FINANCIAL RISKS OF FRAUD IN THE SYSTEM OF INSURANCE RELATIONS: ECONOMIC CONSEQUENCES AND COUNTERMEASURES

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Abstract. Insurance fraud is one of the most common types of economic offenses that has accompanied the development of insurance relations over a long historical period. Its spread negatively affects the financial stability of insurance companies, violates the principles of fair distribution of insurance risks, and creates an additional burden on bona fide participants in insurance relations.

The purpose of the article is to study insurance fraud, reveal its characteristic features and ways of manifestation, as well as find ways to combat financial abuse in the insurance sector. The motivational basis of insurance fraud is mainly associated with the desire to illegally obtain material benefits, reduce one's own financial expenses or evade contractual obligations. At the same time, the nature of the motives may vary depending on the status of the offender, the characteristics of the insurance product, the economic situation and the level of control by the insurance company.

One of the main features of insurance fraud is the illegal encroachment on the property interests of the insurer or other participants in insurance legal relations. An obligatory characteristic of insurance fraud is its illegal nature, which is manifested in the intentional misleading of the insurer by providing false information, concealing material circumstances or falsifying documents.

Due to the large scale of financial abuse in the insurance market, the author has shown the need to find effective ways to overcome this problem. The methods of combating insurance fraud at different stages of execution of the insurance contract are outlined. In the scientific research the author

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emphasizes the tactical and strategic methods of combating financial abuse in the insurance business, as well as points to the expediency and effectiveness of application in the process of detection of fraudulent schemes of software, technical and operational ways. The article proves the need to consolidate the efforts of the state, insurance companies and their associations in order to combat the manifestations of insurance fraud in Ukraine.

It has been established that in the context of digitalization, the role of modern technologies in detecting and preventing insurance fraud is increasing. The use of Big Data tools, artificial intelligence and behavioral analytics for the timely identification of suspicious transactions is of particular importance. It is substantiated that effective counteraction to insurance fraud requires a comprehensive approach that combines the improvement of the internal control system, the development of human resources and the active interaction of insurers with state and law enforcement agencies.

INTRODUCTION

The development of the insurance market is one of the important factors in the formation of an effective economy and is entirely dependent on its state. Today, there are a number of problems that hinder the development of the insurance market in Ukraine, namely: imperfection of the legislative framework, low level of insurance culture, underdevelopment of the institute of personal insurance, etc. Among the important destructive factors of influence, financial fraud and fraudulent schemes in insurance activities can also be distinguished.

Insurance fraud is one of the most common types of economic offenses that has accompanied the development of insurance relations over a long historical period. Despite the improvement of regulatory and legal regulation, financial control mechanisms and risk management systems, this phenomenon remains an urgent problem of the functioning of the modern insurance market. Its spread negatively affects the financial stability of insurance companies, violates the principles of fair distribution of insurance risks and creates an additional burden on bona fide participants in insurance legal relations. The conditions of digital transformation of the economy, the development of information and communication technologies and the expansion of electronic channels of interaction between insurance market entities have significantly contributed to the complication of insurance fraud

schemes and the emergence of new ways of illegally obtaining material benefits.

The methodological and informational basis of this scientific research is the analysis of articles, scientific works of domestic and foreign scientists on financial fraud in the insurance sector, as well as statistical data, regulatory legal acts and Internet resources. In the process of scientific research, the methods of analysis and synthesis, induction and deduction, observation and comparison were used.

The purpose of this scientific work is to study insurance fraud, reveal its characteristic features and methods of manifestation, as well as find ways to combat financial abuse in the insurance sector.

1. Determinants of the Emergence and Features of the Manifestation of Fraud Risks in Insurance Activities

Insurance fraud is the unlawful actions of the subjects of the insurance contract aimed at obtaining insurance compensation by the insured through deception or abuse of trust, making a significantly smaller amount of insurance premium through a fictitious analysis of possible risks, concealing important facts and nuances during the validity of the insurance contract, the insurer's refusal to make insurance payments without good reasons and guarantees, as a result of which the subjects of the insurance contract are given the opportunity to illegally level the basic principles of insurance and receive an unlawful benefit for this.

The essence of insurance fraud lies in the deliberate commission of unlawful actions aimed at illegally appropriating the insurer's funds or obtaining other material benefits through deception, concealing essential information, falsifying documents or manipulating the terms of the insurance contract. Such actions are characterized by the presence of direct intent and a selfish purpose, which distinguishes them from errors or unintentional violations that may arise in the process of implementing insurance legal relations. The main goal of insurance fraud subjects is to obtain unlawful financial benefit at the expense of the resources of insurance companies or other participants in the insurance market.

In the scientific literature, insurance fraud is interpreted as a type of financial fraud that encompasses a complex of intentional actions or inactions of participants in the insurance process aimed at misleading the

insurer regarding factual circumstances that are important for the conclusion, execution or termination of the insurance contract.

A feature of insurance fraud is that its subjects can be not only insureds, but also other participants in the insurance market, in particular insurance agents, brokers, expert appraisers, employees of insurance companies and third parties involved in the process of settling insurance cases. This indicates the complex and multi-level nature of the said offense, which requires a comprehensive approach to its detection, prevention, and minimization of negative consequences.

The spread of insurance fraud causes significant economic, social and reputational losses for the insurance sector. The payment of unjustified insurance claims leads to a decrease in the financial resources of insurers, a deterioration in their solvency indicators and a decrease in the efficiency of insurance reserve management. In order to compensate for the losses incurred, insurance companies are forced to revise their tariff policy, which is often accompanied by an increase in the cost of insurance services for honest customers. As a result, the level of availability of insurance protection decreases and the competitiveness of the insurance market as a whole weakens. The level of development of financial fraud in the insurance sector is inversely proportional to the development of the country's economy. Thus, during periods of significant financial and economic crises in the state, there is a significant increase in the number of illegal actions that entail significant financial losses for both the insured and the insurer. For a deeper understanding of the essence of insurance fraud, let us dwell on the characteristics of the signs by which it is possible to identify the risks of a crime for participants in the insurance market (see Fig. 1).

Today, insurance fraud is one of the most widespread types of offenses. The most popular risks of insurance fraud, in our opinion, are: violation of insurance rules, safety precautions; reporting false information regarding the object of insurance; concealing information about the risky circumstances of concluding an insurance contract; presenting falsified documents; concealing circumstances or distorting information regarding the occurrence of an insured event; double insurance; prior collusion with representatives of the insurer, experts, appraisers, lawyers, employees of medical institutions or auto repair shops; concealing information from the insurer regarding receiving compensation from the perpetrator of the insured event.

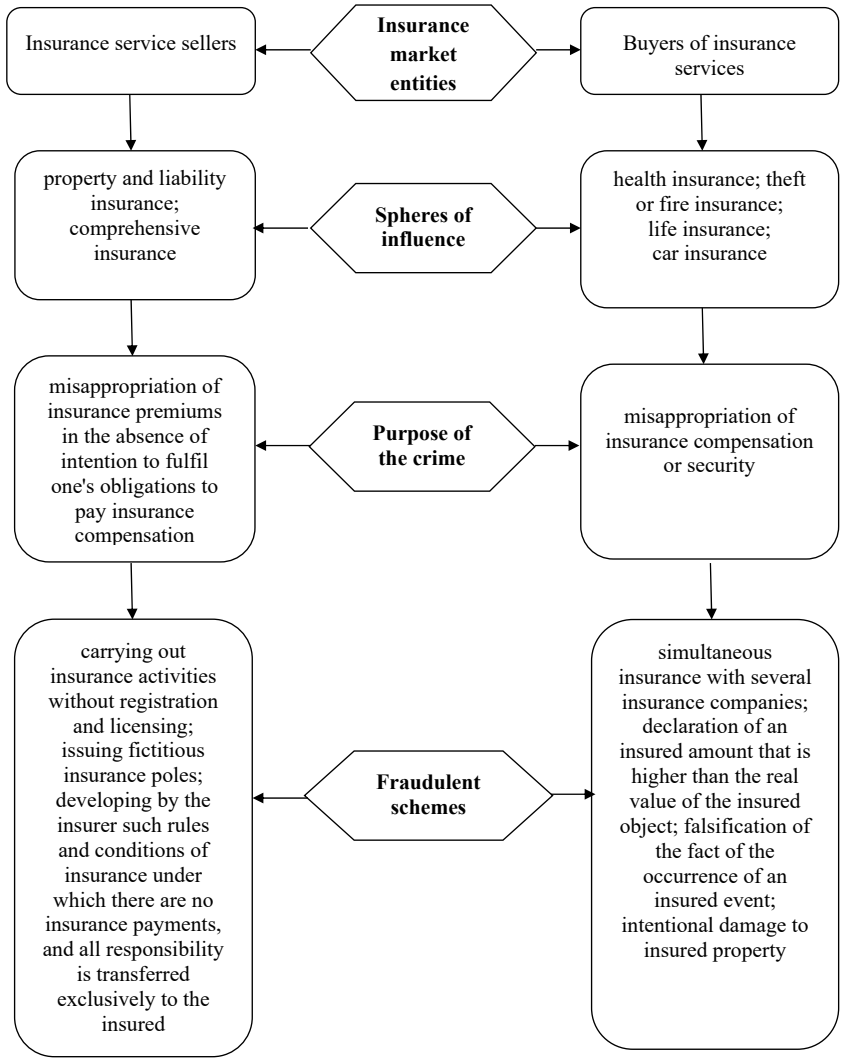


Figure 1. Characteristic signs of fraud in the insurance sector

Source: compiled by the author based on [1, pp. 480-482; 2]

In addition to financial consequences, insurance fraud negatively affects the level of public trust in the insurance institution. The increase in the number of fraudulent schemes complicates the procedures for settling insurance cases, strengthens control measures by insurers and increases the duration of insurance claims verification. This, in turn, can lead to a deterioration in the quality of customer service, the emergence of additional administrative costs and a decrease in the efficiency of the operation of insurance companies. In view of this, combating insurance fraud is one of the priority areas for ensuring the financial security of the insurance market and an important condition for increasing its stability and transparency.

One of the key areas of research into insurance fraud is the establishment and systematization of causal and motivational factors that lead to the commission of illegal actions in the field of insurance services. Analysis of the motives of insurance fraud allows not only to understand the nature of this phenomenon more deeply, but also to form effective tools for its prevention, timely detection and minimization of risks for all participants in the insurance market.

The motivational basis of insurance fraud is mainly associated with the desire to illegally obtain material benefits, reduce one's own financial expenses, or evade contractual obligations. At the same time, the nature of the motives may vary depending on the status of the offender, the characteristics of the insurance product, the economic situation, and the level of control by the insurance company. The most common motives for committing fraudulent acts in the insurance sector include:

– misappropriation of insurance payments or their part for the purpose of personal enrichment;

– the desire to receive insurance compensation in an amount exceeding the actual losses incurred;

– the desire to compensate for previously paid insurance premiums by unjustified receipt of insurance payments;

– using the fact of the occurrence of an insured event to overestimate the amount of material damage and obtain additional financial benefits;

– avoiding the fulfillment of financial obligations or shifting responsibility for the consequences of an insured event to the other party to the insurance contract [3].

The above-mentioned motives form the basis for the implementation of various fraudulent schemes, which differ in scale, level of organization and degree of public danger.

Thus, abuse in the insurance sector has a negative impact on society and is accompanied by financial risks that complicate the formation of insurance funds to fulfill the main obligations under insurance contracts. Financial fraud in the insurance sector hinders the stable operation of business entities, stimulates the emergence of new economic risks and eliminates any incentives for innovation in entrepreneurial activity.

Having studied the specifics of the activities of insurance market participants, we believe that the main factors of the growth of abuse and financial fraud in this area can be conditionally divided into three groups – financial, legal and social (see Fig. 2).

Today, there are about two hundred ways to commit crimes in the insurance sector, the essence of which depends on the type of insurance: voluntary or mandatory, property, life or liability insurance. Among the subjects who commit financial fraud in insurance activities, one can distinguish not only insurers and policyholders, but also other intermediaries who indirectly influence the commission of illegal actions, namely: expert appraisers, employees of technical service stations, representatives of car dealerships, lawyers, notaries, medical professionals, law enforcement officers, etc.

In the scientific literature, economic offenses in the insurance sector are classified depending on the nature of their organization and the method of implementing the criminal intent. The most common is the division of insurance fraud into professional and amateur.

Professional insurance fraud is a complex system of pre-planned and carefully organized illegal actions that are carried out with the aim of systematically obtaining illegal profit. As a rule, such schemes are implemented by organized groups of individuals whose activities have the characteristics of a clearly structured criminal mechanism. Such groups may include specialists from various fields of activity, including lawyers, medical professionals, expert appraisers, intermediaries and even employees of insurance companies. Using professional knowledge, official authority and access to information databases, they create conditions for the illegal receipt of insurance payments, falsification of documents or artificial

formation of insurance cases. This type of fraud is characterized by a high level of latency and causes significant financial losses to the insurance sector.

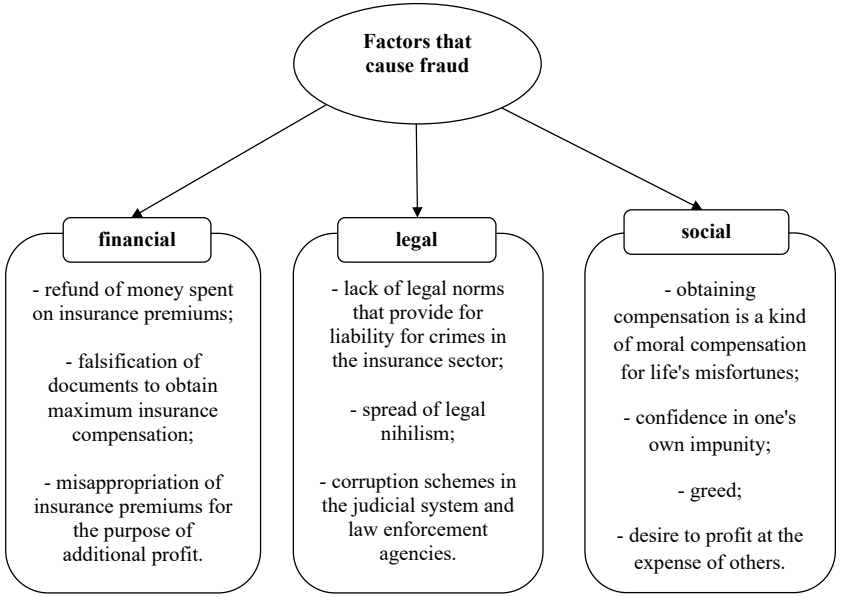


Figure 2. Factors of growth of abuses and financial frauds in the insurance sector

Source: compiled by the author based on [2; 4]

Unlike professional, amateur insurance fraud does not have signs of complex organization and is usually carried out by individual policyholders. Most often it arises as a result of the desire to obtain additional benefits during the settlement of a real insurance event. Typical manifestations of such fraud are overstating the amount of losses, concealing circumstances that are essential for assessing the risk, providing inaccurate information about the nature of the event or deliberately distorting information about the insured object. Despite the relatively small scale of individual cases, the mass of such violations significantly affects the financial results of insurers and increases the costs of implementing control procedures. Research in the

field of combating insurance fraud shows that the ratio of professional and amateur fraud is on average 1:10 [2].

Such statistics confirm that the bulk of fraudulent actions fall on individual policyholders who use the capabilities of the insurance mechanism to obtain undue benefit. At the same time, professional fraud, despite its relatively lower prevalence, causes the largest economic losses to the insurance sector, as it is characterized by a high level of organization, significant amounts of illegally obtained funds and the complexity of the process of detecting and documenting illegal activities.

Depending on the nature of the formation of criminal intent and the specifics of the implementation of illegal actions, insurance fraud is expediently divided into planned and situational.

Planned insurance fraud is characterized by preliminary preparation and purposeful organization of illegal activities. Its distinguishing feature is the presence of a pre-formed intention to obtain unlawful material benefit even before the conclusion of the insurance contract. In most cases, the implementation of such schemes requires careful planning, coordination of actions of several people, and sometimes the assistance of employees of insurance companies or other participants in the insurance process. That is why this type of fraud is characterized by a high level of organization and difficulty in detection.

Situational fraud usually involves policyholders who have concluded a contract for the purpose of classical insurance protection. However, when an insured event occurs, they may take actions related, as a rule, to concealing the true causes and circumstances of the event in order to avoid a refusal to pay or to artificially inflate the amount of damage. For example, this is concealing the fact of the driver's drunkenness, inaccurate information about the insured event, attempts to issue previously received damage for new damage [5].

One of the important classification features of insurance fraud is its division into internal and external depending on the subjects of committing illegal actions. This type of fraud can take place at any stage of the insurance contract:

– after the declaration of risk by the insured or his representative, if the distortion of information is intentional;

– when selling the contract by the insurer's representative (insurance employee or agent);

– after filing a claim [6].

Internal insurance fraud is a type of economic offense committed by employees of an insurance organization or other persons who have access to the insurer's internal business processes. Such actions can be carried out both independently and in collusion with policyholders, beneficiaries, insurance intermediaries or other interested parties. The peculiarity of internal fraud is the use of official authority, professional competence and access to confidential information to obtain unlawful material benefit. That is why this type of fraud poses an increased danger to the insurance company, since its consequences are not only direct financial losses, but also a violation of the effectiveness of the corporate governance system, a decrease in the quality of internal control and a deterioration in the reputational capital of the insurer.

Key manifestations of internal insurance fraud include intentional distortion of information regarding the causes, conditions and consequences of an insured event, falsification of loss assessment results, manipulation of the insured value of insured objects, performance of dubious reinsurance transactions, as well as deliberate violation of underwriting and insurance claims settlement procedures. A separate group of risks includes cases of intentional misleading of policyholders regarding the terms of insurance coverage, forgery of documentation, illegal correction of information in electronic databases, corrupt actions and other forms of abuse of office. Significant damage to insurance activities is also caused by cases of intentional concealment of material circumstances of an insurance contract or assistance in the illegal receipt of insurance compensation by third parties.

Current trends in the development of the insurance sector indicate the transformation of traditional forms of external fraud and the emergence of new risks due to the digitalization of financial services. One of the most significant threats is the growth of cybercrime, which creates additional opportunities for unauthorized access to insurers' information systems, theft of personal data of clients and manipulation of electronic documents. Schemes of using fake or duplicate documents, falsification of individual data, illegal identification of individuals and submission of fictitious

statements about the occurrence of insured events are becoming increasingly widespread.

The issue of financial fraud is quite relevant for the domestic insurance market. In Ukraine, insurance fraud accounts for 21% or 1.5 billion UAH. of gross payments, in particular: 25% for voluntary health insurance, 23% for CASCO insurance, 18% – OSAGO, 16% – liability insurance, 14% – tourist insurance, 12% – property insurance and 10% – accident insurance. Insurance experts are sounding the alarm: every fourth voluntary health insurance policy, every tenth accident insurance policy is fake [2].

Having studied the structure of insurance fraud in the world, we can conclude that financial fraud in the insurance sector abroad has its own characteristics. For example, in the USA, more than 80% of fraudulent schemes fall on health insurance, while only 10% on auto insurance, crimes in the field of home and life insurance account for 1.5% and 1.2%, respectively. As for the European continent, financial crimes in the field of auto insurance (about 60%), home insurance (25%) and health insurance (about 10%) prevail. If we consider the total amount of losses abroad caused by financial fraudsters, they are quite impressive in the USA – over 100 billion USD every year. Most European insurance companies have an average of up to 10-15 billion USD in financial losses from illegal actions of fraudsters annually [7].

Therefore, due to the significant scale of financial abuses in the insurance sector, domestic insurance companies and the government are faced with the acute problem of finding effective ways to overcome this problem.

Given the existence of different groups of entities in the insurance market, in our opinion, it would be advisable to divide the methods of combating fraud in this area into two stages:

1) verification at the stage of concluding an insurance contract;

2) verification at the stage of investigating an insured event.

Tactical methods of combating insurance fraud at the stage of concluding an insurance contract include a detailed check of the insured, a review of the condition of the insured object, monitoring insurance histories (if any), a questionnaire regarding the special conditions of the contract, etc.

As for the second stage, the following tactical methods should be followed: a full investigation of all circumstances of the insured event, a study of the motivations of the beneficiary and the insurance company,

as well as the use of special research tools. The latter include means of operational, technical and programmatic detection of insurance fraud.

Insurance fraud detection software works best in the field of civil liability insurance when detecting those insurance cases that were staged with the aim of misappropriating insurance companies' funds. For example, the use of special software products in auto insurance will make it possible to design the expected deformation of a vehicle in a specific collision, calculate the trajectory of vehicles at the time of collision, and determine possible damage.

Operational methods for detecting insurance fraud include not only the activities of investigative bodies, but also the involvement of insurance companies in cooperation with business entities that provide professional services in the field of security.

A study of foreign experience shows that an important element of combating insurance crimes is the formation of centralized registers of insurance cases, losses, and facts of unfair behaviour of insurance market participants [6]. Innovative digital technologies are actively used to detect fraudulent schemes, including document verification tools, tools for analysing information from social networks and open Internet resources, specialized information platforms, as well as mechanisms for engaging the public through hotlines and other communication channels. At the same time, in Ukraine, the process of forming an effective system for combating insurance fraud is at the stage of formation, and the functioning of a comprehensive information base of insurance cases and coordination of relevant measures remain underdeveloped.

In the context of the digital transformation of the financial sector, the use of modern analytical technologies is a key factor in increasing the efficiency of internal control of insurance companies. Their application ensures timely detection of risky operations, increases the accuracy of forecasting possible threats and contributes to the formation of a preventive risk management model. Big Data technologies are of particular importance, which allow for multidimensional analysis of significant arrays of structured and unstructured information in order to identify hidden patterns, relationships and potential risks. At the same time, artificial intelligence and machine learning algorithms provide automated information processing,

identification of atypical behavioural patterns and prompt detection of suspicious transactions.

One of the most promising areas for improving mechanisms for combating insurance fraud is the use of behavioural analytics. In particular, automated systems are able to record atypical activity during the execution of insurance contracts, submission of applications for the occurrence of insured events or the payment of insurance payments. Analysis of such deviations provides the possibility of early detection of potential violations and significantly reduces the cost of conducting additional inspections.

An important tool for detecting illegal schemes is also a comprehensive analysis of information about insurance cases. Thanks to the use of modern data processing algorithms, insurance companies are able to establish hidden patterns, identify the concentration of suspicious applications in certain regions, insurance segments or among certain groups of clients.

The practice of leading international insurance companies demonstrates the high efficiency of using digital tools to detect and prevent insurance fraud. The combination of Big Data technologies, artificial intelligence, geoinformation services and analysis of open sources of information allows for multi-level verification of insurance claims, assess the reliability of the submitted data and promptly identify signs of potential abuse. As a result, financial losses of insurers are significantly reduced, the quality of customer service increases and trust in the insurance sector is strengthened.

An equally important element of the system for combating insurance fraud is the development of the human resources potential of insurance organizations. Increasing the professional competence of employees is ensured through the implementation of specialized educational programs, trainings, practical seminars and certification courses aimed at developing skills in working with modern analytical tools and risk assessment methods.

At the same time, the effectiveness of the fight against insurance offenses largely depends on the level of cooperation between insurance companies and law enforcement agencies. Such interaction ensures effective exchange of information, coordination of joint actions and increases the effectiveness of the investigation of insurance fraud cases.

Today, there are many ways to combat corporate fraud and actions to detect it in a timely manner, but not all of them bring a positive result.

The most effective, in our opinion, are complex measures that combine the following areas:

1) effective control procedures – the creation of corporate control aimed at eliminating profit losses associated with corporate fraud; development of measures aimed at prevention; early detection of fraud risks and the formation of an effective internal control system [8]; the use of tools that ensure economic security and internal investigations.

Modern organizations operate in conditions of high competition and strict regulatory requirements. This requires them not only accuracy in conducting financial transactions, but also the ability to effectively prevent possible risks associated with fraud. One of the key tools for achieving these goals is the internal control system.

Internal control is a structured approach to management and supervision aimed at ensuring the accuracy of financial information, compliance with regulatory requirements and improving the efficiency of the enterprise. The main goal of internal control is to minimize financial risks, including fraudulent actions that can be committed by both employees and management. The internal control system is developed individually for each enterprise, taking into account its size, industry and specifics [9]. It should be implemented in all business processes, from financial management to personnel policy. The objectives of internal control include ensuring the reliability and completeness of financial reporting, preventing and detecting fraud, strengthening corporate ethics and complying with regulatory requirements, including increasing operational efficiency by reducing the level.

2) personnel policy – the formation of an impeccable corporate culture, personnel certification, the formation of a personnel reserve, the creation of favorable working conditions, etc. When communicating in person at meetings and corporate meetings, explain to employees the importance of ethical business conduct, convey the management's position on corruption and fraud. Conduct internal training for employees on the topic of ethical practices and punish those who initiated fraud [10, p. 172]. A regulated system of training and advanced training of employees of all structures and levels plays an important role in ensuring the economic security of the enterprise.

3) creation of a corporate security service – a separate unit of specialists of various profiles (economic, legal, IT sphere), whose competence will

include the accumulation of information and control over the company's activities in various business processes. An important task of the corporate security service is to timely receive information about the preparation of illegal actions, about the fact of fraud.

The issues of implementing and improving the internal control system are especially relevant in the context of digitalization and automation of business processes. Innovations open up new opportunities for increasing the transparency of operations, but at the same time create additional risks, such as cybercrime and manipulation of various data. In these conditions, a reliable internal control system becomes not just a mandatory element of management, but also a competitive advantage.

In order for the internal control system to be effective, it is important to adhere to such principles as transparency (ensuring the availability of information for all stakeholders), regular audit (organization of verification to assess the effectiveness of the implemented measures), personnel training (conducting regular training of employees on compliance with company policy), technological support (use of licensed software).

Thus, the formation of an effective internal control system in insurance companies involves the implementation of a comprehensive risk-oriented approach, which includes the development of internal regulations, the construction of a multi-level corporate governance system, regular risk assessment and the implementation of appropriate control measures. An important component of such a mechanism is continuous monitoring of the insurer's activities, which ensures timely detection of deviations from established standards, minimization of financial losses, and increasing the level of financial stability of the institution [11].

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2. Fraud in the Social Security System: Forms of Manifestation and Ways to Overcome Them

Within the framework of social policy research, social security fraud is usually interpreted as a conscious and purposeful submission by an applicant of false or distorted information in order to illegally obtain material benefits or other types of benefits. This also includes cases of deliberate concealment

by citizens or untimely notification of changes in their circumstances that affect the possibility of receiving social assistance from the state.

In most developed countries, fraud is defined as deliberate deception of relevant authorities in order to obtain undue advantages, which is classified as an administrative or criminal offense depending on the scale of the violation [5]. Along with this, the phenomenon of corruption in the social security system is separately distinguished, which consists in the conscious use of official position by employees of relevant institutions to obtain personal gain or other undue advantages. At the same time, in the process of analysis, it is important to draw a clear distinction between intentional violations (fraud and corruption) and unintentional deviations in the form of errors (see Fig. 3).

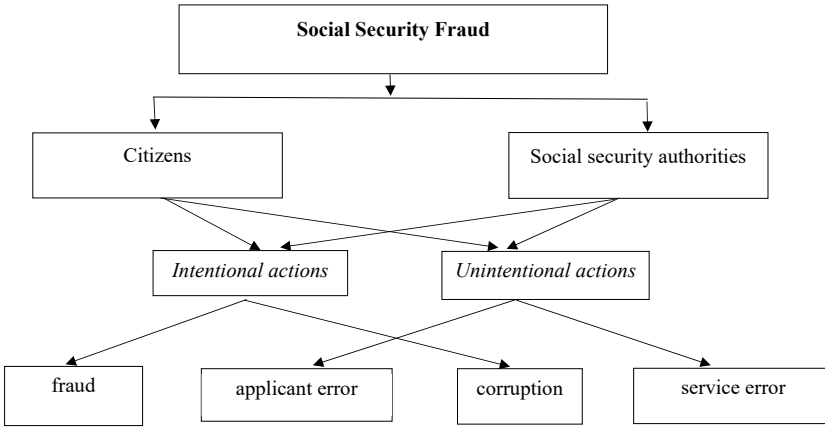


Figure 3. Understanding the essence of fraud in the system of social security of citizens

Source: compiled by the author based on [12; 13]

The latter are not intentional and can occur both on the part of beneficiaries and officials. They manifest themselves in the form of inaccurate submission of data or erroneous decisions on the assignment of payments. The main reasons for such situations are the complexity of social security procedures, as well as inadequate professional competence of staff.

Therefore, as can be seen from Fig. 3, it is important to clearly distinguish between fraud and corruption, taking into account possible errors on the part of both applicants and employees of authorized bodies. An error is considered as an unintentional submission of inaccurate or distorted information by the applicant, as well as the adoption by officials of decisions on the assignment of social benefits based on insufficiently substantiated or incorrect conclusions. At the same time, the improper accrual of benefits may be due to both individual factors and institutional features, in particular, the insufficient level of professional training of personnel, the complexity of regulatory and legal support and the multi-level nature of the social security system, which increases the likelihood of unintentional errors in the process of its functioning.

The main categories of fraudulent actions in the field of social security usually include:

1) the institutional complexity of the social security system, which creates the prerequisites for the simultaneous receipt of social benefits under different administrative or territorial social programs, and also contributes to the emergence of fraudulent practices due to excessive regulation of procedures, the complexity of regulatory requirements and the imperfection of mechanisms for verifying the identity of the recipient [6];

2) abuse of procedural mechanisms, which includes submitting multiple applications by citizens with the aim of illegally receiving assistance, incorrect or intentionally distorted interpretation of the criteria for assessing the financial situation of households, as well as the use of false information or schemes for manipulating identification information regarding persons who are assigned social benefits;

3) improper behaviour of applicants and recipients of social assistance, which is manifested in concealing real income, their deliberate understatement, as well as in concealing facts about changes in financial or family status that directly affect the right to receive relevant social benefits. The latter are not intentional and can occur both on the part of beneficiaries and officials. They manifest themselves in the form of inaccurate submission of data or erroneous decisions on the assignment of payments. The main reasons for such situations are the complexity of social security procedures, as well as inadequate professional competence of staff.

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In general, different types of social benefits are characterized by specific models of fraud risks, which necessitates a differentiated approach to the development and implementation of measures to counter such violations within the framework of the state social protection policy.

The domestic practice of the social security system is represented by the system of compulsory social insurance and the system of social protection.

Under compulsory social insurance, citizens have the right to receive material security and social services in connection with retirement, health (payment of temporary disability certificates and processing of payments for loss of working capacity due to disability), loss of employment, etc.

As for the social protection system, in Ukraine there is a significant number of social benefits and privileges: social assistance to low-income families, assistance to families with children, assistance to internally displaced persons, social assistance to orphans and disabled children, subsidies for reimbursement of housing and communal services, privileges for certain categories of citizens in accordance with current legislation, etc. As can be seen from the list of services and benefits provided by the state for certain categories of citizens, they are an effective tool of social policy and are subject to abuse by both service consumers and persons who prescribe them.

Despite significant amounts of state spending, the social support system in Ukraine is characterized by insufficient effectiveness. Data from annual sample household surveys conducted by the State Statistics Service indicate that a significant share of social transfers falls on households with higher incomes [14]. This situation indicates a low level of targeting of social assistance, which reduces its focus on the most vulnerable segments of the population.

A significant factor also remains the preservation of the system of benefits that are provided to certain categories of citizens without fully taking into account their financial situation, despite the gradual narrowing of their scope in recent years. At the same time, the lack of an integrated register of social assistance recipients significantly complicates determining their total number. Information about recipients is scattered and is formed within the framework of individual social protection programs, which reduces the level of transparency and limits the effectiveness of managing the social support system as a whole.

In modern social security systems of most countries, one of the pressing problems remains fraud by recipients of social benefits. The scale and intensity of such violations are determined by a set of factors, among which the leading role is played by the structure of social benefits and the conditions for their assignment, as well as the effectiveness of the mechanisms of initial verification when accessing the relevant programs.

An important element of combating abuse is the so-called input control, which includes a set of administrative and confirmatory procedures aimed at verifying the reliability of the information provided by the applicant. Its functional purpose is to establish compliance between the declared socio-economic status of a person and the actual conditions that determine the right to receive state assistance. Most social assistance programs are characterized by strengthening preventive approaches aimed at preventing abuse, which is implemented through the establishment of requirements for the submission of a significant number of supporting documents and the processing of applications for various types of social benefits, including pensions.

One of the effective procedural tools for assessing the legality of the assignment and receipt of social assistance is verification, the main purpose of which is to establish whether the recipient meets the specified legislative criteria, whether he has an actual right to the relevant payments, or whether the payments were assigned as a result of the submission of false information, errors or administrative inaccuracies. In a general sense, verification is an integral part of a broader system for combating fraud in the field of social security. At the same time, in the absence of a developed comprehensive control model, it can be implemented as a one-time verification procedure, which is carried out, for example, after the formation of a register of social assistance recipients or in cases where there are grounds for in-depth analysis.

Considerable attention within the verification procedures is paid to checking the targeted use of budget funds, in particular, confirmation that social payments are received by real persons who have legal grounds for them, and not by fraud subjects. A key element of effective verification is interdepartmental interaction and data exchange, which allows for a comprehensive assessment of the real property status and social status of the recipient. This includes checking the level of income and other characteristics that affect the right to receive social assistance. For this, both state information registers and data from private structures, in particular banking institutions, investment and insurance companies, are used.

According to the generalized results of international research, the implementation of social benefits verification procedures can provide a significant reserve for reducing budget expenditures, which in some

cases can reach 20–30% of the total amount of social sphere financing [15, p. 84]. At the same time, these indicators should be considered as extremely possible, since their achievement requires an appropriate level of institutional capacity and effectiveness of control mechanisms.

Practice shows that the greatest potential for savings is observed in those social security systems that are characterized by a low level of identification and personification of beneficiaries, as well as a complicated structure of administrative procedures [16]. Under such conditions, the likelihood of non-targeted or erroneous allocation of financial resources increases, which, in turn, opens up wider opportunities for their optimization by introducing comprehensive verification tools.

Regarding the effectiveness of the implementation of verification procedures in domestic practice since 2016, it should be noted that this government project did not bring significant results in saving funds from the State Budget [8]. This is explained by the lack of a systematic approach to solving the problem of fraud in receiving social assistance. One of the key obstacles that hindered the prompt implementation of verification mechanisms was the lack of a consolidated electronic register of recipients of social payments and benefits, which are financed from both the state and local budgets. The implementation of the verification project also revealed a serious problem of inadequate information interaction between various state bodies and institutions, the full exchange of information between which is hindered by the lack of a single universal identifier that would be used in all state registers.

The leading tool for detecting the misuse of social benefits is the activity of the social inspectorate. However, the activity of social inspectors in modern conditions has low effectiveness. One of the determining reasons for the low effectiveness of control measures is the organizational dependence of the controller himself, because he checks the activities of the institution to which he himself belongs. Among other factors, it is worth noting the insufficient level of digitalization, the lack of a risk-based selection system for conducting inspections, as well as the excessive burden on inspectors with additional functions. The vast majority of inspections focus on analysing the income of recipients, while the assessment of their property status is carried out to a limited extent. The practice of inspections at the place of residence is also widely used. A significant obstacle is the lack of

direct access of inspectors to state electronic databases, which forces them to send numerous requests to various institutions, which complicates the inspection process in time.

A problematic aspect in the work of social inspectors-controllers is that the mechanism for reimbursement of overpaid state funds is implemented exclusively through the courts. At the same time, the absence of penalties provided for by law for recipients of social benefits for submitting inaccurate information significantly reduces the preventive effect of the control system. Similarly, the imperfection of the mechanisms for holding employees of social security bodies accountable for possible corrupt actions negatively affects the level of institutional integrity in the field of social assistance.

CONCLUSIONS

A comparison of practices of different countries in building fraud prevention systems in the field of social security shows that achieving high performance is possible only if a holistic and multi-level risk management model is implemented. Such a model should provide not only for deterring unscrupulous behaviour of recipients of social benefits, but also for significantly reducing the number of errors that occur in the activities of bodies responsible for administering assistance. The key role in this is played by the integration of preventive, analytical and control tools that function as a single system. This includes, in particular, the implementation of mechanisms for early risk detection, automated data verification procedures, the establishment of effective information exchange between state institutions, as well as increasing the professional competence of employees involved in the process of assigning social benefits. We believe that the key elements of the system for combating fraudulent schemes should be:

– prevention of fraud – the introduction of effective control at the initial stage of considering applications for the assignment of social benefits; informing persons applying for social benefits about the possibility of being held administratively and criminally liable in the event of knowingly providing false information; improving the qualification level of social inspectors responsible for making decisions on the allocation of social assistance through their systematic education and professional training; carrying out systematic information and explanatory work among the

population to prevent fraud and highlight its legal and socio-economic consequences;

– identification of fraud facts – through integration, comparison and analytical processing of significant amounts of data on recipients of social assistance; conducting control measures, including checks on the material and living conditions of applicants and recipients of social benefits in accordance with clearly regulated procedures; joint control measures with other state bodies or institutions (tax service, banks, prosecutor's offices, etc.);

– curbing the level of fraud – applying a system of sanctions to violators, which provides not only for the return of illegally obtained funds, but also for the imposition of financial penalties in the form of fines; confiscation of overpayments; consideration of cases of financial fraud in court and bringing the guilty to justice;

– assessing the effectiveness of measures to combat fraud – continuous monitoring of the allocation of material support and social services to citizens; assessing the effectiveness of the implementation of control measures; comparative analysis of the amount of losses caused to the state from the detection of fraudulent schemes in the social security system to the amount of budget funds spent on the administration of mechanisms to combat abuses in this area.

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To implement an effective internal control system, in our opinion, it is necessary to follow a certain sequence of actions, namely:

1) investing in the digitalization of processes – the implementation of modern technologies such as AI and blockchain allows you to minimize the human factor and increase the accuracy of control [4];

2) continuous training of employees – staff must understand the importance of following procedures and be aware of new methods of preventing financial fraud;

3) modernization of internal control – updating rules and procedures in accordance with changes in legislation and the economy [17, p. 380-382];

4) implementation of internal and external audits – systematic inspections allow you to quickly identify problems and eliminate them in a timely manner.

Companies that invest in the development and maintenance of an effective internal control system not only reduce the risks of fraud, but also strengthen their positions in the market, increasing the trust in themselves from all stakeholders.

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