD TRIANGLE

The elements of the fraud triangle were formulated following a study conducted by Cressey (1950:740), in which he interviewed people convicted of crimes where the main components were that the person must have held a position of trust and the person must have violated the trust; he referred to this category of people as “trust violators”. It is argued that there is some alignment between this and consumers of an insurance contract, where the contract is based on good faith and the relationship is one of trust (Lesch & Brinkmann, 2011:17; Viaene & Dedene, 2004:314). It can therefore be contended that a policyholder committing insurance fraud could be regarded as a “trust violator”.

Cressey (1950:740-742) concluded that the crucial ingredients for violation of trust crimes are “non-shareable” pressure, opportunity and rationalisation. These elements

together became known as the fraud triangle. While Cressey is credited for identifying the elements making up the fraud triangle, there is still uncertainty on who coined the term “fraud triangle” (Huber, 2017:37). Figure 5 presents the fraud triangle.

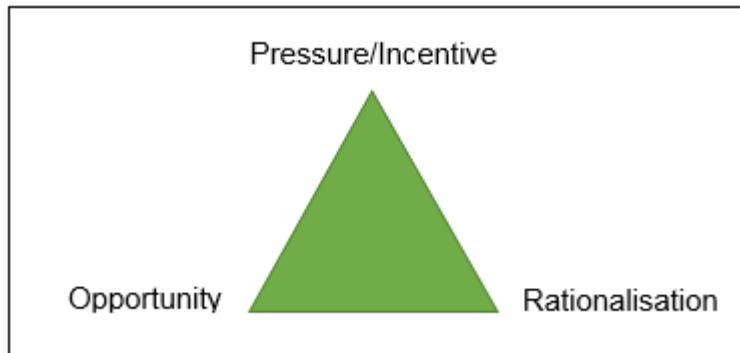


Figure 5: Fraud triangle (Cressey, 1953)

The main elements of the triangle are described in the sections below.

3.2.1 Pressure or incentive

According to Cressey (1950:741-742), the source of the pressure is normally of an urgent financial nature due to a non-shareable problem. Cressey argues that the pressure is caused by the urgency of the non-shareable problem and the inability to resolve this problem through legitimate means. Financial pressure is a common reason for people committing fraud. It is the main reason for a law-abiding citizen to turn to crime (Biegelman & Bartow, 2006:33). Cressey (1950:741) also found that, in certain instances, factors other than financial need played a significant role in creating pressure. These included “antagonistic attitudes towards the employer, feelings of being abused, underpaid, or discrimination”.

Murdock (2008:81) posits that pressure is created through problems caused by immoral personal behaviours such as gambling, drugs, extramarital relationships or the need to live lavishly. He also includes political and social factors that create pressure on reputation. Lister (2007:63) identified three categorises of pressure, namely personal-related pressure, employment-related pressure and external-related pressure. Pressure or incentive is a relevant and measurable construct in consumer insurance fraud. In terms of consumer insurance fraud, it is postulated that both financial and non-financial pressure play a role.

Dionne and Wang (2013:83) found that insurance fraud was more rife during bad economic times. They argue that, during tough economic times, consumers are more inclined to commit insurance fraud due to financial constraints (Dionne & Wang, 2013:74). Dionne and Gagné (2002) and Dean (2004) further found a link between consumers' acceptance towards claims padding and policy deductibles. They found that respondents were more accepting of claims padding because they wanted to compensate for the high deductibles.

Studies by Tennyson (1997:260, 2002:52) found that consumers who had a bad perception of the insurance industry or who had a negative claims experience were more accepting of insurance fraud. Consumer surveys by the CAIF (1997:17; 2008:11) also revealed that consumers reported high insurance fraud tolerance levels due to financial reasons such as seeking a fair return on premiums and non-financial reasons such as insurers making too much money.

3.2.2 Opportunity

Cressey (1950:742) postulates that the trust violator must possess the “technical skill” to commit the transgression, while Lister (2007:65) contends that, regardless of the pressure, a person can only commit fraud if there is opportunity. Opportunity refers to the ease with which a person can commit fraud without the possibility of detection, as well as favourable conditions that allow for the perpetration of fraud. This opportunity is facilitated by weaknesses in processes or systems. Opportunities are manifested in processes or systems where there is an absence, lack of or non-compliance with controls (Kassem & Higson, 2012:191-192; Murdock, 2008:81). The degree of opportunity is normally associated with a person’s position, authority and access to assets and records (Biegelman & Bartow, 2006:34). Khan (2012:43) reports that opportunities are also created by poor ethics, insufficient training, inadequate supervision, no prosecution of transgressors, weak anti-fraud programmes and poor policies and procedures. He maintains that this is the only element of the fraud triangle that the intended victim can control.

Opportunity is a relevant concept in the study of policyholder insurance fraud. In reference to policyholder insurance fraud, several authors report that insurance fraud has manifested itself since the dawn of insurance due to the moral hazards cultivated through insurance (Hoyt, 1990:304; Lesch & Brinkmann, 2011:18). Other researchers argue that insurance fraud is a “self-created” crime because of the opportunities created in the manner in which the concept of insurance and the insurance industry operates (Ericson et al., 2002:537; Tennyson, 2008:1181). In support of this argument, Ericson et al. (2000:537) contend that opportunities for insurance fraud exist due to

weaknesses in the underwriting processes used for new policy inceptions and poor claim processes.

Various studies indicate that information asymmetry between consumer and insurer within the insurance industry has produced the greatest opportunity for insurance fraud (Dionne, 1984:304-321; Tseng & Shih, 2012:164-165; Viaene & Dedene, 2004:315).

These studies found that consumers have access to private information, which provides them with the advantage and opportunity to disclose information that is most beneficial to them. Studies also confirm that the manner in which insurance contracts are designed facilitate consumer insurance fraud. It has been found that certain types of insurance contracts make fraud possible (Dionne & Gagné, 2002:213-230; Dionne & Wang, 2013:67-92).

3.2.3 Rationalisation

Cressey (1950:743) states that rationalisation involves a process whereby the trust violator suppresses the criminality of his or her conduct by attempting to make it seem more morally acceptable, for example using terms like “borrowing” instead of stealing. According to Biegelman and Bartow (2006:35), rationalisation refers to the manner in which a fraudster justifies the unlawful or unethical conduct.

Sykes and Matza (1957:667) refer to rationalisation as techniques of neutralisation. In a study on delinquency, Sykes and Matza (1957:667-669) identified five techniques of neutralisation, namely denial of responsibility, denial of injury, denial of victim, condemnation of the condemners, and appeal to higher loyalties. Sykes and Matza (1957:666-667) contend that neutralisation techniques often allow people the latitude to engage in delinquent behaviour without feeling that they have violated any social

standards; the authors consider neutralisation techniques as a method people use to justify non-adherence to social standards. In addition to the neutralisation techniques proposed by Sykes and Matza (1957:667-669), Heath (2008:603) also proposes the concepts of “everyone else is doing it” and claim to entitlement as additional techniques of neutralisation.

Rationalisation is relevant in the study of policyholder insurance fraud. In terms of consumer insurance fraud, Brinkmann (2005:186) indicates that neutralisation plays a role in harmonising moral norms and immoral behaviour. Brinkmann (2005:186-187) therefore posits that neutralisation techniques are relevant to consumer insurance fraud. Consumer studies (CAIF, 1997:17, 2008:11-12) found that respondents felt that it was acceptable to defraud insurers because no “one was getting hurt” or “because everyone was doing it”.

Lister (2007:64-65) fittingly summarises the elements of the fraud triangle when he identifies pressure as “the source for the fire”, opportunity as “the fuel that keeps the fire burning” and rationalisation as “the oxygen that keeps the fire burning”. In recent times, the fraud triangle has formed the basis for further development. Albrecht, Howe and Romney (1984) included “personal characteristics” and “occupational environments” as additional elements, and developed the “fraud scale”. Wolfe and Hermanson (2004) used the elements of the fraud triangle to develop the “fraud diamond”, which includes “capability” as an additional element. The fraud triangle has also been used within the audit fraternity for fraud risk management, and the elements have been incorporated into the Statement on Auditing Standards 99 (Kassem & Higson, 2012:193).

The usefulness of the fraud triangle was illustrated in a study undertaken by LaSalle (2007:74-87). In this study, one group of students was provided with an overview of the Committee of Sponsoring Organisation framework, while another group of students was provided with an overview with the fraud triangle. The students were requested to evaluate risk relating to a specific scenario. It was found that the group that was briefed on the fraud triangle performed better than the other group.

In this section, it was postulated that the fraud triangle is a useful theoretical model to assist in explaining why consumers commit insurance fraud. In the next section, the discussion focusses on the theory of planned behaviour and the elements underpinning this theory.

3.3 THEORY OF PLANNED BEHAVIOUR

The theory of planned behaviour was developed by Ajzen (1991) to address shortcomings identified in the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), which was criticised for not considering obstacles or resources required in the pursuit of an individual's intention to behave in a certain way (Doll & Ajzen, 1992:755; Fukukawa, 2002:102). According to the theory of planned behaviour, human action is informed by "the attitude toward the behaviour, subjective norm and perceived behaviour control" (Ajzen, 1991:179-211, 2002:107). Ajzen (1991:181, 2011:1113) points out that the main objective of the theory of planned behaviour is to predict behavioural intention. Figure 6 below illustrates the theory of planned behaviour.

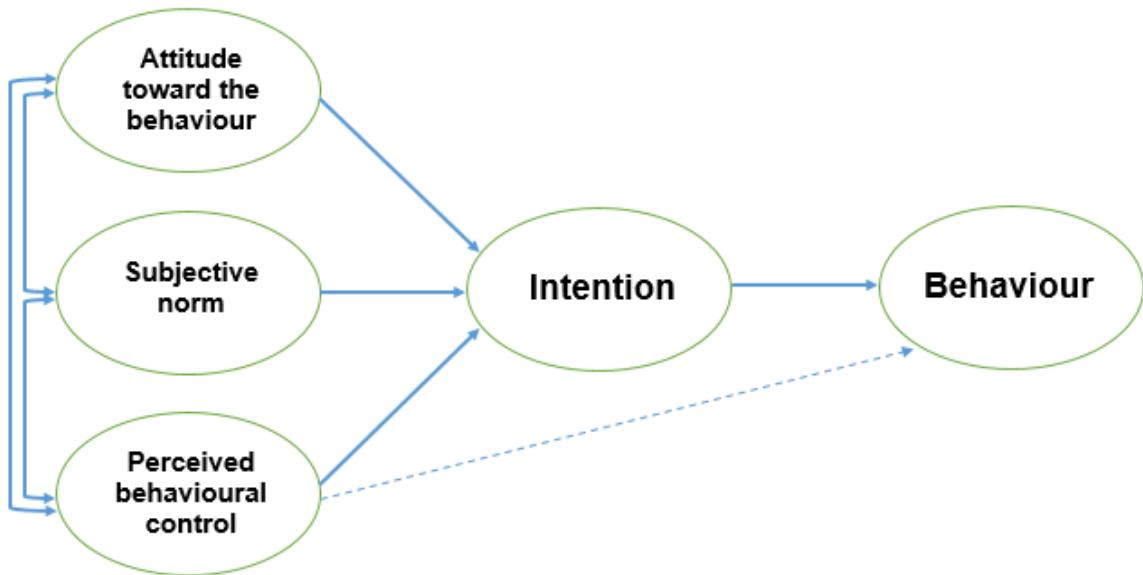


Figure 6: Theory of planned behaviour (Ajzen, 1991)

According to Doll and Ajzen (1992:755), beliefs are also important factors in forming an individual's behavioural intention. In line with the theory of planned behaviour, they identified "behavioural beliefs", which influence attitudes towards behaviour, "normative beliefs", which impact on subjective norms, and "control beliefs", which influence perceptions of behavioural control.

3.3.1 Attitude towards behaviour

Ajzen (1991:188) describes attitude towards behaviour as "the degree to which a person has a favourable or unfavourable evaluation or appraisal of the behaviour in question". Doll and Ajzen (1992:755) add that the outcome and cost factor involved in continuing with the behaviour are strongly related to attitude towards behaviour. They maintain that this results in individuals favouring behaviour which yields positive results rather than behaviour which yields negative results. Fukukawa (2002:103) refers to attitude towards behaviour as either "risk taking", which generates thrill or

excitement to the individual, or “expediency”, where the individual acts without consideration towards the ethicality of the behaviour but focusses primarily on the resulting benefit.

Data to measure attitude towards behaviour are gathered from questions about “intention to engage in hunting”, being measured on a scale ranging from extremely unlikely to extremely likely (Hrubes, Ajzen & Daigle, 2001:168), drinking alcohol and avoiding alcohol, or eating junk food and avoiding junk food, being measured on a scale ranging from worthless to valuable and good to bad (Ajzen & Sheikh, 2013:157).

Attitude towards behaviour is a relevant concept in the study on policyholder insurance fraud. Researchers (Hoyt, 1990:311; Tennyson, 1997:248; Viaene & Dedene, 2004:320) have found a link between cost-benefit analysis and the consumer's propensity to commit insurance fraud. They point out that, if there is a low detection rate and high return, there is a high probability that the consumer will commit insurance fraud. Fukukawa (2002:111) found that unfairness played a role in respondents' accepting attitudes towards insurance fraud, while studies by Tennyson (1997:260, 2002:52) found that consumers who had a bad perception of the insurance industry or who had a negative claims experience were more accepting of insurance fraud.

3.3.2 Subjective norm

Ajzen (1991:188, 195) defines subjective norm “as the perceived social pressure to perform or not to perform the behaviour” and adds that consideration is given to how peers will respond to the specific behaviour. Doll and Ajzen (1992:755) contend that this belief is associated with the expectation of individual or groups who are either

approving or disapproving of the behaviour; this approval or disapproval will determine the person's behaviour.

Fukukawa (2002:103) argues that subjective norm is restrictive in that it refers to people who are close to the individual such as family, friends and parents. He feels there may be others in society who will have an impact on the individual's decision to behave. Fukukawa (2002:103) therefore opts to use "social influence" instead of "subjective norm". He posits that this reflects societal responses to the specific behaviour as well. The change in the term does not affect the credibility of the results in using the theory of planned behaviour.

Data to measure subjective norm are gathered from items such as "most people important to them think that they should hunt" (Hrubes et al., 2001:168).

Subjective norm is relevant to the study on policyholder insurance fraud, as the acceptability of insurance fraud is determined by how the consumer perceives his or her peers will respond to the behaviour (Tennyson, 2008:1194; Tseng & Su, 2013:39). The CAIF (1997:7; 2008:5) consumer studies found that high tolerance levels for insurance fraud created a more accepting attitude towards insurance fraud.

3.3.3 Perceived behavioural control

Ajzen (1991:188) describes perceived behavioural control as "the ease or difficulty of performing the behaviour and it is assumed to reflect past experience as well as anticipated impediments and obstacles". He adds that resources and opportunities are key determinants in that, if the individual has the available resources and there are plenty of opportunities, then the individual exercises better control over his or her

behaviour (Ajzen, 1991:196). Fukukawa (2002:104) asserts that perceived behavioural control is about avoiding trouble and opting for simpler means to pursue the behaviour, while according to Hess (2007:1785), perceived behavioural control relates to the individual's ability, past experience, competence and any anticipated obstacles.

Data to measure perceived behavioural control are gathered from items such as "if I want I could easily conserve energy this semester" (Ajzen, Joyce, Sheikh & Cote, 2011:105) and "I am confident that if I wanted to, I could drink alcohol (Ajzen & Sheikh, 2013:157).

Perceived behavioural control is relevant to the study on policyholder insurance fraud, as information asymmetry between consumer and insurer within the insurance industry has produced the greatest opportunity for insurance fraud (Dionne, 1984:304-321; Tseng & Shih, 2012:164-165; Viaene & Dedene, 2004:315). Studies (Dionne, 1984:304-321; Tseng & Shih, 2012:164-165; Viaene & Dedene, 2004:315) have found that consumers have access to private information and therefore have the advantage and opportunity to disclose information that is most beneficial to them. Insurance contract design also facilitates consumer insurance fraud, and it has been found that certain types of insurance contracts make fraud possible (Dionne & Gagné, 2002:213-230; Dionne & Wang, 2013:67-92).

In addition to the aspects discussed above, a brief overview is provided regarding personal norms, moral norms and intention in the theory of planned behaviour.

3.3.4 Personal and moral norms

Ajzen (1991:199) postulates that, in certain circumstances, it is possible to include personal or moral norms to the theory of planned behaviour as a fourth dimension. This is especially relevant when attempting to predict behaviours associated with cheating or unethical conduct.

3.3.5 Intention

Ajzen (1991:181) points out that intention refers to “how hard people are willing to try, or how much of an effort they are planning to exert, in order to perform the behaviour”.

Data to measure intention are gathered from items such as “I am planning to conserve energy this semester” (Ajzen et al., 2011:105) and “I intend to drink alcohol” (Ajzen & Sheikh, 2013:157). Ajzen (1991:181, 2002:107) postulates that, as a general rule to this theory, “the more favourable the attitude and subjective norm and the greater the perceived control, the stronger should be the person’s intention to perform the behaviour in question”.

The theory of planned behaviour has been successfully used in various studies to predict behaviour with accuracy (Ajzen & Sheikh, 2013; Ajzen, Joyce, Sheikh & Cote, 2011; Bamberg, Ajzen & Schmidt, 2003; Buchan, 2005; Fukukawa, 2002; Hrubes et al., 2001). The theory is capable of being enhanced by adding other dimensions not catered for (Ajzen, 1991:199) or expanding on the existing dimensions (Fukukawa, 2002:103) without compromising the credibility of the results. Using this theory allows for the gathering of large amounts of valuable data, which could be used to implement controls or better understand the subject being researched (Ajzen, 1991:206).

The discussion above focussed on attitude towards behaviour, subjective norm and perceived behavioural control as the three critical components to the theory of planned behaviour. The next section focusses on the possibility of combining the fraud triangle and the theory of planned behaviour as a model to explain fraudulent or unethical behaviours.

3.4 COMBINING THE FRAUD TRIANGLE AND THE THEORY OF PLANNED BEHAVIOUR

Both the fraud triangle and the theory of planned behaviour have been used separately to either explain why people commit fraud or to predict people's behaviour (Cohen et al., 2010:275; Haithem et al., 2014:318-319). These theories have been successfully used in various studies regarding fraud, unethical behaviour and corruption.

While the fraud triangle and the theory of planned behaviour have been used separately in studies, Cohen et al. (2010:275-276) argue that the complementary nature of these theories makes it possible for an integrated approach as a single framework. A similar argument for joining both the fraud triangle and the theory of planned behaviour was put forward by Haithem et al. (2014) and Brown et al. (2016).

In developing a combined model of the fraud triangle and the theory of planned behaviour, Cohen et al. (2010:275-276) analysed the components of each model. While acknowledging that "attitude" is not the same in both theories, they postulate that "attitude" in the fraud triangle is broad enough to include the main building blocks of the theory of planned behaviour, namely attitude towards behaviour, subjective norms and perceived behavioural control (Cohen et al., 2010:275).

Cohen et al. (2010:275-276) add that even the additional concept of personal or moral norms, which Ajzen (1991:199) suggested could be added as a further dimension, can be included in their combined framework. They refer to this model as the “extended theory of planned behaviour”, which is illustrated in Figure 7.

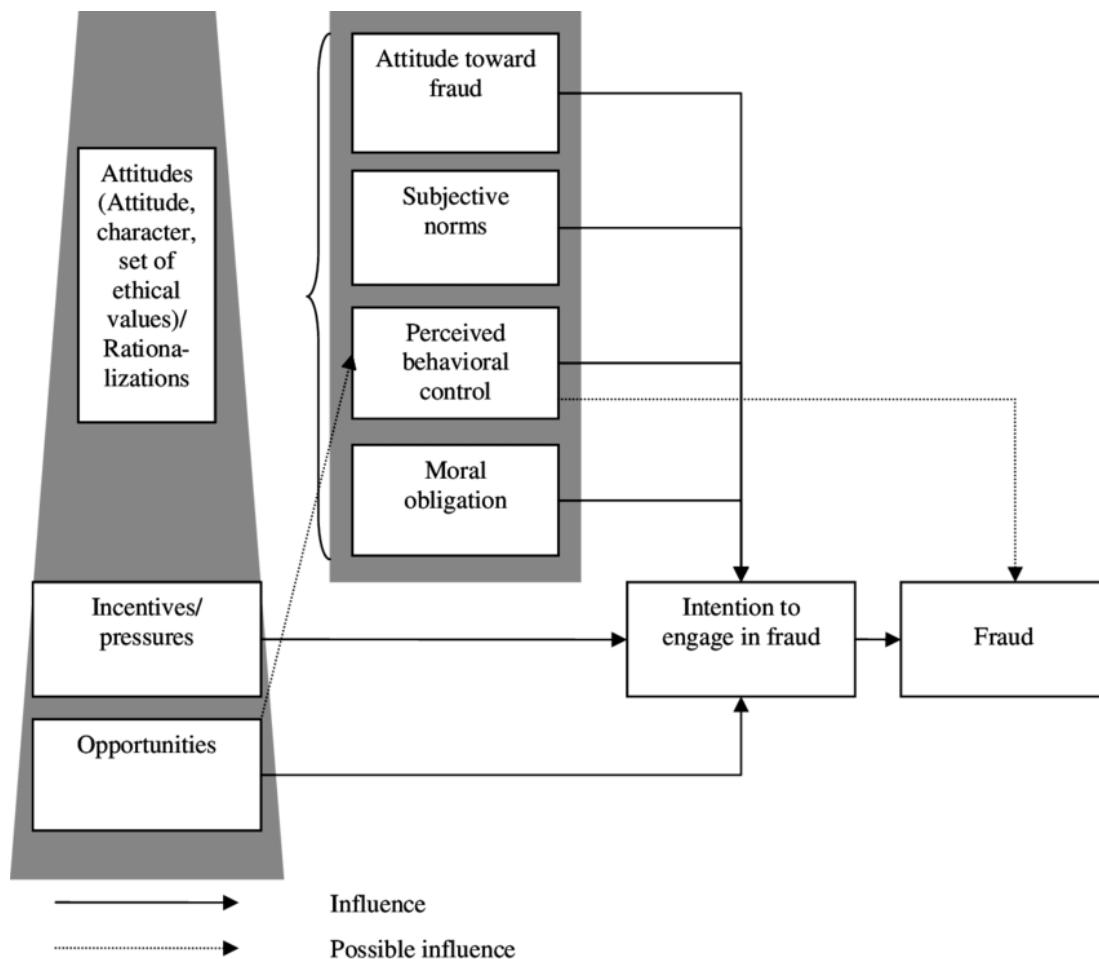


Figure 7: Combination of fraud triangle and theory of planned behaviour (Cohen et al., 2010:275)

Cohen et al. (2010:276) further add that “incentives/pressure” and “opportunities” cannot be incorporated into the theory of planned behaviour, because incentives or pressure and opportunity are dependent on “external stimuli” for fraudulent behaviour. They do, however, feel that a possible relationship exists between opportunities and

perceived control behaviour and therefore indicate this link with an arrow between both concepts in the diagram.

Cohen et al. (2011:287-288) found huge value in combining the fraud triangle and the theory of planned behaviour as a model in their study because it provided a better understanding of the factors shaping attitude formation towards committing fraud. They were also able to provide more insightful recommendations based on the various elements of the theory of planned behaviour and the fraud triangle.

Haithem et al. (2014:317-319) also opted for an integration of the fraud triangle and the theory of planned behaviour in their study on fraud perpetrated within the banking and insurance sector. They argue that, while the elements of the fraud triangle are the “main triggers” for consumer fraud, these “triggers” also play a role in predicting the consumer’s intention to behave fraudulently. They also agree that attitudes or rationalisation in the fraud triangle could include the three main building blocks of the theory of planned behaviour, as can be noted in their diagram.

The combined framework these authors developed is illustrated in Figure 8.

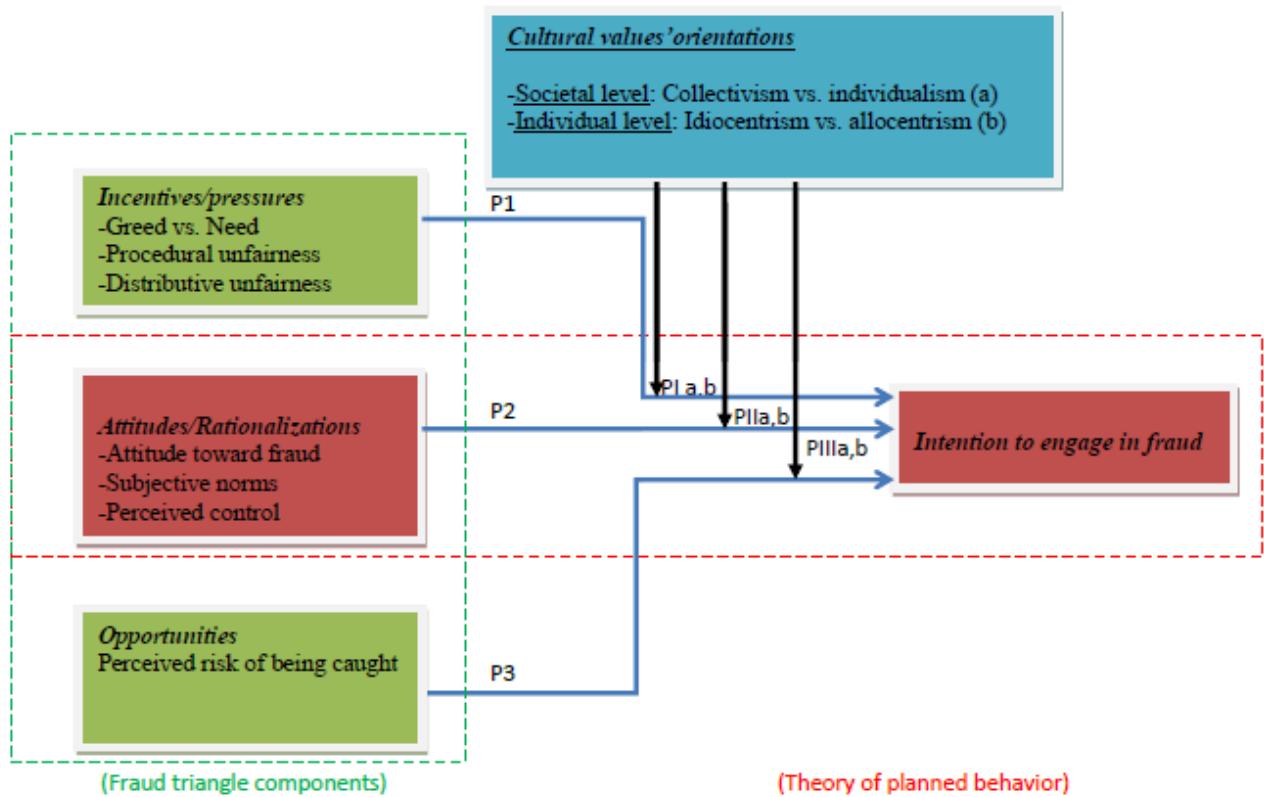


Figure 8: Combination of fraud triangle and theory of planned behaviour (Haithem et al., 2014:320)

Haithem et al. (2014:320) added culture as a moderator to their model and justify this inclusion by explaining that they believe culture plays a role determining whether a consumer behaves fraudulently or not. They argue that a consumer's decision to behave dishonestly is dependent on society's response to such behaviour; the consumer is more likely to act dishonestly if society is accepting of such behaviour (Haithem et al., 2014:319-320). Haithem et al. (2014:324) found that "fraud triggers" differed, and the consumer's willingness to behave fraudulently was influenced by different cultural factors. They add that consumer fraud can be better detected and prevented by understanding cultural diversity (Haithem et al., 2014:324-325).

Brown et al. (2016:33) also adopted a combination of the fraud triangle and the theory of planned behaviour in their study on accountant whistleblowing intentions. They posit that the usefulness of the combined model is based on the fact that, while the components of the fraud triangle provide insights about the existence of external opportunities and incentives informing perceptions of control and norms, the theory of planned behaviour provides deeper insights on the individual's judgement, rationalisation and behavioural intention.

These authors illustrate their combined model as presented in Figure 9.

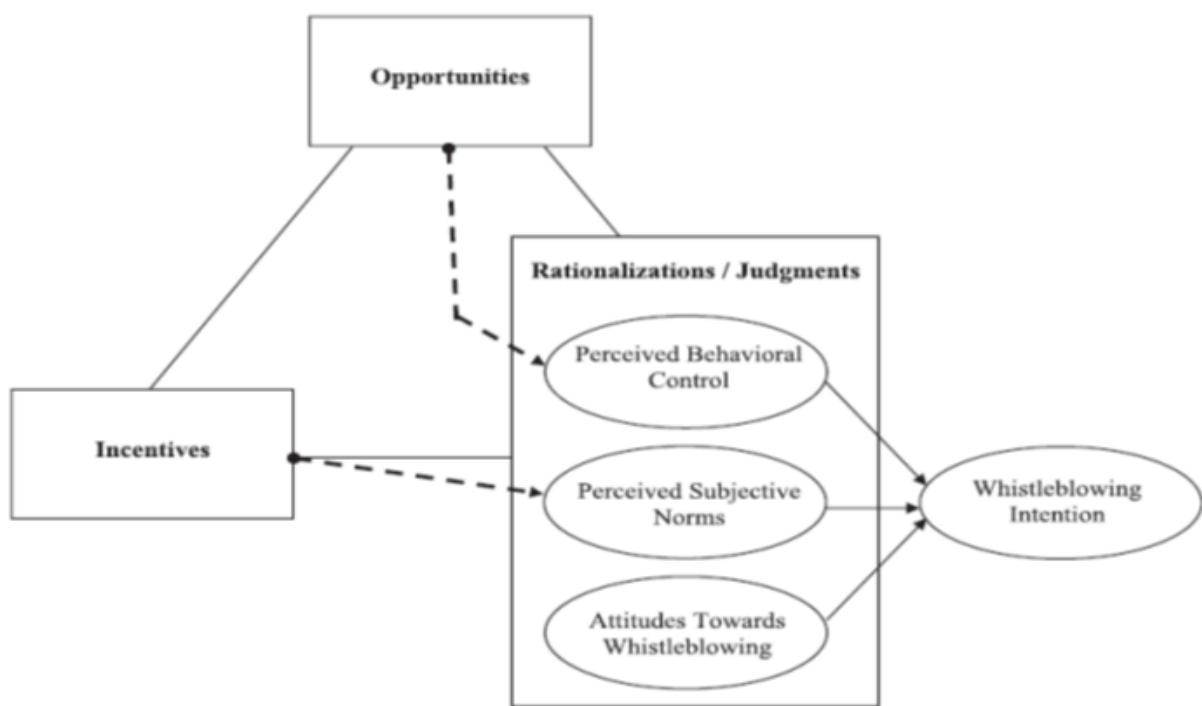


Figure 9: Fraud triangle and theory of planned elements contributing to whistleblowing intention (Brown et al., 2016:34)

The model in Figure 10 below illustrates the various components of the combined models encompassing the factors identified in Brown et al.'s (2016:38) study of whistleblowing intentions.

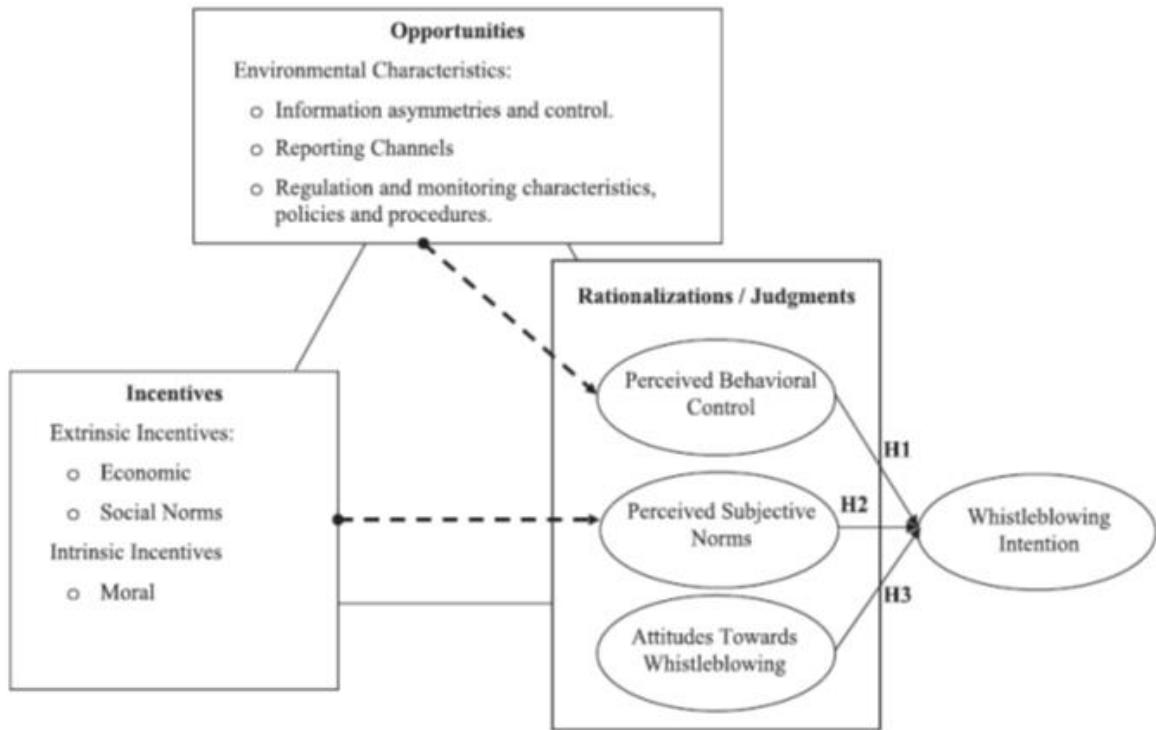


Figure 10: Integrated model and predicted relationship for whistleblowing intention
(Brown et al., 2016:49-50)

The authors found that, with the combined model, they were able to identify both environmental and individual factors that played a role in informing an individual's intention in whistleblowing (Brown et al., 2016:49-50). They assert that the information they gathered through the use of this integrated model assisted in providing solid recommendations.

There is empirical evidence to support the view that both the fraud triangle and the theory of planned behaviour can be joined into a single model. This integrated approach provides the added advantage of identifying factors influencing fraudulent behaviour and being able to predict fraudulent behaviour. The studies carried out using this integrated approach have found great value therein (Brown et al., 2016; Cohen et al., 2010; Haithem et al., 2014).

The integrated model of the fraud triangle and the theory of planned behaviour formed the theoretical basis for this study. The conceptual framework of this integrated model proposed by Haithem et al. (2014:320) was most appropriate for this study. The model was found most useful for studies on consumer dishonesty with a specific focus on insurance fraud, making it ideal for the current study. Further, the model also incorporates culture as a factor that influences a consumer's dishonesty; studies on consumers' tolerance to insurance fraud have also found culture as a factor influencing tolerance attitude towards insurance fraud (Dean, 2004:68; Tseng & Su, 2013:39). It is argued that this model is flexible, thus making it possible to include tolerance as a moderator.

This section examined the possibility of joining the fraud triangle and the theory of planned behaviour as a single model. Studies that incorporated this integrated model were also discussed.

3.5 CHAPTER SUMMARY

This chapter followed on the literature presented in Chapter 2, but focussed specifically on discussing a number of theories relevant to this study. An explanation was provided, delimited specifically towards three theories, namely the fraud triangle, the theory of planned behaviour and an integrated model consisting of both the theory of planned behaviour and the fraud triangle. The integrated model consisting of both the fraud triangle and the theory of planned behaviour was found to be most suitable for this study.

Chapter 4 provides a discussion of the research design and methods employed in this study.

CHAPTER 4: RESEARCH DESIGN AND METHODS

4.1 INTRODUCTION

The research design and the research methods employed during this study are discussed in this chapter. The type of inquiry strategy used is presented first, followed by a discussion on sampling, data collection and data analysis. Third, the concepts of reliability and validity are addressed to demonstrate the quality of the research design. Finally, ethical considerations pertinent to this study are discussed.

4.2 DESCRIPTION OF RESEARCH DESIGN AND RESEARCH METHODOLOGY

According to Babbie and Mouton (2001:74), research design and research methodology are two different concepts and should not be confused. They describe a research design as “a plan or blueprint” to conducting research. Saunders et al. (2009:136) posit that a research design is a “plan” describing the process used to answer the research questions. Research design thus involves the setting out of the overall picture of how the research will be done. Research methodology, on the other hand, describes the methods used for collecting, analysing and interpreting data during the course of the study (Creswell, 2009:15). Research methodology thus refers to the methods used by a researcher for the evidence gathering, evidence analysis and evidence interpretation necessary for the study.

4.3 RESEARCH DESIGN

This research was aimed at exploring fraud tolerance level as a predictor of insurance claims behaviour in SA. It was an empirical study, which refers to research conducted

to investigate “real life” problems, which are achieved by the collection of new data or the analysis of available data (Babbie & Mouton, 2001:74-75). The new data or original data collected during a research study are termed primary data (Babbie & Mouton, 2001:76; Welman et al., 2005:149). This study investigating fraud tolerance level as a predictor of insurance claims behaviour in SA falls within the definition of “real life” problems, and the researcher collected and analysed primary data. It is thus argued that this was an empirical study.

This study was descriptive and explanatory. Descriptive research involves the observation and description of a situation or event (Babbie & Mouton, 2001:80-81; Saunders et al., 2009:140). Although Saunders et al. (2009:140) acknowledge the usefulness of a descriptive study in management and business studies, they argue that descriptive studies on their own provide little value in research. They confirm that a descriptive study will normally be followed by an explanation, which they term as “descripto-explanatory studies” (Saunders et al., 2009:140). Welman et al. (2005:23) contend that descriptive research aims to “explain and predict behaviour”.

Explanatory research is primarily focussed on determining the relationships between variables within a problem (Saunders et al., 2009:140). Babbie and Mouton (2001:81) contend that explanatory studies are used to show the “causality between variables or events”. However, they argue that for there to be a relationship of causality, three criteria, namely “the cause precedes the effect in time, there is an empirical correlation between them and the result must not be founded on a third variable”, must be present (Babbie & Mouton, 2001:82). Welman et al. (2005:22-23) describe explanatory research in terms of explaining the “why” in relation to certain circumstances or “what” the nexus is between things. This study focussed on the relationship and perceived

relationship of fraud tolerance and insurance claims behaviour in SA, which could be addressed by a descriptive explanatory study.

Cross-sectional research refers to a study undertaken of phenomena where all data are collected at a single point in time (Leedy & Ormrod, 2010:186). Saunders et al. (2009:155) describe a cross-sectional study as a “snapshot” of the problem being studied at a specific moment in time. A cross-sectional design was used in this study, as all data were collected through a semi-structured questionnaire at a certain point in time.

Creswell (2009:3) states that there are three types of research designs, namely qualitative, quantitative and mixed methods. He contends that quantitative research involves numbers and “closed-ended questions”. Quantitative research is mostly concerned with testing relationships between variables, which is achieved through the use of measuring instruments (Creswell, 2009:4). According to Leedy and Ormrod (2010:96), the purpose of quantitative research is to “explain and predict”, “to confirm and validate” or “to test theory”. They further posit that quantitative research is used to measure known variables where the methods and guidelines employed during the study are fixed and where the researcher is detached from the study (Leedy & Ormrod, 2010:96).

Saunders et al. (2009:151) explain that quantitative research normally involves the collection of data through questionnaires, producing numeric results after data analysis. A quantitative design was used for this research to test the relationship between two variables, namely insurance fraud tolerance level and claims behaviour. This design was most suitable for the current study. Semi-structured questionnaires

were used to collect data on insurance fraud tolerance and claims behaviour. The analysis of these data produced results in numeric format.

4.4 RESEARCH METHODOLOGY

Research methodology refers to the approach a researcher utilises for data collection, data analysis and interpretation of results for the study (Creswell, 2009:15; Saunders et al., 2009:3). Research methodology thus refers to the methods used by a researcher for the evidence gathering, evidence analysis and evidence interpretation necessary for the study. Creswell (2009:12) lists experimental and non-experimental as strategies most associated with quantitative studies. He points out that surveys, which are classified as a non-experimental strategy, are useful where the study involves examining trends, attitudes or opinions. Leedy and Ormrod (2010:187) point out that survey research encompasses the gathering of information about people or groups of people by soliciting responses to questions being posed on the topic being studied.

This was a non-experimental study, and a questionnaire was therefore used to collect data for this study. To this end, it was necessary to develop and construct an instrument to measure policyholders' insurance fraud tolerance level within a South African short-term insurance context.

4.5 STUDY POPULATION AND SAMPLING

The study population, sampling technique and sample size for the study are described below.

4.5.1 Study population

The theoretical population for a research study is regarded as the group of people or elements that the researcher wants to draw conclusions about (Babbie & Mouton, 2001:100). For this study, the population is defined as all short-term insurance policyholders who have personal lines insurance policies in SA. According to SAARF (2016), the total population of such policyholders in 2015 was estimated at 1.765 million individuals. The distribution of policyholders by province and personal income is presented in Table 4.

Table 4: Estimated number of short-term insurance policyholders with personal lines insurance policies in South Africa in 2015 (SAARF, 2016)

	Demographics / Household / Geographic									TOTALS	
	Province										
	WC	NC	FS	EC	KZN	MP	LIM	G	NW		
TOTAL	318 383	14 594	81 677	113 072	462 477	134 615	54 710	507 140	78 366	1 765 034	
R1-R499	96	4	25	34	140	41	17	153	24	534	
R500-R599	0	0	0	0	0	0	0	0	0	0	
R600-R699	83	4	21	29	120	35	14	132	20	459	
R700-R799	271	12	69	96	393	114	47	431	67	1 501	
R800-R899	146	7	38	52	212	62	25	233	36	811	
R900-R999	0	0	0	0	0	0	0	0	0	0	
R1000-R1099	1 321	61	339	469	1 919	559	227	2 104	325	7 323	
R1100-R1199	0	0	0	0	0	0	0	0	0	0	
R1200-R1399	2 315	106	594	822	3 363	979	398	3 688	570	12 836	
R1400-R1599	1 952	89	501	693	2 836	825	335	3 109	480	10 822	
R1600-R1999	492	23	126	175	714	208	84	783	121	2 726	
R2000-R2499	1 201	55	308	426	1 744	508	206	1 912	296	6 656	
R2500-R2999	3 097	142	794	1 100	4 498	1 309	532	4 933	762	17 168	
R3000-R3999	5 139	236	1 318	1 825	7 464	2 173	883	8 185	1 265	28 488	
R4000-R4999	4 410	202	1 131	1 566	6 406	1 865	758	7 025	1 085	24 448	
R5000-R5999	6 878	315	1 765	2 443	9 991	2 908	1 182	10 956	1 693	38 132	
R6000-R6999	7 005	321	1 797	2 488	10 176	2 962	1 204	11 158	1 724	38 835	
R7000-R7999	8 375	384	2 149	2 974	12 166	3 541	1 439	13 341	2 061	46 430	
R8000-R8999	10 572	485	2 712	3 754	15 356	4 470	1 817	16 839	2 602	58 607	
R9000-R9999	5 791	265	1 486	2 057	8 412	2 449	995	9 225	1 425	32 106	
R10000-R10999	19 472	893	4 995	6 915	28 284	8 233	3 346	31 016	4 793	107 947	
R11000-R11999	8 664	397	2 223	3 077	12 586	3 663	1 489	13 801	2 133	48 033	
R12000-R13999	18 587	852	4 768	6 601	26 999	7 859	3 194	29 606	4 575	103 041	
R14000-R15999	19 482	893	4 998	6 919	28 300	8 237	3 348	31 033	4 795	108 005	
R16000-R19999	29 252	1 341	7 504	10 389	42 491	12 368	5 027	46 594	7 200	162 166	
R20000-R24999	32 572	1 493	8 356	11 568	47 314	13 772	5 597	51 883	8 017	180 572	
R25000-R29999	23 522	1 078	6 034	8 354	34 168	9 945	4 042	37 468	5 790	130 401	
R30000-R39999	19 851	910	5 092	7 050	28 835	8 393	3 411	31 619	4 886	110 047	
R40000-R49999	12 800	587	3 284	4 546	18 593	5 412	2 199	20 388	3 150	70 958	
R50000-R59999	6 426	295	1 648	2 282	9 334	2 717	1 104	10 235	1 582	35 622	
R60000+	8 346	383	2 141	2 964	12 124	3 529	1 434	13 295	2 054	46 270	
No personal income	26 467	1 213	6 790	9 400	38 445	11 190	4 548	42 158	6 515	146 726	
Refused	33 797	1 549	8 670	12 003	49 093	14 290	5 808	53 834	8 319	187 362	

4.5.2 Sampling technique

Any researcher needs to consider whether sampling is required for a study (Saunders et al., 2009:210). While it may be possible to collect data from all members in a defined population, it is often impossible to do so due to time, money and accessibility constraints, as was the case in this study. Therefore, it is essential for the success of the study to draw a sample that can provide data to address the research objectives,

keeping a balance between accuracy, precision and available resources that would be considered acceptable for the scientific community.

In choosing an appropriate sampling technique, it is important to recognise the two main approaches, namely probability or representative sampling and non-probability sampling (Saunders et al., 2009:213; Welman et al., 2005:56-57). Each of these offers certain advantages and limitations given the particular study aims and design.

With probability sampling, the researcher has the ability to determine the sampling error upfront and to generalise the findings of the study (Babbie & Mouton, 2001:202).

In non-probability sampling, members of the population are selected through a non-random method, which means that there is no assurance of population representation, and there is further a risk that some members of the population have minimal or no chance of being included in the sample (Leedy & Ormrod, 2010:211). Despite these shortcomings, non-probability sampling is still useful in research, especially in instances where there is a need to gain “theoretical insights” on a topic being researched, where there are limited resources pertaining to costs or where there is difficulty in identifying the specific sample frame (Babbie & Mouton, 2001:166; Saunders et al., 2009:233).

For example, despite the advantages that a random sampling technique offers in terms of representativeness of the total population, the unavailability of an accessible sampling frame for this study restricted the employment of this approach. While it has been posited that probability sampling allows for generalisation, it has also been argued that it is still possible to generalise the findings of a study where non-probability sampling was used, albeit not statistically (Saunders et al., 2009:213). It is further

argued that the large sample size obtained during this study mitigates the disadvantages of non-probability sampling.

It is also important to recognise that addressing the research objectives for this study was not dependent on the sample being representative of the total overall population in terms of all observable demographic identifiable characteristics, such as income, age, gender, ethnic group and residence province. Rather, the aims of the study speak to the deductive nature of testing the theoretical propositions through relationship analysis and group differences given the available sample. The sample remained relevant to the context of policyholders in SA despite the non-probability sampling.

Further, there is no central repository in SA that contains a list of all policyholder information. Policyholder information is kept and maintained only at the insurer with whom the policyholder is insured. Due to competitiveness and legislative restrictions, obtaining a general population of all policyholders in SA is difficult. This further reinforces the argument for the use of a non-probability sampling technique as ideal for this study.

Examples of non-probability sampling techniques include purposive or judgemental sampling, quota sampling and snowball sampling (Babbie & Mouton, 2001:166-167).

Snowball sampling technique was used for this study. Babbie & Mouton, 2001:167 and Saunders et al., 2009:240 recommend the use of snowball sampling technique and argue that this technique is most effective and provide the only solution when it is difficult to locate individuals of a specific population. Thus the choice of snowball sampling is most appropriate for this study.

4.5.3 Sample size

Leedy and Ormrod (2010:213) contend that a larger sample is most beneficial when carrying out research, but this offers little guidance to researchers in determining the precise size of an appropriate sample. Gay, Mills and Airasian (cited in Leedy & Ormrod, 2010:213) suggest the following when determining the sample size:

- For smaller samples (100 or fewer), the entire population should be sampled.
- For a population size of about 500, 50% should be sampled.
- For a population size of about 1 500, 20% should be sampled.
- Beyond a certain point, a sample size of 400 should be adequate.

Welman et al. (2005:69) suggest that larger sample sizes reduce the error rate. Saunders et al. (2009:219), basing their calculation on a 95% accuracy level, indicate that 384 participants would be required for a sample population of larger than a million. SAARF (2016) estimated the total number of policyholders in SA as 1.765 million in 2015. Applying the 95% confidence measure proposed by Saunders et al. (2009:219), this would mean that 384 participants were required for this study. This sample size was also regarded as sufficient for the envisaged statistical analysis to be employed, including identifying group differences, correlation analysis and regression analysis. However, a final sample of 560 was realised, exceeding the minimum suggested sample size.

4.6 DATA COLLECTION

Saunders et al. (2009:154) argue that there is a close nexus between the data collection method and the results it yields. Therefore, they suggest that a researcher

should be guided by the research questions and objectives of the study when choosing an appropriate data collection method.

4.6.1 Survey research

A survey strategy is a popular and cost-effective method used in descriptive and explanatory studies where the aim is to collect data from large populations by asking questions and recording the respondent's answers (Leedy & Ormrod, 2010:187). Leedy and Ormrod (2010:187) state that survey strategy is suitable for research that examines peoples' "characteristics, opinions, attitudes or previous experiences".

According to Saunders et al. (2009:144), a survey strategy is typically used in studies to answer questions regarding "who, what, where, how much and how many". They state that data collected through a survey strategy allows the researcher to do comparisons, to explain reasons for relationships between variables and to develop models (Saunders et al., 2009:144).

This study tested the relationship between insurance fraud tolerance and claims behaviour. It was necessary to collect large amounts of data on various aspects of tolerance and claims behaviour from a population of policyholders to test this relationship. A survey strategy was therefore most appropriate to achieve the aims of this study.

4.6.2 Measuring instrument

Saunders et al. (2009:210) posit that data collection is dependent on time, money and access. Leedy and Ormrod (2010:189) contend that questionnaires as a data

collection instrument are beneficial in that the researcher is able to gather data from large populations from a multitude of different geographical locations in a cost-effective manner. They posit that questionnaires grant respondents the freedom to complete questions privately. This guarantees anonymity, especially on sensitive topics, thus allowing respondents to be truthful in their responses (Leedy & Ormrod, 2010:189).

According to Welman et al. (2005:152), questionnaires are useful to gather biographical information as well as information on behaviour, opinions, beliefs, convictions and attitudes. Babbie and Mouton (2001:265) maintain that questionnaires are suitable for gathering data from large populations, and that questionnaires involve either posing questions to respondents or asking respondents whether they agree or disagree with certain statements. Babbie and Mouton (2001:265) argue that a self-administered questionnaire, which is completed by the respondent, offers more benefits than other methods through which questionnaires are administered in that there is no risk of interviewer bias, it offers more privacy to encourage respondents' participation on sensitive topics, and it is faster.

These factors prompted the decision to use a semi-structured questionnaire to collect data for this study. The advantages of collecting large amounts of data from respondents in different geographical locations, the cost-effectiveness, the sensitivity of this study as it relates to fraudulent claims, a topic affecting a respondent's integrity, and the timing made a questionnaire an ideal data collection instrument.

Babbie and Mouton (2001:233) indicate that the use of both questions and statements is valuable in that it is flexible and makes the questionnaire "interesting". The questionnaire contained open-ended questions, which provided respondents the

opportunity to state their own answers. The questionnaire also included closed-ended questions, which provided respondents with a number of pre-populated options from which they had to choose a response accurately reflecting their opinion. There were two scenarios included in the questionnaire, and respondents were provided with several statements related to the scenarios. Respondents had to choose an option that accurately reflected their opinion.

According to Babbie and Mouton (2001:239), the structure and layout of a questionnaire are critical to the data collection process; there is a risk of misinterpretation, confusion and respondent frustration if the layout is incorrect. Saunders et al. (2009:362) confirm that the design of a questionnaire has an impact on the response rate, validity and reliability of the data.

The items on the questionnaire were arranged in a logical sequence so as to ensure that the flow of information made it easy for respondents to understand what information was being sought. The structure of the questionnaire elicited information on, amongst others, insurance ownership, perceptions towards the insurance industry and own insurer, factors influencing tolerance for insurance fraud, reasons for insurance fraud, consequences of insurance fraud and demographic information. The structure of the questionnaire also ensured that sufficient data were collected to substantiate the findings and conclusions.

The questionnaire was divided into various sections. Section A contained three questions to gather data on the respondents' use of channel, short-term insurers used and primary insurer:

1. Through which channel do you currently manage your short-term insurance policy?

- Direct
- Broker
- Online

2. At which company(ies) do you currently have short-term insurance? (You can choose more than one company.) Please choose all that apply:

- ABSA Insurance
- AIG
- Auto & General
- Bryte Insurance (previously Zurich)
- Dial Direct
- FNB Insurance
- Hollard
- King Price
- MiWay
- Old Mutual Insure (previously Mutual and Federal)
- OUTsurance
- Santam
- Standard Bank Insurance
- Other (please specify)

3. If you have policies with more than one short-term insurer, which one do you regard as your main or primary insurer? Please choose only one of the following:

- ABSA Insurance
- AIG
- Auto & General
- Bryte Insurance (previously Zurich)
- Dial Direct

- FNB Insurance
- Hollard
- King Price
- MiWay
- Old Mutual Insure (previously Mutual and Federal)
- OUTsurance
- Santam
- Standard Bank Insurance
- Other (please specify)

Section B contained three items, which collected data on the respondents' perceptions towards the short-term insurance industry in general and their own insurer:

4. What is your perception of the following entities? Please choose the appropriate response for each item.

	Very negative	Fairly negative	In-between	Fairly positive	Very positive
Short-term insurance industry in general	1	2	3	4	5
Own primary short-term insurer	1	2	3	4	5
Brokers	1	2	3	4	5
Insurance assessors	1	2	3	4	5

5. Please indicate if you agree or disagree with the following statements about short-term insurance companies in general. Please choose the appropriate response for each item.

	Definitely disagree	Do not agree	Neither agree nor disagree	Agree	Definitely agree
Have policyholders' best interest at heart	1	2	3	4	5
Delivering on promises they make when the policy was sold	1	2	3	4	5
Delivering a prompt service	1	2	3	4	5
Handling claims in a professional manner	1	2	3	4	5
Handling claims in a fair manner	1	2	3	4	5
Looking for reasons not to pay a claim	1	2	3	4	5
Treat policyholders like a criminal when a claim is submitted	1	2	3	4	5

6. Please indicate if you agree or disagree with the following about your own short-term insurance company. Please choose the appropriate response for each item.

	Definitely disagree	Do not agree	Neither agree nor disagree	Agree	Definitely agree
Have policyholders' best interest at heart	1	2	3	4	5
Delivering on promises they make when the policy was sold	1	2	3	4	5
Delivering a prompt service	1	2	3	4	5
Handling claims in a professional manner	1	2	3	4	5
Handling claims in a fair manner	1	2	3	4	5
Looking for reasons not to pay a claim	1	2	3	4	5
Treat policyholders like a criminal when a claim is submitted	1	2	3	4	5

Section C contained six questions, which aimed at collecting data on the respondents' perceptions on why people commit fraud or do not commit fraud:

7. What do you believe are the main reason why people in South Africa commit short-term insurance fraud?

8. To what extent do you believe the following are reasons people commit insurance fraud in South Africa? Please choose the appropriate response for each item:

	Definitely disagree	Do not agree	Neither agree nor disagree	Agree	Definitely agree
To get back at short-term insurance companies who make too much profits	1	2	3	4	5
Looking for a 'fair return' on premiums paid	1	2	3	4	5
To save money or reduce costs	1	2	3	4	5
To get expensive work done that would otherwise be unaffordable	1	2	3	4	5
If insurance companies treated people more fairly, people wouldn't try to commit fraud that much	1	2	3	4	5
Forced to commit fraud	1	2	3	4	5
People commit fraud, because they believe it is seen as common practice in South Africa (everybody else is doing it)	1	2	3	4	5
It is not that a specific person got hurt	1	2	3	4	5
To make up for the excess payments	1	2	3	4	5
It is okay to inflate the claim just by a little bit	1	2	3	4	5
It is easy to commit short-term insurance fraud	1	2	3	4	5
Insurance companies tolerate to some extent claims padding (i.e. inflating claims)	1	2	3	4	5
Insurance companies do not prosecute fraudsters	1	2	3	4	5
Policyholders have a strained relationship with their insurance company	1	2	3	4	5

9. Are there any other reasons you can think of why people commit short-term insurance fraud?

10. What do you believe are the main reasons why a person would not commit short-term insurance fraud?

11. To what extent do you believe the following are reasons why people do not commit short-term insurance fraud in South Africa?

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
Moral character	1	2	3	4	5
Cultural beliefs	1	2	3	4	5
Fear of being caught	1	2	3	4	5
Fear of prosecution	1	2	3	4	5
Lack of opportunity to commit fraud	1	2	3	4	5
Religious beliefs	1	2	3	4	5
Understand the negative impact of insurance fraud on the sustainability of the insurance industry	1	2	3	4	5
Fear of humiliation if caught	1	2	3	4	5
Have a good relationship with their insurance company	1	2	3	4	5

12. Are there any other reasons you can think of why people do not commit short-term insurance fraud?

Section D contained two items. The first item probed respondents in relation to the types of insurance fraud committed in South Africa. The second item aimed to measure the perceived difficulty of submitting false and inflated claims.

13. What do you believe are the most common types of short-term insurance fraud committed in South Africa?

14. Please rate the following:

	Extremely difficult				Extremely easy
Difficulty in submitting an inflated claim	1	2	3	4	5
Difficulty in submitting a false claim	1	2	3	4	5

Section E aimed to measure levels of tolerance towards insurance fraud, and contained a single item:

15. Indicate to what extent you agree or disagree with the following statements. Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
People might have justifiable reasons for behaving unethically in certain situations	1	2	3	4	5
People might have justifiable reasons for inflating their claims	1	2	3	4	5
I am tolerant of people who inflate their insurance claims	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because I don't want to get involved	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because it is done by everyone anyway	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because in most cases it is difficult to prove	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because in most cases it is not that serious or wrong	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because no one gets hurt	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because people want to make up for their excess payments	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because short-term insurers treat claimants like criminals	1	2	3	4	5

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because short-term insurers act unethically themselves	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because it is done by everyone anyway	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because short-term insurers are always looking for ways to reject claims	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because I do not think that inflating a claim is a crime	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because short-term insurers do no prosecute offenders (this behaviour is condoned by short-term insurers)	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because this behaviour is condoned by brokers	1	2	3	4	5
Although I might believe that short-term insurance fraud is wrong, I tolerate/endure it because this behaviour is condoned by the salespersons/marketers employed by short-term insurers	1	2	3	4	5

Section F collected demographic data about the respondents:

16. Residential province:

- Eastern Cape
- Free State
- Gauteng
- KwaZulu-Natal
- Limpopo
- Mpumalanga
- Northern Cape
- North West
- Western Cape

17. Your gender:

- Male
- Female

18. Your age:

19. Highest education level obtained.

- Some secondary schooling
- Matric/Grade 12
- Post matric qualification: Certificate
- Post matric qualification: Diploma
- Post matric qualification: Degree & higher
- Other (please specify)

20. What is the income category that best describes your personal gross monthly income before tax and deductions? Please choose only one of the following:

- Less than R5 000
- R5 000 – R7 500

- R7 501 – R10 000
- R10 001 – R15 000
- R15 001 – R20 000
- R20 001 – R25 000
- R25 001 – R30 000
- R30 001 – R40 000
- R40 001 – R50 000
- More than R50 000
- Refused

The variables that are distinguished during the analysis are described next.

4.6.3 Variables

A variable refers to the characteristic, quality or attribute that is the central focus of a study; it has two or more potential values and is capable of change (Creswell, 2009:49-50; Leedy & Ormrod, 2010:224; Welman et al., 2005:16). According to Leedy and Ormrod (2010:224), when studying “cause and effect relationships” between variables, the aim is to establish the impact one variable will have on another variable. Variables are classified as being either independent or dependent (Saunders et al., 2009:367).

An independent variable is that characteristic, quality or attribute which a researcher chooses and manipulates to figure out what effect this will have on another variable (Creswell, 2009:50; Leedy & Ormrod, 2010:224; Welman et al., 2005:16). A dependent variable is that characteristic, quality or attribute which is closely monitored to see how it responds, changes or reacts with the introduction of an independent variable (reswell, 2009:50; Leedy & Ormrod, 2010:224; Welman et al., 2005:16). In this study,

insurance fraud tolerance was the dependent variable and policyholder claims behaviour (attitudes and opinions) served as independent variable.

The data collection process for this study was done in two phases, as discussed in the two sections that follow. Firstly, it involved a pilot study to confirm the validity and reliability of the questionnaire as the measuring instrument. Secondly, it involved the actual administering of the final questionnaire to respondents.

4.6.4 Pilot testing

Pilot testing or pre-testing is an essential step undertaken during the design of a questionnaire to ensure that the respondent understands the questions being asked and to further ensure that the questions being asked are correctly framed to elicit the desired information (Leedy & Ormrod, 2010:196). Babbie and Mouton (2001:244) contend that the purpose of pilot testing is to identify errors and ambiguous questions, especially in studies where the population sample consists of different cultural groups or languages. Pilot testing involves a process where the questionnaires are handed to several friends or experts with the request that they complete the questionnaire and provide feedback on issues such as clarity and understanding of questions, errors, logical sequence of questions, and the overall layout and design of the questionnaire (Babbie & Mouton, 2001:244; Leedy & Ormrod, 2010:196).

The questionnaire for this study was piloted amongst 15 respondents. All errors, suggestions and refinement to questions were taken into consideration, and the necessary adjustments were made. Clear definitions of inflated and false claims were included in the questionnaire to ensure that there was a clear understanding of these terms amongst all respondents. The structure of the questionnaire was also adjusted

to ensure that there was a logical flow. Questions on insurance ownership were placed at the beginning of the questionnaire, while the less inspiring demographic questions were placed at the end. This was done to generate respondent interest in completing the questionnaire.

4.6.5 Administering the final questionnaire

A well-drafted covering letter or e-mail to respondents explaining the value, objectives and purpose of the study is important in assisting respondents to decide whether they want to participate or not. It is argued that a good cover letter and a good design will positively influence the response rate (Babbie & Mouton, 2001:243; Leedy & Ormrod, 2010:194; Saunders, 2009:389, 395). This cover letter is therefore the researcher's marketing opportunity to motivate and encourage would-be respondents to participate in the proposed study.

Clear instructions and guidelines must be included at the beginning of the questionnaire; this is even more important for self-administered questionnaires (Babbie & Mouton, 2001:243; Leedy & Ormrod, 2010:194; Saunders et al., 2009:389). These instructions serve as a guide to assist respondents to navigate through the questionnaire, thereby removing any frustration or confusion.

An e-mail was sent out to respondents two weeks before the actual survey was sent out. It was an introductory e-mail advising respondents about the objectives and purpose of the study and to be on the lookout for the questionnaire. This e-mail also contained a supporting letter from the supervisor to authenticate the study.

A self-administered questionnaire was used for this study. An e-mail with a link to the online survey questionnaire, which was published on LimeSurvey, was sent out to all respondents. The respondents were able to access the survey by clicking on the link.

An introduction section was included at the beginning of the survey to inform respondents of the purpose and objectives of the survey. Respondents were also assured of their anonymity in completing the questionnaire. Each section of the survey contained clear instructions to assist and guide respondents in answering the questions.

The validity and reliability of the questionnaire are discussed next.

4.7 VALIDITY AND RELIABILITY

The integrity and rigour of a questionnaire and the findings it yields are dependent on the questionnaire's validity and reliability (Babbie & Mouton, 2001:118-119). According to Saunders et al. (2009:371), a valid questionnaire assures the researcher that the correct data will be collected, and a reliable questionnaire provides assurances that the same data will be collected consistently. The validity and reliability of the questionnaire used in this study are described below.

4.7.1 Validity

According to Leedy and Ormrod (2010:97-98), validity is classified as either internal or external. External validity refers to whether the findings of the study can be generalised to the larger population. External validity and generalisability of the findings are linked to population sampling, which was discussed in the section about sampling technique.

The term “internal validity” refers to the precision with which the questionnaire can measure the items the researcher intended to measure (Leedy & Ormrod, 2010:28, 97). In other words, internal validity provides assurances that the items on the questionnaire have the ability to measure what it is supposed to measure. To make certain of internal validity in this study, the following processes were followed:

- A comprehensive literature review was conducted on insurance fraud tolerance and policyholders’ claims behaviour. The literature review provided valuable insights in identifying the various themes and constructs necessary for this study.
- The questionnaire and the items contained therein were reviewed and discussed with insurance fraud specialists to ensure that all themes and constructs were incorporated, thus contributing towards ensuring content and construct validity.
- A pilot study was conducted with 15 respondents to ensure that all questions were clearly articulated and understood.
- A statistician with experience in the field of short-term insurance fraud and consumer behaviour research was consulted to review the questionnaire and determine whether the constructs could be measured and analysed given the research objectives.

4.7.2 Reliability

The term “reliability” refers to the robustness of the questionnaire to deliver consistent results if administered repeatedly (Leedy & Ormrod, 2010:29). This means that, if the same research would be conducted by someone else utilising the same processes, it would produce similar results. Saunders et al. (2009:373-374) caution that processes

employed to ensure questionnaire reliability can be time-consuming and can cause frustration for respondents.

To assess the internal consistency reliability of construct (scale) measures, the Cronbach's alpha coefficient was calculated. The minimum acceptable norm of 0.6 for internal consistency reliability proposed by Hair, Black, Babin and Anderson (2014:90) was adopted. In cases where the scale had fewer than 10 items coupled with a low Cronbach's alpha value (<0.6), the mean inter-item correlation for the items was also inspected, for which Briggs and Cheek (in Pallant, 2011:6) recommend an optimal range from 0.2 to 0.4.

The following processes were employed to enhance reliability in this study:

- No incentives were paid to respondents for participating in this study.
- Questionnaires were e-mailed directly to the respondents.
- The questions were simple and easy to understand.

4.8 ASSUMPTIONS UNDERLYING THIS STUDY

The following basic assumptions underpinned this study. It was assumed that:

- Insurance fraud tolerance level is a measurable construct that can be defined and measured through a quantitative strategy of inquiry.
- Insurance fraud tolerance level can be used as a construct to predict policyholder behaviour.
- The sample selection and sample size were suitable to provide sufficient data required for the purposes of this study.

- The questionnaire used in this study accurately measured the constructs it was intended to measure.

4.9 DATA ANALYSIS

Data analysis is a process that involves the analysis and interpretation of the collected data. The results of this analysis either support or disprove that which is being considered in the study (Welman et al., 2005:211). Saunders et al. (2009:416) suggest that, when analysing quantitative data, it is important to ensure that due consideration is given to the following:

- type of data collected;
- how the data were collected;
- how the data were coded;
- how the data were weighed, especially when dealing with certain sampling types; and
- what method was used to identify errors.

IBM SPSS (version 25) was used for the statistical analysis of the data. The following comprised the data analysis plan:

- Calculating univariate frequency and descriptive statistics in order to assess the variation per question and/or scale item.
- Constructing bivariate cross-tabulations to investigate group differences. This was coupled with hypothesis testing to identify statistically significant differences. Where two groups were compared, an independent samples t-test was employed. For comparing three or more groups, an analysis of variance was conducted. The

decision to employ parametric tests was based on a sufficiently large sample size and the adoption of the central limit theorem explaining the expected sampling distribution (Field, 2009:42).

- Conducting exploratory factor analysis to further explore the underlying relationship between the ratings of sets of statements. Principal axis factoring was specified as extraction procedure and varimax as rotation method. The aim of this analysis was to identify the emergence of underlying hypothetical constructs and whether these related to previous factors identified in the literature.
- Calculating Cronbach's alpha coefficients and mean inter-item correlations to assess internal consistency reliability.

4.10 ETHICAL CONSIDERATIONS

University of Fort Hare's code of ethics regarding research was strictly adhered to during this study. The following ethical issues pertaining to this study were considered and addressed as follows:

- Voluntary consent and participation: respondents were advised at the beginning of the survey that their participation was voluntary, and they had the option to withdraw from the survey at any time during the survey. No incentives were given to respondents for their participation in this survey. If respondents consented to participate in this survey, they had to click the "next" button on the survey screen. Even after beginning with the survey, respondents were afforded the opportunity to withdraw by clicking the "exit and clear survey" button on the screen.
- Anonymity: the questionnaire was designed so as not to elicit any identifying information from respondents. The respondents were able to access the survey

through a link hosted on an online platform, thereby reducing the risk of any personal information or e-mail addresses being exposed. Respondents were also assured that the findings would be presented from a holistic group perspective rather than at an individual level.

- Confidentiality: the collected data were hosted on an external database with strict security protocols. No identifying information was collected during this study. The findings of this study will be used for publication purposes.

4.11 CHAPTER SUMMARY

This chapter provided a discussion of the research design and methods employed in this study. The sampling technique, data collection strategy, data analysis and ethical considerations for this study were presented. The next chapter provides a discussion of the research results in relation to the research objectives.

CHAPTER 5: RESULTS

5.1 INTRODUCTION

This study set out to investigate consumer fraud tolerance as a predictor for insurance claims behaviour in SA, and to investigate factors that contribute towards explaining levels of tolerance towards insurance fraud. Primary quantitative data for this study were collected through a survey that was conducted amongst a sample of short-term policyholders in SA. A total of 560 valid questionnaires were received and analysed. The results are presented and discussed in this chapter. The chapter is divided into eight main sections, of which this is the first.

Section 5.2 presents the sample profile in relation to demographic characteristics of respondents, primary insurer, the geographic distribution of respondents and channel used to manage short-term insurance policy.

Sections 5.3 report respondents' estimated levels of tolerance towards insurance fraud. This addresses the first research objective.

Section 5.4 presents the results pertaining to respondents' perceived reasons why policyholders in SA would commit insurance fraud, while section 5.5 follows on this by exploring reasons why policyholders would be deterred from committing insurance fraud. Section 5.6 considers the perceived types of insurance fraud committed in SA and difficulty in submitting an inflated and/or false claim. These sections address the second research objective.

Section 5.7 reports on the perceptions of policyholders towards the value proposition of the insurance industry in general versus that of the policyholder's own primary insurer. This addresses the third research objective.

Section 5.8 investigates the statistical relationship between reasons for committing fraud, perceptions of the insurance industry and levels of tolerance towards short-term insurance fraud. This addresses the fourth research objective.

5.2 SAMPLE CHARACTERISTICS

Below, the characteristics of the sample are presented in terms of demographics, primary insurers, residential provinces and channels used to manage short-term insurance.

5.2.1 Demographic profile

The demographic profile of the sample in relation to characteristics such as gender, age, personal income and highest level of education is reported in this section. Past studies have indicated that certain demographic factors play a role in explaining variation in levels of insurance fraud tolerance (Brokesova & Pastorakova, 2013:297-394; Dean, 2004:67-79; Tennyson, 1997:247-265, 2002:35-56).

Table 5 reports the proportional distribution of respondents according to gender, age, personal income and highest level of education. Some respondents, albeit minimal, did not specify their demographics for reasons of confidentiality. The non-responses were considered random and negligible given the large sample size. These non-responses are excluded from reporting.

Table 5: Demographic profile

Variables	Frequency (n)	Percentage
Gender (n = 552)		
Male	300	54.3%
Female	252	45.7%
Age (n = 551)		
19 - 34	85	15.4%
35 - 49	201	36.5%
50 - 65	185	33.6%
Older than 65	80	14.5%
Highest level of education (n = 551)		
Matric/grade 12 or lower	82	14.9%
Post-matric qualification: Certificate	58	10.5%
Post-matric qualification: Diploma	105	19.1%
Post-matric qualification: Degree or higher	306	55.5%
Personal income (n = 508)		
Less than R15 000	44	8.7%
R15 001 to R25 000	90	17.7%
R25 001 to R40 000	128	25.2%
More than R40 000	246	48.4%

Available demographic information on short-term insurance policyholders in SA is limited. SAARF (2016) only reported on the number of policyholders per province and the personal income of the policyholders. The report indicated that 33.3% of respondents had a personal income of less than R14 000; 25.5% of respondents had a personal income of R14 000 to R24 999; 13.6% of respondents had a personal income of R25 000 to R39 999 and 8.7% of respondents had a personal income of more than R40 000. A notable proportion of respondents (18.9%) in the SAARF (2016) study did not indicate their personal income. From a personal income perspective, the sample distribution for this study was more skewed towards higher income groups while the results of SAARF (2016) suggested a skewed distribution towards lower

income. Nonetheless, the sample data provided insight into the explanatory value of income towards insurance fraud tolerance.

5.2.2 Primary insurer of respondents

Table 6 indicates the respondents' primary short-term insurers.

Table 6: Primary short-term insurer (n = 560)

	Percentage
Santam	32.1%
Other insurers	18.7%
Outsurance	10.2%
Old Mutual Insure	8.2%
Hollard	7.0%
Absa Insurance	4.6%
Auto & General	3.6%
Standard Bank Insurance	3.2%
MiWay	3.2%
Dial Direct	2.1%
FNB Insurance	2.1%
King Price	2.1%
Bryte Insurance	1.6%
AIG	1.1%

The term "other insurers" in the table consists collectively of the following options that could be selected in the questionnaire: "other", "no specific one" and "not specified/not certain". KPMG (2017:81) reported that the insurer with the largest market share was Santam with 24%, followed by other insurers³ with 21%, Hollard with 11% and Mutual and Federal (now Old Mutual Insure) with 9% and OUTsurance with 8%; AIG, with 2%, had the smallest market share. The percentages of respondents with various

³ The term "other insurers" is not defined in the report.

insurers in this study were fairly representative of policyholders from the various insurance companies as per the market share reported by KPMG (2017:17). The largest percentage of respondents was insured with Santam (32.1%), followed by 18.7% with other insurers, 10.2% with OUTsurance, 8.2% with Old Mutual Insure and 7% with Hollard. The smallest percentage of respondents (1.1%) was insured with AIG.

5.2.3 Residential province of respondents

Table 7 indicates the distribution of the sample according to the residential province of the respondents.

Table 7: Geographic distribution of sample (n = 560)

	Percentage
Gauteng	54.6%
Western Cape	27.3%
KwaZulu Natal	7.3%
Eastern Cape	4.1%
Free State	2.5%
Limpopo	1.4%
Mpumalanga	1.3%
North West	1.1%
Northern Cape	0.2%

SAARF (2016) reported that the highest concentration of insured individuals was located in Gauteng with 29%, followed by KwaZulu Natal with 26% and Western Cape with 18%; Northern Cape had the lowest concentration of insured individuals with 1%.

Table 7 indicates that respondents were from all nine provinces in SA. Gauteng had the highest number of respondents with 54.6%, followed by Western Cape with 27.3%

and KwaZulu Natal with 7.3%. Northern Cape had the lowest number of respondents with 0.2%.

5.2.4 Channel used to manage short-term insurance policy

Table 8 indicates the manner in which respondents managed their short-term insurance policies. The table also shows the gender, age, qualification and personal income of respondents.

Table 8: Channel by selected demographic groups

	Total (n=560)	Gender		Grouped age				Highest education level				Income category: Personal			
		Male (n=300)	Female (n=252)	19 - 34 (n=85)	35 - 49 (n=201)	50 - 65 (n=185)	66 and older (n=80)	Matric/ Grade 12 (or lower) (n=82)	Post matric: Certificate (n=58)	Post matric: Diploma (n=105)	Post matric: Degree & higher (n=306)	Less than R15 000 (n=44)	R15 001 - R20 000 (n=90)	R20 001 - R40 000 (n=128)	More than R40 000 (n=246)
Direct	46.8%	40.7%	54.0%	52.9%	56.2%	42.2%	27.5%	63.4%	46.6%	41.0%	44.1%	47.7%	55.6%	49.2%	41.5%
Broker	48.0%	54.0%	40.9%	38.8%	41.3%	52.4%	65.0%	34.1%	50.0%	51.4%	50.3%	45.5%	35.6%	45.3%	54.9%
Online	5.2%	5.3%	5.2%	8.2%	2.5%	5.4%	7.5%	2.4%	3.4%	7.6%	5.6%	6.8%	8.9%	5.5%	3.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<i>Pearson Chi-Square (df, n)</i>		(2;n=552)=10.108 <i>p=0.006</i>		(6;n=551)=25.921 <i>p=0.000</i>				(6;n=551)=12.776 <i>p=0.047</i>				(6;n=508)=12.323 <i>p=0.055</i>			

The results revealed that respondents' preference towards managing their policy was divided between a broker (48.0%) and direct interaction with the insurer (46.8%). The preference of the remaining 5.2% was towards an online platform.

In terms of managing a policy through a broker, group comparison indicated that male respondents (54.0%) showed a significantly higher prevalence of managing their policy through a broker than female respondents (40.9%) ($\chi^2(2;n = 552) = 10.108$; $p = 0.006$). In contrast, females showed an inclination for taking out insurance directly with the insurance company (54.0% compared to 40.7% of males).

Differences between age groups and their preferences were also observed ($\chi^2(6;n = 551) = 12.921$; $p = 0.000$). The majority of respondents younger than 50 years made use of direct channels, while older respondents had an inclination to make use of brokers.

With regard to qualification, the main differences were observed between respondents with only a matric or grade 12 qualification versus those with a post-matric qualification. About 63% of respondents with only a matric/grade 12 qualification made use of direct channels, while those with post-matric qualification had a marginal inclination towards using brokers. These differences were also significant ($\chi^2(6;n = 551) = 12.776$; $p = 0.047$).

While no statistical relationship was observed between use of channel and personal income ($\chi^2(6;n = 508) = 12.323$; $p = 0.055$), some underlying inverse trend was observed amongst the higher income groups. As personal income increased, the prevalence of using a broker also increased. In contrast, engaging directly with the insurer or using an online platform decreased.

5.3 MEASURING LEVELS OF SHORT-TERM INSURANCE FRAUD TOLERANCE (RESEARCH OBJECTIVE 1)

This section relates to the first research objective, namely to measure policyholders' self-reported tolerance to insurance fraud. Respondents were asked to rate 17 statements pertaining to their tolerance towards insurance fraud. A five-point Likert-type scale was used to rate the statements, where 1 = definitely disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree and 5 = definitely agree. Higher levels of agreement with a statement would be associated with higher levels of insurance fraud tolerance, while disagreement would be associated with less or no tolerance towards insurance fraud.

Table 9 reports the percentage of respondents who responded "definitely disagree", "disagree", "neither agree nor disagree", "agree" and "disagree" to the various statements. The mean and standard deviation (SD) scores are also reported, providing a sense of the extent of agreement and dispersion of ratings around the mean. To further make sense of the ratings, the scores for "definitely disagree" and "disagree" were combined and classified as "disagree" for reporting purposes. Similarly, the scores for "agree" and "definitely agree" were combined and classified as "agree".

Table 9: Agreement with statements about insurance fraud tolerance in South Africa (n = 560)

	Mean (SD)	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree	Top 2-box
		Definitely disagree & Disagree	Definitely agree & Agree				
People might have justifiable reasons for behaving unethically in certain situations	2.43 (1.190)	29.1%	25.0%	22.0%	21.3%	2.7%	54.1% 23.9%
People might have justifiable reasons for inflating their claims	2.24 (1.148)	32.5%	33.0%	15.5%	16.3%	2.7%	65.5% 18.9%
I tolerate/accept it because short-term insurers are always looking for ways to reject claims	2.14 (1.169)	38.8%	27.3%	18.6%	11.4%	3.9%	66.1% 15.4%
I tolerate/accept it because short-term insurers act unethically themselves	2.11 (1.110)	37.9%	28.7%	20.2%	10.5%	2.7%	66.6% 13.2%
I tolerate/accept it because I don't want to get involved	1.96 (1.102)	45.2%	28.4%	13.4%	10.9%	2.1%	73.6% 13,0%
I tolerate/accept it because in most cases it is difficult to prove	1.98 (1.084)	42.9%	30.9%	13.8%	10.4%	2.1%	73.8% 12.5%
I tolerate/accept it because short-term insurers treat claimants like criminals	1.96 (1.089)	44.5%	28.7%	16.1%	7.7%	3.0%	73.2% 10.7%
I tolerate/accept it because people want to make up for their excess payments	1.81 (1.024)	50.2%	30.2%	10.4%	7.1%	2.1%	80.4% 9.3%
I tolerate/accept it because short-term insurers do not prosecute offenders (this behaviour is condoned by short-term insurers)	1.93 (1.006)	41.8%	33.8%	17.1%	4.6%	2.7%	75.5% 7.3%
I tolerate/accept it because this behaviour is condoned by brokers	1.88 (0.998)	45.2%	30.5%	17.1%	5.2%	2.0%	75.7% 7.1%
I tolerate/accept it because this behaviour is condoned by the salespersons/marketers employed by short-term insurers	1.84 (0.955)	45.5%	32.0%	16.4%	4.6%	1.4%	77.5% 6.1%
I tolerate/accept it because it is done by everyone anyway	1.73 (0.951)	51.8%	32.3%	10.0%	3.4%	2.5%	84.1% 5.9%
I am tolerant of people who inflate their insurance claims	1.77 (0.953)	49.8%	31.1%	13.4%	3.8%	2.0%	80.9% 5.7%
I tolerate/accept it because no one gets hurt	1.69 (0.931)	54.5%	29.8%	10.0%	3.9%	1.8%	84.3% 5.7%
I tolerate/accept it because in most cases it is not that serious	1.71 (0.916)	52.3%	30.7%	11.8%	3.8%	1.4%	83,0% 5.2%
I tolerate/accept it because it is done by everyone anyway	1.71 (0.883)	50.7%	33.2%	12.0%	2.7%	1.4%	83.9% 4.1%
I tolerate/accept it because I do not think that inflating a claim is a crime	1.64 (0.870)	54.8%	31.8%	9.6%	2.0%	1.8%	86.6% 3.8%

On average, the majority of respondents (75.6%) definitely disagreed and disagreed with all of the statements, indicating low levels of insurance fraud tolerance. In contrast, only 9.9% (on average) agreed or definitely agreed.

While these statements individually provided an indication of policyholders' levels of insurance fraud tolerance, the aim was to construct a single measure for tolerance. In order to facilitate this process, exploratory factor analysis was employed to assess the underlying relationship between these statements. Principal axis factoring was specified as extraction procedure and varimax as rotation method. The Kaiser-Meyer-Olkin measure of sampling adequacy revealed a value of 0.954, which indicated that the items (or statements) were factorable (Pallant, 2011:183). Bartlett's test of sphericity was shown to be highly significant ($\chi^2 = (136;n = 560) = 9866.886$; $p = 0.000$). Two factors emerged, explaining 62.6% and 6.2% respectively of the total variance. The rotated factor matrix is presented in Table 10.

Table 10: Rotated factor matrix – statements about insurance fraud tolerance

	Factor		Mean (SD)		Top 2-box (Definitely agree & Agree)	
	1	2	Item	Construct	Item	Construct
I tolerate/accept it because it is done by everyone anyway	0.84		1.71 (0.883)	1.86 (0.833)	4.1%	8.3%
I tolerate/accept it because it is done by everyone anyway	0.84		1.73 (0.951)		5.9%	
I tolerate/accept it because no one gets hurt	0.82		1.69 (0.931)		5.7%	
I tolerate/accept it because in most cases it is not that serious	0.82		1.71 (0.916)		5.2%	
I tolerate/accept it because people want to make up for their excess payments	0.80		1.81 (1.024)		9.3%	
I tolerate/accept it because this behaviour is condoned by the salespersons/marketers employed by short-term insurers	0.80		1.84 (0.955)		6.1%	
I tolerate/accept it because this behaviour is condoned by brokers	0.79		1.88 (0.998)		7.1%	
I tolerate/accept it because in most cases it is difficult to prove	0.78		1.98 (1.084)		12.5%	
I tolerate/accept it because short-term insurers treat claimants like criminals	0.78		1.96 (1.089)		10.7%	
I tolerate/accept it because short-term insurers do not prosecute offenders (this behaviour is condoned by short-term insurers)	0.76		1.93 (1.006)		7.3%	
I tolerate/accept it because short-term insurers are always looking for ways to reject claims	0.75		2.14 (1.169)		15.4%	
I tolerate/accept it because short-term insurers act unethically themselves	0.75		2.11 (1.110)		13.2%	
I tolerate/accept it because I don't want to get involved	0.74		1.96 (1.102)		13.0%	
I tolerate/accept it because I do not think that inflating a claim is a crime	0.72		1.64 (0.870)		3.8%	
I am tolerant of people who inflate their insurance claims	0.54		1.77 (0.953)		5.7%	
People might have justifiable reasons for inflating their claims		0.89	2.24 (1.148)	2.33 (1.094)	18.9%	21.4%
People might have justifiable reasons for behaving unethically in certain situations		0.77	2.43 (1.190)		23.9%	

*Cronbach alpha

A Cronbach's alpha value of 0.97 was calculated for the first factor (15 items) and 0.86 for the second factor 0.86 (two items). Both these alpha values were higher than the minimum acceptable norm of 0.6 for internal consistency reliability (Hair et al., 2014:90). Given the significant percentage variation explained by the first factor (62.6%), it was retained as a measure for insurance fraud tolerance.

The distribution of the summated average score for insurance fraud tolerance is shown in Figure 11. A mean of 1.86 was reported, with a standard deviation of 0.833. Additional statistics showed a median of 1.73, a mode of 1 and a positive skewness of 0.967. While a maximum value of 5 was reported, 75% of respondents reported levels of 2.33 and lower. It is therefore evident from these statistics and the histogram that respondents generally reported low level of tolerance towards short-term insurance fraud.

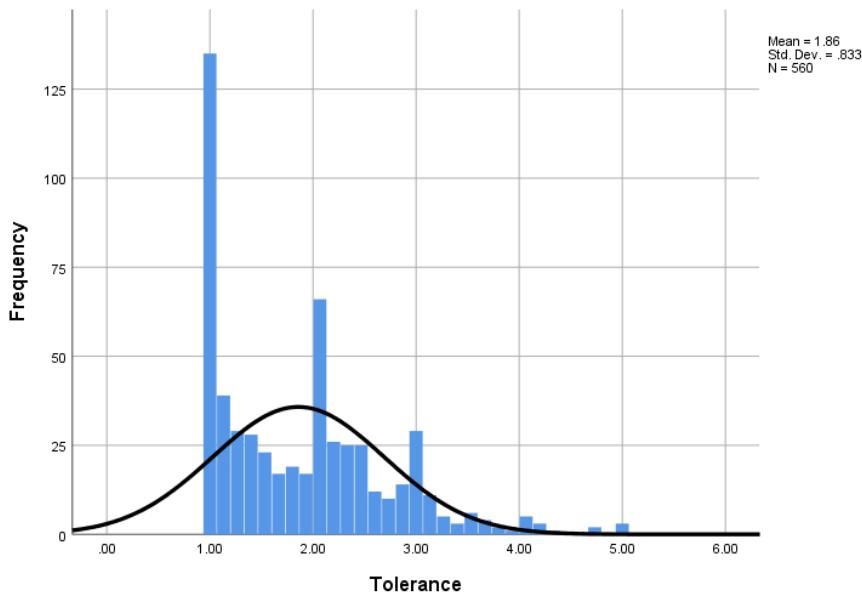


Figure 11: Distribution of insurance fraud tolerance amongst policyholders in South Africa ($n = 560$)

Table 11 reports the mean tolerance levels broken down by demographic groups.

Table 11: Levels of insurance fraud tolerance in South Africa by selected demographic groups

Factor	Total (n=560)	Gender		Grouped age				Highest education level				Income category: Personal			
		Male (n=300)	Female (n=252)	19 - 34 (n=85)	35 - 49 (n=201)	50 - 65 (n=185)	66 and older (n=80)	Matric/ Grade 12 (or lower) (n=82)	Post matric: Certificate (n=58)	Post matric: Diploma (n=105)	Post matric: Degree & higher (n=306)	Less than R15 000 (n=44)	R15 001 - R20 000 (n=90)	R20 001 - R40 000 (n=128)	More than R40 000 (n=246)
Insurance fraud tolerance	1.86 (0.833)	1.86 (0.810)	1.86 (0.861)	2.01 (0.935)	1.79 (0.863)	1.82 (0.761)	1.96 (0.812)	1.91 (0.886)	1.76 (0.824)	1.93 (0.811)	1.83 (0.829)	2.06 (0.927)	2.10 (0.933)	1.87 (0.855)	1.73 (0.777)
Test statistics	$t(550)=-0.052$ $p=0.958$		$F(3, 550)=1.920$ $p=0.125$				$F(3, 550)=0.782$ $p=0.504$				$F(3, 550)=5.432$ $p=0.001$				

The results as reported in the table indicated that tolerance levels seemed to be consistent across gender, grouped age and education, with no significant differences reported in mean levels ($p > 0.05$). Significant differences in levels of tolerance were, however, only observed amongst income groups ($F(3; n = 550) = 5.432$; $p = 0.001$). Higher-income groups were associated with lower levels of tolerance.

5.4 REASONS FOR COMMITTING SHORT-TERM INSURANCE FRAUD (RESEARCH OBJECTIVE 2)

The results presented in this section speak to the second research objective, namely to identify the main perceived reasons for insurance claims fraud in SA. According to the literature, insurance fraud is motivated by a nexus of various factors; it has been indicated that an understanding of these factors and their relationship with each other will assist in gaining greater insight into insurance fraud tolerance (Miyazaki, 2009:589-598; Tennyson, 2002:35-55, 2008:1181-1204). Studies have found that significant data regarding factors which influence insurance fraud tolerance and consumer attitudes could be uncovered by understanding perceptions regarding why people commit or are deterred from committing insurance fraud (CAIF, 1997:1-25, 2008:1-27; Brinkmann & Lentz, 2006:177-195; Dean, 2004:67-79; Tennyson, 2002:35-55, 2008:1181-1204).

For the purposes of this study, it was therefore important to explore the reasons why policyholders in SA would commit or be deterred from committing short-term insurance fraud to fully understand insurance fraud tolerance.

5.4.1 Perceived reasons why people in SA commit short-term insurance fraud (open question)

An open question was posed to respondents enquiring what they believed were the main reasons why people committed insurance fraud in SA. The aim was to explore the top-of-the-mind opinions of respondents without offering a predefined list of reasons as identified during the literature review. A content analysis of the responses received revealed eight major themes. These themes and their proportional distribution are reported in Figure 12.

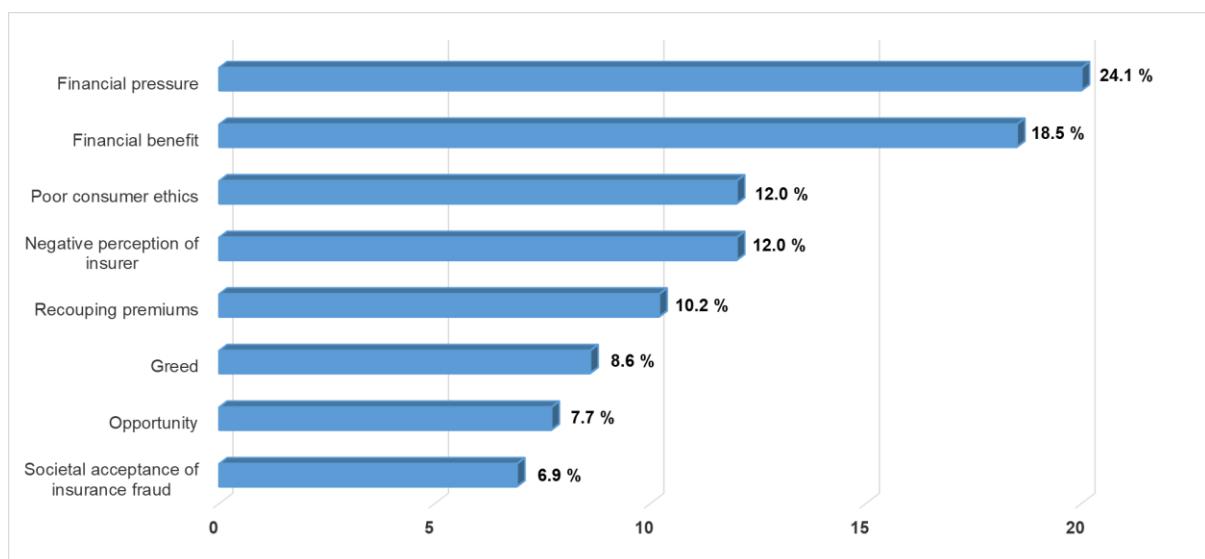


Figure 12: Main reasons why people in SA commit fraud (open question) (n = 491)

Financial pressure (24.1%), financial benefit (18.5%), negative perception of insurer (12.0%) and poor consumer ethics (12.0%) were mentioned by respondents as the four main reasons why people commit short-term insurance fraud in SA. The ranking was based on the number of responses received that linked to the specific theme.

Reviewing the respondents' comments, reasons associated with the high cost of living in SA and the financial burden experienced by consumers seem to be in part what motivates policyholders to commit short-term insurance fraud. This leads again to financial pressures and couples with policyholders' desire to get money easily as a motivating factor to commit insurance fraud – thus, policyholders seek financial benefit.

Respondents also identified a sometimes negative consumer relationship with the insurance company as a contributing factor influencing a policyholder's willingness to commit insurance fraud. Poor consumer ethics was also identified as a reason why policyholders might commit insurance fraud. Respondents believed that policyholders who lacked integrity and had a low value system might be more likely to commit insurance fraud.

Respondents felt that many policyholders sought a fair return for regularly paying their premiums. The desire to get something back can be a motivating factor to commit insurance fraud, especially if policyholders believe the return is not fair. Respondents also believed that greed, opportunity with reference to loopholes in an insurance company's processes and societal acceptance of insurance fraud were factors that influenced people to commit short-term insurance fraud.

Table 12 provides examples of some of the verbatim comments received by respondents in response to the question. The comments are grouped according to each of the four main themes identified above.

Table 12: Main reasons why people in South Africa commit fraud (open question) – verbatim responses

Financial pressure (n = 118)	Financial benefit (n = 91)	Negative perception of insurer (n = 59)	Poor consumer ethics (n = 59)
<i>"Don't have money to replace the item themselves."</i>	<i>"For financial gain."</i>	<i>"They believe the insurance companies are just out to get their money, and by submitting inflated/false claims they are just getting their premium's worth."</i>	<i>"Unethical behaviour."</i>
<i>"Everyone is desperate to make extra money."</i>	<i>"Enrich themselves."</i>	<i>"Insurance is a grudge purchase."</i>	<i>"Unethical and dishonest."</i>
<i>"General desperation in an increasingly challenging economic environment."</i>	<i>"To get cash easily."</i>	<i>"... they feel cheated by the insurance companies."</i>	<i>"Lack of integrity."</i>
<i>"Money problems."</i>	<i>"Self-enrichment."</i>	<i>"Because when they have a genuine claim the insurance companies still don't want to pay out."</i>	<i>"Lack of morality."</i>
<i>"Financial constraints."</i>	<i>"Money, money, money!"</i>	<i>"Insurance is a grudge purchase. It seems to cost a lot ... and then when one does claim the assessor downgrades the claim."</i>	<i>"Moral decay of the society and not fitting and severe punishment."</i>
<i>"Poor economy makes people look for ways (that are not always legal) to get money."</i>	<i>"To get cash at hand."</i>	<i>"Insurance companies are quick to take premiums but often try to avoid paying claims to the extreme."</i>	<i>"No ethical values – wrong is not so wrong anymore."</i>
<i>"Financial constraints with failing economy."</i>	<i>"They want money in their pockets."</i>	<i>"Insurance companies do not deliver on their promises."</i>	<i>"We have become a nation of liars with no moral compass."</i>

5.4.2 Agreement with statements about why people commit short-term insurance fraud in South Africa

Respondents were presented with 14 statements about why people commit short-term insurance fraud in SA. These statements emanated from the literature review and past research conducted in the field of insurance fraud. Respondents were requested to indicate levels of agreement using a five-point Likert-type scale. Table 13 reports the percentage of respondents who responded “definitely disagree”, “disagree”, “neither agree nor disagree”, “agree” and “definitely agree” to the reasons presented for committing insurance fraud in SA.

The mean and standard deviation scores are also reported, providing a sense of the extent of agreement and dispersion of ratings around the mean. To further makes sense of the ratings, the scores for “definitely disagree” and “disagree” were combined and classified as “disagree” for reporting purposes. Similarly, the scores for “agree” and “definitely agree” were combined and classified as “agree”. Higher levels of agreement with a statement would be associated with higher levels of acceptance of that statement being the reason people commit fraud in SA and vice versa.

It should be noted that, in some cases, significant proportions of respondents neither agreed nor disagreed. However, for the purpose of this study, the results focus only on those that agreed in comparison to those that disagreed. In such cases, the standard deviation would typically be higher.

Table 13: Agreement with statements about why people commit short-term insurance fraud in South Africa (n = 560)

	Mean (SD)	Top 2-box						
		Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree	Definitely disagree & Disagree	Definitely agree & Agree
To get expensive work done that would otherwise be unaffordable	3.69 (0.909)	2.3%	8.2%	22.9%	51.3%	15.4%	10.5%	66.6%
Looking for a 'fair return' on premiums paid	3.67 (0.913)	2.9%	7.3%	24.5%	50.7%	14.6%	10.2%	65.4%
To make up for the excess payments	3.63 (0.896)	2.0%	9.8%	24.3%	51.3%	12.7%	11.8%	63.9%
To save money or reduce costs	3.60 (0.913)	2.5%	10.2%	23.9%	51.4%	12.0%	12.7%	63.4%
People commit fraud, because they believe it is seen as common practice in South Africa (everybody else is doing it)	3.53 (1.036)	3.9%	12.7%	26.6%	40.2%	16.6%	16.6%	56.8%
It is not that a specific person got hurt	3.29 (0.975)	4.8%	14.8%	34.8%	37.7%	7.9%	19.6%	45.5%
To get back at short-term insurance companies who make too much profits	3.16 (1.078)	6.8%	22.3%	28.0%	34.1%	8.8%	29.1%	42.9%
It is okay to inflate the claim just by a little bit	2.88 (1.358)	24.5%	15.2%	18.9%	31.1%	10.4%	39.6%	41.4%
It is easy to commit short-term insurance fraud	3.16 (0.979)	6.4%	16.3%	37.5%	34.3%	5.5%	22.7%	39.8%
If insurance companies treated people more fairly, people wouldn't try to commit fraud that much	3.10 (1.139)	6.1%	28.8%	27.9%	23.9%	13.4%	34.8%	37.3%
Policyholders have a strained relationship with their insurance company	3.15 (0.896)	3.0%	18.6%	44.3%	28.2%	5.9%	21.6%	34.1%
Insurance companies tolerate to some extent claims padding (i.e. inflating claims)	2.85 (1.071)	12.7%	23.8%	33.6%	25.9%	4.1%	36.4%	30.0%
Insurance companies do not prosecute fraudsters	2.72 (1.129)	15.9%	27.3%	31.6%	18.9%	6.3%	43.2%	25.2%
Forced to commit fraud	2.38 (1.055)	23.0%	33.2%	29.5%	11.1%	3.2%	56.3%	14.3%

The statements with which the majority of respondents (> 50%) agreed were as follows:

- “To get expensive work done that would otherwise be unaffordable”: 66.6% of respondents agreed with this statement while 10.5% of respondents disagreed (mean = 3.69; SD = 0.909). This indicates that respondents felt that policyholders without the financial means to replace or repair their damaged items would be motivated to commit insurance fraud.
- “Looking for a ‘fair return’ on premiums paid”: 65.4% agreed while 10.2% disagreed (mean = 3.67; SD = 0.913). The responses suggest that respondents believed that policyholders needed to derive some benefit from their insurance companies in return for paying premiums.
- “To make up for the excess payments”: 63.9% agreed while 11.8% disagreed (mean = 3.63; SD = 0.896). This suggests that the payment of excess would play a role in policyholders’ decision to commit insurance fraud.
- “To save money or reduce costs”: 63.4% agreed while 12.7% disagreed (mean = 3.60; SD = 0.913). The responses show that financial difficulties experienced would play a role in the decision to commit insurance fraud.
- “People commit fraud because they believe it is seen as common practice in SA (everybody else is doing it)": 56.8% agreed while 16.6% disagreed (mean = 3.56; SD = 1.036). This suggests that social consensus and lack of negative social stigma about insurance fraud would make it more acceptable for policyholders to commit insurance fraud.

The first four statements contained a financial element and thus related back to the main reasons identified in section 5.4.1, namely financial pressure and financial

benefit. The fifth statement related to the societal acceptance of insurance fraud (mentioned by 6.9% of respondents as reported in section 4.1).

Other statements with which more respondents agreed than disagreed were:

- “It is not that a specific person got hurt”: 45.5% of respondents agreed while 19.6% disagreed (mean = 3.29; SD = 0.975). The responses might be indicative of respondents viewing insurance fraud as victimless.
- “To get back at short-term insurance companies who make too much profit”: 42.9% agreed while 29.1% disagreed (mean = 3.16; SD = 1.078). This shows that respondents believed policyholders would be motivated to commit insurance fraud if they felt that their insurance company was making too much money.
- “It is okay to inflate the claim just by a little bit”: 41.4% agreed while 39.6% disagreed (mean = 2.88; SD = 1.358). The responses suggest that respondents might display a degree of tolerance when a claim was slightly inflated.
- “It is easy to commit short-term insurance fraud”: 39.8% agreed with this while 22.7% disagreed (mean = 3.16; SD = 0.979). This suggests that the respondents felt that fraud was committed due to the opportunity factor being present. Opportunity is linked to weaknesses and control breakdowns in an insurance company’s processes, which makes it easy for insurance fraud to take place. Thus, opportunity has a direct link to an insurance company’s structure and processes.
- “If insurance companies treated people more fairly, people wouldn’t try to commit fraud that much”: 37.3% agreed while 34.8% disagreed (mean = 3.10; SD = 1.139). This indicates that respondents felt that the treatment received from

insurance companies would be considered when deciding to commit insurance fraud.

- “Policyholders have a strained relationship with their insurance company”: 34.1% agreed while 21.6% disagreed (mean = 3.15; SD = 0.896). This suggests that respondents felt that having a strained relationship with the insurance company could play a role in the decision to commit insurance fraud.

The three statement with which a higher proportion of respondents disagreed than agreed were:

- “Forced to commit fraud”: 56.3% disagreed while 14.3% agreed (mean = 2.38; SD = 1.055). Respondents did not feel that people were forced to commit insurance fraud. This suggests that respondents felt that committing insurance fraud was a voluntary decision.
- “Insurance companies do not prosecute fraudsters”: 43.2% disagreed while 25.2% agreed (mean = 2.72; SD = 1.129). Respondents did not feel that an insurance company’s decision not to prosecute offenders was a significant factor motivating the decision to commit insurance fraud.
- “Insurance companies tolerate to some extent claims padding (i.e. inflating claims)": 36.4% of respondents disagreed while 30% agreed (mean = 2.85; SD = 1.071). The responses showed that respondents did not see insurance companies’ tolerance of claims padding as a motivating factor in deciding to commit insurance fraud.

These reasons related either to the conduct of the insurance company or to the conduct of the policyholder. The results indicated that 56.3% of respondents reported

that people were not forced to commit insurance fraud. This suggests that the action to commit insurance fraud was based on own conduct.

Respondents did not consider the conduct of the insurance company in not prosecuting fraudsters and in tolerating claims padding as a significant reason to commit insurance fraud, with 43.2% and 36.4% of respondents respectively disagreeing. This illustrates that respondents felt that the conduct of the insurer played a lesser role in the decision to commit insurance fraud.

To further explore the underlying relationship between the ratings of the 14 statements, an exploratory factor analysis was conducted. Principal axis factoring was specified as extraction procedure and varimax as rotation method. The aim of this analysis was to identify the emergence of underlying hypothetical constructs and whether these related to previous factors identified in the literature. The Kaiser-Meyer-Olkin measure of sampling adequacy revealed a value of 0.802, which indicated that the statements were factorable (Pallant, 2011:183). Bartlett's test of sphericity was shown to be highly significant ($\chi^2 = (91;n = 560) = 1882.448$; $p = 0.000$). Four factors emerged, explaining 11.9%, 10.3%, 10.3% and 9.9% respectively of the total variance. The rotated factor matrix is presented in Table 14.

Table 14: Rotated factor matrix – reasons why people in South Africa commit fraud

	Factor				Mean (SD)	Top 2-box (Definitely agree & Agree)
	1	2	3	4		
It is not that a specific person got hurt	0.753				3.29 (0.975) 3.53 (1.036) 3.63 (0.896) 2.88 (1.358)	51.9%
People commit fraud, because they believe it is seen as common practice in South Africa (everybody else is doing it)	0.617					
To make up for the excess payments	0.504					
It is okay to inflate the claim just by a little bit	0.448					
To save money or reduce costs		0.649			3.60 (0.913) 3.69 (0.909) 3.67 (0.913)	65.1%
To get expensive work done that would otherwise be unaffordable		0.588				
Looking for a 'fair return' on premiums paid		0.511				
Insurance companies tolerate to some extent claims padding (i.e. inflating claims)			0.801			
Insurance companies do not prosecute fraudsters			0.566		2.85 (1.071) 2.72 (1.129) 3.16 (0.979)	31.7%
It is easy to commit short-term insurance fraud			0.538			
If insurance companies treated people more fairly, people wouldn't try to commit fraud that much				0.686		
To get back at short-term insurance companies who make too much profits				0.540		
Policyholders have a strained relationship with their insurance company				0.500	3.10 (1.139) 3.16 (1.078) 3.15 (0.896)	32.1%
Forced to commit fraud				0.282		
Cronbach alpha				0.77 0.66 0.67 0.59		

The first factor spoke to the notion of rationalisation. Rationalisation is the ability to explain away or justify one's wrongful conduct by providing acceptable reasons for such behaviour. Sykes and Matza (1957:666-667) refer to rationalisation as neutralisation techniques that are used to remove the feeling of guilt. Some of the reasons advanced to justify committing insurance fraud include the idea that insurance fraud is victimless, to make up for excess payments and that it is fine to inflate claims by a small percentage. A Cronbach's alpha value of 0.77 was calculated, which was higher than the minimum acceptable norm of 0.6 for internal consistency (Hair et al., 2014:90).

The second factor encapsulated reasons linked to profit and benefit derived from committing fraud. Ariely (2013:27), in explaining the "fudge factor theory", confirms that it is easier for consumers to behave dishonestly if the profit or benefit from the dishonest behaviour does not exceed a certain limit. Profit or benefits can include both direct financial gain as well as other non-financial value proposition derived by receiving property that one did not previously own or having damaged property repaired. A Cronbach's alpha value of 0.66 was calculated.

The third factor spoke to the opportunity to commit fraud. Opportunity refers to deficiencies in an insurer's operations or insurance products, which make it easy for the perpetration of insurance fraud. These deficiencies can be present at any stage in the insurance value chain from underwriting to claims. It has been suggested that information asymmetry is a key factor in creating opportunities for insurance fraud (Dionne, 2012:8-14; Lesch & Brinkmann, 2011:18). A Cronbach's alpha value of 0.67 was calculated.

The fourth factor was linked to the concept of unfairness and injustice. Fairness and justice play a role in influencing consumers' behaviour; a consumer will be motivated to commit insurance fraud if there is a perception of unfairness or injustice on the part of the insurer (Miyazaki, 2009:590-591; Tennyson, 1997:251-252; Tseng et al., 2014:321-323). A Cronbach's alpha value of 0.59 was calculated. This value was just below the minimum acceptable norm of 0.6. However, it must be noted that the Cronbach's alpha value is dependent on the number of items in the scale. When the scale has fewer than 10 items, as in this instance where only four items underlie the construct, the value can be small some instances (Pallant, 2011:6). In such situations, it is recommended to also report the mean inter-item correlation for the items, for which Briggs and Cheek (in Pallant, 2011:6) recommend an optimal range from 0.2 to 0.4. The inter-item correlation for this construct was calculated as 0.269.

Table 15 reports response statistics broken down by demographic groups.

Table 15: Levels of agreement with statements about why people commit short-term insurance fraud in South Africa by selected demographic groups

Factor	Total (n=560)	Gender		Grouped age				Highest education level			Income category: Personal				
		Male (n=300)	Female (n=252)	19 - 34 (n=85)	35 - 49 (n=201)	50 - 65 (n=185)	66 and older (n=80)	Matric/ Grade 12 (or lower) (n=82)	Post matric: Certificate (n=58)	Post matric: Diploma (n=105)	Post matric: Degree & higher (n=306)	Less than R15 000 (n=44)	R15 001 - R20 000 (n=90)	R20 001 - R40 000 (n=128)	More than R40 000 (n=246)
Rationalisation	3.33 (0.791)	3.34 (0.784)	3.34 (0.795)	3.26 (0.927)	3.33 (0.788)	3.32 (0.748)	3.44 (0.696)	3.13 (0.703)	3.06 (0.965)	3.35 (0.836)	3.43 (0.746)	3.32 (0.873)	3.34 (0.846)	3.34 (0.784)	3.34 (0.774)
Test statistics			$t(550)=-0.068$ $p=0.946$		$F(3, 550)=0.797$ $p=0.496$				$F(3, 550)=5.893$ $p=0.001$			$F(3, 550)=0.013$ $p=0.998$			
Profit or benefit	3.65 (0.705)	3.62 (0.711)	3.71 (0.678)	3.76 (0.806)	3.71 (0.672)	3.56 (0.708)	3.65 (0.587)	3.56 (0.784)	3.53 (0.868)	3.68 (0.692)	3.71 (0.652)	3.88 (0.781)	3.69 (0.718)	3.75 (0.697)	3.55 (0.707)
Test statistics			$t(550)=-1.458$ $p=0.145$		$F(3, 550)=2.281$ $p=0.078$				$F(3, 550)=1.687$ $p=0.169$			$F(3, 550)=3.973$ $p=0.008$			
Opportunity	2.91 (0.826)	3.00 (0.804)	2.82 (0.845)	2.89 (0.822)	2.87 (0.850)	2.91 (0.832)	3.02 (0.746)	2.77 (0.706)	2.89 (0.908)	3.06 (0.810)	2.91 (0.838)	2.62 (0.753)	2.87 (0.831)	2.95 (0.842)	2.98 (0.835)
Test statistics			$t(550)=2.678$ $p=0.008$		$F(3, 550)=0.596$ $p=0.618$				$F(3, 550)=2.003$ $p=0.113$			$F(3, 550)=2.524$ $p=0.057$			
Unfairness and injustice	2.95 (0.702)	2.93 (0.701)	2.97 (0.709)	3.13 (0.757)	2.92 (0.690)	2.93 (0.702)	2.89 (0.619)	2.82 (0.658)	2.71 (0.679)	3.06 (0.739)	3.00 (0.691)	3.07 (0.813)	3.02 (0.702)	3.01 (0.719)	2.86 (0.684)
Test statistics			$t(550)=-0.729$ $p=0.467$		$F(3, 550)=0.2331$ $p=0.073$				$F(3, 550)=4.689$ $p=0.003$			$F(3, 550)=2.290$ $p=0.078$			

Levels of agreement were highest for profit or benefit (mean = 3.65; SD = 0.705) and rationalisation (mean = 3.33; SD = 0.791). The lowest ratings were for opportunity (mean = 2.91; SD = 0.826) and unfairness or injustice (mean = 2.95; SD = 0.702).

The following significant differences in mean levels of agreement are reported ($p < 0.05$):

- Males agreed more than females with regard to opportunity.
- Respondents with a post-matric degree qualification agreed more towards rationalisation than those with only matric/grade 12 or a post-matric certificate qualification. The results also showed a positive linear correlation of $r = 0.165$ between levels of education and rationalisation.
- Respondents with a post-matric diploma or degree qualification agreed more towards unfairness or injustice than those with a post-matric certificate. The results also showed a positive linear correlation of $r = 0.117$ between levels of education and unfairness or injustice.
- Respondents earning less than R15 000 personal income per month were more in agreement with profit or benefit than those earning R40 000 and more per month. Lower levels in personal income were associated with higher levels of agreement with profit or benefit, albeit with a very small effect ($r = 0.088$).

5.4.3 Other reasons mentioned why people commit short-term insurance fraud

An additional open question was posed to respondents enquiring whether there were any other reasons why people committed insurance fraud in SA that were not already

mentioned or listed. A content analysis of the 288 responses received revealed seven major themes.

Financial pressure, greed, opportunity and recouping premiums were the top four themes arising from this question. Criminality (6.2%) was the only reason that emerged that was not previously listed in the preceding sections, as shown in Figure 13.

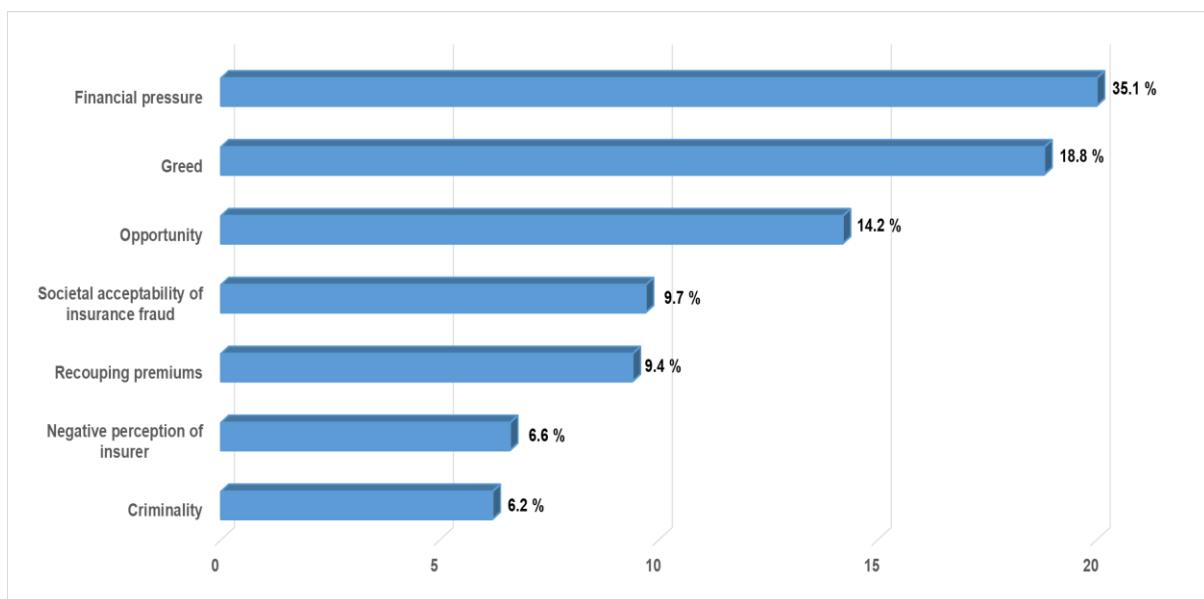


Figure 13: Other reasons why people in SA commit fraud (open question) (n = 288)

Table 16 reports a summary of the reasons why people in SA commit fraud based on the responses from the survey, supported by verbatim quotes from the respondents.

Table 16: Other reasons why people in South Africa commit fraud (open question) – verbatim responses

Financial pressure (n = 101)	Greed (n = 54)	Opportunity (n = 41)	Societal acceptability of insurance fraud (n = 28)
“Economic reasons – cannot pay debt, easy way to get money – almost like using a savings account.”	“Greed and a culture of entitlement.”	“To make money from weaknesses in claims processes.”	“People commit fraud because it is seen as common practice and they feel they can get away with it.”
“Survive in SA with the cost of living”	“People are greedy and Love Nice things the[y] can't afford.”	“Technology makes it easier.”	“It is common in SA to do.”
“Financial difficulties can lead to theft and or fraud.”	“Greed, dishonesty.”	“It is fairly easy to do and people see it as acceptable.”	“You have to believe generally that cheating is acceptable in order to commit insurance fraud.”
“Current economic conditions. not being able to afford daily necessities.”	“Many people are greedy and envious and they are never happy with what they have.”	“Understand the claims process and know the loopholes in the system so that they do not get caught.”	“It is common practice in today's world to survive, even if it means dishonesty.”
“Debt rescue. Putting in a false claim getting money to pay off other debts.”	“I think that its because people are greedy.”	“It might not be that difficult to commit insurance fraud.”	“Inherent culture of lawlessness and crime.”
“Desperate Economic situation.”	“Being greedy.”	“Opportunity.”	“Because others have done it and got away with it.”
“To get the cash to pay for other debt.”	“To some people, it is a game to see how much they can get away with.ie greed.”	“It's perceived as easy to do.”	“Mainly due to the inherent corruptness of society.”

The responses from section 5.4.1 and 5.4.3 were combined to identify the main reason respondents reported why people commit short-term insurance fraud in SA, as indicated in Figure 14.

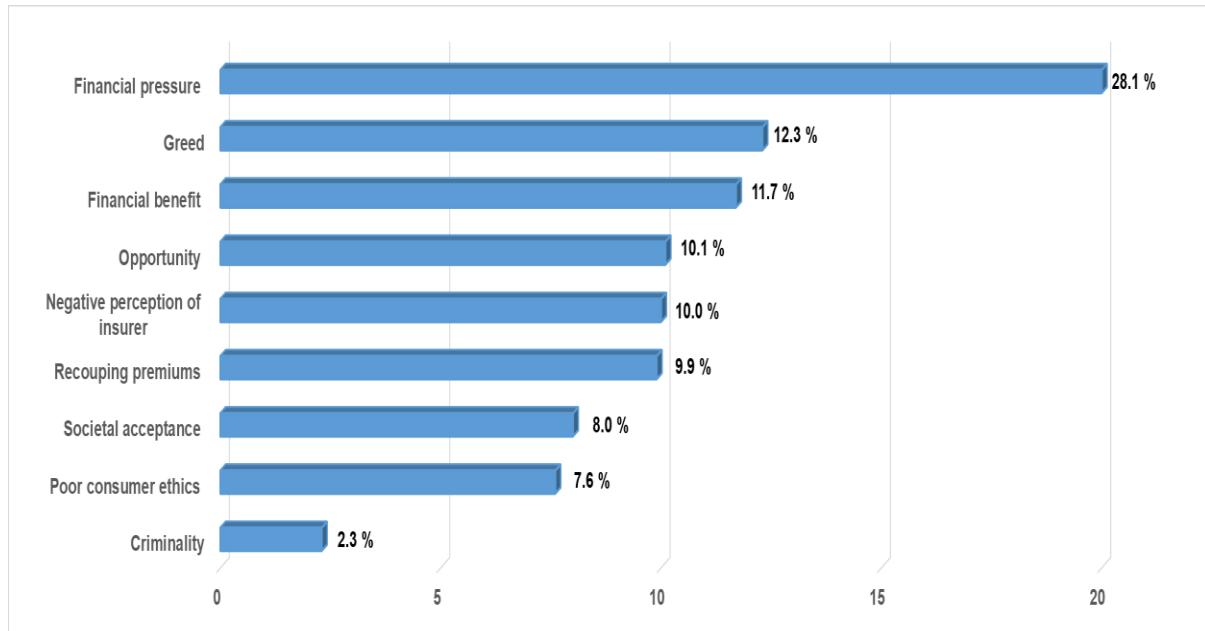


Figure 14: Summary of themes and reasons why people in SA commit fraud

Financial pressure (28.1%) emerged as the most prevalent reason why people in SA commit insurance fraud. This was followed by greed (12.3%), financial benefit (11.7%), opportunity (10.1%) and negative perception of insurer (10.0%). Criminality (2.3%) was indicated as the least common reason why people commit insurance fraud. These reasons are also consistent with the respondents agreeing to the statements in section 5.4.2. The results therefore show consistency in the reasons provided by respondents indicating why people in SA commit insurance fraud.

5.5 REASONS FOR NOT COMMITTING SHORT-TERM INSURANCE FRAUD (RESEARCH OBJECTIVE 2)

The previous section considered the reasons for insurance claims fraud in SA. These results provide a critical understanding of policyholders' perceptions and opinions that can contribute towards theoretical development in this field and help explain aspects such as tolerance towards insurance fraud. However, it is equally important to also understand reasons why policyholders would be deterred from committing insurance fraud. This section explores these reasons and addresses research objective 2.

5.5.1 Perceived reasons why a person would not commit short-term insurance fraud

An open question was posed to respondents enquiring what they believed were the main reasons why people would not commit insurance fraud in SA. The aim was again, as in the case of section 5.4.1, to explore the top-of-the-mind opinions of respondents. From a theoretical perspective and as evident from the literature review, it is equally important to understand insurance fraud in terms of both reasons for committing fraud and reasons for not committing fraud. A content analysis of the responses received revealed four major themes. These themes and their proportional distribution are reported in Figure 15.

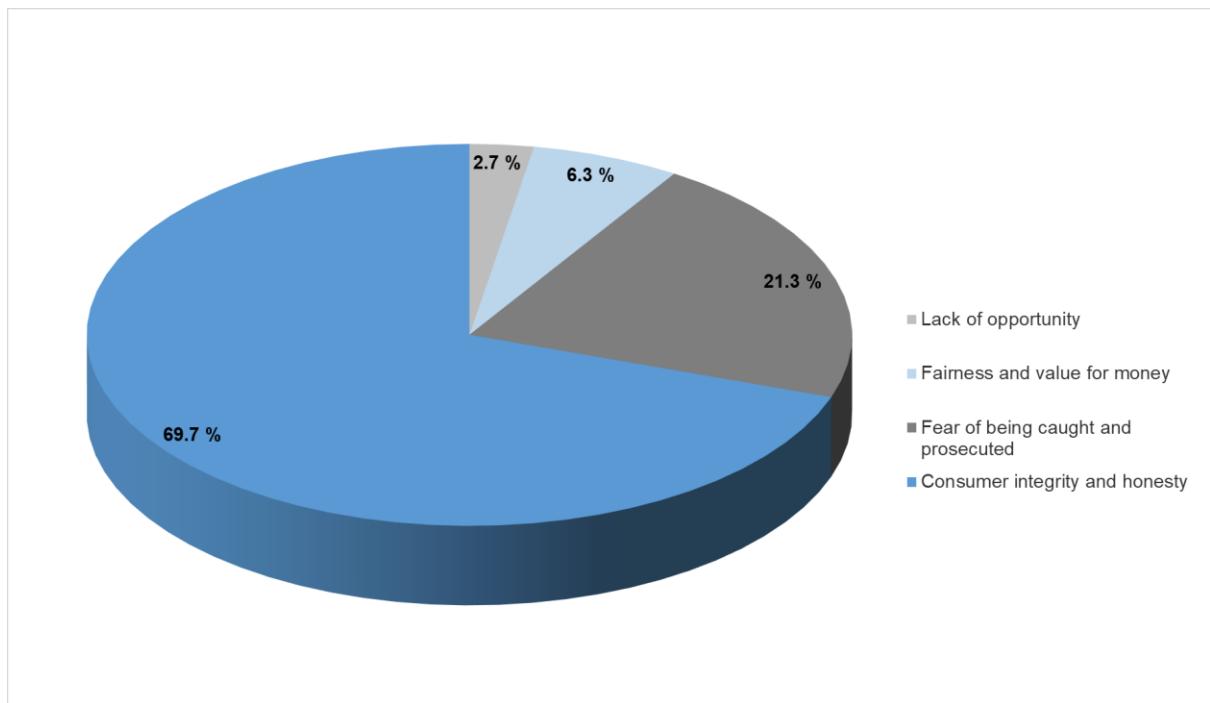


Figure 15: Main reasons why people in SA do not commit fraud (open question)

(n = 560)

The four themes related to consumer integrity and honesty (69.7%), fear of being caught and prosecuted (21.3%), fairness and value for money (6.3%), and lack of opportunity (2.7%).

Some respondents argued in their responses that people who were honest and had good ethical values would not commit short-term insurance fraud. Respondents further indicated that the conscience and principles of honest people prevented them from engaging short-term insurance fraud. This aspect can be considered as internal factors for the person.

The fear factor alluded to by respondents suggested that people would not commit insurance fraud because due to fear of being caught and prosecuted. Respondents indicated that fear of being caught and the subsequent consequences of having

criminal convictions and damage to personal reputation were strong deterrents preventing people from committing short-term insurance fraud. This aspect can be regarded as external factors for the person.

Interestingly, respondents also reported that people would not commit short-term insurance fraud if they felt they were treated fairly by the insurance companies and if people believed they were getting value for money. Respondents alluded to aspects such as good service, good communication, fair settlements and trust, which are expected from an insurance company.

Finally, respondents stated that people would not commit insurance fraud if there was a lack of opportunity. Respondents suggested that the processes within an insurance company must prevent, deter and detect short-term insurance fraud.

Table 17 provides examples of verbatim comments received by respondents in response to the question. The comments are grouped according to each of the four main themes identified above.

Table 17: Main reasons why people in SA would not commit fraud (open question) –
verbatim responses

Consumer integrity and honesty (n = 341)	Fear of being caught and prosecuted (n = 104)	Fairness and value for money (n = 31)	Lack of opportunity (n = 13)
<i>"Ethical behaviour, good morals, believe eg Christian or Hindu."</i>	<i>"Fear of possible prosecution."</i>	<i>"They feel that they are fairly treated."</i>	<i>"Because it is difficult."</i>

Consumer integrity and honesty (n = 341)	Fear of being caught and prosecuted (n = 104)	Fairness and value for money (n = 31)	Lack of opportunity (n = 13)
“Integrity.”	“Fear of being caught and prosecuted.”	“Fair and just replacement of losses.”	“Does not seem possible as this is controlled by insurance appointing own assessors for damages.”
“Moral Integrity and values.”	“Being named and shamed.”	“Fair treatment.”	“Too much effort.”
“Integrity and trustworthy.”	“Afraid of getting caught.”	“If they feel they are being treated fairly.”	“Scared of ramifications. Too difficult. Too much work involved.”
“There are honest people.”	“...the fear of getting caught and what happens if found guilty.”	“Integrity and fair treatment when claimed.”	“Their claim would be disqualified.”
“They have integrity.”	“Reputation, risk of being charged for fraud. loss of work.”	“...great service and value for money from insurance companies.”	“Fear of discovery.”
“Honesty and integrity. A good conscience.”	“Fear of going to prison.”	“If they feel like they are fair[ly] charged and if insurance companies would pay legitimate claims without any struggle.”	“Being found out, with consequences (eg prosecution and/or blacklisting).”
“Honest people with integrity who do want to do the right thing.”	“Believe it is wrong, afraid to be caught out.”	“Good communication. realistic premiums and trust.”	“Not knowing how to, against their values system, not having had an opportunity to, fear of consequences also not knowing that it is doable.”
“Honesty and good principles.”	“Risk of being prosecuted and being found guilty of fraud.”	“If premiums were fair and honesty rewarded.”	“They know the truth will come out sometime.”

Consumer integrity and honesty (n = 341)	Fear of being caught and prosecuted (n = 104)	Fairness and value for money (n = 31)	Lack of opportunity (n = 13)
<i>"There are honest people out there."</i>	<i>"Scared of being caught."</i>	<i>"Getting financial benefits for not submitting claims."</i>	<i>"People will get caught out some way or another – if not now, someday."</i>

5.5.2 Agreement with statements about why people do not commit short-term insurance fraud in South Africa

Respondents were presented with nine statements about why people do not commit short-term insurance fraud in SA. Respondents were requested to indicate levels of agreement using a five-point Likert-type scale (where 1 = definitely disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree and 5 = definitely agree). This means that higher levels of agreement with an item would also signify higher acceptance of that statement being the reason people do not commit insurance fraud in SA and vice versa.

Table 18 reports the percentage of respondents who responded “definitely disagree”, “disagree”, “neither agree nor disagree”, “agree” and “definitely agree” to the reasons presented for committing insurance fraud in SA. The mean and standard deviation scores are also reported, providing a sense of the extent of agreement and dispersion of ratings around the mean. To further makes sense of the ratings, the scores for “definitely disagree” and “disagree” have been combined and classified as “disagree” for reporting purposes. A similar approach was adopted in scores relating to “agree” and “definitely agree”, which were combined and classified as “agree”.

Table 18: Agreement with statements about why people do not commit short-term insurance fraud in South Africa (n = 560)

	Mean (SD)	Top 2-box						
		Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree	Definitely disagree & Disagree	Definitely agree & Agree
Moral character	4.51 (0.708)	0.5%	1.8%	3.9%	33.4%	60.4%	2.3%	93.8%
Fear of being caught	4.06 (0.881)	1.1%	6.1%	11.4%	48.9%	32.5%	7.1%	81.4%
Fear of prosecution	4.00 (0.954)	1.8%	7.5%	12.1%	45.9%	32.7%	9.3%	78.6%
Religious beliefs	3.89 (1.094)	4.1%	8.8%	15.2%	38.4%	33.6%	12.9%	72.0%
Fear of humiliation if caught	3.69 (1.052)	4.1%	10.5%	18.9%	44.6%	21.8%	14.6%	66.4%
Cultural beliefs	3.70 (1.058)	3.9%	8.9%	24.8%	37.7%	24.6%	12.9%	62.3%
Have a good relationship with their insurance company	3.50 (1.106)	5.2%	13.4%	27.0%	34.8%	19.6%	18.6%	54.5%
Understand the negative impact of insurance fraud on the sustainability of the insurance industry	2.96 (1.247)	12.0%	29.3%	23.4%	21.1%	14.3%	41.3%	35.4%
Lack of opportunity to commit fraud	3.00 (1.071)	7.5%	25.9%	34.8%	22.9%	8.9%	33.4%	31.8%

The statements with which the majority of respondents (> 50%) agreed were as follows:

- “Moral character”: 93.8% of respondents agreed with this statement while only 2.3% of respondents disagreed (mean = 4.51; SD = 0.708). The results indicated that a large majority of respondents felt that moral character was a deterrent to committing insurance fraud.
- “Fear of being caught”: 81.4% agreed while 7.2% disagreed (mean = 4.06; SD = 0.881). The majority of respondents indicated that the fear factor, consisting of fear of being caught, fear of prosecution and fear of humiliation, was a key factor that prevented the commission of insurance fraud. This is linked to the associated consequences of committing insurance fraud.
- “Fear of prosecution”: 78.6% agreed while 9.3% disagreed (mean = 4.00; SD = 0.954). This referred to the fear factor, which has already been mentioned under “fear of being caught”.
- “Religious beliefs”: 72.0% agreed while 12.9% disagreed (mean = 3.89; SD = 0.954). The results showed that a large portion of respondents accepted that religion played a role in preventing insurance fraud.
- “Fear of humiliation if caught”: 66.4% agreed while 14.6% disagreed (mean = 3.69; SD = 1.052). This referred to the fear factor, which has already been mentioned under “fear of being caught”.
- “Have a good relationship with their insurance company”: 54.5% agreed while 18.6% disagreed (mean = 3.50; SD = 1.106). Respondents indicated that a good relationship with the insurance company also deterred the commission of insurance fraud.

The statements with which a higher proportion of respondents disagreed than agreed were:

- “Understand the negative impact of insurance fraud on the sustainability of the insurance industry”: 41.3% disagreed while 35.4% agreed (mean = 2.96; SD = 1.247). Respondents did not feel that the sustainability of the insurance industry played a role in preventing the commission of insurance fraud.
- “Lack of opportunity to commit insurance fraud”: 33.4% of respondents disagreed while 31.7% agreed (mean = 3.00; SD = 1.071). Respondents were slightly divided on the role opportunity played in the commission of insurance fraud, with 33.4% disagreeing and 31.7% agreeing.

Similar to section 5.4.2, an exploratory factor analysis was conducted to further explore the underlying relationships between the ratings of the nine statements. The Kaiser-Meyer-Olkin measure of sampling adequacy revealed a value of 0.715. Bartlett’s test of sphericity was shown to be highly significant ($\chi^2 = (36;n = 560) = 1480.025$; $p = 0.000$). Three factors emerged, explaining 29.5%, 12.3% and 6.8% respectively of the total variance. The rotated factor matrix is presented in Table 19.

Table 19: Rotated factor matrix – reasons why people in South Africa do not commit fraud

	Factor			Mean (SD)	Top 2-box (Definitely agree & Agree)
	1	2	3		
Fear of being caught	0.894			4.06 (0.881)	81.4%
Fear of prosecution	0.891			4.00 (0.954)	78.6%
Fear of humiliation if caught	0.468			3.69 (1.052)	66.4%
Religious beliefs		0.745		3.89 (1.094)	72.0%
Cultural beliefs		0.596		3.70 (1.058)	62.3%
Moral character		0.505		4.51 (0.708)	93.8%
Understand the negative impact of insurance fraud on the sustainability of the insurance industry			0.704	2.96 (1.247)	35.4%
Have a good relationship with their insurance company			0.539	3.50 (1.106)	54.5%
Lack of opportunity to commit fraud			0.293	3.00 (1.071)	31.8%

*Cronbach alpha

0.82 0.66 0.54

The first factor represented reasons related to the fear of being caught and prosecuted, and the accompanying fear of humiliation. A Cronbach's alpha value of 0.82 was calculated. This coefficient was higher than the minimum acceptable norm of 0.6 for internal consistency reliability (Hair et al., 2014:90). On average, about 75% of respondents cited reasons related to fear as reasons for policymakers not to commit fraud. Fear of being caught (81.4%; mean = 4.06, SD = 0.881) and prosecuted (78.6%; mean = 4.00, SD = 0.881) outweighed fear of humiliation (66.4%; mean = 3.69, SD = 1.052).

The second factor represented reasons intrinsic to the value system and moral character of the policyholder, shaped in part by religious and cultural beliefs. A Cronbach's alpha value of 0.66 was calculated. Similar to the first factor, on average 76% of respondents cited these as reasons for policymakers not to commit fraud. Of the three underlying aspects, the moral character of the policyholder was the main reason (93.8%; mean = 4.51, SD = 0.708), followed to a lesser extent by religious (72.0%; mean = 3.89, SD = 3.89) and cultural (62.3%; mean = 3.70, SD = 1.058) beliefs.

The third factor represented more extrinsic reasons relating to the relationship with the insurance industry; in other words, understanding the negative impact of fraud on the industry, the client–company relationship and the opportunities present in the industry to commit fraud. A Cronbach's alpha value of 0.54 was calculated. While this value was lower than the minimum acceptable norm of 0.6 (Hair et al., 2014:90), a mean inter-item correlation of 0.275 for the three items was calculated. This met the recommended optimal range from 0.2 to 0.4 as proposed by Briggs and Cheek (in Pallant, 2011:6). On average, only 40.6% of respondents felt that these were reasons for not committing fraud.

Table 20: Levels of agreement with statements about why people do not commit short-term insurance fraud in South Africa by selected demographic groups

Factor	Total (n=560)	Gender		Grouped age				Highest education level				Income category: Personal			
		Male (n=300)	Female (n=252)	19 - 34 (n=85)	35 - 49 (n=201)	50 - 65 (n=185)	66 and older (n=80)	Matric/ Grade 12 (or lower) (n=82)	Post matric: Certificate (n=58)	Post matric: Diploma (n=105)	Post matric: Degree & higher (n=306)	Less than R15 000 (n=44)	R15 001 - R20 000 (n=90)	R20 001 - R40 000 (n=128)	More than R40 000 (n=246)
Fear of being caught, prosecuted and humiliation	3.92 (0.826)	3.77 (0.861)	4.10 (0.734)	4.15 (0.772)	4.00 (0.783)	3.82 (0.837)	3.70 (0.838)	3.91 (0.803)	4.00 (0.733)	3.86 (0.924)	3.92 (0.819)	4.19 (0.695)	3.91 (0.767)	4.10 (0.714)	3.82 (0.883)
<i>Test statistics</i>	$t(549.80)=-4.857$ $p=0.000$		$F(3, 550)=5.869$ $p=0.001$				$F(3, 550)=0.360$ $p=0.782$				$F(3, 550)=4.883$ $p=0.002$				
Morality	4.03 (0.747)	4.03 (0.727)	4.03 (0.778)	4.06 (0.856)	4.06 (0.760)	3.99 (0.720)	4.04 (0.630)	3.90 (0.783)	4.10 (0.790)	3.97 (0.788)	4.08 (0.717)	3.88 (0.866)	4.03 (0.731)	4.02 (0.814)	4.08 (0.699)
<i>Test statistics</i>	$t(550)=-0.100$ $p=0.921$		$F(3, 550)=0.352$ $p=0.788$				$F(3, 550)=1.676$ $p=0.171$				$F(3, 550)=0.939$ $p=0.421$				
Industry relations	3.16 (0.824)	3.07 (0.786)	3.24 (0.859)	3.35 (0.887)	3.16 (0.864)	3.05 (0.798)	3.14 (0.687)	3.36 (0.712)	3.24 (0.975)	3.18 (0.854)	3.07 (0.809)	3.37 (0.973)	3.29 (0.789)	3.24 (0.835)	3.04 (0.795)
<i>Test statistics</i>	$t(550)=-2.446$ $p=0.015$		$F(3, 550)=2.440$ $p=0.064$				$F(3, 550)=2.874$ $p=0.036$				$F(3, 550)=3.980$ $p=0.008$				

The level of agreement was highest for morality (mean = 4.03; SD = 0.747). The second highest rating was for fear of being caught, prosecution and humiliation (mean = 3.92; SD = 0.826). The lowest rating was for industry relations (mean = 3.16; SD = 0.824).

The following significant differences in mean levels of agreement as well as correlations are reported ($p < 0.05$):

- Females agreed more than males with regard to fear of being caught, prosecution and humiliation. The same was true for industry relations.
- Lower age groups are associated with higher levels of agreement with fear of being caught, prosecution and humiliation ($r = -0.176$).
- Lower levels of education were associated with higher levels of agreement with industry relations ($r = -0.124$).
- Lower levels in personal income were associated with higher levels of agreement with fear of being caught, prosecution and humiliation ($r = -0.120$), as well as industry relations ($r = -0.146$).

5.5.3 Other reasons mentioned why people do not commit short-term insurance fraud

An additional question was posed to respondents enquiring whether there were any other reasons why people would not commit insurance fraud in SA, which had not been mentioned previously. A content analysis of 164 responses received revealed that consumer integrity and honesty, fear of being caught and prosecuted, and fairness and value for money featured as other reasons why people would not commit short-term insurance fraud in SA, as shown in Figure 16.

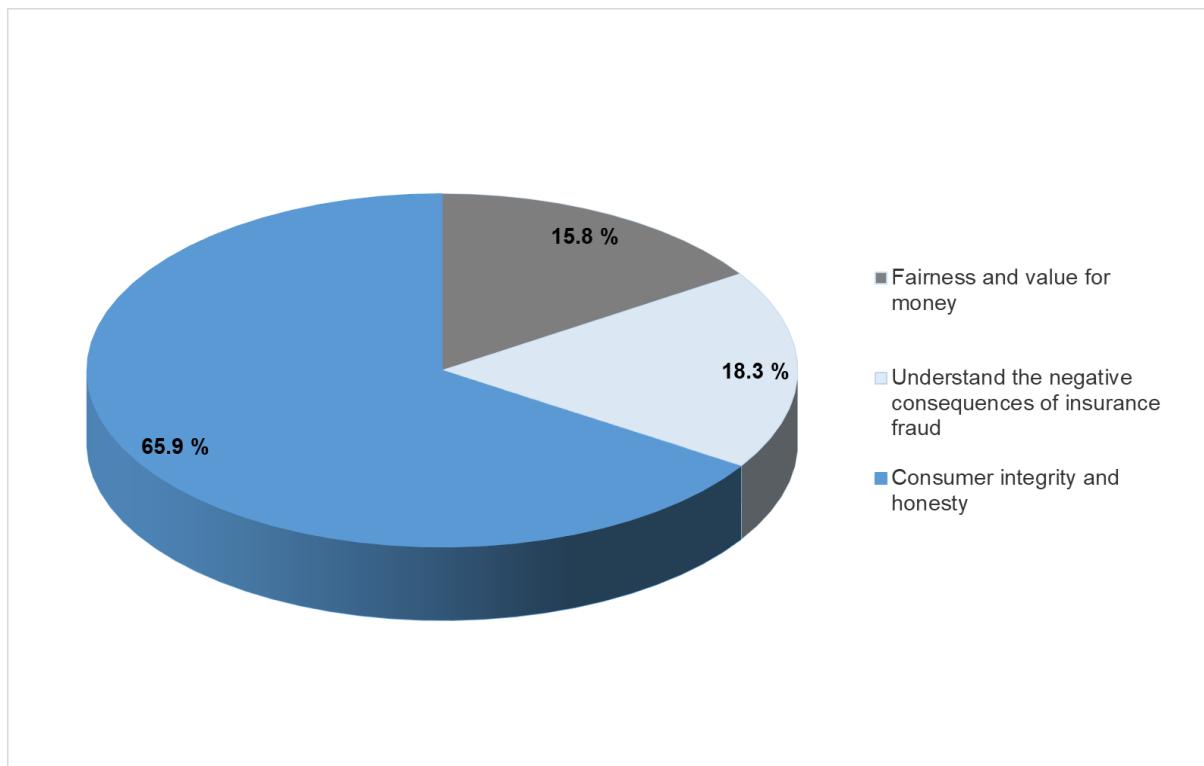


Figure 16: Other reasons why people in SA do not commit fraud (open question)
(n = 164)

These reasons were the same as already identified in section 5.5.1. Respondents reiterated similar comments of good values, morals and honesty for consumer integrity and honesty, damage to reputation and risk of not getting insurance in future for fear of being caught and prosecuted, and insurance companies being loyal to clients for fairness and value for money.

Table 21 represents verbatim examples of the responses received, which have been classified under the respective themes.

Table 21: Other reasons why people in South Africa do not commit fraud (open question) – verbatim responses

Consumer integrity and honesty (n = 108)	Understand the negative consequences of insurance fraud (n = 30)	Fairness and value for money (n = 26)
<i>"They have spirituality, not religion per se. They just know right from wrong and lives in a culture that it is illustrated."</i>	<i>"Not being able to get insurance elsewhere when policy gets cancelled."</i>	<i>"Loyalty towards the company that has been looking after them for so long and in some cases generations."</i>
<i>"Pure honesty and good character."</i>	<i>"May never be granted cover if caught don't want to be noted as a high-risk person."</i>	<i>"If they felt they were getting a fair deal."</i> <i>"Make a client not feel like a criminal when claiming."</i>
<i>"It should not be done ... period."</i>	<i>"Bad publicity."</i>	<i>"They have been treated fairly by their insurance provider."</i>
<i>"Character and personal belief system."</i>	<i>"Want to keep the economy going."</i>	<i>"If they feel they get fair treatment for the premiums they are paying."</i>
<i>"Morals & ethics & upbringing."</i>	<i>"A good understanding of how your fraudulent claims will impact your family & friends & neighbours."</i>	<i>"Excellent benefits and deliveries on promises."</i>
<i>"Conscience."</i>	<i>"Having a blacklisting on name and other insurers in the future turning you down."</i>	<i>"They are treated fairly and [not] like criminals."</i>
<i>"An honest heart and doing what is right."</i>	<i>"Embarrassment."</i>	<i>"Experience of fair treatment by insurer."</i>
<i>"Plain old fashioned honesty and conscience."</i>	<i>"Realising that insurance cover is very important."</i>	<i>"Honest fair treatment no need to."</i>
<i>"People believe in the law of Karma."</i>	<i>"Impact other future dealings with the insurance company."</i>	<i>"Happy with their current company."</i>

The responses from section 5.5.1 and 5.5.3 were combined to identify the main reasons respondents reported on why people would not commit short-term insurance fraud in SA as indicated in Figure 17.

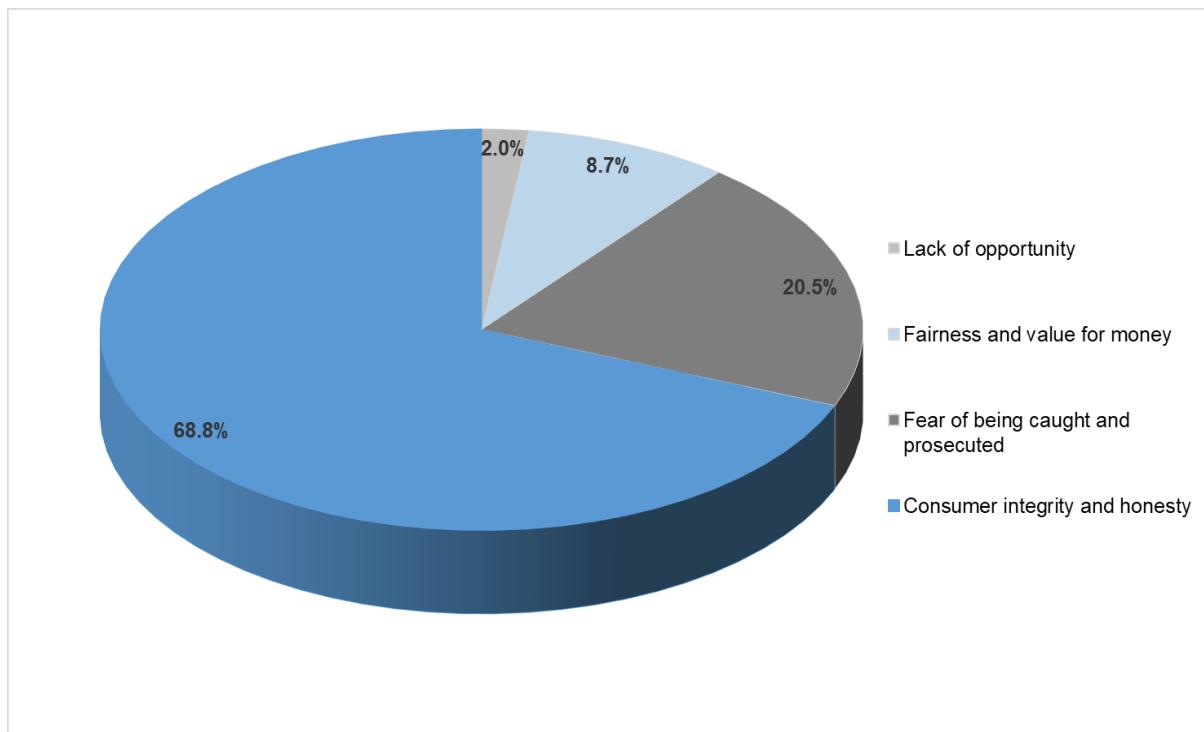


Figure 17: Summary of themes and reasons why people in South Africa do not commit fraud

Respondents felt that consumer integrity and honesty (68.8%) was the most prevalent reason why people in SA would not commit insurance fraud. The next reason indicated by respondents was the fear of being caught and prosecuted (20.5%), followed by fairness and value for money (8.7%), and finally, lack of opportunity (2.0%). The reasons shown in Figure 17 are also consistent with the respondents' agreement with the statements in section 5.5.2.

5.6 PERCEPTIONS ABOUT THE TYPES OF SHORT-TERM INSURANCE FRAUD COMMITTED (RESEARCH OBJECTIVE 2)

This section firstly considers the types and prevalence of short-term insurance fraud that respondents perceived as being committed in SA. Secondly, the perceived levels of difficulty in submitting inflated and false claims in SA are reported. These results,

which are linked to research objective 2, offer additional insight into policyholders' views about the short-term insurance industry, more specifically with regard to understanding the perceived types of claims and policyholders' perceptions about the difficulty of committing insurance fraud.

5.6.1 Perceived types of short-term insurance fraud committed in South Africa (open question)

Respondents were asked to indicate what they believed to be the most common types of short-term insurance fraud committed in SA. A content analysis of the 410 responses received revealed the following types: inflated claims (53.8%), followed by false claims (31.6%), inflated and false claims (12.4%), and finally, underwriting fraud (2.2%). The literature on the types of insurance fraud indicates that inflated claims are more prevalent than false claims, and this has been attributed to the ease with which inflated claims could be submitted (Miyazaki, 2009:589; Tennyson, 2002:36). Inflated claims are the product of a genuine insurance loss, thus making it easier to commit, and are opportunistic in comparison to a false claim, which requires more planning, thus making it slightly more difficult to commit. Figure 18 shows the perceived types of short-term insurance fraud committed in SA.

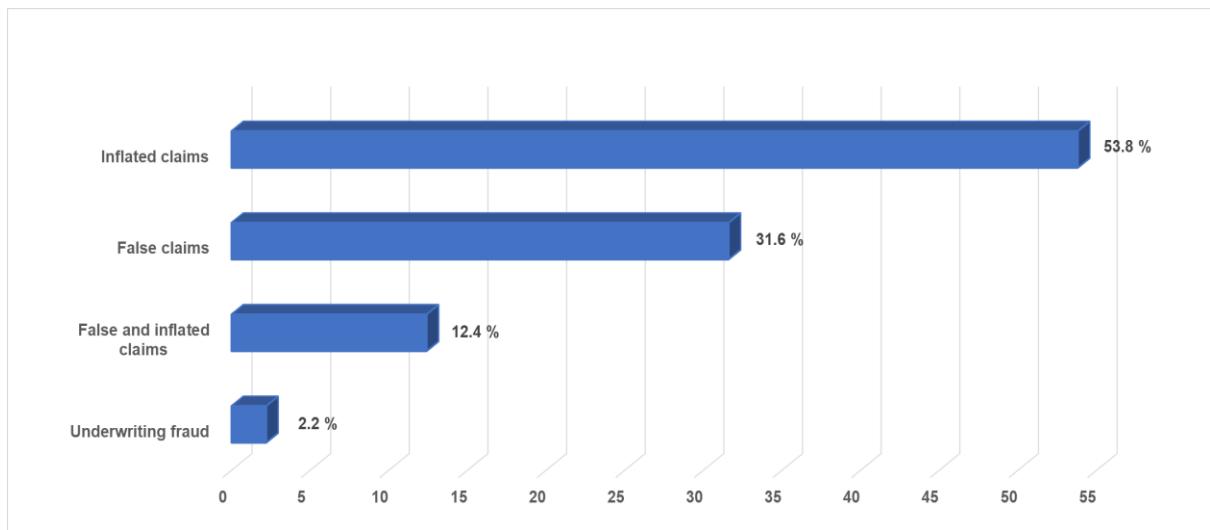


Figure 18: Perceived types of short-term insurance fraud committed in South Africa (open question) (n = 410)

An inflated claim refers to a claim for a genuine insured loss where the quantum or amount being claimed for is more than the actual loss suffered. The actual loss is inflated or increased by the policyholder either claiming for items he or she did not possess or claiming for items not lost or damaged during the insured event. This type of fraud requires no planning and is easy to commit, given that the insured even actually happened and there is a legitimate claim in terms of the insurance contract. An inflated claim is described as opportunistic insurance fraud (Haithem et al., 2014:318; Miyazaki, 2009:589; Tennyson, 2002:36).

A false claim is committed when a policyholder submits a claim for an insured event which did not happen; the insured even is thus staged or created. This type of insurance fraud is described as planned fraud as it requires more planning (Haithem et al., 2014:318; Tennyson, 2002:36).

Underwriting fraud is committed when a policyholder provides incorrect or false information when incepting an insurance policy. This is done to obtain better premium rates, or it is done with the intention of committing a false claim at the later stage.

5.6.2 Perceived levels of difficulty in submitting inflated and false claims in South Africa

Respondents were asked to rate the difficulty of submitting firstly, an inflated claim and secondly, a false claim. A five-point Likert-type scale was used where 1 = extremely difficult and 5 = extremely easy. Table 22 presents a summary of the response statistics.

Table 22: Perceived levels of difficulty in submitting inflated and false claims in South Africa (n = 560)

Difficulty in submitting...	Mean (SD)	Extremely difficult				Extremely easy	Top 2-box	
		2	3	4	Difficult	Easy		
An inflated claim	3.01 (1.240)	16.6%	14.3%	33.4%	23.4%	12.3%		
A false claim	2.67 (1.221)	22.7%	19.6%	34.1%	15.0%	8.6%	42.3%	23.6%

The results suggest that respondents, in general, were divided about the difficulty of submitting an inflated claim in SA, with about a third (30.9%) rating it as difficult, a third as undecided (33.4%) and another third (35.7%) as easy. In contrast, submitting a false claim was perceived by more respondents to be difficult (42.3%) than easy (23.6%), with 34.1% being undecided, as shown in Figure 19.

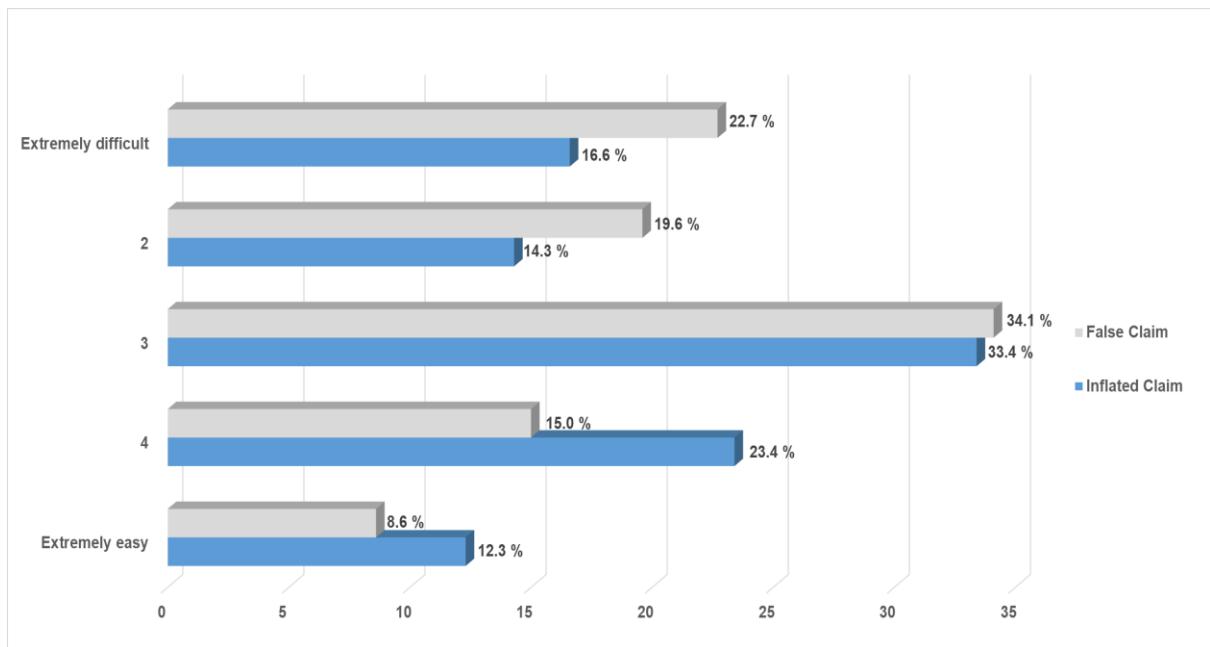


Figure 19: Perceived levels of difficulty in submitting inflated and false claims in South Africa (n = 560)

Table 23 reports response statistics broken down by demographic groups.

Table 23: Perceived levels of difficulty in submitting inflated and false claims in South Africa by selected demographic groups

Difficulty in submitting...	Total (n=560)	Gender		Grouped age				Highest education level				Income category: Personal			
		Male (n=300)	Female (n=252)	19 - 34 (n=85)	35 - 49 (n=201)	50 - 65 (n=185)	66 and older (n=80)	Matric/ Grade 12 (or lower) (n=82)	Post matric: Certificate (n=58)	Post matric: Diploma (n=105)	Post matric: Degree & higher (n=306)	Less than R15 000 (n=44)	R15 001 - R20 000 (n=90)	R20 001 - R40 000 (n=128)	More than R40 000 (n=246)
An inflated claim	3.01 (1.240)	3.13 (1.215)	2.87 (1.260)	2.91 (1.240)	3.03 (1.220)	3.02 (1.302)	3.05 (1.135)	2.95 (1.351)	2.83 (1.187)	3.19 (1.352)	3.00 (1.158)	2.59 (1.226)	2.53 (1.163)	2.98 (1.180)	3.25 (1.213)
Test statistics		$t(550)=2.440$ $p=0.015$		$F(3, 550)=0.250$ $p=0.861$				$F(3, 550)=1.244$ $p=0.293$				$F(3, 550)=9.921$ $p=0.000$			
A false claim	2.67 (1.221)	2.78 (1.187)	2.56 (1.256)	2.62 (1.144)	2.61 (1.241)	2.75 (1.261)	2.71 (1.150)	2.74 (1.341)	2.60 (1.154)	3.03 (1.297)	2.56 (1.147)	2.55 (1.337)	2.37 (1.166)	2.73 (1.141)	2.76 (1.226)
Test statistics		$t(550)=2.116$ $p=0.035$		$F(3, 550)=0.525$ $p=0.665$				$F(3, 550)=4.152$ $p=0.006$				$F(3, 550)=2.652$ $p=0.048$			

The following significant differences in mean levels of agreement as well as correlations are reported ($p < 0.05$):

- Males rated the level of difficulty to submit an inflated claim higher than females did. The same was true for submitting a false claim.
- Respondents with a post-matric diploma qualification rated the level of difficulty to submit a false claim higher than those with a lower level of education and those with a post-matric degree qualification. The latter group rated the difficulty level the lowest.
- Higher levels in personal income were associated with higher perceived levels of difficulty in submitting either an inflated or false claim.

5.7 PERCEPTIONS ABOUT THE SHORT-TERM INSURANCE INDUSTRY IN SOUTH AFRICA (RESEARCH OBJECTIVE 3)

Two main questions were posed to respondents. The first assessed their general views and opinions on the South African insurance industry, including insurers, brokers and assessors. The second gauged their perceptions towards the value proposition of the insurance industry in general versus that of their own insurer. The literature review suggested that tolerance towards insurance fraud might be explained in part based on policyholders' positive or negative perceptions towards agents in the industry, the industry itself and accompanying value propositions.

5.7.1 Perceptions about short-term insurers, brokers and assessors in South Africa

Figure 20 reports the percentage distribution pertaining to the views held by respondents on the insurance industry. Respondents were asked to indicate whether they viewed these entities as very negative, fairly negative, in-between, fairly positive or very positive.

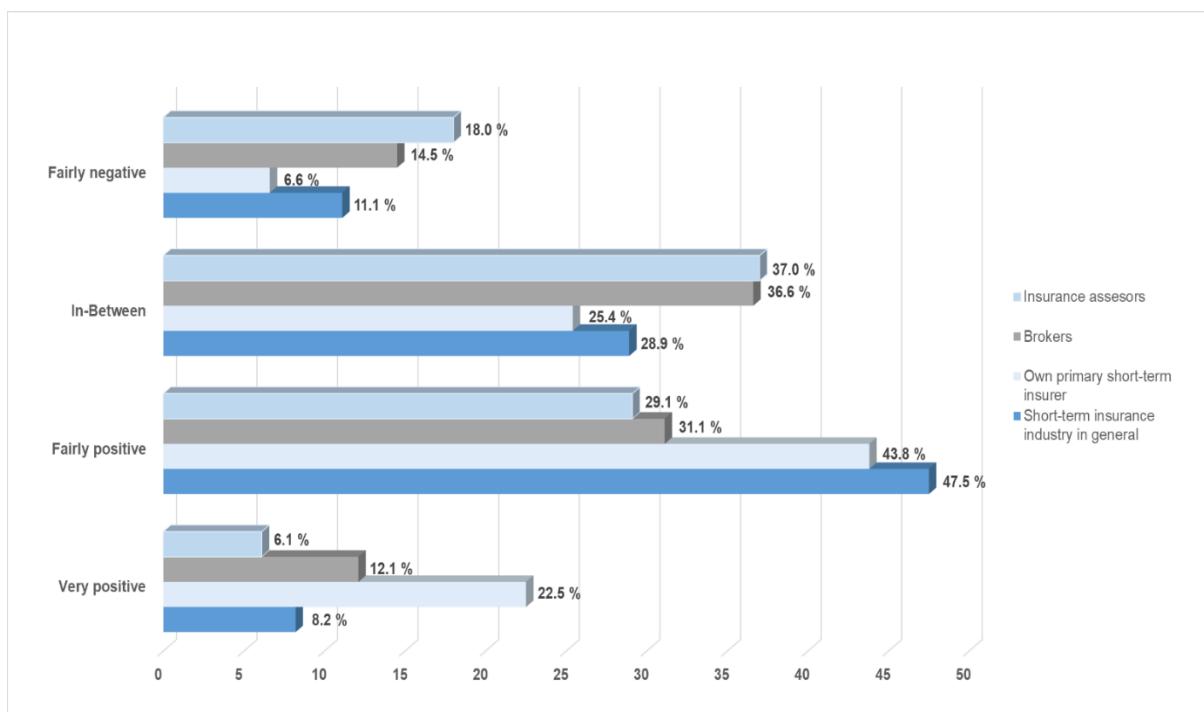


Figure 20: Perceptions towards short-term insurers, brokers and assessors in SA

Table 24 summarises the statistics for this question.

Table 24: Perceptions towards short-term insurers, brokers and assessors in South Africa (n = 560)

	Mean (SD)	Very negative	Fairly negative	In-between	Fairly positive	Very positive	Top 2-box
		4.3%	11.1%	28.9%	47.5%	8.2%	Very & fairly negative
		1.8%	6.6%	25.4%	43.8%	22.5%	Very & fairly positive
Short-term insurance industry in general	3.44 (0.944)	5.7%	14.5%	36.6%	31.1%	12.1%	15.4%
Own primary short-term insurer	3.79 (0.927)	9.8%	18.0%	37.0%	29.1%	6.1%	8.4%
Brokers	3.29 (1.042)						20.2%
Insurance assessors	3.04 (1.053)						27.8%
							35.2%

Table 24 provides a summary of responses and descriptive statistics. The majority of respondents reported positive views (fairly and very positive) towards the short-term industry in general (55.7%) as well as their own primary short-term insurer (66.3%). This comparison, however, does suggest a gap between views on one's own insurer and the industry in general.

Focussing specifically on brokers and insurance assessors revealed less positive views (43.2% and 35.2% respectively). Further analysis showed that respondents making use of direct channels to manage their short-term insurance portfolios were significantly less positive (30.5%) towards brokers compared to those who used brokers (58.4%) ($z = 6.450$; $p = 0.000$).

Further analysis considered differences in perceptions across demographic groups. These results are reported in Table 25.

Table 25: Perceived types of short-term insurance fraud by selected demographic groups

	Total (n=560)	Gender		Grouped age				Highest education level				Income category: Personal			
		Male (n=300)	Female (n=252)	19 - 34 (n=85)	35 - 49 (n=201)	50 - 65 (n=185)	66 and older (n=80)	Matric/ Grade 12 (or lower) (n=82)	Post matric: Certificate (n=58)	Post matric: Diploma (n=105)	Post matric: Degree & higher (n=306)	Less than R15 000 (n=44)	R15 001 - R20 000 (n=90)	R20 001 - R40 000 (n=128)	More than R40 000 (n=246)
Short-term insurance industry in general	3.44 (0.944)	3.36 (1.000)	3.55 (0.852)	3.59 (0.930)	3.51 (0.949)	3.31 (0.976)	3.39 (0.879)	3.59 (0.902)	3.71 (0.879)	3.40 (0.884)	3.36 (0.980)	3.32 (1.073)	3.32 (1.047)	3.62 (0.888)	3.42 (0.939)
<i>Test statistics</i>		$t(5498.883)=-2.430$ $p=0.015$				$F(3, 550)=2.369$ $p=0.070$				$F(3, 550)=2.961$ $p=0.032$				$F(3, 550)=2.186$ $p=0.089$	
Own primary short-term insurer	3.79 (0.927)	3.80 (0.917)	3.78 (0.940)	3.76 (0.882)	3.82 (0.904)	3.68 (0.996)	3.99 (0.819)	3.70 (0.885)	3.76 (0.865)	3.75 (0.896)	3.83 (0.968)	3.55 (0.926)	3.70 (0.867)	3.85 (0.870)	3.84 (0.985)
<i>Test statistics</i>		$t(550)=0.323$ $p=0.747$				$F(3, 550)=2.270$ $p=0.079$				$F(3, 550)=0.517$ $p=0.671$				$F(3, 550)=1.689$ $p=0.169$	
Brokers	3.29 (1.042)	3.29 (1.076)	3.29 (1.010)	3.32 (.929)	3.26 (1.027)	3.20 (1.102)	3.55 (1.005)	3.34 (1.114)	3.34 (1.085)	3.34 (1.090)	3.25 (1.011)	3.05 (1.238)	3.08 (1.124)	3.48 (0.980)	3.31 (1.035)
<i>Test statistics</i>		$t(550)=0.041$ $p=0.967$				$F(3, 550)=2.280$ $p=0.086$				$F(3, 550)=0.343$ $p=0.795$				$F(3, 550)=3.351$ $p=0.019$	
Insurance assessors	3.04 (1.053)	2.95 (1.056)	3.14 (1.035)	3.29 (0.998)	3.15 (0.984)	2.79 (1.123)	3.05 (1.030)	3.24 (1.001)	3.22 (1.009)	3.10 (1.079)	2.92 (1.065)	2.95 (1.099)	2.77 (1.017)	3.30 (0.985)	3.02 (1.055)
<i>Test statistics</i>		$t(550)=-2.195$ $p=0.029$				$F(3, 550)=5.851$ $p=0.001$				$F(3, 550)=2.998$ $p=0.030$				$F(3, 550)=5.011$ $p=0.002$	

The following significant differences in mean levels of agreement as well as correlations are reported ($p < 0.05$):

- Females were more positive towards insurance assessors and the insurance industry in general than males.
- Respondents aged 19 to 34 years were more positive towards insurance assessors than the other age groups.
- Lower levels of education were associated with being more positive towards the insurance industry in general and towards insurance assessors.
- Higher levels of income were associated with being more positive towards brokers and insurance assessors.

5.7.2 Perceptions about the value proposition of the short-term insurance industry and own primary insurer

Figure 21 reports the aggregated agreement (agree and definitely agree) percentage pertaining to respondents' views on the insurance industry in general and their own insurance company specifically.

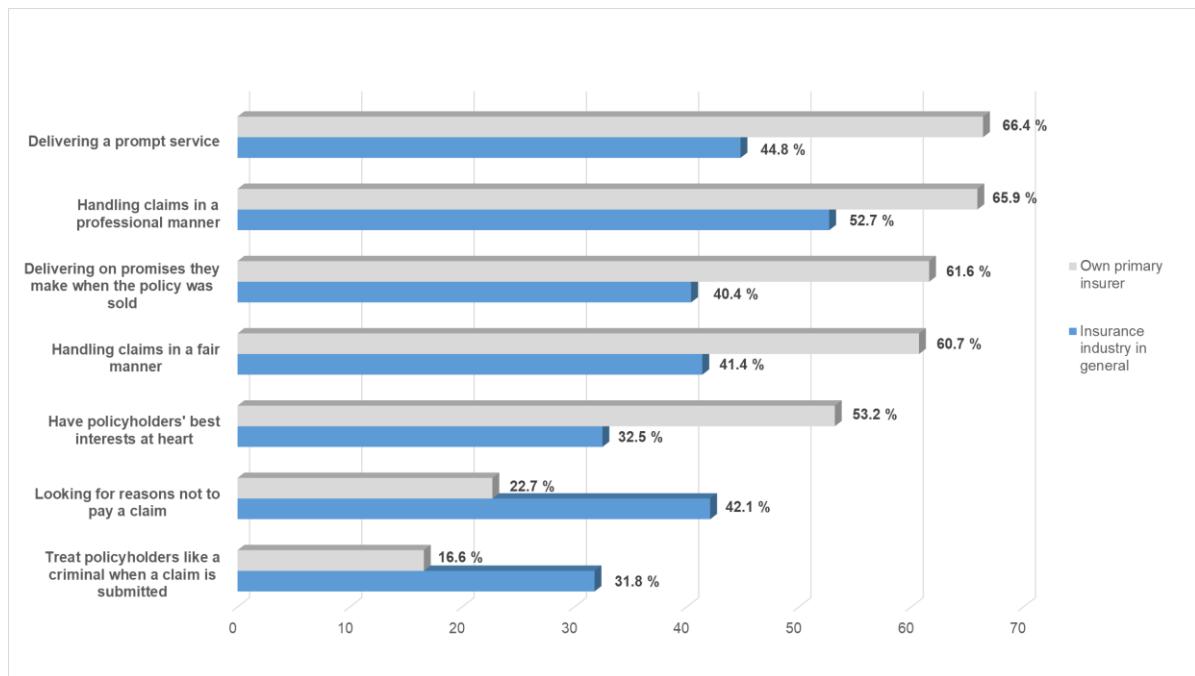


Figure 21: Perceptions towards the value proposition of the insurance industry – industry in general versus own insurer

Table 26 provides a summary of responses and inferential statistics.

Table 26: Perceptions towards value proposition of the insurance industry – industry in general versus own insurer (n = 560)

	Mean (SD)		Correlation	Paired samples test	Top 2-box (Definitely agree & Agree)	Proportional z-test
	Insurance industry in general	Own primary insurer				
Have policy holders' best interest at heart	2.91 (1.041)	3.44 (1.015)	0.672*	t (559)= -15.178; p=0.000	32.5%	z = 7.004; p=0.000
Delivering on promises they make when the policy was sold	3.12 (0.966)	3.61 (0.914)	0.602*	t (559)= -13.893; p=0.000	40.4%	z = 7.113; p=0.000
Delivering a prompt service	3.27 (0.923)	3.69 (0.949)	0.587*	t (559)= -11.770; p=0.000	44.8%	z = 7.278; p=0.000
Handling claims in a professional manner	3.41 (0.915)	3.72 (0.893)	0.553*	t (559)= -8.405; p=0.000	52.7%	z = 4.5016; p=0.000
Handling claims in a fair manner	3.21 (0.969)	3.62 (0.956)	0.527*	t (559)= -10.300; p=0.000	41.4%	z = 6.456; p=0.000
Looking for reasons not to pay a claim	3.25 (1.105)	2.64 (1.142)	0.548*	t (559)= 13.600; p=0.000	42.1%	z = 6.959; p=0.000
Treat policyholders' like a criminal when a claim is submitted	2.97 (1.073)	2.49 (1.085)	0.599*	t (559)= 11.896; p=0.000	31.8%	z = 5.931; p=0.000

*Correlation is significant at the 0.05 level (2-tailed).

The results indicate that the majority of respondents (on average about 61%) held positive perceptions towards their own primary insurer having policyholders' best

interest at heart, delivering on promises made when the policy was sold, delivering prompt service and handling claims in a professional and fair manner. In addition, respondents also felt that their primary insurer did not necessarily look for reasons not to pay a claim or treat policyholders like criminals. Despite the majority consensus, the results showed that about 39% of respondents on average were not convinced. This represents about 4 in 10 respondents.

The results also showed that respondents held more positive perceptions about their own primary insurer than their overall view of the short-term insurance industry. Statistically, these differences were significant ($p < 0.05$). This divide was also presented in section 5.7.1. In fact, less than 50% of respondents were positive towards the insurance industry in general.

Table 27: Perceptions towards value proposition of own insurer by selected demographic groups

	Total (n=560)	Gender		Grouped age				Highest education level				Income category: Personal			
		Male (n=300)	Female (n=252)	19 - 34 (n=85)	35 - 49 (n=201)	50 - 65 (n=185)	66 and older (n=80)	Matric/ Grade 12 (or lower) (n=82)	Post matric: Certificate (n=58)	Post matric: Diploma (n=105)	Post matric: Degree & higher (n=306)	Less than R15 000 (n=44)	R15 001 - R20 000 (n=90)	R20 001 - R40 000 (n=128)	More than R40 000 (n=246)
Have policy holders' best interest at heart	3.44 (1.015)	3.38 (1.048)	3.52 (0.951)	3.59 (0.930)	3.46 (1.024)	3.37 (1.077)	3.40 (0.949)	3.65 (0.894)	3.71 (0.879)	3.42 (1.007)	3.33 (1.065)	3.25 (1.059)	3.39 (1.024)	3.63 (0.860)	3.41 (1.090)
<i>Test statistics</i>		$t(550)=-1.628$ $p=0.104$		$F(3, 550)=0.929$ $p=0.426$				$F(3, 550)=3.625$ $p=0.013$				$F(3, 550)=2.062$ $p=0.104$			
Delivering on promises they make when the policy was sold	3.61 (0.914)	3.59 (0.958)	3.63 (0.858)	3.62 (0.873)	3.61 (0.954)	3.56 (0.955)	3.71 (0.799)	3.79 (0.913)	3.72 (0.744)	3.46 (0.899)	3.59 (0.944)	3.32 (1.073)	3.53 (0.889)	3.72 (0.869)	3.66 (0.924)
<i>Test statistics</i>		$t(550)=-0.482$ $p=0.630$		$F(3, 550)=0.542$ $p=0.653$				$F(3, 550)=2.411$ $p=0.066$				$F(3, 550)=2.519$ $p=0.057$			
Delivering a prompt service	3.69 (0.949)	3.70 (0.993)	3.68 (0.903)	3.62 (0.873)	3.62 (0.993)	3.72 (0.959)	3.88 (0.919)	3.83 (0.979)	3.59 (0.918)	3.69 (0.891)	3.68 (0.973)	3.50 (1.191)	3.66 (0.914)	3.75 (0.860)	3.74 (0.941)
<i>Test statistics</i>		$t(550)=0.194$ $p=0.830$		$F(3, 550)=1.540$ $p=0.203$				$F(3, 550)=0.823$ $p=0.481$				$F(3, 550)=1.014$ $p=0.386$			
Handling claims in a professional manner	3.72 (0.893)	3.70 (0.946)	3.74 (0.828)	3.75 (0.800)	3.66 (0.898)	3.69 (0.955)	3.89 (0.857)	3.93 (0.886)	3.60 (0.877)	3.66 (0.897)	3.70 (0.898)	3.50 (1.089)	3.66 (0.938)	3.80 (0.833)	3.75 (0.866)
<i>Test statistics</i>		$t(549.022)=-0.601$ $p=0.548$		$F(3, 550)=1.380$ $p=0.248$				$F(3, 550)=2.002$ $p=0.113$				$F(3, 550)=1.529$ $p=0.206$			
Handling claims in a fair manner	3.62 (0.956)	3.59 (1.003)	3.67 (0.888)	3.59 (0.930)	3.67 (0.895)	3.52 (1.027)	3.70 (0.999)	3.82 (0.918)	3.55 (0.976)	3.52 (0.952)	3.60 (0.967)	3.32 (1.137)	3.49 (0.963)	3.72 (0.947)	3.67 (0.932)
<i>Test statistics</i>		$t(548.433)=-0.952$ $p=0.341$		$F(3, 550)=1.010$ $p=0.388$				$F(3, 550)=1.630$ $p=0.181$				$F(3, 550)=2.653$ $p=0.048$			
Looking for reasons not to pay a claim	2.64 (1.142)	2.67 (1.188)	2.58 (1.063)	2.87 (1.183)	2.55 (1.113)	2.68 (1.190)	2.55 (1.078)	2.57 (1.144)	2.36 (1.071)	2.70 (1.200)	2.70 (1.135)	2.70 (1.133)	2.90 (1.209)	2.50 (1.072)	2.60 (1.155)
<i>Test statistics</i>		$t(547.796)=1.022$ $p=0.307$		$F(3, 550)=1.812$ $p=0.144$				$F(3, 550)=1.593$ $p=0.190$				$F(3, 550)=2.332$ $p=0.073$			
Treat policyholders' like a criminal when a claim is submitted	2.49 (1.085)	2.44 (1.109)	2.53 (1.031)	2.80 (1.121)	2.47 (1.091)	2.49 (1.099)	2.19 (0.956)	2.56 (1.166)	2.24 (0.865)	2.63 (1.120)	2.45 (1.080)	2.64 (1.036)	2.71 (1.114)	2.41 (1.008)	2.40 (1.120)
<i>Test statistics</i>		$t(550)=-1.000$ $p=0.318$		$F(3, 550)=4.451$ $p=0.004$				$F(3, 550)=1.814$ $p=0.143$				$F(3, 550)=2.244$ $p=0.082$			

The following significant differences in mean levels of agreement as well as correlations are reported ($p < 0.05$):

- Younger respondents were more in agreement that their own insurer treated policyholders like a criminal when a claim was submitted than older respondents.
- Lower levels of education were associated with higher levels of agreement with the respondents' own insurer having policyholders' best interest at heart.
- Higher levels of income were associated with higher levels of agreement with insurers handling claims in a fair manner.

5.8 RELATIONSHIP BETWEEN REASONS FOR COMMITTING SHORT-TERM INSURANCE FRAUD, PERCEPTIONS ABOUT INDUSTRY AND LEVELS OF TOLERANCE (RESEARCH OBJECTIVE 4)

The last research objective focussed on the statistical relationship between reasons for committing fraud, perceptions of the insurance industry and levels of tolerance towards short-term insurance fraud (research objective 4). A regression analysis was employed to identify the variables that best helped explain levels of tolerance. The following 17 variables were included in the analysis:

- Reasons for committing insurance fraud:
 - rationalisation;
 - profit or benefit;
 - opportunity; and
 - unfairness or injustice.

- Reasons for not committing insurance fraud:
 - fear of being caught, being prosecuted and humiliation;
 - morality; and
 - industry relations.
- Difficulty in submitting claims:
 - difficulty in submitting an inflated claim; and
 - difficulty in submitting a false claim.
- Perceptions of the insurance industry (primary insurer):
 - having policyholders' best interest at heart;
 - delivering on promises made when the policy was sold;
 - delivering a prompt service;
 - handling claims in a professional manner;
 - handling claims in a fair manner;
 - looking for reasons not to pay a claim; and
 - treating policyholders like criminals when a claim is submitted.

An overall adjusted R-squared of 22.3% was reported. This was indicative of the percentage variation explained by the 17 variables. Further inspection of the results showed that the variance inflation factor values were less than 10 for all variables, thus excluding issues related to multicollinearity (Pallant, 2011:158). No outliers were detected based on the reported Mahalanobis distances. To assess the null hypothesis that multiple R in the population equalled 0, an analysis of variance was conducted. The results were significant ($F = 11.007$; $p < 0.001$).

These results allowed for the identification of the variables that were significant in explaining overall variation in levels of insurance fraud tolerance. The results are reported in Table 28.

Table 28: Regression analysis

		Std Beta	t	Sig.
Reasons for committing insurance fraud	Rationalisation	-0.056	-1.263	0.207
	Profit or benefit	-0.015	-0.318	0.751
	Opportunity	0.145	3.422	0.001
	Unfairness/injustice	0.269	5.880	0.000
Reasons for not committing insurance fraud	Fear of being caught, prosecuted and humiliation	-0.012	-0.280	0.780
	Morality	-0.138	-3.396	0.001
	Industry relations	0.167	3.849	0.000
Difficulty in submitting claims	Difficulty in submitting an inflated claim	-0.008	-0.149	0.882
	Difficulty in submitting a false claim	-0.031	-0.558	0.577
Perceptions of the insurance industry	Have policyholders' best interest at heart	-0.197	-3.125	0.002
	Delivering on promises they make when the policy was sold	0.127	1.820	0.069
	Delivering a prompt service	-0.114	-1.777	0.076
	Handling claims in a professional manner	0.069	0.979	0.328
	Handling claims in a fair manner	-0.083	-1.104	0.270
	Looking for reasons not to pay a claim	0.001	0.015	0.988
	Treat policyholders' like a criminal when a claim is submitted	0.077	1.276	0.203

The following were included as significant explanatory variables of tolerance (based on a 95% level of confidence). The standardised beta gives an indication of the relevant weight or contribution in explaining the variation (one standard deviation change in the explanatory variable would result in a one standard deviation change in insurance fraud tolerance).

- Unfairness or injustice (std. beta = 0.269): higher levels of agreement with unfairness or injustice as a reason for committing short-term insurance fraud were associated with higher levels of tolerance.
- Having policyholders' best interest at heart (std. beta = -0.197): higher levels of agreement with own insurer having policyholders' best interest at heart were associated with lower levels of tolerance.

- Industry relations (std. beta = 0.167): higher levels of agreement with industry relations as a reason for not committing short-term insurance fraud were associated with higher levels of tolerance.
- Opportunity (std. beta = 0.145): higher levels of agreement with opportunity as a reason for committing short-term insurance fraud were associated with higher levels of tolerance.
- Morality (std. beta = -0.138): higher levels of agreement with morality as a reason for not committing short-term fraud were associated with lower levels of tolerance.

5.9 CHAPTER SUMMARY

This chapter presented the results pertaining to the four research objectives. First, levels of short-term insurance fraud were measured (objective 1). This was followed by identifying reasons for committing insurance fraud in SA as perceived by respondents (objective 2). Similarly, reasons were identified why policyholders would not commit fraud (objective 2). Perceptions of the insurance industry were also gauged (objective 3). Lastly, using multiple regression analysis, the main explanatory variables in explaining levels of tolerance were identified (objective 4).

In the next chapter, conclusions pertaining to the original research objectives are made, areas for future research are identified and limitations of the study are discussed.

CHAPTER 6: CONCLUSIONS, IMPLICATIONS & IMPERATIVES FOR FUTURE RESEARCH

6.1 INTRODUCTION

This chapter provides a summary of the research findings as well as conclusions derived. Where relevant, the research findings are aligned to the literature. The implications that the research findings hold for researchers and short-term insurance practitioners, including marketers, communication specialists and management, are discussed. The chapter also includes an overview of the chapters of this study as well an evaluation of each research objective to determine whether the outcomes of the research findings were achieved. Finally, a section on imperatives for future research is presented.

6.2 OVERVIEW OF CHAPTERS

This section contains a summary of the various chapters.

Chapter 1

This chapter provided some background explaining the concept of short-term insurance, the role of insurance and fraud in the insurance industry. A discussion on the types of insurance fraud and its impact on the insurance industry was presented. This chapter also highlighted the limited insurance fraud research in South Africa, especially in the academic repository. More formally, the chapter presented the problem statement, purpose statement, research

aims and objectives and importance and benefits of the study. The study delimitations and assumptions were noted, as well as definitions of key terms.

Chapter 2

The literature review for this study was discussed in this chapter. A detailed discussion was presented on the value of insurance in society, fraud within the insurance industry, the types of insurance fraud, namely opportunistic and planned fraud, and the negative impact of fraud on insurance companies and policyholders. The various fraud prevention strategies employed by insurance companies and the insurance industry to curb insurance fraud were discussed. Previous international studies examining the cost of insurance fraud, the reasons for insurance fraud and consumer tolerance for insurance fraud were described, and the need for more insurance fraud research in South Africa was highlighted.

Chapter 3

This chapter contained a discussion on the theories relevant to this study. An explanation was provided delimited specially towards three theories, namely the fraud triangle, the theory of planned behaviour and an integrated model consisting of both the theory of planned behaviour and the fraud triangle. The integrated model consisting of both the fraud triangle and the theory of planned behaviour was found to be most suitable for this study.

Chapter 4

In Chapter 4, the research design and methods used for this study were discussed. A motivation was provided for using a quantitative design in this study. The two sampling

techniques, namely probability and non-probability sampling, were explained, and the reasons for selecting a non-probability sampling technique for this study were detailed. The semi-structured questionnaire used to collect the data was discussed, along with details on the design. The data analysis plan was presented, as were the relevant ethical considerations.

Chapter 5

The analysis and the results of this study were presented and discussed in this chapter. The demographic profile of the sample was reported, after which the research results pertaining to each research objective were detailed.

Chapter 6

In this the final chapter, recommendations are made based on the research findings, namely reasons why policyholders commit insurance fraud, policyholders' perceptions of the insurance industry and policyholders' tolerance for insurance fraud. This chapter also includes a section which discusses imperatives for future research.

6.3 RESEARCH AIMS AND OBJECTIVES

The primary aim of this research was to measure policyholders' tolerance towards short-term insurance fraud. Secondary to this was to understand how certain factors, including policyholders' attitudes and perceptions towards the insurance industry, can explain levels of tolerance.

More specifically, the research objectives can be stated as:

- To understand and measure policyholders' tolerance to insurance fraud.
- To identify the main reasons for committing insurance claims fraud and for not committing insurance claims fraud.
- To measure policyholders' perceptions towards the insurance industry, their own primary insurer, brokers and insurance assessors.
- To investigate the relationship between perceptions towards the insurance industry, primary insurer, broker and insurance assessors, levels of tolerance, and reasons for insurance fraud.

6.4 CONCLUSIONS

This section presents the conclusions of the study as they relate to each research objective.

6.4.1 Research objective 1: To understand and measure policyholders' tolerance to insurance fraud

Tolerance has been identified as an important factor influencing consumer attitudes towards insurance fraud. Some studies have found that factors such as high insurance premiums, excess payments, consumer relationship with insurers, consumers' previous claims experience and societal acceptability of insurance fraud play a role in shaping a consumer's tolerance level (Miyazaki, 2009:590-591; Tennyson, 1997:251-252; Tseng et al., 2014:321-323).

This study set out to firstly measure the tolerance levels of policyholders in SA. In doing so, respondents were asked to rate 17 statements pertaining to their tolerance towards insurance fraud. Following a statistical data reduction process whereby the distributions and underlying correlations between the 17 items were examined, an index for short-term insurance fraud tolerance was constructed. The final index was based on the average summated scoring of 15 of the original 17 items. Scores ranged between 1 and 5, with lower scores associated with low levels of tolerance and higher scores with higher levels of tolerance.

The results revealed that tolerance towards insurance fraud amongst policyholders in South Africa was relatively low. Three out of every four respondents (75%) reported a tolerance level of 2.33 or lower on the index. The results also showed that tolerance levels were consistent across gender, grouped age and education.

The findings of this survey are line with other studies conducted previously. Tennyson (2002:44) reported on the results of a survey conducted in the US on consumer attitudes where it was found that, while insurance fraud was very common, the tolerance for insurance fraud amongst the respondents was very low.

Researchers in a survey conducted by the CAIF (1997, 2008) on insurance fraud tolerance in the US were able to classify respondents into four groups which based on the level of tolerance for insurance fraud. Realists were identified to have a low tolerance for insurance fraud, conformists were identified to be fairly tolerant of insurance fraud, moralists were identified to have the least tolerance, and critics were identified to have the highest tolerance (CAIF, 1997:3-4; 2008:5). In comparing findings from 1997 to findings from 2007, the

percentage of moralists, who were the least tolerant of insurance fraud, had decreased from 30% in 1997 to 26% in 2007, while the critics, who were the most tolerant of insurance fraud, had increased from 20% in 1997 to 26% in 2007 (CAIF, 2008:5). These findings suggest that tolerance for insurance fraud amongst the American population is increasing. However, the findings (CAIF, 1997:4, 2008:5) still indicate that there were larger percentages of respondents who were moralists and realists with a low tolerance for insurance fraud (51%; 47%) in comparison with critics (20%; 26%), who had the highest tolerance for insurance fraud respectively.

The study conducted by Brinkmann and Lentz (2006:185-186) found that there was a greater percentage of moralists amongst both Norwegian and German citizens who showed a low tolerance for insurance fraud.

There is thus alignment between this study and previous studies exploring the same aspect.

6.4.2 Research objective 2: To identify the main reasons for committing insurance claims fraud and for not committing insurance claims fraud

In this section, reasons for committing and not committing insurance fraud are presented, followed by types of insurance fraud and the perceived difficulty of committing insurance fraud.

6.4.2.1 Reasons for committing fraud

A review of the literature revealed that there is consensus amongst researchers and academics that insurance claims fraud generally consists of two distinct forms, namely

opportunistic and planned (Crocker & Morgan, 1998:356; Haithem et al., 2014:317-318; Insurance Europe, 2013:7; Miyazaki, 2009:589; Ormerod et al., 2012:371; Tennyson, 2002:36; Tseng & Su, 2013:38). Opportunistic fraud is usually perpetrated by an individual who inflates or exaggerates the value of a valid or legitimate loss suffered; the intention is to obtain a better financial benefit than the actual loss suffered (Haithem et al., 2014:318; Miyazaki, 2009:589; Tennyson, 2002:36). Planned insurance fraud occurs when a claim is submitted for an insured event or loss that did not occur, and involves elaborate planning with the aim of gaining financial benefit; it is simply a claiming for a loss that did not happen (Haithem et al., 2014:318; Tennyson, 2002:36, 2011:151-155).

Following from the literature review, the study aimed to understand the reasons for committing short-term insurance fraud in SA as perceived by policyholders. In addressing this objective, respondents were first asked in an open question to present reasons why people commit short-term insurance fraud in SA. From the analysis, four main reasons emerged, namely financial pressure, financial benefit, negative perception of insurer and poor consumer ethics. Financial pressure and benefit are attributed to the high cost of living in SA and the financial burden experienced by consumers, which in turn are motivating factors for policyholders to commit short-term insurance fraud. This leads again to financial pressures and couples with policyholders' desire to get money easily as a motivating factor to commit insurance fraud – thus, policyholders seek financial benefit. The results also revealed that respondents identified a sometimes negative consumer relationship with one's insurance company as a contributing factor to committing insurance fraud.

Further probing, in the form of evaluating a set of reasons derived from the literature, identified four underlying factors, namely the notion of rationalisation; reasons linked to profit and benefit derived from committing fraud; opportunity to commit fraud; and unfairness and injustice.

The first factor, namely rationalisation, relates to the ability to explain away or justify one's wrongful conduct by providing acceptable reasons for such behaviour. The second factor encapsulates the reasons linked to profit and benefit derived from committing fraud. Profit or benefits can include both direct financial gain as well as other non-financial value proposition, which is derived by receiving property which one did not previously own or having damaged property repaired.

Opportunity refers to deficiencies in an insurer's operations or insurance products, which make it easy for the perpetration of insurance fraud. These deficiencies can be present at any stage in the insurance value chain from underwriting to claims. It has been suggested that information asymmetry is a key factor in creating opportunities for insurance fraud (Dionne, 2012:8-14, Lesch & Brinkmann, 2011:18). The last factor is linked to the concept of unfairness and injustice. Fairness and justice play a role in influencing consumers' behaviour; a consumer will be motivated to commit insurance fraud if there is a perception of unfairness or injustice on the part of the insurer (Miyazaki, 2009:590-591; Tennyson, 1997:251-252; Tseng et al., 2014:321-323).

From the results, it can be argued that:

- Financial pressure is driven by the high cost of living in South Africa and the financial burden experienced by consumers.
- Financial benefit is motivated by policyholders' desire to make money easily.
- Negative perception of the insurer is associated with a strained relationship between the policyholder and the insurer. Policyholders are willing to commit insurance fraud if they have a bad relationship with their insurer.
- Poor consumer ethics are driven by the lack of integrity and low value system.

Some of the findings regarding this study objective align to results reported in previous studies, such as the CAIF's (1997, 2008) studies on consumer insurance fraud, which explored reasons for committing insurance fraud. As with the CAIF studies (1997:17, 2008:11), this study also found that the statement "looking for a fair return on premiums paid" emerged as one of the key reasons why consumers committed insurance fraud. The CAIF studies (1997:17, 2008:12) also found that the statement "forced to commit insurance fraud" was the reason respondents least agreed with as a reason for committing insurance fraud. These aspects are all related to either financial pressure or policyholders looking for a return on premiums paid. Other studies (Dean, 2004:67-79; Miyazaki, 2009:589-598; Tennyson, 2002:46) also found that reasons related to fairness, relationship with insurers, previous claims history and consumer ethicality were found to be reasons for consumers wanting to commit insurance fraud.

The findings of this study are therefore consistent with some of the previous studies conducted.

6.4.2.2 Reasons for not committing fraud

From an open response, the following emerged as the main reasons for not committing insurance fraud: consumer integrity and honesty; fear of being caught and prosecuted; fairness and value for money; and lack of opportunity.

The findings further indicate that:

- Consumer integrity and honesty are motivated by factors such as good ethical values and morals, honesty and integrity displayed by policyholders.
- Fear of being caught and prosecuted is associated with having a criminal conviction, damage to personal reputation and not being able to take out insurance again.
- Fairness and value for money are linked to good customer service, fair treatment and good communication by insurers.
- Lack of opportunity is related to robust processes to detect and prevent insurance fraud.

Further probing revealed three factors that to some extent underlie the reasons above. The first factor represents reasons related to the fear of being caught and prosecuted, and the accompanying fear of humiliation. The second factor represents reasons intrinsic to the value system and moral character of the policyholder, shaped in part by religious and cultural beliefs. The third factor represents more extrinsic reasons relating to the policyholder's relationship with the insurance industry.

The findings of this study are consistent with the findings of other studies. In a study conducted by Brinkmann and Lentz (2006:177-195) on consumer morality, they found that

consumer ethics played a role in preventing consumers from committing insurance fraud. The CAIF (1997:17) found that, amongst the reasons consumers indicated as reasons for not committing insurance fraud in the US, the majority of the respondents (63%) indicated consumer morality, followed by fear of being caught and prosecuted (22%) and lack of opportunity (3%). These findings are in line with the findings of this study. Tennyson (2008:1192-1195) also argues that social stigma and consumer ethics are important factors which reduce the temptation to commit insurance fraud.

The findings are therefore aligned to previous research.

6.4.2.3 Types of short-term insurance fraud committed

The findings revealed that the two most prevalent type of insurance fraud in South Africa as perceived by respondents were inflated claims and false claims.

6.4.2.4 Level of difficulty in submitting inflated and false claims

Respondents were somewhat divided about the difficulty of submitting an inflated claim in SA, with about a third each rating it difficult, undecided and easy. In contrast, submitting a false claim was perceived by significantly more respondents to be difficult than easy.

The findings of this study regarding the types of insurance fraud and the difficulty in perpetrating these types of fraud are consistent with the literature. An inflated claim refers to a claim for a genuine insured loss where the quantum or amount being claimed for is more than the actual loss suffered. The amount of the actual loss increased by the policyholder either claiming for items he or she did not possess or claiming for items not lost

or damaged during the insured event. An inflated claim is described in the literature as opportunistic insurance fraud (Haithem et al., 2014:318; Miyazaki, 2009:589; Tennyson, 2002:36). This type of fraud requires no planning and is easy to commit, given that the insured event actually happened and there is a legitimate claim in terms of the insurance contract.

A false claim is committed when a policyholder submits a claim for an insured event which did not happen; the entire insured event is staged or created. In the literature, this type of insurance fraud is described as planned fraud as it requires more planning (Haithem et al., 2014:318; Tennyson, 2002:36).

There is agreement that inflated claims and false claims are the two most common types of insurance fraud experienced in the insurance industry. Inflated claims are more prevalent and widespread because of the ease with which they can be committed compared to false claims (Brokesva & Pastorakova, 2013:297; Miyazaki, 2009:589; Tseng et al., 2014:323).

The findings of this study are consistent with the findings of previous studies on this topic.

6.4.3 Research objective 3: To measure policyholders' perceptions towards the insurance industry, their own primary insurer, brokers and insurance assessors

In this section, policyholders' perceptions regarding the short-term insurance industry, their own primary insurer, brokers and insurance assessors are presented. This is followed by a discussion about the value proposition of insurers.

6.4.3.1 Perception towards short-term insurance industry

Regarding the perception towards the short-term insurance industry in general, the findings indicated that slightly more than half of respondents had a fairly positive perception of the insurance industry in general. Differences between demographic groups were also evident.

6.4.3.2 Perception towards own primary insurer

The findings indicated that respondents were more positive towards their own insurer than the industry in general.

6.4.3.3 Perception towards brokers and insurance assessors

The findings regarding policyholders' perception of brokers revealed that more respondents were positive than negative towards brokers and assessors.

6.4.3.4 Value proposition of insurers

The majority of respondents held positive perceptions about their own primary insurer having policyholders' best interest at heart, delivering on promises made when the policy was sold, delivering prompt service and handling claims in a professional and fair manner.

The findings of this aspect of the study are important as it was found that the relationships between consumers and their insurance company played a role in influencing insurance fraud tolerance amongst consumers. Studies have found that consumers with a less positive view of their insurance company indicated that they were more accepting of insurance fraud

(CAIF, 1997:15; Tennyson, 2002:51-52). Accenture (2010:2-11) found that good customer service was important to consumers in maintaining a positive relationship with their insurers. The study also found that poor service from insurance companies encouraged consumers to commit insurance fraud.

There is alignment between this study and previous research with regard to this aspect.

6.4.4 Research objective 4: To investigate the relationship between perceptions towards the insurance industry, primary insurer, broker and insurance assessors, levels of tolerance, and reasons for insurance fraud

Levels of tolerance were found to be best explained by respondents' perceptions towards:

- unfairness or injustice as a reason for committing insurance fraud, where higher levels of agreement were associated with higher levels of tolerance;
- their insurer having policyholders' best interest at heart, where higher levels of agreement were associated with lower levels of tolerance;
- industry relations as a reason for not committing insurance fraud, where higher levels of agreement were associated with higher levels of tolerance;
- opportunity as a reason for committing insurance fraud, where higher levels of agreement were associated with higher levels of tolerance; and
- morality as a reason for not committing insurance fraud, where higher levels of agreement were associated with lower levels of tolerance.

The findings in this section are positively linked to other studies conducted on consumer attitudes towards insurance fraud. Miyazaki (2009:589-598) found that respondents were more accepting of inflating claims where there was a high deductible, as the respondents felt that the high deductible was unfair and unethical on the part of the insurers. Tseng and Shih (2012:163-174) in their study found a positive relationship between fairness and ethical behaviour amongst respondents. Brinkmann (2005:183-197) found that respondents were more tolerant of insurance fraud if they believed that the insurers were making huge profits to the detriment of the consumers, while Tennyson (2002:52) found that respondents who had a positive relationship with their insurer were less likely to be tolerant towards insurance fraud.

6.5 RECOMMENDATIONS

Based on the findings of this study, the following recommendations are proposed:

Enhancing consumer education

- Insurers should provide meaningful information to policyholders on the value of insurance to society at large.
- Insurers must explain what insurance is and how it works so that there is better understanding of insurance processes amongst policyholders. A greater awareness must be created of the terms and conditions that are included in the policy contract.
- Insurers should advise consumers on the impact of insurance crime and more especially link insurance fraud to high costs of insurance, thus resulting in higher premiums to policyholders.

- Insurers must proactively provide adequate warning to policyholders about the consequences of committing insurance crime, namely the rejection of claims, termination of insurance contracts, reporting of criminal cases and the possibility of criminal convictions.
- Insurers must educate policyholders on the negative impact of insurance fraud, thereby creating a negative social stigma associated with insurance fraud.

Improving the image of insurance industry

- Insurers must introduce and explain the role of the insurance assessor during the insurance sales process, not only during the insurance claims stage. This will provide policyholders with more information about the responsibilities and the reasons for appointing insurance assessors, as well as what policyholders can expect during the claims stage.
- The insurance industry must develop and embark on an intensive marketing campaign to educate people on the contribution the industry makes to society by uplifting communities and stimulating economic growth. Insurers must explain that value is also provided to the non-insured population, especially during natural and man-made catastrophes.

Lobbying the government to make insurance fraud a priority crime

- Currently, insurance crime is not viewed as a serious crime. The insurance industry must lobby the government to ensure that insurance crime becomes a priority crime, similar to what the tobacco industry has done in SA.

Promoting zero tolerance towards insurance fraud

- Insurers must be urged to sign a code of conduct within the insurance industry where each insurer undertakes to report criminal cases and terminate relationships with perpetrators of insurance fraud, irrespective of whether there was a loss or not. This will prevent insurance fraudsters from moving from one insurer to the next.
- Insurers should maintain a national database of insurance fraudsters that can be accessed by the various insurers.
- Perpetrators of insurance fraudsters should be named and shamed within the legal parameters.

Regulators in the insurance industry

- Regulators should encourage insurers to provide adequate warnings for policyholders to better understand the consequences about committing insurance fraud.
- Regulators should strictly monitor and review an insurers consumer education and awareness initiatives on insurance fraud.

Conduct more insurance fraud research in South Africa

- The insurance industry should partner with academic institutions to encourage more academic research on insurance fraud.

6.6 LIMITATIONS

Based on the literature review, the following limitations have been formulated:

- The academic literature on insurance fraud in South Africa is limited. While it is possible that some research has been conducted on insurance fraud in South Africa, the findings of such research were not available in academic repositories. Such research may have therefore been excluded.
- There were limited published statistics on both the number and costs of insurance fraud in SA; most of the statistics provided were contained in media reports. It was thus not possible to provide the true and accurate costs of insurance fraud in SA.

The following limitations can be cited following the completion of the research and the reporting of results:

- While the sampling procedure was aimed to collect data from a purely random sample, this process was to some extent restricted. While an effort was made to assess the sample compared to known population characteristics, some deviations were evident. This was primarily due to the lack of a complete sampling frame of all policyholders in South Africa. Nonetheless, the sample provides a reasonable reflection of the opinions of policyholders in South Africa.
- The use of a survey strategy to some extent restricted the collection of data that can fully explain the reasons why a respondent might provide a particular response. However, it was within this context that the survey strategy was selected.

6.7 IMPERATIVES FOR FUTURE RESEARCH

The following imperatives for future research are put forward:

- While this research study followed a largely positivistic, deductive and quantitative approach, significant value and insight can be added by also considering other approaches, including interpretivist and qualitative methods, that can either corroborate or triangulate the findings of this study.
- This study focussed on insurance claims fraud in personal lines insurance; there is an opportunity to conduct similar studies in commercial insurance or other classes of insurance.
- The extent of other types of insurance fraud affecting short-term insurance fraud can be investigated.
- This study did not focus on fraud prevention initiatives employed by insurers. There is thus an opportunity to conduct research on fraud prevention strategies adopted by insurers to prevent insurance fraud. This could include the use of technology in fraud prevention initiatives.
- Consumer education initiatives employed by insurers in South Africa can be investigated.
- Similar studies can be conducted within the long-term insurance sector.
- A victimology study of insurance fraud can be undertaken, thereby attempting to identify the victims of insurance fraud.
- The costs of insurance fraud in South Africa can be investigated.

6.8 CHAPTER SUMMARY

In this chapter, consideration was given to the conclusions of the study with regard to policyholders' tolerance towards short-term insurance fraud and understanding how certain factors, including policyholders' attitudes and perceptions towards the insurance industry, can explain levels of tolerance. Conclusions were then drawn based on the results of the study. Thereafter, some limitations of the study were noted. Lastly, imperatives for future research were stated.

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APPENDIX A: ETHICAL CLEARANCE CERTIFICATE



University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE **REC-270710-028-RA Level 01**

Certificate Reference Number: BAR101SCHE01

Project title: Fraud tolerance level as a predictor of insurance claims behaviour: A South African study.

Nature of Project PhD in Criminology

Principal Researcher: Moonsamy Perumal Chetty

Supervisor: Prof J Barkhuizen

Co-supervisor: N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document;
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: *Research that includes children as per the official regulations of the act must take the following into account:*

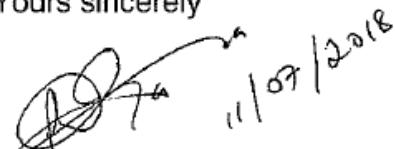
Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
 - Any unethical principal or practices are revealed or suspected;
 - Relevant information has been withheld or misrepresented;
 - Regulatory changes of whatsoever nature so require;
 - The conditions contained in the Certificate have not been adhered to.
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office.

The Ethics Committee wished you well in your research.

Yours sincerely



A handwritten signature in black ink, appearing to read "Pumla Dineo Gqola". To the right of the signature, there is a handwritten date "11/07/2018".

Professor Pumla Dineo Gqola
Dean of Research

05 July 2018

APPENDIX B: EDITOR'S CERTIFICATE

Susanna Elizabeth Louw

Phone 076 588 8561

Email anzelle@wordfix.co.za

SATI membership number 1002866

EDITING DECLARATION

DATE: 2020-01-23

I, SE Louw, hereby declare that I have done language editing for the study titled ***Fraud tolerance level as a predictor of insurance claims behavior: A South African Study***, with the exception of images and verbatim quotes.

If further information is required, please contact me.

SE Louw

Susanna Elizabeth Louw

2019-01-23

Date

APPENDIX C: LETTER FROM SUPERVISOR



University of Limpopo
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3195, , Email:jaco.barkhuizen@ul.ac.za

To Whom It May Concern

Doctoral Research: Student MP Chetty – University of Fort Hare

Mr Moonsamy Perumal Chetty is a student at University of Fort Hare. He is currently completing his Doctoral Degree in Criminology under my supervision.

The topic of Mr Chetty's study is *Insurance fraud tolerance as a predictor for claims behaviour: A South African study* will focus on measuring and identifying factors which contribute towards a short-term insurance policyholder's tolerance towards insurance fraud.

He will be conducting large scale empirical study and the outcomes will assist in better understanding insurance claims behaviour.

Mr Chetty will be using a semi structured questionnaire to collect data for this study. As Mr Chetty's supervisor of this research, I would appreciate it if you could assist in completing this questionnaire.

Please feel free to contact me directly if you have any questions; my details are listed below.

I appreciate your assistance

Prof. Dr. Jaco Barkhuizen
PhD Human Science-Victimology (Tokiwa, Japan); MA (Psych); B.A. Hons (Crim); B.A. Hons (Psych)
CRIMSA President (2018-2020)
Department of Criminology and Criminal Justice University of Limpopo
Tel no: +27 (0)15 268 3195
Email: jaco.barkhuizen@ul.ac.za

Finding solutions for Africa

APPENDIX D: INFORMED CONSENT

Dear Prospective Participant,

You are invited to participate in a survey conducted by Moonsamy Perumal Chetty under the supervision of Jaco Barkhuizen, a professor in the Department of Criminology towards a Doctoral Degree at the University of Fort Hare.

Background of the study and criteria for participation

The survey you received is part of a study which is being conducted to understand the impact of consumer fraud tolerance on claims behaviour within the short-term insurance industry.

It is anticipated that the information gathered from this survey will help the researcher identify factors which inhibit and/or enhance fraud tolerance and what influence if any such factors will have on claims behaviour.

Your responses to the items in the survey will help the researcher obtain as much information as possible to better understand this topic.

To help you decide whether you would like to participate in this survey, please read the following information.

All information collected in this survey will be confidential

Voluntary consent and anonymous nature of this survey

It will take no more than 30 to 40 minutes of your time to complete this survey if you choose to participate.

You are under no obligation to complete the survey and you can withdraw from the study at any time before submitting the survey. The information that you provide will in no way be connected to you since the survey is anonymous and does not require any identifying details.

For this reason, once you click the "submit" button at the end of the survey, the researcher will not be able to trace your submission; hence you will not be able to withdraw your responses.

By submitting your responses at the end of the survey, you agree that the information you provide may be used for research purposes, this includes dissemination through peer-reviewed publications and conference proceedings.

No incentives are offered for participation in this survey.

The researcher undertakes to keep any information provided herein confidential and to report on the findings from the perspective of the participating group and not from the perspective of an individual.

Research ethics

The research was reviewed and approved by the University of Fort Hare's Research Ethics Committee (UREC); certificate reference number BAR101SCHE01 refers. You are welcome to contact Professor Jaco Barkhuizen via e-mail jaco.barkhuizen@ul.ac.za should you have any questions regarding the ethical aspects of the study.

If you consent to participate in this survey, kindly follow the instructions. If not, you may close this page.

There are eleven (11) sections in this survey and while it might appear that there are duplications with some of these items this similarity is due to the overlap of the constructs being measured.

There are no right or wrong answers in the questionnaire. It merely reflects your opinion. Please choose the option that accurately describes your honest opinion.

Thank you for your time and interest in participating in this survey, your input will be extremely valuable to the success of this research study.

It would be greatly appreciated if you would share this survey link with your family, friends, colleagues and/or acquaintances who are short-term insurance policyholders/clients to participate in this survey.

Remember, you are free to withdraw from the study at any time prior to clicking the "submit" button at the end of the survey.

*

Please choose **only one** of the following:

- I voluntarily participate in this survey*

APPENDIX E: QUESTIONNAIRE

FRAUD TOLERANCE AS A PREDICTOR FOR CLAIMS BEHAVIOUR: A SOUTH AFRICAN STUDY

There are 54 questions in this survey

INTRODUCTION

Dear Prospective Participant,

You are invited to participate in a survey conducted by Moonsamy Perumal Chetty under the supervision of Jaco Barkhuizen, a professor in the Department of Criminology towards a Doctoral Degree at the University of Fort Hare.

Background of the study and criteria for participation

The survey you received is part of a study which is being conducted to understand the impact of consumer fraud tolerance on claims behaviour within the short-term insurance industry.

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No incentives are offered for participation in this survey.

The researcher undertakes to keep any information provided herein confidential and to report on the findings from the perspective of the participating group and not from the perspective of an individual.

Research ethics

The research was reviewed and approved by the University of Fort Hare's Research Ethics Committee (UREC); certificate reference number BAR101SCHE01 refers. You are welcome to contact Professor Jaco Barkhuizen via e-mail jaco.barkhuizen@ul.ac.za should you have any questions regarding the ethical aspects of the study.

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There are eleven (11) sections in this survey and while it might appear that there are duplications with some of these items this similarity is due to the overlap of the constructs being measured.

There are no right or wrong answers in the questionnaire. It merely reflects your opinion. Please choose the option that accurately describes your honest opinion.

Thank you for your time and interest in participating in this survey, your input will be extremely valuable to the success of this research study.

It would be greatly appreciated if you would share this survey link with your family, friends, colleagues and/or acquaintances who are short-term insurance policyholders/clients to participate in this survey.

Remember, you are free to withdraw from the study at any time prior to clicking the "submit" button at the end of the survey.

*

Please choose **only one** of the following:

- I voluntarily participate in this survey*

SHORT-TERM INSURANCE PROFILE

1. Through which channel do you currently manage your short-term insurance policy?

Please choose **only one** of the following:

- Direct
- Broker
- Online

2. At which company(ies) do you currently have short-term insurance? (You can choose more than one company)

Please choose **all** that apply:

- ABSA Insurance
- AIG
- Auto & General
- Bryte Insurance (previously Zurich)
- Dial Direct
- FNB Insurance
- Hollard
- King Price
- MiWay
- Old Mutual Insure (previously Mutual and Federal)
- Outsurance
- Santam
- Standard Bank Insurance
- Other (please specify):

3. If you have policies with more than one short-term insurer, which one do you regard as your main or primary insurer?

Please choose **only one** of the following:

- ABSA Insurance
- AIG
- Auto & General
- Bryte Insurance (previously Zurich)
- Dial Direct
- FNB Insurance
- Hollard
- King Price
- MiWay
- Old Mutual Insure (previously Mutual and Federal)
- Outsureance
- Santam
- Standard Bank Insurance
- Other (please specify)

4. Please indicate the type of short-term insurance cover you currently have (with all insurers):

Please choose the appropriate response for each item:

	No	Yes
Vehicle insurance	<input type="radio"/>	<input type="radio"/>
House content insurance (cover for contents inside the house)	<input type="radio"/>	<input type="radio"/>
Home owners insurance	<input type="radio"/>	<input type="radio"/>
All risk insurance (<i>covers you for the loss, theft or damage to items you normally carry with you outside your house e.g. clothing and personal effects; personal documents, coin or stamp collections; transport of groceries and household goods; keys, locks and remote control units; wheelchairs; bicycles; cellular telephones; television sets, video recorders, decoders, video cameras; computer equipment and items in a bank vault</i>)	<input type="radio"/>	<input type="radio"/>
Business insurance	<input type="radio"/>	<input type="radio"/>
Other (specify below)	<input type="radio"/>	<input type="radio"/>

Other (please specify)

Only answer this question if the following conditions are met:
Answer was '

Yes

' at question '5 [B4]' (4. Please indicate the type of short-term insurance cover you currently have (with all insurers): (Other (specify below))

)

Please write your answer here:

5. Have you claimed in the last 24 months?

Please choose **only one** of the following:

- Yes
- No

What type of claim have you submitted?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '7 [B5]' (5. Have you claimed in the last 24 months?)

Please write your answer here:

PERCEPTIONS TOWARD SHORT-TERM INSURANCE INDUSTRY

Feelings towards insurers

6. What is your perception of the following entities?

Please choose the appropriate response for each item:

	Very negative	Fairly negative	In-between	Fairly positive	Very positive
Short-term insurance industry in general	<input type="radio"/>				
Own primary short-term insurer	<input type="radio"/>				
Brokers	<input type="radio"/>				
Insurance assessors	<input type="radio"/>				

7. Why do you say so?

Please write your answer(s) here:

Short-term insurance industry in general	
Own primary short-term insurer	
Brokers	
Insurance assessors	

8. Thinking about claims experiences in general (your own experience, as well as those of other people you know), please rate the following.

Please choose the appropriate response for each item:

	Very negative	Fairly negative	In-between	Fairly positive	Very positive
Your general experience with past claims submitted with current and/or other insurers	<input type="radio"/>				
Your general experience with past claims submitted specifically with your current insurer	<input type="radio"/>				
Experience with your most recent claim	<input type="radio"/>				
General perception based on the claims experiences of other people you know	<input type="radio"/>				

9. Thinking about the premium you pay, keeping in mind your excess amounts payable, would you say it is reasonable or unreasonable?

Please choose the appropriate response for each item:

	Very unreasonable	Fairly unreasonable	In- between	Fairly reasonable	Very reasonable
Insurance premiums	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Please indicate if you agree or disagree with the following statements about short-term insurance companies in general.

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
Have policy holders' best interest at heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delivering on promises they make when the policy was sold	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delivering a prompt service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Handling claims in a professional manner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Handling claims in a fair manner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking for reasons not to pay a claim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treat policyholders' like a criminal when a claim is submitted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. Please indicate if you agree or disagree with the following about your primary short-term insurance company.

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
Have policy holders' best interest at heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delivering on promises they make when the policy was sold	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delivering a prompt service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Handling claims in a professional manner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Handling claims in a fair manner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking for reasons not to pay a claim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treat policyholders' like a criminal when a claim is submitted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PERCEPTIONS TOWARDS ETHICAL/UNETHICAL BEHAVIOUR

Please note the following concepts:

Inflated claim (claims padding) are claims for a legitimate loss or damage where the amount claimed for has been inflated to obtain a higher settlement

False claim (stage or planned) refers to a claim for a loss or incident which did not happen. The entire event has been fabricated.

12. Below is a number of situations or scenarios that you might face on a day-to-day basis. Please indicate if 1 = Strongly believe that it is wrong; to 5 = Strongly believe that it is NOT wrong.

Please choose the appropriate response for each item:

	Strongly believe that it is wrong 1	2	3	4	Strongly believe that it is NOT wrong 5
Returning damaged goods when the damage was your own fault	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Returning an item after finding out that the same item is now cheaper in a sale	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Misrepresenting facts about a child's age to get a lower entrance price or access to a movie	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Misrepresenting facts on an insurance application in order to obtain lower premiums	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not saying anything when the waiter or waitress miscalculates a bill in your favour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting too much change and not saying anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changing original receipts or estimates to increase the amount of an insurance settlement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Observing someone shoplifting and ignoring it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Misrepresenting facts about an incident to obtain insurance coverage for a loss not covered in terms of a policy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not telling the truth when negotiating the price of a new motor vehicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Installing software on your computer without buying it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submitting a false or inflated claim because no one is actually getting hurt anyway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
'Burning' a CD rather than buying it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Returning merchandise after buying it and not liking it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changing the drivers particulars to ensure the claim gets paid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spending over an hour trying on clothing and not buying anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Downloading music from the Internet instead of buying it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Strongly believe that it is wrong	1	2	3	4	Strongly believe that it is NOT wrong	5
Inflating a claim. In other words submitting an insurance claim for a genuine loss but claiming a higher amount for the actual loss or damage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Buying counterfeit goods instead of buying the original manufacturers' brands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Reporting a false loss to an insurance company in order to recoup premiums already paid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Returning to the store and paying for an item that the cashier mistakenly did not charge you for	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Correcting a bill that has been miscalculated in your favour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Submitting an insurance claim for damages that occurred prior to incepting the policy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Buying branded or labelled clothing that might not be genuine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pretending to be stuck in traffic as an excuse for being late	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Taking a R20 lying around at work and not enquiring about its rightful owner – after all, if you don't, someone else would	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Inflating the claim amount to make up for the excess payment linked to the claim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Avoid telling the truth in order to stay out of trouble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Making photocopies for personal use at work, without getting permission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Using someone else's cellphone without asking them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Buying pirated DVDs and CDs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bribing an official to encourage them to make a decision in your favour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Submitting a false claim because everybody is doing it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
It is OK for someone to steal food if they are unemployed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Talking on your cellphone when driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Working on your cellphone when driving (e.g. sending or reading an sms)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

	Strongly believe that it is wrong	1	2	3	4	Strongly believe that it is NOT wrong	5
Submitting an inflated claim because everybody is doing it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

13. Tell me how often do you believe these situations happen? [1 = Not at all; 2 = Rarely or only occasionally; 3 = Fairly often; 4 = Very often]

Please choose the appropriate response for each item:

	Not at all	Rarely or only occasionally	Fairly often	Very often
Returning damaged goods when the damage was your own fault	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Returning an item after finding out that the same item is now cheaper in a sale	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Misrepresenting facts about a child's age to get a lower entrance price or access to a movie	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Misrepresenting facts on an insurance application in order to obtain lower premiums	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not saying anything when the waiter or waitress miscalculates a bill in your favour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting too much change and not saying anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changing original receipts or estimates to increase the amount of an insurance settlement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Observing someone shoplifting and ignoring it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Misrepresenting facts about an incident to obtain insurance coverage for a loss not covered in terms of a policy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not telling the truth when negotiating the price of a new motor vehicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Installing software on your computer without buying it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submitting a false or inflated claim because no one is actually getting hurt anyway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
'Burning' a CD rather than buying it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Returning merchandise after buying it and not liking it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changing the drivers particulars to ensure the claim gets paid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spending over an hour trying on clothing and not buying anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Downloading music from the Internet instead of buying it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inflating a claim. In other words submitting an insurance claim for a genuine loss but claiming a higher amount for the actual loss or damage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Not at all	Rarely or only occasionally	Fairly often	Very often
Buying counterfeit goods instead of buying the original manufacturers' brands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reporting a false loss to an insurance company in order to recoup premiums already paid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Returning to the store and paying for an item that the cashier mistakenly did not charge you for	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Correcting a bill that has been miscalculated in your favour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submitting an insurance claim for damages that occurred prior to incepting the policy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Buying branded or labelled clothing that might not be genuine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pretending to be stuck in traffic as an excuse for being late	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking a R20 lying around at work and not enquiring about its rightful owner – after all, if you don't, someone else would	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inflating the claim amount to make up for the excess payment linked to the claim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoid telling the truth in order to stay out of trouble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making photocopies for personal use at work, without getting permission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using someone else's cellphone without asking them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Buying pirated DVDs and CDs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bribing an official to encourage them to make a decision in your favour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submitting a false claim because everybody is doing it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is OK for someone to steal food if they are unemployed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talking on your cellphone when driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working on your cellphone when driving (e.g. sending or reading an sms)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Submitting an inflated claim because everybody is doing it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. What do you believe are the most common types of short-term insurance fraud committed in South Africa?

Please write your answer here:

15. Please rate the following (1=Extremely difficult to 5=Extremely easy):

Please choose the appropriate response for each item:

	Extremely difficult	2	3	4	Extremely easy
Difficulty in submitting an inflated claim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty in submitting a false claim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

REASONS FOR COMMITTING SHORT-TERM INSURANCE FRAUD

16. What do you believe are the main reasons why people in South Africa commit short-term insurance fraud?

Please write your answer here:

17. To what extent do you believe the following are reasons people commit short-term insurance fraud in South Africa.

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
To get back at short-term insurance companies who make too much profits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking for a 'fair return' on premiums paid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To save money or reduce costs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To get expensive work done that would otherwise be unaffordable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If insurance companies treated people more fairly, people wouldn't try to commit fraud that much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forced to commit fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People commit fraud, because they believe it is seen as common practice in South Africa (everybody else is doing it)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is not that a specific person got hurt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To make up for the excess payments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is okay to inflate the claim just by a little bit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is easy to commit short-term insurance fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insurance companies tolerate to some extent claims padding (i.e. inflating claims)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insurance companies do not prosecute fraudsters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Policyholders have a strained relationship with their insurance company	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. Are there any other reasons you can think of why people commit short-term insurance fraud?

Please write your answer here:

19. Some policy holders inflate claims hoping that insurance companies will not get suspicious. What percentage do you think claims are on average inflated?

Only numbers may be entered in this field.

Please write your answer here:

20. Please rate the following (1 = Definitely disagree to 5 = Definitely agree)

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
If I wanted to I could easily inflate an insurance claim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I wanted to I could easily submit a false claim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CONSEQUENCES OF SHORT-TERM INSURANCE FRAUD

21. To what extent do you agree with the following statements about the consequences of short-term insurance fraud in South Africa?

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
Fraud leads to higher short-term insurance premiums	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Premiums would decrease if incidences of short-term insurance fraud decline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Premiums would continue to rise even if short-term insurance fraud were eliminated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. By what percentage do you estimate premiums are higher because of short-term insurance fraud?

Only numbers may be entered in this field.

Please write your answer here:

REASONS FOR NOT COMMITTING SHORT-TERM INSURANCE FRAUD

23. What do you believe are the main reasons why a person would NOT commit short-term insurance fraud?

Please write your answer here:

24. To what extent do you believe the following are reasons why people do not commit short-term insurance fraud in South Africa?

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
Moral character	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fear of being caught	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fear of prosecution	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of opportunity to commit fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Religious beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand the negative impact of insurance fraud on the sustainability of the insurance industry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fear of humiliation if caught	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a good relationship with their insurance company	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. Are there any other reasons you can think of why people do not commit short-term insurance fraud?

Please write your answer here:

TOLERANCE TOWARDS SHORT-TERM INSURANCE FRAUD

26. Indicate to what extent you agree or disagree with the following statements:

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
People might have justifiable reasons for behaving unethically in certain situations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People might have justifiable reasons for inflating their claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am tolerant of people who inflate their insurance claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because I don't want to get involved	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because it is done by everyone anyway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because in most cases it is difficult to prove	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because in most cases it is not that serious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because no one gets hurt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because people want to make up for their excess payments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because short-term insurers treat claimants like criminals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because short-term insurers act unethically themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because it is done by everyone anyway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because short-term insurers are always looking for ways to reject claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because I do not think that inflating a claim is a crime	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because short-term insurers do not prosecute offenders (this behaviour is condoned by short-term insurers)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because this behaviour is condoned by brokers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Although I might believe that short-term insurance fraud is wrong, I tolerate/accept it because this behaviour is condoned by the salespersons/marketers employed by short-term insurers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. Which would you say is the main reason people tolerate short-term insurance fraud in South Africa?

Please choose **only one** of the following:

- They don't want to get involved
- The incident might involve a trusted friend or relative
- Difficult to prove it
- In most cases the incident is not that serious
- Everyone is doing it anyway
- No one is getting hurt (there are no victims)
- Short-term insurers treat people like criminals
- Short-term insurers are looking for ways to reject claims
- Inflating a claim is not a crime
- Offenders are not prosecuted
- It is a grudge purchase
- Have a negative relationship with their insurer or the insurance industry
- Had a previous bad customer experience with short-term insurer
- Other (please specify)

28. To what extent do you agree with the following statements about the tolerance of short-term insurance fraud in South Africa?

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
People who tolerate short-term insurance fraud are most likely to inflate their claim when they suffer a loss or damage (inflated claim are genuine claims for a genuine loss but the estimate is increased to get a higher settlement)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People who tolerate short-term insurance fraud are most likely to submit false claims (false claim is a claim for a fabricated or staged incident)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

REPORTING OF SHORT-TERM INSURANCE FRAUD

29. Have you ever reported someone for committing short-term insurance fraud?

Please choose **only one** of the following:

- Yes
- No

30. How would you go about reporting short-term insurance fraud?

Please choose **only one** of the following:

- Police
- Broker
- Call insurance anonymous fraud-line
- Other (please specify)

31. How effective do you perceive anonymous fraud call lines to be?

Please choose **only one** of the following:

- Not effective at all
- Not effective
- In-between
- Effective
- Very effective

DETERING SHORT-TERM INSURANCE FRAUD

32. What can insurance companies do to deter/discourage short-term insurance fraud in South Africa?

Please write your answer here:

GENERAL STATEMENTS

33. To what extent do you agree with the following statements?

Please choose the appropriate response for each item:

	Definitely disagree	Disagree	Neither agree nor disagree	Agree	Definitely agree
People should be made aware of the consequences of short-term insurance fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insurance companies are doing enough to educate the public about the consequences of short-term insurance fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brokers are doing enough to educate the public about the consequences of short-term insurance fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short-term insurance companies should provide warnings to policyholders' on the consequences of short-term insurance fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brokers should take more of an active role in explaining the consequences of short-term insurance fraud to policy holders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People should be rewarded for reporting cases of short-term insurance fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short-term insurance companies should simplify the policy wordings so that it is easy to understand the terms and conditions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am concerned about the extent of short-term insurance fraud in South Africa	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I understand that short-term insurance fraud will have a negative impact on the future of the short-term insurance industry in South Africa	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SCENARIOS

34. Inflated claim ("claims padding")

X's house was burgled into and several items were stolen, the actual loss suffered by X totalled to R10 000. X has an insurance policy with ABC insurance company. The insurance policy covers loss due to burglary with an excess payment of R1000 for such claims.

Please indicate how acceptable you find X's behaviour?

Please choose the appropriate response for each item:

	Always acceptable	Usually acceptable	Usually not acceptable	Never acceptable
X submits a claim to ABC insurance company for R11 000 (inflated the claim by R1000) because he/she wants to make up for the excess payment of R1000	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she wants to recoup premiums already paid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she wants to make up for a previous claim which ABC insurance company rejected because X did not have the specific cover	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she believes everyone is doing it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she believes no one is getting hurt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she believes that short-term insurers are making huge profits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she believes that the assessor will in any case reduce the amount as they normally do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated by R5000) because he/she believes that short-term insurers/assessors treat policyholders like criminals when they submit claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated by R5000) because he or she believes that assessors treat policyholders like criminals when they submit claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Always acceptable	Usually acceptable	Usually not acceptable	Never acceptable
X submits a claim to ABC insurance company for R15 000 (inflated by R5000) because he/she believes that short-term insurers look for reasons not to pay out claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she wants to use the extra monies to buy new watch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated by R5000) because he or she believes that assessors look for reasons not to pay out claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she wants to use the extra monies to pay an outstanding account	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she wants to use the extra monies to pay for a well-deserved holiday	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company for R15 000 (inflated the claim by R5000) because he/she wants to use the extra monies to pay for school fees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

35. False claim (staged or planned)

X has an insurance policy with ABC insurance company. The insurance policy covers loss due to burglary with an excess payment of R1000 for such claims. The policy has been in force for several years and X has not submitted any previous claims. X decides to submit a false burglary claim with ABC insurance company.

Please indicate how acceptable you find X's behaviour?

Please choose the appropriate response for each item:

	Always acceptable	Usually acceptable	Usually not acceptable	Never acceptable
X claims that the loss was between R1000 to R10000	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X claims that the loss was between R10000 to R20000	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X claims that the loss was between R20000 to R30000	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X claims that the loss was between R30000 to R40000	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X claims that the loss was between R40000 to R50000	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X claims that the loss was >R50000	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

36. X indicates the following as reasons for submitting the false claim

Please indicate how acceptable you find X's behaviour

Please choose the appropriate response for each item:

	Always acceptable	Usually acceptable	Usually not acceptable	Never acceptable
X submits the claim to ABC insurance company because he/she wants to recoup premiums already paid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits the claim to ABC insurance company because he/she wants to make up for a previous claim which ABC insurance company rejected because X did not have the specific cover	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits the claim to ABC insurance company because he/she believes everyone is doing it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits the claim to ABC insurance company because he/she believes no one is getting hurt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits the claim to ABC insurance company because he/she believes that short-term insurers are making huge profits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits the claim to ABC insurance company because he/she believes that short-term insurers treat policyholders like criminal when they submit claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance because he or she believes that assessors treat policyholders like criminals when they submit claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company because he or she believes that short-term insurers look for reasons not to pay out claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits a claim to ABC insurance company because he or she believes that assessors look for reasons not to pay out claims	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits the claim to ABC insurance company because he/she wants to use the monies to buy new watch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits the claim to ABC insurance company because he/she wants to use the monies to pay an outstanding account	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
X submits the claim to ABC insurance company because he/she wants to use the monies to pay for a well-deserved holiday	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Always acceptable	Usually acceptable	Usually not acceptable	Never acceptable
X submits the claim to ABC insurance company because he/she wants to use the monies to pay for school fees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37. By what percentage do you think it is acceptable for X to inflate his claim?

Only numbers may be entered in this field.

Please write your answer here:

DEMOGRAPHICS

38. Residential province:

Please choose **only one** of the following:

- Eastern Cape
- Free State
- Gauteng
- KwaZulu-Natal
- Limpopo
- Mpumalanga
- Northern Cape
- North West
- Western Cape

39. Your gender:

Please choose **only one** of the following:

- Male
- Female

40. Your age (in years):

Only numbers may be entered in this field.

Please write your answer here:

41. Home language (spoken most often at home):

Please choose **only one** of the following:

- Afrikaans
- English
- Ndebele
- Northern Sotho
- Southern Sotho
- Swati
- Tsonga
- Tswana
- Venda
- Xhosa
- Zulu
- Other (please specify)

42. Highest education level obtained:

Please choose **only one** of the following:

- Some secondary schooling
- Matric/Grade 12
- Post matric qualification: Certificate
- Post matric qualification: Diploma
- Post matric qualification: Degree & higher
- Other (please specify)

43. What is the income category that best describes your personal gross monthly income before tax and deductions?

Please choose **only one** of the following:

- Less than R5 000
- R5 000 - R7 500
- R7 501- R10 000
- R10 001 - R15 000
- R15 001 - R20 000
- R20 001 – R25 000
- R25 001 – R30 000
- R30 001 – R40 000
- R40 001 – R50 000
- More than R50 000
- Refused

44. What is the income category that best describes your household's gross monthly income before tax and deductions? (NOTE: Household income is the estimated combined monthly earnings of all adult household members).

Please choose **only one** of the following:

- Less than R5 000
- R5 000 - R7 500
- R7 501- R10 000
- R10 001 - R15 000
- R15 001 - R20 000
- R20 001 – R25 000
- R25 001 – R30 000
- R30 001 – R40 000
- R40 001 – R50 000
- More than R50 000
- Refused

45. Please indicate which of the following items, if any, are presently in your household?
(NOTE: This question is used to calculate a living standard measure as part of respondent segmentation analysis).

Please choose the appropriate response for each item:

	No	Yes
A fridge or fridge - freezer combination	<input type="radio"/>	<input type="radio"/>
Free standing deep freezer	<input type="radio"/>	<input type="radio"/>
A washing machine	<input type="radio"/>	<input type="radio"/>
A tumble dryer	<input type="radio"/>	<input type="radio"/>
Dishwashing machine	<input type="radio"/>	<input type="radio"/>
A swimming pool	<input type="radio"/>	<input type="radio"/>
A floor polisher or vacuum cleaner	<input type="radio"/>	<input type="radio"/>
A microwave oven	<input type="radio"/>	<input type="radio"/>
An electric stove	<input type="radio"/>	<input type="radio"/>
A tv	<input type="radio"/>	<input type="radio"/>
Home theatre system	<input type="radio"/>	<input type="radio"/>
Zero or only 1 radio set (excluding a car radio)	<input type="radio"/>	<input type="radio"/>
A dvd or blu ray player	<input type="radio"/>	<input type="radio"/>
3 or more cellphones	<input type="radio"/>	<input type="radio"/>
2 cellphones	<input type="radio"/>	<input type="radio"/>
A personal/home computer such as laptop or desktop (pc)	<input type="radio"/>	<input type="radio"/>
A home security service	<input type="radio"/>	<input type="radio"/>
Pay tv subscription e.g. M-net, DStv or Starsat	<input type="radio"/>	<input type="radio"/>
Air conditioning (excluding fans)	<input type="radio"/>	<input type="radio"/>
One or more cars	<input type="radio"/>	<input type="radio"/>
Tap water in household/on stand	<input type="radio"/>	<input type="radio"/>
Hot running water from a geyser	<input type="radio"/>	<input type="radio"/>
A Telkom or Neotel landline	<input type="radio"/>	<input type="radio"/>
A domestic servant or houseold helper or gardener	<input type="radio"/>	<input type="radio"/>

	No	Yes
A flush toilet (inside or outside house)	<input type="radio"/>	<input type="radio"/>
A built-in kitchen sink	<input type="radio"/>	<input type="radio"/>

46. Please indicate your ethnicity:

Please choose **only one** of the following:

- Asian
- Black
- Coloured
- Indian
- White
- Other (please specify)

47. Marital status:

Please choose **only one** of the following:

- Married - Civil (church or magistrate)
- Married - Traditional (lobola/bogadi/other)
- Married - Civil and traditional
- Betrothed and living together
- Live together
- Divorced/estranged
- Widower/widow
- Never married/single
- Other (please specify)

48. Housing:

Please choose **only one** of the following:

- Owner
- Rent
- Other

49. Please select the life stage grouping most representative of your current situation:

Please choose **only one** of the following:

- At-home single:** Up to 34 years old, living with parent(s)/immediate family (at place of residence), no dependents, not married, not living with a partner/significant other
- Young independent single:** Up to 34 years old, not living with parent(s)/immediate family (at place of residence), no dependents, not married, not living with a partner/significant other
- Mature single:** Over 35 years old, not living with parent(s)/immediate family (at place of residence), no dependents, not married, not living with a partner/significant other
- Young couple:** Up to 49 years old, no dependents, married, living (at place of residence) with a partner/significant other
- Mature couple:** Age 50+, no dependents, married, living (at place of residence) with a partner/significant other
- Single parent family:** Not married, not living together (at place of residence) with a partner/significant other, have dependent child(ren) (own or other)
- Young family:** Married or living together (at place of residence) with a partner/significant other, have at least one dependent child under 13 years (own or other)
- Mature family:** Married or living together (at place of residence) with a partner/significant other, no dependent children under 13 years (own or other). At least one dependent child over 13 years (own or other)
- Golden nest:** 50+ years, married, living together (at place of residence) with a partner/significant other, no children or dependent child(ren) (own or other)
- Left alone:** 50+ years, not married, not living together, no children or dependent child(ren) (own or other)

50. Dependents: How many people are fully or partially financially dependent on you?

Please write your answer(s) here:

People financially dependent on you -

Fully

People financially dependent on you -

Partially

Submit your survey.

Thank you for completing this survey.

APPENDIX F: TURNITIN REPORT

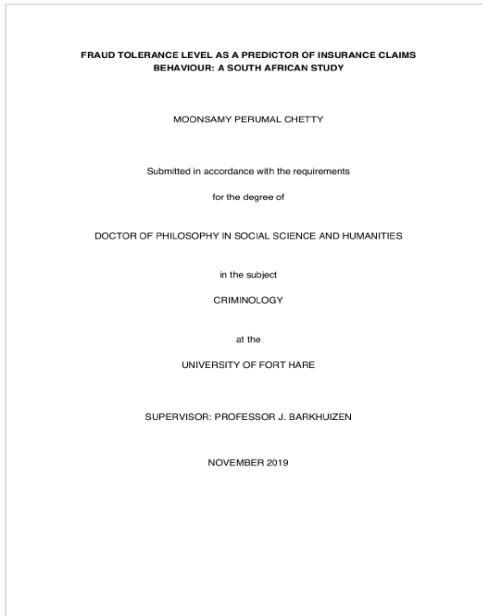


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