
Assessing the Factors Causing Delay by Insurance Companies to Pay Claims to Customers: A case of selected Insurance Companies, and Pensions and Insurance Authority (PIA)

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Article DOI: [10.59413/eafj/v3.i2.8](https://doi.org/10.59413/eafj/v3.i2.8)

Abstract:

This study examined the efficiency of insurance claims processing in Zambia, emphasizing the time insurers take to settle claims and concerns over delayed payments. Employing quantitative and qualitative descriptive research methods, primary data was collected from employees of Pensions and Insurance Authority (PIA) and three (3) insurance companies. Open-ended questionnaire was distributed to PIA, a census was conducted on fifteen (15) employees for the qualitative analysis but only seven (7) responses were recorded. A closed-ended questionnaire was distributed amongst three (3) insurance companies after the census, which determined the thirty-six (36) participants that were selected for the quantitative part. Taking a descriptive approach for the analysis of both qualitative and quantitative data, the findings suggest favorable perceptions of insurers' claim processing efficiency, especially regarding effective handling systems and adherence to payment timelines. Business management gaps leading to delays in payments align with existing literature. Recommendations include investing in advanced technologies, implementing automated communication systems, adhering strictly to legal requirements, fostering transparency, and modernizing documentation processes. These measures aim to enhance claims processing efficiency and customer satisfaction. Overall, the study underscores the need for improvement in the insurance industry's claims processing practices, offering actionable insights for insurers to address delays and enhance their service quality.

Keywords: Claims Processing Efficiency, Cash flow constraints, Legal related issues, Regulatory Compliance

1. Introduction

This chapter covers the study background, statement of the problem, research objectives coupled with research questions and finally a conclusion is provided. The background highlights what insurance is all about, how it begun in Zambia, where it is now and how the insurance world would be in view of the current situation. The statement of the problem has been clearly defined warranting the need for undertaking this study.

1.1 Background

Insurance is a crucial tool for managing future uncertainties and financial losses. Scholars have defined insurance as a service that transfers certain financial risks to an insurer in exchange for a fixed payment (Afolabi, 2018). Rejda (2008) emphasizes that the heart of insurance lies in sharing or pooling losses, spreading them over a group to substitute average loss for actual loss. Rastogi and Shankar (2007) highlight the significant role of the insurance industry in contributing to a country's financial sector and providing social security, particularly in developing countries.

A contract of insurance involves one party, the insurer, undertaking to make a payment to another party, the policyholder or a third party, if a specified event occurs, in exchange for a premium (Afolabi, 2018). The insurer is obligated to manage claims and ensure prompt payment when due (Irukwu, 1989). Claims management involves the entire claims process, focusing on monitoring and reducing claims costs (Wedge & Handley, 2003).

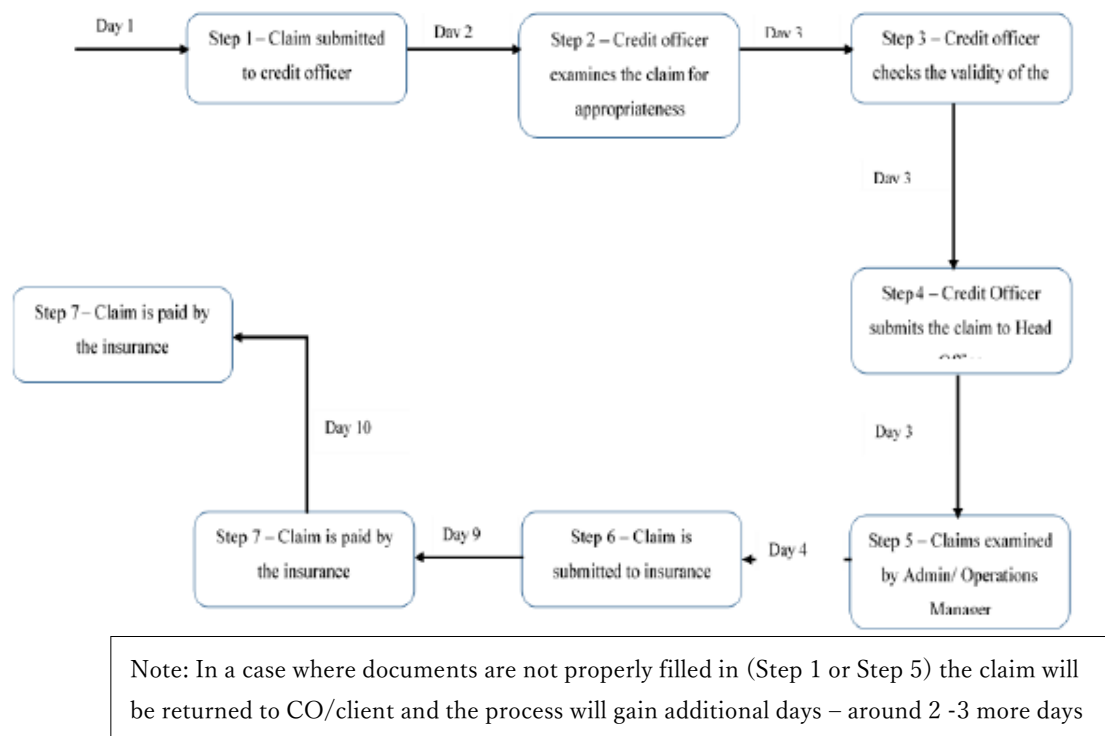
The late payment of insurance claims has been a persistent issue, particularly for commercial policyholders. Delays in payment can severely impact an organization's cash flow and its ability to continue trading after an insured loss (Butler & Francis, 2010). The definition of delay, however, remains a point of debate.

In the United Kingdom, while the Financial Conduct Authority (FCA) requires insurers to handle and settle claims promptly, it doesn't specify what constitutes a reasonable time for claim payment (FCA, 2017). This lack of clarity contributes to uncertainty regarding claims processing.

Insurance is also seen as a means of savings, with insurance companies deducting agreed-upon amounts from individuals' paychecks to be returned after a specified period (Afolabi, 2018). Despite its potential benefits, insurance penetration in Zambia remains low, with less than 4% of the adult population insured (Zambia Statistical Agency, 2021).

However, the insurance industry in Zambia has seen significant growth, with the establishment of regulatory bodies such as the Pensions and Insurance Authority of Zambia (PIA) to ensure good regulation (Chilufya, 2021).

In Zambia, the duration between the submission and payment of a claim varies among insurance companies, with no specific regulations stipulating a standard timeframe (Manje, 2005). Below is a graphical representation of a typical insurance company's claim management process, indicating the days within which a claim should be paid (Figure 1). Claims paid after the stipulated time are considered delayed.



Source: Researcher's Construct (2023)

Assuming there are not any hitches, a claim with correctly completed documentation is supposed to be paid within 10 days, as shown in Figure 1. However, clients believe that it takes longer. This is what has necessitated the current study.

1.2 Statement of the Problem

The late payment of insurance claims, particularly for commercial policyholders, has been a significant problem for many insurance companies. Delays in claim payments can severely impact an organization's cash flow, hindering its ability to continue trading following an insured loss. Similarly, delays in paying insurance claims to individuals affect

individual budgeting, including consumption spending and investment. However, current laws do not oblige insurers to compensate insured parties for losses suffered due to delayed claim payments (K&L Gates, 2016). Although the Financial Conduct Authority rules require insurers to handle and settle claims promptly, any failure to do so does not enable insureds to claim compensation; they can only claim the amount due under the policy terms (K&L Gates, 2016).

In Zambia, there have been numerous complaints regarding insurance companies' denial or delay in paying claims to customers (Zambian Insurance Journal, 2019). While studies from other countries like India, Ghana, Kenya, and Ethiopia have documented reasons for claim payment delays (Pandey & Rao, 2013; Boadi et al., 2017; Cheluget & Kitaka, 2020; Lemma, 2019), few studies have empirically investigated the factors limiting insurance companies from paying claims on time in Zambia (Manje, 2015; Jere, 2020). Documentation problems, attributed largely to loan officers being occupied with delinquent borrowers, and the demanding paperwork involved in the claims settlement process have been identified as factors contributing to delays (Zambian Insurance Journal, 2019). However, these factors were only explored within one insurance company.

Therefore, this study aims to investigate the factors causing delays in insurance claim payments by insurance companies in Zambia. Despite existing regulations mandating prompt claim settlement, complaints about delays and denials of claims persist. With limited empirical research on this issue specific to Zambia, this study intends to identify and analyze both internal operational challenges within insurance companies and regulatory oversight by the Pensions and Insurance Authority (PIA) that contribute to delays in claim settlement.

1.3 Objectives

The General objective

To determine factors causing delay by insurance companies to pay insurance claims to customers; a case study of three (3) selected insurance companies.

Specific objectives

1. To examine factors causing delays on the payment of claims by insurance companies.
2. To identify business management gaps in insurance companies that cause delay in paying insurance claims to customers.

3. To propose ways that could enhance the efficiency of insurance companies in processing claims.

1.4 Significance of the study

This study aims to identify factors within insurance companies that cause delays in claim payments, helping them develop better strategies. By addressing these gaps, insurance companies can improve efficiency and customer satisfaction, ultimately boosting confidence in insurance enrolment and financial performance. This will contribute to economic growth and increase contributions to Zambia's economy.

2. Literature Review

This section presents both the theoretical and literature pertaining to the study.

2.1 Empirical review

The second chapter analyzes research on insurance companies' delays in claim payments, focusing on global, regional, and Zambian works, evaluating determinants.

Global Context

Tennyson's 2020 study examined the evolution of the civil liability framework governing insurance claims settlement in the United States, focusing on the impact on disputes and litigation. The study used an extensive dataset of automobile insurance claims in 42 states over 25 years, examining the historical development of the insurance bad faith doctrine. The findings showed that the modification of bad faith standards initially led to a rise in insurance claim settlement failures, with an increase in litigated claims and litigation progressing to trial. However, as the legal framework developed, the diminishing ambiguity surrounding bad faith tort law gradually limited the potential for disputes in settlements, ultimately decreasing the occurrence of unsuccessful claim settlements in first-party automobile insurance claims.

Morley et al.'s 2006 study explored the nature of health insurance claims in the United Kingdom, revealing that the recruitment, training, and retention of intelligent and competent staff fall under the purview of the claims manager's responsibilities. However, research has found that claims staff members often resign from their positions and require replacement due to multiple factors beyond the manager's jurisdiction. The quantifiable direct costs related to employee turnover and replacement are measurable, but there are

also indirect costs associated with employee attrition, such as the decline in customer service and satisfaction.

Regional Context

Ajemunigbohun, et al. (2022) conducted a study on the relationships between claims settlement and risk attitudes in motor insurance policyholders in Lagos, Nigeria. The research design was a cross-sectional survey, with a questionnaire administered to 287 individuals who hold motor insurance policies. The results indicated that the settlement of claims plays a crucial role in attracting individuals with rational risk attitudes. The study suggests that motor insurance providers should implement compelling claims packages to enhance the level of confidence among the motoring communities. The revitalization and empowerment of the motor insurance public complaint commission by the government is necessary to effectively address the various issues pertaining to motor insurance claims that may arise for either party involved in the motor insurance contract.

Ndubuisi (2008) reported high levels of market indiscipline in the way insurance business is conducted in Nigeria. They observed that operators in this market engage in unethical practices such as rate cutting and hiding basic facts that policy holders should know from them. A key means to build trust is through ethics, doing things in the right way that it should be done.

Akinbola and Tsowa (2010) noted that cash flow is a problem for insurance businesses in Nigeria, as insurance companies struggle to settle their claims, meet their day-to-day obligations, and lack investible funds. They also pointed out that there was no standard for insurance business in Nigeria, despite there being recognized regulating bodies. A large number of practitioners managing insurance business in Nigeria are under qualified, which has done a great harm to the business.

Sodzi-Tettey, et al., (2012) conducted a study to evaluate the claims management processes for two District MHIS in the upper East Region of Ghana. The primary data collection employed a combination of qualitative and quantitative approaches, utilising interview guides and checklists as instruments. The research findings indicate that the provider's viewpoint was influenced by technical difficulties, leading to the rejection of unverifiable claims primarily due to inadequate filing systems. The completion of claims forms often exhibited deficiencies, particularly in relation to claim numbers and performed procedures. There were difficulties encountered in ensuring adherence to Standard Treatment Guidelines by non-medical billing officers, such as the transcription of a doctor's diagnosis onto claims forms by accounting officers.

Patricia (2015) investigated on motor insurance as compulsory for vehicles operating on Ghanaian roads, providing protection against potential risks. A substantial dataset from insurance records was employed to ascertain the average duration for losses to transpire and be compensated by insurance firms in Ghana. The study used the Kaplan-Meier approach and the Cox proportional hazard model to investigate whether the type of insurance has an impact on the time required for claims to be settled and to identify which variables significantly contribute to the settlement duration. The findings indicated that age, gender, and marital status serve as significant risk factors influencing the occurrence of losses, though they do not significantly affect the payment of claims as determined by both the log-rank test and the Cox proportional hazards regression model. Conversely, the type of policy and the type of vehicle emerged as notable factors affecting the survival duration of claim settlements. This underscores the consideration of these risk factors in the determination of premiums in Ghana.

Kiana (2010) assessed the challenges in management of general insurance claims in Kenya. The research study employed a survey research design to investigate the population of interest, which consisted of all General Insurance Companies in Kenya. The findings revealed that the primary challenge in the management of General Insurance claims in Kenya is attributed to weak underwriting standards and a significant prevalence of fraudulent activities. Insurance companies need to embark on prompt settlement of claims, create awareness, and build confidence for more people to go for insurance.

A study by Ntumnde (2012) that there is strong insurance apathy in Cameroon, as most Cameroonians have a very poor opinion of insurance as a means of protecting their interest in the event of loss. Many have tales of disappointments at the hands of insurance companies. They actually believe insurance companies are simply out to make money rather than pay claims. It is thought that insurance companies are prompt to collect premiums but slow to settle claims made against them by the insured and beneficiaries who are less well informed of the mechanism of insurance (Ntumnde, 2012). As such claim's avoidance is the major reason for consumer apathy towards taking advantage of insurance services. Insurance companies need to embark on prompt settlement of claims, create awareness, build confidence for more people to go for insurance. As most people refrain from insurance because of the poor attitude of some insurance companies and their intermediaries (Kwanga, 2017).

Zambian Context

Jere's (2020) study aimed to investigate insurance claims management systems and develop a web-based application for managing claims. The research focused on the top ten insurance companies in Lusaka district and identified vulnerabilities in the insurance claims process, including claims notification, document submission, and initial claims processing. These security weaknesses contribute to the prevalence of fraud within the industry.

Kaoma (2020) assessed factors influencing the performance of the insurance industry in Zambia using a combination of primary and secondary data. The study revealed that operational efficiency of ZSIC was impacted by factors such as insured premium delays, fraudulent claims, and a lack of technical expertise in insurance services. Both studies highlight the need for improved security measures in the insurance industry.

Gaps in Literature

Existing research recognizes the importance of addressing delayed claim handling in the insurance sector, yet there is a noticeable lack of studies specifically investigating the root causes of delays in claim payouts by insurance firms, particularly within the Zambian context. While studies like Kiana (2010), Akinbola and Tsowa (2010), Ndubuisi (2008), and Ntumnde (2012) acknowledge the significance of addressing delayed claim management, they primarily focus on its impact on profitability and customer trust rather than exploring the underlying causes of these delays. Moreover, the current body of research provides general summaries of obstacles faced by the insurance industry, such as lack of market discipline, cash flow problems, and client indifference, without explicitly linking these concerns to delayed claim payments. Additionally, the scarcity of published research studies conducted in Zambia exacerbates this gap, hindering efforts to develop precise interventions and regulatory structures aimed at enhancing claim processing efficiency and improving consumer satisfaction. Therefore, this study aimed to fill this gap by conducting empirical research specifically examining the causes of delays in claim payouts by insurance firms operating in Zambia. Through thorough evaluations of claim processing procedures, stakeholder interviews, and surveys, the research aimed to uncover significant challenges and systemic issues contributing to delays, providing insights to policymakers, regulatory bodies, and insurance firms to develop specific strategies for optimizing claim management processes and improving the overall performance of the insurance industry in Zambia.

2.2 Theoretical Framework

Transaction Cost Economics (TCE)

Transaction Cost Economics (TCE) is a theory that examines the costs of transactions between economic entities and the factors influencing governance structures to minimize these costs (Williamson, 2009). TCE can be applied to analyze the costs associated with investigating and processing insurance claims, including verifying claims, assessing the extent of loss, and determining appropriate compensation. Insurance companies may prioritize cost reduction over timely claim payments, which can lead to delays in claim processing (Williamson, 2009). Additionally, monitoring policyholders to prevent fraud or assess risk can also result in delays as companies seek to minimize costs (Williamson, 2009).

Resource Dependency Theory

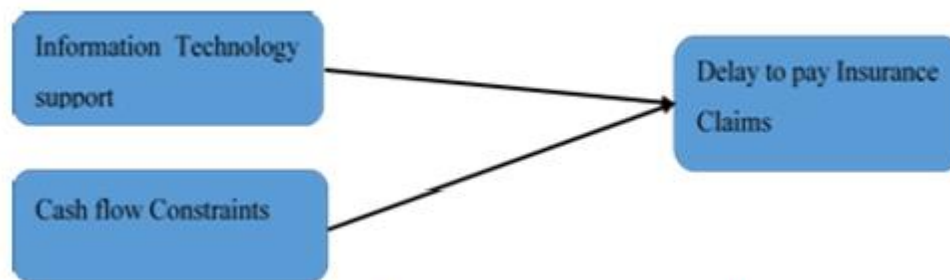
Resource Dependency Theory (RDT) explains how organizations rely on external resources such as information, technology, and regulatory compliance to achieve their objectives (Jiang et al., 2022). Developed by Jeffrey Pfeffer and Gerald R. Salancik in 1978, RDT aims to minimize dependency and ensure a stable supply of resources. In the context of insurance claims processing, RDT helps identify how insurance companies rely on resources like IT systems, data analytics, and regulatory compliance frameworks. Inadequate or mismanaged resources, such as outdated IT systems or lack of robust data analytics capabilities, can lead to delays in claim payments. (Jiang et al., 2022).

Agency Theory and insurance

Agency theory, rooted in the seminal work of Jensen and Meckling (1976), provides a valuable framework for understanding the dynamics between insurance companies and customers. It highlights the inherent conflicts of interest between these parties, with insurance companies aiming to minimize financial liabilities and optimize profitability, while customers seek prompt and equitable claim resolutions. Delays in claim payments often arise from this misalignment of objectives, with insurance companies potentially prolonging processes to retain funds longer for financial gains. Moreover, information asymmetry, where insurance companies possess more knowledge about claims procedures and coverage terms, exacerbates delays in the claims handling process. Regulatory oversight, such as that provided by the Pensions and Insurance Authority (PIA), plays a crucial role in mitigating these delays by implementing monitoring and control mechanisms. Through its exploration of conflicts of interest and information asymmetry, agency theory offers insights into the underlying causes of delays in claim payments and underscores the importance of effective regulatory oversight in the insurance industry.

2.3 Conceptual framework

The review of empirical and theoretical literature led to the development of the conceptual framework



Source: Researcher's Construct (2023)

2.4 Summary

The chapter reviews existing studies in the field, identifies gaps in the literature, and develops a conceptual framework. It then outlines the methodology for collecting and analyzing data.

3. Research Methodology

3.1 Introduction

This chapter provides details of the study methodology to be employed. It covers the research design, data source, sampling technique procedures to be used, data collection instruments, study variables, data cleaning processes, analysis and ethical consideration.

3.2 Research Approach

A mixed-method approach was used to answer the research objectives, incorporating philosophical assumptions and methods of inquiry. This approach combines both qualitative and quantitative data, facilitating a comprehensive and meaningful explanation of research issues. It provides a solid foundation, allows for methodological adaptability, and facilitates a comprehensive understanding of individual cases.

The mixed-methods design enables researchers to comprehensively address research inquiries by incorporating both quantitative and qualitative approaches.

A mixed-methods design is considered the most effective approach for addressing research inquiries, as it combines the strengths of two different methods while mitigating

the limitations associated with each method. As a result, the use of mixed-method research designs is becoming increasingly important for answering impact research questions.

3.3 Research Design

This study employs a descriptive sequential explanatory research design, which combines both quantitative and qualitative data to investigate the identified problem. Saunders (2007) suggests that research designs serve as the roadmap for systematic management research, outlining the process from data collection to analysis. The descriptive sequential approach allows for a comprehensive exploration of the research problem.

3.4 Study Population

The study population is the specific group of individuals or organisations from which data is collected or observations are made in a research study or investigation (Creswell, 2014). For this study, the research population consisted of the Pensions and Insurance Authority (PIA) and three insurance companies: A, B, and C. An open-ended questionnaire was distributed to the PIA, and a census was conducted on 15 employees in 2018 for qualitative analysis.

3.5 Sample Size

In 2018, a census was conducted on the employees of the Pensions and Insurance Authority (PIA), resulting in a total of 15 participants. Subsequently, a closed-ended questionnaire was distributed to three insurance companies (A, B, and C), from which a total of thirty-six participants were selected for the quantitative phase of the research. The sample size of thirty-six was determined based on the availability and willingness of participants from the claims departments of the three insurance companies and the PIA. The table below illustrates the distribution of the sample size from each company:

Company Name	Number of participants in the Claims Department
PIA	15
A	12
B	12
C	12

3.6 Data Collection Methods

The study utilized questionnaires to gather primary data from seven employees of PIA and selected insurance companies. The questionnaires included both open-ended and closed-ended questions, with more closed-ended questions for easier responses and time-saving during interviews. The study aimed to understand respondents' perspectives and needs.

3.7 Validity and Reliability

Validity

Validity in research refers to the accuracy and reliability of research instruments in measuring the intended constructs. In both qualitative and quantitative research, validity is crucial for ensuring trustworthiness and adherence to scientific methodology. In quantitative research, validity is determined by the extent to which measuring instruments accurately assess the intended constructs. Lee J. Cronbach and Paul E. Meehl introduced the concept of validity in the mid-20th century, focusing on psychological tests. Validity in research includes internal validity (credibility) and external validity (transferability). Researchers employ various methodological approaches to ensure validity and reliability, such as triangulation, prolonged contact, member checks, saturation, reflexivity, and peer review.

Reliability

Reliability in research evaluates the consistency, precision, and repeatability of study results, ensuring that recorded scores accurately represent the actual scores of the instrument. In both quantitative and qualitative research, reliability is crucial for assessing the consistency of findings. In quantitative research, reliability refers to the consistency, stability, and replicability of results, while in qualitative research, it pertains to the consistency of the researcher's approach. Reliability coefficients, bounded between 0 and 1, are commonly assessed using statistical tests of correlation. High reliability is essential, especially in high-stakes environments, with coefficients of 0.8 or 0.7 often considered acceptable. Reliability, while essential, is not the sole determinant of research validity, though it significantly enhances the precision of research outcomes and the accuracy of decisions.

3.9 Data Analysis

The study used Microsoft Office Excel 2019 for qualitative data analysis, focusing on identifying recurring themes and patterns. Open-ended questions in the questionnaire provided detailed narrative data. Quantitative data was cleaned, coded, and analysed using SPSS version 27. Descriptive statistics were used to organize and generate data, including percentages, for understanding and decision-making. Both qualitative and quantitative data were used for detailed analysis.

3.10 Ethical Considerations

This chapter provides an overview of the research approach, design, target population, sample size, sampling techniques, data analysis methods, reliability, validity, and ethical considerations associated with the study. Additionally, it presents the conceptual framework used in the study to guide the research process.

4. Presentation and Interpretation of results

4.1 Description of Study respondents

The respondents' descriptive statistics were classified based on their Gender, Age, Education level Occupation, and Type of Insurance.

Table 1: Descriptive

Variable	Description	Frequency	Percent
Gender	Male	21	58.3
	Female	15	41.7
	Total	36	100
Marital Status	Never married	16	44.4
	Married	18	50
	Formerly Married	2	5.6
	Total	36	100
Education Level	Certificate	3	8.3
	Diploma	12	33.3
	Bachelors	17	47.2
	Masters	4	11.1
	Total	36	100
Occupation	Underwriter	13	36.1
	Claims assessor/ Claims Manager	12	33.3
	Accountant	1	2.8
	Other	10	27.8
	Total	36	100
Type of Insurance	Motor	20	55.6
	Other	16	44.4
	Total	36	100

Table 1 presents descriptive statistics for key variables. Out of 36 participants surveyed, 21 were male (58.3%) and 15 were female (41.7%). In terms of marital status, 44.4% had never married, 50% were currently married, and 5.6% were formerly married. Education levels varied, with 8.3% holding a certificate, 33.3% having a diploma, 47.2% possessing a Bachelor's degree, and 11.1% holding a Master's degree. Regarding

occupation, 36.1% were underwriters, 33.3% worked as claims assessors or claims managers, 2.8% were accountants, and 27.8% held other occupations. Finally, 55.6% of respondents had motor insurance, while 44.4% had other types of insurance. These statistics provide valuable insights into the demographic and professional composition of the participants, aiding further analyses of factors contributing to claim payment delays within the insurance industry.

Background Information

Table 2: Background Information

Items	N	Mean	Mode	Std. Deviation	Skewness
I) The Company has systems in place for handling claims	36	4.58	5	0.649	-1.986
II) The Company ensures that it pays on the first come first paid principle	36	4.25	4	0.77	-0.87
III) The Company pays within the specified period after claim has been filed	36	4.14	4	0.867	-1.117
IV) The Company pays within Six (6) Months	36	4.42	5	1.156	-2.313
V) The Company pays within a year and beyond	36	1.67	1	1.331	1.967

The data presented in Table 2 provides valuable insights into respondents' perceptions of various aspects of insurance claim processing. On average, respondents believed that insurance companies have effective systems in place for managing claims (mean = 4.58), follow a "first come, first paid" principle (mean = 4.25), and adhere to specified claim payment timelines (mean = 4.14). However, while there was agreement that claims are settled within six months (mean = 4.42), there was more disagreement regarding prompt payment within a year or more (mean = 1.67). Overall, the data suggests positive perceptions of insurance companies' claim processing efficiency, particularly for shorter payment durations, but there is more variability and disagreement regarding longer payment periods. These statistics offer valuable insights into respondents' perspectives on critical aspects of the insurance industry, which can be further explored in the study.

Perceived Challenges faced in settling Claims and Improvements

Table 3: Perceived Challenges faced in settling Claims and Improvements

Items	N	Mean	Mode	Srd. Deviation	Skewness
I). There are a lot of challenges your company faces in settling claims	36	2.58	2	0.77	0.897
II). How would you describe the extent of challenges in your Company	36	2.33	2	0.828	0.071
III). To what level do these challenges affect your Company	36	2.39	2	0.964	0.334
IV). The Company has put measures in place to overcome challenges on the payment of insurance claims	36	4.25	4	0.5	0.454
V). The Company has a process of prioritizing payment of claims on the First come and first to be served basis	36	4.19	4	0.749	-0.772

Source: Researcher's compilation

The observations below are deduced from this Table:

This section analyzes and interprets the data from Table 3, which examines respondents' perceptions of the challenges faced by their insurance companies in settling claims and the perceived improvements made in response to these challenges.

Item I: Perceived Challenges in Claim Settlement

Item I reveal that, on average, respondents perceive challenges in the process of settling claims, with a mean score of 2.58. While acknowledging these challenges, respondents do not perceive them as insurmountable, as indicated by the mode of 2. The standard deviation of 0.77 reflects a moderate degree of variability in responses, suggesting a range of opinions. The positive skewness of 0.897 indicates a slight tendency towards agreement among respondents, with a fairly balanced distribution of responses. The negative kurtosis of -0.682 suggests a stable perception among participants regarding these challenges, without extreme outliers.

Item II: Extent of Challenges

Item II shows that, on average, respondents perceived the challenges faced by their respective companies to be of moderate intensity, with a mean score of 2.33. The mode of 2 indicates that a significant number of respondents described these challenges as moderate, and the standard deviation of 0.828 suggests some variability in perceptions. The data's skewness of -0.071 and negative kurtosis of -0.582 indicate a relatively balanced distribution of responses, with no pronounced skew in either direction.

Item III: Impact of Challenges

Item III shows that, on average, respondents perceive the challenges faced by their companies to have a moderate level of impact, with a mean score of 2.39. The mode of 2 indicates that a significant portion of respondents views the impact as moderate, and the standard deviation of 0.964 suggests some variability in responses. The positive skewness of 0.334 and negative kurtosis of -0.757 indicate a balanced distribution of responses, with no extreme outliers and a stable perception among participants regarding the impact of these challenges.

Item IV: Measures to Overcome Challenges

Item IV reveals that, on average, respondents believe their companies have implemented substantial measures to address challenges related to claim payments, with a mean score of 4.25 and a mode of 4 indicating strong agreement. The low standard deviation of 0.5 suggests relatively low variability in responses. The positive skewness of 0.454 indicates a tendency towards agreement among respondents, and the negative kurtosis of -0.18 suggests a distribution within the normal range, without extreme outliers, highlighting a consistent perception among respondents regarding these measures.

Item V: Prioritization of Claim Payments

Item V shows that, on average, respondents believe their companies have processes in place to prioritize claim payments on a "first come, first served" basis, with a mean score of 4.19 and a mode of 4 indicating strong agreement. The data reflects moderate variability in responses, with a standard deviation of 0.749. Although there is a slight inclination towards agreement, indicated by the negative skewness of -0.772, the distribution remains within an acceptable range, as suggested by the positive kurtosis of 0.693. Overall, Table 4.3 indicates that respondents acknowledge moderate challenges in claim settlement but believe their companies have implemented substantial measures to address these issues, providing valuable insights for further study.

4.2 Qualitative Analysis

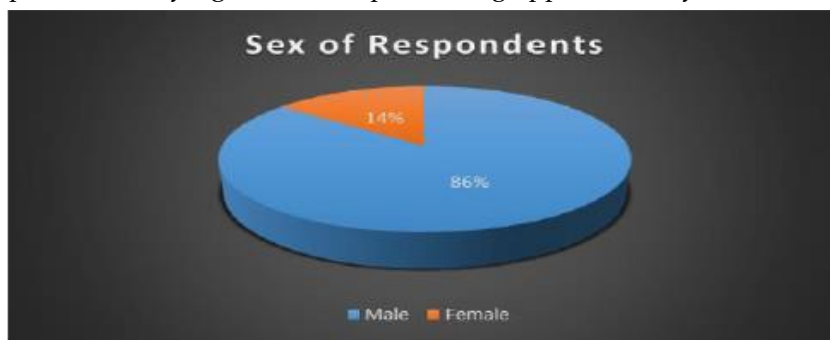
In conducting qualitative data analysis, a census was carried out among fifteen (15) employees to gain insights, resulting in seven (7) recorded responses, which, despite the smaller sample size, provide valuable qualitative data offering insights for the study as presented in the following sections.

1. Age of Respondents

The analysis indicates that the majority of participants fall within a relatively narrow age range, with ages 31 and 37 being the most frequent, each representing 28.57% of the sample. Participants in their late 30s comprise 57.14% of the sample, suggesting this age group may be a relevant factor in understanding the issue of claim payment delays by insurance companies.

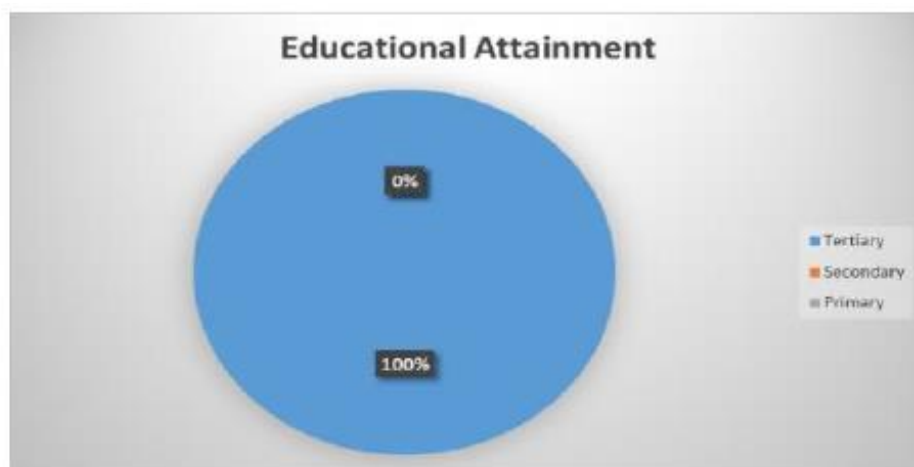
2. Sex of Respondents

The analysis reveals that the majority of respondents were male, with six out of seven participants identifying as male, representing approximately 85.71% of the sample.



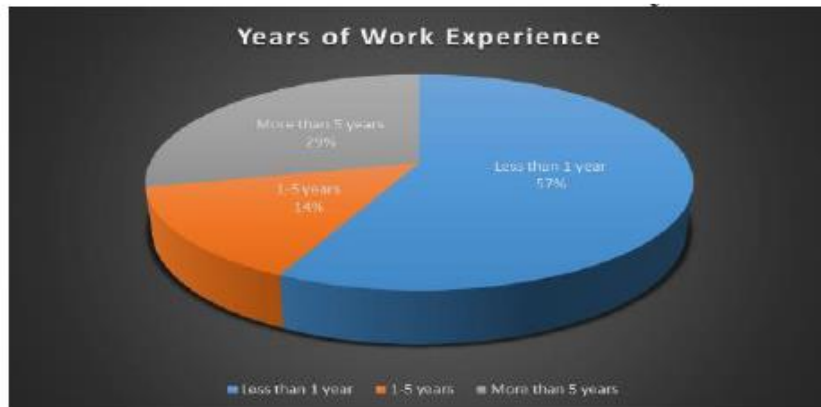
3. Educational attainment

The data analysis reveals that all seven participants in the study possess a "Tertiary" level of education, representing 100% of the sample. This homogeneity suggests a lack of diversity in educational levels within the sample, potentially influencing their perceptions and experiences with insurance companies and claim payment delays. However, this demographic characteristic may not be a significant differentiating factor in assessing the reasons behind such delays.



4. Years in the Insurance Industry

The data analysis reveals a spectrum of work experience durations among the respondents in the insurance industry. The majority of participants, constituting 57.14% of the sample, have less than one year of experience, categorized as 'short-term experience.' One participant (14.29%) falls into the 'intermediate category,' with work experience ranging from 1 to 5 years, while two participants (28.57% of the sample) fall into the 'long-term experience category,' with a tenure exceeding 5 years.



6. How Many Insurance Companies are registered with your Company?

All seven participants unanimously reported that their company is registered with 30 insurance companies, resulting in 100% agreement within the sample. This complete homogeneity in responses suggests a common affiliation among participants with 30 registered insurance companies, potentially influencing their experiences with claim payment delays. However, this characteristic may not significantly differentiate participants in terms of their experience with insurance companies.

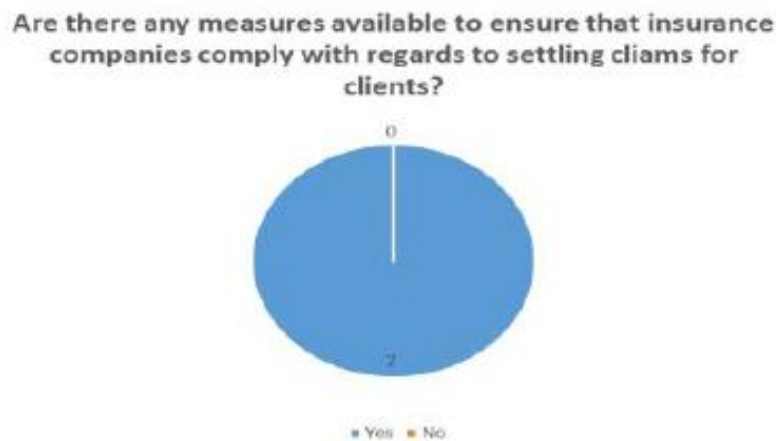
7. Of those that are registered, how would you rate compliance in line with settling clients claims for the following companies?



The analysis indicates that 71.43% of participants rated the compliance of companies A, B, and C as "Very Good" or "Good." However, one outlier with a varied rating for company C suggests a more diverse perspective regarding its performance in settling clients' claims.

8. Compliance Measures

From Figure 8, all seven participants responded affirmatively, indicating that there are measures in place to ensure compliance by insurance companies when settling claims for clients. This unanimous response results in 100% agreement within the sample (Figure 8), demonstrating a complete consensus among participants regarding the existence of such measures.



9. What are some of these measures set by the regulatory body?

The responses collected provide insights into the regulatory framework aimed at safeguarding the interests of policyholders, which can be grouped into distinct themes.

9.1 Claims Handling Procedures and Policies: Participants revealed that a significant aspect of the regulatory measures centers around claims handling procedures and policies. The regulatory body requires insurance companies to submit their claims policies or procedures for strict review to ensure fairness, transparency, and customer-friendliness in the claims settlement process, promoting trust and safeguarding the interests of policyholders.

9.2 Timely Claims Processing: Participants noted that regulators mandate insurance companies to establish claim turnaround periods for various types of claims, emphasizing timeliness and efficiency in claims processing. Additionally, policyholders are encouraged

to report insurance companies that take an excessive amount of time to settle claims, highlighting the importance of addressing delays and providing swift resolutions to policyholders' claims.

9.3 Market Conduct and Customer Concerns: Participants highlighted a distinct theme around market conduct and addressing customer concerns, revealing the presence of a dedicated department tasked with ensuring market conduct compliance and handling customer concerns. Regular engagement with insurers to enhance business practices and procedures, along with constant inspections of business operations, demonstrates the regulator's commitment to maintaining ethical and fair market practices, underscoring their role in protecting the interests of policyholders and maintaining industry integrity.

9.4 Regulations, Standards, and Capital Requirements: Regulatory bodies play a pivotal role in shaping the insurance industry by issuing regulations, standards, guidelines, and directives, encompassing various measures such as reviewing insurance products, setting minimum capital requirements, and ensuring adequate capitalization. This comprehensive regulatory framework fosters industry stability and compliance, emphasizing fairness and ethics for both policyholders and insurance companies, although further research is needed to gauge its effectiveness in addressing delays in insurance claim payments and its influence on the study's objectives.

10. What are some of the observed factors that you think cause insurance companies to delay payment of claims?

A significant portion of participants, constituting 42.86% of the sample, highlighted financial and risk management as a leading factor in delays in insurance claim payments. Poor cash flow management by insurers, combined with concerns about potential fraud in claims, led to insurer scepticism and extensive investigations, ultimately resulting in delays. Inadequate underwriting practices and claims handling, including undercutting premium rates and a lack of fully documented claims, were identified by 28.57% of respondents as contributing to delays.

Additionally, a lack of standardized claims procedures within insurance companies, leading to policyholders' confusion about necessary documentation, was cited by 14.29% of participants. Poor liquidity levels, insufficient information from policyholders, and the submission of incomplete documents also contributed to delays. Finally, 14.29% of participants emphasized regulatory and governance challenges as factors in the delays, including insolvency concerns, liquidity challenges, and poor governance or management

within insurance companies. The absence of comprehensive laws and standards governing claim settlements, along with a lack of enforcement and insufficient laws, were also identified as contributing factors.

11. Any suggestions and/or recommendations to improve insurance company's settling claims for clients.

The most prevalent theme, voiced by 42.86% of respondents, emphasized the importance of clarity and transparency in the claims process. Participants suggested attaching claims procedures to policy documents to ensure insured individuals are well-informed about required documentation, reducing opportunities for insurers to exploit missing documents to delay payments. A second key theme, supported by 28.57% of participants, stressed the significance of proper underwriting and risk management by insurance companies. Ensuring sound underwriting processes and maintaining sufficient liquidity to settle claims promptly were seen as crucial steps to mitigate delays and meet claim obligations more efficiently.

Additionally, 14.29% of participants focused on the importance of standardized claims procedures and public awareness, emphasizing the need for well-understood, standardized procedures and improved public awareness. The remaining 14.29% of responses centered on regulatory measures and penalties, proposing the introduction of fines and sanctions to penalize delayed settlements, along with improved monitoring, inspection processes, and the enforcement of service charters to ensure compliance with established standards. These diverse recommendations reflect a comprehensive approach to addressing the complex challenges of insurance claim settlements, with a focus on transparency, proper risk management, standardized procedures, regulatory measures, and increased public awareness to enhance the process and expedite claim payments. Further research may be necessary to evaluate the effectiveness of these recommendations and their potential impact on the study's objectives.

4.3 Discussion of research findings

To examine factors causing delays on the payment of claims by insurance companies. The study findings indicate that various factors influence the timely payment of claims by insurance companies. Respondents perceive efficient claim handling systems, adherence to specified claim payment timelines, and the "first come, first paid" principle positively, resulting in timely claim settlements. This aligns with Tennyson's (2020) findings on the impact of legal and regulatory frameworks on claims processing efficiency, suggesting that regulatory factors significantly affect the claims payment process. Similarly,

Ajemunigbohun et al.'s (2022) study on claims settlement and risk attitudes among motor insurance policyholders in Lagos, Nigeria, mirrors the importance of timely claims settlement, indicating its significance in ensuring customer satisfaction and trust. The qualitative approach identifies financial, operational, regulatory, informational, and customer knowledge aspects as factors contributing to payment delays, highlighting the need for various strategies to mitigate these delays and ensure more timely claim settlements.

In conclusion, the study emphasizes the complex interplay of factors influencing payment delays and suggests strategies to mitigate them. The findings resonate with existing literature, aligning with Tennyson's (2020) examination of the legal framework governing insurance claim disputes in the United States and Ajemunigbohun et al.'s (2022) study on claims settlement and risk attitudes among motor insurance policyholders in Lagos, Nigeria. These studies collectively indicate that factors related to the efficiency of claim processing systems, adherence to principles, and the prompt payment of claims are pivotal in shaping policyholders' satisfaction and trust, suggesting a cross-cultural and regulatory consistency in the factors influencing claims payment and customer experiences within the insurance industry. Further research and comparative analysis may be necessary to establish these relationships more robustly.

To identify business management gaps in insurance companies that cause delay in paying insurance claims to customers.

The study's second objective focuses on identifying business management gaps within insurance companies that contribute to delays in paying insurance claims to customers. These gaps encompass operational inefficiencies, technological shortcomings, deficiencies in underwriting and risk assessment practices, limitations in claims handling personnel, resource allocation inadequacies, and shortcomings in customer communication. Addressing these internal aspects, including compliance with legal and regulatory requirements, fraud detection and prevention, and establishing comprehensive data management systems, is crucial for enhancing the efficiency and effectiveness of claims processing within insurance companies. Bridging these management gaps is essential for improving customer satisfaction, promoting industry trust, and maintaining a competitive edge in the market, allowing insurers to expedite claims processing, reduce disputes, and provide timely and reliable claims settlements to policyholders.

The study's investigation into business management gaps within insurance companies aligns with a body of literature focusing on claims management processes and challenges. Studies conducted by Sodzi-Tettey et al. (2012), Kiana (2010), and Jere (2020) provide valuable insights that support the aims of this investigation. Sodzi-Tettey et al.'s

research emphasizes the significance of efficient claims management processes and highlights how operational inefficiencies and resource allocation inadequacies can lead to delays in claims payments. Similarly, Kiana's study sheds light on the challenges associated with general insurance claims management, emphasizing the impact of inadequate technology, underwriting processes, and resource allocation on claims processing times. Jere's work, focusing on technological solutions, underscores the critical role of modern technology and effective data management systems in ensuring efficient claims processing, collectively reinforcing the importance of recognizing and rectifying internal gaps to streamline claims processes, enhance customer satisfaction, and contribute to the overall development of the insurance industry.

To propose ways that could enhance the efficiency of insurance companies in processing claims.

The study's third objective, aimed at establishing measures to enhance the efficiency of insurance companies in paying claims, addresses critical challenges within claims processing. Based on the study findings, several measures are proposed to improve claims processing efficiency. These include modernizing claims handling systems, investing in advanced technology such as artificial intelligence and machine learning, streamlining documentation procedures, simplifying claims submission processes, implementing automated communication systems to keep policyholders informed about their claim's status, ensuring adequate training for claims personnel, proper resource allocation, regular auditing, and quality control. Additionally, leveraging data analytics, benchmarking industry best practices, customer education, transparent communication, robust fraud prevention measures, feedback mechanisms, and a commitment to transparency are essential components of a comprehensive strategy to enhance efficiency in claims processing. These measures not only benefit policyholders but also serve as a competitive advantage for insurance companies, contributing to customer loyalty and trust in the industry.

The pursuit of the study's third objective to establish measures for improving claims processing efficiency aligns seamlessly with a broader literature context encompassing topics such as insurance apathy, factors influencing industry performance, and market indiscipline. Studies conducted by [Ntumnde \(2012\)](#), [Kaoma \(2020\)](#), and [Ndubuisi \(2008\)](#) provide valuable insights that support the aims of this investigation. The emphasis on efficient claims processing, transparency, proper risk management, standardized procedures, regulatory measures, and increased public awareness highlighted in the study's recommendations resonates with the broader exploration of factors impacting the efficiency and effectiveness of the insurance industry. Implementing these measures has

the potential to streamline claim settlement processes, reduce delays, and ultimately enhance the overall experience for policyholders, contributing to the industry's growth, credibility, and fostering greater public trust. Further research and practical assessments are crucial to fully understand the effectiveness of these recommendations in achieving the research objectives.

4.4 Summary

This study has offered valuable insights into the factors causing delays in insurance claims payment, identified critical business management gaps, and proposed measures to enhance efficiency. By addressing these issues, insurance companies can improve their claims processing systems, reduce delays, and ultimately enhance customer satisfaction and trust. Further research and practical assessments are recommended to validate the effectiveness of these recommendations in achieving the study's objectives and improving the overall claims experience for policyholders.

5. Summary, conclusions and recommendations

This chapter summarizes research findings on factors causing insurance company delays in paying claims, focusing on three selected companies. It discusses the study's objectives, recommendations, limitations, and potential future findings, comparing and contrasting the results from the case study.

Summary of Findings

The research aimed to identify factors causing delays in insurance companies' payment of claims to customers. The study found that while efficient claim handling systems, adherence to timelines, and the "first come, first paid" principle contribute to timely claim settlements, delays exceeding a year negatively impact customer satisfaction and trust. Factors such as financial issues, operational inefficiencies, inadequate documentation, fraud, and regulatory challenges were identified as causes of payment delays. Addressing these challenges requires clear regulations, strong governance, and customer education. Furthermore, the study identified business management gaps within insurance companies, including operational inefficiencies, technological shortcomings, and deficiencies in underwriting practices, which contribute to delays in claims processing. To enhance efficiency, the study recommends measures such as modernizing claims handling systems, streamlining documentation procedures, automating communication with policyholders, providing adequate training and resource allocation, leveraging data analytics, and implementing robust fraud prevention measures. These measures not only

benefit policyholders but also contribute to building industry trust and maintaining a competitive edge.

Recommendations of the Study

In light of the research findings presented in and discussed in the previous chapter, the following recommendations have been made;

Policy recommendations

1. Improve transparency and communication channels.
2. Enhance risk management protocols and optimise operational efficiency.
3. Establish a comprehensive and resilient system of regulations and mechanisms for enforcing them.

Recommendations for Future Studies

- Comparative Analysis.
- Longitudinal Studies.
- Customer Feedback Mechanisms.
- Capacity Building: Research capacity-building initiatives for claims personnel.

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