EXTENDING STATE BENEFITS TO VULNERABLE WORKERS IN THAILAND

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Abstract

The goal of this article is two-fold: 1) to give an overview of the availability of the new social insurance scheme for workers in the informal sector in Thailand; and 2) to analyze imperfections of this particular scheme in terms of difficulties in practice. The criteria used for analysis are based on the distinction in the social insurance scheme between formal workers and informal workers. It seems to be equally fair, but in reality it is not. The basic concept of social insurance is also examined to provide an understanding of state benefits provided by the government. Finally the paper attempts to offer other alternatives to increase economic security for informal workers, other than social insurance, based on the strength of Thai communities.

Introduction

Many nations have some sort of social welfare programme, with varying ranges of benefits. Some are totally financed by the government (from taxes), but most rely on regular contributions from individuals, employers, and possibly also the State. For example, Britain has long had a 'National Insurance' system which provides free medical services (doctors, clinics, hospitals), old-age pensions, and other benefits, paid for by monthly contributions to the State from employers and employees, with relief for the low-paid and unemployed. Singapore has long had its CPF (Central Provident Scheme), with monthly contributions, aimed mainly at providing healthcare and a retirement pension (Low and Aw, 2004). Hong Kong has its MPF (Mandatory Provident Fund) which provides retirement income, funded by contributions from employees and employers (MPF, 2003).

Korea developed a three-pillared pension system: a mandatory National Pension System established in 1988, covering all citizens (except government employees), funded by contributions from employees and employers; a Retirement Allowance System, mandatory on all organizations employing more than five people, funded solely by the employer, but using insurers and fund managers; and a voluntary Personal Pension system, paid for entirely by an indi-

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vidual, but with tax incentives (Li and Hatton, 2004). China, with its huge and aging population, is creating a multi-tier pension system, with special attention to agricultural workers who are mostly on low incomes and who traditionally relied on retirement support from younger family members (Zhang, 2008).

In Thailand, the present government (as at May 2011) has instituted developments to include a community social welfare system in the national agenda. The government emphasizes its national policy for the population's quality of life by promoting social welfare. This begins with a continuation of various social security programs which were introduced by previous governments, such as free hospital medical services. The government has initiated a free 15 years education program, and a national saving fund scheme to guarantee the elderly future security. Also, the extension of social insurance to include informal workers has been considered, and informal workers were finally allowed to enroll in the social insurance system at the end of 2010.

The intention to provide social welfare to all the population throughout the country is a significant contribution to people's quality of life, especially the availability of financial security to non-mainstream workers. Actually, there was a strong request from those workers 15 years ago, because these informal workers then had no guaranteed benefits in their lives. They faced uncertainty and insecurity about employment, health, and retirement. Their lives when compared with employees from the formal sector were totally different in term of economic security. Formal workers are those who have a fixed job and regular salary. Government employees and public employees receive benefits from their employing organization. Understandably, informal workers wanted to have similar benefits. It is their right to get at least social insurance. As a result the government announced that the social insurance scheme is now open to all workers, in both the formal and informal sectors.

Everyone can buy social insurance, like buying coverage from an insurance company. Initially the basic benefits received were for death, sickness and disability. The workers were unhappy with the benefits, because they felt them to be unfair. They wanted a security equal to employees in the formal sector, so they presented their demand again. As a consequence, the government extended the scheme by including add-on voluntary benefits, for unemployment and retirement. The government also recognized the needs of informal workers by offering a saving policy to secure their income after retirement.

Examining this announcement and the favorable policy towards informal workers, there are several points of concern. The improved social insurance scheme was designed to satisfy informal workers who had long demanded the same economic security as formal workers. But the scheme lacked a feasibility study and practical implementation details. This fundamental imperfection will be discussed in this paper. Finally some alternatives to social insurance, which are applicable to a developing country, will be explored.

Characteristics of Informal Workers

Informal workers, who formerly could not register into the social insurance security system, have become the majority of workers in the economy. According to statistics from the National Statistical Office of Thailand (NSO), the number of informal workers has been increasing continuously for the last 5 years (2005-2010). The data from a 2010 survey shows that the number of informal workers is 24.1 Million persons, which is 62.3% of the total workforce (NSO, 2010).

Most of these informal workers are in agriculture, trading and services, and industrial production. The major characteristics of this group are low education, and from low-income families or poor households. Therefore they are not able to choose good jobs which have high remuneration. They have few chances to ask for their rights. All these conditions are linked closely to vulnerability. Morduch (1999) stated in his research paper for the World Bank that many poor households are exposed regularly to risks from illness, harsh weather, political instability and economic mismanagement. Concern with vulnerability may be both intrinsic and tied to implications for income generation as well as to the longer-term consequences for the health and education of children (Brue, McConnell, and Macpherson, (1989; Jacoby and Skoufias, 1997; Hoddinott and Kinsey, 1998; and Rose, 1999).

Most informal workers were originally farmers or in other agricultural jobs. Then the reduction in their earnings due to increasing capitalism pushed them to find jobs with higher income. The younger farmers moved to find a job in a city and became daily workers. They expected to earn more money so they could send money back to their rural family. Unfortunately, their expectations were not realistic. High competition in cities, high cost of living, limited types of available jobs, and low wages are the conditions that cause these workers to suffer in the country's rush to relatively uncontrolled capitalism. When these workers cannot generate enough income to send back to their family, finally their only security and solid base, which is their land, has to be sold. This sale is a severe blow to their lives, and cuts off any escape from their poor life of daily workers.

Another situation that the informal workers have to face is economic insecurity. This is a consequence of uncertainty of job security and income. Economic insecurity can be caused by a person losing his income, being forced to assume excessive or additional expenses, or earning an insufficient income. Economic insecurity may also be experienced if there is uncertainty regarding the continuation of future income (Rejda, 2001). In practice, most employers refuse to be liable for any expense except wages payment. The employer tries to set an employment rate to be low as possible, in order to save cost, increase the profit margin, and increase the company's competitive strength in the market. Eventually, an informal worker's life is of lowering standard. Some of them work in non-safety work places, need to work longer periods than usual, and do dangerous tasks.

The International Labor Office ILO, (2003) and Sivalak, (2005), defined common problems affecting workers in the informal economy as follows;

1. Poverty due to low and unsteady income.
2. Unprotected by labor laws and social security laws. Basic rights not respected.
3. Lack of access to occupational safety and hygiene.
4. Limited access to capital.
5. Limited opportunity for training and development.
6. Labor relations problems.
7. Insufficient data on informal labor by types, areas and nature of problems, making it difficult for protection and improvement, particularly in the case of agricultural workers.

Due to the above conditions, the workers have to endure considerable worry, fear, anxiety, and psychological discomfort. They need better security and protection, somehow.

Present Benefits for Informal Workers

In the past there were no specific state benefits for informal workers. This matter was discussed for a decade but with no response from the government. In 2001 the government introduced a low-cost health program at government hospitals for medical services, available to Thai people (Lawrence, 2005). Later, in 2010, the program was slightly amended by improving service quality, but the concept remains unchanged. This medical services is for all Thai people, therefore, it automatically includes informal workers. The provided social welfare is based on benevolent benefit or optimal taxation theory. The theory of optimal taxation came about in an attempt to determine the optimal tax policy (i.e., tax and penalty rates). Then the government distributes this tax revenue among all the people in the country (Gerxhani, 2004).

The next state benefit to consider is the Educational Scheme. This benefit is for all Thai people. It was initiated by the current (May, 2011) government. The main theme is to provide a free 15 years quality education program. It is not specific to informal workers only.

For a farmer who is counted as an informal worker in the agricultural sector, he has a welfare benefit from the government through the rice price insurance scheme. In addition, farmers can buy crop insurance to guarantee their income due to natural disaster when they cannot reap a regular harvest. The main aim of this benefit is to compensate the reduction in the farmer's income because of uncertainty of the market price and the weather. This benefit is limited to agricultural workers only.

In addition to benefits provided by the government, there is choice of private insurance available for informal workers. In September 2003, in a government initiative through the Insur-

ance Commissioner's Department in the Ministry of Commerce, a low-price insurance scheme, named 'Ua-arthorn' (We Care) was made available from insurance companies. This insurance policy mainly covered personal accident risks. The aim was to ensure security in people's lives and to assist low-income people to have coverage for some life risks. This is a low-cost policy, which makes no mention of availability criteria such as income level, and can be bought by anybody, although higher income people would also buy similar products but with higher benefits (and premiums) sold in the traditional way by insurers (Lawrence, 2005).

After exploring the availability of benefits for informal workers, eventually the Social Insurance Scheme is the main social security to which we should pay attention. This scheme was initially for employees who work in private companies (i.e. non-government). It is an employee benefit enforced by law to provide security for employees. The principle is emphasized by the benefits paid to provide a certain standard of living to a contributor (worker) when he loses his earning because of old-age, disability or retirement. Social Insurance also covers medical care, unemployment, and maternity benefits. The Social Insurance Scheme collects contributions from three parties: employer, employee, and government. It was mentioned in the Introduction about the demand from informal workers to extend social insurance coverage to them. The government realized the justice of their case and decided to include those workers in the Social Insurance scheme with effect from May 1, 2011. Simultaneously with the government announcement, the Social Security Office (SSO) opened its doors for all persons to buy this social insurance. It also includes informal workers or anybody who is not an employee of an enterprise. The concept is based on voluntary insurance, similar to buying insurance coverage from a private insurer. However, after the voluntary option was announced, representatives from the informal sector argued that there was inequality of government support and insurance benefit when compared with formal workers. The representatives stated that if it is a voluntary social insurance, it would be better to retain the risk among the group, or practice self-retention, or buy insurance from a private insurer (only for higher income persons). In response, the government announced a new social insurance scheme for informal workers.

Social Insurance: The New Scheme for Informal Workers

The Prime Minister embarked on this social insurance scheme for informal workers, implemented on May 1, 2011. The government will contribute money to the social security scheme in addition to that for the workers in the formal sector but at a different rate. In joining the Social Security Scheme, informal workers would be offered two options. In the first option, they will contribute 70 baht a month and the Government will contribute 30 baht. In this option, they will be entitled to three types of compensation, for sickness, disability, and death. In the second option, informal workers will contribute 100 baht a month and the Government will contribute 50 baht. Under this option, they will receive a pension, along with the entitlements for sickness, disability, and death. The Ministry of Labor expects that around 2.4 million

informal workers will join the social security system in 2011. Out of this number, 600,000 workers are in Bangkok and 120,000 in Bangkok's vicinity, while 1.68 million are in other provinces. The participants include, among others, vendors and hawkers, taxi drivers and motorcycle taxi drivers (Government Public Relations Department 28/02/2011).

Actually this scheme has been modified from the existing social insurance Article 40 of the Social Security Bill, which initially covered death, disability and childbirth. Then extra coverage was added to the scheme, with some conditions about the contribution from government. The comparison of coverage, payment, and contributors is shown in the following Table.

Table: A Comparison of Social insurance Benefits for Formal and Informal Workers

	Article 33	Article 39	Article 40	New Article 40
Eligibility	All formal workers between 15-60 years old	Former formal workers, who terminate their employment and contribute for not less than 12 months, are not eligible for benefits (and should buy private insurance)	Informal workers or anybody who does not fit the criteria under Article 33 and Article 39.	Informal workers or anybody who does not fit the criteria under Article 33 and Article 39.
Coverage	Death, disability, sickness, childbirth, child-care, elderly pension, and unemployment,	Death, disability, sickness, childbirth, child-care, and elderly pension	Death, disability, and childbirth,	Death, disability, sickness, childbirth, elderly pension,
Payment	Maximum THB750 per month	THB432 per month	THB3,360 per year	THB3,360 per year
Contributors	Employee, Employer and Government		Insured himself	Insured and Government (only first year)

THB = Thai Baht

Source: Social Security Office (2010) and summarized by the author

Another populist policy accompanying social insurance is the National Saving Fund Bill. This seems to duplicate the social security fund because the members need to contribute their money in order to receive old-age pensions after retirement. The target group also includes informal workers as eligible members once the bill is enacted into law. Matching contributions from government, and interest from members' savings in the fund, will enable subscribers to receive an old age pension after retirement. Member must contribute either 50, 80 or 100 baht

to the fund each month. The government's contribution is up to 50% of the member's contribution. A member will receive a monthly pension from the fund for six years following their retirement at 60 years. The monthly pension will range from 1,000 to 3,000 baht, depending on the contribution. The Nation Saving Fund will offer welfare benefits to 26 million informal workers ranging from farmers, motorcycle taxi drivers and taxi drivers, hawkers, and to others self-employed (Bangrapa, 2011).

Contract Problems

According to the government's intention to improve the living standard and quality of life of the population in Thailand, the government tries to initiate many populist policies, and social security for informal worker is one part. The social security policy for informal workers is a response to their demand to have the same economic security as workers in the formal sector. There was a feasibility study about starting social insurance for informal workers. The research was designed to identify preference and attitude to be a member of a social insurance scheme. This is a good start, but the government as the policy maker should undertake a deeper policy research study.

As to such policy research, Peter Rossi and his colleagues (Rossi, Freeman & Rosenbaum, 2004) stated that policy research refers to a varied group of activities. What ties these different variations together, however, is that they are all focused on helping policymakers to solve social problems. Policy research is defined as the process of conducting research into, or analysis of, a fundamental social problem in order to provide policy makers with pragmatic, action-oriented recommendations for alleviating the problem. The policy research process consists of five major activities:

1) preparation for a policy research study,
2) conceptualization of the research study,
3) design and completion of the technical analysis,
4) interpretation of results and appraisal of flexibility of possible recommendations,
5) communication of result and recommendations to policy makers.

Extending social security to informal workers is a fundamental social problem. The policy makers should know why the new social insurance scheme for informal workers has been implemented. Social insurance is only one type of social security. There are other social securities such as Public or Social assistance, Provident Fund, and Universal Program. Therefore, the policy researcher should add alternatives / options as input which will help the policy makers to make decisions.

When the announcement of social insurance for informal workers was released, feedback

about unfairness came from representatives of informal workers in the National assembly of Thailand. In considering the benefits and contributions in the Table above, it will be agreed that the government has provided benefits, but there are imperfections. Examining the relationship between benefits and premium payments, it would be agreed that there is a positive relationship: when the premium is high, the benefits coverage is broad. But looking at the characteristics of informal workers, it can be seen that something is not correct. First the informal workers have an unstable and low income. They themselves need to spend money to survive before sending the rest to their family. They are mostly part of poor families. Therefore they may not have enough income to pay a social insurance premium. One condition for continuity of contract is that the insured must not stop paying premium for more than three months, otherwise the contract will be terminated. Generally, if a worker lets the contract terminate, he will neglect any continuation. He will think that he and his family can survive in the short term, rather than worry about long term finance. This practice can make social insurance unsuccessful for informal workers, who have especially hard economic lives.

Second is the situation of an insured who is an informal worker but has no employer to contribute money to the fund. The Benefit Fund consists of only two parties, worker and government, so the fund size is smaller than the formal sector's fund (which does include an employer). It therefore seems reasonable that benefit payments should be less than in the formal sector, but the risk exposure of informal workers is greater than those employed in the formal sector. Studies of informal workers (Nirathorn 2009; NSO, 2010), describe how these workers, constitute the largest sector, are on low incomes, have irregular or seasonal employment, are mostly self-employed (e.g. farmer, motorcycle-taxi driver, hawker, street-stall vendor). 21.5% (out of the 48.5%) earn a living from day to day, and 19% are classified as having heavy manual work. Their workplaces are not safe, and injuries occur from hazardous chemicals and machinery. The studies also indicate that informal workers have longer working hours, and no time in a long working day for fitness exercise, which is why they are exposed to health problems. Fray (1989) emphasizes their lack of means to voice their concerns in the political-economic process. They have no trade union or HRM manager to help them negotiate for their rights. They have to endure their many difficulties, with little support or recognition. On the other hand, they are continually exposed to risks: illness, irregular jobs, unemployment, poverty, and non-respect of their human rights. This means that the risks faced by informal workers are greater than by formal workers. Therefore social insurance for informal workers should be reformed and customized to fit their special needs and risk exposure.

Third, is the issue of the duplication of sickness coverage under social insurance and the Universal Coverage of Health Care Scheme (UHC) which originally limited the charge for medical expense to only 30 Baht. The data from the Public Health Ministry stated that UHC provides broader coverage than social insurance, and therefore informal workers prefer to use medical services from UHC rather than from social insurance. This raises the query of why social insurance is needed and why an extra premium has to be paid for medical benefits

Moreover there is some restriction on using medical services. If someone applies to be a member of social insurance, that person must use the 30 Baht Scheme from social insurance. This 30 Baht scheme has wider coverage than social insurance for medical expense; this makes the worker wonder why he should have to contribute to social insurance. However, social insurance is for more benefits than merely medical. But a worker in the social insurance scheme, with these wider benefits, must use that scheme, and can only use the 30 Baht scheme when the social insurance benefit is exhausted. On the other hand, the duplication of coverage could be the cause of unfairness to those who have no knowledge about coverage.

Some Alternatives

There are some possible alternatives, suggested by researchers, to the present provision for informal workers. It is well known that informal workers are from low income households, which means that their insecurity problem is related to poverty. Rajeda (1999) defined poverty as an insufficiency of material goods and services in which the basic needs of individual and families exceed their means to satisfy them. He also explored several theories to explain poverty. First, the 'personal differences theory' states that people are poor because of personal characteristics which make them different from the majority. For example, people are poor because of inadequate education and work skills, low productivity, poor motivation and work habits, mental or physical disabilities, lack of marketable skills, and addiction to alcohol or drugs or gambling. Second, the 'social barriers theory' states that society follows formal or informal policies that cause poverty and make it difficult for the poor to escape from poverty. Discrimination between groups is a good example of this theory. Lastly, the 'random events theory' states that individuals or families are poor because of events largely beyond their control. An example is where a family head becomes totally disabled or dies prematurely. These theories are used as background information to institute social security in U.S.A., and can also be applied to Thai society, but the government needs to pay attention to all the factors related to informal workers.

Public assistance could be another solution to assist this group, because it is a welfare program providing finance or vouchers for poor individuals and families who are not eligible for benefits from social insurance. Public assistance can also be used to provide supplemental income to people whose benefits from social insurance or other public programs are inadequate, and to those with small or nonexistent financial resources. A third reason is that some individuals and families are unable to attain a minimum standard of living because of physical, psychological or emotional problems. Finally, public assistance is used because of society's philosophy toward the poor. Because of personal factors or character defects, some individuals are unable or unwilling to work and contribute to society. Although they are unproductive, society does not necessarily cast these persons aside as worthless. It can be considered that society should assist its less able members to become productive if possible (Rejda, 1999). However, if the

government is concerned to provide public assistance, the programme must be carefully designed, to avoid the well-known insurance problems of adverse selection and moral hazard.

A community-based social welfare system is another possibility for informal workers and is relevant to the culture of Thai society. The government intends to promote community social welfare nationwide during the next few years. The Prime Minister believes that this policy will promote long-term saving and social security, and will create social capital for the future of the country. There is a longstanding foundation for this, as Thailand has good socio-cultural relationships at the village level, even in distinct communities within towns and cities (Komin, 1991; Pongsapich, 1998). This can be a good motivation to continue social-mindedness into future generations, through a community social welfare system which would help people at the grassroots level in their localities. It fits neatly with attempts to fulfill the needs of communities, upgrade standards of living, reduce debt, generate income, and provide basic security for health, education, funerals, the elderly, the disabled, and labor rights protection through established community structures, their leadership system, rituals and processes. This uses and promotes the strength from shared values, culture, compassion, social capital, and local wisdom, which enable Thai communities to solve their problems and achieve self-reliance (Nirathorn, 2009).

Conclusion

Social Insurance for informal workers is the policy that the government has embarked on to raise living standard for the people who work in this sector. If it goes beyond words and politics it can help informal workers to have economic security, because the economic objectives of social insurance are

1) to provide basic economic security to the population
2) to prevent poverty
3) to provide stability to the economy, and
4) to enhance individual and community self-esteem and responsibility.

Basic economic security is needed against the financially challenging risks of premature death, old age, sickness, disability, and unemployment. If the question is asked: "does social insurance for informal workers have coverage based on the economic objective?", the answer will be "Yes". However, if the details are examined, reform should be seriously considered.

All of the above discussion shows that informal workers in Thailand have specific features that need to be deeply understood. There are various factors, not only economic or monetary considerations, to explain the difficulties of informal workers. Therefore the government should consider these many and varied aspects, so as to deal effectively with this problem. Moreover,

each possible solution should be studied further in order then to actually satisfy the specific needs of informal workers.

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THE DARKER SIDE OF INSURANCE

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Abstract

It seems that insurance and fraud go together, insurance being about money – premiums and claims. Fraudulent claims are made by policyholders, agents, and repairers, sometimes aided by solicitors and doctors. The extent of fraud is vast but cannot be quantified exactly, although estimates can be made from detected fraud. The insurance industries in most nations now spend much money and time on fraud detection and prevention, through a variety of organizations and techniques, usually in alliance with the government and police.

Insurers are said to make some fraudulent claims inevitable, knowing human nature, because of wider cover and breaches of basic insurance principles such as indemnity. The most fundamental principle is 'utmost good faith', which is obviously breached by fraudulent claimants but also by proposers at the underwriting stage. Insures themselves can be part of the darker side, through manipulating the complex insurance accounting calculations, especially the setting up of financial reserves from which to pay future claims. Mis-selling by insurers' agents also happens, plus delay and deception by insurers.

All this sullies and threatens the operation of insurance, which otherwise provides so many essential benefits to individuals, organizations and the economy. Controlling the dark side is a never-ending vigilance. Examples of fraud and control are given from many countries, but particularly from Britain and Singapore.

Introduction

Insurance provides many benefits, so many that modern civilized people and nations would be vastly poorer in the health, wealth, and education. Many research studies have demonstrated the link between insurance and the economy (e.g. Skipper, 1998). Trade would be at a low level as Banks would not lend money, and traders would not risk transporting their goods very

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far. Without the financial security of insurance to cover financial loss through various perils, the wealth now generated through intra-national and international trade would be absent, and with it the money to finance education, healthcare and other basic necessities. At the personal level, individuals and their families would be ruined by illness, death and disaster if there were no insurance available. Yet the image of insurance remains murky, and efforts to inform the public about its widespread benefits seem to fail.

However, there is indeed a darker side to insurance, some of it obvious, some esoteric, and some hidden. The most obvious area of darkness is fraud committed by policyholders when they make a claim. Fraud is defined by the Collins Dictionary as "deliberate deception, trickery, or cheating, intended to gain an advantage". Fraud is a social cost which interferes with the normal cost mechanisms between insurers and customers (Mehr and Cammack, 1980). Fraud is also committed by organisations involved in the consequences of accidents, such as vehicle repairers, salvage agents, builders, and others. Adjuncts to insurance are involved, such as loss adjusters. Insurance employees, such as claims officers and motor engineers, can succumb to temptation of bribes. Less well known are the deceptions and delays practiced by some insurers. Hidden is the deliberate manipulation of insurance accounting, and the fraud committed by those who hack into computer systems and are in collusion with insiders.

Of course, not all those people commit fraud, otherwise insurance would cease to function. But those that do, offer examples to copycats, and also cause honest policyholders to pay more in premiums to cover this financial wastage. Insurance is a peculiar commodity to buy and sell: a promise to pay financial reimbursement if certain perils occur. Probably all other organisations have a fraud element: it is well known that they suffer 'shrinkage' of stock and equipment due to staff or customers. But one of the basic distinguishing principles of insurance is that of trust, 'utmost good faith'. This article will proceed to explain 'utmost good faith'. Examples of various types of fraud will be described, plus some of the actions taken to minimise this dishonesty.

Insurance is Based on Trust and Honesty

An insurance policy is a legal document which specifies the identity of the Insured person or organization, the sum insured, the perils covered, exclusions, warranties, and conditions which must be observed. The document consists of many words and a few numbers. Over centuries the words have undergone many challenges in the courts over interpretation of meaning, which in common law (judge-made law) sets precedents for subsequent cases. Over time, as society changes, precedents can be overturned by new interpretations by courts (or by legislation).

Insurance has some very basic principles which are extremely important foundations, and without which insurance could not operate, and which are so basic and long established that a

court will accept them even though these principles may not explicitly appear in the policy. The most basic are: utmost good faith, the duty of care, and indemnity.

'Utmost Good Faith', which used to be expressed in Latin – *uberrimae fides* – is the principle that there must be total honesty between the insured and insurer. The need for this principle was initially that a proposer for insurance knows the good and bad details of what he wants to insure, while the insurer knows almost nothing unless told by the proposer. The insurer will accept or decline the offered risk (and decide the price and terms if accepting the risk) based on the facts of the risk as declared by the proposer. Obviously the information must be correct, honestly given by the proposer. If relevant information is not disclosed, or is untrue, then the insurer bases its decisions on flawed facts. The disclosure duty is at inception, during the contract, at renewal, and in making a claim (Park, 2004). Taken to its extreme, if too many proposers give dishonest or inadequate information, the insurer will be charging premiums below prices which the true risks warrant. The insurer will then find that its costs outstrip its premium income, resulting in insolvency. Insurance would collapse.

Insurance policies include a condition that the Insured must exercise reasonable care of what is insured. It means that the Insured must behave responsibly, as though he were not insured. One of the problems of insurance is morale hazard, usually defined as 'carelessness', meaning that the Insured, because of the existence policy, is more careless than he would otherwise be. This was the principle behind marine insurers' refusal to provide any collision cover. They later relented but only to provide 75% of a ship-owner's liability for damage to others (Hazelwood, 2010).

The principle of indemnity is that an Insured should be reimbursed by the Insurer only to the extent of being placed in the same position as he was immediately before the incident (Thomas and Wilson, 2005). If the insured car was a total loss, and was five years' old a new car would not be provided, only a replacement car of similar age and condition, or an equivalent sum of money. If the car could be repaired, and become more valuable because in a newer or better condition, this is called 'betterment' and the principle of indemnity entitles the Insurer to reclaim from the Inured the amount of betterment. This principle protects the Insurer against moral hazard, where an Insured deliberately damages his car to have it 'bettered'.

The disadvantages of insurance include insurance induced losses (which would not have occurred if there were no policy), fictitious losses (which did not occur or not as seriously as claimed), and the deep-pocket syndrome where fraudulent claimants justify their dishonesty by saying that insurers have deep pockets and can afford to pay, and nobody loses. Having described some fundamental principles which allow insurance to operate at all, various types of fraud will now be examined.

Fraud against the Underwriter

Underwriting fraud is where lies are told about the risk, or information deliberately withheld, at inception or renewal, or where there is a significant undisclosed change of risk within the period of insurance. This is a breach of utmost good faith. One third of Britain's largest commercial firms supply false information on proposal forms (Jones, 2007).

There are several types of underwriting fraud (described by Hill, 2010). Premium fraud is where relevant material facts are deliberately withheld or misrepresented so as to reduce the premium. Examples are not disclosing information about past accidents and convictions, telling lies about ages, where the car is kept, or occupation. A major example is 'fronting' where a named young driver on his parent's policy is actually the main driver. Induced Premium fraud is where a customer is actively encouraged in premium fraud by a broker, sales agent or insurance employee so that more policies can be sold. Cover fraud is where the objective is to obtain cover which would have been refused if the full facts were disclosed. Premeditated claims fraud is where a policy is deliberately bought with the specific intention of later submitting a fraudulent claim.

Ghost-broking fraud is where a fraudster deliberately misrepresents himself as a broker to obtain policies through the insurer's on-line sales channels, to commit various frauds, with misrepresentation of details or subsequent cancellation, without the Insured's knowledge. The customer later finds that his insurance is invalid. There is massive ghost-broking by organized fraud gangs in most European countries, with one gang successfully committing more than 10,000 such frauds against one insurer in 18 months. Refund fraud is where the fraudster abuses the insurer payment systems to obtain refunds on policies taken out by using stolen debit and credit cards. Here also, organised gangs can cause extreme losses for targeted insurers, and the gangs sometimes recruit an insurer's own employees as insiders. Certificate fraud is where a fraudster applies for a motor policy and then cancels it (for a refund), continuing to use the certificate as false evidence of insurance when requested by police or others (Hill, 2010).

Another fraud, which involves non-disclosure and deliberate intention to defraud from inception, is where more than one insurance policy is taken out with different insurers. This is known as double insurance (although it may include more than two insurers), and refers to insurance policies which have the same subject matter, same insurable interest, covering the same property liability or person. It is illegal, and obviously is done with intent to make more than one claim for the same incident. Economic recessions, such as the present one in USA and Europe and elsewhere, tempt people to do this (Li, 2010).

One estimate, based on country-wide statistics, is that insurers may be losing at least 10% of their GWP to underwriting fraud. The detection and risk control of underwriting fraud is different from that of claims fraud (Hill, 2010).

Fraud by Claimants, and Collusion by Others

Insurance fraud, by policyholders and third parties, is a constant concern, in most countries. In Britain, it was estimated that in 2009 undetected fraud cost insurers £5.2 million every day (£1.9 billion annually), and this represented an increase of 24% over two years (Pratt, 2009). Fraud which was actually detected and prevented in 2009 saved British insurers £730 million, an increase of 30% over 2007 (Goldman, 2010). The Association of British Insurers (ABI) carried out research into the public's attitudes, and found that 44% of those surveyed thought that increasing the value of a claimed item was acceptable or borderline, and 30% felt the same about overstating the extent of damage. These figures are considered to be unrealistically low when compared to the actual number and cost of detected fraudulent claims. It is difficult to change these attitudes: people think that having paid premiums over a few years they should get their money back, somehow, like a return on investment (Baker, 2003). The ABI reported in 2008 that 1 out of 11 claims had a fraudulent element, with 85% of these involved exaggerating the value of a genuine loss. Half of all detected fraud involved household insurance, yet fraud is also rampant in motor claims. A moneysupermarket.com report in 2010 suggested that 20% of young drivers had 'staged' an accident in order to make a fraudulent claim (Goldman, 2010).

Most insurance fraud is opportunistic, customers yielding to the temptation of the situation; but there is an increase in organized fraud committed by criminal gangs (Jones, 2008). The rise of criminal gangs particularly affects car insurers in Britain. This fraud is known as car crash fraud. A gang's car will deliberately crash into the back of an insured car. The criminals make their money by making false personal injury claims against the other insurer, the proceeds being used to fund other forms of serious crime. It began in the 1990s and spread from its origin in the North West of England (Jones, 2008). In one case, forty people were brought to court in 2008, after a two-year investigation by the Bedfordshire Police and the Insurance Fraud Bureau, for making false insurance claims totaling £5.2 mn. after staged collisions (The Independent, 17 June 2008, p19).

Life insurance has its own fraud claimants. Faked deaths, to claim the proceeds of a life assurance policy, are well publicized when proved. The intent to defraud may be there at inception (disclosure), during, or at the end of a life policy (claim). Several prominent people in Britain, including a cabinet minister, have 'disappeared' over the years, presumed dead, but later found to be living elsewhere. In another case, a man faked his own death but was later found to be living in a hole under the floorboards, while his family pursued a claim totaling £150,000 sum assured. Another case involved the murder of a business partner so that the policy proceeds would support the struggling business (Purdy, 1995).

There is fraud in commercial insurance, up to one in seven large organisations' claims being exaggerated; and one twelfth of smaller firms openly admitting to exaggerating property or

motor claims (Jones, 2007).

Marine insurance is the oldest type of insurance. It too regularly faces fraud problems, although the extent is difficult measure as the evidence often lies at the bottom of the sea. A new problem emerged with the introduction of electronic bills of lading, huge container ships, and the requirement of Port authorities that emails should be sent to them with details of cargoes to be landed. Hackers into the websites joyfully found the identities of containers containing the most valuable cargo, and conspired with port insiders to make the container and its contents 'disappear'. Another problem is that of 'phantom cargoes', for example, when a container is found to be full of sand. In many fraudulent marine claims there is almost always collusion between thieves, insiders and officials, and sometimes the Insured.

The classic marine case is the 213,000 ton tanker Salem which sank off West Africa in 1980. A massive claim was made of £25 mn for the cargo of oil. Scotland Yard and insurance investigators were called in, and the fraud was revealed. The oil had been surreptitiously landed in South Africa and sold for £20 mn. Seawater had then been secretly pumped into the ship's empty tanks, and the ship was then deliberately scuttled: the businessmen behind the fraud were jailed (Miller, 1995). The International Maritime Bureau is closely involved in fighting marine fraud. It was established in 1981 by the International Chamber of Commerce.

In property claims, for houses and commercial premises, builders and repairers are often in collusion with the Insured. The bill may be inflated by the amount of the insurance deductible, or include items not damaged. It would be too expensive for insurers to investigate every claim. In motor insurance, the insurer's own motor claims engineers, who inspect damaged cars and agree the extent and cost of repairs with the garage, can be in collusion to share the profits from inflated bills.

Loss adjusters, who are independent claims investigators, hired for a fee either by the insurer or claimant, have been known to collude in fraud. Sometimes, claims handlers within an insurance company collude in fraudulent claims, and insures usually have extra-special checks on claims made by staff on their own policies.

Regrettably, "criminal gang fraudsters are aided by apparently respectable businesses such as accident management companies, credit hire companies, storage and removal companies ... [and] even solicitors and doctors" (Jones, 2008, p30).

Breaching the Indemnity Principle is a Cause of Fraud

To increase premium income, the important basic insurance principle of indemnity was breached by insurers in the 1970s in property policies, especially by offering replacement-as-new cover

for home insurance. It was actually advertised as 'new for old'. This created moral hazard, the ever-present fear in insurance; it was an incentive to fraudulent claims. So was the introduction of 'all risks' cover, accidental damage, however caused, rather than the traditional specified perils. The author was an insurance centre manager in England then, and it came to his notice that in one housing estate in a northern city the same burnt carpet was being passed around, and other were deliberately damaged by burning coal 'falling' from the then open fires in every home. Some neighbours talked to claims investigators. Others talked to their neighbours: 'Get a new carpet to replace your old dirty worn carpet, or sofa, or whatever, the stupid insurers will pay'.

Also there was no previous claims experience data for these new extensions of cover, but the sum insured had to be on a replacement-as-new basis, not indemnity, so premium income was higher, theoretically, but not usually in practice, and therefore 'Average' was applied to under-insurance, which created customer dissatisfaction. However hard insurers try to formulate their policies in simple language, the principles and concepts are poorly known and understood.

Commercial property insurance also breached the indemnity principle by offering replacement-as-new, and the same fraud and Average problems occurred. Arson is always a threat, especially in recessions, when goods or buildings are deliberately burnt to provide insurance payment. On average, the damage done by arson is greater than that of accidental fire (Swiss Re, 1989). Loss of Profits insurance (later named Business Interruption insurance) breaches the principle that losses consequential to physical loss or damage are not insurable, again because of moral hazard.

Insurance Fraud in Singapore

Fraud affects Singapore as it does almost every other country, but Singapore has a longer history than most of taking decisive action. Most claims fraud is committed by personal policy-holders – car and home insurance. Insurance companies used to take the view that to publicise these criminal acts, or to report these incidents to the police, would be counter-productive as it would give other people ideas of how to cheat. This used to be the case in Singapore, until the General Insurance Association and NTUC-Income Insurance decided to involve the police and to publicise criminal convictions from the early 1990s (Lawrence et al, 1998).

Many examples were publicized by the insurers and newspapers. Some claims were exaggerated, the damage to the vehicle being aggravated after the accident by the repairer using a hammer, or replacing parts which were never damaged, or switching good parts with damaged parts from another vehicle. Often, the Insured was not involved in the deception and was surprised when shown the evidence. In other cases, the repair bill was inflated: the repairer

would fix the licence plates onto a similar badly damaged car. Sometimes the Insured was involved, by taking a proportion of the inflated claim payment made to the garage (Straits Times: 4 April 1992, 25 February 1995). Touts used to patrol the highway, listening to radio reports by the police of accidents. They would rush to the scene, offer a full claims administrative service to the Insured, and tow the car to a dishonest repairer (Straits Times, 15 April, 1992). Syndicates of repairers were involved in defrauding insurers. A policy deductible was negotiated with the repairer: the profit from the inflated repair cost being enough to cover the deductible and reward the repairer.

The repairers struck back at attempts to expose them. A senior claims executive was lured out of a Wedding dinner and beaten up. The excuse made to the court by the repairer was the executive was making it difficult to make a living (Straits Times, 18 February 1995). An insurer's motor engineer was attacked by a group of repairers for being too strict in his assessment of repair costs.

Motor claims fraud continues in Singapore, but its extent is controlled by systems introduced by insurers. There must be immediate reporting of accidents (made easy by mobile phones and a 24-hour hotline), taking photographs taken at the crash site, at the repairer's workshop, and on completion of repairs. Insurer's now have a list of authorised repairers, who agree hourly rates for repairs, and other conditions. There are also Vehicle Assessment Centres providing a one-stop centre for motorists after a crash. These centres have the latest sophisticated technology (Straits Times, 6 February 1995). All these measures have the full support of the Automobile Association of Singapore, who also set up a federation of workshops, to raise the integrity of this trade and ensured fair prices and reliable service. Miscreants are expelled. Insurers now use centralized digital databases of current and past claims, and similar central registries have been set up in other countries. The cost is very low, thanks to ICT.

Singapore insurers continue to report fraud cases to the police, and the media highlight those convicted. A recent example is that three people involved in a car-taxi crash in 2008 made fraudulent claims for personal injuries. They were found guilty by a district court, but blamed a tow-truck driver who told his wife and daughters to pretend they had been in the crashed car, and persuaded friends to pretend they had been passengers in the taxi. These phantom passengers claimed for whiplash injuries and other pain. A lawyer instructed by the phantom passengers became suspicious about 20 personal injury claims arising from the car-taxi accident and another crash, and reported this to the government's Commercial Affairs Department (Singh, 2010).

The investigation then conducted by the Commercial Affairs Department widened to include those cheating three other insurers, and five people were jailed. The mastermind had friends at car repair workshops who referred victims to him for help in filing insurance claims. He would induce others to pretend they had been passengers. He also staged his own accidents, also with phantom passengers. The fraud was discovered because of discrepancies in the state-

ments made by the 'victims' (Singh, 2010).

The General Insurance Association of Singapore has now been urged by the Insurance Executive Director of the Monetary Authority of Singapore to set up a central fraud database to enhance fraud detection (Asia Insurance Review, Vol.11, Issue 65: website accessed 4 April 2011).

Insurance Fraud in some other Countries

In Malaysia, there was a warning that insurance fraud could affect economic stability if not controlled, as insurance premiums would have to keep rising (Ong, 2005) At the time it was estimated that 10-15% of claims had fraudulent elements. The central bank, Bank Negara Malaysia, which is also the insurance regulator, set up an anti-fraud unit in 2004 which introduced three insurance fraud monitoring mechanisms: an electronic information database, a verification system for checking submitted claims information, and an application database to detect multiple life policies taken out with various insurers.

Fraud is a serious issue in USA. The Coalition Against Insurance Fraud (CAIF) estimated in 2007 that fraud cost insurers at least US$80 billion every year. Health care insurance fraud is serious: the National Health Care Anti-Fraud Association (NHCAA) estimated that over US$50 billion annually is lost to outright fraud: other estimates put it as high as US$200 billion. USA also has crash-for-cash criminal gangs (KPMG, 2007b).

India has insurance fraud problems. Jayaprakash (2004) proposed detailed action to collate and analyse data to establish the size of the problem. Korean insurers experience fraud (Kim and Kim, 2010). In Thailand, one example is marine fraud connected with the theft from barges going down the Chao Phraya river to transfer their cargoes to ocean ships. Criminal gangs steal 30-40 1,000kg sacks of rice and sugar from each boat that passes. There is collusion involving barge supervisors, surveyors, and ocean ships (Keeratipipatpong, 2011).

In Hong Kong, there is a rising trend of insurance fraud, both opportune and organized. If it is not forcefully controlled it will undermine the proper functioning of the insurance market and the cost would eventually have to be shared by all customers. This financial leakage has to be plugged, and a Task Force has been set up to help insurers report suspicious claims to the authority and take proactive prevention. As an example, in 2009 the Task Force helped insurers handle two cases with claim amounts exceeding HK$3 million each (Choi, 2010).

Deception and Delay by Insurers

From over thirty years of practical insurance experience, the author has accumulated knowl-

edge of the operations of many insurance companies, especially in England, but knows that insurers' dark practices extend to many countries. There is the initial routine rejection of claims, especially liability and travel claims. Protracted arguments are used over cover, exclusions, and amounts. Third party claimants are treated worse. The purpose is to delay or avoid eventual payment., thus improving cash-flow, increasing investment income, and sometimes enabling reserves to be under-estimated.

There is also inertia selling. This is where the insurer offers wider cover at renewal, for additional premium, through 'negative option'. This means that the Insured has to deliberately state that he does not want what is offered; otherwise the cover and additional premium is automatic.

A recent example of insurers acting against the interests of customers is where motor insurers in Britain have been accessing competitors' planned price changes. Car insurance in Britain is fiercely competitive, mainly through TV advertising and on-line quotation comparisons. In many countries, motor insurance accounts for the largest share of general premium income. The attraction of this business for insurers is the premium volume, the steady monthly cash-flow income (almost non-seasonal) and the investment income that this can generate, with the long-tail effect of liability claims meaning that payments are postponed, often for years.

In this specific case, British insurers had been accessing data of competitor's detailed pricing structures and plans through shared software provided by a credit firm, Experian. One big motor insurer, RSA (Royal Sun Alliance) reported this practice to the Office of Fair Trading (OFT) for a possible infringement of competition law. The OFT investigated and in 2011 seven insurers (including RSA) agreed to limit the data accessed. Now, the data will be anonymous and will represent the average of five insurers, and will not include planned price changes (Yahoo UK & Ireland, Finance; yahoo.co.uk, accessed 26 March 2011).

Insurers consistently have a bad image, however hard they try to inform the public of what insurance is and how it if so beneficial. To the layman, insurance is an esoteric necessity which he would rather not spend money on, and finds his claim is rejected or reduced because of some policy words. The millions of satisfied customers receive no publicity from a media interested only in negatives.

The image issue, which contributes to people feeling justified in making fraudulent claims, gets a ritual hearing at annual conferences, such as the UK Insurance and Financial Services Conference in September 2002. The industry berated itself, rightly, for its publicized failures, such as the massive mis-selling of endowment pension policies in the 1990s, the failure of the Equitable Life company, and the hidden undisclosed commissions paid to advisers and agents. The Consumer Association was reported as stating that 'if this industry can rip off the consumer, it will'. The best attended meeting at the conference was on the topic of 'An Issue of Trust'. One

CEO asked whether the industry was now operating under the practice of 'utmost bad faith'. Unfair treatment, fraudulent activities and mis-selling, can happen even in a financially sound and transparent insurer (Miani and Dreassi, 2008).

Causes

Crime and greed are a permanent part of human life. We are flawed individuals living in flawed societies. A sense of honour and honesty is developed through many sources, especially parents, religion, education, and prevailing culture and its role models. Legal penalties, including fines and imprisonment, are a deterrent for many.

A rare philosophical statement by a senior insurance manager examined developments in society and individual ethics at the end of the last century in Britain, which particularly affected personal policyholders. As society became richer "the materialistic outlook bred contempt for basic and traditional values such as honesty. ... Keeping up meant possessions at any price by borrowing thieving or putting in bogus and exaggerated claims" (Garwood, 1994: p5). At the same time, insurers offered wider cover for home insurance, including replacement-as-new and accidental cover (such as a paint pot accidentally spilt on the carpet). It seems that insurers abandoned sound underwriting principles in the race for growth and market share, compounded by aggressive advertising and marketing.

Other writers have blamed the huge increase in lawyers who specialize in personal injury claims and advertise heavily their no-win no-fee service. These lawyers promote minor or non-existent injury claims, in a blame-and-claim society. In research, an insurer found that 57% of solicitors surveyed reported a rise in fraudulent personal injury claims over the previous ten years, for invented or exaggerated injuries, especially after car accidents. Also involved, indirectly, are the many TV price comparison sites for motor insurance, where it is easy to enter false data onto a computer screen to find the cheapest price (Goldman, 2010).

Fraud Control Measures in Britain

The Association of British Insurers (ABI) has long been very active in combating fraud, through its Fraud Prevention Bureau (Litton, 1998). Its Motor Insurance Anti-Fraud & Theft Register (MIAFTR) has been operating since 1987. There is also the Electronic Life Industry Exchange Intermediary Register, the Credit Anti-Fraud Register, the Equipment Register, and the Art Loss Register. The ABI set up the Claims & Underwriting Exchange (CUE) in 1994, which is a database register of current claims and for the past three years, which makes it easy to identify regular claimants who might switch insurers. There are also links with other IT databases such as credit-worthiness agencies covering individuals and companies, and others

which perform financial stress tests on companies, looking at solvency and liquidity. The head of one of these insurance databases said in 1995 that 50% of all fire claims were due to arson (Shillito, 1995). There is also an online vehicle identification system, providing registration and other details.

Other agencies involved are the Financial Services Authority (FSA), the Insurance Fraud Bureau (IFB), the National Fraud Authority (NFA), The Fraud Prevention Service (FPS), and the CIFAS, the UK's overall fraud prevention service. The IFB, set up in 2006, is funded by the insurance industry, and focuses on detecting and preventing organized and cross-industry insurance fraud. IFB insurers (who have more than 95% of the UK's personal insurance claims) share their claims data through the CUE. IFB works with many UK and international police forces, and operates a free telephone 'cheatline' for anonymous information (Goldman, 2010). In its first twelve months, it saved the industry £8 million, after initiating 20 police operations leading to 74 arrests (Jones, 2008). The IFB says that crash-for- cash gang fraud reduced by 11% in its first two years because of its intervention, and also reported that these reduction are seen when it works jointly with 13 police forces, but in areas with non-involved police forces, crash-for cash fraud is increasing (Pratt, 2009).

The NFA is an agency of the office of the government's Attorney-General, and works with a variety of organizations including government, law enforcement, and voluntary bodies to focus and co-ordinate fraud generally across the UK. The FPS covers organizations involved in banking, credit cards, asset finance, retail credit, mail order, insurance, investment management, telecommunications, factoring and share dealing. Members share information on fraud, and its CIFAS was the first data sharing scheme of its kind in the world (Goldman, 2010).

In addition to databases and matching-software, insurers have also moved into the behavioural sciences to detect claim fraud. They use psychological profiling and cognitive interviewing. Voice Recognition Analysis (VRA) has been used since 2002: it works like a lie detector identifying stress, and is mostly used for telephone conversations with claimants. Claimants dare not refuse permission for this device to be used (Jones, 2008). Obviously the front-line control is exercised by claims handlers and assessors, who now receive regular training in fraud detection. Private investigators are also used, and they are also specially trained (Jones, 2007).

Some fraudsters whose claims are rejected by the insurer even take their case to the Insurance Ombudsman, well known for forcing recalcitrant insurers to make personal insurance payments but who will reject claims where there is evidence of fraud (Jones, 2008).

Most fraud control is directed at individuals, personal policyholders, because of their number, but commercial fraud also has its techniques, many of which are common to those used for individuals. There is a role for forensic investigation of business claims, by identifying fraud

markers, and the use of experienced forensic teams and forensic accountants. The key to successfully identifying a claim as fraudulent is motive. This is usually financial, hence the need for forensic accountants (Parton, 2006).

Manipulation of Insurance Accounting

Insurance accounting is very different from accounting for others. Although non-life policies are usually issued for one year (with renewal options), that premium income can be spread over two calendar years, and claims payments can be spread over ten or more years (Abbott, 1990). Yet annual insurance accounts are understandably required, by the shareholders, tax authorities, and insurance Regulators. The major problem is that a financial reserve has to be created, set aside, from which to pay all outstanding claims. Claims reserving is where 'creative accounting' can be found, and can make it appear in the annual company statement that the insurer has made a profit whereas the reverse may be true. It is complicated by such arcane issues as IBNR (claims incurred but not reported) and a variety of actuarial methods.

Inadequate reserves puts an insurer in a dangerous position as its solvency margin is incorrectly calculated and it may be unable to meet its obligations (Tang, 2003). If an insurer is in a period of increasing premium income, it is easier to show a fake profit. A declining account is when the truth rapidly emerges. Sophisticated data software, if correctly programmed, can be made to show whatever the insurer's top managers want. Claims reserves must include future expected payments and expenses, so that the insurer is "able at all times to meet its commitments to policyholders and beneficiaries" (Cholvijarn, 2003).

Reserves have to be adjusted as the facts become increasingly known, especially for liability claims which have a long-tail stretching to ten years or more, and insurers tend to underreserve when premium rates can be high in hard markets (Swiss Re, 2006). Regulators are paying more attention to the quantification of uncertainty (KPMG, 2007a).

Insurance law regulation varies across countries, although there are moves for international standardisation). Regulators usually require monthly/quarterly and annual statistical statements, and can make random inspections to an insurance company, but this depends on the regulator having enough skilled staff (Tang, 2003), and whether it is in a country which truly operates the rule of law rather than the rule of cronies and 'persons of influence'. In Britain, the Financial Services Authority (FSA) banned 13 people with fines of over £400,000 (Goldman, 2010). In Singapore, the insurance regulator, within the Monetary Authority of Singapore, has the authority to suddenly turn up on an insurer's doorstep and demand to see all the records, documents and computer data. It actually does that, and publishes its findings in its annual report, which refers from time to time to underestimation of claims reserves.

In Thailand there is not the same level of skilled independence and authority, although improvements are being made. Insurance, because of its cash-flow funds, is an attractive industry to be in for those with evil intent, and it also has money-laundering possibilities. An actuary involved in insurance in Thailand commented that there is no problem in Thai insurers meeting the new risk-based solvency capital rules which will be implemented in September 2011. Rather, he sees the key threat to insolvency is fraud, pointing out that five insurers became insolvent in the past ten years, not because of lack of capital but because of internal fraud (Chye, 2011).

Some insurers have foreign domicile, usually in a tax haven, where company details can not be forcibly disclosed to an enquirer; in some it is impossible to discover the owner of the insurer or any financial details. Some domiciles are even fictitious. Assets are fake, including Hitler bonds, coal deposits, penny shares, real estate miles from any road, and cross-holdings in equally dubious sister companies (Jones, 1995). There are failures every year by some insurance companies when their insolvency is discovered. In Britain it tended to be rapidly expanded car insurers whose owner manipulated the reserve system – until eventually exposed by falling sales or discovered by the Regulator.

Conclusion

It is depressing to report such widespread dishonesty in what is such a beneficial industry. But hiding it, pretending it does not exist, which used to be the case so as not to encourage copycats and not further damage the reputation of insurance, is fortunately long gone because of fraud's increasing extent in societies which seem to have weakened their traditional values. Publicising convictions, and the fact that insurers now use very sophisticated detection devices and other controls, reminds the public that there is the risk of being caught. The presence of fraud in a claim voids the cover, meaning no payment at all and probably a police report. Insurance Regulators, Ombudsmen and consumer associations, are a check on the less-than-honest behaviour of some insurers. Limiting dishonesty in insurance is an essential but never-ending process.

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