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ScienceDirect
International Journal of the Sociology of Law
35 (2007) 127–142

International Journal of the Sociology of Law

www.elsevier.com/locate/ijsl

Insurance fraud in Taiwan: Reflections on regulatory effort and criminological complexity

Susyan Jou[a,*], Bill Hebenton[b]

[a]*Graduate School of Criminology, National Taipei University, 69, Sec 2, Chien-Kuo North Road, Taipei 104, Taiwan*
[b]*Centre for Criminology and Socio-Legal Studies, School of Law, University of Manchester, Oxford Road, Manchester M13 9PL, UK*

Abstract

The nature and prevalence of insurance fraud has been studied only to a limited extent, even in the USA and Europe. Nevertheless, national authorities have pressed ahead with various approaches to control such fraud. This paper briefly outlines the nature and difficulties around measurement of insurance fraud and reviews key international trends in the regulation of fraud. It then presents the findings of an empirical study of insurance fraud in Taiwan and recent proposals for anti-fraud control. It analyses these findings in the context of actual practices of insurance companies which give evidence to the idea that 'moral hazard' is embedded in the institutional arrangements, social relationships, and moral economies of private insurance.

Keywords: Insurance fraud; Taiwan

1. Insurance fraud and regulatory effort

The recently published Global Economic Crime Survey 2005 concludes, not unexpectedly, that fraud is "a significant and growing threat worldwide" (Price Waterhouse Coopers, 2005). Yet, for individual countries it is obvious that the dynamic nature and prevalence of fraud (in which insurance comprises an important element) is largely unknown; and accordingly efforts to combat such criminality are underdeveloped. In the United Kingdom, for instance, a recent official report has outlined the lack of

*Corresponding author.
E-mail addresses: sjou@mail.ntpu.edu.tw (S. Jou), bill.hebenton@manchester.ac.uk (B. Hebenton).

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doi:10.1016/j.ijsl.2007.04.002

knowledge of either the extent, costs or indeed comprehensive nature of types of fraud (Attorney-General's Office, 2006). On estimates of the extent of fraud in the UK the report notes:

> The most widely quoted estimate is the £14 billion per year calculated by the National Economic Research Association in 2000. But this estimate was done in three weeks and was based on a review of secondary sources. Recently, Norwich Union updated this figure to £16 billion adjusting it for five years of inflation since the original calculations. The most recent estimate of UK corporate fraud was £72 billion a year (equivalent to six percent of corporate revenues) quoted by Mishcon de Reya. This estimate excludes the cost of investigating and prosecuting fraud … and so is not a total estimate of fraud which would be even higher. (Attorney General's Office, 2006, para 3.14)

Similarly, on types of fraud, the same UK government report concludes that while there is good information about such frauds where the victims are large organisations or government departments, and where the victims are small businesses or individuals, then the data about their scale is non-existent and so much goes unreported.

Internationally, commentators within the insurance sector have also pointed to the difficulties in estimating the prevalence and costs of insurance fraud (NICB, 2000; Coalition Against Insurance Fraud (CAIF), 2003). There are at least three obstacles. First, the covert nature of fraud (Dionne, 2000), secondly, sensitivity to change (CAIF, 2003), and finally, lack of consensus on what actually constitutes insurance fraud and on which form of fraud upon which to focus (Derrig, 2002). At the practical level, insurance fraud has many aspects—given the phenomenon's creative dynamism. Fraudulent activities are commonly classified under three main categories:

a. exaggeration of an otherwise legitimate claim;
b. premeditated fabrication of a claim;
c. fraudulent known disclosure or misrepresentation of material facts.

All insurance frauds, however, "share the distinctive common characteristic that, unlike bad debts, for example, or conventional property crime such as burglary, they are not self-disclosing. Their essence is to appear as normal and to be processed and paid in a routine manner" (Clarke, 1990, p. 1). It follows that insurers will normally only have an idea of the nature and extent of a fraud if they take specific detection measures. While the three-way classification is broadly accepted, it is also pointed out that any adequate typology of insurance fraud must include an understanding of internally versus externally perpetrated, together with fraud committed at the underwriting stage as well as the claims stage (see Vianene and Dedene, 2004). Even the common assumption within the industry that around 10% of all claims are fraudulent is untested (Derrig, 2002, argues for a range downwards from 10% to 0.5%).

Given all the measurement difficulties, estimated figures, for instance on insurance claims fraud, such as the UK's £1.5 billion per annum (Attorney-General's Office, 2006, para 3.17), can only at best highlight the substantial size of the insurance fraud problem. Yet contemporary anti-fraud regulation has moved apace (Baldock, 1997; National Insurance Crime Bureau, 2000; Coalition Against Insurance Fraud, 2003; Attorney-General's Office, 2006). Anti-fraud activities have sought specifically to develop means for:

improving claim screening facilities; providing special training for front-line office staff and claim handling personnel; investing in specialised investigator's skills; improving communication and cooperation within the industry and between the industry and police and prosecution; and improving internal audit.

At the international level, there is a trend to establish national centralised insurance fraud bureaux (USA, Canada, most EU states). These agencies normally have the duties to help insurers and other stakeholders to investigate cases of suspected fraud so that they can be readily prosecuted. Some fraud bureaux have prosecutors assigned. The other clear trend is towards an operational shared database, pooling intelligence across the sector and ensuring appropriate protocols for information sharing with the police. Contemporary anti-fraud regulation in the USA, for example, appears to have a number of interlocking components: a national agency, sponsored by insurers, with an associated database—the National Insurance Crime Bureau (NICB); most states have classified insurance fraud as a serious crime and provide immunity for those who report fraud; immunity statutes protect the person or company that reports insurance fraud from criminal and civil liability; state level fraud bureaux are state law enforcement agencies, mostly located in the Department of Insurance where investigators review fraud reports and begin the process of prosecution; a number of states require insurer' fraud plans, including special investigation units (SIUs) to identify fraud plans; specific mandatory requirements tailored to particular classes of insurance (e.g. photograph inspection laws in relation to motor vehicle, and in health care, anti-runner laws).

Australia, for example, has sought to: agree to a definition of insurance fraud and legislating to make it a specific offence; reform state legislation to eliminate inconsistencies on a host of matters affecting insurance policies and investigations into insurance fraud which would reduce the burden and increase the effectiveness of investigators' work, while prompting police to give greater priority to investigating insurance fraud matters; establish a framework for greater data sharing from both private- and public-sector insurers—with details of professional indemnity and public liability claims data for a national claims and policies database, and to provide insurers access to the numbers within approved guidelines; establish a NICB-style task force. In the UK, recent initiatives include a specific Fraud Bill brought before Parliament, establishment of a high level government Fraud Review Team overseen by the Financial Services Authority reporting on strategic action, and at the industry level the creation in early 2006 of an Insurance Fraud Bureau to improve the capability of member insurers to prevent, detect and investigate organised insurance fraud. The Bureau is tasked with coordinating direct action to optimise the disruption of organised and cross-industry fraud by leveraging existing shared data to detect potential fraud, developing an investigation approach to managing fraud events impacting multiple insurers, and facilitating recovery from and prosecution of existing fraudsters, and disruption of nascent fraud networks (for details on the 'intelligence-led' basis of such an approach, see Detica, 2005).

2. Criminological complexity

Insurance remains an under-researched institution, especially among sociologists and criminologists (see Baker and Simon, 2002; for an earlier assessment, see Strange, 1996). Yet, what is known, points to the regulatory effort in the financial field being inherently problematic (Levi, 1995). Despite the mandate to ensure the integrity of financial markets

through active regulation, the very act of enforcement has the potential to not only impede the fluidity and flexibility of exchange, but also subjecting these actors to unwanted scrutiny. This is because of the contradiction between order, stability, and transparency as the stated cornerstones of a fair and equitable market system, and the reality that the generation of wealth within financial markets depends upon instability, risk and the ability to take advantage of insider networks and so on. Existing criminological and socio-legal research has highlighted the complex relationship(s) between the insurance business, fraud, and the criminal justice system (see, for example, the ground breaking theoretical work of McBarnet (1991); more generally, Ewald (1986, 1991); more recently, the edited collection of Baker and Simon (2002); Ericson et al. (2000, 2003); for European work, see the edited collection under Lemaitre (1995); for UK based work, see generally, Clarke (1999); Litton and Pease (1984), and Litton (1990, 1998)).

Some of the most interesting empirical and theoretical work by criminologists has sought to focus on the dominant neoclassical economics concept of 'moral hazard'; a technical term for the effect that insurance has on the incentive to avoid a loss. Like other incentives, moral hazard is a product of the reward structure provided to individuals by their environment and is traditionally focused on the 'insured' party. Yet, recent work would suggest, rather, that moral hazard comprises the ways in which an insurance relationship fosters behaviour by *any* party in the relationship that immorally increases risk to others; in other words, how private insurance is socially organised also offers incentives to other parties in the insurance relationship to engage in risky behaviour with immoral consequences. Indeed, arguably, insurers themselves are often influenced in ways which encourage them to put others at risk, including their policyholders, employees, competitors, and governments.

In what follows we present the results of a small-scale empirical study of insurance fraud in Taiwan. Our study had two aims: it sought first to identify a typology of insurance fraud cases and describe the main characteristics of cases, second to examine recent anti-fraud reforms in Taiwan in the context of actual practices by insurance companies which give evidence to the idea that 'moral hazard' is indeed embedded in the institutional arrangements, social relationships, and moral economies of private insurance.

3. Insurance in Taiwan

According to a recent public opinion poll, 86% of Taiwanese had purchased some form of insurance in the previous 12 months—including private health insurance, accident insurance, and life insurance (Taiwan Insurance Institute, 2005). The majority spent between USD $700–1500 on the payment of insurance last year, 15% about USD $1500–3000, and 13% less than USD $700. Among those who had purchased insurance products, nearly 40% made at least one claim (Taiwan Insurance Institute, 2005). The economic growth rate of Taiwan in 2004 was 5.7%. The average income per capita equals NT $413,786 (US $12,404) with a real income growth of 1.3%. Unemployment decreased from 4.9% to 4.4%. With the price index remaining stable while the employment market continued to improve, insurance products have become more affordable. Indeed, 2004 premium income in Taiwan continued to grow. Total premium income reached about USD $39 billions, an increase of 15% on the previous year (Taiwan Insurance Institute, 2004).

In Taiwan, many of the issues facing the insurance industry—for example, climate change and the impact of changing weather patterns, the threat of terrorism, regulatory

change, public liability, and wider law reform—have been the subject of broad community debate and discussion. One industry issue yet to be discussed more widely is that of insurance fraud, which carries a cost not only to the insurance industry itself but also to the wider public. Insurance fraud is an issue which has been insufficiently addressed—at least in comparison to the response of insurance industries in, say, the USA and to a lesser extent other European Union states. Individual insurance companies are tapping into an array of tools and strategies to battle the problem of fraud, case by case. But insurance fraud persists, while the industry as a whole, and policymakers and law enforcement agencies have only recently begun to muster the energy to coordinate and respond proactively. Taiwan is only about one-third of the UK population , but has insurance fraud claims estimated at some £2 billion per annum (Jou et al., 2006).

4. Nature of insurance fraud in Taiwan: case analysis

In order to analyse the nature of insurance fraud in Taiwan, the Annual Insurance Fraud Statistics (保險詐欺案例彙編 2005) were examined. This database produced by the Taiwan Insurance Institute (保險事業發展中心) is an annual report of typical and new forms of fraud—and used in the training of insurance agents. We have selected 16 cases in Table 1 covering the four major types of insurance in Taiwan. There are some identifiable commonalities within and between the different forms of insurance fraud.

4.1. Life insurance

Typical life insurance fraud in Taiwan can be classified into two categories: first, offenders murder the victim either personally or by hiring a third party and soon make the insurance claim as the victim's beneficiaries. Second, the offender forges his or her own death certificate as a result of an accident and have their beneficiaries to make the claim. Both types of life insurance fraud share some common elements: (1) offenders usually buy multiple life insurance within a short period of time, (2) a great deal of such cases are committed by more than one offender, each plays different roles in the fraud, and (3) the fatal 'accidents' are all well planned. For instance, Case A1 in Table 1, the offender staged a false car accident and immediately took the victim to hospital. However, the offender purposively failed to disclose the victim's chronic diabetic history to medical staff and this was a key contributory factor in the victim's death, recorded at the hospital's Accident and Emergency Unit. As just mentioned, the offender in Case A1 planned the crime very carefully. Case A3 and Case A4 had also been planned well ahead of the claim. They each had married an unsuspecting victim, then bought multiple life insurance, staged 'phoney' accidents, and made the claims without any regret. Again, the life insurance fraud exemplifies the rational choice of the criminals. (4) Insurance companies in Taiwan generally do not have the capacity to verify forged documents and have no developed mechanisms for information exchange, especially with other regions outside of the country.

4.2. Medical insurance

Unlike life insurance fraud which appears to be engaged in mostly by unorganised opportunists, many casualty insurance cases are committed by organised or professional criminals (Case B1, B2 and B4). In Case B4, for example, the fraud was committed by

Table 1
Typical insurance fraud in Taiwan: selected cases

Case no.	Insurance type	Modus operandi	Criminal codes involved	Results
A1 (2003)	Life	The offender staged a false car accident to injure the victim (offender's uncle) and concealed the victim's medical condition (diabetes) at the emergency unit resulting in the victim's death. The offender claimed the victim's life insurance for an amount of USD $400,000	Murder Fraud	Appealing
A2 (2003)	Life	The offender forged a car accident police report and death certificate to claim life insurance worth USD $50,000	Forgery Fraud	No payment settlement made with insurance company
A3 (1985–1998)	Life	The offender murdered his two wives and three sons to claim life insurance worth USD $750,000	Murder Fraud	Convicted of murder
A4 (2000)	Life	The offender set up a fire causing his wife's death and claimed life insurance of about USD $1,080,000	Murder Arson	On trail
B1 (2003)	Casualty	An insurance agent assisted the offender to create a staged car accident; this was to allow costs of surgery on the offender's previously injured legs—claimed medical insurance of USD $30,000	Not prosecuted	No payment settlement made with insurance company
B2 (2003)	Casualty	Co-offender staged a car accident and broke the offender's hand. The offender claimed medical insurance of USD $700,000	Assisted assault Fraud	Convicted of assisted assault
B3 (2005)	Casualty	The offender forged medical receipts to claim a medical insurance amount of USD $57,000	Forgery Fraud	Under investigation
B4 (2004)	Casualty	Nine offenders forged several US hospital medical receipts to claim travel/medical insurance amount of USD $90,189	Entrap government officials making mistaken records Fraud	Under investigation
C1 (2000)	Fire	The offender set fire to his own factory and claimed an amount of USD $1,200,000	Arson	Convicted of arson
C2 (2005)	Fire	The offender set fire to his rented factory and claimed amount USD $450,000	Arson Forgery	On trail

Table 1 (*continued*)

Case no.	Insurance type	Modus operandi	Criminal codes involved	Results
C3 (2003)	Fire	The offender set fire to the warehouse and claimed an amount of USD $2,100,000	Arson	Appealing
C4 (2002)	Fire	The offender set fire to his rented factory and claimed an amount of USD $4,500,000	Arson Fraud Forgery	On trail
C5 (2003)	Fire	The offender set fire to his warehouse and claimed an amount of USD $80,000	Arson Fraud	Convicted of arson
D1 (2005)	Motor	The offender reported that his 1-month-old BMW had been stolen and claimed loss of USD $115,000 (the car was later found and resold immediately to a dealer)	Fraud Fabricated accusation	Convicted of fraud
D2 (2002)	Motor	The offender registered a 'ghost' car from the Dept. of Motor Vehicles by forging tax and import papers, reported the car was stolen 3 months later and claimed loss of USD $42,000	Forgery Fraud	Lack of sufficient evidence, not guilty
D3 (2003)	Motor	The offender pawned car, and later reported it stolen and claimed for loss of USD $64,000	Fraud Fabricated accusation	Convicted for fraud and fabricated accusation

organised criminals. They had systematically recruited new members and sent them out to the USA for travel purposes. When members came back, the group would forge US hospital medical invoices to make medical insurance claims. To avoid the police or insurance company's investigation, they would use invoices from different hospitals and regularly change/update the list of members. In this case, 34 claims were made through 15 Taiwanese insurance companies.

In Case B1, another example, the insurance agent who initiated the fraud with an accomplice was a frequent ''stalker'' in hospitals and clinics always on the look out for easy targets (patients) and persuading them to ''co-operate'' with the fraud. Once the target agreed to go along with the plan, one of the group members would assist the target to purchase multiple insurance, then to stage a fake accident (usually a car accident or a criminal 'violence' episode) causing some injury to the target (for example, the famous ''Golden finger'' or ''Golden hand'' cases meaning a finger/toe or a hand being cut off or severely damaged). The group would of course help the target make claims and negotiate with insurance companies for settlements. Some members of the organised group are also of course in charge of necessary violence and intimidation. When insurance companies delay or possibly deny the claim, violent threats can sometimes be used towards the insurance companies. In addition, most insurance companies lack sufficient resources to investigate these suspicious claims. Insurance companies usually try to negotiate a ''reasonable'' settlement with the 'suspected' claimant; this is often done in order to protect

their business reputation, maintain quality of service, and after considering the cost–benefit of legal actions. When the agreement is reached, none of the parties would be interested in taking legal action against each other to further determine the nature of the suspicious claims. For this reason, casualty/medical insurance along with motor insurance are the two most under-reported forms of insurance fraud in Taiwan.

4.3. Fire (arson) insurance

The offenders here are mostly the business owners, but not necessarily owners of the properties. In our selected cases, in four out of the five cases analysed, the properties had been rented in a very remote location. There are other significant factors on this form of insurance fraud as well: first, claims usually relate to events that happen in the middle of the night when no staff or neighbour is likely to be present. Second, claimants would wait no more than 1 year to make the claim from the initial premium payment. Third, claimants have difficulty in providing necessary documentation about proof of purchase, values of their lost goods, commodities, merchandises, or machines, and so on. Fourth, claimants appear to show little interest in his/her property loss.

4.4. Motor insurance

For motor insurance fraud cases, the offenders usually own luxury vehicles that obviously do not approximate to their likely annual income (or more broadly socio-economic status). In Case D1, the offender was unemployed and made a living by gambling, but made a motor theft claim 1 month after purchasing an expensive BMW vehicle. Another characteristic of this fraud is that vehicles are usually stolen very quickly after the initial premium payment (1 month for D1, 3 months for D2, and 4 months for D3). Furthermore, stolen vehicles are soon 'found' by the owners and resold to dealers or third parties following the settlements.

Our case analysis allows us to draw some interesting observations about the nature of fraud among these forms of insurance. In Taiwan, insurance fraud is highly profitable for the offenders, especially casualty/medical and motor insurance frauds. The individual insurance companies have no clear motivation or ready capacity to further investigate the relatively "small" amount of suspicious claims. The main interest of the companies is in some sense to deny or minimise the claims instead of seeking criminal prosecution via the courts. In addition, the loss can be absorbed in future higher premiums across the pool of insured clients. The whole process inevitably results in many insurers being only too willing to take the risk because they have no legal cost if the claims are denied. In other words, the moral hazard of insurance fraud in Taiwan (as elsewhere) is partly created by the 'wilful ignorance' and apparent lack of enforcement action by the insurers, combined with the relatively low 'risk' of detection as perceived by the claimants.

5. Control of insurance fraud in Taiwan

Taiwan's Financial Supervisory Committee in 2003 reformed and enhanced the capacity of the main government agency, the Taiwan Insurance Bureau, to supervise the insurance industry (Act Governing the Establishment of the Financial Supervisory Commission, Executive Yuan (Promulgated on July 23, 2003)). As part of the reform, the Bureau was

tasked with developing policy on the control of insurance fraud. In pursuit of its aims, the Bureau established the Insurance Anti-Fraud Institute (IAFI) in 2004 to coordinate relations between the insurance industry, insurance development association, prosecutor's office, police, and other sector professionals.

Since the Taiwan Insurance Bureau's establishment in 2003, it is possible to identify several themes in the Bureau's approach.

- *Strengthening cooperation and making available insurance expertise in prosecutions*: Liaison meetings have been regularly held with prosecution offices to enhance their understanding of the nature of insurance fraud and related crime. Specific plans such as "anti-fire insurance fraud", "anti-motor insurance fraud", and "anti-phony death and forged death certificate life insurance fraud" have been published and discussed with prosecutor's offices in response to the concerns of the Bureau and insurance industry more generally.
- *Improving information and reporting systems*: The Life Insurance Association of Taiwan with the assistance of the Insurance Bureau has designed and established the compulsory policy reporting and information enquiry systems for insurers which relate to (1) a person purchasing life insurance or casualty insurance over the amount of USD $10,000, (2) the insuree is a child under 14, and (3) casualty insurance policies sold over the average amount. From 2004, the Bureau also required the Non-life Insurance Association to adhere to the policy data enquiry and reporting systems.
- *Sharing online information with prosecutors*: The Life Insurance Association has begun to share its database with prosecutors, especially for those cases involving suspicious claimants and failure to disclose relevant information. It is expected that this will permit prosecutors to have access to more comprehensive and effective information in the investigation of any offences related to insurance fraud.
- *Introducing suspicious claims reporting systems*: The Bureau has regulated the insurance companies to establish a unit or hotline for claims. Any suspicious claims have to be reported to the Insurance Associations. In the future, reporting systems connected to IAFI and the wider criminal justice system will be established.
- *Raising public awareness about insurance and the matter of fraud*: Along with the Insurance Development Association, Life Insurance Association, and Non-life Insurance Association, the Insurance Bureau undertakes a great number of activities to raise public awareness about insurance resources as well as holding regular seminars with criminal justice experts to promote their anti-fraud agenda.
- *Promoting new measures that allow for insurance fraud cases to be heard in specialist courts*: The Insurance Bureau has recommended to courts that insurance fraud should be classified as a major financial crime, to be heard in the already existing specialist financial criminal court. Conviction rates for insurance frauds may, as a result, be increased. Furthermore, use of specialist judges may make the entire criminal process more effective.

We sought to contextualise the current anti-fraud policies in Taiwan by conducting semi-structured interviews with 'experts' associated with the insurance industry and its regulation—our sample, including a judge, a prosecutor, university academics, industry regulators, senior civil servants, and insurance professionals, was generated through snowball sampling. Interviews, 11 in total, were conducted between December 2005 and

February 2006. Interviews were tape-recorded and transcribed. Our interview protocol raised the following issues:

- experience of dealing with insurance fraud;
- why insurance frauds happen in Taiwan;
- the difficulties of investigating, prosecuting, and convicting suspicious claims;
- possible solutions for preventing, detecting, and controlling future insurance fraud.

Demographic details of our interviewees are given in Table 2. Three of our 11 interviewees had at least 18 years experience in the Taiwanese insurance industry. In this sense, they have been witnesses both to Taiwan's broader social change in general and to the particular changes within the organisation of the insurance industry itself. These interviewees were well aware of the strategy and tactics (skills) of the insurance 'world' and the needs and perceived vulnerabilities of insurance clients (Bourdieu and Wacquant, 1992). Our interviewees included four law enforcement agents, including police officers, an experienced judge, a prosecutor, and two academic professors specialising in insurance and criminal law in Taiwan. Our expert sample also comprised two senior civil servants who had around 10 years experience of supervision of the Taiwanese insurance industry.

As we made clear earlier, Taiwan's Insurance Bureau has delivered some key outputs in controlling insurance fraud since 2003. Yet, neither the insurance industry nor senior civil servants are fully satisfied with existing outcomes. One senior civil servant in our interviews said that "*I think 3 out of 10 medical insurance claims are involved in some sort of scams in Taiwan … but there is no way we or the government can detect or control it now.*" (Z02). An insurance law professor also mentioned that "*as one of the founders of IAFI, it thus far is rather disappointing to all of us.*" (Z07)

Indeed, as we noted in our discussion of the criminological complexity of the phenomenon of insurance, moral hazard leading to fraud is endemic to some of the ways in which the insurance industry organises and conducts business. In what follows, we present the findings from the 'expert' interviews—focussing on various dimensions of insurance

Table 2
Demographic characteristics of interviewees

Assigned identification number	Gender	Occupation	Length of work experience (years)	Direct experience with insurance fraud cases
Z01	M	Judge	6	No
Z02	M	Insurance industry	30	Yes
Z03	M	Insurance industry	23	Yes
Z04	M	Arson detective	12	Yes
Z05	M	Prosecutor	8	Yes
Z06	M	Insurance industry	18	Yes
Z07	M	Insurance law and regulations professor	20	Yes
Z08	M	Criminal law professor	10	No
Z09	M	Senior civil servant	8	Yes
Z10	M	Senior civil servant	10	Yes
Z11	M	Police officer	10	Yes

work in Taiwan which illustrate the tropes of moral hazard at the level of organisational structures and practices.

6. Challenges faced by the government, insurance industry, and individual policyholders: findings from 'expert' interviews

It is worth pointing out that these interviews permit, arguably, an invaluable insight into the economic, moral, and social epidemiology of insurance fraud in Taiwan. To use Bourdieu's terminology, through our interviews with people within the 'field' of insurance and its regulation we were able to discern how, in their practice, they had developed a 'feel for the game'—the taken-for-granted, institutionalised ways of seeing and reasoning generated by the 'habitus' of insurance (Bourdieu and Wacquant, 1992). As far as we can ascertain, none of the tropes (or perhaps we can call them 'challenges') that emerge from our analysis of the interview data and which are outlined below, have so far either been considered by government or been explicitly included in the development of regulatory policy in Taiwan. For the purposes of clarity and force of effect, we have condensed the key tropes that emerged from our analysis of the interview data into short aphorisms. We think, again to use Bourdieu's terms, that this use of aphorism captures the genuine logic-of-practice more succinctly.

First, let us consider what we may call the "**You buy in a hurry! We pay at our leisure!**" syndrome. The insurance industry in Taiwan is renowned for negative images of hurried selling of products without careful monitoring, of delaying or withholding settlement of claims, and of acknowledging no wider social responsibility but simply to seek increased profits (Lee, 2004). Consequently, the public reputation of insurance is rather negative and insurance agents busy in selling more of their commodity are held in low esteem. Three of our interviewees all addressed this point by saying that: "*sometimes insurance agents convince the clients to buy the insurance products without stating clearly about the legal terms and conditions*" (Z09), "*if the insurance company can take some responsibility to guard against high risk clients and refuse their applications, then insurance fraud would have been reduced a great deal*" (Z05), "*if an insurance company does not take the obligations to review the applications carefully and follow the governmental rules, why do the government afterwards have to spend so much resources to clean up their mess*?" (Z08) All of these responses indicate that many criminal justice officials and legal experts see the insurance companies in Taiwan as lacking of sense of self-governance, a sense of social responsibility, and a wilful ignorance current regulations and legal order. One important effect of this negative public image is that, where insurance companies incur substantial loss via organised criminal activity, then as 'victims', the insurance companies attract little sympathy from either criminal justice professionals or the general public. That is to say that the public perceives the cause of insurance fraud to be partly due to the negligence of the insurance business.

Second, a cultural attitude of "**I Get What I Pay For**". Policyholders buy insurance in order to offset the risk of uncertainty in the future. However, the premiums are usually perceived as excessively high (for example, the full coverage for motor insurance or medical insurance); as a result, policyholders might try to "collect back" the premiums by making exaggerated claims every year. In other words, to get what you pay for is not morally and economically "wrong" for Taiwanese. For motor and medical insurance are especially true. One insurance adjuster said that "*policyholders know that it costs about*

3000–5000 Taiwanese dollars per day to stay in hospital bed, but you can make a 50,000 Taiwanese dollars medical claim per day from the insurance company. Some hospitals with lots of vacancies would not mind how long the "healthy" patients stay because they can get government subsidy as well. No one loses. It's a win-win situation." (Z03) One judge stated "*for suspicious small claimants, it's not appropriate for the State to get involved if the insurance company can settle it privately or through civil law procedures.*" (Z01) Another criminal law professor mentioned this too: "*Sure, abuse of insurance resources is blameworthy, but what about more serious financial crime?*" (Z08) This kind of thinking, more popularly expressed in Taiwanese society allows individual policyholders to remain unperturbed by moral guilt.

Third, what we may term the "**Catch Me If You Can**" viewpoint. Except for the insurance bureau officials and insurance industry representatives, all our other interviewees perceived insurance fraud as a "misdemeanour". One detective expressed his concerns: "*some suspicious insurance fraud cases take time to investigate and gather evidence. But what do we get from cracking an insurance fraud case? Not much. Police would rather spend time in investigating other major but easy crimes such as drugs or lethal weapons apprehension than working on an insurance fraud case.*" (Z11) For the insurance industry, their main concern is to make all suspicious claims ineligible. Taking claimants to criminal court is not cost effective for insurance companies. Two insurance adjusters expressed similar thoughts: "*We prefer settling suspicious cases outside of the court, because the conviction rate is very low. It also does not 'look good' for insurance companies to be seen to be taking their clients to court all the time. It will affect our business image.*" (Z02) "*We would not take our clients to court unless they are truly vicious. We know that this may indeed somehow encourage more insurance fraud. Because the criminals are of course aware that no serious legal consequences would happen even if their fraud is discovered. But to us, it is no loss as long as there is no claim payment made.*" (Z03)

One fire detective further said that "*Insurance frauds are hard to gather evidence and prove guilt in court unless they are committed by organised or serial criminals. The recent famous arson case by Pong's group*[1] *I dealt with it—the conviction was mainly based upon a large amount of circumstantial evidence rather than direct evidence. This group committed 17 arson cases in 7 different cities and successfully made 12 claims. If they had not been using a similar MO, we would not have known about their crimes.*" (Z04) With no genuine label of shame, little legal consequence and low conviction rates—these factors have made motivated insurance fraudsters prepared to take the risk. As our interviewee pointed out "*For the client, I win if you can't catch me. I have nothing to lose even if you do catch me.*" (Z03)

Fourth, "**All You Can Eat**" policy. The ideal of private insurance industry is risk pooling. Do policyholders understand this concept? No. One insurance law professor opined, with some anger that: "*Taiwanese have this "all you can eat" attitude in many aspects. They think that as long as the money is from my own pocket, it does not matter how much you use it, especially with other people's or government money. They don't understand or see that basic concept of insurance is to share risk within a pool. If they have a chance accident (true or false, small or big) to make a claim, they would like to get all the premium they have been paid forin return.*" (Z07) One senior civic servant with the National Health Insurance placed the blame with the insurance industry: "*We are very powerless.*

[1] A famous organised arson insurance fraud case in Taiwan. Mr. Pong was the leader of the group.

The Insurance industry sometimes designs and sells some "devious" products to trap potential policyholders. For example, one of the main reasons I think health insurance fraud is getting worse in Taiwan is the product of "maintenance health" meaning the insurance company pays a daily fixed fee directly to the insurer regardless of types or levels of services provided by physicians. No invoices or receipts are needed. I think the insurance industry should take more consideration for their social responsibilities and be more sensitive to our culture." (Z10)

Like other commodities in the free market, the private insurance business is seen as a matter of free choice between sellers and buyers. Individual buyers and sellers are assumed to take their responsibilities when purchasing the product. As our expert interviews illustrate, "trying to sell as much as sellers can with minimal costs" and "trying to gain as much as buyers can with most benefits" are both considered rational choices. However, unlike regular commodities, the concept of insurance is nominally based on managing risk within a pool. When an individual buys the insurance product and an insurance company sells it, they have agreed to participate in the risk sharing pool and are responsible for other consumers' interests. In this sense, the Taiwanese ideologies of "selling with little screening", "get what you pay for", "catch me if you can" or "all you can eat" are certainly part and parcel of how insurance claims fraud is largely an artefact of how the industry itself organises to deal with it.

7. Discussion

In modern, high efficiency, low-cost societies, financial crime in general represents a high reward, low-risk activity. With 'lighter touch' operations and pressures on cost, not only does the operating environment make it easier to commit fraud, but investigations and criminal prosecutions are not always considered cost effective for what appear to be small-scale frauds. For the insurance sector in particular, the moral hazards embedded in the social organisation of private insurance lead to various kinds of immoral risky behaviour by those insured, insurance companies, and their employees, and to intensified efforts to regulate this behaviour. The important findings from our study give evidence to the notion that the moral hazards of insurance fraud in Taiwan are indeed largely embedded in the institutional arrangements, social relationships, and moral economies of the private insurance industry—as well as in cultural and moral outlooks. The developing regime of anti-fraud policies in Taiwan, unfortunately, has not fully recognised or been fully informed by the nature of insurance fraud "construction". In Taiwan's case, neither the general public nor the criminal justice system clearly label insurance fraud as 'immoral'. Insurers and companies neglect to distinguish the insurance product from other commodities in the free market. The state overestimates the "inclusionary and exclusionary" mechanisms of the workings of private insurance. Given the current situation and policies, the higher the benefits for insurers and insurance companies, the greater the risk of moral hazard and the greater the possibility of committing "taken-for-granted" insurance fraud in Taiwan.

Our approach to the issue of insurance fraud and regulatory effort has been informed by an emerging theme in comparative criminological research—namely, that while much that is common to the cultures of control in contemporary advanced economies is the result of broad social, cultural, political, and economic pressures, so it is also the case that particular social and cultural contexts frame and shape in very different ways apparently mobile 'regulatory approaches' (see Melossi, 2000). In this sense, insurance fraud

regulation is as much a matter of cultural meaning as of instrumental effectivity. As we have noted in this particular study of Taiwan, such meaning will vary from culture to culture (and is probably not homogenous within cultures). We are of the view that there is considerable theoretical potential in seeking to develop an interdisciplinary 'cultural embeddedness' approach which emphasises the need to understand how cultural values underpin particular understandings of 'risk' and 'insurance' and the implications for regulatory effort. For example, if we take the case of the People's Republic of China, a society in transition, where transformation from a planned economy to a market economy has been shifting the principal part of risks from the government to the company and the individual—a key theoretical issue is to understand how changing cultural values relate to the generation of an 'insurance culture' with Chinese characteristics (Sun Qixiang, 2000, p. 12). Any such study requires the criminologist to engage with interdisciplinary socio-historical investigation. The study of life insurance as a cultural practice, for example, has been moving in from the margins of social historical enquiry for some time now. As early as 1979, Viviana Zelizer took an important step beyond the confines of institutional history with her study of public debates about the moral implications of life-insurance practices in nineteenth- and twentieth-century America (Zelizer, 1979). In the context of British and continental European historiography, the consolidation of a number of related paradigms in the 1980s began to point towards a research agenda which would situate the development of systems for insuring the person in the context of changing ways of understanding and representing the individual and social relations (see the cultural history by Clark, 1999). There is now evidence that criminologists interested in understanding contemporary insurance fraud and its regulation are indeed engaging more fully with this literature (see Ericson and Doyle, 2006).

In the modern era, no government can afford to lose the 'institution of insurance', simply because some risks are too large for individuals to self-insure and some are outside what is seen as government's liability. Neo-liberalism spotlights private insurance as the responsible market-based alternative, as opposed to depending on the state for managing risk. Indeed, private insurance has become a central institution of governance beyond the state, a key institution for aspects of governance such as risk management, security provision and population management. Private insurance configures risk in all other important institutions, not only by defining and managing risks, but ironically by 'creating' them. An irony, indeed, probably not lost on Karl Marx all those years ago, when in relation to crime, criminal law, and the professor, he noted:

> The criminal produces not only crimes but also criminal law, and with it, the professor who gives lectures on criminal law, and in addition to this, the inevitable compendium in which the professor throws his lectures on the general market as 'commodities'. (Marx (edition 1969), p. 375)

Acknowledgements

We wish to acknowledge and thank the following agencies for their invaluable assistance in the completion of this project: the Insurance Bureau of the Republic of China (Taiwan), the Insurance Anti-fraud Institute of the Republic of China (Taiwan), and the Taiwan Insurance Institute. Comments from the journal's referees were helpful in clarifying our thinking on certain matters.

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