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The Effect of Fraud Opportunity on Occupational Fraud among Insurance Companies in Kenya

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Abstract

Purpose: Fraudulent activities in insurance has become common. To address this persistent vulnerability and fill the knowledge gap surrounding the structural and behavioral drivers of such fraud, this study critically examines the effect of fraud opportunity on occupational fraud in insurance companies in Kenya.

Methodology: The study adopted the explanatory research design. The target population comprised of the 58 insurance companies that are registered under the Insurance Regulatory Authority (IRA). The validity and reliability of the research instruments was tested before the actual data is collected. The validity and reliability of the research instruments was tested before the actual data is collected. The study adopted stratified random sampling procedure. The sample size for the study was 384 employees. The study collected primary data through Semi –structured questionnaires and interview guides. The data collected was then edited, coded and analyzed using the SPSS v27 statistical software. Descriptive statistical analysis was used to determine mean, standard deviation, frequency counts and percentages which was also be presented in output tables as results. Inferential statistics involved simple and linear regression and correlation analyses. The research findings were presented in tables and graphs.

Findings: The findings were both the correlation and regression results ($r=0.739$, $R^2=0.547$; $\beta=0.884$, $p<0.05$) showed there is a statistically significant relation between fraud opportunity and occupational fraud.

Unique Contribution to Theory Practice and Policy: The study recommended that insurance companies should review and reinforce internal control systems to close loopholes that create opportunities for fraud.

Keywords: *Illegal Behavior, Law Enforcement, Insurance, Personnel Management, Fraud Opportunity, Internal Controls*

JEL Codes: *K42, G22, M52*

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INTRODUCTION

Occupational fraud in insurance companies arises not only from individual misconduct but from systemic opportunities embedded within complex operational environments. These firms handle vast financial transactions, sensitive data, and intricate claims processes with conditions that, when coupled with weak internal controls and high-pressure targets, create fertile ground for fraud. Employees, agents, and executives may exploit these vulnerabilities through asset misappropriation, corruption, or financial statement manipulation, often using sophisticated tactics and technologies. The ACFE (2022) reports over $3.1 billion in global losses from occupational fraud, with asset misappropriation being most common and financial misstatement causing the highest median losses. Similar patterns are evident in Kenya, where the insurance sector's structural vulnerabilities mirror global trends, making it imperative to understand how fraud opportunity enables such schemes. This understanding is crucial for designing effective controls, restoring public trust, and safeguarding the integrity of the insurance sector.

Across global insurance markets, occupational fraud has proven less a matter of personal desperation and more a consequence of institutional design flaws that create fertile ground for exploitation. In countries like the U.S., Australia, and Germany, fraud schemes persist not simply because individuals feel pressured, but because systems allow them to act with impunity, through opaque processes, fragmented oversight, and underutilized analytics (Zeller & Scherer, 2022). Whether it's premium diversion, collusion, or falsified documentation, the common denominator is opportunity: loopholes, lax controls, and environments where accountability is diluted. This global reality sets the stage for examining African contexts, where similar institutional gaps have enabled fraud to flourish.

Occupational fraud in African insurance markets is increasingly driven by systemic gaps that create opportunities for misconduct. In Nigeria, losses exceeding N300 billion annually stem from weak regulatory oversight and low fraud awareness, while South Africa's R800 million in fraudulent claims highlights deficiencies in internal monitoring (Geldenhuys, 2020). Morocco's surge in motor insurance fraud, despite market maturity, reflects how operational complexity can outpace control systems (Hejazi & Khamees, 2022). Egypt's high fraud risk is linked to ineffective regulators and outdated detection tools (Ayboga & Ganji, 2021), and Tanzania's financial losses are tied to poor supervision, weak controls, and dishonest employee behavior (Ameir, 2021). These regional cases underscore a broader continental trend. One that resonates with Kenya's experience, where institutional blind spots and inadequate safeguards similarly enable occupational fraud.

Occupational fraud in Kenya's insurance sector continues to thrive where control systems are weak or outdated, creating clear opportunities for exploitation. Despite oversight by the Insurance Regulatory Authority (IRA), the sector has faced rising fraud cases, with a 24% increase reported between 2018 and 2019 and losses amounting to KES 363 million, largely from deceptive fire policy claims (IRA, 2020). Common schemes include false claims and policy manipulation, which not only inflate operational costs but also erode trust and drive-up premiums for honest policyholders (Otiso, 2021). Regulatory breaches in 2022 led to fines totaling KES 94.85 million, reflecting persistent gaps in compliance and internal governance. These figures are drawn from Mwongela (2022), whose study on regulatory frameworks confirmed the link between weak oversight and fraud vulnerability in Kenya's insurance sector. Although insurers have adopted

technologies and stricter verification processes to curb fraud, perpetrators continue to exploit digital platforms and systemic loopholes to stay ahead of detection efforts. This is further evidenced by Onyango et al. (2025), whose analysis of sectoral interconnectedness highlighted how digital transformation, while promising, remains under-leveraged in fraud prevention strategies. These dynamics underscore the critical role of fraud opportunity, enabled by institutional vulnerabilities, in shaping the trajectory of occupational fraud among insurance companies in Kenya.

Problem Statement

Insurance companies in Kenya are expected to uphold financial integrity, protect policyholder interests, and foster trust through robust governance and risk management frameworks. However, the increasing sophistication of fraud schemes, particularly those exploiting digital platforms and systemic loopholes, has exposed critical vulnerabilities in internal controls and oversight mechanisms. According to the Insurance Regulatory Authority (IRA), documented financial irregularities linked to occupational fraud rose sharply, with 127 cases reported in 2020 compared to 83 in 2019, signaling a troubling trend (IRA, 2020). It is important to note that these figures may not reflect the full extent of fraud due to underreporting and limited detection, which constrains the comprehensiveness of regulatory data.

These fraudulent activities, including embezzlement, false claims, and manipulation of financial records, have eroded profitability and strained the ability of insurers to meet legitimate obligations. Such activities are primarily enabled by fraud opportunity stemming from weak internal controls, poor oversight, inadequate audit mechanisms, and evolving digital vulnerabilities. The ripple effects extend beyond financial loss, affecting customer premiums, benefit structures, and overall trust in the sector. These are consequences of fraud, not its causes, and they underscore the broader impact of unchecked misconduct.

The consequences of occupational fraud are felt across multiple stakeholders: insurers, policyholders, regulators, and employees. Customers face higher premiums and reduced benefits, while companies suffer reputational damage, declining market share, and increased operational costs due to investigations and litigation. Internally, unchecked fraud undermines employee morale and weakens organizational culture. Although previous studies have examined fraud in Kenya's insurance sector, most have focused on general causes or behavioral drivers, leaving a gap in understanding how fraud opportunity (enabled by weak systems and evolving tactics) specifically contributes to occupational fraud (Onyango, Kariuki & Musumba, 2023). This study aims to fill that gap by examining the structural and procedural enablers of fraud within insurance companies, offering insights that can inform targeted interventions and strengthen institutional resilience.

LITERATURE REVIEW

Theoretical Framework

The Fraud Triangle Theory, developed by Donald Cressey in 1953, posits that fraud arises when three elements converge: opportunity, pressure, and rationalization. For this study, the focus is on fraud opportunity, which refers to the conditions that enable individuals, particularly those with access to sensitive systems or weak oversight, to commit fraud without detection. Capability, often nested within opportunity, highlights how certain employees exploit structural vulnerabilities such

as poor internal controls or lax supervision (Cressey, 1953). This theory informs the research by offering a lens through which to examine how organizational weaknesses in Kenyan insurance companies create openings for occupational fraud. For instance, in some Kenyan insurers, manual claims processing systems and limited audit trails have enabled staff to alter records or approve fictitious claims without immediate detection.

It helps construct the framework by emphasizing the need to assess institutional safeguards, access privileges, and procedural loopholes that may facilitate fraudulent behavior. While the theory has limitations, such as its individual-centric focus, it has also been critiqued for not fully accounting for technologically driven fraud such as cyber-manipulation of digital records or collusive schemes involving multiple actors across departments. These forms of fraud are increasingly relevant in Kenya's digitizing insurance landscape, where systemic vulnerabilities are often exploited collectively. Nonetheless, it remains a valuable tool for diagnosing the systemic enablers of fraud and guiding the development of targeted mitigation strategies within the Kenyan insurance sector.

Conceptual Framework

A conceptual framework helps explain the various structures of research work in a visual or textual format and their linkages by incorporating the fundamental elements of research theory (Bryman, 2017). The independent variable in this study was fraud opportunity, and the dependent variable is occupational fraud in insurance companies in Kenya. Empirical studies have demonstrated that fraud opportunity is enabled by weak internal controls, limited oversight, and unrestricted access to sensitive systems. It is a significant predictor of occupational fraud. For instance, Albrecht et al. (2016) emphasized that opportunity is the most critical enabler in occupational fraud cases, while Wanyama and Mutswenje (2020) linked structural weaknesses in Kenyan financial institutions to increased fraud vulnerability. These findings support the selection of fraud opportunity as the key variable in examining occupational fraud within Kenya's insurance sector.

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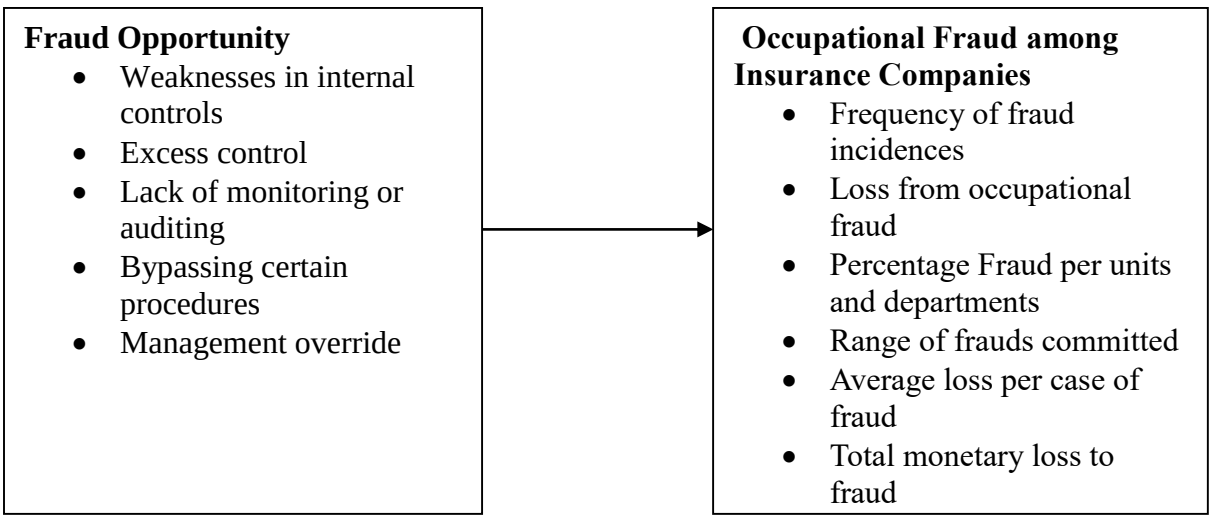

Figure 1: Conceptual Framework

Empirical Review

The effect of fraud opportunity on fraud incidences is a critical aspect of understanding and mitigating fraud within insurance companies. Employees or individuals with access to insurance systems identify vulnerabilities or weaknesses in controls, systems, or procedures that allow them to exploit opportunities for fraudulent activities (Sabatian & Hutabarat, 2020). In cases where there is a lack of transparency or accountability in insurance procedures, employees may find it easier to manipulate transactions or manipulate vendors, increasing the likelihood of fraud occurrences (Dewi & Anisykurlillah, 2021). Additionally, the level of opportunity may be influenced by the organization's risk management practices and its commitment to fraud prevention measures. However, both studies focus broadly on procedural weaknesses without isolating specific organizational structures or contextual factors unique to the Kenyan insurance sector. This presents a contextual gap that warrants localized investigation.

Suh, Nicolaides and Trafford (2019) study sought to determine the impact of reducing opportunities and fraud risk factors on occurrence of occupational fraud within financial institutions in South Korea. The study utilized survey questionnaires to collect data from 395 respondents and the data gathered was analyzed using logistic regression model. The results underscored that opportunity is the primary instigator of white-collar crime and the effectiveness of control mechanisms, which integrate preventive and deterrent measures in the qualitative internal control aspect, holds greater significance in fraud prevention than the sheer presence of numerous anti-fraud controls. In addition, the findings also indicated that employees within Korean financial institutions perceive the risk of management overriding controls as more crucial than collusion within their organization. There is a conceptual and contextual gap in this research since it does not extensively discuss on how fraud opportunity is an internal driver of fraud incidences rather it on the mitigating opportunity to reduce fraud risks. Additionally, it also targeted financial institutions and particularly banks instead of insurance companies which was

the area of focus in this study. This highlights the need for sector-specific studies that examine how fraud opportunity manifests within insurance operations, particularly in emerging markets like Kenya.

Ajemunigbohun, Isimoya and Ipigansi (2019) study examined the likelihood of occurrence of insurance claim fraud in homeowner's insurance within the Nigerian insurance industry. The study targeted 221 participants from 31 purposively selected general insurance companies. The data gathered through structured questionnaires was analyzed using frequency percentage and T-test statistics. The results discovered that there was rising trends in fraudulent behavior related to homeowner's insurance claims in the selected general insurance companies. It was also established that insurance claim fraud had a negative and significant effect on premiums for homeowners and consumers perceive a higher likelihood of fraud in homeowner's insurance claims. Therefore, the study recommended that there is need for the implementation of robust fraud deterrent measures to foster a secure, trust-driven, outcome-focused, and reliable market environment in the insurance industry. There exists a conceptual and contextual gap in this research since it fails to outline the various fraud opportunity available in general insurance companies and how they contribute to claim fraud occurrences. Additionally, this research is limited to examining claim fraud cases in general insurance companies but the present study filled this research gap by examining different fraud cases in all the insurance companies in Kenya. Furthermore, the study does not explore internal organizational dynamics—such as access control, audit limitations, or collusion—that may create fraud opportunity, indicating a gap in operational-level analysis.

Kimani, Kariuki and Mwangi (2021) study examined the relationship between fraud opportunity and fraud incidences in Kenyan insurance companies. The study adopted a quantitative approach and a cross-sectional survey design. The sample size was 150. The data were collected using a self-administered questionnaire and analyzed using descriptive and inferential statistics. The study found that the main sources and types of fraud opportunity were collusion, bribery, kickbacks, false invoicing, overcharging, substitution, and misappropriation. The study concluded that fraud opportunity was a significant factor for explaining fraud incidences in Kenyan insurance companies, and that strengthening the internal control system and enhancing the transparency and accountability of the insurance procedures were essential for mitigating fraud risks. There exists a methodological gap in this study as it utilized a cross-sectional survey design which does not emphasize on determining the relationship between the study variables. Thus, this study utilized the explanatory research design so as to determine the cause-and-effect relationship between internal drivers and fraud occurrences in insurance companies in Kenya. Additionally, the study did not disaggregate fraud opportunity by organizational function (e.g., underwriting, claims, finance), leaving a gap in understanding how specific departments contribute differently to fraud risk.

METHODOLOGY

This research utilized a sample size of 384 employees in four key departments including underwriting, claim, finance and risk management departments. The 384 employees comprised the unit of analysis in this study while the 58 registered insurance companies in Kenya were the unit of observation and target population. This study adopted an explanatory research design. To determine the appropriate sample size from these target population, the researcher used the

Fischer's (1961) formula, since the target population was more than 10,000 employees. Thus, the sample size was 384 employees. Further, the study also used the stratified random sampling technique to select a representative sample of employees from four key department in the insurance companies that are affected by occupational fraud incidences, including underwriting department, claims department, finance department and risk management department. Therefore, each stratum had a representative sample of 96 employees. This sampling technique ensures that subgroups (or strata) within a population are adequately represented in the sample. This study used structured questionnaire and interviews. The questionnaire was designed to capture both quantitative and qualitative data. A 5-point Likert scale was used for most closed-ended questions to allow respondents to express the degree of their agreement or disagreement with given statements. In this study, pilot testing was done on respondents randomly selected from other insurance departments and used 10 per cent of the sample size. This translated to 38 respondents undertaking the pilot testing. Content validity was ensured by subjecting the instrument to the review and opinion of the study supervisors. The pilot findings indicated the internal consistency for all the items were within KMO acceptable level of 0.5-1. The study adopted a Cronbach alpha reliability method to measure the extent in which results are consistent. The pilot study conducted yielded a Cronbach alpha of 0.818 for perceived pressure which indicated the internal was within Cronbach's alpha acceptable level of 0.7-1. Data was cleaned to get read of possible outliers, and entered into SPSS version 27 ready for analysis. Descriptive statistical analysis determined mean, SD, frequency counts and percentages which was also be presented in output tables as results. Inferential statistics involved simple and linear regression and correlation analyses. Study's multiple regression model was as follows;

$$Y = \beta_0 + \beta_1 X_i + \varepsilon_i \quad \text{(i)}$$

RESULTS

Response Rate

A total of 384 questionnaires were administered, out of which 269 were properly filled and returned, resulting in a high response rate of 70%, as illustrated in Table 4.1. According to Mugenda and Mugenda (2003) and Kothari (2004), a response rate of 50% is considered adequate for a descriptive study. Therefore, the achieved response rate of 70% surpasses the minimum acceptable threshold, indicating a robust level of participation.

Table 1: Response Rate

Response	Frequency	Percent
Returned	269	70%
Unreturned	115	30%
Total	**384**	**100%**

Demographic Characteristics

This section presents descriptive statistics of the respondents in terms of department, level of education and years of service in the company.

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Department

The respondents were asked to indicate in which department they work in and the findings are shown in the figure 2. The findings indicate that majority of the respondents work in claim department (27.9%), followed by Risk Management department (24.9%), then Finance department (24.2%) and the minority being those who work in Underwriting department (23%). The predominance of respondents from the Claim department (27.9%) reflects the department's central role in fraud detection and resolution, as supported by Kiana (2010), who identified claims units as critical touchpoints in managing and investigating insurance fraud in Kenya.

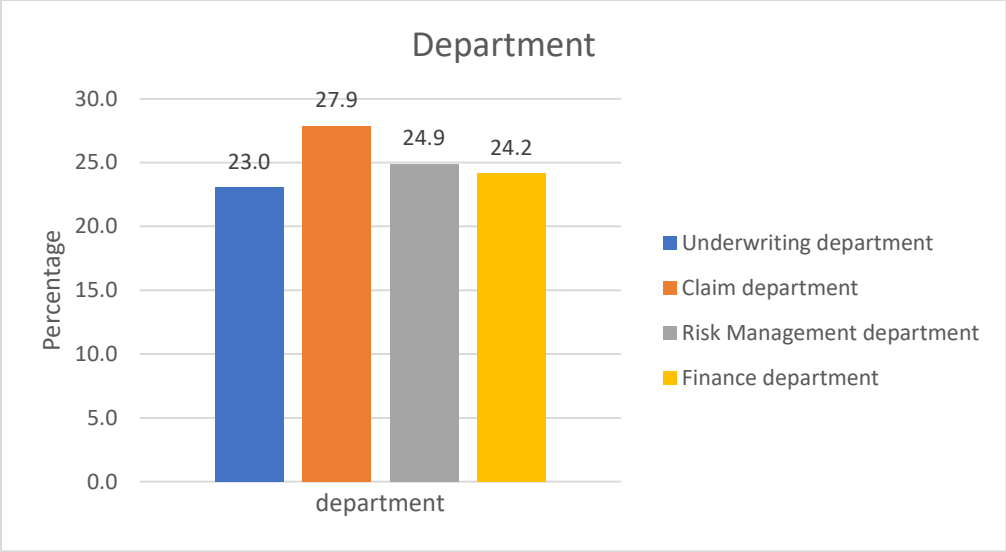

Figure 2: Department

Level of Education

The respondents were asked to indicate their level of education. The findings are shown in the figure 3. The findings indicate that the majority of respondents are bachelor's degree holders (70%), followed by master's degree holders (18%) then those who attained diploma (10%) and the minority being PhD holders (2%). This educational distribution is consistent with workforce trends in Kenya's insurance sector, where tertiary education serves as a core prerequisite for professional roles. The Insurance Regulatory Authority (IRA, 2021) highlights this pattern, noting that Bachelor's qualifications dominate mid-level staffing, with growing adoption of postgraduate credentials in managerial positions.

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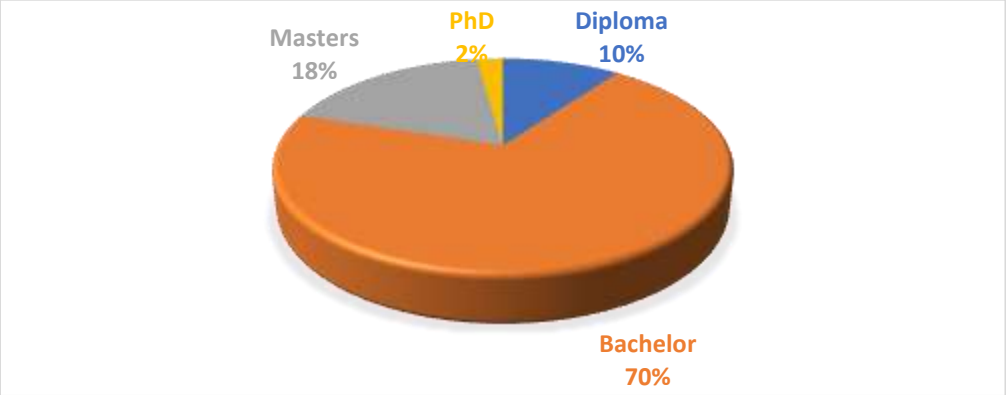

Figure 3: Level of Education

Time of Service

The respondents were asked to indicate the number of years they have worked in the company. The findings are shown in figure 4 below. The findings indicate that most of the respondents have worked for 6-10 years (60%), while the rest of them have worked for 1-5 years (10%), 11-15 years (10%) 16-20 years (10%) and those that have worked for over 20 years (10%). The predominance of respondents with 6–10 years of service (60%) aligns with sectoral trends observed by Masese (2013), who found that mid-career professionals constitute the bulk of operational staff in Kenyan insurance firms, particularly in departments vulnerable to occupation fraud.

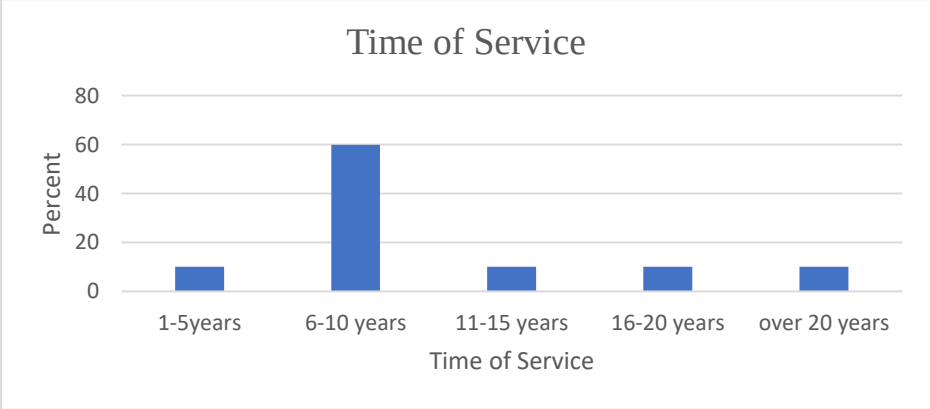

Figure 4: Time of Service

Descriptive Statistics

The second objective of the study was to examine the effect of fraud opportunity on occupational fraud in insurance companies in Kenya. The respondents were asked to indicate their level of agreement or disagreement with the statements relating to fraud opportunity and their responses were rated on a five-point Likert scale. The results are presented in the Table 3.2.

Table 2 indicates that the respondents strongly agreed that there are weaknesses in internal controls that could allow fraud (mean=3.98). The respondents also strongly agreed that some employees have excessive control over financial transactions (mean=3.96). There is a lack of monitoring or

auditing in some departments was highly rated with a mean of 4.11. Majority of respondents supported that it is easy to bypass certain procedures (mean=4). Similarly, majority of the respondents advocated that management sometimes overrides internal controls (mean=3.99).

The overall mean score was 4.00 and the standard deviation was 1.10. The respondents generally agree with the concerns raised about fraud opportunity. In line with these findings, the study by Kimani, Kariuki and Mwangi (2021) on the relationship between fraud opportunity and fraud incidences concluded that fraud opportunity was a significant factor for explaining fraud incidences.

Table 2: Fraud Opportunity on Occupational Fraud in Insurance Companies

Statement	N	Min	Max	Mean	Std
There are weaknesses in internal controls that could allow fraud	269	1	5	3.98	1.106
Some employees have excessive control over financial transactions	269	1	5	3.99	1.135
There is a lack of monitoring or auditing in some departments	269	1	5	4.11	1.041
It is easy to bypass certain procedures.	269	1	5	3.96	1.114
Management sometimes overrides internal controls	269	1	5	3.99	1.110
Average				**4.00**	**1.10**

Correlation Analysis

A correlation is used to estimate the strength of the linear relationship between two variables representing how closely two variables co-vary ranging from -1 termed as perfect negative correlation through 0 or no correlation to +1 termed as perfect positive correlation (Schober, Boer & Schwarte, 2018). Correlation is measured by correlation coefficient that represents the strength of the putative linear association between the variables in question (Mukaka, 2012). The interpretation of correlation coefficients follows the classification as suggested by Cohen (2013): Weak correlation: $0.10 \leq r < 0.30$; Moderate correlation: $0.30 \leq r < 0.50$; Strong correlation: $r \geq 0.50$.

The research study focused on obtaining the correlation between fraud opportunity and occupational fraud. From the findings in Table 3, Correlation coefficient of $r = 0.739$ indicates a highly positive correlation between fraud opportunity and occupational fraud. The relationship is statistically significant ($p = .000$). This suggests that fraud opportunity has an effect on occupational fraud. These results concede with those of Kimani, Kariuki and Mwangi (2021) who investigated the relationship between fraud opportunity and fraud incidences and concluded that fraud opportunity was a significant factor for explaining fraud incidences.

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Table 3: Correlation Analysis

		Avrg_Fraudopportunity	Avrg_Occupationalfraud
Avrg_Fraudopportunity	Pearson Correlation	1	.739**
	Sig. (2-Tailed)		0.000
	N	269	269
Avrg_Occupationalfraud	Pearson Correlation	.739**	1
	Sig. (2-Tailed)	0.000	
	N	269	269

Regression Analysis

To ascertain how rationalization influences occupational fraud in insurance companies, regression analysis was performed. The model fitness findings were shown in Table 4.

The R Square value is 0.547, meaning that 54.7% of the variation in occupational fraud is explained by fraud opportunity. In other words, fraud opportunity explains a portion of the changes in the occupational fraud in insurance companies, while the remaining 45.3% is influenced by other factors not included in the model.

The ANOVA results presented in Table 4 shows that the regression model is statistically significant with p-value of 0.000. This indicates that fraud opportunity has a significant impact on the occupational fraud in insurance companies.

The null hypothesis two stated that:

H_{02}: *There is no statistically significant relation between fraud opportunity and occupational fraud among insurance companies in Kenya.*

This hypothesis was tested and the null hypothesis (H_{02}) was rejected in favour of alternative hypothesis (H_2) and concluded that there is a statistically significant relation fraud opportunity and occupational fraud among insurance companies in Kenya. These results coincide with those of Suh, Nicolaides and Trafford (2019) who sought to determine the impact of reducing opportunities and fraud risk factors on occurrence of occupational fraud within financial institutions in South Korea. The results of the study underscored that opportunity is the primary instigator of white-collar crime. The regression of coefficients results was presented in Table 3.4. The coefficient for fraud opportunity is ($\beta = 0.884$), meaning that for every one unit increase in fraud opportunity, the occupational fraud in insurance companies is expected to increase by 0.884 units, assuming all other factors remain constant. This is statistically significant, as evidenced by the p-value of 0.000. From the interview, the senior officer of IRA highlighted that "*IRA is responsible for monitoring insurance operations, and our role often involves identifying systemic vulnerabilities and areas where fraud risks may be higher. Weakness in internal control is an opportunity that we have noted severally. It leaves a gap for fraud activities to be carried out*."

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These results coincide with those Ajemunigbohun, Isimoya and Ipigansi (2019) study examined the likelihood of occurrence of insurance claim fraud in homeowner's insurance within the Nigerian insurance industry. Their study found out that the likelihood of occurrence had a significant effect on fraud.

Hence the resultant regression model was;

$Y = \beta_0 + \beta_3 X_3 + \varepsilon$

occupational fraud = **0.416** + **0.884** fraud opportunity + ε

Table 4: Regression Analysis for Fraud Opportunity

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate		
1	.739[a]	0.547	0.545	0.62150		

a. Predictors: (Constant), Avrg_Fraudopportunity

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	124.455	1	124.455	322.200	.000[b]
	Residual	103.134	267	0.386		
	Total	**227.589**	**268**			

A. Dependent Variable: Avrg_Occupationalfraud
B. Predictors: (Constant), Avrg_Fraudopportunity

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	0.416	0.199		2.093	0.037
	Avrg_Fraudopportunity	0.884	0.049	0.739	17.950	0.000

a. Dependent Variable: Avrg_Occupationalfraud

CONCLUSION AND RECOMMENDATIONS

Conclusion

Insurances in Kenya are under considerable occupational fraud due to fraud opportunity, which is compounded by weaknesses that could lead to fraud in internal controls and employees having excessive control over financial transactions. Also, other employees believe the lack of monitoring or auditing in some departments, the ease to bypass certain procedures and the fact that management sometimes overrides internal controls lead to fraud.

The study therefore concluded that fraud opportunity significantly impacts occupational fraud. These results agree with the study by Kalovya (2023) on the the predictors of occupational fraud losses in insurance firms in Tanzania that revealed fraud opportunity has a positive and significant effect on occupational fraud.

Recommendations

To keep up with prevention of occupational fraud, it's recommended that insurance companies should review and reinforce internal control systems to close loopholes that create opportunities for fraud. This includes clear segregation of duties to prevent employees from having excessive

control over financial transactions. The study recommends establishing frequent, independent, and comprehensive monitoring and auditing processes across all departments to detect and deter fraudulent activities early. The board is encouraged to implement regular ethics training and foster a workplace culture that discourages fraudulent behavior, emphasizing integrity and accountability. That would ensure management adheres strictly to internal controls and minimizes overrides except in exceptional, well-documented circumstances with appropriate authorization.

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