EVALUATION OF FRAUD MANAGEMENT STRATEGIES ADOPTED BY INSURANCE COMPANIES IN KENYA

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A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION, SCHOOL OF BUSINESS, UNIVERSITY OF NAIROBI.

2016

DECLARATION

I Thomas Victor Oduor Odhiambo hereby declare that this Research Project entitled **EVALUATION OF FRAUD MANAGEMENT STRATEGIES ADOPTED BY INSURANCE COMPANIES IN KENYA** is my original work and has not been presented for a degree in any University.

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ACKNOWLEDGEMENTS

I would like to thank the Almighty God for good health and strength freely granted to me and for keeping me focused through the entire MBA program. Special thanks to my supervisor Dr. James Gathungu for having supported me to conduct a thorough research. I particularly appreciate his strictness with details and continuous guidance, patience, constructive criticism and encouragement throughout the research project period. Thank you for your understanding and for agreeing to supervise my work. I would like to thank my lecturers for having dedicated their time to mentor and pay attention to any issue I raised.

I would like to thank the management of Insurance Regulatory Authority for allowing me time out of office to do my research work. Their full support and sponsorship towards my MBA studies is a big plus.

I would like to thank Mr. Sammy Mutua Makove, the CEO & Commissioner of Insurance who encouraged me to pursue the MBA program and even authorized full sponsorship for the program. He kept reminding me that I am equal to the task and even giving me words of encouragement all along. Without his support, I may not have come this long. May God bless him.

I am so grateful to my colleagues at work whose support I sought and who stood by me along the way. I wish to mention Sammy Makove; Edward Opiayo; Mary Azegele, Susan

Opiyo and Elias Omondi for listening to me and giving me encouragement which went a long way to enable me complete this project.

I would not want to forget the respondents from different insurance companies for giving me their scarce time and for their invaluable input during data collection.

God bless you all.

DEDICATION

To my dear wife, Scholastica A. Oduor and my children Samson, Fiona, Faith, Audrey, Olga, Justine and Cedric Oduor who kept reminding me that I can make it. Thank you for your prayers, encouragement, understanding, patience and moral support throughout the MBA program.

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ABBREVIATIONS AND ACRONYMS

AIBK	Association of Insurance Brokers of Kenya
AKI	Association of Kenya Insurers
AKR	Association of Kenya Reinsurers
BFID	Banking Fraud Investigations Department
DCI	Directorate of Criminal Investigation
IFIU	Insurance Fraud Investigation Unit
IIK	Insurance Institute of Kenya
IRA	Insurance Regulatory Authority
PHCF	Policyholders Compensation Fund
PTA Re	Preferential Trade Area Reinsurance Company
SIU	State Investigation Units

ABSTRACT

Insurance is important in the development of modern economies including Kenya's. This is because insurance is a mechanism through which losses are replaced thereby facilitating sustainable economic development. Over the years, fraudsters have realized that the insurance industry is highly liquid and permeable to fraud and have proceeded to invaded the industry with high intensity and unless urgent and stringent actions are taken by individual insurance companies, the industry regulator, industry associations and the Government, the industry runs the risk of further weakening of its already fragile liquidity and as a result compromising its claims settlement ability, performance and ultimate stability. Some Kenyans involve in fraud partly because they feel the premiums they pay are lost or because fraud is a victimless crime as nobody in particular is directly affected. A survey was conducted among 25 of the 50 insurance companies to establish specific fraud management strategies in use and evaluate their effectiveness. Data was collected, coded, analyzed using descriptive statistics and presented. The study established that insurance companies use normal internal control systems such as internal and external audit functions, underwriting, claims management, IT and management committees to manage fraud. The study established that strategies adopted by insurance companies to combat fraud are ineffective leading to increasing cases and cost of fraud. That most companies shy away from investigating and prosecuting suspected fraudulent claims exposing this weakness to fraudsters who exploit it to their advantage. The study recommends that urgent action be taken by the Government and its agencies, IRA, as well as individual insurance companies and their associations if they are serious about saving the industry from the pangs of fraudsters.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The study focuses on insurance companies in Kenya given that they are exposed to fraud risk and require appropriate strategies to help them manage its impact in their performance. Strategy is defined by Scholes & Johnson (1993) as the direction and degree an association uses to address the issues of its stockholders. Strategic management is additionally characterized as the arrangement of choices and activities that outcomes in the detailing and execution of arrangements to accomplish an organization's destinations (Pearson and Robinson, 2007). An organization's strategy is an important element of its management process (Aosa, 1992).The concept of strategy has in recent years grown in stature and importance thus covering every facet of management (Ansoff, 1991). Ansoff (1980) noticed that nature is always showing signs of change making it basic for associations to ceaselessly adjust their exercises to succeed. Because environment is important, organizations have to respond to its dynamism, heterogeneity, instability and uncertainty (Thompson, 2005). Such enterprises must consistently adjust to the earth keeping in mind the end goal to guarantee themselves of survival. (Porter, 1980; Aosa, 1997; Pearce & Robinson, 1997. Hamel & Prahalad, (1999) wrote that "Destiny is not a matter of choice. It is not a thing to be waited for, it is a thing to be achieved. In any case, without a perspective about the open door for change, an organization is probably going to relinquish the future than possess it".

The threat of fraud to insurance companies emanate from both their internal and external environments. Fraud is one of the causes of the collapse of many insurance companies in

Kenya. Mwangi (2013) reasoned that Kenyan insurance companies have undergone very tough times incurring huge payouts in form of claims, a significant proportion of which is fraudulent. In a study on the "Response strategies to fraud-related challenges by Barclays Bank of Kenya", Cheptumo (2014) recommended reforms in the police and judiciary, review of fraud legislation, review of features of security documents including the National ID, Driving licenses, passports & Title deeds, constant monitoring of staff, employee screening and staff account management, among others.

Three theories have been identified to anchor this study. The theories include the Fraud Management Life Cycle, the Nash Equilibrium Theory and the Resource based theory. The Fraud Management Lifecycle Theory, advanced by Wilhelm (2004) identifies eight stages that organizations need to put in place to effectively manage fraud including Deterrence, Prevention, Detection, Mitigation, Analysis, Policy, Investigation, and Prosecution and Information Technology. The Nash equilibrium theory by Nash (1950) is an answer idea of a non-agreeable amusement including at least two players, in which every player is expected to know the balance methodologies of alternate players. Resource Based hypothesis, presented by Grant (1991) is about the match an association makes between its inner assets, the aptitudes and the opportunities made by the outside environment.

1.1.1 Concept of Strategy

Strategy is the course and degree association take, over the long haul, to convey competitiveness in the midst of a continually changing business environment. Viable strategy arranges an association's resources and center abilities to enough meet its objectives and destinations. System makes a culture in the firm in which the firm just

spotlights on the esteem including needs in its central goal and vision (Johnson and Scholes, 2008). Competitive methodology is gone for making an integrity of fit between the company's inward assets capacities and the ecological difficulties confronted (Aosa, 1992). Strategy is a multi-dimensional idea and different creators have characterized system in various ways.

Organizations that fail to adapt to environmental challenges often experience survival challenges and are in most cases driven out of business by their competitively shrewd counterparts. Dominant firms, therefore, keep re-thinking their strategies in addition to developing innovative ways to counter environmental threats. An organization's strategy is an important element of its management process (Aosa, 1992). Strategic management has been widely acclaimed as one of the most effective management tools use by companies in strengthening their performance through effective decision making, systematic planning and implementation (Wheelan & Hunger, 1995). Ansoff (1965) viewed strategy as the "common thread" tying an organization's activities and its market.

1.1.2 Concept of Fraud

Fraud is commonly understood as dishonesty calculated for advantage. A person who is dishonest may be called a fraud. Albrecht et al (1984) classified nine motivators of fraud as Living Beyond Means, Overwhelming Desire for Personal Gain, High Personal Debt, Close Association with Customers, Perception that Pay Was Incommensurate with Duties, Wheeler-Dealer Attitude, Feeling Challenged to Beat the System, Excessive Gambling Habits, Undue Family or Peer Pressure. Richard Hollinger & John Clark concluded that employees steal primarily as a result of workplace conditions.

A look at the many empirical observations reveal that Cressey's non-shareable external factors and Hollinger and Clark's structure and behavioral standards of the work environment emerge as likely components impacting working environment extortion. It is sensible to contend that a man may require assets to pay off an obligation, or the individual may feel came up short on and spurred to confer misrepresentation even without a prompt monetary need. Both external and internal factors play a role in the commission of fraud in the insurance industry. In fact, more outsiders have been found to involve in insurance fraud than is the case in other trades. Policyholders, Doctors, Health facilities, Polices, Lawyers, Garages, employees, Intermediaries and the like frequently get involved in insurance fraud.

1.1.3 Insurance Fraud

Insurance fraud, otherwise termed as claims extortion is a criminal demonstration which involves acquiring monetary benefit from backup plan or protected utilizing distortion of truths or falsifications (Derrig, 2002). Insurance fraud undermines the relationship amongst guarantors and policyholders since it exhausts the store pooled from the guaranteed (Yusuf, 2009). Opiyo (2013) contended that misrepresentation is a genuine business chance which represents a major test to the protection area as misfortunes brought about by deceitful actions influence the development of the protection business. Insurance misrepresentation has existed as far back as the start of Insurance in Lloyds and is as old as the business itself (Ngosiah, 2012). Fraud misfortunes are every now and again part of a financial externality, where one business takes activities or ceases from acting and therefore, passes on, forces or encourages costs upon different business (Ijeoma and Aronu, 2013). Fraud is bogus representation of a self evident actuality whether by words or by direct, by false or deluding affirmations, or by camouflage of

what ought to have been uncovered, that tricks and is proposed to cheat another so that the individual will follow up on it to her or his legitimate damage (Clemency, 2002). In an unpublished PwC review for associations in the budgetary administrations industry, misrepresentation was appeared to be the most noteworthy hazard influencing CEOs and senior administration but then in a nation plagued by extortion, no doubt banks are ease back to report it, and the courts delinquent to convict. IRA expressed that in 2013, claims settlement was troublesome as far as volumes, petitioner's weight and misrepresentation which prompted to expanded misfortune proportion (Kenya Insurance Industry Outlook, 2013). Extortion has had expansive results to the Kenyan economy specifically and the world when all is said in done (Irungu, 2012).

While the CBK (2010) review demonstrated that 95% of respondents have an autonomous hazard organization work, one is compelled to scrutinize their viability when it turns out, as indicated by PwC Kenya, that banks were unable to recover around KES 761 million to misrepresentation in the six-month time frame, January to June 2010 and a stunning 1.7 billion KES in the three months August to October 2010. The Banking Fraud Investigations Department (BFID) reported that the taking off levels of bank related wrongdoing on their books is as an immediate aftereffect of disappointment by banks to remedy the issue. Banks, insurance agencies and other budgetary foundations are being requested to build up an organized structure where they can share extortion data among themselves to decrease the ascent of government evasion and fraud cases in East Africa. East African banks have lost around Sh4.06 billion since 2011 because of fraud yet the figure could be altogether Banks, insurance companies and other financial institutions are being urged to establish a structured framework where they can share fraud information amongst themselves to help reduce the rise of money laundering and

fraud cases in East Africa. East African banks have lost approximately Sh4.06 billion since 2011 due to fraud but the figure could be significantly understated because of the high number of unreported misrepresentation cases (Nyamu, 2012).

1.1.4 Fraud Management Strategies

Insurance companies in Kenya need to develop and implement fraud manage strategies appropriate for their fraud risk profile or classes of business they underwrite. Companies underwriting personal insurance business such as motor private, medical and personal accident are more exposed to fraud than those underwriting motor commercial, life or fire industrial insurance. Kenya's insurance companies have almost surrendered to fraudsters to the extent that they ordinarily generate net profits from non-core activities such as asset management, fund investments, unit trusts and deposit administration schemes. Some light needs to shed to make these companies develop and implement effective fraud management strategies to return the industry to its rightful trade of underwriting.

Fraud management technique is an abnormal state anticipate how foundations ought to approach actualizing avoidance of cases of frauds. The tactic shapes the most essential part of the extortion counteractive action arrange and, accordingly should be uncomplicated and practicable. The extortion counteractive action system is a result of the organization's misrepresentation management approach and the establishments' extortion chance profile. It portrays how continuous extortion management will function in the organization. The methodology includes recognizable proof and appraisal of powerless ranges, distinguish where exposures to misrepresentation exist inside the organization's present working frameworks and techniques. Once these exposures have

been recognized then it will be conceivable to execute activities to counter the exposures and, wherever conceivable, forestall or lessen the rate of misrepresentation later on.

The methodology ought to likewise include a reaction arrange with clear techniques on the most proficient method to address controls lack. Fraud reporting ought to be a piece of the reaction plan or examination approach. The reaction plan ought to likewise plot the exercises and the staff in charge of particular reaction exercises. It ought to incorporate enactment that is significant to tending to common and criminal acts against the foundation. The procedure ought to instill against misrepresentation culture with structures set up to advance and instruct all partners about the organization's way of life on extortion. The fraud anticipation technique and usage plan ought to in a perfect world be produced together to guarantee network and coherence.

1.1.5 Insurance Industry in Kenya

The Kenyan insurance industry is the fourth most developed in Africa in terms of penetration (3.1%) after South African (14%), Mauritian (8%) and Namibian (6%). The industry continues to experience growth in premiums (IRA, 2012) with gross direct premium growing by 22.1% from Kshs.90.2 billion in 2011 to Kshs.110.09 billion. Non-life business contributed 66.2% of the total premium with life business contributing 33.8%. Industry total assets grew by 26.7% from Kshs.246 billion in 2011 to Kshs.311 billion in 2012. Underwriting profit grew by 28.6% from Kshs.2.42 billion in 2011 to 3.11 billion in 2012. However, underwriting profits under motor private business portfolio declined by 135% (IRA, 2012).

Kenya's insurance industry is regulated by the IRA. There are a number of associations representing various interest groups in the industry including Association of Kenya Insurers (AKI), Association of Kenya Reinsurers (AKR), Association of Insurance Brokers of Kenya (AIBK), the Insurance Institute of Kenya (IIK) among others. There are a number of regional reinsurance companies operating in Kenya under regional charters including PTA RE, Africa Re (IRA, 2012).There are 170 registered insurance brokers, 24 medical insurance providers, 4,803 insurance agents and slightly over 300 insurance service providers. Other institutions playing significant roles in Kenya's insurance industry include the Policyholders Compensation Fund (PHCF), a special unit of the Directorate of Criminal Investigation (DCI) founded in 201 specifically to investigate and prosecute insurance related offenses.

1.1.6 Insurance Companies in Kenya

There are forty eight direct insurance underwriters and three reinsurance companies in Kenya making a total of fifty one insurance companies. Of the 51, twenty four are short or general underwriters, twelve are long term or life underwriters while twelve are composites or companies transacting both life and general classes of business. Under life insurance business, two insurance companies account for 38% of the Gross Direct Premium. Six medium companies account for 41% while fourteen companies account for 20.6% of the Gross Direct Premium. Under general insurance business, three insurance companies account for 26.7% of the Gross Direct Premium. Thirteen medium companies account for 49.4% while 18 companies account for 24.69% of the Gross Direct Premium. The largest insurance company in Kenya in 2012 was Jubilee accounting for 11.3% of total industry gross premiums.

1.1.7 Guidelines Issued by the Authority to Improve Industry Performance

Whereas the Authority has made it mandatory for all insurance companies to invest in the appropriate IT systems and other relevant technologies to help curb fraud, the findings of this study demonstrates that there is little consistence with this prerequisite. The Authority has also issued several guidelines to stabilize the conduct of insurance business, including fraud. The guidelines are listed here below;

1. **Guidelines on Anti-Money Laundering Act and Prevention of Terrorism Act;** These guidelines are aimed at facilitating insurers to detect, deter and report incidences of possible crimes related to proceeds of crime and money laundering in the insurance industry

2. **Guideline on Risk Management and Internal Controls for Insurance and Reinsurance Companies:** To provide assurance that the insurer's risks are appropriately managed**.**

3. **Guideline on External Auditors to Insurance and Reinsurance Companies;** Aimed at ensuring that insurers financial statements are prepared accurately and are free from material errors, whether due to fraud or error.

4. **Guideline on Insurance Risk for Insurers;** Aimed at ensuring that insurance companies are managed in a sound and prudent manner. Recommends effective risk management systems for identifying, assessing and mitigating risks inherent in the insurer's core business processes.

5. **Guideline on Suitability of Persons for Insurers:** Aimed at ensuring that all persons involved and responsible for the ownership, stewardship, and management of an insurer are and remain suitable to fulfill their respective roles.

6. **Guidelines on Claims Management for the Insurance Industry:** Aimed at to enhancing efficiency, transparency and disclosure of information to policyholders.
7. **Guideline on Market Conduct for Insurers:** Aimed at fair treatment of customers through ethical behavior, acting in good faith and the prohibition of abusive practices.
8. **Guidelines on Market Conduct for Insurance Investigators & Motor Assessors:** The aim of these guidelines is to enhance best practices in the conduct of insurance business and to improve the image of the insurance industry.
9. **Guidelines on Market Conduct Guidelines for Insurance Intermediaries:** These guidelines have been issued by the Authority in order to streamline the operation of insurance business in Kenya. If well implemented and adopted by insurance companies, the guidelines can significantly improve efficiency, performance and profitability of the insurance industry.

These guidelines are aimed at enhancing efficiency, performance and stability of insurance companies insurance in Kenya.

1.2 Research Problem

Challenges facing modern financial institutions managers are the threats of competition and environmental dynamism that affect their strategic planning (Njenga, N. & Osiemo, 2013). Fraud poses significant and costly problem for both policy holders and insurance companies. (Sybase, 2012). Despite sophistication and volume of fraudulent claims, the vice continues to increase with insurers not upping their game in combating it with the public and investors being the ultimate losers. Fraud emanates from both internal and external sources thereby posing substantial cost to our economy and the world's (Jans,

2010). PwC (2009) further indicated that fraud rose from position 23 in global ranking in the 2009 risk survey to position 4 in the East Africa survey. This indicates that fraud is significantly affecting Kenya's insurance industry.

While the insurance sector contribute 2.91% of Kenya's GDP, is a major source of savings and investment and a leading employer, insurance fraud insurance fraud costs the Kenya over KES 4 billion yearly (IRA, 2012). As per IRA (2012), claims acquired under general insurance was found to include 40% component of extortion meaning an expected KES 9 billion misfortune (IRA, 2012). In a 2012 report by IFIU, representatives and operators stole KES 184 million and KES 65 million separately. Misrepresentation influences safety net providers' gainfulness and undermines its strength and open certainty. As indicated by the report, more than ten insurance agencies have shut shop in the previous decade because of fraud (IFIU, 2012).

A lot of research has been embraced on the nature, degree and effect of misrepresentation on the execution of insurance agencies the world over. Okwachi (2009) conducted research on effectiveness of state regulation of the insurance industry in Kenya, Wairimu (2010) researched on challenges in management of general insurance claims, Somme (2012) wrote on the extent and effect of fraud, Kuria & Moronge (2013) wrote on the impact of fraud control mechanisms on the growth of insurance companies in Kenya. However, very little research has been directed towards understanding the strategies local insurers use to deter, prevent, detect, isolate, measure and their effectiveness.

This research project is meant to address three questions; specific strategies Kenyan insurance companies use to combat fraud. How effective the existing strategies are in combating insurance fraud. Whether Kenyan Insurers are willing to change and adopt better fraud management strategies.

1.3 Research Objectives

The study is aimed at achieving the outlined objectives:

i. Identify the existing fraud management strategies used by Kenyan companies to combat insurance fraud.
ii. Assess the effectiveness of these strategies in combating insurance fraud.
iii. Establish whether insurance companies in Kenya are willing to re-examine the existing strategies should it come out that they are not effective.

1.4 Value of the Study

The study is aimed at helping the insurance industry appreciate a holistic approach to fraud management by avoiding to treat fraud as an economic externality that should be avoided and rather than confronted. To alert Government agencies including IRA and IFIU that that things are not right and raising concern that industry players are not doing enough to stem fraud and that the stability of the industry is at risk.

Public universities, tertiary institutions, research organizations and individual researchers interested in the field of insurance shall use the findings to further their research on insurance fraud. This study is aimed at emboldening the researchers resolve to establish the effectiveness and efficiency of the fraud management strategies in the insurance industry in Kenya.

The research findings will help individual insurance companies understand their position in the war against insurance fraud. Some may pull up their socks while others may seek to enhance their existing fraud management strategies with weaker ones overhauling their existing strategies. The study aims at underscoring the need for adoption of appropriate strategies in managing insurance fraud. The study findings would paint a picture that would enable policymakers pinpoint the areas that require policy overhaul, re-formulation and implementation and continuous review.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews previously written literature on fraud and how it relates to fraud management strategies used by insurance companies in Kenya. The chapter also reviews the theories, strategies and practices already adopted elsewhere to assess, quantify, report and control the impact of fraud on the performance of insurance companies and other industries.

2.2 Theoretical Foundation

Fraud management is of critical importance to policymakers and the management of insurance companies if only they wish to improve their performance and provide better services to their clients while paying handsome dividends to shareholders. Three theories have been advanced to advance the concept of enterprise continued growth and development. The theories include the Fraud Management Life cycle, then Nash Equilibrium Theory (part of the wider Game Theory) and the Resource based theory.

Wesley (2004) defined Fraud Management Lifecycle Theory as a comprehensive way to deal with extortion management (Wesley, 2004). This is an advancing and versatile hypothesis to evolving circumstances. Wesley recognized the eight phases as discouragement which includes activities and exercises expected to stop or anticipate fraud before it is endeavored, avoidance went for keeping fraud from happening, recognition which is gone for distinguishing and finding extortion preceding, amid, and

consequent to its finishing. Moderation is intended to prevent misfortunes from happening or keeping on happening and also frustrating a fraudster from proceeding or finishing false action. Examination and Analysis manage misfortunes that have as of now happened are recognized and contemplated with a view to deciding its effect. Approach is intended to make, assess, impart, and help the organization of strategies to lessen rates of extortion. Arraignment is about regulating discipline on fraudsters. The eighth stage is Information Technology that assumes a profitable part all through the Fraud Management Lifecycle. IT guarantees that no single stage in the Lifecycle is let well enough alone for its proficient and adaptable frameworks, procedures, or staff. IT assets are the way to the achievement or disappointment of the exercises in the individual extortion stages and now and again the achievement or disappointment of the whole Fraud Management unit.

The Nash Equilibrium or Game Theory is a game of two un-cooperative players where each player is unwillingness to change his position unless the change is likely to make him win the game. Unless the change influences the other player to change his position to the advantage of its competitor, each player will maintain his position. It was designed by Nash in 1950. In the theory, an equilibrium point is reached where all players choose actions which are best for them based on their opponents' choices.

Grant (1991) defined Resource Based Theory as the match organizations make between their internal resources, the skills and the opportunities created by the external environment. Organizational resources are critical in the formulation of strategy and leads to the ultimate realization of corporate performance. From the point of view of the insurance industry, resources mean the internal systems and processes, qualified staff and

information technology deployed to combat the impact of fraud on the profitability of the organizations.

While, the Nash Equilibrium theory explain why insurance companies must act to manage fraud, the Resource Based and Fraud Management Lifecycle theories outline the stages industry players need to follow in managing fraud using both internal and external resources at their disposal. Failure to honor the three theories has let down the insurance sectors the world over.

2.3 Role of Strategy in Fraud Management

"Effective system designs a company's assets and center skills with a specific end goal to meet its objectives and targets. Processes makes a solid culture in representatives leaving the firm to concentrates on esteem including needs in its main goal and vision (Johnson and Scholes, 2008). Aggressive technique plans to make integrity of fit between the company's inside assets capacities and the natural difficulties confronted" (Aosa, 1992).

Linn (2008) characterized procedure as "the match between association resources, aptitudes and the natural opportunities against dangers the association faces from the outside environment". "The motivation behind system is to give directional signals to the association that allow it to accomplish its objectives while reacting to the open doors and dangers in the earth" (Pearce and Robinson, 2001). Johnson and Scholes (2008) characterized procedure as the "heading and extent of an association that preferably coordinates the aftereffects of its changing surroundings and specifically its business sectors and clients to meet partner desire".

The way of insurance business makes it profoundly defenseless to extortion. By generating large and steady flow of cash through insurance premiums, insurance companies become highly attractive to fraudsters.

2.4 Fraud Management Strategies

Given the extent to which the world is exposed to fraud, it is important for companies to put in place elaborate fraud management strategies should they want to survive. The strategies must contain high level implementation plan and policy. Fraud management strategy forms the most critical part of the fraud avoidance arrange and should in this manner be uncomplicated. The methodology must stay commonsense. Associations must build up operational management as clear arrangements and techniques with a specific end goal to diminish frequencies of fraud (Hansen, 2009). It is imperative for associations to make and keep up extortion strategies for controlling workers" (Biestaker, Brody, & Pacini, 2006). Biestaker (2009) states that company boards are responsible for the development of anti-fraud policies. For its part, management should focus on identifying and understanding causes of fraud and signs of staff and client misconduct which may undermine business objectives. Management ought to likewise figure out if hostile to fraud control projects are working and are compelling in diminishing fraud occurrences. Organizations ought to set up better methods for planning and assessing controls with a specific end goal to counteract, identify and react properly to fraud and wrongdoing. This technique might help associations to accomplish the most elevated amount of business trustworthiness through sound corporate administration, internal control and straightforwardness.

According to KPMG (2006), effective business-driven fraud risk management approach should encompass controls with three key objectives. Prevent, Detect and Respond. KPMG states that an effective fraud management strategy has four phases including: Assessing Risks; Designing Programs (Controls to prevent, detect and respond); Implement the new controls and Evaluate (Assess existing controls including internal control protocols or due diligence practices).

In the Unites States, insurance companies consider technology as being critical to the effective management of insurance fraud. There is an explosion of fraud-detecting strategies in the US with more organizations receiving progressively advanced databases and information mining systems to help with distinguish fake claims and forward the same to the State Investigation Units (SIUs). These advances have helped back up plans to gather and investigate volumes of cases data and to identify and hail suspicious cases in view of particular qualities. The e-business world has refuted conventional extortion location systems, driving guarantors to grow new answers for battle misrepresentation. Innovative improvements in protection extortion examination have forced on US insurance agencies the tremendous weight of staying aware of the most recent advancements. Safety net providers in the US are compelled to pick, actualize and keep up suitable innovation for their associations. Insurance agencies in Kenya need to get from the US given the rate at which they are embracing e-trade in their business.

Cheptumo (2014), in a study on the "Response strategies to fraud-related challenges by Barclays Bank of Kenya" recommended that there should be reforms in the police, that the judiciary needs to be empowered through reforms; that review of Fraud Legislation be conducted; that review of security documents (The Kenyan National ID, Driving

licenses, passports and Title deeds) be undertaken; that constant staff monitoring and motivation be enhanced including employee screening and account management.

Wilks (2004) said fraud can be managed through strategic frameworks involving Board of Directors, Audit Committees, Management and Staff. There must exist written policies, fraud risk assessment mechanisms to identify fraud hot spots, fraud reporting procedures, fraud investigation processes, corrective action and continuous monitoring. The establishment of similar strategies will make committing fraud in the insurance industry in Kenya difficult thus driving them away. Bloomfield (1997) argues that the relationship between the auditor and the auditee influences the outcome of the fraud audit setting. Bloomfield's theory has led to the development of three levels of reasoning. The first level was designed by Zimbelman and Waller (1999) as reasoning that is not strategic. They called this Zero-Order Reasoning where auditors only consider conditions that directly affect themselves but not others including audit fees, sampling costs and penalties. Here auditors assume that the auditee is not aware of the audit procedures and will not act to defeat them, a fact that is not likely.

The second level is the First-Order Strategic Reasoning. Here, the auditor anticipates the reaction of the auditee including incentives to conceal information. The auditor then modifies his audit plans with the aim of detecting concealment. The third level is the Higher-Order Strategic Reasoning where auditors consider additional, potentially infinite layers of complexity, including the likelihood that the auditees may anticipate the auditor's behavior. Higher-Order auditors use non-standard procedures that anticipate auditee's decisions. Though many researchers believe that Higher-Order Strategic Reasoning sounds unnatural and difficult, only a handful of researchers are keen on it.

However, it remains a field of study those seeking to combat insurance fraud should research on given that insurance fraud is as complex as the Higher-Order Strategic Reasoning itself.

Tennyson & Salsas-Forn, (2002) provides two varieties of audit methods insurance companies can use. First is the non-routine handling methods involving use of independent Medical Exam (IME), directing therapeutic review, performing site examination, looking for recorded or sworn explanations from the petitioner, the protected or an observer to the mishap, referral to an exceptional examination unit and utilizing movement checks including observation of the inquirers or talking neighbors and different people acquainted with the petitioner's exercises. Utilization of reviewing systems in extortion recognition in the protection business has not been across the board however safety net providers are starting to understand the upsides of utilizing it. Other option extortion administration systems incorporate; Centralized Fraud Management; Decentralized Fraud Management; Enterprise Fraud Management; Fraud Automation: Fraud Management Procedure; Fraud Management Process; and Fraud Management Program.

From the above literature, it can be observed that approaches to fraud management are varied. It wouldn’t be practical for an insurance company to adopt all available fraud management strategies at the same time due to resource and capacity limitations. It is also worth noting that not all insurance companies face the same types, magnitude and impact of fraud. Life companies undertake rigorous underwriting of risks compared to their general insurance counterparts and therefore face less exposure to fraud losses. Personal insurance underwriters such as medical, motor private and personal accident insurance are more exposed to fraud losses compared to corporate business underwriters such as

motor commercial and fire industrial insurance. This means that each insurance company will adopt different strategies based on their exposure to the vice. However, Fraud Management Life Cycle theory and Bloomfield's Audit Methods apply to all insurers. In Kenya, a centralized claims management system needs to be implemented and monitored by IRA since insurers may not be willing to share their data with fellow underwriters. "Implementation of Cheptumo's "Response strategies to fraud-related challenges" are external to the industry and can only be implemented by the state.

2.5 Importance of Insurance

Insurance is a chance exchange instrument that guarantees use to completely or halfway make up for loses or harm brought on by event(s) outside the ability to control of the safeguarded. In return for the commitment by the insurer, the insured agrees to pay agreed premium. (Vaughan & Vaughan, 1995). Mirsha (2004) divides insurance into two. He defines insurance from a functional viewpoint where he links insurance to a cooperative society which spreads losses from a few over a larger number of members. This is the view taken by Takaful concept of Islamic insurance.

Insurance is a contract where the willing buyer agrees to pay premium while a willing seller agrees to pay losses. Insurance is used to protect the financial well-being of individuals, companies and entities should unexpected loses occur. Insurance is a weapon against underdevelopment represented by poverty, disease, unemployment and adverse balance of trade in Africa (Swalehe, 2005). As a responsible citizen, insurance is a major tax generator, a campaigner of good governance and it meets the societies concerns through corporate social responsibility (ABI, 2007). These arguments bring out the

important role insurance plays in society and why it should be safeguarded by well-intentioned members of the community.

2.6 How Fraud affects Insurance

By its very nature, insurance business is highly susceptible to fraud. By accumulating large amounts of liquid assets in the form of premium and reserves, insurance companies present an ideal environment for fraudsters due to the steady flow of liquid and near liquid funds.

"Insurance fraud is an unlawful follow up on the piece of either the purchaser or merchant of a protection contract. Insurance fraud from the guarantor (dealer) incorporates offering strategies from non-existent organizations, neglecting to submit premiums and stirring arrangements to make more commissions. Purchaser extortion incorporates overstated cases, distorted medicinal history, post-dated strategies, faked demise or hijacking, murder and significantly more. Protection extortion, otherwise called claims extortion is a criminal demonstration including getting monetary profit from safety net provider or guaranteed utilizing distortion of realities or affectations" (Derrig, 2002).

"Insurance fraud undermines the relationship amongst guarantors and policyholders since it drains the reserve pooled from the guaranteed" (Yusuf, 2009). As per the Association of Kenya Insurers (AKI), "protection extortion has added to the fall of 10 insurance agencies inside the previous two decades and costs the protection business KES 4 billion".

Ernst and Young (2011) embraced a review on Insurance fraud with a specific end goal to decide the protection misrepresentation situation, potential hazard it stances and its potential monetary effect and additionally industry hones intended to counter misrepresentation chance. The review discovered claims or surrender-related extortion containing the most noteworthy rate took after by premium redirection by middle people and representative related fakes.

Insurance fraud increases the cost of insurance to buyers. Companies hard hit by fraud end up losing business to their more efficient competitors. Insurance fraud has serious financial implications on insurers by threatening their viability and as a result compromising their profitability. The report acknowledged the fact that though fraud has a significant negative effect on insurance companies, fraud incidents are often under-reported. Nevertheless, fraud incidents have been on the increase over the years. Health/Medical insurance is the most affected by fraud due to overstating of claims or document manipulation by policyholders and health providers. Okura (2013) carried out a study on the relationship between good peril and insurance.

2.7 Summary of Empirical Studies and Knowledge Gaps

No.	Study	Study Focus	Methodology	Main Findings	Knowledge Gap	Focus of the Current Study
1.	Tajudeen Olalekan Yussuf and Sunday Stephen Ajemunigbohun	Effectiveness, Efficiency and Promptness of claims handling	Survey	Promptness in claims management improves customer satisfaction	Factors that influence promptness in claims settlement	Fraud as an influencing factor in claims settlement
2.	Sharon Tebbyson and Pau SSalsas-Forn	"Fraud detection and deterrence objectives"	Survey	"Use of audit in the state of Massachusetts for both deterrence and detection of insurance fraud"	Other alternative fraud management strategies	Fraud management strategies
3.	KPMG	East African Insurance Landscape. Challenges and Opp	Survey	Fraud is indeed significant financial, strategic and operational risk to the sustainability of the insurance sector and is on the increase.	Other alternative fraud management strategies	Alternative fraud management strategies
5.	Kiana Mercy Wairimu	Challenges in Management of General Insurance Claims in Kenya	Survey	1. Weak underwriting standards 2. High level of fraud	1. Causes of insurance fraud 2. Strategies used to fight fraud	Specific causes of insurance fraud high claims ratio

SOURCE: Researcher 2016

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The chapter outlines the methodology the researcher used in conducting this study including the research design, the target population, sample sizes and sample procedures, instruments for data collection and techniques for analyzing the data.

3.2 Research Design

“Research design is a plan of the strategies and procedures to be embraced for gathering and investigation of the information required in getting answers to research question ” (Kothari, 2004). This study adopted the cross-sectional descriptive research design to assess the state of preparedness of the insurance industry in Kenya to manage insurance fraud. According to McBurney and White (2009), (2009), “descriptive research design describes the state of affairs as they appear on the ground”. The design identifies every phenomenon in relation to what, when, who and how it appears in the study (Sekaran & Bougie, 2009). The approach is also efficient in administration (Mugenda & Mugenda, 2003) given that the time and financial resource constraints. The design enhances validity, reliability and generalizability of the research findings and involves quantitative and qualitative collection and analysis of data.

3.3 Population of Study

There are fifty one direct insurance underwriters and three reinsurance companies in Kenya making a total of fifty four companies. Of the 51 direct underwriters, twenty five are short term or general underwriters, sixteen are long term or life underwriters while ten

are composites or companies transacting both life and general classes of business. The researcher will also collect data from the Insurance Regulatory Authority (IRA) and Insurance Fraud Investigation Unit, (IFIU).

3.4 Data Collection

The researcher conducted the survey using both primary and secondary data through descriptive survey design. However, due to the unresponsiveness and lack of cooperation of some insurers, the researcher had to conduct research on the 25 cooperating insurers. Still the 25 insisted on personalized administration of the quest. The researcher resorted to use of interview guides. The interview guides contained open-ended questions. Secondary data was obtained from company magazines, newsletters and manuals, past research, AKI annual reports, IRA annual report and other sources of data relevant for the study.

Standard introduction letters were sent to all insurance companies seeking permission for the study. Primary data was collected to address the project specific questions while secondary data such as reports, magazines and newsletters were relied upon to corroborate the primary data.

3.5 Data Analysis

The researcher coded the collected data and entered the same in the computer and it using descriptively using descriptive statistics. Descriptive data analysis involved inspecting, cleaning, transforming, and modeling data with the goal of discovering useful information, suggesting conclusions, and supporting decision making.

Analyzing descriptive statistics helped generate mean, median, mode, frequencies, percentages, variance and standard deviation vital in interpreting the research questions and achieving research objectives. Data was summarized using a combination of tables, graphs and charts) and the results discussed.

CHAPTER FOUR

DATA ANALYSIS, FINDINGS, PRESENTATIONS AND DISCUSSION OF RESULTS

4.1 Introduction

Chapter four presents analysis of data, the findings, presentations and discussion of results with regard to the objectives of the study. The objective of this research was to do an evaluation of the effectiveness of fraud management strategies adopted by insurance companies in Kenya. The data was collected from 25 insurance companies, the Insurance Regulatory Authority and the Insurance Fraud Investigation Unit. The respondents were senior executive staff at the Risk management level, underwriting and claims management levels. The findings are presented in percentages and frequency distributions and interpretations made out of the graphs and pier charts drawn.

4.2 Profiles of the respondents

The researcher targeted both claims and risk mitigation departments with a response rate of 87%. Of the respondents, 17 were female while only 8 were male. This translated to 68% female respondents and 32% male respondents. The study established that more women than men are ascending to management positions in the insurance industry.

Table 1

EMPLOYEES		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	FEMALE	17	68.0	68.0	68.0
	MALE	8	32.0	32.0	32.0
	Total	25	100.0	100.0	100.0

Source: Field Data

Table 1 Distribution of respondents by gender

Table 2

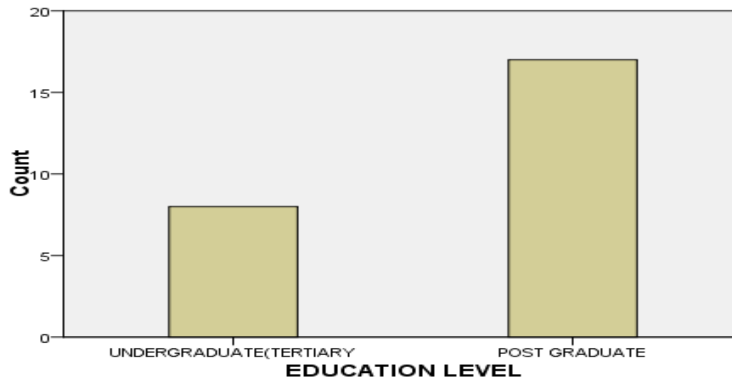
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	BELOW 30 YEARS	8	32.0	32.0	32.0
	31 to 40 YEARS	13	52.0	52.0	84.0
	41 to 50 YEARS	3	12.0	12.0	96.0
	Above 50 YEARS	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Source: Field Data

Table 2 Age brackets of respondents

Out of the 25 respondents, 52% were from between the ages of 31 to 40 an indication that young people are on the lead. This is clearly indicated in figure 1above. The findings revealed that a good number of the respondents have post graduate degrees compared to those with undergraduate or tertiary levels of education.

Figure 1



Source: Field Data

Figure 1 Academic qualifications of respondents

Majority of the employees at management level are holders of post graduate degrees compared to managers with undergraduate degrees and lower.

Table 3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LESS THAN 5 YEARS	10	40.0	40.0	40.0
	5 to 8 YEARS	8	32.0	32.0	72.0
	9 to 12 YEARS	1	4.0	4.0	76.0
	13 to 15 YEARS	3	12.0	12.0	88.0
	Above 15 YEARS	3	12.0	12.0	100.0

Source: Field Data

Table 3 Work experience of the respondents

The numbers of years the respondents have served their current employers vary from 5 to over 15 years. Specifically, majority (40%) of the respondents had worked in their

respective organizations for less than 5 years, 32% had worked for 5 to 8 years and the rest 12% had worked for over 13 years and above. This shows that there is high mobility of employees within the insurance industry. This movement implies that there is little difference in expertise between one organization and the other as employees find it easy to move on in so long as they are capable of earning more money from the next employer. In addition, it implies that companies are not keen on investing on long term development of employees but instead keep poaching from each other. This trend impacts negatively on the level of expertise acquired by employees which is another reason most of the existing employees have not developed deeper understanding of the operational aspects of their organizations and are less capable of establishing and sealing fraud loopholes within the industry.

This movement implies that employees take less time to settle in one organization and as a result taking less time and interest in learning and understanding the systems of their employers something that can assist in curbing system flaws. The findings also imply that insurance companies are not keen on investing in long term development of their employees. They instead resort to poaching from each other whenever they need specialist skills. Following this high mobility, there is some likelihood that the same employees could be responsible for the high rate of fraud in the industry as they can easily expose their former employers particularly when their exit was unceremonious.

4.3 The Role of company management in combating insurance fraud

The Claims Department receive and register claims. Before a claim is admitted and payment made, it has to go through a series of manual and electronic processes of receiving and processing. Processing claims involve thorough verification of the claims information against the company database as contained in the policy files and the proposal forms. If well performed, this process unveils either compliance upon which a claim is admitted and settled or a number of inconsistencies which lead to step two involving investigation.

The study established that upon isolation of inconsistencies, some companies conduct investigation to validate the findings. Some, straightaway decline payment and refrain from involving investigators and possible prosecution. If the cases involve internal staff, most insurance companies often reprimand or dismiss the staff and lay the matter to rest only for the criminal to find him/herself placement in another insurer. This goes against the Regulators guideline on fit and proper requirements. Because the regulator will have no basis of approving the criminal as a manager in another company, the criminal will enjoy the opportunity of perpetrating the heinous behavior as long as they wish.

Decision to investigate suspected claims are informed by among others inconsistency in claims information, defaced documents supporting the claim, submission of fake documents and contradictory statements. Other signs include high frequency of claims from one quarter, perfect claims documentation, attempts to bribe, too much pressure for settlement, high value claims settled by third parties for reimbursement etc.

Whereas 30% of the claims staff stated that they report to the General Manager, an equal number 30% report to Claims Manager and about 20% were not sure whom they report to as they report to either the General, Claims or other managers. Some thresholds require permission of the CEO or even board committees. Reporting to different managers and seeking authority to settle claims is safeguard against staff-fraudster conspiracy.

The Claims Department staff also perform end of the year review in order to ascertain whether there are areas of strength to maximize on as well as areas of weaknesses to improve upon. The review findings are escalated and discussed at management and board committee levels with the overarching goal of charting the way forward. Still, not much progress towards fraud mitigation has been achieved.

Table 4

		N	Marginal Percentage
REPORTING STRUCTURE OF FRAUDULENT CLAIMS	GENERAL/CHIEF CLAIM MANAGERS REPORT TO CEO AND MD	17	60.0%
	GENERAL MANAGERS REPORT TO CHIEF CLAIM MANAGER	4	20.0%
	OTHERS	3	6.0%
	NO RESPONSE	1	4.0%
Valid		25	100.0%
Missing		0	
Total		25	
Subpopulation		1	

Source: Field Data

Table 4 Reporting structure for staff of Departments

4.4 Role of Information Communication Technology in Fraud Management

Information Communication Technology (ICT) and Biometric data management are quite key in mitigating fraud losses. Biometric technology is used to isolate qualitative risks. These gadgets identify the moral hazard in persons by comparing people fingerprints, palms and facial attributes with similar data extracted earlier and stored in company databases.

Almost 97% of the respondents concurred that ICT should play a critical role in claims management. However, the same group raised concerns that the framework of the ICT infrastructure in Kenya's insurance industry is not capable of detecting, isolating and preventing internal or external insurance fraud.

Minimal application of information technology in the insurance industry in Kenya is disturbing given the significant investment most insurance companies have made in information technology in the recent years. While the IT infrastructure is there, what is lacking is simply sourcing appropriate software and employing highly qualified and experienced staff that is well remunerated to handle fraud. Some insurance companies that have already established internal fraud units and are doing fairly well in combating fraud. Those with risk management divisions that handle fraudulent cases are also doing quite well.

4.5 Fraud management process

Before a claim is admitted and payment made, it has to go through manual and electronic process of receiving and processing. Processing involves thorough verification of the reports against the company contained in the policy files and the proposal forms. If well performed, this process exposes a number of fraudulent activities.

Upon exposure of fraudulent cases, some companies order investigation to validate the findings. Some, straightaway decline payment and refrain from involving investigators and possible prosecution. If the cases involve internal staff, the staff is often dismissed and the matter laid to rest only for the criminal to find him/herself placement in another insurer.

Investigations are informed by among others inconsistency in claims information, defaced documents supporting the claim, submission of fake documents and contradictory statements. Tables 3, 4 and 5 illustrate the options open to insurers seeking to deal with suspected fraudulent cases.

Table 5

		n	**marginal percentage**
Establishment of fraudulent claims	Through investigations	17	68.0%
	Contradictory documentation	2	8.0%
	Pushing for payment	2	8.0%
	Others	1	4.0%
	No response	1	4.0%
	Not applicable	2	8.0%

Source: Field Data

Table 5 How various insurance companies establish fraudulent claims

Table 6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	REJECT	21	84.0	84.0	84.0
	REPORT TO AUTHORITIES	2	8.0	8.0	92.0
	PROSECUTE	1	4.0	4.0	96.0
	NO RESPONSE	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Source: Field Data

Table 6 Options open to insurance companies upon establishment of fraudulent claims

The study established that most insurers prefer rejecting suspected fraudulent claims but most preferably settling them out of court. A number of options are open to insurers whenever they come across a suspected fraud.

Some of the options include:

4.6 Role of Internal and external audit in fraud management

Both internal and external auditors play a third level function with the board and senior management playing second level role while internal control systems play the last role. The auditors provide assurance to management that the control functions are appropriate and are working. Their role is to point out weaknesses in the systems and recommend courses of action to be taken. In addition, the auditors assist in investigating and pointing out gaps in operational systems that may create room for fraud.

While internal auditors perform continuous surveillance functions, external auditors perform annual audit to ensure that internal control systems are effective, efficient and

adequate. External auditors prepare post audit management letters where they point out specific system weaknesses they observe during audit and set timelines within which management have to effect adjustments. Despite the study establishing that both internal and external auditors perform their functions as expected in the companies surveyed, their effort has not helped in combating insurance fraud. This is partly because management rarely implements their recommendations. As well they rarely follow these recommendations to ensure compliance.

4.7 Different classes of business exposed to insurance fraud

The study sought to establish the specific classes of business negatively impacted by insurance fraud. The findings shall aid the Authorities and industry players to focus more fraud mitigation resources in these classes thus achieving more value.

Table 7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Motor Vehicle Insurance(General Insurance)	9	36.0	36.0	36.0
	Medical Insurance	8	32.0	32.0	68.0
	Personal Accident	2	8.0	8.0	76.0
	Others	2	8.0	8.0	84.0
	No Response	2	8.0	8.0	92.0
	Not Applicable	2	8.0	8.0	100.0
	Total	25	100.0	100.0	

Source: Field Data

Table 7 Classes of insurance business affected by insurance fraud

The study established that 36% of the respondents believe that motor vehicle insurance is more exposed to fraud followed closely by Medical Insurance at 32%. Other insurance products prone to fraud are Personal Accident at 8%, Micro Insurance and Group Life at 8%. Respondents expressed concern that personal insurance business is more exposed to insurance fraud compared to commercial insurance due to moral hazard. This is more evident in Theft, Motor and Medical insurance. For example, when a patient attends hospital, payments of bills are pegged on whether one is paying cash or via insurance with the latter attracting almost double rates. The same practice is common with motor garages.

4.8 Effectiveness of Fraud Management Strategies Employed by Kenyan Insurers

Fraud within the insurance industry is making a serious dent on the potential growth of the industry and weakening the industry stability. Table 4.8 shows how fraud impacts insurance business.

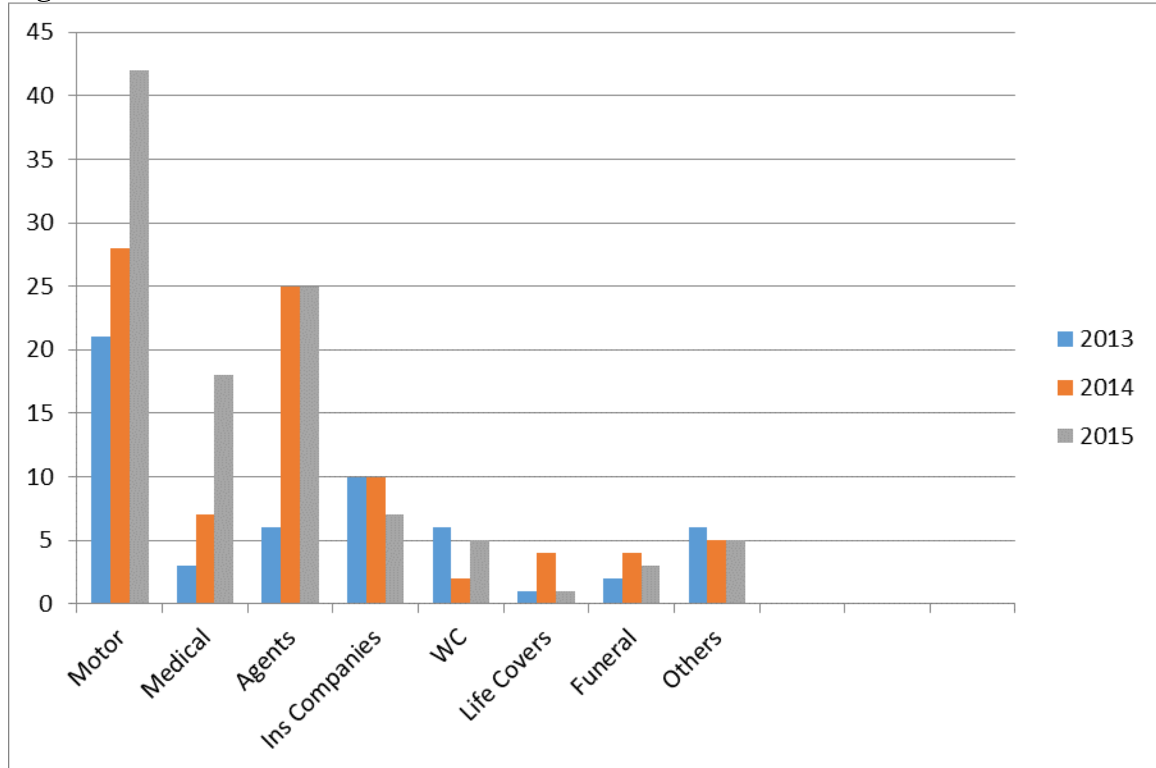
Table 8

Classifications	Nature of fraud	2013	2014	2015
Motor	Injury claims/Forged Certificates/Damage & Theft claims	21	28	42
Medical	Fraudulent Claims	3	7	18
Agents	Theft by agents/Commission fraud	6	25	25
Company Employees	Theft by employees	10	10	7
Workmen's Compensation	Fraudulent WCA Claims	6	6	0
Life Covers	Fraudulent Life Claims	1	4	5
Funeral Expenses	Fraudulent Funeral Claims	2	4	1
Others	Personal Accident/Policyholder/Advocates etc.	6	5	8

Source: Field Data

Table 8 How fraud impacts insurance business

Figure 2



Source: Field Data

Figure 2 How fraud impacts insurance business

Table 4.8 and figure 4.2 illustrates data from IFIU which demonstrate that by the end of 2015, insurance fraud in Motor and Medical classes of business have been growing at double digit rates since 2013. Fraud by insurance agents also quadrupled between 2013 and 2014. Fraud committed by company employees remained unchanged and declined marginally in 2015 confirming the impact of IFIU in frustrating employee efforts.

Generally, the impact of fraud on the insurance industry is quite high given that Motor is the largest class of insurance business followed closely by Medical. According to IFIU, fraud committed by insurance agents has been growing at very high rates. It is important

to note that the numbers presented in these diagrams and graphs represent a very small proportion of the actual figures on the ground. This is because fraud detection strategies in Kenya are very young and less effective to the extent that over 90% of the cases still go undetected. The real impact is in billions of Kenya Shillings.

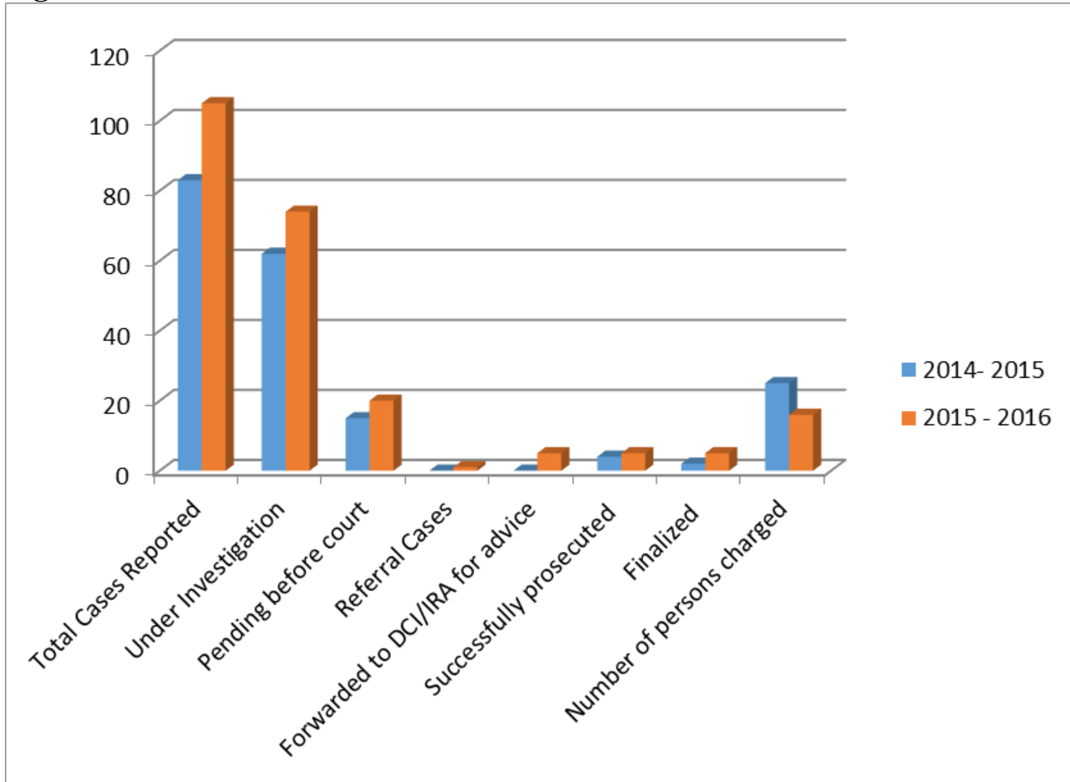
Table 9

No.	**DESCRIPTION**	**1ST July 2014-30TH June 2015**	**1ST July 2015- 31ST March 2016**
1	Total Cases Reported	83	105
2	Pending Under Investigation	62	74
3	Cases pending before court	15	20
4	Referral Cases	0	1
5	Forwarded to Authorities for advice	0	5
6	Successfully prosecuted in court	4	5
7	Cases finalized and complainants advised	2	5
8	Number persons charged in court.	25	16

Source: Field Data

Table 9 Comparison of Investigation status between FY 2014/2015 and FY 2015/2016

Figure 3



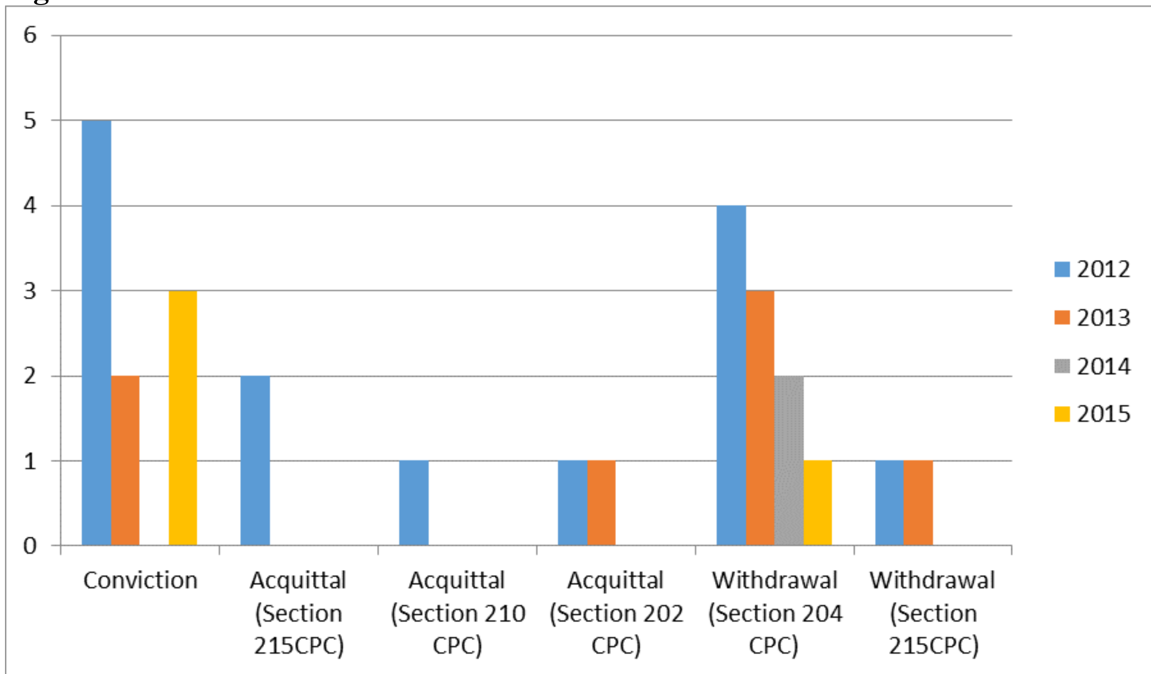
Source: Field Data

Figure 3 Comparison of Investigation status between FY 2014/2015 and FY 2015/2016

The number of cases reported, investigated and taken to court increased between 2014/2015 and 2015/2016 financial years. However, the number of cases referred, forwarded to DCI/IRA for advice, successfully prosecuted and finalized went down. This means that despite the high number of cases reported, only a few get finalized successfully. At the same time, the rate of resolution of reported fraudulent claims has been declining signifying that we are not winning the war against fraud.

Again, it is important to note that the numbers reported above are highly conservative given that over 90% of claims go unnoticed and if noticed, majority are concluded at company level and never reported to the authorities for follow up.

Figure4



Source: Field Data

Figure 4 Disposal of cases presented before court

<u>Key;</u>

1. ***Conviction***: The state of being found and proven guilty as charged.
2. ***Acquittal***: When a case is terminated by court due to various reasons, including lack of adequate evidence.
3. ***Withdrawal***: When the plaintiff (the party who initiates a lawsuit) appears before court and requests that the case be terminated following an out of court settlement.

4. ***CPC***: Criminal Procedure Code.

Respondents in this study have raised issues regarding the effectiveness of IFIU since inception. The issues thus raised are clearly illustrated in figure 6 above. IFIU was

established in 2011. Figure 6 above illustrates that in 2012, when IFIU was closing its first year since establishment, the number of convictions (sentencing) of insurance fraudsters was at its highest. The number of acquittals for lack of adequate evidence was equally high. It can be argued that the number of acquittals were high because the IFIU team was less experienced and was still on the learning curve.

In 2013, the number of the number of convictions went down drastically. However, the number of acquittals dropped significantly signifying improvement in the teams' experience in conducting investigations. In contrast, the number of withdrawals shot up sharply. The high rate of withdrawal of fraudulent cases by insurance companies following out of court settlements with suspected fraudsters is evidence enough that either their fraud management strategies are not effective occasioning the withdrawals for fear of judgment being passed against them or their unwillingness to pursue suspected fraudulent cases to conclusion.

This unwillingness influenced the work of IFIU in 2014 when no convictions were preferred; no acquittals made; all the cases investigated by IFIU were withdrawn by insurance companies under Section 204 of the Criminal Procedure Code. The immediate reaction by the Authority and the Kenya Police Service was the transfer of most of the IFIU officers back to the service.

Out of the 25 respondents, 44% reported having negative attitude towards court battles with clients. This is because many have lost hope with Kenyan courts since they take too long to conclusively handle insurance fraud cases. Only about 12% were positive about

taking fraud cases to court saying they look at it as a last option. However 70% seem to prefer handling fraud cases out of court since it is much cheaper and more convenient to both parties.

Table 10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NEGATIVE ATTITUDE	11	44.0	44.0	44.0
	POSITIVE ATTITUDE	3	12.0	12.0	56.0
	4	2	8.0	8.0	64.0
	NO RESPONSE	5	20.0	20.0	84.0
	NOT APPLICABLE	4	16.0	16.0	100.0
	Total	25	100.0	100.0	

Source: Field Data

Table 10 Insurers' attitude towards court battles with clients

This is an avenue to fraudsters to perpetuate fraud since they know that the chances of them being taken to court should they be discovered is slim. At the same time, they know that court cases take so long to conclude. Thirdly, they know that whatever penalties and fines that may be preferred are lenient and much lower than the benefits they are likely to get from fraud. These are loopholes that need to be sealed.

4.9 Is IRA doing enough in combating Insurance fraud in Kenya?

Table 11

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	13	52.0	52.0	52.0
	NO	11	44.0	44.0	96.0
	88	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Source: Field Data

Table 11 How the respondents perceive the role of IRA in fraud management

Asked what they felt about the role of IRA in combating fraud, 52% of the respondents felt that the Authority is taking steps towards combat insurance fraud. However, the respondents argue that the Authority still needs to do more if they expect industry perception towards it to improve. They argue that the Authority's consumer protection department insists on fast claims settlement which is counterproductive on fraud. Given that fraudsters prefers faster conclusion of their activities, such haste works to their advantage.

The Regulator is also watering down the legal content of insurance policies which was initially designed to protect insurance contracts. By simplifying insurance contracts in the spirit of simplicity of understanding, the end result is that it becomes increasingly difficult to defend fraudulent cases in court with less legal fabric.

The respondents also complained that staff of insurance companies and some intermediaries who have been implicated in fraudulent activities still end up operating in the industry with the approval of the regulator. They cited a number of cases where they have thrown out employees and intermediaries and reported the same to the Authority yet the officers still find themselves in the industry through disguise.

4.10 Role of IFIU in combating insurance fraud

The Insurance Fraud Investigation Unit (IFIU) is a unit of the Directorate of Criminal Investigation (DCI), a service of the National Police Service. Other services are the

Kenya Police Service (APS) and Administration Police Service (APS). Of the 52 respondents interviewed, 52% felt that IFIU has brought some improvement in the insurance industry, see Figure 11 below. As more members of the public and the fraud cartels learning about IFIU role in fraud investigation and prosecution as well as publication of cases they have so far unearthed, the magnitude of fraud commission is slowing.

However, some factors inhibit the effectiveness of IFIU in the fight against insurance fraud. These include the increasingly high number of cases being submitted to IFIU, the limited number of IFIU officers (11 in number) who perform investigations, prosecution as well as administrative work has slowed down its effectiveness on the ground. As a result, it is taking increasingly longer periods to have fraudulent cases referred to IFIU concluded. Others complained that IFIU, as a body, still favor policyholders and their beneficiaries and tend to ignore the concerns raised by industry members.

Table 12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	13	52.0	52.0	52.0
	NO	8	32.0	32.0	84.0
	88	3	12.0	12.0	96.0
	99	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Source: Field Data

Table 12 How respondents perceive the role of IFIU in fraud management

4.11 Do you report suspected fraud cases to IFIU

Figure 12 below shows that 40% of the respondents agree to say that yes report suspected fraudulent activities immediately to IFIU. However 28% of the respondents feel that IFIU has not done much on the ground to bring to book a good number of the reported fraudsters.

Table 13

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	10	40.0	40.0	40.0
	NO	7	28.0	28.0	68.0
	88	7	28.0	28.0	96.0
	99	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Source: Field Data

Table 13 Number of respondents reporting suspected fraud to IFIU

4.12 Discussion of Results

4.12.1 Introduction

The purpose of this study was to evaluate the effectiveness of fraud management strategies adopted by insurance companies in Kenya. The first study objective was to identify the existing fraud management strategies used by Kenyan companies to combat insurance fraud. The second objective was to assess the effectiveness the strategies in combating insurance fraud. Third was to establish whether Kenyan insurance companies

are willing to re-examine the existing strategies should it come out that they are not effective.

Effective fraud management strategy should ideally have four phases including: Assessing Risks; Designing Programs (Controls to prevent, detect and respond); Implement the new controls and Evaluate and Assess existing controls including internal control protocols or due diligence practices. “Effective business-driven fraud risk management approach encompasses controls that have three objectives. Prevent, Detect and Respond” (KPMG, 2006).

Generally, the study observed the following;

1. Unwillingness by insurers to investigate and where possible, prosecute suspected fraudulent cases ranks high and instead opting to reject or settle such cases out of court. The high rate at which insurance companies seek withdraw fraudulent cases submitted by IFIU to courts.
2. Reluctance to compute and publish fraud statistics to enable the Government understand the magnitude of the problem.
3. Reluctance to publicize the list of staff, intermediaries and members of the public involved in fraud or attempted fraud.
4. Reluctance by insurance companies to share client information as a way of narrowing down on the fraudsters. This is so despite spirited efforts by their very Association of Kenya Insurance to facilitate the process. Their defiance is despite the success of the banking sector in reducing perennial loan defaulters through sharing of information.

Regarding the effectiveness of existing fraud management strategies, the study concludes that the existing strategies are ineffective based on the growth trend fraud has adopted. That fraudsters are increasingly outsmarting existing strategies thus posing great danger to the future performance and overall stability of Kenya's insurance industry. Failure to continually monitor and enhance their existing fraud management strategies including internal and external audit functions and board committees. Failure to implement recommendations made by internal and external auditors.

The researcher's null hypothesis that Kenya's insurance companies are not willing to combat insurance fraud is therefore supported by the research findings.

4.12.2 Identification of the existing fraud management strategies used by insurers

The study established that Kenyan insurance companies have put in place a number of strategies to combat insurance fraud. Most of these strategies are centered on internal control systems such as board and management committees, IT systems, underwriting and claims procedures and manuals, job descriptions (responsibility & accountability), risk management function, compliance function, actuarial function, investigation, internal and external audit functions. The study established that most insurers rely on management to formulate and implement appropriate internal control mechanisms for use in mitigating insurance fraud.

Internal Controls can be described as effective when they are capable of identifying scenarios in which theft or loss could occur and determining if existing control mechanisms are capable of effectively managing risks to acceptable levels. Companies should also consider as a key area of focus in fraud risk assessment the risk that senior

management might override important financial controls and manipulate financial reporting. Sound internal control systems should be capable of identifying and measuring specific risks that expose the organization to losses. It is when exposure to losses have been identified and evaluated that organizations will consider themselves capable of countering and, wherever possible, mitigating, deterring and preventing the incidences of fraud in the future.

The strategy should also involve a response action plan with clear procedures on how to address controls deficiencies. Fraud reporting, prosecution, continuous investigation and assessment are key to managing fraud. Formulation and implementation of appropriate policies should be part of preparedness to respond. The response plan should also outline the activities and the personnel responsible for specific response activities. At regulatory level it should include relevant legislation capable of addressing civil and criminal acts against institutions. The strategy should be designed to inculcate anti-fraud culture within organizations as well as to promote and educate all stakeholders about an organization's culture on fraud. The fraud prevention strategy and implementation plan should ideally be developed using the bottom-up approach in order to guarantee buy-ins.

Strategy is defined by Scholes & Johnson (1993) as the direction and scope an organization uses to meet the needs of its stockholders. Strategic management is also defined as the set of decisions and actions that results in the formulation and implementation of plans to achieve a company's objectives (Pearson & Robinson, 2007). An organization's strategy is an important element of its management process (Aosa, 1992). Ansoff (1980) noted that the environment is constantly changing making it

imperative for organizations to continuously adapt their activities to succeed. Because environment is important, organizations have to respond to its dynamism, heterogeneity, instability and uncertainty (Thompson, 2005). Such enterprises must continuously adapt to the environment in order to assure themselves of survival (Porter, 1980; Aosa, 1997; Pearce & Robinson, 1997. Hamel & Prahalad, (1999) wrote that "Destiny is not a matter of choice.

The threat of fraud to insurance companies emanate from both their internal and external environments. Fraud is one of the causes of the collapse of many insurance companies in Kenya. Mwangi (2013) reasoned that Kenyan insurance companies have undergone very tough times incurring huge payouts in form of claims, a significant proportion of which is fraudulent. In a study on the "Response strategies to fraud-related challenges by Barclays Bank of Kenya", Cheptumo (2014) recommended reforms in the police and judiciary, review of fraud legislation, review of features of security documents including the National ID, Driving licenses, passports & Title deeds, constant monitoring of staff, employee screening and staff account management, among others.

Three theories have been identified to anchor this study. The theories include the Fraud Management Life Cycle, the Nash Equilibrium Theory and the Resource based theory.

Fraud management strategy outlines a high level plan on how Institutions should go about implementing fraud prevention policy. The strategy forms the most important part of the fraud prevention plan therefore it must be uncomplicated and practical. Operational governance in the form of clear policies and procedures reduces incidences of fraud (Hansen, 2009). Every institution should create and maintain a fraud policy for guiding

employees (Biestaker, Brody, & Pacini, 2006). Biestaker (2009) states that the board of directors is responsible for the development of anti-fraud policy. As organizations strive to achieve compliance with an array of new anti-fraud laws and regulations, board and management agenda should focus on understanding the fraud risks undermining business objectives, determining whether anti-fraud control programs are effective in reducing fraud instances, gaining instances on better ways of designing and evaluating controls to deter, detect and respond appropriately to fraud and misconduct and achieve the highest levels of business integrity through sound corporate governance, internal control and transparency.

Despite the existence of internal control mechanisms within the insurance companies studied, growth in insurance fraud continues unabated implying that either the strategies are inadequate or the level of enforcement of the strategies is weak enabling fraudsters to penetrate and override them. It is high time Kenya's insurance industry revisited its existing fraud management strategies, reviewing their effectiveness and borrowing a leaf from other sectors, like banking, that have made some inroads in the war against fraud. Kenya's banking sector has made some significant progress in combating fraud with some positive results. The industry may even borrow from other jurisdictions like the US that uses audit as a key arsenal against fraudsters.

4.12.3 Assessment of the effectiveness of fraud management strategies

At the establishment level, most insurance companies formulate and implement appropriate policies, strategies, processes and procedures that they believe are capable of running their businesses effectively and efficiently. However, as time ticks by,

developments in the environment supersede the existing control systems thereby exposing the company to unexpected threats and resultant losses unless emergency remedial actions are taken.

A report by IFIU indicates that insurance fraud has been on the increase in Kenya's insurance industry over the years. The IFIU report demonstrates that the impact of insurance fraud on the industry is quite high given that the two largest classes of business, Motor and Medical are the most highly targeted by fraudsters. According to IFIU, fraud committed by the Insurance Agents has been increasing at unprecedented levels. This is an element of great concern to policymakers within the industry and to Government and its agencies. It should, however, be noted that the figures generated by IFIU represent only a small proportion of fraud committed on the ground reason being that very few cases of suspected fraud are reported to the Authorities leaving out huge unreported cases. In actual sense, over 90% of suspected fraudulent cases still go undetected and unreported.

Insurance business, by its very nature, is susceptible to fraud by generating large steady flow of cash through insurance premiums and reserves. Steady cash flow is an important economic resource that is very attractive and easily diverted. Large accumulations of liquid assets make insurance companies attractive for fraud and loot schemes.

The result of an industry porous to fraud is disastrous. Insurance fraud undermines the relationship between underwriters and policyholders since it depletes the fund pooled from the insured (Yusuf, 2009). Opiyo (2013) argued that fraud is a serious business risk which poses a very big challenge to the insurance sector as losses caused by fraudulent

activities affect the growth of the insurance industry. Kenya Insurance Industry Outlook (2013) stated that claims settlement was difficult in terms of volumes, claimant's pressure and fraud which led to increased loss ratio. Fraud has had far reaching consequences to the Kenyan economy in particular and the world in general (Irungu, 2012). Fraud is a significant and costly problem for both policy holders and insurance companies in the insurance sector (Sybase, 2012). Despite the grim picture, sophistication and volume of fraudulent claims, fraud continues to increase yet insurers are not upping their game in combating it with the public being the ultimate sufferers. Both internal and external fraud present a substantial cost to our economy worldwide (Jans, 2010). PwC (2009) further indicated that fraud raised from position 23 in global ranking in the 2009 risk survey to position 4 in the East Africa survey, which shows fraud is significantly affecting the industry.

To borrow a leaf from the banking sector is a PwC Report which stated that while the CBK (2010) survey showed that 95% of respondents have an independent risk management function, one is forced to question their effectiveness when it comes out, according to PwC Kenya, that banks lost approximately KES 761 million to fraud in the six-month period, January to June 2010 and a staggering 1.7 billion KES in the three months August to October 2010. To emphasize the magnitude of fraud in the banking sector, Nyamu (2012) argued that East African banks have lost approximately Sh4.06 billion since 2011 due to fraud but the figure could be significantly understated due to the high number of unreported fraud cases. The case could be worse in the insurance industry given that the banking sector have more effective fraud management strategies and its

anti-fraud watchdog, Kenya Depositors Insurance Corporation has stronger remedial strategies.

This study confirms the researcher's null hypothesis that insurance companies are not willing to act on fraud giving leeway to fraudsters to raid the industry with impunity. The industry borrows its decision not to act on fraud from the Nash Equilibrium or the Game theory. According to the Game theory, by Nash, insurers look at the cost of a claim on one hand, the cost of investigating a claims with the intention of reducing the ultimate cash outflows.

Claims presented to an insurance company may include a variety of different components. One is valid expenses that should be paid in full by the insurer. Next is an excessive/un-reasonable charge on a claim that would ordinarily be covered. The proof of un-reasonability can only be defined and determined through negotiation, arbitration and if necessary litigation. Third component could be a claim on a service not covered under the policy. Fourth component is a claim on an incident not covered by the policy.

Under the Nash Equilibrium Theory, the insurer will compare the cost of a claim without any investigation, the likelihood of any savings should investigations be conducted, the level of investigation and cost investigation and then make a decision whether to investigate or not. The optimal level of investigation is determined when the slopes of the cost of investigation equals the savings from investigation.

The study established that insurers also rely on the Resource Based theory by focusing on maximizing the bottom-line rather than focusing on activities that would compromise the very bottom-line.

The study findings disapprove the notion by insurers that avoiding investigations and prosecutions protect their bottom-line. The study established that while the number of fraudulent incidences are on the increase, the amounts lost per incident is becoming larger day by day thus compromising the liquidity, performance, stability and going concern of insurance companies.

Kenya Insurance Industry Outlook, 92013) stated that “claims settlement was difficult in terms of volumes, claimant’s pressure and fraud leading to increased loss ratio”. “Fraud has had far reaching consequences to the Kenyan economy” (Irungu, 2012). “Fraud is a significant and costly problem for both policy holders and insurance companies” (Sybase, 2012). “Both internal and external fraud present a substantial cost to our economy” (Jans, 2010).” Fraud rose from position 23 in global ranking in the 2009 risk survey to position 4 in the East Africa survey” PwC (2009).

4.12.4 Evaluate willingness of insurance companies to re-examine the existing strategies

The findings indicate that insurance companies are not willing to change their strategies despite strong indications that fraud is having a negative impact on their bottom-line. This argument is supported by reluctance by insurers to investigate and prosecute fraudsters as a deterrent. Secondly, insurers are reluctant to compute and publish fraud statistics to enable the Government understand the magnitude of the problem. Third is the reluctance by insurers to publicize the list of their staff, intermediaries and members of the public found involving in fraud. This approach shall send a very strong warning to the perpetrators as well as the Government agencies responsible for enforcement of law and order. Fourth pointer is that during this research study, company staff tended to be cagy

when filling the questionnaires and reserved, particularly when responding to fraud related questions.

The fifth evidence is the unwillingness of industry players to adopt and implement several industry guidelines issued by the regulator. The sixth evidence is the unwillingness of the industry to share information that would help expose fraudsters and bring sanity to the industry. The banking sector has led the way in sharing information about their clients in order to tame credit default. This has significantly lowered credit default with many defaulters rushing to repay outstanding loans the moment they are circulated to CRBs. This is the panacea to insurance fraud. Attempts by the Association of Kenya Insurers (AKI) to convince insurance companies to share information failed, partly due to misplaced fear that players would lose clients to their competitors.

The researcher performed a study on IFIU which established that the number of withdrawal of cases by insurance companies opting to settle the cases out of court was highest in 2013/2014 FY when IFIU investigations, prosecutions and convictions by courts was at its peak. This is evidence enough that either the companies' fraud management strategies are not effective or that insurers are unwilling to pursue suspected fraudulent cases to conclusion. These withdrawals adversely influenced the work of IFIU in 2014. During 2014/2015 FY, the number of cases investigated by IFIU plummeted with the few preferred to court ending up as withdrawals by insurance companies under Section 204 of the Criminal Procedure Code.

To emphasize this argument is the research by Ijeoma & Aronu, 2013 who postulates that fraud losses are frequently part of an economic externality, where one business takes

actions or refrains from acting on fraud and as a result, passing on, imposes or facilitates costs upon other businesses (Ijeoma & Aronu, 2013)".

The behaviour of insurance companies investigating insurance fraud follows the Nash Equilibrium or Game Theory where companies weigh the gains of contesting claims against the actual cost of claims. Where the gains are lower than the actual cost of claims, insurers choose to pay and ignore investigation and prosecution and vise versa. Under this arrangement, insurers look at the cost of claims, the cost of investigating a claims and the potential for reducing claims costs is developed and analysed in a game theocratic approach.

Claims presented to an insurance company may include a variety of different components. One is valid expenses that should be paid in full by the insurer. Another component could be an excessive/unreasonable charge on a claim that would ordinarily be covered. Unreason ability can only be defined and determined by negotiation, arbitration and if necessary lawsuits. A third component could be a claim on a service not covered. Fourth is a claim on an incident not covered by the insurance policy.

Lastly, the insurance industry rests on the glories of two theories used in this study. One is the the Nash Equilibrium Theory in which the insurer compares the cost of a claim without any investigation, savings should investigations be conducted, level of investigation, and cost of investigation and then makes a decision as to whether to investigate or not.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

This study objective was meant to establish the specific fraud management strategies employed by insurance companies in Kenya in the war against insurance fraud, to evaluate the effectiveness of these strategies and to come up with alternative recommendations based on empirical research findings. All these were undertaken in the spirit of steering the insurance industry to safer grounds away from fraudsters. The researcher conducted a field study using questionnaires and interviews among 25 out of Kenya's 50 insurance companies. The study was conducted among some Chief Executive Officers, Claims Managers or Senior Claims Officers, Internal Audit and ICT Managers as well as among staff of IRA and IFIU. The researcher also performed a thorough literature review targeting those who had conducted similar research. The study was premised on three theories. The Resource Based theory, Fraud Management Cycle and the Nash Equilibrium/Game Theory.

The study established that 40% of the respondents had worked with their respective organizations for less than 5 years, 32% for between 5 and 8 years and 12% for over 13 years and above. This depicts high mobility of employees implying that employees take less time to understand the systems of their employers thus weakening their ability to detect and deter fraud.

The study established that most companies shy away from investigating and prosecuting suspected fraudulent claims. Fraudster have known this weakness and are exploiting it to

their advantage. The study found out that where fraud involves staff, most insurers often reprimand or dismiss the staff and lay the matter to rest only for the criminal to find him/herself placement in another insurer and continue perpetrating the heinous behavior. They treat fraud as an economic externality.

While 97% of the respondents concurred that ICT should play a critical role in claims management, a similar number raised concerns over the capability of the existing ICT infrastructure in Kenya's insurance industry to combat insurance fraud. They argued that insurers have not invested appropriately in hardware and software to enable them deal with the fraud menace.

The study established that both internal and external auditors perform duties diligently and make appropriate recommendations on how to tighten weaknesses complete with timelines. However, their efforts have not helped in combating insurance fraud partly because management rarely implements their recommendations.

Of the 25 study respondents, 36% of believe that motor vehicle insurance followed closely by Medical Insurance at 32% are more exposed to fraud. Other prone products include Personal Accident, Micro Insurance and Group Life at 8%. Respondents pointed out that personal insurances are more exposed to insurance fraud compared to commercial insurance. For example, when one attends to hospital, payments of bills are pegged on whether one is paying cash or via insurance with the latter attracting almost double rates. The same practice is common with motor garages.

The study established that the two Government agencies responsible for enforcing market conduct, IRA and IFIU, are taking steps towards combating insurance fraud. However,

respondents still felt that the two are not doing enough. That IFIU should enhance its investigation efficiency on financial crimes in order to reduce the high number of cases dismissed by courts. That IRA should enforce the many guidelines it has issued to the industry to increase compliance if they are serious about taming insurance fraud.

5.2 Conclusion

This study concludes that strategies used by Kenyan insurance companies are not effective to combat insurance fraud. Despite their reliance on the Nash Equilibrium/Game theory and the Resource Based theory and treating fraud as an economic externality, fraud is increasing in volumes and amounts at a rate that threatens the very stability of Kenya's insurance industry, the society, businesses and the economy in general.

The conventional strategies of internal controls are either weak or not properly formulated, implemented, reviewed (monitored/evaluated/assessed/audited) and redressed.

Urgent action needs to be taken by the Government and its agencies, IRA and IFIU as well as individual insurance providers and their associations if they are serious about saving the industry from imminent collapse.

5.3 Recommendations

There is need for the Authority to conduct thorough investigation of the various industry internal control systems and assess their effectiveness in combating insurance fraud. The Authority should then seek alternative fraud management mechanisms used successfully in other jurisdictions and discuss the same with industry players. The Authority should

then recommend the agreed upon alternatives complete with timelines for implementation. Insurance companies should also re-examine their existing fraud management strategies to establish why they are not helping in the fight against fraud.

The researcher recommends the development of strong regulations in place of industry guidelines. This is because some of the industry players may perceive guidelines as having no legal basis and simply ignore them of take offense. Parliament should play a significant role in the development of appropriate regulations in place of the guidelines should the latter fail to take effect.

The Authority should also consider factoring internal control systems as part of its current Risk Based Supervision framework. Weaker internal controls should attract additional capital under the current Risk Based Capital regime. This shall serve as a rioting act to players as raising significant additional capital is not a walk in the park for industry shareholders.

The Authority should develop regulations requiring all insurance companies to compile and submit statistics on fraud to enable the Government understand the magnitude of the problem. The Authority should enforce the guidelines it has issued to the industry and strictly monitor their adoption and implementation. The Authority and AKI should revisit means of ensuring that insurance companies share data as a way of taming insurance fraud. The Authority should enhance the capacity of IFIU to effectively manage fraud cases submitted to it. Parliament should pass legislation that would give the regulator more powers to bite and tame insurance fraud in Kenya. Ansoff (1980) noted that the environment is constantly changing making it imperative for organizations to continuously adapt their activities in order to succeed.

5.4 Limitations of the study

The study was restricted within the insurance industry whose head offices are located in Nairobi. This should have made the study much easier to administer. However, given the nature of the study, the researcher met a lot of resistance from the study subjects.

When the researcher sent out introductory letters and study questionnaire to be completed and returned by the subjects, the researcher waited for a whole month without receiving any response. The researcher responded by making telephone calls to Chief Executive Officers. Still the CEOs insisted that the study had to be personally administered. They needed further assurance that the findings will not be used for any other purpose rather than for the MBA program despite the earlier assurance.

It took time to administer the study than earlier anticipated as the study subject kept rescheduling meetings and some CEOs insisting that only they can provide answers. The researcher had anticipated conducting a census but this was made impossible by these challenges.

I believe that the problems arose because the researcher works with the industry regulator, the Insurance Regulatory Authority and the companies may have suspected that this was an unofficial audit on their systems. However, the overall outcome of the audit was very encouraging.

5.5 Areas Suggested for Further Research

Following the study findings suggesting strongly that the existing industry fraud management strategies are not effective, the Authority should evaluate each of the existing insurance fraud management strategies in order to ascertain their strengths and

weaknesses. The Authority should conduct further research to establish alternative strategies used successfully in other jurisdictions with the overarching goal of enhancing the existing strategies.

All this should be done in the interest of Kenyans who are keen on using insurance as a risk management mechanism but whose efforts are frustrated by fraudsters whose sole objective is to enrich themselves out of the system weaknesses of Kenya’s Insurance industry.

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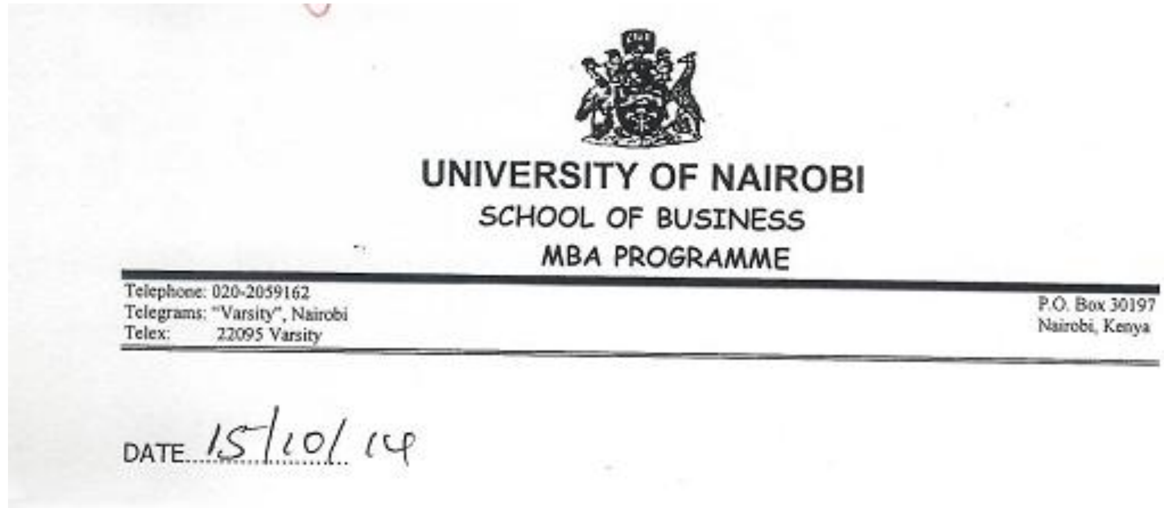
APPENDICES

APPENDIX I



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P.O. Box 30197
Nairobi, Kenya

DATE 15/10/14

TO WHOM IT MAY CONCERN

The bearer of this letter THOMAS VICTOR ODUOR ODHIAMBO

Registration No. D61/79898/2012

is a bona fide continuing student in the Master of Business Administration (MBA) degree program in this University.

He/she is required to submit as part of his/her coursework assessment a research project report on a management problem. We would like the students to do their projects on real problems affecting firms in Kenya. We would, therefore, appreciate your assistance to enable him/her collect data in your organization.

The results of the report will be used solely for academic purposes and a copy of the same will be availed to the interviewed organizations on request.

Thank you.

PATRICK NYABUTO
MBA ADMINISTRATOR
SCHOOL OF BUSINESS

APPENDIX II

Introductory letter

Dear colleagues,

I am currently an MBA (Strategic Management) student at the University of Nairobi, Department of Business Management. I am carrying out research on the effectiveness of fraud management strategies adopted by insurance companies in Kenya. Your worthy contribution to the research will help the industry find solution to this menace.

Your authentic response to the study questions will NOT be used for any other purpose other than for this noble academic objective. Kindly spare a few minutes to answer questions in this questionnaire and to respond to issues raised by the researcher.

Let me take this opportunity to thank you dearly for your time and support.

Thomas Victor Oduor

0721237365

APPENDIX III: QUESTIONNAIRE

Section A: Personal Details

Name: (Optional)……………………………………………………………

Department……………………………………………………………

Position/Title….…………………………………………………………...

Number of Years worked……………………………………………...

Main Duties………………………………………………………......

CONFIDENTIAL STATEMENT

The researcher would like to make it clear that whatever information obtained from respondents to this questionnaire will be treated as confidential and for the purpose of this research only and that the respondents are not required to disclose their identities.

Section A

1. What is your gender?

   1) Male [ ] 2) Female [ ]

2. To what age bracket do you belong?

   1) Below 30 years [ ] 2) 31-40 years [ ]

   3) 41-50 years [ ] 4) Above 50 years [ ]

3. What is your Highest Level of formal education?

   1) Primary Level [ ] 2) Secondary Level [ ]

   3) Tertiary Level [ ] 4) Graduate Level [ ]

   4) Post Graduate Level [ ]

4. Do you possess any professional qualification(s)?

   1) Yes [ ] 2) No [ ]

   If yes state ………………………………………………………………

5. For how long have you worked in the insurance industry?

   1) Less than 5 years [ ]   2) 5-8 year [ ]

   3) 9-12 years [ ]   4) 13-15 years [ ]

   5) Above 15 years [ ]

Section B: Research Questions

1. Role of Company Management in Fraud Management

   i. Does your company have a fully-fledged claims management department?

   1) Yes [ ]   2) No [ ]

   ii. To whom does the claims manager report?

   …………………………………………………………………………………

2. Development of Fraud Management Strategies

   i. Does your company have specific fraud management strategies?

   1) Yes [ ]   2) No [ ]

   ii. Who is develops the strategies?

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   …………………………………………………………………………………

   iii. How often are the strategies audited?

   …………………………………………………………………………………
   ………………………………………………………………………........................

   iv. How often are the strategies reviewed and revised?

   …………………………………………………………………………………
   ………………………………………………………………………........................

3. Fraud Management Processes

i. Does your company have in place documented (manuals/software) processes to help in detecting fraudulent claims?

1) Yes [ ] 2) No [ ]

ii. At what levels are the processes?

a. Intermediary level

b. Underwriting level

c. Claims level

d. At settlement level

iii. Have you, in the course of your duties come across suspected fraudulent claims?

1) Yes [ ] 2) No [ ]

iv. How do you establish that these are fraudulent claims?

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………………………………………………………………………………………
………………………………………………………………………………………
……………………………………………………………………………………….

v. How often do you experience such cases?

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………………………………………………………………………………………

vi. How do you treat such cases?

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………………………………………………………………………………………
………………………………………………………………………………………
……………………………………………………………………………………….

vii. Have the processes/procedures ever been reviewed and/or revised?

1) Yes [ ] 2) No [ ]

4. Role of Internal Audit in Fraud Management

i. What role does internal audit play in fraud management?

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…………………………………………………………………………………
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ii. What role does external audit play in fraud management?

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iii. Do the two audit functions unearth fraudulent cases?

1) Yes [ ] 2) No [ ]

5. Role of Intermediaries in Fraud Management

i. To what extent does your company rely on insurance Agents, Brokers, Medical Insurance Providers and other service providers (Claims Settling Agents) in claims management?

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…………………………………………………………………………………
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ii. What is the threshold they are allowed to handle?

6. Claims Handling & Information Management Systems

i. To what extent does your company use IT systems in claims management?

a. Receiving
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…………………………………………………………………………
…………………………………………………………………………

b. Processing

………………………………………………………………………
………………………………………………………………………
………………………………………………………………………

c. Storage (safety)
………………………………………………………………………
………………………………………………………………………
……………………………………………………………………….

d. Retrieval
………………………………………………………………………
………………………………………………………………………
………………………………………………………………………..

e. General claims database management
………………………………………………………………………
………………………………………………………………………
………………………………………………………………………..

ii. Do you use particular software to manage claims information?

1) Yes [ ] 2) No [ ]

iii. According to you, how reliable is this software?

1) Yes [ ] 2) No [ ]

iv. Does the software help you separate fraudulent from genuine claims?

1) Yes [ ] 2) No [ ]

v. Is your claims management IT system audited and if so how often?

1) Yes [ ] 2) No [ ]

7. Fraud Handling Thresholds

i. What is the upper limit of claims you are authorized to handle?

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……………………………………………………………………………….

ii. What is the upper limit of claims you are authorized to approve?

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iii. Who handles and approves claims beyond your limit?

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8. Impact of Fraud in your Company Performance

i. In your own opinion, to what extent do you think your company suffers from insurance fraud?

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…………………………………………………………………………………
………………………………………………………………………………….

ii. What classes of business are more exposed to insurance fraud?

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…………………………………………………………………………………
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iii. To what extent does fraud affect the performance of your company in Kenya Shillings (In Millions and above)?

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iv. Does your company quantify (Data) the amount of fraud suffered in Kenya Shillings?

1) Yes [ ] 2) No [ ]

v. Does your company report fraud losses to the auditors, AKI and IRA?

1) Yes [ ] 2) No [ ]

9. Action on suspected Fraudulent Claims

i. What action does your company take on suspected fraudulent claims? Reject/Prosecute/Report to Authorities/Simply ignore

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…………………………………………………………………………………
…………………………………………………………………………………
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ii. Does your company settle disputed claims out of court and why?

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iii. What types of disputed claims do you settle out of court?

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…………………………………………………………………………………
……………………………………………………………………………........

iv. How often does your company settle disputed claims out of court?

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………………………………………………………………………………….

v. What is your company's attitude towards court battles with clients?

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10. Industry Regulation and Fraud Management

i. Do you think the Insurance Regulatory Authority (IRA) is doing enough to combat insurance fraud?

1) Yes [ ] 2) No [ ]

If so how? ……………………………………………………………………...

…………………………………………………………………………………
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ii. Are Anti-money laundering guidelines from IRA helping combat fraud?

1) Yes [ ] 2) No [ ]

iii. How do you perceive the Claims Management Guidelines from the regulator? Are they of any help?

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iv. Has the creation of the Insurance Fraud Investigation Unit (IFIU) had an impact on the prevalence of insurance fraud? If so how? If not, why do you believe so?

1) Yes [ ] 2) No [ ]

Provide explanation

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………………………………………………………………………………
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v. Do you report suspected fraud cases to IFIU? Do they handle the cases conclusively?

1) Yes [ ] 2) No [ ]

Answer explanation

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11. The Role of IFIU in Fraud Management

vi. What role does IFIU play in combating insurance fraud in the insurance industry in Kenya?

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vii. Does IFIU perform any investigations regarding insurance fraud?

1) Yes [ ] 2) No [ ]

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…………………………………………………………………………………………
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viii. Does IFIU prepare any prosecutions of suspected insurance fraud?

1) Yes [ ] 2) No [ ]

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……………………………………………….

ix. How many cases lodged in court by IFIU end up:

a. Acquitted?
………………………………………………………………………………………
b. Withdrawn?
………………………………………………………………………………………
c. Terminated)
………………………………………………………………………………………

x. Kindly provide reasons for acquittals, withdrawals and convictions.

………

xi. Does IFIU get support from insurance companies during fraud investigations?

………

xii. Are there cases where IFIU investigation and prosecution efforts frustrated by industry players?

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12. The Role of IRA in Fraud Management

xiii. What role does IRA play in combating insurance fraud in the insurance industry in Kenya?

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…………………………………………………………………………………………

xiv. Does IRA conduct investigations regarding insurance fraud?
1) Yes [ ] 2) No [ ]

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xv. If not, who conducts investigations on fraud in the insurance industry in Kenya?

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xvi. What action do you take against industry members implicated in fraudulent activities

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…………………………………………………………………………………………
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xvii. Does IRA get support from insurance companies during fraud investigations?

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xviii. Are there cases where IRA investigation efforts frustrated by industry players?

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APPENDIX IV

LIST OF COMPANIES IDENTIFIED FOR RESEARCH

COMPOSITES	LOCATION
1. Corporate Mr. Wasike: Mobile: 0722316500	Lenana Rd. (Yaya center)
2. Geminia Mr. Lawi Kariuki/Ndegwa Mobile: 0202782000	Upper Hill
3. Kenindia Mr. Ogola Geofrey: Mobile: 0721445215	CBD
4. Takaful Mr. Omar: Mobile:	Lenana Rd (Yaya)
5. Jubilee Life/General Mr. Tumbo: Mobile: 0738120052	CBD
6. Madison/Life Maurice Maina Gorge Odera: Mobile: 0722725416	Community
7. APA General/Life Mr. James Ngunjiri: Mobile: 0722276556	Ring Rd. Parklands
8. Barclays Life Mr. Michael Ngila/Grace Kabue: Mobile: 0203641000/0733676556/0722276556	Acacia Bld., Westi

9. Britam General/Life Upper Hill
Mr. Jay Kosgey/Ndirangu:
Mobile: 0720702839/0718031939

10. Capex Life Galana Plaza, Ngong Rd
Mr. Peter Ogunnira:
Mobile: 0715140074

11. CIC General/Life Upper Hill
Mr. Ezekiel Owuor:
Mobile: 020283000

12. GA General/Life Community
Claims Mr. Piyush Shah:
Mobile: 0202711633/4

13. Old Mutual Upper Hill
Mr. Chris Nyokangi:
Mobile: 0711010000

14. AAR Williamsons – Community
Mr. Caroline Munene:
Mobile: 0202895000
0202715319

15. AMACO Transnational Plaza, CBD
Mr. Jonah Tomno:
Mobile: 0202204000
0202204444

16. AIG Edensquare, Chiromo Rd. Westi
Mr. Catherine Igathe:
Mobile: 0203676000

17. Directline: Hazina Towers CBD

Mr. Terry Winjeje:
Mobile:

18. **Heritage** Mamlaka Rd., CFC Hse

Mr. Godfrey Kioi:
Claims Manager: Boniface Irungu
Mobile: 0711039000

19. **Xplico** Parklands, Park Place 5th Flr.

Mr. Benson Chege:
Mobile: 0700111999

20. **Resolution Insurance** Lenana Rd., Roshanmer Plaza

Mr. Alice Mwai:
Mobile: 0202894000
Tel: 0203874774

21. The Monarch

David Murage
0786426931/0705426931/0202338132

22. Gateway Insurance

Samuel Okwachi/George Kuria
0719035140

23. ICEA Lion/General

Stephen Oluoch
0719071000

24. Intra Africa

Mike

25. Saham Insurance

072219486