Countering Fraud in the Insurance Industry:
A Case Study of Malaysia

Mudzamir Mohamed

The thesis is submitted in partial fulfilment of the requirements for the award of
the degree of Doctor of Philosophy of the University of Portsmouth

September 2013
Institute of Criminal Justice Studies
AUTHOR’S DECLARATION OF ORIGINALITY

I hereby certify that I am the sole author of this thesis. I also certify that, to the best of my knowledge, my thesis does not infringe upon anyone’s copyright nor violate any proprietary rights and that any ideas, techniques, quotations, or any other material from the work of other people included in my thesis, published or otherwise, are fully acknowledged in accordance with the standard referencing practices.

I declare that this is a true copy of my thesis, including any final revisions, as approved by University appointed committee and the ICJS office, and that this thesis has not been submitted for others higher degree to any other University or Institution.

Signature : [Signature]
Name : Mudzamir Mohamed
Date : 18/09/2013
ACKNOWLEDGEMENTS

I wish to express my sincere appreciation for the unlimited support in my thesis from my supervisor, Prof. Mark Button. His non-stop motivational support for academic and personal matters kept me on the track for completing this doctoral study. I should also not forget my other supervisor, Graham Brooks for the ideas that enhanced the quality of my writing throughout the process. I believe that my colleagues and fellow academics in School of Accountancy, University Utara Malaysia did moreover, make contributions with comments for the improvement of the quality of the thesis, especially Prof. Kamil, Prof. Mahamad, Dr Zuaini, Dr Noraziah, Arbi, Dr. Norzalina and Dr. Rosli.

There is also some special person that has been supportive during conducting this research who is not to be forgotten. Thanks to those respondents who spent their precious time during interviews and my observation visits; I really appreciated it in depth; thanks as well to my other fellow friends who contribute for the motivational factors; Pravin, Dr Khalil, Ridzuan, Azizi, Miss Harizam, Shahril & Tan. Without the help from them, this project would not have been undertaken.

My family also deserves special attention for their courage and support. Thanks to my beloved wife and my mother who highly understands the time spent on the project. Unlimited thanks for my late father who passed away during this research that was the most influential person in my life. Without his support, I would have been unable to achieve this stage, and I will always remember your courage dad.
ABSTRACT

Insurance fraud is noted as one of the most significant challenges to the financial stability of the insurance market (Wells, 2011; Yusuf & Babalola, 2009). The main purpose of this study is to explore and access the magnitude of the issues in a company setting and gather responses from the general environment regarding this threat. Due to the Malaysian cultural set up, there are gaps of research in this topic as fraud issues are considered sensitive and taboo. Although some researchers have shed some light on issues pertaining to fraud in Malaysia, however these studies have focused purely on mitigation and countering in the economic dimension without making relationship with authorities concerned.

This study looks to support the idea of Malaysia’s current Prime Minister, Dato Mohd Najib Tun Razak, which are encompassed in the 'Economic Transformation Plan'. During the start of his Prime Minister role he urged all sectors to be more transparent and responsive. Besides, the pattern of an economic downturn for a second wave in 2008 demanded the insurers to offer fewer products or services, and at the same time be more stringent on the policy inclusions (Bank Negara Malaysia (BNM), 2010).

This research has examined a broad volume of articles from specific areas of fraud including cases of insurance fraud. This is done to grasp the fraud control strategies and the current trends in Malaysia. This research applies multiple research methods that comprise of interviews', observations and document inspections within the selected companies. This to facilitate the coherence and collaborative work of the authorities selected in the case study which are crucial in evaluating the process of countering fraud. In order to ensure the success of this study, it utilized and adopted the CIPFA Red Book 2 as the main benchmark to gauge the initiatives of countering fraud in the Malaysian insurance industry.

The findings of the study revealed that there are two companies integrating good initiatives which enable them to avoid insurance fraud cases to a greater extent. However, one of the
companies did not address the issues entirely as the operation of the working environment is atypical. All professionals agreed upon that this task, countering fraud and corruption, demands a certain set of skills. By that, this advocates the idea that countering fraud initiatives are not for a single performer imposition only.

On the contrasting side, due to the hierarchy and supremacy in Malaysia, Bank Negara Malaysia (BNM) plays a vital role in the insurance market. However, they are still unwilling in making these concerns part of the national agenda since many companies have only recorded a satisfactory level in integrating the functions of combating fraud. However, specialists have urged some officials and relevant authorities, insurers and professionals in making precise arrangements to embark on the issues in an appropriate process.
**FORM UPR16**  
Research Ethics Review Checklist

Please complete and return the form to Research Section, Quality Management Division, Academic Registry, University House, with your thesis, prior to examination

<table>
<thead>
<tr>
<th>Postgraduate Research Student (PGRS) Information</th>
<th>Student ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidate Name: MUZAMIR MOHAMMED</td>
<td>435068</td>
</tr>
<tr>
<td>Department: ICJS</td>
<td></td>
</tr>
<tr>
<td>First Supervisor: MARK BUTTON</td>
<td></td>
</tr>
<tr>
<td>Start Date: 29 SEPTEMBER 2008</td>
<td></td>
</tr>
</tbody>
</table>

Start Date: (or progression date for Prof Doc students)

<table>
<thead>
<tr>
<th>Study Mode and Route:</th>
<th>Part-time</th>
<th>MPhil</th>
<th>Integrated Doctorate (New Route)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prof Doc (PD)</td>
</tr>
</tbody>
</table>

| Title of Thesis: Countering Fraud in the Insurance Industry: A Case Study of Malaysia |

<table>
<thead>
<tr>
<th>Thesis Word Count:</th>
<th>79,474 words</th>
</tr>
</thead>
</table>

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University's Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study.

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

**UKRIO Finished Research Checklist:**  
(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: http://www.ukrio.org/what-we-do/code-of-practice-for-research)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Have all of your research and findings been reported accurately, honestly and within a reasonable time frame?</td>
<td>YES/NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td>Have all contributions to knowledge been acknowledged?</td>
<td>YES/NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td>Have you complied with all agreements relating to intellectual property, publication and authorship?</td>
<td>YES/NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td>Has your research data been retained in a secure and accessible form and will it remain so for the required duration?</td>
<td>YES/NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e)</td>
<td>Does your research comply with all legal, ethical, and contractual requirements?</td>
<td>YES/NO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Delete as appropriate

**UPR 16 (2013) – November 2013**
Candidate Statement:

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

<table>
<thead>
<tr>
<th>Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):</th>
<th>11/12:14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed:</td>
<td>(Student)</td>
</tr>
<tr>
<td>Date:</td>
<td>31/1/2014</td>
</tr>
</tbody>
</table>

If you have not submitted your work for ethical review, and/or you have answered 'No' to one or more of questions a) to e), please explain why this is so:

| Signed: | (Student) |
| Date: |   |

vii
ETHOS DEPOSIT AGREEMENT FOR
UNIVERSITY OF PORTSMOUTH THESSES

COVERED WORK
I, Mudzamir MOHAMED [School of Accountancy, University Utara Malaysia, 06010 Sintok, Kedah, MALAYSIA], "the Depositor", would like to deposit

[Countering Fraud in the Insurance Industry: A Case Study of Malaysia], hereafter referred to as the "Work", in the University of Portsmouth Library and agree to the following:

NON-EXCLUSIVE RIGHTS
Rights granted to the University of Portsmouth through this agreement are entirely non-exclusive and royalty free. I am free to publish the Work in its present version or future versions elsewhere. I agree that the University of Portsmouth or any third party with whom the University of Portsmouth has an agreement to do so may, without changing content, translate the Work to any medium or format for the purpose of future preservation and accessibility.

DEPOSIT IN THE UNIVERSITY OF PORTSMOUTH LIBRARY
I understand that work deposited in the University of Portsmouth Library will be accessible to a wide variety of people and institutions - including automated agents - via the World Wide Web (University's Institutional Repository (IR)). An electronic copy of my thesis may also be included in the British Library Electronic Theses On-line System (ETHOS).

I understand that once the Work is deposited, a citation to the Work will always remain visible. Removal of the Work can be made after discussion with the University of Portsmouth Library, who shall make reasonable efforts to ensure removal of the Work from any third party with whom the University of Portsmouth has an agreement.

I AGREE AS FOLLOWS:
- That I am the author or co-author of the work and have the authority on behalf of the author or authors to make this agreement and to hereby give the University of Portsmouth the right to make available the Work in the way described above.
- That I have exercised reasonable care to ensure that the Work is original, and does not to the best of my knowledge break any applicable law or infringe any third party's copyright or other intellectual property right.
- The University of Portsmouth do not hold any obligation to take legal action on my behalf, or other rights holders, in the event of breach of intellectual property rights, or any other right, in the Work.

*Delete this sentence if you do NOT wish your thesis to be deposited in ETHOS but please be aware that ETHOS may, at some future date, harvest thesis details automatically (including the full text) from the University's Institutional Repository available at http://eprints.port.ac.uk

Signature:  

Date:  31/1/2014
# TABLE OF CONTENTS

**CHAPTER 1**

1.1 Rationale .................................................................................................................. 1  
1.2 Statement of Aims ....................................................................................................... 5  
1.3 Motivation and Significance for the study ................................................................. 5  
1.4 The Structure of the Thesis ....................................................................................... 8  
    1.4.1 The Features of the Chapters ............................................................................... 8  
    1.4.2 An Outline of the Chapters ................................................................................... 8  

**CHAPTER 2**

COUNTERING FRAUD: A REVIEW OF LITERATURE .........................................................

2.0 Introduction .................................................................................................................. 10  
2.1 What is fraud? .............................................................................................................. 10  
2.2 Types of fraud ............................................................................................................. 17  
    2.2.1 Benefit fraud ....................................................................................................... 20  
    2.2.2 Embezzlement ..................................................................................................... 21  
    2.2.3 Management fraud ............................................................................................. 21  
    2.2.4 Investment Scams ............................................................................................... 22  
    2.2.5 Vendor or Supplier Fraud .................................................................................... 23  
    2.2.6 Customer Fraud ................................................................................................... 24  
    2.2.7 Miscellaneous/Specific Fraud .............................................................................. 25  
2.3 Extent of fraud ............................................................................................................ 29  
2.4 Causes of Fraud and Occupational Fraud ................................................................. 33  
2.5 Initiative to Combating Fraud and Occupational Fraud ........................................... 37  
2.6 Focusing on Insurance Fraud .................................................................................... 41  
    2.6.1 Definition of Insurance Fraud ............................................................................. 41  
    2.6.2 Types of Insurance Fraud ................................................................................... 42
CHAPTER 4 ......................................................................................................................................................96

4.5 Economy ..................................................................................................................................................96

4.6 Criminal Justice System in Malaysia.................................................................................................97

4.7 Insurance Industry in Malaysia ..........................................................................................................103

4.7.1 Insurance and takaful ....................................................................................................................104

4.7.2 Types of Insurance .......................................................................................................................104

4.7.3 Takaful Insurance ........................................................................................................................106

4.7.4 The difference between Takaful and Conventional Insurance ..................................................107

4.7.5 Types of Takaful in Malaysia ......................................................................................................109

4.8 The Insurance Industry and its Governance in Malaysia .................................................................111

4.9 Roles of Insurance Association in Malaysia ......................................................................................118

4.9.1: Persatuan Insurans Am Malaysia (PIAM) or General Insurances Association of Malaysia (GIAM) .................................................................................................................................118

4.9.2: LIAM (Life Insurance Association of Malaysia) ........................................................................119

4.9.3 NIAM (National Insurance Association of Malaysia) ..................................................................120

4.9.4 MTA (Malaysian Takaful Association) .....................................................................................120

4.10 Conclusion ........................................................................................................................................122

CHAPTER 5 ..............................................................................................................................................123

INSURANCE FRAUD IN MALAYSIA AND THE NATIONAL RESPONSE ........................................123

5.1 Introduction ..........................................................................................................................................123

5.2 General classification on insurance fraud in Malaysia ......................................................................123

5.3 The magnitude of insurance fraud in Malaysia .................................................................................125

5.4 Major types case of insurance fraud in Malaysia ...............................................................................129

5.4.1 Life Insurance ...............................................................................................................................129

5.4.2 Health Insurance ..........................................................................................................................131

5.4.3 Automobile Insurance ..................................................................................................................132

5.4.4 Property Insurance .......................................................................................................................133

5.5 Countering Fraud Strategies regarding Bank Negara Malaysia (BNM) and Law Enforcer ...........136
5.5.1 Central Bank of Malaysia (Bank Negara Malaysia, BNM ) ............................. 137
5.5.2 Law enforcement as a prevention and control through the Insurance Act 1996 and
AMLA 2001 ....................................................................................................... 137
5.5.3 Initiative to cultivate anti-fraud culture .................................................... 140
5.5.4 Training on anti-fraud by BNM and agencies’ ............................................ 142
5.5.5 Less prosecution and trial data publicly available ..................................... 144
5.5.6 Other supported acts, guidelines or mechanisms aiming at countering fraud .... 146
5.6 Strategies through the Associations, Professionals and Industry Level ............. 148
5.7 Conclusion ....................................................................................................... 163

CHAPTER 6 ........................................................................................................
COUNTER FRAUD STRATEGY OF MALAYSIAN INSURANCE COMPANIES:
ADOPTING THE RIGHT, ACCURATELY IDENTIFYING THE RISKS AND CREATING & MAINTAINING A ‘STRONG’ ANTI-FRAUD CULTURE........................................

6.1 Introduction ..................................................................................................... 164
6.2 Adopting the Right Strategy in Insurers ........................................................ 167
6.3 Accurately Identifying the Risks in Insurers Strategy ..................................... 177
6.4 Creating and Maintaining a Strong Structure ................................................ 183
   6.4.1 Having the necessary authority support .................................................... 183
   6.4.2 Specialist training and accreditation ....................................................... 188
   6.4.3 Propriety Checks ..................................................................................... 192
   6.4.4 Effective relationship with other organizations ....................................... 194
6.5 Conclusion ....................................................................................................... 196

CHAPTER 7 ........................................................................................................
MALAYSIAN INSURANCE COMPANIES RESPONSES ON FULLY INTEGRATED
ACTION PLAN ,DEFINING SUCCESS FOR COUNTERING FRAUD & SURVEY OUTPUT........................................................................................................

7.1 Introduction ..................................................................................................... 197
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2</td>
<td>Taking Action to Tackle the Problem</td>
<td>197</td>
</tr>
<tr>
<td>7.2.1</td>
<td>Culture</td>
<td>199</td>
</tr>
<tr>
<td>7.2.2</td>
<td>Deterrence</td>
<td>207</td>
</tr>
<tr>
<td>7.2.3</td>
<td>Prevention</td>
<td>212</td>
</tr>
<tr>
<td>7.2.4</td>
<td>Detection</td>
<td>216</td>
</tr>
<tr>
<td>7.2.5</td>
<td>Investigation</td>
<td>222</td>
</tr>
<tr>
<td>7.2.6</td>
<td>Sanctions</td>
<td>227</td>
</tr>
<tr>
<td>7.2.7</td>
<td>Redress</td>
<td>234</td>
</tr>
<tr>
<td>7.3</td>
<td>Defining Success</td>
<td>226</td>
</tr>
<tr>
<td>7.4</td>
<td>Follow-up Survey</td>
<td>236</td>
</tr>
<tr>
<td>7.4</td>
<td>Conclusion</td>
<td>240</td>
</tr>
</tbody>
</table>

Chapter 8

CONCLUSION: ‘AGENCY’ LEVEL OF IMPLEMENTATION AND ULTIMATE CHANGES

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.0</td>
<td>Introduction</td>
<td>242</td>
</tr>
<tr>
<td>8.1</td>
<td>‘Agency’ is better than ‘industry-widen’</td>
<td>243</td>
</tr>
<tr>
<td>8.2</td>
<td>Key findings from the evaluation</td>
<td>244</td>
</tr>
<tr>
<td>8.2.1</td>
<td>Adopting the right strategy</td>
<td>245</td>
</tr>
<tr>
<td>8.2.2</td>
<td>Accurately identifying the risks</td>
<td>247</td>
</tr>
<tr>
<td>8.2.3</td>
<td>Creating and maintaining the strong strategy</td>
<td>247</td>
</tr>
<tr>
<td>8.2.4</td>
<td>Action to tackle the problem</td>
<td>250</td>
</tr>
<tr>
<td>8.2.5</td>
<td>Defining Success</td>
<td>256</td>
</tr>
<tr>
<td>8.3</td>
<td>Theoretical and Research Implications</td>
<td>257</td>
</tr>
<tr>
<td>8.4</td>
<td>Conclusion</td>
<td>261</td>
</tr>
</tbody>
</table>

REFERENCES
APPENDICES

1. Questions Set for Insurance Companies based on the Unit
2. Questions Set for Central Bank & Insurance Association
3. Questions Set for the Anti-Fraud Specialist in Insurance Fraud
4. Follow-up Survey Questions
5. Terms Related to Takaful Insurance Coverage
LIST OF TABLES

Table 2.1 Modified BNM Categorical Of Insurance Types and Example of Action 42
Table 2.2 Comparative judgement on the selection of the countermeasures /instruments of evaluation. 54

Table 3.1 Objectives, Research Questions and Research Method Applied in the Study 57
Table 3.2 The Interview Process That Involved The Groups And Objectives Achieved Through The Session 62
Table 3.3 Documentary Sources Available For This Research 73
Table 3.4 Comparative Judgement on The Selection Of The Instruments Of Evaluation 70

Table 4.1 Malaysia’s Populations in 2009 93
Table 4.2 Malaysia’s Economic Indicators In 2009 97
Table 4.3 Key Insurance/ Takaful Indicators 2006 To 2009 113
Table 4.4 Insurance and Takaful Operators in Malaysia in 2010 114
Table 4.5 Malaysia’s Insurance Market Result from 2005 to 2009 117

Table 5.1 The Categories Of Insurance Fraud In Malaysia Insurance Market 122
Table 5.2 Parties Involved Directly/Indirectly With BNM In Countering Insurance Fraud in Malaysia 124

Table 5.3.1 Adapting the right strategy ( Item 1.2 CIPFA Red Book 2) 148
Table 5.3.2 Adapting the right strategy 2 (Item 1.3, 1.4 And 1.5 CIPFA Red Book 2) 151
Table 5.3.3 Measuring Fraud and Corruption Lossess Item 2.1, 2.2 And 2.3 CIPFA Red Book 2 155
Table 5.3.4 Items on the themes Of maintaining A Strong Strategy (item 3.1,3.2,3.4.3.5,3.6 &3.9 from CIPFA Red Book 2 158

Table 6.1 Demographic Information of the Respondent Companies with Comparisons on Some Features. 165
Table 6.2 Item 1.1 And 1.2 CIPFA Red Book 2 for Insurers Evaluation 168
Table 6.3 Items 1.3 till 1.6 CIPFA Red Book 2 for Evaluation of Insurers 172
**LIST OF FIGURES**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>the Fraud Triangle</td>
<td>15</td>
</tr>
<tr>
<td>2.2</td>
<td>Classification of Occupational Fraud Based On 2010 Report To The Nations</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>on Occupational Fraud and Abuse (ACFE, 2010, Pg.7)</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Map of Malaysia</td>
<td>88</td>
</tr>
<tr>
<td>4.2</td>
<td>Malaysia Criminal Justice Court Systems</td>
<td>99</td>
</tr>
<tr>
<td>8.1</td>
<td>The Determination of Initiative Level for the Companies from the Case</td>
<td>260</td>
</tr>
</tbody>
</table>
CHAPTER 1

INTRODUCTION

1.1 Rationale

The problem of insurance fraud has been growing in recent decades (Boyer, 2000a; Yusuf & Babalola, 2009; Krawczyk, 2009) but at the same time insurance companies appear unaffected by the problem with stable profits each year (Neimi, 1995; Bourgeon, Picard & Pouyet, 2008; Lesch & Byars, 2008.). It is possible that these companies are passing the burden on to the customers through increments in the premiums paid by them (Neimi, 1995; Croacker & Morgan, 1998) or by enhancing fraud deterrence procedures in company operations (Krawczyk, 2009; Bermudez, Perez, Ayuso, Gomez & Vazquez, 2008; Piccard, 2000).

Fraudulent action by policyholders (claimants) is one of the major concerns in the insurance market (Krawczyk, 2009). A number of studies have different estimates on the amounts of insurance fraud but it shows a relevant and tremendous increase on the real data reported (Yusuf & Babalola, 2009). Some of the public data on insurance fraud available at Coalition Against Insurance Fraud (CAIF) (2006) has estimated that the cost in the United States is at least USD80 billion a year and health care fraud costs almost USD54 billion a year. Meanwhile in 1996, a European Insurance Anti-Fraud Guide reported that the cost of fraud in the industry has estimated not less than EU$8 billion or approximately 2 percent of total annual premiums paid to the whole class of insurances.

In Malaysia, there have been many insurance fraud cases reported during the last few decades, but no official estimates have been calculated by any authorities or governmental bodies. There is a lack of research conducted on fraud in general and insurance fraud specifically as it is determined by the country’s traditions that look as less ‘transparent’ in discussing these matters in-depth within government agencies, private practices or academics in general (Regarding the works done by Transparency International, Corruption Perception Index 2007-2011). Besides, there were some initiatives taken by the auditing firms nationally
in Malaysia to disclose some estimation for fraud generally for the industry but the methods used were not as conclusive and within specified acceptable data ranges due to certain limitations of data collection and the participants (regards to work done by KPMG on the Fraud Survey Report biannually and Price Waterhouse Coopers, Global Economic Crime Survey by industry).

Looking at the conditions of the insurance market features (Neimi, 1995; Krawcyzk, 2009) and competitiveness of the industries (Boyer, 2000; Bourgeon, Picard & Pouyet, 2008), it is difficult to determine any specific methods for classification on insurance fraud. To overcome the limitation, Yusuf & Babalola (2009, p.3) introduced some classification of insurance fraud that can be defined into four main categories:

- **Internal Fraud**: Fraud action taken by an inside party in companies against the organization such as employees, management or board of director or involved in collusion with an outsider.

- **Policyholder or claimant fraud**: Fraud action against the insurer in purchasing a product and/or effecting some of the insurance products by obtaining unlawful coverage or payment

- **Intermediary fraud**: Fraud action by intermediaries against the insurer and the policyholders. This may be the agents or brokers of the insurer.

- **Insurer fraud**: Fraud action taken on behalf of the organization against the insured through policy tossing or mis-selling.

If insurance fraud is not taken into consideration, it would have an effect on the profitability of insurance companies and would also be damaging to the function of insurance in economic and social structures (Viaene et. al, 2007). In order to overcome this, Dionne, Guiliano & Picard (2009) have suggested that an insurance firm needs to commit to a claim audit strategy to ensure solvency for companies. By chance, it is clearly stated that the individual defrauding the system has a clear economic incentive (Hoffman, 2003).
This research will determine the policy implemented by insurers in tackling claimant fraud and intermediary fraud. On general ideas, positive way to determine fraud is pre-emptive strategies taken by the insurer on preparing the tight internal control system of the company that enables to detection fraud and also reduce the possibilities of system abusing. Since, fraud is not a self-revealing phenomenon, insurers need to commit their resources (Viaene et al, 2007) to detect fraud. Within the claims department, it is a ‘grey area’ to identify the characteristics that can distinguish a fraud claim from the valid submissions (Dionne et. al, 2009). By that, practically the determination of suspicious claims handling continues to be subjective in nature. So, the main idea in this research is also to determine how companies deal with suspicious claim handling because it will lead to a better probability of countering fraud incidents. Martin (2000) has proposed that outsourcing the investigations to a third party is the better ideas as it enables to overcome the problems of transaction costs, moral hazard and possibility of renegotiation. This tells the reasons on why there exists formal involvement of loss adjusters as part of fraud management systems in companies.

At a general glance, the insurance industry in Malaysia remains dominated by foreign insurance providers (as stated in the US Department of Commerce 2008 Country Commercial Guide) and along the way the Malaysian government is continuing to promote Islamic insurance and reinsurance, known as takaful sectors, as part of its strategy to market the country as a global hub for Islamic financial services. The government trust that within these two mainstreams of the insurance sectors, it will enhance the stability, effectiveness and efficiency of the industry itself to cater specific issues including the issues of fraud in the industry. Besides, the Central Bank of Malaysia (Bank Negara Malaysia abbreviation of BNM), is the main body for regulation and supervision for the industry, and has reported stronger solvency positions and enhanced asset-liability management contributed to the sustained performance of the industry in 2011(extract from Financial Stability and Payments Systems Report (BNM, 2012)).

The main references for the industry are the Insurance Act No. 553 (Act of Malaysia) of 1996 and 1996 Insurance Regulations amended in 2005, which includes the structure of the licensing, regulation and supervision of the industry. Malaysia has completed a detailed self-

---

1 Takaful insurance is the Islamic insurance concept that grounded by the Islamic muamalat (business) ideas that concentrated more on sharing responsibilities, mutual protection and profit sharing between the insurers and policy buyers.
assessment in April 2005 through the observances of the Insurance Core Policies (ICPs) developed by the International Association of Insurance Supervisors (IAIS) in 2005, according to Asian Development Bank’s 2005 Report. With respect to ICP number 27, p. 275 that catered for fraud issues, Malaysia reported as follows:

“With respect to insurance fraud, the BNM, as stated in its 2005 Insurance Annual Report, collaborates with the insurance industry and relevant law enforcement agencies through various initiatives under the anti-fraud joint committees. A fraud surveillance system has also been implemented to monitor incidences of the fraud. Nevertheless, there is insufficient information publicly available clearly identifying Malaysia’s compliance with this principle”

Based on the notation above, it can be highlighted that countering insurance fraud has become the major consideration for Malaysian insurance companies since the BNM advocated the arrangements in 2005 where most of them needed to co-operate in fighting fraud as the global and national threat. However, the initial ideas and surveillance systems which have been implemented look more towards the operationalization of insurance companies itself.

This research later will be discussed in next chapters on the ideas that have been accredited by the BNM to all insurers through relevant documents and interviews, with several officers in relation to the procedural practices. Meanwhile, involvements of the substitute NGOs in the industry like the National Institute of Insurances (NII), National Institute of Claim Social Society (NICS), National Insurance Association of Malaysia (NIAM) and Association of Malaysia Loss Adjusters (AMLA) pair the ideas and commitments on the initiatives that have been taken by the subsystems of insurances industry.

This in-depth case study has investigated the initiatives of countering fraud within the series of prevention, detection investigation, prosecution and deterrence in the operation of insurance companies through their routine procedures and regulations. In order to make more viable comparison, this case study has mingled the CIPFA Red Book2, a comprehensive practical standard for countering fraud in the UK, as a benchmark to assess the effectiveness of Malaysian insurance companies’ counter fraud strategies. In addition, this research was
able to draw conclusions on how well insurance companies are countering fraud by making cumulative point on the ordinal scale for precise criteria. By that, it have provided an original contribution to the body of knowledge by revealing the scale and nature of the problem of insurance fraud combined with the sensible strategies in the industry and companies, which is under-researched internationally and also specifically in Malaysia.

1.2 Statement of Aims

The aims of this study in general are to assess the strategies aimed at countering insurance fraud in Malaysia at a national, industry and company level. While using mix instruments, it is hoped that this case study will provide an insight into the different angles of initiatives taken by each respondent’s company in implementing anti-fraud and reducing-scams on insurance products through normal processes and procedures. Specifically, the study objectives are:

To review the countering fraud strategies implemented by Malaysian insurance companies.
To review support of another parties from insurance industry on the strategies used against fraud and scams in practice,
To make a possible evaluation of the counter fraud strategies in the Malaysian insurance companies for company and industry levels.
To suggest any appropriate suggestions as feedback for companies and regulatory bodies

1.3 Motivation and Significance for the study

The Insurance Services Malaysia Berhad² (ISM), the most credible insurance industry research firm has estimated that bogus insurance claims are one of the most popular insurance fraud methods in the country and costs £102 million (RM500 million³) a year (Business Time Online, 2008). This estimation is taken based on the 17 percentage of total £613 million (RM3 billion) yearly claims in the Malaysian insurance market. Based on the ISM, most of

² Berhad is for limited company by common shares
³ As the exchange rate on the 1st October 2012 (£1= RM4.9)
the 52 member companies that offer insurance are stepping up their efforts in areas of fraud identification and prevention as part of their wider enterprise risk management strategy. These efforts include leveraging the fraud databases and technology to be more efficient in identifying fraud. While at the industrial level, consumer education campaigns have been promoted regarding what constitutes insurance fraud and its negative impact toward the economy and consumers.

Central Bank of Malaysia (Bank Negara Malaysia (BNM)) has developed a system named e-Fids (electronic fraud information database system) that maintain and correlates all database on all fraud and defalcation cases or breach of ethics code that reported by the insurers and it was based on the simple mutual sharing. Based on the news public announcement, this database has showed in 2004 that the numbers of cases had increased from 437 reported cases in 2003 to 763 reported cases which involved £4.9 million (RM24.1 million) (increasing from £2.2 million (RM10.9 million) in 2003)(Bernama.Com, 2005).

The effect from the act of fraud makes the company demotivated to offer extra ranges of products due to these fraudster threats. They may impose more underwriting requirements and restrict their scope of coverage to cap losses due to scams or fraudulent acts (Boyer, 2001, Derrig, 2002; Yusuf & Babalola, 2009). At the same time, there are possibilities that the insurance providers would withdraw covers to the sectors that are economic threats (Viaene, 2004; Chyzhov, 2010).

The most notified effect of insurance fraud is when insurers delay of the settlement, even though genuine claims are being processed (Pathak et. al, 2005; Schiller, 2006). Insurance companies scan for potential fraud and will carry out thorough investigations when fraud is suspected. The stringent claim settlement procedures put in place by the insurance companies to reject the fraudulent claims inevitably result in the delay of genuine claims (Tennyson & Salsas, 2002; Hoyt et. al., 2006). This would be more strenuous when the customers are in need of the claims and it handicaps them. This can be hindered if the customers are well-educated regarding the consequences of fraudulent claims and scams on insurance products by the initiatives taken through insurance education (Crocker & Morgan, 1998; Derrig et. al., 2002; Moreno et. al, 2006).
This study can be seen as supporting the Malaysian government’s initiatives on reducing fraud in the government and private sectors in order to create a more transparent and accountable country as mentioned by the current Prime Minister for the Government Transformation Program (GTP)\(^4\). The Central Bank of Malaysia plays the major role as a monitoring and supervision department under government to ensure that all insurance companies have a better and wealthier environment to run their business in the current economic condition as in Insurance Annual Report (BNM, 2006). Based on the said objectives earlier, some research questions that arise are to be discussed in later chapters, which are:

1. What is the current condition of countering insurance fraud activities in Malaysian companies based on the Central Bank of Malaysia’s perspective?
2. Is the anti-fraud culture already becoming a major consideration for Malaysian insurance companies from the industry society ideas?
3. What are the process and procedures that are involved in the claims unit of Malaysian insurance companies that enable prevention and detection of fraud?
4. What is the method used for risk assessment in determining the possibility of insurance fraud from their customers? (claimant and intermediary fraud)?
5. What are the major red flag techniques that are being used by the claims and investigation unit in determining the possibility of fraud?
6. Did the anti-fraud and scam strategies used benefit the Malaysian insurance companies based on cost consideration?
7. How were the investigations administered in Malaysian insurance companies when suspected fraud and scams are confirmed?
8. What are the practices of prosecution procedures for cases involved with insurance fraud by insurance companies?
9. Is the existing legislation the main function in order to ensure that procedures for sanction are implemented?
10. Why are fraud deterrence issues becoming so crucial in the current economic conditions for the companies?
11. What is the best implementation to deter fraud and scam cases based on the insurances product and cross services in the companies?

\(^4\) Dato’ Seri Muhammad Najib Tun Razak is the 6\(^{th}\) Prime Minister in Malaysia since independence and being succeeded on 3\(^{\text{rd}}\) April 2009. He introduced Government Transformation Program that emphasizes more on the transparency and accountability through 9 Key Performance Indicators.
12. Is the company evaluation on the countering initiatives through CIPFA Red Book 2 going to show good indicators for all participating companies in this case study?

1.4 The structure of the thesis

1.4.1 The Features of the Chapters

This thesis contains eight chapters, including a conclusion. In facilitating exploration of ideas and concepts, each chapter is divided into their own sub-topics with specific headings. Beginning with Chapter 2, each chapter will have an introduction and conclusion that have summarised the ideas and concepts discussed and to establish a link to subsequent chapters. Any terminology that is introduced for the first time will be followed by a definition or an explanation where appropriate.

1.4.2 An Outline of the Chapters

Chapter 2 provides a literature review; it explores fraud in general, types of fraud, the extent of fraud and causes of fraud and corruption. This chapter narrows down to the issue of insurance fraud. Models and strategies for countering fraud are also presented in Chapter 2. In addition, the model of countering fraud from the US, UK and Asia are discussed further.

Chapter 3 is concerned with the research methodology. The chapter describes the various methods of data collection and how the research questions are formulated. Techniques employed in order to prepare the case study and the selected interview with the key players involved. The researcher also, includes the observations that have been formalised in insurance companies itself during the normal operational environment. Some ideas collected from the documentation provided by the respondent also include the discussion of the methods used.

In Chapter 4 important information concerning Malaysia is explored. A brief history of Malaysia and socio-political issues will be discussed to set the tone of the country’s norms and traditions. This will lead to the inclusion of the case study companies’ introduction and their performance in the insurance industry. It will include the company’s brief history, organization charts, and claiming procedures.
Chapter 5, 6, 7, and 8 are the results chapters. These have been allocated based on the level of initiatives taken in different settings. Chapter 5 presents the discussion on the environment in the insurance market towards the implementation of anti-fraud strategies. The discussion will be regarding the initiatives taken through BNM, Malaysia insurance association and the loss adjusters’.

Chapters 6 & 7, present a thorough discussion based on evaluation regarding the CIPFA Red Book 2 components. Chapter 6 will cover the part of adopting the right strategy, accurately identifying the risks, and creating and maintaining a strong strategy. The items under each of the topics will evaluate the three responding companies on the strategy implemented.

Chapter 7 is the continuity of the evaluation under the CIPFA Red Book 2 that relates to the topics of taking integrative action to tackle the problems and defining success. This chapter is important in order to determine that all the actions listed are taken by the companies in order to ensure that they are adopting the right strategy. At the end, justification of the success is needed in order to ensure that the company can take some relevant corrective action.

Chapter 8 stands as the conclusion part of this case study. Countering fraud seems to be highly important in insurance companies but it needs more involvement of the managerial processes directly. Besides, this study also had some limitations due to the access of some restricted documents and limited observation which are only to specific companies who might assume it to be restricted. Output omitted to be different based on the current practices where a lot of new products and campaigns have been established by the insurance companies against fraud situations. This research is one of the general reviews to evaluate and determine the seriousness of the insurance industry in countering fraud within their organization and the general industry sector as a whole.
CHAPTER 2

COUNTERING FRAUD: A REVIEW OF LITERATURE

2.0 Introduction

Fraud is defined as applying the methods of deception or any device, that would culminate in an individual or groups gaining advantages over others, by making wrong suggestions or not telling the truth which includes all surprises, tricks, cunning or dissembling, in any unfair way (Albrecht, Albrecht, Albrecht & Zimbelman, 2011; Fraud Act, 2006; Wells, 2011). Fraud is a major threat to the economy because economist determined that fraud can ‘rise’ more during bad or unstable economic conditions within organizations (Jones, 2004) or sometimes in the country (Gill, 2011; Sherman, 2010; Vogel, 2010). However, in the private sector such as the insurance industry, the competition exists as the ‘check and balance’ elements for performance of their stake holders and they are in need of better governance structure to ensure the survival of the company (Well, 2011) or in finding a way to reduce loss from fraud with better estimation for the fraud cost in the economy (Button, Gee & Brooks, 2012). This chapter will explore the research on fraud in the economy, as a whole, in extent and also the causes. It will also look more deeply into the insurance fraud problem in relation to the economy. By the end of the chapter, it hopefully enables a better understanding of the threats of insurance fraud as one of the biggest problems in economics nowadays (ACFE, 2011; Gill, 2011; KPMG, 2010; Barnes & Webb, 2007).

2.1 Defining fraud

Defining fraud is something that can be difficult to determine precisely and it should be considered based on situational settings. This idea can also be described regarding the sectors, authority, professional body’s interpretation and the impact of practices. Based on the generalised definition, fraud can be determined as actions by some party with the intention to other parties that enables financial advantages. (Albrecht et. al., 2011; Wells, 2011) and also sometimes non-financial (Butler, 2004; Azfar & Nelson, 2005) due to the ability and power
of the fraudster over the resources and the assets in the organization (Belkoui, 2000; Feldman, 2001; Dronberger, 2003; Jones, 2004; Payne & Ramsay, 2006; Boehm, 2007; Levi et. al., 2007; Johnston & Frimpong, 2008). While, the definition of fraud given in the UK HM Treasury Fraud Report 1994-1995, p.10 is more favourable in describing fraud in the economy sector as:

‘The use of deception with the intention of obtaining advantage, avoiding an obligation or causing loss to a third party’

This definition directly prescribes that fraud is more towards the economic advantages perspective when somebody misuses their position and intentionally takes advantage of their position and causes loss to the other party. This could also be related to Section 4 of the Fraud Act 2006, UK, which interprets fraud regarding abuse of position as stated below:

(a) occupies a position in which he is expected to safeguard, or not to act against, the financial interests of another person,
(b) dishonestly abuses that position, and
(c) intends, by means of the abuse of that position—
   (i) to make a gain for himself or another, or
   (ii) to cause loss to another or to expose another to a risk of loss.

Both the definitions above look onto general economics ideas and may not be directly targets in the private sector. However, the public sector is one of the major victims of fraud where attempts generally affect society, which possibly includes the company’s shareholders and individual interests within the corporation. In the general public arrangement, the public servant is acting on behalf of the tax payers or other elected representatives, unlike the shareholder (Smith, Button, Johnston & Frimpong, 2010; Levi, Burrows, Fleming & Hopkins, 2007; Jones, 1993).

Another acceptable definition of fraud by government bodies that is useful to consider is from the US Government Audit Office (GAO) report (1981, pg. 2) which states fraud as

“...any willful or conscious wrongdoing that adversely effects the Government’s interests. It includes, but is not limited to, acts of dishonesty which contribute to a
loss or injury to the Government. The following are some samples of fraud or other unlawful activity: falsification of documents, such as time cards or purchase orders; charging personnel expenses to Government contracts; diversion of Government property or funds for unauthorized uses; submission of false claims, such as invoices for the services that not performed or materials not delivered; intentional mischarging or misallocation of contracts costs; deceit by the suppression of the truth; regulatory or statutory violations, such as bribery, theft of Government property, graft, conflict of interests, and gratuities; and any attempt or conspiracy to engage in or use the above devices.”

The definition given by GAO above is more attached to idea of countering fraud based on the operation part added with justification according to their auditing reports. It look more specifically highlights to the potential for fraud that may exist in government offices that is employment fraud such as embezzlement, corruption, misuse of contract terms etc. By that, it created red flags for the government officer as it is treated as major concerns by the government office. The International and Assurance Standards Board, 2004 the worldwide standard setting body for auditing, accounting and assurance profession determine fraud as:

‘...intentional act by one or more individuals among management, those charged with governance, employees, or third parties, involving the use of deception to obtain an unjust or illegal advantage.’

The definition describes fraud within a private organization setting whereby a person misuses the powers and authority given to them in order to gain benefits illegally. This determines that the possible parties involved if the fraud was perpetrated in a private organisation taking into consideration the types and size of organisation and areas of business (Well, 2011; Bierstaker, Brody & Pacini, 2006; Belkaoui & Picur, 2000). Hence, another big anti-fraud professional, based in the US, the Association of the Certified Fraud Examiners (ACFE) describes fraud as more towards occupational fraud and defined it as “the use of one’s occupation for personal enrichment through deliberate misuse or misapplication of the employing organization’s resources or assets” (ACFE, 2011). This interpretation looks at fraud in a more direct way and becoming useful when the association mainly uses as classification to produce the report named ‘Report to The Nation’ every two years. The
reports are using to upholding the condition of occupational fraud in US society and it is rapidly becoming wider as the association branches are also trying to compile the same report in the country where it is extensively established (ACFE, 2011).

Another common practitioner that is actively formulating the standards and solutions towards the business problems or issues is commonly known as association of external auditing. For example in UK they are remarks the fraud issues in the Auditing Standards Board’s Statement of Auditing Standards (SAS) 110 (para.4) states:

“... “fraud” comprises both the use of deception to obtain an unjust or illegal financial advantage and intentional misrepresentations affecting the financial statements by one or more individuals among management, employees, or third parties.

Fraud may involve:
- falsification or alteration of accounting records or other documents
- misappropriation of assets or theft
- suppression or omission of the effects of transactions from records or documents
- recording of transactions without substance
- intentional misapplication of accounting policies
- wilful misrepresentation of transactions or of an entity’s state of affairs.”

The above definition has determined that fraud is an intentional act made by somebody towards other parties that enables this person to produce misleading financial information. As a result, the users at the end are going to suffer a loss as the determinant (Button et.al, 2012). Obviously, the above definition describes the action of an insider in an organization or who is attempting to mislead other parties. While, SAS has also pointed out that: “It is for the court to determine in a particular instance whether fraud has occurred”. This statement highlights the importance of reminding the general public that until a case has been proven, a person charged with allegations of fraud are not considered guilty. This utterly means that someone who involved with fraudulent activity will not be treated as a criminal offence (unless caught in the act) and will need some care procedures before the case is proven (Boehm, 2007; Schoepfer & Piquero, 2009; Krause, 2010).
Another definition of fraud by the anatomy of fraud and developed by Albrecht et. al. (2011, p.7). The components of this anatomy are:

1. A deception / misappropriation occurs
2. An anomaly is discovered
3. The suspected perpetrators/s is/are identified
4. Evidence is gathered
5. The matter is reported externally
6. The evidence is strong enough to support a prosecution
7. The perpetrator/s is/are found guilty of committing a crime

The anatomy illustrates that fraud is something that should be managed internally, based on a specific rule of thumb or proper structure. It needs to counter possible fraud by using proper procedures and elements considering that the responsibility of determining the cases is up to the fraud investigators, liquidators or investigators; and less involvement of the enforcement officer such as the police (Payne, 2006; Levi, Fleming & Matthew, 2007) until the cases and prosecution is proven.

In discussing occupational fraud, the fraud triangle is highly relevant because it is widely accepted as the general cognitive idea to describe the situation. In the initial period, a fraudster’s actions are most likely related to the fraud triangle. The fraud triangle was introduced by Donald R. Cressey (1973). Firstly, the factors that probably are becoming the major considerations in occupational fraud are pressure, opportunity and rationalization. Pressure is a chief motive behind fraud as when a person is under pressure either within a monetary and non-monetary need, they tend to act without consideration of the factors. Next, opportunity is another forcing factor as because of the condition of the company or organization system, this provides a chance or opportunity for the perpetrators to carry out fraudulent activities. Finally, when both factors exist and complement each other, the perpetrators usually attempt to make their own standing point by looking at the norms, trends and patterns that enables them to make the rationalization (ACFE 2009, 2011). By that, it can be said that the fraud triangle can be used as an instrument that will enable the general public to understand the definition of occupational hazard as a whole.
Figure 2.1 the Fraud Triangle

Another idea that needs careful consideration in defining fraud is how it is correlated to
corruption. Most of the time, fraud and corruption have been grouped together in order to
indicate the cases of illegal activities in organizations (Cheeseman, 2009; Jones, 2011). If we
look at the discussion carried out by some scholars in the US, fraud is the main classification and corruption becomes the sub item (with reference to works done by Bierstaker, 2006; Payne, 2006; Albrecht et al., 2011; Wells, 2011). So, it is necessary to understand the
meaning of corruption in order to sustain the interpretation of fraud. Based on the Oxford
Dictionary corruption is;

“willing to act dishonestly in return for money or personal gain, or, evil or morally depraved”

While the definition for fraud in the same dictionary is:

“Wrongful or criminal deception intended to result in financial or personal gain”

Both definitions of corruption and fraud are related as being a wilful action carried out with intention to gain for either personal or financial reasons, and that both actions are morally degrading. Another good interpretation regarding corruption is the legal definition, which is:

“An act done with an intent to give some advantage inconsistent with official duty and the right of other. It includes bribery, more comprehensive; because an act may be corruptly done, though the advantage to be derived from it be not offered by another.”

(see http://www.lectlaw.com/def/c314)
The above definition of corruption is similar as the dictionary definition given earlier in this thesis, but leans towards the scope of the organization when it classifies acts of misuse of power or rights given to the perpetrator. This practical definition is appropriate for anti-fraud agencies’ interpretation on corruption as an attack on the organization. For example, Transparency International (TI) has defined corruption as “the misuse of entrusted power for private gain”. The details in ‘Global Corruption Report 2007’, describe corruption as a private game by parties in the organization that can be determined resulting in both financial or non-financial and material and non-material gains, such as the power in political arenas and professional ambitions.

The definition by TI appears similar to the definition of corruption by the United States Agency for International Development (USAID) in their Anti-Corruption Strategy that defines it as “the abuse of entrusted authority for private gain”. This is based on authority including all small and functional departments. Both definitions look similar in order to determine the misuse of power that is known as ‘entrusted power’. This appears that the person might be related to the power holder and could enable a diverse decision based on their influence. By the way, Organizational fraud is clearly defined as the action of officers who deviate from their personal duties in a public role by accepting something for private-gain (whether financial or non-financial) and it violates the organizations rules (Klitgaaard, 1988; Jones, 2004; Welsch, 2004; Smith, 2005; Iyer & Somociuk, 2006; Johnston, 2008). This definition is more appropriate when discussing public fraud because most of the scholars would relate it with actions by the public officer (Welsch, 2005). The officers would be able to use their power to exploit the other party in order to gain a return that might be financial or non-financial. This return is actually generated with an immoral intention to corrupt the whole operation of the organization (Rijckeghem & Weder, 2001; Hodess & Wolkers, 2004; Pillay, 2004).

Based on several definitions cited and the fraud triangle, occupational fraud can be classified as a branch of corruption, in terms of many meanings, and indeed the beginning of acumen on the issue is to subdivide and unpack its vast concept. By generally postulating, it can be noted that occupational fraud is the misuse of office for unofficial ends occurring mostly in the government sector (Jones, 2011). This can be concluded that fraud is related to power and gain when trust that is given by the political factors. Besides, occupational fraud are
looks attractive when abusing this trust and they manipulate it in order to create more than what they can earn with their basic salary (Rijkeghem & Weder, 2001; Pillay, 2004; Lambsdorff, 2007).

Although, we tend to infer that corruption is morally unethical committed within government and its subdivisions mainly by the corrupted officers, of course it also subsists in the private sector (Campos, Lien & Pradhan, 1999; Lambsdorff, 2007). In fact, the private sector is involved in most of the government corruptions (Jones, 2004; Boehm & Olaya, 2006; Levi et al., 2007). The statement is generally believed to be correct because most of the time the officers would be practicing their authoritative powers with the person within the economy and mostly with the private sectors. For example, customs officers would practice their investigating and assessment power with the trader doing business in the general economy environment. Sometimes, they have been given money to corrupt the system in terms of being less strict during assessment or to be more considerate. It can be said that the private sectors are directing less transparent work of the public sector as the results of occupational fraud.

By merging both definitions of fraud and corruption per say as occupational fraud, it could be beneficial in the following chapters to discuss both together in order to have a clear standpoint on the occurrence of fraud against or on behalf of the organization. We can presume now, fraud is broader in definition (Butler, 2004; Levi & Burrows, 2008) if compared to corruption but it can be used interchangeably based on the condition of the actions and consequences of those actions’ on the organizations.

2.2 Types of fraud

A common way to classify fraud is by dividing frauds based on intention; whether it is committed against the organization or those that commit fraud on behalf of the organization (Albrecht et. al., 2011). Fraud that is committed by the employee where the victim is the organization is the most common type of fraud, yet it is hard to detect due to the sophistication of the organization and tasks (Belkoui, 2000; Herbert, 2005; Boehm, 2007; Levi et. al., 2007; Button, Johnston & Frimpong, 2008; Doig & Macaulay, 2008). While, the types of fraud that happens on behalf of the organization are tend to be less frequent but it
involves larger amounts financially, such as the major scandals as Enron and Tyco (KPMG, 2005; Scanlan, 2008).

There is a general classification made by the ACFE (2011, p.5) on the major categories on ‘occupational’ fraud that is;

1. **asset misappropriation**, which involves the theft or misuse of an organization’s assets
2. **corruption**, in which the fraudster wrongfully uses their influence in a business transaction in order to procure some benefit for themselves or another person, contrary to their duty to their employer or the rights of another and
3. **fraudulent statements**, which generally involve falsification of an organization’s financial statements

This above general classification by the ACFE is based on the assumption that fraud is something that connects the occupant to the fraudster. This classification is based on their action and itemized consequences of their action. This classification is better suited to the organization that is private where they do not have authority power towards the general public. Even though, it is also applicable when discussing economy fraud because it can contribute to insurance fraud generally. The diagram regarding the ACFE classification can be found in Figure 2.2 below.
Figure 2.2: Classification of Occupational Fraud (Fraud Tree) based on 2010 Report to the Nations on Occupational Fraud and Abuse (ACFE, 2010, pg.7)
Hence, the types of fraud noted on the above table, enables us to classify it to several general themes based in the economic sector that are significant with business fraud as several subtopics below, due to the contents of this thesis, not every fraud is going to be discussed here but at least all those discussed are going to be directly or indirectly related to insurance fraud;

2.2.1 Benefit fraud

Benefit fraud is defined as act of falsely claiming or receiving money from the government as benefit from public money on the basis that it is legally allowed but with intentionally lying on certain information (Jones, 2011). This is usually some activity involved with Social Security, Department of Work and Pensions (DWP) etc. Based on the Social Security Fraud Act 2001 in UK;

*Benefit fraud occurs because people lie about their circumstances, or deliberately fail to tell DSS or authorities administering Housing Benefit or Council Tax Benefit about a relevant change. Cross-checking the information that claimants provide against independent sources of information helps to detect benefit fraud.*

(see http://www.opsi.gov.uk/acts/acts2001/en/ukpgaen_20010011_en_1)

Based on the notations above benefit fraud can be known as an action which people intentionally initiate in order to mislead officers from doing their jobs and it is against the organizational function to allocate for social or welfare activities. The perpetrators are determined making wrong doings that enable sanctions being taken against them in general conditions because it can be considered as lying with the economic intention (Levi & Burrows, 2008). At the same time, the officers may face some confusion regarding the documentation produced when in some cases it might involve claiming on the insurance schemes. This would lead to the wrong payments of insurance claims at the end.
2.2.2 Embezzlement

Embezzlement is the act of dishonestly appropriating or secreting assets, that carry financial meaning, by one or a group of individuals to whom such assets have been entrusted. Embezzlement is a crime against ownership because the owner’s right to control the disposition and the use of the property. This would involve the conversion elements when it was substantial inference with the true owner’s property rights (Albrecht et. al., 2011).

There were no criminal offences under the name of embezzlement in the Common Law. It is actually a statutory crime that progressed from Larceny. However, larceny requires the perpetrator to intrude the assets at the beginning while embezzlement is an action that is partly from the originally lawful action by employees. So, it can be concluded that embezzlement is another design of larceny in order to cover a fraudulent act that is not covered by larceny. It is more highly related with public officers because they have some assets in control based on their fiduciary duty (NHS, 2006; Lambsdorff, 2007). This embezzlement activity relates to insurance claim are going to unjustified on the assets or on the misplacing of the assets. Out of this act, it would induce the payment of claims for the good that lost from this type of fraud.

2.2.3 Management fraud

This type of fraud generally is a fraud perpetrated against an organization or sometimes on behalf of the organization done by the upper authority person/s in the organization in order to fulfill their specific intention or vision (Jones, 2011). The most popular definition from Delphi Financial Services is;

*Management fraud is also known as fraudulent financial reporting, is the deliberate fraud that committed by managements that injures the investors and creditors through materially misleading financial statements*

(see http://www.delphisfinancial.com/glossary.php?letr=M)

This definition concludes that the consequences of management fraud are more towards the whole meaning of their fraudulent actions, obviously relating to the action on financial
reporting fraud only. This is vital because as it draws the attention of the management and shareholders towards the ending benefit of the organization as a whole. By that, proper and transparent financial reporting is highly essential in this action (Albrecht et. al., 2011). While, sometimes the majority says that management fraud is determined by involving falsifying financial information for the benefit of the person committing the crime only (Turner, 2008). This also includes false transactions and accounting entries, bogus trades, and self-dealing by corporate insiders, including insider trading, kickbacks, backdating of executive stock options, misuse of corporate property for personal gain and individual tax violations (Wells, 2011). In relation to the insurance industry, management fraud would be falsifying the real assets value under insured, and this action would make the insurers use wrong judgement on the insurance contract. There is a possibility when claims over arson or any insurance claimable incidents submitted from higher level management in order to recover from a big loss from normal operation.

2.2.4 Investment Scams

Investment scams are closely related to the idea of management fraud. While, these scams are usually fabricating worthless investments and sold to unsuspecting investors in order to gain some unreal profit. This involves the investor in three different types of scenarios that is, the investor believes that the investments are authorised, the investor wrongly believes that investments are regulated or when investors incorrectly believe that investments have been authorised (Levi & Burrows, 2008). The case of ‘Ponzi Scheme’ is one of the most significant example of how fraud schemes are manoeuvred in the environment.

A ‘Ponzi scheme’ is a fraudulent investment operation that would require to pay returns to separate investors from their own money or money that has been paid by subsequent investors, rather than any actual profit generated, mostly known as the pyramid schemes sometimes (Lipton, 2010). This scheme usually offers returns that other investments cannot guarantee in order to allure new investors, in the form of short returns that are either abnormally high or unusually consistent based on the schemes. The perpetuation of the returns from this scheme would be advertised and requires an ever-increasing flow of money from investors in order to keep the cycle going (Bhattacharya, 2003; Bierstaker, Brody & Pacini, 2006; Albrecht et. al., 2011;). Investment fraud is having the ability to cause some
disruption to the insurance product if some investors involved are being defrauded by the insurance agent that actually creates some bogus investments in the name of the real company and collect money from the customers.

2.2.5 Vendor or Supplier Fraud

Vendor fraud is another common type of organizational fraud in the United States, and comes in two main types that are (1) fraud perpetrated by vendors acting alone, and (2) fraud perpetrated through collusion between the buyers/workers and vendors (Albrecht et. al., 2011). It can be seen as a wide span of abuse, from the fraudster creating fictitious companies and submitting bills for payments, sometimes it involves the suppliers who are lodging invoices and charging you more than they are due, and also collusion with organization employees to help the supplies to traverse through company internal control.

Based on the ACFE there is a common type of vendor fraud determined as (Wells, 2011);

- **Vendor masking**: companies use tricks of the trade to hide their true identity. It’s very hard to detect and recover the lost funds
- **Inside job**: current or former employees with the knowledge of organizations’ internal control use the information to perpetrate the fraud without being detected
- **Flying under the radar**: criminals avoid detection by using ‘proven’ techniques for blending in with legitimate invoices, vendors and, payments
- **Organized crime billing schemes**: sophisticated groups of criminals take savvy, organized approaches to defrauding the whole organization

Based on these several types of vendor fraud, it can be said that this fraud has two structures. Most of the time, this fraud would be more dangerous to the organization when it is related to an insider. It can be a breach of trust by employees and it makes loopholes for determining inefficiencies of the organization’s internal control. This fraud occur as positively looks like a medium for testing control procedures and it would be too late if the cost is high to the whole structure (Payne, 2006). In insurance context, this fraud can be a threat for the company because when the company is determined to have less power for internal controls, it would
increase the risks associated with it. By that, premiums need to be altered based on the case and on the inefficiency of the internal control structure.

2.2.6 Customer Fraud

The idea of customer fraud is engaging in activities such as, the customer either pays the full price for goods purchased, or they get something for nothing, or they deceive an organization into giving them something that they should not have (Albrecht et. al., 2011). Other constructive definitions on customer fraud from a marketing scope is from Tian & Keep (2002) that is;

“........refers to an act or course of deception that is practiced by individuals against retailers or manufactures with a view towards gaining an advantages in the exchange that would not be available without covertly breaking the rules or norms of customers’ exchange behaviour stabled by marketers.”

The definition is more emphasize at the action taken by the individual in creating advantages by fiddling the whole organization. This is the act of consequences from the intention of the general public to defraud back the organization. Besides that, it is applicable in the context of insurance organizations as most probably we can determine that users of the product or services are civilians who have their own interests (Adams, 2010).

While on a public organization, such as general health care services, the customers as civilians with rigorous intention will be applying their rights when using all public property equipment in their daily life (Jones, 2011). However, there are times when the motivation of the civilian is to overrule the systems for their own benefit (Herbert, 2005; Levi & Burrow, 2008). This describes customer fraud when the output of these activities is something that they are not supposed to have or accept, but by mistake this has been allocated when people use unlawful initiatives (Dronberger, 2003; O’Donnel et. al, 2007) as just what happened in the benefit fraud.

In contrast, there are some situations when the customer becomes the victim in situations unknown to him as a hoax due to limited knowledge. Then, they might be defrauding with

24
certain amounts of money that are not supposed to be spent or can be spent minimally by somebody that is more expert in demonstrating their professionalism (Griffith & Shaw, 2000; Feldman, 2001; Abramovsky, 2008), i.e. insurance company or insurance agents. This idea can be found plainly in the practice of healthcare when patients are alienated from the system. So, this group of people will pay whatever was charged on the bill without querying the accuracy. This creates opportunities for the practise and if they are motivated, the scams would be worth it to them (Mars, 1984; Hyman, 2001; Busch, 2008b). Most of the time, the payer of these charges are the insurances companies and they become the victims.

2.2.7 Miscellaneous/Specific Fraud

This is actually not a specific type of scam but it might be the combination of other types or a special type of fraud. The classification used by Albrecht et. al. (2011) and Wells (2011) in order to demonstrate the various methods of fraud created is based on the situational, proportional, conditional, intentional, and pressure. Some of these types of fraud can be determined as:

1. **Identity Fraud**- the scam generally formulated to facilitate other crimes, such as credit card fraud, cheque fraud or benefit fraud (NHS, 2006; Levi & Burrow, 2008). This kind of fraud is mostly with the intention to defraud others and gain financial and non-financial benefits by mimicking a certain identity.

2. **Insurance fraud**- the hoax that usually involves the person making a wrong insurance claim in order to defraud a company. This involves multiple methods and multiple products of the insurance company (Wells, 2004). This industry has a different effect from country to country based on the needs and fundamentals of the policy in that country, where France made compulsory for their insurance companies but not in the UK (NHS, 2006). This will be discussed in more detail in subtopics below because insurance frauds are the type of fraud that involves a majority of concern in business fraud (ACFE, 2010; Gill, 2011).

3. **Healthcare fraud**- is one type of white collar crime that involves the dishonest filling of claims in order to gain a profit and other methods of defrauding the whole health care system (Hyman, 2001; Dronberger, 2003). This type of fraud is slightly different between countries.
and it is based on how the system is financed (NHS, 2006). Some practitioner schemes includes, individuals obtaining subsidized or fully-covered prescription pills that are actually unneeded and then selling back for profit; billing by practitioners for care that they never rendered; filing duplicate claims for the same service rendered; altering the dates, description of services, or identities of member providers; billing for non-covered services fabricated as covered services; modifying medical records; intentionally reporting an incorrect diagnosis for repeating; repeat the medical procedures with an aim to maximising the claims; use of unlicensed or accredited staff; accepting or giving kickbacks for member referrals; waiving member co-pays; and prescribing additional and unnecessary treatments (Busch, 2008; Griffith & Shaw, 2000).

On the other hand, members of the community can commit fraud with these schemes by providing false information when applying for benefits or services, forging or selling prescription drugs, using transportation benefits for non-medical related purposes, and loaning or intentionally using others insurance cards (Feldman, 2001; Hyman, 2001; Busch, 2008a). Health care fraud is highly related with insurance fraud because the final victims in the systems that need to settle the bills are the insurers.

4. *Charity fraud*—can be broadly defined as fraud that is formulated again or within a charitable organization (FAP, 2008). This is an act involving deception when money is collected from people who believe that they are making donations for charities. While, actually the perpetrators are taking the money for their own benefit. This type of fraud becomes a major problem when the perpetrator sometimes acts on behalf of the real organization with fake identities, culminating in the real organization being treated as irresponsible in managing funds or careless in organizing the security of the organization (MacPherson, 1995; Lambsdorff, 2002; Jones, 2004).

5. *Cheque frauds*—this involves activities or forging and or making unlawful use of cheques in order to illegally acquire or borrow funds that do not exist in the account balance or account- holder’s legal ownership in the time period (Belkaoui & Picur, 2000; Bierstaker et.al, 2006). There are several methods used such as floating (the time between the negotiation of the cheque and its clearance at the bank), kiting (where funds are deposited before the end of the float period to cover the fraud), and paper hanging (where the float
offers the opportunity to write fraudulent cheques but the account is never reloaded) (Wells, 2002; Well, 2011).

6. Counterfeiting products, money and intellectual properties - involves broad categories of precious substances in order to gain some rapport, credible to the users and gaining monetary and non-monetary benefits from it (Levi & Burrows, 2008; Albrecht et. al., 2011). When counterfeiting a product, it is more about the imitation which infringes upon a trade mark, patterns or logo that are held by certain corporations or state. Sometimes, the same product were have to produce to bypass the monopoly of brands but this unlawful act are taking advantage on the established name of certain corporation (OECD, 2008). With reference to money, it is about the activity of creating the forgeries and circulating it in the money market with clear unlawful intention (Derrida, 1993). While, a counterfeit intellectual property comprises of many items such as pharmaceutical inventions, technological software or hardware, books, articles, etc (see http://www.ipo.gov.uk/home). This is also, treated as illicit because it does not give an acknowledgement to the owner of such items.

7. Cybercrime - is a computer crime that can be defined as a criminal activity that involves the information technology infrastructure, including illegal access (unauthorized access), illegal interception (by technical channel of non-public transmission of computer data to, from or within the computer infrastructure), data interference (unauthorized damaging, deletion, deterioration, alteration or suppression of computer data), system interference (interference with the functioning of the computer system by inputting, damaging, deleting, deteriorating, altering or suppression computer operation system), misuse of devices, forgery (identity fraud) and electronic fraud (schemes that try to cheat the other users) (Grabosky, 2006; Fafinski, 2009;). The act of cybercrime is becoming a major threat to the public and private sectors since the initiatives of moving most of their operation by using an application through computerized infrastructures. This make the works to be more efficient and effective, but threats create a mass of problems and most of the time the computerized threats are in order to generate financial gain.

8. Procurement fraud - this involves fraud and corruption during the purchasing process, in the public and private sector, including several methods such as price-fixing rings, misuse of insider information in the development and application of contracts (Levi & Burrows, 2008). Typically, procurement fraud involves an employee working with the outside vendor of a
company to defraud his employer through bogus and inflated invoices, services and products that are not delivered, work that has not been done and some manipulation in the contract. At the exchange, the employee would get their kickbacks. Often, the perpetrators would establish shell or shadow vendors that are dummy companies with puppets or fictitious CEO’s and manipulates them to con their own company (Greene, 2003; Wells, 2004).

9. Tax fraud- involves the act of individuals or organizations to comply with the taxation system whether direct, indirect or excise tax imposed by the authorities with the unlawful intention of using some formulated method (MacPherson, 1995; Wells, 2004; Welsch, 2005; Levi & Burrows, 2008). Tax fraud is becoming the national agenda because if the dishonest people are not paying their fair share of tax it does not create a “level playing field” for businesses or customers. This can lead to negative effects on society such as higher prices, possible tax increases by the government and inadequate funding for government function. The burden of covering these shortages falls on honest taxpayers and the public in general.

10. Bribery or Entice- is a form of pecuniary corruption that is an act of implying money or gift that alters the recipient’s decision towards fiduciary duties or items in an economic transaction (Wells, 2011). The bribe is something that influences the decision made by the recipients. Based on the legal definition in Black’s Law Dictionary (2012) bribery is,

_The offering, giving, receiving, or soliciting of something of value for the purpose of influencing the action of an official in the discharge of his or her public or legal duties._

This means that it is one form of fraud that is highly dangerous because it will become the disease in organizations as everybody is exposed to this kind of threat when carrying out their routine jobs or fiduciary duties (Hodess & Wolkers, 2004; Welsch, 2005; Lambsdorff, 2007)

Even though, there are still many types of fraud existing in the world nowadays, the categorization stated above is suffice to determine the kind of fraud and the organization involved. Most probably, fraud determination is going to fall into several categories (Wells, 2004; Iyer & Somociuk, 2006; Levi et. al, 2007;Button, et. al., 2008; Levi & Burrows, 2008) based on the justification made by the anatomy of how fraud is defined (Belkaoui & Picur, 2000; FBI, 2005;Albrecht et. al., 2006) and how it impacts on society as a whole (Feldman,
The next part will discuss the extents of fraud.

2.3 Extent /level of fraud

Fraud and corruption against the economy has existed from time immemorial and it is now receiving an increased global awareness (Levi, 2007). The problem plagues both developing and developed countries (Pillay, 2004). The Global Economic Crime Survey that has been assessed by the PWC in November 2011 have showed a ‘big’ surprising fact about how arousing the economic crime especially fraud activities. In their estimation that almost 1 out of 10 reported frauds will be involved in an amount more than USD 5 million. While, 56 per cent of the respondents can be sure that fraud involved in companies are internal jobs. Also, surprisingly they indicate 61 per cent of companies still have a business relationship with perpetrators even after they have been identified (PWC, 2011).

In Australia & New Zealand, according to the KPMG biennial Fraud and Misconduct Survey in 2010, they have noted that the loss due to fraud increased from AUSD301.1 million in 2008 to AUSD345.4 million in 2010. The average loss for each organization for at least one incident also rose from AUSD1.5 million in 2008 to AUSD3 million in 2010. 53 per cent of the respondents experience at least one fraud incident in their company with more than 500 employees during the survey period conducted. An interesting fact also disclosed was that at least 11 respondents have fraud losses that exceed AUSD 1 million in each period and most of them are finance and insurance companies (KPMG, 2010).

The United Kingdom economy is also having no exception regarding the increment of the cost of fraud estimates where a lot of authorities and agencies have their own indicators and values. In 2011, National Fraud Authority (NFA) has estimated the cost of fraud in the Annual Fraud Indicators to the nation’s economy is £38.4 billion (NFA, 2011). While, according to the KPMG Fraud Barometer that mainly considers fraud cases that amount to more than £100,000 (to be heard in a UK crown court) 74 per cent of fraud are commercial business which in the first half of 2011 were valued at £47.8 million (that is from the total of £60 million during the year) (KPMG, 2011). Hence, based on the PWC Global Economic Crime Survey in 2011 also, about 51 per cent of the UK organizations report on economic
crime and insurance fraud is the third most common type of economic crime (PWC, 2011). Not be forgotten, in 2007, the Associations of Chief Police Officer (ACPO) also estimated the cost of fraud and predicted it to be at £14 billion per year (ACPO, 2007). While, Association of British Insurer estimated that insurance fraud would cost £2 million in 2011 and added at least £44 increment to premiums paid annually by UK households (ABI, 2011).

While, in Malaysia according to the KPMG Fraud Survey 2009, it determined fraud as a serious threat within companies in Malaysia with 49 per cent of the respondent companies at least experiencing one fraud case during the survey period. From these cases, about 47 per cent have disclosed a total loss of £ 13.05 million (RM63.95 million) while the remaining did not reveal the exact figures. There are about 714 separate cases of fraud in total that have been reported by 84 per cent of the respondents while the remaining is left as unsure about the numbers of fraud incidents. This survey has been administered to almost all companies listed in Bursa Malaysia (Malaysia main stock market) and a selection of the top 1,000 ranked companies (KPMG, 2010).

Actually, fraud has been noted as a worldwide sharing problem without considering the level of the country’s economy or the social conditions. In all probability, every country could publish a similar volume of economic crime amounts and estimates whether they are of first or third world countries (Welsch, 2005). The fact that much of the Third World corruption has important significance with the First World participation is also now a commonplace (Jandosova et. al., 2003). This is because the world today is exposed to the idea of an open world, thus economic and social issues become global issues. This ideas are similar to the ideas of corrupted government agencies (Jones, 2004; Payne, 2008), health care providers (Sparrow, 2000; Busch, 2008;) and corporate dishonesty (Albrecht et. al., 2006; Wells, 2011). This is a common agenda shared between the countries and it is making the world cautious.

The international non-government organization (NGO) Transparency International(TI) focuses on corruption in "international business transaction" and points out that there are First World givers of many Third World bribes (Uhlenbruck et. al, 2006). In coming years, the World Trade Organization will find this issue as a central one (Rodas, 2003). This is probably giving a meaning that the issues of fraud are now global agendas, as it have swept across the world due to international businesses and country engagement (Payne, 2006; Wells, 2011).
In justification of the impact of fraud on economy, Mo (2001) finds a significant impact of corruption on growth between 1970 and 1985 from a cross-section of 45 countries, controlling for initial GDP, population growth and political rights. He modifies the regression by successively including further explanatory variables in the regression to ensure the relationship would be better. In particular, these are the ratio of investment to GDP, the level of political stability (measured by the number of assassinations per million populations per year and the number of revolutions) and human capital formation (measured by average schooling years). He finds that more than half of corruption's impact runs via its effect on political stability, more than 20 percent via its impact on the ratio of investment to GDP, another 15 percent via its adverse impact on human capital formation and the rest is of a direct nature.

The results from the Transparency International (TI) Corruption Perception Index 2011 can be used to raise awareness of the extent and impact of fraud as judged by the general public. The survey was carried out in 183 countries (including the UK and Malaysia) to assess perceptions about corruption per say as occupational fraud, experience of corruption, and expectations concerning corruption levels in the future. The overall results show that parties and political corruption are the main problem. People believe that political parties, followed by parliament/legislature are the institutions most affected by corruption in their country. Corruption Perception Index (CPI), which relates to the perception of well-informed people with regard to the extent of corruption. In 1998, Malaysia was ranked 29th from a sample of 99 countries; falling to 34th in 2002 and 39th in 2004. In the recent 2011 survey, Malaysia was ranked 60th with a score of 4.3. In comparison the UK are ranked 16th place with a score of 7.8. The comparison of this CPI would be relevant to highlight on the possible direction of differentiation for the level of insurance fraud countering initiative since Malaysia is not very concerned on the fraud matters and also having a low level of transparency (TI, 2011).

In addition to this, the cost of fraud and corruption is four-fold: economic, social, environmental, and political. Fraud against public sector agencies affect the community as a whole through loss of government resources (Smith, 1999) or scarce resources are not converted to services benefiting the citizens (Ziegenfuss, 1996; Herbert, 2005). This could also encourage non-financial harm as unwelcomed public attention and media scrutiny could diminish community confidence in public institutions (MacPherson, 1995; Butler, 2004) as well as citizens lose faith in the ability of the government entity’s leadership to govern
(Ziegenfuss, 1996; Rodas, 2003). An example of this is the adverse environmental effects of corruption that were investigated by Welsch (2004) using a cross-section of more than 100 countries. The author argues that corruption increases pollution. This is attributed to both a direct impact of corruption, reducing the effectiveness of environmental regulation, and an indirect impact, through which corruption lowers income. An adverse impact on emissions cannot be established. The author suggests that this may relate to corruption adversely impacting on the accurate reporting of this data. Moreover, significant results can be found for ambient pollution of air (urban sulphur dioxide and suspended particulate concentration) and water (dissolved oxygen demand and suspended solids). These results control income (which is assumed to have a non-linear, U-shaped impact on pollution) (Welsch, 2004).

In addressing the growing concerns regarding the occurrence and scale of public sector fraud, the United Kingdom government, for example, has taken steps which include the formation of institutes such as the National Fraud Authority (NFA), National Fraud Reporting Centre (NFRC). Additionally the introduction and refinement of various governmental financial and non-financial rules, regulations, procedures and acts in order to curb the situations, known as the Fraud Act 2006. They are also supported by the Fraud Advisory Panel (FAP) that monitors alerts relating to the level of fraud and corruption in the country. The Central government departments within major fraud losses also established their own specialist unit such as; The Department for Work and Pensions (DWP), Her Majesty’s Revenue and Customs (HMRC), The Department of Health (NHS Counter Fraud Service), Ministry of Defence Fraud Analysis Unit (DFAU) and the Foreign and Commonwealth Office (FCO) (Levi, et al., 2007; Button et. al, 2008; Levi & Burrow, 2008).

FAP have conducted simple observations of the financial services business and determined that there are numerous typologies in the economic, which motivate criminal activity. During this study that established in UK it was shown typology of piracy and copyright theft, identity theft, theft by employees or directors, breach of fiduciary trust, false accounting, corruption, phoenix companies and long-firm fraud. This type of crime affects the economies specifically, the business itself, the business sector and has also disrupted the reputation of the financial centre in business as a whole (Wright & Sylla, 2003).

The fraud extent shows the increment of numbers in term of cases and financial gains at the same time. Besides that, almost all countries, crossing all over sectors have started initiatives
to measures the fraud level concisely in order to curb it with proper establishment of authority and regulatory bodies.

2.4 Causes of Fraud and Occupational Fraud

In the economic sector, the entities involved are better placed to determine the possible causes of fraud, as they take up their daily operational duties. This would help to develop anti-fraud strategies within the organization. Transparency International (TI) has reported a 1994 research project carried out by the Independent Commission Against Corruption (ICAC) in New South Wales, Australia regarding this matter in 2003. The ICAC objective is to determine the code of conduct public sector employees would judge as corrupt, and determine factors that might keep them from reporting it (Watson, 2003, p.41). The survey results revealed:

*Individual respondents differ sharply on their views of what was- or was not - corrupt. [It] is important for all who are interested in minimising corruption to realise that what any one public sector employee understands as ‘corrupt’ may not be shared by his or her colleagues. This lack of commonality of understanding adds to the difficulty of combating corruption.*

In most of ‘private gains’ cases from the public money, it is important to take into consideration that the driving factors behind this are not always monetary, but may also link to status and power. Lambsdorff (2002) pointed out that non-monetary forms are often preferred since they are less traceable and more difficult to prove by prosecution authorities. The culprits of private gain do not need to report directly to the corrupt agent, which may also benefit members of his family or friends, for example. On the private side, occupational fraud is used either to avoid due costs, for example to avoid certain institutional processes, or to obtain some undue benefits that wouldn’t have occurred otherwise (Rose, 1996; Adams, 2010). In the context of the insurance, the cases of fraud are always being dissolved by rejecting payments.
Belkaoui & Picur (2000) identify situations most conducive to fraud using four theories from criminology: conflict and consensus approaches, the ecological theory, cultural transmission theory, and anomie theory. Conflict and consensus approaches hypothesize about law and society (Carley, 1978 as cited by Belkaoui & Picur, 2000). The consensus approach sees law developing out of public opinion as a reflection of popular will, whereas the conflict approach sees law as originating in a political context in which, influential interest groups pass laws that are beneficial to them. To explain fraud in an accounting environment, the conflict approach would argue that accounting interest groups (influential groups) present a favourable picture by insisting that they can have control over fraud. This leads to less stringent regulations enacted for fraudulent cases. The consensus approach, on the other hand, refers to the widespread consensus regarding the community’s reaction to accounting fraud and to the legislation enacted. The approach may have resulted from either the ignorance or the general indifference of the public in relation to a situation. The ecological theory assumes that criminal behaviour is a product of common values incapable of realization due to social disorganization. Social disorganization is the decrease in influence of existing rules of behaviour on individual. Fraudulent behaviour in accounting is a result of a basic social disorganization. It is the general public’s failure to function effectively as an agency of social control that is the immediate cause of corporate fraud. Unlike the ecological theory, the cultural transmission theory attempts to identify the mechanisms that relate social structure to criminal behaviour. One mechanism is the concept of differential association, implying that fraudulent behaviour in accounting is learned. (Belkaoui & Picur, 2000; Bazley, 2008). In relation to this study, it is relevant to have a look at the dimension related with insurance fraud which are multi-level as it involves with ecological, cultural and anomie theory. (Yusuf & Babalola, 2009)

The crimes that occur in relation to accounting within the government sector are complex and hard to be determined (Bierstaker et. al. 2006; Albrecht et. al., 2011). Accounting itself acts as the social construction for the government which oversees all public responsibility in each agency and therefore, the government needs to have their own socially developed principles and guidelines that would lead the inclusion of all (Wells, 2011). In their mission to promote better governance, the Government should not exclude agencies from being prone to fraud by promoting public accounting systems that would be more transparent and reliable in the form of modified accrual systems(accounting entry system) (Marshall, Wayne & Viele, 2010). But the importance of assessing the power of institutions, particularly in government
agencies, including the accounting matter is perhaps to encourage a better governance policy and help the government to inspire more reliable policies to be used (Razaee, 2002; Chang & Li, 2011). The case is applicable by putting the government in a private company situation.

The problems of improving the internal controls in the public and private sectors are becoming major concerns (Jones, 1993; Ziegenfuss, 1996; Smith, 2005). To prevent this, accountability must be facilitated through clear and transparent documentation and internal auditing procedures. Clear and standardized rules of behaviour have to be introduced in day-to-day business with ‘well-defined’ responsibilities (Pillay, 2004). Documents, reports, and data concerning decision-making should be made available on the internet for anyone interested. Decisions must be verifiable and reproducible. In order to minimize the risk of fraud, correct accounting is crucial: receipts and bills must be checked, and expenses, where possible (Wells, 2004). Technical issues and decisions should be taken in working groups and not by single regulators, and tracks on the decision-making process should be recorded (Jones, 1993; Belkaoui & Picur, 2000; Hoffman, 2003).

When fraud cases occur, the economy is not only affected by financial losses, but is also a reflection on the ineffectiveness of accounting systems, internal control structures and performance of those in charge of the resources in each agency (Doig & Macaulay, 2008). It is interesting to look at internal auditors’ perspectives, as to how aware they are of fraud, and have them share their experience and how they prepare their agencies against fraud taking into account current the fraud situation in federal government agencies i.e. in the United Kingdom (Button et. al, 2007). The fraud environment in the economy is a dominant one that contributes more cases in insurance because the opportunity creates earlier in the economy (Yusuf & Babalola, 2009).

Robert, Gilovich & Regan (1996) have conducted an experiment on fraud and corruption, in which individuals could simultaneously choose the bribe they receive and the level of damage done to their principal. As detection, decisions were determined only by individuals’ willingness to place self-interest over the concerns for others. In their experiment neither different degrees of risk aversion nor different expectations about the behaviour of others mattered. Their results support the notion that people as the ‘economists’ tend to pursue their own interest more than others. They make comparisons with the students that do not alter their attitude towards corruption as they progress through university, regardless of whether
they are students of economics or of any other field. This contradicts the notion that the more self-interested behaviour of economists is a result of economics education; rather, it supports the self-selection hypothesis. So, as the insurance is the economy output product, it will turn to ideas that those who have the economic education would rather less being included in the cases of insurance fraud (Thanasegaran & Shanmugam, 2008).

In order to make broader comparisons, it is wise to take into account other perspectives on the level of fraud and corruption within in a country. For example, a survey commissioned by the UNDP on perceptions of corruption in Kazakhstan details views of the government officials relating to corruption. Quantitative research was conducted (focus-group discussions) and (by interview). It was found that the two most prevalent types of corruption in Kazakhstan in the opinion of civil servants are bribery (31%); and provision of favours to relatives (22%). Causes of corruption cited includes low standard of living, low professional level of civil servants, disparity between responsibility and salary, and failure to comply with laws, and high taxes. Finally, anti-corruption measures were proposed by civil servants, which include improvements on people’s living standards, strict observance of laws and legitimacy, increase in official’s salaries, and simplification of bureaucratic procedures (Jandosova, et. al., 2003). This directly shows that there is some mechanism that is viable to control the occupational fraud in the workplace.

Based on Fjeldstad & Tungodden’s (2001) research in Tanzania, the government reaction or prosecution failure had created consecutives methods of corruption. They argued that the way customs services were downsized in Tanzania was a failure because those officials who were fired at a later stage became intermediaries and created trusted corrupt relationships. After an initial crackdown on corruption, corrupt networks revitalized and strengthened, and corruption returned to its original level. Apparently, strategies in fighting corruption may fail if they do not adequately take into consideration network ties and mechanisms that facilitate corruption (Flanary and Watt, 1999).

Smith (1999) argues that the use of computer technology by government agencies creates additional risk of fraudulent conduct within organizations. These fall into five categories, which are theft of benefits, money, information, hardware and software, and time. The ideas on controlling the possibility incidence of fraud, three matters need to be effectively managed: culture, control environment, and accountability (MacPherson, 1995). While,
Klitgaard (1998) has promoted that for cultural change or change in consciousness to reduce corruption, cultivated highly ethical conduct through a code of conduct for government official, statements of accountability, and other approaches to reduce corruption based on the operational of the government are required. Technology and the cultural conduct are supposed to be realign if that is possibility of the fraud elements would be exist in the company.

Lambsdorff (2002) concluded that some limitations have to be bore in mind that cases of repeated transactions, asymmetry and leniency may be fruitless. Thus, asymmetry and leniency may unfold their effects in rather a short time, large transactions which often at times are part of grand corruption schemes. But, it is very difficult for prosecutors to establish the link between the officials’ services and the bribe payments, because of the complex and subtle payment or gift-exchange schemes involved during long time periods. An example of some undesirable outcomes would result in when a public official harasses businesspeople and attempts to extort a bribe. Clearly, the solicitation of such a payment should be subject to legal punishment. This shows that consideration of these issues provides a potential dilemma to lawmakers, because respective sanctions are likely to squeeze the bribe-takers into a ‘pact of silence’.

Moreover, given the lack of legal enforcement, transaction costs might increase as more complex and thus costlier safeguard mechanisms have to be sought (Lambsdorff, 2002; Wells, 2011). Most of the time environmental effects in an organization actually motivate the situation. When corruption becomes the norm, everybody would consider it to be something practical in the organization (Jones, 2004; Johnston; 2005; Iyer & Somociuk, 2006).

2.5 Initiative to Combating Fraud and Occupational Fraud

Fixing fraud and occupational fraud in economy is not easy because it is the cumulative effect from various aspects of politics, social, economy and the environment (Jones, 1993). Klitgaard (1988) has noted one of the successful examples of countering fraud with several themes:
Punish some major offenders.
The more successful strategies are known as "fry a few big fish." It is essential for the authority body or company to determine the major offender because they are the master minds in almost every fraudulent situation (Jones, 1993). When a culture of exemption from punishment exists, the only way to break it is by trying to prove the number of major corrupt figures to be convicted and punished (Johnston, 2005). For example, it is wise if the government quickly attempts to identify a several tax evaders, a few big bribe givers, and a few high-level government bribe takers (Lambsdorff, 2007).

Involve the people in diagnosing corrupt systems.
Successful campaigns involve the people that might come from the general public, educators or professional bodies that have expertise in giving their wise thoughts to tackle the current condition of fraud in an organization (Iyer & Samociuk, 2006;). The organization needs to ‘listen’ to the voices of the people because these citizens are actually the most appropriate sources than those being provided by government agencies. A lot of applicable elements available in order to gain their response includes systematic client surveys, citizens’ oversight bodies for public agencies, the involvement of professional organizations, hot lines, call-in agents, educational programs, village and borough councils etc. (Well, 2004; Johnston, 2005). Business people and relevant stakeholder groups should participate with the protection of anonymity in the indicative studies of how corrupt systems of procurement, contracting administration, and how it should be functioning (Duso, 2005).

Focus on prevention by repairing corrupt systems.
It is vital to tackle corruption efforts when the initiatives to fixing the corrupt systems (Levi et. al., 2007). The most important emphasis needs to consider on preventing corruption at the first stage because so much money would be involved in making such authority body responsible with, developing policy and strengthening current law and order in official offices (DiPierto, 2003; Jones, 2004; Johnston, 2005; NHS, 2006).
Reform incentives and salaries

One of the major contributors of corruption has been determined by ‘unfair’ mechanisms of incentives and salaries (Herbert, 2005; Levi & Burrow, 2008). In many third world countries public sector wages have fallen so low that a family cannot survive with the current economic conditions and high inflation rates (Gupta, Davoodi & Tiongson, 2001). Moreover, the public officers also try to adopt performance measurements that probably lack in measurement tools which makes corruption flourish. Unfortunately, most organizations now days implement a performance measurement that impacts on salaries and incentives. This culminates in enhancing the motivation of low performance people to engage in elicit activities that increase fraud and corruption in the public sector (MacPherson, 1995; NHS, 2006). Wisely, more, physiological performance measures should be introduced to ensure a different interpretation on the incentives. (Jones, 1993;).

Boehm (2007) also highlighted that direct rewards for behaving honestly are one of the most brilliant ideas in order to improve the system. It creates an intrinsic motivation in the minds of staff because it raises the incentive to not engage in corruption but to work better in order to achieve the incentives offered.

There is some notion in organizations that the burden to detect fraud is placed on an internal or external auditor (Hillison et. al., 1999; Bierstaker et. al, 2006). For example, we can look into SAS 110 that sets out the external auditors’ current responsibilities regarding the reporting of fraud. It notes that, “if they discover a fraud auditors should as soon as practicable communicate their findings to the appropriate level of management, the board of directors or the audit committee” (para 41), but “when a suspected or actual instance of fraud casts doubt on the integrity of the directors, auditors should make a report direct to a proper authority in the public interest without delay and without informing the directors in advance” (para 52).

Wright (2007) stressed that fraud is something that is related to economic motivation, tools that might be effective in combating it are law enforcement or using services in the financial services industry. Something related to law enforcement is just like making a bill in the legislation structure that includes all types of fraud existing in the country. Besides that, effective use of power of an enforcement officer also becomes crucial in order to maintain the
structure of curbing fraud situations. The power includes arrest, investigation and prosecution, restitution for the fraud situation and also the asset of recovery from the case. Meanwhile, in order to use the financial services industry, fraud needs to be included as a business risk in the organization. When included in the risk, fraud would be analyzed during risk assessment as it is enacted and is emphasized in the risk strategic planning. While planning risk, they need to have a clear emphasis on the attitude of the company towards whistle-blowing in the anti-fraud policy, this is essential (Wells, 2011). When they have the policy, it should be ‘functioning’ as the statement of the policy and needs to be disseminated to the members of the organization (Albrecht et al, 2011). They would also need to be members of the organization committees and need to have their own assigned responsibilities according to the policy. The most effective tools also are to make sure that ethical culture towards anti-fraud being institutionalized to the whole members of the organization.

In the UK, through Fraud Review 2006, some significant improvements on combating fraud direction in the public and private sector, as well as a whole were noted by Doig & Macaulay (2008). Some output noted by the researcher is the establishment of the National Fraud Strategy Authority (NFSA) that is involved as the main national integrative authorities’ bodies in order to make recommendations towards the initiatives of curbing fraud in the public sector as a whole. Additionally, the multi-agency coordination groups within the NFSA are going to function as facilitators to anti-fraud work in priority areas designated by the authority. In 2011, NFSA took the initiative of Fighting Fraud Together which is a strategic alliance initiative under the Home Office to ensure that every unit aiming to combat crime manages to collaborate together, to share certain resources on mutual understanding and ability to have a proper arrangement without clashes among them UK (NFSA, 2011).

Fighting fraud and corruption is only one part of a broader effort and crucially needs an institutional adjustment, the systematic recasting of information and incentives in public and private institutions (Boehm, 2007; Button et. al., 2008). For example, in Australia, the government issued a fraud control policy in May 2002 in the form of regulations made under the Financial Management and Accountability Act 1997 (NHS, 2006). The introduction of the Fraud Act 2006 in the UK covers any obscure justification on fraudulent activities that is considered as a major initiative towards combating fraud and corruption. (Levi et. al., 2007Levi & Burrows, 2008)
2.6 Focusing on Insurance Fraud

2.6.1 Definition of Insurance Fraud

In the last chapter, the term insurance fraud was defined using some of the dictionary and practitioner ideas. Once again, it is wise to look at general ideas of what constitutes fraud;

*Insurance Fraud occurs when people deceive an insurance company or agent to collect money to which they aren’t entitled. It is a criminal act requiring a material and intentional misrepresentation in order to obtain a benefit, or cause a benefit due someone to be denied. Similarly, insurers and agents also can defraud consumers, or even each other’s.*

(from https://fraudeducation.com/Medical_Insurance_Fraud_Red_Flags.pdf)

While, for Malaysia, the BNM and all the insurance companies’ cooperation provided an explanation that interprets insurance fraud as (based on insuranceinfo.com.my),

‘*Insurance fraud or takaful fraud is any deliberate deception/ dishonesty committed against or by an insurance company or takaful operator, insurance or takaful agent, or consumer for unjustified financial gain. It occurs and may be committed at different points in the transaction by different parties such as policy owners, third-party claimants, intermediaries and professionals who provide services to claimants. The nature of these frauds may vary from an inflated/ exaggerated value of a legitimate claim to a completely fabricated or bogus claim where losses never really occurred’*

The definition above is detailed and determines insurance fraud in the industry with the emphasis on the possible parties that might be involved. Nonetheless, one of the most essential components that would declare it as insurance fraud is when the deceiver intentionally perpetrates the insurance company or takaful operators, officer in a company or a third party. This would involve either financial or non-financial gain as the result of the deception.
2.6.2 Types of Insurance Fraud

The Association of British Insurers (ABI) can be used as an example in a real economy situation. ABI categorises two major types of fraud, that is: premeditative (hard fraud) and opportunistic (soft fraud) (ABI, 2006). Premeditative (hard) fraudsters plan their offence in advance, by taking out an insurance policy to obtain money or another advantage that they are not entitled to (CAIF, 2007). Hard fraud occurs when someone deliberately plans or invents a loss, such as a collision, auto theft, or fire that is covered by their insurance policy in order to receive payment for all damage claims (Krawczyk, 2009). Criminal gangs are sometimes involved in hard fraud schemes that can steal millions of dollars with major plans that would enable taking advantage of the policy terms by the companies (Yusuf & Babalola, 2009).

Meanwhile opportunistic (soft) fraudsters inflate or exaggerate a genuine claim against their insurance policy to obtain more money than they are entitled to (III, 2007). For example, when making a ‘bogus’ claim on their home contents insurance policy following a burglary, an opportunistic fraudster may exaggerate the value of the stolen items (ABI, 2005). Palasinki (2009) found in his research regarding insurance claimants that most of drivers interviewed; on the average of all male drivers know about how to commit insurance fraud and to make it successful. In the detailed, they have determined as very creative in the representation of fraudulent behaviour and at the same time assumed as did not reserve the ideas of morality.

Again, Insurance Info produced by BNM in Malaysia, has classified the groups of insurance fraud into 4 main categories as circulated to all insurers in the country that is as in the schedule, but as revised with support from documentation from ABI (2011), it is wise to have 5 categories as a general guideline for all parties in insurance environments that can be classified within Table 2.1 below, that is;

Table 2.1: Modified BNM categorical of insurance types and example of action

<table>
<thead>
<tr>
<th>Categories</th>
<th>Example of the actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating fraudulent claim (Making a falsified claim)</td>
<td>- Bogus claims for any accidents or injuries that never happened</td>
</tr>
<tr>
<td></td>
<td>- Wrongly claim for personal accidents in the case of self-inflicted injuries</td>
</tr>
<tr>
<td>False claim on the unidentified object in the food or drink</td>
<td>-False claim on the unidentified object in the food or drink</td>
</tr>
<tr>
<td>Make a faking death for benefit or filling death claims</td>
<td>-Make a faking death for benefit or filling death claims</td>
</tr>
<tr>
<td>Arson</td>
<td>-Arson</td>
</tr>
<tr>
<td>Overstating amount of loss (Exaggerating amount of claims)</td>
<td>-Inflated or ‘padded’ claims when the illegal act on the genuine amount of accident</td>
</tr>
<tr>
<td>-Inflating value of the items taken during a burglary/ theft</td>
<td>-Inflating value of the items taken during a burglary/ theft</td>
</tr>
<tr>
<td>-Hospital or medical care providers inflating medical bills</td>
<td>-Hospital or medical care providers inflating medical bills</td>
</tr>
<tr>
<td>Misrepresenting facts to receive payments (Providing wrong details)</td>
<td>-Making multiple claims by having multiple insurance coverage with different companies or takaful operators for one vehicle and for one particular accident</td>
</tr>
<tr>
<td>-Claiming illegal damages or prior damages occurring in the current accident</td>
<td>-Claiming illegal damages or prior damages occurring in the current accident</td>
</tr>
<tr>
<td>-Claiming for total disability or partial disability for a minor or unserious injury</td>
<td>-Claiming for total disability or partial disability for a minor or unserious injury</td>
</tr>
<tr>
<td>-Receiving payment for disabilities while able to work elsewhere with same work tasks.</td>
<td>-Receiving payment for disabilities while able to work elsewhere with same work tasks.</td>
</tr>
<tr>
<td>-Medical service providers charging for services not rendered or provided.</td>
<td>-Medical service providers charging for services not rendered or provided.</td>
</tr>
<tr>
<td>-Claiming for false disability</td>
<td>-Claiming for false disability</td>
</tr>
<tr>
<td>-Medical service providers adding unnecessary treatment</td>
<td>-Medical service providers adding unnecessary treatment</td>
</tr>
<tr>
<td>-Charging for medical tests that are not provided</td>
<td>-Charging for medical tests that are not provided</td>
</tr>
<tr>
<td>Bogus agents/ sale of forged cover notes (Forging documentation and identities)</td>
<td>-Sale of insurance by some parties unlicensed by insurance company or takaful operators</td>
</tr>
<tr>
<td>-Someone purporting to become an agent with the insurance company or takaful operator</td>
<td>-Someone purporting to become an agent with the insurance company or takaful operator</td>
</tr>
<tr>
<td>-Sales of forged cover notes by touts or organised syndicates to those knowingly or unknowingly</td>
<td>-Sales of forged cover notes by touts or organised syndicates to those knowingly or unknowingly</td>
</tr>
<tr>
<td>-Purchase of cover notes for the purpose of securing road tax for expired ones on motor vehicles</td>
<td>-Purchase of cover notes for the purpose of securing road tax for expired ones on motor vehicles</td>
</tr>
<tr>
<td>Staged insurance claim</td>
<td>-Staged accidents or by staged chained collision</td>
</tr>
<tr>
<td>-Staged slip and falls creating accidents</td>
<td>-Staged slip and falls creating accidents</td>
</tr>
<tr>
<td>-Staged burglary, theft or vandalism</td>
<td>-Staged burglary, theft or vandalism</td>
</tr>
<tr>
<td>-Staged motor theft or organised</td>
<td>-Staged motor theft or organised</td>
</tr>
<tr>
<td>-Staged homeowner accidents</td>
<td>-Staged homeowner accidents</td>
</tr>
</tbody>
</table>
2.6.3 The Extent of Insurance Fraud

Studies regarding fraud cases have shown that the biggest amount of loss is from insurance fraud since the last decade in major economies such as the US and European Countries (Dixon, 2007; Yusuf & Babalola, 2009). The Association of British Insurer (ABI) has also estimated that the insurance industry loses over GBP3 billion to fraud each year (ABI, 2009). However, it states that due to improvements in detection techniques, this estimate which was higher in previous estimates made in 2006 where just over GBP1.5 billion each year was the cost of insurance fraud. They believe the rise in number is due to low volumes of fraud cases have been decreasing but the high impact fraud cases have been increasing as there are well-organized. After all, the estimates may not be conclusive for the all parties in the insurance industry as the real loss may be due to some restrictions on the data and sensitive cases involved.

The Coalition Against Insurance Fraud (CAIF) in the United States has estimated that in 2006 a total of about $80 billion was lost due to insurance fraud and it cost $950 a year for each family populated (CAIF, 2006). From that estimation, health care fraud contributes a significant amount of around $ 54 billion a year. Health care fraud is difficult to tackle due to the involvement of some ‘major’ parties in the economy and practises such as a practitioner, a lawyer and even sometimes an insurance companies’ employee (Hoyt, Mustard & Powell, 2006). Meanwhile, in Australia, they estimated almost 10 percent of premiums paid by customers would be accumulated as insurance fraud cost for each year in amounts would be AUS$ 1.4 billion (Smith, 2005b).

In Malaysia, the Insurance Services Malaysia Bhd (ISM), an industry research firm has estimated that bogus insurance claims count as one of the insurance fraud methods, and cost the country’s economy RM500 million a year (Business Time Online, 2008). This estimation is based on over 17 percent of total RM3 billion yearly claims in the country’s insurance market. Based on the ISM, most of the 52 member companies that offer insurance nowadays are stepping up their efforts in areas of fraud identification and prevention as part of their wider enterprise risk management strategy (to be determined in this research as one of the objectives). These efforts include the leveraging of fraud databases and technology to be more efficient in identifying fraud (MII, 2009). While the initiatives in the industrial level,
they taking efforts to promote a consumer education campaign on what constitutes insurance fraud and its negative impact toward the economy and consumers.

At the same time, according to an unpublished and internal data by Royal Malaysian Police in Malaysia, it can be concluded that about 10 to 15 percent of claims in Malaysia have fraudulent elements and also the number of suspected frauds have increased on a yearly basis (RMP, 2009). Malaysian insurers relate more to the regulation of the central bank rather than implement their own insurance policies. Central Bank (BNM) has a system called e-Fids (electronic fraud information database system) that maintains a database on all fraud and defalcation cases and breach of code ethics reported by the insurers. This database showed in 2004 the numbers of reported cases had increased from 437 cases in 2003 to 763 cases that involved RM24.1 million (an increase from RM10.9 million in 2003). (Bernama.Com, 2005)

One of the biggest insurance fraud cases in Malaysia was in 2009 showing fraud charges that amounted to RM1.2 million for one single case. This case involved a paralysed lumberjack that was trying to cheat officers at Kurnia Insurance (Malaysia) Berhad by convincing them that the details on a claim given through two legal firms were true. This showed one of the biggest case that involved the intention to overrun the detection system but failed to be granted by the insurance providers since the elements of fraud was corroborated in the judgement (News Strait Times, 2009).

2.6.4 Effect of Insurance Fraud

Most of the time companies are still not very concerned about insurance fraud because it looks like it’s not going to involve their financial stability, but in poor conditions it actually gives a negative effect to consumers in the industry (Viaene, 2004; Thanasegaran & Shanmugam, 2008; Yusuf & Babalola, 2009). Most of the time, insurance frauds appear to be directly related to the ‘unexpected’ increments in premiums and product prices (Dixon, 1995; Crocker & Morgan, 1998; Bermudez, 2007). The costs incurred by insurance companies or takaful operators in combating and paying fraudulent claims will ultimately be passed on to insuring the public in the form of higher premiums (with refer to study by Hoyt et. al., 2006 and Yusuf & Babalola, 2009). Insurance fraud also results in higher prices for goods and
services as business incurs incredible costs when insuring property and stock to the final users (Schiller, 2006; Thanasegaran & Shanmugam, 2008)

Insurance fraud leaves a negative effect to the company as they do not to offer further range of products due to threats by the perpetrators of fraud. This insurance company would looked to impose more underwriting requirements and restrict their scope of coverage to cap losses due to scams or fraudulent acts (Boyer, 2001, Derrig, 2002; Yusuf & Babalola, 2009) as deterrence strategies through ‘strict’ contracts. At the same time, there are possibilities that the insurance providers would withdraw cover to certain sectors that are highly threatened with fraud (Cummins & Tennyson, 1996; Duffield & Grabosky, 2001; Viaene et. al, 2007).

Another well-known effect of insurance fraud is the action by the insurance companies to delay settlement even though the claims are genuine (Pathak et. al, 2005; Schiller, 2006). When insurance companies are suspicious of any claims they will then carry out thorough investigations. The stringent claim settlement procedures put in place by insurance companies to reject fraudulent claims inevitably results in the delay of genuine claims (Tennyson & Salsas, 2002; Hoyt et. al, 2006). This would create more hassle to the customers that are bust of the claims and makes them handicapped temporarily. By that, it is highly important for the customer to be well-educated regarding the consequences of fraudulent claims and scams to ensure they are not trying to commit fraud and burden other consumers (Crocker & Morgan, 1998; Derrig & Zicko, 2006; Moreno et. al, 2006).

2.6.5 Countering Insurance Fraud: Development in UK

The numbers of fraud cases that have increased nowadays within the industry have urged for the establishment of formal arrangement of initiatives among the entire insurers, in a joint effort to counter the issues in a more serious way. In the UK, the establishment of the Insurance Fraud Bureau (IFB) are looking at a ‘well prepared’ and wise decision due to the high cost of insurance fraud. As estimated by ABI in 2011, the cost of insurance fraud is almost £2 billion and the cost of each individual household is an increment of £44 for policies annually. Insurers also uncovered about 2,500 fraudulent insurance claims every week in 2010. (ABI, 2011)
NFA have also joined the ABI in Fighting Fraud Together in a 5 years initiative that indicates they will be joining an effort across the field in order to gain on fraudsters on the economy (NFA, 2011). Some of the important notations in the plan are;

*Stronger collaboration within and across the sector*

Leading businesses, such as banks, the payment industry and insurance companies, are joining forces to strengthen their industry wide abilities to tackle fraud, as well as engaging with local and central government and law enforcement such as sharing data with the National Fraud Intelligence Bureau.

*(pg. 14)*

*Increased awareness of fraud*

The profile of fraud has been increased amongst senior decision makers in government and the private sector, resulting in increased investment and focus. More collective action across the public sector in areas such as procurement fraud is underway. The insurance industry has recently announced its intention to fund a dedicated police unit based in the City of London Police to boost enforcement, prevention and disruption activity following the example set by the UK payments industry which has funded the Dedicated Cheque and Plastic Crime Unit for nine years. This has saved the industry an estimated £370 million...

*(pg. 15)*

(NSFA, 2011)

Besides the ABI, insurers, specialist, law adjusters and the investigation industry in the UK have joined together under a coalition name Insurance Fraud Investigation Group (IFIG). The IFIG started in the mid-1990s and it allows a free joint collaboration of expertise without concerns of any authority with the aim of countering fraud, sharing profiles of fraudsters, having a forum for discussion and sharing relevant intelligence data. IFB is becoming more trustable and powerful organization compared to IFIG effectively from 2006 (IFB, 2006). The IFB also have a special line, Fraud Cheatline, which enables fraud to be reported as soon as possible and the line is highly effective after 5 years of mitigating and reporting insurance fraud in the UK. Unfortunately, in Malaysia, as insurance fraud is not taken very seriously, this kind of arrangement and development remain at the ideas level.


2.6.5.1 Prevention and deterrence of insurance fraud

Prevention and deterrence of insurance fraud are essential at industry and company level because it needs to address the bigger agendas among insurers and the business environment. At industry level, the ideal initiatives are the attitude change that considers insurance fraud as the significant aspect in the economy without underestimating the amount involved (Brinkman & Lentz, 2006; Abramovsky, 2008).

The major prevention strategy available to insurers and at industrial levels are the establishment of data mining that enables the possibility of matching and sharing among all insurers. The data would be kept with certain tagging based on the fraud cases and level of triggers for the investigation. This then enables sharing and random access capacity among the insurers during a normal period of insurance claims (Boyer, 2000b; Dorn & Levi, 2006; Chapman, 2007; Pijec-Bach & Ieee, 2010; Ngai, Hu, Wong, Chen &Sun, 2011).

Deterrence ideas have determined that people who commit crimes on the basis of rational expectation on the perceived benefits and know the threat of legal sanction (harshness and velocity of the punishment) will be deterred for fear of punishment. On the idea of morality assumptions, teaching situational ethics (cause and effect) has been proposed as one idea to mitigate and produce a model of deterrence (Crocker & Morgan, 1998; Dean, 2004; Bourgeon et. al., 2008).

In the economists’ setup, they are more concentrated to truth-telling mechanism that induces the agent to reveal private information in an honest manner in the case of insurance policy (Crocker & Morgan, 1998). Most importantly, in order to ensure that the consumer would behave, the insurers have designed the contract of insurance premium that would be paid by the customers based on the chosen and optimal coverage with additional concerns (Brinkman & Lentz, 2006; Hoyt et. al, 2006; Viaene et. al., 2007). Crocker & Morgan (1998) determined that when designing the contracts, the parties exchange prediction, hence implementation will occur on the basis of the information asymmetry. In addition, they are able to design the agreement; simultaneously they are able to construct some agreement that alleviates the incentives of agents to exploit this advantage through fraudulent acts. As a consequence, it shows that contract design is highly important to ensure that it enables a reduction in the
possibility of fraudulent activities to be executed by both parties (Picard, 2000; Schiller, 2006).

At the same time a more widely recognised method of deterrence of insurance fraud is through post claim auditing (Picard, 1996; Dixon, 2004; Yusuf & Babalola, 2009). Some researchers added up that occupational and technological device auditing strategies can be viewed as strong and effective ways for checking the impact of fraud in claimant settlement (Morse & Skaaja, 2004; Morley et. al., 2006; Bermudez et. al, 2008; Thanasegaran & Shanmugam, 2008). Crocker & Tennyson (2002) suggest that the best remedy against fraudulent claiming is first, auditing the obvious claim that meets the characteristics of a potential fraud and then denying those that could be invalid. This enables the ability of auditing as deterrence tools. Secondly, it is better for the insurer to underpay most of the claims that are expected to be possible fraud. At the end, it possibly would reduce the motivations of the fraudster to add costly scams to inflate claims or appeal the case of underpaying to the higher authorities.

2.6.5.2 Detection and investigation of insurance fraud

The detection of insurance fraud can be formulated in two steps. The first step is to identify suspicious or ‘bogus’ claims that have a high possibility of being fraudulent. This can be done by computerized statistical analysis or by referrals from claims adjusters or insurance agents (Schiller, 2006). Simultaneously, the public can provide tips to insurance companies, law enforcement and other organizations regarding suspected, observed, or admitted insurance fraud perpetrated by other individuals based on the services of ‘fraud line’ or ‘open tipping’ that is established in most country. This possibility would be passed to the investigator to formulate the relevant procedures to entertain the input (Wells, 2011).

Due to the mass numbers of claims submitted each day, it would be far too expensive for insurance companies to have employees check each claim for symptoms of fraud because it would incur extra costs (Moreno et. al, 2006; Schiller, 2006). Instead, many companies use computers and statistical analysis to identify suspicious claims for further investigation. This would be created by red flags on certain policies and claims based on the risk determined on regulated laws (Pathak et. al, 2005; Hoyt et. al, 2006; Viaene et. al, 2007). The final task
would be based on the works done by the investigation officer whether it would need to proceed on to investigation procedures (CAIF, 2007).

Usually, the claim handlers are the first people who are able to determine any red flag that contains anomalies, inconsistencies, patterns of fraudulent claims and staged claims characteristics (Chapman, 2007; Outreville, 2010). This is usually nurtured through experience, written policy or a sharing basis within the organization (Jin, Rejesus & Little, 2005; Yusuf & Babalola, 2009). After the indicators are confirmed as much as possible, they are usually cross-checked through the claim database either as a single company or sharing with others. If all details are proven, the claim handlers usually bring it to their superiors to discuss further action that might involve private investigators or loss adjusters (Womack, 1998; Coenen, 2009; Dionne, Guiliano & Picard, 2009).

Unfortunately, claim handlers are often inexperienced, with less training and subject to higher work time turnover that does not enable them to work as effectively as a professional insurance fraud detector (Kang, Hong, Lee & Kim, 2010). They may not be very familiar with the professional database that would cause several problems to the worksheet such as unconfirmed spelling, data out-dated, quality of database is inaccurate, missing the full set of data makes it time consuming. In order to maintain the ability of the claim handler, insurers are urged to invest more in training and exposure to fraudulent claims (Morley, Ball & Ormerod, 2006; Michael, 2007).

After having the work done by claim handlers they would submit it to either an inside or outside investigator (Morse & Skajaa, 2004; Miyazaki, 2009). Most insurance companies have their own in-house staff to run investigations on suspicious claims. This team is located in the investigation department, risk analysis department or sometimes also in the claim department itself (Martin, 2000). They are mostly someone who already has experience such as ex-police officers or private investigators in order to ensure they are able to exercise their own professional investigation skills (Silverstone & Sheetz, 2007). The reasons for having an investigator from the internal party is mostly a political factor that ensures the evidence and details of any case do not leak out from the organization. Besides that, it can ensure better communication among the investigators with members of staff and also customers will feel more comfortable in giving their responses (Boyer, 2000; Kim & JeanKwon, 2006; Chang & Li, 2011).
The outsiders who are highly involved with insurance fraud investigation are private investigators and loss adjusters. Both of these are also trained officers that come from a background which is highly knowledgeable about the insurance industry and able to communicate well with the insurers, agencies, enforcers and customers (Clarke, 1990; Gill, Wooley & Gill, 1994; Lesch & Byars, 2008). They have more relevant skills that are needed during the investigation. Also, their efficient timing and reliable output plays a heavy in deciding fraudulent cases. Private investigators mostly come from investigation firms, auditing firms, security firms and undercover agencies. While, loss adjusters are mostly registered loss adjusters’ members and have a vast range of connection in the industry (Price, 1991; Martin, 2000; McMillan, 2006). In the UK, they have a special loss adjuster society that is known as The Chartered Institute of Loss Adjusters (CILA). The Malaysian environment that contributes toward this kind of detection and investigation will be discussed further in Chapters 5, 6 and 7 where there will be some evaluation towards the involvement of the party in those tasks.

2.6.5.3 Sanction and criminal prosecution

As known by all insurers, some quarters of the police force lack interest in insurance fraud cases because most cases are kept securely and unreported within the company border for certain reasons (Clarke, 1998; Doig, Jones & Wait, 1999; Seog, 2010; Subelj, Furlan & Bajec, 2011). Thus, it becomes a challenge when bringing the case for the insurer and making it as a relevant idea in conjunction with the relevant authorities on the issues i.e. Insurance Fraud Bureau (UK) and Coalition against Insurance Fraud (US) (CAIF, 2007). Most insurance fraud cases also are not able to recover all the loss because it is usually something that is ‘well expected and estimated’ by the company. Besides, with regards to reputation, all companies carry out sanctions to be more favourable to their customers. This is why the idea are involved that the company still having businesses with their ex fraudsters as getting the ‘best’ of business efforts (Upton, 2005; Outreville, 2010 ;). The records of the criminal prosecution are also limited within the insurance fraud cases in order to maintain the survival of the company in the long run (Ericson, Barry & Doyle, 2000; Dean, 2004; Godfrey, 2009). This idea is very hard to be implemented in Malaysia which is referred to in Chapter 7.
2.7 Selection of the Countermeasures

In order to ensure that combating fraud is successful, all the initiatives need to have certain countermeasures that particularly relates to the action that have been taken. There are many countermeasures within the market and professional bodies, which can be arranged that can counter fraud. Among those that can be used practically and publicly available is CIPFA Red Book 2, 2006; Alarm UK Standards (National Forum for Risk Management in the Public Sector) 2008; IIA US, AICPA, ACFE, Managing the Business Risk of Fraud: A Practical Guide, 2007; and Financial Service Authority (FSA) UK: A Firm’ High Level of Management of Fraud Risk, 2007.

The elements within the Table 2.2 below play a major decision for using the CIPFA Better Governance Forum: Managing the Risk of Fraud Actions to counter fraud and corruption as the instruments is included in the discussion of evaluation in the findings of the research. The first is the aspect of retrospective and prospective, which considers the elements of current practice in the company and not to let the future planning on the prospective time concerns. The second is the compatibility of the elements being evaluated within any types of the organization. In comparison to others, the CIPFA Red Book 2 has more compatibility and flexibility in making the evaluation in the industry, which is beneficial for the research. Thirdly, the elements of evaluation look convenient to adapt in the evaluation and features of the research that are being administrated. Others appear too simple and some might be too complicated to be used by comparing the objectives and data that had already been collected.

The HM Treasury’s (2003) Managing the Risk of Fraud A Guide for Managers, the joint National Audit Office/HM Treasury (2004) Good Practice in Tackling External Fraud are examples. Following on from these and emerging from CIPFA’s work on better governance came the Red Book and then Red Book 2 from the CIPFA Better Governance Forum Counter Fraud Advisory Panel (CIPFA, 2006). The CIPFA Red Book 2 was chosen because it has been produced as a result of the input of various key public sector bodies and experts. Besides, it received the endorsement of the Government’s National Fraud Strategic Authority when it was launched in 2006, with the then interim Chief executive Sandra Quinn stating:

*I am pleased to commend the CIPFA Red Book 2. This valuable resource provides a holistic framework for countering fraud and corruption that supports and is aligned*
to the approach of the National Fraud Strategic Authority, which aims to reduce the harm caused by fraud through the creation of a hostile environment for fraudsters

It was therefore decided to use this guide as the benchmark. However, it could be argued that the development of this guidance has been framed with a public sector organisation in mind. Nevertheless the holistic approach outlined in the document in the authors view, provides a standard which any organisation: public, private or voluntary could follow. The standards set out in the Red book 2 are what an organisation is strongly advised to do to counter fraud successfully under the 5 sections:

- Adopting the right strategy
- Accurately identifying the risks
- Creating and maintaining a strong structure
- Taking action to tackle the problem
- Defining success
Table 2.2 Comparative judgement on the selection of the countermeasures /instruments of evaluation

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The concentration of the instruments</td>
<td>Managing the risk of fraud-actions to counter fraud and corruption from several aspects of the organizational structure</td>
<td>To the risk advisors, as helping to understand fraud, managing, and mitigating the risks of fraud to clients organization</td>
<td>Managing the business risk of fraud on the practical guide more towards using elements of scorecard</td>
<td>Upper level management engagement on mitigating fraud as the main agendas</td>
</tr>
<tr>
<td>The timing of the implementation</td>
<td>Prospective and retrospective elements included</td>
<td>More to prospective suggestion</td>
<td>More to auditing and prospective element</td>
<td>The prospective element more towards planning</td>
</tr>
<tr>
<td>Applicable of the instruments towards the insurance industry research</td>
<td>The element which is simple and suitable to this research data output</td>
<td>The element is more towards the risk advisor who are not the major concerns of the research</td>
<td>The practical elements but not all elements in the instrument are applicable to be adapt in the insurance environment</td>
<td>The research does not merely concentrate on upper level management</td>
</tr>
</tbody>
</table>
2.8 Conclusion

This chapter started with the defining of fraud in order to gain understanding of the types of fraud that is occurring. Besides, this is also to distinguish that there was a correlative effect and occasionally this takes place in the economic condition where there is an interconnection between a public and private setting. Then, this was followed by a comprehensive list of possible actions that would be incurred in the economic setting with multiple conditions and exceptions created by fraudsters. Furthermore, the extent of fraud in the economy highlights the seriousness of these threats in a global economic perspective and specifically on the Malaysian environment. In order to deter the cause of fraud, it is possible to identify the economic consequences of the general social environments. After that, the ideas of combating fraud and corruption could be the best possible options ready to be implemented in the economic setting. A detailed discussion that concentrates on fraud in insurance is needed to keep track with specific issues that will be discussed in this thesis as whole. Not to be left out, the ideas on how the countermeasures are being selected is also discussed with comparisons to create positive ideas on selections of the instruments. The following chapter will thoroughly discuss on the administration of the research with the concepts used, collection of data process and brief details of the companies and the research instruments involved.
CHAPTER 3

RESEARCH METHODOLOGY

3.0 Introduction

This chapter will discuss the methods used in this research to investigate insurance fraud in Malaysia. The chapter describes the interviews, documentation secured and observation undertaken for this research. It will highlight some of the significant challenges of researching this topic in Malaysia. The remaining chapter will discuss in detail the constraints involved during the administration of the research, data collection process, analysis and the assumption underlying the whole process. Finally, it will highlight the reasons for selecting CIPFA Red Book 2 as the evaluation criteria on the issues.

3.1 Research Aims and Methodology

As mentioned earlier in the Chapter 1, this research has determined 4 main objectives together with 12 research questions. To achieve that, a methodology was designed to accomplish the objective and also the research questions that were determined earlier (Silverman, 2010). Table 3.1 below simplified the relationship between all of these ideas when the aim is followed with relevant research questions associated with it and it will follow through to the research methodology that has been administered throughout this study.
Table 3.1: Objectives, Research Questions and Research Method Applied in the Study

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Research Questions</th>
<th>Research Method Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>to review the counter fraud strategy implemented by Malaysian insurance companies.</td>
<td>- What are the processes and procedures that are involved in the claims unit of Malaysian insurance companies that enable prevention and detection of fraud?</td>
<td>- Semi structured interview with the claims unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Observation</td>
</tr>
<tr>
<td></td>
<td>- What is the method used for risk assessment in determining the possibility of insurance fraud from their customers (claimant and intermediary fraud)?</td>
<td>- Semi structured interview with the investigation unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Risk policy observation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Claim handling document inspection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Follow-up survey</td>
</tr>
<tr>
<td></td>
<td>- What are the major red flag techniques being used by the claims and investigation unit in determining the possibility of fraud?</td>
<td>- Semi structured interview with claim/investigation unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Policy documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Follow-up survey</td>
</tr>
<tr>
<td></td>
<td>- Did the anti-fraud and scam strategies used benefit the Malaysian insurance companies based on cost consideration?</td>
<td>- Semi structured interview with claim/investigation unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Documentation inspection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Follow-up survey</td>
</tr>
<tr>
<td></td>
<td>- How are the investigations administered in Malaysian insurance companies when suspected fraud and scams are confirmed?</td>
<td>- Semi structured interview with investigation unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Interview with Royal Malaysia Police (RMP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Follow-up survey</td>
</tr>
<tr>
<td>Question</td>
<td>Methodologies</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>What are the practices of prosecution procedures for cases involved with insurance fraud by insurance companies?</td>
<td>Semi structured interview with investigation/claim unit, Policy inspection (observation), interview RMP, Follow-up survey</td>
<td></td>
</tr>
<tr>
<td>-What is the current condition of countering insurance fraud activities in Malaysian companies based on the Central Bank of Malaysia’s perspective?</td>
<td>Semi structured interview with BNM,</td>
<td></td>
</tr>
<tr>
<td>-Is the anti-fraud culture already becoming a major consideration for Malaysian insurance companies from the industry society ideas?</td>
<td>Semi structured interview with PIAM, LIAM, AMLA, NICS, Claim Adjusters, -Follow-up survey, Interview with RMP</td>
<td></td>
</tr>
<tr>
<td>Is the company evaluation on countering initiatives through CIPFA Red Book 2 going to show good indicators for all participating companies in this case study?</td>
<td>Semi structured interview with claim/investigation unit, Document inspection, Observation, Review the details of CIPFA Red Book 2</td>
<td></td>
</tr>
<tr>
<td>Is the existing legislation the main function in order to ensure that procedures for sanction are implemented?</td>
<td>Opinion gathered from semi structured interview with insurance company and industry, Interview with RMP</td>
<td></td>
</tr>
<tr>
<td>Why are fraud deterrence issues</td>
<td>Semi structured interview with claim/investigation officer</td>
<td></td>
</tr>
</tbody>
</table>
becoming so crucial in the current economic conditions for the companies? - Informal ideas from insurance companies, industry and practitioner

What is the best implementation to deter fraud and scam cases based on the insurances product and cross services in the companies? - Semi structured interview with claim/investigation officer - Follow-up survey - Interview with RMP

Table 3.1 above illustrates all the methods administered during the process of this study. All the methods implemented in the schedule are relevant with the research questions and aims of the study which was set earlier. Meanwhile, as the study is more qualitative in nature, it is wise to look at the ideas in detail that is concentrated to the interview phases.

3.2 Organization of the Study

Considering the type of case study in nature, the study used numerous qualitative methods to accomplish it (Yin, 2009) with the variety data collection method, at micro or company level, which is through semi structured interviews, documentation inspection and general observation of the operation as noted also in Table 3.1. Besides this, during the macro level in relation to the environment factor, the method of personal qualitative interviews and documentation inspections were utilized. In general, it is estimated that the case study would be administered in two different stages of research that is national (strategic) level and local
(operational) level. Besides, the study has included a follow-up survey as part of the method after the viva voce session in order to strengthen the input of the case study.

3.2.1 Semi-structured interviews

In the initial stages, the national level, semi-structured interviews were conducted with the main key players on anti-fraud and scams policy at the Central Bank of Malaysia (BNM), Association of Malaysian General Insurance (PIAM) and Malaysia Institute of Insurance (MII). The contents of the interview related to effectiveness of the policy implementation regarding the internal control and fraud prevention in the overall industries with consideration to the Insurance Act 1996 and Anti Money Laundering Act 2001. The interviews were also directed at The Association of General Insurance Malaysia (GIAM), National Association of Malaysia (NIAM), National Institute of Claim Society (NICS), Association of Money Loss Adjuster (AMLA) and some private investigator companies. These associations are supported in-terms of general understanding about their functionality on the issues and also their own initiatives that is part of countering fraud in the industry. After the viva the researcher was motivated to obtain some opinions on the issues from the perspective of the commercial crime unit in the RMP. This adds value in relation to the opinions of the law enforcement group.

Meanwhile the target for the second stage, the operational level, interviews were going to be conducted on the implementation of anti-fraud and scam strategies in three of the selected insurance companies in Malaysia. Documentary evidence was collected during the second stage together with some observations on the operational part of the Claims Unit and Investigation Unit. At the practical level, some of the interviews were conducted with the private practitioner on the insurance fraud investigation. The company that has been chosen is based on the suggestion given by the officer in the MII and response by the company itself.

The form of data collections are through document analysis and interviews with key personnel (Button, 2007). Considering the large dimension included in the research questions that needed to be answered, this study would require multiple research methods. This is often referred to as triangulation (Hagan, 1993) or multiple sources (Denscombe, 2007). The use
of the multiple research methods hopefully would be able to delve into this in more detail and discover outputs that might not have become apparent through more superficial research. In addition, the output would be highly reliable and more balanced (Button, 2007). In this study, structured and semi-structured interviews will be combined with observations as well as documentary analysis. The structured interviews were submitted earlier to the interviewees before the organized session in their premises or outside appointments. The structured interviews enable the interviewee to be prepared before the session is administered that is more towards the operationalization in the Claims and Investigation Units of the selected insurance companies. This interview at macro level and outsiders of insurance will be on several themes which were discussed prior in receiving the email. The answer is not purely directed with the questions that have been discussed in the topics. This is due to their standings as different issues will require a different discussion.

This research can categorize the respondents into 3 main groups which is the regulatory view (consists of an officer from BNM, PIAM, GIAM and MII), the insurance companies respondents (consists of claims and investigation units from 3 insurances company) and the professional bodies in insurance fraud (from two companies, AMLA, NICS and NIAM). The RMP from commercial crime unit is part of this group of three where they represent law enforcement. These three groups have been allocated with different sets of questions but the themes for each set are going to be similar considering the anti-fraud culture, fraud planning, fraud prevention, fraud detection, fraud investigation, fraud resolution, fraud deterrence and the regulations regarding mitigating fraud.

Table 3.2 below illustrates the key subjects that have been included in the three groups that accommodated the researcher with the issues. Even though all the groups are involved, not all of their statements have been included in the evaluation in the following chapter due to agreement of confidentiality between the person and the researcher regarding ethical consideration.
Table 3.2 The Interview Process that Involved the Groups and Objectives Achieved through the session

<table>
<thead>
<tr>
<th>The Party/Organization Involved</th>
<th>People involved with the interview (number of people in that position)</th>
<th>Numbers of meeting/s with the researcher (place of interview being administered/ months and time of the interview)</th>
<th>Objective achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatotry / BNM</td>
<td>Conglomerate Surveillance Officer (1)</td>
<td>1 (BNM Headquarters, Kuala Lumpur, Malaysia/ January 2010/ 3-4.30pm)</td>
<td>-Market background - the BNM initiative - the issues current situation - the insurance companies networking</td>
</tr>
<tr>
<td>Regulatotry / BNM</td>
<td>Forensic Accounting Officer (1)</td>
<td>2 (BNM Headquarters, Kuala Lumpur, Malaysia/ January 2010/ 3-4.30pm &amp; 10-12pm)</td>
<td>-Market background - the BNM initiative - the issues current situation - the regulation framework to mitigating fraud -the tools and techniques used in the accounting perspective - the insurance companies networking -the BNM associated initiatives in a long run period</td>
</tr>
<tr>
<td>Regulatory/ PIAM(GIAM)</td>
<td>Secretary of association (1)</td>
<td>1 (GIAM registered office, Kuala Lumpur, Malaysia, January 2010/ 11am-12.30pm)</td>
<td>-The anti-fraud culture situation in Malaysia -Fraud planning in the development of countering initiatives in the market -preventative and controlling measures involved in the market conditions -Fraud awareness planning -training involved regarding fraud and</td>
</tr>
</tbody>
</table>
**Regulatory/ MII**  
The spokesman for market supervision / related with ISM(1)  
1(MII Registered Office, Kuala Lumpur, February 2010/ 1-4 pm)  
-the current market condition on the issues  
-general planning to mitigate fraud in companies  
-the initiative that contributes to the MII that is not conclusive  
- the technique that determines the red flag as one of the techniques shared with concerns of the members  
-the roles of the supervision department under BNM or MII that just facilitate the treatment by the companies  
-level awareness in the market that can be determined  
-training that is supported by the professional and assistance by MII  
-Less numbers of prosecution data that has been published to the general public due to secrecy and contractual agreement

**Insurers/ Ling Insurance**  
The claim officer under the automobiles division (1)  
3(Ling Insurance Headquarters, Jalan Raja Chulan, KL/ January, February 2010 (10am-12pm)  
-Process and procedure involved with claims that are related to fraud deterrence and detection ideas  
-Method practiced to determine the red flags and the experiences of the cases of fraud determined  
-Specific guidelines or procedures that help to detect and confirm fraud or scams  
- Any training being exposed to the officer that might help them to prepare for the scams that involve the association  
-Prosecution chart and experience in cases of fraud that acknowledge the association.  
-Possible guidelines purely generated internally by the company/ the part taken by the association in resolution of integrated cases.
- Determination of the risk associated in each of the tasks being done by them
- The estimation of the cost of fraud cases determined including the employment of the third party, time consuming and the possible delay in settlement of claims

| Insurers/ Ling Insurance | The internal investigation officer in the internal audit (1) | 1 (Ling Insurance Headquarters, Jalan Raja Chulan, KL / January 2010 (4pm-6pm)) | The ideas that initiate any investigation regarding fraud
- The criteria developed to determine if the investigation would be internal or external
- Normal structure/ framework to conduct the fraud related investigations
- The determination of the level of highly related fraud cases
- The procedure involved when the cases are confirmed - prosecution involved
- Legislation that is used for the deterrence effect in the contractual agreement
- Resolution of normal cases that are repeated in the same expected manners. |

| Insurers/Amy Assurance | The insurance claims officer on life insurance (2) | 1 (Amy Assurance, Jalan Ipoh, KL, Malaysia, January 2010 (12-3pm)) | Process and procedures that are involved with claims that are related to fraud deterrence and detection ideas
- Methods that are practiced to determine the red flags and the experiences of the cases of fraud determined
- Specific guidelines or procedures that help to detect and confirm fraud or scams
- Any training exposed to the officer that might help them to prepare with the possibility.
- Determination of the risk associated in each of the tasks being done by them |
<table>
<thead>
<tr>
<th>Insurer/ Assurance</th>
<th>The Investigation Officer (1)</th>
<th>1(Amy Assurance, Jalan Ipoh, KL, Malaysia, January 2010 (10am-1pm)</th>
<th>-The estimation of the cost if a fraud case is determined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurer/ Ethical Insurance</td>
<td>The Assistant Manager of Claim in the Non Motor and Non-Life (1)</td>
<td>2(Ethical Insurance, Jalan Bangsar, KL, Malaysia, January/February 2010 (12:30pm &amp; 10am-12pm)</td>
<td>-Process and procedures that are involved with claims that are related to fraud deterrence and detection ideas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Methods practiced to determine the red flags and experiences of cases of fraud determined</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Specific guidelines or procedures that help to detect and confirm fraud or scams</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Any training exposed to the officer that might help them to prepare for the possibility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Determination of the risks associated in each of the tasks being done by them</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-The estimation of cost if the fraud case is determined including the employment of a third party, time consuming and the possible delay in settlement of claims</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-The staff that are associated with the department trained for these cases</td>
</tr>
</tbody>
</table>

- The ideas that initiate any investigation regarding fraud
- The criteria developed to determine if the investigation would be internal or external
- The procedures involved when the cases are confirmed- prosecution involved
- Legislation that is used for deterrence effects in the contractual agreement
- Resolution of normal cases that are repeated in the same expected manners.
| Professional/ NICS | The spokesman of the association (1) 1(NICS Members Office, Kuala Lumpur, Malaysia, January, 2011,1-3pm) | Malaysia, February 2010 10am-12pm) | investigation would be internal or external - Normal structure/ framework to conduct the fraud related investigation - the determination of the levels of related fraud cases - The procedure involve when the cases are confirmed- prosecution involved - Legislation that is used for the deterrence effect in the contractual agreement - Resolution of the normal cases that are repeated in expected manners. - the eFids system ideas and the contribution of the unit to report using the system - the networking with one officer in the Royal Malaysian Police to the issues - The main function of the investigation unit is more towards the internal auditing after all because due to limitation in the number of staff that are needed associated with cases of fraud -the claim society interpretation on fraud - the structure developed by the practitioner in claims to detect fraud - the method and experience that is shared among the members to detect fraud - the cases that occurred in Malaysia that are related to the claimant - the complexity of the existing tools and the readiness of the company to invest in those tools - the challenge to determine fraud cases that are usually brought to court - the guidelines that exist in the market are not enough when the claim society members need to use their own jurisdiction |
| Professional/NIAM | The spokesman/secretary on behalf of the NIAM (1) | 1(NIAM Registered Office, Kuala Lumpur, Malaysia, January, 2011, 10am-12pm) | - deterrence in the contract would enable the claim to be more free from fraud treats
- the fraud issues in the situation of the insurances setting
- best practices that can be integrated in the implementation of countering fraud that comes from prevention, detection, investigation, resolution and deterrence effects in the market situation
- the fraud alerts options that are viable in the market and benefits the insurer in general
- the companies that are involved with NIAM initiatives in combating fraud in the real market conditions in insurance.
- the guidelines that are applicable to be followed if the insurers are making arrangements with NIAM
- continuous training offered by NIAM regarding fraud issues and the sharing opportunities in the association
- the reflection towards others entity in the market place setting that need to be crammed together in order to make the issues such as serious agendas for the practice insurance officer or professional in an investigation |
| Professional/AMLA | The committee members on behalf of the committee (2) | 2(AMLA Members Office, Kuala Lumpur, Malaysia, April, 2011, 1-3pm) | - the fraud determination in the loss adjustor’s experience
- the method of detection and investigation fraud that is practiced to conform the situation of the cases
- past experience regarding the types of fraud that exist and the possible planning |
| Professional/Justice Adjusters | The CEO of the companies (1) | 2( Outside of office, Kuala Lumpur, Malaysia, March, 2010,1-3pm) | for scams that have been programmed by the perpetrator.  
-the loss adjustor techniques that might be reasonable to detect the cases in general circumstances.  
-the planning carried out by the companies in order to ensure fair participation of the loss adjusters in the cases  
-the popular methods that are being used by the loss adjustors as a resolution to fraud cases  
-the possible initiatives that are taken by the insurers with the help of the loss adjustors in training initiatives for the insurers officer  
-the suggestions made by the loss adjusters towards the development of a better environment towards making the countering of fraud a priority in the insurers operational agendas.  
-fraud cases in the normal operation of the adjusters  
-definition by the adjusters based on experience and complexity of the cases of fraud and the intensity of the insurers need for the adjusters  
-the expertise involved with the operation of the company regarding the areas of fraud and the insurance products in Malaysia  
-the training and sharing opportunities that exist in Malaysia for insurance fraud cases  
-the costing and budget that generally would be involved by the insurers due to the complexity of the cases  
-the data that involves cases that need a higher method and are treated as serious prosecutions |
the general market acceptance on the works done by the adjusters in the industry.
-the lobbying ideas to the regulatory party to ensure that all adjustors are able to practice fairly.

| Enforcement/ Commercial Crime Unit from Royal Malaysia Police (RMP) | Deputy Director (2) | 2 (UUM, Kedah and Kuala Lumpur, Malaysia, Dec, 2012, 10am-2pm) | ideas on fraud cases that normally happened in Malaysia environment
-the complexity of the cases happened and the expected number of the cases happened yearly
-the possible reasons that contributes towards the cases in general
-the background and expertise that supposed to be included on the officer that would be responsible to handle the cases
-the training that being provided to the officers that involved with the unit.
-the link between the unit with the others industry players basis
-the possible data that can be disclose to the general public on the insurance fraud
-the legislation that directly involve to prosecute the perpetrators
-the best way on deterrence the act from being the normal way of doing business or norms to the society. |

Table 3.2 above illustrates the comprehensive works that was carried out by the researcher detailing the numbers of meetings and the objectives that have been achieved during the meeting. The structure of the interview for the group of insurers are consistently in way the output expected are going to be well said in order to create the points of the ordinal scale in the Chapter 6 and 7. However, the differences in the other groups of respondents are because
they play different roles in the industry and the output from them is expected to enhance the company results earlier. If there is more than one meeting, it shows that the next meeting is not in a formal context as it was a need or arranged by the respondent, over lunch or dinner due to the demands of the interviewee and probably it the serious objectivity with the issues taken.

The group of professionals was the second wave of interviews after the first visit because it was based on the lack and loopholes determined to support the interview in the phase of regulatory and insurer groups. They became the third group that responded but their analysis is in Chapter 5 which discusses the industry responses. The interview with the regulatory groups was semi structured with the earlier themes being submitted in emails and most of them were accustomed to the objectives of the organization. The private investigators company consisting of loss adjusters was on a voluntary basis with recommendation from the officer from the insurances companies. It was a good opportunity for the researcher to discuss in detailed of sharing experiences with the firm CEO and it enabled the researcher to take a better understanding of the industry’s reaction, as a whole, and specific ideas in the operationalization of the investigation. Besides, as suggested during the viva voce, the interview with the law enforcement officer would complete the ideas on the countering fraud as it will allow different views and opinions.

The insurance companies involved in the interview are among the most prestigious insurers in Malaysia which is justified through the intensity of products offered and the market share in the industry. All the companies also have mutual agreement outside of Malaysian insurers in order to have mutual contracts and operations proportionately. Table 6.1 in Chapter 6 will provide details and comprehensive data which are able to be disclosed to the general public due to the ethical agreements during the approval of research within the company environment. The researcher also sought consent regarding any relevant identity that would be exposed due to the competitiveness and confidential issues being noted by the official in the company.

3.2.1.1 The pilot test
In the earlier stages, prior to testing the three groups the questions were screened by the Malaysia Institute of Insurance (MII) in order to ensure that coverage in the research was not
beyond reasonable limits of research in the Malaysian insurance market. This was considered as the pilot test when the practitioner involved with the MII were going through the questions and recommended certain changes that enabled the set of questions to be more practical than theoretical in nature. In order to make it more practical, they questionnaires were distributed to numerous of their members to ensure that the question asked will be relevant and align with the works done by the insurer officers.

This is particularly for the set of questions that were structured for the insurance companies’ officer as they would be able to entertain something that enabled them to answer within the specified elements of their normal work tasks. The process of piloting the questions helped the researcher to cross over to the terminology that is the norm in Malaysian practices. Additionally, abbreviations were used to enable the practitioner to understand the general terms that could be alien wording to the general public.

The pilot study also highlighted some sensitive issues regarding politeness and how the questions should be worded. The MII recommended that some of the questions be reworded to ensure positive feedback. For example, the question relating to the investigation unit’s procedure and controls of the unit are likely to be amended from:

What are the main procedures in normal investigations?

After the suggestion from the MII it was amended to:

Are the procedures implemented now interrelated with the function of fraud investigation in the company?

Even though, the expectation of the answers is likely to be similar, the way of asking more sensitively would enable the companies not to disclose a possible answer which could threaten confidential matters. The help given by the MII and the respective pilot study test is for the purpose that this study might help and enrich the components of the research done by the institutes. In addition, most of the time they gave a supportive letter that helped the researcher to go to the respective companies.
3.2.2 Documents inspections

Another major source of information for this research was through secondary data such as documents, written guidelines, written rules, relevant forms, and some other documentary evidence. However, not all the documents were able to be accessed by the researcher as in Malaysian insurance companies there are few guidelines, acts and procedures that are considered to be publicly available files with regards to inspection and by BNM permissions.

The researcher was able to access on certain inside and confidential documents purely based on ethical concerns, consideration and agreement with the insurance claim handler. The internal policy documents are very relevant in order to evaluate the components of combating fraud especially when it is related to the criteria in the CIPFA Red Book 2. Most of the files that investigate fraud cases are treated as ‘secret and confidential’ by all of the insurers but they compromised and allowed a certain level of exposure for the academic purposes of this research. So, due to the agreement that some might be relevant with regards to prevailing cases, the company’s identity was kept anonymous at all times. Besides, most of the investigation ideas and stages had been revealed during the document examination and the date highlighted the timeframe taken in accomplishing specific kinds of cases. Each of the companies involved estimated allocation several times for fraud cases and estimated the cost benefit analysis in order to maintain the benefited activities from the thorough and costly investigation because experts from outside had been brought in. In order to enhance the ability and importance of source documents, Scott (1990, pg 12) defined them as:

“...accounts, returns, statutes and proclamations that individuals and groups produce in the course of the everyday practice and that are geared to their immediate and practical need.”

Based on the Scott classification documents are referred to their authorship and the level of access it has. Authorships are ranged between personal, private and public which would relate to access levels of closed, restricted, open archival and open published. By using the classification above Table 3.3 below illustrates some of the information of the documents that were involved in this study.
Table 3.3 Documentary sources available for this research

<table>
<thead>
<tr>
<th>Access</th>
<th>Authorship</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed</td>
<td>LI- Detailed file investigation of one sample case with memos, forms and resolution from all parties. (Detailed investigation file with concerns from Executive officer)</td>
<td>LI- BNM Specific Announcement on Controlling Fraud</td>
</tr>
<tr>
<td>Restricted</td>
<td>AA- Case Report examples by claim handlers</td>
<td>AA, LI &amp; EI- BNM GP14 Determination of Insurance fraud Red Flag LI- BNM E-Fids Report for 5 years</td>
</tr>
<tr>
<td>Open Archival</td>
<td>EI- Fraud Reporting Policy for M Fortis Holding Berhad &amp; Operating Entities</td>
<td>LI &amp; EI- Police statistics on business crime report</td>
</tr>
<tr>
<td>Open Published</td>
<td>AA- Claim handler general guidelines on fraud detection responsibility</td>
<td>AA, LI &amp; EI- Annual BNM Report for the industry</td>
</tr>
</tbody>
</table>

AA=Amy Assurance, BNM= Bank Negara Malaysia
LI= Ling Insurance, EI= Ethical Insurance
3.2.3 Observation

The observation of this case was as a silent observer where the status of the researcher was known, but did not take part in the activity (Gold, 1969). This would be the most appropriate because sometimes, due to the high demand of insurance services and the increasing numbers of insurers, it has proven difficult if the researcher took part in their operation on the basis rules. This enabled the researcher to only attend discussions or briefings of the cases that related to the topics of the study. Besides, only 2 of the company studies’ allowed the researcher to carry out the observations which were Ling Insurance and Ethical Insurance. While, another one rejected the request and stated that it was not within their power to enable an outside researcher to be within company facilities during their normal working period because their workload was too heavy. The main ideas involved with the observation in these insurance companies was to have on-site experience of how the implementation of procedures of detection, investigation and prosecution were implemented to ensure the risk assessment control regarding possible fraud that has been included in their normal operations.

Ethical Insurance allowed the researcher the ability to attend major discussions that is the case investigation meeting among the claim handlers with the risk unit that included the investigation teams in numbers of unsolved cases. During the observation, when the researcher was allowed to be in the company premises for a week, he was exposed to the stages that are involved for each case and time period that included before the company had resolved the case. While, Ling Insurance enabled the researcher to join the early briefing on the current cases, the amount of possible fraud in currents months and also the researcher was updated by the private investigator whose was responsible for each current open case. This opportunity can help the justification being made in the evaluation procedures and accurately determine the possible ordinal cumulative score for the insurer involved. To overcome the time restrictions with Amy Assurance, the researcher made a formal appointment out of office hours with the claim unit chief to get a better picture of the claim handler routine and effective involvement of the investigators/ lawyers of the company.

3.2.4 Follow-up Survey

The survey is one of the methods that were included in this research after the viva voce presentation in order to strengthen the thesis presentation and the coverage on the issues of
countering fraud in general. Questionnaires were set up to make the survey successful and it was very hard to get the target respondents regarding fraud by the claimant. In order to achieve its objective, the researcher once again cooperated with Malaysia Insurance Institute to ensure that the respondents are involved directly with the claimant.

Since the association have organized scheduled training courses yearly, the researcher has taken the opportunity to make the data collection during the period of those courses. The courses that interconnect with the claims officer work is named as A Comprehensive Courses in General Insurance- Claims on 21 until 23 May, and A Comprehensive Course in Insurance Fraud and Investigative Workshop on 17 until 20 June 2013. Both of the courses were held in the Seri Pacific Hotel, Kuala Lumpur and it was joined by most of the claim officers from all over Malaysia and several companies.

The part of the survey asked questions on the 6 main themes that are anti- fraud culture, fraud prevention and control, fraud awareness and training, fraud control operation, crime prosecutions and also act/ guidelines to practicing the policy. This also was in line with the countermeasure that is Red Book 2. The sample of the questionnaire used in the survey is located in Appendix 4. The survey was distributed during the day of the program with pre-stamp envelopes provided to ensure that they have no hassle in returning it to researcher. The numbers of questionnaire that were distributed is 55 for each of the session due to the numbers of the participants decreasing during the second day of courses.

After a month of waiting until early July 2013, the researcher only manages to get back 37 responses for the questionnaire along with the several attempts of calling them back. The possible reasons of the low response rate are because the claim officer assumed that the questionnaire is not part of their courses. Some misplaced and did not welcome the researcher’s attempt to replace it with new ones. The researcher also was given various excuses from the respondents. Main reasons for the late or non-response is due to their environment of work that is time consuming, they are unable to complete the survey, some also mentioned that it was quite disturbing to reveal their professional opinions on related matters. This is also related to the culture of Malaysian that taking the ideas of fraud of something that highly sensitive to being discussed within or outside the organization.
3.2.5 Selection of the Countermeasures- CIPFA Red Book 2

Data collected during interview was obtained using the filing style because qualitative manners are more meaningful in finding the consistency of the output before using the element of evaluation. The analysis will be descriptive and qualitative in a manner to show the existence of countering fraud policy, the strength and weaknesses, and also any related suggestions to the current implementation by using selected elements known as CIPFA Red Book 2. The instrument chosen as the model of evaluation was based on comparative ideas which were taken into consideration and illustrated on Table 2.2 in the previous chapter. Even though, the elements of quantitative were included in the research since survey was also added to the research instruments. Nonetheless, the surveys are not going to be discussed using the Red Book 2.

3.3 Gaining Access

Gaining access was one of the major issues during the case study research because it proved difficult to get the professionals and practitioners to spend time answering the questions. This was the major challenge faced when trying to arrange interviews. At the proposal level, the research was to concentrate on public health fraud issues in Malaysia that were creating tremendous chaos with the Ministry of Health; they rejected the proposal twice based on the justification of the sensitivity and internal security of the government agencies. As insurance is an industry that is directly related to the proposed ideas which is part in the health industry, the researcher has adapted the ideas and administered it in insurance industry within the coverage on private practice only. This also relates to the culture and customs of Malaysia and its relevant to the understanding on the ideas in Chapter 4. On the other hand, to enable the staff of insurance companies to disclose some internal documentation is something which entails ethical consideration because of the connotation that outsiders will sometimes disturb their privacy. Besides that, another possible conflict existed during the time to let the ‘outsiders’ to be present in the companies on a normal day of operation to check and also to carry out some surveillance work to have an insight of the entire working process which involves various elements.

A solution would be to have a regulatory body that would make some restrictions towards any research being conducted in the country. In Malaysia, if the researchers that need to go
through some economic entity and conduct any policy types of research, they have instructed to register with the Economic Planning Unit (EPU), under the Prime Minister Department. The researcher completed the internet registration and submitted documents, proposals and target groups for the research. For a period of time, they are kept in vitae for approval of the research. After meeting with some key personnel in the EPU, they do allow it to be conducted in a manner that will not underestimate any companies and would make company names anonymous. This purely relates to the culture of transparency as they would not accept any published academic’s output that would incur a bad reputation especially if the research was conducted outside of Malaysia.

After approval by the EPU, the researcher needed to go through the approval of the Central Bank of Malaysia because it is necessary to obtain an agreement with somebody in the bank. The approval process is consumes a lot of time because research themes in the fraud areas are considered as ‘grey’ contents which are most likely to be investigated by the researcher. After numbers of attempts, two of the officers agreed to respond to the issues brought about by the research which were from the officer in the Conglomerate Surveillance Unit and an officer from the Forensic Accounting Unit. Both of them responded in a general sense because a lot of matters of these issues are majorly by the Financial Investigation Unit which comes under the radar of the Central Bank itself.

The Malaysia Institute of Insurance was the major company that made the research more successful because they made suggestions and proposed a lot of people that enabled the researcher to create a connection and meet with them. MII itself is the organization that is established as an agency under the Central Bank of Malaysia to cater for any related issues in the insurance market and also as licensing agents’ for insurance agents and provide insurer guidance relating to the market. The MII helped the researcher to go through the proposal and test the questions to enable respondents to give supportive comments in relation to the subject studied.

Following MII’s recommendation, they obtained a favour from the PIAM in order to support the ideas given by the bank officer. The PIAM officer received the researcher’s appointment positively as they were looking at the possibility of this research being a positive landmark in establishing more effective ways of catering for fraud issues in the market. They made several comments and made introductions to several parties to enable the researcher to
acquire relevant contacts regarding the issues which included the professional associations namely NIAM, NICS and AMLA.

The insurance companies that have been chosen to be included were based on the performance and market share for each of them. The company required the approval from general management before they could accommodate the researcher regarding the issues to be discussed. After approval was obtained, a meeting was arranged with the person in charge of the company. This, in a way obliged them to answer the questions as, in almost all cases, they were following a superior order from within the company. They were quite supportive in answering, as usually the set of questions were submitted as early as one week before the interview was conducted and a suitable date for this was arranged. Dates and times were changed frequently during appointments due to the respondents being on a tight schedule and needing to make professional comments relating to the whole operation of units and the company in general. In addition, they were also contacted after the interview regarding further queries that appeared during analysis and transcription. Following this, communication was either via the phone or email as a repeated interview session would cause considerable disturbance to their busy schedules.

Meanwhile, to contact the person that is directly involved with the works of investigation and prosecutions posed a further challenge. Most of the people are also representatives for the associations which are AMLA, NICS AND NIAM. In this case, the researcher received help from the officer in the insurance company’s claim department because most of them are close colleagues and this is good opportunity for the researcher. In addition, they work for the insurers and are receiving the cases from them. Access was very good but some cases were delayed regarding further investigation which was due once again to their tight schedules. Nonetheless, the output from them clarified ideas regarding the running of the insurance industry generally and also the issues of fraud in particular. This also related to issues during the research that were highly sensitive for certain parties and the Malaysian culture that does not cater for discussing such issues.
3.4 Time frame

During the period this research was conducted, certain development happened in the country’s economy. The research started as early as 2009 when BNM and EPU had the green light for the research to be conducted as it would have the policy benefit for the country. During the early stages of proposal and getting cooperation, there were still a lot of grey areas that was likely to be included. As the Red Book became the main reference in order to detailed the data collection process it sped up the time.

Almost all data collection on the interview was done in 2010 when the issues of fraud became a serious care for all the insurance companies. In 2011, the second wave of the interview was done to ensure that the respondents really understand the particular elements that were included in the Red Book 2. This revisiting and rephrasing activity was done to ensure that ordinal scale that includes in the discussion is valid.

After the viva voce presentation in 25 September 2012, it involved some more time on collecting the data as the follow-up surveys and the inclusion of the law enforcer interview was required to be included. After all, during this time frame, a lot of awareness has developed and some of the company that involved the early interview during 2010 was merged or taken over by others. Even though, they might have some major reconstructions, the validity of the interview output was still acceptable because the officers carrying out their tasks from the particular companies were still the same. It merely was just a change in the ownership structure and the operationalized.

3.5 Data Analysis and Writing Up

All interview schedules were developed with respect to the target groups in the research. These hopefully could be suited to tackle all issues from two main streams namely industry and insurance companies. Based on the description of the selected company that were available for the discussion part with reference to Table 6.1, it was hoped that the outputs covered by the company were substantial enough and that people that were able to determine the current condition of countering efforts on insurance fraud. The questions in the interview schedule were not the same as the evaluative factors that include the 5 themes of assessment from the CIPFA Red BOOK 2.
In order to analyse the data, the available software was Nvivo 8 which was used to analyse the themes based on combating fraud functions that are anti-fraud culture, fraud detection, fraud deterrence, fraud investigation, fraud sanction, punishment and fraud education. The software was very time consuming to run and it took a lot of relationship functions which caused the analysis to be slower. After determining to adopt the CIPFA Red Book 2 the evaluation criteria function, the researcher reconstructed the analysis by using a manual filing system that was still related to the themes of analysis but was more directed as the instruments had all the 5 main components – adopting the right strategy; accurately identifying the risks; creating and maintaining a strong structure; taking action to tackle the problem; defining success. Even though sometimes, the output of the interview would clash among the items of evaluation but a follow-up call or meeting was arranged to rectify the information given earlier.

In general, the interview with the Central Bank and Association established under the law mentioned about issues which caused the most concern and the existence of some efforts at industry level; not only looking at the initiatives internally but relating to the companies’ policy. Besides, it was rectified that the regulator and the main supporters in the industry were well aware of the situation and progressively encouraged the initiatives that had been taken by the company using ‘average’ supportive tones. At the same time, they can be highlighted as a supporter of the general aims but the frontline is still the officer in each of the insurances companies that the work is related to the practical parts. The interview with the BNM was more descriptive in matters that would be highlighted under several themes by using the themes description. Meanwhile, the analysis for the other industry people were based on the first three themes of the CIPFA Red Book 2 on adopting the right strategy; accurately identifying the risks and creating and maintaining a strong structure. The other two themes were not evaluated at industry level because it was not related to the implementation and would be awkward if the party which is not involved with the practice were to justify the themes.

Meanwhile, interviewing with the insurance company mostly dominated the issues of their counter fraud initiatives and arrangements that consider the current situation in the Malaysia insurance market in 2010 & 2011. Initiatives taken by the company, as expected, would be rarely different and concentrated more to the intensity of the company operation. Not all
companies were expected to have the same initiatives as they mainly had different backgrounds and also history of establishment. It was noted that, the Malaysian insurance industry is dominated by foreign insurers (BMI, 2012) which disables the company from acting without addressing the headquarters directive instructions. Besides, if any changes in the market take place, it would become the major trend in all companies eventually operating in the domestic market as the risk would be shared with mutual partners in the European and US market (MII, 2009). Nevertheless, the aims of this study are purely at the claims and investigations unit because this is becoming the main depot for possible fraud that is perpetrated by an outsider. Also, this unit mainly supports the process of deterrence and related parts of the organization structure with fraud issues that might exist.

Interviews in the third wave concentrated on the professionals and practitioners in the insurance market to complement the environmental ideas towards the issues. The interview was conducted with the assumption that the professionals and practitioners are the workers who are part of the system that support the initiatives of mitigating fraud, they have a better judgement because the issues and experiences that affects them are more conducive to anti-fraud works. Besides, they are better exposed and well trained to counter the act of fraud and scams in insurance companies. It can be concluded that all insurance companies subsidised the works because fraudulent investigations and resolutions are something treated as other ‘extra initiatives’; taken by the companies and they treat it as an advantage if they could handle the cases as detailed in their normal operational situation. Regarding cost, it benefits them to subsidise it to external professionals that are more enthusiastic and practical mixed with extra experience, backgrounds knowledge and intensive training. This interview was also analysed under the industry ideas regarding the initiatives of combating fraud.

Data was collected through four main mediums which were interviews, documents inspection, observation and survey. The interviews were recorded and written responses were collected. This showed that the data was scattered with major elements that enabled a conclusion on the research questions were to be drawn from the interviews. The source of information necessitated it being transcribed before it became a statement for using the evaluation instruments. Some of the respondents were confident to use English fully, while others preferred to respond using their native language of Malay. All the interviews are directly translated in English, therefore this leads to a situation where there are some grammatical errors, particularly tenses as English is the second language in the Malaysian
environment. Direct translations were used to ensure the validity of the interviews not compromised. To ensure the understanding researcher has makes some correction on the grammar but it still bringing the same meaning by the speakers. By the way, the English talks are well accepted as Malaysian English.

Another challenge for this research in defining the terms and abbreviation as the terminology used by the practitioners sometimes bring different meanings. The terminology and abbreviation was more widely used among the officers and even sometimes they could not give an exact definition of the terminology or abbreviation used. This had prone to be a particular disadvantage, but, with help from the MII officer and a dictionary of insurance terms and abbreviation in the MII library, it became manageable. The issues of terms and abbreviations, although not major, was essential as it made the interview process smoother and enabled the researcher to master the ‘terms’ before conducting the interviews.

The rationale for using the Likert Scale from 0 to 3 is to show the extent of the respondent’s agreement towards the ideas in the items of evaluation and it has been evaluated through the method of data collection. The ordinal scores are in order to show the different ordinals between the companies and to indicate different ranges. The usage of cumulative ordinal scores at the end of the discussion in Chapter 8 are for the purpose of weighting the initiatives fairly with the ordinal scores that were collected through the evaluation items. It is not the intention to evaluate which company is, but, to freely justify the initiative arrangements that were more intense compared to the others.

The follow-up survey is presented with a simple descriptive statistic in order to show the agreement of the respondents toward the statements noted in the questionnaire. Most of the ideas show high agreement on certain criteria and the survey actually highlights on the originality and relevance by MII education and research unit. This to ensure that the set of 38 questions that includes most close-ended and several open-ended are really being understood.

The presentations of the survey are in the percentage of agreement and this would counter the situation of the fraud in most of the companies in Malaysia. This is because the participants of the courses that are involved in the survey are representative from several insurance companies. At the same time, the follow-up survey is to strengthen the case study to generalize the output. This is also to have insights that although all the company have
countering fraud initiatives, the level of the initiatives are different from each other due to certain conditions in the company.

3.6 Ethical Issues

During the research, the researcher did not report everything that was solely collected during the interview sessions as there were concerns regarding sensitivity issues that had been highlighted during the data collection. During the interview, the respondents from insurance companies tended to make general statements regarding policy, implementation or practices but as noted and agreed, whether orally or written, the researcher needed to be aware of the highlighted sensitivity issues as most of the respondents were in the private sector. In the private sector, concerns are always raised regarding the security of company data, the practices in the company and any confidential matters that relate to the client should be their major concern. This arose through the informed consent that was agreed before conducting the research, confidentiality statements and the possible conflict of interests based on the respondent’s position. Quite often, the researcher was stopped from asking further questions on some of the matters due to concerns of confidentiality being breached.

Meanwhile during the follow-up survey, the information provided on the first page of the questionnaire directly imposed the objective of the research. The researcher also highlight that the research is only for academic purposes and the involvement is based on voluntary basis. This would directly take attention and care of the respondent regarding the ethical consideration for the survey.

In addition, for the interview, the information sheet and the consent form are part of the ethical considerations of this research. Both of them will serve to explain to the respondents the intent of the research. In addition, the application to the Research Committee had been completed and sent. The most important thing, as determined by the Social Policy Association (2009) is that participation in criminology should be based on information being freely given and noted in the informed consent of the subject to the researcher. In this research, the participation of each subject was based on the offer made by the researcher and they voluntarily opted in with permission from their superior in the organization. These consent ideas were implemented when the researcher initiated the interview by using the consent forms, information sheets, simplified proposals and letters of invitation. After
examining the contents of consent, the respondents were informed that they were free to choose whether to continue participating or not. There were three incidents during the research when respondents rejected the informed consent and decided not to take part due to issues of sensitivity, confidential concerns and time constraints. All the companies who agreed to the terms within the consent form and the information sheet, due to some misunderstanding regarding the ideas sometimes did not give priority to allow access to certain information, particularly documentation. Only certain companies allowed the researcher to analyse areas in the policy that existed within the company.

During the study, the recording equipment was used in the cases where the respondent felt that it would not cause any major disturbance. The majority of the respondents were quite uncomfortable when asked if the interview could be recorded and in return, they noted that it would be possible that during the interview session they could unintentionally disclose confidential information which could jeopardise their position in the company. To be on the safe side, they decided it was better to make a statement in a written manner and no recording device should be used. Most of the time, the interview process was supported with documents that may help the researcher to have a real experience regarding the documentation involved even though it was categorized as confidential.

Consent during the interview was in the form of a statement made by the officer on behalf of the organization. It needed to be different from a personal statement because the research being administrated was based on the action done by the company regarding general concepts. Even though, some of the general arguments on the application involved in the market conditions are the comments against the market as a whole, the researcher tried to ensure it followed entity statements only.

The methods of documentation inspection and observation in the company became a serious ‘caution’ in matters of confidentiality for the insurance company during the research. Almost all officers in the companies allowed the researcher to glance through the investigation fraud case files. The files were classified as ‘red files’ that identified them as confidential as it was important academically for the research. Nonetheless, they were shown on the condition that no pages would be photocopied or captured in any way through media technology. These actions endorsed that confidentiality was still a major concern in the data collection of the documents. Regarding the observation, the researcher was allowed to enter the company on
for half day training in the claims department and attended some of the major fraud case
meetings in the investigation departments. This was possible with the consent from the
superior in the company. But again, the researcher was warned not to expose any of the
minutes or documents as this would destroy the trust given by them.

This study as with other studies is expected have findings which will answer the research
question that has been elected in the research construction of the framework. The major
distinction in the quantitative method is when the element of statistical methods will stand as
the main point relating to generalization of the concepts. While in the qualitative study, the
specific criteria were set up in order to ensure the study was ‘trustworthy’ with the elements
being seriously concern. As a case study that already involves both elements of qualitative
and quantitative, by nature, this study will not make any generalizations in the market but,
based on the concepts being developed it will show simple trends in the insurance market in
Malaysia regarding the ideas of countering fraud by way of operationalized ideas and the
subsystems that influence the issues to be more serious.

When relating to Lincoln & Guba’s (2000) guidance on the level of trustworthiness of
qualitative research, they determine it as having an element of credibility (able to be justified
by internal validity), transferability (can be able for external validity), dependability (it has
the quality of reliability) and conformability (is objectively driven). This study can be
determined as trustworthy because of the elements included on the grounds of the process of
the research through the reporting phases of the study. The study includes an element of
credibility because it was administrated using a scientific case study methodology that allows
the use of variety sources to justify the output. It was systematically developed based on the
conceptual framework that resulted from the ideas of fraud definition to issues concerning the
overall insurance industry. Besides, the systematic ideas in the case study ensure clear guides
regarding the research’s transferability.

The research as a case study is not to make any generalization on what happened in the
general market of insurance but analytically it is valid in making some changes to the policy
ideas of the regulatory, insurers and professionals in the market. The research is proved to
have dependability because it comes directly from the main sources of the information and all
supporters are also the major players within the industry. The research development is
constructive due to the help of an institute that really needs some research in the related areas
as the sources of information to be recited in the public practices as general in nature. Finally, on the conformability, the research design, methodology and procedures are maintained in the descriptions and documentation. It ensures the objectivity with the elements and the responsive feedback from the sources that can be justified as credible in making any assumptions about the issues being discussed.

3.7 Conclusion

The elements of the methodology are the components that help the researcher to realize the objectives that are being created with the relevant research questions. A case study is something that can be directly administrated without the possibility that it would be helped by the groups of respondents in the market. As insurance is something that is becoming one of the needs in the economy, the complexity of the markets and the competitiveness of the insurers are making them strive to offer multiple numbers of products. By that, the research administered on general ideas for them were wasting time and resources. The next chapter will be more relevant in knowing Malaysia as a country with multiple races and elements. The following chapter will also introduce the insurance industry directly with the special feature of ‘takaful’ markets. Meanwhile, Chapters 5, 6 and 7 will be anchoring on the discussion of the output of the data collection process based on the evaluation adapted from the CIPFA Red Book 2.
CHAPTER 4

MALAYSIA AND THE INSURANCE INDUSTRY IN CONTEXT

4.0 Introduction

The previous chapter has initiated the idea on the processes involved for achieving the objectives with consideration to the relevant steps to realize all objectives that are specified in the earlier stages. This chapter discusses Malaysia in brief and considers aspects of its history, demographics, politics, economics, culture and some ideas on the criminal justice systems in-place. Then, the discussion will be on the insurance and takaful information in general. After that, this discussion will concentrate on the governance structure of insurance and takaful in Malaysia with elaboration on the functions of the association in the country. These are actually the base of the findings for the researcher in setting the cultural settings that would give the distinctive effect on the application of the market setting with consideration to the history, demographics, economy, politics and culture specifically. The uniqueness of the market with the added concepts to the insurance that comes from assimilation ideas of religion into the practice present certain ‘pros’ and ‘cons’.

4.1 Malaysia in General

Malaysia is one of south-east Asia’s most vibrant economies, the fruit of decades of industrial growth. It is also a politically stable country (BBC, 2012). Malaysia is a country combined of multiple races and religions; with the majority of the population Malay in all the states but the Chinese hold the country’s economic stability\(^5\).

Malaysia consists of thirteen states and three federal territories of 329, 847 square kilometres (127, 355 sq miles) (CIA, 2010; Constitution of Malaysia). Malaysia’s capital city is Kuala Lumpur, while Putrajaya is becoming the federal government offices territory (established

\(^5\) Based on the shareholders and market ownership by races reported in yearly basis. This effects the tremendously efforts by the Government to increase capital ownership of ‘Bumiputeras’ (sub origins) up to 30 percent in public companies ownership since 70s till now under New Economic Policy(NEP) .
under 4th Prime Minister, Dr Mahathir Mohamed). The population of Malaysia is 28.31 million people (Statistical Departments, 2009).

Figure 4.1 Map of Malaysia

Malaysia is separated by the South Chinese Sea into two regions: Peninsular Malaysia and Borneo Malaysia that is also well known as East Malaysia (consists of Sabah, Sarawak and Labuan Federal Territory). The country shares borders with Thailand, Singapore, Indonesia, Brunei and The Philippines. While, the location of the country is almost on the equator, it has a tropical climate where most places are wet throughout the year, and seasons can vary depending on a variety of factors including elevation and proximity to the ocean. Malaysia is in the dry and wet seasons throughout the year without any specific indicatives of seasons.

Malaysia is one of the countries that have adopted the Westminster parliamentary system that is named as ‘system raja berparlimen’. The Government is headed by the King of the federation, selected through the monarchy systems and rotation system among the sultanates in the specific state of Malaysia. The current king of the federation is Royal Highness Sultan Abdul Halim Muadzam Syah ibni Almarhum Sultan Badlishah who was installed in the position based on the rotation as the 14th king from 13 December 2011 (as on 1st March 2012) for the period of 5 years. Based on the system’s implementation, only the person with
royal blood in the rotation system can be elected as the king because some of the state is being headed by personnel appointed by Federal Governments.

Even though the head of the federation is the King, the head of the government is the Prime Minister, who is the head of the majority party elected through democratic elections. Federal legislative power is entrusted through federal parliaments and 13 state assemblies. The judiciary is independent of the executives and the legislatures that have the power over the appointments of the judges on the court systems. The current prime minister of the federation is Najib Abdul Razak, the 6th Prime Minister since independence, from the party United Malays National Organizations (UMNO), which forms the ruling coalition party National Front. 6

Malaysia’s ethnic groups comprise of Malays (main sub origins so called as ‘Bumiputeras’) with a majority of 54 percent, Chinese 25 percent, Indian 7.5 percent, 11.8 percents of other Bumiputeras (other sub origins that are not from Malays ethnics especially in Sabah and Sarawak areas) and 1.7 percent of others ethnics. The communities coexist in relative harmony even though racial tension occurs at certain periods of times (not to mention the 13 May 1969 massacre7). The different ethnic groups share Malay Language as the main medium of communication in the country, while English language is considered as the second language because of its colonial history. Others languages are widely used, such as Mandarin, Cantonese, Tamil and Urdu etc without any restriction by the government but not in official communications. The multi-racial composition actually reflects during the British colonial era when foreign workers from India and China had to be brought into the federation of Malaya (at that time) to work in the tin mining industry (Chinese) and rubber plantation (Indian). The labelling of the ethnic groups has existed since the British Imperialism period and has expected to have ended through Malaysia Economic Plans.

---

6 The coalition is starting from the first election in 1952. Even though the composition of the coalition always changed over the years
7 May 13 Incident in 1969 was racial riots that occurred and the height of the problem of unity in Malaysia. This tragedy has resulted the loss of lives and property and has a close relationship with the “General Election 1969” that becoming the dark period of the nation history. National emergency plan has declared on the night of 16 May 1969 that federal constitution been suspended for a while.
4.2 History of Malaysia

The name of Malaysia is adopted from the federation of Malaya, Singapore, North Borneo (then known as Sabah) and Sarawak on the 16 September 1963. Malaysia’s prehistoric period commenced from the effects of the earliest known human settlement around 40 thousand years ago and lasted until the establishment of the Sultanate of Malacca around 1400 years ago, a date which is commonly used as the beginning of the nation's history. However, the long pre-historic period is gaining attention as most of the existing literature on prehistoric civilizations mentions the greatness of Malacca (Gomez, 2004).

After conquering Goa, the Portuguese realized that South Asia could enrich them and not India. They collected information from each of the sailors who came to Goa and finally concluded that those who ruled Malacca will have the power to bring down Venice. Starting from small reasons, such as to save their personnel from imprisonment in Malacca, it then became to a developed idea of conquering the kingdom. D’Albuquerque employed various strategies and continuously attacked Malacca until it finally fell to the Portuguese on August 10, 1511. Thus, Sultan Mahmud II and his family retreated to Ulu Bertam, Pahang. The retreat of the Sultan enabled the Portuguese to destroy the remnants of opposition from the royal army of the Malays, Gujarati and India. During the earlier stages of conquering, the Portuguese army captured people every corner of the city and killed anyone suspected of opposing them, whether man, woman or child (Andaya & Andaya, 2001).

On August 15, 1795, British forces arrived in Melaka and took control of it from the hands of the Governor of the Netherlands, Abrahamus Couperus from the consequences of the “Velvet Revolution” in their country. Despite opposition to the submission of Malacca to the English, it did not cause any friction between them. Melaka continued to be governed by Dutch officials under the supervision of a British Resident. Based on the Treaty of Vienna in 1814, Malacca was returned to the Netherlands on 21 September 1818, but eventually surrendered Malacca back to the British on March 17, 1824 following the Treaty of London. This agreement allowed the two Western powers to focus their attention on areas of their respective territories (Gomez, 2004).
On October 1945, the British announced a bold step to end the government's indirect way of uniting all the states into the Union of Malaya under a Governor who had executive power. It was also proposed to introduce Malayan citizenship which would give equal rights to those who acknowledged Malaya as a homeland. Although the states were part of the Malayan Union proposal, it would be a British Colony. Singapore would become a separate colony. Malayan Union and Singapore would have a Governor, Executive Council and Legislative of their own (Cowan, 1961).

On 1 April 1946, the Malayan Union was established, and Sir Edward Gent was appointed Governor of the Malayan Union in Kuala Lumpur. However, UMNO had claimed that the Malayan Union was dissolved and replaced by the Federation of Malaya. The Federation of Malaya which was proposed consisted of nine Malay states and two states were British colonies. It was also suggested that a High Commissioner and not a Governor will be appointed as a representative of the British Government. The proposal also stipulated that apart from the Malays, only the second generation of Chinese, Indian and other races be entitled to a status of federal citizenship. Due to the rationale of the proposed Federation of Malaya, the Malayan Union was formally dissolved on January 31, 1948. Dissolution of the Malayan Union in 1948 had forced the British to open the way for independence of the Federation of Malaya. As a result of two major stresses of the Country Emergency Events and developments of the UMNO Malay nationalist movement, the British started an electoral system in 1951 at the local level election (Kheng, 2002; Gomez, 2004).

The problems in securing the cooperation of politicians from the major ethnic groups in this country in the fight for independence were successfully overcome by the formation of the alliance between UMNO, Malayan Chinese Association (MCA) and the Malayan Indian Congress (MIC). When the first federal elections were held in 1955, the alliance of UMNO-MCA-MIC, led by Tunku Abdul Rahman had obtained a great victory by winning 51 out of 52 seats contested. Tunku Abdul Rahman was appointed as the first Chief Minister of the Federation of Malaya. The alliance successfully forced the British to relinquish their sovereignty on 31 August 1957; hence the Federation of Malaya achieved its independence (Andaya & Andaya, 2001).

The first step in the formation of Malaysia began in 1961 through a proposal to form a broader alliance that included the Federation of Malaya, Singapore, Sarawak, Sabah and
Brunei made by Tunku Abdul Rahman. The proposal was generally accepted by the people of Malaya and Singapore, but it raised scepticism among the people of Sabah and Sarawak. However, the proposal was objected by the Philippines, which had claimed rights over Sabah. This proposal also received opposition from Indonesia who viewed it as a move to invade Borneo by Sukarno and the Indonesian Communist Party. However, continued opposition from the Philippines and Indonesia confrontation had caused the United Nations to send a mission into Borneo in 1963, which also reported that the opinion of the public was in favour of joining Malaysia. Thus, on 16 September 1963, Malaysia was officially formed and it consisted of the Federation of Malaya, Sabah, Sarawak and Singapore. Brunei rejected the motion to join Malaysia. However, in 1965, Singapore withdrew from Malaysia and became an independent country (Cowan, 1961).

### 4.3 Demographics

Malaysia is comprised of various races and religions, with the Malays being the largest ethnic group. In terms of the constitution, Malay is defined as someone who practices the Malay culture, speaks the Malay language in daily life and a Muslim. In the Malaysian context, the term indigenous is often used. An indigenous person is considered as the sub origin people of Malaysia, which includes the Malay, Dayak, Iban, Kadazan, Dusun and Kadazan others (Crouch, 1961).

According to the Bulletin of Statistics (issued September 2009), the population in Malaysia stood at 24.8 million. The Malays represent 54% of the population which is about 13.48 million people. Sub origins (other than Malays) were 2.93 million people representing 11.8%. Thus indigenous people represented 65.8% in the total. Approximately 25% of the population is Chinese ethnic that is approximately 6.22 million people, 7.5% of Indians with a total of 1.86 million people, while other people were about 1.7% with a total of 318.9 thousand people. Almost 85% of Indians in Malaysia are from the Tamil community (Statistic, 2010).
Table 4.1: Malaysia’s Population in 2009

<table>
<thead>
<tr>
<th>No</th>
<th>Status</th>
<th>Race</th>
<th>Total (persons)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bumiputera</td>
<td>Malay</td>
<td>13.48 million</td>
<td>54</td>
</tr>
<tr>
<td>2</td>
<td>Bumiputera</td>
<td>Non-Malay</td>
<td>2.93 million</td>
<td>11.8</td>
</tr>
<tr>
<td>3</td>
<td>Non-Bumiputera</td>
<td>Chinese</td>
<td>6.22 million</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>Non-Bumiputera</td>
<td>Indian</td>
<td>1.86 million</td>
<td>7.5</td>
</tr>
<tr>
<td>5</td>
<td>Non-Bumiputera</td>
<td>Other</td>
<td>318.9 thousand</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>24.8 million</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Malaysia Statistical Department, as on 17/9/2009)

4.4 Politics

Malaysia adopted a multi-party political system since the first election in 1955, based on the concept of "who serve" (first-past-the-Post). Malaysia's major political party, United Malays National Organisation (UMNO), has held power with the party - since the independence of Malaya in 1957. In 1973, the alliance of parties based on race had been replaced with a larger alliance – named National Front (Barisan Nasional) - which consists of 14 parties. Today, the National Front alliance three major key components are the UMNO, MCA (Malaysian Chinese Association) and MIC (Malaysian Indian Congress). The Prime Minister of Malaysia is a member of the Malay party (UMNO) in the National Front alliance (Crouch, 1996).

Most probably the politics "for religious harmony and equality of race" is very fragile, and the "fragility is due to religion and race identification and is paired with the supremacy of Malay people met with the ambitions of other nations for equality.” As the majority of the people in Malaysia consist of Malay Muslims, there was a consensus to establish a Islamic state. However, this was met with opposition as non-Malays demanded equal rights in which the constitution cannot be adjusted to fit such demands. This was one of the biggest problems that challenged the authority of rule of the Malays (USDoS, 2010).

In early September 1998, Prime Minister Mahathir bin Mohamed dismissed Deputy Prime Minister Anwar Ibrahim on charges of committing acts of immorality and corruption.
However, Anwar reputed that the expulsion was due to the difference of political ideology between him and Mahathir. He launched a series of protests held to demand reforms in the Malaysian political landscape. Later, Anwar was arrested, beaten while detained in prison (including beatings by the Chief of Police), and charged with corruption offenses, in the contexts of moral law, litigation, prosecution, including obstruction of justice and sodomy. In April 1999, he was found guilty on four charges of prosecution in corruption and sentenced to imprisonment for six years. Again in August 2000, Anwar was found not guilty of sodomy and not guilty for corruption charges. The prosecution had involved nine consecutive years after the offense was only dropped for a sixth year. Both trials were regarded by local and international observers as unfair. Anwar's conviction on sodomy was turned into wrongful charges and after he completed six years' imprisonment for corruption, he was released. Upon the case, in the November 1999 general election, the National Front won with three-quarters of the total parliamentary seats, but seats for UMNO had fallen from 94 to 72. Their opponent, Front Alternative that is the opposition coalition, led by the Pan-Malaysian Islamic Party (PAS), had increased to 42 seats in parliament and at the same time PAS in Kelantan regained control of the state government (only one state under opposition administration at that time) (USDoS, 2010).

In the general election in March 2004, Dato 'Seri Abdullah Ahmad Badawi, successor of Tun Dr Mahathir, led the National Front to achieve significant results in the ballot. At that time the coalition government dominated 92% of the seats in Parliament. In 2005, Tun Dr. Mahathir said "I believe this nation should have a government that is strong but not too strong. A two-thirds majority, as I enjoyed it when I was prime minister is enough, but a majority of 90% is too strong. He stressed that:

"We need the opposition to remind us, if we make a mistake. If you are not opposed, you think everything you do is right."

The above statement was proved to be correct as in the next general election in March 2008 the opposition parties managed to stop the National Front from winning a majority of ⅔ for the first time since 1969, which was 82 out of 222 parliamentary seats. This could be due to

---

8 Even though after retirement on 31 October 2003, but Tun Dr Mahathir Mohamed still have the power of speech to make some comments towards the Governments and have its own personal blog (http://chedet.co.cc/chedetblog/) that making his own statement towards the government policy and action after his retirement.
Pak Lah’s low reputation and he subsequently stepped down in October 2008 and was replaced by the current Prime Minister, Dato Seri Muhammed Najib Tun Razak (succeeded on 3rd April 2009). Meanwhile, the three main opposition parties, the People’s Justice Party (*Parti Keadilan Rakyat*), Democratic Action Party (DAP) and the Pan-Malaysia Islamic Party (PAS) formed an alliance, called the People’s Alliance, after the elections in 2008. They also gained power of management in 4 states.

Freedom of speech is considered low in Malaysia and this has led to the creation of movements such the People Alliance coalition. The simple layman cannot make any comments and condemn the ruling party or government publicly, if that happened, the emergency act is used for this situation. These people will be caught or brought to some isolated place without being charged in the normal judiciary process. Based on the Annual Survey carried out on Political Rights and Civil Liberty in 2011, it was evident that Malaysia falls into the category of ‘Partly Free’ where the score for political rights and civil liberty were 4 (Freedomhouse.org, 2011). For the Democracy Index in 2008, Malaysia was ranked at number 68 that looked better than the nearest neighbours Singapore and Indonesia (from www.economist.com in 2008).

Meanwhile, a survey done by Transparency International (TI) on Corruption Perception Index (CPI), aggregated the perception of well-informed people with regards to the extent of corruption, defined as the misuse of public power for private benefit can be one of the outside interpretations on Malaysia’s politics. In 1998, Malaysia was ranked at number 29 from a sample of 99 countries; it fell to 56th place in 2010 and slipped again, to number 60th in 2011 survey (Transparency International, 2011). The reduction in governmental ethics appear to be supported as the Malaysian Anti Corruption Agency (MACA) has reported on corruption in government agencies between the years 1999 and 2003, which found that the Royal Malaysia Police (*Polis Diraja Malaysia*, PDRM) were the most corrupted agency, compared with the next most, the Town Councils and the Road Transport Department (USDoS, 2010). The political situation in a country like Malaysia will determine the types of policy that are likely to be implemented, particularly in such a sensitive issue – fraud in the administration (Lipton, 2010)
4.5 Economy

The economic system in Malaysia in the early 19th century until the year 1963 could be categorized into two major forms of self-sufficiency economy and commercial economy. The shape and economic activities of their practice is influenced by the system of government in the past. For example, ordinary people became farmers, merchants; the Royals were the owners of mining sites and others. Economic self-sufficiency is the purpose of economic activity or simply being unable to meet the daily needs of the family. Meaning, the economic activity will be used for their family. Any excess production will be sold and the proceeds will be used to purchase other essential goods including basic needs such as clothing and so on. Economic activity which are categorized as major self-sufficiency activities are farming, fishing and collecting forest products. Besides, such activities do not require the use of many currencies (Gomez, 2004).

The Commercial economic system only existed in Malaya after the British colonial presence in the 19th century. This intensified form of economy exercised when they started to collect taxes from people and forced them to use cash as the major method of economic exchange. This is because those who failed to pay the tax would be punished. One significant development during that time can be seen in the commercial sector and mining.

Nowadays, Malaysia can be categorized as a developing country, with market-oriented practices and an open market. In 2007, the Malaysian economy was the 29th largest economy in the world according to parity purchasing power of gross domestic product. In 2009 the Gross Domestic Product was estimated at RM 512.4 billion with a growth rate of -1.7% since 2008 (due to recession in previous years). As the indicators also show, Malaysia as a Southeast Asian nation has experienced economic growth sharply and led the development during the end of the 20th century and has a GDP per capita of RM24, 055, and also manufacturing has been regarded as a national industry. The detailed performance is in the table below that includes the main economic indicators in 2009.
Table 4.2 Malaysia’s Economic Indicators in 2009

<table>
<thead>
<tr>
<th>Malaysia Economy Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currency</td>
</tr>
<tr>
<td>Financial year</td>
</tr>
<tr>
<td>Trade Association</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Statistic</td>
</tr>
<tr>
<td>GDP position</td>
</tr>
<tr>
<td>GDP</td>
</tr>
<tr>
<td>Increment in GDP</td>
</tr>
<tr>
<td>Per capita income</td>
</tr>
<tr>
<td>GDP per sector</td>
</tr>
<tr>
<td>Inflation rate (CPI)</td>
</tr>
<tr>
<td>People under poverty lines</td>
</tr>
<tr>
<td>Unemployment rate</td>
</tr>
<tr>
<td>Labour force</td>
</tr>
<tr>
<td>Total export (f.o.b.)</td>
</tr>
<tr>
<td>Total import (c.i.f)</td>
</tr>
<tr>
<td>Major exports</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Major imports</td>
</tr>
</tbody>
</table>

9 All the GBP amount is stand based on the exchange rate on 1st December 2012 that is GBP1= RM 4.90
### 4.6 Criminal Justice System in Malaysia

Malaysian law is based on a common law legal system, as a direct result of the invasion of Malaya, Sarawak and North Borneo by the British since the early 1800s to the 1960s. Supreme law, the Constitution of Malaysia, outlines the legal framework and citizen's rights. Federal law is enacted by Parliament in respect of the whole country. There is also a state law that is enacted by the Legislative Assembly (Dewan Undangan Negeri, DUN) and associated with the state. The Constitution also allows multiple unique judicial systems, such as secular laws (criminal and civil) and Shariah law. Implementation and the relationship between the two legal systems are quite complicated and have caused uncertainty.
Figure 4.2 Malaysia Criminal Justice Court System

Federal Court
History: Came into existence on 1 January 1985, replacing the Judicial Committee of the Privy Council. Originally the Supreme Court, and renamed in 1994.

Jurisdiction: Hears appeals on criminal matters from the Court of Appeal, where such matters originate in the High Court (art. 121(2), Federal Constitution; s. 87, Courts of Judicature Act 1964). Hears referrals from any court on constitutional matters (art 128(2) of the Federal Constitution).

Special Court
Jurisdiction: Under art. 162(3) of the Federal Constitution of Malaysia, this court hears all civil or criminal cases brought by or against the Yang di-Pertuan Agong (the Malaysian monarch, elected by the Conference of Rulers), or against any of the nine Malay Rulers. In addition, it has the same jurisdiction and powers as vested in all other Malaysian courts.

Composition: Under art. 162(1) of the Federal Constitution, the Special Court is made up of the Chief Justice of the Federal Court, the Chief Judges of the two High Courts and two other current or former judges of the Federal Court, or the High Court, appointed by the Conference of Rulers.

Court of Appeal
History: Established in 1994.

Jurisdiction: Hears appeals from the High Court (art. 121(1B) of the Federal Constitution). Cases are substantive, where the case originates in the High Court, and on points of law, where the case has enjoyed an appeal from a subordinate court (s. 50(1-2), Courts of Judicature Act 1964).

High Court in Malaya – High Court in Sabah and Sarawak
Jurisdiction: These two High Courts have coordinate jurisdiction and status. Each has jurisdiction to try all offences committed within their regional jurisdiction, and various extraterritorial offences (s. 22, Courts of Judicature Act 1964). The High Courts try all capital cases. They hear appeals from the lower courts. They may pass any sentence permitted by law (s. 22(2), CA 1964).

Sessions Courts
Jurisdiction: Try all offences other than those punishable with death (s. 64, Subordinate Courts Act 1948).

Maximum penalties: Natural life sentence (s. 64, SCA 1948).

Magistrates’ Courts
Jurisdiction: Try all offences for which the maximum sentence does not exceed 10 years’ imprisonment, or a fine only (s. 85, Subordinate Courts Act 1948).

Court for Children
History: Established by the Child Act 2001.

Jurisdiction: Try children between 10 and 18 years old (s. 2, CA 2001).

Maximum penalties: If found guilty of a non-capital offence, children may be sent to an approved school or released on bail. Those guilty of a capital offence are detained in prison at the pleasure of the Yang di-Pertuan Agong (the elected Monarch) (ss. 91-97, CA 2001).

(Taken from http://www.acclawyers.org/resources/jurisdictions/malaysia/ accessed on 1 Jan 2012)
Based on figure 4.2 above, Malaysia has two courts systems that are inclusive of the High Court and Subordinates Court. The High Court combines the Federal Court, Court of Appeal and High Court. The High Court has supervisory jurisdiction, and converts the results of the Subordinate Courts, as well as jurisdiction to hear appeals from the Subordinate Courts, both for civil and criminal cases. The Court of Appeals generally hears all civil and criminal appeals against decisions of the High Court, unless the court orders or decisions are made by consensus. The Federal Court is the highest court in Malaysia. Federal courts can hear appeals of civil cases decided by the Court of Appeals where the Court gives leave to do so. These courts also hear appeals of criminal cases from the Court of appeals in respect of cases heard by the High Court original jurisdiction, the case is not appealed on the decision based on the Subordinates Courts (Fook & Hassan, 2011).

While the subordinates courts are Sessions Courts, Magistrate Courts, Shariah Courts and other types of courts. Sessions Courts are similar to the Court of Quarter Sessions in England, the Sessions Court has jurisdiction to try offenses not punishable by death. Courts are presided over by Session Court judges (formerly President of the Court of Session). The Sessions Courts also hear all civil cases where claims exceed £5,100 (RM25,000) but not exceeding £51,000 (RM250,000), except for cases involving motor vehicle accidents, suffering, and cases between landlords and tenants this court has unlimited jurisdiction . While, for the Magistrates' Court, the magistrates are divided into First Class and Second Class, First Class Magistrates have legal qualifications and greater powers. Second Class Magistrates are now not normally appointed. Magistrates' Courts hear civil claims not exceeding £5,100 (RM25,000) . First Class Magistrate Courts generally have the power to try all criminal offenses where imprisonment does not exceed 10 years or punishable by fine only, but may impose a penalty not exceeding five years imprisonment, or a fine up to £2,040 (RM10,000) and / or caning sentence of 12 times. Magistrates' Courts also hear appeals from the Court and contact. Another court is the court that has jurisdiction to hear civil claims not exceeding £10.20 (RM50), if the parties are Asian and understand the Malay language. There is a parallel system of state Shariah Courts which has limited jurisdiction of Islamic law (Shariah) states. Shariah courts only have jurisdiction over matters involving Muslims, and generally cannot impose a sentence of more than three years imprisonment, a fine of £1,020 (RM5,000), and / or caning sentence more than six times.( All the financial means based on rate £1= RM4.9 as at 1st December 2012) (Fook & Hassan, 2011).
The Royal Malaysia Police (PDRM) is a Malaysian police team consisting of more than 90,000 officers and members, and their headquarters are in Bukit Aman Police Headquarters, Kuala Lumpur. This establishment is unique because compared with other countries; the organization is centralized, where all forms of general policing duties (General ordinate) to intelligence are under its jurisdiction. Now the Chief of Police (the Highest position) is held by Tan Sri Ismail Omar (starting from 1st September 2010) (RMP, 2011). Most probably this position was appointed by the King of Malaysia based on the suggestion by the Cabinet of Malaysia.

Apart from two departments involved in the administration of the Department of Management and Logistics Department, the Police has five departments involved in crime prevention, namely the Department of Criminal Investigation, Narcotics Criminal Investigation Department, the Department of Homeland Security and Public Order (KDN / KA), Special Branch and the Department of Commercial Crime Investigation. Departments are headed by directors with the rank of Commissioner of Police (Three Star General). The police force in Malaysia have receive thousands of arguments on professionalism and the transparency of their implementations of their job due to the political condition and misuse of police power in certain cases (the Internal Security Act, 1960 caused major issues due to police power).

Not to omit the function of the Malaysian Prison Department11 (Jabatan Penjara Malaysia) which is a department controlled by the Ministry of Internal Security (put under power of the Prime Minister since the 2nd Prime Minister Tun Abdul Razak). This is the jail where convicted offenders are sentenced by court. It is also a detention and recovery institution which owns human resource machinery and strength quality and is proactive in implementing visions, missions and objectives that have been suggested.

---

10 ISA is a preventive detention law in force in Malaysia. One may be detained by police for 60 consecutive days without trial for anticipated actions threaten national security or any part thereof. After 60 days, a prisoner may be detained for another two years if approved by the Minister of Home Affairs, and thus enable the continued detention without trial.

11 This departments put under the Ministry of Home Affairs in Malaysia Government that charged for domestic affair such as public safety, civil defense and immigration.
In the year 1923, the Visiting Justice System was introduced. Prison industries were expanded to include printing work, weaving, sewing, rattan, and metalwork. The following year, 1924, rock-breaking work was abolished and replaced with pounding coconut husks. On 2 November 1995, the Prison Act 1995 was enforced to replace the former Prison Act and on 1 September 2000, the Prison Regulations 2000 was enforced to replace previous regulations. The previous acts and regulations have been used for a long time, thus changes and reforms were necessary to meet current needs and demands to streamline the management and administrative machinery of the prison institution. In an era of development and modernisation, the Malaysian Prison Department realises that it should not be contented with its past achievements, but it should instead move forward and innovate in order to assist the prisons administration in dealing with modern culture through criminology, penology and overall social control (Fook & Hassan, 2011)

The pattern of the political conditions that were embedded purely with the ex-colonial legislative in the country had actually built Malaysia on its own landscapes of economic and social in their own specific terms. The custom that has been bred through the majority of ethnics in the country dominated the pattern on economic transaction and also components of the workforce in the criminal justice system. The criminal justice systems that are helping to supervise the economic stability and the social interaction are main contributors from the insurance industry perspective. The industry needs to be more concerned about the culture sensitivity of the social community, economic perspective of industry and the criminal justice system in helping the stability and survival of the company. This is impossible if the insurance company are able to survive on long term basis such as Kurnia Insurance and MAA, as others collapse when the company is not well adapted with social contacts and the economic reception of the company is affected (MII, 2009). While, the governance from the criminal justice system includes debates in parliament about insurance products and limitation for the insurers are actually helping out the industry to be stable and most importantly, the contribution of ideas helps in the invention of Takaful (Islamic) insurance (BNM, 2006; SEC, 2007).
4.7 Insurance Industry in Malaysia

After the general picture of Malaysia has been considered, this chapter will now move on to Insurance Industry ideas in Malaysia. The next part will discuss more in relation to insurance, the takaful and the products for both systems. Besides that, it will scratch into some knowledge in the governance body of the industry and also on the association that exists to strengthen the industry at the moment (Ismail, 2006).

The insurance industry in Malaysia is dominated by insurance products and takaful products. Both have different regulations, supervised under the Insurance Act 1996 and the Takaful Act 1984. The major difference is that takaful products are governed under Shariah (Islamic) law. By that, the establishments of the insurance companies and products in Malaysia would be based on either one of these acts and sometimes there are companies that promote and operate both types of systems under one trademark (Ahmad Mazlan Zulkifli, Badrul Hisham Abdul Rahman, Nasser Yassin & Jamil Ramly, 2012).

When discussing the market share, the insurance industry in Malaysia remains dominated by the foreign insurance providers, as noted in the US Department of Commerce 2008 Country Commercial Guide, and the government are continuing to promote Islamic insurance and reinsurance, as part of its strategy to make the country a global hub for Islamic financial services. Meanwhile, the Central Bank of Malaysia (known as Bank Negara Malaysia (BNM)) as the regulatory main body for the industry, has reported stronger solvency positions and enhanced asset-liability management contributed to the sustained performance of the industry in 2007, 2008 and 2009 through the Financial Stability and Payments Systems Report (replacing the Insurance Industry Report since 200512).

In order to gain more understanding, it is better to discuss the insurance and takaful ideas in order to maintain a level of understanding of the operations within the industry for the overall report.

---

12 Before 2005, Insurance Industry and Takaful Industry have their own specific report that showing the both performance in the economic indicators. But, in order to make the sure that all well-regulated industry is connected each other, the BNM have compressed it in one report namely as Financial Stability and Payment System Report
4.7.1 Insurance and takaful

Insurance is the transfer of risk by an individual, such as yourself, or an organisation, such as your business, to the insurance company. The person or organization that is transferring the risk will thus be known as the policy owner. The insurance company receives payment in the form of premiums and will make compensations in the event of losses or damages sustained by the policy owner. Meanwhile, takaful is a protection plan based on Shariah principles. By contributing a sum of money to a common takaful fund in the form of participative contributions (tabarru’), the customer undertakes a contract (aqad) to become one of the participants by agreeing to mutually help each other, should any of the participants suffer a defined loss (Simon, Rifaat & Volker, 2009; Sohail, 2007).

Both insurance and takaful have similar basic principles. For instance, the insured must have a legitimate financial interest in the risk that the policy owners are insuring, meaning they must suffer a financial loss when the insured event occurs. Any party can also buy more than one policy or plan to protect a particular risk but in the event of loss or damage, that party can only make one claim. The amount payable will then be contributed by the insurance companies involved. As such, policy owners cannot profit from a general insurance policy or takaful plan. If they suffer a loss, they will be compensated accordingly and no more than that. They will be paid or ‘indemnified’ to the position they were in before the loss. However, if they wish to cover life, they can buy more than one policy (Ahmad Mazlan Zulkifli, Badrul Hisham Abdul Rahman, Nasser Yassin & Jamil Ramly, 2012; Simon et. al.).

Meanwhile, insurance or takaful contracts are contracts of utmost good faith (trust). Thus, the policy owner needs to disclose all material information required. If any of the relevant material facts are not disclosed, the policy may be invalid and they will not be protected against any loss or damage. Other terms that related to the Takaful in the coverage of the insurance can be found in Appendix 5.

4.7.2 Types of insurance

The main categories of the insurance are life insurance and general insurance. Life insurance is an insurance coverage that pays out a certain amount of money to the insured or their specified beneficiaries upon a certain event such as death of the individual who is insured.
This protection is also offered in a family takaful plan, a Shariah-based approach to protecting policy owners and their family (Ahmad et al., 2012).

The coverage period for life insurance is usually more than a year. So, this requires periodic premium payments, either monthly, quarterly or annually. The risks that are covered by life insurance are usually premature death, income during retirement and illness from the normal kind of diseases. The main products of life insurance include whole life, endowment, investment link, life annuity and medical health. Whole life is the life-long protection and premiums are paid throughout your life and the money including any bonuses will be paid when the policy owner passes away or suffers total and permanent disability. Endowment is a combination of protection and savings whereby the money will be paid at the end of a specific period upon the policy owner’s termination or if total and permanent disability is suffered. Meanwhile, investment link insurance, whereby the policy owner pays a premium, is used to buy life insurance protection and units in a fund managed by the life insurance company. The benefits that would be paid to the policy owner or their nominee will depend on the price of the units at the time they terminate their policy or when they pass away. Life annuity plan is a series of payments paid to the policy owner until they pass away. Types of annuity include immediate annuity or deferred annuity. Last and most popular is medical and health insurance which is a policy designed to cover the cost of private medical treatment, which can be very expensive, especially with hospitalization and surgery. In addition, some of these products provide the policy owner with an income stream while they undergo treatment (Ahmad et al., 2012; Simon et al., 2009; Sohail, 2007).

While, general insurance is basically an insurance policy that protects the customer against losses and damages other than those covered by life insurance. The coverage period for most general insurance policies and plans is usually one year, whereby premiums are normally paid on a one-time basis or monthly sometimes. The most common risks that are covered by general insurance includes property loss, for example, a stolen car or burnt house; liability arising from damage caused by the policy owner; accidental death or injury. The main products of general insurance include motor, property (house), personal accidents, medical and health, and travel. Motor insurance is required when a policy owner buys a motor vehicle. Motor insurance covers their vehicle such as a motorcycle, car or lorry, in case of accident or theft. Meanwhile, property insurance is one of the most important insurance policies when a policy owner invests in property such as a house or premises. There are three
main types of policies which the user can buy to protect these investments, which are basic fire policy, house owner’s policy and householder’s policy. For personal accidents insurance, it is an annual policy which provides compensation in the event of injuries, disability or death caused solely by violent, accidental, external and visible events. It is different from life insurance and medical & health insurance. Often, this type of insurance is sponsored by the employment contract. As in the life categories, medical and health insurance is similar but with different terms and conditions. The last in the group is travel insurance coverage which is usually limited to the period of travel. However, some insurance companies may offer various combinations of protection to cater to the specific needs of customers, including long-term annual policies for a frequent traveller. This package can be purchased for people and their family to insure against travel-related accidents, losses or interruptions (Simon et. al, 2009).

4.7.3 Takaful Insurance

Before having a detailed discussion it is better to take a look at the features of the takaful as an alternative to the insurance products used in Malaysia (Ahmad Mazlan Zulkifli, Badrul Hisham Abdul Rahman, Nasser Yassin & Jamil Ramly, 2012). Takaful is an insurance concept which is grounded in Islamic Muamalat, observing the rules and regulations of Shariah. It is a concept that has been in practice for over 1,400 years since the time of Prophet Muhammad. In principle, a takaful system is based on mutual co-operation, responsibility, assurance, protection and assistance between groups of participants. In other words, it is the provision of shared contributions to help those who are in need. These fundamentals are based on the Holy Quran that calls for co-operation:

Allah said:

“...Help Ye one another in righteousness and piety but help ye not one another in sin and rancour... (Al Maidah : 2).

While this concept also, puts consideration as the basis for mutual protection, as said by Prophet Muhammad PBUH.

*By my life, which is in Allah’s power, nobody will enter Paradise if he does not protect his neighbour who is in distress.*

(Narrated by Imam Ahmad)
Although the concept of insurance is permissible under Shariah law, certain practices in conventional insurance breach Shariah law that will be discussed later in this thesis. The current Takaful Practice uses a combination of two types of main ‘Aqad (contracts). These are the contract of Tabarru’ (Donation) and contract of Wakalah (Agency) which are free from the elements of Riba (usury), wager or Maisir (gambling) and Gharar (uncertainty) (White, 2007). The Takaful system stresses the spirit of co-operation and joint responsibility among participants. (Ahmad et. al, 2012; Simon et.al, 2009)

4.7.4 The difference between Takaful and Conventional Insurance

The question may rise regarding the characteristics that isolate Takaful from Conventional Insurance in order to understand its characteristics. Hence, it is vital to understand the characteristics of Takaful in comparison to the conventional insurance. In June 15, 1972, Malaysian National Fatwa Committee conducted research on conventional insurance contracts and in its fifth conference, they decided that life insurance implemented by the current insurance companies as a muamalah was fasid (illegal/damaged) and not in compliance with Islamic principles because it contains elements of gharar (uncertainty), maisir (gambling), and riba’ (usury) (Simon, et.al, 2009; Sohail, 2007).

Gharar means "Uncertainty". The definition of uncertainty in the muamalah (business) transaction can be considered that “when there is a matter that wants to be concealed by one party where it can raise a sense of inequality as well as tyranny to another party". This can be related to the ideas of Islamic Scholar to Ibn Rush, Gharar means:

"The lack of information known about a certain product (object), the existence of uncertainty towards the presence of that object, and the lack in quantity and conciseness on the information about the object".

Another commentator (Simon, et.al, 2009, p.30) on these ideas states that:

"Al-Gharar is defined as a contract that refers to a risk and uncertainty raised from one’s manipulation that causes anguish towards a person that has been oppressed."
For example in the used car business, the customer is not told of the true condition of the car. After the trade of the car is completed, the gharar in the object of trade can be made a reason to cancel the contract. This is because gharar is a result of an oppressive act done intentionally."

An insurance contract contains gharar because when a claim is not made; one party (insurance company) may acquire all the profits (premium) gained whereas the other party (participant) may not obtain any profit what so ever or vice versa when it was made (Sohail, 2007).

The muslim scholars (Ahmad Mazlan Zulkifli, Badrul Hisham Abdul Rahman, Nasser Yassin & Jamil Ramly, 2012) stated that Maisir and Gharar are related. This means that if a transaction consists of elements of gharar hence elements of gambling will exists. These two are much interrelated. Maisir (Gambling) exists in an insurance contract when:

- The participant contributes a small amount of premium in hope to gain a large sum.
- The participant loses the money paid for the premium when the insured event does not occur.
- The company will be in deficit if the claims are higher than the amount contributed by the participants.

The element of riba (usury) exists in the policy loan business offered to the participant as a life insurance product. In this policy loan, the insurance company will charge interest to the participant who made the loan. It is clear here that the interest paid is a form of riba that is prohibited in Islam. The riba element also exists from the profit of the investment fund that will be used for the payment of claims to the policyholders. This is because most of the insurance funds are invested in financial instruments such as bonds and also stocks which contain the element of riba (Sohail, 2007).

Islamic intellects have mutually agreed Takaful to be the substitute of conventional insurance. The tabarru' system will become the main core of the Takaful concept. This system makes insurance comply with the Islamic muamalah. Thus, takaful is free from the elements of gharar and maisir.
Tabarru’ is an Arabic noun that means "donation; gift; contribution". Within the business context, each participant that wants protection from Takaful must be present with a sincere intention to donate in order to help other participants if they are faced with difficulties. In precise words, all participants agree to help one another. The emphasis on this issue can be observed from a fatwa by Dr. Yusuf Al-Qardhawi[^13] that insisted Islamic insurance may exist on the condition that each participant contributes into a fund used to support one another. Today, most companies that practice Takaful are involved in the world of business. Due to that reason, the conditional tabarru' is introduced where each participant involved in takaful needs to donate a sufficient amount to cover expected takaful claims. Thus, if a participant is of high risk to the company, then the rate of tabarru' contributed must be balanced with that risk (Simon et.al, 2009).

4.7.5 Types of Takaful in Malaysia

There are two major categories of takaful insurance in Malaysia that are generally takaful and family takaful. The general takaful ideas are when policy owners contribute a sum of money to a takaful fund in the form of participative contribution (tabarru’). They will undertake a contract (aqad) to become one of the participants by agreeing to mutually help each other, should any of the participants suffer any form of misfortune, either arising from death, permanent disability, loss, damage or any other such misfortunes as covered under the takaful they personally undertake (Ahmad et.al., 2012).

The products under general takaful are home, motor vehicles and personal accident. For home takaful, it is catered for the house owners takaful and householders takaful. Meanwhile, motor vehicles takaful cover policy owners against loss or damage to their vehicle due to accidental fire, theft or accident. It also covers bodily injury or death of a third party as well as loss or damage of a third party’s property. Similar to general motor insurance, there are two types of cover for a motor takaful plan namely third party cover and comprehensive cover. Lastly, is personal accident (PA) takaful which is an annual plan that provides policy owners or their beneficiaries with compensation in the event of death, disablement or injuries arising from accidents. People can either participate in a PA takaful for themselves or a group plan for their family. PA takaful is also available for short periods,

[^13]: Prof Dr Yusuf Qardhawi is one of most famous Islamic scholar from Egyptian economy.
like when people are travelling abroad, to cover them should any accident occur during travel periods just like travel insurance (accessed from http://www.takaful-malaysia.com.my.corporate/takafuloverview/Pages/glossarytakaful.aspx#).

The other categories are family takaful that provides policy holders with both a protection policy and long-term savings. The policy holders and beneficiary will be provided with financial benefits if they suffer a tragedy. At the same time, they will enjoy an investment return because part of their contribution will be deposited in an account for the purpose of savings. They also have a choice of maturity periods and there is no forfeiture in the event of cancellation of that coverage. At the same time Malaysian government allowed personal relief on tax relief to participants in family takaful (accessed from http://www.takaful-malaysia.com.my.corporate/takafuloverview/Pages/glossarytakaful.aspx#).

The products under family takaful are ordinary family plans, investment linked, children’s education and, medical and health. For the ordinary family plan, it comes with individual family takaful and group family takaful. Individual family takaful includes education, mortgage, health and riders. Participants and their beneficiaries will receive financial benefits arising from death or permanent disability, as well as long-term savings (investment), and investment profits that are distributed upon claim, maturity or early surrender. Meanwhile, group family takaful is developed for employers, clubs, associations and societies. The plans include group education, group medical, health and riders. Participants will receive protection in the form of financial benefits arising from death or permanent disability (accessed from http://www.takaful-malaysia.com.my.corporate/takafuloverview/Pages/glossarytakaful.aspx#).

The investment-linked takaful is a plan that combines investment and takaful cover. Participant contribution gives them a takaful cover, which includes death and disability benefits, and also an investment in a variety of Shariah-approved investment funds of the policy owner’s choice. This package offers unique features that have the flexibility to choose your own level of protection and investment, amount of contribution, switching between the investment funds and can claim at any point in time. Meanwhile, Child Education Takaful Plan (CETP) provides the participants with protection and long-term savings to finance the higher education expenses of their child. Participating in a CETP also makes them eligible for personal tax relief of up to a maximum of RM3,000 per year (£625) for the combination of
both medical and education plans. (accessed from the http://www.takaful-malaysia.com.my/corporate/takafuloverview/Pages/glossarytakaful.aspx#).

Lastly, the medical and health takaful gives participants cover for the cost of private medical treatment, like hospitalisation, surgery and treatment, if participant are diagnosed with certain illnesses or involved in an accident. The cover acts as a stand-alone policy or can be added to a basic family takaful plan, providing better coverage and benefits from both policies (Ahmad et.al, 2012).

4.8 The Insurance Industry and its Governance in Malaysia

The Central Bank of Malaysia (BNM) was established under the Central Bank of Malaysia Act 1958 to regulate and supervise the financial sector in Malaysia. They actively regulated the insurance industry in full by t 1988 and played a major role in policy development, administration and enforcement, actuarial function, consumer education and complaint handling (ADB, 2001). Most probably, the insurance act gave the task to BNM on the policy developments such as licensing, regulation and supervision of the insurance and reinsurance companies, insurance brokers and financial advisory businesses.

The Insurance Act also enacts rules on the financial requirements, high level of disclosure, and transparency in the operation of insurance and takaful operators. While, Insurance Regulation circulated by BNM prescribe detailed implementation of the mandatory requirements. Each year, the BNM circulates the Insurance Industry Report to the general public which details the condition of the industry at that period of time. While, starting from 2005, BNM combined this report to be included in the Financial Stability and Payment Report, in order to measure the performance of this industry together with other financial service industries in Malaysia (BNM, 2005; BNM, 2012).

The ten-year Financial Sector Master Plan (FSMP) was formulated by the BNM in 2001 in order to set a timeline for some liberalization of the insurance industry. Phases of the liberalization include increased cap on foreign equity, opening the reinsurance market for more outside competition and excluding more restrictions for the employment of foreign specialists. As included in the Insurance Industry Annual Report in 2005, 16 out of 31
recommendations of FSMP had already been implemented in order to strengthen resilience, building the capacity and capability of the domestic insurers, increasing the professionalism and corporate governance in the industry and also strengthening consumer protection and supervisory frameworks (BNM, 2005).

Despite the global financial crisis and economic slowdown in the country in 2009, BNM still continued to advance the development of a sound and progressive insurance and takaful industry that would enhance their performance and contribution to the Malaysian economy. It is also aiming to position the industry for a more deregulated pricing environment for motor insurance (BNM, 2010). The increments of the insurance policy cost involved last year actually gained a negative response by the customers. The table below shows the developments in the industry from 2006 until 2009.

According to BNM’s 2009 Annual Insurance Statistics and Annual Takaful Statistics, stronger solvency positions and enhanced asset-liability management contributed to the sustained performance of the insurance, reinsurances, takaful and retakaful sectors in 2009. As per the table below, in 2009, Malaysia had about 39 insurance companies, reduced from the year before, including, 9 life-insurers, 7 reinsurance companies, 8 takaful operators and 2 retakaful operators. It shows stability in the takaful market because it can still survive with both parallel in conventional and Islamic finance, also enhancing its significance in the Malaysian financial system (BNM, 2010).
Table 4.3: Key Insurance/ Takaful Indicators 2006 to 2009

<table>
<thead>
<tr>
<th>Market Structure</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Of licensees</td>
<td>121</td>
<td>126</td>
<td>128</td>
<td>127</td>
</tr>
<tr>
<td>Direct insurers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life</td>
<td>8</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>General</td>
<td>26</td>
<td>25</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Life and General</td>
<td>8</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Professional reinsurers</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Insurance brokers</td>
<td>35</td>
<td>34</td>
<td>34</td>
<td>33</td>
</tr>
<tr>
<td>Adjusters</td>
<td>38</td>
<td>37</td>
<td>37</td>
<td>36</td>
</tr>
<tr>
<td>Financial Advisers</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>No. Of registered agents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life</td>
<td>75,340</td>
<td>78,587</td>
<td>74,887</td>
<td>80,078</td>
</tr>
<tr>
<td>General</td>
<td>40,869</td>
<td>39,165</td>
<td>38,766</td>
<td>35,930</td>
</tr>
<tr>
<td>Registered Takaful Operators</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>No. Of registered agents</td>
<td>15,194</td>
<td>43,843</td>
<td>60,197</td>
<td>88,895</td>
</tr>
<tr>
<td>Family</td>
<td>11,188</td>
<td>32,987</td>
<td>44,222</td>
<td>55,898</td>
</tr>
<tr>
<td>General</td>
<td>4,006</td>
<td>10,856</td>
<td>15,975</td>
<td>32,997</td>
</tr>
</tbody>
</table>

(Source from Annual Insurance Statistics and Annual Takaful Statistics 2009)

Meanwhile, the list of Licensed Insurance Companies and Takaful Operators in Malaysia as in Central Bank of Malaysia 2010 are as in the table below (with the merger and changing on the share composition\textsuperscript{14}.


\textsuperscript{14} Most of the insurance operators looking on merging and combining with other players as their strategies to capture the Takaful market in Malaysia.
Table 4.4: Insurance and Takaful Operators in Malaysia in 2010

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>American International Assurance Bhd</td>
<td>Foreign</td>
</tr>
<tr>
<td>2</td>
<td>Etiqa Insurance Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>3</td>
<td>Hong Leong Assurance Bhd</td>
<td>Local</td>
</tr>
<tr>
<td>4</td>
<td>ING Insurance Berhad</td>
<td>Foreign</td>
</tr>
<tr>
<td>5</td>
<td>Malaysian Assurance Alliance Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>6</td>
<td>MCIS Zurich Insurance Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>7</td>
<td>Prudential Assurance Malaysia Berhad</td>
<td>Foreign</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Life Business Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General Business Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>13</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>----</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>17</td>
</tr>
<tr>
<td>18</td>
</tr>
<tr>
<td>19</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>21</td>
</tr>
<tr>
<td>22</td>
</tr>
<tr>
<td>23</td>
</tr>
<tr>
<td>24</td>
</tr>
</tbody>
</table>

**Takaful Operators**

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CIMB Aviva Takaful Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>2</td>
<td>Etiqa Takaful Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>3</td>
<td>Hong Leong Tokio Marine Takaful Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>4</td>
<td>HSBC Amanah Takaful (Malaysia) Sdn Bhd</td>
<td>Local</td>
</tr>
<tr>
<td>5</td>
<td>MAA Takaful Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>6</td>
<td>Prudential BSN Takaful Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>7</td>
<td>Syarikat Takaful Malaysia Berhad</td>
<td>Local</td>
</tr>
<tr>
<td>8</td>
<td>Takaful Ikhlas Sdn.Bhd.</td>
<td>Local</td>
</tr>
</tbody>
</table>

(Source: Bank Negara Malaysia as listed on the official website on 1st June 2010)

The financial market needs to be tempered with effective regulation and supervision and the insurance industry is one of the many financial market players that need to be well regulated, which is the case in the Malaysia. One of the key lessons learnt from the financial crisis is that unfettered financial market innovation and over reliance on financial leveraging instruments by non-regulated financial institution can be a source of financial instability (MII, 2009).

Insurers have also experienced market-to-market losses from equity holding and reserve pressures from the lower interest rate environment. However, overall in 2009, the industry remained generally sound. The insurance industry in Malaysia has remained well capitalized, with a capital adequacy ratio well above the minimum regulatory requirement. The industry has also continued to record strong profits of RM1.9 billion (£395,834 million) despite more
challenging operating environments. As a part of the pre-emptive measures announced in 2008, access to BNM liquidity facilities is also extended to insurance companies and takaful operators (MII, 2009).

Based on Table 4.5 below on the Insurance Industry for 5 consecutive years from 2005 till 2009, it shows that the market is expanding from the operating profit (slow during 2007 and 2008 because the market share was not stable worldwide), excess over income in life insurance, and also continued development in the family takaful. During that period, the general takaful is the worse on the premium and operating income. This was contributed by big fraud cases in the Bank Islam Group through Takaful Insurance Bhd that was under a massive reorganization. While, before in the year of 2006 and 2007, the company becoming the main dominators for the Islamic banking areas for the decades in Malaysia (BNM, 2008).

After all, the assets contribution to both insurance and takaful industries became stable because of an increment pattern period of 5 years. This was generated by the policy developed in the market by the BNM that ensured all players had tight control to adapt to the new risks based on the supervisory framework. The BNM further issued this concept paper that addressed the future determination of solvency, as well as the supporting institutional risk management and governance framework that insurers would need to have in place. In 2009, it showed that all companies maintained insurance fund assets at RM 148,672.4 million (£30,974 million) and RM 12,445.4 million (£ 2,593 million) respectively for Life & General Insurance and the Takaful Sector.

All in all, life insurance claims appear to be the largest in the claims paid for that 5 year period and increased due to the development in the life insurance income during the same period. From the claim pattern, it shows that the consumers were more confident with life insurance during that period in comparison to general insurance, even though life insurance still needed the agents to function effectively to ensure that the products were marketable in the industry (Khanal, 2007).
Table 4.5: Malaysia’s Insurance Market Result from 2005 to 2009

<table>
<thead>
<tr>
<th>Item (RM million)</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underwriting profit</td>
<td>611</td>
<td>490.3</td>
<td>16</td>
<td>111.6</td>
<td>675.1</td>
</tr>
<tr>
<td>Operating profit</td>
<td>1,588.2</td>
<td>1,460.5</td>
<td>1,339.0</td>
<td>611.4</td>
<td>1,801.0</td>
</tr>
<tr>
<td>Life Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>20,963.5</td>
<td>23,772.7</td>
<td>27,923.6</td>
<td>26,896.9</td>
<td>29,754.0</td>
</tr>
<tr>
<td>Outgo</td>
<td>11,314.3</td>
<td>12,453.8</td>
<td>14,652.6</td>
<td>19,624.5</td>
<td>19,118.0</td>
</tr>
<tr>
<td>Excess of income over outgo</td>
<td>9,649.2</td>
<td>11,319.0</td>
<td>13,271.0</td>
<td>7,272.4</td>
<td>10,635.9</td>
</tr>
<tr>
<td>Family Takaful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>1,226.6</td>
<td>1,594.0</td>
<td>2,375.8</td>
<td>2,838.6</td>
<td>3,361.7</td>
</tr>
<tr>
<td>Outgo</td>
<td>583.1</td>
<td>791.6</td>
<td>1,012.5</td>
<td>1,378.5</td>
<td>1,699.9</td>
</tr>
<tr>
<td>Excess of income over outgo</td>
<td>643.6</td>
<td>802.4</td>
<td>1,363.3</td>
<td>1,460.1</td>
<td>1,661.7</td>
</tr>
<tr>
<td>General Takaful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underwriting profit</td>
<td>107.5</td>
<td>-9.5</td>
<td>-91.3</td>
<td>82.5</td>
<td>147.8</td>
</tr>
<tr>
<td>Operating profit</td>
<td>127.2</td>
<td>31.1</td>
<td>-37.6</td>
<td>141.0</td>
<td>227.0</td>
</tr>
<tr>
<td>General Insurance Net claims</td>
<td>3,905.3</td>
<td>4,261.7</td>
<td>4,606.4</td>
<td>4,786.9</td>
<td>5,560.3</td>
</tr>
<tr>
<td>Life Insurance Net policy benefits</td>
<td>6,268.7</td>
<td>7,311.1</td>
<td>9,653.6</td>
<td>10,014.1</td>
<td>11,834.7</td>
</tr>
<tr>
<td>General Takaful Net claims</td>
<td>116.9</td>
<td>157.1</td>
<td>218.6</td>
<td>234.1</td>
<td>304.2</td>
</tr>
<tr>
<td>Family Takaful Net policy benefits</td>
<td>347.2</td>
<td>400.8</td>
<td>534.7</td>
<td>632.0</td>
<td>904.0</td>
</tr>
<tr>
<td>Insurance Fund Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life &amp; General</td>
<td>96,638.4</td>
<td>108,470.1</td>
<td>122,414.3</td>
<td>130,940.9</td>
<td>148,672.4</td>
</tr>
<tr>
<td>Takaful</td>
<td>5,878.4</td>
<td>6,899.0</td>
<td>8,818.3</td>
<td>10,569.4</td>
<td>12,445.4</td>
</tr>
</tbody>
</table>

4.9 Roles of Insurance Association in Malaysia

Malaysia determined as no specific association that going to custody the welfare of insurers and cross functional make it becoming complicated\(^\text{15}\). There are four main trade associations for insurers in Malaysia and these are: PIAM (Persatuan Insurans Am Malaysia- General Insurance Association of Malaysia), LIAM (Life Insurance Association of Malaysia), NIAM (National Insurance Association of Malaysia) and MTA (Malaysian Takaful Association). During the interview, only PIAM and NIAM are contributing towards the next chapter that is contribution of the association towards the issues of countering fraud in the company. Below is the general information on the objective and functionalities of each specific function for them in order to create the real picture of the insurance association function in Malaysia. At the end, the table is used to give a clear differentiation among all of these associations.

Each of the associations have been established for the purpose of meeting the demands for each specific market; except the NIAM which is more towards the ‘belonging ideas’ to fight with foreign insurers in the market. In each of the associations they developed their own specific objectives and also activities for helping insurers in the Malaysian market. All the insurers’ employees can choose to join any association based on their own preferences, objectives and idealisms. After all, the employees need to bring back some positive contribution to the companies and also continuous professional development for themselves.

4.9.1: Persatuan Insurans Am Malaysia (PIAM) or General Insurances Association of Malaysia (GIAM)

There are 39 member companies of PIAM comprising licensed general insurance companies operating in Malaysia. The members are made up of 23 general insurers, 10 composite insurers and 6 general reinsurers, as on 1\(^\text{st}\) April 2009. From the 39 members, 24 companies were domestic operations while 15 were foreign companies. The key objectives and powers of PIAM are to serve all the general insurers’ as stated below:

\(^{15}\) The function of the association is overlapping with the others. The BNM giving the freedom to all the insurers’ workers or the agents to join any of the association as long it is registered. On the professionalism of the industry player it will be accumulated by Malaysia Insurance Institute (MII), that is BNM controlled bodies.
To promote the establishment of a sound insurance structure in Malaysia in co-operation and consultation with Bank Negara Malaysia.

To promote and represent the interests of members in or connected with Malaysia by all means and methods consistent with the laws and Constitution of Malaysia.

To render to members where possible such advice or assistance as may be deemed necessary and expedient.

To take note of events, statements and expressions of opinion affecting members, to advise them thereon and represent their interests by expression of views thereon on their behalf as may be deemed necessary and expedient.

To work as far as possible in co-operation with other similar associations elsewhere in the world.

To circulate information likely to be of interest to members and to collect, collate and publish statistics and any other relevant information relating to general insurance.

To work in conjunction with any legal body or any chamber or committee or commission appointed or to be appointed for consideration, framing, amendment or alteration of any law relating to insurance.

To organise and manage arrangements and matters of common interest, concern or benefit to members or any group of members and to collect and manage funds for the same.

To make rules, regulations and bye-laws in accordance with these Articles in consultation with Bank Negara Malaysia.

(accessed from http://www.piam.org.my/about.htm on 1st June 2010)

4.9.2: LIAM (Life Insurance Association of Malaysia)

The Life Insurance Association of Malaysia (LIAM) or ‘Persatuan Insurans Hayat Malaysia’ is a trade association registered under the Societies Act 1966. It was registered under the name of Life Insurance Association on 26 March 1968. LIAM has a total of 18 members, of which 16 are life insurance companies and 2 life reinsurance companies. It is a statutory requirement under section 22 (1) of the Insurance Act 1996, (or section 3(2) (e) of the repealed Insurance Act 1963) for all life insurance/life reinsurance companies to be members of LIAM. Objectives of LIAM stated for all the members and the market are:
To promote public understanding and appreciation for life insurance;
To improve the image of the life insurance industry through self-regulation;
To give support to the regulatory authorities in developing a strong and healthy industry;
To enhance the professionalism of staff and agents through continuous training and education;
To liaise and work with local and foreign life insurance organisations towards achieving common objectives and benefits.


4.9.3 NIAM (National Insurance Association of Malaysia)

The National Insurance Association of Malaysia (NIAM) or Persatuan Insurans Kebangsaan Malaysia was established in 1973 and registered under the Societies Act 1966. Currently, it has 32 member companies comprising of 15 general insurance companies, 4 composite insurance companies, 5 life companies, 4 takaful companies and 4 reinsurers. This association is more towards the unification of all the ‘Malaysian insurers’ in the market to support and custody the welfare of each team members.

The main objectives of NIAM to all the members:

- To promote and safeguard the interests of members in all their activities
- To facilitate joint action by members in respect of any matters which may affect any of them
- To promote or undertake any project which will enhance or contribute to the standing and reputation of its members in society
- To secure and support the promotion of Bills in Parliament which will protect the interests of or be advantageous to its members


4.9.4 MTA (Malaysian Takaful Association)

The Malaysian Takaful Association (MTA) was conceptualized in 2003 as the alliance that promotes and counsels the takaful industry in Malaysia since the developments of the market
appeared to be aggressive and simultaneously, the pioneer in the Asia Pacific region. It has 12 registered operating members and is distinguished with worldwide recognition as the body of reference pertaining to the fundamentals of takaful. Among others, the association was established with the salient objective to further the interests of takaful in Malaysia as well as the interests of its members generally, this are consistent with the objects of the Constitution of the Association (BNM, 2004).

The Association was established to foster cooperation and mutual understanding amongst its registered members, whilst furthering the interests of the takaful concept in Malaysia by any or all of the following means and by other such means as deem expedient in the interests of the Association, among others:

- To promote the foundation of a sound takaful structure in Malaysia with cooperation and consult from the Director-General of Takaful.
- To promote and represent the interests of members registered or connected to MTA by all means and methods that is consistent with the laws and Constitution of Malaysia.
- To render to members when possible, such advice or assistance may be deemed necessary and expedient.
- To take note of events, statements and expressions of opinion affecting members, and advise them thereon and represent their interests by expression of views thereon, on their behalf as deemed necessary or expedient.
- To constitute strategic alliances and co-operation with other similar associations both locally and internationally.


Summarization of all the association function and the important of their contribution was illustrated in table 4.6 below.
Table 4.6: The Comparative among the Insurance Association and their Contribution

<table>
<thead>
<tr>
<th>Features</th>
<th>PIAM</th>
<th>LIAM</th>
<th>NIAM</th>
<th>MTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>39</td>
<td>18</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Type of members</td>
<td>Both insurance and takaful</td>
<td>Only insurance segment</td>
<td>Both insurance and takaful</td>
<td>Only takaful segment</td>
</tr>
<tr>
<td>The law abide</td>
<td>Insurance Act</td>
<td>Insurance Act</td>
<td>Non (as societies)</td>
<td>Takaful Act</td>
</tr>
<tr>
<td>The relationship with BNM</td>
<td>Help BNM directly on promoting /organizing/training in general insurance intensively</td>
<td>Help BNM directly on promoting /organizing/training in life insurance intensively</td>
<td>No direct. But concerns on the bill of parliaments that relates to members.</td>
<td>Help BNM directly on promoting /organizing/training in takaful intensively</td>
</tr>
<tr>
<td>Relationship with adjustors</td>
<td>Not really tight and based on the case</td>
<td>Not really tight and based on the case</td>
<td>Have a direct relationship with Association of Malaysia Loss Adjustors (AMLA)</td>
<td>Not really tight and based on the case</td>
</tr>
</tbody>
</table>

4.10 Conclusion

The foundations of Malaysia and the indices insurance industry in this chapter have been conceptualised to set the main ideas of the culture and market which are exclusive to this country. The social and economic information were provided to assist in the understanding of the market reaction, cases, and economic assumptions to cater for the issues of fraud in the insurance market. Chapter 5 will explore the environment of economic components on the part of regulatory and professional responses towards the issues of fraud in the insurance industry. Together with that, there will be a detailed discussion on the criminal justice system to mitigate the situation of insurance fraud in Malaysia with some cases examples given. Chapters 6 and 7 will contain the detailed analysis of the evaluation of insurers using the CIPFA Red Book 2.
CHAPTER 5

INSURANCE FRAUD IN MALAYSIA AND THE NATIONAL RESPONSE

5.1 Introduction

The issue of insurance fraud is not only the responsibility of the insurance companies but is one for national bodies. All parties involved in the market need to have a collaborative arrangement in order to counter the serious issues. The previous chapter illustrated the characteristics of the Malaysian insurance industry as the basis for understanding the systemic dimension of the business process. Meanwhile, this chapter will discuss in detail the extent of insurance fraud in Malaysia together with some cases. It also emphasizes the initiatives of countering fraud on the regulatory perspective that is Central Bank (Bank Negara Malaysia, BNM) PIAM, association and professional loss adjusters.

5.2 General classification on insurance fraud in Malaysia

‘Insuranceinfo’ is the formalized coalition established by regulatory and some of the insurers in the market. It is intended to generate general information, sources and simple sharing among all in the insurance market that is the customer, the insurer and the regulators. They have the published agendas that discusses on issues regarding market consideration that includes fraud related ideas. Based on Insuranceinfo.com.my, one of the coalition initiatives through the website is they have classified the groups of insurance fraud into 4 main categories (as circulated to all insurers in the country and as in the schedule below). It has been determined that three of the categories listed below are directly related to the claims handling process (in bold below);
Table 5.1 The categories of Insurance Fraud in Malaysia Insurance Market

<table>
<thead>
<tr>
<th>Categories</th>
<th>Example of the actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating a fraudulent claims</td>
<td>- Staged accidents or by staged chained collision</td>
</tr>
<tr>
<td></td>
<td>- Bogus claims for any accidents or injuries that never happened</td>
</tr>
<tr>
<td></td>
<td>- Wrongful claim for personal accidents in the case of self-inflicted injuries</td>
</tr>
<tr>
<td></td>
<td>- Staged slip and falls created accidents</td>
</tr>
<tr>
<td></td>
<td>- False claim on unidentified object in food or drink</td>
</tr>
<tr>
<td></td>
<td>- Make or faking of death for benefit or filling death claims</td>
</tr>
<tr>
<td></td>
<td>- Staged burglary, theft or vandalism</td>
</tr>
<tr>
<td></td>
<td>- Arson</td>
</tr>
<tr>
<td></td>
<td>- Staged motor theft or organised</td>
</tr>
<tr>
<td></td>
<td>- Staged homeowner accidents</td>
</tr>
<tr>
<td>Overstating amount of loss</td>
<td>- Inflated or ‘padded’ claims when the illegal act on the genuine amount of accident</td>
</tr>
<tr>
<td></td>
<td>- Inflating value of the items taken during a burglary/ theft</td>
</tr>
<tr>
<td></td>
<td>- Hospital or medic care providers inflating medical bills</td>
</tr>
<tr>
<td>Misrepresenting facts to receive</td>
<td>- Making multiple claims by having multiple insurance coverage with</td>
</tr>
<tr>
<td>payments</td>
<td>different companies or takaful operators for one vehicle and for one</td>
</tr>
<tr>
<td></td>
<td>particular accident</td>
</tr>
<tr>
<td></td>
<td>- Claiming illegal damages or prior damages occurring in the current accident</td>
</tr>
<tr>
<td></td>
<td>- Claiming for total disability or partial disability for a minor or unserious injury</td>
</tr>
<tr>
<td></td>
<td>- Receiving payment for disabilities while able to work elsewhere</td>
</tr>
<tr>
<td></td>
<td>- Medical service providers charging for services that not rendered or provided.</td>
</tr>
<tr>
<td></td>
<td>- Claiming for false disability</td>
</tr>
<tr>
<td></td>
<td>- Medical service providers added up any treatment that unnecessary</td>
</tr>
<tr>
<td></td>
<td>- Charging for medical test that not provided</td>
</tr>
<tr>
<td>Bogus agents/ sale of forged</td>
<td>- Sale of insurance by some parties unlicensed by insurance company or</td>
</tr>
<tr>
<td>cover notes</td>
<td>takaful operators</td>
</tr>
<tr>
<td></td>
<td>- Someone purporting to become an agent in the insurance company or</td>
</tr>
<tr>
<td></td>
<td>takaful operators</td>
</tr>
<tr>
<td></td>
<td>- Sales of forged cover note by touts or organized syndicates to those</td>
</tr>
<tr>
<td></td>
<td>knowingly or unknowingly</td>
</tr>
<tr>
<td></td>
<td>- Purchase of cover notes just for the purpose of securing road tax for the</td>
</tr>
<tr>
<td></td>
<td>expired one on motor vehicles</td>
</tr>
</tbody>
</table>

(Source from Insuranceinfo.com.my accessed on 1st June 2010)
The general classifications that have been determined above are action-based rather than giving specific names to the fraud strategies or scams involved. It ensures that all insurers are able to grab the general ideas on the basic principles to the situation that generally would lean towards more serious fraud strategies in the market place. Besides, this general route is produced by BNM with help from some of the major insurers, more specific and technical guidance regarding the ideas of insurance fraud expected to exist within the insurer’s normal operational procedure.

5.3 The magnitude of insurance fraud in Malaysia

On the regulation side, the Insurance Act No. 553 (Act of Malaysia) of 1996 and 1996 Insurance Regulations, which was amended in 2005, provides guidelines from BNM on the licensing, regulation and supervision of the industry. Besides, Malaysia completed a detailed self-assessment in April 2007 of its observation on the Insurance Core Policies (ICPs) developed by International Association of Insurance Supervisors (IAIS) number 2000, based to Asian Development Bank’s 2001 Report structures’ on the insurance markets. With regards to ICP number 27 which caters for fraud issues, the country performance has been determined as follows:

“With respect to insurance fraud, BNM, as stated in its 2005 Insurance Annual Report, collaborated with the insurance industry and relevant law enforcement agencies through various initiatives under the anti-fraud joint committees. A fraud surveillance system was also implemented to monitor incidences of fraud. Nevertheless, there is insufficient information publicly available clearly identifying Malaysia’s compliance with this principle”

(ICP by IAIS No.2000 Assessment, No. 27)

Based on the report above, Item 27 which relates to countering insurance fraud has been highlighted as a major consideration by the Malaysian insurance companies with joint work by BNM that advocate such arrangements since 2005. The issues of countering insurance fraud have been highly ‘favoured’ as one of the national industries agendas, as most of them are urged to cooperate with others in the fighting these threats through fraud reporting, fraud investigation and fraud prevention programs (BNM, 2006). Thus, the initial ideas on
surveillance relating to the systems implemented by the internal operation procedures, especially in the claim processing units has become crucial in mitigating these issues (the Star, 2011).

In line with the rapid changes of the insurance industry, BNM, as the main local authority body, has moved from ‘prescriptive details regulation’ for each insurer to get a more simplified and flexible operating instructions (MII, 2010). Nowadays, insurers are operating in an environment where regulations are general in principle. The simple principle-based ideas have greater expectation and demands for the leadership and senior management of insurance companies as fundamental changes drivers (BNM, 2010). In particular, a senior management of insurers needs to raise the organization’s strategic orientations, rather than merely complying with a minimum set of prescribed guidelines. A pre-requisite for this transformation is that senior management acquires a thorough understanding of the relationship and inter-linkages between the various components of the insurance business, and to manage these dynamics in a manner that optimizes performance and also simultaneously countering the fraudulent act (MII, 2011).

As in one of the documentation outputs of this cooperation, between BNM and all the insurance companies’, they keep consistently maintain the general publication through online in order to educate the society in Malaysia on insurance through insuranceinfo.com.my, as mentioned in 5.2. This has been made accessible through public networking on BNM websites, which is utilized by Malaysian insurers. They provide a clear explanation on each component within the industry operation, including insurance fraud,

‘Insurance fraud or takafal fraud is any deliberate deception/dishonesty committed against or by an insurance company or takafal operator, insurance or takaful agent, or consumer for unjustified financial gain. It occurs and may be committed at different points in the transaction by different parties such as policy owners, third-party claimants, intermediaries and professionals who provide services to claimants. The nature fraud may vary from an inflated/exaggerated value of a legitimate claim to a completely fabricated or bogus claim where losses never really occurred’

(Insuranceinfo.com.my, 2005)
The definition in practice suggests insurance fraud in the industry with related parties that might be involved, alongside the constructive objectives that are aimed at financial gain. These notations are based upon the normal class of cases of insurance fraud under researchers such as Jou & Hebenton (2007) and Yusuf & Babalola (2009) where the fraud activities in the insurance industries are commonly classified under 3 main categories:

- **Fraud by opportunistic in the general insurance where exaggeration of an otherwise legitimate claim.** (directly with the insurance claims processes)
- **Fraud by commercial general insurance that contemplating fabrication of a claim** (when initiate by the companies)
- **Fraud that is well organized with the idea on the disclosure and misrepresentation of material facts** (also would highly related with the claims).

In relation to the Malaysian data, the Insurance Services Malaysia Berhad (ISM)¹⁶, one of the major insurance industry research firms, has estimated in instances of bogus insurance claims, it costs the Malaysian economy approximately RM500 million (£104 million) a year (Ismail, 2006). This estimation is accumulated by over 17 percent from a total RM3 billion (£625,000 million) yearly claims in the countries insurance markets as fraudulent. This estimation have been developed through the data submitted and analyzed in the e-Fids system that solely belongs to BNM. Due to this estimation, approximately 52 member companies that currently offer insurance (in 2009 assumptions) are stepping up efforts in areas of fraud identification and prevention as part of their wider enterprise risk management strategy. These efforts include ensuring the fraud databases and technology is more efficient in identifying fraud. Additionally, the industry delegates among the BNM and associations, are aiming to promote education campaigns to the public to introduce the negative impact fraud has on the economy and consumer (BNM, 2010). As a result of this, enforcement officials that revealed the Malaysia data on fraud concluded that 10 to 15 percent of the claims in Malaysia have a fraudulent element, increasing on yearly basis (RMP, 2005).

Based on the current economic settings relating to ‘flexibility of regulation’, Malaysian insurers’ are concerned with the prescribed regulations of the central bank and have enforced

---

¹⁶ They also provide professional services named as ISM Fraud Management Services through the database supported on the ISM Claim Information System and ISM Claim Verification system. This is a listed company.
their own insurance procedures with the help from professionals and associations. As a result, one of the major ‘output’ initiatives in countering the issues, the Central Bank (BNM) has implemented a system known as, e-Fids\textsuperscript{17} (electronic fraud information database system) that maintains a database on all fraud, expected fraud, defalcation and breach of ethic cases reported by the insurers. Since 2001, sharing knowledge electronically via the database which all key personnel has access to (Specifically the investigation and internal audit function) has played an important role. This became recognized by the market place in 2005. This database has shown that the number of reported cases in 2003, increased from 437 cases 763 cases in 2004, involving RM24.1 million (£ 4.82 million) (an increase from RM10.9 million (£ 2.18 million) in 2003). (Bernama.Com, 2005)\textsuperscript{18}. There are no publicly available data made by BNM or RMP in recent years.

In the market, it is wise to say that, consequences of the insurance fraud threats can justify when the settlement is delayed, even though genuine claims have been submitted (Pathak et. al, 2005; Schiller, 2006). This is evident in Malaysia where a standard settlement period in 2001 was recorded as 9-11 weeks. In 2009, this increased to 11-15 weeks as a result of increasing complicated cases (MII, 2011). Whilst monitoring operation, insurance companies are expected to develop their own indicators (the red flags) on fraud and carry out thorough investigations when fraud is suspected. As a result of this, stringent claim settlement procedures have been put in place by insurance companies which reject fraudulent claims as this delays genuine claim (Tennyson, 1997; Hoyt et. al., 2006). The training program added with experiences for claim officers enables them to manage the complications more effectively, which consumes less time and more effective. (BNM, 2010). This would be more stressful when the customers are in need of the claims and it makes them have less personal time. Consequently, it is highly important for customers to be well-educated on the consequences of fraudulent claims and scams in relation to insurance products (Crocker & Morgan, 1998; Derrig et. al., 2002; Moreno et. al, 2006). There are some significant cases,
where Malaysian insurers have been taken to court due to delayed payments of claims (can be related to the case of the Asian Paper Mills Bhd vs Progressive Insurance Bhd). Furthermore, companies are unable to recover this cost.

5.4 Major types case of insurance fraud in Malaysia

The types of insurance fraud with multiple variances of creativity of the fraudster or claimant through a variety of insurance products are available in the open market. In Malaysia there are four major case areas in insurance fraud which consists of the market, life, healthcare, automobile and property industry (based on the interview with BNM and PIAM). Below is an in-depth case discussion from the law journal;

5.4.1 Life Insurance

We are well-known on the major examples of life insurance fraud in Britain with the John Darwin disappearance case. An ongoing investigation into the fake death of the British former teacher and prison officer John Darwin, who turned up alive in December 2007, five years after he was thought to have died in a canoeing accident. Darwin was reported as "missing" after failing to report to work following a canoeing trip on March 21, 2002. He reappeared on December 1, 2007, claiming to have no memory of the past five years (Daily Mail, 2011).

In Malaysia, the most appropriate case illustrating life insurance fraud is the Malaysian Assurance Alliance Bhd vs Chong Nyuk Lan in High Court Sabah and Sarawak on 20th August 2002. The direct extract from the case presented in law journal is set out below:

> The deceased had signed for a life insurance policy on 1 February 1994. On 19 March 1996 the policy premium was not paid thereby resulting in the policy having lapsed. The deceased was therefore required to sign a Long Form Health Certificate (LFHC) as a statement of the deceased that his health was not impaired in any way. Thereupon the policy was reinstated. On 1 October 1997, the deceased was
pronounced dead following a heart attack. A claim for the payment of the policy by
the respondent/plaintiff was rejected by the appellant/defendant.

The appellant/defendant argued that a reinstatement of a policy constituted a new
contract and thus computation of the two years period should start from the
reinstatement date and not from the original date of issuance of the policy. The
respondent/plaintiff argued that s. 147(4) of the Insurance Act 1996 (‘the Act’) applied and that computation of the two years period should start from the time the
policy was originally effected. The appellant/defendant appealed against the
decision of the session’s court judge which had allowed the plaintiff’s claim and
submitted that there was a fatal non-disclosure of material fact, namely, that the
deceased was suffering from hypertension and elevated cholesterol level in the
LFHC.

Factors to consider are as follows:

1. The computation of the two year period should start from the time the policy
   was in effect from regardless of a lapse or renewal of said policy.
2. The defendant should be precluded from contesting the validity of the policy
   on the grounds of false and non-disclosure of material, unless fraud is alleged,
   which the defendant did not pursue.
3. Thus it should not be allowed to have the benefit of the second limb of the said
   s. 147(4) of the Act and the issue of non-disclosure of material should not arise at
   all.

   (CLJ, 2003 pg.245-250)

According to this case, the policy was effective from the 1st February 1994 and the claim for
payment came in 1997. The claimant possibly did a wrong claim and on the period of
coverage by the policy. It is clear that two year period had expired and the defendants were
attempting to contest the validity of the policy based on incorrect assumptions, which the
court did not accept. As a result, the defendant cannot be pursued under the assertion of the
fraud as the real reason of the death was disclosed. The issues on the benefit of the second

130
limb is not stated clearly in the 147 (4) of the Insurance Act. Finally, the consequence of this is that the defendant is dismissed a liable with costs.

5.4.2 Health Insurance

According to Roger Feldman, Blue Cross Professor of Health Insurance at the University of Minnesota, one of the main reasons that medical fraud is such a prevalent practice is because nearly all of the parties involved are able to find it favorable in some way. Many physicians see it as necessary to provide quality care for their patients. Many patients, although disapproving the idea of fraud, are sometimes more than willing to accept it when it affects their own medical care. Program administrators are often lenient on the issue of insurance fraud, as they want to maximize the services of their providers (Feldman, 2001).

One of the biggest health insurance fraud cases in Malaysia in 2009 recorded a fraud case involving RM1.2 million\textsuperscript{19} in one single case. This case involved a lumberjack who was ‘paralyzed’ trying to cheat the officers at Kurnia Insurance (Malaysia) Berhad by convincing them, that the details of his claim submitted through two legal firms were true. In this situation, Wong Ngan Nyok, was charged for cheating the officers of the company because he convinced them that claims submitted through T. Rajagopal & Co. & G. Dorai & Co. were true. Both firms were representing Wong’s employee, K. Achutan that was involved in the accident.

In the claim, Wong described that his employee Achutan was hit by a lorry driven by another employee, Pang Kee Chong, in Jempol, Negeri Sembilan, causing him to be paralyzed. This dishonesty resulted in a compensation claim of £239, 972 (RM1,175,862.52), as the accident happened in the workplace. The main perpetrator in this case is Wong himself, while Pang and Anchutan were charged for aiding and abetting. This is the biggest case that went to trial overrunning the insurance detection and regulatory system in the Malaysia as the element of fraud is highly corroborative in judgment. (News Strait Times, 2009)

\textsuperscript{19} RM1.2 million is equal to GBP 250,000 (as the GBP1= RM 4.9 based on the exchange rate at 1\textsuperscript{st} October 2012)
5.4. 3 Automobile Insurance

The Insurance Research Council in the United States estimated that in 1996, approximately 21 to 36 percent of auto-insurance claims contained elements of suspected fraud (Tennyson, Sharon & Pau, 2002). There is a wide variety of schemes used to defraud automobile insurance providers. These ploys can differ in complexity and severity (Derrig, Johnston & Sprinkel, 2006; Viaene, et. al. 2007; Bermudez, et. al., 2008). Examples of soft auto-insurance fraud can include filing more than one claim for a single injury, filing claims for injuries not related to an automobile accident, misreporting wage losses due to injuries, or reporting higher costs for car repairs than those that were actually paid.

One of the popular method used is "crash for cash" scams that involve random unaware strangers, set to appear as the perpetrators of the orchestrated crashes. Such techniques are the classic rear-end shunt (the driver in front suddenly slams on the brakes, eventually with brake lights disabled), the decoy rear-end shunt (when following one car, another one pulls in front of it, causing it to break sharply, then the first car drives off) or the helpful wave shunt (BBC, 2009). Fewer ‘crash for cash’ cases are brought to the court in Malaysia because the insurer usually refuses to pay the claims. This relates to the case of Tang Tung Thian & Anor Vs United Oriental Assurance Sdn Bhd., details are presented below:

*The appellants took out a comprehensive motor insurance policy in respect of their already damaged vehicle. The proposal form was filled by a person alleged to be an agent of the respondent insurers. The answers provided in the proposal form failed to disclose that the vehicle had been involved in an accident. Later on the appellants lodged a police report that the vehicle had been stolen and filed a claim against the respondent for the loss of the vehicle. The appellants however failed to upkeep their installment payments for the vehicle and the plaintiff financier commenced an action against them. The appellants then issued a third party notice against the respondent for indemnity against liability to the full extent of the plaintiff’s claim against them.*

*The following needs to be taken into account:*

1. *A contract of insurance is a contract uberrimae fidei; the non-disclosure of material by the appellants gave the respondent a right to avoid the contract.*
2. The appellants did not adduce evidence to discharge the burden of proving that loss by theft was a peril insured against or covered by the terms of the policy.

3. The respondent was caught by surprise as the allegation of forgery was not set out in the pleadings.

4. There was no evidence that the respondent withheld or suppressed evidence by not calling certain witnesses. As such s. 114(g) Evidence Act 1950 was not applicable

(CLJ, 2000, pg. 822-832)

Due to the lack of evidence the case was dismissed and the appellant was liable for the costs because elements of fraud did exist in the case.

5.4.4 Property Insurance

In property insurance, the main motive for fraud includes obtaining payment that is more than the value of the property destroyed, or to destroy and subsequently receive payment for goods that could not otherwise be sold. According to the Insurance Information Institute, in the US the property-casualties insurers paid-out are approximately £183.4 billion (US$275 billion) on average annually between 2000 to 2007, and determined that cumulatively insured losses is more than £1.47 trillion (US$ 2.2 trillion) (Hartwig, 2008). The claim involved for this fraud is typically high in amount because the amount would be a major risk for insurers, thus this relates to the growing concerns in the company. A court case in Malaysia relating to property fraud is evident in the case of the Cita Marine Sdn Bhd VS Progress Insurance Bhd & Anothers on 28 August 2000. Details from the law journal are below:

*The defendants applied for the plaintiff’s action to be set aside on the ground that the High Court of Sabah and Sarawak at Miri had no jurisdiction to try this action and that it should be tried in the High Court of Malaya at Kuala Lumpur, which not only has jurisdiction, but is also the most convenient forum for its disposal.*

*The plaintiff who owned a vessel, operate its business from a registered office in Miri. The defendants ran an insurance business from their headquarters situated in Kuala Lumpur. By a marine insurance policy, the defendants agreed to insure some insurable interests of the vessel against the perils as stated in the policy.*
While the policy was still in force, the vessel sank and was lost by the perils of the sea. The plaintiff subsequently lodged an insurance claim for their loss at the defendants’ headquarters in Kuala Lumpur. Thereafter, the plaintiff initiated this action against the defendants for failure or neglect to pay the plaintiff the sum insured under the policy for the loss of vessel. Subsequently the defendants repudiated liability.

It was decided that the High Court in Sabah and Sarawak at Miri had jurisdiction to hear this case as it had satisfied the requirements of paras. 23(1)(a), (b) and (c) of the Courts of Judicature Act 1964 (the “Act”) in that the cause of action arose in Miri, ie the first defendant who is one of the co-insurers, has a place of business in Kota Kinabalu and Kuching which is within jurisdiction of the High Court of Sabah and Sarawak; and also, on the facts on which the proceedings are based, exist or are alleged to have occurred in Miri.

The facts in this case to be further considered are:
1. The act which gave the plaintiff cause for complaint was the defendant’s refusal, omission or unwillingness to pay the sum claimed by the plaintiff under the insurance. The cause of action for the insurance claim did not arise on the occurrence of the circumstances as set out in item 67 of the Sarawak Limitation Ordinance as contended by the defendants. The ordinance is only applicable in determining the limitation period within which a suit of the nature described therein is to be instituted and has no application in determining the cause of action of any act complained of.
2. It is clear that the failure, neglect or unwillingness on the part of the defendants to make the said payment took place at the first defendants’s headquarters in Kuala Lumpur, where the claim was lodged. Therefore, the place where the cause of action arose is Kuala Lumpur.
3. Since the first defendant had a place of business in Kota Kinabalu and Kuching, the High Court of Sabah and Sarawak, by virtue of the circumstances set out in para. (b) of sub-s. 23(1) of the Act, would also have jurisdiction in respect of this action.
4. It is the view that the places where the cause of action arose or where the premium was paid or policy issued are only relevant in determining jurisdiction, and has no application in determining the most suitable or appropriate forum. The defendants in rejecting the plaintiff’s claim alleged that the vessel sank in normal weather conditions due to natural wear and tear which was excluded from the maritime policy coverage. Hence, the material witnesses for this action would be the owner of the vessel and its crew members at the time of the incident and not the officers and servants of the defendants since there was no evidence to show that the said policy itself was being disputed. Likewise, the documentary evidence that was relevant to the action was those related to the vessel and not those related to the policy. Furthermore, as the defendants were financially strong, they could easily absorb any expenses incurred in having this action heard in Miri.

(CLJ, 2001, pg. 506-515)

The case was won by the plaintiff when the court made the decision based on the supporting documents that they had received and witnesses heard. There was evidence to determine that the case was applicable to be in the High Court Sabah or Sarawak and there were no disputes for the defendants to bring it to the Peninsular Malaysia because the operation materials and all witnesses resided in Miri, Sarawak. At the same time, the company was looking financially strong and sound and looked capable of sending any party as representatives to the trial without being able to give any excuses. The second item in the case was that the company maintained the vessel with specific records that ensured it would be in good condition. Besides, the witnesses of the sunken vessel were the owner of the vessel and members of the crew and proved more reliable in giving perspectives of how the situation stood. As a matter of concern, the company could not deny the claim. Finally, the court dismissed the case with the defendants needing to bear the cost.
5.5 Countering Fraud Strategies regarding Bank Negara Malaysia (BNM) and Law Enforcer

Countering insurance fraud in other countries from the perspective of ‘broad market’ initiatives are more considered on the very specific formation of the unit that caters for the whole process of fraud cases from reporting, investigation, data collection to redress of the case. For example in the United Kingdom, there is the National Fraud Authority (NFA) under the Home Office that works closely with the Association of the British Insurers (ABI, as the main association in the insurance industry) and also specifically with the Insurance Fraud Bureau (IFB, that was established in July 2006). The specialized work on the whole process in relation to fraud is carried out by the IFB and they receive the sources of data directly supported from ABI and NFA. This is based on the consensus agreed by them in terms of the ‘fighting fraud together’ ideas in the Strategic Plan to reduce fraud (NFA, 2011). While, in the United States of America, the Coalition Against Insurance Fraud are the collaboration, since 1993, between insurance organizations, government agencies, consumers and legislative bodies in order to mitigate fraud in the insurance industry. The coalition in terms of anti-fraud legislation, educate the general public and provide services for anti-fraud in full terms. This type of combined effort is well structured and again there is no clash of function in countering fraud in the big market condition (CAIF, 2007).

In Malaysia, the arrangements that are seen in the UK and the US are not apparent in the industry since there is still a ‘grey’ area of responsibility about the issues of insurance fraud and there is no specific body or agencies formed to tackle it. Exceptionally, these issues are taken with consideration to the broad specific area and merely exclusive for the insurance companies own objectives. Incidentally, from the broad market perspective, the roles played by Bank Negara Malaysia is generally the supervision government entity to ensure that the fraud problem is being treated as fair concerning issues in the industry. Despite keeping this official arrangement, it is less reliable as the current market trends show that fraud is better treated internally through matters confidentially within specific borders of the company and willing to share with the public (BNM, 2010). The Royal Malaysian Police act as the main law enforcer which will treat reported fraud cases either under Criminal or Civil Law.
5.5.1 Central Bank of Malaysia/Bank Negara Malaysia (BNM)

The Central Bank of Malaysia (Bank Negara Malaysia, BNM) is the regulatory and enforcement body responsible for insurance and takaful issues in Malaysia. Indirectly, the involvement in countering fraud issues are becoming part of the national agenda and a major concern for BNM since major fraud cases such as ‘Enron’ and ‘World Com’ exploded in the world media, particularly in all financial markets including the insurance industry in Malaysia. Their involvement strategies are through legislative enforcement, cultural cultivation in financial services, periodical fraud training provided, sharing the data on fraud cases and providing supporting documentation.

5.5.2 Law enforcement as a prevention and control through the Insurance Act 1996 and AMLA 2001

Enforcement of the law by BNM as the key regulator of the insurance industry are through two main specific provisions in the Insurance Acts 1996 and some provisions in the Anti-Money Laundering Act 2001 (AMLA 2001). These two legislations were rectified to concern the power and penalties of the fraudster including ideas of financial terrorism (the well planned fraud action by major syndicates).

Section 9 of the Insurance Act determines financial terrorism is being carried out by companies who are conducting their business without appropriate licensing. Also, Section 10 describes more on an unlicensed insurance business. In Section 184, the action of acting as agents or brokers for an unlicensed person without the Licensing Bureau approval, (which in Malaysia is the Malaysia Institute of Insurance) (MII) is against the law. While, Section 205 covers the action that might be considered as trying to defoliate the system by falsifying, omitting, altering, etc. entries in documents with the intention of deceiving the user. This part can be the most appropriate for BNM as the main aspects controlling the possibilities of fraud in the operation and specifically in the claim procedures. Section 212 determines that any attempts, abetments or conspiracies that culminate in negativity, which impacts the financial structure, will be considered as a serious financial crime by BNM.
BNM also sponsor insurers with general guidelines regarding advisable action to be taken against fraud which is known as JP 3/1/99. This guideline promotes creation of an anti-fraud culture and indicates what needs to be considered by the insurers when countering the possibilities of fraud operationally. Also, JPI/ GPI 14 are the more relevant and the specific guidelines highlight the need for strengthening the claim process to curb the possibilities of fraud in the claims operation because, it is naturally highly exposed to fraud. Even though, BNM is the sole regulation provider for the guidelines and restrictions in the industry, the others agencies participate as enforcement agencies including Royal Malaysia Police (RMP/ PDRM), Anti-Corruption Commission (ACC) and Royal Customs (RC). At the same time, BNM allowed association established under the Insurance Act and Takaful Act, which are PIAM (Persatuan Insurans Awam Malaysia (General Insurance Association of Malaysia), LIAM (Life Insurance Association of Malaysia), AMLA (Association of Money Loss Adjusters) and MTAB (Malaysia Takaful Advisory Board). The RMP function is to conduct an investigation based on the reports by either insurance companies or BNM under the Commercial Crime Unit. They also try to ensure that they can collect relevant evidence if the party is tried in court. While, for ACC and RC, they will entertain the case if it is relevant to the acts and regulations that allows their participation. The societies or associations contributions will be discussed in detail in the next point.

Table 5.2: The parties involved directly/indirectly with BNM in countering insurance fraud in Malaysia

<table>
<thead>
<tr>
<th>Agency/Institution/Association</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Corruption Commission</td>
<td>Indirectly involved in insurance fraud if the menace involves a specific internal person within the organization</td>
</tr>
<tr>
<td>Royal Malaysian Police</td>
<td>Directly involved with BNM if the case is related to the penal code and criminal act that can be reported</td>
</tr>
<tr>
<td></td>
<td>Indirectly involved to compile the sources that might be directly submitted to them not through the BNM</td>
</tr>
<tr>
<td>General Insurance Association of Malaysia (PIAM)</td>
<td>Directly involved with the fraud cases that are considered to relate to all general insurance products</td>
</tr>
<tr>
<td>Life Insurance Association of Malaysia (LIAM)</td>
<td>Directly involved with the fraud cases that are considered to relate to all types of life insurance products</td>
</tr>
<tr>
<td>Association of Money Loss</td>
<td>Directly involved with the fraud cases that are being</td>
</tr>
</tbody>
</table>
Adjustors (AMLA) | investigated and other rendered services provided by the AMLA members
---|---
Malaysia Takaful Advisory Board (MTAB) | Directly involved with fraud cases that are considered to be related to all general and life takaful products
Royal Custom (RC) | Indirectly/Directly involved with the BNM if cases are related to companies registered by RC services.

While, the AMLA Act 2001 are the spectrum of laws that only consider fraudulent actions when it involves with the insurance companies specifically. For example, the circumstances that might involve with these companies are (AMLA, 2001):

- Money laundering offence involved in the operation and products within the company.
- Financial terrorism that gains benefits from insurances
- Reporting obligation which would induce the reporting of insurers
- Investigation on money laundering that would involve the insurance companies relating to them
- Suppression of terrorism financing offences and freezing, seizure and forfeiture of the terrorist property involved in insurance coverage from the companies.

The officers at BNM and RMP have determined that the Insurance Act and the AMLA 2001 were effective in controlling the possibilities and the seriousness of the situation. There are about 223 serious offences which are listed from 35 pieces of legislation listed in the Second Schedule of the AMLA 2001. For RMP, financial terrorism is included in the Penal Code and has enactment in the following areas:

- 130N-Providing or collecting property of a terrorist act
- 130O- Providing services for terrorist purpose
- 130P- Arranging or retention or control of terrorist property
- 130Q-Dealing with terrorist property

Incidentally, the maximum penalty that would be incurred is different between those two laws. In the Insurance Act, the amounts needed to be paid back are the amounts suffered by...
the victimized company or party during, which are not more than 5 million. While the AMLA 2001 offences’ have determined that the fine for this offence does not exceed 5 million with imprisonment not exceeding 5 years.

The research has managed to gather information throughout the interview with the officer in BNM that represent this body on the Financial Intelligence Unit and Conglomerate Surveillance Unit. Both of them were involved for 3 sessions of the interviews that was conducted in January 2010 at the BNM headquarters, Kuala Lumpur. The opinions were based on the nature of their works and professional judgments through their experiences in the industry. Besides, the response gathered from Royal Malaysia Police was taken during the Fraud Talk organized by Universiti Utara Malaysia (where the author works). The officer involved is from the Commercial Crime Unit squad of Alor Setar and Kuala Lumpur. This interview was done in December 2012.

5.5.3 Initiative to cultivate anti-fraud culture

The Central Bank believe that combating fraud is more towards the mechanisms seen in the market situation where fraud can be looked at as an opportunity in the market, as stated by the officer during the interview;

“Fraud actually comes from the opportunity in the industry and also by chances when the player has an opportunity to defraud the system. It is becoming a big problem to the financial sector as the whole. So fraud is becoming the main agents of destruction to the system.”

(Regulator/BNM Financial Intelligence Unit Officer)

From the statement, it concludes that fraud is a threat in all financial sectors that are governed by BNM and not specifically insurance. It will become a serious matter as in the UK they have their own Insurance Fraud Bureau for matters becoming a major consideration in the Financial Services Sectors. But in Malaysia, BNM had placed trust that all insurers still have the ability to put the culture of anti-fraud in their organization.
Culture emphasizes the involvement of the whole general public. In looking for better models of culture of anti-fraud, it is wise to determine the victims of the fraudulent situations in the market. The BNM officers stressed that victims of the situation are not solely single people but more of the whole component of the environment of Financial Service Sectors (FSS). This entity determines groups of companies, customers and employees. This particular group is the target for cultivation of the culture on fraud hatred in general. During the interview, the BNM officers determined that in most situations the companies will always lose. So, it is better to have a culture cultivating process towards combating fraud to exist in companies.

In order to create a better culture, BNM have established and improved the market prescribed guidelines and have suggested the particular steps that can be viably taken by the insurers in the operation to determine fraud. This will be also be updated at the level of fraud deterrence in companies’ operation.

BNM have indicated that all insurance companies in Malaysia are very protective and aware of the seriousness of fraud issues and have managed to make their own structure. Based on the interview, the officers stated that;

“If we look to all the insurers, they have their own structure in order to curb the fraud situation in the companies. We are just able to make some recommendations on the guidelines (GP) that are not very specific. But the details procedure was produced on their-own. In order to make the investigation well we do incorporate them with our Financial Intelligence Unit (FIU) that is more secrecy than the police force in Malaysia”

(Regulator/BNM Conglomerate Supervision Unit Officer)

From the above ideas, the companies are already prepared for the possible unethical situation such as fraud since insurance is a fully regulated industry, thus BNM are not going to make the laws or regulations to be too rigid. They intend to give more opportunities for the insurer’s to prescribe their own initiatives and solutions for combating fraud.
On the side of RMP, the culture of the anti-fraud is something that a must in each of the companies because that they are prone to have fraud cases since they operate in the general public, as mentioned by:

“Company is the public property if they are listed. Since then, they supposed to comply with the awareness in the general public consumption for the insurance product. As the insurance are creating so much opportunity for the defrauding their system, the culture to counter the problem is a must for each of the company in the domain of society space. They supposed to alerts and make their own precautious.”

(Enforcement/RMP Commercial Crime Unit Officer, Kuala Lumpur)

Meanwhile, as BNM imputed another measure to ensure that anti-fraud culture was being cultivated for all insurers through implementing the Anti-Money Laundering Act (AMLA 2001). These are the tools for countering financial terrorism. They have organized a committee named the National Coordination Committees for countering money laundering activities associated with it. Besides that, the role played by the FIU is very thorough in order to set up deterrence activities towards insurance fraud in the financial sectors as a whole. But it is hard to measure the intensity as numbers of confidential procedures are implemented.

5.5.4 Training on anti-fraud by BNM or RMP

BNM does not provide training directly to the insurers or workers in the industry. They have their own specialist in the unit in the banks known as Anti Fraud and Forensic Accounting unit that was designed specifically for financial service companies for recommendation guidelines and mostly serve the BNM internal departments.

But, at the same time, BNM have the governor’s initiatives agencies namely the Malaysia Institute of Insurance (MII) (which incorporated with this research) specifically train people in the insurance industry including licensing training as the professional practices. Among the module courses supplied by these training institutes is training concerning the issues of fraud that is based on the case and the market demands based on yearly schedule. Most of their anti-fraud contents can be estimated as highly concentrated as they might have a talk session or ad-hoc seminars within the licensor holders.
The ad hoc issues being discussed in the sessions or seminars cover almost all areas in fraud from preventive, detection, investigation, prosecution and case studies. While, some items determined by the BNM officers are discussed in the modules of licensing and professional. For example, the accredited agent’s examination will only cover the ideas of fraud detection and the indicators. If they need more topics, they need to sit for more subsequent events or courses that are conducted by the MII. The BNM officers again stressed that licensed investigators and adjustors are more relevant in order for the companies to keep updating on the practical part of combating fraud.

RMP did not have any specific module under Commercial Crime Unit for the training of anti-fraud to the insurance company directly. The officers merely draft some unofficial meetings with ex-policeman from the unit that particularly joins the insurance investigative teams. A lot of them are joining the private company on the ideas for extra pay and more flexible working conditions. As mention from the interviewee from RMP;

“The RMP are actually the feasible and complacent when you are younger. It need some energy and more strict routine works in the forces. But the pay sometimes is not that worth. On that side, most of the commercial crime officer like and attract more to works in the private place. Some of us manage to open our own firms and create the possibility for the tasks own our own. This is more likely the independence in minds. …

….We did sharing a lot with the colleagues that ex-policeman and they can reciprocally giving some beneficial information to us. Unfortunately there is no official training that we provide to them. Sometimes, they did asked us to make the official presentation in the general convention where the statistic is their main concerns”

(Enforcement/RMP Commercial Crime Unit Officer, Kuala Lumpur)

BNM are satisfied with the roles played by the MII in making the programs and seminars that highlight issues of insurance fraud in Malaysia. However, it is still on a small scope based on the economic perspective. In reality, BNM expects the ability of the companies to handle the situation on their own because they seldom have reports from the insurers with significant numbers of fraud cases. BNM FIU officers’ determined that less report transmitted to them through e-Fids, assumes effective internal controls for curbing the fraud situation. While,
RMP agree that due to the specific elements in the industry that require more experts on it, they are not going to contribute on the training but rather focus on sharing the experiences with them.

5.5.5 Less prosecution and trial data publicly available

BNM cannot estimate accurately on the prosecution data as sometimes some cases are taken as irrelevant as the numbers are so small and the volume is not worth. The AMLA 2001 laws are becoming important with insurance fraud because in 2002, the act of inclusion of insurers, takaful operators and offshore insurers in the listings table became so crucial in the market. This is an indication that it cannot be omitted by BNM and it was about 223 cases of financial terrorism in the country reported by FIU (Financial Investigation Unit) from 2002 to 2007. Meanwhile, the data in the Commercial Crime Unit that considers the internal data have shown only the percentage of the cases in the insurance. From that, it shows that there is an increase from 12 percent in 2008 to 35 percent in 2011, the portion of the insurance fraud cases as the part of the other commercial crime.

The major types of prosecution involved in the last five years is the imprisonment of the agents or brokers which involved more than RM 5 million in a single case alone. In this case a person from one insurance company was involved with negligence and corruption of the payments made by its customers. It was not remitted to the headquarters for a long period of time. In some circumstances when one of the policy holders made claims to the companies they finally clarified that the officer in the branch had misused funds and not submitted it to the head office. This officer had to pay a 5 million fine at the end of the case. Meanwhile, the claims cases noted by BNM in the year of 2009 as a case of health insurance claims illustrated above.

If the report is lodged to RMP, investigation tasks are transferred to from BNM or the insurance companies. RMP will have the full control to elements of evidence on the case trial. Nonetheless, the cases will not be submitted until the court intends to do so, as mentioned;
“The insurance claim cases are proven as the most secretive element of resolution because sometimes we don’t know the party that is going to withdraw from the trial. The cases that handed by us are usually the complex one when there is no one settlement that are going to being taken by them. Unfortunately, in most of the case sometimes the insurance companies have stopped the prosecution due to some of the vague elements in the case. The simple solution also taken is to reject the total claim made.

(Enforcement/RMP Commercial Crime Unit Officer, Alor Setar)

While, officers in FIU also noted, there is also the case of the Royal Customs taking place in the prosecutions step because they are involved in such situations where companies attempt to go against the law under the power of customs officers. BNM FIU officers’ gives example of this case as when a company tries to bring goods from outside that are not allowed for exports according to customs regulations. At the same time they insure these ‘unlawful’ goods, in order to ensure that they would have less risk during their transaction. After being caught by the Royal Customs, they claimed it back from the insurers and then the insurers will require making necessary clarifications with the officers. At the end of the case, these companies were charged in court with the intention to distract the Royal Customs decision as they had insured the transaction at an earlier stage.

BNM have agencies such as the Financial Mediation Bureau (FMB) that cater for the situation if there are any disputes between the company’s personnel and they are still not satisfied with the decision made by the insurers or any financial services sectors. FMB has the power to query the companies in order to justify and clarify the reports made by the customers. The insurers need and are obligated to answer the FMB. If the case is unsolved, the FMB will go through BNM to make a direct complaint regarding the company. Most of the time, BNM determine this mechanism to be effective in solving any redundant claims by both parties. Data from the FMB is considered as classified and is not exposed to the general public on the assumption that this channel of reporting of disputes appears to be highly effective and efficient.

As the mentioned by the commercial crime unit in RMP, there were no cases in regards of the biggest prosecution cases involved in the Malaysian insurance industry because out of court
resolutions are the normal route taken due to no hassle involved as it costs less. In 2010, there was one case of arson in Malaysia by a paper mill owner which involved billions of money that is still under trial. This case was highlighted because the facts of the cases appear irrelevant but the case is still not defined as fraud. The paper mill company has still managed to continue their operation because only one of the warehouses was involved in the fire. In regards to RMP, they determined that this case can be proven that insurance fraud is less in the volume but high in the amount of each case.

5.5.6 Other supported acts, guidelines or mechanisms aiming at countering fraud

BNM Conglomerate Supervision Officers’ indicate that Malaysia still has numbers of supporting acts that would help with the operation of insurers and also curb fraud in their operation. The Shariah Compliances for the takaful operators under the Takaful Act 1984 have a monitoring mechanism in the framework that ensures the initiatives against fraud are enhanced from year to year in order to maintain sustainable developments of the entities.

While, the general Anti-Corruption Act (ACA), 1997 are looking at the general guidelines in the financial service sectors. Additionally, the Bank and Financial Institution Act (BAFIA), 1989 have aggressively made a recommendation on the corporate governance structure that caters for the issues of fraud in companies. Ruling by this act, in 2008, BNM caught a major case of fraud that involved an Islamic Bank in Malaysia that was declared as the biggest corruption case in the banking sector, this company also offered insurance products. Furthermore, the other acts that contribute to the power of BNM in order to stress the ideas of countering fraud are the Islamic Banking Act 1983, Securities Industries Act 1983. Most of the insurers are unlisted companies and some are subsidiaries from the parent overseas companies in the insurance markets in Malaysia. By that, these BNM Conglomerate Supervision Officer claimed that market regulation and laws that regulated insurers is hard to be centralized compared to the market orientation group of companies that are listed in the local bursar. So, the Bursa Malaysia (Malaysia Bursa) Regulations on the listed companies Securities Commission listing requirements are determined as not very well for the agendas of countering insurance fraud.
In RMP perspective, the penal code are the main sources of the prosecution that would be involve with the insurance fraud perpetrators because the other acts that are related will be inducing from their main act of crime, as mentioned;

“The Fraudster is those people that are sometimes well-educate with the system components in the industry. There is the trends show that perpetrators are those well-known on the act and regulations involve with their act. Our main regulation is on the penal code and other criminal act based on the offences. This was interrelated because the criminal are not going to launch only single attack but it more towards the well plan crime in the commercial set-up. So, the act of crime are going to be differ based on the side that being perpetrate or attack by them”

(Enforcement/RMP Commercial Crime Unit Officer, Alor Setar)

The BNM FIU Officers during interview had emphasized that internal anti-fraud strategies inside insurance companies itself appear to be a more effective way of combating fraud by the insurers. BNM is just the intermediary between them and their customers to ensure that both sides are catered for. However, he said that the e-Fids (electronic fraud information database) is one of the strategies where they have a database for all the cases and chronologies until the end of their investigation. This is based on the idea of knowledge sharing that would increase awareness of other insurers.

Meanwhile, most of the insurers’ claims unit has a system called Insurances Claims verification Systems (ICVS) that was developed by the ISM, whereby it is able to determine and make comparisons between real and fake claims. If insurers manage to settle using insiders for the claim, no more adjuster/liquidators are needed for this claim. Besides, almost all companies have an Application & Claim Information Database (ACID). This is another strategy that appears to be an effective way to determine if wrong claims are submitted. It looks clear that BNM have a lot of control tools and mechanisms but the arrangements to make it existing as the main specific issues agency are not involved here. It might not be within the power of BNM to join the initiative but requires more judiciary powers to combine all the related parties. This is possible to be done under the Ministry of Finance rather than BNM. RMP are not part of the ICVS and ACID but they can make an order to BNM to supply certain information needed for the cases if they are only available there.
5.6 Strategies through the Associations, Professionals and Industry Level

The anti-fraud strategies that exist in the market environment involve the insurers association, a professional practice in the claim handling process and industry player in general. The strategies implemented by this particular party will be discussed in the several tables below that are part of the items adopted from the CIPFA Red Book 2 (the number of items is based on the book without changes). Not all items from the instruments will be evaluated in this part because only items that can be discussed in general industry interpretation have been selected. The evaluation is based on the interview responses with the representatives from the PIAM (Persatuan Insurans Am Malaysia- General Insurance Association of Malaysia), Association of Money Loss adjusters (AMLA), National Institute of Claim Society (NICS) and one loss adjuster firm, Justice Firm. The details on each of the interviews are presented in Table 3.2 in Chapter 3. The reason for using these instruments to evaluate the interview data is to synthesize the respondent’s ideas with the proper themes that will be discussed in the following chapters.

5.6.1 Adopting the right strategy

Under adopting the right strategy elements, it can be noted that is there a clear remit ‘to reduce losses to fraud and corruption to an absolute minimum’ covering all areas of fraud and corruption affecting the organization’ can be found in Table 5.3.1 below;

Table 5.3.1 Adapting the right strategy (item 1.2 CIPFA Red Book 2)

<table>
<thead>
<tr>
<th>ADOPTING THE RIGHT STRATEGY: KEY ELEMENTS OF A STRATEGIC APPROACH</th>
<th>PIAM</th>
<th>AMLA</th>
<th>NICS</th>
<th>JUSTICE ADJUSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a clear remit ‘to reduce losses to fraud and corruption to an absolute minimum’ covering all areas of fraud and corruption affecting the organization?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The aim- ‘to reduce losses to fraud and corruption in all areas to an</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>
The aim to reduce losses in fraud cases in all areas to an absolute minimum for all insurers is the policy for all the companies receiving all parties’ general agreement. They determine that most of the insurers will have a policy towards reducing the losses to a minimum level. Based on the representative from the PIAM who stated;

“This is victimless crime. i.e. if the company being defrauding by the consumer and they expect cases of fraud. They would not pay the claim that been lodge. By that, they would be any loss. But if they any loss been involved with the claim, at the end of the period or new policy bought, the company would be able on their own jurisdiction to increases the amount of the premium with certain amendments to the clause on the coverage. So, if they is a cases most probably nobody are going to be victim. But in the case of the selling false policy by the agents these might be the main consents when there is no insurance coverage if something happen and the payments might be taken away by the agents. So, in the claim cases, there is no victim on the system.”

(Professional/PIAM Representatives)

The statement above mentioned that to ensure that companies do not have big possibilities of loss, there is the policy that the company would increase the amount of premiums paid by the customer. While, they believe that the policy would involve members of association in almost all cases being identified as the most important. They stated in the interview that;

“ the companies have the structure that enable them to combating fraud in the general task. But they are going to use the services of our members in the investigative task because they have estimated to reduce possible bigger losses”

(Professional/AMLA Representatives’)

<table>
<thead>
<tr>
<th>absolute minimum’ - is the policy in the organization</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Important massage that there are not “safe” areas</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
As the loss adjuster association rendered the services to the companies, they knew all their clients were ready with the policy to make sure there was minimum loss involved in the cases of fraud. Additionally, in the NICS which is the society of workers in the insurers itself, it was stated that;

“As the claim fraud handling association we, ensure all the members are going to helps the companies in advising them to have the clear policies. The work that we done all the years are on the purpose to give minimum losses that might be involve by the companies that we serviced with”

(Professional/NICS Representatives’)

On the other hand, NICS is determined that all workers in insurance have clear written policies to ensure they would have minimum losses for almost of them. The Justice Adjuster, the professional investigator, also determined the ideas as the loss adjusters that;

“Every company has their own policy and it is synthesis with the work done with the loss adjusters that going to maintain the minimum losses by the appointed companies”

(Professional/Justice Adjuster CEO)

The statement from the professional adjuster justified that most of the times companies will create a policy to ensure less possibilities of loss. Then, they will consult and render the professional services of an adjuster to maintain the losses in a relevant range.

However, none of the respondents from the market environment were able to make a statement that the companies use a mechanism for showing the non-“safe” areas. This is because the environments of operation for the insurers involve risky working environment. At the same time, no respondents were able to comment regarding the relevance of the items as they spoke on behalf of the society represented and not the companies. On associations’ observations, no companies are able to show that it is unsafe to execute fraud in their company.

Meanwhile Table 5.3.2 below shows the strategies that are mentioned in 1.3, 1.4 and 1.5 which is 1.3 ‘are the effective links between ‘policy’ work (to develop anti-fraud and corruption and ‘zero tolerance’ culture, create a strong deterrence effect and prevent fraud
and corruption by designing and redesigning policies and systems) and ‘operational’ work (to
detect and investigate fraud and corruption and seek to apply sanctions and recover losses
where it is found)?. Item 1.4 ‘Is the full range of integrated action being taken forward or
does the organization ‘pick and choose’ the action. Item 1.5 ‘Does the organization focus on
outcomes (i.e. reduce losses) and not just activity (i.e. number of investigation, prosecution)’

Table 5.3.2 Adapting the right strategy 2 (Item 1.3, 1.4 and 1.5 CIPFA Red Book 2)

<table>
<thead>
<tr>
<th>KEY ELEMENTS OF A STRATEGIC APPROACH</th>
<th>PIAM</th>
<th>AMLA</th>
<th>NICS</th>
<th>JUSTICE ADJUSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the effective links between ‘policy’ work (to develop anti-fraud and corruption and ‘zero tolerance’ culture, create a strong deterrence effect and prevent fraud and corruption by designing and redesigning policies and systems) and ‘operational’ work (to detect and investigate fraud and corruption and seek to apply sanctions and recover losses where it is found)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good counter fraud measures and policy are mutually supportive. Review/ introduce i.e. Fraud response Plan, Whistle Blowing Code</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>-</td>
</tr>
<tr>
<td>As well as applying this</td>
<td>-</td>
<td>√</td>
<td>-</td>
<td>√</td>
</tr>
</tbody>
</table>
to current activities, ensure proportionate counter fraud measures are applied to:
- new system/procedures
- findings from fraud investigations

<table>
<thead>
<tr>
<th>Is the full range of integrated action being taken forward or does the organization ‘pick and choose?’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated action- point 4 in this guidelines adopted</td>
</tr>
<tr>
<td>Does the organization focus on outcomes (i.e. reduce losses) and not just activity (i.e. number of investigation, prosecution)</td>
</tr>
<tr>
<td>Politicians/ management make clear that reducing fraud is the key aim</td>
</tr>
</tbody>
</table>

The association in the industry has determined that insurers in Malaysia have good policies for countering fraud as well as for measuring it. The PIAM noted that almost all of the companies managed to measure that would enhance their abilities to respond to fraudulent situations. AMLA as the loss adjustors association also determined that companies have a good structure, because if not, they would be unable to determine fraud in the initial stages. Then, the following investigative works will be done by the loss adjusters. While, NICS members as part of the company did agree on good policy and measures being supportive as they are the responsible parties in the insurers to carry out the initiatives. Also, as the CEO of Justice Adjusters could not comment regarding the statement as they prefer to maintain
confidentiality on behalf of their customers and they have numbers of insurer companies as the customers.

However, on the part of the application, the current activities that will be updated in any new system and procedures together to report the output finding; only PIAM and NICS do not make any comments regarding these matters. Nonetheless, they rather determine that it is based on the manager discretionary to make the suitable changes to the policy and report the changes a needed. While the AMLA have noted that;

“one of the primary function of the AMLA is to represent any matters that affecting the interest in the insurance industry. So that, the members will always consider if the is the critical modification on the strategy the associated members would let the client to making the modification and making any perspective reports’

(Professional/AMLA Representatives’)

The idea in the statement directly indicates if the interests are directly relevant to the associations, members of them will acknowledge the clients during their works. So, this will strengthen the client strategy in determining that their operation is valid. While, the Justice Adjusters, one of the AMLA members stated;

“The works that we done is more towards identify, gather evidence and then preparing the reports to our client. During the process, if there is any deficiency in the customer detection or any other part of fraud system deterrence it will be highlight in the report submitted. This is for the improvement of the policy implement by the client”

(Professional/Justice Adjusters CEOs’)

The statement made by the Justice Adjuster have noted that if there is any respective suggestion needed to improve the customer’s policy, it will be submitted through the report of cases that has been under their investigation. While, considering the action taken by the organization whether it is selective or integrative, PIAM and NICS again cannot justify the statement because it is out of their realm. A representative from AMLA stated;

“Based on the real market condition, we can simplified say that all the companies involves in the insurance industry are well prepare in order to curb with the situation. They have integrates reaction to deals with the external fraud. This can be seeing in
the claim department exactly when they have internal strengthens procedure that consider the possibilities of the fraud in each submitted claim”

(Professional/AMLA Representatives’)

The statement above agrees with the idea that insurers in Malaysia have a good structure and integrates it very well to overcome the issues of fraud especially in the claim departments. While for the Justice Adjuster, he made a statement that;

“The better structure in the client firms is making our work more fluent and systematic. The direction and importance of each suspected cases would be prevail when we consult with companies and they able to give cooperation in most of situation. Their structure is well connected with the investigative works so it means it’s in proper manner in making the better representation of the situation.”

(Professional/Justice Adjusters CEOs’)

From the respond, the interviewee made positive remarks that the managers or politicians are clearly aiming to reduce fraud which happens with the insurers. PIAM, AMLA, NICS and Justice Adjusters agreed that it is the main objective for all the companies to ensure that loss is reduced to possible numbers without making any modifications to the main operation of the companies.

5.6.2 Accurately identifying the risks

Only Items 2.1, 2.2 and 2.3 are able to adapt to the market environment in Malaysia because they can be justified based on their simple observation and restricted clients. Table 5.3.3 shows the justification on Item 2.1 which is ‘are fraud and corruption considered as part of the organization’s strategic risk management and arrangements?’, Item 2.2 ‘Is the organization seeking to identify accurately the nature and scale of losses to fraud and corruption?’ and also Item 2.3 ‘Does the organization use accurate estimates of losses to make informed judgments about levels of budgetary investment in work to counter fraud and corruption?’.
<table>
<thead>
<tr>
<th>ACCURATELY IDENTIFYING THE RISKS</th>
<th>PIAM</th>
<th>AMLA</th>
<th>NICS</th>
<th>JUSTICE ADJUSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEASURING FRAUD &amp; CORRUPTION LOSSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are fraud and corruption considered as part of the organization’s strategic risk management and arrangements?</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counter fraud action is risk based. Risk management arrangements consider fraud and corruption.</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Is the organization seeking to identify accurately the nature and scale of losses to fraud and corruption?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holistic actions to counter fraud should take place even where there is a lack of current accurate fraud management</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Does the organization use accurate estimates of losses to make informed judgments about levels of budgetary investment in work to counter fraud and corruption?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The application of resources is informed by fraud risk including financial loss and savings.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From the above table, initiatives for countering fraud are essential to be included as the ‘risk based’ action because the possibilities of lost incurred is higher for the insurance operation. As all the associations agreed that the initiatives of countering fraud and control are going to determine the risk part of their works. PIAM mentioned that they do determine all companies are going to make sure the possibilities of fraud included in the operational risk yearly. While, AMLA have the ideas that;

“All the companies have the systems and the philosophy towards each of their product. The preventive system towards the fraud was existed internally and considering as the going concerns matters in the company. With the philosophy in the product it can be detected back to the contract signed by the customers that contains certain terms and conditions applied”

(Professional/AMLA Representatives’)

It can be clearly concluded that the AMLA did understand the growing concerns and the required initiatives that would encourage the insurers to indicate the risks related to the transaction. Philosophies in the product are more to determine certain allocated risk in the features that exist exclusively for each of the products. Meanwhile, the NICS officers noted that;

“We have created the possible list of the red flags that enable the claim handler able to detect the fraud within the normal operation of the insurers.”

(Professional/NICS Representatives’)

The statement above shows that the red flags as one part of the operation and the indicators if the risk assessments need to be done on the claims. As the red flags were considered as one of the major elements of control, it determines the claim handlers are always associated with
the risk in the normal course of operation. The Justice Adjusters, on the other hand, determined that;

“Fraud comes through the normal operation done by the claims department. Most probably the claims fraud is essential by the companies and the area where the adjusters’ going to be involves is increased. A thousand claims submitted and can be possible that adjusters determine the half of it contains the elements of the fraud”

(Professional/Justice Adjusters CEOs’)

The allocation of probability is using by the insurance companies and it includes the consultation works done. Claim handlers actually were making assumption based on possibilities that each claim submitted that about more than half of its might contains the element of fraudulent. Estimates on the claim resources is informed by the fraud risk application but it is still considered a blurred area for PIAM and NICS comments. While, AMLA can determine that;

“ If we can say same it would be incorrect because the different level of operation by the insurers are going to concentrate on the different level of complexity of claim handling and settlement. But, the resources on determine of the issues will going to be extensively use to reduce the opportunity of the claimant to overrun the systems.”

(Professional/AMLA Representatives’)

The AMLA statement is to simplify the ideas that the resources used to reduce the risks are likely to involve the different kind of insurers operation. The companies of loss adjuster are helping the insurers in reducing the possibilities of wrong claim. It also have been agreed by the Justice Adjuster statement that;

“It is depends on the type and typical of the case. At the same time it’s depends on the type of the operation. The resources is going to be differ but in the same ideas of curb the wrong claimant, the cost benefit analysis would be included”

(Professional/Justice Adjusters CEOs’)

157
5.6.3 Creating and Maintaining a Strong Structure

The statements under the themes of creating and maintaining a strong structure that is adapted from items CIPFA Red Book 2 items includes of 3.1, 3.2, 3.4, 3.5, 3.6 and 3.9; altogether with simplified comments from the market parts and professionals in the table 5.3.4 below;

Table 5.3.4 Item on the themes of maintaining a strong strategy (Item 3.1, 3.2, 3.4, 3.5, 3.6 & 3.9 from CIPFA Red Book 2)

<table>
<thead>
<tr>
<th>Creating And Maintaining A Strong Strategy</th>
<th>PIAM</th>
<th>AMLA</th>
<th>NICS</th>
<th>JUSTICE ADJUSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having The Necessary Authority Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do those tasked with countering fraud and corruption have the appropriate authority needed to pursue their remit effectively, linked to the organization’s counter fraud and corruption strategy?</td>
<td>CAN’T DETERMINED</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>The job of the counter fraud professionals puts into the counter fraud and corruption strategy and there are mutually supportive.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>The organization makes clear the provision of this authority in documents such as standing financial instruction/ MOU/ partnership agreement</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3.2 Is there strong political and executives support for work to counter fraud and corruption?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>“Strong” is mean genuine- i.e.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
policy declaration of zero tolerance, public statements, involvement or provision of risk proportionate resource allocation.

### SPECIALIST TRAINING AND ACCREDITATION

<table>
<thead>
<tr>
<th>3.4 Are those working to counter fraud and corruption professionally trained and accredited for their roles</th>
<th>PIAM</th>
<th>AMLA</th>
<th>NICS</th>
<th>JUSTICE ADJUSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertaking the right action and being effective through a combination of relevant experience, accredited qualification and continuous professional development</td>
<td>CAN’T BE DETERMINED</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.5 Do those employees who trained and accredited formally review their skills base and attend regular refresher courses to ensure they are abreast of new developments and legislation?</th>
<th>PIAM</th>
<th>AMLA</th>
<th>NICS</th>
<th>JUSTICE ADJUSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization has a personal development process to help identify skill gaps and support continuous professional development</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Individual take steps to keep up to date</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

3.6 Are all those working to counter fraud and corruption undertaking this work with a clear framework and
3.9 Are there framework agreements in place to work with other organizations and agencies. Relationships are agreed. This is intended to clarify issues such as responsibilities/obligations, exchange of information, liaison/communication/meeting with key personal. It can be accomplished through framework agreement, memoranda of understanding and service level agreements.

<table>
<thead>
<tr>
<th></th>
<th>PIAM</th>
<th>AMLA</th>
<th>NICS</th>
<th>JUSTICE ADJUSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The behavior of counter fraud specialist is ethical. Activities are governed by a code of conduct/ethical framework.</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>DECOMMING EFFECTIVE RELATIONSHIP WITH OTHER ORGANIZATION</td>
<td>CAN’T DETERMINED</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

From the above table, it can be considered that the support of any authority can effectively enhance the works done in combating fraud either directly or indirectly. The support also provides direct link on the strategies and the party responds positively to this. When
discussing about the ideas regarding the job of the counter fraud professional, it mainly covers on strategies related to counter fraud and how the professional is provided mutual support. PIAM could not make any comments, while AMLA assumed that loss adjusters help in developing the profession in a more meaningful way. NICS determine that the influences of outsiders are giving effect to the claim handlers and also, the Justice companies assume that the third parties are helping with better solutions and ideas. On the comments for a clear provision in regards whether if there were existing documents, PIAM determined that the investigation reports are always being submitted to BNM for reference. Meanwhile, the members of AMLA contribute as part of the partnership with the other bodies. NICS take part in the agreement only when specialists in the claims are needed. In the Justice Adjusters, the companies have always made provision with others to maintain good reputation and relationship with insurers.

When commenting on the ideas of the strong political and executives support for countering fraud works, all respondents find that there is a positive support in all aspects. PIAM assumes the support from the managerial perspective as their intention to cooperate is because countering fraud is a national agenda. While AMLA and Justice Adjustors support by allocating funds for the jobs and also provide connections which are highly required to get sources of the cases input. While, the support is needed in drafting the budget for the NICS as it was part of their strategy.

In talking about accreditation that is needed on countering fraud works, only three of the respondents answered. AMLA determined that sharing experiences are highly important to ensure that works related to counter fraud is done effectively. NICS emphasized that they attempt to have personal sessions to justify cases on fraud. They ensure that the members are well trained and aware of recent happenings. While for the Justice Adjusters, they have specified certain expert for each of these works. All their workers are accredited with some learning programs in ensuring they are well updated with knowledge and skills enhancement.

While, considering that the employees were enriched with updates and development of new skills, all the respondents in the interview viewed this positively and well understood this idea. PIAM determined that the members are well aware on the development but they do not supply the training on it. Also, this includes licensing and well-trained personnel. While, AMLA assumes that all members are aware with the updates and able to gain new
knowledge. They are keen to ensure that all members are well-equipped. In addition, the association’s collaborative work by la sharing with world-wide widens their international scopes of operation. For NICS, they determine that all professional should obtain wise opinions and expose themselves continuously to training. This is true as all the insurance claim handlers are able to update themselves on certain issues. For Justice Adjusters, they always ensure the workers are well trained and at the same time only selected workers are exposed to the new techniques based on the needs.

Issues on taking the counter fraud as the clear framework of standards are determine as positive output from the respondents. The fraud specialists are considered as ethical and governed by specific code of conduct. PIAM agree that all their members are working with the relevant code of conduct either as insurance agents or adjustors. AMLA determined that all of them are well licensed with the Ministry of Finance. In NICS, the claim handlers are also registered with Ministry of Finance and also have obtained the practice license. In Justice Adjustors, companies are only chosen based on their registration and a good track record to continue their professional work.

Only three respondents answered the ideas that there is an agreement of framework in place where they are working with others in an organization or agencies but not for PIAM. In AMLA, all the loss adjustors are required to follow the term of the agreement and will response in professional ways to maintain the integrity of the association and satisfaction of the customers’. While, the NICS has ensured that all claim handlers are aware on the borders and limitation within their work scope, this is to ensure no potential conflicts of interest arise. For the Justice adjustors, they keep supervised work done by their workers. Each work will be facilitated by the more senior staffs in order to check on the terms that need to be completed. The agreement will guide their workers’ job.

All selected contents of evaluation from the above discussions are specified and agreed based on interviews with Malaysian insurers’ broad market spectators and showed having a strong supportive level in creating and maintaining a good structure to act as an insurance fraud watchdog. This environment is enables them to react and cooperate in order to develop various structures of countering fraud. Also, by maintaining a corroborative group, it is easier to mitigate the issues. After all, there needs to be more serious arrangement that is sponsored by the regulators of the markets or the law enforcers.
5.7 Conclusion

When glancing through the steps taken by BNM and some associations, it can be highlighted clearly that ideas of fighting insurance fraud in the market are not essentially at an organizational level but concentrates on operational initiatives within the companies. Ideas are clearly justified through the statements from adjusters and associations who ‘aggressively’ highlight that they aggressively contributed within the company operation policy to engage in serious arrangements concerning fraud issues. The regulators and the associations only provide ideas and policy support in broad market ideas in order to ensure that initiatives taken by the insurers are successful. It will be advantageous when looking at the detailed evaluation by the CIPFA Red Book 2 in the next chapter to explore the depth of internal operational praxis in three selected insurers of Malaysia and that basically on the claims processing and investigation practices.
6.1 Introduction

In a free market competition, different insurance companies are expected to have different strategies to overcome any constraints in operation even though they are in the same markets and environments (Wells, 2011). Besides, it helps in a semi structured insurance market which does not regulate practices and internal policies in order to maintain independence and freedom in an open market competition. The Malaysian insurance industry is mainly dominated by international insurance providers or jointly established with international insurers (BNM, 2006). It is very important that the company formulates the right strategy in order to tackle the issues of fraud in the industry within their own structure. The strategy that has been adapted should evaluate the impact of possible risks related to it. It is also better to determine that the strategies are well executed and ‘fit’ well within the organization and environment.

Before embarking on the features in the CIPFA Red Book 2, it is better to make some simple comparison between the three companies regarding the background of their operation and scope in the market. Table 6.1 below shows the overall demographic information of the companies that are involved in this case study.
Table 6.1 Demographic Information of the Respondent Companies with comparisons on some features.

<table>
<thead>
<tr>
<th>The item (Berhad in English is public limited companies)</th>
<th>Ethical Insurance Berhad</th>
<th>Ling Insurance Berhad</th>
<th>Amy Assurance Berhad</th>
</tr>
</thead>
<tbody>
<tr>
<td>The size of the companies (based on the BNM data of Net Income in 2010)</td>
<td>2nd in the market share of Malaysian insurance</td>
<td>4th in the market share of Malaysian insurance</td>
<td>7th in the market share of Malaysian insurance</td>
</tr>
<tr>
<td>Numbers of employees</td>
<td>More than 500</td>
<td>More than 500</td>
<td>More than 500</td>
</tr>
<tr>
<td>The products of insurance available</td>
<td>Conventional insurance Conventional life insurance Takaful products Takaful life products Reinsurance market</td>
<td>Conventional insurance product Conventional life insurance product</td>
<td>Conventional insurance product Conventional life Insurance product Reinsurance market</td>
</tr>
<tr>
<td>The coverage of the operation</td>
<td>The biggest networking for the whole of Malaysia.</td>
<td>Selective regions in Malaysia with limited numbers of products offered in and out of head quarters</td>
<td>The whole of Malaysia, but more specifically within the central region.</td>
</tr>
<tr>
<td>The types of company</td>
<td>The combination of a company that anchors in the conventional and takaful markets</td>
<td>The Netherland based company but with free operational entity operations.</td>
<td>Malaysian based company which operates locally with the parent company support.</td>
</tr>
<tr>
<td>Relationship with the parent operation</td>
<td>The operational chains stand with the major bank in the Malaysia economy</td>
<td>Standalone insurers that have direct connections with the main company based outside</td>
<td>The operation rings that under the major bankers in the Malaysia economy</td>
</tr>
<tr>
<td>Mutual support or agreement partner</td>
<td>Have mutual agreement and support</td>
<td>Have brand names that have created a niche in</td>
<td>Have mutual support from the life insurers in</td>
</tr>
</tbody>
</table>
Internationally from one of the big British insurers, the insurance market known worldwide, the European markets

<table>
<thead>
<tr>
<th>The unit which responded to this study</th>
<th>The non-motors and non-life unit Reinsurances</th>
<th>The motors unit</th>
<th>The life insurance unit</th>
</tr>
</thead>
</table>

**Counter fraud operation in the company relating to fraudulent claims**

- Each specific insurance unit has their own initiatives.
  - The Investigation unit’s function is to report to the authorities and investigate the internal cases only.
  - Internal audit is responsible for the whole company counter fraud activities as macro scope.
  - The investigation unit would involve external investigators appointed based on the unit’s suggestions.
- The company have a Fraud Management Unit (FMU) that is centralized to cater for the problem.
  - The individuals unit has the mechanism of detection and reporting.
  - Investigation is carried out by external investigators.
  - The action would be based on the FMU.
  - Internal audit are responsible for reconciling all the cases.
  - The Investigation unit only become involved with internal fraud and report matters to authorities.
- Detection and reporting is carried out by the officers.
  - The investigation would be detailed by the lawyers if the cases are bogus and need some expertise involvement.
  - The investigation unit in the company make a proposal of investigation on the instigation of the case only.
  - Internal audit are involved in strengthening the inclusion in the policy.
  - All of the cases from start to finish are for the person responsible for the unit.

As was discussed in Chapter 3, once the research process was underway using the CIPFA Red Book 2 as a mean to assess the counter fraud strategies of different companies, it stood out as the best way to objectively assess them. Detailed reasons were given to justify this standard. The rest of this and Chapter 7 will now undertake a detailed assessment of the three companies and their counter fraud strategies against these criteria. The legends that are
applicable for all the following tables are presented in the Chapter 6 & 7 are: C (0) for non-agreed or can’t determine, Y (3) for yes as fully agreed, P (2) for as it partly agreed on the items N (1) for least agreed. These legends and score are to justify the company reaction based on the response made during interviews, internal documentation that being discussed in the Table 3.3, and also the observation methods in the part 3.2.3.

Y(3) are the scored the best in the interview. This was highly agreed as their statements and written documents are supported with statement and through observations made, either explicit or implicit actions. While, P(2) will give labels to the company when it shows only partly agreement, or the documents that exist do not purely support the statements or the observation done are shown only partial agreement. For N(1), it is least agreed when in the interview the statement look on low agreement, or the documents are not really inline to support or the observation is at a minimal level on the statements. Finally, C (0) shows non-agreement or cannot determine when the statement is made in the interview, or there is no documentary evidence existing to support the statements or the observation does not totally support the statements. Each of the statement that is itemized comes with the ordinal scales in order to enable the attributes to be ranked properly based on the initiatives level (Kemp & Grace, 2010; Silverman, 2010) and to determine the probable score for each item. By that, in the end we will be able to conclude which company has more initiatives than others by using this evaluation. The comparison is just relative to this sample and not applicable in general for other players in the industry and is within the control of research methodology (Yin, 2009).

6.2 Adopting the Right Strategy in Insurers
The most distinct factor in measuring strategy is the ability of the company to choose and then implement it to effectively improve practice. Table 6.2 below shows the evaluation on items 1.1 and 1.2 in the CIPFA Red Book 2 on strategic objectives of the insurer involved in this case.
ADOPTING THE RIGHT STRATEGY:
KEY ELEMENTS OF A STRATEGIC APPROACH

<table>
<thead>
<tr>
<th></th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Does the organization have a counter fraud and corruption strategy that is clearly linked to the organization’s overall strategic objectives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A counter fraud and corruption strategic plan has been formulated.</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td>It contains actions to reach goals (desired end).</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td>The goals are aligned to the aims of the organization</td>
<td>N(1)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td>Do not isolate- counter fraud work is not sole or main objective, not at end in itself</td>
<td>N(1)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Heavy link to good overall governance</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>A strategic plan is essential in establishing an anti-fraud culture.</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Advocates zero tolerance.</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>1.2 Is there a clear remit ‘to reduce losses in fraud and corruption to an absolute minimum’ covering all areas of fraud and corruption affecting the organization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The aim- ‘to reduce losses in fraud and corruption in all areas to an absolute minimum’ - is the policy in the organization</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Important message that there are not “safe” areas</td>
<td>C (0)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
</tbody>
</table>

From the table above, it shows that out of the three companies, Ling Insurance and Ethical Insurance had a clear strategic plan to deal with fraud, but Amy Assurance did not make any direct effort to maintain the strategy in a high level of management on countering fraud. Amy Assurance claims that the department’s interpretations on countering fraud were too general and based on the determination from documentation. The officers have been given authority in order to justify the documents submitted and interviews were conducted with the
claims officer who considered life insurance claims. It was noted during the interview that on a strategic level there were no strategic concerns in particular over countering fraud and corruption due to the expectation that the size of the operation was too small. From an observation made regarding the internal documentation, the company had the initiative in countering fraud and corruption but it was in a higher strategic level that was not related to the operation directly but more to frauds and scams in the company. This was supported with notations in the interview ideas that stated;

“ We do have the anti-fraud structure in the internal audit department but just solely in the whole organization interpretation that not directly would involves with the works done by the claim department”

(Insurer/Amy Assurance Claim Officer (CO) 2)

Ling Insurance had a better strategy for countering fraud, starting with the control element of the claims through to the process of handling claims. Through the policy document inspection, the company formulated the implementation of a better structure through strategic level initiatives by producing general countering fraud guidelines named ‘Claim Fraud Management Framework’. In the mission statements of this framework they stated that;

“The development and implementation of organizational claim fraud management framework within the Ling Insurance Berhad, leading to better management insight on the claim matter, better understanding on the legal implications, improved claim ration, improved operational controls and operational risk profile which fits the risk appetite of the management”

(Documents/Ling Claim Fraud Management Framework V1)

The mission statements above indirectly ensured that Ling Insurance makes the goals that are aligned with the aim of the whole organization in their best interest. They are also determined of the desired goals by understanding the implementation, improving the claim ratio, improving internal controls and ensuring that the objective of counter fraud activities is aligned with the company’s overall strategy. While, the environment of zero tolerance was emphasized in the objective of the framework through documentation inspection which stated that ‘the company will try the best to ensure the cases of fraud will be acknowledged
and reported within the proper channels of reporting in order to increase all the employees awareness on the case’.

Next, Ethical Insurance practises a more competent strategy in order to ensure good governance for fraud claim cases. They do not make a single stand objective of counter fraud strategy but places it as the end product and their services performs. Through documentation inspection internally, at the strategic level companies include policy documents that is known as “Fraud Reporting Policy for related companies under M Bank Group of Companies” produced by the compliance division with helped by the internal audit of the parent company with regulatory body advice. Inside of the policy they determine that;

“The Groups (companies conglomerate in banking and insurance services) expects the highest standards of conduct and integrity from all that have dealing with it including staff, policyholders, agents or vendors collaborating with any staff. It is committed to the elimination of fraud and to ensuring that all activities are conducted ethically, honestly and to the highest possible standard of openness and accountability”

(Documents/Fraud Reporting Policy for M Fortis Holdings Berhad & Operating Entities)

The mission statement above shows that the company have established a strategic level of ideas for countering fraud and corruption in the whole organization. Also, the policy determined that the individuals included are organization members with the purpose determined specifically for those writing policies for promoting a better culture, coordinated with the investigative tasks, to ensure time effectiveness and resources used to establish improved prevention, detection and of great importance to enhance awareness.

Based on the interview taken, all companies’ responded positively regarding the aim of anti-fraud in claims to reduce losses that are caused to a minimum amount, even though, on inspection of Amy Assurance it appeared to be only moderately considered. Based on observation of the company, nowadays policies that are implemented are the ‘best temporary solution’ to possibilities of fraud in their operation. As noted, claims and benefits fraud might involve a large amount for those companies but at the same time they are able to stabilise their revenue accounts. Even though, the best strategies are being used, yet potential deviance still exists. The aim to reduce losses from fraud cases is given below based on interviews conducted:
Amy Assurance officers (life insurance) states that:

“That is good the controls that have being implement when we can reduces the cost from the fraud possibilities and it very highly determine in the claim operation. We can rely even though the numbers of staff is small in handling the cases”.

(Insurer/Amy Assurance Claim Officer (CO) 2)

Ling Insurance officers (motor insurance) determines in statements that:

“Highly effective and cost reducing with the structure strategy is needed. But we make a changes rapidly based on the demand of the case. But the currents structure is good enough to make the prevention and investigation. If the big case usually we going assisted by outside investigator like Approved Group Forensic”

(Insurer/Ling Insurance Claim Officer (CO) 1)

Besides, in the documents Ling Insurance described that their company has the rationale of having fraud management frameworks in order to reduce losses to a minimum level as stated;

“One of the primary reasons for the organization to have a claims fraud management framework is to ensure that the internal and external claims fraud are minimized so that the organization does not suffer material financial and reputation losses in the long term”

(Document/Ling Claim Fraud Management Framework V1)

Meanwhile, the Vice President (Non Motors) in Ethical Insurance Berhad did also note that:

“We have the process flow that has been determined in the system with the framework that has been determined. Till now, we have made the better reduction in the possibilities payment on the fraud claim with the help from PIAM (for the meeting) and the claim adjustors (for the thorough investigation). But the claims paid amount is still keep increasing.”

(Insurer/Ethical Insurance Vice President Claim)
Also according to documentation regarding ethics, the company drew attention to the policy which reads;

“The Group has the right to protect its assets and the obligation to secured environment for its staff”

(Documents/Fraud Reporting Policy for M Fortis Holdings Berhad & Operating Entities)

All notions above indicate that the system of claims is not a ‘safe’ place to commit any kind of fraud. However, Amy Assurance cannot justify whether they have such policies as throughout the interview the officer failed to demonstrate that they have such policies intact. The existence of a policy can at least show that the company indicates that committing fraud is not safe. The ordinal cumulative score from Table 6.2 for each company respectively are: 6 for Amy Assurance, 26 for Ling Insurance and 24 for Ethical Insurance. The following items below indicate if the policy is integrated sufficiently with the implementation in practices, as noted in Table 6.3 below.

Table 6.3: Items 1.3 till 1.6 CIPFA Red Book 2 for Evaluation of Insurers

<table>
<thead>
<tr>
<th>KEY ELEMENTS OF A STRATEGIC APPROACH</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3 Do the effective links between ‘policy’ work (to develop anti fraud and corruption and ‘zero tolerance’ culture, create a strong deterrence effect and prevent fraud and corruption by designing and redesigning policies and systems) and ‘operational’ work (to detect and investigate fraud and corruption and seek to apply sanctions and recover losses were found)?</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Good counter fraud measures and policy are mutually supportive. Review/ introduce i.e. Fraud response Plan, Whistle Blowing Code</td>
<td>C(0)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td>Build in and balance the risk of fraud against the need to deliver services.</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td>As well as applying this to current activities, ensure proportionate counter fraud measures are applied to: - new system/procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

172
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>findings from fraud investigations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.4 Is the full range of integrated action being taken forward or does the organization ‘pick and choose’?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated action- point 4 in this guidelines adopted</td>
<td>N(1)</td>
<td>Y(3)</td>
</tr>
<tr>
<td><strong>1.5 Does the organization focus on outcomes (i.e. reduce losses) and not just activity (i.e. number of investigation, prosecution)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Politicians/ management make clear that reducing fraud is the key aim</td>
<td>C(0)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Action should not take place just so that criticism of inaction can be avoided, but to achieve goal, tangible result in terms of improved public confidence and reduced losses</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
<tr>
<td><strong>1.6 Has the strategy been directly agreed by those with political and executive authority for the organization?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff needs to know where the buy-in is from those in control and that it will be implemented. The governing body, citizen groups like unions, partners. The association determine the organization commitment to countering fraud</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
</tbody>
</table>

The table above mainly concerns about the elements of the strategy formulated in the practical linkage. Items in 1.3 shows the links strategy and its operationalization can be determined in the claim departments of Ling and Ethical Company only. It is indicated as highly effective as the strategy was updated and reviewed based on the current situation and also issues related in the companies or market place. By considering the internal audit department function, all companies within this research were determined as well ‘exposed’ and ‘balanced’ on the risk factor operation that includes fraud. They maintain some inside structure or communication with external parties mainly to combat fraudulent claims. Partly for Amy Assurance, based on the interview, counter fraud is measured through their involvement of internal auditing in claim handling on life insurance;

“Each of the claims has the ideas for possibility of fraud then with any respective guideline providing by the internal audit department we then reconcile back the works by the claim receiver.”
While, through observation in Ling Insurance, the officers claimed that they are able to determine the policy on certain levels of effectiveness due to the involvement of the Fraud Claim Committee, as it is part of the Claim Fraud Management Framework. The company officers noted in the interview that;

“It is acceptable and highly effective ideas of the fraud detection and prevention. We have the committee that would do some revision on the works done by the officer. At the same time can be noted that all of them doing the job simultaneously with the real function that to process for the claim”

(Insurer/Ling Insurance Investigation Officer)

Ling Insurance appeared consistent in balancing the risk of fraud against the need to deliver services. At the same time, they managed to ensure that the layout processes in the companies contribute in ensuring a well-functioning system and the main pillars for this is the Fraud Management Network. They have also routed out sample criteria’s of claims expected as an example of detailed procedure with timing considerations to ensure that the operation of the anti-fraud strategy would not affect the normal course of operation.

The claims department of Ethical Insurance appears to be able to synthesize the claims handling functions all together and simultaneously, obtaining counter fraud strategies with the help of integrated computerised systems internally. They have also established in the same processing system call as ‘The Fraud Reporting Policy’ to enhance their ability of operationalized of claims management system. During the interview they noted;

“We have the reporting policy that could lead the initiative of countering fraud and it will be revised by the member group of company compliance division. They would ensure that the ideas of countering fraud being embed in the fraud reporting at first place.”

(Insurer/Ethical Insurance VP Claim)

“The company have the structure that can manage to make any changing to the current strategy to counter fraud. We got problems with the shortage numbers of staff to make the investigation insider. Also, help the claim department on the claim cases
but the report will always been produce to the management in order to submit to the Internal Audit department for the M Group of companies”

(Insurer/Ethical Insurance VP Investigation)

If related to the integrated actions that are based on the policy documents, only Ling Insurances and Ethical Insurances have this within their structure. This is because only both of them appear to have a formal established internal control structure on fraud based on the observations made. While, in Amy Assurance, the officer’s just attempt to follow the guideline strategy that is developed internally. In practice, they pick and choose only highly related actions in countering fraud as general precautions. So, they might be induced to implement certain important strategies such as prevention, detection and investigation within a small scale of authority powers. Hence, based on the observation in the company documentation and independent observation, the idea of being fully integrated only applies to Ling Insurance, while Ethical Insurance only have a partial integrated action on countering fraud and Amy Assurance can be justified as having a non-integrated.

In the document inspection, it was noted that only Ling and Ethical Insurance are more focused on the outcomes of the policy rather than the details implementation being discussed. In Amy Assurance the guideline is ‘highly-restricted’ by the internal audit. They then highlight the relevant steps need to be taken by the staff to decrease the possibility of loss due to fraud actions based on areas of interest determined later. The company attempts to increase public confidence during the period of investigation in the company. Temporarily in 2009 and 2010, the main company were in the process of merging with one of the major life insurance company (MAA Insurance). While, in the other two companies, the management have implemented clear outcomes expected through documentation in the policy and framework. Both companies make corrections regarding indicators in the system that are noted as success intervals in the numbers through the recovering loss from the anti-fraud strategy and cases.

The links between the policy documents regarding operationalization also concerns the agreement of the strategy makers with the authority party. In this case, all companies can somewhat have possibilities to be involved under the Insurance and Takaful Market Supervision Department in the Central Bank (BNM). At the same time, associations involved are to ensure that the company has valued to contribute that would support their policy and
not only the outcomes. Based on independent observation, it was noted that at least all the companies researched have support from the one or more related parties in the Malaysia insurance industry. Officers from Amy Insurance noted that;

“The procedure on detection and prevent is more to be insider approach. But we also were help by the National Institute of Claims Society (NICS) since the chief of claim is the committee members of the association. While, the Life Insurance Association of Malaysia (LIAM) as the association are going to share the feedback and making regular meeting. During that time they would distribute the case facts. So, the centralization on the system developments is still in the company efforts and works”

(Insurer/Amy Assurance Claim Officer (CO) 1)

While, the ideas from Ling Insurance was;

“...Actually we have the circulation and guidelines from the BNM to all the companies and the claim unit specifically. We have the GPI 14 that is the Guidelines on Claims Settlement Practices. If talking on the motor vehicles claim procedure to countering fraud, In Section C we have something that specific on the fraud controls procedures on all claims and also motor claims.”

(Insurer/Ling Insurance Claim Officer)

Thus, Ethical Insurance also noted that;

“…No specific guideline that from BNM and within claims and complains, we work for the guidelines…”

(Insurer/Ethical Insurance VP Claim)

From the interviews, it can be concluded that the researched companies have a strategy that only moderately agrees with the political and executive authority in the market. The general guidelines look as prescriptions; have been given by the BNM as the authority body to all the insurers. The main reason for this action as noted in previous chapter is that the initial ideas of BNM is to provide all companies more independence in having their own specific structure and method to cater for fraud problems. At the same time, associations and Central Bank (BNM) continuously contribute general ideas on mitigating insurance fraud in the market for sharing purposes. The ordinal cumulative score from Table 6.3 for each company respectively are 5 for Amy Assurance, 16 for Ling Insurance and 14 for Ethical Insurance.
6.3 Accurately Identifying the Risks in Insurers Strategy

Risk is the main concern when the companies are eager to be involved in any long or short term strategies that would involve operational practices. Manageable and appropriate responsibility units are able to make the risks to be justified. Table 6.4 will discuss Items 2.1 till 2.3 on concerns for strategic risk management accuracy and budgeting.

Table 6.4: Items 2.1, 2.2 and 2.3 from CIPFA Red Book 2 for Evaluation of Insurers

<table>
<thead>
<tr>
<th>ACCURATELY IDENTIFYING THE RISKS</th>
<th>MEASURING FRAUD &amp; CORRUPTION LOSSES</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Are fraud and corruption considered as part of the organization’s strategic risk management and arrangements?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counter fraud action is risk based. Risk management arrangements consider fraud and corruption.</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td></td>
</tr>
<tr>
<td>2.2 Is the organization seeking to identify accurately the nature and scale of losses to fraud and corruption?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The organization has adopted a definition of fraud and a method of quantification for known losses and losses prevented.</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td></td>
</tr>
<tr>
<td>There have been crucial initiative with the Managing Risk of Fraud ideas</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td></td>
</tr>
<tr>
<td>Measured counter fraud outcomes should not be restricted to only prosecuted criminally (beyond reasonable doubt) and should include civil (balance of probabilities), disciplinary and administrative action.</td>
<td>P(2)</td>
<td>P(2)</td>
<td>P(2)</td>
<td></td>
</tr>
<tr>
<td>Guidance not to restrict the scale of losses only to fraud detected</td>
<td>N(1)</td>
<td>N(1)</td>
<td>C(0)</td>
<td></td>
</tr>
<tr>
<td>Measuring fraud is informative and important</td>
<td>P(2)</td>
<td>P(2)</td>
<td>P(2)</td>
<td></td>
</tr>
<tr>
<td>Holistic actions to counter fraud should take place even where there is a lack of current accurate fraud management</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td></td>
</tr>
</tbody>
</table>
2.3 Does the organization use accurate estimates of losses to make informed judgements about levels of budgetary investment in work to counter fraud and corruption?

| The application of resources is informed by fraud risk including financial loss and savings. | N(1) | Y(3) | C(0) |
| Targeted and proportionate budgetary investment is prompted and justified through robust data in counter fraud reports. | N(1) | Y(3) | N(1) |

Risk management is the chief part of the operation that urgently needs to be considered in the company performance measurement by their shareholders. The company should also consider the risk factors when deciding the company’s strategic goals whilst considering the amount of financing that is involved on the risks elements. From the above table, it can be concluded that, all responding companies effectively include the risk of possibilities of fraudulent claims in the claims department’s normal operation risks. At the same time, through inspection of the annual report of each company, it was realized that all the companies’ annual reports had included the risk assessment section for a certain period. All the companies’ were able to provide detailed information on the risk assessment because it is part of their course of operation in the insurance market. Amy Assurance determined that the risk factors had been considered through the statement of the possible method that can confirm fraud involved with;

“..there is no certain ideas on the percentage risk of possible fraud do taking part in the company but the sense of wrong doing is still be there. So, in the risk assessment still obtained annually, we always allocated some portion of expected risk for the fraudulent claims.”

(Insurer/Amy Assurance Claim Officer (CO) 2)

This showed directly that the company acknowledged the risk of fraudulent claims and the cost associated with them as normal issues. So, they are always prepared to include it in the yearly risk assessment. On the contrary, Ling Insurances forecast the risk related to fraudulent activities within their Claim Management committees. This was discovered during
the observation in the company operation and was supported by the interview comment below;

“…the risk of possible fraud would be discussed in the claim management committees meeting and then they would decide each years the percentage level of it. It would be based on the observation taken from the year before...”

(Insurer/Ling Insurance Claim Officer)

This indirectly shows that Ling Insurance has a structure that discusses risk related to fraud claims in a ‘well-organized’ structure. Based on the document, inspection from the internal audit departments revealed that all members in the committees organised by the company internal auditor contribute towards the risk percentage determination based on relevancy and accuracy. Hence, Ethical Insurance has had more serious discussions at management level simultaneously with the operational level. They noted in the interview that;

“The risk assessment is becoming the major concerns in the firm strategic meeting and been determine during each proposal of coverage been submitted. We will ensure that we have the certain level of acceptable of risk being incorporate with every policy proposal. This is because the claim is more highly relate with the type of policy submitted to the companies.”

(Insurer/Ethical Insurance VP Claims)

Ethical Insurance stated that the estimate could be determined as a highly integrated estimation because it was based on the possible risk of claims at the initial stage when the proposal of the policy was being created. Nonetheless, they projected that the risk estimates on possible claims without caution to the possibility of fraud elements. In practice, it is impossible to determine the amount of frauds as a percentage as it is possible that all the claims may not include the fraudulent ones. During the observation, it was noted that the company have an embedded information system that automatically calculates each insurance proposal before it is recommended to the customer.

All in all, the researched companies assumed that it was better to determine if the companies accurately identified the nature and scale of losses due to fraud, as per Item 2.2 in CIPFA Red Book 2. It is because measuring fraud is highly informative and important for them. The
companies have a different interpretation regarding the nature and sums of loss. Normally, 
average awareness to risky transaction for every company involved is based on the nature of 
policy and the scale of the losses expected from past cases. This is noted in the Amy 
Assurance ideas that somewhat agrees in a situation that;

“…Obvious fraud is death claim as we are in the life operation. There is one special 
case when this person by a lots of insurance policy from several company. Then there 
would be gathering by the Reinsurance Company. Then, they know the particular 
person have several policies with different companies So, this can create by 
suspicious. It did happen. This is because no specific guidelines for the life policy 
such as based on the salary. But everybody is free to buy policy from any insurance 
company…”

(Insurer/Amy Assurance Claim Officer (CO) 1)

“ we didn’t have any specific losses expected but they is one cases that we have that is 
a one million plus policy amounts that this person is die overseas. The reinsurance 
carried out the investigation and the group of people because the date of the policy is 
quite new. This is just an example of the suspicious cases. It cannot be determine as 
the fraud”

(Insurer/Amy Assurance Claim Officer (CO) 1 & 2)

Amy Insurance concluded on the nature of fraud and the type of operation. Unfortunately, 
they are unable to predict accurately on the amount involved. This is because the details of 
the cases would be different based on the attributes. Ling Insurance determines the nature of 
cases and concurrently they calculate estimates based on the committees’ judgment;

“..we are having a lots of possible motor insurance fraud. The latest we have the claim 
on one of Nissan fair lady car last year when the damage on the airbag is not as what 
expected to consider the safety technical by the car makers. The amount at first look 
not so genuine that is less than specific amount for the airbag would charge. When we 
looking in details the insured amount is cover the airbags. So, at last the adjusters 
make the confirmation that the case is the genuine one.”

“.Yes there is one cases that about RM200, 000 on the insurance claims…After it 
wall determine as the fake one, we are not paying for the claim and we are giving the 
opportunity for them to bring the case to the court..”

(Insurer/Ling Insurance Claim Officer)
The above statement shows how Ling Insurance determines the nature of their possible losses from fraud activities based on detection from their previous experiences. They cannot estimate directly the possible risk from fraud because claims in the motors insurance department are relatively small but high in number of cases. Meanwhile, Ethical Insurance did express clearer ideas regarding the nature and estimated losses from claims fraud. But they do express reservation on the unpredictable amount of losses as per the statement below;

“…the case is complex sometime involved more than one insurer. This exactly happen in the case on the reinsurance case when we are sharing the responsibilities with other insurance companies. We also have the case of the fire when it involves with the companies that not making the property security precautions in their own building. This would let to the rejected of the claim as they are not following the rules and policy contents. Actually it is the arson ideas. Thanks God that we are not making any payments.”

“...so, far the claim cases that happened would not be bring to the court but we wouldn’t pay for the claim and we can detect it earlier within our system. With this it is can be determined that we have quite good claim handling officers and the supportive adjustors that would always reduce the possibilities of the loss to the companies.”

(Insurer/Ling Insurance Investigation Officer)

From the experience of Ethical Insurance, it can be summarized that they have identified specifically the possible types of fraud that is randomly involved within the company operation. Their environment is challenging as they operate in the non-motor and non-life sector, with consideration for the takaful and insurances product claims simultaneously. It should be noted that the company manage to determine fraud claims precisely due to the work of their adjusters and investigators. Not to forget, they clearly justify the related risks in the early stages of their claims system.

The accurate scales of loss are very useful in order to level the budgetary investment in works that are directly connected with countering fraud, as Item 2.3 in the evaluation and this truly applicable in the case of Ling Insurance. For others, it is considered that the work of countering fraud is done as an extra to the normal duties of claim handling. This quite hard to
be determined and allocated to the budget because the initial countering fraud works are embedded with internal sources within the organization. Amy Insurance justified that there was no budgetary investment for countering fraud. They stated that;

“...We have to do the initial investigation on our own. There is no one specializing on it. At some time we need to go to the field. Even though, we actually sometimes don’t have the time to do the thing. After the proof of the case can be pretty sure, we would appoint the lawyers or the penal adjustors. Penal adjustors will continue to do the investigation research. Finally, the claim officer would determine the result whether it is real or the forged. By the whole process it can be noted that the investment to do this work is not directly related with the numbers or amount of fraud detect before.”

(Insurer/Amy Assurance Claim Officer (CO) 1)

With regards to document inspection, in Amy Assurance the level of budgetary investment on the action would be followed up in stages after the claim officers prepare their own initial investigation which is part of their main job responsibilities. This type of practice is different to Ling Insurance where they have internal committees within the company. Thus, they would make the budgetary allocation for the works being done;

“...If in house cases proven we have investigator departments under Claim Fraud Management Unit...While also to check for the consistency we have Corporate Audit Investigation Unit that also have been responsible to make thorough investigation before the cases is going to the public investigators or the adjustors. We make the budget for the initiatives involves within the framework”

(Insurer/Ling Insurance Investigation Officer)

The unit involved with the initial investigation in Ling Insurance decide their own budget before considering appointing any outsider in the case. They consider this more of a function in the Claim Fraud Management Unit (CFMU), thus this would effectively determine the specific budget for the unit.

Ethical Insurance’s practice regarding budget for anti-fraud works are weak and different to the others. The claim handler officers are fully responsible for the works of countering fraud from beginning to end of expected fraud cases. They do not have a targeted and proportionate
budget at all in the situation. Hence, it cannot be determined whether they have a direct proportionate budget. After the case is proven, Ethical Insurance directly passes the case to the adjusters. There is budget allocated for all the company in order to carry out investigations outside of the normal routine work of the claim handlers but it cannot be exposed to the general public and this also includes operational cost for the claim department. Specifically, the determined budget lean towards appointment of the adjustors, lawyers for the legislative cases, private investigators and also cost for attending courses that would be related to the investigation unit. The ordinal cumulative scores from Table 6.4 for each company respectively are 16 for Amy Assurance, 23 for Ling Insurance and 17 for Ethical Insurance.

6.4 Creating and Maintaining a Strong Structure

After adopting and measuring the strategies, the companies need to adapt it to ensure it is viable and fits with the firm’s circumstances. They would need other types of complementary resources for the situation such as necessary authority support, specialist training and accreditation, propriety checks and creating effective relations with other organizations.

6.4.1 Having the necessary authority support

Support for the strategy is necessary in order to achieve objectives that have been aligned based on the formulation of it. Table 6.5 below refers to having necessary authoritative support.

Table 6.5: Items 3.1, 3.2 and 3.3 from CIPFA Red Book 2 for Evaluation of Insurers

<table>
<thead>
<tr>
<th>Creating And Maintaining A Strong Strategy</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Do those tasked with countering fraud and corruption have the appropriate authority needed to pursue their remit effectively, linked to the organization’s counter fraud and corruption strategy?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The job of the counter fraud professionals puts into the counter fraud and corruption strategy and they are mutually supportive.

The organization makes clear the provision of this authority in documents such as standing financial instruction/ MOU/ partnership agreement

<table>
<thead>
<tr>
<th>3.2 Is there strong political and executive support for work to counter fraud and corruption?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Strong” means genuine- i.e. policy declaration of zero tolerance, public statements, involvement or provision of risk proportionate resource allocation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.3 Is there a level of financial investment in work to counter fraud and corruption that is proportionate to the risk that has been identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to reduce fraud is demonstrated by the overall level of investment, the timescale, risk, results and the application of resources.</td>
</tr>
</tbody>
</table>

From the table above, it can be concluded that all three companies have the necessary support from the counter fraud specialists in the industry, for Items 3.1 either partly or fully. With regards to insurance claims, the organization would be the National Institute of Claim Society (NICS that is established under NIAM) and the Association of Malaysia Loss Adjustors (AMLA) that supply the services to all companies in the industry such as technical parts and support services. The associations gives full support integration to ensure that each company is able to handle cases with different levels of difficulty and attributes through training and services rendered. Amy Assurance officers’ moderately agreed and stated during the interview that;

“…NICS will training when all staff ‘required for’ to attend based on the demand without any specific schedule. Our chief of the claim departments are member of committees for the association and this is the great opportunities for the development activities to the officers. At the same time we have the training done by our panel lawyer that is based on the demand based on the cases and contemporary issues in the market”

(Insurer/Amy Assurance Claim Officer (CO) 2)
The statement stated that NICS are involved in fraud issues which are also based on the demand by the company officer. At the same time, the company has support from a law firm which would give particular legal exposure regarding the possibilities of fraudulent actions. This was also based on the demand by the companies. But the company does not have any clear provision for having financial instructions or partnership agreement. Any arrangement would be an ‘ad hoc’ basis only without a permanent engagement. Meanwhile, Ling Insurance also has support on counter fraud work from professional bodies. They noted in the interviews that;

“Yes, we have sometimes organized the internal courses on the matters based on the demands. It would consider the elements of fraud detection on the claims. Sometimes it comes from the Forensic Investigators Specialist companies and our panel loss adjusters that specifically to train the officer. We also have the external course from the BNM run through the MII when it would cover during the training of the professional courses.”

(Insurer/Ling Insurance Claim Officer)

Their officer’s statement indicates the existence of an outside panel (one of the private investigators firms) called the Forensic Investigation Specialist that helps companies to solve cases and injects supportive ideas regarding countering fraud. Simultaneously, based on observation, the contribution of the loss adjusters’ is essential in assisting Ling Insurance officers on the issues, especially in detailed-case investigations. This engagement has financial provision and agreement with the parent company to ensure the works of countering fraud have appropriate support. Ling Company also noted the fact that Central Banks (BNM) through their units MII also generated ideas in countering fraud initiatives. In Ethical Insurance, they also mentioned the contributions of the Central Bank (BNM) regarding strategy support for countering fraud as stated;

“Yes. We do have general strategy support from MII and BNM. But it is still important on the internal training and experiences sharing. The internal training was from our liquidators and Royal Malaysia Police (RMP) sometimes since a lot of our members is ex policemen. This is based on the suitability. If yes, we would send our people”
“The cases of the insider corruption will be investigated by the RMP if we make the reports and most probably by the concerns. Besides, almost of the members is the ex-RMP officer, so that we have the strong support with the external links on the counter fraud and corruption”

Ethical Insurance stated that they had direct mutual support from NICS and members of AMLA that are respectively the major learning centre and service support association to the claim department during the observation time. They also highlighted that they sometimes gained support from the Royal Malaysia Police in order to ensure the strategy of countering fraud is valid with the national agendas. This means that they are engaged with political contacts with enforcement bodies to support their works in relation with countering fraud and hence creating environments of ‘collaborative sharing’.

With regards to Item 3.2, which refers to the strong political and executive support to counter fraud, Amy Assurance determined that there were no policy declarations existing as the main weaknesses to show directly the management support. Meanwhile, for Ling Insurances through Fraud Management Committee, it has enabled the whole organization to join initiatives to tackle fraud as a serious concern. Their committees are well supported with the help from the external professional. They are able to combine the power within the claim and investigation unit under the Fraud Claim Management Unit in order to discuss the relevant details and resolution of any cases. Ling Insurance stated that there are other functions, which can be found from their internal documentation;

“…In order to curb the fraud in the company, we need to cooperate tightly each other in sharing the information especially with the claims unit because most of them need the investigation tasks. Between that, the Claim Committee and Corporate Audit Investigation are among the main close departments that would contribute a lot in our model of works…”

“..the likely fraud investigation most probably going to have the longer period of times and it would take about 12 weeks to be completed on average without any
delaying on tasks. Week 1 and 2 is still on the works of the data entry and claim assessor and in here there would determine the possibilities of fraud or to pass it to Fraud Management Unit (FMU). FMU would take almost a week to determine whether it need inquiry/investigation or it would be proceed to the claim. If need investigation, FMU would take about 2 weeks finalized the in house investigation that is our work. In Week 6, if there is no fraud established with the claims so, it would be settle that claims. But if Fraud established then they would prepare for the Fraud reporting procedure…report to corporate audit services (CAS) for submitting the documents for BNM reporting…..prepare the Investigation report (our works). Then, we discuss the case with head of benefits and head of life operation. In week 7, the Benefits division would present the case to Claim Committee for decision and next courses of action. They also would brief the case to legal division. In this they would determine claims decision, CAS for detailed investigation, appoint any external investigator, lawyer if necessary and lodge the police report. In week 8 to 11 the CAS would done the investigation. Update it to FMU and Head of benefits. Then determine the legal advised. In Week 12, CAS would present the investigation report, preliminary or the final one then present the finding to Claims Committee. Finally, decision would be paying the claims or further action on legal part.”

(Subtract from Documents/Ling Claims Fraud Management Framework IV)

This model of working chart as noted in the internal documentation is the idea on how they work with a checklist of the investigative support from the Claim Committee and also the corporate audit service departments. There are detailed steps which are needed in an investigation and the output expected by the committees at the end of the tasks. Hence, the supporting ideas being induced in the claims committees in Ethical Insurances stated that;

“The act of the investigation in Malaysia is no law binding action. But here we have the guidelines from our parent companies on investigation procedures and taking notes. Basically based on the internal regulation, manual to guides the procedure...But it is still the just a generally guide. They also would support the expertise in the case with some budget yearly on the work done for that”

(Insurer/Ethical Insurance Investigation Officer)
Ethical Insurance stated that they always had support on the guidelines from their biggest parent company (the biggest banking conglomerate company in Malaysia). The parent company gives support to ensure that the investigation department and the claims department are able to cope with the issues coming from the internal audit department’s perspective. From the observation made, the purpose of this is to ensure the companies’ at any time during normal operation, have synchronized objectives with the parent company. Thus, the claims and investigation unit still have their own authority towards a critical path in their operations which are known as totally responsive units.

Based on the observation in-house, all companies have clearly stated that potential risk that has been determined and forecasted on a yearly operation basis are not used in determining amount that would be in the financial investment for counter fraud activity. The risk analysis that has been estimated and forecasted was only for the purpose for allocations the number of staff in handling potential extra work. Thus, the companies’ staffs are simultaneously doing their claim handling job with countering fraud works as for Items 3.3. The ordinal cumulative scores from Table 6.5 for each company respectively are 3 for Amy Assurance, 9 for Ling Insurance and 8 for Ethical Insurance.

6.4.2 Specialist training and accreditation

Special training by a ‘well-known’ personnel or expert is needed in order to make countering fraud and corruption strategy reliable and effective. The training might be applicable for the fraud busters, the fraud examiner, loss adjusters, internal auditing, practices lawyers etc. Table 6.6 indicates the evaluation from the interview, observation and documents inspection on the specialist training and accreditation through proper training, method of training, intensiveness of training and objectivity of the training.

Table 6.6: Items 3.4, 3.5 and 3.6 CIPFA Red Book 2 for Evaluation of Insurers

<table>
<thead>
<tr>
<th>SPECIALIST TRAINING AND ACCREDITATION</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4 Are those working to counter fraud and corruption professionally trained and accredited for their roles</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

188
<table>
<thead>
<tr>
<th>Question</th>
<th>Y(3)</th>
<th>Y(3)</th>
<th>Y(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertaking the right action and being effective through a combination of relevant experience, accredited qualification and continuous professional development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Do those employees who are trained and accredited formally review their skills base and attend regular refresher courses to ensure they are abreast of new developments and legislation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The organization has a personal development process to help identify skill gaps and support continuous professional development</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Individual take steps to keep up to date</td>
<td>P(2)</td>
<td>P(2)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>3.6 Are all those working to counter fraud and corruption undertaking this work with a clear framework and standards of personal conduct?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The behavior of counter fraud specialist is ethical. Activities are governed by a code of conduct/ ethical framework.</td>
<td>P(2)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
</tbody>
</table>

From the table above, it can be concluded that the main elements of training are the types of training methods, contents, intensity of training and accreditation. These are the main factors of the structured training in countering fraud within a company. From the responses taken, all the companies’ appeared to be at above average ordinal score on the issues of counter fraud training because most of them have better than basic training and ‘well-exposed’ officers as for Items 3.4 and 3.5. The Amy Assurance officer in the statement noted that;

“… we have training on the fraudulent act and the tactics from the penal lawyer and adjustors. No specific schedule that have been allocated to all the staff because we having the shortage numbers of staff that would handling a higher volumes of claims because it is only centralized to be process here”

(Insurer/Amy Assurance Claim Officer (CO) 1)

“… External parties are involved in the training from lawyer, investigators etc. Most probably the MII don’t have it”

(Insurer/Amy Assurance Claim Officer (CO) 2)
They have also documented that the training given from the agencies are determined as the experts in their fields which are related to investigation works and the legislation enacted for civil actions. Besides, they also clearly state that training is from outside parties and not from the MII. They are concerned that fraud issues are one of the major issues which need adequate training by the MII. They feel frustrated with the ignorance regarding training as the MII and BNM voice that they are the regulators, and in their view, should be more proactive in training, not merely organising a yearly seminar. Thus, for Ling Insurance training is an internal workshop usually based on practical parts of the insurance claims handler and fraud. They noted this in the following way:

“No...it’s not really a formal training. We have been supply with the guidelines and it would be more to experiences gain during our works. You would be able to smell something on the unfaith policy. Be at first we need the longer time to detect it and it’s based on the cases that we conduct”

“…If in the unit, it would be on the works specification training...that is claims settlements practices- this would include of the idea on the fraud detection and prevention. While, fraud claims detection is on the criteria to be consider. Then Cases and red flag indicators- we have the discussion among the officer and sharing the knowledge among departments…”

(Insurer/Ling Insurance Claim Officer)

“It is more to be the internal training. Through the company initiative in talk, courses. But for the outside training it would be on the main officer. After that this person going to sharing back the information with the junior officer in some discussion among us”

(Insurer/Ling Insurance Investigation Officer)

Ling Insurance pointed out that the training is not too important but will come simultaneously with the functions responsible by the department. The policy states that, training is mostly within the organization members and sometimes based on ad-hoc basis to highlight certain issues. Besides, it was observed that they sometimes organize a session that enables individuals to gain knowledge from others with formal training to stimulate the environment of information sharing, as Item 3.6. Ethical Insurance also has training conducted by
professional parties that enables attention to be drawn to the claim handlers regarding management issues surrounding fraud claims. This was stated as;

“...training that would be conducted is just up to department. More deeply we consider on the case need. Most of the times we have sharing the information on the case in order to make sure the awareness is higher in all the claim unit. We ensure the deliberate and sharing ideas always with us.”

“Not to miss out the MII sometime last time with PIAM do organized some courses that related to the countering the fraud but it stop right now...RMP and BNM sometimes bring the matters of the fraud to insurances companies that would be making the training with case studies method”

(Insurer/Ethical Insurance VP Claim)

“The training is highly based on the experiences because we sometimes make the session that just on the purpose of sharing and gathering the related information on the cases. Any outside workshop also been organized by the liquidators, it still based on skills and the ideas”

(Insurer/Ethical Insurance VP Investigation)

Based on observation of the training records, Ethical Insurance stressed that training is organized on a case basis with the accredited people mentoring the talks on issues of fraud. These trainings are presented by the BNM and the RMP, or their experienced members. They support ideas that claim officers are able to enrich their knowledge in a plenary session when they would be encouraged to share knowledge. Besides, during normal operation, workers are encouraged to voice critical suggestions which are observed during their day to day routine.

It can be somewhat concluded that the above suggests that all companies justify trainers in fraud and scam issues are respected people who are knowledgeable of the ethical framework in the company and professional, as Item 3.6. All the researched companies have at least some amount of proper training inside the organization and some obtain accreditation from the authority and professional bodies in the fraud claim management. Mostly, they are concerned with the aspect that is clearly linked with responsibility and practical conduct directly related to their work through training. The ordinal cumulative score from Table 6.6
for each company respectively are 9 for Amy Assurance, 10 for Ling Insurance and 11 for Ethical Insurance.

6.4.3 Propriety Checks

Propriety checks are the components for human resources that are always implemented to ensure reliable, relevant and objectivity of information provided by all parties involved inside or outside the company for validation. Table 6.7 below determines the effectiveness of the process being implemented by insures and the intensity of them which applies to the procedure of these checks.

Table 6.7: Item 3.7 and 3.8 CIPFA Red Book 2 for Evaluation of Insurers

<table>
<thead>
<tr>
<th>PROPERIETY CHECKS</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.7 Is there an effective propriety checking process?</td>
<td>P(2)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td>All applicants (including contractors, staff, promotions) for job are “vetted” by trained staff and outcomes determine what actions are taken</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applicants authorize propriety checks.</td>
<td>P(2)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td>Potential checks include identity, qualifications, address, references, employment, data matching and criminal records</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>3.8 Does the organization regularly review its propriety checking and are random checks carried out to ensure that it is implemented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The organization ensures that this customer screening process is robust. Initiatives may include reporting results, periodic independent review, spot checks, liaison agreement with stakeholder such as groups, agencies, professional bodies</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
</tbody>
</table>

From the table above, it can be seen that the companies’ somewhat make ‘tight checks’ on staffs that are responsible for claim handling and investigation works, Item 3.7. Based on the observation in all companies, the staffs are screened ‘simply’ on their background, such as
identity, educational qualifications, past experience, address, references and criminal record. The screening process, for the positions of claims officers and investigations officers is not very tight and is an internal procedure. Amy Assurance stated that;

“Not all people are going to be given the responsibilities that relate with the claim handling jobs exactly in the life insurance environments because we need the trustworthy person in order to ensure that there is no possible collusion with the outsider. Because of the tight screening it makes us always at the shortage numbers of staff but for sure it not that complicated”

(Insurer/Amy Assurance Claim Officer (CO) 1)

The company’s policy document also determines that the process is to concentrate on the person’s background because life policy would involve the lowest volume but higher amount claimed, making it risky for companies. Company officers are needed to give details of previous experience because there is few staff in these departments. While, Ling Insurance appears to have the propriety checks in order to ensure the person is credible and able to converse with customers.

“…we are expected the people that enables to talk to the customers and the penal regarding the claim issues with the proper and well adjust with the situation. If the check made some order that this person have the bad records on the mentally disturbed, he can’t managed the challenge”

(Insurer/Ling Insurance Investigation Officer)

Ling’s possible reason for this is the motor insurance claims industry needs diligent people who are able to build good relations with the customers. These people are expected to have the ability to conduct the preliminary investigations based on past experiences. Ethical Insurances propriety checks are made on a random basis according to demands by the management. This enables the management to estimate the ability of the claims and investigation units. Potential inclusion of the checks on the claimant is embedded in the companies claim system that can be directly reconciled if suspected cases appeared.

The function and methods of the propriety checks differ between companies but they have obtained objectives that are independent from the claim and investigation units in operation
regarding Item 3.8 either partially or fully. Amy Assurance had a moderate score as they only carried out checks on the customer based on random recommendations by the lawyer. The other two companies make checks on customers as part of fulfilling the tasks of the unit in each period of reconciliation. Hence, this is the bigger task as noted in both policies of the respective company. The ordinal cumulative score from Table 6.7 for each company respectively are 9 for Amy Assurance, 10 for Ling Insurance and 10 for Ethical Insurance.

6.4.4 Effective relationship with other organizations

The relationship of the environment with other related organizations is vital for survival in the insurance market. Table 6.8 below includes the initiative of making an agreement with outside parties, appropriateness of the collaboration, and intensity of meetings that renew and update the agreement of exchange benefits.

Table 6.8: Item 3.9, 3.10 and 3.11 CIPFA Red Book 2 for Evaluation of Insures

<table>
<thead>
<tr>
<th>DEVELOPING EFFECTIVE RELATIONSHIP WITH OTHER ORGANIZATION</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9 Are there framework agreements in place to work with other organizations and agencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships are agreed. This is intended to clarify issues such as responsibilities/obligations, exchange of information, liaison/communication/meeting with key personal. It can be accomplished through framework agreement, memoranda of understanding and service level agreements.</td>
<td>P(2)</td>
<td>P(2)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>3.10 Are the framework agreements focused on the practicalities of common work?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The agreement concentrates on issues that support effective operational cooperation i.e. mutual interest, viable and helpful agreement to deliver work that is not merely theoretical. Potentially such as joint planning and coordinated action.</td>
<td>P(2)</td>
<td>P(2)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>3.11 Are there regular meetings to implement and update these arrangements?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrangements are maintained and kept up to date and</td>
<td>C(0)</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
</tbody>
</table>
relevant. This may include inter-organization meetings and joint-review board specified in MoU’s as well as wider liaison/coordination through groups such as the local regional fraud forum.

Overall, from the above table, clear guidelines have been included in the manual of operation for all companies’ claim departments that they can share and create effective relations with all parties related to the claim function and investigative works item 3.9, 3.10 and 3.11 either partially or fully in agreement. The Amy Assurance officer noted that,

“We are going to cooperate with the other companies by the times we have been invited to have joining the meeting to settle the consensus that being sharing among us. We are going to have some cases when we have the fraudster that tries to cheat at one time with three different insurance companies. We can sit down and sharing the information that would benefit us in the operation”

(Insurer/Amy Assurance Claim Officer (CO) 2)

Based on the common agreement with their external party as lawyer and liquidity, the company is open to have a relationship in sharing common interests during the investigation and claim reporting but not fully in their main duties. It is the same for Ling Insurance who indicates that they are open to discussions with other insurers in order to obtain any updates on the types of fraud schemes. The company officers’ justified that the needs for these meetings are most of the time settled by the professional organization and is supported by other insurers.

In Ethical Insurance, from the observations made, the officers have regular meetings that are organized by the NICS and PIAM to handle some cases that have been involved more than one claim unit in different locations. The officers noted that,

“…we are going to have the regular general meeting among the claims society members in order to share some problems and also making some contributions towards the whole industry...We have the better organization that could make the job as the claim officers is not becoming isolated with others.

(Insurer/Ethical Insurance VP Claim)
Their staff statement showed that the claim officer’s society is progressive in order to share techniques and tactics that are related to their operationalization. From observation in the company, the officers are able to create their own social communities in order to have a better relationship that would benefit the claim department. In order to make it possible, it should have a genuine level of cooperation that enables contribution from all parties involved. Unfortunately, it was not possible to qualify the regularity of these meetings as all companies were reluctant to reveal this information as they consider it to be a personal matter. None of them were willing to share the meeting arrangements during the observation or interview sessions. This is because the claim and investigation truly involves sensitive data. The ordinal cumulative score from Table 6.8 for each company respectively are 4 for Amy Assurance, 4 for Ling Insurance and 6 for Ethical Insurance.

6.5 Conclusion

The strategy for the critical success factors towards countering fraud determined as the main nodes for championing the initiative for countering fraud for the insurers of this case study. By adopting a relevant, reliable, effective and objective strategy, a positive outcome for the initiatives is expected. While adopting various strategies, risks are the factors that should not be neglected because it optimizes the current initiatives. As for the life cycle, implementation and continuous improvement of the strategy can be enhanced by making some arrangement with other professionals that are more experienced, well-equipped, have a broader understanding and able to share collaboratively. The next chapter will concentrate on the implementation and define success areas for the initiatives of countering fraud on the selected case studies in Malaysia. Besides, it will supplement with the response from the follow-up survey done to the claim handler on the countering fraud issues.
CHAPTER 7

MALAYSIAN INSURANCE COMPANIES RESPONSES ON FULLY INTEGRATED ACTION PLAN, DEFINING SUCCESS FOR COUNTERING FRAUD & SURVEY OUTPUT

7.1 Introduction

Highly effective strategies are valuable when they are able to integrate action plans on the strategies listed and formulated. Within the common life circle, the corrective action would the subsequent action taken to ensure that the initiatives are not going to be superficial. At certain points, it is reminiscent for company to define their success of initiatives taken for certain issues. This chapter will discuss in-depth the action taken by insurance companies to tackle fraud by using the CIPFA Red Book 2, the evaluation continues from previous chapter and will also conclude the initiatives taken at company level. To enrich the experience on determining the appropriate level of countering fraud from the general public, the output of the survey gave some general picture on the issues.

7.2 Taking Action to Tackle the Problem

Great strategy and planning is more favourable when followed by appropriate integrated actions. In countering fraud it is important that all relevant elements for countering fraud are taken seriously to ensure efficient and effective initiatives. Table 7.1 below gauges the understanding regarding the seriousness of initiatives by case companies’ based on the implementation of their necessary action related to countering fraud.

Table 7.1: Item 4.1 CIPFA Red Book 2 for Evaluation on Insurers

<table>
<thead>
<tr>
<th>Taking the full range of actions and integrative different strands</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Is the organization undertaking the full range of necessary action</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A holistic approach is used incorporating action on culture, deterrence, prevention, detection, investigation, sanction and redress.

Based on the table above, companies researched take action in the different departments that considers a full holistic approach for countering fraud indicators either partially or fully. The partially are interpreted as the company has only taken certain numbers of action for countering fraud. Hereby, it showed that only Ling Insurance take full action regarding taking care of such problems and due to observation the structure comes from the company headquarters in the Netherlands. The department involved in the process would either inside or outside of the organization. The process considered is based on the claimed settlements and benefits paid operation only in the company. The ordinal cumulative score from Table 7.1 for each company respectively are 2 for Amy Assurance, 3 for Ling Insurance and 2 for Ethical Insurance. Table 7.2 below illustrates the picture of corroborative contribution by and for the holistic approach taken in the companies involved. The claim department is not involved in all those related to counter fraud action where it is separated in other departments.

Table 7.2 : The Department In The Organization That Contributes In The Holistic Approach Of Countering Fraud

<table>
<thead>
<tr>
<th>Counter fraud action/indicators</th>
<th>The units and departments involve with (by companies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy Assurance</td>
<td>Ling Insurance</td>
</tr>
<tr>
<td>Ethical Insurance</td>
<td></td>
</tr>
<tr>
<td><strong>Culture</strong></td>
<td></td>
</tr>
<tr>
<td>The whole units in organization</td>
<td>The whole units in organization</td>
</tr>
<tr>
<td>The whole units in organization</td>
<td>The whole units in organization</td>
</tr>
<tr>
<td><strong>Deterrence</strong></td>
<td></td>
</tr>
<tr>
<td>The investigation unit only</td>
<td>The investigation units</td>
</tr>
<tr>
<td>Penal lawyer</td>
<td>The claim adjustors</td>
</tr>
<tr>
<td>The investigation unit</td>
<td>The investigation units</td>
</tr>
<tr>
<td>only</td>
<td>The claim adjustors</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
</tr>
<tr>
<td>The internal audit</td>
<td>The claim department</td>
</tr>
<tr>
<td>The claim department</td>
<td>The claim department</td>
</tr>
<tr>
<td>The claim department</td>
<td>The investigation unit</td>
</tr>
<tr>
<td>The claim department</td>
<td></td>
</tr>
<tr>
<td><strong>Detection</strong></td>
<td></td>
</tr>
<tr>
<td>The claim department</td>
<td>The claim department</td>
</tr>
<tr>
<td>The claim department</td>
<td>The claim department</td>
</tr>
<tr>
<td>The claim department</td>
<td></td>
</tr>
</tbody>
</table>
### Investigation

<table>
<thead>
<tr>
<th>Department</th>
<th>The claim department</th>
<th>The adjustors</th>
<th>The lawyer</th>
</tr>
</thead>
<tbody>
<tr>
<td>The adjustors</td>
<td>The investigation department</td>
<td>Claim fraud management unit</td>
<td>The lawyer</td>
</tr>
</tbody>
</table>

### Sanctions

<table>
<thead>
<tr>
<th>Department</th>
<th>The internal audit</th>
<th>The corporate audit services</th>
<th>The investigation department</th>
</tr>
</thead>
<tbody>
<tr>
<td>The internal audit</td>
<td>The investigation department</td>
<td>Claim fraud management unit</td>
<td>The adjustors</td>
</tr>
<tr>
<td>The investigation department</td>
<td>The claim department</td>
<td>Adjustors/liquidator</td>
<td>The lawyer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claim committees</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head of benefit</td>
<td></td>
</tr>
</tbody>
</table>

### Redress

<table>
<thead>
<tr>
<th>Department</th>
<th>Internal audit</th>
<th>Claim committees</th>
<th>The management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim department</td>
<td>Management</td>
<td>The claim department</td>
<td></td>
</tr>
</tbody>
</table>

## 7.2.1 Culture

Culture is the motivational element that needs to be highlighted in the organization to ensure the spirit of anti-fraud is always in any department. Table 7.3 below showed consideration of the existence of anti-fraud programs to nurture culture, clear objective to work on the goodwill of the organization, effective program to evaluate fraudulent action, arrangements are related to the whole aspect of the organization and all the stakeholders being clear on anticipated ideas or initiative needs.

Table 7.3: Item 4.2 to 4.7 CIPFA Red Book 2 on Culture for Insurers Evaluations

<table>
<thead>
<tr>
<th>TAKING ACTION TO TACKLE THE PROBLEM—CULTURE</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2 Does the organization have a clear programme of work attempting to create a real anti-fraud and corruption and zero</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

199
tolerance culture (including strong arrangements to facilitate whistle blowing)?

| The strategy and work programme address the approach to culture and change. | C(0) | Y(3) | P(2) |

The strategy is publicized, promoted and commits to protecting those who report instances of misconduct.

| Actions may include face to face fraud awareness training/ campaigns/ presentations/ refreshers/ inductions, hotlines/mailboxes, delivering communication strategy and electronic/ hard copy information/ newsletters/ surveys/ producing documentation to contribute induction packs/ leaflets/posters | P(2) | Y(3) | Y(3) |

The aim is to involve the honest majority in owning the approach and creating a supportive culture that counters fraud.

| 4.3 Are there clear goals for this work (to maximize the percentage of staff and public recognize their responsibilities to protect the organization and their resources?) | P(2) | P(2) | P(2) |

Target and timelines are established for work on culture

| 4.4 Is this programme of work being effectively implemented? | N(1) | Y(3) | C(0) |

Action is planned (for instance to present at all inductions sessions), delivered and results are measured (for instance
<table>
<thead>
<tr>
<th>Question</th>
<th>N(1)</th>
<th>P(2)</th>
<th>P(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5 Are these arrangements in place to evaluate the extent to which a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>real anti-fraud and corruption culture exists or is developing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>throughout the organization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff awareness is measured through a questionnaire. The sources of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>referrals are categorized and assessed for cultural implications.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other indicators are noted-these may include requests for the input/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>advice of counter fraud professionals and the degree of cooperation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>on the counter fraud work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6 Are agreements in place with stakeholder representatives to work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>together to counter fraud and corruption?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreement such as charter/ protocols/ partnership agreement with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>staffs groups/professions/unions. Operational staff are involved in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>identifying fraud risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.7 Have arrangements been made to ensure that stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>representatives benefit from successful counter fraud and corruption</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>work?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stakeholders obtain return on investment in term of loss prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and actual recoveries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feedback is provided so that remedial action can be taken and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>recovered losses are returned.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial recoveries and loss prevention goes to, or stays with, the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stakeholder.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
From the table above, Ling and Ethical stated that the anti-fraud culture is the most essential part which is emphasized by the management in all units involved with claims and investigation part. They instil in all employees through strategy, program and communication that is circulated to all levels of operation, as per item 4.2. In Amy Assurance, it cannot be directly determined because the program has been organized and while they have tried to attract the involvement of the honest majority to support the anti-fraud culture, they do not have a strategy or action which can be implemented directly. It was noted that:

“..The company always ensure that the anti-fraud is not only being in one specific unit but all units would work together within the Amy Assurance to ensure that we be able to work as a team. We are making a clear intention and objective in the claim department that the claim supposed to be free of the fraudulent elements in order to reduce the losses to the company to ensure everybody noticed the intention. We also make sure everybody will work on their best either inside or outside people”

(Insurer/Amy Assurance CO Claim Officer 2)

This statement does not prove that Amy Assurance have set reliable and realistic targets that should be achieved by the officers in the Claims Department that would ensure that fraud would not affect the normal cause of the operation. Nonetheless, they noted in the observation that the company always ensures that elements of the anti-fraud culture will always take first priority. While, Ling Insurance department supports they also note during the session that the culture of hatred to fraud and highlight fraud as a serious threat which is the responsibility of the whole organization. From the observation in the company, it appeared that they make their aims and strategies are placed in the Fraud Management Unit to ensure that everybody is familiar with their policy and able to work successfully. Nevertheless, the strategy taken is not well promoted to outside parties. They carry out certain actions as mentioned in the guidelines of the unit and noted during the interview that;

“The fraud awareness management will be the important concern within the whole unit workers and customers regarding the claims. So, the involvements in Claims Committee are going to be setting up from the head of each insurance product line that is individual life, general insurance and employee benefits”

(Insurer/Ling Insurance Claim Officer)

Also included in some of the internal documentation that was;
“.. Task of Claim Fraud Management Unit…Review and recommend necessary amendment to the Fraud Management set-up and framework for business management’s approval. Such approval will subsequently be tabled to the BOD for endorsement.”

(Documents/Ling Insurance Claim Fraud Management Framework v1)

In Ling Insurance, the front level people that accept the claims at the registration procedure are well-trained officers with the behavioural aspects of the claims. They noted in the interview that;

“..the process of receiving and registration of the claim need to be compulsory been trained the behavioural aspect of the fraudster…After all we have been clarify the ideas of what is the fraud and how it will causes the bad reputation towards our operation..”

(Insurer/Ling Insurance Investigation Officer)

The training noted above shows that all officers are aware that fraud is detrimental to the organization. They understand the attributes of fraudulent acts and at the same time are aware of the cause and effect of fraud on the company and society in general. They publicize this to the employees and the agents to ensure the culture of anti-fraud is their major concern. This is quite an effective strategy as the company benefits for creating a good culture.

Ethical noted that they have concerns for the culture of anti-fraud on a centralized management level and this can be noted as a partial approach on creating the specified culture. The investigators in the company also mentioned during the interview that;

“..Since the company is one of the subsidiaries of the big banking chains, the concerns of the anti-fraud culture in the financial market are over exposed to the each of the employees in the organization. We have the internal audit departments sometimes that have the set of questions that would justify the response from each level of employee on the fraud ideas and the bad impacts towards the organization...”

“We instil to all the employees, branch workers, managements and specially agents on the ideas of the anti-fraud in the whole company structure. They need to understand it
to ensure that they are not trying to make something on their own benefits that would neglect their main responsible to the company’s core operation. They have been highlight through the management expectations set that the fraud is the major concerns for the employee. For the customer, we have the declaration of statutory rights when they make a claim. Here they will justifies that all information provided is right”

(Insurer/Ethical Insurance VP Investigation)

From the interview above, it clearly supports that the culture of anti-fraud is widely known in the company and outside of the organization. They also manage to introduce it at the early stages when all individuals create relations with the whole organization. Besides, the implementation carried out by the internal audit departments in Ethical Insurance can be the best example that the insurance company is aware and always ensures the whole organization and officers have ideas on anti-fraud. They have their own concepts and programs that have been introduced from time to time for members of staff regarding the anti-fraud arrangement but it is in the preliminary phases of implementation. This can be noted as first action to create good culture.

Ling Insurance is the only company that has specific targets and timelines regarding the responsibility of staff in order to protect the company that compares with the Claims Fraud Management Framework, Item 4. It was observed that the company had a questionnaire regarding culture on fraud cases compared to others. This is done every 6 months within the claim officer environment. It was noted during the interview that;

“The time is most crucial in all established the framework that enables to make the specific outcomes from the environments. The committees will endorse and make the recommendation on the change to the culture about every 2 years period in order to make specific arrangement to ensure every aspect to be reconsidered in the companies.”

(Insurer/Ling Insurance Investigation Officer)

Meanwhile, in Ethical targets and timelines cannot be determined as the company treats it as an internal matter in relation to the auditors. In Amy Assurance, there is no specific
arrangement to cater for the problems as the culture dimension is not a significant concern in the department operation.

Overall, none of the companies collect feedback or data to ensure that implementation through programs are effectively used to enhance the ability of the officers to mitigate fraud and corruption cases, Item 4.4.

While almost none of the companies are ‘well-planned’ to introduce anti-fraud culture to be included in the induction sessions as per Item 4.5. The staff awareness of anti-fraud culture is always measured through a questionnaire in Ling Insurance when the company render Approved Forensic Investigation Group services that make assessments in the claim unit’s awareness and anti-fraud culture is part of it. While, Ethical Insurance has arranged to assess the culture awareness program through the courses by the Licensed Adjustors towards their employees and main companies’ customer.

Agreement to work together on the counter fraud initiatives is also one of the major parts in the anti-fraud culture that was found to be only partially imposed in all of the companies. They have different implementations that highlight the initiatives through the client charter, framework, operation protocol and agreement with outsiders, Item 4.6. Amy Assurance stated that they take the ideas of arrangements on agreement with the company lawyer. During the internal documentation inspection, the company have proper contract with the law firms that would be the panel, the fees on the cases and the circumstances that would be involved between the parties. They stated during the interview that;

“We do have the initiatives and the program with the company lawyer that always making the units is highly considerate on the cases, features and attributes towards the fraudulent latest ideas. We have the agreement together that ensure they will always support us with the technical and settling issues ideas. It is sort like the service to us...”

(Insurer/Amy Assurance CO Claim Officer 1)

Ling Insurance has a protocol and agreement to countering fraud within the Claim Fraud Management Framework and it just noted certain protocol seriousness in the agreement of the
framework without any legal concerns. The meeting among the committee members are rarely organized it is not based periodically. Some of the incept from the framework is;

“For the Claim Fraud Management to function from ground zero, there has to be an experienced core team who is proficient in investigation matters with expertise in medico-legal matters to drive the function. The team should consist of members who are well versed with the business as well as those with the relevant expertise required.

“The objective of this framework is to have a comprehensive and effective strategy to combat fraud against or within the Company”

(Documents/Ling Insurance Claim Fraud Management Framework v1)

On Ethical Insurance, they have arrangements which are included in the policy statement of the fraud reporting but again it cannot be fully agreed because this is at a general or macro level of financial services operation. The incept from the documents that can be noted as;

“The purpose of the policy is to have a coordinated approach in dealing with suspected fraudulent activities and to avoid damaging reputation of the persons suspected but subsequently found innocent of wrongful conduct and to protect the Group from potential civil liability”

(Documents/Fraud Reporting Policy M Holdings Berhad)

Only Ling Insurance and Ethical Insurance highlight the potential benefit to their stakeholders directly if they are successful in countering fraud, Item 4.7. Both companies include an official statement of the policy that are respectively Claim Fraud Management Framework and Fraud Reporting Policy. Ling Policy has stated about potential benefit of countering fraud as it ensures no suffering from material financial and reputation losses and also the liabilities of the parties. While, in the Ethical, the policy only can be justified as partial because they have just noted that the intention of countering fraud is to protect the assets and shareholder wealth for the company only without the details amount liable for.

As for the feedback and financial recoveries towards the stakeholder’s information, no companies discussed on the matter since it depends on the managerial tactics to tackle the interest of the party involved with the company. The ordinal cumulative score from Table 7.3
for each company respectively are 11 for Amy Assurance, 21 for Ling Insurance and 16 for Ethical Insurance.

### 7.2.2 Deterrence

Deterrence is more important in certain types of organizations and is proven effective in insurance companies because it can be included in the contractual agreement. Table 7.4 below shows the viability of deterrence effects, availability of specific deterrence programs, initiatives of deterrence well known in the public and the objective of it to reduce loss.

Table 7.4: Item 4.8 to 4.11 CIPFA Red Book 2 on Deterrence for Insurers Evaluation

<table>
<thead>
<tr>
<th>TAKING ACTION TO TACKLE THE PROBLEM- DETERRENCE</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.8 Does the organization have a clear programme of work attempting to create a strong deterrence effect?</td>
<td>N(1)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td>A specific programme aimed at deterrence. Proactive work-communication, establishing agreement with stake holders, induction, other events, training, creating disincentives such as sanction and redress are all things contributed to deterrence. Aimed at staff, service users, service providers, partners.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.9 Does the organization have a clear programme of work to publicise the: -hostility of the honest majority to fraud and corruption -effectiveness of pre-emptive arrangements -Sophistication of arrangements to detect fraud and corruption</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- professionalism of those investigating fraud and corruption and their ability to uncover evidence;  
- likelihood of proportionate sanctions being applied; and  
- likelihood of losses being recovered?

<table>
<thead>
<tr>
<th>Needs</th>
<th>C(0)</th>
<th>Y(3)</th>
<th>N(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal and external publicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forge relationship, take advice from, and involve the organization’s press officer.</td>
<td>N(1)</td>
<td>N(1)</td>
<td>N(1)</td>
</tr>
<tr>
<td>In-year report, annual reports, survey results, policies, plans, initiatives, payslip information, report case outcomes, emails.</td>
<td>P(2)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td>Press releases, newspaper/ magazines articles, tv, radio and media briefings.</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td>To provide the clear message that organization is serious about countering fraud</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td>Demonstrating the impact by highlighting successes</td>
<td>C(0)</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
<tr>
<td>Making clear potential fraudsters are up against active, dedicated professionals who may have many advantages over them (such as the law, training, organization support, access, data, resources)</td>
<td>N(1)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td>4.10 Has the organization successfully publicized work in this area?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results- such as: hits on the intranet site, press release, leading to inclusion by the publication, distribution level (e.g. local/national/international), appearance</td>
<td>C(0)</td>
<td>P(2)</td>
<td>C(0)</td>
</tr>
</tbody>
</table>
in electronic alerts, survey measurements of staff/public awareness, feedback

4.11 Has the publicity been targeted at the areas of greatest fraud loss?

The appropriate publicity initiatives/methods are consciously considered in plans, initiatives and specific cases.

<table>
<thead>
<tr>
<th>C(0)</th>
<th>Y(3)</th>
<th>C(0)</th>
</tr>
</thead>
</table>

The intended result being achieved the highest level of fraud deterrence impact by employing the most fitting approach to publicity.

With reference to Item 4.8 on the table above, Amy Assurance do not have a clear deterrence programme if compared to the other two companies; this is because the company did not include deterrence as one of their actions in fraud mitigating initiatives. The deterrence program can be deemed as partial in Ling Insurance and Ethical Insurance, when they have a better framework that can demonstrate the seriousness for the company to counter fraud with a proper deterrence model. Through observation in Ling Insurance, the company designed a documentation known as the Claim Fraud Management Framework with the committees from all departments to ensure the involvement of all employees and also, it is accessible in their own intranet. This framework will actually bring together the whole process and determine the output to the last person’s interest. The mission statements for the framework were noted as;

“The development and implementation of an organizational claims fraud management framework within the Ling Insurance, leading to better management insight on the claim management, better understanding of the legal implications, improved claims ratio, improved operational controls and operational risk profile which fits the risk appetite of the management”

(Documents/Ling Insurance Claim Fraud Management Framework V1)

From the notation included in Ling Insurance’s mission statement of the framework it can be digested that the expectation of management in deterrence will be included in the circulated
documents inside the claim and investigation units of the company. They also understand and try to give feedback towards the framework that has been laid out in order to ensure correct management of fraud cases.

While in Ethical Insurance, the Fraud Reporting Policy shows that the intention of the policy is to create a strong deterrence effect. The reporting policy stated that the most fundamental ideas that need to be achieved by the policies are;

“The policy would promote the culture of honesty, openness and accountability within the Group of company.”
“Have a coordinated approach in dealing with suspected fraudulent activities and to avoid damaging the reputation of the persons suspected but subsequently found innocent of wrongful conduct and to protect the Group from potential civil liability”
“Raise awareness of fraud among staff and provide them guidance on the action to be taken when they suspected any fraudulent activity”

(Extract from Documents/Fraud Reporting Policy for M Holding Berhad)

The purpose of the policy is to determine that the company successfully disseminates information regarding fraud policy and expect that employees and members of staff would be able to use the policy suggested in a proper manner. This means the deterrence ideas have been put in the policy which is in the company’s own interest.

Item 4.9, relating to the publicity of deterrence effects to ensure that the framework is designed to support deterrence ideas, only Ling Insurance have internal and external publicity. The two other companies have this only partially for company employees. This can be justified through the interview where it was noted that;

“the company always try to announced to all stakeholders if the company involved with any subsequence effect with the big fraud cases. They will ensure everybody knew and the main aim to deliver the feeling of unsafe to making fraud in our company.”

(Insurer/Ling Insurance Claim Officer)
Besides Ling Insurance, none of the other companies are involved in public relation works that announce to the general public about any cases and investigations regarding any fraud cases. However, all companies partially deliver an annual report, press release and mission. Despite these facts, the companies take countering fraud extremely seriously. This can be acknowledged through the Annual Reports years 2005 to 2011 of Amy Assurance, Ling Insurance and Ethical Insurance. These annual reports can be obtained through the company websites or the Malaysia Bursar announcement, which also sometimes includes a summary of the Internal Audit Report. While, in the Director’s Report, it was merely mentioned that lately after the Central Bank keep repeating the seriousness of the matter, the companies started to respond but this was insufficient in their reports.

Against none of the company can’t be determine having highlight the success because they are trying to reduce the possibilities of disclose individuals or customers name in the general public, Item 4.10 and only Ling Insurance are making some simple press release and inclusion on their 2010 Annual Reports. Most of the companies just merely attach the potential insurance fraud in the markets based on the general information pamphlet that are produced by the PIAM and BNM.

Only Ling Insurance appear to have some initiatives to publish regarding the success story of countering fraud that is disclosed through international electronic media and noted;

“We do manage to make the publication in the regional office medias about the jointly initiatives with the professional on the publication of the framework as the guidelines inside the organization”

(Insurer/Ling Insurance Claim Officer)

Considering publicity, it can be determined that all the companies agree that they publish only specific areas based on the interest given which is determined by the committee. Not all areas of countering fraud works are disclosed because they still contain certain confidential matters that always need the approval of internal audits. In most cases, Ling Insurance stated that they are trying to ensure publicity is achieved and the intended outcome is to ensure they create appropriate publicity as in Item 4.11. They stated that;
“Our selected publicity are based upon the initiative that it would attract the customers confidence and the worker motivations in work. We want to put trust in our product as the philosophy of our product that let we manage the benefits of yours”

(Insurer/Ling Insurance Investigation Officer)

The ordinal cumulative score from Table 7.4 for each company respectively are 9 for Amy Assurance, 23 for Ling Insurance and 12 for Ethical Insurance.

7.2.3 Prevention

Prevention is the best single initiative but may bring the biggest impact in the operation of the company where it can be included through contract or through public announcement programs. Table 7.5 determines the preventative elements such as planning of anti-fraud policies; reducing the reporting deviance, and priority to corrective action.

Table 7.5: Items 4.12 to 4.14 CIPFA Red Book 2 on Prevention for Insurers Evaluation

<table>
<thead>
<tr>
<th>TAKING ACTION TO TACKLE THE PROBLEM- PREVENTION</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.12 Does the organization seek the design fraud and corruption out of new policies and systems and to revise existing ones to remove apparent weaknesses?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraud proof procedures/ systems to avoid occurrence &amp; re occurrence of fraud</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Protect ability to prosecute by demonstrating organizational effort to counter fraud.</td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Involve and encourage staff to identify weaknesses.</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Link to and act to, results of reviews.</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td>4.13 Do concluding reports on investigations include a specific section on identified policy and system weaknesses that allowed the fraud and</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

212
corruption to take place?

<table>
<thead>
<tr>
<th>Report highlight weaknesses, agreement is reached to address and follow up take place to confirm action.</th>
<th>P(2)</th>
<th>Y(3)</th>
<th>P(2)</th>
</tr>
</thead>
</table>

4.14 Is there a system for considering and prioritizing action to remove these identified weaknesses?

<table>
<thead>
<tr>
<th>A clear system is in place which grades system/procedure weaknesses and assigns responsibility for change implementation within a timescale.</th>
<th>C(0)</th>
<th>P(2)</th>
<th>C(0)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Counter fraud plans include post case follow up.</th>
<th>C(0)</th>
<th>C(0)</th>
<th>C(0)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Audit committee reports/discussion/review/input/influence/monitoring/sign-off</th>
<th>P(2)</th>
<th>Y(3)</th>
<th>Y(3)</th>
</tr>
</thead>
</table>

Based on the table, it can be noticed that the companies' create an internal audit assessment in the claims department to ensure that they have a fraud procedure that can avoid the occurrence and re-occurrence of the illegal activities, Item 4.12. They all have the assessment on the weaknesses of the current policy and solutions to increase the effectiveness of the claim policy and it can be partially agreed for Amy Assurance. Mostly, all companies include this activity within their manual of daily working operation the aspects of corrective action. Nevertheless, Amy Assurance rejected to act upon the result of reviews because they are not entirely relying to the ideas from the internal audit department. For the other two companies, they are taking reciprocal action as the investigation and claims unit are attempting to act on their weakness from the review.

Amy Assurance prevention is considered an improvement of the strategies based on a case basis as it includes the internal audit manual of the companies. For example, to cater for life fraud claims, these would be based on the practitioner’s suggestions in the case. It was noted in the officers statements that;

“Each times when we have the difficulty on the certain elements of the potential fraudulent of the case ...we will back to our lawyer or the penal adjustors. We will refer back to them and make some improvement to our current policy practices…”

213
“Not all the case will be the same if consider on the death claim the prevention is through the first screening on the documentation when they submitted the claim. The originality is important and it comes directly from the authority that can produce the documents in the genuine and originality manners”

(Insurer/Amy Assurance CO Claim Officer 2)

Amy Assurance look at changes on the policy practice based on the suggestions by the related party involved in the operation. They look at the case basis for ideas of prevention and it is selective on certain types of claims. Thus, only the most likely fraud cases would come into consideration. This is most likely to emboss the prevention already being instilled within the ‘Statutory Declaration’ which is included in the claims forms during registration of the claims.

While, for Ling Insurance improvements of their preventative steps are with the committees engaged in the Claim Fraud Management Unit. This has specific responsibilities as noted in the framework except that;

“The unit need to collate and compile statistics for further analysis to determine or prove trends, which may relevant as the guidance for some fraudulent cases”
“The unit periodically brief and highlight new analyses and trends to claim assessors so that the red flag indicators can be used to flag out potential claims for confirmation of the suspicion”

(Documents/Claim Fraud Management Framework v.1)

Through the written objectives, it was noted the company utilizes the committees in identifying the weaknesses that would be considered by the accessory in claim handling departments, Item 4.13. Ling Insurances' also have clear assignments based on the responsibility charts in the framework which is to ensure that prevention is effective. Ethical Insurance reported regarding their fraud reporting policy that;

“Any frauds in relation to insurance claim involving policyholders, third-party claimants and/or professionals or service providers acting on behalf of the policyholders or third –party shall be handled by the Claims Department (Life and Non-Life)”
“A standard practice instruction (SPI) on IMDC as issued by the ORM, Risk Management in Parent Companies in July 2006 for the Group Company. It provide the process and systems to manage and report individual operational incidents which occurred within Group of Company, from the point of discovery until resolution”

(Document/Fraud Reporting Policy for M Holdings Berhad)

Ethical Insurance indicate through documents that they give the full responsible of prevention to the claims departments as the authority for the whole function for making corrective action towards the procedure weaknesses. Besides, if the cases involve inside personal, it would be related to the SPI, which was noted to be responsible from the beginning to the end of the case. The ideas of prevention in ISP are solely based on the work done by the internal audit function.

In Amy Assurance, there is no clear automated system which determines the procedures for weaknesses and changes within a time scale. While for Ling Insurance, it exists when the Claim Fraud Management Framework directly determines the time period of reviewing back the action to counter fraud in the claims unit that is estimated in every 2 years.

While Ethical Insurances state that they also have a clear system for making adjustments in the claim reporting policy as;

“the internal audit would able making any arrangement and adjustment on the task and responsibilities of the countering fraud based on the weaknesses determined. The revision time based on the management discretionary”

(Document/Fraud Reporting Policy for M Holdings Berhad)

Only Ling Insurance noted that counter fraud plans can be assumed as integrated plan activities that would include – posting case follow up, thus partially agreeing with Item 4.14. The audit committee works for reporting the case and implementing it in all companies either partially or fully. It is to ensure that the case would not be repeated and that red flags are always highlighted as the cases are reported in the BNM system known as E-Fids (electronic fraud information database). This stores the name and companies log record of expected and fraud practice as a possible alarm notice to all insurers. Additionally, the audit committees report is also the most common referred report used by all the researched companies, in
determining preventive measures based on the lack of control procedures in the operation that is overrun by the fraudster. The ordinal cumulative score from Table 7.5 for each company respectively are 11 for Amy Assurance, 20 for Ling Insurance and 16 for Ethical Insurance.

### 7.2.4 Detection

Detection is the activities that are undertaken in the normal operation procedure of the insurance claims unit. Proactive and effective detection would enable fraudulent claims to be discovered starting from the submission of forms. Earlier detection is able to reduce the loss for the insurers. Table 7.6 below determines an existing effective whistle blowing policy, intelligence techniques, multiple methods that best work together, and response to detection is effectively reported, investigated and activated.

Table 7.6: Items 4.15 till 4.20 from CIPFA Red Book 2 on Detection For Insurers Evaluations

<table>
<thead>
<tr>
<th>TAKING ACTION TO TACKLE THE PROBLEM- DETECTION</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.15 Are there effective ‘whistle-blowing’ arrangements in place?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A well ‘publicized’, user friendly and readily accessible policy and process is in place</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Fraud suspicions are dealt with counter fraud professionals</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>Internal and external hotline and ready access to counter fraud staff in place</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td>The sources and nature of disclosures is monitored</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>4.16 Are analytical intelligence techniques used to identify potential fraud and corruption?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data matching initiatives are carried out and acted upon. Variances analysis is undertaken across a range of activities.</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td><strong>Unusual trends/ anomalies indicating potential fraud. Information from external is included</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Counter fraud staff can build pictures of transactions/ activity that is indicative/ provide evidence of fraud.</strong></td>
<td>P(2)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td><strong>4.17 Are there effective arrangements for collating, sharing and analysing intelligence?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data warehousing is used to collect and analyse data from a variety of sources.</strong></td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td><strong>Counter fraud professionals are aware of the consequences of Data Protection on data sharing.</strong></td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td><strong>Memorandum of understanding are exists on the sharing data between organization</strong></td>
<td>C(0)</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
<tr>
<td><strong>Connections are made between individual pieces of intelligences gathered.</strong></td>
<td>C(0)</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
<tr>
<td><strong>4.18 Are the arrangements in place to ensure that suspected cases of fraud or corruption are reported promptly to the appropriate person for further action?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A fraud response plan is in all cases of suspected fraud.</strong></td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td><strong>The organization has a clear policy on the reporting of actual or suspected fraud/crimes/misconduct</strong></td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td><strong>Induction training, on-going staff awareness training, staff employment contract requirement to adhere to above</strong></td>
<td>C(0)</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
<tr>
<td><strong>Suspected cases are reported to and investigations are only undertaken by trained counter fraud professionals,</strong></td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
</tbody>
</table>
Evidence is not compromised.

| 4.19 Are arrangements in place to ensure that identified potential cases are promptly and appropriately investigated? | Y(3) | Y(3) | Y(3) |
| All fraud referrals are risk assessed and timescales are agreed for the completion of all investigations, taking account of potential further evidence and finance. Action is undertaken within operational manual and code of conduct requirements. | |
| 4.20 Are proactive exercises undertaken in key areas of fraud risk or known systems weaknesses? | Y(3) | Y(3) | C(0) |
| A proactive fraud plan is developed based upon an assessment of known fraud risks. | |
| Counter fraud resources are directed to areas with the greatest potential benefits. | C(0) | C(0) | C(0) |

From the table above regarding Item 4.15, a whistle blowing policy exists in all the companies' and they make it publicly known with professional support. These policies are involved with all kinds of the fraud either dealing with an insider or outsider, and the nature of the information is directly disclosed during the investigation period. However for the hotline, based on the observation, only Ling Insurance makes it publicly available but Ethical Insurance remains silent even though the system exists. Once again, it cannot be determined whether Amy Assurance have their own or an outside hotline. Regarding the policy, Amy Assurance officers do support that;

“The company group have the whistle blowing policy that been always updated by the company lawyers and it can become the best to ensure that we can detect through the report coming to use. Even though sometime the detection is most on the work done by the officer in the operation”

(Insurer/Amy Assurance CO Claim Officer 1)
While, Ling Insurance determined in the interview that;

“Whistle-blowing policy is the tipping that can direct the investigation to the case. But sometimes we make the follow up base on the indicators determine then the witness are more towards to telling the truth. The internal course of fraud also uses this method to ensure the better report on the activity of countering fraud. We have the code of ethics for the reporter”

(Insurer/Ling Insurance Claim Officer)

Ethical Insurance noted in the policy that;

“Fraud Reporting Hotline is a reporting mechanism for all employees under M Group to raise their concerns via secured and protected facilities, which are managed and controlled by an authorized Senior Management staff of Band E and above. The details is in the Fraud Reporting Hotline Handbook published in July 2004”

(Documents/Fraud Reporting Policy for M Holdings Berhad)

The method of detection in the companies can be categorized based on a case basis idea without the use of any particular sophisticated tools apart from early detection where they have certain guidelines embedded in the claim registration systems, Item 4.16. There are no data matching techniques that can be determined in Amy Assurance, while a simple method is used by Ethical. While, the Ling Officer uses the intelligence technique database on the matters through invigilation of the company system in the observation stages. All the companies agreed that they rely on the ability of experienced staff to sense the probability of fraudulent claims based on trends and previous ideas. Amy Assurance stated during the interviews that;

“Normally by verifying the original documents...If in the branch, branch officer and branch manager have authority to verify it and also for the customer care department, officers have to view the original documents. Justify the originality. It based on the types of the claims…Death claims is straight forward…If neutral kind of illness is nothing to verify on unless looking to any circumstances; hanging or
murdered...Death overseas need to be very careful...Look to country where the events happen. If develop country like US, it easy to trace back the place that the events happened, some places like India, it is difficult for you to go back to where the actual place taken...Questionable whether the documents release is the original or the forged one.”

“Sometime we based on the analysis. But most of the time it on the human sense-cannot use the system. It based on the experience...when you work longer in the department then you will have more experiences. It just like six sense...You can remember the case pattern actually- Based on personal justification”

(Insurer/Amy Assurance CO Claim Officer 1)

The company practise is to use an early detection method in the documentation with an officer who is able to verify claims authentication. The customers always fail on the first screening when they have been detected through the processing system. Nonetheless, it still depends on the experiences of recurring case facts and patterns. This takes a longer period of experience and real case exposures.

Ling Insurance stated that detection and conformity are simultaneous actions carried out through the setting up of the Claims Fraud Management Unit. From the documentation inspection, it was observed that they normally carry out the required actions such as;

“Study and identify unusual trend within the claim pattern for possible tagging by way of red flag indicators”
“Setting the parameters on instances in respect of the tagging of red flag and the follow through process to preserve evidences of this nature”
“Where necessary, conduct visits to the hospitals, clinics and/or workshops to ascertain and verify the situation as indicated in the trends analysis”

(Documents/Ling Insurance Claim Fraud Management Framework)

Ling Insurance clearly indicates red flags for cases based on previous experience and add supplement guidelines by the professional bodies, Item 4.17. Then, they carry out analysis to detect the evidence by tagging and confirming to clients and other related parties. The arrangement in Ling appears to be appropriate, as at the end of a period they can justify whether or not to seek help from outside parties. Ethical Insurance’s procedure, regarding
detection of suspected insurance claims is the task of the claim department, which is done solely by the claim officers, who stated that;

“We always tell the officer to checks on the indicators/pointers…it is based on the pointer…Even like car theft,…In car insurance, It could fix up…We asked to call the financial, check the loan, even he services the car, if the default in long period…It might be the pointers…Based on the same document…We asked the original one”

“Fraud detection is through experiences and come with the few pointers i.e. looking at the dates, any inconsistencies and also point of the impact”

“It will be based on the analysis, experience… Then it would be highlight to the adjuster”

(Insurer/Ethical Insurance VP Claim)

Ethical Insurance also utilizes red flag pointers similar as Ling Insurance. They then carry out an analysis and with experience; it helps in interpreting the possible fraud case based on details. Following this, the preliminary works are passed through to the adjusters who are involved in the case. It can be concluded here that, all of the companies use the same procedures of initial investigation but in Ling Insurances it is more centralized and committees are involved with all methods of detection. While the other two companies, the operation is to gather the supportive detection before the ‘suspected fraud case’ is brought to management level.

None of the companies are able to confirm whether they are willing to share the data between the organizations while other two justified that sharing can be possible based on mutual interest but currently there is no proper arrangement. This may be due to the unit response on the study having limited sources. Meanwhile, none of them are able to show connections made between individuals that have intelligence to be gathered together in the cases.

All study companies agree on the idea that they have fraud responses plans and a clear imposed policy to report fraud and corruption cases in normal company conducts Item 4.18. Only Ethical Insurance has determined that they include regular training for staff because they are aware of the sophistication of the situation in the detection of cases changing by technology advancement. After detection, all the researched companies agreed that the suspected cases would be investigated by trained professionals and initial evidence collected
would be submitted. The money loss adjuster, private investigators or liquidator are the main parties involved in the investigations because they are trained and accredited by the enforcement and regulatory bodies.

Besides, only Ling Company has clear guidelines on conducting initial investigation after detection, Item 4.20. It is followed by certain ethical policies to classify the evidence and they need to ensure all supportive evidence is handled by the appointed professional investigator. While, in Ling Insurance they have produced a proactive plan which was noted as;

“We have developed the framework based on the ideas that we know the possibilities on the fraud keep increasing in this modern world and the economic situation when everybody are opportunist. So, the involvement from the detection until full report of investigation presented will be among all the committees’ members of claim unit that is officers and managers”

(Insurer/Ling Insurance Claim Officer)

Meanwhile, none of the other companies agreed on the ideas that fraud detection is directed to the areas that have the greatest potential because they cannot justify the greatest potential benefit. They felt that detection initiatives were embedded in the normal routine of works. The ordinal cumulative score from Table 7.6 for each company respectively are 27 for Amy Assurance, 38 for Ling Insurance and 33 for Ethical Insurance.

7.2.5 Investigation
The investigation is the steps taken by using internal or external capacities in the insurers in order to confirm facts of the cases and details through a proper circulated work. Following an investigation the next order of action can be decided and a follow up action can be taken. Table 7.7 below determines the effectiveness of work, guidelines existence, authority powers needed, timely works circle and gathering the effectiveness of the investigation for the researched companies.
<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.21 Is the organization’s investigation work effective?</strong></td>
<td>P(2)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>An analysis is undertaken of investigations carried out, to access the timeliness, outcomes, level of sanctions, prosecutions and amount of loss recovered. Continuous feedback is given to the client/stakeholder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Could include the measurement of the percentage of positive case outcomes, recover and loss prevention, number of cases ‘tripled-tracked.’</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td><strong>4.22 Is it carried out in accordance with clear guidance?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear operating procedures exist for counter fraud professionals undertaking their work</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>A quality assurance process is in place. Work is completed per any operational manuals.</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td><strong>4.23 Do those undertaking investigation have the necessary powers, both in law, where necessary, and within the organization?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial regulations clearly stipulate powers. Policies and procedures embed this into organization, and provide</td>
<td>P(2)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
</tbody>
</table>
methods and name authorizing officers.

<table>
<thead>
<tr>
<th>Partnership agreement gives internal right of investigation.</th>
<th>C(0)</th>
<th>C(0)</th>
<th>C(0)</th>
</tr>
</thead>
</table>

4.24 Are referrals handled and investigations undertaken in a timely manner?

<table>
<thead>
<tr>
<th>All referrals are logged and the progress of those which are subsequently investigated, are regularly monitored. Measured against timescale/ operational manuals and partnership agreements.</th>
<th>P(2)</th>
<th>Y(3)</th>
<th>P(2)</th>
</tr>
</thead>
</table>

4.25 Does the organization have arrangements in place for accessing the effectiveness of investigations?

<table>
<thead>
<tr>
<th>Client feedback is sought for each investigation carried out. Investigators are given feedback on their performance.</th>
<th>C(0)</th>
<th>C(0)</th>
<th>Y(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent quality assurance of outcomes.</td>
<td>C(0)</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
</tbody>
</table>

From the table above, all companies' have determined that they have effective investigative initiatives based on the level of outcomes, sanctions and the continuous feedback given by the customer on the credibility of the claim handling system, Item 4.21 either partially for Amy and fully for the other two companies. Based on the internal documentation, Amy Assurance determines that success cannot be associated with the percentage of positive outcomes, recover and loss prevention because it is rarely quantified in the environment of life insurance, which is due to numbers of the exclusion and terms that distinguish them from other types of insurance. For instance, Ling Insurance during the interview noted that;

“Investigation proved have decreased policy per claim ratios and we indicates that the objections to pay to some irrelevant claim would be the success factor for us if we could suspected some element on the fraud existence”

(Insurer/Ling Insurance Claim Officer)
While, the Ethical Insurance officer states that the effectiveness on the investigation through the work done by the loss adjusters as;

“We have recovered most thousands of money from the investigations done by the adjusters that can minimize the possibilities we make the wrong payments to the fraud claim. The amount of recovery is the better measurement from the work done if concern on the fee paid for the works done”

(Insurer/Ethical Insurance VP Claim )

Investigation works done in the claim departments and appointment of outsiders is based on the determination of management guidelines that are emphasized on certain qualities needed, Item 4.22. In Amy Assurance the investigative works is centralized to the Claim Unit based on their work charter as they are responsible for the whole procedure. It still depends on the complexity of the works and that they are within their abilities. This happened because the company policy is solely based on a certain threshold. If the cases are more than RM5 million the investigation is directly passed to a lawyer firm and private investigator to handle the procedure. The statement made during the interview regarding investigation by the claim officer is;

“If talking on the investigation, we are going to do the investigation on our own. But there is no one specialised on it. But we still base on the supports by the company lawyer and the guideline provided. We need to go to the field. Even though, we actually sometimes don’t have the time to do the thing. Then id the cases is the big threshold the penal adjusters will do the investigation research. But at the end, the claim officer would determine the result whether it is real or the forged.”

(Insurer/Amy Assurance CO Claim Officer 1)

The investigation carried out by the claim officers in Amy Assurance is merely based on the guidelines provided and some advice from the lawyers firm on gathering evidence. At the moment, they mention that the current applicable guidelines are fair enough for them to work to. But, due to a shortage of staff and time constraint, they sometimes need to delay the claims. On the other hand, they believe that these disadvantages alarm the fraudster as it does not give the opportunity for the claimant to overcome the current system.
Ling Insurance’s investigation is determined as an effective way when the task is allocated within a specific timeframe for 4.24 and is partially agreed by the other two companies. The Ling internal procurement company has the procedure and a timeline for standard claims which includes timing for the investigation procedures to be in place. The company officer also stated in the claim fraud management framework that;

“The Investigation Unit roles are to provide an independent investigation report for the FMU and claims committees to deliberate on the next course of action. There must be a constant flow of information within FMU, CAS and Claims Committee.”

“To carry out the investigative work with all possible legal means and methods which are agreed by the FMU and Claim Committee”

“To highlight any process flow and control weakness that has been identified during the course of action”

“To manage and be the liaison party to the appointed Private Investigator, adjusters or Solicitor”

(Insurer/Ling Insurance Investigation Officer )

The investigation works done by Ling Insurance look to be more effective and systematic within the timeframe of 11 weeks, the claim management system would omit the results on the claims system. At the same time, investigation officers and adjusters need to highlight any possible weakness in the company claims systems and credibility of the officers to manage the outsider involvement with the case. In Ethical Insurance, investigation on the claim is under the power of the claims department and they can appoint an outsider based on the case facts, preference and concerns on the monitoring. This is partially outside the border. This mainly can be related to the notation that;

“The investigator from the Compliance Division is to empower to conduct any investigation without regards to the suspected wrongdoer’s length of service, position/title or relationship.

“Claims related investigation is all in the claim departments where they have all the authorities that relate to the actions taken for the claim investigation. They have their own team that able to ensure the investigation is effectively. At the same time, the adjustors would help if the case is giving the big financial effect to the company”

(Insurer/Ethical Insurance VP Investigation)
It is clearly shown that the powers of the compliance department are not involved in the cases of claim fraud division when the claim officers carry out the investigation with the guidance and law provided, Item 4.24. They are also empowered to appoint the adjusters and investigators based on their preference. The usual time spent on the investigation is based on the complexity and only selected cases are brought to court. The arrangement in-place is determined to be highly effective and able to settle the case even though it relates to the insurances and takaful products, Item 4.25. Besides, they have determined the clients’ feedback on the investigation help to confirm post statutory declaration situation if the cases are proven with the elements of the fraud. Also, none of the companies include the elements of quality assurance to determine the effectiveness of each investigation. The ordinal cumulative score from Table 7.7 for each company respectively are 12 for Amy Assurance, 17 for Ling Insurance and 18 for Ethical Insurance.

7.2.6 Sanctions

Sanctions are the penalties imposed on the perpetrators for violating the social norms. In the case of insurance, the fraudsters are usually accused under civil or criminal charges based on the cases. Table 7.8 below is based on the policy matters on sanctions, the types of sanction involved, timely matters of sanction, and extended application of the sanction that is available in the market place.

Table 7.8: Items 4.26 till 4.29 from CIPFA Red Book 2 on Sanctions for Insurers Evaluations

<table>
<thead>
<tr>
<th>TAKING ACTION TO TACKLE THE PROBLEM- SANCTIONS</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.26 Does the organization have a clear and consistent policy on the application of sanctions where fraud or corruption is proven to be present?</td>
<td>C(0)</td>
<td>P(2)</td>
<td>P(2)</td>
</tr>
<tr>
<td>The approach is that use of sanctions will always be considered and will be applied appropriate to the case. The full range</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
available will be considered and their application is discretionary as appropriate to individual cases. This policy is unambiguous, consistent and known to be powerful weapon in armoury of the counter fraud professionals. It is the framework for sanctions that is clear and consistent, not that the same sanctions will be applied.

4.27 Are all possible sanctions-disciplinary/ regulatory, civil and criminal- considered?

Policy is to investigate to criminal standard and to “triple track” including applying sanctions. Do not prejudge at the beginning whether the case is, for instance, only a disciplinary matter.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C(0)</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
</tbody>
</table>

4.28 Does the consideration of appropriate sanctions take place at the end of the investigation when all the evidence is available?

All the evidence is available at the end of an investigation enabling appropriate sanctions to be considered/reconsidered. Be concerned about the sanctions, considering the whole range, i.e. do not limit, and ensure full penalty/record, providing recompense and inability of fraudster to gain similar employment.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y(3)</td>
<td>P(2)</td>
<td>Y(3)</td>
</tr>
</tbody>
</table>

4.29 Does the organization monitor extent to which the application of sanctions is successful?

Investigations outcomes are monitored

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
</tbody>
</table>
regularly and compared to previous outcomes to ensure that sanctions are being consistently applied.

| Independent quality assurance of outcomes. | C(0) | C(0) | C(0) |

From the table above, Amy Assurance directly declared that policy on sanctions is not clear and based on the situational effects, Item 4.26. The other two companies agreed that they have a clear policy in the earlier framework but it can be considered as partial as there is no full range of sanctions available since the company mostly closes the cases before they are brought to higher authorities. It is safe to assume that all companies are taking the simple resolution of refusing to pay for the submitted claims, Item 4.27. Sometimes, they have been summoned to court because of this action.

Nonetheless, it does not give a bad reputation since the case is almost always won by the company as the statutory declaration has been put ‘in advance; within the claim form for all the companies. This makes it difficult to determine if all possible sanctions are considered because all the companies prefer not to pay the claim as a simple solution to the cases and if it is wrongly paid out will not reimburse. On Item 4.28, in Amy Assurance, disciplinary action is one of the most common types as they notify the claimant when it is suspected. They give negative feedback during the initial investigation stages. They usually delay the claims and require resubmission. However, in most cases the fraudster will not resubmit and the case is closed. If such situation like this exists, the company just place the claim 'on-hold' unless they were summoned by the claimant.

While, Ling Insurance even though after the evidential matters is supplied, the sanction result on the current practices is still based on the decision made by the FMU and the Claim Committees. This is inputted through the standard operation procedure of the company. The officers also stated that;

“The legal division will review all information gathered by the FMU and CAS to ensure that they are obtained within the legal means and they are credible. For this
purpose, it is expected that FMU and CAS brief the legal division of all aspects of
evidence gathering and the modes employed.”

“Throughout the investigation, the legal division has to be constantly briefed and
updated on the development of the cases. This is to facilitate the legal division to have
clear understanding of the situation before the appropriate legal opinion can be
provided”

“The normal cause of action is to summoned the fraudster back in the court of
sometimes we just send the declaration not to pay for the claims”

(Insurer/Ling Insurance Investigation Officer)

Ling Insurance also makes the same action to refuse payment for the claim or summoned
back if the case is substantial. After all, the impact of action is based on the legal division’s
advisement. Nonetheless, the claim departments can opt to make their own decision.

Ethical Insurance maintained the same circumstances on sanctions-disciplinary because they
have always determined the cause-benefit analysis (CBA) of bringing the matter to the court.
It is excluded unless the cases have been paid in the claim early and crucial evidence comes
after. Then, the decision will be based on the company’s lawyer. The vice president of claims
noted that;

“No big case till now in our company. At same time, no insurers were delighted to
bring up the case that would give bad reputation to them. Almost of the time, they are
also losing to the case most of the time. Not many cases on insurance fraud bring to
the court. They are also no industrial effort to culprit to the court. Market still
perceived that insurance fraud is the victimless crime.

(Insurer/Ethical Insurance VP Investigation)

The officer declared that the situation of Ethical Insurance and others in general are the cases
are seldom brought to trial. This is because the company does not want to tarnish its
reputation due to being different to the Malaysian customs'. Most of their cause of action is
based on ideas that insurance fraud are not criminal victims, hence the company will attempt
to alter premium to be paid in the policy. This action is for rectification over the costs of fraud
and so that they would not have extra risk from the possibility of fraudulent acts.
All companies are in agreement on monitoring outcomes of the cases because all the cases are reported to the RMP or BNM in order for them to carry out follow-up actions, Item 4.29. The companies are always updated on the development of the case on a time basis. Nevertheless, all the companies appear not to have a suitable independent quality assurance in place for the monitoring of post sanction cases. Most of them determined that the procedure seemed unnecessary because it was costly and not potentially giving monetary benefits in the long terms of operation. The ordinal cumulative score from Table 7.8 for each company respectively are 5 for Amy Assurance, 8 for Ling Insurance and 7 for Ethical Insurance.

7.2.7 Redress
Redress generally can be defined as an action to take recovery, restitution, or relief from damages from the act of the perpetrators when the statutes action has expired. It is a possible action for all companies in the economic condition especially for insurance companies when they want to do what is best for stakeholders. Table 7.9 below determines the redress of the insurers on the ‘clear’ of the policy, effectively recover losses, fully used of the legal aspects, monitoring the recovery process and the successful recovery rate.

Table 7.9: Items 4.30 till 4.34 from CIPFA Red Book 2 on Redress for Insurers Evaluations

<table>
<thead>
<tr>
<th>TAKING ACTION TO TACKLE THE PROBLEM- REDRESS</th>
<th>Amy Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.30 Does the organization have a clear policy on the recovery of losses incurred to fraud and corruption?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The policy outlines for recovering losses, on the outside policy or with stakeholders</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>P(2)</td>
</tr>
<tr>
<td>Clarity helps shows fairness, limiting the risks of challenge &amp; adverse publicity, encourages reporting of suspicions, deterrence and counter fraud culture</td>
<td>C(0)</td>
<td>C(0)</td>
<td>C(0)</td>
</tr>
<tr>
<td>4.31 Is the organization effective in recovering any losses incurring by fraud and corruption?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The progress of recovering losses is monitored for each case, and all options for recovery are considered.  

<table>
<thead>
<tr>
<th>The progress of recovering losses is monitored for each case, and all options for recovery are considered.</th>
<th>P(2)</th>
<th>P(2)</th>
<th>Y(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is standard procedure</td>
<td>N(1)</td>
<td>N(1)</td>
<td>N(1)</td>
</tr>
<tr>
<td>4.32 Does the organization use the criminal and civil law to the full in recovering loss?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The options are considered and are not mutually exclusive.</td>
<td>Y(3)</td>
<td>Y(3)</td>
<td>Y(3)</td>
</tr>
<tr>
<td>4.33 Does the organization monitor proceeding for the recovery of losses?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The progress of recovering losses is monitored for each case.</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>C(0)</td>
</tr>
<tr>
<td>4.34 What is the organization’s successful recovery rate?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery rates are monitored. Options include year on year comparisons, benchmarking and percentage of cases with positive recovery outcomes.</td>
<td>C(0)</td>
<td>Y(3)</td>
<td>C(0)</td>
</tr>
</tbody>
</table>

From the table above, Ling Insurance and Ethical Insurance agreed that the policy on countering fraud directly has an impact on recovery of losses and is shared with the stakeholders (item 4.30). In Amy Assurance, they do have it but there are no clear statements regarding risk and deterrence. Ling Insurance showed that the policy in Claim Fraud Management Framework documentation are very detailed in determining risk sharing and deterrence effects to all the customers and the company employees. While for Ethical, they have highlighted that redress is only successful in the major group of banking and it is just partial because it can only make certain sequence effects to the management and shareholders. None of the companies are able to determine that they have a clear policy that is able to show fairness, the risk of challenges and adverse publicity because these are not well documented and discussed in any of the company policies.

The companies actually have limited case that highly cost them from fraud action (Item 4.31). Most of them reconsider the amount of the premium paid by the customers or they might take
legal action. In Amy Assurance the redress is through the use of statutory declaration if they can prove that the fraud occurred in the cause of claimant action. They would ask the claimant to pay back the amount that includes the legal and financial cost incurred by the company.

Ling Insurance on the other hand would do the same as Amy Assurance but more systemically embedded with the decision from the FMU, Claim Committees and the management concerned. This ensures that the cases are in the scope of the management interest and they can maintain their reputation within all the international branches. They also would ensure that the decision complies with the international management strategy.

Ethical Insurance noted the ideas of redress are informed by the general management of their parents companies and monitored by the management because the policy states it directly. At the same time, the officer also noted during interview that:

“Compliances shall submit the information on cases of fraud/suspected fraud via eFIDS as and when the fraud is detected but not later than two days from date detected pursuant to the Guidelines on Electronic Submission of data to BNM under Fraud Information Database System (eFIDS).”

“Should the amount of the fraud is RM50,000 and above or is with modus operandi that carry systemic risk, with adverse implication on the industry, the Group shall alert BNM via telephone or facsimile within 24 hours of detection and followed by preliminary report as well as full investigation report”

(Insurer/Ethical Insurance VP Investigations)

From the statement, it shows that the insurer is liable to ensure that they able to alert others in the system regarding potential threats within normal circumstances. They, as the victims, need to submit the loss insured and how they recover from the loss from serious threats by the fraudster in a report to the E-Fids. It is extremely important that Central Bank is informed regarding these cases.

All companies agree on Items 4.32 that they are well prepared to use criminal or civil law to some extent regarding the recovery loss process. In Amy Assurance, the assistant from the
company lawyers would carry out the process to speed it up. While in Ling Insurance, the Fraud Management Unit would see that the company ensures they have less potential of loss in all cases involved. At Ethical Insurance, laws are also used which directly relate to the company investigation unit and the lawyer associated with the case.

Only Ling Insurance agreed with the statement that they monitor progress for recovering loss for each of the cases and successfully monitor that the recovery rates are always evaluated (Item 4.33 & 4.34). This is through the works done by the adjusters, liquidators and private investigators where everybody is responsible to ensure the process of recovering. They calculate the recovery rate for each case in the claims departments on a yearly basis but it is treated confidential as the benchmark to evaluate the exercised policy. This is included in the Fraud Management Framework. It is difficult to make a comment on the other two companies because it is not mentioned in the documentation, and was also not mentioned during the observation or interview. The ordinal cumulative score from Table 7.9 for each company respectively are 6 for Amy Assurance, 15 for Ling Insurance and 9 for Ethical Insurance.

### 7.3 Defining Success

Defining success is essential during initiative implementation as the benchmarking items towards the planning of the better steps, investment and allocation of humans. This enables to create a deterrence effect to the general public that is able to show the company’s credibility and transparency. The definitions for success are included in Table 7.10 below based on the response given during the interview and the circulation of news in the company organization and to shareholders.

Table 7.10: Defining Success in the Study Companies’ Based On the Itemised Evaluation

<table>
<thead>
<tr>
<th>Items defining success</th>
<th>Companies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amy Assurance</td>
</tr>
<tr>
<td>Risk fraud awareness</td>
<td>The risk on the fraud includes in the financial statement</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>and policy development.</td>
<td>independent risk assessor always being appointed to determine the level</td>
</tr>
<tr>
<td>Indicators embedded</td>
<td>Includes and always being updated on the currents cases and trends Some guidance extra from the Private Investigator</td>
</tr>
<tr>
<td>Fraud awareness on</td>
<td>Increase in the policy and claim management</td>
</tr>
<tr>
<td>Achievements in the countering fraud</td>
<td>Having the lawyer advised on the big and higher volume cases</td>
</tr>
<tr>
<td>Policy established</td>
<td>Normal claims policy that can detect the potential fraud</td>
</tr>
<tr>
<td>Cost savings</td>
<td>Highly effective because the amount of the life policy is big.</td>
</tr>
</tbody>
</table>

The non-motor and non-life claims at the lower level and the company always win in the court case.
7.4 Follow-up Survey

With 110 numbers of questionnaires distributed to the representatives of the companies as mentioned in Section 3.2.4, only 37 returned the questionnaires after a waiting period of two months. Thus, the responding rate which accumulates to 33.64 per cent enables the researcher to draw limited conclusions on the matter. According to Sekaran (2004), a 30 per cent of response rate is needed to make the finding eligible in generalization. The respondents in the survey were dominated by the Claim Handlers/Executives, which marks up to 73% and followed by the Licensed Adjustors that accumulates to 27%. The courses that were followed by them under MII can be categorized as 62.12 per cent are from the ‘A Comprehensive Courses in General Insurance Claims’ while the remaining (37.84 %) are from the course of ‘A comprehensive Courses in Insurance Fraud & Investigative Workshop’ that was organized in two different times by MII.

Talking about the anti-fraud culture, 97.3 per cent of the respondents agreed that their company does anticipate that kind of culture in their organization. Mostly, it involved the detection and prevention of fraud. While, only 51.35 per cent determined that internal audit department is the main party responsible to cultivate the culture of anti-fraud in the organization. The other 48.65 per cent determined that as not relevant. The effort to achieve an anti-fraud culture was through campaigns and talks by the respective speakers on the issues. A general view from the respondents about fraud determined that fraud as is bad as 20 respondents agreed its negative impact which accumulates to 54.05% per cent. Meanwhile, 12 people (32.43 per cent) claimed that fraud issues depend on the situation while only a meagre of 5 respondents (13.53 per cent) mentioned that fraud is good.

The respondents agreed that fraud and corruption were clearly defined in their code of conduct, act or regulation at the highest level which comes up to 97.3 per cent. On the extents of the fraud and the dimension of it, they prefer to determine fraud occurs more domestically (more towards internal matters) as 67.57 %, followed by the small scale (planned), 18.92% and the national (big scale) 13.51%. Meanwhile, not all of them agree that occupational fraud is the main type of fraud as only 67.58 per cent agreed to it while 32.43 per cent argued it as none.
Followed by that, in terms of number, only lower number of frauds are handled by the company (56.76%), medium at 37.84% and higher at 5.4%. While, in terms of the monetary values, high amount of money dominated when more than RM5,000 as it is rated at 45.95 per cent, followed by less than RM1,000 at 29.73 per cent and last in the range is RM 1,000 to RM5,000 at 21.32%. To know about the effect when fraud is publicly known, it is rated as becoming worse to the perpetrators by 70.27%, no effect at 21.62% and it becoming better at 8.11%.

In part of fraud prevention and control, the responses determined that 83.78 per cent agreed that there is a specific policy on fraud control. 13.51 per cent claimed there is none and only 2.71 mentioned unknown. The development of the policy looks at the Investigation and Legal Department efforts. This policy also can be considered as highly revised at 64.86%, not revised at 29.73% and unknown at 5.41 per cent. This also supports the notion as the companies are looking to develop a specific code of ethics (54.05%), not involved (29.73%) and unknown at 16.22%. They agree highly based on the numbers that the code of conduct which includes the surveillance of the company (25), to put a better control policy (23) and to make sure that everybody follows the laws (11). The code of ethics as the conduct in the company looks as effective (81.08%) at higher rate. Only 13.51 % determine it as not good and 5.41 % unknown.

In the part about the fraud risk assessment, the inclusion of the risk assessment programs and indicator are rated higher at 83.78%. Also, a higher percentage determine that fraud risk assessment are the main aspects in countering the fraud as 86.49% agree and the other 13.51% say no to inclusion of this type of risk assessment. In regards to the numbers of the activities, it is included in the Table 7.11 below.
Table 7.11 - The score from all respondents on the fraud risk assessment activity (this activity as in the Albrecht, 2011)

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Score from 37 respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Theft</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>Income received not brought to account</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>Illegal transfer or diversion of money</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>Changes or addition to payee details through financial systems</td>
<td>28</td>
</tr>
<tr>
<td>5</td>
<td>False creation of or unauthorized updates</td>
<td>31</td>
</tr>
<tr>
<td>6</td>
<td>Unauthorized use of cheques</td>
<td>32</td>
</tr>
<tr>
<td>7</td>
<td>Wrong claimants</td>
<td>31</td>
</tr>
<tr>
<td>8</td>
<td>Grant funds are misappropriated</td>
<td>14</td>
</tr>
<tr>
<td>9</td>
<td>Overspend on the medicine supply</td>
<td>17</td>
</tr>
<tr>
<td>10</td>
<td>Making a contract on the interest</td>
<td>18</td>
</tr>
<tr>
<td>11</td>
<td>Overestimated the charges not based on the budget</td>
<td>23</td>
</tr>
<tr>
<td>12</td>
<td>Theft of sensitive data</td>
<td>22</td>
</tr>
</tbody>
</table>

Mentioning about fraud awareness and training, 87.49 per cent of the respondents determined that there is fraud awareness program in the departments. Only 13.51 per cent mention there is no program in the company. The programs that were provided are the Fraud Risk Assessment talk and also the Fraud Policy meeting among the staffs. This is because majority of them agreed that it has a moderate effect on fraud awareness in the company at 59.46 %, high at 27.03% and low at 13.51%.

The ethical awareness is the major concern in all the respondent companies as 81.08%, mention unknown, while 13.52% state yes and none at all is lowest at 5.41%. As they are under the MII on the licensed claim handlers, they were following the ethics being indoctrinated by the MII as they agree at 86.49% and still unknown at 13.51%. Most of them agree that they have been given fraud related training at 89.19% on detecting fraud, countering fraud and fraud case study. Only 10.81 % did not have general fraud training.

The investigation staffs is the part of the company that would require in-depth training on investigative methods and for this, 30% agreed to it, while 16.22% rate as no training was
included and only 2.7% responded as unknown. They determined a higher rate as 86.49% consider that there is someone in the company who have the required skills in the investigation departments. Most of the training on fraud related activities can be categorized as outsource activity recording the highest value at 83.78%, while outsources at 13.51% and in-house at 5.41%.

When considering fraud control operation, again the entire respondents agree at 81.08% that there are operational structures that are responsible to manage fraud issues seriously in the company. The department indicates that the functioning roles in fraud control are Accounts (35.14%), Auditing (37.84%), Management/general department (21.62%) and others that specifically as legal department (5.42%).

They determine the effective mechanism of fraud reporting, as score per 37, are hotlines (25), high level of management (30), internal auditor (31), online reporting (10) and others that are specified as RMP, Authority or BNM (10). Meanwhile, when talking about the major source of fraud record, it is determined from the internal data and industry report as equivalent to 40.54% while other as internet, outside database at 18.92%

Frauds also look at the quality assurance process. High numbers of respondents determine that their company have a quality assurance system at 81.08% and only 13.51% said as unknown and 5.41% determine as none. While if relate to the red-flag as the occurrences of the fraud, it is recorded that claim (33), report (31), documentation (32), calls (30) and others that specified as incidents at 20 score. The respective department that manages the red flag when it is detected is the legal and investigation department.

If we relate to the crime prosecution data to be known in the public place, the majority of it indicates at 81.68% that as no disclosure has been made on the misconduct to the outsiders, such as the general public, regulators or the self-regulators as this adds up to higher contradictions on the ideas of transparency. Meanwhile, 86.49% of them agree that they are cooperating completely to the appropriate regulator or law enforcer. This shows that the regulators and enforcer are playing the major roles to keep the data and making some policy decision. This is in line with the interview done in the previous parts.
As the act and regulation are the main base that enhances the reliability for referencing in the fraud program. Most of them determine that Insurance Act (54.05%) and AMLA (45.95%) as the main act regarding fraud action or corruption in the company. While, the code of the professional act are those prescribed by the MII are the most relevant that is 31 out of 37 score. The remaining agreed that the licensor adjustors manual and Private investigators manual are the reference code of professional reference. The other rules that happened to contribute on the countering fraud are from the BNM General Practices Guidelines.

The aim of the follow-up survey is to strengthen the output from the main interview that is being done and presented using the CIPFA Redbook 2. As the itemized aspect in the Red Book 2 was also in line with the general question, these are included in the survey. Nonetheless, the survey enables to enhance the understanding of the general public about current situation of countering fraud in the insurance industry in Malaysia. As the respondents are the workers in the public area within the industry, the survey attempts to gear up the under stability of the current condition that requires some ideas of enrichment of the efforts done concurrently.

7.5 Conclusion

Most of the companies have ‘systematic' success in this study based on the framework of evaluation that could lead to a generalised idea of a well-managed claims handling and investigation policy. With regards to the total sum, Amy Assurance appeared to miss many elements of actions towards fraud issues due to having fewer employees to support the function effectively. While, Ling Insurance looked to have more advantages as it added an international perspective mixed with local expertise in the company management structures. Ethical Insurance also showed impressive numbers of actions and successes as a company which is a subsidiary for one of the biggest financial conglomerate in Malaysia. They at the same time get personnel expertise and advice from the parent company. In the industry, they have an international partner which is Fortis Insurance, a UK based company. The conclusions for implementation and defining success are more meaningful when interpreted and discussed in the next chapter. The implementation of the countering fraud in general from the survey is at a satisfactory level because it covered most of the initiative components.
More discussion in relation of the survey together with other methods will be in the next chapter. The interpretation of the cumulative of the ordinal scores will also be ranked in the following chapter to determine which company has more initiatives compared to the others. In addition, the elements and instruments of management are wise to be merged together for this discussion to enable it to be more descriptive and interpretive with the cultural elements that need to be considered.
CHAPTER 8

CONCLUSION: ‘AGENCY’ LEVEL OF IMPLEMENTATION AND ULTIMATE CHANGES

8.0 Introduction

This research has provided an original contribution to the body of knowledge by discussing the problem of insurance fraud and the strategies to deal with it in Malaysia. Not only is this an area which is under-researched in many other countries, but it is also considered as a sensitive issue in Malaysia which has received very little attention in general by looking at less supported literature (Bernama, 2005; RMP, 2009; Thanasegaran & Shanmugam, 2008; Beach & Stern, 2011) and less publicly-available data to analyse (MII, 2011; PWC, 2011; BNM, 2012). The provision of data in this area on Malaysia is therefore very rare and this study offers unique insights on this problem and how it is dealt with in this country.

Overall, this research has examined the Malaysian insurance industry strategies to combat fraud as ‘integrated initiatives’. These are based on the systematic evaluation that is introduced by the CIPFA Red Book 2 that manages all the relevant items from planning through to the end of measuring the whole initiatives. This standard has been determined as a good standard of evaluation as it is widely used by governmental and non-governmental bodies in the UK (CIPFA, 2006).

The companies involved in this study have made involvement possible from the claims and investigation units to highlight the initiatives taken on behalf of the company. While, the outside parties directly relates with the initiatives to contribute ideas on supportive programs, documentation, campaigns etc. that enable the campaign to combat fraudulent threats to be boosted. Beside, a follow-up survey that was administered stood as the medium in obtaining the general statement from the population of claim handlers on the initiatives as the whole. In using the tools of evaluation, it is highlighted clearly that all the researched companies do not have the same type of initiatives; they have different initiatives in terms of intensity and levels of cautiousness. This leads to the idea that the theme in the initiatives is more towards the ‘agency’ initiatives as more reliable rather than an ‘industry-widen’ structure to overcome the problem. This chapter will draw out the key findings and contribute some ideas for future
research and policy arrangements in general. Before presenting a detailed discussion, information will be presented regarding the perception towards initiatives by the companies and the insurance market in general.

8.1 ‘Agency’ is better than ‘industry-widen’

The initiatives taken by the researched companies have generated the belief that it is better to have something that exists in ‘agency’ words that has the power to realistically comply with the ideas or objectives to combat issues such as fraud in the market. Each of the company is appearing as the agent of economy and would prefer their own types of efforts rather than being subjected by the efforts that do not represent their own structure and type of operation. As in the Malaysian market situation, the regulators and policy makers have made it clear that they will not enact any ‘industry-widen’ guidelines; as they have concluded that the practice on combating fraud can be within the insurers systems with the help of professionals that enables them to achieve certain abilities and competences to overcome the problems.

While, the insurance companies have determined that a variety of simple ideas employed can be the best solution in countering superficial issues. For example, Amy Assurance has established a committee under the internal auditor of the company to have a detailed internal audit structure that enables countering fraud as one of their initiate which is in par with the national view. While, Ling Insurance have the Fraud Management Committee that was established as a cross departmental committee with the purpose of ensuring that every department contributes, which enables them to overcome the threats as a whole organization. Finally, Ethical Insurance, also have initiatives that involve integrated computerized system on reporting cases of investigation for fraud to ensure all parties are able to share the data within the company with the same objectives to mitigate fraud. This can be found in details at Chapter 7.

From the broad professional and association ideas, PIAM, AMLA, NICS and Justice Adjusters agree that the professional bodies play a vital contributing role to strengthen the initiatives to ensure that all insurers are able to overcome the difficulties relating to technicalities, timing and costing. NICS have highlighted that not every officer is able to counter fraud with details procedures and techniques because it is not their designated job and it can be considered as an extra initiative in their main tasks. Even though, NICS are
represented as the most promising society that caters for fraud issues with documentation ideas on policy and technical workshops, they still under estimate the functions of the claim officer and investigation officer as the fraud busters since they are less empowered by the insurer’s management team itself. This has been supported also by the ideas from PIAM and AMLA. The PIAM officers make a clear statement that ‘insurance fraud is a victimless crime’. It can be generalised that even though the situation has worsened with time and the level of complexity has increased, the insurers are wiser in managing the situation by segregating the losses towards the insurance policies through increments on the policy price and also, less variety of the policies provided.

On the other hand, the Justice Adjusters have suggested that it is wise to acknowledge the importance of the adjusters, liquidators and investigators in the situation of fraud in insurance. They have stressed that lobbying needs to be boosted in the Malaysian system to increase the involvement of this particular party to solve the fraud cases for the insurers and this idea has started since 2005 from of the Central Bank of Malaysia Governors’ speech. The company have detailed the advantages that could be justified by the insurers in widely using their services in the market such as effective costing, saving time of investigation, more technicalities experts and better exposure of the case. There would be some disadvantages to their involvement such as ideas of integrity and secrecy in the company operation. The ideas and themes towards combating fraud in detailed are something new to the market and have been discussed since the statement from the Central Bank Governor in 2005. These ideas have brought some national initiatives in the Malaysian insurance market since the market during that period was dominated by outsider insurers. As they have a better structure that is brought from their originated country, this influences the regulators decision that the initiation of combating fraud should stem from the operation counterparts and not from them. The people who specialise in combating fraud will likely benefit as the company will usually not develop a new agency structure to cater and prefer to consult with the expertise to eliminate cost and reduce the timing involved (Ismail, 2006).

8.2 Key findings from the evaluation

The main objective of the research is to determine the intensiveness of the initiatives taken by the insurance companies in Malaysia on the issues of countering fraud. At this point, it is
better to remember the key findings through insurance companies and outsiders in the market on the level of achievement by relating it back to the criteria evaluation in the CIPFA Red Book 2.

8.2.1 Adopting the right strategy

Ling Insurance and Ethical Insurance appear more consistent on the ideas that they have for countering fraud and corruption strategies as it is linked to the organization’s strategic objectives in a long term basis. While Amy Assurance only advocates zero tolerance ideas within their strategic objectives that can be determined as anti-fraud strategy. These are included in the discussion in Chapter 6. Table 8.1 below illustrates the cumulative ordinal score taken from the item that considers adopting the right strategy that is presented in the related table in comparison to the full ordinal score.

Table 8.1: Ordinal score from each table presented for each company on the item evaluation of adopting the right strategy

<table>
<thead>
<tr>
<th>Presented in table</th>
<th>Am Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
<th>Full Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2</td>
<td>6</td>
<td>26</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>6.3</td>
<td>5</td>
<td>16</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>42</td>
<td>38</td>
<td>48</td>
</tr>
</tbody>
</table>

All the companies agree on the statement that there is a clear remit ‘to reduce losses from fraud and corruption’ to an absolute minimum covering all areas of fraud and corruption in the organization. This leads to the sharing of ideas since most of the internal control structures of the company’s objective are need to include ideas to reduce the possibility of loss. These were also supported by the external party in Chapter 5 when they agreed that all of the companies in the industry are aware that there is a possibility of bigger losses due to the fraud cases.

While, talking on the effective links between the policy and the practical side, all the companies agreed that the consistency for that in the cases of fraud but only Amy Assurance highlight the lacking on proportionate counter fraud measure applied to new system as the issues is not well catered with their environment. On the other hand, the external response
showed a pattern of inconsistency. This was possibly due to the different numbers and features of customers that were being consulted or advised by them.

The plan of implementing a fully integrated action was only agreed by Ling Insurance and Ethical insurance. This integrated plan is not implemented by Amy Assurance due to the small sizes of the claims and investigation unit in the company. For the outsider, only adjusters can justify whether the companies in Malaysia have implemented the integrated action in point 4 because these parties are involved with the whole structure of fraud deterrence for their clients.

From Table 8.1 it can be concluded that all the companies do agree that they are adopting the right strategy and they are willing to make certain focus and decision on the outcomes regardless of the numbers of activity involved in order to highlight the importance of the output not just to ‘window dressing’ with the activity without knowing the effectiveness of it. The outsider also fully agreed on the ideas that can justify as the seriousness of all party to look at the last output of the strategy. In comparing the better company, Ling Insurance lead the ordinal score with 42, followed by Ethical Insurance with 38 and finally Amy Assurance with 11.

In regards to the follow-up survey, the general claim handler and licensed adjustors are considered as also adapting the right strategy since majority of them, about 97.3%, agree that the companies are clearly defining the code of conduct, act and regulation. Unfortunately, the general claim handler and licensed adjustors mention that fraud is becoming well known, hence leading to even more complex cases. They generally agree that fraud mitigating efforts are being played by the accounts and auditing departments.

While concerning on the output of evaluation and survey, it was suggested that lobbying power from political personnel and authorities confirm on adopting the right strategies. These are great concerns and are simply deal through the approval from management and audit department. While, the outside party determined that they could not make any judgement on the preferred strategies as they are not purely familiar in a broader organization set up.
8.2.2 Accurately identifying the risks

Risks are the main concerns on contractual agreement and also the operational need to be justified accurately on fraud cases. All companies agreed that the risk of fraud and corruption was considered through the risk assessment of the whole organization. This was due to the work done by the internal control and determining the fraud in insurance as the normal cause of the operation. These matters were positively agreed on by all the outsiders in the industry that were involved. Also included in the survey, most of the company include risk assessment as the part of the mitigation of fraud in the company.

All surveyed company concluded that they were seeking to identify accurate nature and scale of losses from fraud and corruption. This is because they were already made available through the risk assessment unit to determine the portion of risk from fraud and corruption. However, under the items listed in the evaluation, Amy and Ethical do not agree to the ideas that it would be restricted to the areas where the fraud detected. Meanwhile, these outsiders of industry also agree that it is important for the company to determine the amount and nature accurately for the advantages of the company itself.

Table 6.4 are mainly ordinal score for the identifying the risk factor that have determined from a full score of 27, Ling Insurance was the highest with 23, while the rest only attempt at 16 and 17 respectively for Amy Assurance and Ethical Insurance. This is because Ling Insurance agreed to the ideas of organization to use the accurate estimates of losses in order to generate level of budget investment in the activity of countering fraud and corruption. This was due to the existence of Fraud Management Committee that was officially in control over the budget of fraud management activities. Again, the adjuster agreed that only some of the organizations are having this kind of activities due to the variety of clients and as known the Malaysian insurance industry is controlled by external insurers. While, the survey have stressed that most the respondents determined that their company have fraud risk assessment and have numerous of activity involved, these are noted in Table 7.11.

8.2.3 Creating and maintaining the strong strategy

Creating and maintaining a strong strategy was discussed in the last two chapters under the themes that is having the necessary authority support, specialist training and accreditation,
propriety checks, and effective relationship with others organization. Table 8.2 below illustrates the cumulative ordinal score of items related to creating and maintaining a strong strategy that is presented in the table, through a comparative full ordinal score.

Table 8.2: The ordinal score from each presenting table for each company on item creating and maintaining the strong strategy

<table>
<thead>
<tr>
<th>Present in table</th>
<th>Am Assurance</th>
<th>Ling Insurance</th>
<th>Ethical Insurance</th>
<th>Full Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.5</td>
<td>3</td>
<td>9</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>6.6</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>6.7</td>
<td>9</td>
<td>10</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>6.8</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>33</td>
<td>35</td>
<td>45</td>
</tr>
</tbody>
</table>

From Table 8.2 above, all the insurers involved agreed that it is necessary to have an appropriate strategy which is maintained regularly. Again, Amy Assurance’s ordinal score was less compared to the others with 25 from a possible 45. For this particular evaluation item, Ethical scored the highest, followed by Ling Insurance.

Only Ling Insurance is certain that they have a genuine policy declaration from the executive and the planned involvement from the adjustors on the ideas of the executive and political support. The professional outsiders also agreed that there is a need for this policy and support for it. Unfortunately, none of the companies are able to show that the level of investment for this kind of work is proportionate with the risk determined because most of them have admitted that the budget is usually based on the percentages of the claims that are involved each year. It will always increase based on the current data.

Training and accreditation is essential for countering fraud and corruption. From the survey, almost all of the respondents agreed that their company is providing general fraud training at 89.19% when they list fraud deterrence; countering fraud and fraud case study are among the popular topic being discussed. The result from survey also stressed that almost all of their investigation staff are fully equip with the knowledge gained through training and can be considered as highly skilled to perform their jobs.
On overall from both interview and survey, companies agreed that the workforce that is involved in countering fraud and corruption need to be trained and accredited for their roles. This is because they are doing something that is relevant and important in current economic conditions. AMLA makes this compulsory because it should be a competent person carrying out the work related to countering fraud and corruption. It is also agreed by NICS that offers the packages of training in the industry currently on fraud and corruption. The training is something that needs to be continuous and refreshing with new ideas to be explored. All the companies agreed that the officer needs to attend continuous training to ensure that they have fresh ideas. It was also agreed by outside components within the industry that officers need to update their knowledge on a regular basis.

At the same time, all of the insurers involved have also agreed that the people involved with combating fraud need to have a specific code of ethics as this was considered to be professional work environment. This has also highlighted that the companies believe that the work concerning anti-fraud and corruption should be carried out by an accredited person. This is to ensure that the level of security and transparency of the data that they deal with will be adequately safeguarded. At the same time, the outside practitioners receive these suggestions with an open hand as it would inevitably create more opportunities for them. As result in the follow-up survey, the elements for code of ethics in the company were embossed with the ideas as surveillance of the company, to put the control policy and to ensure that every components of the company obey the law and rules.

Relating to the propriety checks that was the human capital process, all the companies agreed to each statement. They determined that in order to have adequate forces to tackle fraud, they first need to go through with effective propriety checks. Concurrently, it is better to have regular review on the checks with the possibility of random checks being carried out. This was also one of the internal control elements in the internal audit structure for all the insurers and mostly done by the internal audit departments.

In having and maintaining a strong strategy, the relationship with relevant parties is very important as they provide support to ensure the success of the strategy. Again, all the companies agreed to all the statements that determined the need to have an effective relationship with other organizations. They also agreed that there should be an agreement framework in place to enable work with other agencies or organizations. It is necessary to
ensure the terms of these relationships are clear and delivered to each side of the agreement. This was also supported by the outsiders in the industry when they agreed that collaborative engagement appears to contribute positively for all parties in the industry. In the survey, the respondents were determined that the company need to cooperate with the appropriate regulatory and the enforcement bodies which ranked at 86.49%.

All insurance companies also concurred in agreement from the interviews that they included the practicalities of their day to day work and they needed to have regular meetings to update the arrangement. This is important to ensure that the engagement of each party is really meaningful for the insurers to enhance the ability of the strategies listed for countering fraud. These parties include bankers, adjusters, auditors, investigators or government agencies that are part of the system that enables the function of countering fraud and corruption to be enhanced.

### 8.2.4 Action to tackle the problem

All insurers agreed that they take all the necessary actions that are needed in the implementation of integrated settings to combat fraud which are, culture, deterrence, prevention, detection, investigation, sanction and redress. Table 7.1 showed the ordinal scores which were 2 for Amy Assurance and Ethical Insurance while Ling Insurance scored the maximum 3. Incidentally, this is not work that is singularly carried out by the claim department but the collaborative action by other departments to certain that insurers in general commit towards the objectives of combating fraud as a whole organization. Table 7.2 helps to illustrate the components of the organization which contributes directly towards the developments of these initiatives.

Table 7.3 relates totally to the culture implementation where Ling Insurance scored the highest ordinal cumulative score with 21, followed by 16 for Ethical Insurance and 11 for Amy Assurance. Ling Insurance and Ethical Insurance look consistent to promote a clear program that work towards making anti-fraud as a zero tolerance culture exists in the organization. However, Amy Assurance did not fully agree on this because they did not emphasize the strategy of anti-fraud in the management structure officially. It was more from the recommendation by the officers that are involved with fraud cases only. The mechanism
of the whistle blowing policy did exist in all companies but more towards the reporting end up to a senior management level. Also, the target and times towards establishing the culture was only emphasized by Ling Insurance. They are committed in having a time frame towards the development of the anti-fraud culture in the company organization. They make short and long term plans that are included in Fraud Management Framework. Unfortunately, none of the companies make effective arrangements on actions that would enable further nurturing for this culture. All of them assumed that culture cannot be estimated accurately from the program since the establishment of it is not really in an official arrangement setting. Nonetheless, Ling Insurance and Ethical Insurance received some feedback from the staff after the program that includes the areas of anti-fraud culture in order to measure the understanding or need for that program.

All companies show positive initiatives to attract all stakeholders to contribute towards the success of the anti-fraud culture by making public announcements concerning the companies’ initiatives. This was embedded in some of the official documents such as the claim form which clearly states that anti-fraud and corruption are becoming a major concern for the operation of the company. Only Ling Insurance and Ethical Insurance clearly state the positive outcomes which would be beneficial to stakeholders with cultural implements. They noted the advantages through the policy that the reduction in fraudulent claims would ensure the claim pay out cycle would be shorter and more efficient.

With regards to deterrence, Table 7.4 showed again that Ling Insurance scored a higher ordinal cumulative with 23, but Ethical Insurance and Amy assurance scored 12 and 9 respectively. Only Ling Insurance and Ethical Insurance showed that they have a clear program of works to induct the deterrence effect towards their customers. This ensured that the structure of anti-fraud exists in the companies and it also shows the stages to stimulate the deterrence is vital and long term for the customers. The ideas imposed with the purpose to generally make effect are mix up and not all arrangements are taken up due to the customer segments is slightly different. None of the company is involved in publicity that would show the impact of a good anti-fraud arrangement through highlighting the success of the program. This is due to the ideas that almost all the numbers of fraud cases are estimations, the success stories are considered as internal achievements and not suitable for the public, which reflects the cultural setting of Malaysia. As the international companies localized, Ling Insurance
published something in the newspapers that able to highlight the company is having a better fraud buster mechanism.

While, to cater for the ideas of making better arrangements of the effect, all companies still highlights the loss to make the deterrence effect. This is to ensure that they are extra cautious and aware on the segments that contribute to the cases of fraud as the red flags. Ling Insurance noted that they would include the intended results in that deterrence campaign as it is a major investment in the more highly possible areas that is in the motor vehicles policy.

Table 7.5 relates to prevention and the ordinal cumulative score showed Ling Insurance with 20, Ethical Insurance with 16 and Amy Assurance with 11. All of the companies carried out a progressive revision on the policy as they can then determine if any weaknesses exist in the anti-fraud structure. This can prevent any repetition of similar cases that can cross over the current internal control that has been implemented. Usually, the action directed comes from the report that would show which areas are more exposed to the practice of fraud and red flags will allow the officers to take immediate responsive action.

In relation to grading the weaknesses, Amy Assurance neglected to determine the existence of these clear guidelines that enables them to carry out corrective action. They just base it on the general practice of prevention but do not have a level for threats to be reported. The other two companies have a system that enables them to prioritize action towards the most affected and possible threats. All companies monitor any transactions that are relevant for multiple types of action to prevent possible threats.

All the companies already embed a whistle blowing arrangement in the current structure to enable the companies to cater for fraud successfully because all of them believe that outside tips are the best channels for combating fraud. Even though their policies are probably the same, all the companies employ a variety of methods for the implementation of whistle blowing tips. Amy Assurance makes it possible through their direct approach to the third party involved with the client’s policy. While, Ethical Insurance and Ling Insurance have a more comprehensive structure that enables multiple channels of reporting any illegal actions regarding the clients and policy provided.
All of the companies also make use of technological advancement that embeds the analytical analysis that enables them to obtain reciprocal reports to determine the potential clients with the relevant red flags indicators. This analytical report would guide the decision regarding prevention and enables the company investigators to do their job more accurately. The output of all the initiatives was not well shared among companies because it more likely to become the red flags and considered to be confidential items. In Ethical Insurance and Ling Insurance, there is no such agreement or MOU that exist to facilitate a sharing basis. While, Amy Assurance agreed with sharing because it enables them to cross check the person that possibly have had several cases before with other insurers. All the companies determined that they have a fraud response plan at least to respond to any red flags that are determined in early detection. These response plans open the investigation files before they start the procedure of investigation. The appointment of the investigation is decided by this response team in order to look at possible losses and case structure complications.

Not all of the companies have a proactive action plan implemented as Ling Insurance who would endeavour to detect possible fraud in the system even though they do not have a red flag action in the earlier stages. Through their system, it is possible that a red flag would be found because the company strengthens their claims procedure in a 12 week cycle that look at delayed payments. Ultimately, it still enables the company officers to work in an effective manner to enable them to trace any irregularities in the whole structure. However in both Amy assurance and Ethical Insurance, the resources of countering fraud are just directly involved with the areas that have a possible return for the initiatives. The areas are more selected than and not as wide as in Ling Insurances. Selected areas can lead to less chance of being effective to detect real fraud. The ordinal score for detection is referred to in Table 7.6 where Ling Insurance scored the highest with 38, followed by Ethical Insurance with 33 and for Amy Assurance with 27, which was quite poor.

The investigation works appear effective in all of the companies. Table 7.7 shows that Ethical Insurance has the highest ordinal cumulative score with 18, followed by Ling Insurance with 17 and Amy Assurance with 12. This is because all the companies choose to have more effective outside investigators and experts who are well acquainted with the procedures in the market. Almost all of the companies carry out a cost benefit analysis before engaging with the investigators and mostly only selected bogus cases will be investigated with a thorough detailed procedure that would engage them for a longer period of time. The investigations
were usually carried with clear procedures in the company and engaged the financial authority to ensure proper steps being taken. The procedures involved are within the knowledge of the company even though they outsource the practice of the investigation.

While, this practice is under the control of the Central Bank to ensure that the code of ethics is followed in all cases. All referrals that were related to the case were effectively monitored by the companies, to ensure the confidentiality and objectivity of the investigation were met without affecting to the engagement with the client. At the same time, only Ethical Insurance tends to know their client’s feedback when they are involved in the investigation. For them, it is highly important to know the client’s perspective towards the investigation and to determine the performance of the investigators. This helps the companies to ascertain which investigator companies are more appropriate for their cases. Only Ling Insurance and Ethical Insurance have a consistent policy regarding the application of sanction because they have a list of the possible results from previous cases. Amy Assurance does not have any consistent policy on sanction because their work depends on the policy implemented by consult lawyers, referring sanctions to the power of the company lawyer. The decision is non-consistent and towards a case basis. This can be found in Table 7.8 where sanctions are discussed. Ling Insurance and Ethical Insurance scored 8 and 7 respectively, while Amy Assurance just managed to score 5.

When choosing sanctions, all companies agreed that they have causes of action within criminal and civil action. This was related to the features and the seriousness of the cases towards the company and general public. The most popular sanction was opting not to pay for the claim. This was simple but would have future implications if the cases were brought to the court if the claimant was not satisfied with the case output.

In all of the companies the application of the sanction takes place at the end of the cases as it needs to be thoroughly investigated. All of the investigator’s works and agreement from the board of fraud management helps the company to make a decision regarding the cases. The monitoring process ensures the application of sanctions to clients as the company wants to certain that the deterrence effects are being imputed with resolutions. However, they never engaged any independent quality assurance to monitor the process of sanctions since this will cost more.
Luckily, all the companies have a proper policy that can recover losses regarding fraud and corruption. This was understood by the ideas that all transaction was covered by the policy of trust and the company have special terms in agreement to reject any types of the claim that obviously includes elements of the fraud. The company also determined to manage it by making the risk level for any policy that was agreed with the clients in order to manage the recoverable investments.

From the survey, it can be concluded that the responses totally agree that the company are anticipating anti-fraud culture in the company by 97.3%. This is because most of the company are well aware about the problem as the survey was taken during courses that directly discuss insurance fraud and the claim handlers function to mitigate the potential fraud. All of the respondent determine that the company have the fraud control policy at the 83.78%. This includes components of risk assessment activity and the complete code of conduct in the company on the matters. The company at the survey also were having the fraud awareness campaign that appear to be consistent and prepared their staff for any possibilities with proper training on fraud that dominantly from the outside speakers. As their assumption that it is a must for all company to have the fraud control operation, the survey listed some of the popular method of the fraud reporting and the applicable fraud data that would be referred as their guide. The survey listed the normal red flags at the same time in order to highlight the possible indicators. Unfortunately, it was clearly shown in the survey that the company are not prone to sharing cases within the company with outsiders unless it was assumed to classify as the criminal conduct.

From interview, almost all the companies used civil or criminal law in order to recover the losses because it is vital to ensure that the clients tend to be more responsible for the payback. Relate to Table 7.9 on the redress, again Ling Insurance scored the highest ordinal cumulative with 15 compared to Ethical Insurance with 9 and Amy Assurance with 6. In these stages, most of the company have a monitoring process of the recovery of the loss to ensure that it is not lacking in their system. In the same time, the success rate of recovering will be monitored and this is fast becoming one of the critical success factors for the action contributing to the initiatives of countering fraud action.
8.2.5 Defining Success
The company have several areas that can be defined as success factors which are included in Table 7.10. Most probably the risk of fraud awareness is embedded for all of the companies in their operational guidelines and the financial internal control structures. This is because all companies in the industry are categorized as controlled fully regulated industry by the Central Bank where almost all of them need to comply with certain criteria of operation. Fraud and corruption criteria are always major considerations in the normal operating environments. That includes the indicators of illegal actions such as fraud and indicators are constantly updated in order to keep track with the threats in the market place. The awareness of this is highlighted through the claim management and the establishment of a committee to manage fraud cases.

After all, the achievements stated by the companies are measured differently. In Amy Assurance, they estimate the achievement when the company lawyer is able to ensure that the company are not making a wrong payment towards the cases of fake claims. Ling Insurance assesses their achievement based on when the structure of countering fraud is functioning well and able to reduce a lot of cases reported. While, Ethical Insurance justify their achievements when their external investigators are able to save a lots of money through the correct channels of investigation.

Policies established in the company which specifically target countering fraud are usually the correct guidelines which are modified regularly to ensure that it is aligned with the current economic setting and appropriate for the company mode of operation. The effect of downsizing and reorganization of the company effects the policy investment when it will be more limited due to future expected events.

Cost saving is among the features that enrich the success of the initiatives taken. In Amy Assurance, it showed that if the initiative succeeds it would contribute towards high savings since the amount of life policy is high and expensive. While, in Ling Insurance if the ratio of claim decrease, it would assist the company in generating more income proportionately. In Ethical, the settlement outside of court is more favourable because it vastly reduces the costs that would be incurred by a court case.
8.3 Theoretical and Research Implications

Based on the previous chapter, there were numbers of phenomenal theoretical observations being exercised through the evaluation in the CIPFA Red Book 2 and the findings of the selected case studies of Amy Assurance, Ethical Insurance and Ling Insurance. Besides, when the survey was conducted, in general all the claim handlers and the loss adjustors are represented through the company that are either directly or indirectly involved within Malaysia insurance industry. From this, it was clearly shown that all of the companies studied to make comprehensive strategies in their initiatives to counter the fraud problem in the company operation that is mainly concentrated with fraudulent claims. The claim officers, investigation officers, loss adjustors and private investigations are experienced and simultaneously highly cautious to the possibility of fraud threat in their daily works routine.

The insurers needed to out-source professional works especially on the preventative, investigative and sanctions work. This is because, companies assumes all officers need to have limited knowledge on general terms to combat the fraud in the works, but the technical and professional work would be accomplished by using a third party service. Meanwhile, from Chapter 5, the associations looked as do not have enough power on the issues because it can be more related to internal matters and could be strengthened within the company internal control structure. The associations were just functioning on matters of sharing and agent meetings to enable the insurers to unite for the purpose of knowledge, experience and technology.

The interview findings are only based on three of all insurers in Malaysia and some interviews with the association. It may not be conclusive enough and need further investigation possibly using an empirical and theoretical structure that can be applied to the issues. Meanwhile, the survey helped the researcher in making general statements on several themes. However, it cannot represent the whole population of the insurers as whole because the survey considered the fraud themes that in the courses of MII which are really related in the matters. To highlight that, the research was the first of its type to be brought into the insurance market ideas in Malaysia since the issues have not been discussed in this country’s setting before. The issues appear of a ‘sensitive’ nature as they relate to the company’s internal control that would be the concerns of the internal auditor only. As the survey only
had 33% with the directed sample, it is considered to be good enough for some generalization (Sekaran, 2004).

The myths that case study based research always brings a risk that they might not be representative of the whole situation regarding the issues. By that, the follow-up survey hopes to overcome those loop-holes in making possible generalization on the issues. Therefore, it is important that other continuous research is carried out with a comparable economic setting in order to assess if the findings of the research is able to be generalised. It was useful that the research was carried out within the Institute of Insurance Malaysia companies’ members to ensure that it was widely collaborated and the investigative matters would be reliable and other general concerns. To highlight that the status of the companies that are dominated by the foreign players somewhat shows some implication to localized any prescribes law in the domestic markets.

A significant finding in Chapter 5 was the importance of the roles played by the external adjustors and investigators in the market as they were really helpful in making the structure of the initiatives to be more powerful and reliable as a control strategy to the threats. This can be seen through the contribution of this party in the control framework that always been behind-the-scene structure and they can be included at any modules for combating fraud. The adjustors at the same time are well trained and more exposed to the latest tactics of the possible fraud claims. This kind of experience and training is impossible to be gained by the insurer’s officers since their purpose is not to work for the company on the objectives of combating fraud.

Other issues arising that also require further research. The change of tasks for combating fraud from the claim officer to the outside professionals needs further investigation. This would create the issues of confidentiality, the strategy, the tools and the total budget allocated for the initiatives. In the current setting, it looks like the use of the outside professionals are merely voluntary steps since the whole market place still considers that the problem is not the worse threats. However, due to the facts that the numbers of the losses due to fraud in insurance published by ISM are tremendously rising each year, there is a possibility that the need for an outside professional would become reality and companies will be more willing to appoint them rather than having the internal expertise.
The regulations in Malaysia also need to be strengthened in order to make sure that the country is seriously tackling on the issues of fraud and corruption. The law regarding protection against a whistle blower was introduced in late 2010 known as the Whistleblowing Protection Act 2010. This act is one of the initiatives that would be the national agenda against fraud and corruption to ensure that everybody is brave enough to go upfront for reporting fraudulent and corrupted acts that happen within the government and private institutions as the whole economic structure. The ideas have been imputed in the law but until now the implementation of the policy is still in doubt. Due to this research, the company can gain advantage if the law was being offered to combat again illegal act in the company.

The pattern of the respondents actually showed the general assumption whether it is done with free will or merely fulfilling their obligation either in the interview session or through survey. In the Amy Assurance, the officer looks to offers the details and data on the case just base on the structured questions that were delivered earlier. So, they are answering in a more structured with less elaboration. They also limit the data and documents that are submitted in the interview session. While, in Ethical, the interviewer is given a good welcome and involved with some organized programs. This enables the researchers to inspect for some documents and conducting observations on the sites. After that, the collection processes look more persuasive and representable to the researchers. The situation in Ethical also took place during the interview session with the Ling Insurance. Nonetheless, all the companies should be given a huge appreciation because among all of the insurers listed in the MII members, just three were willing to cooperate with the research exercised. This situation was also quite critical when the questionnaire which was distributed in the survey with pre-stamp envelopes, only saw a very low return rate although the researcher employed a directive sampling population.

Considering the level of implementation of countering fraud in the company from the interview, documentation and observations, and based on CIPFA Red Book 2 evaluation the level of the initiatives can be ranks as the figure 8.1 below;
Based on the Likert scale, the company that can be determined as highly ingenuity and more concentrated on the works done in the five groups above where the highest total ordinal cumulative score is 327. All insurers scored in the evaluation criteria as analysed in Chapter 6 and 7 brings the ordinal cumulative score from the table in order to determine levels of initiative from them. Ling Insurance and Ethical Insurance respectively scored 243 and 203. Ling Insurance scored at the mid height even though they heavily rely on outside professionals because they have circulated the Fraud Management Framework and equally Ethical Insurance, although they are more towards their internal strengths. While, Amy Assurance are determined as having mid low initiatives because the company fully rely on the works of outsiders and the control in house is very limited in application. This is the classification based on the interviews, documents, observations and criteria of evaluation in the CIPFA Red Book 2.

The levelling is not for the purpose of comparison but more towards supervising the pattern that occurs in the market from the well-known companies. This enables the conclusion that the level of initiatives is different in the companies in Malaysia but still on a satisfactory level where none of the companies were noted to have zero initiatives.
Possible research can be administered to all the other insurance companies in order to determine the level of initiatives in the companies as the whole market player. Besides, the follow-up survey which was more directives did not provide much conclusive evidence. It can be done with the cooperation of all the players but it would be difficult to administer unless BNM ordered all of them to be participate. If this was possible, Malaysia would be able to produce some indices on the level of the implementation by insurance companies on countering fraud strategies as a national agenda. By that, researchers need to develop their own evaluation structure rather than relying on the professional to produce a structure because it needs to be ‘well customized’ with the national culture rather than fully adopting.

8.4 Conclusion

The Malaysian insurance industry is dominated by foreign insurers. It looks progressive and well prepared in the ideas of confronting with the insurance fraud in the last 5 years. All insurers are more towards individualist initiatives and need more collective support in order to cooperate. This can assume that the progress to counter fraud are more toward the ‘agency’ efforts and not in the ‘industry-widen’ policy. This case study provides supportive evidence that it needs for more serious arrangements in the whole industry.

At the same time, this case study can be opted for initial comparison on the setting up landslide for the issues as it can be well discussed within the whole industry players as normally organized by NIAM in the forum on ad hoc basis nowadays in Malaysia. But possibly, issues would remain untouched when the insurers prefer to stick with their own strategies and tactics that-so called ‘agency’ efforts. Hence, fraud issues are like to continue to be taboos for open discussion and internal matters, without considering the benefits of a sharing basis. By the way, certain considerations need to be overcome before any collaboration exists such as costing, long term benefit, timing and the information sharing. It was possible sinking and distort due to the assumption that ‘insurance fraud is the non-victim fraud’.

261
REFERENCES


ACFE. Association Of Certified Fraud Examiners (2006). Report To The Nation On Occupational Fraud And Abuse. Austin, Texas, US.
Aetna Insurance, C., & Grant, B. F. Queen's Bench, Appeal Side : Benjamin Grant, (Plaintiff In The Court Below) Appellant, And The Aetna Insurance Company, (Defendants In The Court Below) Respondents: [S.L. : S.N, 1860?].


Vols 1 And 2, 242-249.
Constitution Of Malaysia (1957). Malaysia Act


Corruption In Kazakhstan’, UNDP
Klitgaard, R. (1995), ‘ Institutional Adjustment And Adjusting To Institutions’Discussion
KPMG(2005), Fraud Survey 2004 Report, KPMG Forensic, Malaysia
KPMG(2010), Fraud Survey 2009 Report, KPMG Forensic, Malaysia
KPMG. (2011). Business Under Threat As UK Fraud Exceeds £1bn Retrieved 1 Jan, 2012,
From
Http://Www.Kpmg.Com/Uk/En/Issuesandinsights/Articlespublications/Newsreleases/
Pages/Business-Under-Threat-As-Uk-Fraud-Exceeds-%C2%A31bn.Aspx
False Claims Act. [Historical Article,:]. Annals Of Health Law /Loyola University
Chicago, School Of Law, Institute For Health Law, 19(1 Spec No), 13-17.
Krawczyk, M. (2009). The Role Of Repetition And Observability In Deterring Insurance
Political Studies, 53(1), 222–239
Lambsdorff J. G. (2007), The Institutional Economics Of Corruption And Reform: Theory,
Evidence, And Policy. Cambridge University Press, Cambridge
Journal Of Economic Behavior & Organization 48, 221-241
; London: Mcgraw-Hill.
Jacob's Precedents Of Pleadings (14th / General Editors: Lord Brennan, William
Blair ; Advisory Eds.: Brian Langstaff, Sir Robin Jacon ... Et Al. Ed.). London: Sweet
& Maxwell.
And Empirical Journey. British Journal Of Criminology. 48, 293-318
Economic Impact Of Fraud In The UK, Report For The Association Of Chief Police
Www.Acpo.Police
Lewis, P. R., Reynolds, K., & Gagg, C. (2004). Forensic Materials Engineering : Case
Http://Www.Lectlaw.Com/Def/C314


Malaysia Annual Budget (2008). Ministry Of Finance
Malaysia Annual Budget( 2009). Ministry Of Finance


Meier, B. D., & Homann, D. (2010). Fraud In The Health-Care System From The Perspective


Elsevier Ltd: Journal Of Criminal Justice.
Disability Claims [Electronic Resource] : Early Risk Identification, Intervention, And
Papers : The Anatomy Of A Fraud. Santa Barbara ; Chichester [Etc.]: Wiley.
NY: John Wiley and Sons, Inc.
94(4), 22.
Silverstone, H., & Sheetz, M. (2007). Forensic Accounting And Fraud Investigation For
Regulatory Issues. Wiley Finance
Internationally On The World's #1 Auction Site. New York: AMACOM.
Retrieved From Business Time Online Website:
Economic Cooperation.
Smarzynska, B.K. And S. Wei (2000), ‘Corruption And The Composition Of Foreign Direct
Institute Of Criminology, April 1999
Institute Of Criminology
Sohail J. (2007). Islamic Insurance: Trends, Opportunities and the Future of the Takaful,
Euromoney Books

Standards Australia 2003, AS 8001-2003 Fraud And Corruption Control’, Standards Australia International, Sydney


Welsch, H., (2005), ‘Corruption, Pollution And Economic Development’, Transparency International


APPENDIX 1: QUESTIONS FOR INSURANCE COMPANIES BASED ON THE UNIT

PART A: CLAIMS UNIT

<table>
<thead>
<tr>
<th>ITEM</th>
<th>AREAS/ QUESTIONS</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1</td>
<td>Process and the procedures of the claims unit</td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>What is the procedure involves in the claims?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>How the unit determine the real or forged claims?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>What is the control that involve in the process?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Is there any incidents when the claims unit have detect any fraud occurred on claims?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>How effective the current control that in practice detect insurance fraud and scams?</td>
<td></td>
</tr>
</tbody>
</table>
### Part 2: The method to determine and confirms on the red flags

<table>
<thead>
<tr>
<th>Q</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>How the claims unit determines any claims as red flags?</td>
</tr>
<tr>
<td>Q2</td>
<td>What is the method used in determined the red flag? Is the method is automated or based on analysis?</td>
</tr>
<tr>
<td>Q3</td>
<td>How’s effective the current method used in determine the red flags?</td>
</tr>
<tr>
<td>Q4</td>
<td>What are the criteria that would confirm the red flags as the possible fraud?</td>
</tr>
<tr>
<td>Q5</td>
<td>Which parties that would be contributing in confirm the red flags occurred as the possible fraud incidents?</td>
</tr>
<tr>
<td>Part 3</td>
<td>Procedures specific from AMLA 2001 that able to detect fraud or scams</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Q1</td>
<td>Is any specific procedure that enacted in AMLA would consider as fraud detection?</td>
</tr>
<tr>
<td>Q2</td>
<td>Who and how the procedure would be run in the claims unit?</td>
</tr>
<tr>
<td>Q3</td>
<td>Based on the previous experiences, what types of insurance fraud or scams that have been detected using the procedures?</td>
</tr>
<tr>
<td>Q4</td>
<td>Is any training provided internally or externally provided in related to the procedures that being done?</td>
</tr>
<tr>
<td>Q5</td>
<td>After the determination of the red flags using these procedures, what is the responsibility of this unit on the investigation?</td>
</tr>
<tr>
<td>Part 4</td>
<td>Specific training involved in enhance the ability to detect and prevent fraud or scams</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Q1</td>
<td>If any training provided in detect and prevent the insurance fraud in the unit?</td>
</tr>
<tr>
<td>Q2</td>
<td>What are the specific components or model of the training relate to prevent and detect the fraud?</td>
</tr>
<tr>
<td>Q3</td>
<td>Is the training provided internal or externally?</td>
</tr>
<tr>
<td>Q4</td>
<td>How effective the training provided in increasing the skills or professes on using the method of detection?</td>
</tr>
<tr>
<td>Q5</td>
<td>What is the intent or possible training that claims unit hope would be increase the unit ability in prevent and detect the fraud incidents?</td>
</tr>
</tbody>
</table>
## PART B: RISK ASSOCIATES UNIT

<table>
<thead>
<tr>
<th>Item</th>
<th>Areas/Questions</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1</td>
<td>Risk Assessment method that been implemented</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>What is the main function of the risk unit?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>What is the risk determined by the unit based on the insurance product that available in companies?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>Which party that going to be involved in the risk assessment process for any insurance premiums?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>What type of the risk assessment method involve currently?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>How’s effective the current method of risk assessment in determining the possible fraud?</td>
<td></td>
</tr>
<tr>
<td>Part 2</td>
<td>The cost incurred during the process of estimation</td>
<td>Remarks</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Q1</td>
<td>What is the cost involved during the process of risk assessment?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>What is the cost of risk if based on the interpretation of the unit?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>Does the risk cost is usually is more than the assessment cost? How the company determine the risk for low cost premiums?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Does the cost incurred during assessment are going to inflate the cost of the premiums paid based on the high risk profile or companies?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>Did the cost of fraud prevention would be acknowledge as the components that paid by the customers?</td>
<td></td>
</tr>
</tbody>
</table>
### Part 3

**The major red flags determine for prevention of the fraud**

<table>
<thead>
<tr>
<th>Question (Q)</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>What are the main red flags in the risk assessment unit?</td>
</tr>
<tr>
<td>Q2</td>
<td>Is the incompliance is can be consider as the major red flags? Why?</td>
</tr>
<tr>
<td>Q3</td>
<td>What is the method of determining the red flag in the risk assessments units?</td>
</tr>
<tr>
<td>Q4</td>
<td>What are the major red flags that have been determine till now in the unit based on the previous cases?</td>
</tr>
<tr>
<td>Q5</td>
<td>Would this kind on red flags detection in the units would be able to use as the fraud prevention in insurance?</td>
</tr>
<tr>
<td>Part 4</td>
<td>Procedure for company that determined as highly risk for fraud</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Q1</td>
<td>How the company or customer risk is could be determine as risk likely for fraud or scam?</td>
</tr>
<tr>
<td>Q2</td>
<td>What is the level of risk that still can be tolerated as the less risky to fraud?</td>
</tr>
<tr>
<td>Q3</td>
<td>What are the following procedures if the customers have been determine as possibly fraud occurred?</td>
</tr>
<tr>
<td>Q4</td>
<td>Are the customers going to be acknowledging if the risk assessor determine the case of possible fraud for some explanation?</td>
</tr>
<tr>
<td>Q5</td>
<td>Can the risk assessment function overall been determine as the fraud prevention, detection and investigation effectively to curb fraud and scams?</td>
</tr>
</tbody>
</table>

xxx
PART C: INVESTIGATION UNIT

<table>
<thead>
<tr>
<th>Item</th>
<th>Areas/Questions</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1</td>
<td>How the investigation formulate in the companies</td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>What is the main function of investigation unit?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>When the unit are going to start for the investigation? What type of case? What factors contributes for this to initiates?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>What is the power of the investigation unit?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Does the investigation unit been related to any restriction, regulations and laws to determine the cases that need for investigations?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>What is the relationship of this unit with the other respective unit? In the case of fraud, is the report from others unit need before the main procedure maintain?</td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>What are the main procedures in normal investigation?</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>Is the investigation for the likely fraud cases are different compare to general purposes of investigations?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>How the unit determine that the case is highly relevance and cost beneficial to been investigated?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Is the unit are going to done investigation on the fraud by using the internal or outside expertise? In what condition that the outside expertise would involves with the fraud investigation?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>Is the current practice investigation procedures taken for the last cases are effective enough to solve the cases?</td>
<td></td>
</tr>
<tr>
<td>Part 3</td>
<td>Prosecution procedures when the criminal or civil case determine</td>
<td>Remarks</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Q1</td>
<td>After the investigation completed and determined, what is the prosecution process involves?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>How are the unit determining the types of prosecution based on different cases and different insurance product?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>Is any specific tribunal or bureau that going to consider on the prosecution process in Malaysia?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>What is the function of the unit in the main prosecution cases?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>Are there any cases of prosecution whether criminal or civil cases that already involved in the companies? Any specific data?</td>
<td></td>
</tr>
<tr>
<td>Part 4</td>
<td>The current legislation used in order for the sanction process</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>What is the related law on the punishment process??</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>Which authorities body that playing the main function on the sanction for the insurance fraud and scams?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>What type of normal punishment that involved usually on the cases of the insurance fraud? Any related data?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Are any serious cases of sanctions that involve the company lately? Does the investigation unit playing the major roles in that case?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>How is effective the tasks of the investigation unit in playing the roles as the fraud/scams investigation, redress and sanction for the company operations?</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 2

### SET 1: QUESTIONS FOR CENTRAL BANK AND INSURANCE ASSOCIATION

<table>
<thead>
<tr>
<th>Item</th>
<th>Areas/ Question</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1</td>
<td>Anti fraud culture that exist in insurance industries in Malaysia</td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>What types of insurance fraud do exist and what is extents in Malaysia?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>Who usually involved in this type of fraud?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>Who is the main victim in the industry?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>What are the initiatives taken by the company to reduce the fraud possibilities (Government, Companies or Individual)?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>Is all insurers taken fraud as the serious matters in operation?</td>
<td></td>
</tr>
<tr>
<td>Q6</td>
<td>Do you pursue measures to create anti fraud culture exist among the insurer, specifically in what area?</td>
<td></td>
</tr>
<tr>
<td>Part 2</td>
<td>Fraud prevention and control through the enacted in Insurance Act 1996 and AMLA 2001</td>
<td>Remarks</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Q1</td>
<td>What is the laws and regulation that would prevent and control insurance fraud incidents in Malaysia?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>Which bodies entices the laws and restriction?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>What is the function of Insurance Act 1996 in order to curb the insurance fraud?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>In what circumstances the Anti Money Laundering Act 2001 (AMLA) functioning in order to curb with fraud and scams by the customers?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>Did Insurance Act 1996 and AMLA 2001 able to becoming the tools in preventing and controlling the fraud?</td>
<td></td>
</tr>
<tr>
<td>Q6</td>
<td>What is the maximum penalties that would imply under Insurance Act 1996 and AMLA 2001?</td>
<td></td>
</tr>
<tr>
<td>Part 3</td>
<td>Fraud awareness and training provided in the market or by the BNM or PIAM</td>
<td>Remarks</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Q1</td>
<td>Do BNM/PIAM offer any fraud awareness and training?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>Does any other organization or professional bodies that provide the fraud awareness and training on anti fraud in Malaysia?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>What are the component / syllabus of the anti fraud training that organized for the insurer?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Does everybody, the insurers or the members must to go for this kind of training? How frequent of that training?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>Is the training on the anti fraud effective and efficient based on the current situations to insurance companies?</td>
<td></td>
</tr>
<tr>
<td>Q6</td>
<td>Did the training that undergo by BNM or PIAM is successful till now in curbing the fraud cases in Malaysia?</td>
<td></td>
</tr>
<tr>
<td>Part 4</td>
<td>Prosecution data in Malaysia on the insurance fraud</td>
<td>Remarks</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Q1</td>
<td>Is the any insurance fraud prosecution in Malaysia? What is the current data?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>What is the major type of prosecution/trial that involved? Are there any civil sanction?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>How big the lost is related to major and minimum types of prosecution? What is amount of loss of the cases that would consider to tribunal charges?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Which related regulated officer that involved with the prosecutions directly and indirectly? Any tribunal or bureau involved? Any financial intermediaries involved?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>How effective the prosecution of insurance fraud in Malaysia? How effective the function of tribunal that established?</td>
<td></td>
</tr>
<tr>
<td>Q6</td>
<td>Do we have any big example of the insurance fraud prosecutions in history?</td>
<td></td>
</tr>
<tr>
<td>Part 5</td>
<td>Act and guidelines existed in the operation regards on anti fraud and scams.</td>
<td>Remarks</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Q1</td>
<td>Is there is other regulation that would be follow by the insurers in order to curb the fraud action (other than Insurance Act 1996 and AMLA 2001)?</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>Who are the regulatory bodies in relation to that acts or regulations?</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>Does the Bursa Malaysia (KLSE) created any restriction or regulation on enduring the insurance companies in the listed market from any potential fraud?</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Is the Securities Commission (SC) playing any function on the insurance companies to shrink out the possibilities of insurance fraud?</td>
<td></td>
</tr>
<tr>
<td>Q5</td>
<td>Is the internal guidelines and regulations would exist on the issues?</td>
<td></td>
</tr>
<tr>
<td>Q6</td>
<td>How’s effective and efficient of the anti fraud strategies inside and outside of the insurance companies?</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 3

SET 3: QUESTION FOR THE ANTI FRAUD SPECIALIST IN INSURANCE FRAUD

<table>
<thead>
<tr>
<th>Item</th>
<th>Issues/ Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1: Anti fraud culture</td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>What are the features for the types of works that this firm involve?</td>
</tr>
<tr>
<td>Q2</td>
<td>What could understand as the ant fraud culture in companies?</td>
</tr>
<tr>
<td>Q3</td>
<td>How are you determining that anti fraud culture exist in the organization?</td>
</tr>
<tr>
<td>Q4</td>
<td>What is the component in that culture that need to be obviously implemented?</td>
</tr>
<tr>
<td>Q5</td>
<td>How are we determining the effective and efficiency of any anti fraud culture in the organization?</td>
</tr>
<tr>
<td>Q6</td>
<td>Does any of insurance company in Malaysia did implement the culture formally in their main operation?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Part 2: Fraud prevention and control</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Q1</strong></td>
<td>Is there any initiative of fraud prevention in the insurance companies as your last experience?</td>
</tr>
<tr>
<td><strong>Q2</strong></td>
<td>What type of prevention and control against fraud that exist?</td>
</tr>
<tr>
<td><strong>Q3</strong></td>
<td>Are all the insurance companies implementing the same method of prevention and control?</td>
</tr>
<tr>
<td><strong>Q4</strong></td>
<td>Is the method of prevention and control that currently implement in the companies really works?</td>
</tr>
<tr>
<td><strong>Q5</strong></td>
<td>If not, what was your suggestion to improve the prevention and control activities?</td>
</tr>
<tr>
<td><strong>Q6</strong></td>
<td>What were the most suitable ideas on prevention and control for insurance companies in Malaysia due to the environment of business in here?</td>
</tr>
<tr>
<td>Q1</td>
<td>Does any program on fraud awareness being implement in most of the insurance companies?</td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Q2</td>
<td>What the main awareness on the nature is of works that your companies done basically?</td>
</tr>
<tr>
<td>Q3</td>
<td>Does the fraud awareness been highlighted in your client companies on the normal routine operation?</td>
</tr>
<tr>
<td>Q4</td>
<td>Does any companies doing the formal training on the fraud awareness??</td>
</tr>
<tr>
<td>Q5</td>
<td>Does your company offer any module on the fraud awareness for outsider training?</td>
</tr>
<tr>
<td>Q6</td>
<td>What was the relevant knowledge on the fraud that you think to have with the entire insurer regarding the anti fraud initiatives?</td>
</tr>
<tr>
<td></td>
<td>Part 4: Fraud control operation</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Q1</td>
<td>Does the insurance companies always done the control on the routine basis against the fraud?</td>
</tr>
<tr>
<td>Q2</td>
<td>What was the normal written or verbal inspection that related with the controlling the fraud with the customers?</td>
</tr>
<tr>
<td>Q3</td>
<td>Does the normal routine procedure always been inspect with the controls elements on documentation and records?</td>
</tr>
<tr>
<td>Q4</td>
<td>What was the function that could be playing by the investigator to inspect the log of activities and customer background in the cases?</td>
</tr>
<tr>
<td>Q5</td>
<td>How much the level of exposure that the investigator would be able to concern in the routine activities?</td>
</tr>
<tr>
<td>Q6</td>
<td>Does the investigation would relate to the internal audit control mechanism when doing the thorough checks on the fraud items?</td>
</tr>
<tr>
<td>Q1</td>
<td>What is the type of crime that exists for most of the fraud cases? Is it civil or criminal?</td>
</tr>
<tr>
<td>Q2</td>
<td>What is the main classification for the crime that involves?</td>
</tr>
<tr>
<td>Q3</td>
<td>How the initial investigations that would involve your company?</td>
</tr>
<tr>
<td>Q4</td>
<td>Which cases that usually been referred to the outside investigators?</td>
</tr>
<tr>
<td>Q5</td>
<td>How the cost of the investigation would be benefited the insurer on your ideas?</td>
</tr>
<tr>
<td>Q6</td>
<td>What is the background of the investigators that would involve on certain cases?</td>
</tr>
<tr>
<td>Q7</td>
<td>Does this company have the employee on the permanent basis?</td>
</tr>
<tr>
<td>Q8</td>
<td>What is the rate for investigators? Is it depends on the complicated of the cases involved?</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Q9</td>
<td>Does the company would have the problem in some of the cases of investigation when the preceding is failed?</td>
</tr>
<tr>
<td>Q10</td>
<td>What is the normal type prosecution that involved?</td>
</tr>
<tr>
<td>Q11</td>
<td>Does your company have a big record on the fraudster trial in this country?</td>
</tr>
<tr>
<td>Q12</td>
<td>Does the Central Bank playing a major role in the trial of the fraud relating to fraud in insurance? How they playing their function?</td>
</tr>
<tr>
<td>Q13</td>
<td>What is the main function of Financial Resolve Tribunal in the cases of the insurance fraud? How effective their function?</td>
</tr>
</tbody>
</table>

Part 6: Act and guideline regarding the policy

<table>
<thead>
<tr>
<th>Q1</th>
<th>What is the main act that needs to be obtaining for the function of the investigators?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2</td>
<td>When the investigator are going to contact for the law firms or continue procedure after the fraud investigation</td>
</tr>
<tr>
<td>Q3</td>
<td>Does the laws and orders in Malaysia able to curbs with the insurance fraud or scam?</td>
</tr>
<tr>
<td>Q4</td>
<td>What was exactly the function that can be enacted from Insurance Act 1996 and Anti Money Laundering Act 2001 regarding the insurance fraud acts and scams?</td>
</tr>
<tr>
<td>Q5</td>
<td>Does the Royal Malaysia Police playing the major function in the works of the investigators? How?</td>
</tr>
<tr>
<td>Q6</td>
<td>Does the Central Bank (BNM) need all the investigators to be reported or registered with their authority bodies or tribunal? How?</td>
</tr>
<tr>
<td>Q7</td>
<td>Does the works of investigators would involved the other parties like Anti Corruption Agency, Federal bureau of Investigation, CIA or other related investigative bodies?</td>
</tr>
</tbody>
</table>
APPENDIX 4:
SURVEY ON COUNTERING FRAUD IN THE INSURANCE INDUSTRY- A GENERAL VIEW FROM INSURANCE PRACTITIONERS

Researcher: Mudzamir Mohamed, UUM and Research Unit of Malaysia Institute of Insurance, MII Malaysia

You are being invited to take part in this research study. Before you decide it is important for you to understand that the research is being done are for ACADEMIC consent and it involves only the practitioners on the insurance industry especially those involve with this Insurance Fraud courses. Please take time to read the questions carefully and you can ask the researcher if there is anything that is not clear or if you would like more information. The participation is on the voluntarily basis and it is for the benefit of insurance industry.

You will be review regarding the topics of the practice of countering fraud in your organization. You would be expected to contribute your professional view regarding the issues. If there are any possible follow up interview to be done, we would notified you in advance. The practice of the countering fraud that will be asked consists of anti-fraud culture, fraud prevention strategies, fraud detection procedure, fraud awareness and training, any crime prosecution actions and relevant act.

The information provided would be kept by the MII and the researcher for the purpose of academic and policy development.

Name:
Organization/ Companies:
Courses involved with MII:
Part 1 – Anti fraud culture

1. Is your company involved to anticipated the anti-fraud culture? (tick any once)
   - YES
   - NO
   If YES, What kind of activity that have been organized?

2. Is internal audit department (IAD) will be the main respondent for the this culture cultivate? (tick any once)
   - YES
   - NO
   - If Yes, What kind of effort emphasis by IAD?

3. How you define fraud? (tick any once)
   - Bad
   - Good
   - Depends

4. Is it the fraud and corruption is clearly defined in any company code of conduct, act or regulations? (tick any once)
   - YES
   - NO

5. What is the level of the fraud that usually engages, (tick any one)
   - national,
   - domestic
   - small scale

6. Is the occupational fraud or the corruption is the main type of corruption that do exist for the time being? (tick any one)
   - YES
   - NO

7. How many fraud and corruption case has been handled? (tick any one)
   - Lower
   - Medium
   - Higher
8. Total value of fraud cases. (tick any one)
   o Less than RM1,000
   o RM1,000 to RM5,000
   o More than RM5,000

9. Is any relevance changes to the level of fraud since the cases is well known to the public? (tick any one)
   o It is becoming better
   o It is becoming worse
   o No effect

Part 2 – Fraud prevention and control

10. Is the any specific policy on fraud control (tick any one)
    o Yes
    o No
    o Unknown

11. If yes, Who is contributing in the development of policy?

12. Have policy been revised along the period of time due to the sophistication in the environment? (tick any once)
    o Yes
    o No
    o Unknown

13. Have the company develop the specific codes of ethics and conduct (tick any once)
    o Yes
    o No
    o Unknown

14. What is the objective that put in the code of conduct? (tick more than one)
    o The surveillance of the company
    o To put better control policy
    o To make sure that everybody follow the laws

15. What is the effects that code of ethics or conducts currently? (tick any once)
    o Effective
16. Did your company include risk assessment program and indicators in the operation? (tick any once)
   - Yes
   - No
   - Unknown

17. Did your company have the fraud risk assessment? (tick any once)
   - Yes
   - No

18. If yes, is it relating to (tick more than one)
   - Theft
   - Income received not brought to account
   - Illegal transfer or diversion of money
   - Changes or addition to payee details through financial systems
   - False creation of or unauthorized updates
   - Unauthorized use of cheques
   - Wrong claimants
   - Grant funds are misappropriated
   - Overspend on the medicine supply
   - Making a contract on the interest
   - Overestimated the charges not based on the budget.
   - Theft of sensitive data

Part 3 – Fraud awareness and training

19. Is there any fraud awareness program in the departments? (tick any once)
   - Yes  …..(stated)………………………………………
   - No

20. How serious the effect of the fraud in the company? (tick any once)
   - High
   - Moderate
   - Low
21. Is the ethical awareness becoming the major concerns in company? (tick any once)
   o Yes
   o No
   o Unknown

22. Is the professional ethics on the Insurance industry as recommended by MII is highly considered? (tick any once)
   o Yes
   o No
   o Unknown

23. Does the general fraud training provided? (tick any once)
    Yes
    No
    If yes, state some………………………………………………

24. Does the investigation staff is going through the training regarding the investigation method? (tick any once)
   o Yes
   o No
   o Unknown

25. Is there anybody consider as a highly skill in the investigation department? (tick any once)
   o Yes
   o No
   o Unknown

26. If there is outsourcing of the provision of training on the fraud related matters? (tick any once)
   o Yes
   o Sometimes
   o No, all in-house
Part 4 – Fraud control operations

27. Are any operational structures responsible for managing fraud (tick any once)
   - Yes
   - No
   - Unknown

28. Which authority department that have been given to that function? (tick any once)
   - Accounts
   - Audit departments
   - Management / General departments
   - Others, specific

29. What is the mechanism for fraud reporting? (tick more than one)
   - Hotlines
   - High level of management
   - Internal auditor
   - Online reports
   - Others, specific

30. What is major source of the fraud record in the company? (tick any once)
   - Internal data
   - Industry report
   - Others, specific

31. Does quality assurance system exist? (tick any once)
   - Yes
   - No
   - Unknown

32. What are the normal red flags on the occurrence of the fraud action in the company? (tick more than one)
   - Claim
   - Report
   - Documentation
   - Calls
   - Others, Specific
33. What are the departments that are going to be involved with fraud when red flag exist?

Part 5 – Crime prosecutions

34. Did the company actually promptly, completely, and effectively disclose the existence of the misconduct to the public, to regulators, and to self-regulators? (tick any once)
   - Yes
   - No

35. Did the company cooperate completely with appropriate regulatory and law enforcement bodies? (tick any once)
   - Yes
   - No

Part 6 – Acts and guidelines in practicing the policy

36. What is the act related to the fraud or corruption in the company? (tick any once)
   - Insurance Act
   - Others, State

37. What is the code of professional practice applicable? (tick any once)
   - MII Code of professional conducts for insurance companies
   - Others, state

38. What are any other rules that related to the countering fraud? (tick any once)

#End of questions

Thank you for your cooperation.
APPENDIX 5
Glossary of Takaful

**FAMILY TAKAFUL**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants' Account</td>
<td>An account to credit a portion of contributions from the participant for the purpose of investment/savings</td>
</tr>
<tr>
<td>Participants' Special Account</td>
<td>An account to credit a portion of contributions from the participant for the purpose of tabarru’</td>
</tr>
<tr>
<td>Takaful Annuity</td>
<td>A contract that provides a stream of periodic income upon retirement for a term dependent upon human life.</td>
</tr>
<tr>
<td>Contributions</td>
<td>Monetary contribution provided once or periodically by a participant to a takaful operator for the purpose of investment and tabarru’.</td>
</tr>
<tr>
<td>Retakaful Operator's Deposit</td>
<td>An amount deposited with or retained by a takaful operator by way of security for performance by the retakaful operator of its retakaful contracts.</td>
</tr>
<tr>
<td>Certificate Document</td>
<td>An evidence of a contract between a participant and a takaful operator which sets out the terms and conditions of the particular certificate.</td>
</tr>
<tr>
<td>Mortality Table</td>
<td>A statistical table showing the death rate at each age, usually expressed as the number of deaths per thousand.</td>
</tr>
<tr>
<td>Expense Rate</td>
<td>The ratio of total expenses for the year (including commissions, salaries, etc.) to the sum of total contribution income other than single contribution and consideration for annuities.</td>
</tr>
<tr>
<td>Surplus at Valuation Date</td>
<td>Excess of the takaful fund carried forward over the actuarial liabilities of a takaful fund of family takaful business.</td>
</tr>
<tr>
<td>Net Investment Income</td>
<td>Returns on investments less rates and taxes.</td>
</tr>
<tr>
<td>Rider</td>
<td>An attachment to a certificate that modifies its conditions by expanding benefits.</td>
</tr>
<tr>
<td>Investment-linked Takaful</td>
<td>A contract where the certificate benefits at any time vary according to the value of the underlying assets at the time.</td>
</tr>
<tr>
<td>Individual Family Takaful</td>
<td>A contract that provides takaful benefits payable to an individual upon death/total permanent disability or periodic income to participant upon retirement.</td>
</tr>
<tr>
<td>Group Family Takaful</td>
<td>Family takaful (usually without medical examination) on a group of people under a master Certificate. It is typically issued to an employer for the benefit of employees, or to</td>
</tr>
<tr>
<td><strong>Medical and Health Takaful</strong></td>
<td>A contract that provides specified medical treatment benefits such as the cost of hospitalisation, surgical and physician consultation fees against risks of a person being diagnosed with certain illnesses or having injury arising from an accident.</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Claims</strong></td>
<td>Notification to a takaful operator that payment of an amount is due under the terms of the certificate.</td>
</tr>
</tbody>
</table>

**GENERAL TAKAFUL**

<table>
<thead>
<tr>
<th><strong>Net Contributions</strong></th>
<th>Gross contributions less all retakaful contributions payable.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross Direct Contributions</strong></td>
<td>Contributions on original gross rate charged to clients in respect of direct takaful business without any deduction for commission or brokerage.</td>
</tr>
<tr>
<td><strong>Average Clause</strong></td>
<td>Stipulates that a takaful fund is only liable for such proportion of the loss as the sum covered bears to total value at risk.</td>
</tr>
<tr>
<td><strong>Indemnity</strong></td>
<td>Restoration to the claimant of a loss by payment, repair or replacement.</td>
</tr>
<tr>
<td><strong>Total Loss</strong></td>
<td>A loss of sufficient size so that it can be said there is nothing left of value.</td>
</tr>
<tr>
<td><strong>Underwriting Profit / Loss</strong></td>
<td>Earned contribution income less net claims incurred, commissions and management expenses.</td>
</tr>
<tr>
<td><strong>Retention Ratio</strong></td>
<td>The ratio of net contributions to gross direct and retakaful accepted contributions less retakaful within Malaysia.</td>
</tr>
<tr>
<td><strong>Claims Ratio</strong></td>
<td>The ratio of net claims incurred to earned contributions.</td>
</tr>
<tr>
<td><strong>Earned Contribution</strong></td>
<td>Net contributions less provision for reserves for unearned contribution (RUC) at the year-end plus the RUC at the beginning of the year.</td>
</tr>
<tr>
<td><strong>Unearned Contribution</strong></td>
<td>Contributions already received in respect of risks which are still unexpired at the end of the accounting period.</td>
</tr>
<tr>
<td><strong>Reserves</strong></td>
<td>Contributions on original gross rate charged to clients in respect of direct takaful business Without any deduction for commission or brokerage.</td>
</tr>
<tr>
<td><strong>General Takaful</strong></td>
<td>Protection to participant for losses arising from perils such as accident, fire, flood, liability and burglary.</td>
</tr>
<tr>
<td><strong>Facultative Treaty</strong></td>
<td>A retakaful contract under which a ceding takaful operator members of an association.</td>
</tr>
</tbody>
</table>
has the option to cede and the retakaful operator has the option to accept or decline individual risks.

**Excess of Loss Treaty**

A type of retakaful treaty which provides that the retakaful operator pays all or a specified percentage of a loss arising from a particular occurrence or event (frequently of a more or less catastrophic nature) in excess of a fixed amount and up to a stipulated limit.

**Proportional Treaty**

A contract under which a takaful operator and a retakaful operator participate proportionately in the contributions and losses on every risk that comes within the scope of the contract.

**Net Claims Incurred**

Net claims paid less provisions for outstanding claims beginning of the year plus provisions for outstanding claims at the end of the year.

---

**FIQH CONCEPT**

**Mudharabah**

An agreement between the entrepreneur and the capital provider in a business venture to share profit based on an agreed profit-sharing ratio. Losses are borne by the capital provider.

**Shariah**

Islamic laws.

**Tabarru’**

A portion of participant's contribution for the purpose of mutual helps and used to pay claims Submitted by eligible claimants.

**Takaful**

Mutual guarantee provided by a group of people against a defined risk or catastrophe befalling one's life, property or any form of valuable things.

**Tijari**

Commercial business.

**Wakalah**

Agent-principal relationship, where a person nominates another to act on his behalf.

**Wakil**

Agent

**Hibah**

Gift

**Rabbul Mal**

Capital provider

**Qard**

Loan

**Qard al-Hasan**

Lending without interest or benevolent loan

**Riba**

Usury, Interest which is unlawful in Islam
<table>
<thead>
<tr>
<th>Arabic Term</th>
<th>English Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mudharib</td>
<td>Entrepreneur</td>
</tr>
<tr>
<td>Ra’sul mal</td>
<td>Takaful Contribution</td>
</tr>
<tr>
<td>Tijari</td>
<td>Commercial or private section</td>
</tr>
<tr>
<td>Ta’min</td>
<td>Insurance</td>
</tr>
<tr>
<td>Wali</td>
<td>Guardian</td>
</tr>
<tr>
<td>Wasi</td>
<td>Executer</td>
</tr>
</tbody>
</table>