Fraud and Corruption in the Insurance Industry: An Austrian Perspective

Maximilian Edelbacher and Michael Theil

Introduction

In democratic countries economy only functions, if basic principles are respected. Evidence of this thesis can be dramatically found by reviewing the history of countries in transition. After World War I and World War II, Germany, Austria and other European countries experienced a dramatic breakdown in the basic principles of law. Immediately after the breakdown of the monarchy and the Nazi regime, banking systems were destroyed, money was lost, and a black market developed in Germany, Austria and other European counties. These markets were ruled by violence, fear and organized criminals. People did not trust each other as well as the public institutions, and law and order were not functioning. The basic principles in a stable democratic country are:

1. Pacta sunt servanda **(1)**
2. Uberimae fidei **(2)**

Edelbacher (personal experiences) served on several missions by UNO and OSCE in Central Asia between 1999 and 2005. During the time he spent on these United Nations missions to countries in the midst of political turmoil, he immediately recognized that these principles where not fully respected in some of Central Asian countries. For example, rules and regulations of a banking system were not in power in one of these countries. People lost their money deposited in

M. Edelbacher (✉)
Academic Council of the United Nations, System Liaison Office Vienna, Vienna, Austria

M. Theil
Institute of Risk Management and Insurance, Vienna University, Vienna, Austria
e-mail: Michael.Theil@wu.as.at

P. C. Kratcoski, M. Edelbacher (eds.), *Fraud and Corruption*,
https://doi.org/10.1007/978-3-319-92333-8_9

the banks, broke down, and were no longer functioning shortly after the democracies were in transition. The people had no trust in the banking system and avoided saving money in the banks.

Basics of Insurance

The idea of insurance was originally developed to protect human beings against the consequences of natural disasters and other catastrophes which would otherwise ruin their lives if they did not have some relief from their losses. Theil (2012, p. 279) sums up the underlying principles followed by insurance companies. Theil states, "The main competence and therefore, the main reason for existence of insurance companies is their unique capability of dealing with risks other economic entities are unable or barely able to handle. In particular, the core techniques that insurance companies to manage risk are risk selection, risk pooling, building of reserves, and further transfer of risk". Thus the basic principles of insurance during the present time are based on the idea of solidarity and sharing of risks. The group, through their purchases of policies, contributes to the solution of the problem of the individual who may have suffered a tremendous loss as a result of some form of a disaster.

This notion of solidarity can be summed up in the following proverb:

> "A sorrow shared is a sorrow halved",
> as the proverb goes, or
> "One for all, and all for one".

However, this notion of solidarity presupposes mutual trust among the participants, the notion of "uberimae fidei". At the same time, the insurance industry is based on the probability of making a profit. The probability that the money taken in from premium holders will exceed that which is paid out to premium holders is the basic mathematical principle upon which the industry is based. If the mathematical assumptions, the precalculated harmony, are upset, the system will be out of balance. Crime is a factor, which may destabilize and seriously endanger the system. Thus, the development of crime has to be closely observed, and if the rate of crime increases, the insurance industry must develop counteracting mechanisms to combat the threat to the industry.

Insurance Fraud

Insurance fraud is sometimes referred to as the country's most popular sport. On the one hand, this type of fraud is not perceived as a criminal act; on the other hand, people tend to assume that insurance companies – in their glass-fronted palaces – are rolling in money. Those committing insurance fraud are unaware of any perpetrator-victim relation. A depth analysis on the meaning and the purpose of insurance illustrates this point more clearly.

Insurance fraud is not a new problem; as Prof. Dr. Geerds, University of Frankfurt am, Germany (1983), noted, insurance fraud has been committed ever since insurance has been available in the market. Fraud has been committed by all classes of individuals and by businesses and industry all over the world. Insurance fraud is a crime against property. The specific nature of insurance fraud is determined by the insurance contract between the insurer and the insured. This contract obligates the insurance company to indemnify the insured contingent on an uncertain, future event. In the case of insurance fraud, such an event is:

- Brought about on purpose.
- Pretended to have occurred.
- An actual loss is exploited.
- A contract is made on an unlawful basis.

Legal Provisions against Insurance Fraud in Austria

According to the Austrian Criminal Code of 1975, the definition of insurance fraud is met if there is an intent to cause damage, a loss has occurred and/or an attempt has been made to cause a loss (Geerds, 1983). In the course of the revision of the Criminal Code, Section 151 was introduced as a special provision covering insurance abuse. However, it turned out that in practice this provision is no more than a dead letter, as it is only applied to a very limited extent – mainly in the case of fictitious ski theft (Austrian Criminal Code, 1975, p. 92).

The provision of Sect. 298 of the Criminal Code (Austrian Criminal Code, Section 146ff, 1975, Section 298) regarding the pretence of a punishable act is applied occasionally. As a matter of principle, the police and the law enforcement authorities apply the general provisions of the Criminal Code regarding fraud, i.e. Sects. 146 and following, to combat insurance fraud.

Section 167 of the Criminal Code (Austrian Criminal Code, Section 167, 1975), i.e. the provision on perpetrators making voluntary amends, may give rise to problems in the course of co-operation between the insurance industry, the "anti-fraud squads" and the criminal police. The jurisdiction and the award of damages are based mainly on the so-called contingency principle, which means that a case is assessed according to the effect and the consequences of the event.

Understanding the Psychological Aspect of Insurance Fraud Motivation

In a literal sense, in reference to insurance terms, it is the event rather than the material property, which is covered by insurance. However, the victim expects the insurer to replace the property lost, regardless of why the loss occurred. Hence, taking out

insurance is perceived as a way of "making the damage undone". Moreover, many policy-holders – particularly those hit by major accidents – expect more than just financial indemnification. They want someone who cares and understands, that is, policy-holders desire human support and assistance, and they need someone to talk to about their fears and anxieties. Given the fact that insurers are neither confessors nor psychotherapists, many people feel left alone in their despair, particularly those who do not have family and friends to console them regarding their loss.

The insurance company has failed to fulfil their longing for care, recognition, love, feeling of community and security in life. In the event of a loss, the individuals concerned perceive the service they are getting from the insurer as materialistic and formalistic, but not very helpful in psychological terms.

After having paid their insurance premiums for a long period of time, many people become aware of two things:

1. *In the event of a loss, you never get what you really expect.*
   - The loss has occurred despite payment of the premium.
   - The accident cannot be made undone.
   - Claims adjustment and indemnification are experienced in purely material terms; personal care and attention are lacking.
2. *Having been loss-free for some time, many people tend to take stock*:
   - After so many years of paying the premium, one has never received anything from the insurance company.
   - Hence, an attempt will be made to get at least part of the money back.

For the individual, the insurance principle and the idea of solidarity underlying the insurance system are rather difficult to grasp, since people are not made sufficiently aware of the fact that "a sorrow shared is a sorrow halved". This is due, in some part, to the advertising line taken by many insurance companies, who have a tendency to underline the savings idea and the "waste not, want not" approach above that of a "we care" approach.

Organization of the Insurance Business in Austria

The Austrian insurance branch registered 88 members and 26,300 employees. The volume of premiums rose from 9.5% to 15%, 32 billion Euro in the end of 2005 (Association of Austrian Insurance Companies, 2006). Results of the year 2006 showed excellent performance of the insurance business in Austria, and it is presumed that more than a 10% of growth will be expected over the ensuing years (Association of Austrian Insurance Companies, 2006). The reason for the rapid growth is predominately due to the expansion to the eastern part of Europe. The Bulgaria and Romania developments were very fruitful. Austrian insurance companies and financial institutions make a lot of money in this portion of Europe.

Dimensions of Insurance Fraud in Austria

Last statistics show that about 3.2 million cases of damages were reported to Austrian insurance companies. It is estimated that between 5 and 10% of these reports may be fraudulent reports. That means the dimension of insurance fraud may reach nearly 1 billion Euro. Out of this about 15% can be clarified and stopped as fraud by specialists of insurance companies and reported to police and justice.

Types of Crime Affecting Private Insurance Industry

The following types of crime, as covered by the Austrian Criminal Code, are connected with insurance fraud:

- Homicide, bodily injury and traffic accidents
- Property offences, such as robbery, burglary, theft of motor vehicles, embezzlement, cheque and credit card fraud, insurance fraud, arson, white-collar crime, industrial crime and drug-related crimes

As regards homicides, bodily injuries and traffic accidents, no reliable statements can be made on their economic dimension. At a meeting of insurance experts held in Maria Alm (3), the amount of insurance paid resulting from aggressive offences was quantified within a range of ATS 40 to 50 billion (Kuratorium Sicheres Österreich Meeting in Maria Alm, 1993). This figure should only be taken as a rough estimate. In the case of homicides, the assumed loss of productivity would also have to be taken into consideration, to establish an estimate of the total loss from homicides. In the case of bodily injuries due to negligence, the average costs of treatment and therapy would have to be related to the number of cases reported.

The economic impact of crimes against property is easier to quantify. An attempt to establish the costs of crime for the national economy resulted in a total economic loss of ATS 4.4 billion due to robberies, burglaries and high-tech crime. In 1993, for example, 15,214 dwellings and 13,424 shops were broken into. Assuming an average indemnification of ATS 20,000 per burglary loss, a total of 0.573 billion were paid out by insurance companies for burglary claims in 1993. If indemnification paid out under fire, household accident and motor-all-risk insurance policies are added to the above, the total loss amounts were to approx. ATS 9 billion = € 0,0678 billion in 1993 and will have increased nearly double in 2006.

The costs of drug-related crime are not to be underestimated. At the Kuratorium Sicheres Osterreich meeting in 1993, addiction-related costs in Austria were estimated at ATS 5 billion.

Types of Insurance Fraud in Austria

Types of insurance fraud reveal all kinds of criminal activities. Murder cases, violence crime, burglary, theft of cars, arson cases and a very great number of accidents are the main "modi operandi" of criminals who engage in insurance fraud. As the number of stolen cars, burglaries and robberies has increased dramatically in the last 5 years, insurance companies are confronted with enormous losses not only by insurance fraud but actually also by increasing crime rates. Especially the number of burglaries has doubled in the last 5 years.

Profile of the Offenders

Based on the personal experience in police work (**3**), insurance fraudsters were not as mobile as other fraud criminals in the past. But this fact will probably change very soon, because criminals learn easily.

Analysing the profiles of insurance fraud criminals in Austria, based on the statistics of the last 30 years (Edelbacher, 1995), it can be assumed that:

Approx. 3% are organized criminals/terrorists.
Approx. 12% are professional criminals.
Approx. 85% are non-professional criminals.

Insurance fraudsters are found in all income classes, education levels and age categories. Females are represented more often in cases of insurance fraud than their appearance as offenders for other types of crime.

A study of PricewaterhouseCoopers published in the year 2005 (Edelbacher, 2017) analysed a picture of white-collar criminals showing rather men, more than 35 years old, and established in the higher-ranking leadership. But this analysis dealt only with white-collar crime in firms, and criminals are coming rather from the inside than from the outside. Some insurance fraud is perpetrated by the staff of the insurance companies, but the amount in terms of the total number of cases is relatively small. Generally, offenders are persons who are known to the insurance agencies only by their policy numbers. The main feature of an insurance fraud is that there is no existing personal link between the offender and the victim. This relationship generally makes it generally so easy to commit insurance fraud, because there is no criminal energy needed to be active against a congregate person or victim. To commit robbery or burglary, for example, there always has to exist aggregated criminal energy against a person. The criminal in violent crimes must be aware of the victim's strengths and abilities to fight back in a direct person-to-person criminal event. This is not necessary when committing insurance crime. It is a safer and more elegant way to make money.

Fight Against Insurance Fraud

Although many investigators believe the amount of insurance fraud is widespread, little is known about how to detect it. Many attempts have been made to find indicators for insurance fraud. These attempts are however hampered because very often they are relying on characteristics of previous fraud cases. Edelbacher (2017, p. 11) notes "At the Vienna University of Economics and Business Administration we elaborated indicators including information about uncovered fraud cases. The methods applied to the detection and prosecution of insurance fraud are based on criminalistics. Criminalistics is concerned, above all, with the investigation and solution of criminal cases and is defined as the science of crime control through crime detection and crime prevention. The investigative techniques used are aimed at the detection of criminal behaviour and the solution of criminal cases".

Criminologists study the underlying causes leading to criminal behaviour, while the goal of the criminalists is to detect the crime and/or to investigate the crime and hopefully arrest the perpetrator of the crime. The long-range goal is to clear the crime and close the books. To this end, the investigator uses the tactical and technical means of criminal investigation (Schwind, 1993).

Indicators of Insurance Fraud

The methods used to recognize crimes are based on principles developed in the field of criminology. These principles follow a three-step process. They are:

1. First: a starting information, suspicion.
2. Second: knowledge has to be added to the original knowledge base.
3. Third: sufficient evidence is gathered to convict the alleged criminal/offender.

The investigator follows the seven "golden rules" related to gathering of evidence and establishing sufficient proof to convict the perpetrator of the crime. The "**six golden rules**" (Schwind, 1993, p. 9) are:

1. *Who* has committed a crime?
2. *What* was done?
3. *When* did the crime happen?
4. *Where* was the crime committed?
5. *How* was the crime committed?
6. *Why* was the crime committed?

Methods to Recognize Fraud

Basically recognizing fraud can be done in two ways: gathering material evidence and interviewing people who are involved in the investigated crime. For a long period of time, interviewing was the only method used to prove a crime. That has changed dramatically since evidence gathering became more and more important. Especially forensic methods have improved so very much that a change of strategic methods was the consequence.

Strategies of Insurance Companies

Insurance companies have a major problem in recognizing fraud because of the enormous number of cases they have to deal with each day. In Austria each year, about three million cases of compensation are asked by customers, and it is very difficult to filter the suspicious cases from those that are legitimate. This problem became more and more difficult to solve because the number of employees, who deal with such cases, is reduced each year. The basic fact is that each year an increasing number of compensation cases has to be handled by a decreasing number of insurance employees. Very often the fluctuation of employees is dramatic, and the professional knowledge of the more experienced employees is lost.

The Board of Insurance Investigators (Edelbacher (2017, personal experience/interview with P. Klaus, 4/7/1996)) to fight fraud was founded in 1996. This forum still exists, the basic goal of the Board was to gather knowledge about what is going on in the field of insurance fraud and to find answers on what to do and how to do it in order to be successful in combatting fraud. Each insurance company selects and educates an expert or a number of experts who deal with insurance fraud. These experts co-operate at the board of experts which is homed in the Austrian Board of Insurance Companies (Verband der Versicherungen Österreichs). This board has regular yearly meetings, exchanges knowledge and co-operates with law enforcement agencies, prosecutors service and judges. Checklists of indicators of fraud were developed to provide indicators of fraud. The Board of Experts reports to the authorities of their companies and the Austrian Board Organization of Insurance.

Central Information Bureau (ZIS)

The central information system (ZIS-Austria) (Edelbacher, personal experience (2017)) (Edelbacher, 1996) and interview with P. Klaus, 4/7/1996) was introduced by the Association of Austrian Insurance Companies in the early 1990s, following the Dutch model. Edelbacher (2017, p. 13) notes, “Detecting fraud is, above all, a problem of large numbers. With more than 3.2 million loss events per year, it is

quite impossible for 1500 claims managers to identify each and every case of insurance fraud. For years, demands had been voiced for insurance companies to establish files of policy-holders reporting losses. A comparison of such files permits the statistical evaluation of loss frequencies and loss probabilities".

The preliminary work on the present Austrian system was started in 1989. Based on the Dutch system, the Dutch system provides not only for the establishment and maintenance of files but also for an exchange of information between the police authorities and the insurance industry. These methods have been particularly successful in the solving of motor vehicle theft. Unlike German motor vehicle insurance companies, which only report cases meeting certain criteria to the German association, Austrian insurers report all current motor vehicle loss data to the computer centre of the association on a daily basis. Thus, the Austrian system is more efficient than the German one. Since the beginning of 1996, it has been possible for all insurers to report losses also in other classes of business (household, fire, marine insurance, etc.) automatically to the computer centre for further processing within ZIS. To optimize the supply and evaluation of data, the individual insurance companies still have to adjust their own EDP systems accordingly. The following checklists were developed by the Association of the Austrian Insurance Companies and are in the training manual of Austrian insurance companies.

Box 1 Two examples of a checklist (Association of the Austrian Insurance Companies, 2006)

Check personal profile of insurer and victim

- Check family name – are there existing relations, family and friendship between insurance owner and victim?
- Check first name – very often first and second names are changed to irritate the insurance company.
- Check date of birth – changes of this dates can be a starting point of fraud.
- Check profession of your customer – it may explain an irregular claiming.
- Check family status – can be important.
- Check education – it can be the link between insurer and claim customer.
- Check liquidity – can be crucial; very often lack of money is the motive for fraud.
- Check dates of insurance contract – fraud is started rather soon after signing contract.
- Check insurance policies themselves.

Checklist to analyse a claim

- Check report of claim (compatibility and plausibility).
- Check report and compare what was told to the insurance company and what was told the police.

(continued)

- Check what was told to friends and family.
- Check causality of the reported claim.
- Check plausibility of circumstances.
- Check ownership.
- Check travelling.
- Check report of experts.
- Check circumstances of the claim.
- Check papers (originals.)
- Check behaviour of your customer.

In Austria insurance companies decide how to deal with their customers. If an insurance company is suspicious about a claim and can prove the illegality of the claim, it can be decided to inform the customer about their goals of regulation or to make a criminal report to the police. If the customer agrees to withdraw his/her claim, a report to the police is not necessary. It all depends which deal is settled between insurance and customer.

Strategies of Police

Law enforcement authorities depend on the findings they get from the claim managers of the insurance companies. In addition, they have access to other sources of information, such as their own internal records on suspects, categories of infractions and general findings. Criminal record searches and other investigative methods, such as searches for persons and property; information systems of the criminal police; evaluation of information received from public prosecutors' offices, courts and banks (as a rule, the latter can only be obtained upon judicial order); queries addressed to insurance companies, credit card companies, car hire companies, casinos and registration offices and queries concerning the registration of motor vehicles; inspection of the land register; and queries addressed to postal and other authorities, including queries addressed to foreign authorities via Interpol, widen the range of possibilities for the police to obtain information in cases of fraud or other criminal acts. Once the desired information is available, further steps are taken in the following order (Association of Austrian Insurance Companies, 2006):

- Description of the state of affairs
- Co-ordination within the investigating authority
- Co-ordination with other authorities
- Analysis of the state of affairs/further planning
- Establishment of contacts with other authorities
- Co-operative arrangements with other authorities/institutions

- Participation in working groups/special commissions
- Development of fraud control strategies
- Implementation of operational measures
- Arrest/questioning of suspects
- Reporting to the public prosecutor's office/court

Basically, other organizations, institutions, detective agencies or individuals act according to the same pattern. The question of whether or not to take operational measures at an earlier stage of the investigation (e.g. observation) should always be considered. For some time, insurance fraud used to be a popular method applied by terrorist organizations in need of money.

Those who have police experience know that criminals quickly learn what techniques the police use to investigate crimes, and they know that criminals will change their mode of operations to confuse the police. The criminal community is not bound to formal restrictions. They exchange knowledge and practical experience and adapt easily their patterns of behaving to stay successful. Insurance defrauders learn fast about which insurance companies are difficult to cheat and which companies are easy targets. The new structure of the European Union with the lowering of security at the borders makes it easier for criminals to use the opportunity of a free market and the advantage of freedom of mobility of people and goods. Until recently international insurance fraud was not a great problem, but this is likely to change in Europe because the market has changed (Edelbacher, 2016).

The growth of the insurance markets in Europe might result in an increasing amount of fraud by organized criminal groups and terrorist groups. This experience was learned from the intelligence gathered on organized crime and terrorist activities in other types of crimes, such as smuggling of humans, drugs and weapons. No borders mean diminished control. This is an advantage for the transnational economy as well as for criminals. A growing market means growing danger for the global society.

Methods of Prevention

Edelbacher (2017, p. 15) states "It is interesting to note that insurance fraud often hinges on some form of collusion between suspects, insurance staff, repair workshops and persons with insider or expert knowledge. According to police experience, a certain amount of tension often exists between the office workers of an insurance company and its field staff, which may result in operational weaknesses. Sometimes, not enough care is exercised in the selection and recruitment of insurance staff. Another identifiable 'weakness' results from the intensive and frequent points of contacts between the sectors concerned, the claims handling procedures applied and the difficulties of objective loss adjustment. In many cases, the mere inspection of the property to be insured would be enough to prevent a loss; however risks are frequently underwritten without adequate knowledge of the facts of the case".

As has been pointed out for years, improvements are needed both on the part of the police and in the insurance industry. To some extent, improvements have already been achieved.

The Public Image of the Insurance Industry

The insurance industry should be making a continuous effort to remind everybody of the underlying principle of insurance. On this issue, Bogner (1987) stated that it takes "continuous effort and unconditional sincerity with customers if the insurance industry is to improve its public image. In addition, the insurance companies must provide concrete examples of their commitment to providing quality service to their customers. A good marketing organization alone will not protect companies against the deterioration of their public image in the coming decades". Dr. Höfner referred to a certain feeling of unease among the public, which manifests itself more specifically in the form of discontent with high premium payments, slow loss adjustment and insufficient indemnification. On top of that, the luxurious office building occupied by insurance companies is taken as a sign of unsatisfactory management of the policy-holders' money. An insurance company is perceived to work well if:

- Claims are handled quickly.
- Customers get personal service and sound advice.
- The company acts as a true partner of the insured.

However opinion surveys have shown that people regard insurance companies as being hard to understand, impossible to influence, rather selfish, showing little social concern and uncaring but necessary, nevertheless. Hence, there is a need for:

- More information
- A clear presentation of the services offered
- Transparent management
- Individual and personal advice by qualified staff

Involving the Public in the Prevention of Insurance Fraud

As mentioned earlier in this chapter, the public tends to have a relatively negative image of insurance companies. Thus, the common citizen may not be too concerned about the insurance companies losing money as a result of fraud. In fact, some members of the public who are policy-holders and were not satisfied with the outcome of a claim they filed may have some degree of satisfaction in knowing that the insurance companies were victimized. They fail to see that the additional costs the insurance companies may incur as a result of fraud and are generally passed on to the policy-holders through an increase in the cost of their premiums. Thus it makes

sense for the insurance companies and the public to join hands in combatting insurance fraud, in that in the long run, both may benefit from attempts to prevent fraud through public relations activities.

Public relations activities should underline the fact that insurance fraud is not a petty offence but a criminal offence punishable under criminal law. It is important to make people understand that insurance fraud is not fashionable; it is not directed against anonymous institutions but against all the honest policy-holders who do not engage in fraud and therefore have to pay a higher premium. At the same time, attention should be drawn to the high probability of insurance fraud being detected (through special measures, well-trained claims managers and dedicated computer programs). For years, the insurance industry has been co-operating closely with the Federal Ministry for Internal Affairs of Austria. Numerous measures are being taken – with considerable success – to maintain a high level of security in the country. Security, after all, is a matter of great concern for everybody, as it affects all aspects of our lives.

In order for the insurance companies to be successful in their attempt to enlist the public in the fight against insurance frauds, they must make several significant changes. These include:

Maintaining high standards and ethical principles In an era characterized by materialism and selfishness, it is essential for enterprises to set examples by adopting firm positions. In practice, this means that director generals and managing board members have to be made aware of the need for clear guidelines, patterns of behaviour and principles to go by. If purely economic considerations impact on the decision whether or not to report a case to the police, such principles become watered down and become unclear for both staff members and clients. If the top management does not comply with the rules, why should others follow such guidelines.

Establishing clear guidelines and patterns of behaviour The outcome from the interrogation of insurance crime offenders showed that a lot of criminals were motivated to engage in an insurance fraud because of their personal disappointment in dealing with insurance companies. Very often something was sold as insurance coverage that was not fulfilled when assistance by insurance was needed. Such an experience was very often the starting point of insurance fraud.

Establishing transparency of terms and conditions of insurance contracts Simple and transparent terms and conditions, easy to understand for everybody, have always been high on the list of desiderata of the insured. Given such conditions, they would have to worry less about the "small print" on the policy form and the promises made by the insurance agent, which cannot be kept in the event of a loss.

Correcting the handling of claims The line that separates goodwill claims handling practices from insurance fraud tends to get blurred. Occasionally, insurance companies

decide to indemnify the policy-holder even if a formally valid claim does not exist. Thus, policy-holders may feel tempted to present their loss events in a somewhat modified form than the way the event occurred. Correct loss adjustment based on uniform principles and unconditional reporting of serious losses – cases of fraud – to the authorities would therefore be desirable (adoption of generally valid guidelines for all insurance companies).

Establishing a long-term approach Insurance companies would be well-advised to adopt a long-term approach and look beyond the annual presentation of the balance sheet. A focus on individual customer care, the granting of bonuses for additional safety measures taken, the issue of profit-sharing certificates and others are instruments well-suited for the long-term planning and monitoring of corporate performance in the insurance industry.

Increasing awareness-building and training Insurance fraud can be counteracted through awareness-building and training measures. Frequently, fraud may already be suspected upon first inspection of the loss, if the description of the situation given by the person reporting the loss or his accomplice cannot be objectively verified by the loss inspector. Through appropriate training, police officers and insurance staff can be sensitized to the fact that things may not always be what they appear to be at first sight and that action should only be taken upon thorough investigation of all elements of the event. What looks like a burglary may not necessarily be one. And what looks like a fire may be more than just that.

Recruitment of specialists We live in an age of growing specialization. Naturally, this also applies to insurance fraud, a broad field ranging from fictitious theft to arson, and from self-mutilation to murder. To meet the continuous challenges of solving fraud cases takes the investigator's full personality; it takes intelligence, eloquence, skill, stamina and imagination, as the perpetrators of fraud are skilled and imaginative and it takes a smart investigator to track down a smart offender (Kratcoski & Edelbacher, 2016). Hence, finding suitable specialists is a justified concern of both the law enforcement authorities and the insurance industry. If this issue is not taken as serious as it should be, it can be the starting point of a wrong development in the long run. Very often the growing of the market is the only concern of an insurance company, but this approach is too short in understanding the complexity of the problem.

Co-operating with the law enforcement authorities Co-operation between the law enforcement authorities and the Austrian Insurance Association has been intensified following the establishment of the Association's computer centre. The Insurance Fraud Control Office is planning a wide range of activities for the near future. Training seminars are to be offered for claims managers and members of the "anti-fraud squad" employed by insurance companies. Specialized seminars are intended to deepen the contacts between the law enforcement agencies and the insurance industry.

Changing the reporting practice of insurance companies Besides ethical principles, clear, practical and procedural guidelines and co-operation with the law enforcement authorities, the reporting of punishable offences by the insurance companies is another important issue to be discussed. Based on personal police experience (**4**), reporting practices of insurance companies in Austria tend to vary greatly from company to company. This is a fact which not only the police but also the offenders are aware of. Professional defrauders, in particular, know very well which company will or will not report suspected cases of fraud to the police. They clearly benefit from this lack of uniformity of reporting practices. The perpetrators know very well where to claim a fictitious loss and adapt to new circumstance rather than not to try to commit the fraudulent act. As it already was mentioned, criminals have the ability to learn very fast. Their ability to adapt to new conditions is better than the ability of official organizations.

Innovations for the Prevention of Fraud

Private investigators as well as the public police will have to be constantly learning how to use the new technologies if they are to be successful in the detection and prevention of fraud in the insurance industry. We are living in a fascinating world of technical revolution. Especially the electronic sector is developing so fast that we have to learn to utilize the new methods for obtaining information almost every day. Computer technology has influenced administration and investigation techniques dramatically. The main problem of investigation in the insurance industry is handling and selecting the great number of claims. There is the pressure to recognize in a very short period of time what claims to appear to be fraudulent in order to start an investigation in such cases.

New computer software opens opportunities to find better strategies to succeed in selecting and differing bad claims from those that are legitimate (Schwalb, 2007a). The longer frauds go undetected, the larger the potential for loss and the smaller the chances of recovery.

The Association of Certified Fraud Examiners (ACFE) (2002) estimated that six percent of the insurance organizations' revenues will be lost each year as a result of occupational fraud. This 6 percent constitutes hundreds of billions of dollars lost to fraud in the insurance industry worldwide. For example, in 1 year, The ACFE's 2002 Report to the Nation on Occupational Fraud and Abuse covered 663 occupational fraud cases that caused more than $7 billion in losses. More than half of the frauds in this study involved losses of at least $100,000, and nearly one in six resulted in losses in excess of $1 million. In addition to the direct dollar costs of fraud, organizations must cope with a range of indirect costs. Damage to a company's reputation can have substantial fallout and possibly lead to drastic setbacks in the economic market. The loss of customers' confidence in the company generally translates into reduced revenues and profits. Also, employee morale can suffer, impacting organizational productivity and the ability to attract and retain qualified staff.

The Traditional Approach to Preventing Fraud

Organizations traditionally have looked to prevent and detect fraud by implementing appropriate internal controls. Internal audit typically tests and validates these controls during regular audit processes. Although this approach generally leads to a discovery of almost 20% of the fraud cases, the internal controls are essentially reactive. Internal controls combined with external audits are responsible for uncovering an additional 30 percent of the detected fraud, but the balance of cases, more than half of the detected fraud cases, come to light through tips or by chance discovery. In many organizations, both systems and their underlying transactions have become increasingly complex, with data volumes growing at an exponential rate. While strong internal controls and audit procedures play a role in preventing and detecting fraud, it is unrealistic to assume that they can be completely effective. The ACFE (2002) study found that 46 percent of detected frauds occurred because of insufficient controls. An additional 40 percent of the fraudsters exploited the situations where controls were ignored. For many organizations, there remains a strong likelihood that a significant number of frauds are simply never detected. Even when frauds do come to light, many detection methods, such as audit procedures, are employed after the fraud has taken place. The longer frauds go undetected, the larger the financial loss is likely to be and the smaller the chance of recovering the funds or assets from the perpetrator.

Both the Association of Certified Fraud Examiners and the American Institute of Certified Public Accountants specifically refer to the use of computerized analysis to assist in fraud detection techniques. Such analyses are particularly effective in detecting frauds that fall into the most common fraud categories – asset misappropriation and fraudulent disbursements. Both professional associations detail indicators of the most common types of fraud and cite examples of the kinds of analyses that can be performed to detect them. However, many organizations use such techniques only on an occasional test basis and often only in reaction to suspected problems. In many cases, the tests performed are fairly simplistic and are unlikely to uncover more sophisticated fraud schemes. *Transactional analysis* is one of the most powerful ways of detecting fraud within an organization Schwalb, 2007b. To maximize its effectiveness as a fraud detection system, the transactional analysis needs to:

- Work with a comprehensive set of indicators of potential fraud – taking into account the most common fraud schemes as well as those that relate specifically to the unique risks a particular organization may face.
- Analyse all transactions within a given area and test them against the parameters that highlight indicators of fraud.
- Perform the analyses and tests as close to the time of the transaction as possible, ideally even before the transaction has been finalized and preferably on a continuous monitoring basis.
- Allow easy comparisons of data and transactions from separate business or operational systems.

This last point is of particular relevance. Many suspicious transactions or patterns only come to light when transactional data from one system is compared to that of another. In a simple example, this would involve comparing addresses of paid vendors with employee addresses, to detect potential "phantom vendor" schemes. Individuals intent on fraud seek out organizational "soft spots" where there is little regular cross-system data validation – they provide a golden opportunity for frauds to continue undetected. A well-designed and well-implemented fraud detection system, based on transactional analysis of operational systems, can significantly reduce the chances of frauds occurring and then remain undetected. The sooner indicators of fraud are available, the greater is the potential to recover losses and address the weaknesses of the anti-fraud control system. The timely detection of fraud directly impacts the bottom line by reducing losses for an organization. Effective detection techniques serve as a deterrent to potential fraudsters, as well as employees, who know experts in fraud prevention are present and are looking for fraud and thus are less likely to commit fraud because of a greater perceived likelihood that they will be caught.

The many contributions to fraud prevention in the insurance industry include: ACL enables timely fraud detection and prevention, and ACL provides businesses with complementary services and assists in the completion of business intelligence. ACL's approach is to give organizations access to all their data, thus enabling them to independently analyse and validate data and transactions for integrity, in a fraction of the time that was required in the past. ACL's powerful analytics and robust capabilities have enabled tens of thousands of organizations around the world to achieve fast feedback, reduce risk, assure compliance, minimize loss and enhance profitability while making decisions with speed and confidence. With ACL's assistance organizations can now trust their data. ACL is a proven performer, with clients in 176 countries, including 83 of the Fortune 100 and nearly half the Global 500. ACL clients also include more than 500 national, state and local governments on six continents and all the *Big Four* accounting firms.

Summary: A Need for International Co-Operation

Crimes of fraud have plagued the insurance industry ever since its first development many centuries in the past. Although the crime persists, the method used to commit the crime by fraudsters has changed dramatically. The methods to be used to detect and investigate fraud in the past were generally determined by the individual insurance companies. However, in the present time, as a result of the huge increase in international crime, it requires international co-operation among the members of the insurance industry as well as that of the police and the public to prevent fraud in the insurance industry.

Another important issue is to create enough flexibility and mobility in the organization to be able to react to new dangers. The enlargement of the European Union brings in more diversity between the poor and rich countries. It is possible that

criminals will see the enlargement of the European Union as a challenge. We have seen such a development in the field of international financial fraud. It would be very logical if defrauders will expand their field of expertise in insurance fraud. A number of Austrian insurance companies are expanding their businesses in those nations that have recently become members of the European Union. Their goal is to create new markets and expand their businesses. But we can fear and expect that not only will business grow but criminal gangs will also use the growing market for their interests by expanding their illegal enterprises.

Austrian insurance companies have reduced their activities to fight insurance fraud because they only see the new opportunities of the growing market and not the increased threat from criminals. It looks like they are neglecting to employ the mechanism that is effective in detecting insurance fraud. This neglect may create danger becoming more vulnerable to the criminals who are constantly learning new techniques for committing crime. A key feature of this new weakness in the fight against fraud is that each insurance company is concentrating only on its own success and fail to realize that co-operation is a necessity to combat crime in the industry. The Association of Austrian Insurance Companies is weakened when the individual interests of each company are their main goal, not the interests of the entire industry. Such behaviour may be short-minded as seen in a longer run and period of time. The quick success makes individual insurance companies blind against the possible new dangers, especially since the nature of insurance fraud has become more global and some of the criminals from the Eastern European countries are very efficient in developing new techniques for committing fraud.

Discussion Questions

1. Discuss the reasons why some policy-holders rationalize and justify their fraudulent activity.
2. What are some of the major reasons for the increase in international insurance fraud?
3. Identify the types of fraud that are most frequently committed against the insurance companies, and give the profiles of the types of offenders.
4. Identify transactional analysis, and discuss how this approach is used in combatting insurance fraud.
5. Discuss the typical process followed in the investigation of potential insurance fraud by insurance fraud investigators.
6. Discuss the process followed by the public police in the investigation of insurance fraud.
7. Identify the underlying principles of insurance, and discuss how fraud can lead to a disruption of the insurance industry.
8. Austria has often been identified as a “pass-through” country. Discuss the meaning of this designation, and indicate how being a “pass-through” country is related to international crime and insurance fraud in Austria.
9. Discuss the relationship between the “open borders” policies of the European Union and different types of international crimes, including insurance fraud.
10. Discuss how new innovations in technology have benefitted insurance fraudsters. How have these innovations benefitted the insurance fraud investigators?

Notes 1. Roman law, "pacta sunt servanda" – "treaties have to be fulfilled".
2. Roman law, "uberimae fidei" – "you have to trust each other".
3. Edelbacher, personal work experience.
4. Edelbacher personal observation.

References

Association of the Austrian Insurance Companies. (2006). *Training manual*. Association of Austrian Insurance Companies: Salzburg, Austria.

Association of Austrian Insurance Companies. (n.d.) www.vvo.at – Information about the Austrian insurances.

Association of Certified Law Examiners (ACFE). (2002). *Report to the nation on occupational fraud and abuse (pp.1–42)*. http:www.acfe.com (Accessed 8/10/2018).

Austrian Criminal Code, section 151, in power since 1975, and Theodor Gösswein-Seiko DDr., "Vernehmungskunde", p.92, published By Leykam, Verlag für recht, Staat und Wirtschaft, Graz 1979.

Austrian Criminal Code, Section 298, in power since 1975.

Austrian Criminal Code, Section 146ff., in power since 1975.

Austrian Criminal Code, section 167, in power since 1975.

Bogner, F. (1987). Speech titled "Fight against insurance fraud" presented at the Kuratorium for Verkehrssicherheit: Osterreich.

Edelbacher, M. (1995–2017). Lecture: *Strategies to fight insurance fraud. Internal Publication* by the Vienna University of Economy and Business Administration, Financial Department. Vienna, Austria.

Edelbacher, M. (1996, 4/7/). Interview of Pokorny Klaus on Dachverband der Osterreichischen and personal experience as chair of the Austrian Insurance Fraud Control Office (2004–2006).

Edelbacher, M. (2016). Insurance fraud. Presentation at the COB Academy Advanced: Insurance Fraud in the MTPL Claims Handling, Brussels, 25 Feb 2016.

Edelbacher, M. (2017). *Fight against insurance fraud,* Paper presentation at the in Brussels, pp. 1–25.

Geerds, F. (1983). Zur-sozialen problematek des Versicheringsmissbrauches- Die Kriminellen Praktiken und ihre Folgen fur des Versicherungswesen- Lecture held at Fourth Insurance Symposium in Graz.

Geers, F. (1984). Zur-soziale problematek des Versicheringsmissbrauches- Die Kriminellen Praktiken und ihre Folgen fur des Versicherungswesen. Die Versicherungsrundschau (39), 3–4. pp. 96–99.

Kratcoski, P., & Edelbacher, M. (2016). In J. Eterno & C. Simonson (Eds.), *Insurance fraud. Detective investigations handbook* (pp. 67–86). Boca Raton: CRC Press /Taylor &Francis Group.

Kuratorium Sicheres Österreich Meeting in Maria Alm. (1993). Salzburg, Austria 3.

Schwalb, T. (2007a). Insurance applications. Accessed 4/26.2014

Schwalb, T. (2007b). White paper: Fraud detection and prevention: Transactional analysis for effective fraud detection. Retrieved 4/26/2014

Schwind, H. (1993). Eine praxisorientierte Einführung mit Beispielen", (6th edition), in *Kriminalistik,* (28) Heidelbarg, Kriminalsitik Verlag, Heidelberg, Verlag. :pp 9

Theil, M. (2012). In M. Edelbacher, P. Kratcoski, & M. Theil (Eds.), *Dealing with insurance: What can be learned? Financial Crimes: A threat to global security* (pp. 269–287). Boca Raton: CRC Press/Talyor &Francis Group.