Analytical Critique

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**Introduction**

Fraud is just another major form of theft; it also includes deception. There is also a gain in financial advantages that are associated with fraud. However, the term insurance fraud covers a wide range of issues (Craglia et al., 2020). Insurance fraud particularly, includes the exaggeration of different legitimate claims, accompanied by some intentional misinterpretation of the facts and complex organized manipulations of claims that are processed to gain some financial advantage, when there is no actual loss (Singh et al., 2020). It is also highlighted that the total cost of insurance frauds is also somehow challenging to estimate the underlined precision. In 2017, the insurers analyzed and detected an output of $280 million in the insurance cases that excluded the claims that were related to personal injury. This number is more like a representation of the total amount of the selected insurance fraud only, however, an estimate of the value of undetected insurance frauds in the Australian market is not yet found. It is also highlighted that there are some particular initiatives that are made to enhance the capacity of the industries to identify the currently undetected and unapproached insurance fraud activity (Vanhoeyveld et al., 2020).

 According to the Insurance Council of Australia and the Insurance Fraud Bureau of Australia, insurance fraud is an illegal action that is either on the part of the buyer or the seller of the insurance contract. Also, Insurance Fraud from the issuing party includes different selling policies that are made by non-existent companies who actually fail to submit different promises as well as charging policies that can create more commissions (Insurance fraud, 2020). However, buyer fraud is more like an exaggerated claim along with some falsified medical histories with dead policies and critical fraud. It may also include murder, kidnapping, and the incidents of fake deaths. The most exaggerated form of insurance fraud can be personal claims, which is also called opportunistic fraud. It is also highlighted that the premeditated or planned frauds are actually committed by professional fraudsters and they are usually counted in organized criminal gangs (ICA, 2020).

**Discussion**

 Insurance Fraud is called “**Specific Intent Crime”** where the suspect is found to have intended to defraud. It also means that a prosecutor has to prove that the person has involved the other party with an already determined ambition to commit defraud.

**Government Initiatives**

According to Sheedy (2015), Insurance Fraud was given little attention until 1980, however, the scenario has changed now because of the rising cost of the organizations and insurance crime rings. Almost all states have taken strong initiatives so that these laws can be enacted to some degree and there would be an ease in specifying crime on that penal code. However, according to Lin et al., (2020), by 2016, almost all the states, including the District of Columbia had enacted laws that identified and classified frauds as a type of crime or something that is punishable. There are some anti-fraud platforms that are set up by the District of Columbia, in the form of bureaus that have limited powers while some states have more than one bureaus to address cases. Also, deferral antifraud legislation is also designed and defined to address fraud such as The Violent Crime Control and the Law Enforcement Act (1994) which ensures that insurance fraud rates can be mitigated as it is affecting the interstate commerce (Sowah et al., 2019). Belciug et al., ( 2020) included The Health Insurance Portability as well as Accountability Act of 1996 as these platforms have made some "Knowingly and willful” anti-fraud efforts so that fraud cases can be combated in both public as well as private sectors.

**Legislation**

The fraud offences are counted and quoted under the 2009 Act (Fraud, 2020), taking into account that there are a lot of offences that are found in this act such as Indenter, Forgery, and Fraud Offence. As per the 2009 Act, the Crime Act is repelled by repealing the number of providers related to forgery and fraud. The Schedule 2 has repeated a large number of frauds and forgeries such as the ss 158, 164-178, 178A, 178B, 178BA, 178BB, 178C, 179-185, 185A, 186, 527, 527A, 527B, 528, 545A, and 547A crime acts. Much like the other areas that are defined for sentencing, it is highlighted that the starting point in determining the appropriate sentences for a specific fraud is dependent on the elements where the statuary is maximum (Braithwaite, 2020).

 Gilmour et al., (2019) asserted that the Insurance Fraud Bureau of Australia is more like a working element of the Insurance Council of Australia that was established with the aim to help to combat the insurance fraud in almost all possible forms. Also, some of the specific mandates to IFBA include the intention to include information collection, analysis, and sharing of the information related to insurance frauds that help and facilitate the insurance company or members of ICA that are working against the insurance fraud. It also helps to inform the community regarding design making and the other law enforcement investigations activities, reduction in the indigence as well as the impact of insurance fraud on the honest and dominant policyholders. According to ICA (2020), IFBA actually works or exists to help the industries so that they can stop committing insurance fraud. Also, it can help to calculate the costs that are not passed on to the community members. However, either insurance fraud is committed on any of the one-off ways that are called opportunity or there are a long series of the frauds that are committed by some professional criminals. In addition, Craglia et al., (2020) asserted that the insurance fraud criminals are treated to be accused of indictable offence where different penalties are mandatory such as imprisonment for up to 10 years or an end of substantial fine or both can be expected.

**Regulatory Instruments**

Regulatory instruments refer to the classical instruments of politics that are used to solve and analyze some economic as well as social conflicts. However, these regulatory political interventions can sometimes go beyond the advisory services or financial incentives that bind different regulations. There are different regulatory instruments that are making up the complete framework of insurance frauds. Firstly, Australia has made some proper initiatives to introduce transparency in different industries and organization that are dealing with insurances (Gilmour et al., 2019). Then, rigid laws are made so that the culprit can be made aware of the kind of punishment that he might be getting after committing the crime. According to Vanhoeyveld et al., (2020), there are some ground initiatives that are taken, such as Model Insurance Fraud Act which is one of the regulations because it recognizes not only production as well as state investigation in insurance fraud. Both defines, punishment and sometimes jail of three to five year. It might also take the form of restitution, any kind of community service or heavy fines. The fine can range from $500 to double of it. It is also highlighted that this just an overview of the punishment that is designed as per classical political instruments to ensure accountability, this punishment and charge can be enhanced under the impact and the ratio of the fraud (Sheedy, 2015).

**Investigation**

Investigation refers to the set of strategies or the platforms that are designed so that the stance can be analyzed and some solid decisions can be made. In terms of Insurance Frauds, ‘The Insurance Fraud Bureau of Australia is designed with the postural aim to investigate insurance fraud claim, taking into account that this platform is one of the major accountability sources (Insurance fraud, 2020). This measure is established by the insurers so that they can be supported by coordinate actions against the individuals who commit insurance fraud in Australia (Fraud offences in NSW, 2020). Also, ICA (2020) claims, IFBA uses different techniques and models for carrying out the investigation. Many of the Australian as well as international insurers take part in IFBA, with an aim to use the services so that they can work collaboratively with the companies as well as that they can protect the honest customers by helping with the enforcement of laws. Also, they can identify and take actions against those who commit crimes. According to the Insurance Council of Australia , a cost is estimated that is more them one million dollars and this cost is covered by the honest policymakers for excluding frauds and exaggerate different claims in terms of the statutory schemes (Insurance fraud, 2020). As per, Fraud (2020) in NZD, there are about 10% of the insurance claims that are fraudulent, and it usually costs NZD $150 million to $ 250 million in a year. It is also important to note that the IFBS declined and they refrain from starting any prominent or a detailed note regarding the investigation on the claims. However, they asserted that it includes a large sum in Melbourne operating in motor vehicle accidents as well as other motor vehicles in the NSW that are involved in the repair of the damaged vehicles (Gilmour et al., 2019).

Another picture of the case is depicted by Craglia et al., (2020) asserting that the insurance fraud is not rising, in fact, he found the insurance fraud to be having a consistent status. This statement was made by Kier who is the spokesman of IFBA, who have an experience of about 20 years. He is of the view that insurance fraud is the representation of the element of society that tries to gain something from the industry or the insurance products. Also, he asserted that the total ratio of the people who are committing this fraud is making a very small percentage of the customers.

**Other countries' approaches to addressing the crime**

 Insurance Frauds is one of the major criminal threat that is faced by different countries, taking into account that all the countries have taken some considerable measures so that this threat can be mitigated if it cannot overcome (Timofeyev et al., 2019). In America, Insurance Fraud makes up about 10% of the total property or causality insurance. There are different cases that are included in insurance fraud such as loss in the industries, and the loss of adjustment expenses every year. Within the last five years, every year, there is a loss of 30 million dollars at the edge of insurance fraud. There are different approaches that are used by the United States of America so that Insurance Fraud can be addressed, such as the Federal Bureau of Investigation that has investigated about 3 to 10% of the medical expenditures and they are found in both public as well private healthcare institutions (Singh et al., 2020). In addition, the United States Department of Health and Human Services Centre or Medicare and Medicaid Services has found that for 2010, the healthcare fraud has amounted between the revenue of $ 77 billion and $ 259 billion. The investigation by both the departments actually signifies how these departments were working to address insurance frauds. In addition, Lin et al., (2020) introduced different practical reform such as No-Fault fraud and many other policies that are introduced so that insurance frauds can be addressed as primary needs. Different task forces are also working to address this issue, taking into account that the Fraud Bureau is one of the direct platforms that address insurance frauds at the primary level. Technology is also directed in a subject way, with an aim to reduce the insurance frauds. This technology is deployed in different systems such as automated system, automobile premium evader, rate-evasion tech and predictive modelling. Also, a major positive note is, these policies and models are taken very seriously by the insurers, thus fully acted upon (Lin et al., 2020).

**Industry Response**

Along with reforming the political systems that they can be made efficient in dealing and investigating the insurance frauds, different department such as industries are also directed to increase their accountability and take serious efforts to ensure the adequacy of different insurances. Almost all the industries have reposed with a positive note, taking into account that a free e-book is already available on the internet that can act as a guide book for the employers so that they can take initiatives to address any fraudulent attempts either by the employees or by another central party that is getting in business with some industry. This is basically employees of the marketing industries. However, in healthcare, Belciug et al., (2020) mentioned exl’s medconnection as a platform that helps the healthcare institution in terms of empowering and improving its productivity for the adjusters in terms of all the legal authorities, staff and the nurses. This web-based tool is more like an offer for employees that can facilitate investigation between the existing systems without offering any upfront capital expenditure. Braithwaite (2020), included Patient snapshot as one of the major measures that are taken by the healthcare department for ensuring clear insurance. Also, industries are using anti-fraud technology adequately so that the risk and the cases of insurance feuds can be reduced. The stance of insurance frauds in terms of vehicles is one of the major points of discussion, taking into account that company stakeholders are trying to introduce online database that can be used by the buyers and then a stance and check and balance can be ensured so that there are reduced chances of frauds. However, in order to mitigate the frauds that are done by the buyers of vehicles in terms of the client are now directed to visit a physician or some emergency room so that their medical record can be maintained and then it can help to reduce the issues that are faced by the employers (Braithwaite, 2020). Chart notes are one of the major fraudulent mitigating measures that are used by almost all the industries. The chart defined the laws that can address fraud. It is also found to educate the law enforcers also which can help to inflate the amount of loss in some particular claim (Tarr & J. A, 2019).

**Initiatives, Strategies and Activities**

 Currently, there are some major initiatives that are taken by the Australian government in the form of different approaches, strategies and activities. Some of the examples are Models, Legal obligations and reporting platforms. In addition, different private platforms and companies are also working so that they can analyze frauds and the fraudulent.

However, a lack of coherent approach is one of the issues that is identified in terms of the methods and approaches that are currently used by the organizations and government to address “Insurance Fraud”. In order to address these issues, there are some major additions required in the context of relevant policies (Fraud offences in NSW, 2020). These additions and extensions are in the form of the new addition which can be technological and more professional so that the criminal disguised as needy people and target customers can be dealt with accountability, as well as the economy of the country can be saved from getting ruined.

There are different initiatives activities and strategies that can be used for reducing insurance frauds

**Implementation of a foundational Framework**

 Foundational Framework refers to the establishment of a fraud-detection strategy that can address different issues that are associated with insurance frauds such as checking of claims in the subject of purchases, identification of frauds, improvement in terms of fraud investigation and then a follow up to make the change behaviours in terms of making fake claims. This framework demands some, "out of the box initiatives” that can help the employees to automate the situational knowledge of different professional and ensures a systemic arrangement of insurance claim structure that can be followed in all the industries (Lopata, 2018). This framework is important because different industries are using different initiatives and approaches for the identification of insurance frauds while there are a lot of industries that are a complete failure in catching up to the trend. One of the examples of the structural framework can be technological use in terms of some software’s that will not only reduce the hustle that is associated with defining frauds but it will also keep the industries up to date with the new hampering or tampering and the ways of frauds. Thus, this framework will not only increase the use of strategies but it will be a positive approach to the country (Braithwaite, 2020).

**Identifying the relative level of the fraud potential**

 Identification of the relative level of the fraud potential is also important, taking into account the initiation of the Special Investigation Unit that can bring efficiency and savings in accountability. The significance of this strategy lies in the analysis of the theft because there are more dangers in terms of something on display or something that is new rather an already stolen object. Thus, insurance fraud can be mitigated in a far better way by using Relative level of fraud potential because it will increase awareness and approach to investigation and analysis (Tarr & J. A, 2019).

**Review and Rescoring of claims**

It is observed that many of the fraudulent claims particularly in terms of vehicle claims are very common. The reason behind this prevalence is the measure of ignorance that is found in these industries. Initializing review and rescoring of claims will not only help to catch the one who has bought the product but it will also keep the company updated about the current happenings and strategies that can be used in future for the identification of any frauds (Sheedy, 2015). The significance of this strategies lies in two different dimensions, on one side, it will initiate the ability of the company to keep follow up with the customers and overcome the issues in terms of product condition but it will also make the buyers conscious that if they will do any kind of misconduct it will be caught (Sowah et al., 2019).

**Using** **a layered** **approach**

“Layered Approach” Is a terminology that is used in Information Technology and this term refers to the use of a variety of tools, technique and product. As internet and technology have brought a shift in the practices of different departments, the same stance of software's and technology is required in making and offering insurances. It will not only facilitate the buyers who will be using the insurance policy but it will also help to get a keen insight into the actions of the company. The underlying significance of the approach lies in the fact that buyers, as well as purchasers, can keep a follow-up or tracking of the services that they are using. Also, it will help to gain public confidence (Sowah et al., 2019).

**Briefing analytics**

 Analysts are one of the major element in an organization, taking into account that they can do more than enough good to the industry, in the context of insurance fraud, the industries should be taught and trained to make use of data analytics. It is important because the data analytics, as well as different predictive models that are used by the insurers, can allow and direct different companies to evaluate and analyse both internal and external sources of data so that gaps can be identified. The identification or the analysis of the patters or the anomalies can play a central role in large databases where it is hard to maintain a check and balance, also these tools can help to define if there is a discrepancy in the data. This approach is highly recommended because traditional approaches are more focused on detection after payments are made, and in a number of cases, it is of no use. So, this approach will help to analyse and identify the stance of claims and issues without getting ditched by the buyers or receivers also, this approach can help to track any kind of fraudulent before time or doing payments (Sowah et al., 2019).

**Using Business Laws**

Another major addition to the identification and detection of insurance frauds is the use of business laws. It is observed that in many cases, issues occur because significance is not given to the business rules or some additional information is given to the employees as well as the buyers of the insurance. In such a case, business rules can be one of the best fit because business rules deal in transparency and there are rare chances for the space of frauds. Also, there are clear penalties mentioned, so it is easy for the third person to analyse the issue and opt for accountability or the required solutions (Yusof et al., 2019).

**Conclusion**

 Insurance frauds are serious forms of theft and intentional crime. It needs special significance in the form of regulated policies and infrastructure. These initiatives are required because insurance frauds are doing serious harm not only to the companies but also to the economy of the country.

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