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Insurance Fraud: Theoretical Conceptualization and Countermeasures

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Abstract. Ensuring the effective functioning of insurance companies and the proper level of their financial security is impossible without the formation and implementation of an effective system for detecting and countering insurance fraud, which causes negative consequences for the companies themselves, their clients and counterparties, and the country's insurance market in general. The purpose of the article is to generalize the theoretical foundations of insurance fraud and substantiate practical recommendations for combating insurance fraud in the modern conditions of the functioning of insurance companies of Ukraine using the best experience of organizing the fight against fraud in the insurance systems of the leading countries of the world. In the process of carrying out a scientific search, in order to achieve the specified goal, the following general scientific methods were used, which ensure the reliability of the obtained results and conclusions, such as: the method of theoretical generalization; monographic and comparative; method of comparative analysis; graphic; abstract logical method. For the success of the fight against fraud, it is justified to build a hierarchical structure for combating insurance fraud, which will cover the entire market and will be carried out at the state level and at the level of the insurance company. The main goal of the proposed system is to prevent cases of insurance fraud, exchange information on the facts of falsification of insurance events and control compliance with the law. The insurance fraud prevention system at the level of insurance companies is proposed to be segmented into the following groups: financial investigations; building a fraud prevention mechanism; search and return of assets, support in disputes and handling of cases.It has been determined that the very segmentation of a company's anti-fraud efforts is necessary in order to cover all the areas of risk associated with causing losses to companies as a result of fraud. Therefore, the proposed ways of combating insurance fraud are based on a systemic approach, and their complex application can give its synergistic effect and make it possible to cover all risk areas associated with causing damage to companies as a result of fraud, abuse, employee negligence and other frauds as both within the company and in relations with counterparties, and will also contribute to safety in the insurance market

Keywords: insurance fraud, insurance market, insurance companies, insurance market regulation

INTRODUCTION

Ensuring the effective functioning of insurance companies and the proper level of their financial security is impossible without the formation and implementation of an effective system for detecting and countering insurance fraud, which causes large-scale negative consequences for companies, their stakeholders and the insurance market in general. In the countries of Western Europe and the USA, 15% of payments from insurance cases go to fraudsters [1]. Similar statistics are not known in Ukraine. It is worth noting that even the National Bank of Ukraine, which, in particular, supervises domestic insurance companies, does not have similar statistics. However, according to the Report of the General Prosecutor's Office of Ukraine "On Criminal Offenses Committed at Enterprises, Institutions, Organizations by Types of Economic Activity", it follows that the share of crimes committed in the field of insurance, reinsurance of non-state pension provision, in addition to mandatory social insurance, from the total number of crimes committed in the field of financial activity in 2020 ranges from 7.2% to 10.6%, in 2021 – from 9.8% to 16.0% [2].

Despite the efforts made by the insurance community, the authorities and law enforcement agencies to combat insurance fraudsters, in particular with regard to market segmentation, licensing and prudential supervision, reporting, inspections, corporate governance

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and protection of consumer rights, the involvement of international and Ukrainian experts to develop concepts, development proposals for legislative and regulatory changes and preparation of drafts of relevant acts [3], the problem of insurance fraud continues to remain relevant and cause great economic losses. Therefore, it is advisable to consider the justification of ways to combat insurance fraud systematically, and only a comprehensive application can give its synergistic effect and make it possible to cover all risk areas associated with causing damage to companies as a result of fraud, abuse, employee negligence and other frauds both within the company, as well as in relations with counterparties, and will also contribute to security in the insurance market.

Various scientists have made a significant contribution to the study of insurance fraud problems and the study of ways to regulate insurance fraud prevention. Ya.V. Mykytenko, V.S. Fomina proposed a system of measures for the prevention of insurance fraud, which should be based on the automation of the fight against fraud, the use of artificial intelligence, the culture of combating fraud and the prompt exchange of information [4].

In the studies of V. Andrienko, R. Kobko [5], it is proven that the level of economic security of the insurance market is determined by how effectively the subjects of the insurance market can effectively resist existing and potential threats and eliminate negative factors affecting the functioning of the insurance market.

Studying the motives for its implementation is important when developing ways to combat insurance fraud. Thus, researchers B. Loveday, J. Jung [6] indicate that fraud, like any crime, is a product of three factors: motivated offenders; the presence of a potential victim or target; lack of an effective supervisory body. This general rule applies regardless of whether it is fraud against government assistance programs, against the elderly, or misappropriation of corporate assets by a company director.

J. Jung [7] provides a characterization of insurance fraud, including its nature, the Scholar argues that insurance fraud is highly fragmented and each offense is not significant enough to cause active public interest or police intervention. Scientists identified and diagnosed three problems: lack of awareness, lack of national leadership, and limited attention of investigative bodies to insurance fraud. Based on these, three recommendations were proposed: (1) the initiation and development of a national initiative by the central government, (2) the use of a dynamic concentration approach to send deterrence threats to potential fraudsters, and (3) the use of big data technologies to identify the clandestine activities of organized groups.

In their research, P. Grabosky, G. Duffield emphasize that the most common motivation for fraud is economic. Another motivation is moral satisfaction. Scientists believe that those caught at the scene of fraud get joy from their own skill, which increases their prestige, causes pride and a desire for revenge [8, p. 2].

A similar opinion is held by L. Shirinyan [9, p. 337], who believes that economic incentives for fraud are due to the existence of information asymmetry. You can agree with this, because according to the Law of Ukraine "On Insurance" [10], all parties to an insurance contract at any time are obliged to act with maximum conscientiousness, honesty to each other, which obliges the parties to mutually disclose all information known to them. Access to relevant information is usually limited to one of the parties to the agreement. A participant who possesses certain information has an advantage, which often serves as an incentive to commit fraud. Asymmetric information leaves participants with no other option but to trust each other for the duration of the agreement. The many opportunities that naturally arise for one or more interested parties due to the lack of complete information provide clear economic incentives to commit fraud.

Without diminishing the importance of scientific intelligence in this area, it is worth paying more attention to the definition of problems related to the spread of insurance fraud in Ukraine and the justification of the anti-fraud structure at the state level and at the level of the insurance company.

The purpose of the article is to generalize the theoretical foundations of insurance fraud and substantiate practical recommendations for combating insurance fraud in the modern conditions of the functioning of insurance companies of Ukraine using the best experience of organizing the fight against fraud in the insurance systems of the leading countries of the world.

MATERIALS AND METHODS

This article is aimed at consolidating and conducting a literature review with the aim of generalizing the theoretical foundations of insurance fraud and substantiating practical recommendations for combating insurance fraud in the modern conditions of the functioning of insurance companies of Ukraine using the best experience of organizing the fight against fraud in the insurance systems of the leading countries of the world.

In the process of carrying out a scientific search, in order to achieve the specified goal, the following general scientific methods were used, which ensure the reliability of the results and conclusions obtained, such as: the method of theoretical generalization – to formulate one's own approach to understanding the essence of insurance fraud; monographic and comparative – to systematize the scientific approaches of scientists to the theoretical aspects of insurance fraud and expand the methodological basis for justifying the creation of a system for combating insurance fraud; the method of comparative analysis – to compare the actual data of the activity of insurance companies of different periods; graphic – for visual display of research results; abstract-logical method – in the process of forming theoretical generalizations and conclusions.

The information base of the research was served by normative legal acts, in particular the Law of Ukraine "On Insurance", the Criminal Code of Ukraine; consolidated statistical data of the State Statistics Service of Ukraine,

reports "On Criminal Offenses Committed at Enterprises, institutions, organizations by types of economic activity" of the General Prosecutor's Office of Ukraine for 2020-2021, Internet resources; monographic, periodical and reference publications; reporting materials of specialized organizations of various countries (National Insurance Crime Bureau, Insurance Bureau of Canada, Gesamtverband der Deutschen Versicherungswirtschaft, Association of British Insurers, Federation of Finnish Financial Services), the main task of which is to ensure control of the insurance market and combat fraud on it, and data from their official websites; reports of the international auditing company Price Waterhouse Coopers; results of own research and calculations.

In accordance with the formulated goal, the stages of the research were: the study of the theoretical foundations of insurance fraud, the definition of its main types; analysis of the performance indicators of insurance companies in the modern conditions of the spread of insurance fraud; substantiation of ways to combat insurance fraud in the modern conditions of operation of insurance companies of Ukraine. The used methodology contributed to the solution of the task and the justification of practical recommendations for combating insurance fraud in the modern conditions of the functioning of insurance companies of Ukraine using the best experience of organizing the fight against fraud in the insurance systems of the leading countries of the world.

RESULTS AND DISCUSSION

In Article 190 of the Criminal Code of Ukraine [11], fraud is interpreted as a crime against property, which is carried out through "... seizing someone else's property or acquiring the right to property by deception or abuse of trust..." [11]. The International Association of Insurance Supervisors (IAIS) defines fraud as an act or deliberate concealment of information with the aim of obtaining an unfair advantage for the fraudster himself or for a third party [12].

International auditing company Price waterhouse Coopers interprets fraud as deliberate deception with the aim of stealing money, property or legal rights [13, p. 15]. The Association of Certified Fraud Examiners (Association of Certified Fraud Examiners) defines fraud in organizations (or so-called "corporate" fraud) as "...the use of official position for the purpose of personal enrichment through the intentional misuse or abuse of the resources and assets of the employer organization..." [14, p. 9].

The most discursive questions remain the definition of insurance fraud. It should be noted that there are no unified approaches to the interpretation of the content of insurance fraud in the Ukrainian financial literature. In many cases, the term "insurance fraud" is interpreted as deception, illegal behavior. Various definitions of insurance fraud, which can be the basis for understanding the concept itself, are presented in Table 1.

Table 1. The range of interpretations of the definition "insurance fraud"

Author	Definition
V.L. Plastup [15]	Insurance fraud is the illegal behavior of the subjects of the insurance contract, as a result of which the subjects of the insurance contract get the opportunity to illegally and free of charge rotate capital to their advantage
A.V. Tkachuk [16, p. 21]	Insurance fraud is a cunning and clever deception; seizing individual property of citizens or acquiring the right to property by deception or abuse of trust.
O.I. Baranovsky [17]	Insurance fraud is the obtaining of insurance compensation by the insured by deception or abuse of trust, or by paying less than necessary, with a normal assessment of risks, insurance premium, as well as hiding important information at the conclusion or during the period of validity of the insurance contract
L.V. Shirinyan [9, p. 343]	Insurance fraud is a conspiracy or deliberately illegal behavior of certain subjects of insurance relations, intentionally incorrect display (presentation) of data regarding the terms of the insurance contract, as a result of which such subjects get the opportunity to illegally change (use) the terms of the insurance contract to their advantage or receive compensation without proper grounds arising from the legislation, to take possession of someone else's property or acquire rights to property by deception, abuse of trust
O.R. Kryvytska [18, p. 149]	Insurance fraud is an illegal action by the subjects of the insurance contract, or third parties, as a result of which the subjects of the contract get the opportunity to turn capital to their advantage on an illegal and free basis

Source: *systematized by the author*

The review of works reveals that the conceptual apparatus regarding insurance fraud, which would cover all subjects of the insurance market, remains undeveloped, which necessitates the formulation and definition of the concept of "insurance fraud" taking into account the role of the main subjects of the insurance market. So, based on the key characteristics of insurance fraud and taking into account the interpretation of this definition by scientists, an author's approach to defining the essence of this concept was formed. Insurance fraud can be considered as intentional actions of the subjects of the insurance contract, aimed at obtaining illegal benefits by deception or abuse of trust.

Insurance fraud can be classified depending on the subjects whose rights are violated; purposes of criminal acts, fraudulent acts; areas of insurance in which fraud is most widespread [4]. The indicated classification features are of significant importance in identifying possible threats to subjects of insurance relations. Yes, according to Y.V. Mykytenko, V.S. Fomin. the goals

of criminal actions for the insurers or insurance intermediaries themselves are the illegal appropriation of insurance premiums in the absence of the intention to fulfill their obligations to pay insurance compensation; for policyholders – illegal obtaining of insurance compensation or security; for employees of an insurance company – illegal obtaining of benefits by causing property damage to insurers and policyholders [4]. According to the identified motives for committing insurance fraud, it is possible to distinguish certain groups of fraudsters with characteristic psychological features (Fig. 1). Fraud can be divided into two groups: planned and situational. A key feature of planned fraud is extensive training, sometimes involving a group of people and with the assistance of insurance company employees. This can be insurance of duplicate cars, insurance of damaged cars followed by the announcement of an insurance event, insurance of property in several different insurance companies to receive several insurance payments at once, staging of insurance events (accidents, thefts, arson and flooding, robbery). Situational fraud usually concerns insurers who have entered into a contract for the purpose of classic insurance protection. However, in the event of an insured event, they may take measures, as a rule, to hide the true causes and circumstances of the event, in order to avoid payment refusal or artificial overestimation of the loss [19].

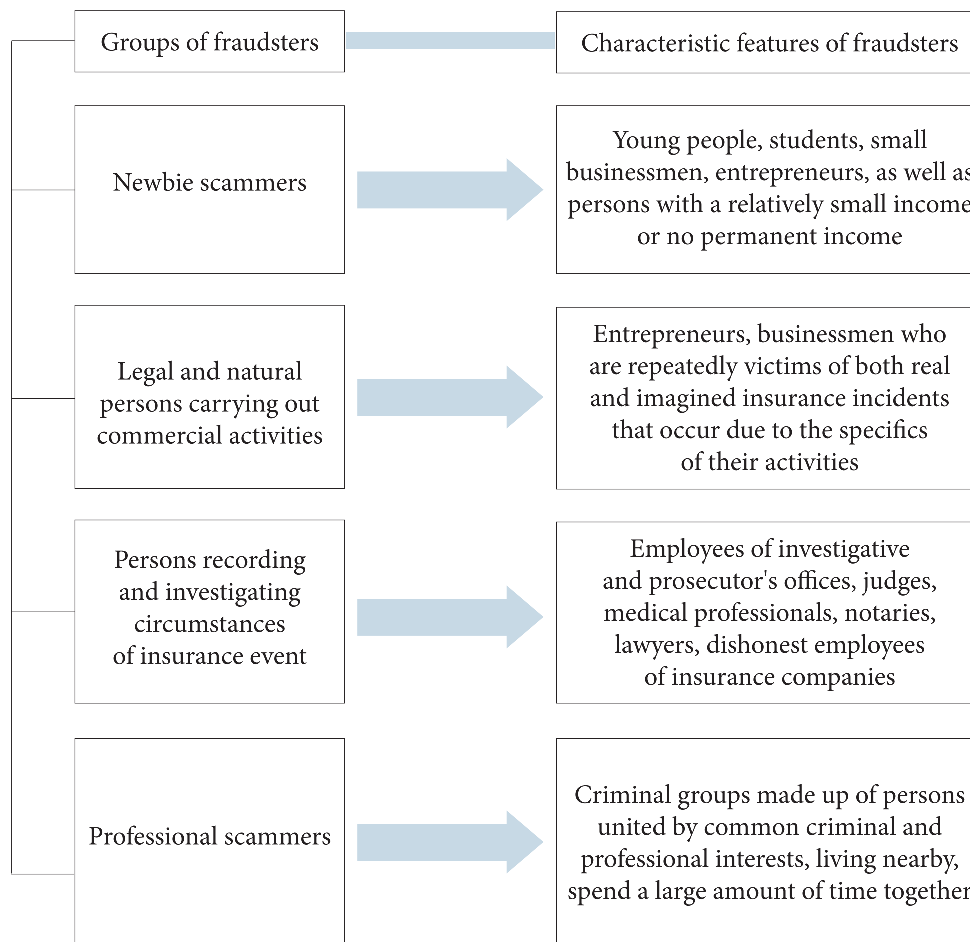

Figure 1. *Groups of fraudsters in the insurance sector*

Source: *compiled by the author using [9; 15; 20]*

The scale of insurance fraud varies from country to country. According to estimates by Insurance Europe [21, p. 9], fraud accounts for up to 10% of all claims costs in Europe. However, this number varies between countries and insurance classes depending on the functioning of the market and the distribution of a particular type of insurance. The approach to detecting insurance fraud also differs in European countries. Some countries (UK, Germany, Sweden, France, Finland) place great importance on establishing an accurate estimate of detected and undetected fraud, while others (USA, Canada, France) focus on reducing the number of known fraud cases. However, the objective remains the same: to determine the extent to which anti-fraud initiatives are successful and whether further action is needed.

The insurance industry loses huge sums due to criminals. Figures from the Association of British Insurers (ABI) [21; 22] show that approximately £1.9 billion (€2.2 billion) of fraud goes undetected each year, with the value of detected fraud increasing by 7% to £983 million in 2020 sterling (1148 million euros). Figures from Insurance Sweden (Larmtjänst) [23] in Sweden show that insurance fraud investigators set up by insurance companies conducted 6,200 suspected fraud investigations

in 2020 and detected fraud totaling €40 million. Research has shown [21] that 10-20% of all fraudulent claims are claims for damages arising from events that never happened (ie false statements) and 80-90% of all fraudulent claims are exaggerated. In France, 35,042 fraudulent insurance claims were recorded in 2020, resulting in 168 million euros not being paid.

A study conducted by the Insurance Association (FFI) in Finland showed that 27% of policyholders indicated that they knew someone "...who defrauded their insurance company" [21].

In Ukraine, the situation is a little calmer. This is due to the fact that the insurance market is not as developed as in Europe and the USA, so there are fewer fraudsters. The share of insurance cases with signs of insurance fraud is about 1.5-2% of all registered losses [19]. The main field of activity of insurance fraudsters was and remains auto insurance – CASCO and OSCPV [24]. In some European countries, 80% of insurance fraud cases are related to motor insurance. At the same time, attempts to make a profit from insurers take place in real estate insurance (both for individuals and for businesses) and in personal insurance (from accidents, civil liability insurance, etc.).

The number of insurance companies in Ukraine has a tendency to decrease, mainly due to the introduction by the National Bank of Ukraine of new requirements for their activities: updating mandatory standards for insurers, aimed at ensuring the appropriate level of solvency and liquidity of insurance companies, reducing the level of riskiness of operations, improving the quality assets and strengthening financial stability in the market of insurance services. A significant reduction in the number of insurance companies on the insurance market of Ukraine is also caused by the annual increase in the number of frauds in this area. Thus, in 2020, compared to the same period in 2017, the number of companies decreased by 84 SC [25]. For a more detailed analysis of the insurance market, the dynamics of the number of insurance companies and the level of their concentration were determined (Table 2). This will help to assess the overall potential of these financial institutions for insurance services.

Table 2. Dynamics of the number of insurance companies and their concentration in Ukraine

Number of insurance companies	2017	2018	2019	2020	The first half of 2021
Total quantity, units	294	281	233	210	181
Including IC "non-Life"	261	251	210	190	162
Including IC "Life"	33	30	23	20	19
Top 100 IC "non-Life", %	97.6	97.9	98.1	98.9	99.1
Top 150 IC "non-Life", %	99.5	99.7	99.8	99.9	99.9
Top 10 IC "Life", %	95.9	96.9	96.7	97.1	97.4
Top 20 IC "Life", %	99.9	100.0	100.0	100.0	100.0

Source: *built on materials [25]*

It should be noted that the peculiarity of the development of the Ukrainian insurance market is that 89.5% of it consists of "non-life" insurance companies (insurance companies dealing with risk types). The reason for the low level of development of life insurance is that the population of Ukraine does not have free funds and trust in the insurance system as a whole. The indicator of the number of insurance companies should be considered together with the indicator of the concentration of the insurance market. Thus, as of the end of 2020, only 150 "non-Life" insurers out of 210 (71.4%) accumulate 99.9% of all collected insurance premiums [25]. That is, we can talk about the existence of "pseudo insurance" on the insurance market, since 0.1% of insurance premiums are collected by 60 out of 210 insurers. A similar trend is observed in the life insurance market. During 2017-2021 10 ICs (50.0% of the total number of Life ICs) accumulated 97.1% of insurance premiums. All this confirms the low level of social security of the population of Ukraine, because the receipt of life insurance premiums and the number of insurers of this type are too small to ensure sustainable development. The study of the dynamics of the number of insurance companies and their concentration in Ukraine is limited to data for the first half of 2021 due to the lack of published official statistical information on the number of insurance companies as of the beginning of 2022.

Insurance fraud in the market of insurance services has significant consequences, causing significant losses for all subjects of the insurance market. Fraudulent lawsuits and the costs of investigating suspected fraud lead to higher insurance premiums for honest customers [26]. Fraud investigations also affect insurers and their ability to process genuine claims quickly.

Sufficiently complex systems of prevention, detection and management are required for the success of the fight against fraud. For this, it is necessary to create an environment against fraud.

The fight against fraud in the field of insurance forces insurers to unite and create unions, and the state to take effective measures to solve this problem. Thus, in almost all developed countries, where insurance plays an important role for the effective functioning of the national economy, there are specialized organizations whose main task is to ensure the control of the insurance market and to oppose the manifestations of fraud on

it. Thus, in the USA there is a National Insurance Crime Bureau (National Insurance Crime Bureau), founded in 1992 [27]; in Canada, the Insurance Bureau of Canada was established in 1964 [28]; in Germany – the German Association of Insurers (Gesamtverband der Deutschen Versicherungswirtschaft) [29]; the Association of British Insurers has been operating in Great Britain since 1985 [22]; the Federation of Finnish Financial Services (Federation of Finnish Financial Services) has been operating in Finland since 2009 [30]. Analyzing the activities of the presented organizations, it was established that in order to reduce the negative impact of fraudulent actions on the subjects of the insurance system, the countries keep registers of insurance losses, and therefore of cases of insurance crimes, as well as organizations that fight against insurance fraud in order to detect insurance fraud. Actively use the latest technologies, such as electronic devices to identify the authenticity of documents submitted to support claims, as well as verify available information from social networks and other websites, hotlines and other methods, involving a wide range of the public in the fight against insurance fraud, etc. Thus, it can be stated that the association of its participants plays an important role in activating and improving the functioning of the insurance market. The level and potential of market development is determined by the presence of various types of such associations and the consolidation of their members' activities. Each such association has its own purpose and task and plays an important role in the intensive development of the insurance market. The main reason for the creation of such associations is the inability of individual insurance companies to independently solve problems that constantly arise in the insurance market, inhibit its further development, and hinder the development of insurers' business [31, p. 248]. As of the beginning of 2022, the National Association of Insurers of Ukraine, the League of Insurance Organizations of Ukraine, the Insurance Business Association, the Motor Transport Insurance Bureau of Ukraine and others operate in Ukraine, whose activities are primarily aimed at activating the development of the insurance market of Ukraine, but it is necessary to form a new model of combating fraud [32].

Taking into account all participants of the insurance market, it is advisable to propose different hierarchical levels of the structure of combating insurance fraud. There will be a market-wide response structure that will take place at the state level and at the insurance company level. State regulation of insurance activity in the field of combating insurance fraud involves the use of a number of methods of direct and indirect influence, forms of regulation and tools (Fig. 2). The introduction of a system to combat insurance fraud at the state level is not only important, but also necessary. According to V. Andrienko and R. Kobko, state regulation of the insurance market remains the most effective and important mechanism for controlling the effectiveness of the functioning of insurance companies and ensuring the economic security of the insurance market [5, p. 9]. The authors support the opinion of scientists, since state regulation can significantly affect the safety of the insurance market and the growth of trust in it on the part of citizens and enterprises.

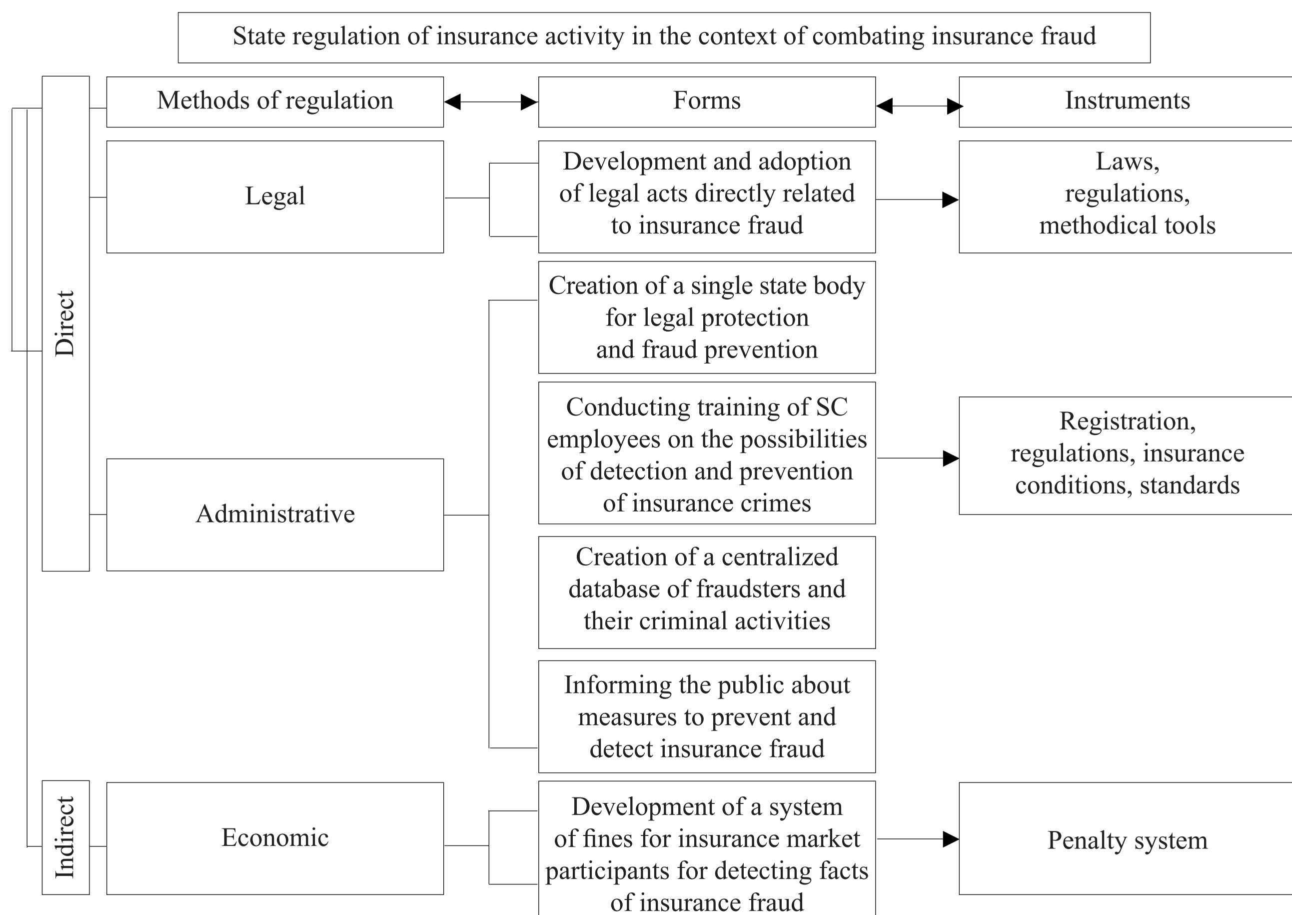

Figure 2. *The system of combating insurance fraud at the state level*
Source: *developed by the author*

The main purpose of the proposed system of combating insurance fraud at the state level is to prevent cases of insurance fraud, exchange information about the facts of falsification of insurance events and control compliance with the relevant legislation [9, p. 354]. Therefore, the system will contribute to the protection of the rights and economic interests of the subjects of the insurance market and the growth of trust in it.

The insurance fraud prevention system at the level of insurance companies is recommended to be segmented into the following groups: financial investigations (analysis of the current security system in the company; evaluation of procedures and internal policies); building a fraud prevention mechanism (preparation of a plan of anti-fraud measures; organization of the work of a corporate hotline; preparation of an online application form; organization of the work of the security service and internal control); search and recovery of assets, assistance in disputes and case proceedings (identification of lost profits and opportunities; collection of hidden information about the parties to the dispute; evaluation of the dispute and development of a strategy; assistance in negotiations; pre-trial recovery of assets; court assistance, provision of expert testimony). The very segmentation of a company's anti-fraud efforts is necessary in order to cover all areas of risk associated with causing losses to companies as a result of fraud, abuse, employee malpractice and other manipulations both within the company and in relations with counterparties.

Realizing the scale of losses in the insurance market for insurance companies, the construction of a fraud prevention mechanism should be focused on the following components:

1. *Automation of the fight against fraud*. It is important to develop fraud detection capabilities with technical support. Many industries and sectors are actively using big data technologies to suit their needs. Similarly, big data technology can be a useful tool for detecting cases of insurance fraud, as the number of claims for insurance benefits increases over time. Big data technologies can benefit key stakeholders as they will be able to detect cases of organized fraud in the first place.

2. *Use of artificial intelligence*. Artificial intelligence can be used to analyze images while checking for fraud. Insurance companies can use these technologies to improve and streamline their risk analysis and fraud detection processes.

3. *Anti-fraud culture*. Such a culture requires structured communication between departments, senior management involvement, fraud awareness training and agreed performance standards for staff. There are many examples of positive world experience in this aspect. For example, in Germany, Denmark, Finland, annual training is held for claims handling specialists to teach them how to detect and fight fraud. The training is conducted by practitioners of the insurance industry, legal advisers, technical specialists, police experts and medical scientists.Participants can take an exam to earn a Certificate of Expertise in Insurance Fraud Detection. In Finland, the insurance federation has been organizing seminars and training with the police, other authorities and the media for 30 years. In the UK, bodies such as the IFB and IFED run specialist anti-fraud workshops for staff, and many insurance companies additionally run early and career-long training programs for staff and appoint "fraud advocates" who highlight and remind colleagues about the possibility of fraud in all areas of business [21].

4. *Exchange of information*. All insurance companies would benefit from joining forces and sharing information on the origins of fraud. It is worth noting the existing foreign experience regarding the exchange of information about fraudsters in the field of insurance. In particular, in Croatia, Estonia, Finland, Germany, Ireland, Malta, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden and Great Britain, there is an exchange of information about fraudsters in the field of insurance between insurance companies. Insurance companies are transparent about this and act in accordance with data protection and privacy requirements. There is also cross-border cooperation. Insurance companies of the Scandinavian countries meet regularly to discuss trends and problems in combating insurance fraud. And in France, Sweden and Great Britain, insurance companies have created formalized groups to investigate insurance fraud [21].

In France, insurers created a national body (Agence pour la lutte contre la fraude à l'assurance, ALFA) in 1989 to investigate suspicious claims. ALFA aims to contribute to the fight against fraud by developing appropriate tools to help the industry fight fraud. These include: training and certification of fraud investigation agents, advice on handling fraud cases that target multiple insurers at the same time, and advice on managing relationships with law enforcement [32].

In Sweden, insurance companies have created special investigative units that are responsible for detecting insurance fraud. Insurance Sweden encourages these units to report detected or suspected fraud to the police [33].

In the UK, the Insurance Fraud Bureau (IFB) focuses on detecting and preventing organized and cross-industry insurance fraud. The IFB leads or coordinates the industry's response to the detection of criminal fraud networks and works closely with the police and other law enforcement agencies [33]. It encourages and helps people to report suspected or known fraud anonymously through the insurance hotline.

Without the active response of all market participants, in particular the state, and the insurance companies themselves, positive changes in the context of minimizing the risks of insurance fraud are impossible. That is why the proposed ways of combating insurance fraud are based on a systemic approach, and their complex application can have a synergistic effect in combating fraud and contribute to security in the insurance market.

CONCLUSIONS

It stands to reason that detecting and reducing insurance fraud is a key priority for insurers. Honest customers should

not have to pay the price for fraudsters through higher premiums. The insurance industry continues to improve its systems and controls to ensure that all types of fraud are detected and prevented.

Insurers' methods are constantly evolving to deal with changes in the behavior of fraudsters. It has been proven that it is necessary to build a hierarchical structure to combat insurance fraud, which will cover the entire market and will be carried out at the state level and at the level of the insurance company. The proposed system of combating insurance fraud at the state level, which involves the use of a number of methods of direct and indirect influence, forms of regulation and tools. The main purpose of the proposed system is to prevent cases of insurance fraud, exchange information on the facts of falsification of insurance events and control compliance with the relevant legislation. The expediency of segmenting the company's anti-fraud efforts is substantiated.

Thus, it is proposed to segment the insurance fraud prevention system at the level of insurance companies into the following groups: financial investigations; building a fraud prevention mechanism; search and return of assets, support in disputes and handling of cases. Such a system will make it possible to cover all risk zones associated with causing damage to companies as a result of fraud, abuse, employee malpractice and other frauds both within the company and in relations with counterparties.

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Страхове шахрайство: теоретична концептуалізація та шляхи протидії

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Анотація. Забезпечення ефективного функціонування страхових компаній, належного рівня їх фінансової безпеки неможливе без формування і впровадження дієвої системи виявлення і протидії страховому шахрайству, що спричиняє негативні наслідки як для самих компаній, їх клієнтів і контрагентів, так і страхового ринку країни загалом. Метою статті є узагальнення теоретичних засад страхового шахрайства та обґрунтування практичних рекомендацій щодо протидії страховому шахрайству у сучасних умовах функціонування страхових компаній України з використанням передового досвіду організації боротьби з шахрайством у страхових системах провідних країн світу. У процесі здійснення наукового пошуку, для досягнення визначеної мети було використано такі загальнонаукові методи, що забезпечують достовірність отриманих результатів і висновків, як: метод теоретичного узагальнення; монографічний та порівняльний; метод порівняльного аналізу; графічний; абстрактно-логічний метод. Для успіху боротьби з шахрайством обґрунтована побудова ієрархічної структури протидії страховому шахрайству, яка охоплюватиме весь ринок і буде провадитися на державному рівні та на рівні страхової компанії. Основною метою запропонованої системи є запобігання випадкам страхового шахрайства, обмін інформацією про факти фальсифікації страхових подій та контроль за дотриманням законодавства. Систему протидії страховому шахрайству на рівні страхових компаній запропоновано сегментувати на такі групи: фінансові розслідування; побудова механізму протидії шахрайству; пошук і повернення активів, супровід в спорах і розгляді справ. Визначено, що саме сегментування зусиль компанії з протидії шахрайству є необхідним для того, щоб охопити всі зони ризику, пов'язаних з нанесенням компаніям збитку в результаті шахрайства. Отже, запропоновані шляхи боротьби зі страховим шахрайством базуються на системному підході, а їх комплексне застосування може дати свій синергетичний ефект та дасть змогу охопити всі зони ризику, пов'язані з нанесенням компаніям збитку в результаті шахрайства, зловживання, службовою халатністю співробітників та інших махінацій як всередині компанії, так і у відносинах з контрагентами, а також сприятиме безпеці на страховому ринку

Ключові слова: шахрайство у страхуванні, страховий ринок, страхові компанії, регулювання страхового ринку