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Abstract

Insurance fraud:
causes, characteristics and prevention

by

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Although there is a growing volume of research on various kinds of fraud, relatively little has been written about insurance fraud. Even fewer studies have been undertaken on the prevention of insurance fraud. This study aims to fill this gap. It focuses not on large-scale corporate fraud but on individuals 'fiddling' their home, motor and travel policies.

During the course of this study, the researcher surveyed the public and found that insurance fraud is commonplace, and committed by people of different classes—often unwittingly, and rarely with much regret. Insurance companies were surveyed, and data collected by interviews with insurance staff. It emerged that many insurers did not realise they had an insurance fraud problem, and those that did were either doing little to prevent it or were using ineffective methods. Insurance fraudsters are often given a great deal of help, often by officials who abuse the trust placed in them; insurers' relationship with the police and with loss adjusters is not geared to stopping fraudsters, and insurance fraud is thus rendered easier. To illustrate this, and with the help of an insurance company, the researcher conducted a mock insurance fraud, and found it easy to commit.

This study shows that insurance fraud is mostly an opportunistic crime. Within the study of crime prevention there is an approach which seeks to reduce the number of offences by curtailing the opportunities for crime. This is known as 'situational crime prevention', and is based on the 'rational choice perspective'. Professor Ron Clarke, whose name is most closely associated with the approach, has called for more research to apply the principles and techniques of opportunity reduction to a range of crime types. This thesis represents an attempt to do this in relation to insurance fraud, and in so doing to stimulate ideas on how insurance fraud can be tackled effectively. In addition, it offers a new perspective on the situational approach and the techniques of opportunity reduction, plus a revised classification of these techniques. At the same time it offers a critique of the situational approach itself. The findings suggest that if fraud within the insurance industry is to be taken seriously then there are a range of structural concerns that need to be tackled, and that this moves beyond the scope of situational prevention.
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During the time it has taken to research and write this thesis I have married, had three
children, started two businesses, and had one incredible time.
Dedication

For Martin, Emily, Karis and Oliver. I love them very much.
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1. Introduction

This thesis is about insurance fraud. In particular, it seeks to understand the characteristics of three types of insurance fraud, looking at how and why they occur. The overall aim is to assess the applicability of R.V. Clarke’s (1997) situational crime prevention model to insurance fraud, and the potential for reducing opportunities for these types of crime.

Businesses have been seen as legitimate targets for a range of offences, including shop theft, staff dishonesty and criminal damage, although there has been relatively little research on the business as victim (see Levi and Pithouse 1988; Levi 1992b), especially where the offence is insurance fraud. There are several reasons why this subject is important and why it was chosen as an area of study.

The first reason is that the subject is under-researched, and that previous studies have been limited in coverage.1 While there have been a number of anecdotal articles in the press and media about insurance fraud,2 and practitioners and those working in the industry have offered important insights,3 there have been only a few academic reviews.4

In the UK it is possible to identify just two notable studies of insurance fraud in recent years. The first was by Michael Clarke (1989; 1990a) and the second by Roger Litton (1990). In addition there has been one German study (Wittkämper et al 1991). Although somewhat limited in both methodology and scale—Clarke
readily admitted that his research was restricted to 'matters of general policy and experience' (Clarke 1989: 2)—these studies have been useful in highlighting important features of the offence, and not least in outlining the related problems faced by the insurance industry.

Thus there are a number of gaps in our understanding of the offence: research on fraud at the underwriting stage appears to have been ignored altogether; and there is little discussion of offending behaviour. Moreover, while there has been a range of initiatives to tackle fraud—following Clarke's (1989; 1990a) work—these have largely been focused on detection and investigation rather than prevention. This emphasis has been reflected in a large number of seminars and conferences and in the literature published in professional magazines and journals. Even the ABI's Crime and Fraud Prevention Bureau, which publishes a newsletter with information on initiatives, conferences and research within the industry, has a tendency to focus on issues relating to the detection and investigation of insurance fraud rather than on prevention. The Bureau is hardly to blame: it is merely reflecting the industry's current stance on fraud and the lack of fraud prevention initiatives. Indeed, there is confusion about even quite basic issues such as the legal definition of fraud, as well as about its scale and cost. It is hoped that this thesis will help to fill the gap in the research, and thereby assist in developing a greater awareness of the potential for prevention.

The second reason why this subject was chosen is to test the applicability of a situational crime prevention framework. Insurance fraud is often committed because people seize an opportunity that is presented to them, and the situational
crime prevention approach is based on the premise that the best way to reduce crime is to curtail the opportunities for committing it. The approach is closely linked to the rational choice perspective, which argues that people commit a crime in the belief that the chances of success are greater than those of failure, or that the potential benefits outweigh the likely costs. And, so the argument goes, eliminating or reducing the opportunities makes crimes less likely, because rational people will judge that they are not worthwhile.

Most of the research in this area has focused on theft and burglary, and the applicability of the situational approach has rarely been evaluated in the context of fraud. One of the leading proponents of situational crime prevention, Ron Clarke, has called for more research along the lines of this thesis. In his view, situational crime prevention has great potential to reduce fraud. Indeed, a recent classification (Clarke 1997) includes a new category to cover the growing number of offenders who commit petty rather than serious crimes during the course of their work.

In assessing the situational approach in the context of fraud there are two different aims. The first is to offer insurers and those who work with them a way of thinking about reducing and eliminating fraud. This is something which is at present lacking, and may explain, in part, why fraud prevention is seen as a low priority among insurers. This is not to suggest that situational measures are always the most appropriate, although they have helped in reducing credit card fraud (Levi et al 1991), but they do provide a means by which insurers can take practical steps to reduce fraud rates (Levi and Handley 1998). The second aim is to learn about the theory and practice of insurance fraud prevention. As will be shown,
situational crime prevention has not been systematically evaluated in a business environment; such an evaluation, however, would make it possible to look at the scope of the approach in the solving of crime problems and at its limitations in different contexts.

At least one weakness of the situational model—linked to its more common application to public-sector contexts—is that it appears to take for granted the proposition that crime reduction is an unqualified good. In the commercial sector there is rather more emphasis on the business case, which includes a host of influences, not least cost-effectiveness. Although cost-effectiveness was not an integral part of this research—which would have required a very different type of approach—it is of central importance in insurance companies’ decisions as to whether they should implement various measures, and so some comment is necessary. It is important to understand how priorities for prevention are established, following on from a consideration of how risks are assessed. As far as insurance fraud is concerned, these issues have remained largely unresearched.

The third reason why this subject was chosen is to understand how insurance companies manage crime—how they perceive and respond to different types of fraud risks. This analysis moves beyond merely situational issues to an assessment of the insurance industry and the way it is structured, including how it sells policies and the endemic scope for abuse of trust. It will be shown that insurance companies are sometimes providing easy opportunities for policyholders to commit fraud, and often little is being done to remove such opportunities. A case in point is the response to victimisation, since it seems plausible that if an
individual's fraud remains undiscovered he/she is likely to try again. The use of ‘Hunter’ (a database used to identify fraudulent claimants) by one insurer produced one or two cases of repeat fraud a week. This was confirmed by Levi, who noted:

Fraud victimisation is a repeat risk for any particular financial institution. Lightning can and does strike twice in the same spot, in the case of relatively low cost frauds such as credit card fraud, thousands of times. So reaction to the last offence is proaction to the next, but only if it has some preventative element in it. It is working out just what preventative components to put in that is the primary task. (1997: unpaginated)

If insurers recognise this, and the evidence suggests that some do, then in not reacting by putting preventative measures in place they are precipitating their own victimisation (Levi and Pithouse 1988). Could it be that it is not cost-effective to prevent some types of insurance fraud, and so insurance companies make no attempt to reduce or eliminate known opportunities for it? Or is it that insurers know so little about it that they do little to prevent it? In other words, is the absence of any fraud prevention measures the result of experiment and analysis of impact, or is it simply that so long as premium income exceeds expenditure little is done—in short, are insurers calculated in their assumptions, or merely negligent?
The fourth and a closely related reason why the subject is important and worthy of research is that learning about how crime prevention priorities are established invites consideration of ethical strategies and their relationship to business principles. There is a range of studies which have drawn attention to business malpractice in pursuit of profit (for example, Box 1983; Vagg and Harris 1998; Walklate 1989). As Michael Clarke notes:

Why should anyone suppose that the business has any need of ethics? Is its job not to get on with producing, selling and making a profit by whatever ingenious means it can devise, save that it must stay in the limits of the law? (1990b: 231)

Against this, as Clarke goes on to acknowledge:

The objectives of profit, security and growth are required to be tempered by due concern for the legitimate interests of employees, customers, creditors and the public at large. Business is, in other words, increasingly under pressure to exercise self-restraint and to ensure that it does not exploit and oppress others with whom and through whom it works. (1990b: 232)

Just how these demands are managed merits research, not least where there is scope for insurers to deny a legitimate claim in order to avoid payment, and sell inappropriate (but profitable) policies to unsuspecting clients, as was the case in the pension mis-selling scandal (Select Committee on Treasury 1998).
For these reasons it is important to understand who loses from fraud; would a business-oriented insurance company allow itself to lose in this way? In Chapter Two it will be shown that there are at least four groups who gain from insurance fraud: fraudsters; insurers; society (people as a whole), via the black economy; and loss adjusters and private investigators; and that there are five groups who lose: insurers; policyholders; shareholders; individuals and businesses priced out of the market; and society at large. Precisely because there are thus gainers as well as losers from insurance fraud, a policy aiming to reduce or eradicate it will be controversial.

The fifth reason why the subject is important is that the types of insurance frauds examined here involve a wide range of individuals—not just the so-called underclass, allegedly the typical perpetrators of other types of crime, but also the middle and upper echelons of society and members of the ‘professional’ classes. This type of fraud is more akin to ‘fiddling’ or petty dishonesty than to big corporate frauds (Mulcahy 1990). Its ‘normality’ is part of its interest, because offenders rarely incur public wrath, the police are often uninterested, and it is the victims who are seen as culpable. This context is important, and attempts at prevention need to take account of it.

**Frauds on travel, motor and household policies**

The focus of this thesis is on fraud committed by individual policyholders against insurance companies, although, as noted above, it is not always only insurers who
are the ultimate losers. While there are large-scale insurance scams, and these are
likely to make the headlines, this is not the most common type of fraud, nor,
overall, the most costly. It is perhaps helpful to begin with an explanation as to
why household, motor and travel policies were chosen for analysis in this thesis.

Each of these types of policy offers a different threat to the insurer, and included
in this is the recognition that a different response to each is needed. This is useful
in assessing the relevance of the situational crime prevention framework, not least
as to whether prevention is possible, feasible and cost-effective in these different
contexts. Studying just one type of fraud was considered too narrow, and three
offered a comparative insight.

Travel, motor and household insurance were chosen because they are the types of
insurance which are most closely linked together. They are all classified under the
‘General Insurance’ heading, and they are also policies which are sold to
individuals, though each is sold in a different way. The three types of insurance
may all be sold as part of a package—for example, household insurance with a
mortgage, travel insurance as part of a holiday, motor insurance in conjunction
with the purchase of a new car. Sometimes these types of insurance are even given
away free as part of an incentive scheme. However, there are also interesting
differences between them. Household and motor insurance are annual policies;
they require detailed information, are underwritten and renewable, and are
therefore subject to a relationship with the insurer, who will be able to build up
details of a policyholder’s claims history. Travel insurance, on the other hand, is
usually short-term (although longer-term policies are available), it is normally not
renewable, it is not underwritten and few details are known about the customer’s claims history. The size of claims also differs, in that losses from an individual motor loss claim are usually far higher than those from a travel claim, and so the potential losses from fraud are correspondingly greater. Yet exaggerating a claim, claiming for a loss that did not occur, multiple claims, ‘fronting’ and misinformation occur with all three types of policies.

The present study was designed to consider frauds against insurance companies by policy-holders, where the insurers were the immediate victims. There were three other reasons why these types of fraud were chosen. First, these were the types of fraud which, at the time of the research, insurers were particularly concerned about, and so access was more likely to be granted. Second, the ABI had already initiated research within this area by producing an annual fraud survey, which looked at motor, travel and household insurance fraud. The present author’s study, sponsored by the ABI, was viewed as an opportunity to build on and extend this research. Third, and importantly, the ABI was able to help with access to insurance companies to research these types of frauds.

These types of frauds are not of course the only ones committed against insurance companies, but all research projects have to limit their scope and so inevitably some types of fraud have here to be excluded—for example, fraud involving internal collusion and large-scale organised fraud. There are several reasons for this. First, such frauds would involve evaluation of a much broader range of issues, and it would not be possible to do justice to them in the space available. Second, in the preliminary stages of the research it became clear that insurers were
less candid about their internal problems, and about staff collusion in particular. It thus appeared doubtful that insurers would help with data collection, particularly with regard to such sensitive areas. The third point is that the ABI, which was funding the study, steered the research towards what it considered to be the more commonly occurring high-volume, low-value frauds. The ABI viewed these as costly to deal with. This is not to suggest that the frauds excluded from this study are unimportant, but that most researchers have to compromise with access providers between what is practicable and what is ideal.

**Objectives**

In looking to fill the gap in understanding the prevention of a specific type of offence, a number of issues need to be addressed. There are three specific objectives of this study which seek to provide new insights into the causes and characteristics of insurance fraud, as a basis for thinking about prevention.

1. To elucidate the process leading to insurance fraud:

   a) Why do people commit fraud? Are offenders rational and would responses based on reducing opportunities have significant potential?

   b) How do people commit fraud? This will provide an insight into the opportunities that are available, and hence what the focus of situational techniques should be, or whether situational techniques are appropriate for the types of opportunities that exist.
c) Who commits fraud? This will provide clues as to where prevention methods might be targeted. For example, the objective and technique of stimulating conscience is more appropriate for those who might be concerned about getting caught.

2. To look at what is being done by insurers to tackle the problem:

   a) What are the insurers’ attitudes to insurance fraud and their assessment of the threat that they are facing?

   b) What are insurers doing to tackle fraud? Are they creating opportunities for the fraudster by what they do and do not do? This entails looking at the insurers’ systems, especially at the inception and claims stages (since this is where fraud occurs), and also at those who are employed in the fight against fraud, especially loss adjusters.

3. To examine how Ron Clarke’s opportunity reduction classification relates to insurance fraud:

   a) The opportunities exploited by the fraudster and the ways that they can be eradicated or reduced need to be identified.

   b) This is the first time that the classification has been applied to insurance fraud. There have been only limited attempts to evaluate situational prevention in a commercial environment. One objective is therefore to understand whether the techniques of situational prevention provide a helpful framework for responding to insurance
fraud, and what types of modifications (if any) in the classification are necessary.

c) It is also important to take account of the limitations of the classification: are situational techniques all that are needed, what prevents the techniques from working effectively, and what else needs to be done to prevent insurance fraud?

Outline of the thesis

Chapter Two serves as a background to the thesis. There are a number of issues that have been included here because they are important starting points. These include a discussion about what is meant by fraud: there is disagreement amongst leading authorities as to what constitutes fraud, and this has complicated prevention strategies within the industry. Similarly, the scale and cost of insurance frauds are important, and these aspects are also discussed—although perhaps the most prominent message here is that there is widespread ignorance both within and outside the insurance industry. Given that the industry itself creates opportunities for fraud, these too are evaluated, and the concept of ‘trust’ is introduced. This has long been recognised as crucial to opportunity, and this is no less the case where insurance frauds are concerned. Influences outside the industry are important too: insurance as a business is subject to wider social economic pressures and business trends, and examples are discussed to illustrate this. Throughout Chapter Two the aim is to understand the commercial context in which insurance operates and insurance fraud takes place; this is an important
factor, and one that is frequently disregarded by those who write about situational prevention.

Chapter Three outlines the research methodology. The study incorporated a number of approaches. In order to gain an insight into the perspective of the insurance fraudster a survey of members of the public was included; about one in ten had committed an insurance fraud, although many more knew others who had. It was not the case that they felt particularly guilty—indeed, some felt that the money they had obtained was rightfully theirs. Insurers were also surveyed, and here it was anticipated that the response would be low, even with ABI support. However, the aim remained to collect basic data, and also to request a personal interview with companies to learn about their systems and fraud prevention strategies; and this aim was realised. These contacts facilitated an analysis of files relevant to the study of insurance fraud, and also led to interviews with key personnel. Moreover, time was spent with loss adjusters learning about their systems and their work as well as their relationship with insurers. Also, a ‘mock fraud’ was undertaken to test an insurance company’s systems; this interesting innovation was conducted with the permission of the company concerned, although without the knowledge of its Claims Department staff. It demonstrated that insurance fraud was relatively easy to get away with, and that there were people who were prepared to help. This case study is discussed in Appendix A.

Chapter Four is the final background chapter; it discusses the principles of the rational choice perspective and of situational crime prevention, and looks in particular at Ron Clarke’s opportunity reduction classification. Time is spent
discussing the principle of rationality, and just who becomes involved in insurance fraud, how and why. This is used as background for discussing the principles of situational prevention, and current and potential criticisms of the classification, together with its limitations, are outlined. Despite the fact that the techniques have been evolving since the early 1980s, they have received relatively little critical comment, and the classification has yet to be systematically applied to insurance fraud.

The discussion about insurance fraud is separated into two parts: Chapters Five and Six examine fraud at the ‘sales’, ‘inception’ ‘underwriting’ or ‘proposal’ stage (the terms are used interchangeably throughout the thesis); and Chapters Seven and Eight examine fraud at the ‘claims’ stage. In each case the first of the two chapters examines the ways in which opportunities for fraud are created, and the second looks at how insurers respond (or fail to respond) to those opportunities. At the proposal stage, the concept of trust, introduced in Chapter Two, is discussed, since fraud often takes place where the insurance process allows individuals to exercise autonomy in making decisions, with few checks. At the claims stage four main factors are viewed as influential in facilitating fraud: the difficulty of proving fraud; the role of ‘helpers’ (and this includes the police); the insurers’ tendency to pay rather than investigate; and the effects of the ‘fast tracking’ process.

Chapters Nine and Ten attempt to place the findings in perspective. Chapter Nine examines the potential of Ron Clarke’s techniques of opportunity reduction for reducing insurance fraud. Each of the techniques is discussed, and a revised
classification is offered based closely on Clarke's work. It is suggested that the revised classification provides a helpful framework for guiding practice, but there are limits. For example, there are some issues central to the prevention of fraud, that require more than just attention to situational techniques, and they also facilitate a critique of the situational approach. These points are discussed in Chapter Ten.

Thus Chapter Ten begins with an assessment of the financial case for fraud reduction—a type of assessment frequently missing from discussions of situational prevention—and moves on to consider the practical and ethical reasons why fraud reduction is not an unqualified good. While an industry-wide response is crucial, it will be shown that different insurers attach different priorities to fraud prevention, and that there are a number of practical issues—not least competition—which impede co-operation. These are not situational issues; they are fundamental to the way insurance is organised. Similarly, the way insurers typically relate to loss adjusters and to the police on insurance fraud issues needs to change if there is to be a greater impact on the occurrence of such fraud. Again, these are rather more than situational concerns. The chapter ends with a consideration of the rationality of insurers, where it will be shown that they calculate their response according to different information and often different priorities.

Chapter Eleven attempts to revisit the objectives, and places the findings in a broader perspective. Ultimately, insurers could do much more to prevent fraud,
but it will take a lot more co-ordination, and most of all there must be a will to do something about it.

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1 Clarke, M.J. 1989; Clarke, M.J. 1990a.
5 The following is a list of a few seminars and conferences which have examined insurance fraud: Fraud: Fair Game or Foul, 1 December 1993, London; Current Issues in Claims Handling, 17 October 1995, London; Preventing Fraud, 14 March 1995, University of Leicester; ABI Fraud Seminar, 28 November 1994, London; ABI Fraud Seminar, December 1996, London.
7 Part of the ABI.
2. Background to insurance fraud

Introduction

Insurance fraud is relatively simple to commit, easy to get away with, and seemingly considered 'fair game'—and even legitimate—by a significant minority of the population. But it is illegal, costs the insurance companies millions of pounds, and is by no means 'victimless'. The aim of this chapter is to introduce and examine a range of issues about the insurance industry, fraud, and white collar crime generally, and specifically insurance fraud by customers. The purpose is to identify issues relevant to understanding why and how such fraud occurs, as a basis for discussing ideas on prevention.

There are four broad issues which are used to frame the discussion in this chapter. The first concerns definitions of insurance fraud, and here there are two main points: in terms of the legal and social definitions there are a variety of interpretations, which has created some confusion and has undermined attempts to tackle the problem; and it is important to differentiate between various types of insurance fraud, and where they occur, because they require different types of solutions.

The second broad issue relates to victimisation from insurance fraud. There are problems in measuring the levels of the offence, and in part because of this and in part because of the rather cursory way in which insurers calculate costs,
attempting to work out the actual financial costs of insurance frauds is intrinsically difficult. It will be shown that some insurers use the difficulty of identifying the extent of the offence and of its costs as an excuse to justify paying little attention to tackling it. Indeed, because the perception of some insurers is that they do not suffer greatly from fraud, and others consider the costs of prevention would outweigh the costs of their victimisation, many insurance companies are not motivated to attempt to prevent fraud and can also claim that they are making a sound business judgement. This begs at least two questions, which were raised in Chapter One. The first is who then does lose and gain from insurance fraud, while the second concerns the ways in which insurance companies, if not actively encouraging fraudulent behaviour, at least passively allow it to occur.

The third broad issue examined in this chapter is the manner in which the insurance industry operates. Insurance companies have massive resources and in certain respects are highly sophisticated, yet the frauds that are successfully perpetrated are often simple and mostly opportunistic. There are obstacles built into the way the insurance industry works that hinder the successful implementation of crime prevention measures, and these obstacles need to be understood. The role of agents is a case in point: they sell policies, and are often encouraged by an incentive scheme, and the obvious danger is that they may sell the most profitable or most easily sold policies rather than those best suited to the clients’ needs. Essentially, agents have to be trusted. The element of trust has received extensive comment in the literature, and this work is reviewed in this chapter as it applies to insurance fraud.
Another important dimension of the insurance industry is the process of risk management. The central point is that insurance companies are not public-sector organisations, but are geared to making a profit, and this has an impact on how they manage and react to crime risks, including frauds. Moral hazards are another factor which merits attention, and the discussion focuses on which characteristics and behaviour of the person insured increase the risk of a fraud occurring. There are a number of definitional issues about this type of hazard which have important implications for practice. The concepts of trust, risk management and moral hazard help to understand the context in which insurance fraud is tackled. This is a business environment where priorities are largely determined by the impact on the overall profile of the operation.

The fourth issue considered is the broad context in which insurance companies operate. This is a competitive industry, and there is a broad range of social and economic issues that affect it and in some way have an impact upon insurance fraud by customers. While it is not possible in a single thesis to discuss all these issues in depth, it is nonetheless important to acknowledge their influence. These factors include the price of insurance, competition, technology, changes in weather patterns, and mergers and acquisitions.

**Insurance fraud: defining the boundaries**

The words ‘insurance fraud’ cover a range of offences and, as will be shown, there are many different types of insurance fraudster. The aim of this section is first to examine the different definitions of the offence—one needs to consider these
because in practice there is disagreement among leading authorities about what constitutes fraud. This has practical implications, and it certainly complicates prosecution. It is obviously important to try to resolve the definition issues as a basis for the evaluation in the remainder of the thesis. Following this, the different types of fraudulent behaviour will be considered.

Definitions of insurance fraud

Although insurance fraud is defined under the Theft Act (1969) there are in practice a number of uncertainties about how the law should be interpreted. Section 16 (1) of the Act states that:

A person who by any deception dishonestly obtains for himself or another, any pecuniary advantage shall, on conviction on indictment, be liable to imprisonment for a term not exceeding five years.

Section 16 (2) of the Act defines situations where pecuniary advantage might be taken and section 16 (2) (b) gives the example of an individual who takes out ‘any policy of insurance or annuity contract’.

In addition, section 17 of the Act makes it a criminal offence to make a false account. This includes:

1. Where a person dishonestly, with a view to gain for himself or another or with intent to cause loss to another,
(A) destroys, defaces, conceals or falsifies any account or any record
or document made or required for any accounting purpose, or
(B) in furnishing information for any purpose produces or makes use
of any account, or any such record or document as aforesaid, which to
his knowledge is or may be misleading, false or deceptive in a material
particular;

he shall, on conviction on indictment, be liable to imprisonment for a
term not exceeding seven years.

(2) for the purposes of this section a person who makes or concurs in
making an account or other document an entry which is or may be
misleading, false or deceptive in a material particular, or who omits or
concurs in omitting a material particular, or who omits or concurs in
omitting a material particular from an account or other document, is to
be treated as falsifying the account or document.¹

MacGillivray and Parkington (1988: 228) in their definition state that in order for
an insurance claim to be fraudulent the action needs to be taken knowingly,
without belief in its truth, or recklessly without care as to whether it is true or
false.²

Despite these apparently comprehensive definitions, it is in practice often difficult
to determine whether a claim is fraudulent. For example, Levi (1988) suggested
that it is not always clear whether a loss or claimed loss involves fraud, as some
people may think they have been defrauded when in fact these actions were not criminal, but rather a 'civil deceit' or even within the law (Levi 1988: 1). Levi (1988: 17) also noted: ‘You must not assume that because you have been ‘ripped off’, a crime has been committed.’

It would appear that many insurers agree with Levi that it is extremely difficult to know whether an action is taken knowingly, or without belief in its truth, since this requires that one read an individual’s mind; it is difficult to prove intention. Thus, when questioned on a claim, individuals can argue that although their statements were incorrect, they genuinely believed them to be true. As MacGillivray and Parkington point out:

If the representee knows or ought to know that the representor has no personal experience of the matters stated, that together with the words used may incline a court to construe the statement as an expression of opinion rather than a representation of fact... Even if the opinion held turns out to be unfounded or incorrect, no liability attaches to the maker of the statement, so long as the opinion was given bona fide and truly believed in. (1988: 234)

Some individuals may genuinely believe that certain actions which others would believe are fraudulent are in fact honest; and this view is supported by the findings of the research for this study. It was found during the survey of members of the public that one in every three individuals who had made an insurance claim which
could be interpreted as fraudulent stated that they had been totally honest in making the claim. Thus, although these individuals had misrepresented the facts, according to the law they might not have acted fraudulently insofar as they had not done so knowingly. In most cases what differentiates a fraud from legitimate behaviour is not the action involved but the awareness of the individual concerned that it was fraudulent.

Moreover, some types of actions which insurance companies consider to be fraudulent, such as exaggerated and inflated claims, can sometimes be lawful (ABI 1996b). Michael Clarke (1989: 4) argued that ‘contrary to the industry’s previously strong view and practice’ exaggerated claims did not constitute fraud. He cited two cases in support of his argument.4 According to Clarke, insurance settlements are open to negotiation on both sides and ‘wide differences of opinion and the adoption of positions for bargaining purposes are normal’ (1989: 4). He concluded that:

A claim grossly exaggerated in value cannot be repudiated as a try-on. Only if items are claimed for which clearly did not exist, nor form part of the loss, can the claim be contested with confidence as fraud. (Clarke 1989: 4)

The Court of Appeal in the Orakpo case5 also made a point about exaggeration; Lord Justice Staughton stated that:
Some people put forward inflated claims for the purpose of negotiation knowing that they will be cut down by an adjuster. If one examined a sample of insurance claims on household contents, I doubt if one would find many which stated the loss with absolute truth. From time to time claims are patently exaggerated; for example, by claiming the replacement cost of chattels, when only the depreciated value is insured. In such cases, it may perhaps be said that there is in truth no false representation, since the falsity of what is stated is apparent. I would not condone falsehood of any kind in an insurance claim. But in any event I consider that the gross exaggeration in this case went beyond what can be condoned or overlooked.

Not surprisingly, many insurers have been critical of this view. A spokesperson for the ABI, referring to the last sentence of the above quotation, noted:

I think insurers would disagree with [the implication in] the judge’s statement that some exaggeration is acceptable. If you attempt to claim more than you are due, that is fraud.6

Lord Justice Staughton did not attempt to define at what point a claim does become fraudulent; but he and Michael Clarke appear to agree that some types of exaggeration are not fraudulent.

It is worth pointing out, however, that under MacGillivray and Parkington’s (1988) definition, petty exaggeration of a claim can be categorised as fraud. This
confusion complicates the definition of insurance fraud. Carlsen suggests that fraud is a conscious act and that 'intent separates those innocent from those guilty of fraud' (1992: 101). This conflicts with Lord Justice Staughton’s summing-up in the Orakpo case, in which he makes it clear that inflating claims can be condoned in some cases ‘knowing that they would be cut down’. It is even more interesting to note that Diacon and Carter (1992: 171) do not even use the words ‘knowingly’ or ‘without belief in its truth’. In their definition an inflated claim in itself constitutes fraud, a view with which insurers seem by and large to agree. Diacon and Carter define a fraudulent insurance claim in the following way:

A claim is fraudulent if the insured is attempting to recover more than he is entitled to, if he has not in fact suffered loss at all, or if he has either deliberately caused loss or exaggerated its size. (1992: 171)

In their definition Diacon and Carter ignore fraud at the inception of a policy, and there is no mention of this in their book. The Munich Reinsurance Company, however, includes this aspect and defines insurance fraud in the following way:

Fraudulent behaviour on the part of the policy holders or third parties aimed at obtaining insurance protection that would not otherwise be granted, paying a lower premium than would normally be charged or obtaining compensation or higher compensation under false pretences. (undated a: 6)
The current disagreement between insurers and other experts as to what constitutes fraud means that prosecution is more difficult. Launching a fraud prosecution when there is a chance the action may not ultimately be defined as an offence is an impediment to a commitment by the industry to pursue prosecutions. For the accused there is always the option of stating that they believed they were negotiating compensation and, with precedents to support them, the lack of clarity over definition is a fraudsters’ friend. In law an individual can only be convicted of committing a fraud if he/she did so knowingly or recklessly. Moreover, a tight definition would help to teach policyholders, potential fraudsters and all those involved in the policing process the boundaries of behaviour, and there would be an opportunity to reinforce this message at strategic points, which might help prevention. The absence of an agreed definition will involve some people being falsely accused of fraud, when what they are actually doing is pursuing a legitimate approach to settling a claim. And the problems of securing convictions mean that resources are wasted, and the image of companies as providing a service to policyholders is threatened.

Yet this is only a part of the problem, and even with an agreed definition an offence of fraud could still be difficult to prove. For example, even if low levels of exaggeration were deemed to be fraud, they would still be difficult to prove. Exaggeration is difficult to identify, and (perhaps especially at low levels) difficult to show that it was done purposely. If a policyholder lies, by claiming that a non-existent item has been stolen, the insurance company’s best witness would often be the thief!

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Notwithstanding these legal uncertainties, it is necessary to adopt a working definition for the purpose of any discussion of the implications of insurance fraud and of ways of dealing with it. On balance, it is the author’s view that the approach of insurers is along the right lines. People who exaggerate a claim mostly (although not perhaps always) do so because they want to deceive the insurer and to receive more compensation than they are due. Exaggeration is therefore (mostly) fraudulent. In its simplest form and for the purposes of this thesis insurance fraud can be defined as follows:

Insurance fraud occurs when an individual, or group of individuals, seeks to obtain an advantage, in money, goods or services, through an insurance policy by way of deception. This can occur at any time during the life of a policy, from its inception through to the claims stage.

This definition can be justified because it does not limit itself to specific types of fraud which occur at particular points in time. It incorporates all forms of deceit connected with an insurance policy and at all stages in the life of a policy.

Types of insurance fraud

Insurance fraud can occur at two main stages in the life of a policy: the inception/renewal stage and the claims stage. The types of fraud that occur at the inception of a policy are as follows:
**Fronting.** This ordinarily occurs in connection with motor fraud—when, for example, parents insure a vehicle under their own name (claiming ownership) on behalf of their child. In this way insurance can be obtained at a preferential rate, or the risk insured where otherwise it might have been refused.

**Misrepresentation.** This is where an individual knowingly omits to tell the insurer about factors that could affect the risk, or provides false or misleading information. This type of fraud can occur at the inception of a policy or at the claims stage. Insurance can thus be obtained where otherwise it might have been refused, and/or at a preferential rate, and a successful claim can be made where otherwise it would have been rejected. For example, an applicant may tell the insurer that there has been no claim during the previous five years when in fact such a claim has been made.

**False insurance.** This happens when an individual or group of individuals seeks insurance for a risk that does not exist in order to make a claim on the policy at a later date.

**Multiple policies.** This is where an individual takes out a number of policies in order purposely to make multiple claims for the same loss at a later date. 9

The types of fraud which occur at the claims stage are as follows:
Exaggeration. Exaggeration can take three forms:

- **Inflation of value**: where an individual knowingly claims for more than the value of the item.
- **Extra items**: where an individual adds to a claim one or more items.
- **Improved model**: where an individual claims for an improved (and more costly) model.

Multiple claims. This type of fraud overlaps with multiple policies, and can take two forms:

- An individual claims under more than one legitimate policy for the same loss; for example, a camera may be lost on holiday and the policyholder claims through his/her travel insurer and household insurer for the same loss, and is paid twice.\(^\text{10}\)
- An individual takes out a number of policies, on the basis of false declarations, in order to make multiple claims for either a fictitious or a genuine loss.\(^\text{11}\)

False claim. A false claim can be made in two ways:

- An individual takes out valid insurance and afterwards decides to make a false claim.
- A policy is taken out with the purpose of committing fraud, and a false claim has thus been planned from the beginning. Examples here include staged accidents.
Insurance fraud: assessing the problem

This section of the thesis seeks to establish the scale of the problem posed by insurance fraud; there are at least four issues worth considering. The first is the level of fraud, and the problem associated with generating accurate figures. The difficulties of identifying the extent of insurance fraud mirror the problem of identifying the extent of other frauds. A second issue is that of cost; this is important given that the extent of the cost to the insurer will determine the priority the company attaches to tackling insurance fraud—insurers are commercial companies and therefore the overall consideration is the profit or loss. Indeed, following from this, it is difficult to imagine that insurers would allow themselves to lose from fraud, and thus the third issue which merits attention here is a discussion of the losers and gainers from insurance fraud. It is important to understand fraud prevention as a business activity, and because for a company there may be more sense in allowing fraud to occur rather than incurring the cost of prevention (and thereby taking on itself the role of victim), the concept of victim precipitation merits a comment; this is the fourth issue.

Victims of fraud

It is commonly acknowledged that a huge amount of fraud goes undetected (Audit Commission Bulletin 1996), and even when frauds are discovered businesses are sometimes reluctant to admit them for fear of embarrassment and adverse publicity (Ernst and Young 1993). Ernst and Young found that over a third of the companies surveyed admitted having suffered a fraud without reporting it (Ernst
and Young 1993). Also, there is a reluctance to prosecute (Clarke 1989: 4). The reasons for this reluctance include, first, the fear of bad publicity, which could lead to competitor advantage; second, the fear of putting ideas into policyholders’ heads (Clarke 1989: 4); and third, the fact that, although there may be a strong suspicion that a fraud has been conducted, it is often difficult to prove. A fourth reason for reluctance to prosecute is that a fraud may have been detected before any loss has occurred, and there may thus be little incentive to take action; fifth, there is a possibility of damage to staff morale; and sixth, there may be a fear of a loss of consumer confidence.

Even when fraud is reported to the police by businesses, the true extent of the problem may be hidden; there are various reasons for this. One is that in 1980 the Home Office decided that closely related offences should be recorded as just one offence (Levi 1987: 4). Thus if someone steals a chequebook and subsequently cashes 30 cheques, this is looked upon as one offence. This would have a marked impact on the recording of fraud, which often involves a number of deceptions (Levi 1987).

Indeed, most of the research on the extent of fraud has relied on little more than educated guesses. The 1995 Criminal Statistics for England and Wales groups all cases of fraud and forgery together, and even then the number of cases is surprisingly low—only 133,000 in that year, representing three per cent of all recorded crime. The ABI estimated in 1995 that 4.9 per cent of all non-life insurance claims were fraudulent, which amounted to 279,000 cases (1995a: 4). It seems reasonable to suppose that such statistics represent only the tip of the
iceberg, because many frauds remain undetected, and so the true number of frauds will be far higher.

It is generally accepted that insurance fraud represents a huge problem to the insurance industry, and as Litton has stated 'it would be naïve of any insurer to base his behaviour on any other premise' (1990: 120). Attempts have been made to estimate the size of the problem, but the conclusions of these surveys vary markedly owing to the different perceptions of the problem and the different methodologies used. The results of surveys have not been consistent, the findings as to the proportion of frauds among insurance claims ranging from 3.5 per cent (ABI 1996) to 50 per cent (Chartered Instituted of Loss Adjusters 1992); one could conclude from these figures that during 1999 there were between 432,900 and 5.5 million cases of insurance fraud.13 There are those who would argue that the latter figure was 'just a little too high'.14 While there remains a very wide discrepancy in the estimates of fraud, the extent is still huge.

The enormous variations in the assessment of fraud may be due to the different parameters and methodologies used in conducting the surveys, a point which will be discussed later. The surveys do, however, bring out some interesting points. One German survey found that the mean of the estimates of the level of fraudulent claims was 10 per cent (Wittkämper et al 1991: 37), but the level of baggage insurance fraud was placed at 20 per cent and of house contents insurance in the region of 15 per cent. At the same time another German survey found that 14.9 per cent of those who had made claims for contents insurance had committed a fraud, compared with 8.3 per cent of those who had claimed through their building
insurance (GfK Marktforschung GmbH 1987). In other words some types of insurance may give rise to a higher proportion of fraudulent claims.

A study by the Munich Reinsurance Company found that:

Although roughly two-thirds of private cars are fitted with normal clear-glass windows, two-thirds of all glass breakage claims in motor own-damage insurance are for the more expensive tinted windows.

(undated b: 7)

If this finding is accurate it indicates that in the period covered up to one-third of claims for glass breakage in cars were fraudulent, or that thieves particularly targeted these cars (or both).

Although studies have shown that there are a larger number of frauds conducted against household policies (ABI 1995a: 4; Wittkämper 1991: 27) and travel policies (Wittkämper 1991: 27), most insurers believe that in terms of cost, motor insurance accounts for by far the greatest losses through insurance fraud (ABI 1999). By understanding that this is the case insurers can decide where their priorities lie in fighting fraud, although more research is needed.

The survey undertaken for this thesis found that the majority of frauds are basically genuine claims which have been exaggerated and inflated. The ABI in their survey of insurance fraud found that insurers themselves estimated that 39 per cent of all insurance fraud in the non-life business constituted inflated and
misrepresented claims (ABI 1999: 12). Although the ABI survey was based on ‘guesstimates’, this high figure is indicative.

Cost of insurance fraud

Fraud is certainly costly (Levi 1987: 23), yet in the UK there are no official estimates of the extent and cost of insurance fraud, nor are there any reliable calculations of the costs of preventing the offence. The ABI estimated that the cost of insurance fraud totalled £650 million in 1999 (ABI 1999). A report by Mintel (1994) suggested that insurance fraud accounted for ten per cent of payments. This would mean that in one year £1.5 billion was lost by insurers through insurance fraud. While one always has to be careful about the type of data included and the methods used to calculate losses, more specific insights are possible. For example, the ABI noted that the average household expenditure in 1997 on motor insurance was £324.00 (ABI 2000c: 82) and that the estimated cost of motor fraud as a percentage of premium income was 3.9 per cent (ABI 1998), that is £12.64 per household; and this is a conservative estimate (as will be shown later). Similarly, the average household expenditure in 1997 on structure and contents insurance was £261 (ABI 2000c: 82), and the cost of fraud as a percentage of premium income was estimated at 3.7 per cent (ABI 1998), i.e. £9.66 in the average premium. In other words, on just household and motor insurance fraud, and on these conservative estimates, the costs per household are at least £22.30 per annum. These costs are invariably passed on to the policyholder through increased premiums.
The scale of losses is not peculiar to Britain. Research in Germany indicates that in 1991 losses resulting from insurance fraud totalled DM3 billion, or £1.2 billion (Wittkämper et al 1991). In Austria the figure for insurance fraud reported in 1988 was put at Sch2 billion, or £926 million (Wiener Zeitung 1988). In the USA health care fraud was estimated at $80 billion (Witkin et al 1992). A further report puts US insurance fraud at US$17 billion annually in property and casualty lines and US$50 billion in health insurance (National Underwriter 1992). Another report, by the Munich Reinsurance, cites a speaker at a meeting of insurance specialists in Coronado, California, as asserting that 15 per cent of all claims payments were attributable to fraud. The report also stated that:

Depending on the country and class of insurance to which the figures apply, it is estimated that claims payments resulting from fraud may account for as much as 50% of premium income. (undated a: 7)

The report continues on a more cautious note, suggesting that the figures usually quoted are between ten per cent and 30 per cent of premium income, and that these are probably not too wide of the mark.

Most surveys of insurance fraud, however, miss the point that it is not only the direct costs which need to be included but also the indirect and consequential costs such as lost jobs, bankruptcies (Munich Reinsurance Company undated a: 7), court proceedings and offensive and defensive loss prevention measures (Munich Reinsurance Company undated a: 7). The Munich Reinsurance Company
report goes so far as to suggest that these direct and indirect costs total US$20 billion annually in the USA alone.

Partly because researchers are working with different variables and lack data, their estimates of the costs of insurance fraud vary considerably. While it is commonly acknowledged (Wittkämper et al 1991) that some countries have a tendency to suffer more because of differing national attitudes towards honesty, this question of costs has received little scholarly attention. Insurance fraud is expensive, and not all the costs can be absorbed by the industry: a large part is passed on to the consumer through higher premiums (ABI 1992), although in practice there are a variety of losers.

Who loses and who gains from insurance fraud?

This thesis examines the role of the company as the victim, since it is looking at different types of frauds against insurance companies. However, in that the study looks at the role of companies in preventing fraud, it examines how they manage fraud. In the commercial world, and insurance companies are commercial, the priority is profit—indeed, survival depends on it. Given this, is it realistic to believe that insurance companies would tolerate a position in which they lost from fraud (unless they were not aware that it was happening)? Similarly, is it realistic to assume that they would spend more on fraud prevention than the cost of the offence? If they fail to take action against fraud, on the basis that it is not financially worthwhile, they are effectively precipitating the offence. The subject of who loses and gains from fraud, and the role insurance companies play in their
own victimisation, are thus important. This sub-section will therefore consider who loses and who gains, and will then introduce the concept of victim precipitation.

As mentioned in the previous chapter, it is possible to identify at least five potential losers from fraud. First, insurers may lose: they suffer as premiums increase because of fraud, as people can no longer afford to buy policies or extend their insurance (see below), so companies lose premium income. Even if premiums do not rise, insurers can also lose out (particularly if claims rise) as the margins between premiums and claims decrease. Insurance companies lose money also from any investigation they may carry out into fraudulent behaviour.

Second, policyholders may lose. They may suffer through increased premiums, as a result of the costs of fraudulent claims which are passed on, or perhaps via others means such as reduced quality of service. For example the interim results from a crime survey conducted by the Forum of Private Business in 1994 found that 10.8 per cent of all companies questioned had no insurance; and of these just over 60 per cent said that they were not insured because it was too expensive. Third, shareholders, or those who own the company, may lose. Fourth, losers include those individuals and businesses that cannot afford policies as a consequence of increased premiums. Fifth, sectors of society may lose: in extreme cases insurance fraud, particularly when linked to arson, may cost lives (Stuart King 1993), and where businesses are forced to close there may be loss of jobs and services (Tilley 1993).
Sometimes, identifying who wins and loses is problematic. For example, when there is misrepresentation or fronting at the inception of a policy there is no loss to the insurer unless a claim is made. Moreover, the insurers would have gained by receiving the benefit of a premium that they might not otherwise have received, while the policyholder would have received his/her policy at a reduced price. Similarly with exaggeration at the claims stage, it could be argued (as noted above) that this provides a basis for negotiation, except where exaggeration takes the form of adding extra items to a claim.

It is possible to identify at least four groups who gain from insurance fraud, although the first three do so via unethical and illegal means. First, fraudsters gain if they get away with the fraud. Second, insurers may gain (as already noted) in that with fronting and misinformation they get a premium from a policy which they would not have otherwise underwritten, and which they can void if a claim is received. In this way they would make a profit, although of course the fraudulent policyholder would, if found out, lose from the whole claim being refused, even if he/she was not prosecuted. Moreover, this may lead to revenge and contribute to a negative attitude towards the insurance industry on the part of policyholders who have tried to cheat their insurers, and also on that of those who did not realise that their actions were fraudulent. Third, participants in the black economy will gain as a result of fraudulent claims feeding that economy, for example where builders collude with claimants to get the cost of building work (illegitimately) covered by insurance. The fourth group gaining from fraud includes loss adjusters and private investigators, who would have much less work to do if everyone was honest.
Victim precipitation

Levi (1981: 126) noted that: ‘It is an analytical truth that all victims bear some responsibility for their victimization’, although the extent to which victims precipitate the crimes committed against them varies greatly. This is an important issue, and not least when the ‘victim’ is an organisation that is geared to making a profit. In such circumstances it may make economic sense to allow victimisation in the interests of improved profit. Thus, victimisation may occur in a company which is motivated by greed or is reckless (Croall 1992; Levi 1992a). In a more general sense Clarke (1990a) has argued that companies can hardly be surprised that they are victimised if they do not challenge known opportunities for crimes to be committed against them; and they may not do so where it does not make economic sense.

Research by Levi (1992a) has shown that corporate victims are more likely than individual victims to believe that the offence committed against them was preventable, and they accepted that the police had a less significant role in crime prevention than was accepted by individual victims. Indeed, the literature on corporate crime is replete with examples of companies who have prioritised profits over issues such as health and safety and the environment, making money while others suffer as a consequence (see for example, Box 1983; Slapper and Tombs 1999). It is an interesting question—though beyond the scope of this study—whether companies fine-tune their other risks in a more economically efficient way.
In other words, the possibility exists that insurance companies will allow frauds to take place against them if the costs of responding are greater than the damage done to themselves. In such cases their behaviour may not be illegal, but will be unethical. There is a massive amount of literature on the subject of policing crimes at work, much of it evaluating the merits of different types of regulatory regimes (for example, see Levi 1987; Slapper and Tombs 1999). While this is beyond the scope of this research, further comment is needed on the extent to which insurance companies ‘allow’ crimes to take place.

Indeed, it will be shown that if there were a genuine concern to tackle fraud then there are a number of steps a company could take to ensure that it was not victimised. That these are not taken, it will be suggested, is because of ignorance and because of other priorities, not least that such measures were not perceived to make economic sense. The word ‘perceived’ is important here, because few companies appeared to have calculated this in any scientific way. It was generally no more than a perception, based on slight evidence such as available statistics on the number of cases observed and the experience of having assessed and investigated fraud cases.

There were a number of examples of victim-precipitation. Insurers encourage fraud against themselves at the sales stage because it is more important (and more cost-effective) for them to sell policies than to take steps which would help prevent fraud (such as checking customer details carefully and fully, and ensuring that the policy is suitable for the customer’s needs). Then there are claims exclusion clauses, which (among other things) induce claimants to seek ways of
fraudulently manipulating a claim to circumvent those clauses. And because policyholders believe they are being treated unfairly and become bitter, they seek revenge by exaggerating claims or claiming for non-existent losses. These issues could be tackled if the will and resources were there, but ignorance and a preference for other priorities stand in the way.

**The insurance process**

This section discusses the role of insurance and how it is sold to others. It incorporates a discussion of three important areas: interpersonal trust, risk management and moral hazard. These concepts are important in understanding the business context in which insurance fraud takes place and in which it therefore has to be tackled. Essentially, insurers 'trust' agents to sell policies in a well-intentioned way. In practice this trust is frequently compromised. Risk management helps insurers decide and act upon priorities, while moral hazard is a significant concept in evaluating risk. These elements are important to an understanding of how fraud is identified and managed. There are other issues too: the use of loss adjusters is a case in point, but there is little research on this topic, and hence it was included in the research and will be commented upon more fully in Chapter Ten. This section continues with a broader look at the insurance process.
Background to the insurance process

In its simplest form, an insurance policy is a contract by which one party (the insurer) agrees to indemnify the other party (the policyholder) against loss, in return for a set payment. If a loss does occur the insurer pays out a sum which has been calculated on an agreed basis.21 The amount of premium the policyholder pays will vary according to the type of risk and the protection required.

Insurance works because the premiums paid by a large number of policyholders are pooled together. It can be assumed that only a proportion or a minority will suffer a loss in any one year. Insurers hope that the pooled premiums will therefore cover the cost of any payments as well as of their administration charges, while giving their company a profit.

Much of the insurance available today comes under the heading of general insurance, and covers motor, accident and health, property, general liability and pecuniary loss. General insurance contracts are usually (but not invariably) in force for only a year,22 and the insurer will typically offer to renew the policy at the end of the year for the same or a changed premium. In 1999 a total of 658 insurance companies were authorised to conduct transactions in general insurance within the UK (ABI 2000a). By the end of 1999 the general insurance business in the UK generated £27.2 billion per annum in net premium income (ABI 2000a),23 with claims at £14 billion (ABI 1999: 40, 45).
It is estimated that 80 per cent of travel insurance is sold through travel agents and tour operators (Mintel 1996). Others who sell travel insurance include credit card organisations, medical insurance companies, brokers, banks, motoring organisations, chemists and newsagents. According to the Mintel Report (Mintel 1996), only seven per cent of travel insurance is sold directly by insurance firms. Like travel insurance, household policies are sold through a diverse range of outlets apart from the insurer—including banks, building societies, solicitors and estate agents—over the Internet, via coupons at airports and through brokers.

Third party motor insurance is compulsory. Under the Road Traffic Act all motor vehicles must have at least third party cover if they are to be driven on public roads (ABI 2000a: 14). Of motor policies sold, 20 per cent cover third-party liability, fire and theft and the remaining 80 per cent offer comprehensive cover (ABI 2000a: 14). While around 30 per cent are sold directly by insurers (ABI 2000a: 15), the majority of motor insurance policies are sold through intermediaries and company agents.

The majority of households in the UK have some form of insurance, which by 1998/99 cost the average household £1042 (ABI 2000b: 2). Indeed, expenditure on insurance represents on average the fourth-largest item of household expenditure, coming after transport, food and housing (ABI 2000b: 3). A report by the ABI estimates that seven per cent of a UK household’s total income in 1998/99 was spent on insurance (ABI 2000a).
Some forms of insurance are compulsory, as for example has been pointed out above in relation to motor vehicles (ABI 2000a). Other compulsory insurance includes employers’ liability insurance and public liability insurance (e.g. for riding schools). Similarly, banks and building societies may require mortgagors to take out household and life insurance as part of the agreement. For the most part, however, insurance is taken out by people and companies because they fear the possibility of big losses.

Whatever the reason for seeking insurance, individuals can purchase a policy in a variety of different ways. Insurance is sold principally via insurance brokers and other independent intermediaries, by company agents or directly by insurers. This variety makes the process difficult to control, and provides opportunities for fraud.

Insurance brokers and others act as intermediaries between the insurer and the purchaser. Normally they are paid commission by the insurance company, but are not its employees. Brokers can offer the purchaser a range of products from different insurers (ABI 1996a), and because there is a choice, a prospective policyholder may get the insurance cover he/she requires at a more advantageous price. In addition the broker may help the purchaser fill out any forms, although this is not recommended practice—it is forbidden by most large firms, and not all brokers offer this service. Some brokers, however, offer additional services, such as negotiating claims; some even have authority to settle claims.

One major problem can arise from using brokers, in that they are not legally tied to a particular insurer: if a broker acts fraudulently or is negligent, and the
claimant consequently suffers a loss, the insurer has no legal responsibility (Diacon and Carter 1992: 148). A firm or individual who wishes to use the title 'insurance broker' must be registered by law with the Insurance Brokers' Registration Council, which has the responsibility of ensuring that the requirements of the Insurance Brokers (Registration Act) 1997 are met (ABI undated a: 10). Although brokers make up most of the category of independent intermediaries, there are other independent agents who sell insurance, including banks, building societies, tour operators, travel agents, credit card companies, estate agents and motor traders. These and other agents are required to abide by the ABI Code of Practice for the Selling of General Insurance (ABI undated a: 10). At the same time, insurers have agreed to ensure that those who sell their insurance abide by these conditions.

The second group of insurance policy providers are agents. These range from persons who are directly employed by a particular insurer to large firms and self-employed agents who have legally binding agreements with a number of insurers. Company agents will offer the purchaser a restricted choice, and the disadvantage of using such an agent is that the insurance on offer may not fit the requirements of the purchaser. The advantage of doing so, however, is that if the agent acts fraudulently or is negligent the insurer has a legal responsibility to the insured (Diacon and Carter 1992: 249).

The third way that insurance may be sold is directly through the insurer. Although in the past insurers have mainly sold their policies through brokers and agents, there is a trend towards direct sales. Indeed, in 1999 17 per cent of all general
business was sold directly by insurers (ABI 2000c: Table 104). However, it is interesting to note that for personal lines of business (including household insurance) the figure was higher, having doubled over ten years to 24 per cent in 1999 (ABI 2000c).

Whatever the method chosen, the process of purchasing insurance is an easy one; it can be done over the telephone and/or by filling in a proposal form. A series of questions are asked, and those taking out insurance are expected to disclose all material facts relating to the risk, whether they are asked for them or not. Failure to disclose these facts can result in the policy being voided by the insurer and any claim under the policy rejected. The contract of insurance comes under the heading of *uberrimae fidei* or ‘utmost good faith’. The insurance contract is very different from other business contracts, which are not based on good faith but on the principle of *caveat emptor* or ‘let the buyer beware’ (Diacon and Carter 1992).

The insurer will decide whether to insure the risk and if so at what premium, after which a proposal form will be sent out to the prospective policyholder for completion and signature. An underwriter will determine whether or not to insure the risk, taking into account such factors (depending on the type of insurance) as age, location, degree of moral hazard involved, etc. The underwriter will determine the premium, especially in commercial insurance. Sometimes actuaries (and for that matter underwriters) may be used to calculate motor insurance premiums, by using a combination of risk theory and statistics to determine the probability of a loss occurring.
However, because it is easy to buy insurance, it is correspondingly easy to commit fraud. Premiums are based on the information that the prospective policyholder provides; and by deliberately distorting or withholding certain information an individual can avoid an increased premium. One example of this would be an assertion that one has never had a car accident, when this is untrue. Not only is this fraudulent (because it is obtaining insurance by deception), but insurers perceive that it increases their exposure to risk.

There are also opportunities to commit fraud at the claims stage. All the policyholder has to do is to provide false information about a loss, and this information is often not checked by the insurer; for example, the value of items which have been stolen can be overstated. Although it is the claims department that usually deals with any claims, not all insurers handle claims in-house. It is not unusual for insurers to retain specialist firms whose job it is to negotiate claims settlements. There is a growing trend for insurance companies to entrust the claims process to loss adjusters (Banner 1997). This is cost-effective, but the disadvantage is that the insurer loses a degree of control over the claims process.

When a claim is received, its validity under the policy conditions is examined. At this stage it will be either rejected, because it does not meet the criteria laid out in the policy, paid in part or in full, or sent for further investigation; this may be an automatic procedure because of the type of claim, or reflect the fact that the claim appears suspicious. Finally such a claim is paid or rejected, or in rare instances becomes the subject of litigation.
At the end of the period of insurance (usually a year) the insurer may offer to renew the policy, possibly at a new rate, or the policyholder may seek insurance elsewhere. If the policy is renewed, the insured person will need to disclose any new information that could affect the insurer’s assessment of the risk. Renewal is legally viewed as entering into a new contract.

Fraud can be committed at both the inception of a policy or at the claims stage. Because insurance is sold through many different outlets, insurers often have little control over who their policyholders are and what checks are made. And although insurers have contracts with principal agents, essentially they rely on trust to ensure that the policies are sold correctly. There is a theoretical discussion about the role of trust in agency relationships in the context of fraud, and this subject merits specific review here.

The concept of interpersonal trust and insurance fraud

Since Cressey’s (1971) work on embezzlement, in which he identified breach of trust as a crucial factor characterising offenders’ behaviour, a range of authors have underlined the crucial role that trust plays in capitalism and in modern business (for example, Clarke 1990; Levi 1987; Shapiro 1984; 1990). As Cressey noted at the time, business cannot operate without trust, and yet this is one of the factors that provide the opportunity for fraud.

Shapiro’s (1990) classic paper is frequently referred to in this respect. She outlined the ways in which the job positions where post-holders were given an
element of trust were those that created the opportunities to commit fraud, with those further up the hierarchy having more autonomy (see Slapper and Tombs 1999). Similarly, those in an agency relationship with an organisation are trusted to be honest, yet there is plenty of scope for this trust to be abused. Croall (1992; 1999) looked at abuse of trust from the point of view of the expert's power over the lay client or inexpert employer. These issues have important implications for insurance fraud, although perhaps in slightly different ways.

Unlike other forms of contract, a contract of insurance is based on trust or 'utmost good faith'. It is important to understand how a breach of trust may work both ways: the insurer may not be honest with the policyholder, and this can result in the latter receiving inadequate cover and as a consequence a reduced payment from a claim, or a voided policy. The reverse can be true too: the policyholder may not be honest with the insurer, by providing false or misleading information. Both of these possibilities merit further comment.

Insurers have to trust agents to ensure that clients are sold the correct policy to meet their needs (rather than the policy that makes the most money for the agent). As Croall has noted (writing in a slightly different context):

Consumers are ripped off by a lot of misleading and fraudulent sales practices which deceive them about the quality, amounts or value of goods and services. (1992: 22)
As will be shown, some policyholders are resentful towards insurance companies—because they feel that policies have not met their needs, and they only find this out when they make what they believe to be a valid claim.

The principle of utmost good faith characterises the relationship between insurers and policyholders, as well as between insurers and the agents they use to sell their policies. Agents can provide expertise in and knowledge of ways of selling policies that insurers do not have, and it may be difficult for the latter to monitor quality and performance (Shapiro 1990: 349). The insurer trusts the agent, but the extent to which the former endeavours to find out about any bad practices is crucial here. As noted above, if agent and insurer are making a profit, then errant agent behaviour may be as much a consequence of turning a blind eye to known or suspected unethical practices as of a breach of trust. In a different sense, there is a potential for agents to steal the premiums and not issue a policy at all; in this way both the insurer and policyholder can lose out. Without controls agents are in a position to behave in this way, and Shapiro’s warnings are relevant.

However, customers do put their trust in the insurance company and/or its agent to sell them the correct policy. Their trust is abused where their needs are incompetently, dishonestly or inaccurately considered. The prospective policyholder is often ignorant of detailed issues and consequently has little power. This is also true when a claim subsequently occurs and the insured requires advice about cover; the organisation has a greater knowledge about the service and can exploit this (Moore 1980, cited in Clarke 1990: 242).
When people take out insurance, they have to be trusted to tell the truth. And when a claim is made policyholders have to be trusted not to lie, for example by exaggerating, or to include other losses not relevant to that claim—the checks that would need to be made to guarantee veracity would be too time-consuming. It is the abuse of this type of trust that accounts for much of the fraud that is discussed in this thesis. As Shapiro notes, this abuse can appear as 'misrepresentation, deception, exaggeration, omission, distortion, fabrication, or falsification of information' (1990: 351).

It seems that faced with the abuse that occurs through having to trust, against the cost of checks that would need to be made to curb such abuse, insurers accept that it will occur, and balance the costs by themselves engaging in abuse of trust. The problem is that in so doing they create a climate of mistrust, which some people then use as a reason for seeing insuring companies as 'deserving victims'. This point will be returned to later.

Risk management: establishing priorities for fraud management

The question of how companies manage threats is broadly the subject of risk management, and where these threats involve crime or security, they may fall within the ambit of security management or crime risk management. The processes by which companies assess such threats and then manage them are relatively under-researched topics. There is some evidence that the means by which assessments are made and priorities established are crude at best, although this is a vital area and one where competence is rewarded (Levi 1987). As
Burrows found from his research with companies, crime risk management depends:

... on comprehensive assessment of the losses being sustained from crime, of how these occur, and of emerging vulnerabilities. These functions are underdeveloped in nearly all companies. (1991: 38, original emphasis)

Shapland (2000), meanwhile, found that a crime audit could lead to a change of priorities.

At least part of the problem is the difficulty of working out costs, not just within companies but also in respect of the costs to the criminal justice system, as noted by Levi (2000). Indeed, much academic research, and not least that which involves evaluating prevention measures, has tended to give little attention to cost-effectiveness. The lax attitude to risk assessment and crime prevention is typified by companies’ attitudes to fraud:

The belief that opportunities to commit fraud will, in time, be exploited – and that this principle is in many cases overlooked by those designing systems and procedures – was widely accepted by all approached. (Burrows 1991: 21)

Some companies have worked out that the penalties that are imposed are less than the profits that can be generated from offending. For example, Braithwaite found
that fines for tampering with odometers were low, and lower than the profit that could be obtained; he concluded that: 'Any rational assessment by a dealer who is interested in maximising his financial returns must convince him that this form of crime does pay' (1978: 120). However, Braithwaite did not examine whether the car dealer would ultimately lose sales through bad publicity if the public or customers found out—in such a case crime might not pay. It is a subject which merits more research. On the other hand it cannot be assumed that it makes good financial sense to seek to prosecute all types of offences. Pyle, in his assessment of responses to tax evasion, noted that:

the detection and prevention of evasion require the use of scarce resources that have alternative uses. Inevitably the policy decisions must balance costs against benefits. The consequence is that it may be desirable to let some evasion take place. (1989: 172; see also MacDonald and Pyle 2000.)

A number of writers have noted that tackling crime has to be seen as making 'economic sense' (Clarke 1990a; Levi 1987), because there are costs to most crime prevention measures, and there are 'financial opportunity costs' to even reporting fraud (Levi 1992a: 188). As Levi observed:

'The rational capitalist ... might state that 'action against fraud should be at the level which optimises the balance between enterprise and fraud prevention'.' (1987: 80)
But, as Levi recognises, the real problem is knowing what the optimum is, and this is the opportunity that good risk management offers. However, the difficulty of forecasting the future makes this optimisation hard to achieve.

But even if one accepts the commercial reality, that not all offences can be prevented all the time, there is still the issue of deciding which ones will be the priority, especially where the desirability of preventing crime is ‘less engrained’ (Levi 1987). This has been the concern for a number of writers who have outlined the consequences, not least the reality that profitable policies have been pursued at the expense of human lives:

A society in which the social production of goods and services is dominated by commercial considerations will be likely to generate a certain human sacrifice. (Slapper and Tombs 1999: 144)

So deciding how decisions are made about priorities is crucial. And such decisions are not just important at the life-and-death level (albeit these are the most important). Indeed, a study of insurance frauds as discussed in this thesis provides an opportunity to examine how crime prevention is established as a company priority. Certainly research has shown that insurers need to balance these issues. For example, Clarke (1990a) notes that the costs of checking insurance claims means that insurers choose to pay out and ‘hope’ that fraud does not occur too frequently. The costs include the difficulty of obtaining sufficient proof. Clarke also notes that companies see their image as important, and they fear a public
reaction—indeed, this is why, for example, they refrain from devising a list of drivers’ histories, which would greatly assist fraud prevention efforts.

Moral hazard

Moral hazard is an important concept in discussions about insurance fraud. Diacon and Carter (1992: 297) defined it as: ‘behaviour by the insured which increases the chance or size of an insured loss’. There are a number of outcomes of such moral hazard behaviour that have implications for the insurer: the insured may not act in his/her own best interests, may be unreasonable or careless, and (of particular relevance here) may commit insurance fraud (see Litton 1990: 98–100). In other words some types of people are more prone to have losses and make claims than others, and part of the problem that insurers have with moral hazard is that it is difficult to identify these types of people, with judgements often being made simply on a suspicion.

Moral hazard is therefore a type of risk. A risk in insurance terms is the likelihood of a loss occurring. Litton (1990) has broken risk down into two specific areas: first, physical hazards, which occur naturally and can be removed or dealt with by policy conditions; second, moral hazards, which are conditions of the insured person or some other person which increase or decrease the probability, frequency or severity of a loss. Moral hazard is more difficult to assess and measure, and as a consequence much more difficult to manage (Litton 1990: 96). It is moral hazard which is most relevant to insurance fraud, because it focuses on characteristics of the insured which might make an insurance policy more prone to fraud.
Moral hazard has been broken down further into two distinct categories: moral hazard and 'morale hazard'. Moral hazards are dishonest tendencies by the insured which induce him/her to defraud (Mehr and Cammack 1976), whereas morale hazard is attributed to carelessness or indifference on the insured’s part.

Insurers have in the past protected themselves against moral hazard at the expense of policyholders. Indeed some of the practices employed by insurers could be regarded as being unfair. For example, Alport (1988: 111) suggests that insurers should always pay out less on a claim than the amount lost. Holton (1973) argues that deductibles should be charged to an insured’s claim. He states that if a deduction is made in a claim, the amount that the insured would receive is smaller and there would be less temptation for the insured to cause a loss or make a claim. However, this may not entirely hold water: as this research shows, claimants will sometimes increase their claim in order to cover the deduction. Litton has argued that even if deductions were used to control moral hazard.

Certain moral hazards may emanate from parties other than the insured — striking employees, disgruntled customers or an ex-employee with a grudge. (1990: 102)

There may be little the insured could do about such individuals.

As a last resort, insurers can ultimately control moral hazard by cancelling a policy, without giving notice to the policyholder or even a reason for the decision (Litton 1990: 101). However, this could be considered unethical; and for the
insured, there is not only the loss of cover to deal with, but the cancellation may act against them when they seek a replacement, and have both practical and financial implications.

The insurance contract is unique, as ‘utmost good faith’ should apply to both the insured and the insurer, but as Litton (1990: 100) states, this is not currently happening; the insurer is rarely judged in the same way as the insured. Litton (1990: 110) notes that solutions rest on getting rid of public ignorance, and on a better understanding of the ‘biases, prejudices and errors’ which can underlie insurers’ judgements about moral hazard. And in some cases it may be possible to build conditions into policies; a case in point may be the requirement that the insured keep insurers advised of any changes in conditions affecting the policy.

The topic of assessing risk is an important one, and will be returned to later in the thesis in looking at the insurer’s response to fraud.

**Insurance fraud in context: the impact of socio-economic changes**

The cost of claims constitutes the insurance industry’s major cost. Much of the fraud discussed in this thesis took place as part of a legitimate claim, so it is evident that the trends affecting claims are of interest to those involved in tackling fraud. This also represents an opportunity to ‘piggy back’ fraud prevention strategies on the back of initiatives which have a different primary purpose. Among the many issues that could be discussed, several trends are mentioned to illustrate the wide range of ways in which socio-economic changes can have a
direct impact on insurance. The trends to be considered are the price of insurance, competition, technology, climate changes, and mergers and acquisitions.

The price of insurance affects its demand (Taranto 2000). Insurance premiums rose during the late 1980s and 1990s, and the cost of some types of household and motor policy increased at above the rate of inflation (ABI 2000b: 10). Taranto (2000) noted that half of households without home contents insurance were unable to afford it. It should be noted, working from ABI figures, that eliminating insurance fraud could result in reductions of five per cent on the cost of structure and contents insurance, and four per cent on motor insurance. If cost is an issue this could encourage those who might otherwise not be able to afford insurance to buy it. In the meantime Taranto (2000) speculated that households are electing to pay a higher excess in exchange for lower premiums. In such circumstances, as has been shown, the incentive to commit insurance fraud, in order to recoup the higher excess charges, is even greater.

As premiums have increased, so competition between insurers has grown more intense—which in itself stands in the way of co-operation—and insurers are seeking new ways to remain competitive. One way to remain competitive, noted in interviews for this study, is to make changes to policies. Changes may take the form of a strict claims handling policy designed to reduce pay-outs—for example notifying an insurer of a loss within a set period of time—or new exclusions which limit the policyholder from claiming or impose rigid conditions on a claim. These practices, as has been shown, can encourage fraud.
Another way of remaining competitive is to change sales policies. Direct sales are becoming more common, accounting for 24 per cent of personal lines in 1999, and 34 per cent of motor insurance is sold this way (an increase of six per cent over a five-year period). While only 17 per cent of household policies are sold direct, even this has increased by four per cent over the same period (ABI 2000a: 42). However, while this method cuts out some of the problems identified in the thesis over the use of agents, it creates other problems: it is impersonal; it does not provide much time to examine policy requirements in depth; and there are no visual aids to help customers understand their policy at the point of purchase. This can lead to the wrong policy being issued, while at the same time the insurer has little knowledge of the policyholder, no form of identity is required, and if a policy is underwritten immediately, with few checks, this leads to a situation which can facilitate fraud.

There is some evidence that if practical advice is given by the insurer to policyholders about how to protect their property, fewer losses will occur and thus there will be fewer claims. Indeed, situational crime prevention’s success is based on the premise that crime, and particularly property crime, can be thwarted by a range of measures (Clarke 1997). Indeed Taranto (2000) discussed how car security has improved with alarms, immobilisers and tracking devices, and so motor theft claims have been reduced (ABI 2000c: 41). A final point about competition is made by Taranto (2000), who noted that motorists are now shopping around for insurance to find the best deals. This can have an impact on fraud, because when customers are new, the insurer does not have a comprehensive history of them, and the risk they pose is unknown.
Developments in technology are affecting opportunities both for offenders and for crime prevention. The availability of some goods, especially highly portable 'hot' products such as mobile phones (Clarke 2001), creates problems for insurers. In addition, computer chips are particularly valuable, and there is an enormous opportunity presented for crime using the Internet. The Internet has 150 million users world-wide, with 80,000 more coming on line each day (Kemble 2000). E-commerce broadly means buying and selling goods electronically via electronic data interchange, the Internet, interactive TV, 'smart cards', mobile communications and computer telephony interchange. Often e-commerce is more cost-effective and speedier: insurers can gather information on a customer without having to retype it (Meridian Research Analysis 1999). As Levi and Handley (1998: 5) noted, breaches in security happen instantaneously over the Internet, which means that companies can be subject to huge losses in a short space of time. Moreover, it is easier to stay anonymous. One of the advantages of e-commerce is that customers can be expected to confirm that they have read the terms and conditions of a policy appearing on the screen. This interests regulators because it could reduce mis-selling by providing evidence that an individual has read the terms and conditions (Kemble 2000). This is a valuable part of fraud prevention—if it works in practice. In reality, there are drawbacks which can have an impact on fraud—for example, its impersonal nature and speed appear to provide good conditions for would-be fraudsters. There may also be problems if policyholders fail to interact with the computer properly (purposely or not) and end up with inappropriate cover, which again can lead to fraud.
Climatic conditions may also be a factor. The weather has caused major problems to insurers (ABI undated b). In 1998, the cost of weather damage claims represented the largest source of claims. Climate changes are taking place over a long period of time, and it is not yet clear what impact these changes will have. However, if the floods, storms and heavy rainfall that have been experienced recently in the UK are in any way symptomatic of a trend, these claims will represent a growing area of concern for those interested in fraud prevention, particularly if there are a higher number of claims, since fraud often occurs as part of a legitimate claim.

Mergers and acquisitions have had a major impact on the insurance industry, and there have been several high-profile mergers. Some of the most notable include: AXA Equity and Law with Sun Life and Provincial Holdings, to form AXA Sun Life, in 1997; Commercial Union with General Accident, to form CGU, in 1998; Gan with Lombard General to form Groupama, in 2000; CGU with Norwich Union, to form CGNU, in 2000. In addition, there have been a large number of acquisitions over this period, which means, for example, that the UK general insurance market is dominated by a few, very large insurers. CGNU is the largest of these, with a net UK premium income for general business of £4.98 billion in 1999—this is almost 22 per cent of total net UK premium income for ABI members. Indeed, the market share held by the top five insurers increased from 49 per cent in 1996 to 62 per cent in 1998 (ABI undated b), and to 69 per cent in 1999 (ABI 2000c). The ABI's insurance fraud statistics for 1999 (ABI 1999) estimate that fraud cost 3.7 per cent of premium income. This means that fraud on general insurance at CGNU would have cost £184 million during 1999 (and this is
likely to be an underestimate). Clearly, there is ample scope for suggesting that there could be enormous savings from a (cost-effective) strategy to tackle fraud.

One of the problems of mergers is that they can create more complex organisations (Perman and Scouller 1999), itself a reason why merged organisations are often found to have failed to capitalise on their potential for improved performance (Mueller 1988). Perhaps not surprisingly then, incompatible systems (including computers and databases) and different cultures and priorities, as well as different departmental structures, combine to make problems for fraud prevention. Some of these problems reflect the traditional low priority attached to fraud prevention.

It has been estimated that the high rate of UK mergers and acquisitions has been driven by expansion into Europe, and that a large number of UK insurers are being taken over by their European counterparts (ABI 2000d). The European Union is the largest source of overseas premium for UK insurers (ABI 2000d), and in addition the UK is active in the emerging markets of Central and Eastern Europe. One of the problems insurers face in Europe is that a product may meet standards in one country but may not in another. One can speculate on the likely changes that these emerging markets may have on fraud, but combined with other trends, notably technology, this is an issue that will require close scrutiny by those with fraud risk management responsibilities.
Conclusion

Insurance fraud by customers is a type of deception that has received little coverage in the research literature. It involves an offence committed against insurance companies, but one in which victims play a leading role in their own victimisation. In pursuit of their business goals, insurance companies create opportunities for fraud to be committed against them, and at least to some extent this can be controlled. However, there are more important priorities, such as making a profit, and unless a company can be convinced that its bottom line is adversely affected it does not view it as good risk management to engage in expensive and often untested prevention measures, or to take steps that might impede normal business. This stance, whether unethical or not, is entirely rational (the concept of ‘rationality’ is discussed further in Chapter Four) if profits are the guide to good practice. One example is the way that policies are sold, which invites agents to abuse trust. There is nothing unusual in this, and while previous research already reviewed has shown that fraud occurs where people are in a position to abuse trust, the problem is that the organisation of the insurance business provide them with opportunities for doing so. Little is known, meanwhile, about how loss adjusters are used and the potential role they have in fraud identification and control.

Insurers could argue that as long as the market can endure the increase in policy prices which offsets the cost of fraud, then the latter may be worth tolerating. Parallels can be drawn with tax evasion, where the costs of attempting eradication may be too high a price to pay. As Pyle noted:
It is not altogether the case that evasion is altogether the evil that popular discussion of the problem would suggest. Also, except in the most likely situations, the detection and prevention of evasion requires the use of scarce resources that have alternative uses. Inevitably then policy decisions must balance costs against benefits. The consequence is that it may be desirable to allow some evasion to take place. (1989: 172)

However, it is certainly not the case that no-one loses from fraud—there are indeed losers, including those who are unable to afford insurance or the type of policy they need. Hence there are ethical issues about an approach geared to profit. In any event, it is far from obvious that the real risks from this strategy have been properly understood. Fraud risk management seems to receive a low priority, and little is known about the scale and costs of insurance fraud—or for that matter about the cost of its prevention—among the public and insurers. It is hardly surprising that there is little clarity about which preventive strategies are the most appropriate. Companies are sometimes seen as being negligent in their response to the threat of crime, somewhat missing the point that it may be economically more efficient to tolerate some crime.

However, these approaches clearly have certain implications. Insurance fraud is simple: a policy is easy to obtain; one can even get help with completing the form; and there are few independent checks because one is trusted to be truthful. The way the insurance business is conducted creates opportunities for fraudsters, and those who sell insurance are motivated by incentives which are not sensitive to the
search for fraudulent applicants. Competition within the industry means that there is little co-operation, and in any event different companies adopt different strategies and attach different priorities to fraud prevention. There is confusion about what characterises a fraudulent transaction, and even the police and the courts have what appear to be ambivalent attitudes. The aim of this thesis is to make sense of these issues as a way of framing a response for insurance companies to the fraud problem.

1. Taken from Section 17 of the Theft Act 1968
2. See Derry v Peek 1889 14 App. Cas. 337.
4. Cann v The Imperial (1875) and Norton v Royal (1885).
6. The ABI spokesperson made this comment anonymously.
8. The terms 'inception' and 'renewal' are used interchangeably, to avoid repetition.
9. This is done without informing the insurer about the other policies, otherwise the legal principle of contribution would operate.
10. This is done without informing each insurer about the other policies, otherwise the legal principle of contribution would operate.
11. This is done without informing each insurer about the other policies, otherwise the legal principle of contribution would operate.
12. These figures were obtained by calculating the percentage of total claims (5.7 million), estimated at 4.9 per cent.
13. As there is no information available on the total number of non-life claims made per year, the figure of 11.1 million during 1999 has been used; this figure comes from an ABI fraud survey. However, not all companies approached answered the survey; and the figure is therefore likely to be an underestimate. (Taken from the ABI Crime and Fraud Prevention Bureau Annual Report, 1999).
15. Because of the high value of individual payments.
16. Levi found in his research on fraud in general that if the costs of theft, burglary and robbery were combined together, the total figure would represent only 33 per cent of the cost of recorded fraud throughout the UK, which was just over £2 billion in 1985.
17. This figure was reached by adding the total number of payments for UK non-motor insurance (one-year business) to those for UK motor insurance (one-year business), i.e. £7.8 billion + £7.2 billion. These totals were taken from the ABI’s Insurance Statistics Year Book 1989–1999 (2000c), pp 40 and 45.
18. The exchange rate used was DM2.5336 to £1.00 sterling, taken from The Times, 6/12/96, p 25.
19. The exchange rate used was Sch2.16 to £1.00 sterling, taken from The Times, 6/12/96, p 26.
20. The loss of jobs can occur when organisations cannot afford to insure themselves, because of high premiums (this study having shown that fraud can increase premiums). Should a loss
occur within the organisation, the costs of reinstatement may be too high and the business has to close down, with the consequent loss of jobs.

21 As discussed with Roger Litton, personal correspondence, February 2000.

22 ‘Some insurers issue three- to five- year policies. Property policies may be annual, but subject to a long-term agreement. Non-annual travel policies are usually valid for a few weeks’ holiday (but in force for longer to cover cancellation). Contingency policies may have no expiry date. Warranty and indemnity policies are in force for three–six years, etc …’ Roger Litton, personal correspondence.

23 The term ‘general insurance’ includes motor, accident and health, property, general liability, and pecuniary loss insurance.

24 This includes third party, fire and theft.

25 This figure represents the average yearly expenditure of all households on all forms of insurance, but excludes personal pensions.

26 Roger Litton, personal correspondence.

27 The main difference between insurance brokers and other intermediaries is that the former are regulated by Act of Parliament.

28 They can sell the products of up to six different insurance companies.

29 Roger Litton, personal correspondence.

30 Roger Litton, personal correspondence.

31 Some financial institutions may sell their own insurance products, in which case they may also come under the category of company agent.

32 Proposal form signatures are mandatory in some classes of insurance. They may be dispensed with in others, but are required in the majority of cases. Roger Litton, personal correspondence.

33 Any information which is material to the risk insured and which could increase the chances of a claim must be revealed to the insurer. For example, if a house has a history of burglary, or if an individual has recently had a heart attack and is applying for health insurance cover, then the insurer needs to know this.

34 Uberrimae fidei: most commercial contracts do not require either party to divulge any information that is not requested. In this way both parties will try to make the best deal without being dishonest. These types of contract work on the premise ‘let the buyer beware’ or caveat emptor (Diacon and Carter 1992). The contract of insurance is different because it relies on uberrimae fidei or ‘utmost good faith’. In this way all parties to the insurance contract are required by law to disclose any material fact which is relevant to the risk, even if it is not asked for. Failure to disclose information by the insured can render the policy invalid, and the insurer may have the right to avoid the contract (Association of British Insurers undated a: 11). In order for an insurer to avoid a contract it must be proved either: 1. that a material fact was misrepresented, and that a material fact was involved; or 2. that the material fact was deliberately withheld, and that there was concealment (Diacon and Carter 1992).

35 The total net premium for UK general business in 1999 was £22.03 billion (ABI 2000c: 35).
3. Research methodology

Introduction

There have been a number of studies which have examined different forms of dishonesty that might be defined as fraud. These include medical fraud (Lewis and Lewis 1970), pharmacy fraud (Vaughan 1983), corporate fraud (Bologna 1984), long-firm fraud (Levi 1981), tax evasion (Deane 1981), credit-card fraud (Levi 1992a; Tremblay 1986), cheque and credit-card fraud (Levi et al 1991; 1998), retail-refund fraud (Challinger 1997), social-security fraud (Kuhlhorn 1997) and various types of fiddling (Biggus 1972; Ditton 1977; Gill 1994; Mars 1973). However, apart from small-scale studies by Clarke (1989; 1990) and Litton (1990), there have been few academic studies specifically on insurance fraud by customers.

Part of the problem is that insurance fraud is obviously a difficult topic to research. Insurers are often reluctant to discuss the subject and, even when they do, they tend to be secretive and misleading, fearing that the results will be both bad for publicity and advantageous to competitors. Many insurers prefer to state that they do not have a fraud problem, and hold few if any records of suspect frauds. Gaining reliable information from the public can be equally difficult, as people who are interviewed are naturally reluctant to admit committing fraud. This chapter explains how the researcher set about overcoming some of these difficulties.
An illustration of the problems of methodology is provided by the discrepancy between the results of surveys conducted by the ABI (1996) and the Chartered Institute of Loss Adjusters (1992). The ABI survey estimated that fraudulent claims represented three per cent of all claims, whereas the Chartered Institute of Loss Adjusters put the figure at 50 per cent. The reason for the difference may well be the methodologies used, as well as the institutions' differing interests. In both surveys respondents were asked to provide their best 'guesstimate' of the problem. However, individuals' perceptions are unlikely to be accurate, but merely reflect their particular knowledge and experience, together with information they might have received from media reports and colleagues. It could be argued too that the insurers questioned in the ABI survey would naturally suggest a low figure, because they deal mainly with routine insurance work and rarely come across instances of fraud. On the other hand, loss adjusters are expected to be suspicious of the claims that they handle, and may indeed only deal with suspect cases, so they might be expected to believe that the incidence of fraud is high. In view of this, the survey figures, although interesting, cannot give an accurate representation of the true extent of the problem.

Some methodologies would not be appropriate for the study of insurance fraud. For example, self-report studies might well produce inaccurate results, as fraudsters are likely to be reluctant to admit that they have committed an offence, and some may not even know whether or not they have done so (Jupp 1989: 102).

There are other methodological problems. For example, after two fraud surveys conducted by the ABI, the figures that were given to the press were very different
from the actual results. When questioned about this, those responsible admitted that because of the nature of the survey it was difficult to calculate the results accurately.\(^1\) It was even admitted later, during an interview given by a representative of the ABI, that the figures were generated for publicity purposes. In the survey literature a different picture was shown. The ABI claimed that the survey produced ‘more accurate figures on the size and trends of fraudulent insurance claims’ and that they had a ‘statistically valid sample from the industry as a whole’ (ABI 1994: 8; ABI 1995c: 4). The report as published stated that ‘fraudulent insurance claims totalled around £600 million in 1994’ (ABI 1994), but there was no explanation of how this total was arrived at.

The ABI figure is likely to be wildly inaccurate, because the premium income that this figure was based on (£7.3 billion) was far below the real total for 1994, which was £22.05 billion in commercial and personal lines (ABI 1996f). Also, a number of major insurance firms refused to fill in the questionnaire, so important data were missing. Although the questionnaire asked about different categories of insurance, no questions were asked about travel insurance fraud. Despite these shortcomings, the survey received much publicity and was reported in the press as factual information.

Another problem with surveys is that they only give a snapshot of individual experience of insurance fraud. Some surveys may seek data for a specific period of time or, as in Gill et al’s survey (1994), ask questions about an individual’s last claim. To date there have been no longitudinal studies of insurance fraud.
The definition of insurance fraud used in some surveys may also be flawed, and certainly varies: for example, the ABI includes inflated claims within its definition of fraud (1995a). As has already been shown in Chapter Two, however, it is debatable whether some inflated claims should be defined as fraudulent.

The purpose of this chapter is to explain and justify the methodologies adopted at the various stages of the study.

**Methodology and previous research on insurance fraud**

Much of the research that does exist on insurance fraud is limited in scale. For example, Litton received only 69 responses to his questionnaire—and, in any case, those surveyed comprised only police, insurers and people in higher education; it was not representative of the population as a whole (Litton 1990: 144).\(^2\) The questionnaire itself was structured with mainly closed questions, so individuals had little opportunity to express their broader thoughts on the topic. Potentially important qualitative data from individuals such as the police and insurers were therefore not collected. It could be suggested that only a partial, albeit useful, look was taken at a complex subject.

Clarke’s research (Clarke 1989), which was one of the first studies of its kind, aimed to identify the issues surrounding insurance fraud. It was based on unstructured interviews and should also be viewed with caution, as only 11 respondents were questioned.\(^3\) The interviewees comprised senior insurers, loss adjusters and officers of the police and fire services. Although Clarke’s research
gave a fascinating insight into insurance fraud from the perspective of those who
have to deal with the problem, he, like Litton, failed to bring the general public
into the picture. It could be argued that the only sure way to gain an understanding
of insurance fraud is to question those who have committed it.

In order to gain a more thorough understanding of insurance fraud the author of
this thesis questioned both insurers and the general public, and supplementary
interviews were conducted with loss adjusters, the police and other relevant
individuals. In addition, and in co-operation with other insurers, the researcher
committed a simulated, 'pretend' insurance fraud during the course of the study
(see Appendix A). This research, together with a review of relevant literature and
case studies, has produced a more comprehensive base, from which to derive in
turn a fuller picture of insurance fraud.

Thus a variety of methods were used: questionnaires, interviews, observation,
documentary analysis and a review of the existing literature in order to produce
adopted a similar approach in his study of dishonest bread salesmen, using
literature searches and in-depth interviews, together with participant observation
(and including working as a bread salesman).

None of the existing research on insurance fraud uses 'methodological
triangulation', despite its usefulness for pinpointing 'the values of a phenomenon
more accurately by sighting in on it from different methodological viewpoints'
(Brewer and Hunter 1989: 17–18). Methodological triangulation has been
criticised for potentially offering conflicting results (Brewer and Hunter 1989: 17–18), but Jupp counters this by arguing that:

[Triangulated measurement balances] the strengths and the weaknesses of differing methods ... [and] therefore, maximises the theoretical value of any research by revealing aspects of phenomena which the use of one method alone would miss. (1989: 72–4)

An outline of the study

The objective of the current research was to carry out a critique of Ron Clarke’s opportunity reduction classification as it applies to insurance fraud. The approach of situational crime prevention is based on the hypothesis that crime is committed by rational individuals, who make decisions and take (at least some) account of the risks involved in ‘the crime’ and of the potential rewards from committing it (the notion of rationality is discussed further in Chapter Four). By questioning members of the general public, by way of a semi-structured questionnaire, it was possible to establish that individuals were rational and that the decision to commit fraud was based on a judgement of the opportunities and of the (lack of) risk. The answers also demonstrated that those committing fraud found it easy to excuse their actions. The findings from the questionnaire were interesting, and have been published in a separate article (Gill et al 1994); however, they have been used to support arguments in this thesis where appropriate.
During the course of the study insurers were also questioned. They were invited to fill in a questionnaire, and a number also provided contact details. All those who were willing to be interviewed were contacted. Some insurers were even prepared to give the researcher access to their data and records. This methodology offered a clear insight into the opportunities for committing fraud. Again, this provided support for the view that insurance fraud is committed because those opportunities exist and because the risks are often minimal. Indeed, the results of the research strongly confirmed that Clarke’s (1997) situational techniques could be appropriately applied to insurance fraud prevention.

Supplementary data for this study were also provided by interviews with loss adjusters, police officers and other relevant personnel. The purpose was to identify issues and discuss ideas from a variety of perspectives. To gain an even more in-depth understanding of insurance fraud the researcher (with the agreement of the insurer concerned) committed a mock insurance fraud in order to show how easily it could be done.

**Seeking permission and gaining access**

Insurance fraud is seen as a difficult subject to research because of the sensitive nature of the topic. Clarke (1989), when studying the subject, found that ‘the insurance industry is characterised by a considerable caution about airing its concerns in public, to the point of secretiveness on many issues’ (1989: 3). He complained about the difficulty of gaining access to insurers. In overcoming this problem the researcher was fortunate in having the support of the ABI, the
representative body for many of the large UK insurers. In order to elicit the maximum number of responses from insurers, the ABI agreed to distribute a two-sided A4 questionnaire, designed by the researcher, requesting information on the methods insurers used to detect and prevent fraudulent claims. It was hoped that insurers would feel more comfortable completing a questionnaire that came with a letter from their lead body. (A copy of the questionnaire is provided in Appendix B.)

The aim of this procedure was to develop an understanding of the attitudes insurers held, and the systems and procedures they used, when dealing with fraud. The questionnaire acted as a foundation for further in-depth interviews with insurers and provided a framework for further questioning; it also helped to give a fascinating insight into insurance fraud from the insurers’ perspective.

The questionnaire was divided into three parts. The first section examined the attitudes and views of insurers. It aimed to establish the companies’ perception of insurance fraud, and whether enough was being done to tackle it. Questions were asked about how insurers prioritised the investigation, prevention and detection of fraud, as well as how they could improve the way they dealt with it. The second section of the questionnaire looked at fraud in specific detail, and included questions on the types of insurance fraud and on whether or not insurers prosecuted fraud through the judicial system. The third and final section addressed issues relating to the structural arrangements and operational procedures for dealing with fraud. This third section helped to identify whose responsibility it was to deal with fraud, and the training given to staff.
Towards the end of the questionnaire the respondents were asked whether they would be willing to assist further by answering follow-up questions. The aim of the questionnaire was to provide helpful basic data, with the potential for later personal contact.

A total of 430 questionnaires were distributed, of which 232 went to general insurers, 153 to life insurers and 45 to companies handling both general and life insurance. In effect this was to all members of the ABI. The researcher received 43 replies (a ten per cent response rate). Of these, 13 came from the top 15 non-life insurance companies listed according to premium income (The Times 1995). Thirty-two companies expressed a willingness to participate further by giving the researcher the opportunity to interview staff about company strategies. Although this may seem to be a low response rate, the interviews provided important insights and facilitated excellent contacts. Those who replied appeared enthusiastic about the research, and as Benney and Hughes state: 'information is the more valid the more freely given' (1984: 219). Although many insurers were reluctant to get involved, those that did reply proved to be curious to know more and willing to help.

The researcher found that the technique of snowball sampling (Burgess 1990: 55) was also useful. Insurers provided names and addresses of their industry colleagues (sometimes after much prompting), who helped further. This broadened the subject base because the majority of insurers who were contacted on this basis were happy to discuss their experiences in tackling fraud. Such a system of sampling is inevitably biased and self-selective. May suggests that:
[This] may also lead to the researcher collecting data which reflect a particular perspective and thereby omitting the voices and opinions of others who are not part of a network of friends and acquaintances (1993: 100).

However, the objective was to identify issues, and in a world shrouded in secrecy the snowballing method certainly generated a considerable amount of useful information. The information, once gathered, was checked against that from other sources and, as will be seen, the findings were consistent.

Arrangements were made to visit all 32 insurers who had offered further help. The objective of the initial visit was to gather general information, to develop a rapport and to gain the interviewees' confidence. In this way the researcher was able to persuade some insurers to allow further access to confidential information.

After the initial interviews, nine of the larger organisations offered the researcher access to their records, as well as complete case material on suspected and proven insurance fraud. This information proved highly valuable.

Other methods of gaining access to material included meeting people at conferences and seminars held at the ABI and other venues on the subject of insurance fraud. In addition, the researcher presented conference papers and discussed ideas with the audience. Although initially cautious, the professionals
often opened up, and these informal discussion seminars often led to invitations to follow-up meetings.

**Use of records and documentary research**

Where possible the researcher aimed to use existing data, in particular fraud cases recorded by loss adjusters, insurers and the police. The aim was to follow cases from the initial claim to the outcome.

An advantage of using data that has been collated and recorded by others is that it is 'very much in the hands of others and may not be influenced by the theoretical ideas in which the researcher is interested' (Jupp 1989: 32). By using case studies it was possible to analyse the reactions of organisations and individuals to fraudulent claims, and the constraints and limitations on those dealing with such frauds. A picture emerged of how insurance fraudsters go about it; an insight into past events was gained which did not rely totally on an individual’s recall and was untainted by the researcher’s own ideas. Using interviews only for the research could have proven problematical, particularly as insurance fraud was considered by most to be such a sensitive topic. There was a danger that those interviewed might hide or distort the truth, not necessarily in order to deceive but to give a favourable impression of themselves and of their organisations which might otherwise be regarded as having on occasion made serious blunders.

Once the case studies had been collected and analysed the researcher then went back to interview those who had formulated the data, so gaining a deeper insight
into specific cases and how they were dealt with. This gave important clues as to how the offences could have been prevented.

It was clear from cases recorded by loss adjusters that the former were affected by bias. Different loss adjusters recorded data slightly differently; and some were more experienced or capable than others and thus more likely to identify fraud. The case studies did, however, provide a rich and colourful tapestry of the types of fraud and the way they are dealt with.

Since the cases which were examined were recorded by five different loss adjusters, an insight was gained into a variety of approaches and policies; but in order to achieve some consistency two criteria were applied in the selection of cases. First, all cases had to have been filed in 1994 and, second, fraud had to have been either proved or suspected. Different loss adjusters tackled cases of fraud very differently, and the standard of their reporting varied. Some adjusters had a tendency to go into greater detail and enquired more closely into suspected cases of fraud. Hence the drawback of using case studies—while interesting and informative, they can rarely be representative of the whole. It should be noted too that the researcher was told that some of the most ‘juicy stuff’ had been removed from the file for fear of infringing the Data Protection Act. In this way there was an ‘official version’, which at times was very different from the ‘unofficial version’ reflecting the loss adjuster’s true perceptions. It was sometimes possible to get closer to the latter by speaking to the adjusters involved with the case.
In addition to researching cases held by loss adjusters, the researcher was able to gain access to one insurer’s case records. These proved to be a valuable reference point, as they followed insurance claims through the process from detecting the fraud to proving that it had occurred. It was interesting to note that not all cases were successfully prosecuted, and that some cases of suspected fraud could never be proved, at least not reliably enough to justify a prosecution. Although individual cases will not be discussed below, because they were usually very long and complex, many lessons were learned as to how both loss adjusters and insurers dealt with suspected cases of insurance fraud.

**Questionnaires**

The researcher wished to generate views from the general public to ascertain details about previous claims on travel and household insurance policies, and specifically to gain information about fraudulent behaviour in these claims. Those who had made one or more claims were asked whether they had increased their last claim by more than was lost or stolen, or whether they had been dishonest with their insurer in any way in their last insurance claim. Then respondents were asked whether they knew of others who had been dishonest, and were also questioned about their attitudes to various frauds in order to gain an insight into the context and culture in which fraudulent claims were made.

Clearly, this is a sensitive issue, and while the aim was to gain as much information as possible about fraudulent behaviour such sensitivity needed to be recognised in the methodology. In particular, care was taken to elicit information
in a context in which people would be likely to give honest and candid answers. At the same time it was understood that some individuals who had committed a fraud would not be aware that their behaviour was considered to be fraudulent. The questions needed to be worded carefully, and the respondents needed time to answer and to be assured of complete anonymity.

Thus it was decided to undertake the survey on ferries, by means of a printed questionnaire distributed to all passengers once the journey had started and collected at its completion. The advantage of ferries was that large numbers of people were available for relatively long periods; permission was given to travel on the trip from Ramsgate to Dunkirk (a journey of two-and-a-half hours) and on that from Sheerness to Vlissengen trip (an eight-hour journey). Two large ferry companies granted permission for the questionnaires to be distributed.

Interviews would have been preferable, but the ferry companies were keen to minimise the disturbance to passengers, hence the use of questionnaires. It was not always possible to involve all passengers; some had cabins and slept all the way, some ferries were too full, making it difficult to hand the questionnaire to everyone, and some passengers did not want to participate. Clearly, there is no claim here that the findings are representative of all claimants, but the data are interesting and provide some important insights.

The survey was conducted over a three-week period in February and March 1994. In all, 638 people completed the questionnaire. Of these, 589 had at some stage held a household insurance policy (29.8 per cent of whom had made a claim) and
565 said that they had at some stage taken out travel insurance (60 per cent of whom had made a claim). Of those who gave personal details, three out of five were male and two out of five were female. They ranged in age from 15 to 90, while the mean age was 43 years. Two out of three respondents were employed, and nearly a fifth were retired (19.4 per cent); 7.6 per cent were unemployed. The vast majority of the sample were resident in the UK at the time of completing the questionnaire. It was impossible to test whether these figures were representative of household insurance policyholders, as there were no available figures.

Analysis of the questionnaire showed that there were 58 references to instances of household insurance fraud. Of these, 24 indicated a lack of total honesty with insurers, 22 referred to claims of more value than what was lost, stolen or damaged (this excludes those who claimed for items on ‘new for old’ policies), and 12 referred to increasing the claim to cover an excess. These 58 instances were mentioned by 36 people (9.4 per cent of respondents who had made a claim on their household insurance policy). Almost one in ten who last claimed on their household policies could be classified as having committed fraud on their last insurance claim. This was considered an under-estimate, as there may have been those who were reluctant to admit to their dishonesty. An in-depth analysis of this questionnaire was not included because the focus of the research was on insurers and the way that they tackled fraud. Where appropriate, however, the results of this survey were used to illustrate specific points, and to amplify statements made by insurers.
The questionnaire needed to be carefully worded, so as to leave no room for ambiguity and to ensure that the respondent was in no doubt about what was being asked. In the study by ABI/Gallup (1992) one question was:

I would like to ask you a few questions about bogus and inflated claims made to insurance companies. Do you know anyone who has put forward such a claim to an insurance company?

This question assumed awareness of what a bogus and inflated claim is, which the respondent may not have been sure about, and this may have partly accounted for the low level of affirmative responses. Also, the question asked whether the respondent knew anyone who had put forward a bogus and inflated claim. This question, taken literally, does not make sense, because it is impossible for a claim to be both bogus and inflated. Unless questions are clear, the responses become invalid. As Marsh states:

The danger comes in using words whose ambiguity is unintended and unknown: the meaning of the question to different respondents is varying according to contextual factors that we may be unaware of. But it is important to remember that the most likely result of this ambiguity will be to produce seemingly more random data, obscuring real relationships, rather than leading us into mistaking true relationships which in fact just stem from differences in meaning. (1984: 100).
As is the practice with major surveys, such as the British Crime Survey, this researcher ensured that questions were adjusted to meet the specific needs of the research. Examples of the questions used during the course of this research are given below. (Affirmative answers to these questions indicated fraud.)

- Do you know of anyone who has successfully increased the value of an insurance claim to receive extra money, goods or services?

- Do you know anyone who has successfully added more items than were lost, stolen or damaged to their insurance claim?

- Do you know anyone who has successfully made up an insurance claim to receive money, goods or services?

- Do you know anyone who has successfully claimed through several insurance policies for the same items that were lost, stolen or damaged? 

There were other areas that needed careful attention. For example, in two surveys, one by ABI/Gallup (1992) and the other by Litton (1990), the findings were very different, even though similar questions were asked. One reason for this is that ABI/Gallup used a representative sample of the population, whereas Litton used a small sample consisting of 69 respondents drawn from the police, senior insurance officials and students in higher education. The responses to Litton’s survey would thus potentially be biased, as respondents (apart from students in higher education) would almost certainly have some knowledge of insurance fraud in their line of work.
As fraud is a sensitive topic, how to ask people whether they had committed a fraud posed a problem in the drafting of the questionnaire. Litton explains that:

Even in a questionnaire described as anonymous, respondents may not be willing to admit fraudulent or semi-fraudulent behaviour (or behaviour which the subject believes may fall into such a category) (1990: 147).

This researcher circumvented this problem by asking different questions about an individual’s last claim, with no mention of the word ‘fraud’. For example:

- Did you make a claim for a greater amount than was actually lost, stolen or damaged?
- If you paid an excess, did you claim for more to cover this?
- As far as you are aware, were you totally honest with your insurance company?

There were two criteria for noting whether respondents had committed insurance fraud: they had first to answer one of these questions in the affirmative, and then to qualify their response to show that the act was fraudulent rather than (say) accidental.

One hypothesis was that those who commit fraud often do not know that they have done anything wrong. By asking different questions placed at different points in the questionnaire, it was possible to draw useful conclusions about this. The
survey found that just over half of those who had fraudulently claimed for more than they should thought that they had been completely honest with their insurer—they were unaware that their action constituted fraud.

As always with surveys, the questionnaire needed to be carefully thought out, as validating the sample was going to be difficult. There were no figures to show whether respondents formed a representative sample of those who had had home and travel insurance; there are no nationally available statistics on the number of claims in these classes of insurance, let alone a profile of the claimants. Even if national statistics were available, validation would be difficult, and misleading conclusions could be drawn since those who took out the original insurance policies might not be those who ultimately claimed (for example, other family members might have claimed).

The results probably under-represent those who have committed fraud, for three main reasons. First, the questionnaire asks about the last claim on a specific type of insurance, and an individual could have committed fraud either on a previous claim or on a different type of insurance. Second, an individual might not have claimed directly but a member of the family might have done so; he/she might recall the claim, and even know what had been claimed for, but not know whether fraud had taken place. Third, individuals might well have been reluctant to admit that they had committed a fraud.
The problems with offender accounts

The survey on the ferries, designed to identify people who had committed insurance fraud and obtain details about their behaviour, suffered from a number of methodological flaws. There is nothing unusual about using offenders, whether in prison or not, as a source of information for a whole range of offences—for example, burglary (Bennett and Wright 1984; Maguire 1982), commercial robbery (Gill 2000), embezzlement (Cressey 1953), fraud (Levi 1981), handling stolen goods (Klockers 1975) and shoplifting (Butler 1994), to name but a few. Indeed, Clarke (1997) has suggested that offenders provide an important source of ideas for crime prevention, and lamented the lack of research from this perspective.

The difference in this research study was that the insurance fraudsters had probably not been identified as guilty, and many others would not have defined their own behaviour as illegal. In fact most crime surveys, whether victimisation surveys or offender (self-)report studies, word their questions to ensure that legal classifications, or a person's perceptions of them, do not cloud judgement about his/her behaviour, and these principles were adopted here. The questions were based on those used in the British Crime Survey. But the methodology is crucial: postal surveys, favoured because they can reach a dispersed population cost-effectively, are most limited when dealing with sensitive issues, and questions about insurance fraud are sensitive. Interviews, favoured because they provide a chance to engage the subject, are time-consuming and expensive, and therefore popular where samples are small. They are seriously limiting when one objective of the research was to gain an insight into the levels of fraud, and this is why a
survey during ferry voyages was chosen—where the questionnaire was distributed, completed and collected during the journey; it was anonymous, people had time to answer, and could seek clarification from the researcher.

Nevertheless, there are still problems here in being sure that the views collected reflect actual behaviour. At least some of the problems of research with offenders was avoided in that these offenders were not in prison. Nevertheless, one cannot supplement the data with observation of behaviour (Polsky 1971), which as Levi (1981: 328) notes is not just a problem of prison interviews: ‘Access is not a sufficient condition for validity of observation.’ Levi (1981) sought to validate his data by assuring interviewees of confidentiality, and reduced the need for them to lie by clarifying his role and the purpose of his research. Moreover, he sought to check the data he was given with others he knew to be involved in incidents.

For Levi (1981), interviewing offenders in prison was advantageous because they had had time to reflect. This is an important point, probably under-recognised by the research community, and certainly an issue relevant to this study. Precisely because many people do not consider insurance fraud a crime (as the findings showed), and because details about motive are crucial, finding people with time to think about the questions and their responses was important. For the purpose of the research the ideal solution would have been to ask those who had made a claim not directly related to actual loss to reflect on their behaviour. The prison setting was absent, but the need to find people with time to reflect was an issue, and this affected the methodology and the decision to survey people on ferries. Unfortunately, it was not possible to check the data, although there was
consistency between data provided by the ferry passengers and that provided by the findings from both the survey of and interviews with insurers, loss adjusters and others.

**Semi-structured interviews with insurers**

The researcher found that the semi-structured interviews were rewarding, and a rich source of information; at the same time the respondents were able to 'speak freely and at length using their own concepts and terminology' (Bennett and Wright 1984: 7). It was through interviews that new information was revealed and different perspectives discussed; some of the information might never have come to light otherwise. Semi-structured interview can also be useful in providing a 'greater structure for comparability over the focused interview' (May 1993: 93).

One method that the researcher employed was to ask those interviewed to draw an organisational chart of the company. These charts were particularly helpful: apart from showing the communications between departments, they identified the key individuals who dealt with fraud and their connection with others.

The interview schedule for insurers was initially tested out on both underwriters and sales staff, and the same questions were put to staff who worked in different departments. As a result of this trial, some questions were altered and others were added. Unlike Clarke, who found that claims managers were on the whole 'more difficult to interview than others, more measured in their responses, more likely to deflect and even refuse questions' (1989: 3), this researcher found that a number
of insurers were relaxed when answering questions and provided some very candid responses. These interviews proved to be an excellent source of information. Although initially wary, on the whole the interviewees were keen to help and were prepared to spend a great deal of their time discussing the subject of fraud. It was as a result of these initial meetings that the researcher was able to interview ‘front-line staff’, i.e. those who deal with claims on a day-to-day basis. Their information made an important contribution and formed a good basis for comparison.

Initially during the interviews the researcher used a laptop computer to record answers. The advantage of this method was that data could be entered faster than if hand-written, and time was saved as notes did not have to be deciphered and typed up. Later it was found that although respondents were happy to permit the use of a laptop during questioning, they appeared to be deterred by its presence. The researcher was aware that as soon as the laptop was turned off, usually towards the end of an interview, the conversation became more relaxed as the researcher was no longer occupied with typing nor were there the distracting sounds of the keyboard.

Initially the researcher was reluctant to use a tape recorder, fearing that respondents might feel uncomfortable, particularly as insurers often did not want to be identified or seen to be ‘revealing all’. However, one insurer commented at the end of an interview that he would have preferred the use of a tape recorder, as then there would be no opportunity to quote him out of context. Although May
(1993: 104) suggests that ‘some people may find the tape recorder inhibiting and not wish their conversation to be recorded’, he also admitted that:

Tape recording can assist interpretation as it allows the interviewer to concentrate on the conversation ... once the conversation is started many people can forget the tape is on (1993: 104–5).

Bennett and Wright have also suggested that, ‘as the interviews can be tape-recorded and transcribed verbatim respondents’ methods of describing and explaining their behaviour can be preserved’ (1984: 7). Ultimately this technique proved to be very valuable.

**Participant observation**

In order to gain first-hand experience of how insurers tackle fraud, the researcher was able to accompany some insurance investigators and loss adjusters when they went out to investigate cases of suspected fraud. During these excursions the researcher was able to observe confrontations with suspects, some of whom openly admitted to fraud. Participant observation proved a valuable experience; as Jupp says:

Participant observation can provide valuable insights into specific intersections between social interactions, history and social structure … [and] can give insights into meanings, definitions, actions and interactions in specific contexts’ (1989: 63).
In addition to watching insurers and loss adjusters at work in the field, the researcher also participated in a mock insurance fraud. With the full agreement of the insurance company concerned, but without the knowledge of the general claims staff, a fraudulent claim was drawn up and submitted. The objective here was to determine how easy it was to make a fraudulent claim, to gauge the insurers’ response, and more generally, to gain a better understanding of the claims process and of the opportunities and risks involved in committing a fraud.

The methodology throughout the survey of the general public was designed to test the premise that insurance fraud occurs because individuals are rational in deciding whether or not to commit a fraud. Because of the use of semi-structured questionnaires, individuals were able to express their own thoughts and feelings, and it proved possible not just to establish how people commit fraud and the types of fraud that they commit but also their attitude to their behaviour and the rationale behind it.

**Conclusion**

This chapter has discussed the rationale for studying insurance fraud via triangulation. It has noted that it is a difficult topic to research and has attracted little previous academic attention. This difficulty derives from a number of issues. There is disagreement as to what constitutes insurance fraud, and this has complicated research and the insurance industry response. It has meant that statistics on levels of fraud are unreliable, even leading some insurers, as will be shown, to believe that they did not have a problem. The fact that insurance is a
competitive industry has meant that collaboration has in practice not always been a priority even where it has been preached, and there remained a good deal of secrecy amongst insurers about aspects of fraud. The vagueness of the definition of fraud, and the culture surrounding the way claims are made, have meant that many people who commit fraud do so without believing they are guilty. It is against this background that this research was undertaken.

It will be recalled that the three main objectives of the research were: to understand the process of committing fraud; to study insurers’ response to the problem; and to apply Ron Clarke’s opportunity reduction classifications to insurance fraud by customers. In order to fulfil these objectives data were gathered from the general public, via questionnaires, to provide insights into the fraudsters’ perspective. In addition, semi-structured interviews with insurers were carried out to obtain their views on fraud and to learn about their practices in tackling fraud at both the inception and the claims stage. Loss adjusters, the police and others also provided their own unique perspectives. Participant observation was conducted, which included observing different types of insurance fraud investigators in their work, and taking part in a mock fraud. Finally, case studies were examined, most often by studying the records retained by agencies.

At each stage care was taken to gain the confidence of those being approached, fraud being a sensitive area for both insurers and policyholders. Questions in surveys were designed to take account of the lack of agreed definitions; the survey of policyholders was designed to ensure anonymity, and was conducted in an environment where people had time to think about their answers. Because
insurance fraud is a concern not just for insurers and policyholders, but also for loss adjusters and the police, time was spent ascertaining the views of the latter groups, sometimes just by interviewing key personnel and on other occasions via observation and by studying files. The point is that these different methodologies with different agencies facilitated important insights into the very nature of insurance fraud.

The approaches provided a rich source of data. What emerged was the finding that the industry appeared to have got it wrong. Insurers lacked a true understanding of how and why insurance fraud occurred, and their responses reflected this. By examining fraud and the response to it from different perspectives it was possible to establish just how people were able to exploit the opportunities that were presented to them. This in turn provided a basis for the development of a set of techniques for preventing insurance fraud, drawing on Ron Clarke’s opportunity reduction classification.

The next chapter will assess the applicability of Clarke’s situational crime prevention framework to preventing insurance fraud. It will begin by locating situational crime prevention within the broader criminological literature.

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1 During the course of this research, it was found that a number of insurers complained of not understanding the ABI’s questionnaire, and either tried to complete it as best they could, or refused to fill it in.
2 Litton (1990: 150-1) acknowledges that his sample was unrepresentative, partly because of the difficulty in locating suitable groups of subjects and partly because of the desire to include police officers and insurance officials.
3 Clarke himself maintains that his inquiry was limited to ‘matters of general policy and experience as regards the incidence and management of fraud. Hence, although individual cases were often mentioned for the purposes of illustration, a detailed review of a representative series of cases was not attempted.’ (1989: 2)
4 It would be impossible to get a true representation of fraud cases because, first, insurers were selective in deciding which cases should be dealt with by a loss adjuster (this often being based on nothing more than 'gut feeling'), and second, because some frauds may never be identified.

5 This question was in fact a mistake, and taught a lesson. It was excluded from the calculations, as it is possible for a person legitimately to claim different proportions of a loss through several different policies, with the full knowledge of the insurance companies involved—i.e. with no fraud necessarily in question.
4. Rational choice, situational crime prevention and the insurance fraudster

Introduction

Criminological theory seeks to explain the causes of crime and methods of preventing or reducing it. One such method is opportunity reduction (Clarke 1997). As discussed previously, this is based on the proposition that specific forms of crime can be prevented or reduced if the opportunities that make these crimes possible are curtailed. This approach is known as situational crime prevention, and has been credited with providing a basis for thinking more constructively about security and crime risk management in business (Gill 1998; 2000; see also Levi and Handley 1998). This makes the approach attractive for insurance companies, on the basis that insurance fraudsters are to some extent rational and commit the offence because they are presented with opportunities. If so, situational crime prevention can be used as a framework to guide the response, and thereby to offer insurance companies a framework, which they presently lack, for reducing the incidence of at least some types of insurance fraud.

Situational crime prevention is an approach to crime prevention based on responding to the event rather the offender, and hence parallels are often drawn with routine activity theory (for a review of this point see Felson and Clarke 1998).\(^1\) Situational crime prevention is closely associated with Professor Ron Clarke, who has published a range of material on the subject (e.g. Clarke 1980;
Clarke 1992; Clarke 1996; Clarke 1997; Clarke and Homel 1997; Clarke et al 2001). His techniques are the most widely quoted, and have been used by authorities such as the Home Office Crime Prevention College as a guide to practical action. This thesis is a development of Clarke’s work in that it attempts to apply the techniques of situational crime prevention to a new area, insurance fraud. Recently Bowers (1999) used routine activity theory as the framework for her doctoral dissertation and applied it to a new area, namely non-residential crime. The present thesis is very much in line with that approach.

This chapter begins by assessing the foundation of situational prevention, that is the perspective of rational choice, including a discussion of what is meant by rationality. Some of the criticisms of the rational choice model are discussed. Given that situational measures are focused on influencing an offender at the scene of the crime, it is important to distinguish the ‘involvement decision’ from the ‘event decision’, so that the process of becoming involved in crime can be evaluated. If insurance fraud is to be prevented it is important to understand the type of threat posed by the offender. The chapter moves on to consider the causes of insurance fraud and includes consideration of what motivates often otherwise law-abiding people to commit the offence. The availability of opportunity emerges as a common feature. But the issue is not just about why people commit fraud, it is also about how they do so. As will be shown, some writers on fraud have suggested that the offence becomes possible because fraudsters employ ‘techniques of neutralisation’ (Matza 1964), while others have questioned its presence (Levi 1981). By way of introducing findings generated from this research, the debate is reviewed. Consideration is also given as to who is involved
in committing offences; in short, it seems that fraudsters are a varied group of people, who commit offences because they are provided with opportunities that occur as part of the way the insurance process operates. Many of them say they do not feel guilty, which stems, in part, from the negative view people have of insurers.

In the second part of this chapter the definition and key principles of situational crime prevention are evaluated. While Ron Clarke’s sixteen techniques are assessed (particularly the new fourth column), much of the critique is left to Chapter Nine, where the findings from this research will be incorporated. This present chapter concludes by offering an evaluation of situational crime prevention techniques. The overall aim of the chapter is to review the main tenets of the situational approach, as a basis for evaluating its applicability as a framework for insurers to use in combating certain types of insurance fraud.

**Rational choice in perspective**

The rational choice perspective had its origin in the early classical school of criminology (Beccaria 1963). Classical criminology argued that humans were ‘rational, free and governed by self interest … they are all endowed with free-will and with the faculty of reason’ (Young 1986: 256). Humans were seen as self-interested and their self-interest as being tempered by ‘rational calculation’ (Young 1986: 257). They were responsible for their acts, and could be deterred by fear of punishment (Vold 1986: 27).
Many years later, but following in this same classical tradition, the early economic choice perspective of crime evolved (Becker 1968). Its proponents believed that the decision to commit crime was similar to any other decision: the likely costs and benefits of an action were analysed before a decision was taken. The decision to commit a crime was an exercise of free choice and had nothing to do with cultural or biological factors (Vold 1986). This was an important point, because while cultural or biological conditions are difficult to change, decisions are much less so. The benefits of crime were to be seen not just in terms of financial rewards but also of an increase in psychological satisfaction, and the possibility of acquiring gains with very little effort (Vold 1986: 31).

These ideas were developed into the ‘rational choice perspective’ by Clarke and Cornish (1985; see also Cornish and Clarke 1986). The approach is not without its critics. For example, from an economic perspective Pyle (1995) has argued that Becker (1968) ignored the moral qualms which individuals may have about their actions. In developing their perspective Cornish and Clarke (1986) addressed some criticisms of the earlier ‘economic choice’ perspective. These include an assertion that the economic model ignored rewards which were not material, and another that the theory was insensitive to a variety of criminal acts which had different costs and benefits. An example of both these concerns can be found in Trasler’s discussion of expressive crimes (1986). But, as Clarke argues (1987: 118), those who commit ‘expressive’ crimes may plan and execute them with a high degree of rationality. Even crimes that are pathological may be carried out in
a rational way. There is much to commend a focus on the situational ‘triggers’ of expressive crimes as a way of reducing opportunities or facilitators.

Another criticism is that the data were insufficiently precise to carry out more detailed analysis. Ron Clarke dealt with this by explaining that crimes which fulfil an offender’s needs, for example by providing money, status, sex or excitement, require the making of sometimes very basic choices and decisions (Clarke 1997). Indeed, it is now accepted that offenders do not weigh up all the costs and benefits; the rationality suggested is of a ‘limited’ or ‘bounded’ nature (Clarke and Cornish 1985; Cornish and Clarke 1986; Clarke 1997). The choices offered can be constrained by the availability of information, time and ability (Clarke 1997). As Clarke argues, the rational choice perspective ‘sees crime as the outcome of the offender’s choices or decisions, however hasty or ill-considered these may be’ (1987: 118). The decision-making process is thus in fact quite straightforward.

The fourth criticism of the earlier ‘choice model’ argued that the concept of the decision-maker carefully calculating the advantages and disadvantages did not fit in with the concept of the opportunistic and reckless criminal (Clarke 1997; Clarke and Felson 1993). However, it could be argued that even the opportunistic and reckless criminal makes a rational decision. A study on robbers by Gill (2000) found that 96 per cent displayed some form of reasoning when committing the offence. Sullivan (1993) also argues that even those who are reckless are rational. Thus it is important to be clear about what is meant by ‘rational’.
What is ‘rationality’?

It is important to establish a definition of ‘rationality’. In theory, being in control of one’s mental faculties, and being able to weigh up the pros and cons (on the basis of whatever knowledge is available), are key defining features. In practice, determining the levels of control someone has over his/her mental faculties, and establishing just how much knowledge was available and how much was considered in making a decision, are fraught with problems, especially when the aim is to test these empirically.

Economists have probably treated this the least problematically. In Pyle’s (1989) study of tax evasion, models were based on the premise that individuals showed high degrees of rationality (see also Deadman and Pyle 2000). A common economic formulation is to examine ‘utility’; this is where:

> Judgements are made of the gain to be realised (the ‘expected utility’) from a particular course of action. If the expected utility of a given activity exceeds that of another activity it is predicted that an individual will prefer the given activity. (Fielding et al 2000: 2)

In fact a range of disciplines have contributed to what has been termed the ‘rational choice perspective’. Cornish and Clarke sum up the approach as follows:

> The term ‘rational’ emphasizes the notion of strategic thinking – of processing information, of evaluating opportunities and alternatives;
the term 'choice' emphasizes the notion that criminals make decisions; and the term 'perspective' stresses that the approach is not intended as a theory but as an organizing framework; a way of arranging existing theory and data to throw light on criminal behaviors. (1986: vi)

Even where offences appear to have pathological motivations there may be some points of rationality offering clues for prevention. But what really lent appeal to the rational choice perspective, at least for crime prevention purposes, was that it separated the involvement decision from the event decision. Thus, if prevention focused on the event, and more importantly the circumstances of the event, it might lead to offenders being deterred altogether, or perhaps deflected to committing a less serious crime. Situational crime prevention came into vogue, offering as it did realistic possibilities for preventing crime.

While it has long been recognised that different offenders will make different types of decisions at different types of scenes and when contemplating different types of crimes, research is scarce. Thus, while it is known, indeed it is perhaps obvious, that the more organised professional criminals make more thought-out and reasoned decisions in committing offences than do opportunists, we are less clear how the fraudster makes such decisions, and how situational measures may have an impact upon them. At least for insurance fraud, these issues have remained largely unconsidered.

Yet we do know that fraud can be a tempting option, as Virta noted: 'One can do it in peace and it does not include the risk of getting caught at the moment of
committing it’ (1999: 125). And one can do it easily. Theoretical explanations have suggested that Sutherland’s (1949) ‘differential association’ is influential—put simply, that is the greater emphasis of negative as opposed to positive influences on individuals. An overlap with learning and subculture theory is also evident (see Slapper and Tombs 1999). Differential association has been seen as relevant in explaining bribery (Green 1990). On a more general level, Kramer, in his study of the US shuttle disaster, noted:

The shuttle case study provides general support that criminal or deviant behaviour at the organizational level results from a coincidence of pressure for goal attainment, availability and perceived attractiveness of illegitimate means, and an absence of effective social control (1992: 239).

The test for researchers is to understand the pressures that combine to cause decisions to commit fraud. It is especially helpful for prevention when these decisions are based on the same influences, since reducing or eliminating the latter can impact on fraud, and this is more obviously the case where the decision-maker weighs up these influences (that is where he/she is rational) before committing fraud. The findings from this research on the rationality of insurance fraudsters will be addressed in Chapter Nine, but of more immediate concern is the process by which people become involved in insurance fraud.
**The decision process: the theory of how people become involved in crime**

The rational choice perspective is useful for an understanding of insurance fraud. For example, individuals will decide whether they wish to become ‘criminally involved’, that is whether they want to achieve rewards by devious means. They then consider which opportunity offers their desired outcome, and this is weighed up against any perceived risks that could jeopardise that gain. The decision whether or not to commit a crime may not just be based on the opportunities available. An individual, having made an ‘involvement decision’, then makes an ‘event decision’ which is dependent on the immediate circumstances and the opportunities available at that time. Situational measures would be expected to have more of an influence on decisions made closer to the event (Bennett 1986; Heal and Laycock 1986; Sanderson 1992); indeed, this is the point of situational measures. Such measures put into practice at a specific location and at a specific time can influence the ultimate decision whether or not to commit a crime; and it is an understanding of the potential criminal’s decision-making process which makes it possible to determine when and where these measures should be placed. It should be remembered that a person’s decision to commit a crime will be influenced not only by situational measures but also by other variables. As Clarke (1980) points out, a process of rationalisation is involved:

Components of subjective state and thought processes which play a part in the decision to commit a crime will be influenced by immediate situational variables and by highly specific features of the individual’s
history and present life circumstance in ways that are so varied and
countervailing. (1980: 138)

In other words, although an individual’s decision to commit a crime may be based on a rationalisation of the risks and opportunities, his/her background and current circumstances will also have a major influence on the decision. As Wittkämper *et al.* suggest:

The potential offender does not find himself in a ‘vacuum’; rather environmental variables or socioeconomic variables (e.g. unemployment) have an influence on how the structure of opportunity for crime is assessed and on the structure of opportunity for crime itself (1991: 67).

In this way an individual’s past or present circumstances, together with environmental conditions, may influence the process of rationalisation. Ekblom (1994: 195) goes further, arguing that it is difficult to distinguish the causes of criminal behaviour from the ‘processes underlying all behaviour’. He cites as examples of influencing factors ‘environment, motivation, emotion, learning, perception, moral values and reasoning and rational choice’. Ekblom goes on to explain that there are ‘distal’ causes of crime which are remote—indeed he has renamed these causes ‘remote’—and ‘proximal mechanisms’ (now referred to as ‘immediate’) which are ‘directly linked to the event in question, and are generally close in time and space’ (Ekblom 1994: 195). Distal causes, which might result from childhood experiences or even genetic inheritance, are remote and difficult
both to identify and tackle. An individual through the course of his/her life experiences so many different conditions that it would be very difficult to establish which were responsible for criminal tendencies. At the same time there are events which may cause some people to turn to crime, while others subject to the same events continue to live a normal life—an example of this is losing a job. An individual’s disposition may converge with a situational event or opportunity, and as a result a criminal act is committed (Ekblom 1990).

**Why do people commit fraud?**

Identifying what causes people to commit fraud (or any other offence) is problematic. Within the literature on fraud and white collar crime a range of explanations have been offered; these have been best analysed by Green (1990). The range of relevant theories is probably, in part, a consequence of the wide range of offences and offenders encompassed by the terms ‘white collar’ or ‘corporate’ crime. Thus while Cressey (1971: 75) believed that embezzlement was brought about by a person having a non-shareable financial problem, Green (1993) found that such a problem was not always present. And while Sutherland (1949) concluded that offences were caused by differential association, Wheeler (1993) found from his research that the decision to offend was not based on the influence of other offenders.

A number of writers have concluded that a big influence on the decision to commit fraud is the need to generate profits, inducing people to compromise integrity (see Clinard and Yeager 1980; Coleman 1992), once again illustrating the
importance of the business environment. Clinard’s (1983) study of retired middle managers revealed that the most commonly cited pressure they had suffered was to maintain profits and keep costs low, while Braithwaite found that:

The deepest reason for all forms of used car fraud, as expressed by the managers and owners themselves, is the savageness with which the competitive struggle is fought in an exploitative capitalist milieu. (1978: 121)

There are other factors too, including greed or carelessness (Levi 1992a), revenge and ideological reasons (Wheeler 1993) sometimes brought about by a perceived injustice—illustrated in studies of tax evasion where people rebel against what they perceive as the excessive demands of taxation (Pyle 1989). On a more general level, Doig has noted that the conditions for fraud exist when ‘some benefit is available, where the opportunity and incentive is present and the risk of discovery is low’ (2000:108).

The vast majority of insurance fraudsters are not habitual criminals. As discussed below, they are distinguished by their very ordinariness. Even so they fall into distinct categories. There are those who commit insurance fraud and do not believe it to be wrong. A study of the general public’s views on this issue, which was conducted for this thesis, found that over one-third (12 out of 36) of the individuals who had committed a fraud on their last claim believed that they were totally honest. However, there are others who knew that it was unacceptable behaviour and that it was a crime, but at the same time rationalised their actions as

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being justifiable in the circumstances. Their behaviour was often inspired by their experience or perception of insurers. Gill et al found that insurance fraudsters gave the following reasons for their behaviour:

I had never claimed before and decided it would be worth it.

It was the first claim I've made after years of paying premiums. (1994: 75)

In other words these individuals knew what they were doing, and had made a rational decision to commit an act which they believed to be justified. However, there were others within this broad category who rationalised their behaviour by placing the blame firmly on the insurers; for example:

The insurance companies are screwing as much money as possible from its [sic] customers, therefore I shall screw them for as much—if not more.

Many people today are making false claims; as a result of this, insurance policies are increased [sic]. In order to offset these increases it leaves me no choice but to join in the rat race (Gill et al 1994: 75).

These excuses fit neatly into Sykes and Matza’s ‘techniques of neutralisation’ (1957: 22), according to which the individual offers ‘more or less honourable
motives for dishonourable acts' (Downs and Rock 1992: 173). Downs and Rock argue that deviant acts become more palatable to those who commit them:

[When] acts and states can be reassessed as worthy or innocuous, when they can be presented as not ‘really’ deviant, it is a little easier to accept them (1992: 173).

The motive of these individuals in the context of insurance fraud is to get their own back on insurers; benefiting materially from their actions may be only a secondary motive. They may not set out originally to commit insurance fraud; however, their past experience or perception of insurance companies means that they have no option but to commit fraud in order to get what they believe to be rightly theirs. They cannot get what they want by honest means, so they act dishonestly. One individual who was questioned in the course of a survey for this study, and who had committed an insurance fraud, stated when asked about his travel claim:

I am not confident from a previous experience that insurance companies settle claims fairly and I wanted to set this right.

This particular individual had had his luggage stolen. In his claim he told the insurer that the luggage had been under someone else’s supervision at the time, when in reality it had been left unsupervised. In order to make a convincing claim he had to falsify the circumstances of the loss. He justified his action as being perfectly fair, since he felt that insurers had in the past been unfair. This
individual's behaviour was thus represented as a direct consequence of a 'previously bad experience'. He had learnt that it was necessary to commit fraud in order to get the outcome he felt was equitable. However, motive is not enough for a fraud to be committed; there also needs to be the opportunity (Clarke and Felson 1998). The fraud described above was only possible because an easy opportunity presented itself: the insured person had had his luggage stolen. If this had not happened, it is doubtful whether a fraud would have been committed. It is this category of fraudster who fits into Levi's (1998: 9) category of 'intermediate planned fraudster' (which will be discussed later in the chapter). As Levi explains, this type of fraudster may start out with honest intentions but for various reasons, including resentment, later commits fraud (1998: 9). There are also those individuals who change the circumstances of their loss to fit the policy, not because they are angry or frustrated with an insurer but for the simple reason that if they did not their claim would not be successful (Munich Reinsurance Company: undated b).

Some policyholders commit fraud to get their premiums back, in some cases because they resent paying premiums. Another view is put forward by Bremkamp (1989: 65–70), who believes that individuals no longer associate insurance with covering risks but see it as 'a sort of giro account for deposits and withdrawals'. In other words, committing an insurance fraud is equivalent to drawing funds from the bank.

The majority of loss adjusters who were questioned (Chartered Institute of Loss Adjusters (CILA) 1995) believed that some normally honest members of the
public were less than honest with their insurance claims because they felt that everyone was doing it and that it was a point for negotiation. A significant minority believed that policyholders committed insurance fraud because it was a way of making money, and that insurance companies have made it easy (CILA 1995).

Research for this study has shown that it is easy to conduct insurance fraud, with little or no risk of being caught. However, the majority of people do not buy policies in order to commit fraud: most of those who commit fraud do so on the back of a genuine claim. These individuals are motivated by greed and the opportunity to ‘make a bit extra’. Had there been no reason to claim in the first place, they might never have had an opportunity or an inclination to commit fraud. There are individuals in well-paid employment who could afford to act honestly but still choose to act deceitfully, because an opportunity presents itself. As Durkheim explains: ‘The more one has, the more one wants, since satisfactions received only stimulate instead of filling needs’ (1952: 246–2).

However, it would be wrong to suggest that all those who commit insurance fraud are driven by greed. There are also those (although they are far fewer) who commit fraud for reasons of need. For example, an individual whose deteriorating roof is leaking may not be able to claim legitimately because this would be regarded as wear and tear. Unable to afford to pay for the repair, he/she might falsify the situation and claim instead for storm damage—in other words, tailoring the loss to fit the policy. Or there is the example of a family who are about to have their house repossessed and commit arson in order to make a claim; here it could
be said that desperation would be the motive behind the fraud. In such cases Merton’s strain theory (Merton 1968) could be applied, to a limited extent, insofar as the individuals concerned are unable to fulfil their needs legitimately and so turn to crime in order to get what they want or, more important, what they ‘need’.

Wittkämper et al (1991) have argued that individuals’ awareness of right and wrong, together with their status in society, can determine whether they commit insurance fraud. This relates not only to the perceived risk of being stigmatised if the crime is found out but also to the prospective offender’s perception of the situation, which reflects personal values. Wittkämper et al (1991) state that the literature assumes there is a lack of awareness of the illegality of insurance fraud. Thus insurance fraud will be socially acceptable to some people, particularly if others in the peer group also find it acceptable. This latter point is endorsed by an ABI/Gallup survey (1994) which found that twice as many individuals who knew someone who had committed an insurance fraud agreed that it was acceptable to do so. Thus people who find insurance fraud acceptable are more likely to be associated with others who have committed fraud, a finding which was backed up by Gill et al (1994) in their study on insurance fraudsters.

The British Social Attitude Survey (1987) found that although nine out of ten respondents thought that it was wrong to exaggerate a burglary claim by £100, just over a quarter said that they would do this if the situation arose. Wittkämper et al (1991) quote the Austrian Gallup Institute’s survey (1984: 194–201), which found that nearly half of those taking part saw the ‘unlawful behaviour of the insured as
acceptable’, at least under certain conditions. This was confirmed in another survey conducted by Noell-Neumann.\textsuperscript{5}

Insurers, along with other large and anonymous organisations, are often seen as fair game by members of the public. There is the belief that such organisations deserve what they get, and can afford to pay. The British Social Attitude Survey (1987) found that twice as many respondents said that they would keep an overpayment of change from a large shop than would do so in the case of a small corner shop. It comes as no surprise perhaps that people identify more with a small corner shop, and are therefore more reluctant to treat it dishonestly than a large department store, the latter is not only faceless but may be perceived as being able to afford the loss. Further research is needed to confirm that the same is true of those who commit fraud against large insurers.

During this study, one respondent, when asked why he had claimed for more than he was entitled to, responded with ‘Why not?’ (Gill \textit{et al} 1994). He could see no reason why he should not inflate his claim. Another respondent when asked the same question stated simply that he had committed insurance fraud ‘because I could’.

\textbf{Who commits fraud?}

It would be wrong to suggest that insurance fraud is generally committed by a criminal underclass. Indeed, researchers in Germany have found that it is ‘virtually impossible’ to define the characteristics of the insurance fraudster and that the
'potential offender tends to be an average person' (Wittkämper et al 1991: 161).

Anyone who has an insurance policy can turn out to be an insurance fraudster. Levi (1988) found that fraudsters in general fitted into three categories. 'Pre-planned fraudsters' intended to defraud from the outset and pre-planned their fraud. 'Intermediate planned fraudsters' started out with honest intentions but, for reasons of 'bad company, resentment or a penchant for expenditure in excess of income', subsequently became involved in fraud. And lastly there were those described as 'slippery slope' fraudsters, who never intended to commit fraud but who were reckless and resorted to fraud as a way of dealing with debts. Levi sets the fraudster apart from normal society in that certain influences and incidents in an individual’s life may drive him/her to commit fraud.

Although Levi's categories (1988) relate to fraudsters in general, they are relevant to insurance fraud, but a fourth category needs to be added in this context. These are the 'sly manipulators': individuals who commit fraud because society leads them to believe that it is morally acceptable, and even normal, behaviour. Insurance fraud and similar crimes carry very little in the way of stigma, and 'frequently someone who is caught committing insurance fraud doesn’t think it is wrong' (Cole 1991: 15). Indeed it has been said that frauds such as tax evasion are even built into national cultures. Cahn states that tax evasion is a 'firmly established American custom' and that it is a crime practised by 'citizens of all ranks and of every level of repute' (1968: 195). Thus certain types of fraudulent behaviour may become part of an accepted standard of behaviour, and the
fraudster, far from being perceived as a criminal and set apart from the rest of society, is seen to be acting in an acceptable way.

Levi noted (1988: 12) that ‘many of the most scandalous affairs in the 1980s have been generated by persons of impeccable social background and no previous record of dishonesty’. It is interesting to note that it is often those most trusted in society who commit insurance fraud. As Wheal says:

Doctors, police officers, bank managers, insurance brokers and retired people have all been exposed as being economical with the truth by CUE [Claims and Underwriting Exchange]’ (1996: 29).

Despite the fact that insurance fraud is commonly practised throughout society, there are certain factors that may make an individual more inclined to commit fraud. For example, research for this study found that nearly half of all respondents knew someone who had committed insurance fraud, while 86.1 per cent of those who admitted to committing a fraud on their last insurance claim knew of someone who had successfully done so. This suggests that insurance fraud is common, and that those who know of others who have committed an insurance fraud may feel more confident in committing fraud themselves, given that these others have got away with it.

Age may also be a factor. Not only were those under 45 more likely to know someone who had committed insurance fraud, they were also more likely to have committed one themselves (or at least were more ready to admit to having done
so). Gill et al (1994) also found that of those who admitted to having committed an insurance fraud on their last claim, 53.3 per cent (16 out of 30) had been under 30 at the time (as compared with 22.8 per cent of legitimate claimants). However 90 per cent of all fraudulent claimants (27 out of 30) were under 45 at the time (as compared with 65.8 per cent of legitimate claimants).

There are a number of reasons why older people may be less likely to commit insurance fraud. A study by Jones and Levi (1983) found that older individuals were likely to judge frauds more seriously than the young. Johnston and Wood (1985) in their survey found that intolerance of fraud increased with age. As research for this study has found, older people are less likely to know someone who has committed a fraud (or at least less likely to admit to knowing someone). Further research is needed to determine whether age is a genuine factor in determining who commits insurance fraud, or whether the young are merely more likely to be open and honest about their opinions and actions when responding to surveys of this nature.

Although in some cultures fraud is regarded as acceptable and rational behaviour, this acceptance alone does not lead a person to commit a fraud. It is the opportunities that are available which ultimately determine whether fraud is carried out. This point will be discussed later in the context of situational measures.
Insurance fraud and the limitations of techniques of neutralisation

Explanations as to why otherwise honest people commit (white collar) crime have tended to focus to some extent on the ability of the individual to verbalise or neutralise their behaviour. As Green noted, although people may be influenced by differential association, ‘they may or may not commit crimes, depending upon their abilities to invoke techniques of neutralization’ (1990: 83). There is a logic to this, since, as Conklin (1977) noted, people in business probably have a greater need to deny criminal intentions than juveniles. The early work of Cressey was influential in looking at how embezzlers were able to breach the trust placed in them, and found the explanation in techniques of neutralization (according to Green 1990, these are excuses used before the crime has been committed) or verbalizations (following Green 1990, these are excuses after the event). As Cressey noted:

Whether verbalizations be called ‘rationalizations’ or ‘techniques of neutralization’, they function to permit behaviour that would otherwise be unavailable or unacceptable to the actor. These verbalizations are data to be studied in an attempt to explain the actor’s behaviour, whether the behaviour involves embezzlement or some other kind of other non-biological ‘deviation’ (1971: preface, unpaginated).

As Coleman noted:
These rationalisations were not just *ex post facto* excuses cooked up to justify an action already taken, but were psychologically present before the crime was committed and were a major part of the original motivation for the act (1992: 57).

However, Levi (1981) has questioned whether the techniques of neutralisation are quite so omnipresent, and quite such a necessary condition for some types of fraud. As Croall (1992: 69) noted, ‘offenders rarely risk massive disapproval’ because of the ambivalence surrounding offences, so why should such techniques be necessary? Moreover, Levi (1981: 86) noted that being sure that these excuses were present before the event is ‘empirically problematic’. And it is legally so as well, in that a criminal prosecution requires evidence of criminal intent and this is difficult to obtain (see Szockyji 1993). Even if the individuals say they neutralised their behaviour, and believe it to be true, it does not mean that they are right. In essence this comes down to the extent to which one accepts that language depicts action; as Levi (1981: 87) noted, in practice ‘verbalisation is part of what we mean by ‘behaviour’’. Nevertheless, it is important to recognise that techniques of neutralisation are based on the assumption that people do (or would) feel guilty about their actions, and that some sort of ‘remedial work’ (citing Goffman 1971) is needed (Levi 1981: 86). However, Levi found that long-firm fraudsters did not feel guilty:

None of the accounts of motive here have indicated any guilt about the behaviour. The existence or non-existence of guilt is not something that is scientifically demonstrable, despite psycho-analytical claims to
the contrary. If one assumes that the guilt is related to the persuasiveness of the negative labelling of any given action by ‘society’, however, then one may conclude that my hypothesis about the lack of guilt is a reasonable one. For there is no great stigma attached to the conduct of ‘slippery slope’ or even ‘intermediate’ fraudsters and, consequently, there is little that requires neutralisation (1981: 99).

Levi’s fraudsters were guilt-free rather than apologetic. Conversely, Clinard and Yeager (1980: 67) felt that because unethical business practices were common, they could become techniques of neutralisation. Of course, both views may be valid, depending on the context and the type of fraud (or other crime) being discussed; hence the need for more research.

It was possible to assess this issue in the present study of insurance fraud. Reviewing the reasons people gave for becoming involved in insurance fraud offers important insights on this question, in particular by looking at how normally honest people become involved in insurance fraud. From the survey, several reasons were offered which seemed to justify the offence. For many, insurance fraud was a chance opportunity arising from a genuine loss. Had the loss not occurred, the fraud would never have taken place. Some of these people did not regard their action as wrong. Others knew it was wrong but felt justified, often because they had taken out expensive policies in the past and had not claimed, and/or because of what they perceived as prior bad treatment by insurance companies. This often related to receiving less from a previous claim than they
thought they were due, or having a claim refused altogether; some had become quite angry. Some noted that they had not made previous claims when they could have, so they decided to claim for more because it was a fair return, and because it was easy to do so. Fraud was seen as particularly easy following the 1987 storms, as insurers advised that claims below £1000 would be paid quickly and without an assessment. Some insurers interviewed acknowledged that they may have given the impression in this period that inflating claims was acceptable and that there was little risk in committing fraud.

So by and large fraud was seen as 'fair game', mostly occurring on the back of a chance opportunity. Offenders justified it as providing a way of making money which it was fair they should have; and some felt they deserved it. So most insurance fraudsters did not feel they had done wrong, and thus had no feelings of guilt. Of course, it may be that the explanations were rationalisations (following Green 1990) and not real indicators of motive; ultimately it is difficult to tell. However, if we assume that these explanations do provide an insight into motive—and they appear logical enough—then following Levi's (1981: 86) findings these fraudsters generally viewed their actions as being either non-criminal or justifiable. This is important for crime prevention, because an important point about techniques of neutralisation is that, where they are used, they act as a check on criminal behaviour. Where people have to overcome feelings of guilt there is another hurdle to jump on the track to such behaviour, and this hurdle mostly did not exist for the respondents to the survey of the general public carried out for this study. Later it will be argued that one of the principal situational opportunities for insurers is to generate feelings of guilt in
(potential) offenders’ behaviour, and this has been acknowledged as a technique of situational prevention.

**How do people commit insurance fraud?**

Those who have written about fraud in a broader context have set out to identify the techniques that fraudsters use. These techniques are varied. Levi for example (1988: 10) suggests that fraudsters play on an individual’s dreams—in other words they charm the intended victim. This is particularly true of those types of fraud that involve direct contact. However, there are other types of fraud, such as tax evasion, benefit fraud and most types of insurance fraud, which require the fraudster to do very little in order to be successful. He/she does not need to be charming. Indeed he/she may need to do little more than subtly misinform or withhold information from the victim. In some types of fraud, the fraudster may not even have to act at all. For example, in one form of tax evasion an individual who is paid informally in cash may merely fail to notify the Inland Revenue. There are other circumstances where the fraudster can appear less than charming. Fraudsters have been known to bully and frighten their victims; it has been acknowledged that for example Robert Maxwell used this approach to achieve his goals (*The Daily Telegraph* 1996). *The Times* reported in 1996 that a group of fraudsters:

threatened to maim staff and burn down offices if they were not paid

... One businessman was reduced to tears after the gang threatened to cut out his liver and eat it in front of his family.
Some fraudsters on the other hand try to create an ‘air of respectability’ by claiming to have ‘impressive qualifications’ or ‘membership of a professional body’, or even (Levi 1988: 10) to be members of the aristocracy, in order to try to win the trust of their victims.

A major characteristic of insurance fraud is that few ‘tools’ are needed to carry out the act. This is important in the context of the present criminological interest in crime facilitators, where one way to prevent crime is to prevent the availability of things needed to facilitate it. Indeed, this issue overlaps both routine activity theory and situational prevention (see Ekblom and Tilley 2000). The problem here is that the facilitator is an insurance policy, and very few skills are needed; apart from a telephone call or the incorrect completion of a claims form, little else is required. It is easy to buy a policy and easy to make a fraudulent claim. There are many opportunities and at present few defences, and herein lies the challenge for insurance companies, and for situational prevention, to provide a framework for the response.

**Situational crime prevention**

Situational crime prevention emerged from the Home Office Research Unit, and was a response to the cry that ‘nothing works’. It can be traced directly to lessons learned from correctional treatment (Clarke and Cornish 1983) and closely followed the demise of faith in rehabilitation programmes (Clarke 1992). The action research model was combined with ‘situational thinking’ to provide a
practical basis for researchers and practitioners to establish new ways of tackling crime (Clarke 1992: 5).

Situational crime prevention has in the past been mainly directed at specific types of predatory offence. It is concerned with changing the environment in a way that makes the potential offender believe that the perceived rewards of committing an offence are so small, and the effort and risks involved are so great, that the crime is no longer worthwhile (Clarke 1992). Clarke suggests that his classification takes a more ‘dynamic view of crime than allowed by dispositional models’ and relates the variations in opportunity to ‘transitory pressures and inducements’ (1992: 8). In defence of opportunity reduction, a number of studies have shown that the risk involved in committing an offence, together with the difficulty of obtaining the rewards and not getting caught, can affect the decision as to whether or not to commit the offence (Bennett and Wright 1984; Brantingham and Brantingham 1975; see also Gill 1998).

Clarke identifies five main points relevant to the definition of situational crime prevention (Clarke 1997), and it is worth reviewing these here. The first is that situational measures are tailored to specific types of crime, and he argues that because each form of crime is distinctive, it has to be tackled in a different way. Maguires’s (1982) study of burglary nicely illustrates this point, with the discovery that burglaries in different areas had very different profiles requiring different types of solutions. The context-specific nature of opportunity reduction measures is discussed below as one of its limitations.
A second feature of situational crime prevention, Clarke states, is that there is a ‘wide range of offenders, attempting to satisfy a variety of motives and who are employing a variety of methods’. These individuals may be involved ‘in highly specific offences’. He emphasises that ‘all people have some probability of committing crime depending on the circumstances in which they find themselves’ (1997: 4). Situational crime prevention thus does not draw any basic distinction between those who commit crime and those who do not (Clarke 1997). This is important in the context of insurance fraud, because many people make insurance claims and are thus in a position to commit fraud—but what makes some do so is the opportunity that is presented to them.

Third, changes introduced into the environment can affect the decision of potential offenders by altering the way they calculate the costs and benefits. The judgements made are dependent on the specific features of the setting. While different offenders will be influenced by different features the aim of research is to try and identify patterns in particular contexts which can guide policy (Pawson and Tilley 1997). A study of insurance fraud needs to test this idea in a very particular context.

Fourth, offenders will make some moral judgements in their evaluation of whether to offend (Clarke 1997: 5). Some offences appear more reprehensible than others, while insurance fraud is entirely acceptable to many. Many fraudsters view insurance companies as entirely deserving victims.
Fifth, situational crime prevention is defined in general terms and does not refer to specific types of crime. As Clarke says, it assumes that it can be 'applicable to every kind of crime, not just to 'opportunistic' or acquisitive property offences, but also to more calculated or deeply-motivated offences' (1997: 5). This is a major advantage, since it offers companies a framework for responding to crimes of all types. Part of the problem, which this thesis seeks to help redress, is that there has been little attempt to research the applicability of the techniques to different crime types. Yet the opportunities for crime are omnipresent.

Indeed, the 'opportunity structure for crime', as discussed by Clarke (1997), is important in this context. Clarke (1997: 14) develops a complex discussion linking ‘potential offenders, and the supply of victims, targets and facilitators’ with the risks, efforts and rewards of committing a crime. What is important is that opportunities occur, and they can be reduced without offenders being deflected elsewhere. This is the potential of the situational approach; moreover, it is practical, and the benefits can be felt almost immediately.

However, the approach has its critics, and this includes the importance it attaches to opportunity. Clarke admitted that 'most criminologists believe that opportunity plays a minor role in crime’ (1992: 3). In defence of his theory Clarke argues that 'all classes of crime, even those motivated by deep anger or despair, are greatly affected by situational contingencies'. Indeed, as Gill (2000) found in his study, most commercial robbers make some sort of rudimentary decision at the scene. Even those who have determined in advance to commit crime may be influenced in some way by what they do or do not find at the scene of a potential crime. More
recently Felson and Clarke (1998) have provided a robust defence of opportunity reduction as a cause of crime, and much work in the UK Home Office is geared to harnessing the potential of opportunity reduction as a method of crime reduction.

A good critique of the situational approach, though seldom referred to, was undertaken by Ekblom (1998). He lists four possible limitations. The first is the possible displacement effect of situational measures, reflecting the concern that they merely deflect offenders elsewhere or to other types of crime, or to new tactics (see Barr and Pease 1990). Worse still is the danger that crime is deflected away from those who can afford measures to those who cannot, and this has to be managed. In fact, as Ekblom notes, the displacement effects are never total, and there may even be some positive consequences such as ‘diffusion of benefits’, for example preventing crime in the area beyond which the situational measures are installed. Later Ekblom develops this limit as a potential ‘harmful consequence’:

> Where design or implementation are carried out insensitively, this could increase fear, limit the freedom of *legitimate* users (of products, environments or services), foster an attitude of victim-blaming; and introduce an unpleasant fortified and beleaguered environment (1998: 28).

A linked concern here is the threat to privacy posed by some systems, such as CCTV.

Ekblom’s second point is that measures grow obsolete, and rarely present a permanent solution. It is certainly true that as offenders adapt their techniques so
good crime prevention needs to be continually monitored and updated. Similarly, and his third point, is that measures are context-specific, in that there are few universal remedies. This is of course the case, although it is perhaps optimistic to expect anything different. The fourth limit identified by Ekblom is that often prevention needs to be carried out via third parties, which can lead to implementation failure.

There are other criticisms of the situational approach. Gill (2000) found in his study of commercial robbers that certain measures had the potential to increase the amount of violence that some robbers were prepared to use. Particularly important as far as the present study is concerned is the apparent assumption that situational measures or crime reduction are an unqualified good. In a business environment where costs are paramount this is far from obviously the case. Another concern is that situational measures are only a partial solution (see Levi and Handley 1998). One advantage of this thesis is that it will be possible to test the robustness of Clarke’s model in a business environment.

**Sixteen techniques of situational crime prevention**

There were originally eight categories of opportunity reduction technique (Clarke and Mayhew 1980). These were then expanded to twelve categories under three headings (Clarke 1992: 13): 1 ‘Increasing the effort’, 2 ‘Increasing the risk’, and 3 ‘Reducing the rewards’. It is this third category of ‘reducing the rewards’ which has undergone change. Clarke gives the reason for this as being that new developments in theory and in the way crime is tackled, and the emergence of new
forms of crime and opportunities to commit crime, need to be addressed and incorporated. The techniques are now arranged under four headings relating to key stages or principles that guide opportunity reduction. The fourth column merits comment because it is new and has hitherto received little attention—and also because it has special relevance to insurance fraud.

Table 1. Sixteen opportunity reduction techniques

<table>
<thead>
<tr>
<th>Increasing the perceived effort</th>
<th>Increasing the perceived risks</th>
<th>Reducing the rewards</th>
<th>Removing excuses</th>
</tr>
</thead>
</table>

(Clarke 1997)

The fourth column, 'Removing excuses', was added in 1997 and is concerned with increasing 'shame and guilt' (Clarke 1997; Clarke and Homel 1997). This new categorisation is a natural development in the classification of the techniques of situational crime prevention, and marks an important step forward. Even before
the addition of this new category, Clarke acknowledged that psychological research on personal traits and behaviour had opened a 'greater than expected role for situational influences' (Clarke 1992; Mischel 1968) and for the 'drift' into misconduct (Matza 1964). Clarke and Homel (1997) later used Sykes and Matza’s (1957) social deviance theory of 'techniques of neutralization' and Bandura’s (1976) social learning theory of violence to give added credibility to the new category of 'Removing excuses' and the neutralisation of criminal behaviour.

This extension was added to take in other crimes, including tax evasion, traffic offences, sexual harassment and theft of employer's property, which, Clarke suggests, 'are as much a province of 'ordinary citizens' as of 'hardened offenders'.' (1997: 16) In his revision of situational crime prevention Clarke recognises that both criminals and 'others' have 'some probability of committing crime depending on the circumstances in which they find themselves' (1997: 16). He goes on to argue:

Opportunities for these offences arise in the course of everyday life for most people and do not have to be sought in the same way as opportunities for auto theft or burglary. (1997: 16)

The frequency of these opportunities, together with the higher status of the 'ordinary offender', may contribute to the lack of moral shame among those committing certain types of crime. Clarke cites Sparrow (1994) as suggesting that 'these offences might more effectively be prevented by increasing incentives or pressure to comply with the law' (1997: 16). An individual's decision whether or
not to offend is based on his/her judgement of the morality of the action (Clarke 1997). People may make excuses for their behaviour by the technique of neutralisation (Sykes and Matza 1957).

There is a danger that the fourth category, 'removing excuses', may push situational crime prevention off course and locate crime prevention measures within long-term dispositional solutions. Clarke and Homel (1997) justify their use of this fourth category by arguing that if they had excluded it there would be a danger of limiting the application of the situational approach. They point out that the focus of situational crime prevention is on specific types of crime, that measures to combat them are delivered at the point the criminal decision is made, and that the inclusion among the techniques of 'Removing excuses' is therefore valid (Clarke and Homel 1997). They appear to be right in this view.

One of the main problems of the situational classification, which Clarke and Homel acknowledge (Clarke 1997; Clarke and Homel 1997), is that there is much overlap and it is not always clear whether the techniques are placed in the correct columns. Some techniques could figure under more than one of the headings. Gill (1998; 2000) found this confusing and partly because of this, and partly because he used the techniques for a different purpose (as a classification for social action rather than opportunity reduction), he presented a different classification. The problem with Gill’s approach is that it runs the risk of confusing the practitioner even further.
Clarke’s framework of situational crime prevention is at the core of this study. The 16 techniques of situational crime prevention will be examined in depth in Chapter Nine, in the context of the findings of the study, and have not been extensively discussed in this chapter in order to avoid overlap.

Are situational crime prevention techniques effective?

At this point, the question needs to be asked as to what evidence there is that situational crime prevention techniques work in practice. In fact, and despite Clarke’s volumes of successful case studies, the evidence is inconclusive in that there is a need for much more research on ‘what works’. Pawson and Tilley (1997) have invited consideration of the contexts in which particular mechanisms (or interventions) produce outcomes (or results). Their methodology, a very recent innovation, is still in its infancy but offers considerable potential to provide better insights into what measures may work in what situations to produce different outcomes.

Another recent criminological finding, which suggests there is considerable potential for situational measures to be effective, follows on from research on repeat victimisation. It has long been clear that crime is not evenly spread—some people, homes and organisations are more at risk than others. What is relatively new is the realisation of the extent to which some are re-victimised. Indeed, it has been found that the best way of predicting who will be burgled is to identify who has been burgled already (Anderson and Pease 1997). This means that it is important to provide situational measures (or other forms of protection) after the
first offence if one is to reduce the risk of further victimisation. Again, there is more research here on burglary than other types of offences.

Certainly, situational crime prevention is not always effective. The techniques can enhance preventative strategies but they may not eliminate the problem (Gill 2000; Clarke 1997), and preventative strategies may not always work as planned. Situational measures may not be implemented correctly; for example on one occasion anti-climb paint was too thinly applied (Hope and Murphy 1983). Other measures, such as the early steering locks, can be easily overcome by offenders (Clarke and Harris 1992). In France offenders found that they could circumvent the technology which protected smart cards by ‘physically trampling on cards to deactivate them’ (Levi 1992a: 152). Other systems may not provide the protection they should; for example, burglar alarms are frequently ignored (Clarke 1997). Measures which prevent some types of crime can act as a facilitator for other types; for example, window grilles protecting downstairs windows can be used as a climbing frame to reach upper floors. Sometimes victims may facilitate crimes by carelessly leaving doors propped open (Clarke 1997).

Inappropriate measures have sometimes been introduced because there was no proper understanding or sound analysis of the problem. For example insurers have developed the Claims and Underwriting Exchange (CUE) database with the intention of catching fraudsters. However, because there is so little detail about the claims recorded on the database it is impossible to identify certain frauds such as exaggerated claims. Some measures may be unsuitable; for example, a number of insurers have purchased specialist document scanning equipment which is
supposed to be used to identify fake or altered documentation (VSC and ESDA machines). However, insurers often do not use these devices, as they take so long to set up and are difficult and time-consuming to use.

Any consideration of the effectiveness of situational prevention must take account of displacement. It has long been held by criminologists that in order to prevent crime one needs to tackle the causes (Hirschi 1969; Ohlin 1970; Sutherland 1924) and that measures which reduce opportunities merely 'suppress the impulse to offend' and that crime is therefore displaced (Clarke 1996). Indeed, a review of the literature shows that the concern about displacement is very much the major concern about situational prevention.

However, the research evidence indicates that displacement is not necessarily the outcome, particularly if the motivation to commit a crime is not very strong (Clarke 1997). Reppetto (1976: 170) points out that it is often assumed that an offender will carry out a set number of offences over a given period; thus if one opportunity is closed off he/she will look around for another opportunity. However, it is indicative that studies in the 1960s and 1970s showed a reduction in suicide rates in England after the introduction of natural gas (Hassall and Trethowan 1972; Clarke and Mayhew 1988). It was found that after the gas supply was changed from toxic to non-toxic gas, there was a reduction in the overall rate of suicide of about 40 per cent (Clarke and Mayhew 1988). Clarke and Mayhew confirmed that there was no corresponding displacement to other forms of suicide. Although Clarke and Lester (1987) found that there had subsequently been an increase in males using other methods of suicide, this increase was not blamed on
'delayed displacement' (Clarke 1997) but on an 'independent increase in the motivation to commit suicide' (Clarke 1997: 31).

A study of motorcycle thefts in Germany found that after the introduction of helmets motorcycle thefts decreased by over 100,000, and there was little evidence to suggest that there was a displacement to other types of vehicle theft (Mayhew et al 1989). Other studies have found no evidence of displacement (Knutsson and Kulhorn 1981; Poyner and Webb 1987).

Clarke states that the offender will only commit an alternative crime if the alternative 'corresponds with the offender's goals and abilities' (1997: 82). If this is so, situational techniques are only as good as the strategies in place to prevent crime. It could be argued that there will always be some form of displacement, since not all opportunities will be closed off (Sanderson 1992) and security may be inadequate (Hough et al 1980; Repetto 1974). However, this problem can be reduced through the implementation of situational measures tailored to meet specific problems in specific contexts. Moreover, there may even be a diffusion of benefits.

For example, Pease (1991) found in his study that when houses that had been previously burgled were target-hardened, the benefits of the situational measures were diffused to other houses on the estate which were not target-hardened. The burglary rate for the whole estate dramatically declined in a process of 'drip-feed' (Pease 1991). Other studies have reported similar findings (Scherdin 1986; Poyner
and Webb 1997; Poyner 1997), confirming that the benefits of situational measures may not be limited to the immediate target.

In short, the evidence suggests that while there may be some displacement, this will not always be total and may even be beneficial, and that while this is a legitimate concern it is not one that should stop us looking for better situational prevention methods.

But there are other concerns which have received little attention. It was noted in Chapter Two that at least one of the problems of situational prevention is that it takes crime reduction as an unqualified good. It was suggested that this was a reflection of its application to public-sector rather than private-sector environments. It is true that there have been only a few attempts to calculate the cost-effectiveness of measures, and often these have been very crude assessments, for example in Clarke et al.'s (2001) evaluation of attempts to tackle cell phone fraud. Moreover, there needs to be a much more rigorous assessment of the contexts in which situational measures are introduced and of the limits of techniques. For example, in the next four chapters problems endemic to the insurance industry are discussed, and it is likely that remedies will move beyond merely situational techniques, although these may prove helpful to insurers in tackling some problems.
Conclusion

This chapter has sought to explain, via reference to previous research, who fraudsters are and how and why they become involved in crime. The discussion is instructive in highlighting the different ways in which fraudsters represent a distinct type of offender committing a distinct type of crime, typically by exploiting opportunities presented to them. The chapter has discussed the concept of rationality and how it applies to insurance fraud. Fraudsters are, it seems, mostly rational—they commit fraud because, put simply, there are immediate advantages available to them in so doing and they do not perceive the risks to be high; many do not consider they are committing a crime at all. The chapter has discussed the concept of rationality, and the extent to which in the case of fraud discussions about ‘rationalisation’ have been tied up with those about the need to ‘neutralise’ the offence. Despite Levi’s (1981) questioning of the relevance of this concept to the fraudsters he studied, it has often been assumed that fraudsters must feel guilty. This is presumably not least the case where those committing fraud are mostly perceived to be honest and not a criminal underclass. Yet, following Levi, it is far from clear that the insurance fraudsters studied here feel guilty. Indeed, it was shown that a significant minority believe they are being honest, and others feel justified in their fraudulent behaviour because of their perception, for a variety of reasons discussed, that insurers were deserving victims.

Many of the issues discussed here will be readdressed in Chapters Nine and Ten. What is important is that insurance companies’ customers, who are not ‘typical’ offenders, engage in fraud against the companies, and do so by exploiting
opportunities that they often come across by chance. Certainly, the offence is easy to commit, requiring few skills and little craft, and it carries little public humiliation—indeed, it seems that there may be some public approval in that insurers are viewed as deserving victims. Certainly, some policyholders justified their actions by referencing previous poor treatment by insurance companies. Later it will shown that even the police are unsympathetic to insurance companies. To this extent, then, insurers precipitate their own victimisation—but only because they are not the ones that ultimately lose, being able easily to pass on the costs to the customer.

The questions for this thesis are just how far a company can prevent insurance fraud by adopting opportunity reduction techniques, and to what extent the limitations of Clarke’s classification, discussed above, are an impediment to their adoption. How robust are they when applied to offences such as the insurance frauds discussed in this thesis, in a private rather than a public setting?

Situational crime prevention offers a framework for individuals and organisations to take steps to reduce the opportunities for crime to be committed against them. The techniques are based on the principle that, whatever someone’s disposition, the likelihood of his/her committing a particular crime can be reduced by manipulating the environment. The effect of situational measures will be greater where an offence takes place merely because an opportunity presents itself and where, but for the chance arising, the offender would not have contemplated that offence. The effect will be less where the offender is not rational and cannot be influenced by situational measures to the same degree, for example because he/she
is drunk or mentally ill (or both). Thus while situational techniques can be implemented to deter all offenders, they are especially effective, in theory at least, as a response to opportunistic offences such as the types of insurance fraud discussed in this thesis.

There is another major advantage to using situational crime prevention techniques, namely that they offer an immediate means of tackling crime. However persuasive the argument that crime is ‘caused’ by unemployment, poverty, poor housing and the break-up of families, recourse to changes in social policy as a remedy offers no attractions to business.

Further advantages of the technique of opportunity reduction are that the measures adopted are not necessarily expensive, and may encourage good practice. In short, despite the finding that many fraudsters commit offences knowingly and because opportunities present themselves, it is not known which measures will work, because the techniques of opportunity reduction have not been applied to insurance fraud before in any systematic way. As Clarke says of the broad issue of applicability:

The moral is that the limits of situational prevention would be established by closely analyzing the circumstances of highly specific kinds of offences ... these limits will expand as wider experience accumulates in applying situational prevention, and as technology expands the scope of feasible action (1992: 22).
This thesis is intended to add to our understanding of which measures will work in tackling insurance fraud by reducing the opportunities for fraudsters. In Chapters Nine and Ten these issues will be re-examined; first, however, there is a discussion, in the next chapter, of the way the insurance industry operates, and how this creates opportunities for fraudsters. This discussion starts at the ‘proposal stage’.

1 Routine activity, which has focused on direct-contact predatory crimes, postulates that in order for a crime to occur there need to be three elements present: a likely offender, a suitable target and the absence of a capable guardian (Cohen and Felson 1979). Routine activity is similar to situational crime prevention in at least two ways. First, it is not concerned with the motivation of the offender or the offender’s disposition, or indeed with social justice. It is concerned with criminal events rather than criminal inclinations—not that it denies that such inclinations exist, taking them rather as a given (Clarke and Felson 1993). The second similarity is that both theories focus on the ‘event’. Routine activity theory ignores ‘anything going on inside the head of offender or victim’ (Clarke and Felson 1993: 2). It was felt that examining the offender’s disposition would distract attention from the point that ‘criminal incidents were criminal acts’ (Clarke and Felson 1993: 2). Indeed, as Clarke and Felson state: ‘Criminal events were moved into center stage and motivations pushed aside’ (1993: 2).

Although there are thus similarities between routine activity theory and situational crime prevention, there is at least one important difference: that the former focuses on the routine activities which bring people together, whereas situational crime prevention focuses on reducing the opportunities available for people to commit crime.

Rational choice perspective and routine activity theory have helped to frame and strengthen situational crime prevention. As Clarke says, the ‘rational choice perspective has provided a framework under which to organize such information so that individual studies produce more general benefits’ (1997: 12).

Routine activity theory has also informed situational crime prevention: ‘The idea of convergence has led to the suggestion that ‘deflecting offenders’ be recognized as a distinct technique of situational prevention’ (Clarke 1997: 12). Both routine activity theory and rational choice perspective can provide a useful framework for situational crime prevention.

2 For example, insurance companies are not liable to pay a claim (even the legitimate part) if any part of that claim is seen to be fraudulent; one insurance company states in its policy documents that: ‘If You or anyone acting for You makes a Claim under this Insurance knowing the Claim to be false or fraudulent, We will not pay the Claim and this Insurance will become void’ (Frizzell Home Insurance (undated: 36).

3 Half of those questioned in a survey by Lloyds Bank (1993) thought that this was likely.

4 This may be true of attitudes towards an understanding that fraud is dishonest; however, as already discussed, a person’s perception of dishonesty bears no relation to his/her ultimate actions (see note 5 below).

5 Noell-Neumann (1985: 588), taken from Wittkämper et al. Noell-Neumann in his survey found that 29 per cent of individuals questioned thought that an excessive claim submitted to an insurance company was completely legitimate.

6 See Chapter Five.
The question referred to ‘anyone’ who committed insurance fraud; some respondents could have referred to themselves, or of cases reported in the media. This should be taken into consideration when interpreting these findings.
5. Fraud at the proposal stage: opportunities

Introduction

This chapter reports the research findings on fraud at the proposal stage. It looks at the two main factors which facilitate fraud: first, the system of selling through unaccountable agents, who put sales above all other considerations; and second, the features of policies which expose them to fraud. While these factors are discussed separately, in reality they overlap. Three case studies are discussed, focusing on the three types of insurance fraud by customers most common at this stage.

Deficiencies of current methods of sale

As previously noted, most insurance is sold through agents, and this can lead to two main problems: first, insurers have little control over the type of person they are insuring; and second, they have little control over the types of policies that are sold.

Insurers admit that often banks or building societies take total control of policies, from issue through to the claim or renewal process. Because of this insurers rely on their agents to detect fraud at the proposal stage. But agents are encouraged by large commissions to sell insurance, and it is not necessarily in their interests to expose fraudulent intent. If they identify a prospective fraudster at the proposal
stage, and refuse to insure him/her, they lose a sale and the commission on that sale. The commissions that agents receive for the sale of insurance policies are often a very important source of income. Reports in the insurance press suggest that travel agents’ and tour operators’ profit margins on the policies they sell are between 30 and 60 per cent (Wheal 1997). It has even been suggested that travel agents obtain bigger mark-ups on insurance, to compensate for their low margins on holiday sales (Wheal 1997). In this way insurers are actively motivating their agents to sell policies, but there is no incentive to prevent fraud.

Agents sometimes sell insurance as a secondary product, in the form of a standard package. As a result, applicants may have little choice as to the type of insurance they purchase, and the outcome may be that their policies are unsuitable or provide inadequate cover. If a policy is not suitable, and a loss occurs, some policyholders are likely to lie on their claims form and misrepresent the circumstances of the loss in order to ensure that the insurer pays out on the claim. For example, valuables might be insured up to a certain limit, say £100 each, and the policyholder might have lost an item which is worth more, perhaps £500. Should such a loss occur, the policyholder might add four fictitious valuables to the claim in order to recover the £500 which the original item was worth. This would be a fraud—but had the policyholder received the correct policy, providing full cover for valuables, he/she would have been able to claim for the true value of £500 without committing fraud. As one claimant said in answer to the questionnaire put to members of the public: ‘If I thought I’d be financially out of pocket I’d increase the amount of my claim.’
It is not unknown for banks to give away free travel insurance as an inducement to open an account (Curphey 1996). Similarly, motor insurance may be included in the price of a new car, and tour operators and travel agents offer travel insurance ‘free’ as an incentive to buy a holiday package. Travel agents may encourage customers to purchase insurance in order to qualify for special offers or holiday discounts (Wheal 1997). It is perfectly legal for travel agents to insist that customers take their policy as a condition of buying a holiday (Elliott 1996), and, because such policies are standard, individuals may not be getting the right one for their particular needs. There is an EU travel directive which stipulates that a tour operator or travel agent must offer insurance. Thus ‘the insurer may have little choice in the type of individual insured’ (Sager 1996). At the same time insurers have little opportunity to ensure that applicants receive the correct cover.

Those who sell insurance often do not know about the products they are selling (McConnell 1996), and many of them have received little or no training in how to sell insurance or to detect fraud. This increases the risk of customers being sold inappropriate insurance policies and of agents and insurers failing to make policyholders fully aware of the terms and conditions of their policies. A researcher at the Consumers Association stated that ‘in a lot of areas the seller doesn’t know enough to point out the level of cover and exclusions’ (McConnell 1996). The consequence may be that a policyholder receives less than the value of a loss (Diacon and Cater 1992)\(^1\) or in some instances nothing at all (Which 1994).

Of those insurers who completed a questionnaire for this research, only three out of 40 (7.5 per cent) said that their underwriting staff routinely received training in
detecting and dealing with insurance fraud. This compared with just over six out of ten (62.8 per cent) who said that their claims staff received training (see Table 1).

The training of underwriting staff to deal with insurance fraud thus appears to be less of a priority than the training of claims staff. This is because many insurers believe that the identification of fraud is part of the duty of the claims department, and need not concern underwriting or sales. It is remarkable that when asked in the questionnaire to suggest ways in which their organisation could deal better with fraud, only one out of 43 insurers mentioned the need for vigilance at the proposal stage. However, as this study shows, fraudulent misrepresentation at the inception of policies is a significant problem.

Table 1. ‘Do the following staff routinely receive specialist training in detecting and dealing with insurance fraud?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims staff</td>
<td>27</td>
<td>62.8</td>
<td>16</td>
<td>37.2</td>
</tr>
<tr>
<td>Underwriting staff</td>
<td>3</td>
<td>7.0</td>
<td>40</td>
<td>93.0</td>
</tr>
<tr>
<td>Other staff</td>
<td>4</td>
<td>9.3</td>
<td>39</td>
<td>90.7</td>
</tr>
</tbody>
</table>

Fraud has traditionally been seen as a minor issue for the sales and underwriting departments of insurance firms. As one insurer explained during an interview: ‘You employ a salesman to sell a policy; they’re not trained or requested to verify whether it’s kosher.’
One claims manager believed that dealing with fraud was indeed a problem only for the claims department:

I think underwriters think it's a claims problem. Underwriters don't really know the details ... I don't think they'll understand ... if you're going to sell a policy how do you know with that policy if someone might commit a fraud?

Although the ABI has a code of practice, a large number of independent intermediaries are not complying with this code (McConnell 1996) and are failing policyholders as far as the terms and conditions of the latter's policies are concerned. The Times has cited research conducted by the Consumers Association which found that only two out of 25 agents surveyed complied with the ABI requirement to display a laminated sheet detailing the cover included in the policy (McConnell 1996). Travel agents and tour operators are simply not informing customers about the details of their travel policies. Some travel brochures have only limited information on insurance and do not mention exclusions (Which 1985). Travel agents often do not provide full insurance policy details until the holiday has been paid for (Which 1985), and there are those who never provide such details. During this research, insurers who discussed the subject agreed that few holiday-makers who took out travel insurance knew the extent and limitations of their policies. Sales personnel often do not want to put customers off by informing them of potential problems and of the limitations of a policy.
Insurers are failing to ensure that their customers get the correct policies for their needs. Policyholders may find out too late, and only when making claims, that they have policies which do not provide adequate cover or contain clauses that prevent them from claiming.

Thus, current sales methods create opportunities and motives for fraud. Not only can this have an impact at the proposal stage but it can encourage fraud at the claims stage.

**Features of policies which make them vulnerable to fraud**

In order to reduce the number of claims, insurers sometimes re-write their policies and increase the number of exclusions. The result may be that policyholders find it more difficult to make a successful claim. Unless individuals are advised of and understand the exclusions, they can find that they are uninsured for a loss. Some companies take exclusions to the extreme; for example in a survey *Holiday Which?* (March 1985) found that one insurance policy did not even cover valuables against loss or damage. Creating exclusions can be construed as acting unfairly, particularly if, for example, the individual acquires the insurance as part of a travel package and has little choice over the policy. Yet according to a newspaper article (*The Independent* 1993) insurers 'have wide discretion over what they put in their contracts which are excluded from the Unfair Contract Terms Act'. In other words insurers are free to include as many exclusions or conditions in the policy as they wish. This can anger policyholders when they
make a claim, and can subsequently provide an excuse, for those who are not adequately covered under the terms of their policy, to commit fraud.

In recent years insurers have also changed the wording of policies, and introduced excess charges (or deductions),\(^4\) with the aim of discouraging claims for small amounts and reducing the number of claims, by persuading individuals to take more care of their possessions, thereby reducing the degree of ‘moral hazard’.\(^5\) However, this study found that policyholders often do not read the small print and do not know that an excess charge applies, and some are shocked when this becomes known. Half of those who committed travel insurance fraud did so to recoup their excess deductions. As one claimant stated:

The excess deduction was a shock. Had I realised this would be deducted, I either wouldn’t have bothered to claim at all (three hours in a police station), or I would have increased the amount to cover the excess.

It is not difficult to see how people can be tempted to commit fraud. Sales personnel need to inform customers of these charges at the proposal stage; as the claimant above stated, he would not have bothered to claim had he known. However, even if he had known, he might have committed a fraud by increasing the amount he claimed for. If the policyholder had been informed about the details of the policy, this might therefore not have prevented the fraud; it might indeed have had the effect of encouraging it. Perhaps the only method of discouraging this type of fraud would be not to charge excess at all. In order to decide the best
course of action insurers need to assess whether more money is likely to be made by charging excess, and accepting that there will be some policyholders who will inflate their claims, or whether they should forgo the income that charging excess brings in order not to prompt a higher proportion of policyholders to commit fraud. This is one example of a case where reducing the motivation to commit fraud might not be in the insurer’s best interest.

Because information is rarely checked for accuracy, it is easy for a person to give false information. This provides opportunities for frauds such as fronting, false disclosure or non-disclosure, and false claiming or exaggeration. It is essential therefore that insurers identify ways of getting accurate information from and about their policyholders.

In theory, motor insurance fraud should be far easier to detect than other types because a large amount of verifiable information is required at the proposal stage. Vehicle registration details and claims history are needed, and this makes it easy for an insurer to check up on an individual at the underwriting stage. Should a claim appear suspect, documentation exists to help clarify the situation. One insurer who was interviewed explained that household insurance, unlike motor insurance, is:

that bit more difficult to identify, to prove the guy is producing false documents ... I suppose on balance, yes, I would say that motor ... is probably that bit easier to prove.
The types of documentary information available include driving licences,⁶ which are obtainable from the DVLA and list any driving convictions. This can be particularly useful in identifying non-disclosure, as one insurer explained:

We get a copy of their licence. Sometimes they’ve got a string of convictions that they haven’t bothered to tell us about.

MOT certificates, taxation disks and registration documents can also be useful in identifying a fraudulent claim, as another insurer pointed out:

Sometimes the registration document doesn’t quite tie in with the person who’s making the claim. It might be a different person’s name, or the address might be different.

Insurers also have access to computerised databases such as MIAFA, which can identify vehicles that have been stolen or previously written off. The Motor Claims and Underwriting Exchange will give some idea of the policyholder’s previous claims history. The ABI also hold a database of stolen MOT certificates, which one insurer found useful:

We’ve actually had cases where the MOT certificate is actually a stolen certificate ... we get a listing from the ABI.

Although all this information can prove helpful, it does bring with it problems for insurers. Information can be out of date and at times inaccurate. Clearly, though,
there is some potential for insurers to exchange information through databases and registers.

Some insurers were unaware of the weaknesses in their systems. One large insurer pointed out that some areas in the country were more prone to crime than others, and said that the company had established procedures within such areas in order to cope with the higher risks:

In areas of Salford and Liverpool we won’t take on business from some brokers unless they actually see the licence while the proposal form is being filled out.

This insurer believed this system to be quite successful. Another insurer told a different story:

One of the other things you do is check the driving licence history. They may have told us that they didn’t have any convictions, but sometimes you do find that they have convictions ... It can appear on their licence, but ... say you were driving this evening and you were stopped by the police and arrested for drunk driving for example, there’s a 100 per cent chance that you’ll lose your licence. You’d lose your licence and you’d get it back in two weeks’ time. You could have a heavy conviction, which makes it difficult and expensive, so what crooks tend to do is at that time before the court case and after they’ve been arrested, they apply for a duplicate licence, saying that their other
one has been lost. When they go to court they go along with the
duplicate licence, the convictions are put onto that licence, they put it
into their back pocket, and they've still got a clean licence.

This insurer went on to say:

We'd only check up if they had a claim. Most companies would
simply ask for a copy of his driving licence and [he] could show them
the one in his back pocket which is clean ... We do actually take it one
step further, because obviously we're wise to that now and we send
£2.50 to the DVLC and they send us a print of his driving licence and
that will reveal any convictions.

Although documentation can be useful in detecting fraud, insurers need to be
aware that those who are determined to commit fraud will find ways of
circumventing the system. The ABI hold a computer register listing stolen MOT
certificates, and one insurer explained that his company used the system always to
check the MOT.

If you always check the MOT on the system, the law of averages is
that you're going to get a certain number of stolen MOTs every year.
And we do; we get stolen MOTs at the rate of one or two a week.

Another insurer explained that there was a gap in the system, and that not all
stolen MOT certificates were registered:
This is quite interesting because this one didn’t actually appear as stolen ... Theft of these MOTs is reported to the police by the garage. The PC will then let the vehicle inspectorate know ... and then the ABI put it in the computer. That means there are delays. At the time this MOT was stolen, this MOT was presented to us, the MOT itself had only been stolen through the garage who previously hadn’t gone through the process. So when we tapped in the number, there wasn’t a problem. So what would then happen is we would pass on and deal with the claim.

Part of the problem with computer databases is that the information takes time to register on the system. One insurer thought that it was easy for a motorist to get hold of an MOT that had just been stolen and had not yet been registered on the ABI’s database: ‘It’s quite easy, if you have the contacts.’ Again this presents a good example of a useful system which falls down because of the lengthy processing procedure. Although technology can be useful it is vital that insurers are aware of the drawbacks of the technology and of the tools that it uses. The insurers in the case cited above only found out that the MOT was stolen because they were suspicious of a spelling mistake on the certificate.

If you look at the MOT the number ‘ninety’ is spelt incorrectly. Now if you are writing out MOTs ten a day, every single day, even if you haven’t got a degree in English, after a while someone is going to point out that you can’t spell ninety. So you would expect that to be spelt correctly.
The insurer in this particular case admitted that if there had not been a spelling mistake and the certificate had not therefore been scrutinised more thoroughly than it would otherwise have been, the claim would have been paid because the vehicle had not been registered as stolen on the ABI database.

Sometimes there is no documentation, or incidents have not been officially recorded. One common motor fraud is the staged accident, where a collision is carried out in order that a claim can be made. Sometimes an accident may even be entirely fictional. One common way of conducting such fraud is through the use of a hire car, as one insurer explained:

You might have damaged your car and need it repairing, so you get your car and go along to a car hire company. They hire a car for the day fully comprehensive. You're driving round the main road, they're driving round the side street into you, smash the car, you claim off the hirer’s insurance and if your car’s written off, they’ll pay out for a new car or they’ll have new wings, new bumpers fitted and a re-spray and all it’s cost you is one day’s car hire.

This insurer went on to explain that often car hire firms have their own insurance and therefore if there is a theft or total loss of one of their cars it will not be entered on MIAFA or Motor CUE. As the same insurer stated:
If everybody’s name went on, we could see that this guy’s hired three cars over the last six months and each time he takes it out, he only takes it out for a day and each time he has an accident.

In reality this information may never be registered on a database by the car hire firms, so that insurers may never have a complete claims history for the individual (or the car).

Although motor insurers have access to documentation and important data sources, the information they have can therefore still be unreliable and incomplete. Even where insurers have easy access to driving licences or motor vehicle registration papers, these are rarely requested. Three of the most common types of motor fraud are non-disclosure of information, false disclosure and fronting—but the insurance industry has done little to prevent them from occurring. Insurers place great emphasis on risk calculation and premium differentials; yet the whole system can be defeated by individuals who simply circumvent it in order to gain favourable premiums.

It can be costly to check and cross-reference information for accuracy. Insurers will have to evaluate whether the savings from closing off the opportunities for fraud outweigh the economies of doing nothing.

Because travel insurance is often sold by travel agents as part of a package policyholders will often not know who they are insured with. They are therefore
unlikely to feel any sense of loyalty towards the insurer. One insurer admitted that policyholders were represented by code numbers. Another stated:

If someone comes to [the insurer] and takes out a policy, you’re probably less likely to put in a fraudulent claim than somebody who’s simply taking out a brochure insurance or insurance through a travel agent ... Because I believe that when somebody positively takes out your insurance they’re associating themselves with you.

This point requires further research; it would certainly be interesting to see if by increasing customer loyalty insurance companies could reduce fraud.

Case studies

Non-disclosure and false disclosure

One of the most common areas of fraud identified by this research was non-disclosure or false disclosure. This is where an individual does not disclose, or misrepresents, relevant facts to the insurer at the initiation of a policy, and so obtains insurance at a favourable rate, or in extreme cases insurance which would otherwise have been declined. Although nearly nine out of ten insurers believed that they had a very significant or moderately significant problem of policyholders not disclosing previous claims when taking out a new policy; as Table 2 shows, few had systems in place at the underwriting stage to tackle it.
Table 2. ‘Do you believe there is a significant problem of non-disclosure of previous claims when new proposals are made?’

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Very significant</td>
<td>9 21.3</td>
</tr>
<tr>
<td>Moderately significant</td>
<td>28 66.7</td>
</tr>
<tr>
<td>Not at all significant</td>
<td>3 7.1</td>
</tr>
<tr>
<td>Not sure</td>
<td>2 4.8</td>
</tr>
</tbody>
</table>

The fact that insurers are failing to face up to the problem is illustrated by the experience of one insurer, who only discovered by accident that he had a significant number of cases of non-disclosure, with the discovery being made at the claims stage:

Eighteen months ago we decided to investigate every motor theft. We didn’t find one fraud, but it was profitable because ... what we did find was fraud in terms of non-disclosure; [one man wanted to] obtain cheaper insurance; [he] hadn’t told us about his convictions, hadn’t told us about some previous accidents ... it was fraud in terms of taking out the policy because they weren’t paying the proper premium for the right risk.
The point here is that if more care had been taken at the underwriting stage this particular insurance firm might never have accepted such customers; and if it had it would probably have been at a higher premium. Despite discovering a number of cases of non-disclosure, the firm did little to prevent these from continuing to occur at the proposal stage. The interviewee said that because cases of fraud were discovered at the claims stage there was no need to prevent them at the proposal stage. 'We were still able to repudiate that claim because of their non-disclosure, so we did find it quite profitable'.

As this case shows, it may not always appear to be in the insurer’s interest to identify non-disclosure or false disclosure at an early stage. There are three reasons for this. First, if it is identified at the proposal stage the insurer has to refuse to provide insurance cover and so loses the premium income. Second, if it is discovered at the claims stage (as the insurer quoted above pointed out) the claim is not met and the insurer loses nothing, while retaining the premium. And third, the implementation of fraud prevention measures at the proposal stage would be costly in time and money.

As we have seen, frauds such as non-disclosure and false disclosure are easy to commit, and by such means a policyholder can save a lot of money. A survey in the Post Magazine (Post Magazine and Insurance Week 1997) found that the difference in premium for the same model of car insured by an 18-year-old male living in London and a 50-year-old couple living in Winchester was £1223. It is easy therefore to see the attractions of non-disclosure or false disclosure. One insurer explained: 'The contracts are price driven; they can see the difference
between price and they hope to get away with it.’ An individual may see no risk in committing motor insurance fraud; and he/she may not even view the action as fraudulent. As another insurer said: ‘The problem you’ve got is people’s perception of what fraud is.’

One insurer described the problem of non-disclosure as widespread. When asked what he believed the proportion of customers misrepresenting information at the initiation of the policy was, he expressed the view that it was:

> About 80 per cent of the population ... In terms of non-disclosure of motoring convictions it’s very high indeed. They’ll take a chance ... they don’t tell you—it’s as simple as that.

The problem with non-disclosure is not only that insurers are losing out through lost premiums but also that the system of premium calculation may be completely undermined. Tighter controls are needed at the underwriting stage. Insurers need to review the types of questions they ask and to train staff to identify discrepancies in the answers.

Non-disclosure can have serious consequences for the policyholder. If the policy is invalidated at the claims stage this means that technically the policyholder has not been insured. He/she has not only broken the law, but if caught may find it difficult to obtain insurance in the future or at least will have to pay a much higher premium.
Although non-disclosure or false disclosure occurs at the underwriting stage, it may only be detected when a claim is made, and only then if the claim is investigated. Insurers need to decide where their priorities lie—these types of fraud can be prevented, but, as we have seen, it may be time-consuming and costly to do so; moreover, insurers will want to be sure that if they decide to have systems in place to prevent fraud this will not have a negative impact on sales.

Fronting

As discussed in Chapter Two, fronting is another form of false disclosure or non-disclosure. This is where customers give false information to the insurer in order to obtain motor insurance or to do so at a low premium. As one insurer explained:

A lot of people do what we call fronting. Fronting is where you’ve got a youngster, an 18-year-old who’s just passed his or her test and have gone out and got themselves a little Fiesta. For an 18-year-old to insure a Fiesta is £600 to £700. So what people do is insure in a parent’s name, telling us it’s their car and just have the son or daughter as a driver. That way the premium is reduced to £200.

The problem here is that the market for motor insurance is price-driven. There is very little difference in the type of policy from one insurer to the next, and an individual seeking insurance is looking for the cheapest, not necessarily the best quality.
Other forms of fronting can occur on the commercial motor side. One insurer described a claim involving a mechanic who was listed on a garage policy. In this case the garage owner gave the named drivers as himself, his wife, some family members and mechanics. The insurer went on to explain:

Clearly they need to drive vehicles that have been taken in to be MOT’d, repaired or collected or delivered to the customers. The vehicles that are covered by the policy are any customers’ vehicles that are in there for repair, no matter why it’s in there, and any vehicle owned by the company ... this particular [mechanic] has bought a Peugeot 205 GTI, which is a high insurance rating. The insurance for that would cost between £1200 and £2000 a year to insure because we don’t want young drivers driving 205 GTIs. So what this guy’s done is let his mechanic go out and buy the car and then he’s registered it in his garage’s name, so it’s included in the garage’s insurance on his motor trader’s policy, with the mechanic as a named driver; but in fact the vehicle doesn’t belong to the garage, it belongs to the mechanic.

The interviewee indicated how the garage owner would benefit here:

It wasn’t costing him any money to do it. He was just helping ... well, he was helping himself really because he’s then got a hold over his mechanic ... So a hold on your mechanic is that whilst you work for me you can run around in this 205 GTI and it won’t cost you a penny to insure it. It’s not costing [the garage owner] anything, but it’s
saving the mechanic £2000 a year in insurance ... If the mechanic turned around one day and said he didn’t want to work there anymore, the minute he walks out the garage, his car’s not insured and he can’t afford to insure it ... So it really is quite a nice hold to have over people ... It’s not so easy to say ‘stick your job, I’m going’.

When asked what would happen to the garage owner, the interviewee replied:

This guy runs quite a successful garage and a car hire business. Now I’ve got to report in to the Birmingham branch to tell them to void the policy, which means his garage isn’t insured ... Well, normally people take out insurance there and then, but he won’t be able to do any of that. Both his businesses are finished because he won’t be able to get insurance. When I say won’t be able to—if his broker shops around they’ll be able to get insurance but it’ll be at the absolute minimum cover and he’ll pay sky-high premiums, so he virtually will go out of business.

This case demonstrates that fronting can be relatively easy to prove, because the registration documentation clearly shows the true owner of the vehicle; and for some offenders it may mean the loss of their livelihood.
New for old

There are certain forms of insurance policy that can be an invitation to commit fraud, for example new-for-old policies. There are those insurers who argue that because items are replaced there is little incentive for an individual to commit fraud. For example one insurer commented:

Three or four years ago, we would have provided you with a cheque ... We'd give you a pot full of cash, so we had raised the expectation and raised the attitude of the policyholder. Now if you do that you get people saying that it was very easy last time and I need some cash, so you whet their appetite ... Now you can't find many insurers who provide a pot full of cash; they all insist on replacement ... It's still open to fraud but it's less open. What are you going to do with three televisions? ... The motive is bound to be cash.

During the course of this research insurers took the view that the policy of supplying new items for old can make good business sense. Insurers are in a strong position to negotiate favourable discounts on goods from distributors. Thanks to this they need, as they admit, to pay less to replace items than they would have to if policies provided for the payment of compensation to policyholders. However, it could be argued that if an item is old, worn or fails to work properly, a policyholder might be tempted to make a fraudulent claim. To make a claim can be easy, particularly as during the 1980s insurance companies changed their household policies to include all risk. Policyholders are thus
covered for everything apart from a few listed exclusions, including accidental damage. Inventing the circumstances of such damage is simple. As one insurer explained:

It’s an open cheque book for fraud; the cover is so wide, including accidental damage. If something gets to five years old it could be tempting to drop it on the floor, i.e. a video. It could have fallen off the side; it’s almost an invitation to write their own cheques.

Insurers may be under the misapprehension that new-for-old policies reduce fraud because cash incentives are withdrawn. But they offer an easy way to replace worn goods and illustrate how the formulation of a policy—for example the inclusion of all risks—can create opportunities to commit fraud.

**Conclusion**

There are many opportunities for fraud at the proposal stage. Insurers choose to have little control either over the agents who sell most of their policies or over the types of people who buy them. This is partly because, first, it would be more expensive to monitor and control agents, and second, insurers are keen to sell as many policies as they can. Both insurers and agents receive little training in the selling of policies, and most receive no training at all in preventing fraud at this stage. The consequences are that people are being sold inappropriate policies and that many agents are not complying with the ABI code of conduct on the sale of insurance. Fraud is often the consequence, as people who have not been informed
about the policy details or are inadequately or inappropriately insured find that the only way to make a successful claim is to lie.

The problem is exacerbated by exclusions buried in the small print that often remain unnoticed until the time of a claim. Although the majority of insurers questioned for this survey believed they had a problem with non-disclosure at the proposal stage, very few recognised this as being a fraud problem, and most were doing little or nothing to tackle it. Indeed, most felt that fraud was a problem for the claims department. If insurers are going to prevent fraud both at the proposal and claims stages, they need to understand just what opportunities there are for fraud and to institute rigorous methods of prevention. This chapter has demonstrated that there are easy opportunities to commit insurance fraud with little risk of getting caught and that it can be financially rewarding. The suitability of these opportunities for treatment through the application of the principles of situational crime prevention will be discussed later. The next chapter considers the insurers' response to insurance fraud at the proposal stage.

1 This can affect the amount from a claim that they may subsequently be entitled to. The amount paid out could be scaled down in proportion to the under-insurance.
2 The ABI code of practice can be found at the ABI website: http://www.abi.org.uk.
3 This researcher on one occasion did not receive a copy of the policy document, even though insurance was taken out with the holiday. Indeed, the only reference to insurance cover was on the invoice. See Appendix A: Case Study: Ring Claim.
4 This is where a set amount of money is deducted from each payment made to the claimant; it is usually around £50, but could be higher.
5 'Moral hazard' is an event or circumstance which increases the chance of the insured suffering a loss (Litton 1990).
6 Copies of these can easily be obtained from the DVLA.
7 This is a fairly new concept, having been first introduced in the early to mid-1980s.
6. Fraud at the proposal stage: the insurers' response

Introduction

The results of the research for this thesis show that it is usually the claims and technical claims managers who are appointed by insurance companies to tackle fraud. It follows that most initiatives designed to reduce fraud are directed at the claims stage in the insurance process. However, as this research has found, fraud can occur at any time in the life of a policy, and so the issue of fraud should be seen as a concern for all departments, from sales and underwriting to claims.

In the previous chapter it was shown that insurers face a number of problems when tackling fraud at the proposal stage. This chapter examines these problems and suggests solutions. It shows, first, that insurers can retain greater control at the proposal stage by selling direct to the public, while retaining current policyholders. Second, it demonstrates how insurers can make sure that the information they hold on customers is accurate.

This chapter then considers ways of reducing the opportunities to commit fraud by changing the contents of policies. It looks at the advantages of linking different types of insurance together—for example travel and household. This would help insurers to build up information on the policyholder, and mean that they would find it easier to spot discrepancies in the information they are given. Lifestyle is
then considered. Although lifestyle analysis does not always identify the fraudster, as fraud often occurs as part of a legitimate claim, if the insurer can prevent a claim then a potential fraud can be blocked.

**Pros and cons of direct sales**

Selling insurance directly to policyholders can have a positive impact on reducing the opportunities for fraud. Insurers who sell policies direct to the customer have a big advantage in that they are in total control of the underwriting process. They do not rely on others—such as banks, building societies, travel agents or brokers—to bring in business; nor do they need to worry that insurance is a secondary product and tacked on to other purchases. Direct-selling insurers have more control at the proposal stage because business is handled in accordance with one centralised system, and uniform underwriting and sales techniques can thus be applied. At the same time commissions to agents are saved. As one non-direct insurer bluntly put it: 'A direct insurance company] pays no commission. It has 15.5 per cent (of premium) overheads on costs and administration; we have 22 per cent.'

A saving on commission not only improves profitability; it may also mean that the insurer can reduce premiums for certain risks. One insurer who did not sell insurance direct to the public pointed out that direct insurers had an advantage in that they are quick to recognise changes and trends and can alter their systems accordingly; and this can be reflected in their premiums.
However, some doubts were expressed about direct selling. A large insurance firm experimented with selling policies direct to the public. The claims manager was sceptical about the experience:

We have had one or two experiences where we did direct mailing through *The Times*, *The Sun* and *The News of the World* and that sort of thing, selling business. A lot of that was actually rubbish. One got the impression that they were simply saying ‘here’s an opportunity for a cheap policy’ and you got claims in the first year of insurance. Whether we just happened to hit the wrong market, I wouldn’t know.

We did find a lot of fraud and exaggeration.

The problem here was not that there was a problem selling direct to the public but that the insurers were prepared to underwrite poor-quality business at low premiums, and in doing so created an opening for policyholders to commit fraud. This is only one experience. Some direct insurers maintain that they have very successful accounts with only a limited amount of fraud; they put this down to tight controls.

Insurers can retain even tighter control over the sale of their policies if they focus on retaining good customers. One of the knock-on effects of selling direct to the general public is that insurers are then in control of their own renewals. For example, the insurer quoted earlier who claimed that the household account was profitable later said that his firm had one of the highest retention rates in the industry, of 87 per cent compared with the 67 per cent which others recorded.
Although he did not acknowledge it at the time, this not only may help to create a profitable account but may also reduce fraud, in that more is known about policyholders and their claims history. Therefore renewal premiums can reflect the appropriate risk.

By retaining policyholders an insurer can reduce the urgency of attracting new business and so maintain a high degree of selectivity; in this way the volume of business becomes less important than quality. To go after new business can be expensive; and at the same time, unless comprehensive checks are carried out, insurers may find that they are unwittingly taking on high-risk policies. If they retain policyholders, on the other hand, it is possible for insurers to be sure of the insurance history (and with good systems there should be no time-consuming and expensive searches); thus an accurate premium can be calculated. Retaining customers is usually a cost-effective option, and also a highly profitable one.

**Insurers' need for effective internal co-ordination**

In the previous chapter it was shown that non-disclosure of information and false information were the most prevalent types of fraud at the proposal stage. The opportunities to commit these types of frauds can be greatly reduced if care is taken to ensure that accurate information is obtained before the policy is underwritten, particularly where renewals are concerned. During the course of this research it was found that there were often no formal channels of communication between the underwriting and claims departments, who often operated incompatible computer systems. Because of this, it was not unusual for the annual
renewal of a policy to be automatic. Where this happens, incredibly, insurers may
be renewing policies with poor claims histories of which they are unaware,
because the claims department has not informed them. Even when the
underwriting department is aware that a policyholder has made a suspect claim, it
may still decide to renew the policy. As one insurer pointed out in relation to such
cases:

The decision is then up to our people whether or not they renew, and I
would say on a number of cases they simply renew the policy.

The reason for this was in part the casual way in which the claims department
informed the underwriters of suspected fraud. Few insurers could point to a clear-
cut procedure within their organisation for informing the underwriting or sales
department of suspected fraudulent claims or, even more worryingly, of fraud
which had been proved. As the insurer who made the above comment went on to
say, when describing how in his firm the underwriting department was kept
informed:

It would simply be by internal correspondence or contact. We
wouldn’t hold anything on our computer system. We’d be in danger if
we started flagging. We can’t do that.

When asked whether in his firm the underwriters were informed every time a
suspect or fraudulent claim was identified, an insurer replied:
Again they're all human beings. I would hope so, yes, but with hand
on heart I couldn't say so every time.

The problem here is that there is no automatic notification system, and so
communication may be random. A number of the insurers who were questioned
admitted to such problems.

Insurers, it seems, are concerned too about possible contravention of the Data
Protection Act (1984), which states that:

If an individual suffers damage because of inaccurate personal data
held about him or her by a data user, he or she is entitled to claim
compensation from the data user ... Data are 'inaccurate' if they are
incorrect or misleading as to any matter of fact.

As one insurer explained:

One of the problems is that we can't mark our computer with fraud
markers because of data protection implications.

Another expanded on the point:

We could put a code on [our computer records] to say that it had been
investigated, but we have to be very wary of the information that we
put on computer for data protection purposes, as you probably
appreciate. If we had a code which said this guy is a likely crook ... we can’t do that and we won’t do that.

Another large firm of insurers did not in any case have the option of putting information on to their database, as they did not have one:

One policyholder has six claims in a three-year period. No one tied it up. We had to search files. We don’t have a database.

There were other insurers who did have databases but who could not cross-reference information because data on different insurance schemes were held on different and incompatible databases. At the same time, some insurers who underwrote block policy agreements through banks or building societies did not have access to databases in order to check. It was obvious that not only were insurers reluctant to mark up cases of fraud or suspected fraud, but their systems would not have been able to identify them anyway.

Most insurers agreed that their problems arose mainly because of inadequate links between the sales/underwriting department and the claims department. The majority were also reluctant to place fraud markers on their computer systems. However, one insurer who admitted that in his firm the links with the underwriting department were inadequate said that he did indeed place markers on his computer files where fraud had been investigated; but the underwriting department did not have access to such data because the system was purely claims-related:
There's a status within the claims system that shows that we've proved fraud on it. We don't actually use the word fraud, because under the data protection act it would be illegal. So it's under a different heading. But basically it is a marker.

However, as this insurer pointed out, it is all very well having markers; but unless an underwriter has access or the claims handler checks, no-one will ever know:

... The status of the claim would obviously show on that file and would show the investigation on it. So they would clearly be able to see that—what had happened to the file.

This insurer went on to say that:

Wherever you get a second claim on a file that's been archived you'd request the achieved file back ... There's a lot of stuff that has manual notes within the file. That's also got a little chat entry which is an entry really like a diary ... So it's unlikely that anyone would miss it providing they open the claim file.

It would seem therefore that, even while in this company computer records did not have a marker, if there had been a previous claim a claims handler or even an underwriter (if he/she knew about the claim) could get hold of the manual file and check that for fraud instead. However, the process of digging out a manual file
appeared time-consuming and impractical, leading some to welcome opportunities offered by new technological systems. Moreover, as another insurer explained:

We don’t interrogate every proposal ... It’s so cut-throat, no one wants to put two pounds on the cost of checking each CUE claim.

Not only may insurers’ current systems be incapable of relaying fraud markers to the appropriate departments, but the Data Protection Act (1984) is, as pointed out above, a source of concern to many insurers.

Although insurers can be nervous about keeping records on suspected cases of fraud, there are obvious advantages in being able to identify those who have committed fraud in the past. Publicity to the effect that insurers hold data on past fraud can help to increase people’s fear of getting caught and deter them from committing frauds. Insurers could close the many opportunities for fraud which currently exist if they had systems that were able to cross-reference all relevant information accurately and swiftly. Such systems would ensure that insurers had records of individuals which would help to validate claims and that they did not renew the policies of those who had acted fraudulently in the past.

Even with a sophisticated database there are no guarantees that a person who has submitted a fraudulent claim in the past will be identified. For example, if a fraudster changes the spelling of his or her name slightly and moves to another part of the country, there will be no match.
Other approaches to reducing risk of fraud

As discussed in the previous section, some fraud can be prevented by changing the way that insurance is sold. Similarly, there are ways in which the terms of the policies themselves can be altered to reduce the scope for committing fraud.

Travel insurance has always been a problematic area to control, particularly as most travel insurance is sold through agents. One way around this would be to include travel cover in household policies. In terms of fraud prevention this has a number of advantages. Household insurance is underwritten and claims are recorded on the CUE\textsuperscript{2} database, which ensures that the insurer will immediately have information about the policyholder and some knowledge of the risk he/she presents. The policyholder ceases to be anonymous. Household insurers can levy an extra charge for adding travel insurance to policies, while not having to pay out hefty commissions to tour operators and travel agents. In addition it could be pointed out to policyholders that any claims for travel losses could affect their no-claims bonus and lead to an increase in premium, which would discourage opportunistic claimants. However, people would still have a choice whether to use their household insurer or to take up a policy offered by a travel agent or tour operator.

A further possibility would be to encourage motor policyholders to obtain household insurance through the same insurer. In this way a database profile of the policyholder could be set up and any inconsistencies between the two policies identified and queried. More would be known about the policyholder, including
his/her claims history under the other policy. It seems clear that there are many benefits for insurers who provide for their customers' total insurance needs, including motor, household and travel insurance, and it is certainly an option that should be given careful consideration.

As mentioned earlier in this chapter, some insurers are trying to improve their efficiency by introducing lifestyle analysis. Although lifestyle analysis was not designed to prevent fraud, it could do just that, simply by identifying individuals who rarely claim. This is an important point, particularly as fraud often occurs on the back of a genuine claim.

Systems are now becoming more sophisticated as well as integrated. The new lifestyle programs will not only analyse existing company data; they will also make it possible to buy in information on such matters as credit ratings, county court judgements, addresses, electoral roll data and a mass of other information available to the public. All this information can then be drawn together, and the individual given a score from one to ten. As one insurer who is developing such a system put it:

\[
\text{All the information which is available in the public domain can be stored on the computer system, and it's available instantaneously.}
\]

Although systems such as lifestyle analysis can be useful, there could be a tendency for the underwriting and even claims functions to become increasingly automated. Lifestyle analysis relies heavily on the accuracy of the information
collated and on the reliability of the program analysing it. Any shortcomings could lead to in accuracies or faulty analysis. Despite such potential problems, a lifestyle system could be good at assessing risks and the likelihood of claims occurring, as well as checking for inconsistencies and the non-disclosure of information at the underwriting stage. However, the problem of judging which types of people are likely to commit fraud and which are not remains. A machine cannot be expected to identify a fraud which leaves no clues and is only found through ‘gut feeling’.

Earlier in the research it was established that there is no one type of person who commits fraud. In recent years research has been conducted with a view to establishing the psychological profile of a typical fraudster (Dodd 1998; 2000). Although such research has reached fascinating conclusions, it is unclear what can be done with it: it would be absurd to suggest that anyone with a similar profile should be accused of being a potential fraudster, or that companies should refuse to insure individuals because their profile matches that of people who have made a large number of claims.

However, it appears that lifestyle analysis is seen as the way forward by many insurers, and this is particularly true of those who sell insurance direct to the customer. One insurer explained that ultimately it was profitability the company strove for, and its systems were dedicated to selecting the best risks:

It’s the system that makes the decision. We’re very careful with our underwriting criteria; the sort of person that we want written into our
books is very carefully written into the system. It could be at the end of that conversation that it's somebody that doesn't meet our profile of the ideal policyholder. We do try very carefully by either questions or by loading the premiums, by the way in which we actually quote for that business, and I think that we’ll quote for most policies, but might actually load others more because it's a risk we don’t want to accept. But we do try to build the level of business that we feel that we're likely to make a profit out of, and not just take anybody on the books and keep our fingers crossed ... The household account is very profitable.

Other insurers charge very high premiums and underwrite high-risk business and even potential fraudsters, in the knowledge that they are making a lot of money through premium income. They do this while being fully aware that they will have to pay out heavily on some claims.

**Conclusion**

Although more research is needed, this discussion has suggested that new technology can be helpful in reducing fraud. The more efficient a computer system is at cross-referencing information at the initiation of a policy, the greater the chance that discrepancies or non-disclosure can be identified. A sophisticated underwriting system can be programmed to take on the best risks—notably those people who statistical analysis shows are less likely to claim. The aim of such
systems is to have fewer claims and thus to reduce fraud accordingly, and the emphasis would be on minimising the number of claims.

It could be argued that seeking out fraud is expensive—it takes time to detect and is difficult to prove. Instead, all efforts should be concentrated on evolving a system to reduce claiming. This can potentially increase profitability, as well as reduce fraud. One way of developing such a system would be to refuse high-risk policyholders, or at least to load the premium accordingly. Another way would be to help individuals avoid a potential loss in order to reduce the chance of a claim, a point discussed in Chapter Nine.

Given greater emphasis on customer care and retention, increased efficiency and claim prevention, insurers would find that they could reduce the incidence of fraud, thus further increasing profitability.

Much could be done to reduce the opportunities for fraud, both in terms of the way that insurance is sold and by altering the terms of policies. In order to get accurate information computer systems could be programmed to cross-check the data from various different sources (e.g. the electoral roll, DVLA, MIAFTR) automatically. Should the computer come upon any inconsistencies, further questions would automatically be provided for the sales staff to ask. The policy would then not be underwritten until all were satisfied. There will be those who argue that such fraud prevention procedures might not fit in with a positive sales strategy. However, these procedures could be combined with a strong customer-care policy: it is better to get things right from the start than to have problems
when there is a claim. At the same time sales staff could benefit, as they have an
incentive (through commission) to sell policies and could be further rewarded
(through bonuses) if there were no claims on the policies they sold.

These points will be reconsidered later. First, fraud at the claims stage is
discussed, beginning in the next chapter with an evaluation of the opportunities
that are available.

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1 Reasons for having a high retention rate could be competitive premium rates that cannot be
matched elsewhere, as well as the fact that buying a policy through a broker or third party,
who may shop around for a client, encourages change. A person insured directly through the
insurer may not be influenced by a third party and may automatically renew.
2 It must be noted that some insurers still have not registered with CUE.
3 However, the danger here would be that some individuals would find difficulty in gaining
insurance, either because they were refused or because the premium was too high.
4 At present, due to the Data Protection Act, some government departments are restricted in the
information that they can release. At the same time others do not have the technology
necessary to provide data instantly.
7. Fraud at the claims stage: opportunities

Introduction

This chapter summarises the research findings on fraud at the claims stage. It looks at the opportunities that arise at that stage, and these are then considered in Chapter Nine in the context of situational crime prevention measures. The present chapter focuses on four main facilitators of insurance fraud, i.e. the factors which make fraud possible. These include: the difficulty of proving that a fraud has occurred; the involvement of people willing to help fraudsters; the awareness that insurers do not investigate some cases of suspected fraud, as they find it quicker and cheaper to pay out on a claim; and the process of 'fast tracking', which leaves insurers little time to look for fraud. Whilst these factors are discussed separately, in reality they overlap.

The opportunities to commit fraud at the claims stage

The difficulty of proving fraud

In order to reject a policyholder's claim on the grounds of fraud, an insurer needs to be able to prove that there is misrepresentation. However, all the insurers interviewed admitted that this is usually very difficult to prove. It should be pointed out here that different types of losses require different types of proof on the part of the policyholder at the claims stage. In the case of travel insurance, insurers require proof that the claimant made the journey, and documentary
evidence of a report of the loss to the police, together with a receipt showing that
the item being claimed for did exist. As regards motor insurance, where an
accident has occurred a claims inspector’s report may be needed, whereas in the
case of household insurance proof may take the form of a receipt, a photograph or
an instruction manual for the item said to be lost.

Proof is often easy to invent. In the case of travel insurance, obtaining a police
report may require no more than a visit to the local police station and the filling-in
of a form (see Appendix A). In the context of both travel and home insurance,
receipts for genuine items can be borrowed from colleagues, friends or relatives
and used to support claims. This is all that many insurers need to pay claims. As
one insurer explained:

A photo of the watch … It isn’t proof that it’s been stolen or lost, but
it’s a start, isn’t it? If they can’t prove they ever had it … I think part
of the policy says that you’re entitled with proof of ownership, and a
receipt is proof of ownership, or a photograph or whatever.

Another insurer explained how easy it is to obtain sufficient proof:

We recently bought my son a second-hand video for his flat and he
hadn’t got the instruction book, so we rang Sanyo and asked them
could they supply one. You pay £6 and they sent him an instruction
book.
And another gave a further example:

My daughter was 21 a couple of years ago, and we bought for her 21st birthday a Gucci watch. We've still got the receipt. I could go on holiday and come back and say: 'That's funny, I suddenly looked and my watch had gone.' 'What was it?' 'A Gucci.' 'Have you got a receipt?' 'Well, I might have one somewhere'. She could be at college, still wearing the Gucci watch and [the insurers] are still paying out for the claim.

This insurer went on to say: 'If you wanted to make a living making fraudulent claims and you were clever enough, you could do it.'

All the insurers interviewed could recall cases where proof of loss was provided and the claim was paid, even though the circumstances of the loss seemed strange. Many insurers pointed out that these types of cases were difficult to clear up. Fraud often went unnoticed when documentation appeared to be in order and the circumstances of the loss seemed genuine. In this way many fraudulent claims slipped through the net and fraudsters were easily getting away with it.

Insurers face a difficult task, for they need proof not only that a fraud has been committed but also that it is the claimant who is responsible. One insurer described a case where a receipt had been submitted which had obviously been altered. When the case was heard in court the insurers lost because they could not prove conclusively that it was the claimant who had sent the receipt, nor that it
was he/she who had altered it. The court decided that it had not been conclusively proved that the policyholder had committed fraud, and the insurers therefore had to pay the claim. The opportunities to commit insurance fraud and get away with it are greatly increased by the fact that it is often difficult for insurers to secure convictions, through either the criminal or the civil courts. Policyholders are thus finding that the risks of committing a fraud can be minimal, while the rewards can be substantial.

Apart from the fact that insurers are finding it difficult to prove cases of fraud in the courts, they have also been up against the problem of the legal aid system. Legal aid is provided by the state to people on low incomes who cannot afford the costs involved in pursuing a case in the courts. In 1995 over 3.5 million people benefited from legal aid (Law Society 1995a) and some of these were individuals pursuing insurance claims.

The major advantage of legal aid is that those in receipt of it have all their legal costs paid. Thus those able to obtain legal aid in order to take an insurance case to court have had very little to lose by pursuing the case, and often much to gain. There are thousands of law practices throughout the country which actively promote the attractions of legal aid, and the Law Society encourages people to make the most of the system. It is quoted as saying that ‘the legal aid solicitor is as essential as your family doctor’(Law Society 1995b).

For insurers, the existence of legal aid has posed serious problems. Insurers interviewed for this study cited this scheme as one of the main reasons why they
preferred to negotiate out-of-court settlements. For insurers, the costs of pursuing a case can be prohibitive. As one explained, there were times when:

we’ve made a commercial decision to pay the claim but that really depends on how far it’s got. I mean there could be various reasons for doing so. The most common one is having your arm twisted when an individual has got legal aid. If he gets legal aid it’s going to cost you more to defend it than it is to make him a payment ... An individual sues you on the back of legal aid, what’s the point of a Pyrrhic victory? Why spend £10,000 defeating the claim when you can settle it for £5000? We’re here as a business, to run on a commercial basis.

It remains to be seen what the effect on insurance litigation will be of the changes affecting the legal aid system which came into effect on 1 April 2000. The main changes are that individuals will be able to enter into ‘no win, no fee’ agreements with lawyers, and that, unlike previously, those in receipt of legal aid will be liable to pay their opponents’ costs if they lose their case. Certainly these changes will tilt the balance of advantage of resorting to the courts in favour of insurers and against individual claimants.

Not only has it frequently been seen hitherto as being in the insurer’s financial interest to pay spurious claims rather than to fight them through the courts, the resort to legal action can also lead to bad publicity, particularly if the claimant is perceived to be a vulnerable member of society; and this can feed public prejudice against insurance companies.
Helpers

Insurers are faced with further problems when 'helpers' are involved; these are individuals who assist policyholders to commit a fraud which the latter might not have contemplated committing themselves, or which they could not have committed. For example a helper might be a builder who suggests to a policyholder that he/she could get a room plastered, or the roof repaired, if he/she puts in a large claim for damage to the insurance company. A helper will often provide a claimant with support for an inflated claim. This might take the form of a written report, which asserts that damage is more extensive than it is and includes an inflated quotation to cover the cost of extra work. Such scams are difficult to detect unless an assessor is sent to validate the claim.

Helpers are trusted by insurers, who use the information that they provide to validate a claim; yet this trust is abused. It will be recalled that the issue of abuse of trust was discussed in Chapter Two (following Shapiro 1990) and it has a particular relevance as far as helpers are concerned. While helpers are an integral part of the insurance business, they are able to abuse trust. Managers or owners of shops, for instance, can be helpers, as one insurer explained:

If somebody is coming into your jewellery shop and saying '... I brought this Gucci watch, £400 and, er, I dropped it on the floor and something fell on it, can you give me a certificate saying that, how much it would cost to replace it, oh can you just write on it that it’s beyond economical repair?' You, as a shop owner, are thinking that if
he gets this he’ll come back in and spend £450 on a new Gucci watch.

So, yes, I’ll give him one if he asks for one.

Such helpers may not be concerned that a fraud is taking place. They may be prepared to help the fraudster because it makes good business sense to do so.

The police can also abuse the trust implicit in their office and become unwitting (or witting) helpers. The police often do not visit a crime scene, and instead provide a crime number over the telephone, without proof that any crime has even been committed; this is common where car crimes are concerned. The crime number is often accepted by insurers as proof that a loss due to crime has occurred. In foreign countries holidaymakers may go to the local police station and obtain a form confirming their loss (see Appendix A). While this helping role is not always tantamount to abuse of trust, it sometimes is. For example, one police officer admitted that when called to a break-in she might, if she felt sorry for a family or elderly person, encourage them to (fraudulently) inflate a claim by adding additional items. She would even suggest values for such items; and she knew that other officers had done the same. She thought there was nothing wrong in this; rather, she felt that she was helping the victims, who were very appreciative.

Helpers pose a problem for the insurer insofar as they substantiate the circumstances or the extent of a claimant’s loss which may never have occurred. Where helpers are involved, particularly the police, it becomes very difficult to
disprove a fraudulent claim. Some insurers despair of resolving the problem; one instanced the following claim which he considered to be suspect:

So we ask him for a receipt and in comes a scrap of paper, with a date on it from Joe Bloggs, High Street, Cambridge: ‘I sold a diamond ring to ... for £2500 and he’s signed it.’ So we ask him for a receipt, so there’s the receipt and there was the proof.

In such ways (whether or not this claim was in fact fraudulent) helpers can create opportunities for claimants to commit fraud which might not otherwise exist. Indeed, during the course of research for this thesis, when a mock insurance fraud was conducted it was found that a tour operator acted as a ‘helper’ by providing the researcher with a letter in support of a claim which was bogus. Without this letter the fraudulent claim would have been unsuccessful (see Appendix A). Thus, by helping to substantiate a bogus claim, helpers can increase the opportunity to commit a successful fraud and reduce, if not eliminate, the risk of the policyholder’s being caught.

Fast tracking

Insurers properly strive for greater efficiency in order to cut costs and improve customer service. ‘Fast tracking’ is the term used to describe an approach aimed at ensuring that claims are dealt with as quickly as possible, but it is a concept rather than a specific method. Because fast tracking requires that claims handlers
react quickly when a claim comes in, this often means they do not have sufficient
time to search thoroughly for evidence of fraud. As one insurer stated:

Claims handlers are under pressure to turn claims round quickly on a
quality basis. The drive for quality has cut the opportunity to detect
fraud.

Other insurers commented:

So the claims are coming in all the time, fraudulent claims; but these
poor claims handlers, who have a lot to do, just plough through these
claims and sometimes it’s impossible to be as thorough as you’d like
to be because of time restrictions.

The pressure is on service to the customer and therefore that’s the
difficulty in fraud identification. You want to be able to identify it as
early as possible, then obviously you can start to investigate and you
have a very good reason for not concluding the claim in the standard
time. [If there is a] delay in handling the claim, then that will reflect
badly on us. So there is this balance and it’s a difficult one.

With fast tracking it is easier for a claims handler to pay out on a claim than to
examine it further. As one insurer said:
The unfortunate thing about it is that these claims handlers are given a pile of claims and no one will ever complain about being paid. But if someone doesn’t get paid within a fortnight, or a month or two months or three months and they start to ring up, and they start to get nasty, and they start to ring every other day and they start to put on pressure, and the solicitor’s letter arrives.

Fast tracking gives priority to speed in order to optimise customer satisfaction. It has many advantages for both the policyholder and the claims handler. The policyholder benefits because claims are handled and paid quickly. The claims handler is relieved not to have to get involved in the minutiae of claims and to be able to process and pay them promptly.

Even when claims handlers were expected to identify fraudulent claims, it was found that they tended to pay claims rather than investigate them closely, as one claims handler admitted:

All [a claims handler] has got to do is write ‘pay’ on the bottom and send it in. All this hassle will go away and he’s left then to get on with his pile of paper work. So to stop doing what you’re doing and to look at a claim in more detail, and hold the payment on it, is only going to cause you hassle. That’s bound to have some bearing, and a solicitor’s letter or an irate policyholder will have the desired effect on some claims handlers. They’ll say: ‘Oh, I’ll just pay it.’ Or it’s complicated and it’s gone on for months and months and months, it’s never going
to go away until you can either prove it’s fraudulent or it’s not covered by the policy. It’s not going to go away, so they pay it.

This researcher found that a number of insurance firms had wall-mounted monitors that displayed the number of calls answered that day, together with the number of calls waiting to be answered. The screens also displayed the name of the staff member who had answered the most calls. One insurer who monitored staff efficiency closely even kept a check on delays in answering calls, as one claims handler explained:

LDA on the monitor stands for ‘average length of delay’, which basically means that if you ring up and everyone’s on the phone and they can’t get through, it will tell you how long that person has been waiting ... each time it goes over ten seconds it affects the service level and brings that down. Basically the service level—the minimum we expect—is about 85 per cent.

Another insurer monitored the length of time that claims handlers were on the telephone. As a claims handler from this firm pointed out:

There is an ICS which is a monitor basically which [has details of each claims handler]. It just says how long you’ve been available. After a call you automatically go into ‘call work’, which basically means that you won’t accept any other calls until you press it off again. It’s not a good idea to stay in that because obviously
management will come down on you if you haven’t been available for a certain amount of time [to answer calls]. We run reports weekly and it says if people have been [sitting] in ‘call work’ for too long, and they get a rollicking.

Although this sort of system may create an effective telephone answering service, it can discourage those claims handlers who may have a suspicious claim from looking into the matter closely. In this way, fraudulent claims are being missed.

In the department described above the pressure was on to answer as many calls as possible in as little time as possible. One claims handler there was disconcerted that a researcher should try and speak to him while he was taking calls—he feared that his call rate would go down and he might lose his place on the score board. Other insurance companies monitored the number of claims processed on each computer. Management was able to see who had handled the most and the length of time it had taken. Staff were only too aware that they had quotas to meet. One insurer stated that his organisation had the ‘BS9790 rating’, and a claims handler said that he had to process all incoming claims within 24 hours to meet the standard of service that the company had set down: He had, he said, little time to look for fraud:

BS9790 is a standard that insurers strive for, we can’t upset the customer as the British Standards go against this. By investigating insurance fraud it takes a long time and cuts down on speed and
efficiency, this contravenes the standard, so we stop investigating it, otherwise we upset the client.

Another trend that has developed during the last few years is for insurers to make claiming easy, and this is seen as good customer service. After the storm of 1987 whole-page advertisements in newspapers emphasised how easy it was to make claims for damage, and some even included claims forms. One insurer interviewed for this research said:

The top layer of insurance management were talking about claims being easy and came on to the market as ‘fast-track’. Fast-track claims, small value, large volumes, push them through. You’re saving on your claims costs in terms of expertise, and there’s high customer satisfaction and therefore a lot of contracts being renewed. [However] the average cost of claims went through the roof. We were employing processors; we weren’t asking them to intervene on the claim [or] to question ... I think it was always there to start with, there had always been a bit of a cat and mouse game as to what would be paid and what wasn’t going to be paid, and all of a sudden insurers started to pay them and that I think might have been the catalyst for people saying: ‘Well, this is a good way of actually getting some money.’

There were also additional problems, as another insurer explained:
Because we’re trying to be competitive we’ve streamlined ourselves; we’re doing away with evidential opportunities in order to compete.

[A direct insurer] doesn’t have brokers, they therefore avoid the commission and can charge cheaper rates ... We [on the other hand] have to look at other ways of fine-tuning, or cut out bits we don’t really need, i.e. the claims form. However you can’t prove fraud without a claims form.

This was not an uncommon reaction. A number of insurers said that it is often not realistic or cost-effective for them to look for fraud in all new policies and claims. However, it is a big mistake for insurers to ignore fraud altogether, particularly as it can impact heavily on their bottom line. Ultimately there needs to be a balance between the aim of creating an efficient and quality service and the prevention of fraud. This study found that there was a tendency for insurers to seek ways of improving speed and efficiency at the cost of tackling fraud. For some insurers fast-track systems are so much more cost-effective that it is worth paying out on suspected fraudulent claims rather than cause delays—simply because it is cheaper to do so. This point would merit further research. Perhaps in the long run this situation will lead more people to commit fraud, as they become aware that the opportunities are there and the risks are low.

**Conclusion**

The evidence reported in this chapter shows that there are many opportunities for fraud at the claims stage. Insurance fraud is easy to commit because it is often
difficult to prove that it is occurring, especially when there are ‘helpers’ willing to abuse the trust placed in them by lending a hand to those seeking to commit fraud. These helpers are people working in official or quasi-official capacities, and indeed are sometimes professionals giving advice as part of their job. The concerns identified by Shapiro (1990) and discussed in Chapter Two are particularly relevant.

Insurers find it time-consuming and expensive to investigate fraud and to prosecute those responsible. It has been shown that modern systems such as ‘fast-tracking’ can encourage insurers to ignore the risk of fraud. There is always a problem when systems which are designed to increase efficiency in other aspects of the business have a negative impact on crime prevention and security—there is nothing new in this finding. However, there is a clear need for insurers to recognise the problem; at present some seem unaware of it. This is a reflection of the low priority insurers attach to tackling insurance fraud.

It has been shown that insurers are creating easy opportunities for people to commit insurance fraud and get away with it. A prerequisite for reducing opportunities is to make it more difficult to commit the offence. Even if a fraud is detected the claim is often paid simply because it is more cost-effective to do so. Moreover, insurers have tended to be reluctant to take suspected cases of fraud to court. At present the insurers’ strategy works in the interest of the insurance fraudster.
These points are discussed further in Chapter Nine, where it is shown that the techniques of situational crime prevention can provide a structure for reducing such opportunities and cutting down insurance fraud. But first, fraud at the claims stage is further examined, concentrating on the response of the insurer, and this is the topic of the next chapter.

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1 The researcher has checked with the British Standards Institute, the ABI and the CII; none of these organisations has heard of this standard.
8. Fraud at the claims stage: the insurers' response

Introduction

The various ways in which fraud may be identified and tackled are examined in this chapter, which also offers an assessment of the limitations of each method. It is argued, first, that some insurers do not appreciate the seriousness of the problem presented by fraud, and that even when they do there is a lack of coordinated effort within companies to tackle the problem. The difficulties of proving fraud are then considered. It is shown that insurers often have little understanding of the systems which could help them to identify fraudulent claims. The methods currently used include intuition ('instinct' or 'gut feeling'), checklists, claims histories, CUE, and even handwriting analysis. The chapter also examines why insurers do not think some frauds are worth investigating or pursuing through the courts. And finally, the tendency towards 'fast-tracking', a system which can lead insurers to ignore fraud, will be re-examined.

Methods of detecting fraud

'The biggest cost to insurance companies is claims', one insurer remarked. He added: 'If you don't control your biggest cost you're going to have problems.' It follows that some efforts to tackle fraud must be focused at the claims stage. As another insurer put it:
I'm involved in looking at [fraud] from a claims perspective—how we recognise and deal with fraud, and whether we need to be doing anything differently within our claims departments. So the focus, I have to say, is very much claims-driven.

In tackling fraud at the claims stage the insurance industry faces two problems. First, systems currently used to detect and prove fraud are ineffective, particularly where such frauds as exaggeration are concerned. Second, some insurers (a minority, on the evidence of this study) do not believe they have a problem with fraud in their company, and so are doing little or nothing to improve their procedures for tackling it. As one insurer stated when asked whether his organisation had a problem with fraud:

We haven't detected that much of a problem within [the insurance company] ... we don't perhaps feel that we should do a great deal about trying to solve a problem that doesn't seem to exist.

Other insurers were uncertain about the extent of the fraud suffered by their company. As one admitted:

I would say now that my biggest area of concern ... is that we have no idea how much there is really, and even with some of the techniques available like CUE, like document analysis, we're not finding what we should be, or what people might suggest we should find.
Even when insurers detected fraud, there was often no effective system for analysing and recording the data; indeed most insurers kept no comprehensive records of fraud cases and some had none at all. One insurer who was interviewed said: ‘We couldn’t tell how many fraudulent cases we’ve had.’

This researcher found that none of the insurers interviewed employed co-ordinated methods to find and prove fraud. There was no uniform pattern in the way fraud was tackled; most systems consisted of a mixture of methods that were largely untested. It is helpful to consider some of these methods in more detail.

Collated experience and ‘gut feeling’

Systems for identifying and detecting fraud vary quite markedly from organisation to organisation. Even among large insurers the method by which insurance fraud is detected is neither structured nor systematic, and sometimes it boils down to simple intuition. One insurer when asked how his organisation identified fraud answered: ‘It’s just a gut feeling.’

There were those who explained that intuition usually derived from experience:

You tend to get a nose for it ... you get an instinct, there are certain factors that fraudulent claims tend to share; you can look back in hindsight and say: ‘Yes, that features quite a lot in what we think are fraudulent claims.’
Yet some insurers were reluctant to admit that they used ‘gut feeling’:

Do you want my commercial answer or my honest answer? ... We look at them on the basis of gut feeling.

This particular insurer went on to say that the reason he relied on ‘gut feeling’ was that there was no other system in place to identify fraud. Although ‘gut feeling’ can be useful, as many police detectives testify, there is a need for more scientific methods. There are at least two problems with using ‘gut feeling’ as the main method for identifying fraud. First, some fraudulent claims appear perfectly genuine, and ‘gut feeling’ will hardly identify these. Second, although ‘gut feeling’ may identify a suspect case, it offers no means of proving that a fraud is being committed. Thus claimants can still get away with it.

Check-lists

Check-lists were used by the majority of organisations in their efforts to minimise the incidence of fraud. However, the way they were used varied from organisation to organisation. Check-lists mainly consisted of a sheet of paper or card with various indicators or pointers on it, the idea being that the claims handler went down the list getting answers to various questions in relation to the claim under consideration. Further investigation was usually suggested if unsatisfactory answers were given.
Insurers believed that check-lists represented a straightforward method by which claims staff could be helped to look for certain characteristic features of fraud before they could move the claim on. As one insurer said:

There would be a series of procedures that they’d have to go through to move on to the next step, one of which will involve considering any fraud indicators, so they’d look at the claim form and they’d automatically be taking note of whether it looked as if somebody had altered the writing on an attached invoice or whether the circumstance looked odd.

Often check-lists did not just focus on fraud but were considered to be part of the normal investigation procedure. Some insurers computerised their check-lists, and one gave all claims staff a copy in CD format. But the staff were not expected to use them on all claims: ‘They would be trained in general terms to know what [the indicators] are and to look at them in certain cases.’

Another insurer stated that it had been the intention that all claims would be checked against the check-list, but he appreciated that this was not feasible:

They should do, but being realistic I don’t believe that they do. I believe we’ve got to be realistic about it. We’re in a service industry. We’re providing a service to our customers and there’s a time taken to complete them, and it would be quite unrealistic to say that every claims handler uses one of those forms for every claim that they have
and particularly one they consider to be a straightforward household claim; and there are lots of them, to be honest.

He added that time constraints and the notion of customer service made it impractical to review each claim in accordance with a check-list, and that it was unrealistic to expect a claim to be checked which appeared to be straightforward. It was possible therefore for a fraudulent claim that appeared normal to be missed.

Check-lists can be time-consuming and awkward to use. One insurer showed the check-list that his organisation used for motor theft. Not only was the form badly photocopied and difficult to follow, it consisted of 40 questions, many of which required time-consuming research to answer. Six of these are listed below:

- Is the MOT certificate on the 'stolen register'?
- Had the insured been drinking alcohol just prior to the loss?
- Does the person in charge of the vehicle have undisclosed motoring convictions?
- Does insured or a family member have criminal convictions?
- Does INFOLINK check reveal financial difficulties?
- Is insured unemployed?
Only the first question could help to prove whether a fraud had been committed. The second and third questions might make it easier for an insurer to reject a claim on the grounds of a breach of the insurance terms, but the remaining three questions would merely provide pointers towards people who might be inclined to commit fraud, but would prove nothing.

Because of the difficulty of filling in the form, claims staff ignored it. As one insurer pointed out:

> It’s a fact of life. If you make things easy for handlers to check, it will get done; if you make it difficult for them, it won’t get done.

The checklists were often devised by claims handlers who admitted that they did not know where fraud was occurring, and were just looking for signs that aroused suspicion. As one insurer explained:

> They were just developed from in-house experienced discussions to see what was out there on the market, picking up bits and pieces that had already been published to see whether we agreed or disagreed with that sort of documentation, really. It was a combination really of getting experienced people together, looking, getting them sitting down and brainstorming. Working out what sort of things we’d be looking for, looking to see what had already been published and to see whether there was anything we hadn’t thought about, and coming out with what was considered to be the most appropriate.
Another insurer added:

People who've got a lot of experience in handling claims, they thought: 'Well, if I'm looking at a claim, the things that would arouse my suspicions are ... ' and they listed all those things down, and some arouse suspicions more than others.

Some insurers provided check-lists on laminated card to act as a reminder to claims handlers.

Some insurers admitted to being sceptical about the use of check-lists; and a few admitted that they believed the indicators these were supposed to produce were probably not the most effective method of detecting fraud. As one insurer explained:

Yes, we have given [claims handlers] lists of pointers in the past but I don't think it's particularly the most effective way of doing it; we certainly want to improve on it.

Some types of fraud would not be picked up through a check-list. For example, when the researcher asked one claims investigator whether an exaggerated claim would be identified if the person who submitted it was quite ordinary in every respect but had decided to add a few extra items to the claim, he responded: 'Then we'd miss it'.
Exaggeration was one form of fraud that most insurers agreed was difficult to detect, and few had attempted to design measures to identify it. Check-lists, as the insurer above testified, would miss this type of fraud, particularly if the claim appeared ordinary in every other respect. This should be of concern to the industry, particularly as many insurers believe that exaggeration is the most prevalent type of fraud. As one noted:

Inflated claims were the largest area of fraud. On the household side a large number of claims are genuine initially ... the burglary did happen or the loss did happen, but they’re then inflated out of all proportion to include extra items, items that were never actually there, increasing the value and so on. That then becomes more difficult to establish ... I think that there’s a whole percentage of people getting away with exaggerated claims and inflated claims ... I would think it’s probably 40 to 50 per cent, probably even more.

Another problem, as one insurer pointed out, is that fraudulent claims may have certain characteristics. It is easy to use these to form the basis for questions on check-lists, yet when these characteristics are analysed properly they may not be meaningful. He went on explain his point in the following way:

If I look through my [fraudulent claims] book and see that there are more claims by people with surnames beginning with S, does that mean that if your surname begins with S, you’re more likely to submit a fraudulent claim? So I could tell the branches that if they get one
where the surname begins with S, send it to me because it might be suspicious, but of course you can’t do that. The points criteria, as I say, is not perfect but it is a measure and we’ve got to measure the claims.

The problem therefore remains that indicators which are currently used to detect fraud may appear helpful, but that their reliability is open to question. It seems clear that the way in which the criteria for check-lists are determined needs to be reviewed.

This research found that check-lists are time-consuming and difficult to use, and are often devised by claims handlers who do not fully understand the fraud problem. The answers to the questions asked provide no proof that a fraud has occurred. Check-lists often do little more than suggest that a claim requires further investigation. One insurer characterised the result of using check-lists as ‘merely a summary, if you like of gut feeling in a lot of cases’.

All this shows that although check-lists are used by many of the large insurers they do little to reduce the opportunities for fraud. They do not make it more risky for an individual to set out to commit fraud because tactics such as exaggeration are often not identified. Check-lists do not make it harder for claimants to commit fraud. However, they can reduce or eliminate the rewards of fraud, particularly if a claim can be rejected on a technicality. At present, the use of check-lists provides an inadequate situational contribution to fraud prevention.
Cross-referencing claims histories and sharing information

The cross-referencing of claims histories and the sharing of information are useful procedures in the combating of fraud—the more comprehensive and accurate the available information on an individual, the easier it is to know when he/she is lying. This should enable insurers to improve the chances of would-be fraudsters getting caught and to increase the effort required to carry out a successful fraud. This researcher found that few insurers recognised this as a positive way forward and that others were using the procedure incorrectly.

When asked in the questionnaire how insurers could improve the way in which they tackled fraud, only three out of 33 mentioned the sharing of information between insurers and other bodies. Those who did recommended more intensive cross-company checking and improved communication between loss adjusters, insurers and the police, as well as easy access to public sector data such as DVLA, tax and social security records.

None of the respondents mentioned the ABI Crime and Fraud Prevention Unit, which was created in 1995 with the specific purpose of opening up channels and improving the sharing of information. Despite the ABI's efforts to promote awareness of the value of such sharing, traditional fears within the industry live on: that the exchange of information risks giving competitors an advantage and causing bad publicity or, worse still, leading to contravention of the Data Protection Act (1984). One respondent commented:
The investigation of insurance fraud is extremely difficult, having to judge the benefit against adverse publicity. Getting it wrong in the slightest can be extremely costly.

Of the three insurers who considered the sharing of information to be important, two had large, dedicated fraud/technical units and the other was developing a more sophisticated computer program which involved lifestyle analysis. It was not surprising therefore that it should have been these organisations which recognised the benefits to be gained through co-operation and the exchange of information.

One of the obstacles to the sharing of information at present, and as noted earlier, is that insurers often operate incompatible computer systems (a problem not confined simply to companies which have just merged). And those who set out to share information could find it expensive, as one insurer explained:

The problem is there isn’t a great deal of co-operation between insurance companies in that field because it’s very difficult to retrieve, and if you didn’t watch you would have about 100 to 200 staff to answer all the queries.

Any information gained in this way should be used as a reference point to check the accuracy of what the policyholder tells the insurer, either at the proposal or at the claims stage. But it has to be recognised that the information may not be complete, so it may be difficult to prove that a claimant has committed fraud in
the past—and even more so that he/she intends to do so in the future. Indeed, even if fraud was suspected in the past, there may be no indication on current records that this suspicion was well-founded. As one insurer said:

We can’t sit on suspected frauds. If a claim is suspect and we couldn’t prove it we probably then wouldn’t do anything else as far as marking it on file.

There are still some claims departments which place great emphasis on searching out the claims histories of current claimants, on the assumption that those who have committed fraud in the past are likely to do so again. But of course the fact that one has committed a fraud in the past does not prove that one’s current claim is fraudulent. One insurer made the obvious point:

The fact that we suspected fraud previously wouldn’t necessarily give us any [fraud]; we couldn’t use that to say that the next claim wasn’t genuine. You have to look at each claim, and there must be something about that claim that you can actually prove is fraudulent.

If used properly, cross-referencing of in-house information about past claims and accessing other insurers’ claims records can be helpful. Insurers can build up dossiers of information on individuals which increase the chances of telling when someone is lying, and thus of preventing a fraudulent claim. So the method has the potential to be used as an opportunity reduction technique, in that it can increase the risks of getting caught and thus act as a deterrent.
Technology used to detect fraud

In recent years two systems have been adopted by insurers to help to detect fraud; both are often used by police forensic departments. These are the video spectral comparator and the electrostatic detection apparatus; a definition of each would perhaps be helpful.

- *Video spectral comparator (VSC):* the VSC is designed to detect alterations to a document, and is used particularly on invoices, estimates, receipts and cheques. The document is illuminated with different light rays from ultraviolet to infra-red, in order to get the writing to fluoresce. Different inks fluoresce more or less intensely under different light rays, and thus alterations to the document made with a different ink from the original will stand out. It is also claimed that the machine can identify forged government forms, certificates, company paper, etc, as any forged document will fluoresce differently from the genuine article.

- *Electrostatic detection apparatus (ESDA):* this equipment can detect indentations produced by handwriting. For example, if a note has been written on a pad, the sheets below are normally indented by the pressure of the pen. ESDA is able to pick up this indentation so that it can be easily read.

These pieces of equipment have been heavily marketed to insurance companies, and some of the larger firms have bought them. Others use loss adjusters who have themselves installed them. Although these machines can be effective in the right circumstances, their use by insurers runs up against a number of problems.
First, while the machines can detect that a fraud is being attempted, they cannot prove that the claimant is the culprit: further evidence is needed. A number of insurers who used one or both of these machines said that they could recall a number of cases where fraud was detected but where it could not be proved that the suspect had committed it. The second problem is that both machines are time-consuming to use. In order to take full advantage of such equipment a company would need a full-time operator continually assessing documents, a use of resources that many insurers could not justify. One said that his company had used the machine to process every motor theft and had not found a single fraudulent claim. Not only was the process time-consuming, but the lack of positive results meant that this particular insurer could not justify using the equipment for every claim. Another insurer with experience of using the VSC machine said:

Over a period of about three or four weeks we actually put through a random selection of documents—about 500 documents altogether we put through the machine, and we detected that one had been altered .... Each document can take a quarter of an hour or so to come through.

It thus took this insurer 125 hours of random trawling to find one case of fraud. This exercise would only have been worthwhile in commercial terms if that claim was for an extremely large amount. He might have been better advised to use the equipment to examine only those cases which he had reason to suspect were fraudulent. The concern was not an isolated case:
It was suggested to us that by analysing invoices and accounts we would find a huge number of altered documents. Well, that doesn’t seem to be coming through at the moment.

The third problem is that if insurers were only to use the machines on claims which they suspected to be fraudulent, those claims would in any case be passed on for further scrutiny. Moreover, cases which were not seen as suspect in the first place might well never be detected. The fourth problem is that it is far from being the case that most fraud takes place using forged documents; this may indeed be the exception rather than the rule. ESDA and VSC will not detect claims for items that were not lost or stolen but for which the claimant has a genuine receipt. They will not expose claimants who obtain genuine estimates and receive payment only to get a job done more cheaply elsewhere. Nor will they detect those frauds where the policyholder has deliberately damaged an item in order to claim. Only on the rarest occasions will the ESDA detect multiple claims (and only then if the indentation shows that another claim was written out). These machines can identify false MOT certificates and driving licences but, even here, if an MOT certificate is stolen but genuine the VSC will not show this.

There are other, more cost-effective ways of identifying forged or stolen certificates: for example a telephone call to the ABI/police register of stolen MOT certificates. Equipment such as ESDA and VSC has exposed attempts at fraud, but its limitations need to be fully understood before purchase.
However, one insurer was particularly pleased with the system because he believed it had saved him money—'about £100,000'—although it was not possible to obtain proof of this assertion. The savings from fraud were calculated as the money saved by not paying out on a claim detected as fraudulent. The costs he included were those relating to staffing and machinery, although his analysis here was not very scientific: his calculations were based on little more than general assumptions about some of the costs involved. There again, he did not feel he had to be very accurate—this point will be addressed in Chapter Ten.

The fact remains that in general the purchase of an ESDA or VSC machine is not the best solution for most insurers if they want to detect fraud. Some admitted in response to questions that they had made little effort to evaluate equipment such as this before it was bought. A few who did not already have the equipment said that if they could afford it they would purchase it. Only one said that his company could afford the equipment but preferred to send selected cases to its loss adjuster, who had such machines, since this was more productive and cost-effective.

**Staff awareness and training**

Staff training can have an enormous impact on the prevention of fraud. Indeed, ten of the 33 respondents in the survey of insurers admitted that they could improve staff training and awareness. During this study it emerged that it was often the most junior staff who processed claims and were ultimately expected to identify fraud. Yet these people had often had little or no training other than on the job. Even where training is given it is often basic, and sometimes inadequate.
One insurer took the line in an interview that ‘our technicians when they are handling a claim are trained to identify a fraud.’ When asked what this training consisted of he said that employees were given:

Some general and very low-level training on identifying fraud from looking at a number of factors on the claim forms and the policy information. I wouldn’t say it’s the most advanced fraud training around. I would have thought it’s very low-level. We tell them that this is how we think that they should be looking at things, cross checking a few bits and pieces. There’s not really a great deal more than that.

During the research fraud training documents were obtained from some leading companies. The level of fraud training was often very rudimentary, and was sometimes only offered to senior claims employees. One interviewee described the type of training senior claims handlers were offered on the CUE system (which is discussed in detail in Chapter Ten):

We ran two regional workshops for all our branches back in February and provided them with training material. So effectively it was a day’s seminar for our senior branch claims people, who are now designated as ‘fraud co-ordinators’ ... It was very difficult to condense everything into a day seminar ... Each of those fraud co-ordinators would then go back into the branch and cascade the training down.
In this case only senior employees received direct training, and by this insurer's admission it was limited in scope. Yet these members of staff were expected to go back to their regions and train their staff in turn. There appeared to be no formal plan for this to happen, only the expectation that it would. One insurer stated that:

We also, in common with other companies, have a referral procedure and an authority procedure, so that if a junior clerk spotted something that they were not happy with, the instructions would be that they would have to refer that upwards to a certain level to get guidance.

Although senior staff may know how to react to fraud, this is of little help if junior staff are unable to identify it in the first place because they lack training, experience or understanding.

Not only do the most junior staff need to be trained to detect fraud, but they also need to be encouraged to do so, as one insurer explained:

I go around to our branches and I've got ten branches in my area ... probably a couple of times a year talking to them about fraudulent claims and making them more aware. I always find that immediately I've been round talking to them about fraudulent claims and making them more aware, I get an influx of claims to look at and then it peters off. So when it starts to dry up, I go around again.
When asked how many claims (during such an influx of suspected frauds) were identified as genuine frauds, this insurer replied: 'More than half.'

The point here is that, while fraud was presumably always being attempted, more was identified when staff were positively encouraged to look for it. This insurer's experience could serve as a general warning that although training may work in the short term, enthusiasm may wane. Staff need to be continually stimulated and made aware of the importance of detecting fraud, otherwise it will go unnoticed.

Situational crime prevention techniques can be applied, and the opportunities for fraud can be greatly reduced if staff at all levels are trained and positively encouraged to detect it. Another potential strategy is to work with others to pool resources and expertise, although this is problematic in practice.

**Paying out on fraudulent claims: the easy option**

It was shown in the previous chapter that opportunities for insurance fraud exist because claimants are aware that insurers do not investigate claims below a certain value.

Some insurers who were interviewed believed that any claim below £500 was not worth investigating, as the cost would often exceed the amount claimed. As a claims investigator said of one particular investigation:
£380 is not a colossal amount. If we were to go running around the
country after every £300 claim it would be cheaper to pay it.

Some insurers investigated the larger claims (whether they suspected fraud or
not). One insurer stated that unofficially all claims over £500 were investigated:

Unofficially I would probably think anything over £500 would ... be
investigated, and this could be done by correspondence, by telephone
or claims inspector. That's not to say that we don't think that there's a
lot of fraud below that.

Another insurer admitted that for claims with 'a monetary value of £200 to £300
we would probably not investigate'.

There seemed to be no industry-wide policy as to which claims should be
investigated and which should not. Insurers had different policies, and some had
no policy at all. But there was general agreement that it was not cost-effective to
investigate low-value claims—even though this risks encouraging members of the
public to put in false claims, knowing that they will have a good chance of getting
away with it.2 The same point was made by one of the insurers:

That is what a lot of people rely on. They rely on claims up to two or
three hundred pounds not even being investigated because it's
uneconomical.
In an attempt to guard against this danger some insurers set no limits below which claims are not investigated. One, whose company did not have a threshold, explained the policy in the following terms:

No, there's no threshold below which we won't investigate. There's nothing set out. Generally claims of £1000 plus are automatically passed on to somebody, but there's no lower threshold if someone isn't happy with the claim, even if it's a couple of pence. There's still a way of doing a degree of investigation, so there's no lower limit.

While this insurer was committed in principle to investigating all doubtful claims, no matter what the amount, he admitted that small claims would be dealt with very differently from the larger ones; it would be cost-effective to investigate a small claim by telephone or correspondence, whereas an investigator or loss adjuster might be sent to look into a big claim. A number of insurers were reluctant to set thresholds for fear that this might encourage fraud; as one explained: 'Thresholds get known very quickly, and that's one way of encouraging fraud.' This was a concern voiced by other insurers, who believed that if insurers were known not to investigate small claims there could be an influx of fraudulent claims at the lower levels.

Some insurers admitted that during the 1987 hurricane the industry was seen to be paying claims for damage quickly and without question. As one insurer explained:
One of the problems with big storms like the hurricane is that insurers, because they're inundated with the volume of work, will tend to dispense of authority up to X pounds and pay anything under that to get [the work] done.

Another insurer suggested that this problem was partly created by the insurers themselves, who took out full-page advertisements making it clear that they would automatically pay claims of under £1000:

During the storms of 1987 and 1990, those companies who had full page adverts in the press saying that they’d pay all claims under £1000, in came the estimates at £975, so that's inviting fraud, it's giving people reasons to do it.

Policyholders were provided with the opportunity, and effectively encouraged, to submit fraudulent claims. Clarke’s (1997) model for situational techniques states that one of the reasons for a crime being committed is that an individual can justify the action to himself.

Insurers need to eliminate the excuses policyholders can find for making fraudulent claims. They need to emphasise that claims suspected of being fraudulent will not be paid out, whatever their value, but thoroughly investigated. At the same time policyholders should be told that making a fraudulent claim is wrong and illegal.
**The impact of fast tracking**

As outlined in Chapter Seven, the aim of fast tracking is to increase the speed and cost-effectiveness of claims processing; however, this is often at the expense of detecting fraud. This section shows that there are nevertheless some insurers who use fast tracking as a tool for preventing fraud.

Some of the insurers interviewed during the course of this study have fast-track systems which are networked to other departments; in this way claims staff have access to underwriting data on screen. The advantage of this is that any discrepancies when claims are submitted can be easily seen. For this system to work, however, information needs to be entered carefully, and needs to be of the right type.

One claims manager who used this system explained that it was a good way to search for discrepancies and improve accuracy. It also saved time, as the operator did not need to re-key the data. Thus by the adoption of a simple system greater efficiency can be obtained at the same time as a means of detecting fraud.

Insurers have other fast-track systems which can help to reduce the opportunities for fraud. One insurer explained that his organisation was developing a new computer system that would only process a claim after a set number of questions were answered. He explained the system in the following way:

The idea is that the most straightforward claims need only a certain number of questions before we can actually validate that claim and
get it settled. But the more complicated claims—we might not get the answer that we want to the question, so we’ll ask another question and we might not get the answer to that, so we’ll gradually go through a number of layers and we’ll have ... flags all over the place which will tell us whether that claim requires further investigation.

He went on:

It’s supported by a customer profiling system that we’re looking at as well, which will help us with using our own internal data such as the claims history, looking at whether they’ve paid their premiums in the past, the range, the type of profit delivered, and we’re also looking at external data as well—lifestyle, demographic information, credit stress. All this will be in the same investigation process so we’ll be hitting them with questions ... We might need to then have some further more detailed investigation of claims.

The advantage of this system is that it is quicker. When claims are registered over the telephone, questions are asked at this point. At the end of the conversation a computer print-out of the answers is sent to the claimant to sign. The system aims to cut down on the paperwork involved as well as to reduce the time it takes to process claims. An important feature of this system is that every part which records claims is pre-set and each claim goes through the prescribed procedure. Claims handlers do not need to rely on ‘gut feeling’ or to decide for themselves which claims need further investigation. The drawback is that technology such as
this will only be useful if the questions asked are indeed valid. When asked about the way in which the questions were decided upon one insurer responded:

We'll sit around a table, I suppose, at some stage ... It'll be a marriage of experience really. I've got 19 years outside, we've got people on the ground in the regions, so we'll be working at putting project teams together and sitting round a table and looking at claims forms to start with, but we'll have a pretty good idea of what we're looking for, I think.

The fact is that fast-track systems are only as good as the way they are designed. They need to be programmed to ask the right questions as well as having the capacity to check the answers. 'A marriage of experience' may not be enough to ensure that the correct questions are being asked.

The use of systems such as these results in the claims process becoming almost totally automated. This underlines the importance, if fraud is to be detected, of the right questions being asked and of the answers being closely checked. Otherwise these systems will only increase the opportunities for claimants to get away with fraud.

One big advantage of fast-track systems for preventing fraud is that often the programmes used can incorporate information from a number of databases and external sources. For example, Experian (a credit reference agency) devised a system which gave houses a rating from one to 1000 depending on the likelihood
of a burglary occurring, with one being the lowest risk and 1000 the highest
(Winnett 1998). The system is constructed on the basis of lifestyle surveys, and
includes data on income, spending patterns and property location. Further
research is needed to establish the accuracy of the data recorded and analysed on
this system, but it could potentially provide insurers with information about high-
risk policies. Although Experian has been accused of devising a system for
‘cherry-picking’—weeding out the highest risks—it could aid fraud prevention in
three ways. First, it would be able to cross-reference and validate the specific
types of information that policyholders provide in order to ensure accuracy.
Second, if insurers were selective and accepted only those risks which were
relatively unlikely to produce a claim, the risk of the type of opportunist fraud
that occurs on the back of legitimate claims would be much reduced. Third, if
individuals were aware that their insurer had accurate data on themselves and the
risk they posed, they might be less inclined to lie.

‘Tele-claims’ systems can also have an impact on fraud. These enable claimants
to telephone immediately they have a claim. They supply full details, and a claims
form embodying those details is printed out immediately and sent to them for
signature. This method of claiming has potential advantages in preventing fraud.
An individual will find it more difficult to make up a convincing story on the
spot, particularly as close questioning may reveal inconsistencies; and a claimant
is less likely to try and change a printed form, as any alterations will be
conspicuous. This is thus potentially a deterrent measure which can increase the
chances of fraudsters getting caught, and is a good example of how a fast-track
system can not only speed up the claims process and ensure that the correct
information is processed from the outset, but also offer a situational technique for helping to prevent fraud.

An additional method that insurers are using to fight fraud is to record all telephone calls, as one insurer interviewed explained:

You can get an awful lot of information from the telephone, which is actually important. We’re actually going into recording telephone calls, but at the moment we aren’t doing that, we haven’t got the equipment to do it ... It’s a way to prove: ‘I told them I’d had two previous claims and they said it didn’t matter.’ The easy way to prove that is to record the call.

Another insurer who used a tele-claims system felt that it provided a useful tool for cross-checking claims data. He suggested that:

[Telling lies] … over the phone is more difficult than on paper. It gives a useful cross-check. If we say: ‘You had a burglary, what did you lose?’ ‘Well, I lost a video’, and then the form comes in that it’s two televisions and a video ... You don’t expect people to know five minutes after they’ve got home how much has actually gone, but you expect them to notice certain things, as I say, like the telly isn’t there any more. So that’s quite a useful cross-check.
Although this system can act as a useful indicator, it clearly cannot always provide proof that a claim is fraudulent.

**Conclusion**

In this chapter the ways in which insurers respond to fraud have been discussed, and it has been shown that there is no uniform response. Some do not fully understand the problems they face and do not have systems in place to deal effectively with them.

Insurers are paying out on claims that are highly suspect. Claims handlers often work under pressure and with systems which are not well designed to tackle fraud. Even where anti-fraud measures have been implemented these have often been found to be ineffective. Insurers, it would seem, are still far from devising a solution to the long-standing problem of fraud. However, it was found during the course of the research for this thesis that it was possible to identify systems which insurers use that do have great potential—certainly much more could be made of databases and the use of information technology. If developed correctly and applied appropriately to tackling fraud-related issues, then there is potential for an impact to be made on levels of insurance fraud.

One option open to insurers which has been neglected, surprisingly, is fraud prevention, as distinct from fraud detection. Databases and information technology can not only have a major impact on fraud, they can help in other aspects of the business, potentially by promoting sales, increasing customer
loyalty and generating a positive corporate image. Thus tackling fraud is part of an approach that is based on good management principles and practice; this is what good security management is about. The problems inherent in bringing this about will be revisited in Chapter Ten. The next chapter will discuss how fraud prevention can work by re-evaluating situational crime prevention in the context of insurance fraud prevention and of the findings from this study.

1  It was mainly the large insurers who had training schedules. Only one medium-sized insurer had a training manual; none of the smaller insurers did.

2  See reference in the following section to the storms of 1987 and 1990, when it was clear that the public believed that claims under a certain value would be paid without question.
9. Insurance fraud and the techniques of situational crime prevention: towards a revised classification

Introduction

The objective of this thesis is to show how insurance fraud occurs and the ways it might be prevented. The findings reported in earlier chapters have demonstrated that there are many opportunities to commit insurance fraud and that the chances of getting caught are relatively low. It has also been shown that, although insurers have done little to tackle the problem effectively, there is much that they could do. This chapter focuses on the extent to which the situational crime prevention techniques discussed in Chapter Four might provide a framework for the insurers' response to fraud.

As outlined in Chapter Four, the situational crime prevention approach has been criticised on theoretical grounds, in part because it relies on the notion that those who commit crime act on a rational decision taken in the light of the opportunities available. The principle behind situational crime prevention is that the more opportunities there are to commit a crime the greater the chance of it occurring. Thus, if the opportunities are eliminated the crime can be prevented. This chapter will first establish whether insurance fraudsters act rationally when they commit an insurance fraud. This is important, as it could affect the extent to which techniques of situational crime prevention can be applied.
A review will then be undertaken of each of Ron Clarke’s techniques of situational crime prevention, with two specific aims.

The first aim is to assess whether each technique is applicable to insurance fraud prevention, and to show how it works or to explain why it does not work. This will help to clarify the ways in which it is possible to respond to insurance fraud and to point to the means by which techniques of prevention could be made more effective. The second aim is to consider what this analysis tells us about each of Clarke’s techniques—whether it can be left as he defines it, whether it needs to be changed in some way, or whether a new one should be created. At the end of the chapter the conclusions will be reviewed so as to provide a critique of Clarke’s classification. Finally, a revised classification will be presented, since some of Clarke’s techniques are found to be wanting: certain of them need to be dropped, others need to be revised in some way, and a new one needs to be added.

Do offenders act rationally?

It was noted in Chapter Four that the techniques of situational crime prevention are most effective where offenders act rationally. Further comment on whether in fact they do is discussed here. Cornish and Clarke (1986) identify two principles for determining rationality: whether offenders evaluated alternative decisions, and whether they made a choice about their behaviour.

In the survey of the general public undertaken by the author there were three specific questions about household insurance that helped to establish the
rationality of those who commit insurance fraud. Clearly there are limits as to how much one can learn from a self-completed questionnaire, and this is a limitation of these data. However, the answers do provide an insight into this much under-researched issue.

In all, 12 respondents admitted claiming more than the loss to cover the excess payment; 22 admitted claiming for a greater amount than was actually lost stolen or damaged; and 24 admitted that they were not honest with their insurer. These 58 responses were distributed among 36 respondents.

However, not all 36 respondents could be confirmed as rational fraudsters, at least not by an analysis of some of the explanations they gave, and this requires more comment.

Of the 12 who increased their claim to cover the excess, seven claimed that they had been totally honest with their insurer in answer to another question. These seven individuals appeared to be aware of their actions, at least judged by their comments, and as such can be classified as rational offenders—for example:

I did it to pay for [the] excess.

Because you are quick enough to charge for insurance but not quick enough to pay out on a claim.

To cover [the] excess.
Object to paying excess.

Why not?

From these quotations, it can be concluded that these individuals knew what they were doing, yet they did not consider their actions to be dishonest. There is no evidence to suggest they felt guilty about their claims, which is consistent with their believing they were not being dishonest.

Only five of the 12 claimed that they knew that their behaviour was wrong; they could thus be considered as rational fraudsters. It is interesting to note that these individuals—who said that they had increased their claim to cover the excess, and also said that they had been dishonest with their insurer—gave reasons very similar to those given by the claimants who thought they had been totally honest. The difference is that these individuals admitted that they knew that their behaviour was wrong. Typical comments included:

Because I’ve paid so much over the years taking excess seems totally unfair. [This fraudster admitted to claiming £750 more that his claim was worth.]

To make more money.

Such a small claim excess was unfair.
Builder suggested this to compensate us and to provide him with a larger amount.

To receive full payment for sink.

An affirmative answer to the second question (asking whether the claim was 'for a greater amount than was actually lost stolen or damaged? If yes, please state why.' ) only sometimes meant that a fraud had been committed. There are two main exceptions. First, where the claim was increased as a point of negotiation and, second, where the policy was 'new for old'. However, such an exception was rare: only one response could be classified in this way, and was excluded from this analysis. Once again someone could only be considered a rational fraudster if he/she knew that what he/she was doing was wrong at the time the claim was submitted.

Of the 22, 11 thought that they had been totally honest with their insurer. Their explanations included:

To cover the cost of the no claims bonus.

The clothing was new and was ruined, I had never claimed before so decided it would be worth it.

To cover inflation and excess.

These individuals considered themselves to be honest, but they believed that they were justified in claiming more. They could be considered as rational offenders.
However, 11 of 22 were rational fraudsters by the definition being used here, which is that there was some sort of strategic thinking which involved a decision which they knew to involve a fraudulent act. Their justifications:

Insurance companies are screwing as much money as possible from its [sic] customers, therefore I shall screw them for as much, if not more.

It was the first time I’ve ever made a claim after years of paying premiums.

Because I could get more money.

Because a friend did the work cheaper.

Excess Unfair.

Compensation for paying excess in the first place.

Because insurance companies rip us off, seen as a chance to get even.

Extra money for myself.

The builder replaced the sink for much less than true value.

To cover the cost and time of getting valuations. To cover cost of incidentals not claimed for. Because we’ll probably be knocked down anyway.

Because I got it replaced and pocketed £145, the repair cost £5, good EH!

After the storms of 1987 [I] saw the opportunity to claim.
The third survey question of relevance to the issue of rationality asked: ‘As far as you were aware were you *totally* honest with your insurance company? If no, please state why.’ Of the 36 fraudsters identified in the research, 12 claimed here that they had been totally honest with their insurer. There were no remarks from these individuals that explained why they felt they were totally honest. It could be argued that if they were honest they would not see a need to explain this. Among those who thought that they had been dishonest with their insurer, the reasons given included:

- Compared to the total amount paid over the last few years in premiums the amount claimed was small.
- Because insurance companies rip us off. Seen as a chance to get even.
- The work wasn’t carried out when I said it was.
- Rebuilt wall myself.
- Ring turned up after claim.
- I claimed for a higher model.
- Washing machine didn’t break it was a lie.

So 24 of the 36 fraudsters, that is two-thirds, are rational fraudsters by the definition being used. More information is needed on the other 12; they were clearly behaving rationally even though they did not believe they were being
dishonest. At least some situational measures will be effective in changing the behaviour of this group.

There is a word of caution needed about these findings, which was outlined in Chapter Four but needs to be re-emphasised. We have to assume that the subjects' description of their actions, state of mind, opinions and so on are fair and accurate, rather than post event rationalisations or instances of self-delusion (or are simply mendacious). It will be recalled that a person may not be rational at the time of the action, but that he/she is able to explain the event rationally afterwards; this is a problem all researchers face (see Levi 1981; Ditton 1977). The persons concerned may believe that the explanations they offer after the event were the same as those they would have expressed prior to or during the event, but this may not be the case. Levi noted: 'The implication of this is that we cannot take their statements about their motives as valid, even if they are honest with themselves' (1981: 87). As he stated:

There is a real problem of interpretation if 'by depicting our actions to ourselves – whether self-consciously or not – in a favourable light, we are able to redefine 'what-might-be-considered-as-crime' as either 'no crime' or 'justifiable crime'. This is true irrespective of whether or not we would feel guilty about our actions if we did define them as 'crime'. (1981: 86)

This issue is also relevant in the context of 'stimulating conscience' discussed later in this chapter.
Some of those in the survey who had committed an insurance fraud were able to rationalise to themselves that they had not committed a crime, in other words that they had been totally honest with their insurer, or that their action had been 'justifiable'. Levi (1981: 86) suggested that such redefinition by individuals occurs irrespective of whether they feel guilty of a crime or not. In this way motives are divorced from guilt, and thus individuals are not necessarily explaining away their actions because they feel guilt, as guilt may have no part to play in their subsequent explanations.

Thus some individuals can rationally commit an insurance fraud unaware that they doing anything wrong, and others do so knowing that they are behaving fraudulently. Situational crime prevention techniques can prove effective in preventing both these groups of individuals from making a fraudulent claim. The next part of this chapter will focus on Ron Clarke’s 16 techniques of situational crime prevention, with a view to showing just how they can have an effect.

*Increasing the perceived effort*

An obvious approach to reducing insurance fraud is to increase the effort required of offenders. The four techniques Clarke includes in this category—target-hardening, access control, deflecting offenders and controlling facilitators—will each be evaluated to test its applicability to the prevention of insurance fraud.
Target-hardening

Target-hardening means the use of physical measures, such as shutters, locks, bolts, gates, etc placed at strategic points, to reduce the opportunities for committing a crime. Target-hardening measures such as these may seem inappropriate to the combating of insurance fraud—an insurer can hardly hope to obstruct would-be fraudsters by the use of locks, bolts and physical barriers. However, this technique can be applied in a different way.

By reducing the number of claims, insurers can reduce the incidence of fraud. They can help to reduce the number of (burglary and arson) claims by encouraging their policyholders to protect their property, and target-hardening is one such protective measure. Most insurers offer help and advice on security and safety matters (Direct Line: undated), and some offer discounts on new locks and alarms for houses and offices and on immobilisers and steering-column locks for cars. All offer no-claims discounts to motor policyholders who do not claim. Some extend this to household policies, and some also offer discounts to individuals who have installed particular security devices, such as burglar alarms, or who are members of a neighbourhood watch scheme. Incentives of this kind provide a means of encouraging policyholders to target-harden and thus to reduce the likelihood of claims (Litton 1990). A technique such as target-hardening is relevant to fraud prevention because it can reduce the need for policyholders to make a claim, which in turn reduces the scope for them to commit fraud on the back of genuine claims.
Access control

Access control usually refers to the control of entrances to and exits from a premises, but in the case of insurance fraud it refers to the control of access to an insurance policy or to the making of a claim.

Access can be controlled in a number of ways. A potential policyholder can be asked detailed questions (in order to minimise the risk of fraud) before being allowed to take out a policy. Staff can be trained to identify key indicators of potential fraud and provided with guidance enabling them to detect fraud more reliably. As we have seen, staff are motivated to sell insurance but not to look for fraud. Insurers could establish a better balance of incentives by providing rewards for staff finding cases of fraud, and thus contribute to making it more difficult to commit.

For policyholders, the act of lying, at either the proposal stage or the claims stage, can generate high rewards, including lower insurance premiums or the receipt of a higher pay-out than they would otherwise be entitled to (or indeed, any pay-out at all). Insurers could reduce the incentive to commit fraud by selling individuals the most suitable policy for their needs and by encouraging them to obtain adequate insurance cover; such approaches can reduce resentment against insurance companies—resentment which encourages fraud. Individuals may additionally be informed of the penalties for lying: for example, it can be emphasised to them that they may not be entitled to any form of compensation at all if they make false statements; that they could be prosecuted and receive a criminal record; or that...
they could in the future be refused insurance. As rational individuals they might not, if they were aware that the risks were greater than the rewards, choose to ‘have a go’. Such basic steps to control access could, by motivating both staff and policyholders, greatly increase the effort involved in committing a fraud, and also reduce its rewards.

With some types of insurance policy it is more difficult to control access and identify fraud. For example, because travel insurance is not underwritten, insurers have few details of travel policyholders. However, insurers could address this problem by requiring agents to ask those applying for travel insurance for their name, address, date of birth, health status, etc. The answers could then be cross-referenced (as they sometimes are). Other methods that insurers could use in relation to travel insurance would be to offer policyholders no-claims discounts (especially where this is linked to household insurance). More insurers could sell travel insurance themselves rather than via agents. This would help to establish tighter control and would also mean that insurers could use the information gained to market other types of insurance.

There is also the potential to link household, motor and travel insurance together to a greater extent than is common at present. In this way individuals would have a ‘one-stop’ insurance policy. One benefit to the insurers would be that they would then hold more accurate details of policyholders and associated risks. For example, it would be more difficult for individuals to claim a more favourable registration address for their vehicle in order to cut their premium, as the insurer would have their household policy and know where the car was based.
Another way that insurers could control access is through the use of CUE. Although a number of the insurers who were interviewed considered CUE to be expensive and time-consuming, it could be used as a deterrent. A publicity campaign similar to ‘crime check’ (ABI 1992) would highlight the strengths of the system and warn that insurers were randomly checking the claims records of all new policyholders, reinforcing what is commonly stated on the proposal form. Even if only new policies were randomly checked this could still reduce insurance fraud, as potential policyholders would not want to risk it; there would thus be a ‘halo effect’ (Scherdin 1986: 232–5). Insurers should announce random checking of both proposal forms and claims, so that individuals would not know which policies would be checked and would thus be less likely to act dishonestly (Scherdin 1986: 232–5). Indeed the benefits of this might be diffused.

A further means of improving insurers’ efficiency would be to ensure that internal computer systems were compatible with each other, and gave access to information from in-house claims and underwriting departments as well as from other insurers (which is especially important after recent mergers). This would mean that individuals’ details would be easily accessible; policies could then be simply renewed or refused. This would have two effects on the fight against fraud. First, it would be difficult for a person with a poor claims history, or one suspected of fraud, to renew his/her policy. Second, it would make it harder for a person to provide false information at the proposal or claims stage, as his/her record would be checked. (It is not that such checks never happen, more that they do not happen often enough.)
This section has shown that Ron Clarke’s technique of ‘access control’ is relevant to the insurance industry, albeit applied in a different way (although Clarke does cite the use of PIN numbers as a form of access control, which is perhaps not too far removed from the interpretation used here). There is arguably a case for creating a new category, but this would complicate matters; and in any event, this broader definition suffices.

**Deflecting potential offenders**

For the insurance industry there are two main methods that can be used to deflect the potential offender. The first is to dissuade policyholders from claiming by charging an excess or deductible. (It will be recalled that if the number of claims is reduced, some frauds will be prevented.) The second is to offer positive incentives to individuals not to claim. Litton (1990: 171) found that the availability of a no-claims discount can discourage claims invention, which is a form of insurance fraud. He notes that one major insurer operated an incentive scheme under which a free renewal was given every fifth year if there had been no claim in the preceding four years; (although the scheme did not work because of the administrative costs). Despite this, Litton felt that the system was useful and could reduce claims in three ways: it could ‘encourage more care to prevent losses, discourage to some extent claim invention, and perhaps discourage some claim exaggeration’ (1990: 171).

There are a number of other and more imaginative methods insurers can use to motivate policyholders not to claim, and thus to deflect them from committing
fraud. The opportunity to be entered into a lucrative prize draw if the policyholder has not claimed during the year, air-mile vouchers, even discount vouchers for high-street shops and tour operators, or discounts on his/her next renewal premium are just a few of the many possibilities. These would be (partly) paid for by stores/airlines as part of their marketing budget. These methods can benefit the insurer not only by cutting the number of claims but also by presenting the company as positive and caring. It will be recalled that some fraudsters view insurance companies as deserving victims, so improvements in the latter's image are important.

By preventing losses from occurring insurers can deflect individuals from committing frauds, particularly frauds committed on the back of otherwise legitimate claims.

Controlling facilitators

‘Controlling facilitators’ is the process of depriving an individual of the means of committing a crime. This technique is applicable to insurance fraud prevention; it can be used in the following ways.

By being selective as to whom they underwrite and by cutting down on the number of policies sold, insurers can prevent insurance fraud because, all other things being equal, there should be fewer insurance claims. However, it is unlikely that insurers will wish to reduce their sales without substantial evidence that this would overall save them money.
Another way is to abolish insurance, on the grounds that insurance itself facilitates crime and thus fraud. Litton (1997: 63) points out that there is still a debate as to whether an individual who is insured is less careful with his/her possessions, and thus increases the likelihood that they will be stolen. If such an assertion turned out to be true, it would suggest that one way to reduce crime and fraud would be to abolish insurance. However, this is not a solution which appeals to the insurance companies. Of course another more realistic solution, noted earlier, is to encourage policyholders to be more careful with their possessions.

More realistically again, insurers could refuse to underwrite those types of policy where fraud can be difficult to prove. For example, it can be difficult to prove fraud, as was shown earlier, in many claims for accidental damage. But if one makes certain conditions, or excludes a risk from a policy (particularly in areas where claims are high), such fraud can be prevented.

Wittkämper (1991: 54) reported that in Germany in 1984 there was a change in policy conditions. Bicycles were taken off general home contents insurance and insured under separate policies. There was a dramatic fall in the number of recorded bicycle thefts—of 30 per cent between 1983 and 1988. It was argued that if in the past many bicycle claims had been fraudulent, then by excluding the risk insurance companies had prevented fraud (see also Litton 1997). However, it should be realised that there is more than one possible reason for the reduction in the number of claims. It could be due to owners being more careful with their bicycles, or to their not reporting bicycle thefts because there would be no benefit in doing so (for example because they no longer had a bicycle policy and could no
longer claim). Although further research is therefore necessary, this is potentially a
good example of how insurers have eliminated a risk (or controlled the
facilitators) and cut claims, and therefore cut fraud. However, before insurers act
to remove cover for specific items on a policy, it is important that the ethical
issues involved should be thoroughly explored.

Insurers could also extend the offer of 'new for old' policies, which do not provide
cash settlements. Although this would not prevent all types of fraud it would
dissuade those who merely want the cash from making fraudulent claims.

Insurers could try out other ideas on how to control facilitators. For example, they
could request a copy of the survey that was conducted when a house was
purchased. This would have two advantages: first, it would pinpoint any problem
areas that might subsequently give rise to a claim; and second, specific areas of
wear and tear could be identified and noted. This would give the insurer a greater
chance of assessing whether a claim was genuine or not. Reduced premiums could
be offered to those individuals whose houses were surveyed and who repaired
their property to a set standard. Insurers could also encourage policyholders to
have an additional survey conducted, and copied to the insurer for reference, in
which expensive household contents would be noted. Those having such surveys
done could be given discounts on premiums (the 'high net worth' insurance
market already does this). Insurers could even consider extending the use of free
surveys to those who had made a recent claim; this could be turned into a public
relations exercise, with insurers recommending ways of reducing the likelihood of
a repeat incident. By using these surveys as a reference insurers would be able to
cross-reference claims, which would help to make fraud more difficult to conduct (although, of course, it would not make it impossible—for instance, people so-minded could borrow an item for the survey and later use this as evidence that it had been 'stolen').

As shown in Chapter Seven, ‘helpers’ also facilitate fraud; but frauds which involve ‘helpers’ can be prevented. In the case of (possibly fraudulent) claims involving building damage, insurers can (and do) send in loss adjusters and provide their own builders to carry out repairs. Insurers benefit, as this cuts fraud; they could also use this procedure to project an image of customer care. Frauds that involve retail staff as ‘helpers’ can also be prevented. For example insurers could insist on seeing all receipts or instruction books, which is a practice favoured by some loss adjusters. They could reward sales staff (in much the same way as credit-card companies do) for reporting customers that they suspect of fraud. Policyholders might be more wary of committing a fraud if they felt that there was an increased chance of their being discovered.

The provision of legal aid is also a potential facilitator of insurance fraud, particularly in personal injury claims. As has been pointed out, suspected insurance fraudsters who pursue a legal claim against an insurer through the courts have stood a good chance of achieving a negotiated settlement, as insurers have been fearful that those on legal aid have unlimited funding to fight their case. They have considered it more cost-effective therefore to pay than to face a claimant in receipt of legal aid. But, as was suggested in Chapter Seven, the changes in the legal aid system which came into effect on 1st April 2000 are likely
to alter the situation in favour of the insurers; but whether legal aid will cease altogether to be a potential facilitator of fraud remains to be seen.

The technique of controlling facilitators is particularly relevant to the prevention of insurance fraud, and does not need to be amended in order to be applied successfully.

*Increasing the perceived risks*

Another possible way of reducing insurance fraud is to make it more risky to commit. There are four techniques that could be used: entry/exit screening; formal surveillance; surveillance by employees; and natural surveillance.

Entry/exit screening

The purpose of entry/exit screening is not to exclude people but to increase the chances of detecting those who do not conform to entry requirements. In Clarke’s classification, entry/exit screening differs from access control in that in the latter case barriers prevent individuals from gaining access, whereas screening establishes whether people have the right to enter or exit. Screening is applicable to insurance fraud prevention, but in some areas there is a large overlap with access control: for example, the barrier that prevents an individual from taking out an insurance policy or making a claim may only be lifted if he/she passes the screening process. Thus some of the methods used in access control and screening
are the same. It should also be pointed out that while entry screening is relevant to insurance, exit screening is not.\textsuperscript{6}

There are many advantages to implementing good screening procedures. Screening can help to ensure that information is accurate and that the customer receives a suitable policy. A good system would provide a series of set questions, the answers to which would be then cross-referenced against other databases. Rewards would be offered to staff who identified a fraudulent claim. Some insurers presently use a basic claims matrix, and this could be developed and its use extended. In this way insurers could encourage staff to screen policies both at the proposal and claims stage.

Insurers should ensure that all sales and claims staff are trained to detect fraud. Insurers could even train agents who deal with policies to screen for fraud; post-office counter employees are a case in point. The post office requires a copy of a valid insurance certificate and an MOT certificate in order to issue a car tax disk. Staff could be trained to spot discrepancies and to look for signs of fraud. Insurance brokers could also be trained to spot and report suspicious claims; there could even be a police administrative unit on the lines of the Canadian example (see below). Indeed, many insurance brokers have proved good at this. By encouraging those within the industry and on the periphery to seek out fraud, insurers could provide an extra barrier against the individual intent on committing fraud and increase the risks of his/her getting caught.
Insurers could improve their screening capabilities (particularly at the claims stage) by involving the police. It was revealed during interviews with insurers that in Britain the police are often unwilling to get involved in cases of insurance fraud, and reluctant to divulge relevant information. In these circumstances, the only way that insurers can obtain information is through informal contact with officers and by building up relationships with them. Research in other countries has found that there are sometimes strong lines of communication between the police, insurers and loss adjusters. Ericson and Haggerty (1997) reported that the Canadian police were prepared, for a fee, to become information brokers to institutions such as insurers. Indeed, police administrative units in Canada liaise with insurers over suspicious claims. Ericson and Haggerty go on to say that: '[Loss adjusters] depend on the police for routine disclosure of relevant knowledge’ (1997: 231).

The Data Protection Acts (1984 and 1998) can hamper the screening process insofar as they make many insurers reluctant to keep information on file. Few insurers keep file or database records on those suspected of fraud, or indeed those proved to have committed it. Thus cross-referencing of information and screening for fraud may not be possible, despite the fact that data on suspected and actual fraud held on computer would be an invaluable source of information for sales, underwriting and claims staff.
Formal surveillance

Clarke’s (1997) interpretation of formal surveillance occurs where police, security guards or store detectives are used to deter potential offenders. Technical systems such as burglar alarms and CCTV can enhance surveillance, and Clarke includes ‘informant hotlines’ and ‘crime stopper’ programmes in this category. For him the main function of formal surveillance is to ‘furnish a deterrent threat to potential offenders’. Although on the face of it formal surveillance would seem to be of marginal relevance in the present context, because most fraud takes place away from the insurers’ premises, in practice some measures can be seen as a form of surveillance calculated to deter those considering committing an insurance fraud. There are three principal measures of this kind.

The first is the use of police at the scene of a loss. Insurers could look to the police to be alert for fraud. If a fraud were detected, the police would need to contact the insurers and inform them (which would require that steps be taken to find out who the insurer was). One approach would be to set up an insurance fraud unit with responsibility for formal surveillance, which would be manned by the police but sponsored by insurance companies—a novel idea, but perhaps one whose time has come.

The second measure, already mentioned above in the context of screening, would involve encouraging key personnel to be proactive in identifying fraud. Post-office counter staff could, as has been suggested above, be trained to check both MOT certificates and insurance documentation carefully for discrepancies in
information when tax disks are purchased. This could help to increase the perceived risk of being caught.

The third measure is the use of insurance fraud hot-lines. The general public could prevent fraud from occurring by informing on people whom they suspect of committing an insurance fraud. With high levels of publicity, this type of system could have the effect not only of catching fraudsters but also of preventing fraud, by increasing the would-be fraudster’s fear of being caught. This is similar to a system called ‘crime stoppers’, which is designed to encourage people to call in with information about criminal offences. It is important to remember that an insurance fraud hot-line could be successful only if individuals were able to judge what fraudulent behaviour was, so there would need to be a strategy for public education.

Thus formal surveillance is a deterrent technique that can be applied to insurance fraud.

Surveillance by employees

Surveillance by employees is the use of staff to monitor clients’ conduct. This could be a useful technique for preventing insurance fraud. If policyholders believed that sales and claims staff were constantly monitoring policies for fraud this would serve as a deterrent, at least for some. This sub-section provides examples of the way in which surveillance by employees can be implemented.
It is not just the claims department that should be on the look-out for fraud. All departments should train their staff to be aware of fraud and to carry out effective surveillance. Part of the fraud problem is caused where staff know very little about the insurance they sell, and are not trained either to detect fraud or to inform people about the policies on offer.

There are some very simple measures that insurers could use to increase the effectiveness of staff surveillance. These include: sending a loss adjuster or assessor to verify a loss (although there will be a question about who pays); placing signs strategically to remind staff to check documentation for fraud; and regular meetings between staff where cases of fraud could be discussed and improved methods implemented for checking and identifying fraud.

Sometimes, because of the way that insurance is sold and claims are paid, it is difficult for insurance staff to conduct any form of surveillance. Policies such as travel insurance are sold by agents through block policies, and so insurers often hold no information on the individual policyholders. In the event of a claim the insurer often does not know about it, as a third party deals with it (many claims-handling systems are out-sourced). The current system of block policies is in fact ripe for fraud because the whole matter is out of the insurers’ control. In order to use employee surveillance insurers need to devise strategies for dealing with these problems.

During the course of research for this study it became apparent that computer systems in different departments of insurance companies were often incompatible.
Therefore in some companies the claims department could not access useful information held by the underwriting department. This could mean that the underwriting department might never be aware if the claims department had identified a policyholder who had submitted a fraudulent claim. It has already been shown that some insurers have renewed policies even when another department had detected a fraud. In order for employee surveillance to work effectively there need to be good channels of communication between the different departments.

Similarly, it was noted that a number of insurers have provided their staff with check-lists. Although useful for reminding staff of the procedures that they need to follow, check-lists can be difficult and time-consuming to use; all staff need to be trained in their use and to appreciate their importance. Checklists, properly designed and user-friendly, can be an effective method by which to validate entitlement and to help surveillance. At the same time there is a danger that this method will not detect the more sophisticated frauds, leading to a false sense of security. More research is needed.

Having accurate information at hand about policyholders can help to generate a strong audit trail. This researcher found that some insurers automatically destroy their claims files after three years, and others put them into storage, which makes access difficult. One insurer, however, had developed an efficient system for scanning all correspondence or information received from policyholders as soon as it arrived, and this was then held on computer. Although this system increased efficiency, a problem with it was that only if one had the original was it possible
to prove that a document was forged or altered. Checking documentation would provide another form of employee surveillance. If policyholders knew that all documentation was checked they might decide it was too risky to embark on this type of fraud. Insurance staff could check documentation in a number of ways. For example they could ask for an applicant’s driving licence in order to check for convictions. However, it is important to be aware, as one insurer explained, that it is easy to obtain a duplicate clean licence—some insurers had not heard of this possibility.

As shown in Chapter Eight, some insurers are also using tele-claims systems to process claims. If used effectively this is a fast way of validating a claim and a useful surveillance tool.

So far this sub-section has focused on employee surveillance of customers. However, employees could also observe other employees to ensure that they are efficiently checking documentation and doing everything possible to detect and prevent insurance fraud.

Surveillance by employees can be used in the above ways to reduce the opportunities for insurance fraud. But, as this sub-section has shown, the methods used, however sound in principle, can only be effective if staff are trained properly. As long as this is appreciated, this situational crime prevention technique does not need to be changed for it to be applied in the insurance context.
Natural surveillance

Natural surveillance comprises measures which enable people to realise that a crime is taking place—for example, improved street lighting. Another example given by Ron Clarke is neighbourhood watch schemes. Clarke believes that the 'capacity of 'natural surveillance' to prevent crime has been overestimated' and goes on to argue that 'people rarely see crime occurring, and when they do, they tend to place some innocent interpretation on the event. They may be reluctant to intervene or believe that the victim may not want assistance' (1992: 18).

Although people may not see insurance fraud occurring, nearly half of all the people surveyed for this study said that they knew of someone who had committed an insurance fraud. Just as neighbourhood watch schemes are designed to encourage residents to watch out for crimes in their immediate locality, so people should be motivated to look out for insurance fraud and report it. One way of doing so is through insurance fraud hot-lines. Hot-lines have already been mentioned, under the heading of formal surveillance, but also fit quite easily under that of natural surveillance. Some overlap between categories is inevitable, but in this particular case it might be more appropriate for the technique to figure under one heading, namely 'surveillance', in order to avoid any ambiguity. This point will be discussed later.
Reducing the rewards

This section considers techniques which make it less rewarding to commit a crime. It examines the four techniques listed by Ron Clarke: target removal, identifying property, reducing temptation and denying benefits.

Target removal

Methods of removing the target of crime cited by Clarke include replacing coin-fed telephone, gas, water and electric meters with those that accept, for example, pre-paid cards, and are thus unattractive to the thief.

There are two main objectives for the insurance fraudster. The first is gaining a policy at reduced cost, and the second is receiving, in respect of a claim, payment to which they are not entitled. The only way to remove the target would be to abolish insurance, which is hardly practicable, but there are other possibilities.

Target removal can apply, in part, because insurers have the right to refuse to insure certain risks, and can then put limits on the amounts that may be claimed; they can thus remove part of the target. In addition they can alter the policy details, excluding for example accidental damage from a policy and items such as bicycles from household cover. In this way insurers can remove some of the targets that they believe are susceptible to insurance fraud by eliminating the potential rewards. There may be ethical problems with this approach, and there are good business reasons for accepting risks, but this is a possibility which should be considered.
Identifying property

Examples of this technique include the installation of microchips in property, the registration of motor vehicles and identification markings on computers. Such markings identify the owner and thus make his/her property 'hot' to handle. Identifying property is a technique which can be applied in the insurance industry and prove useful in preventing fraud.

One example of such application is car ringing. If vehicles are marked in such a way that the identification coding cannot be scratched out, it is easier to identify cars for which false identifications are given. It is not unusual for gangs to steal cars and change the registrations. These cars are either sold on to unsuspecting buyers or insurance policies are taken out on them by the thieves, with a view to faking accidents and making insurance claims. If a more sophisticated method was devised to make it more difficult to change the registration of a vehicle then the rewards of such crimes would be less. Clarke cites Hall (1952) as saying that vehicle thefts declined in Illinois after it became law in 1934 to register all vehicles (1997: 22). In the US a system has been used called LOJACK, where a small transmitter is fitted to the body of a car; it was found that theft rates of cars fitted with this system declined (National Roads and Motorists' Association Insurance Ltd 1990). This type of system can be an important tool against insurance fraud, because if vehicle theft is reduced then, as we have seen, some types of insurance fraud will also be reduced.
Another way to use property marking to prevent insurance fraud would be to encourage policyholders to log the serial numbers of expensive equipment such as computers, hi-fi sets, televisions, etc. At the start of a policy the serial numbers would be made available to the insurer. Should a claim arise insurers would be able to identify the make and model of the stolen item. The insurer would be able to identify the item and its value immediately, thus preventing the policyholder from submitting an inflated claim.

Reducing temptation

Clarke suggests that the mere sight of a tempting target can give rise to a crime—thus if the temptation is removed a crime can be prevented. Examples of methods of removing temptation include that recorded by Kuhlhorn (1997), who showed how welfare fraud in Sweden was reduced when cross-checking of income statements by computer was allowed. In fact the removal of temptation is not only about reducing the rewards, it is also about increasing the risks. The technique of reducing temptation can be applied to insurance fraud prevention, as the following examples show.

This researcher found that some fraud occurred because individuals were angry with insurers when they discovered that their insurance cover was inadequate and failed to cover losses. An individual would subsequently provide false information in order to receive what he/she looked upon as compensation. In this way policyholders were tempted to commit fraud. Insurers could reduce this temptation by providing adequate cover and explaining fully to clients what policies do and do not cover.
As has been shown, policyholders may find it easy to justify fraud because they feel no loyalty to insurers, who are perceived as faceless and remote and are seen as fair game, or even deserving victims. If insurers publicised the message that it is policyholders who suffer most from fraud, and presented themselves in a more caring and sympathetic light, they might be able to reduce the temptation for individuals to commit fraud.

There are a number of other ways in which insurers could reduce the temptation to commit fraud. For example, they could (and increasingly do) respond to claims not with cash payments but by providing 'new for old' replacements. This removes some of the inducement, particularly for those who commit insurance fraud only in order to obtain extra cash. It is easy to fake an accident and make a claim. One way to prevent this type of fraud is to take away the cover for accidental damage in a policy. 'Helpers' too can encourage people to commit fraud, e.g. builders can tempt people to make an excessive claim. Insurers could counteract this by having their own repair or building centres (as some do).

Insurers can also remove the temptation to commit fraud by making it clear (or clearer) that if any part of a claim is fraudulent the whole claim can be rejected. In addition, as practised amongst some insurers, anyone found to have committed fraud could be refused insurance cover in the future.

In summary, there are two ways in which insurers can reduce fraud by reducing temptation: the first is to remove the rewards of yielding to temptation, and the second is to confront policyholders with the damaging consequences of doing so.
Denying benefits

Clarke (1997) sees denying benefits as being related to reducing temptation; but the former technique is distinct in that its purpose is to deny those who go so far as to commit a crime of any benefit from it. Clarke gives the example of ink tags which, if tampered with, leave indelible stains on garments. Denying benefits is a technique that can be applied to insurance fraud prevention.

Insurers can deny benefits to those who are considering fraud, for example by issuing indemnity policies under which only the value of the item at the time of the loss is covered. This may reduce an individual’s enthusiasm to claim (though clearly steps must be taken to ensure that the honest policyholder is not deterred). Alternatively, an excess is charged, which in some cases may exceed the amount of the claim or reduce it to a negligible figure (as is common). Again the policyholder would not think that it was worth claiming in these circumstances.

Another way in which benefits are denied is by the insurer refusing to pay out on a claim if any part of that claim is found to be fraudulent, in which case the claimant is not legally entitled to receive anything. Also, insurers can refuse to insure individuals who have committed fraud or impose high premiums on them. Such people might well find that if they are denied insurance by one company they will be unable to obtain it from any other company, and so will be deprived of the benefits of insurance. Where systems are available for insurers to check the claims history of policyholders this system has real teeth.
Although denying benefits can help to deter potential fraudsters, it is important to recognise that the procedure can also encourage fraud. For example, if an individual feels cheated by an insurer because he/she did not receive the compensation considered appropriate, he/she might be determined to commit fraud the next time a claim is made, in order to gain compensation. And again, a policyholder who has to pay an excess charge may claim for more in order to cover it.

**Removing excuses**

The technique of removing excuses is designed to increase the sense of guilt generated by the committing of an offence. Clarke points out that:

> [People often] make judgements about the morality of their own behaviour and ... they frequently rationalise their conduct to ‘neutralise’ what would otherwise be incapacitating feelings of guilt or shame through excuses (1997: 16).

This section will examine the four techniques he included in this category: rule-setting, stimulating conscience, controlling disinhibitors and facilitating compliance.

**Rule-setting**

Clarke defines rule-setting as removing ‘any ambiguity concerning the acceptability of conduct’ (1997: 23). He suggests that any ambiguity in regulations
will be exploited. The technique of rule-setting is applicable to insurance fraud prevention without any special adaptation, as all organisations need rules and guidelines in order to operate effectively. Staff and customers need to understand what is permissible and what is not, in order to prevent any confusion; and rules provide staff with guidance on how to prevent and detect fraud.

It is important for both staff and policyholders to understand what insurance fraud is. The definition of such forms of fraud as exaggeration can appear ambiguous. The research conducted for this study found that a third of those who exaggerated their last household claim believed that they were honest. Clearly some fraud would not occur if people were informed as to what was permissible and what was not. They would find it more difficult to commit insurance fraud and excuse their behaviour (Sykes and Matza 1957).

Even some insurers interviewed during the course of this research were unclear what insurance fraud was, or unaware that they should be actively seeking to prevent it. If insurers are to educate the general public it is important that they have a clear definition of fraud; at present this appears to be lacking.

Insurers place a notice at the bottom of their proposal and claims forms which asks the signatory to confirm that the document has been completed honestly and accurately. This suggests that insurers will not tolerate fraud; it ensures that an individual faces up to the question whether he/she is being honest; and it maximises the chances of his/her feeling guilty if the facts have been misrepresented.
Rule-setting can also be used to encourage moral condemnation by the general public of behaviour such as insurance fraud. The ABI crime check campaign (ABI 1992) sets out to achieve this with slogans such as 'Cheating on insurance is a crime' and 'We’ll make fraudsters pay, not you'.

Rules can be designed to project helpful and caring messages and to enhance the relationship between policyholder and insurer. For example, insurers could provide clear guidance on how to complete policy and claims documentation. Policyholders could be provided with a victim helpline number to call after they have suffered a loss. Information about local alarm companies offering their services at a special discount could be provided, as well as information on property marking and standard advice on how to secure property and prevent theft. Tradespeople can be dispatched or replacement goods ordered over the telephone. Such an approach could help to prevent fraud in two important ways: first, it would convey a caring image of insurers, thus largely depriving fraudsters of such standard excuses as 'they deserve it'. Second, if individuals are shown how to increase their security (ABI 1998) and can be persuaded to follow the advice, this should reduce the number of claims and thus impact on fraud. The technique of rule-setting can be applied unchanged in the context of insurance fraud prevention.

Stimulating conscience

Stimulating conscience is a technique that focuses on specific forms of crime occurring in discrete and limited settings (Clarke and Homel 1997). The measures
applied are designed to bring the prospective offender's conscience into play at the point of the crime. Such measures include signs which read 'Shoplifting is stealing', television advertisements which depict TV licence evaders as 'common criminals' and posters which tell fare dodgers that they will receive criminal records if caught. This technique can be applied to insurance fraud prevention.

Individuals often justify committing a crime by reducing their culpability in their own minds and placing the blame elsewhere (Sykes and Matza 1957; Bandura 1976). One way in which this can be achieved is by denying that there is a victim (Sykes and Matza 1957), or by blaming and dehumanising the victim (Bandura 1976). Wortley (1996) points out that individuals find it easier to victimise those who are stereotyped as unworthy or even sub-human. He goes on to suggest that one important crime prevention strategy would be to increase the victim's worth. He suggests that this can be achieved by strengthening the emotional attachment that the offender has with the victim. It is harder to offend against a victim with personal qualities (Launay 1987, taken from Wortley 1996). Thus, if potential insurance fraudsters could be brought to identify closely with the victim (the insurer) they would not commit insurance fraud because they would feel too guilty.

Large insurance companies are often seen as faceless organisations. Insurers could change this image and project themselves as more caring and friendly. They could offer good customer care policies, improved communications, and incentive and reward schemes, such as loyalty cards. An even more radical idea would be to offer policyholders a stake in the company as shareholders. All these measures
would be designed to enhance the victim’s perceived worth and thus help to prevent fraud by eliminating the excuse that the victim did not deserve consideration.

As discussed above, insurers can also stimulate their policyholders’ consciences and potential feelings of guilt by placing messages on proposal and claims forms that insurance fraud is wrong.¹⁰

While, therefore, the ‘stimulating conscience’ technique can be applied to insurance fraud as to other forms of crime, its drawback is the underlying assumption that the potential offender has a conscience to be stimulated, or that the actions taken will be salient enough to stimulate his/her conscience at the particular moment of contemplating that fraud. As Nettler (1974: 172) points out: ‘One can be rational without being moral’. Given that insurance fraudsters interviewed in this study appeared not to feel guilty about their offence, and that ‘techniques of neutralisation’ were not applicable, this approach would be fully tested. However, evidence from tax evasion research shows that an appeal to an individual’s conscious can work (Schwartz and Orleans 1967: 274–300). People may reason that it is worth committing an insurance fraud because the rewards are greater than the risks. They may know that what they are planning to do is wrong, but they still commit the fraud because they do not care—in other words, their conscience has not been stimulated. This technique would accordingly be more appropriately placed in the category of ‘increasing the perceived risks’.

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Controlling disinhibitors

Ron Clarke gives a number of examples of psychological disinhibitors. These include alcohol and drugs, which undermine moral inhibitions and impair perception or judgement so that offenders are less aware that they are breaking the law. Also, propaganda, directed at the dehumanisation of target groups such as Jews, can provide the justification for ordinary people to commit crimes (Clarke 1997).

The author’s survey of the general public revealed that 72.1 per cent of respondents found it acceptable to commit insurance fraud. It also found that some of the individuals who had committed fraud believed that this action was not at all wrong. This suggests that the general public’s perception of fraud is misplaced. Insurers need to change the public’s view of insurance fraud and the message needs to be clearly spelled out that ‘insurance fraud is wrong’, that it is no different from other forms of fraud and that it constitutes unacceptable behaviour. Campaigns such as ‘crime check’ could be useful in getting the message across, but insurers face a very challenging task in utilising this technique.

Facilitating compliance

This technique is about devising ways to help people conform. Clarke provides examples such as litter bins, public urinals, which dissuade people from urinating in the street, and graffiti boards. This technique is applicable to insurance fraud.
Insurers can facilitate compliance with the rules by selling individuals the correct policies, and by explaining in depth what the benefits and obligations of the policies are. This would go some way towards stopping policyholders from abusing the system in order to make up for unsuccessful claims.

Other methods that insurers currently use are the statements at the bottom of proposal and claims forms which spell out clearly that fraud is wrong, and that those who commit it will be prosecuted. Advertising campaigns, including posters telling people that insurance fraud is wrong and that those caught may face prison sentences, can also facilitate compliance.

A further way in which insurers can protect themselves against fraud is by informing people that fraud is serious, and that if a fraudster is identified his/her right to claim even for the genuine part of the loss can be forfeited. In addition insurers can make people aware that where a policy has been voided the policyholder may find it extremely difficult to get insurance elsewhere. An individual refused household insurance could even find it difficult to obtain essential insurance such a motor cover. This is a powerful message, which the insurance industry has so far not used to the full.

Insurers have in the past tried to influence their policyholders to think twice before making a claim. One method they have used is to charge a compulsory excess, so that if an individual suffers a loss he/she may be persuaded not to make a claim at all. However, research for this study has found that this is often not the case—individuals are just as likely to exaggerate a claim in order to cover the excess. It
is important that before insurers try to exert influence on policyholders they are aware of the pitfalls. Facilitating compliance is a technique that does not need altering in order to be applicable to insurance fraud.

Rethinking the classification of techniques

In this chapter, 16 opportunity reduction techniques have been examined (see Table 1), with two aims. The first is to establish the extent to which each technique is applicable to insurance fraud prevention, while the second is to consider what this analysis tells us about each technique—whether it can be left as it is, or whether it needs to be changed or a new one created.

The majority of Ron Clarke’s opportunity reduction techniques appear to be both relevant and helpful for an understanding of the impact which situational crime prevention can have in the insurance context. This is a most encouraging finding. However, a number of issues have emerged which need to be considered. These are: the extent of overlap between the techniques; the need to introduce a new technique, which it is appropriate to call ‘incentivisation’; the need for some restructuring of the technique of surveillance; and the application of rule-setting in the insurance context.

Application of opportunity reduction techniques to insurance fraud

Clarke’s opportunity reduction techniques can be applied to insurance fraud, although some are more relevant than others (see Table 1). All the techniques that
come under the heading of increasing the perceived effort (target-hardening, access control, deflecting the offender and controlling facilitators) are relevant. Target-hardening is, however, relevant in a slightly different way: insurers can encourage policyholders to target-harden premises and possessions in order to reduce claims, but fraud is committed on the back of claims and so target-hardening has a more indirect effect in this context than Clarke suggests in his analysis. Access control in the context of insurance fraud does not mean physically barring entry to premises—this technique needs to be redefined in the present context to mean controlling access to an insurance policy.

Although two of the techniques thus need modifying, there are a further two techniques which cannot be applied easily to insurance: these are exit screening and target removal. Exit screening is least appropriate in the context of insurance fraud, because once people finish with their policies there is no further point in screening them. Screening is only relevant at the proposal and claims stage of a policy, that is the entry stage. Target removal is also less easy to apply because, although it is possible to move parts of the target, it is difficult to remove the whole of it, which is the insurance policy or the claim. As has been shown, the rest of the techniques can be applied in a number of ways.
### Table 1. Opportunity reduction techniques and their applicability to insurance fraud

<table>
<thead>
<tr>
<th>Most applicable</th>
<th>Least applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increasing the perceived effort</strong></td>
<td><strong>Increasing the risks</strong></td>
</tr>
<tr>
<td>1. Target-hardening—applicable, but needs reinterpretting</td>
<td>5. Exit screening</td>
</tr>
<tr>
<td>2. Access control—applicable, but needs reinterpretting</td>
<td></td>
</tr>
<tr>
<td>3. Deflecting the offender</td>
<td></td>
</tr>
<tr>
<td>4. Controlling facilitators</td>
<td></td>
</tr>
<tr>
<td><strong>Increasing the risks</strong></td>
<td><strong>Reducing rewards</strong></td>
</tr>
<tr>
<td>5. Entry screening</td>
<td>9. Target removal—although insurers can remove some of the target, they cannot remove the whole target</td>
</tr>
<tr>
<td>6. Formal surveillance</td>
<td></td>
</tr>
<tr>
<td>7. Surveillance by employees</td>
<td></td>
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<tr>
<td>8. Natural surveillance</td>
<td></td>
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<tr>
<td><strong>Reducing rewards</strong></td>
<td></td>
</tr>
<tr>
<td>10. Identifying property</td>
<td></td>
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<tr>
<td>11. Reducing temptation</td>
<td></td>
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<tr>
<td>12. Denying benefits</td>
<td></td>
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<tr>
<td><strong>Removing excuses</strong></td>
<td></td>
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<tr>
<td>13. Rule-setting</td>
<td></td>
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<tr>
<td>14. Stimulating conscience</td>
<td></td>
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<tr>
<td>15. Controlling disinhibitors</td>
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<tr>
<td>16. Facilitating compliance</td>
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</tbody>
</table>

The overlap between techniques

One of the problems identified by Gill (1998; 2000), and confirmed by the findings of this study, is a degree of overlap between the classification of
techniques. While Gill uses this as a justification for reclassifying the techniques, there is a problem with such an approach in that practitioners may become confused. Ron Clarke is right to contend that, where possible, it is wise to look for changes within the existing framework rather than to present a new one. What perhaps needs to be done is to identify the areas of overlap and then to cross-reference the techniques. Where one technique overlaps with another there could be additional gain, insofar as each helps to reinforce the other. A case in point is the overlap between deflecting offenders and stimulating conscience: if a potential offender feels guilty this will tend to deter him/her from committing a fraud, and thus increase the perceived effort of carrying it out.

Similarly, controlling disinhibitors could be included under the heading of deflecting offenders. If people are made aware that insurance fraud is wrong and that it constitutes an offence, they will be ‘deflected’ away from committing the offence and the ‘excuse’ for committing it will have been removed. Target-hardening, to take another case, could be included in the category of deflecting offenders. This is particularly true in the context of insurance fraud because if a policyholder secures his/her property and prevents theft, this will stop a claim being presented and thus prevent a fraud occurring on the back of that claim—in other words the offence has been deflected.

There is also an overlap between entry screening and access control, which was identified by Gill (1998). In the present study it was found that access control and screening (where it occurs) take place at the same point. When someone takes out a policy or makes a claim, screening is part of the process leading to the client
being allowed access to the policy. Therefore, access control and screening could be merged under one heading as far as insurance fraud is concerned.

There is an overlap of another kind. Although target-hardening and access control come under the heading of increasing the perceived effort, they could also come under that of increasing the perceived risks. If insurers encourage policyholders to target-harden their property and so avoid losses, with the result that they do not make claims, it makes it more risky for them to commit insurance fraud, because the claim would have to be totally invented. Such fraud is much easier to detect than other types. The technique of access control could also come under increasing the risk, because if an insurer institutes tighter controls at the proposal and claims stages of a policy there is a greater likelihood of fraud being spotted.

Another overlap occurs between entry screening and surveillance. They come under the heading of increasing the perceived risks but could also come under that of increasing the perceived effort. If an individual was screened at the proposal or claims stage, it would be more difficult for him/her to get away with a fraud, because of the increased likelihood of the screening process detecting it. The same is true of surveillance: if effective surveillance were in place it would be more difficult to commit an insurance fraud because there would be a greater chance of it being identified.

Because there is a good deal of overlap between the techniques of opportunity reduction, and between the headings under which they feature, it is important not to view these techniques in isolation. The overlaps help to provide a more
complete understanding of how to prevent and reduce insurance fraud, and offer added protection. For example, if strong access control made it more difficult to commit fraud and at the same time more risky, these two factors together could provide a greater deterrent.

The introduction of a new technique: incentivisation

During the course of this study an additional technique emerged which could be applied to insurance fraud: this is ‘incentivisation’. Incentivisation is a broad concept which can be applied both to offenders, in the sense of giving them an incentive not to offend, and to insurance company staff, in the sense of giving them an incentive to be particularly attentive to evidence of fraud. This idea is not a new one in criminology. Wilson and Kelling’s (1982) *Broken Windows* illustrated the problems which arise in an area viewed as neglected. One potential solution to this sort of situation is to encourage people to take responsibility for their area—to ‘own’ the problem, as it were. Much of the literature on staff dishonesty has stressed the importance of workers seeing the crimes committed against organisations as crimes committed against their own interests (Challinger 1997: 261). The point about incentivisation is that it encourages people to see fraud and other crime as an enemy that they must play a part in overcoming.

Incentivisation has a place within Clarke’s classification. Stimulating conscience is in a sense an attempt to incentivise. In this thesis it is presented as a technique for inhibiting the potential offender.
Incentivisation could be located within the category of removing excuses. Some people commit insurance fraud because they are bitter towards insurers and see them as fair game. Incentivising people not to claim could be a positive strategy for dealing with this. At present the no-claims discount works in this way, although it could be far more positively presented. Another way would be to advise all customers that if they do not claim they will receive reward vouchers to spend in popular stores; this could in part be paid for by stores and others, as a promotion. This would be to incentivise people not to claim by rewarding them, and at the same time to reduce one of the main facilitators of insurance fraud, the claim. Similarly, insurance company employees could be incentivised to identify some types of fraudulent claims, and rewarded with prizes or extra payment for doing so. This would encourage employees to be more proactive in areas such as screening and access control, which in turn would reduce the incidence of insurance fraud. Masuda cites an occasion when rewarding cashiers for detection of forged or stolen credit cards helped to reduce annual losses from credit-card frauds at an electronic retailer in New Jersey by nearly $1 million (Masuda 1993). One of the main advantages of this technique is that it has the potential to provide a positive crime prevention measure, enhancing customer relations and raising staff morale.

Restructuring techniques: surveillance

Another desirable change in the structure of the opportunity reduction classification emerging from this research is to conflate natural, employee and formal surveillance under one heading of surveillance. Gill (1998; 2000) also
suggests that this would be more appropriate, as the distinction is artificial. There is further evidence from the current study. It was found during the course of the research that insurers were using telephone hotlines\textsuperscript{11} to enable people to inform on neighbours and work colleagues who they knew had committed insurance fraud. Although Clarke places such hotlines in the category of formal surveillance, presumably because he assumes that the police would set these up as part of a surveillance programme (Clarke 1997), this is not true in the case of insurance fraud. This study found that it is insurers and not the police who operate such hotlines. Given this substantial overlap between forms of surveillance it would make sense to draw them together under the one simple heading of ‘surveillance’.

The importance of rule-setting

Rule-setting is an important technique. Clarke (1992) originally placed it under the heading of ‘reducing the rewards’. He argued that all organisations needed to control their employees (Clarke 1992) and that any ambiguity in rules could lead to offences occurring. He subsequently placed rule-setting under the heading of ‘removing excuses’, stating that rule-setting removed any ambiguity and eliminated the excuse that crime was acceptable.

Clarke’s change of mind on this is understandable, but it is questionable whether he was right to re-categorise rule-setting. It is applicable to all four categories, and placing it solely under removing excuses takes away many of the benefits. For example, under the heading of increasing the perceived effort the technique of rule-setting can be used to establish procedures that employees should follow in
order to control access to policies or claims. If employees followed these procedures it would be harder for a person to commit insurance fraud and get away with it. Rule-setting could also come under the heading of increasing the perceived risk. For example, rules could be set which would give clear guidance on how staff should conduct surveillance and screening. Rule-setting could also be placed under the heading of reducing the rewards, for the same reasons that Clarke set out in his earlier work.

As the findings of this study have shown, some people commit insurance fraud because they are bitter towards insurers, having felt unfairly treated at some stage. It is important that any situational technique which is used should not aggravate such bitterness, otherwise the result would merely be to increase the policyholder’s drive to commit fraud. This is why rule-setting is important—it must include guidelines on how techniques are applied so as to avoid any failure of implementation. This is what led Gill (1998) to develop a set of management techniques, which can be useful even if they are somewhat complex for practitioners. The inclusion of rule-setting under this heading will serve the same purpose and provide a framework to guide practitioners.

**Conclusion**

Insurance fraudsters are mostly rational offenders who take up a chance opportunity to commit a fraud. This is a good base for supposing that opportunity reduction techniques could have an impact in reducing instances of fraud. The subsequent analysis has confirmed that the techniques of situational crime
prevention can usefully be applied to insurance fraud, at least to an extent. The classification formulated by Clarke is helpful, and even though revisions have been suggested the main tenets remain in place, as shown in Table 2. There is nothing new in the finding that there are overlaps between the categories. Clarke himself recognised this, and in part it has fuelled his interest in revising and developing the categories over the years, a process that is on-going. Rather than seeing the overlaps as a negative feature, it is suggested that the recognition of where they occur can be used as a basis for reinforcing the value of the technique. Overlaps which emerge from this study of insurance fraud have been discussed above, and there are no doubt more.

Table 2. Sixteen opportunity reduction techniques

<table>
<thead>
<tr>
<th>Increasing the perceived effort</th>
<th>Increasing the perceived risks</th>
<th>Reducing the rewards</th>
<th>Removing excuses</th>
</tr>
</thead>
</table>

The new technique of incentivisation has considerable potential beyond insurance fraud; it also has the advantage of being a positive strategy, helping to overcome or limit some of the more negative effects associated with situational crime prevention. Surveillance has been merged into one classification, that adopted by Clarke being seen as artificial and as serving no real purpose. Rule-setting is crucial, and it is suggested that this should have a place in all four columns; it is an acknowledgement
of the importance of ensuring that good techniques are implemented properly. This revised classification provides a framework to guide insurers.

The problem is that it does not tackle all the problems that have emerged from the research. For example, insurers attach different priorities to fraud prevention, and this, plus other factors such as competition, stand in the way of an industry-wide response. Insurers’ relationships with loss adjusters and with the police need to be addressed; this issue does not concern situational measures, however, and it is discussed more fully in Chapter Ten. So far little has been written about other limitations of the situational model, not least the assumption that fraud reduction is an unqualified good. In fact the business case raises important reservations, which will be discussed in the next chapter.

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1 This is because insurance fraud most often occurs on the back of a legitimate claim.
2 As we have seen in an earlier chapter, even a legitimate part of a claim can be rejected if it were found that any part of it was fraudulent.
3 The ‘halo effect’ was originally observed in a library, where a book detection system was installed, some of the books being tagged and some not. Theft of both the tagged and untagged books fell. This was attributed to the fact that individuals were unsure whether their book was tagged, and thus were not prepared to risk stealing. The same principle could apply to the insurance industry, although more research would be needed clarify the point.
4 The Sunday Times reported that big mergers, such as that of Norwich Union and CGU, had hit customer services and that claims payments had been delayed, with many claimants waiting ‘months for their money because insurers are struggling to cope with the volume of claims’ (The Sunday Times 2001).
5 Clarke argues that there is very little difference between access control and entry/exit screening; however he does state that the primary factor differentiating them is not that individuals are excluded but that the risk of their getting caught is increased (Clarke 1997).
6 Even Clarke (1997: 190) emphasised that exit screening served ‘primarily to deter theft by detecting objects that should not be removed from the protected area, such as an item not paid for at a shop’. There is nothing here that can be applied to the insurance process.
7 The ABI has now introduced insurance fraud hotlines.
8 A concept which was discussed earlier under ‘formal surveillance’.
9 An insurer using CUE is required by law to inform policyholders that their details will be held and stored on the database.
11 The hotlines were organised by the ABI.
10. Rethinking prevention strategies: fraud reduction in a business environment

Introduction

Chapter Nine outlined the ways in which the research findings lend support to situational crime prevention as an organising framework. However, this research has also generated findings which add weight to criticisms of the situational approach and which, indeed, underscore some of the problems of trying to prevent crime in a business environment. This chapter reviews some of the reasons why attempts at fraud reduction in that environment have not worked or have not been taken seriously.

It begins by reviewing the business case for fraud prevention. The implicit assumption that prevention is an unqualified good is questionable when costs are balanced against the bottom line. It is far from obvious that fraud reduction is a desirable outcome of risk management strategies, and this may be illustrated by reference to examples of companies adopting a rudimentary cost-benefit analysis. It should be stressed that this study did not seek to test the cost-effectiveness of different strategies, as that would require a different approach. However, during the course of the research some data were obtained on cost-effectiveness, and these are
reviewed to highlight some of the practical difficulties in prioritising fraud prevention.

The chapter then moves beyond a discussion of financial issues to consider some of the other business costs associated with fraud reduction, principally ethical and practical considerations. This is followed by an examination of impediments to fraud prevention within the insurance industry, including a discussion as to why companies attach different priorities to fraud prevention, and then by a review of the various barriers to co-operation between insurers. The chapter moves on to consider issues that are essentially outside the industry, including the much under-researched relationship between insurers and loss adjusters, and between insurers and the police, the latter being fundamental to successful criminal prosecutions of offences. Finally, and given the points outlined in the discussion the chapter considers whether insurers are rational in the way they approach fraud.

*Fraud reduction: does it make financial sense?*

In a world where the dominant objective revolves around profit, all other objectives, including crime reduction, have to recognise this. Yet many writers on situational crime prevention have ignored this issue (for an exception see Levi et al 1991) and treated situational prevention is as if it were obviously an unqualified good.

Overall, there have been few attempts to study the cost-effectiveness of fraud prevention, again perhaps a reflection of the lack of interest and attention paid to
crime in organisations. Perhaps surprisingly, not even those who work in
organisations and are charged with responsibility for reducing or eliminating crime
have considered this a priority, and insurance companies are no exception. Part of the
problem, noted previously, is the difficulty of establishing the level of insurance
fraud, as well as agreeing a workable definition. Moreover, insurance companies have
rather rudimentary methods of working out losses, so it is difficult to calculate either
the levels of reductions that can be made or the benefits (not least financial ones) that
can accrue from targeted crime prevention initiatives.

Since insurance companies are geared to generating profits, there are particular
problems in building fraud prevention methods into the sales stage. Insurers want to
sell as many policies as possible and agents are often incentivised to do so, and this
gets in the way of crime reduction. In any event, at the sales stage insurers have yet to
suffer a financial loss from fraud; and even if they had, they could simply void the
policy.

The findings from this research suggest that insurers do not know the true benefits or
costs of fraud prevention. This is not always easy to calculate, because as Levi and
Handley note:

Fraud prevention ‘piggy-backs’ on other technological and organisational
changes, many of which would have occurred anyway, making proper
cost-benefit analysis more arduous. (1998: 14)
Such problems bedevil analysis, which is perhaps why both researchers and companies have tended to avoid the issue.

The costs insurers care about the most are those that are not an integral part of conducting business; precisely for this reason, considerable attention is paid to the cost of claims. Insurers lose money if they pay a claim, so they are nearly always interested in this issue. This is why many insurers offer incentives on household policies, by way of premium reduction for membership of neighbourhood watch schemes and for installing certain types of security measures. Hence for most insurers there was more logic in being concerned about loss prevention than about fraud prevention.

Insurers, for the most part, acknowledged that they had a poor grasp of the insurance fraud problem, despite the fact that the ABI had sought to research the issue. Quite simply, insurers did not believe the ABI findings, and thus did not find them helpful in calculating their own risk. As one insurer noted:

One of the problems from our point of view is that we don’t really understand whether those statistics are accurate and what they mean. It’s difficult for us to do a proper cost-benefit analysis on whether it’s worth channelling some more resources into a new system or a new procedure, because we don’t know what the potential benefits are, and that’s probably our biggest problem.
Certainly, amongst those that did attempt to calculate costs there were quite different attitudes to it, resulting in a varied approach to fraud prevention across the industry. One insurer described a case in which his company brought a civil prosecution against a fraudster for a £600 fraud. The insurer noted:

This cost significant sums of money, but as a company we take the view that we must prosecute. It's one weapon we have to combat fraud.

In fact this was little more than a token gesture; the company rarely prosecuted, principally because of the fear of bad publicity. There was no evidence that the company had a media strategy, nor that it sought to use this or other prosecutions to elicit positive media and public responses. This issue was mentioned by a number of insurers. Clarke (1990) is right to outline the concern of insurers about bad publicity, and any framework for working out costs would need to address this.

However, for the most part financial considerations were the main criteria in decisions about whether to prosecute for fraud. As one insurer rather critically noted: '[The] industry isn’t intent on prosecuting fraud; it’s financially motivated, as opposed to morally motivated.' It will be recalled from data presented in Chapter Eight that companies had different thresholds. One insurer noted that his company threshold was sums over £2000, and then only to recover money for fraudulent claims that had already been paid. Even so, other conditions had to be met, primary among them being the belief that the company would win and that the individual had the ability to pay. Clearly, while notions of equality before the law do not apply for some
insurance fraudsters, in this instance is it those with means that fare worse. There was also a lack of faith in the prosecution services, as one respondent to the survey of insurers noted: ‘Most criminal investigations end in a caution, or not proceeded with by the CPS.’

Reluctance to prosecute emerged from answers to a question covered in the survey of insurers shown in Table 1. In all, only 20 out of 43 insurers had taken one or more cases of insurance fraud to court during the previous year. Most noted the difficulty of proving fraud and the often small sums involved, especially on travel policies, and as noted above the cost of prosecution, coupled with the risk of generating bad publicity, also influenced their approach. Motor policies, however, are underwritten, and more is known about the policyholder and the vehicle: there is a good audit trail in the form of tax certificates, certificates of ownership and DVLA registration, MOT certificates and chassis numbers. The financial world has learned that the prevention of fraud and money-laundering is easier where institutions know their customers; there are clear parallels here.
Table 1. Number of insurers who had taken one or more cases of insurance fraud to court in the previous 12 months, by type of fraud.

<table>
<thead>
<tr>
<th>Type of fraud</th>
<th>No. of insurers who said they sold this type of insurance</th>
<th>No. of insurers who had taken one or more cases to court</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal accident</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Travel</td>
<td>12</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Commercial</td>
<td>25</td>
<td>8</td>
<td>32.1</td>
</tr>
<tr>
<td>Household</td>
<td>26</td>
<td>12</td>
<td>46.4</td>
</tr>
<tr>
<td>Creditor</td>
<td>4</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td>Motor</td>
<td>17</td>
<td>11</td>
<td>64.7</td>
</tr>
</tbody>
</table>

Sometimes a fraud prevention policy, or a particular prosecution, was motivated by a desire to show that the company was not a 'soft touch'. One interviewee, an insurance investigator and ex-police officer, discussed just such a case where he felt the costs had been disproportionate:

I’ve been to Birmingham twice over that one claim and at the moment it looks as thought we’re going to be saving the company £380, but how much has it cost me to go? … I mean it’s half a day to go to Birmingham, you can’t do it in an hour. So I’ve had two and a half days in Birmingham, so you really have to think how deep you’re going to enquire into a £380 claim. That’s what a lot of people rely on, they rely on a claim up to £200 or £300 not even being investigated, because it’s uneconomical.
He felt that in the long run his actions would discourage other policyholders from committing fraud, and that in turn would produce a greater saving. Clearly costs need to include the potential deterrent effect that a successful prosecution may have on potential fraudsters.

Some interviewees took the view, not obviously based on a thorough assessment, that insurers did not have to worry about the costs of controlling fraud because, as noted in Chapter Two, they were not the losers. As one insurer said:

But if you want to be cynical about it, it's not us that pays anyway ... I don't know if you own a car yourself, but if you do, it's you that pays, due to the cost of insurance premiums.

Others supported this view—they felt that the insurance company could not lose, it would always get its margin, whatever the market could stand. If premiums were low it took a tough stand on claims, if premiums were higher this was less necessary and fraud was just an element in the whole process.

Another insurer described how he had come to a similar view by conducting a cost-benefit analysis on motor policies. He calculated that it was not cost-effective for his company to tackle fraud at the sales stage (i.e. fronting), even by a quite minor change to working practice:
There are 20,000 pieces of business a day, there's one sale for every four calls, and there are 80,000 calls a day. If we screened each of these calls for fraud by asking one extra question we'd add five seconds to every call; that's 400,000 seconds a day, that's 111 hours, that's 14 extra staff.

If most of the fraud that does occur is inflation of loss, then this would not be picked up at the sales stage, but at the claims stage. The question here is about where to place the effort, whether asking additional questions at the claims stage proves cost-effective. The same insurer noted:

One in five people claim, there's a lower volume [of business than at the sales stage], you spend longer with a customer. The old system was where the average time spent on each claim was 25 hours, it took 50 days to pay a claim, £500,000 was spent a year investigating claims, but none were refuted. However ... we can be far more efficient by asking specific questions [over the telephone] in order to detect fraudulent claims, claims investigation only takes two to three hours, payments are made in a week or two, five per cent of claims are refuted, and there's a saving of £350,000 a year.

This interviewee explained that not only do the detected cases of fraud make a saving in their own right but also the cost of investigating is reduced, and hence there are lower staff costs, claims are dealt with more quickly, and with improved business
practice come better customer relations. These are important points, and at least one insurer is working with a loss adjuster to pilot just such a scheme.

**Ethical and practical reasons for not preventing fraud**

In addition to financial reasons, there are at least two other reasons that complicate fraud prevention, and which receive little discussion in the literature—it may be perceived as unethical, and it may simply be impractical. These each merit a comment.

One of the conclusions from this study is that much fraud is preventable. If reducing or eliminating fraud were the principal aim, and nothing else mattered, there are several strategies that would recommend themselves. Insurers could invest in tools to provide top-quality risk management data, and then refuse to insure people in high-risk areas, or to take on high-risk policies (or items). They could ‘cherry pick’ the best customers. If the industry as a collective adopted this stance then there would be people left without cover, principally the most disadvantaged. It is important to recognise this concern.

Taking fraud prevention seriously will require changes to present practices, and the best methods may not be most compatible with the systems currently in use; a massive reorganisation may be needed, and a re-orientation of the business. Chapter Two discussed some of the socio-economic changes that have an impact on the insurance business, and that in different ways can impact on established priorities.
This is of course partly an economic argument, but it is a practical one too because, in the absence of any certainty about the benefits, the shifting of emphasis is unrealistic. When mergers take place the lack of compatible systems becomes particularly noticeable. Some systems require co-operation amongst insurers to be effective (e.g. Hunter) and insurance companies, as discussed later, have not always been quick to see the benefit of co-operation. Of course, any fraud prevention strategy needs to be on-going: if the company lacks sustained commitment, then opportunities will be exploited by fraudsters (Levi and Handley 1998: 16), and not all companies have the will to prioritise fraud prevention in this way. Indeed, it is apparent that priorities for fraud prevention differ quite markedly between insurers, and this requires further comment.

**Why companies establish different priorities for fraud prevention**

It was noted in Chapter Eight that about three-quarters of respondents placed a high priority on investigating and detecting fraud, and less than two-thirds on preventing fraud. There is nothing especially surprising in this finding: tackling insurance fraud has traditionally been seen as the role of the claims department, and is rarely if ever tackled at the sales and underwriting stage. Thus, perhaps not surprisingly, the majority of insurers felt that they could improve on the way that they dealt with fraud. Of the 33 responses: ten mentioned improved staff training and awareness; seven identified the benefits of CUE, about which there was considerable misplaced optimism, as will be shown later; six mentioned some aspect of technology as an area that could improve fraud investigation; and only three specifically mentioned
improved information-sharing, two of whom had large, in-house, dedicated fraud/technical units.

The survey included questions about specialist fraud/technical units dedicated to tackling fraud. In all, ten of the 43 respondents claimed they had formed such units, and nine of these ten were large insurers with greater resources. Smaller insurers sometimes noted that they were no less committed, but were simply less financially capable of devoting resources to this issue. However, most of the fraud units were small, usually containing no more than four staff (although one insurer had 20) dedicated to tackling fraud. It was of interest that nine out of the 16 (56.3 per cent) who commented on this question said that they did not have a dedicated fraud unit, and suggested that it was the role of the claims department to tackle fraud. Some comments on this issue included:

Point of claims department activity.

Small centralised claims department, so separate unit not necessary.

Claims departments staff ... responsible for detecting and monitoring fraudulent claims.

The claims department detects fraud where possible and management decide appropriate action.

Specific areas of the claims department check eligibility.
We believe every claims handler should be alert to the possibility of fraud and to know what to watch for.

Some, however, did not think they had a problem and therefore had no need for a dedicated unit. For example:

The numbers of insurance fraud detected does not currently warrant a separate department each case is dealt with on merit after consulting HO officials.

No perceived need—with current small volumes fraud is not a problem.¹

It is possible to envisage a vicious circle here: unless staff know what to look for they will not detect fraud, and unless they find fraud they will not realise there is a problem. In any event, different practices existed across the industry.

**Barriers to co-operation on tackling fraud within the insurance industry**

The current trend in crime prevention is that groups of people, whether they be companies, neighbourhoods, communities or countries, should work together to fight crime. The real problem is not the theory, based on the sound sense of combining collective knowledge and experience to fight crime, but the reality of different cultures, different priorities and different agendas complicating the idea of co-operation. This is no less the case when businesses are involved.
In the commercial sector, of course, an additional problem is that there is competition for profit, and ultimately survival. When companies in competition in almost all other respects are asked to come together to share information and adopt a co-ordinated approach, there are almost bound to be conflicts. Not surprisingly, not all companies see crime prevention as non-competitive (Levi 1987). Recently, Levi emphasised this problem in attempts to tackle credit card fraud:

There will always be some conflicts of interest between the key private sector groups – card insurers, consumers (and individual crime victims), merchant service providers, and retailers – and between individual firms within those sectors (2000: 1).

Even within companies there are difficulties. Security management—and this may include fraud prevention—is a low priority within some companies, and there is often conflict between security and other sections of the organisation, for example marketing (see Beck and Willis 1998). As noted above, moral and ethical values differ markedly within organisations (Yeager 1995), which means that priorities differ; and insurance companies are no exception. Michael Clarke notes that because insurers have to be careful not to make fraud look easy, they have kept measures ‘secretive and largely confined to the internal administration’ (1990: 69). In short, there are commercial, as well as structural and cultural reasons, why combating fraud is problematic.
However, effective action is not impossible, and there are some good examples of companies coming together to fight fraud and other crimes. Levi and Handley (1998: 14) note the example of how co-operation between card issuers, merchant acquirers, card schemes and retailers had a positive impact on reducing fraud. Nevertheless, the gains may be short-term because companies can become less enthusiastic if the advantages, especially in financial terms, are not on-going, or if it is perceived that one company gains more from the initiative than another.

To develop effective strategies against fraud there first needs to be an awareness that there is a problem, and this depends on good sector-wide information being available (Levi 1997). There needs to be the political will to act, and in a candid and committed way. Developing good databases and using them to full advantage is dependent on this, and herein lies a major problem. As Levi notes:

> Within the UK, all initiatives are based upon one core principle: that fraud is not a competitive issue. Not everyone shares this view, but the essence of it is to recognise that although your competitors may get more out of collective fraud prevention than you do, you will still be better off than before (1997: unpaginated).

During the research a major initiative designed to tackle fraud was launched. It was heralded as the solution to the insurance fraud problem, and was based on the understanding that insurers could work together in the fight against fraud. It is worthy
of discussion here because it characterises many of the problems which typify the insurance industry's response.

Claims and Underwriting Exchange (CUE)

The CUE system was designed by EQUIFAX in collaboration with the ABI and major insurance companies. Although useful as an underwriting and claims management tool, it was principally launched as an anti-fraud initiative, coming into operation towards the end of November 1994. The system was initially designed to hold data on household claims, and later on motor and travel claims, and to root out potential fraud at both the claims and underwriting stages by cross-matching claims records, mainly by name and address. It sought to verify the proposer's previous household or motor claims history before accepting a risk, and to identify individuals who had made a number of similar claims against different insurers (ABI 1996c).

CUE was a response to the desperation by insurers, especially the larger ones, to be seen to be doing something about fraud. It was effectively a 'quick fix' solution, and it did not work. CUE arrived with unrealistically high expectations. Bob Scott, Chair of Insurance Database Services Ltd, noted that:

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CLUE [as it was then called] will deliver the knockout blow to fraudsters
... I issue a warning now to all fraudsters and potential fraudsters -- you
will be caught. (ABI 1993)
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From the start there was confusion about whether it was really a claims or an underwriting tool. The system was not capable of detecting certain types of fraud, such as exaggerated claims, since it held no specific information on the items claimed for. Nor could it identify individuals who surreptitiously added extra items to a claim, over and above the actual loss that had occurred. CUE also failed to detect those policyholders who had claimed for the first time on their insurance policy but had committed fraud in the process, no matter how large or complex the fraud, because there would be no past records. It might also miss a claim which was purchased as part of a block account, since specific account details would be missing. Other frauds committed by those who inflated prices, e.g. builders, would not be identified because there was no routine entering of third-party or supplier data. As the database grew it became increasingly difficult to identify or track down people with common names. Moreover, fraudsters could circumvent the system by changing their names, as one insurer pointed out:

There are people who reverse their names ... CUE is difficult to track them down because your Abdul Raffik can be your Raffik Abdul and then he takes another middle name.

Even if you spell a name wrong CUE will say that there’s nothing known, so all you have to do is stick an extra ‘e’ on the end of your name and it’ll come up as nothing known, no previous claims.
There were other problems. Since those using the system were charged for each transaction it was deemed to be expensive to use, and there were problems with data matching, as one insurer noted:

[If an individual is going to make a claim every five years] that means that once you’ve got five years’ data on there, there’s a one in one chance of getting a match every time you stick the darn thing in ... I can see a situation where you get a match every time you put in a claim.

Most matches do not mean a fraud has taken place, and detecting which ones do is a time-consuming process. Worse still, the system was not live and so data were not available at the point they were most needed. It is doubtful that the industry ever prepared properly to maximise the effectiveness of the system: only one in 20 underwriting staff received any form of fraud training. Moreover, the failure of many insurers to sign up to its use meant that much data was unavailable; this included policies administered by third parties such as banks, as well as captives, many of whom had not signed up to CUE. There were too many holes through which fraudsters could slip.

CUE can, however, have an important impact on *uberrimae fidei* (‘utmost good faith’). It will be recalled from Chapter Two that this is a doctrine whereby all those who are party to an insurance contract have a legal duty to disclose any material facts which could have an influence on the contract or on the willingness of the other party to become involved in it. Thus policyholders must disclose information to an insurer
which is material to the risk, and at the same time insurers have an obligation not to withhold any information from the prospective policy holder with regard to the risk. One insurer interviewed raised the point that CUE could potentially turn the doctrine of *uberrimae fidei* on its head; just as a policyholder could be accused of fraud by non-disclosure, so could the insurer:

> What happens if I’ve sold my house in Liverpool and it’s had three previous thefts and I’ve sold it so somebody who’s moved into it, they fill in a proposal form saying no previous thefts. Now they’re answering that question perfectly honestly, they send in their proposal form to their new insurer. Their new insurer puts it through CUE, CUE knows that that address has suffered three thefts, so is there an onus on the insurer now to tell the customer that they’re in an address that’s suffered three previous? ... Where’s the onus of utmost food faith? They might just decline the insurance.

The CUE project was not a complete failure; some insurers still use the system today, and CUE has helped (in the broadest sense) to create a more structured forum for debate about fraud issues. One claims manager on the CUE committee, when interviewed, said:

> I’m pleased that insurers are now working much closer. I really do believe we are. I think CUE has helped, there have been a lot of meetings with a lot of insurers, and I think we all accept in general that we’re all
working for the same end. I really do feel that has pulled us together even more.

Moreover, CUE facilitated checks to be made on potential new policyholders, meaning that insurers could be more selective about whom they chose to insure. A high rate of customer retention eliminates the need to check these individuals against CUE at the renewal stage, since details will already exist with the company. Indeed, the high retention rate on policies was one reason why some insurers considered it unnecessary to join CUE—another example of how good management is also good fraud management.

Despite some benefits, CUE is commonly considered an expensive failure as an anti-fraud measure. There was no great understanding of the sorts of frauds the system could detect, nor of the types that it would fail to find. The system was found to be too expensive to use; it was also slow, the data were never live and were thus unavailable at the point when they would have been really useful. Many insurers and others failed to join, limiting the amount of data available and thus the effectiveness of the system. Even its ability to detect risk proved counter-productive for one insurer in the context of ‘utmost good faith’, and common names and simple name changes compromised its effectiveness. A simple analysis at the planning stage would have revealed most, if not all of these shortcomings. Insurers’ experiences of CUE typify the industry’s failure to take fraud seriously, even when resources and a certain amount of co-operation and energy were directed at the problem.
Loss adjusters and insurers: endemic impediments to fraud control

The relationship between insurers and loss adjusters is one where costs are crucial, and this has an impact on fraud control. An insurer employs loss adjusters to check claims and to adjust them to the correct level. They do this by ensuring that the claim is accurate, that it is bona fide and that all the policy conditions are met. Decisions on when to involve loss adjusters were based on varying criteria according to types of policies, in particular the amount claimed, and any concerns the insurers might have—what one insurer referred to as a ‘gut feeling’. Loss adjusters were rarely used, however, for small losses. Insurers generally felt that if the sum involved was small it was cheaper to pay a claim, however questionable. However, there are three points about fraud control that need to be emphasised here.

The first is that loss adjusters are under pressure to deliver a quick and efficient service, and many felt they were not paid enough to find fraud. As one loss adjuster commented: ‘Fees are cut so we can only afford to settle quickly, we can’t afford to keep on investigating a case’. Another confirmed this view:

There are people in adjusting who really all they want to do is just settle claims, because there’s a lot of pressure from insurers to pay claims and get the work turned over quickly. There’s a lot of pressure on fees as well, an adjuster can’t really spend too much time on a claim if they’re only going to get a small fee back for it.
And because the business is competitive, efficiency was linked to dealing with a case as speedily as possible. Another loss adjuster noted that:

Many loss adjusters will just stamp and pass a case because they're seen to be efficient ... fraud is swept under the carpet; it's in no one's interest to find it.

In a competitive market, insurers were understandably concerned to prioritise customer service, and this includes settling claims as speedily as possible; loss adjusters certainly felt this pressure. Fraud investigations take additional time, witnesses are not always easy to contact and enquiries involving the police can take months. Meanwhile, the claimant pestered the insurer for up-dates and payment, sometimes there may be legal threats, and this pressure will be felt by loss adjusters, who feel condemned for doing their job properly. The irony is that loss adjusters are more likely to be praised and rewarded for their efficiency and quickness than for their skills at finding fraud. The policies and practices of many insurance firms with regard to the employment of loss adjusters is therefore not conducive to the identification of insurance fraud. Little wonder that loss adjusters should claim that they were not motivated to look for fraud.

The second point is that although most insurers reported that they engaged loss adjusters at some point, there was a tendency to use a small number of pre-selected loss adjusters. The advantage to insurers with a negotiated contract is that they obtain a better price for each job, and in exchange they guarantee to use the services of the
chosen firm of loss adjusters. There are at least two main problems with this for fraud control. First, loss adjusters in some areas were perceived as better than in others; although a national firm may have a good reputation or be able to agree good rates, the quality of local offices varied. As one adjuster noted:

We have a panel of six loss adjusters now who I use ... I'm not totally convinced. This is not going any further, is it? [Laughs] ... Personally, I'd like to see the use of other ones as well because you do get people locally who are very good, and probably better than ... the national adjuster.

This point is reinforced by the second problem: a high proportion of insurers who said that they had contracts with more than one loss-adjusting firm said that these firms were used on a rota basis, or by a system to ensure that each firm was given equal business. Again this does not ensure cases are always referred to the firms with the most adequate skills. And loss adjusters admitted that fraud investigation was not every adjuster's interest: 'Some people don't like investigating fraud, they don't like asking leading questions and getting into potentially difficult situations.'

The third point concerns the ways in which loss adjusters are paid. All but one of the insurers interviewed had negotiated a fixed fee per job, with a maximum limit should the case prove time-consuming. Because the loss adjuster is paid at a fixed rate, there is little incentive to look for fraud. Moreover, the emphasis on costs results in loss adjusters having to carry out work for less money, in fewer claims being referred and in lower fees being charged. There was a great deal of concern about job security,
several interviewees referred to cost-cutting exercises within their firms, and competition between the adjusting firms was intense. One loss adjuster was paid on a percentage of settlement, and as he noted:

The insurers pay us in proportion to the amounts paid out, so, although we work hard to prove a case of fraud, we don’t benefit from it. It would pay us to have the claim paid out. We try hard to show the insurers that we can identify fraud, but they don’t seem interested.

Some loss adjusters and insurers were equally negative towards each other when they were questioned about skills for tackling fraud. Insurers were often perceived as negligent, being concerned with profits and customer service at the expense of fraud control measures. Loss adjusters were seen as lacking expertise; some insurers noted the big difference between the skills of adjusting and those of fraud identification and investigation, and this difference was reflected in the rarity of fraud units being formed within loss-adjusting offices. The perception was that loss adjusters’ training and experience were insufficient for fraud work, and they did not have the skills needed. Some insurers held loss adjusters in low esteem: they thought little of their work, and regarded them as an unwelcome necessity that disrupted their primary function of claims handling.

For this reason some insurers preferred to refer work, particularly where smaller sums were involved, to enquiry agents. Most were ex-police officers who knew how to obtain information, and usually had investigation skills. However, at least one insurer
saw this as the ‘cowboy’ end of the industry’s work, where results were achieved via intimidation as opposed to subtle investigation. Another noted that he found enquiry agents very effective but was concerned about how they might have obtained their information, and so refrained from openly discussing their involvement.

Some insurance companies relied on their own internal investigations when it came to fraud, and former police officers were viewed as good employees for this role. One investigator explained what he saw as the advantage of internal fraud investigations over referral to loss adjusters:

Loss adjusters don’t investigate the claim ... the loss adjuster is completely independent, although we pay him, he’s completely independent and he comes back and he gives a completely independent report of the claim, but he doesn’t investigate it ... (whereas) ... I go out and make enquiries to either confirm or dispel those suspicions. If the suspicions are confirmed, then I go and consult the policyholder. Now a loss adjuster wouldn’t do that, a loss adjuster would just go out, he’d look at the claim to make sure that it’s covered. He’d look to make sure that the sum insured is adequate for the property that’s been stolen, and ... he’d make sure that the circumstances are covered by the policy and he’d check that what’s being claimed for is worth what’s claimed, and then he’d send his report back to the insurance company. Now, he could do all that and the claim would be fraudulent.
However, there were some good relationships between loss adjusters and insurers. One insurer advised of a loss adjuster who had developed a database where the specifications and details of an item lost or stolen could be entered; the database would then indicate if that model was still available, if unavailable what model superseded it, and where it could be purchased. And there were many other examples.

The problem is that the role of loss adjusters, and the way they are used by insurance companies, means that they are of limited help in tackling insurance fraud. Insurers’ concern with processing claims quickly, the competition between loss-adjusting firms on the one hand and between insurers on the other, the strategy of insurers to pre-select loss-adjusting firms, and payment by a fixed fee method, all combine to make the investigation and control of insurance fraud a low priority.

**The police response to insurance fraud**

The police service commitment to investigating fraud is patchy, and there are problems for companies in ensuring that they have enough evidence to justify police involvement. Plastic card issuers, for example, are keen not to alienate the police with cases that cannot adequately be investigated, so only the cases likely to result in conviction are reported (Levi 1991). Insurers certainly face similar problems. Every insurer interviewed claimed to have had difficulty at some point with the police when dealing with cases of insurance fraud (though sometimes these problems were relatively minor). One insurer noted that the police were no longer prepared to provide burglary report forms to the company on request, and that the most they would do was give out a crime reference number. Another insurer noted: ‘You can’t
ever get them to tell you anything about the burglary’, which was frustrating and made it difficult for insurers to collect the evidence to facilitate a police investigation.

Other examples were more serious, for example where police were known to be sympathetic to fraudsters. One police officer interviewed stated that, in her experience, when colleagues were called to a burglary they were generally sympathetic to the victim, and even though they might suspect that a loss had been exaggerated this would not normally concern them. In her view some officers willingly co-operate in scams by offering ‘off the record’ advice to help victims obtain more money from insurers than they were entitled to. Clearly, more research is needed, but certainly insurers interviewed in this study believed this of the police, often citing their own evidence. In a different way, insurers became frustrated when they did collect evidence which they considered sufficient to excite the interest of the police, only to find the latter unwilling to act. Insurers were aware that unless they completed the investigation first (leaving the police with very little investigative work), the police were often not interested in presenting the case to the Crown Prosecution Service. Insurers also lamented that often cases did not result in charges, and even where they did result in prosecution they lamented what they perceived as the soft sentences handed out.

Some insurers were concerned that police involvement could lead to loss of control over the case. Others favoured police involvement because it demonstrated that the company was tackling the problem. The frustration of insurance companies at what they perceived as lack of police support was compounded by the consequences, and
this included being obliged to pay out on suspect claims. One insurer who was
interviewed felt strongly that the police were inadvertently helping people to commit
fraud, by their inaction and lack of interest. Another insurer who worked for a smaller
insurance company explained that he repudiated every claim that he suspected was
fraudulent, as he could not afford the investigation costs. This was the only way he
could avoid losing money. He admitted that this was unethical, but he blamed the
police for their inaction and their failure to investigate the suspected cases of fraud.

This provides further evidence that statistics for fraud are inaccurate: victims, aware
that police interest will be low, refrain from reporting. As Levi noted:

    Unless the police or other regulatory services are providing a service
    which victims themselves believe are beneficial to them, they will not
    report a fraud unless – as happens for banks in the US – they are legally
    required to do so. (1997: unpaginated)

Without an accurate understanding of the fraud problem, it is unlikely that there will
be sufficient political will or public concern to generate police activity at a
meaningful level.

The best tactic, advocated by a number of insurers, was to get to know the local
police and, where one existed, its fraud squad: personal contacts appeared to count
for a good deal. One insurer explained that he had a good personal relationship with
an officer on the local force, and this resulted in the investigation of fraudulent claims
that he felt would normally have been ignored. However, this type of personal contact with the police was not common. Occasionally, for a variety of their own reasons, the police took an interest in a particular case and then the investigation was carried out with more enthusiasm. In fact, research on some fraud victims' views has found satisfaction with the police to be high (Levi 1992a), although perhaps the police interest here is the desire for a job once their police career is finished (Levi 1999). Certainly insurers felt that ultimately there had to be a change of attitude to the problem amongst the police; many felt that they were fighting the problem alone and that in the long run their fight was destined to fail. As Levi noted:

> The opportunity cost to criminals of attempted fraud currently is low. So, if costly attempts (and successes) are to be discouraged ... police involvement is needed to ratchet up the risk for the potential offender (1997: unpaginated).

Unfortunately, as far as insurance fraud is concerned, there is not much room for optimism.

**Findings in perspective: are insurers rational when tackling insurance fraud?**

It is important to establish whether insurers are rational when tackling insurance fraud. The two criteria that were applied to the rationality of individuals can be used here to consider the rationality of companies: are insurers thinking strategically about
fraud, evaluating alternative methods of addressing the problem? And are they acting on that thinking?

The objective of insurers is to make a profit, and not make a loss. Perhaps all the business decisions that insurers make will in some way or other take account of this need to increase income and reduce costs. Clearly, fraud is a cost, and some measures that are taken to tackle costs may also (perhaps incidentally) tackle fraud; other measures will tackle fraud specifically, providing it is profitable to do so. The question is, what do insurers do, and how do they decide what level of priority to give to fraud? Based on evidence presented in this thesis there are perhaps three different types of approaches to fraud; these have been termed ‘guessing’, ‘limited knowledge’ and ‘strategic knowledge’.

Insurers differed greatly in the extent to which they understood their fraud problem. There were those who made little attempt to do so, and their approach may be best characterised as ‘guessing’. These insurers carried out little more than rudimentary calculations, based on experience, and concluded, usually, that they did not have a problem with insurance fraud or that it would be too expensive to deal with it in an orchestrated way. For example, one small insurer reported that his organisation did not have a problem with fraud. When asked to justify this, he replied that he had not seen one case of fraud in the ten years that he had worked there, and so he assumed that his organisation did not have a problem, thereby justifying its inaction on this issue. This insurer demonstrated that his organisation had not attempted to think strategically about the problems of insurance fraud—although, on the basis of
guesswork, it had made a decision to do nothing, and considered this entirely rational.

It is interesting to note that this insurer had broad responsibilities: he was not highly specialised in any particular area, and there were no fraud experts in his organisation. This is a problem shared by other small insurers—they find it difficult either to identify or to tackle fraud, because of a lack of expertise.

Others did make some attempt to understand the problem, albeit their approach was based on 'limited knowledge'. One insurer said that his organisation thought that it had a problem with motor fraud as a few cases had been identified. Staff had attended a seminar where they were introduced to both ESDA and VSC machines, and, convinced they would help tackle their fraud problems, they bought them (at a cost of over £30,000). However, this only helped identify a few frauds, and the cost of running the machines was far greater than the savings. When asked why he had not considered this beforehand, the insurer replied that he thought that he had a problem, and that he had been told by others the machines would provide the solution, as many insurers were buying them. He could have assessed the problem initially by borrowing a machine, or by having a loss adjuster with a machine to examine a random sample; however, he had failed to do this. Here again is an example of an insurer who made little attempt to assess a problem that he thought he might have: only limited strategic thinking was carried out and there was no attempt to evaluate alternative measures.

Other insurers approached fraud in a way that was based on the 'strategic knowledge' approach. Strategic knowledge attempts a full understanding of the problem. These
insurers worked methodically through a range of costs and then decided what to do, although this led to some different approaches. Nevertheless, it is far from clear that companies understood (or cared about) what the full costs were. While some had considered that some action on fraud could generate an adverse reaction from the public, none appeared to have put an actual cost on this. Thus the term ‘strategic knowledge’ is limited to what is understood within current practice.

Some insurers considered their problem far more strategically. For example, 10 out of 43 insurers who were questioned had a fraud/technical unit. As stated earlier, these tended to be the large well-known insurers, and they appeared to have a greater knowledge of their problems. They collated cases of fraud and tried to learn from them, and in one case sought to establish fraud profiles. They used the information to target their resources on those specific areas of the country which appeared to have a higher incidence of fraud, and on specific types of individual. Only a few cases led to prosecution, but as one of these insurers explained, the aim was either to get the claimant to admit to fraud and thus drop the claim, or to find a technicality within the policy to deny the claim. This insurer was clear that it was not policy to seek to refute all claims on a technicality, as this would be unethical, but only those that the company considered fraudulent and where it was felt there was proof. Although this insurer admitted he was not able to identify all frauds, a high degree of strategic thinking was evident in that he had analysed his organisation’s problem and evaluated alternative strategies in order to make a decision.
Some insurers tackled fraud only as part of a broader strategy to tackle losses. They used insurance actuaries to work out the profitability of insurance, by examining the sales against the costs (the cost of fraud would be hidden in these costs and so be unknown to the actuaries) and finding ways to maximise profits. In practice, profit margins are tight in the insurance industry; one insurer calculated that his organisation made an average £1 profit from each policy, and the company had concluded that it could not afford to investigate fraud, as the costs would wipe out the profits. This insurer did not dwell on whether some types of investigation could be cost-effective—for example, an expensive motor claim, where the cost of investigation could be less than the saving on that claim. This example demonstrates that organisations can employ strategic thinking, and evaluate the situation in a roundabout way, but unless they consider all the factors they may fail to adopt the best strategy, and where fraud control is concerned this appears often to be the case.

No matter how well-informed insurers were when making decisions to tackle fraud, the questionnaires to insurers and subsequent interviews revealed that only three had specific measures in place to tackle fraud at the sales stage. These measures involved cancelling the policies of individuals who had been suspected of or who had committed fraud in the past. The departments that dealt with these cancellations were kept completely separate from the sales department. This created other problems, such as renewal notices being issued by the sales department when these policies had been cancelled by the claims department. Most insurers took the view that sales provided income, and so unless there was a claim there was no loss. It only became a problem if there was a subsequent claim, at which point it was the claims
department's problem and nothing to do with sales. In addition, many sales personnel were on commission, by which they were paid for each policy they sold, so there was no great incentive to worry about fraud.

While insurers vary in their commitment to and ingenuity in tackling fraud, this does not mean that the less active are any less rational in their decisions involving fraud control. As has just been shown, there are different ways that insurers can reach a decision, all of which involve strategic thinking, or the evaluation of alternative solutions, or both of these together. But the real problem is that they are working from a poor information base, and this applies across the whole industry. One can argue that insurers are rational, given widespread ignorance about the problem, but if risk management data could better show the types of risk, and if a methodology could be found to calculate the costs and benefits of different strategies, it seems likely that many companies would act differently.

**Conclusion**

Some of the practical problems that inhibit the successful implementation of crime prevention measures in the commercial environment of the insurance industry have been considered in this chapter. While the findings are discussed in the context of insurance, it seems likely that the same problems exist in other industries which are governed by profit. Business environments offer challenges which, it seems, many crime prevention approaches have yet to take seriously. While social crime prevention strategies, which tackle the root causes of crime, are important, they are
too long-term and too removed from day-to-day business concerns to become attractive options as prevention strategies for business. Situational measures have much to commend them, but there needs to be a more robust evaluation of the benefits.

Fraud prevention is not always seen to be cost-effective, and there may be little impetus to prevent it. The problem is due in part to the crude way that fraud prevention is measured, as well as to the inability in any way to measure the benefits of fraud prevention. It is to be hoped that others will turn their attention to this issue in due course, and in so doing they will want to take account of a broader range of costs, including the potential costs of not responding to fraud and the impact this may have on reputation. The three issues that were mentioned as working against a strategy to confront fraud were costs, ethics and practicalities, but this deserves a comment in a rather different context.

First, a crime reduction strategy can reduce costs and be financially beneficial, facilitating lower premiums and, in theory at least, reducing the chances that individuals will be excluded because they cannot afford insurance. Effective crime prevention can prevent people making claims in the first place. For example, target-hardening can mean that a house is not burgled and a claim not made—most fraud comes on the back of genuine claims, so fraud can to this extent be prevented. There are other ideas too. If policies were linked together, e.g. household, travel and motor, it would be more difficult for a policyholder to commit fraud anonymously and the
insurer could hold more information on him/her, something which does not happen with travel insurance.

Second, a crime reduction strategy may improve the public’s perception of the insurer’s ethics. Improved public relations benefits can also lead to more business, and certainly to better business. If measures were in place at the sales stage to prevent frauds such as fronting, then those insured would have valid policies; and these would not need to be voided at the claims stage, thereby avoiding this controversial and sometimes unethical practice. Certainly, claimants interviewed in this study often held negative views of insurers because of what they perceived as unethical practices by insurers. These perceptions may not have been fair, but they need to be challenged, and an overtly ethical stance could move some way to realising that aim. A company’s reputation is vital, and so are strategies to protect it.

Third, efficient systems for improved management of data can be vital for tackling fraud, and can also generate other benefits such as improved staff morale and customer service. Good systems, backed up by appropriate and effective technology, can greatly enhance strategies to reduce fraud. Levi and Handley (1998: 3), for example, found that plastic card companies and retailers have affected the rate of credit-card fraud by ‘reducing opportunities to offend’. And this can also lead to improved customer service where it is done properly, e.g. by fast tracking. Similarly, a recent review of its activities to accord with money-laundering regulations led to other benefits for the Bank of New York, in that it identified under-performing
accounts and accounts that benefited from being managed in a different way (Complinet.com 1999).

Essentially, the benefits of crime prevention need to be shown in business terms, and this is very often missing because most situational crime prevention has been concerned with the public domain, where issues of cost have been a secondary consideration at best. Commercial organisations engage in a different sort of rationality, where cost effectiveness, often measured crudely, has a greater salience.

It is this philosophy which contributes to insurers’ relationship with others. Fraud prevention is prioritised quite differently by different companies—some are committed but others are less so, and this stands in the way of a co-ordinated response. Commercialism is often an impediment to co-operation with other insurers: there are different opinions about the scale of the problem and therefore about the costs involved, and so industry-wide initiatives are disadvantaged from the start. Loss adjusters, who could have a role to play in fraud prevention, are effectively disincentivised, while the police frequently appear to view insurance fraud as a low priority, and indeed often view the commercial sector as responsible for paying for and organising its own policing.

Insurance companies and the insurance industry can only effectively tackle fraud if they first take the decision to recognise they have a problem, and then take appropriate steps to assess the benefits of different strategies. There is no real
evidence that this is beginning to happen, and meanwhile there will continue to be
victims, although victimisation extends beyond the insurance industry. What this
thesis has endeavoured to show is that given the will, there is in fact a lot that can be
done to tackle fraud. However, prevention strategies need to take account of both the
idiosyncrasies of the insurance process and more broadly the specific challenges
offered to crime prevention in a commercial environment.

1 It was interesting to note that none of the staff within this company received fraud training.
2 For example, some banks and building societies will sell policies from a specific insurer, and sort
   out the claims themselves on the insurer's behalf.
3 It is important to point out here that the majority of respondents to this survey were claims
   managers, and as such were perhaps more familiar with their own department when answering the
   questions.
11. Conclusions

This thesis set out to evaluate insurance fraud carried out by customers and to identify ways in which it could be prevented. The insurance frauds studied are typical of those carried out on home, travel and motor policies; corporate insurance frauds, and other types where the insurance company is the victim, were not covered. Three broad objectives were set. The first was to clarify the process leading to insurance fraud, and specifically to establish why people commit insurance fraud, whether they could be considered rational offenders, how they commit fraud, and who they are. Knowing who commits these types of fraud provides clues as to where prevention measures should be targeted, and understanding the motives and methods of the fraudsters gives clues as to the types of interventions that are likely to be successful.

The second objective was to look at what is being done by insurers to tackle the problem at both the inception and claims stages, the two key points at which fraud occurs. It is important to understand insurers’ attitudes to insurance fraud, their perceptions of the threat, and what they do and do not do to prevent insurance fraud, in order to identify different and potentially better interventions. This is also important in terms of understanding the potential of situational crime prevention to offer an all-encompassing framework for fraud reduction.
The third objective was to evaluate the applicability of Ron Clarke's opportunity reduction framework to the offence of insurance fraud. Since, as has been shown, some individuals can rationally commit an insurance fraud because of the opportunities available, Clarke's opportunity reduction classification, based on rational choice theory, appeared to provide a suitable starting point. Until now Clarke's model has not been applied to insurance fraud, and the purpose of doing this was to evaluate both the relevance of the classification and its value as a framework for preventing insurance fraud. In other words, the aim was to provide insurers with a framework based on theory to guide practice, which is something that is presently lacking. Just as important as identifying the ways the framework can be applied is to understand the reasons why it cannot. This involved reviewing ways in which the classification needed to be refined, and identifying prevention strategies which fall outside the situational crime prevention framework but are nonetheless crucial.

Who commits insurance fraud, why and how?

Insurance fraud is easy to commit, the chances of detection appear low and, even if it is generally considered to be a crime, offenders find it easy to justify. There again the offenders here are not those most typically associated with crime. People may pay insurance premiums for years and not make a claim, and so perceive an excessive claim at some point as fair recompense. Fuel is added to the fire here by the view many hold of insurance companies as uncaring bureaucrats and therefore not 'real victims' when a fraud is perpetrated. In addition, a range of criminological studies
have shown that offenders often commit a crime because they do not believe that they will get caught.

There are different types of insurance frauds on different types of policies, but most of those discussed in this thesis take place on the back of a legitimate policy, and often there is also a legitimate element to the claim. Indeed, it is at the point of the claim that the opportunity is realised; also, beyond this point few other skills are required and, as previously noted, the chances of being prosecuted are low. It is because it is easy, and the victim seen as undeserving, that so many feel able to commit this type of offence.

Most perpetrators of insurance fraud do not feel guilty, and most are aware of what they are doing—it is largely a rational act. Even those who claim they are not committing fraud are behaving rationally, and could be prevented by situational measures or by other means. This thesis has found that there is a lot that insurers can do.

What is being done by insurers to tackle the problem?

This study has shown that many insurers do not have satisfactory systems in place to detect and prevent fraud, and that few checks are carried out on policies. Even when fraud is suspected it is often difficult to prove conclusively. There are individuals, or ‘helpers’, who are willing to assist in the carrying-out of fraud, sometimes
unwittingly. There are few prosecutions and few visible sanctions are suffered by those who are found to have committed the offence. The opportunities for fraud often increase with the introduction of ‘fast tracking’ systems designed to process claims quickly but lacking safeguards against fraud. In this way insurers are creating easy opportunities for fraud at both the underwriting and claims stage.

Independent of this trend there is rarely a co-ordinated and effective strategy for tackling insurance fraud—for the most part insurers appear not to understand the problem and use inadequate systems and procedures which often make life easier for the would-be fraudster. Fraud risk management strategies practised by insurers seem to have a low priority attached to them. Also, there were only fairly crude attempts to discover the impact on the bottom line.

Moreover, the way that policies are sold, and in particular the way that agents are trusted to sell them, merely creates opportunities for fraud which are easily exploited by fraudsters. Insurers employ systems to prioritise profits, and it is not clear to them whether the overall costs of fraud are sufficient to merit special attention. Yet, as this thesis has shown, there is much that insurers can do: fraud can be reduced by implementing effective detection systems, and by adopting a co-ordinated approach focused on reducing opportunities.
**Insurers' response at the proposal stage**

At the proposal stage the priority for insurers and their agents is to sell policies, and concern about fraud is minimal, although CUE is sometimes used;¹ in some cases concern about fraud is not apparent at all. In order to prevent fraud, insurers need to recognise the problem and to create more efficient systems for checking that information provided by applicants for policies is correct. A computer system to cross-reference data from a number of sources and to ensure that the information is accurate is ideal, while more efficient manual systems are a minimum. Whatever methods are used, training is essential, for staff, agents and others involved in the process.

The prevention of fraudulent claims later in the process is helped by effective checks at this inception stage. Given that many people only commit insurance fraud as they make a claim, a reduction in the number of claims will reduce the amount of fraud; so it is important that at the proposal stage the insurer should advise people about the best ways to secure their possessions.² The insurer also needs to ensure that new policyholders understand their policies, what they cover and what they do not, in order to avoid disappointment and frustration later.

While the way policies are currently sold does not make this a realistic aim in the short run, ensuring that people's possessions are adequately covered can weaken the incentive people may feel to submit fraudulent claims. Such an approach has the
added advantage of helping to overcome the perception that insurers are uncaring and
deserve to be made to pay out. They need to project themselves as helpful and
sympathetic. What is perhaps important here is a much better evaluation of the costs
and gains that can accrue from different strategies—at present too much is based on
hunches rather than firm evidence, and this is severely limiting.

**Insurers' response at the claims stage**

Insurers frequently pay out on claims that they strongly suspect to be fraudulent. This
is a reflection of the fact that they often have little time or feel little incentive to detect
and prevent fraud; and ‘fast track’ systems, delivering speed of service to the
customer, may work in the interests of the fraudster. However, there are a number of
measures that it would be relatively easy for insurers to adopt to tackle fraud more
effectively.

One of the main problems which insurers face is that of proving that an insurance
fraud has occurred. Systems for detecting fraud were found to vary quite markedly
from one organisation to another, and in many cases amounted to little more than
intuition. Some organisations just used check-lists, but it was shown that it is difficult
to detect some types of fraud, such as exaggeration, in this way: an exaggerated claim
looks ordinary in every sense. Given that this study found most fraudulent claims to
be based on exaggerated valuations, this is quite an important point. Many insurers
were using systems which did nothing to detect the commonest form of fraud.
Cross-referencing and the sharing of information between different departments and—where the data-protection legislation allows, between different insurers—can provide an effective method of validating information and entitlement. Yet only one of the ten insurers surveyed mentioned this as a useful way to tackle fraud. Most members of staff receive little or no training in how to deal with insurance fraud; there is considerable scope for improvement here.

Part of the problem which insurers face is that in past media campaigns they have advised policyholders that they will process claims quickly; and, quite incredibly, they have on occasion added that they are unlikely to investigate claims below a certain figure. This has provided policyholders with an open invitation to commit fraud, as many insurers admitted. Insurers should have a clear and well-publicised policy that claims where fraud is suspected will not be paid without thorough investigation. In this way, insurers would reduce the chance of fraud by policyholders. This study also found that staff could be motivated to identify fraud through various incentive schemes, which have worked in the retail sector, but none of the insurers interviewed operated such a scheme.

The overriding problem is that insurance companies show little sign of wanting to work together to adopt an industry response. They have different priorities, they are in competition and they are all unclear about exactly what the costs are and about which strategy offers the best way forward. The whole subject is shrouded in confusion, starting with an unclear definition and ending with the lack of a clear industry-wide
policy and approach. The problem is not that each insurance company adopts an irrational approach on the basis of the evidence it has; it is rather that the evidence itself is confused and partial in coverage.

**Clarke's opportunity reduction techniques as they apply to insurance fraud**

Given that offenders are to a greater or lesser extent rational and are responding to opportunities, situational crime prevention presents itself as a suitable basis for tackling the task. But despite encouragement from its principal proponent, Professor Ron Clarke, it had, when this research was begun, not been applied with any rigour to such an offence as insurance fraud. How would the techniques stand up? How useful would they be as a guide to companies in working out their strategy? What revisions in the classification are necessary? What issues does the classification not cover?

The applicability of Clarke's 16 opportunity reduction techniques has been assessed. These are classified by Clarke into four categories: increasing the perceived effort; increasing the perceived risks; reducing rewards; and removing excuses. Apart from analysing the ways in which each of these techniques can be applied to the prevention of insurance fraud, the question was asked whether any of them needs modification in the light of the analysis. It is important to remember that these techniques have been extremely helpful in guiding those involved in crime prevention.
Various textbooks, and certainly the British police’s crime prevention efforts, have been largely based on this approach. Recently Gill (1998; 2000) argued for a complete reworking of the techniques to be incorporated within a broader organisational classification. Similarly, Ekblom (1997) has sought to integrate the techniques into his ‘conjunction of crime and opportunity’. Clarke (personal communication) has argued that to avoid confusing the crime prevention agenda, not least for practitioners, using the same terminology is helpful. The aim of this research has been very much, following Clarke, to assess to what extent the techniques fit the requirements of preventing insurance fraud, with a view to improving the framework as it is commonly understood. For the most part this has worked well.

It was found that Clarke’s techniques offered a useful framework for the prevention of fraud, although some techniques were more relevant than others. Some major revisions were necessary: for example, under the heading of increasing the perceived effort, both target-hardening and access control needed to be reinterpreted for application to insurance fraud. Target-hardening, in the sense of encouraging policyholders to protect their possessions, can have an indirect impact on insurance fraud: it can cut down on the theft of possessions and reduce the number of insurance claims, and thus the opportunities for exaggerated claims. So this is a useful technique, but how and why it is applied need a different explanation.

The technique of access control also needs to be reinterpreted. Access in the context of insurance fraud does not mean physical access to premises, but rather customer
access to an insurance policy. Access to a policy can be controlled in a number of ways: for example, potential policyholders can be asked detailed questions in order to help preclude insurance fraud. At the same time, by asking in-depth questions the insurer can help to ensure that applicants receive the right policies and the correct level of cover, thereby reducing the motivation for them to commit fraud should a claim need to be made. Again, the technique is useful but needs a slightly different interpretation.

Techniques such as deflecting the offender and controlling facilitators, which both come under the heading of increasing the perceived effort, are applicable to insurance fraud. Four techniques which come under the heading of ‘increasing the risks’ are also relevant, namely entry screening, formal surveillance, surveillance by employees and natural surveillance. These can all be used by insurers in devising their strategies for preventing fraud. However, exit screening cannot be fitted into the framework; this is because once people finish with their policy there is no further point in screening them. Screening can only be relevant at the proposal and claims stage of a policy, i.e. the entry stage. This does not make exit screening irrelevant as part of the broad classification; it is merely not a technique which insurers need to consider using. The analysis also showed that there is substantial overlap between some techniques. A case in point is the overlap between formal and natural surveillance, which have many similarities. Fraud hotlines are a form of formal surveillance, because they are set up by organisations such as the police as well as by insurers, yet they rely on informal surveillance by the public for their success.
Some overlap between the broad categories was found. Although target-hardening and access control come under the heading of increasing the perceived effort they could also be classified under that of increasing the perceived risks. If personal possessions and property were target-hardened and access to policies tighter, it would certainly be more risky for an individual to commit insurance fraud; the chances of getting caught would increase. Rule-setting is relevant to all four categories. However, overlap is inevitable, especially in an area as complex as this; but it does not detract from the usefulness of the approach.

Under the heading of reducing the rewards there are three techniques that can be particularly helpful for insurers. This thesis has discussed the ways in which identifying property, reducing temptation and denying benefits could all contribute to reducing insurance fraud were outlined. However, target removal was shown to be less applicable or to need qualification: although insurers could remove some of the target, they could not remove all of it. They could partially remove it by, for example, refusing to insure certain types of risk, particularly those that they believed to be most susceptible to insurance fraud. But the removal of the whole target would require nothing less than the abolition of much of the insurance industry.

Under the final category of removing excuses there are four techniques: rule-setting, stimulating conscience, controlling disinhibitors and facilitating compliance; these are all relevant. This category was newly created by Clarke and Homel (1997), and subsequently revised by Clarke (1997). The new element in the framework is aimed at
removing any excuse for committing a crime, by increasing the shame and guilt of the
would-be offender and removing any ambiguity over the process of committing a
crime. The present research also indicated that there was a need to add a new
technique: ‘incentivisation’. In fact policyholders can be incentivised not to claim,
which is the purpose of the system of excess charges, and to protect their property by
reductions in premiums if they take various security measures. Moreover, an
insurance company employee can be incentivised by means of special rewards to seek
out fraud. This technique, as it is concerned with rewarding constructive actions, adds
a positive element to the 16 techniques of situational crime prevention.

The category of removing excuses has yet to be subjected to any extensive
investigation, but this study indicates that as far as insurance fraud prevention is
concerned it offers many benefits. Indeed, it has a special relevance to insurance fraud
because the latter is carried out by people who often justify their actions by making
excuses but who do not feel guilty. The technique of inducing shame or guilt should
thus prove most helpful, although more research is needed here.

However, the overriding advantage of the classification is that it provides an
organising framework for thinking about prevention. This is important, and it is
something that insurers presently lack. In reality, however, the nature of the fraud
problem is much greater than this. It has been noted that the insurance process creates
opportunities for fraud. As discussed in Chapter Two, Shapiro’s (1990) discussion of
inter-personal trust is important—as she notes, fraud occurs where people are able to
abuse trust. In fact both insurers and policyholders do so, and many of the practical suggestions outlined above are focused on controlling the ability to act in this way. As noted earlier, the industry lacks information and companies have little to go on, which, added to the different priorities amongst insurers and the competition between them, complicates industry-wide initiatives. Other industries, including retailing, have decided that tackling crime is not a competitive issue, and have combined to identify crime problems as a basis for both collective and individual action. There is no reason to suppose that insurers too could not make the same collective effort.

The realities are that no one knows just how much is lost via fraud, nor how much prevention strategies cost; but these data are important. It is not known for certain how much the various losers lose and gainers gain, and hence it is difficult to advocate best strategies. Certainly there is much that could be gained by insurers examining their relationship with loss adjusters, and by looking at ways in which the latter could be more fully involved in fraud identification and investigation; and at least one pilot scheme is under way. Similarly, there needs to be a better understanding of how the police can be involved in support of anti-fraud initiatives. This is a process of education and of developing a common understanding. It may also be a case of presenting the police with an informed picture of the scale of the insurance fraud problem, and seeking to understand how they can work constructively within limitations imposed on their activity. The lack of an industry-wide initiative does not help this task.
The good news from this thesis is that there are real steps that could be taken to tackle insurance fraud, but this will involve a more informed strategy. While criminology has important frameworks to offer it remains true that these have not yet been fully tested in a commercial environment, where priorities are much more focused on benefits to the bottom line. Opportunity reduction offers promise, but it will take more than good situational techniques to tackle the range of opportunities exploited by the insurance fraudster.

**Final comments**

Insurance fraud is a common offence which does not appear to be treated sufficiently seriously by the public, insurance companies or enforcement agencies. Indeed, in their different ways each group contributes to making the process of insurance fraud easy. Enforcement efforts are mostly feeble, and the high costs of fraud are invariably passed on to the customer.

The analysis of why people commit insurance fraud showed just how easy it would be to implement effective measures to combat it; but these have to start with a recognition that there is a problem. A positive approach needs to be encouraged by strategic managers, and it is then a matter of developing a co-ordinated strategy. Given that offenders are exploiting opportunities, the reduction of those opportunities is crucial. There is a framework, situational crime prevention, which is designed to change situations in order to reduce opportunities for crime. It is an approach which
should commend itself to insurers because it offers them a way of doing something practical and effective about the fraud problem.

More research is needed on motivation and the ways in which people set about offending, and on how effective preventive measures are and the contexts in which they are likely to work. It is important to know more about how organisations set priorities and about the impact crimes have on the bottom line and on the prices customers pay. In addition, crime prevention needs to be built into the overall company strategy; it affects and is affected by many parts of the organisation.

Despite the promise of the revised classification of opportunity reduction techniques, more information is needed on costs. This is the reality which induces businesses to act. And the limits of the situational model include the realisation that only some problems can be solved by addressing situational concerns. There are structural problems in the industry; these feed opportunities for fraudsters, and also need to be addressed.

Of course there are other ways to solve fraud and other crime problems. Regulation, beyond the scope of this thesis, is a case in point. This could force insurers to identify and comply with good practice, which in turn could help to prevent fraud. The proposed new General Insurance Standards Council (see the ABI website at http://www.abi.org.uk/industry/abikey/gis/structure.asp) has suggested new standards, including: ‘... explanation of the contract to the customer ... suitability of
the proposed policy to the needs/resources of the customer ... distributors to act in good faith'. This is working from sound principles, but it is clearly early days.

This thesis will, it is hoped, make a modest contribution to the process of informing insurers about methods of crime prevention, and provide an insight into a world shrouded in secrecy and indifference. Although companies are the immediate victims, it is not just they who suffer, and this is why the subject merits wider consideration. Perhaps the most encouraging of the findings is that there is a good deal that can be done; the framework and the ideas are there, but will insurance companies begin by recognising that there is a problem?

1 This system (at the time of this research) was used by only a few insurers at the underwriting stage, and even then it was deemed inadequate because there was no direct on-line access. Thus a policy would be underwritten before the results of a check came through.
2 See www.safetychain.co.uk.
3 This must be used with caution, in order to ensure that staff are not overly zealous in their search and do not upset honest policyholders.
Appendix A
Case study: ring claim

The researcher conducted a mock fraud, with the permission of a travel insurance company. The company agreed to allow the author to challenge its system to see whether a successful insurance fraud could be committed without the knowledge of its claims staff.

In the first instance a travel insurance policy for a genuine holiday was issued (see pages 334-336). The results are as follows.

After arriving back in England after a fortnight’s holiday in Tunisia, the researcher made a fraudulent claim on the holiday insurance policy. The claim was that an engagement ring had been lost in the sea, the details of which are attached (see pages 337-346).

Five days later a letter from the insurance company was received (see page 347) stating that it would not take the researcher’s claim further because the police or a similar authority had not been notified and there was therefore no independent confirmation that the loss had occurred during the period of insurance cover.

The next step was to tell the insurer that it had not been possible to obtain confirmation (see page 348). The company then stated in a letter (see page 349) that it
would be prepared to take the matter further if documentary evidence of the loss from a third party could be obtained. So the tour operator (Panorama) was contacted. The researcher spoke to a woman responsible for Customer Relations, who was told the above story, with an added account of an attempt having been made to report the loss to the police (this was not of course true) and of their being unhelpful. The woman said that this was hardly surprising, because the police in Tunisia would have to take legal action if they issued a report, and they only issued reports where there were cases of violence. She said that she would fax the Panorama representatives to see if one of them could recall being told about the researcher’s ring. She added that if the representatives could not recall any details then Panorama would write a letter stating that the police do not issue statements in Tunisia. She said that she did not want to jeopardise the insurance claim and would do something to help.

The next stage was a letter from Panorama (see pages 350-352) confirming that they did not have a record of the incident and that their representatives did not personally remember any details of the lost ring (this was not surprising because, of course, they had never been told). Panorama stated that because of this they were unable to issue a report, but they enclosed a letter which they felt would help the claim (see page 352). This confirmed the (quite untrue) claim that the representatives and the police had been contacted—and there was thus now some official documentation, as required by the insurers, to support this wholly manufactured story. Panorama, who were clearly keen to help a troubled customer, were also unwittingly helping to facilitate an insurance fraud.
It seemed difficult to see how the insurers could now avoid paying out on the claim: there was 'proof'. A letter was received from the insurance company confirming that they were in a position to proceed with the settlement (see page 355). However, they did stipulate that there was a £200 limit on all jewellery claims and a £30 excess charge. Although it was accepted that the ring was worth £875, the amount that the insurance company was prepared to pay was only £170; clearly this would have caused considerable irritation for most claimants in a similar position.

A cheque was issued for £170 and would have been paid (see pages 355-356). The insurers noted that before completion of the settlement it was sent through one final audit. The notes from the auditor are attached (see pages 357-359).

**Conclusion**

This project reinforced at least three major points. First, that insurance fraud is easy to commit and to get away with. It does not take a lot of expertise, and lends itself to opportunistic offenders. The need for the types of preventive measures outlined in this thesis become all the more urgent.

Second, some key people, often unwittingly, are willing to help (as discussed in Chapter Seven). In this mock example the travel operators adopted a very customer-friendly approach, but faced with some very plausible lies they provided all the confirmation that was needed to support a successful claim. Clearly, had there been
systems in place which detect inconsistencies—for instance, questions about times of visits to police stations, the name of the representative to whom the report was made, and the circumstances of the loss—then this claimant at least would have been put off.

Third, if this case is replicated elsewhere then honest policyholders have every justification in feeling angry with their insurer. If they never receive policy documentation (a point which was discussed in Chapter Five), and find out only after the event that they should have notified relevant authorities of their loss, then there can be little surprise that some people are angry and resentful. Moreover, where the sums they receive are much less than the value of the item lost because of policy restrictions, then there is fertile ground for resentment to fester (again this point is mentioned in Chapter Five), and people are provided with a motive for fraud.

1 When this point was discussed with the ABI before the holiday, they were adamant that an attempt to obtain police involvement would be viewed as wasting police time and was therefore to be avoided.

2 It is interesting to note that a copy of the travel insurance policy did not arrive until after the holiday, with the policyholder back in England (probably because the policy was issued specially). However, a copy of the actual insurance policy—the genuine one covering the holiday and paid for by the researcher—which should have been issued by the agent (Going Places) never arrived. Since in neither case—the policy for the mock fraud and the genuine policy covering the holiday—did the actual policy arrive, there was no way of being aware of the conditions, and this included the need to notify the police. This is an example of how frustration with insurers can arise.
30 March 1994

Andy Freebody
Chase Parkinson
PO Box 400
Weybridge
Surrey
KT15 3LU

Dear Mr Freebody,

I was pleased to have the opportunity to meet you at the ABI seminar on 11 of March. Since speaking with you I have been in contact with John Ludlow and have arranged to see him in early April. Not only did he seem enthusiastic about the plans but he spoke very knowledgeably about insurance fraud in general.

I am extremely excited about the whole concept of testing the claims system, and I am sure my PhD research will benefit from the findings. Equally it should be of interest to you and your firm to find out how easily it is for your clients to get away with insurance fraud.

I hope after this trial run to persuade other insurance companies to participate in the survey. It would then be possible to identify the weaknesses and strengths of several different systems. Ultimately the aim would be to identify screening systems.

Meanwhile I would like to thank you for all your help and I will keep you closely informed of my progress. Wish many best wishes.

Yours sincerely,

Karen A Mochrie
SPECIAL NOTE

This item is tightly bound and while every effort has been made to reproduce the centres force would result in damage.
Dear Miss Mochrie

I am pleased to enclose your travel insurance certificate and am sorry that we were unable to meet before your departure. I trust that the wedding went well, although as I do not know your married name, I have addressed the letter as above.

As agreed between ourselves and Andy Freebody of Chase Parkinson Limited, the purpose of the travel insurance is to test the system and the ease with which it is possible to submit a "fraudulent" claim. To that end, you will upon return from holiday be submitting such a claim and this letter confirms that I am aware of the situation and support your actions. Obviously, once the claim is finalised (whichever way that may be) I would like to meet to discuss your findings and, if a payment is made, it is agreed that you will refund it to the Company. I suggest you keep the original of this letter to ensure there are no unfortunate repercussions.

Yours sincerely

J R LUDLOW
CORPORATE UNDERWRITING SERVICES MANAGER
TRAVEL INSURANCE

Effected with and providing the security of

ECONOMIC INSURANCE Co Ltd

Managed by

CHASE PARKINSON LTD – TRAVEL INSURANCE SPECIALISTS

P.O. Box 400, Weybridge, Surrey KT15 3LU

Telephone: 0932 336655

<table>
<thead>
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<th>TICK BOX AS APPROPRIATE</th>
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<td>20.50</td>
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<th>MISS</th>
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Commencement (Date of Travel): 17/4/94
Period of Insurance (No. of Days): 14
Geographical Area: B
Date of Issue: 22-4-94

Issuing Branch: ECONOMIC SITTINGBOURNE

TOTAL: 20.50

COVER
- Cancellation
- Medical Expenses £2,000
- Repatriation £1,000,000
- Curtailment and Hospital Benefit £2,000
- Luggage and Personal Money £1,500
- Luggage Delay £1,000,000
- Personal Liability £15,000
- Personal Accident £150
- Loss of Passport £250
- Legal Expenses £10,000

(Additional) Delayed Departure £100
(Optional) Missed Departure £500

SUM INSURED

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<th>AREA A: UNITED KINGDOM &amp; Channel Islands</th>
<th>AREA B: EUROPE &amp; COUNTRIES BORDERING the Mediterranean Sea including Madeira, Canary Islands, Jordan &amp; Azores</th>
<th>AREA C: WORLDWIDE EXCLUDING USA &amp; CANADA other than stopovers not exceeding 2 nights in all</th>
<th>AREA D: WORLDWIDE including USA &amp; CANADA</th>
</tr>
</thead>
</table>

Period of Cover: In respect of Cancellation Cover from the date of premium receipt until the commencement of travel date. In respect of all other parts of Cover from the commencement of travel date from the U.K. until return home to the U.K. but not exceeding the Period of Insurance. In respect of one-way journeys cover will cease 24 hours after arrival at the final destination. In the event of the period of the journey being extended due to illness or injury of the Insured or their travelling companion this insurance is automatically extended until the insured is fit to return to the U.K. and until the insured has arrived home or been admitted into medical care in the U.K.

OPTION TO CANCEL
This is your insurance certificate - please read it carefully to ensure that it meets your requirements. In the event that it does not, you may cancel the insurance and receive a refund of the full premium paid, provided that:

a) At the time of cancellation you have not commenced the travel arrangements to which this certificate relates, nor have the travel arrangements been cancelled.
b) Such notice of cancellation is confirmed in writing to the Company who issued the insurance within 14 days of premium receipt.
c) Such notice shall immediately extinguish the insurance from the commencement of the period of cover and shall absolve Insurers of any liability hereunder.

EMERGENCY ASSISTANCE & REPATRIATION

In the event of death or in the event of injury or illness resulting in (i) HOSPITALISATION (ii) REPATRIATION (iii) ALTERATION IN TRAVEL PLANS immediate contact must be made with the emergency assistance service. When calling please state the identity and telephone number of the treating doctor and this insurance certificate no.

THE TRAVELLERS MEDICAL SERVICE
Telephone: 0798-43383
Telex: 878172
Fax: 0798 42164

CLAIMS must be notified immediately in writing to CHASE PARKINSON at the address shown above.
The Company will indemnify the insured up to the Sum Insured in respect of loss of deposits or cancellation charges levied for pre-booked transport and accommodation in the event of cancellation of the insured's travel plans in accordance with the terms of this policy. If any claim is made for damage, theft or loss of any temporary personal property other than baggage and personal effects, cash, bank or currency notes, travel tickets all being owned and taken to, from or during the period of the journey, the Insured shall be liable to produce receipts or other evidence of value and ownership wherever possible and in any event in respect of any item valued in excess of £100 where this is not done liability shall be limited to the intrinsic value of the property or where applicable to the cost of repair (where the property may be restored to its pre-loss condition).

2. Liability shall cease upon the return of the Insured to their place of domicile in the U.K. or upon attendance at a hospital abroad as an inpatient but not exceeding the Sum Insured.

3. The Company will not be liable in respect of the following:
   (i) The first £30 of each claim for each Insured person except claims for deposit where a £10 deductible applies
   (ii) Costs or expenses incurred in pursuance of any claim against a Tour Operator, Travel Agent, Insurer or Carrier
   (iii) Any claim where the Insured was not permitted to make a claim by the Company in the Insured's country of domicile
   (iv) Any claim where the Insured was not permitted to make a claim by the Company in the U.K.

4. Exclusions
   (i) The Company will not be liable in respect of the following:
      (a) Costs or expenses incurred in respect of repatriation to the U.K. (b) Any claim for which the Insured is responsible for damage to property or injury to any person
      (c) Any claim where the Insured is responsible for damage to property or injury to any person
      (d) Any claim arising from the insured party's own negligence or contributory negligence
      (e) Any claim arising from the insured party's own negligence or contributory negligence
      (f) Any claim arising from the insured party's own negligence or contributory negligence

5. Curtailment and Hospital Benefit
   In the event of the insured sustaining bodily injury arising wholly and exclusively from violence or accidental means which injury shall wholly and independently of any other cause result in higher death or disablement the Company hereby agrees to pay to the insured in the event of the insured sustaining such disablement an amount payable under this Section which shall be the lesser of (a) £50 per week or (b) the total compensation payable in respect of the disablement.

6. Legal Expenses
   (a) In the event of the insured sustaining such disablement the Company will not be liable in respect of the following:
      (i) Any claim for which the Insured is responsible for damage to property or injury to any person
      (ii) Any claim arising from the insured party's own negligence or contributory negligence
      (iii) Any claim arising from the insured party's own negligence or contributory negligence

7. Personal Accident
   In the event of the insured sustaining bodily injury arising wholly and exclusively from violence or accidental means which injury shall wholly and independently of any other cause result in higher death or disablement the Company hereby agrees to pay to the insured in the event of the insured sustaining such disablement an amount payable under this Section which shall be the lesser of (a) £50 per week or (b) the total compensation payable in respect of the disablement.

8. Table of Compensation
   (a) Death – 50%
   (b) Loss of one or more limbs or one or both eyes – 50%
   (c) Permanent total disablement – 100%

9. Exclusions
   (a) Loss of limb, loss by severance at or above the waist or anke or permanent total loss of use of an arm or leg
   (b) Loss of any existing reciprocal health care agreement and recover any refunds within that agreement to which the Insured is entitled
   (c) Furthermore the Insured (or their legal representative) hereby authorise the
   (d) Any claim made on the Insured's insurance with the Company in the Insured's country of domicile
   (e) Any claim made on the Insured's insurance with the Company in the U.K.

10. Cover for children aged under 2 is limited to Cancellation and Medical Repatriation expenses only.
May 12, 1994

Claims Department
Chase Parkinson Ltd
PO Box 400 Weybridge
Surrey
KT15 3LU

Dear Sir/Madam,

Please find enclosed my completed travel claims form. I also enclose my insurance certificate, my booking confirmation form and the receipt for my ring. I was unable to get a written report of the loss, because my loss occurred in the sea which was next to a public beach. I tried to find an official to help me search and later to confirm my loss but I was unable to find anyone who would do this.

I would be extremely grateful if you could deal with this matter at the earliest and return the documents enclosed when the matter is settled. If there is any further information that you need please do not hesitate to contact me.

Yours faithfully

Karen Mochrie
Please tick the appropriate box to indicate the type of claim(s) being made.

☐ CANCELLATION  ☐ TRAVEL DELAY  ☐ LUGGAGE & PERSONAL MONEY  ☐ MEDICAL EXPENSES

Name of Insured Person (Mr, Mrs, M/s, Ms) .........................................................

Age:.........................................Occupation ...................................................Nationality ..........................................

Passport Details: Number ........................................................Country of Issue ..........................................

Address to which correspondence shall be sent ............................................................

Telephone Number: Home ......................................................Work ..........................................

Name of Tour Operator ..............................................Name of Travel Agent ..........................................

Country ........................................................Resort ................................................Hotel ..........................................

Dates of Travel: From ..........................................To ..........................................

Please state your Insurance Certificate Number ..........................................

Have you made any other insurance claim in the last 5 years? YES/NO (Delete as Appropriate)

Please complete the appropriate section on the following pages and then sign the declaration below:-

I declare the information given in this form to be true and accurate and in respect of claims involving illness or injury I authorise Chase Parkinson to contact the doctor named within this form and/or my doctor in the UK for any information as may be required and authorise the release of such information to Chase Parkinson. Furthermore, and in respect of any claim, I agree, upon settlement, to transfer all rights of recovery and salvage to the Insurers.

Signed: ........................................................Date: ..........................................

PLEASE ENCLOSE WITH THIS FORM (Originals required, settlement cannot be made on photocopied documents)

CANCELLATION
YOUR INSURANCE CERTIFICATE
YOUR TRAVEL BOOKING CONFIRMATION
YOUR CANCELLATION INVOICE

TRAVEL DELAY
YOUR INSURANCE CERTIFICATE
YOUR TRAVEL BOOKING CONFIRMATION
A LETTER FROM THE AIRLINE (OR SIMILAR)
CONFIRMING THE PERIOD OF DELAY

LUGGAGE AND PERSONAL MONEY
YOUR INSURANCE CERTIFICATE
YOUR TRAVEL BOOKING CONFIRMATION
RECEIPTS OR OTHER EVIDENCE OF VALUE FOR THE ITEMS CLAIMED
A WRITTEN REPORT FROM THE PERSON/COMPANY TO WHOM THE LOSS/DAMAGE WAS REPORTED

MEDICAL EXPENSES
YOUR INSURANCE CERTIFICATE
YOUR TRAVEL BOOKING CONFIRMATION
RECEIPTS OR INVOICES FOR THE AMOUNTS CLAIMED

PLEASE SEND THIS COMPLETED CLAIMS FORM WITH THE ABOVE DOCUMENTS TO:-

CHASE PARKINSON LTD – TRAVEL INSURANCE SPECIALISTS

P.O. Box 400, Weybridge, Surrey KT15 3LU

Telephone: 0932 336655
### CANCELLATION

Names of all those cancelling and thus making a claim:

1. Name: ___________________________ Age: ________
2. Name: ___________________________ Age: ________
3. Name: ___________________________ Age: ________
4. Name: ___________________________ Age: ________
5. Name: ___________________________ Age: ________
6. Name: ___________________________ Age: ________

Date of Cancellation: ________________ Reason for Cancellation: ________________

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<th>Total Amount Paid to Date</th>
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| Amount of Refund from Travel Company | £ | Amount claimed (being the cancellation charges levied after such refund) | £ |

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<td>If your cancellation is for medical reasons the Doctors Certificate below will need to be completed and officially stamped by the sick person's General Practitioner or Hospital Consultant. In the event of death a copy of the Death Certificate will usually suffice but must be accompanied by the name and address of the deceased's doctor. In the event of redundancy an original letter must be produced from the employer confirming that the redundancy falls within the terms of the current Redundancy Act, along with the exact date of notification. An original letter notification from the Court is required regarding Jury Service attendance confirming the dates of notification and attendance.</td>
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**DOCTORS CERTIFICATE (to be completed by a Qualified Medical Practitioner)**

**IN RESPECT OF A CLAIM ARISING FROM ILLNESS OR INJURY**

Full name of Sick Person whose condition prevents the above journey taking place: ____________________________

Date of Birth: ________________ Specific Diagnosis: ____________________________

Date of onset of first symptoms of illness/injury: ____________________________

In your medical opinion what was the exact date that cancellation of the travel arrangements was required: ________________

Please give the reason why the travel arrangements were medically inadvisable: ________________

Has the patient suffered from the above condition before? YES/NO

If YES please give details: ____________________________

In the event of pregnancy state: 1. The E.D.D. ____________________________ 2. The L.M.P. ____________________________

Has there been a complication of the current pregnancy? YES/NO

If YES please give details: ____________________________

Signed: ____________________________ Date: ________________ Doctors Stamp to validate: ____________________________

---

### TRAVEL DELAY

Please list the names of all those delayed and thus making a claim:

1. Name: ___________________________ Age: ________
2. Name: ___________________________ Age: ________
3. Name: ___________________________ Age: ________
4. Name: ___________________________ Age: ________
5. Name: ___________________________ Age: ________
6. Name: ___________________________ Age: ________

Please give details of your original intended departure:

Date: ________________ Time: ________________ Departing From (Name of Airport or similar): ____________________________

Please give details of your actual departure after the delay:

Date: ________________ Time: ________________ Departing From (Name of Airport or similar): ____________________________

What was the reason for the delay? ____________________________

If you wish to provide fuller details please do so: ____________________________
LUGGAGE AND PERSONAL MONEY

Is the claim in respect of:  
- [ ] PERMANENT LOSS  
- [ ] TEMPORARY LOSS  
- [ ] DAMAGE  
(Tick as Appropriate)

When was your property last seen or known to be undamaged:  
Date: 26/14/94  
Time: 1:30  
Place: Beach

When did you discover the loss or damage:  
Date: 26/14/94  
Time: 1:45  
Place: Home

Where were you between the times: Swimming in the Sea

Was the property in your custody at the time of loss/damage?  YES/NO  
(Delete as Appropriate)

If NO please give details: ..............................................................

Have you reported the loss/damage?  YES/NO  
(Delete as Appropriate)

To whom: .................................................................  
Date: .................................................................  
Time: .................................................................

Have you been in subsequent contact with them concerning recovery?  YES/NO  
(Delete as Appropriate)

If YES please give details: ..............................................................

NOTE: A WRITTEN REPORT MUST BE SUPPLIED FROM THE PERSON OR COMPANY TO WHOM THE LOSS/DAMAGE WAS REPORTED TO CONFIRM THE LOSS/DAMAGE AND THE NON-RECOVERY.

Please provide full details concerning the circumstances of loss/damage: I had my engagement ring on my finger before swimming in the Sea. However when I got ashore, there was no sign of it. I swam in the sea and tried desperately to find it, but the water was very deep and I couldn't be sure if it was still in the Sea. I was like looking for a needle in a haystack...

Have you any other insurance covering this loss/damage?  YES/NO  
(Delete as Appropriate)

Name and address of your U.K. House Contents and All Risk Insurers: ................................................................. Policy No.

---

PLEASE LIST THE ITEMS FOR WHICH YOU WISH TO CLAIM AND ATTACH RECEIPTS OR OTHER EVIDENCE OF VALUE WHERE AVAILABLE

<table>
<thead>
<tr>
<th>NAME OF OWNER OF THE PROPERTY</th>
<th>DESCRIPTION OF ITEM</th>
<th>TICK AS APPROPRIATE</th>
<th>SHOP AND TOWN WHERE PURCHASED</th>
<th>DATE OF PURCHASE</th>
<th>PURCHASE PRICE</th>
<th>AMOUNT CLAIMED</th>
<th>TICK AS APPROPRIATE</th>
<th>EVIDENCE OF VALUE</th>
<th>FOR OFFICE USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>K. Machin</td>
<td>18ct 3 stone Sapphire and diamond ring</td>
<td>✔</td>
<td>Pearce and Sons, Leicester</td>
<td>26/14/94</td>
<td>£875</td>
<td>£875</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL

340
Name of sick or injured person

Nature of injury/illness

If injury, how did it occur? 

If illness, have you suffered from this condition previously? YES/NO

If YES please give details

Name and address of the Doctor who treated you abroad

Date of Treatment: From: To:

If hospitalised please state: Date of admission Date of discharge

Name and address of hospital

Did you return to the U.K. on your intended date? YES/NO

If NO please give details including the names of any persons who accompanied you

Did you call our 24 hour MEDICAL ASSISTANCE SERVICE? YES/NO

PLEASE LIST THE ITEMS FOR WHICH YOU WISH TO CLAIM AND ATTACH THE RECEIPTS/INVOICES

<table>
<thead>
<tr>
<th>DATE OF SERVICE</th>
<th>NAME OF DOCTOR OR DETAILS OF THE SERVICE PROVIDED</th>
<th>AMOUNT</th>
<th>HAVE YOU PAID OR IS THE AMOUNT STILL OWING TO THE SUPPLIER</th>
</tr>
</thead>
</table>

Are you a member of a Private Health Insurance Plan? YES/NO

If YES please state the name of the Company and the Policy No. if known

Do you have any other insurance covering the expenses listed above? YES/NO

If YES, please give details

341
<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Initials</th>
<th>RECEIPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs. McBride</td>
<td>28/6/40</td>
<td>SJD</td>
<td>No. 32385 J</td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Stanfield Rd</td>
<td></td>
<td>Clarendon Park</td>
<td>Leicester</td>
</tr>
<tr>
<td>Description</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18ct Sapph Di Ring</td>
<td></td>
<td>N/Sale</td>
<td></td>
</tr>
<tr>
<td>Instruction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIZE TO I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postcard</td>
<td>Telephone</td>
<td>Post</td>
<td></td>
</tr>
<tr>
<td>Work Done</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£875.00</td>
<td></td>
<td>ALL PAID</td>
<td></td>
</tr>
<tr>
<td>Repaired</td>
<td>Invoice No.</td>
<td>Completed</td>
<td>C/P</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

PEARCE & SONS LTD.
7 & 9 MARKET PLACE
LEICESTER
Tel.: LEICESTER 518935

342
Dear Sirs

Please provide our customer(s) with every assistance for their holiday arrangements.

NAME OF CARRIER OR HOLIDAY COMPANY: Panorama Holidays
BOOKING REFERENCE: 252872

CUSTOMER FLIGHT DETAILS:

Outward Date: 17/APR/94
From/To: LONDON GATWICK/MONASTIR
Flight Number: AMM488
Dep/Arr: 1640/1925

Returning From/To: MONASTIR/LONDON GATWICK
Flight Number: MON3621
Dep/Arr: 2040/2325

ACCOMMODATION DETAILS:

Hotel: Diar El Andalous
Resort: Port El Kantaoui

Miss Mochrie has paid in full for these arrangements. Please extend every courtesy and assistance to Miss Mochrie, who is an important Going Places customer.

Yours faithfully

MANAGER
DRAMA 08APR94 0341 40b
RIEVE BOOKING: MISS K MOCHRIE
EATS LONDON GATWICK NORTH TERMINAL
17APR94 LGW/MIR 1640/1925 1770 14NT
01MAY94 MIR/LGW 2040/2325 TUDI
R EL ANDALOUS #1076 BB
T EL KANTAQUI 5*/P42
TWIN3 PB WC BAL CS

int: GOING PLACES ref: ALI
a : A999X Booking Reference: 252872
FINERED

Please ensure clients read our Booking Conditions & sign our Booking Form.

▼ 4 DATA ▼ 2 DISPLAY ▼ 3 INDEX ▼ 5 ▼ 6 ▼ 7 ▼ 8 ▼ 9 ▼ 0

Going Places Leisure Travel Ltd. Registered Office: Wavell House, Holcombe Road, Helmshore, Rossendale, Lancashire BB4 4NB
ABTA number 47064 ATOL number 1179 Registered in England number 102630 Going Places is part of Airtours plc

344
CONFIRM TRAVEL MISS K MOCHRIE

Please collect the total holiday cost. Tickets can be collected from our Representative at the check-in desk.

OUTWARD (Local time)

Depart: LONDON GATWICK NORTH TERMINAL
Checkin: 17APR94 AT 1440 HRS
Takeoff: 17APR94 AT 1640 HRS
Arrive: 17APR94 AT 1925 HRS
At: MONASTIR
Fit No.: AMM488

RETURN (Local time)

Depart: MONASTIR
Checkin: 01MAY94 AT 1840 HRS
Takeoff: 01MAY94 AT 2040 HRS
Arrive: 01MAY94 AT 2325 HRS
At: LONDON GATWICK SOUTH TERMINAL
Fit No.: MON3621

Confirm return timings in resort.

KEY 1 TO CONFIRM —
<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Price x 2</td>
<td>£898.00</td>
</tr>
<tr>
<td>Meal Supplements</td>
<td>£168.00</td>
</tr>
<tr>
<td>Flight Supplement</td>
<td>£10.00</td>
</tr>
</tbody>
</table>

**Total, guarantee no surcharge**: £1076.00

**Payments Received**: £0.00

**EY 1 CONFIRM 2 AGENT DATA**
Dear Ms Mochrie,

We acknowledge receipt of your completed claims form, with the attached documentation, the content of which we note.

It is warranted under the terms of the policy that in the event of any loss or damage, the Police or similar authority must be notified, and in the event of submitting a claim, a written report must be provided from that independent authority, confirming that the loss occurred during the period of insurance.

As you will appreciate, the policy is only operative for a short period of time, and therefore, independent written confirmation must be supplied to confirm that the loss occurred during the period that our Underwriters were "on risk".

We note, with regret, that you are unable to comply with these policy conditions, and as a result, we are unable to consider your claim further on this occasion.

May we respectfully suggest that if the item in question is insured under your Household policy, that you approach the company concerned as they may be in a position to assist you further.

Yours sincerely

[Signature]

for and on behalf of
Chase Parkinson Limited
5 July 1994

Claims Department
Chase Parkinson Ltd
PO Box 400 Weybridge
Surrey
KT15 3LU

Dear Sir/Madam,

RE: Claim Reference R/NS/94/21848

I was extremely upset and angry with your letter of 16 May 1994. During the course of my honeymoon in April, I unfortunately lost my engagement ring in the sea. Not only was the loss of my ring very upsetting, having great sentimental value, but to be told that my claim is not going to be honoured by yourselves makes be very angry. I have complied as far as I can with your policy requirements, by providing you with my insurance certificate, my booking confirmation form and the receipt for the ring. I went to the authorities in Tunisia and told them of my loss however they were very unhelpful and unconcerned. Since your letter I have written to them asking them to provide me with documentation confirming that I visited the police station and asking to confirm my loss. I have yet to hear from them.

My honey moon was turned into a nightmare because of my loss, and now I find that a policy that I purchased in good faith is not being honoured. You can be rest assured I am certainly not going to let the matter drop. I look forward to hearing from you.

Yours faithfully

Karen Mochrie
Dear Ms Mochrie,

We acknowledge receipt of your recent correspondence, the content of which we note.

We would confirm to you, that our further consideration will be given to this matter, upon receipt of documentary evidence from an independent party, confirming that the loss occurred during the period of insurance.

We note that you are currently contacting the authorities in Tunisia, and look forward to hearing from you in the near future.

We would, however, advise you, once again, that we are not doubting your integrity in this matter, however, our Underwriters must receive documentary proof, to confirm that the loss occurred during the period that they were "on risk".

Assuring you of our best attention at all times.

Yours sincerely

[Signature]

For and on behalf of
Chase Parkinson Limited

18/07/94

Ms K Mochrie
39 Craighill Road
Knighton
Leicester
LE2 3FD

Our Claim Ref: K/NS/94/21848

Please quote the above Claims reference on all correspondence
25 August 1994

Claims Department
Chase Parkinson Ltd
PO Box 400 Weybridge
Surrey
KT15 3LU

Dear Sir/Madam,

RE: Claim Reference R/NS/94/21848

I have been in contact with Panorama (the company that I travelled on holiday with). They have written a letter confirming the loss of my ring during my holiday in Tunisia. Please find enclosed a copy.

Should you require any further information please do not hesitate to contact me. Meanwhile I would be most grateful if you would deal with this matter as soon as possible.

Yours faithfully

Karen Mochrie
Dear Mrs Gill

We refer to our telephone conversation regarding your lost ring and we have contacted our local resort office about this.

Unfortunately Karen does not personally remember this although looking through both our resort office and our own filing we do have another very similar case of a ring lost swimming in the sea.

Although we are unable to issue a report we are enclosing with this letter a To Whom It May Concern letter which we hope will be of assistance to you in claiming from the insurance company but please contact us again if we can be of any further assistance.

Yours sincerely

[Signature]

Susan Guaracino
Customer Relations Manager

Enc
To Whom It May Concern

Mrs. Gill travelled to Tunisia on 17th April 1994 booking reference number 252872. During the holiday Mrs. Gill lost a ring and reported this verbally to Panorama’s resort representative and she also reported it to the police station in Sousse. In Tunisia the police will never make a report unless there is firm evidence of theft and criminal activity and even in the cases when they make a report this is never issued without court order as it becomes, under Tunisian law, the property of the Tunisian procurator general.

Yours faithfully

[Signature]

Susan Guaracino
Customer Relations Manager
30 August 1994

Ms K Mochrie
39 Craighill Road
Knighton
Leicester
LE2 3FD

Dear Ms Mochrie

We acknowledge receipt of your recent correspondence, and note the attached letter from the Panorama Hotel Group.

We are therefore pleased to advise that we are prepared on this occasion, to reconsider your claim for the loss of your engagement ring.

However, before we may proceed further would you please confirm to us whether there is a household insurance policy enforce in respect of your U.K. residence.

If such a policy has been effected, could you kindly forward a copy of the policy schedule, this must also confirm as to whether any items have been specifically specified under its cover.

Upon receipt of the above we will be in a position to advise you accordingly.

Yours sincerely

Maurice

for and on behalf of
Chase Parkinson Limited

JL/SP
25 August 1994

Claims Department
Chase Parkinson Ltd
PO Box 400 Weybridge
Surrey
KT15 3LU

Dear Sir/Madam,

RE: Claim Reference R/NS/94/21848

As requested I am writing to confirm that I do not have a household insurance policy with respect to my UK residence.

Should you require further information please contact me.

Yours faithfully

Karen Mochrie
8th September, 1994

Miss K Mochrie
39, Craighill Road
Knighton
Leicester
LE2 3FD

Dear Miss Mochrie,

We acknowledge receipt of your recent correspondence, the content of which we note.

We are, therefore, pleased to advise that we are in a position to proceed towards the settlement of your claim.

Whilst we fully appreciate the circumstances pertaining to the claim, we would wish to advise that within the terms and conditions of the travel insurance policy issued to you, a £200 limit applies in respect of all jewellery. We have, therefore, applied this limit accordingly.

Hence, please find enclosed a Company payment in the sum of £170, this figure being net of the £30 excess applicable under the terms of the policy.

We are pleased to have been of assistance on this occasion.

Yours sincerely

for and on behalf of
Chase Parkinson Ltd

Encl.

JL/YF
Amount in words (rounds)

HUNDRED

THOUSANDS

HUNDREDS

TENS

UNITS

Claimed by

Chase Parkinson Ltd.

Claims Account - E.C.

K M O C H I E

Chase

23 Hanover Square London WIA 4YB

180014

9 September 1994

or Order

£

n 170 00

1041451
1) DONT LIKE THIS.
DONT KNOW WHY.

2) HOW DID A "RESIDENT"
LIVING IN (RED CARPET
WALL) OF INS'D WITH
SITTING SUNKIN.

3) STAFF INVOLVED??
GRAVELY PANS.

5) MORE INQUIRIES
- CREDIT CHEC
- ASK CC - HOW
- I AM NOT HOUSE POOL.

6) FIRST PLANTED PANAMA
- HOLE WAS A "HONEYMOON" FOR
A DR. CILL & MISS MARIE
SO WHY INS'G 1 PERSON
WITH CC - "TOGETHERNESS"

7) PANAMA SAY ERF.
= ALL 4 THEY HAVE NO
09/09/94

Ms K Mochrie
39 Craighill Road
Knighton
Leicester
LE2 3FD

Dear Karen,

You win!

Will you be at the next T.I.C.C. meeting?

If not, I am interested to know the manner in which you obtained the report from the tour operator, and how honest it is.

If there is any further help I can give, do not hesitate to contact me.

Yours sincerely,

Andrew Freebody
09/09/94

Ms K Mochrie
39 Craighill Road
Knighton
Leicester
LE2 3FD

Dear Karen,

I am writing in connection with the research experiment we agreed you would undertake by submitting a fraudulent claim against us.

I feel that at the present time we may have to call it a draw.

I am now enclosing a copy of the settlement letter that was ready to be sent to you along with a copy of the cheque that was drawn.

I am also enclosing a copy of the letter I had prepared to send to you.

However before any cheque is signed and sent in settlement of a claim, the file goes through one final audit. In connection with this I am enclosing a photostat copy of the auditors notes on the claim detailing his feelings, the enquiries he has made and the course of action that he would now like us to follow.

We will unfortunately never know what his attitude to your claim would have been if you had obtained the insurance from your local travel agent.

At least you had defeated the usual claims handling staff, and therefore any other company that did not utilise a system such as ours would have settled your claim.

Will you be at the next T.I.C.C. meeting?

If not I would be interested to know whether the report from the tour company was obtained from them with the knowledge of the research you are undertaking and if not, whether the report is honest in its statements?

I hope to see you soon, and if not wish you well with your research.

Yours sincerely,

Andy Freebody

P.S. The receipt for your ring is encloesd.
Appendix B
We are currently conducting research into insurance at the University of Leicester, your help with filling in this questionnaire would be most appreciated. It is an independent enquiry. All information will be treated in the strictest confidence. It will not be possible to identify individual respondents, nor do we wish to do so. The questionnaire will only take 10 minutes of your time.

SECTION ONE: TRAVEL INSURANCE

I would firstly like to ask you a few questions about travel insurance.

1. Thinking back, have you EVER taken out travel insurance to travel within this country or abroad?

   Yes  □  No □  Not sure □

   If no, or not sure please go to question 16.

2. If yes, have you EVER made a claim on your travel insurance?

   Yes □  No □  Not sure □

   If no, or not sure please go to question 16.

   a. If yes, how many times have you claimed through your travel insurance policy?

      ............................................................................................................................

   b. When did you last claim through your travel insurance policy?
      (Please give year)

      ............................................................................................................................

3. Being specific, on the last occasion did you claim for any of the following? (Please tick more than one option if appropriate)

   a. Theft □
   b. Loss □
   c. Damage □
   d. Other (Please state)

      ............................................................................................................................
4. Being more specific, on the last occasion what exactly did you claim for?
   (please tick more than one option if appropriate)
   - Watch  
   - Camera  
   - Money  
   - Travellers Cheques  
   - Cash Card/Credit card  
   - Cheque book  
   - Jewellery  
   - Other (Please state)
   
   a. Could you please state the monetary value of your claim?
   
   b. Could you give a brief description of the incident that led to your claim?

5. Did you notify the police?
   - Yes  
   - No  
   - Not sure/can't remember

6. How much, or what did you receive from your insurer, if anything?
   (please give monetary value)

7. If the amount, or what you received from your insurer was different to what you initially claimed for, why?
9. How did you decide on the value of your travel insurance claim? (please tick more than one option if appropriate)

Tried to make an accurate guess
From receipts
Asked for advice (Please state where from)
Made it up
Other (Please state)

10. Did you have to pay an excess? (For example, some policies require you to pay the first £30 of your claim. This is what we mean by excess)

Yes □ No □ Not sure □ No, because my claim was unsuccessful □

a. If yes, please state how much?

11. If you paid an excess, did you claim for more to cover this?

Yes □ No □ Not sure □

a. If yes, please state why?

b. If yes, please state why?

12. When you claimed through your travel insurance, did you make a claim for a greater amount than was actually lost, stolen or damaged?

Yes □ No □ Not sure □

a. If yes, please state how much more?

b. If yes, please state why?
13. As far as you are aware, were you totally honest with your insurance company?

Yes ☐  No ☐  Not sure ☐

a. If no, please state why?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

14. Did someone from your insurance company question you in depth about your claim?

Yes ☐  No ☐  Not sure ☐

a. If yes, please state why?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

15. What was the outcome of your claim? (Please tick)

I received what I wanted ☐
I did not get what I wanted ☐
I received what was fair ☐
I withdrew my claim ☐
Other (Please state) ☐

........................................................................................................................................
SECTION TWO: HOME INSURANCE

I would now like to ask you a few questions about home insurance, the questions relate to both building and contents insurance.

16. As far as you can recall, have you or your family EVER taken out a home insurance policy?
   Yes  □  No  □  Not sure  □

   If no or not sure please go to question 33.

17. If yes, how long have you or your family held a home insurance policy? (please tick)
   1 year  □
   1 - 5 years  □
   6 - 10 years  □
   As long as I can remember  □
   Not sure  □

18. Does your home insurance policy offer you the opportunity to gain a no claims bonus?
   Yes  □  No  □  Not sure  □

   a. Would you think twice before claiming if you had a no claims bonus?
   Yes  □  No  □  Not sure  □

   b. Please state why?
   ............................................................................................................................
   ............................................................................................................................
   ............................................................................................................................

   22  23  24  25  26  27  28  364
19. Have you **EVER** made a claim on your home insurance policy?

Yes □  No □  Not sure □

If no or not sure please go to question 33.

a. If yes, how many times have you claimed through your home insurance policy?

b. When did you last claim through your home insurance policy? (Please give year)

20. **Being specific**, on the last occasion did you claim for any of the following on your home insurance policy? (Please tick more than one option if appropriate)

a. Theft □  c. Loss □

b. Damage □  d. Other (Please state)

21. **Being more specific**, on the last occasion what exactly did you claim for? (please tick more than one option if appropriate).

<table>
<thead>
<tr>
<th>Television</th>
<th>Computer equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video recorder</td>
<td>Structural damage</td>
</tr>
<tr>
<td>Jewellery</td>
<td>Furniture damage</td>
</tr>
<tr>
<td>Money</td>
<td>Medical treatment</td>
</tr>
<tr>
<td>Hi-Fi / Sterio</td>
<td>Injury</td>
</tr>
<tr>
<td>Camera</td>
<td>Other (Please specify)</td>
</tr>
</tbody>
</table>
| Camcorder | .................................

a. Could you please state the monetary value of your claim?

b. Could you give a brief description of the incident that led to your claim?

| ............................................................................................................. |
| ............................................................................................................. |
| ............................................................................................................. |
| ............................................................................................................. |
23. Did you notify the police?

Yes □  No □  Not sure/can't remember □

24. How much, or what did you receive from your insurer, if anything? (please give monetary value)

........................................................................................................................................................................................................................................

25. If the amount, or what you received from your insurer was different to what you initially claimed for, why?

........................................................................................................................................................................................................................................

26. How did you decide on the value of your claim? (Please tick more than one option if appropriate)

Tried to make an accurate guess □
From receipts □
Asked for advice (please state where from) □
Made it up □
Other (Please state)
........................................................................................................................................................................................................................................

27. Did you have to pay an excess? (For example, some policies require you to pay the first £30 of your claim. This is what we mean by excess)

Yes □  No □  Not sure □  No, because my claim was unsuccessful □

a) If yes, please state how much?

........................................................................................................................................................................................................................................

28. If you paid an excess, did you claim for more to cover this?

Yes □  No □  Not sure □

a. If yes, please state why?

........................................................................................................................................................................................................................................

........................................................................................................................................................................................................................................
29. When you claimed through your home insurance policy, did you make a claim for a greater amount than was actually lost, stolen or damaged?

Yes □ No □ Not sure □

a) If yes, how much more?
....................................................................................................................

b) If yes, please state why?
....................................................................................................................
....................................................................................................................
....................................................................................................................

30. As far as you were aware, were you totally honest with your insurance company?

Yes □ No □ Not sure □

a. If no, please state why?
....................................................................................................................
....................................................................................................................
....................................................................................................................

31. Did someone from your insurance company question you in depth about your claim?

Yes □ No □ Not sure □

a. If yes, please state why?
....................................................................................................................
....................................................................................................................
....................................................................................................................

32. What was the outcome of your claim? (Please tick)

I received what I wanted □
I did not get what I wanted □
I received what was fair □
I withdrew my claim □
Other (Please state) □
....................................................................................................................
Thinking of insurance in general, do you know anyone who has successfully:

33. Increased the value of an insurance claim to receive extra money, goods or services?
   Yes ☐ No ☐ Not sure ☐

34. Added more items than was lost, stolen or damaged to their insurance claim?
   Yes ☐ No ☐ Not sure ☐

35. Claimed through several insurance policies for the same items that were lost, stolen or damaged?
   Yes ☐ No ☐ Not sure ☐

36. Made up an insurance claim to receive money, goods or services?
   Yes ☐ No ☐ Not sure ☐

If you would like to make any comments, please do so below.

..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
I would now like to ask for your opinions about the following questions.
(Please circle your choice)

On a scale of 1-5 state whether you:

1. Strongly disagree.
2. Disagree.
3. Can't decide.
4. Agree.
5. Strongly agree.

37. There is nothing wrong with deliberately taking a chocolate bar from a shop without paying for it.

38. There is nothing wrong with borrowing £5 from a neighbour knowing that you will never give it back to them.

39. It is acceptable to increase the value of an insurance claim in order to cover the excess. (For example, some policies require you to pay the first £30 of your claim. This is what we mean by excess)

40. There is nothing wrong if a person does not declare all their income to the Inland Revenue.

41. It is acceptable for a person to claim twice, (through different insurance policies) for the same item.

42. There is nothing wrong in picking up and keeping a £5 note that you saw someone else drop.

43. It is acceptable to increase the value of an insurance claim in order to cover the excess and gain extra money from the insurance company.

44. There is nothing wrong with making personal local telephone calls from work.

45. There is nothing wrong with inventing a totally fictitious claim in order to gain money from an insurance company.

46. It is sometimes acceptable to travel on public transport without paying the fare.
47. There is nothing wrong with borrowing £100 from a neighbour knowing that you will never return the money.

48. There is nothing wrong with a bar steward purposely overcharging a person 20p for drink.
I would now like to ask you a few questions about yourself before coming to the end of the questionnaire.

49. Please tick one of the following.

Male □ Female □

50. How do you regard yourself? (Please tick one of the following)

White European □
African/Caribbean □
Oriental □
Asian □

Other (Please state) .................................................................

51. How old are you?
............................................................................................

52. What is your marital status?

Married/Living with a partner □
Separated/Divorced □
Widowed □
Single □

53. Are you:

a. Retired □
b. Unemployed □
c. A student □
d. Employed □

If Employed please state your occupation ......................................

e. Other (Please state)
............................................................................................

54. Which country do you live in? (Please state)
............................................................................................

Thank you for assisting me with the questionnaire.
4. How many cases of fraud conducted against your organisation have been taken to court in the following areas of insurance over the last 12 months? (If none please state none).

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel</td>
</tr>
<tr>
<td>Home (structure and contents)</td>
</tr>
<tr>
<td>Commercial</td>
</tr>
<tr>
<td>Other (Please state)</td>
</tr>
</tbody>
</table>

5. Do you believe there is a significant problem of non-disclosure of previous claims when new proposals are made?

<table>
<thead>
<tr>
<th>Very Significant</th>
<th>Moderately Significant</th>
<th>Not at all Significant</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Do you believe that there is a significant problem of policyholders fraudulently claiming on more than one insurer for the same loss?

<table>
<thead>
<tr>
<th>Very Significant</th>
<th>Moderately Significant</th>
<th>Not at all Significant</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Does your company have a special unit or department that tackles fraud?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If yes please give number of staff in the department</td>
</tr>
</tbody>
</table>

Please give details/Reasons:

---

3. Has the amount of fraud attempted by policyholders against your company in the last 12 months, compared with the previous year (please tick):

<table>
<thead>
<tr>
<th>Increased</th>
<th>Decreased</th>
<th>Stayed about the same</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. Do any of the following staff routinely receive specialist training in detecting and dealing with insurance fraud?

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underwriting staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other staff (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please briefly describe the training received

9. Does your company sell any of the following types of insurance (please tick)

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home (structure and contents)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Would you be prepared to participate in a more in-depth and confidential survey of insurance fraud?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes could you please provide me with the name and contact address of person within your organisation who would be willing to help with further details. I am more than willing to provide you with a complementary copy of my findings when they are available.

Could you send me any company policy documents or any material (other than ABI material on fraud) that you have on insurance fraud? These will be treated with complete confidentiality.

Please write any comments that you may have below:

Thank you for participating in this survey.

Please return the questionnaire to:

Karen Mochrie Gill
C. S.P.O.
University of Leicester
The Friars, 154 Upper New Walk,
Leicester LE1 7QA.
What sort of Policies to you sell

**FRAUD**

Do you believe you have a problem with fraud

How big do you think the problem is

Why

**SPECIALIST UNIT THAT TACKLES FRAUD**

**ORGANISATION CHART**

**RECORDS**

How Long do you keep proposal documents

How long do you keep records of claims

How do you keep your records

Do you keep records of Fraud and Suspected frauds

How do you keep your records.

**DETECT FRAUD**

How do you detect fraud

Who usually detects fraud

How is it dealt with

**INVESTIGATING FRAUD**

Do you or your department Investigate fraud

How

**PREVENTION**

Do you have any measures to Prevent Fraud

**PROSECUTION**

**CUE**

**OUTSIDE AGENCIES WHO HELP (LOSS ADJUSTERS)**
Aims and Objectives of the research

Before preventative policies can be implemented it is necessary to understand the causes, motives and patterns of fraudulent behaviour. The purpose of this research is therefore to evaluate the types of frauds that are suffered by insurance companies; to identify the behaviour of offenders and the methods they use; and to develop fraud preventative policies directed toward the insurance industry.

Background

Apart from small studies by Clarke (1989) and Litton (1990) very little academic research has been conducted in the field of insurance fraud. It has been suggested that fraudulent claims cost the Industry £400 million in 1991 and overall it is believed that close to two per cent of claims are bogus and ten per cent inflated (ABI, 1992, Crime-Check). A survey conducted by the Chartered Institute of Loss Adjusters found that nearly a half of all members interviewed believed that at least 50 per cent of all domestic claims were 'knowingly inflated'.

Nothing however is known about the true extent of fraud, who the perpetrators are and circumstances in which it is committed. The research conducted for this PhD intends to be the first major in depth study of its kind within this field.

Methodological Approach

- Literature Review
- Analysis and evaluation of insurance companies' policy towards prevention, detection and investigation of insurance fraud.
- Survey of the public to ascertain attitudes and experience of insurance fraud.
- Interviews and participant observation with personnel in the insurance industry.
- Interviews and participant observation with loss adjusters and others who investigate insurance fraud.
- Case studies of insurance fraud.
- Interviews with the police and others in the criminal justice system.

Overview

The research is funded by the Association of British Insurers, a body which protects and promotes the interest of its members in the insurance industry (there are 450 members who account for over 90 per cent of the world-wide business of the UK insurance market).

This study will compare and examine travel, home and commercial insurance frauds with the intention of identifying the scale, types, patterns, methods and motives. The research will look at societal and company responses with a view to establishing methods of detection, investigation and prevention of insurance fraud.

For further details contact:

Karen Mochrie Gill
C.S.P.O.
University of Leicester
The Friars, 154 Upper New Walk
LEICESTER LE1 7QA
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London: Mintel.


Munich Reinsurance Company (undated a) *Insurance Fraud in Indemnity Insurance*. Munich: Munich Reinsurance Co.

Munich Reinsurance Company (undated b) *Insurance Fraud*. Munich: Munich Reinsurance Co.


Lunchtime talk, CII, London. 30th April.


Insurance: Analysis of The Situation, Causes and Influences. Etudes et Dossiers


Psychology Today. Vol. 5, pp 22, 24, 26, 64.