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An Assessment of the Stakeholders Perception of Reinsurance and Insurance Products and Services on the Performance of Insurance Companies

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ABSTRACT: *The primary purpose of this paper is to assess the stakeholder's perception of reinsurance and insurance products and services on the performance of insurance companies in Sierra Leone. The general objective of the study is to asses factors influencing performance of insurance industry in Sierra Leone, with the specific aim to identify variables impacting mode of operation in underwriting, claim and finance departments in insurance Companies in Sierra Leone. Both quantitative and qualitative approaches were used in this study. Quantitative results were used to assess the effect of insurance and reinsurance on the performance of insurance companies in Sierra Leone. The qualitative data was used to establish the relationship and magnitude between insurance and performance by explaining the results in the research. In conclusion, the study was able to identify that insurance programmes around the world are highly variable and differ with respect to products, modes of distribution, management capacity, institutional maturity and in numerous other ways. Also, the socioeconomic context and environment in which the insurance programmes evolved influence the development and performance of insurance companies. This diversity makes insurance performance comparisons difficult and sometimes artificial; therefore, a measure of caution should accompany every conclusion about relative performance as in the case of Sierra Leone.*

KEYWORDS: perception of insurance, insurance stakeholders, performance of insurance

INTRODUCTION

The insurance industry faces many difficulties. On the one hand, there are hundreds of insurance businesses with significant capitalization and funding that employ a sizable workforce, and on the other, there are a sizable population and corporate organizations that are protected by insurance benefits (Majmudar & Diwan, 2005). With the liberalization of the market following the adoption of laws within the insurance industry, the Sierra Leonean insurance market, which had previously been monopolized by the government-owned National Insurance Company (NIC), reached a turning point later in the 1990s. Years went by during which time the state retained ownership of 100% of NIC shares, allowing NIC to maintain its monopoly. As severe global economic changes continued, Sierra Leone decided to make significant reforms to its social, economic, and environmental programs (Duramany-Lakkoh, 2020). Economic developments had an impact on international trade, led to inflation, and worsened the quality of life for consumers. With the creation of the Sierra Leone National Insurance Commission, an insurance regime that was more liberalized came into being, and several private businesses were granted licenses.

Despite the government's good intentions in nationalizing the largest financial institutions, the lack of competition in the financial industry resulted in ineffective services, a lack of innovation, and the use of antiquated technology, all of which contributed to subpar service delivery. In essence, insurance is a contract in which one party agrees to hold another party, known as the insurer or cedant, harmless from any obligations that may arise from an insurance policy or contract. Hence, it is a risk management strategy used by insurance firms to protect themselves from monetary disasters that could result from the occurrence of an insured peril. As a result, the short-term insurance market can be seen as less matured and still in its early phases than the long-term insurance market. It also faces a variety of difficulties, including competition, high claims, volatility, and high reinsurance costs. Reinsurance is defined simply as "insurance for insurers" by (Baur & Breutel-O'Donoghue, 2004).

The necessity for a new type of insurance practice was now understood as a result of the quick development in social, economic, and policy domains. Early in the 20th century, modern insurance was introduced to Sierra Leone as a result of our association with European businesses. As the only completely established company in Sierra Leone, The National Insurance Company was the first insurance company to have a full branch office in regional headquarters. Three further businesses were listed. They are Reliance Insurance Trust Corporation, Aureole Insurance

Company Limited, and International Insurance Company Freetown. They were all British possessions.**Statement of the Problem**

The biggest difficulty facing the world's insurance business is still managing the insurance cycle. Human resources, government intrusion, sustaining agency revenue growth/profit, keeping a consistent firm strategy and tactics, and company consolidation are the "major difficulties" facing insurance agents and brokers today. These five issues might even keep brokers, agents, and insurance companies up at night. Insurance companies are under increasing pressure to increase profitability, which is correlated with their capacity for accurate risk assessment, relationship management, and attainment of operational efficiencies. A high degree of risk in underwriting makes it particularly vulnerable to misfortune, which could lead to frequent and significant outflows of compensated funds and, as a result, hurt performance.

Similar to how treating customers well and maintaining them boosts a business's credibility and overall performance, government's decisions have been made at a crucial time for the insurance industry in Africa, which is struggling because of a lack of competent labour. The minimum criteria in accordance with international norms is that banks should significantly contribute to the overall economic development of a nation (Daboh & Duramany-Lakkoh, 2023). For the benefit of the sector, industry stakeholders must recognize the gaps in the provision of insurance services and devise solutions to close them (Meghji, 2008). Insurance looks for ways to tackle the significant issues of fake insurance claims and insurance agent and practitioner misconduct (Sumaye, 1997). The company's operations are weakened by the settlement of a false claim, and profitability and growth are reduced. So, this study was carried out to identify the variables affecting the performance of the overall insurance industry.

The Objectives of the Study

The general objective of the study is to asses' factors influencing performance of insurance industry in Sierra Leone.

Specific Objective

The aim of the study is to attain the following objectives:

i. To identify variables impacting mode of operation in underwriting, claim and finance departments in Insurance Companies in Sierra Leone

Specific Research Questions

i. What variables impacting mode of operation in underwriting, Claim and finance in Insurance Companies in Sierra Leone?

Significant of the Study

In these days of proliferation of operations within insurance industry, many insurance companies sprang up without adequate preparation in the area of technical requirements required in the Insurance Regulations. To safeguard against this unfortunate situation, and more also to protect the insuring public, it is relevant at this junction to highlight the significance of insurance to the and also to analyse the type of insurance covers available and how seriously insurance covers are treated. In order to cushion the effect of financial heavy loss it is very necessary to enlighten the public the effect of insurance industry with particular reference to the benefit provided to the insurer, the insuring public and the nation at large.

Managers of insurance companies have to decide on the level of risk they want to expose the business to vis-à-vis the profitability of the firm. To ensure a potential risk comes with some implications on the books of the company including lower net premium after insurance premium is paid and lower underwriting profits leading to lower return on investment and growth in capital. However, minimizing insurance premium can also have negative consequences to the operations of the company, as risk levels are significantly exposed leading to lower profits and in some cases insolvency in the event of high claims by the insured.

Motivation of the Study

There is no denying that we are aware of the consequences of insurance on the insurance industry, but because of the technical nature of its operation, the general public is less informed. One of the fundamental issues that this paper will do, is to provide answers given by technical expertise in the operations of insurance companies. The paper will also assess how insurance operations has an impact on the way insurance business is generally practiced. Although it may be assumed that the motivation for this research is solely intellectual, the main goal of this paper is to emphasize the significance of insurance. One would be able to understand or have a clear understanding of what insurance entails and the need for insurance in the event of circumventing hazards by exploring the depth and breadth of the insurance profession. The study is also highly beneficial to individual investors who want to invest in insurance industry. It provides them with the pertinent advice, possibly the technical knowledge they require, as well as the dos and don'ts of the operations within the industry. In additions to the above, this paper will be useful to practitioners on the field. Brokers, Agent and Insurance companies will find this project worthwhile because they equally need it as a guide in their day to day running of their business.

LITERATURE REVIEW

Theoretical and Conceptual Framework of the study

Africa has long been familiar with the idea of insurance, and in particular, the "social insurance program" that addresses socio-economic issues (Duramany-Lakkoh, 2020), Community members came together to form a "social insurance fund" by pooling their resources. The "premiums" included everything from tangible goods to moral support to other in-kind donations. Drawings were made out of the money to help the few unfortunate members who were put in danger (Azevedo, 1993). Nonetheless, the historical emancipation of some countries in the continent is strongly tied to the history of the growth of commercial insurance (Throup, 1988). Additionally, the insurance was essentially a social investment where families in a single village would prepare drinks and invite other families to work together on diggings and grass cultivations for that particular farm until it was finished. This process continued for the entire village, and those who did not participate were left behind and were unable to receive assistance when it came to grass farming (Azevedo, 1993).

The question of insurable interest was explained by Mansfield (1807–1869) when he asked, "What was the interest of the red plaintiffs, the reinsurers in the ship?" Although the case involved facultative marine reinsurance, the principle would still hold true even if the subject of reinsurance was the ceding company's liability under the original policy, according to his argument, they had no ownership but did have an insurable interest in the loss they might or would suffer under an insurance policy, for which they themselves were liable. Hansell (1985) divided reinsurance into two categories. The first category is made up of professional reinsurance, whereas the second category consists of insurance firms that accept reinsurance business from other insurance firms on a facultative basis. The main purpose of insurance is to operate as a mechanism for risk transfer, which involves shifting a risk from the insured to the insurer. Although giving the risk to an insurer does not in and of itself guarantee against losses, it does give the insured some measure of financial stability and peace of mind. The insurer aims to make a year and must also pay the operational expenses for the insurance to ensure that each insured's premium is commensurate to the risk they add to the pool (Hansell, 1985).

Belle & Bramwell (2005) states that, agriculture dominates the structure of the majority of African economies, whereas food and beverage production is predominately driven by historical factors. Due to a lack of financial resources to implement structural transformation, some frameworks have not changed for decades (Duramany-Lakkoh, et. al., 2022). Financial institutions have rapidly expanded in countries like Tanzania since the Banking and Financial Institutions Act, which liberalized the financial sector, was passed in 1991. According to Wells and Stafford (1997), a robust insurance industry encourages financial stability in businesses and individuals and lessens

anxiety associated with suffering unanticipated losses or injuries by compensating policy holders in the event of adversity. Santomero and Babbel (1997) demonstrate that insurance gives people peace of mind and increases cost certainty by offering a mechanism through which losses may be shared and uncertainty can be decreased. The performance of the insurance industry, according to Lyaruu and Backéus (1999), can strengthen the security of farmers. Agricultural insurance can obtain credit, improve the farmer's credit risk, and lessen issues related to the need for collateral, which the farmer will have to provide. Bank will be compensated by insurance company if harvest fails. Farmers may have improved access to credit and insurance may be expanded to include the agricultural sector. Via financial institutions, insurance may aid in the commercialization of agriculture and the growth of the rural economy. Tira Report (2010) demonstrates that the insurance sector in countries like Tanzania is performing better than the country's overall GDP. Increased domestic savings, higher per capita income, and the availability of new platforms for investing surplus cash have all contributed to the expansion of the financial services industry. The rise in life insurance premiums is evidence of the increased risk appetite of savers.

Financial Performance of Insurance Companies

All organisations must have access to performance management information in order to operate efficiently (Kaplan & Norton, 1992); (McWilliams, 2009). Nonetheless, there is ongoing discussion over what defines good performance and good metrics of performance (Corrigan, 1998; Kaplan & Norton, 1998). (Maisel, 1992). For instance, given that some companies are negligent in analysing their operations (Kaplan & Atkinson, 1998), financial performance indicators can provide the required information for their operations in contexts that are categorized as crucial decision-making; (Armstrong, 2000). Is it crucial for companies dealing with demand shifts to make use of non-financial information? (Kaplan & Talbot, 1983). An organization's ability to make decisions in a business environment depends on its management, who in turn depend on the accessibility of useful information. Different stakeholders within a business place varying values on performance information. Owners and investors, for instance, are concerned with firm performance to make sure that their investment choices are sound and, if not, to explore for alternatives. Managers prioritize the use of resources by taking into account the performance of a company's divisions. (Lockamy & Cox, 1994); (DUURSEMA, 1999); (Tricker & Dockery, 1995). Performance assessment is viewed more strategically as a crucial tool for keeping a business on track in accomplishing its goals and as a monitoring tool used by the owners of a business where ownership and management are segregated. The business purpose and strategy of each particular organization play a significant role in defining performance, making this process fairly distinctive (Hoffectker & Goldenberg, 1994). However, for a lot of businesses, the key performance indicators usually consist of a mix of figures from two major categories: financial figures and non-financial figures (Barsky & Flick, 1999); (Brown & Mitchel, 1993). In this study uses both financial and non-financial measures to gauge management performance. The management performance will be used to determine the aspects that affect how well the insurance sector performs.

An empirical literature reviews

The effect of insurance and reinsurance on the solvency of primary insurers is very important to look at. Chen *et al,.* (2001) central assumption is that less solvent insurers tend to employ more reinsurance since they can't access the financial market to raise the necessary capital. The analysis included nine hundred eighty (980) property and liability insurance providers. The study finds that the use of reinsurance may serve as a risk indication for the insurer.

Cole and McCullough (2006) looked into the need for reinsurance among businesses in a similar study. The study's goal is to assess how the health of the global reinsurance market affects the demand for reinsurance among property and casualty insurance providers in the United States of America. The study's findings show that an insurer with larger profits has a tendency to rely less on reinsurance since they are better able to withstand financial pressures. The study's findings support the claims made by Graven and Tennant (2003) and Cole and McCullough (2006) that more profitable insurance businesses are better able to absorb significant unforeseen losses and are hence less likely to experience the underinvestment issue.

Mushafiq et al. (2021) set out to conduct a study with the goal of analyzing capitalization policy and its connection to risk-taking. The outcome supports their theoretical hypothesis and further emphasizes the strong correlation between the three essential variables—risk taking, capital, and reinsurance—underscoring the idea that these factors are interdependent. Several scholars have written studies that investigate whether reinsurance practice enhances or detracts from the performance of Pakistani non-life insurers. They contend that insurers should make an effort to lessen their reliance on reinsurance and their exposure to it, regardless of how financially sound or unstable they may be, because an increased reliance exposes them to the possibility of declining performance.

METHODOLOGY

In this study, both quantitative and qualitative methods were employed. The mixed methodological approach (Creswell, 2003), which combines qualitative and quantitative design, has a strong foundation in social science and philosophical literature. The descriptive findings from Sierra Leone were analyzed using the qualitative approach. The impact of insurance and reinsurance on the performance of insurance companies in Sierra Leone was evaluated using quantitative findings. By elaborating on the findings in the research design described later in this section, the qualitative data was used to determine the nature and extent of the relationship between insurance, reinsurance, and performance. On the other hand, our research technique uses quantitative data, with the data made up of and narratives to help explain how variations in different financial factors might be connected to problems with insurance performance policies. In order to shed light on the financial relationship between insurance and reinsurance policy on performance and other variables, the quantitative methodology used a descriptive statistics approach.

Research Design

The study was designed to begin with an extensive examination of the relevant literature, which covered both a general overview of the subject and particular study components that supported the study's findings. The purpose of the study is to determine how insurance and reinsurance policies affected Sierra Leone's insurance industry's performance. To address the study issue posed in the research objectives and questions, quantitative data were used. The five-year period from 2016 to 2020 was covered by the annual time series data used in the study. The questionnaire, focus group discussions, and descriptive statistical methodology framework were used to estimate and analyze the acquired data.

Research Population and Sample.

Senior management, department heads, workers, insured and uninsured, insurance brokers, and insurance agencies from particular insurance companies in Sierra Leone made up the study's targeted audience. With a targeted audience of around 128 significant workers and clients, data for all the variables employed in this particular study, however, respondents were only available from five (5) big insurance companies in Sierra Leone. Table 1 below displays the population and sample data.

Table 1. Date of population and sample

Research item	Population	Sample	% of Population
Insurance Companies	8	5	
Despondence			
Senior Management	56	22	39%
Other Middle Level Staff	64	18	28%
Total	128	40	31%

Source: Researchers' date (2022)

Due to their scale and financial activity, National Insurance Company, Aureol Insurance Company, Ritcrop Insurance Company, International Insurance Company, and Transworld Insurance Company were included in the sample. The study also conducted a second interview with 34 more respondents, 20 of whom were specifically chosen from insurance experts linked to insurance firms and 14 others specifically chosen from academic and professional organizations. This is also done to ensure that the study's opinion is balanced.

The Key Financial Performance Indicators

Creating a realistic picture of a insurance program's overall performance in important areas is the fundamental objective of using performance indicators. This implies that indicators should be calculated from the sum of the data from all partners, even when there are several partners engaged. Since the indicators are viewed from the perspective of the entire program, they can be applied to

all organizational models and types, although not always to all products. This will become clearer when specific performance metrics are discussed, along with a brief discussion of some interpretation concerns that relate to various goods. The 10 key indicators' measured in this study, emphasis is on financial viability, but when viability is absent, their social performance dimension becomes apparent and is seen as the main goal rather than one of the prerequisites for offering effective insurance products. Table 2. below outlined the important performance indicators into four performance areas, but they are not presented in any particular hierarchy.

It is important to recognize how interconnected and dependent many of the indicators are on one another. A program with a high percentage of incurred expenses, for instance, will mathematically (and directly) lower net revenue. A high expense ratio typically indicates inefficiency and poor value, which will eventually lower market satisfaction if it is not remedied. These consequences are longer term and indirect. Lower values of all three variables in the domain of awareness and satisfaction will be a manifestation of lower market satisfaction. In table 2 below, the financial performance ratios are displayed.

Table 2: Financial Performance Rations

CATEGORY	INDICATOR	DETAILS	FORMULAR
Product Value	**Incurred expense ratio**	How efficient is the delivery of microinsurance?	Incurred expenses n / Earned premium n
	Incurred claims ratio	How valuable is microinsurance to the insured?	Incurred claims n / Earned premium
	Net income ratio	Is the microinsurance product or programme viable	Net income n / Earned premium
Product Awareness and Satisfaction	**Renewal ratio**	How satisfied is the insured?	Number of renewals n / Number of potential renewals
	Coverage ratio	How well does the product meet the true need?	Number of active insured n / Target population n
	Growth ratio	How well developed is insurance awareness? How competitive is the product vis-à-vis other products or household risk management alternatives?	(Number of insured n – Number of insured n-1) / Number of insured n-1
Service Quality	**Promptness of claims settlement**	How responsive is the service? How well does product fit the insured's needs?	Rather than using a simple arithmetic average (which is also useful), the indicator is defined in terms of a schedule

	Claims rejection ratio	How well does the insured understand the product?	Number of claims rejected / Number of claims in the sample
Financial Prudence	**Solvency ratio**	What is the insurer's ability to meet future obligations?	Admitted assets n / Liabilities
	Liquidity ratio	How readily can the insurer meet its short-term expense and claim obligations?	Available cash or cash equivalents n / Short-term payables

Data Sources

Both primary and secondary data gathering techniques were used to obtain sufficient evidence for the study. To gather first-hand information pertinent to the research, personal interviews were used as the major data sourcing approach. They comprise data gleaned from individual interviews and focus groups. Focused group discussions allow experts, professionals, and practitioners in Sierra Leone's economics, finance, and accounting fields to contribute. This section is important to the study because it contains information that was provided to professionals who provided educated responses based on their expertise.

Presentation and Analysis of Results

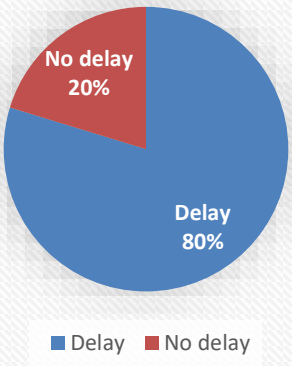
Scope of Service Rendered by Insurance Companies in Sierra Leone

The insurance policy outlines the steps that the insured must take, beginning with the notification of the claim. The insurance provider requires a claim form to be filled out completely, including all relevant information about the risk insured and the incident that caused the loss. The insured will be required to provide evidence that the claim is valid and covered by the terms of the policy, which the insurer will attempt to confirm, if necessary, with the help of a surveyor. The claim will be settled as soon as the insurer is certain that the loss is protected by the policy. If the claim-related policy is reinsured, the insurer will have paid the policyholder for the claim, which will have an impact on a recovery from the re insurer in accordance with the reinsurance agreement's conditions. The information gathered is intended to be used to investigate the claim department's operating procedures and how they affect business performance. The information on how the claim departments of certain insurance firms in Sierra Leone operate is presented in Figure 1 below. The study found that there was no delay in registering a claim, providing evidence of coverage, or notifying authorities of an accident.

based on corporate policies. "All new claims must be accepted within a fair amount of working days, and the customer or intermediary must be informed of the next steps. Within two (2) working days of receiving notified, new claims must be filed. As long as the claim is legitimate and the premium has been paid, the assessor or adjuster shall be informed within two (2) working days of

notification. Findings indicate that out of 74 respondents, 59 (80%) reported there was no delay in premium confirmation, whereas 15 (20%) indicated there was a delay in determining whether the premium had been paid or not.

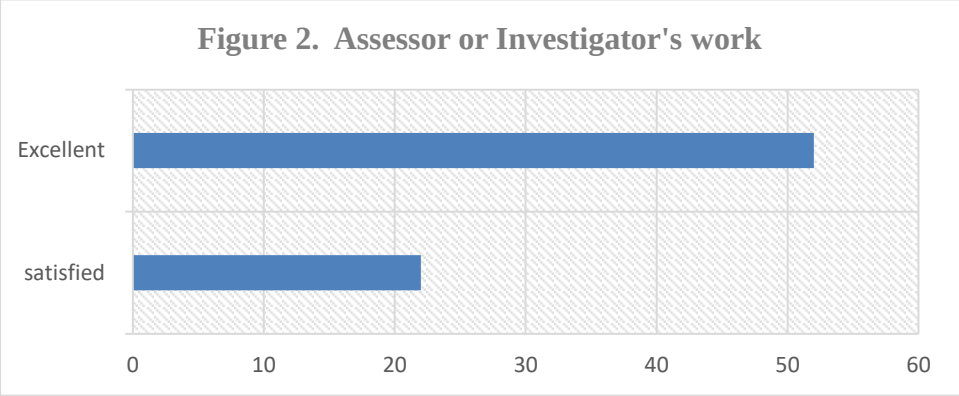
Figure 1. Confirmation of premium



Source: Researchers Survey 2022

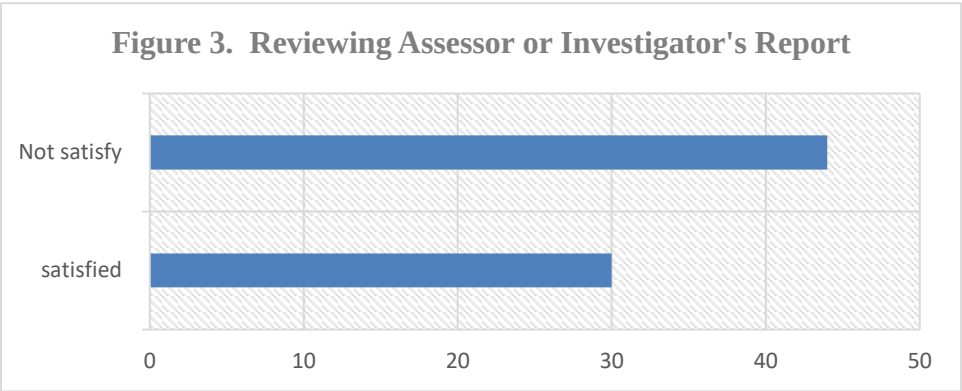
The current study discovered that brokers, agencies, or direct clients who did not disclose clear information regarding payment caused the delay in premium confirmation. In order to prevent this, the company made sure that every premium-related receipt included detailed information about what the customer was paying for. Moreover, intermediaries and insured for failing to pay premium on time or pay after accident which affected paying claim on time created delay in confirmation. Additionally, according to company policy, no claim could be paid out if the premium was not paid or if it was paid after the accident. According to the study, this policy encouraged insureds and intermediaries to make on-time premium payments and decreased delays in timely claim settlement. The advantage to the business was to reduced solvency and increase of liquidity.

According to Figure 2 results, out of 74 respondents, 22 (30%) were happy with the work of the assessor or investigator, and 52 (70%) thought the appointment of the assessor within 48 hours was outstanding. Respondents claimed that the issue was getting the assessor or investigator report, and that after getting the report, it could take up to 12 weeks to get the discharge voucher (DV), yet once the DV was signed, a check was timely and equitably sent. The study also showed that assessors or investigators occasionally produced reports that were ambiguous regarding the amount of money that had to be paid to the insured and rejected genuine claims.



Source: Researchers Survey 2022

Sometimes, despite having a valid claim, the insured failed to submit all the necessary paperwork, including police reports, claim forms, repair estimates, and replacement quotes, which resulted in the insurance company delaying payment. From the 74 respondents, 30 (41%) indicated that management was doing a good job of evaluating the assessor report, as shown in Figure 3 below. On the other hand, 74 respondents, 44 (59%) expressed dissatisfaction with the management's decision-making process, which took 8 weeks to complete and was unfair to the person who suffered damage.



Researchers Survey 2022

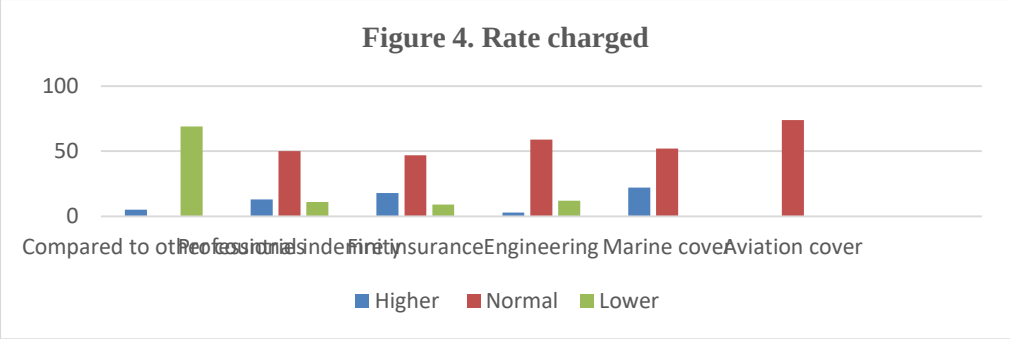
The management demonstrated that the reason for decision-making delays was a lack of information from the insured, assessors, or investigators. An organization's ability to make decisions in a business environment depends on its managers, who in turn depend on the accessibility of useful information. Different stakeholders within a firm have varied needs for performance information by (Duramany-Lakkoh, Measuring Financial Performance for the Sustainability of Microfinance Institutions in Sierra Leone before the Ebola Outbreak, 2021).

In some instances, the insured and intermediaries failed to pay premiums on time, delayed or failed to submit the necessary claim documents on time, reported fictitious claims, paid premium after claims, and lacked sufficient insurance knowledge, which delayed the timely settlement of claims, according to the study. This resulted in higher costs for the business, a decrease in underwriting profit, and an impact on how the business operated. This study discovered that it was challenging for insurance firms to resolve claims as quickly as possible so that their clients could carry on with their operations in a hostile business climate when fraudulent claimants were present.

Delays resulted from the requirement to carefully examine each claim. For instance, between January 1997 and June 1997, the firm's inspectors received about 50 claims for reassessment amounts that were later determined to be false. Individuals were using a number of filthy techniques and games to defraud the government and insurance companies of their money.

Discussion on Variables Impacting Mode of Operation in Finance Department

To determine how well the finance department performs in the insurance sector, it is critical to understand how it operates. According to the report, those surveyed agreed that the finance departments were doing a good job of investing the premiums that were received from intermediaries and insured. The survey also showed that finance departments were struggling with their solvency and liquidity ratios as a result of the insurance market's credit-based insurance service delivery model. The insurance rate is one of the factors used to calculate the premium, or amount, that will be charged for a specific level of insurance coverage. It is unlikely that anyone will purchase insurance, even if it is offered, if the likelihood of an insured event is so high or the cost of an insured occurrence is so high relative to the level of protection provided. Figure 4 presented the Premium charged by Insurance Companies in Sierra Leone. Findings show that out of 90 respondents, 69 (77%) felt that the price for car insurance was low in comparison to prices in other nations, while 5 (5%) answered that the price for motor insurance was excessive.



Source: Researchers Survey 2022

The study found that out of 74 respondents, 11 (14.8%) agreed that the rate was low, 13 (17.57%) complained that the rate was excessive, and 50 (67.57%) indicated that the rate was normal. Examples of miscellaneous cover include profession indemnity, burglary, money in transit, good in transit, all risk, etc. About Fire, 74 respondents expressed their opinions in the following ways: 9 (12.16%) thought the rate was low, 18 (24.32%) thought it was excessive, and 47 (63.51%) thought it was typical. Out of the 74 respondents, 12 (16.22%) of those who responded about engineering claimed the rate was low, but 3 (4.05%) of those who responded about engineering complained that the rate was high, and 59 (79.73%) of those who responded agreed that the rate was normal. Regarding marine coverage, 52 (70.27%) of the 74 respondents agreed that the rate was reasonable, compared to 22 (29.73%) of the respondents who complained that the rate was too high. All 74 (100%) respondents agreed that the rate charged for aviation insurance was reasonable. In Sierra Leone, insurance pricing generally appeared to be based on a practice known as cash flow underwriting. Particularly, for Motor, some of the premium prices given were incredibly inexpensive when compared to market rates. According to the study, the majority of respondents who claimed that insurance companies offer low rates were brokers and agencies, while those who claimed that rates are excessive were insured.

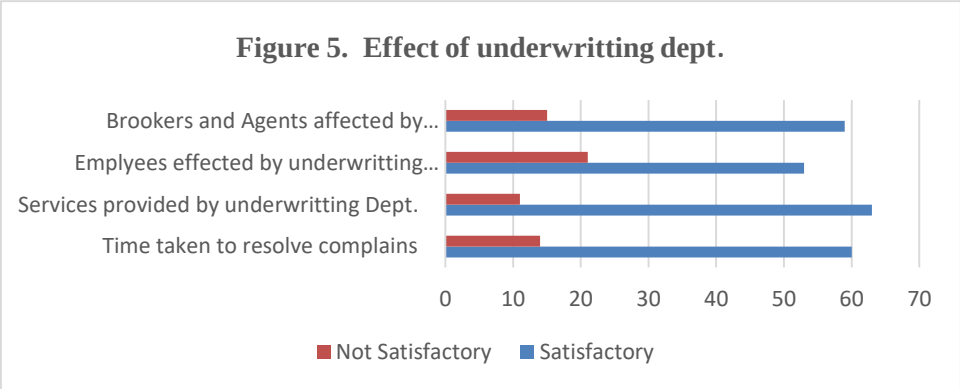
The results show that the premium for auto insurance is charged at a low cost, while the premium for the other variables, including marine and aviation, is substantially normal.

Discussion on Variables Impacting Performance in Service Rendered by Insurance Companies in Sierra Leone

Evaluation of risks (of the insured and the insurance business), estimation of losses, market identification, and risk assessment are four crucial tasks that affect an insurance company's performance. Market penetration and exploitation, as well as investment and operating cost management. Sustainable development and economic viability were the primary performance indicators. After these are accomplished, the company's goals may shift to long-term profitability, growth and expansion, market share, and diversification. Each of these phases calls for planning. The managers' and other employees' personal interests may not line up with those of the company, which makes it difficult to accomplish the organization's objectives. The performance of the corporation was impacted by a number of factors. Several of these came from sources outside the organizations (referred to as environmental factors, and some were internal). Customer, competitor, regulatory, and political conditions made up the environment. The insurance company's front-line management regularly updated its external environment with some of it strategies.

To develop a strategy, it was necessary to identify the prospective insurance market and contrast it with the internal effectiveness of the business. These reasons led to the study's investigation of the variables influencing the performance of insurance providers in Sierra Leone. The study

discovered that the performance of the organizations was impacted by variables that affected performance in the departments of underwriting, claims, and finance and administration.



Source: Researchers Survey 2022

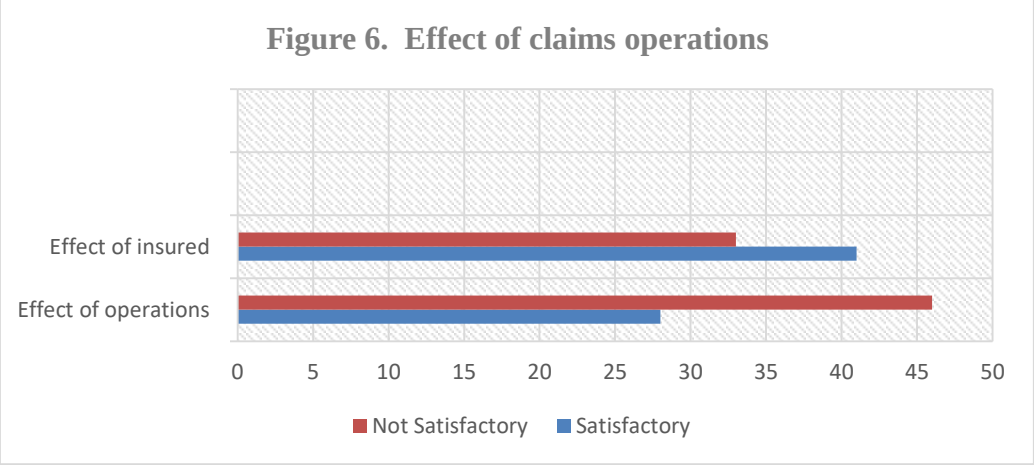
Figure 5 results show that, of the 74 respondents surveyed, 60 (81.1%) said that the time taken by insurance companies in Sierra Leone to provide service and to resolve complaints to their clients in the underwriting department was not affecting the performance of the company because in most cases within 48 hours a client could be served and his or her complaints could be resolved very excellently, while 14 (18.9%) of the respondents said that time taken to provide service and resolve complaints to clients was having a negative impact on the company's performance. This was occasionally brought on by delays in the issuance of policy documents and delays of one to three weeks in the delivery of renewal notes to their clients for renewing their policies, both of which led to a loss of customers and underwriting premium for the company.

According to results, 63 respondents (85.1%) were happy with the underwriting department's quality of services (e.g., timely receipt of renewal notices, acceptance of risk, documentation, cancellation of policies, reasonably priced premiums, prompt claim settlements, and good customer service), while 11 respondents (14.9%) were dissatisfied. This was brought about by personnel failing to deliver policy documents to clients in a timely manner; as a result, the underwriting department needs to speed up paperwork turnaround. User-friendly policy design is essential. The information from Figure 5. above revealed that out of 74 respondents, 53 (71.6%) indicated that employees from insurance companies in Sierra Leone were not adversely affecting underwriting performance, while 21 (28.4%) of the respondents showed that underwriting performance was negatively impacted. Other respondents said that the company must customize the policy documentation to reflect and accommodate the expectations of an ordinary client as most of them had no legal knowledge to interpret the documents. This resulted from their employees' lack of desire, lack of upward and downward communication, failure to visit brokers, lack of employee, agency, and corporate client training. In addition, the study found that underwriters insured things obtained directly from clients and through intermediaries without

choosing risks, which ultimately resulted in losses for the organization in terms of claims (no selection of risk to insure). The survey also found that underwriters were underwriting blindly in order to fulfil their assigned target and budget. They consequently increased the company's running costs, claims costs, and premium income. They also decreased the company's income from claims. Results from 74 respondents, 59 (79.7%) agreed that brokers and agencies did not negatively affect the underwriting performance. Yet, only 15 of the respondents (20.3%) claimed that brokers and agencies had an impact on underwriting performance. This resulted from the company's inability to adequately represent itself to its insured. Some brokers had a small staff of insurance professionals.

Discussion on Variables Impacting Service Rendered of Insurance Companies in Sierra Leone in Claim Department

According to data from Figure 6, just 28 (37.8%) of the 74 respondents thought the assessors and investigators did a good job running the insurance company, while 46 (62.2%) of the 74 respondents were dissatisfied with their performance. This is due to claim reports that were delayed in sending to management for decision-making by assessors or investigators. Also, respondents stated that assessors or investigators occasionally produced inaccurate reports, which led the business to deny claims that were unfair. Internal assessors were used by management to address these issues.



Source: Researchers Survey 2022

However, the study discovered that there was a delay in delivering claim reports due to an increase in claims after using internal assessors. The management has observed that there have been noticeably more claims as a result of greater infidelity by all stakeholders. The management was considering the potential of developing a motor servicing center where all damaged vehicles would

be towed following accidents in order to address these issues. The motor evaluation team will run this center and will offer customers' damaged automobiles quotes right away. After that, garages will be asked to submit bids for fixing these vehicles based on the corporate estimates. In addition to taking care of damaged automobiles, the motor service center will also offer pre-insurance inspection services. According to Figure 6 findings, out of 74 respondents, 41 (55.4%) concurred that insured were having an impact on the claim department's operations. This resulted from failing to pay the premium on time, although 33 (44.6%) of the respondents of the survey claimed that insured had no bearing on the company's operational performance.

Results from Descriptive Statistics

PRODUCT VALUE

Incurred expense ratio

The earned premium for the same period divided by the period's incurred expenses yields the incurred expense ratio indication. The time frame can be an accounting term, such as a fiscal year. According to a 25 percent incurred expense ratio, 25 Leones in expenses are incurred for every 100 Leones in premium income within a particular accounting period.

Incurred expense ratio n = Incurred expenses n / Earned premium n

The total of expenses recognized for period *"n"* using accrual accounting systems is the amount of expenses that have been incurred. This sum should account for all actual costs incurred throughout the period, including commissions and frequently forgotten costs like equipment amortization, depreciation, and software development costs. Costs shouldn't be cut to account for grants or subsidies. It has also been noted that the actual expenses paid out over the same period may or may not match the expenses incurred during that period. Earned premium *n* is the total amount of premium earned as it was recorded for period "*n*" using accrual accounting techniques.

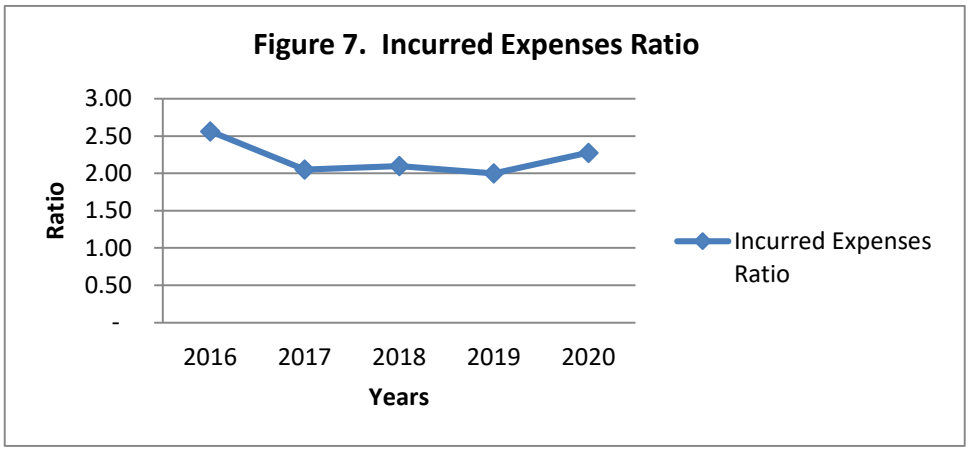
It is slightly different from cash premium minus change in unearned premium reserve on the profit and loss statement, where it equals premium income for the period. Also, if membership or policy costs are being collected, they are not included. It is significant to note that many insurers do not recognize claims settlement costs as an operating expense and instead include them in their claims cost. Such costs should still be accounted for when computing this indicator. Investment costs ought to be quantized as well as included in the factsheet, but this is not done to keep the tool's complexity low. The dates for expenses incurred and premiums generated for the insurance industry in Sierra Leone from 2016 to 2020 are displayed in Table 3 below.

Table 3. Incurred Expenses and Earned Premium from 2016 to 2020.

	2016	2017	2018	2019	2020
Incured expenses	13,250.00	16,662.00	18,626.00	21,016.00	24,405.00
Erned premium	33,979.00	34,179.00	39,078.00	42,030.00	55,560.00
Incurred Expenses Ratio	***2.56***	***2.05***	***2.10***	***2.00***	***2.28***

Source: Researchers Survey 2022

The graphics below serve as an example of costs incurred by the insurance sector between 2016 and 2020.



Source: Researchers Survey 2022

Figure 7. shows that the ratio of expenses to premiums decreased somewhat between 2016 and 2017, was flat for a while, and then began to increase once more. It should be observed that incurred costs reached their greatest level of Le 24,405.00 in 2020 compared to an earned premium of Le 55,560, which was likely caused by inflation and currency volatility.

Incurred claims ratio

The above-described incurred claims ratio indicator is calculated by dividing the total claims paid by insurance firms in a given period by the total premiums collected during that same period. The insurance firms' accounting period was employed in this instance. For every 100 in premiums earned during a particular accounting period, a 70 percent incurred claims ratio means that 70 of those premiums are returned to policyholders as benefits (claims).

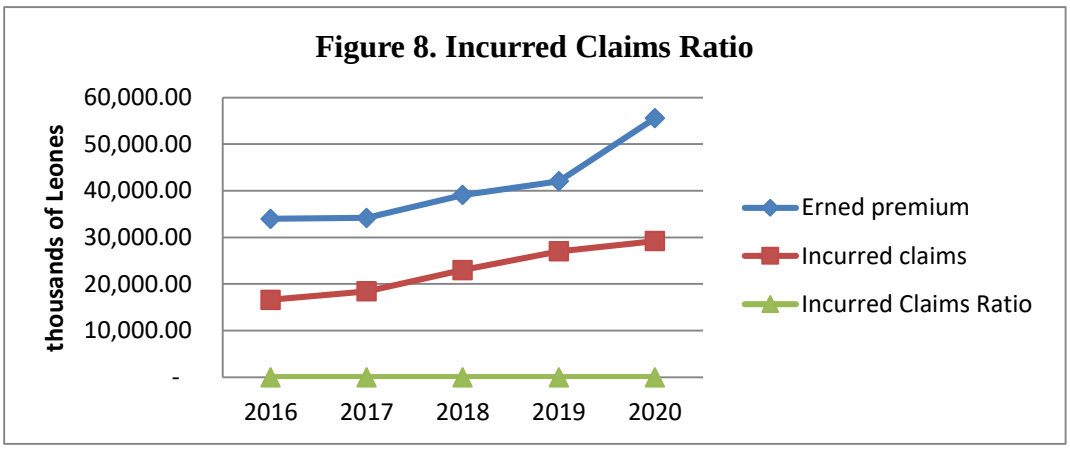
Incurred claims ratio n = Incurred claims n / Earned premium

Benefits paid throughout the period and the change in reserves are combined to form Incurred Claims. Earned premium *n* is the total amount of premium earned as it was recorded for period "*n*" using accrual accounting techniques. It is equivalent to premium income for the period less changes to the unearned premium reserve on the profit and loss statement. As previously noted, there are three different types of reserves to take into account. These reserves must be computed without reinsurance and then adjusted for it in the expenses part of the profit and loss statement.

Table 4. Showing Earned premium and Incurred Claims

	2016	2017	2018	2019	2020
Erned premium	33,979.00	34,179.00	39,078.00	42,030.00	55,560.00
Incurred claims	16,598.00	18,411.00	22,973.00	27,000.00	29,194.00
Incurred Claims Ratio	***0.49***	***0.54***	***0.59***	***0.64***	***0.53***

Source: Researchers Survey 2022



Source: Researchers Survey 2022

According to the data shown in Figure 8. above, earned premium, incurred claims, and incurred ratios are all displayed from 2016 to 2020. The incurred claims levelled down a little between 2019 and 2020, however both the earned premium and the incurred claims have been rising over the period. The incurred claims ratio, meanwhile, remained largely stable at 0.49 and 0.53, barely changing. This essentially means that claims paid out have been proportionate to premiums earned.

Net income ratio

The net income for a period is divided by the earned premium for that same period to calculate the net income ratio indicator. The time frame can be an accounting term, such as a fiscal year. A five percent net income ratio denotes a net income (profit) of five for every hundred in premiums earned

during the accounting period. In a similar manner, a negative five percent ratio denotes a loss of five premium dollars for every one premium dollar earned.

Net income ratio n = Net income n / Earned premium n

Operating income *n* in the period less claims expenses n in the period minus operating expenses *n* in the period = NET INCOME *n* during period "*n*" (prior to non-permanent subsidies and non-operational income and expenses).

Table 5. showing Net Income and Earned Premium

	2016	2017	2018	2019	2020
Net Income	12,687.00	14,627.00	14,386.00	14,717.00	37,256.00
Erned premium	33,979.00	34,179.00	39,078.00	42,030.00	55,560.00
	0.37	0.43	0.37	0.35	0.67

Source: Researchers' date (2022)

It is concerning because net income decreased from 0.43 in 2017 to 0.35 in 2019 and only slightly increased from 2016 to 2017. However the sudden increase from 0.35 in 2019 to 0.67 in 2020 has been a favourable sign of spending restraints and low claims pay-out.

PRODUCT AWARENESS AND SATISFACTION

Renewal ratio

The renewal ratio is the proportion of customers or members who renew their coverage to those who are eligible to do so for a specific period or sample. The renewal ratio calculates the percentage of insured people who continue to participate in the program after their coverage period has ended. If 90 out of 100 insured people renew their policies, only 10 do not, then the renewal ratio is 90%.

Renewal ratio n = Number of renewals n / Number of potential renewals n

The ratio must be computed for either a predetermined time period or a random sample. Since the majority of term insurance policies have a one-year coverage period, it is often measured during this time frame. The proper strategy is to follow a particular cohort or a randomly chosen sample drawn from the insured population at the start of the study period. The ratio can, of course, also be calculated for the full insured population. It's important to comprehend the subtleties of the term and avoid oversimplifying the math. 1500 people were actively insured at the start of 2019 according to the data from our analysis, 500 additional clients sign up for the program in 2020. The numbers of fatalities, dropouts, new participants, and people who reached the age of ineligibility throughout the year are shown in Table 6 below. In this illustration, all clients who

did not pass away or become ineligible owing to old age are regarded as potential renewals. The correct renewal ratio, according to Table 6, is 83.07 percent.

Table 6. Information on Renewal rate ratio

Description	Cohort 1 (existing clients)	Cohort 2 (new clients)	Total
umber that renewed cove rage during the year	end of year) + 10 (died after renewal) + 10 (reached max age after renewal)	n/a	12,020
Number of potential renewals	15,000 (initial) – 490 (became too old) – 40 (died before renewal	n/a	14,470
Renewal rate	12,020 / (15,000 – 490 - 40) = 0.8307	n/a	0.8307

Source: Researchers Survey 2022

Although tracking the reasons for non-renewal might be difficult in practice due to their wide variety, it is crucial to comprehend and document this information if at all possible. To ascertain the cause of non-renewal, some insurers perform a brief exit interview, although this can only be done if the insured is in contact at the time of exit. In the context of this study, it is important to keep an eye on the potential reasons for non-renewal. The database may have the code "unknown" for an insured who leaves for an unspecified cause.

Coverage ratio

The percentage of the target population taking part in the insurance program is known as the coverage ratio. Each insurance scheme covers a specific group of people, households, or assets. The percentage of the target market that the program is actively covering at any given time is known as the coverage ratio.

Coverage ratio n = Number of active insured n / Target population n

Since this is an all-inclusive number that can be used for member-owned schemes, group plans, and other forms of variants, it is utilized in the formula rather than "active policies." As long as the program's information is maintained, it is simple to calculate the number of active insured individuals. The number of insured participants was extensively monitored in this study automatically because it is an important management indicator in and of itself. While being more difficult to define, the target population *n* has been included in this study based on the data presented below. Relevance and explanation One of the most crucial conditions for the long-term viability of insurance is marketing and distribution efficacy.

Table 7. Target markets characteristics

Example	Participation	Target market definition
Clientele	Voluntary	The entire existing clientele.
	Compulsory	The target market of the client as defined in its business plan. This is usually a defined sector of the general public within a defined geographic area.
Community-based health insurance programme	Voluntary	Potentially, all eligible members in the community. However, only certain segments of the community may be eligible; these should be considered as the target market, not the entire community.
	Compulsory	
Individual endowment sold by an insurer	Voluntary	Potentially, all eligible members of the public. However, the insurer may only be targeting certain segments of the population or perhaps only a particular region; in these cases the target market can be more clearly defined and at least crudely quantified.

Source: Researchers Survey 2022

The efficacy of marketing is also greatly influenced by how satisfied customers are with the items and services they receive. Considered to be a major marker of marketing effectiveness is the coverage ratio. The target population in this study is the whole eligible clientele / membership of the insurance target market. These businesses typically have high levels of engagement; therefore, the coverage ratio is near to one (i.e. 100 percent). If that definition were to be applied, the indicator's value for evaluating marketing performance would decrease. A very low participation ratio typically causes higher-than-expected morbidity and mortality rates due to adverse selection in the absence of a screening mechanism. The ideal voluntary participation rate for a target group is a "high" proportion, as this signifies widespread support for the risk-pooling idea. Such a target audience is also probably knowledgeable about the product(s) and is aware of how to take advantage of the benefits.

Growth ratio

Thus, the growth ratio is referred to as the ratio of rising clientele. The growth ratio calculates how quickly the clientele is growing or shrinking. For every 100 clients in the prior year, a program with a 10% annual growth ratio adds 110 clients this year.

Growth ratio n = (Number of insured n – Number of insured n-1) / Number of insured n-1

The subscript "*n*" is only used as a marker to designate a specific period. Determine the number of active participants with valid coverage at the end of the relevant period (number of insured n) as well as the end of the preceding period to calculate the growth ratio for that period (that is number of insured n-1). An analogous algorithm can be applied to determine growth over multiple time

periods. For instance, the following is the definition of the formula for growth over the previous three periods, which include the current period:

Growth ratio n = (Number of insured n – Number of insured n-3) / Number of insured n-3

If the time period in question is one year, the growth ratio defined in the first formula is also the annual growth ratio. In this study, the increase is not being studied over a single year or over a number of years.

Table 8. Total renewing

Description	2016	2017	2018	2019	2020
Target population (insureds, end-of-year	35,000	45,000	55,000	70,000	75,000
Total insured (new and renewed), end-of-year	7,000	9,000	10,000	12,500	14,000
Total renewing		2,440	3,500	5,000	7,000

Source: Researchers Survey 2022

The growth ratio in 2016 is calculated as: Growth ratio 2016 = (Number of insured 2016 – Number of insured 2015) / Number of insured 2016 The growth ratio over the five years from 2016 - 2020 is:

Growth ratio 2016-2020 = (Number of insured 2020 – Number of insured 2016) / Number of insured 2016

= (75,000 – 35,000) / 35,000
= 1.1428 (114.28%%)

The average growth ratio over the years 2016 to 2020 is 114.28% / 5 = 22.26%. This is more than the compounded average yearly growth ratio, which is more beneficial but a little trickier to calculate because it calls for a little more mathematics and exponent use.

Compounded average annual growth ratio formula: number of insured n / Number of insured n-x = (1+g)x where n is the subscript for the final period, x is the number of periods over which growth is to be calculated, and g is the average compounded annual growth ratio. Using the same numbers as above, the annual growth ratio is calculated as follows: Step 1: Set up the equation: Number of insured 2020 / Number of insured 2016 = (1+g)3 → 75,000 / 35,000 = (1+g)3 Step 2: Solve for compounded annual growth ratio g: (75,000 / 35,000)1/5 = (1+g)5/5 → (75,000 / 35,000)1/5 – 1 = g Step 3: Evaluate: g = 0.428 (42.85% per annum)

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SERVICE QUALITY

Promptness of claims settlement

The promptness indicator is a quantitative analysis of the reporting and processing times for a group of claims. The indicator is determined for a group of claims that have undergone full processing, including being paid and denied. Time is calculated from the date the covered event occurs to the day the clients received the benefit(s) or refused them. Be aware that communication and notification to the claimant are still required when a claim benefit is denied;

Table 9. Total response time

No	Event	Reported	Settled	Received	Status	Time to Report	Time to Process	Time to deliver	Total time days
1	26-Dec	01-Jan	17-Jan	19-Jan	Paid	5	14	1	20
2	05-Feb	15-Feb	20-May	0	Danied	10	90	a/a	100
3	28-Feb	04-Mar	20-Apr	20-Apr	Paid	5	45	0	50
4	30-Mar	11-Apr	25-Apr	30-Apr	Paid	5	15	5	25
5	23-Apr	17-May	30-May	07-Jun	Paid	25	15	10	50
						10	**35.8**	**3.2**	**49**

Source: Researchers Survey 2022

Yet, the indicator does not provide a complete picture of claims processing. For instance, it does not account for the number of claims that are not filed because the claimant was discouraged by the extensive documentation requirements, was unaware of the process, was illiterate, or gave up. In other instances, the insured family reside in remote places, making it more expensive to go to the nearest servicing center and/or pursue claims than it would be beneficial to do so. When there is no provider in the insured person's area of health insurance, the motivation to use medical services and file a claim is significantly diminished. The data in table 9. provides a timetable of the amount of time needed to settle claims, which is dependent on the reporting, processing, and delivery times. This assessment, which included the months of December 2019 through April 2022, revealed that the average time it took insurance firms to resolve claims was 49 days.

Typically, clients of insurance need money almost immediately following the occurrence of an insured incident. They may be forced to turn to money lenders, sell profitable assets at a loss, or take other actions that negate the objective of providing the insurance product if there are severe delays; if this occurs, the program has failed to offer sufficient social safety.

Claims rejection ratio

The claims rejection ratio is the percentage of claims that have been refused (disqualified) from receiving benefits for a specific time period or unbiased sample. With a 10% claims rejection ratio, only 90% of the 100 reported claims receive benefit payments, while the remaining 10% are rejected.

Claims rejection ratio = Number of claims rejected / Number of claims in the sample

The number of claims ultimately denied from the set of all claims reported for the time is counted to compute the claims rejection ratio. When compared to claims promptness, the only information needed is whether the claim was paid or refused. Care was taken to make sure that each claim had been given careful consideration before being decided to pay or not. Because many rejected claims take longer to process because more supporting paperwork is needed or because further investigation is needed, it is likely biased to calculate the indicator for a claims sample that has not yet been fully processed. In accordance with this concept, partial rejections are not regarded as refused claims. These are cases where only a portion of the claimed benefit was actually paid and the rest was denied. Partial rejections in health insurance, for instance, are typically brought about by coverage restrictions and exclusions of particular goods like nutritional supplements, as well as by annual benefit caps and other factors. Monitoring partial rejections is a good idea as well because it enables you to see where more product knowledge and coverage are required.

DISCUSSION

Assuring that fund from premium income, interest income, investment maturities, etc. are (re)invested in the appropriate instruments that will generate interest income and mature in a pattern that is as closely synchronized as possible with the insurer's future obligations while maximizing investment returns is the main responsibility of investment management in insurance companies. The insurer may experience short-term liquidity issues if investments in insurance are overly focused in longer-term assets like real estate and long-term bonds. On the other side, excessive liquidity and missed investment opportunities will occur from having too much cash on hand or money invested in short-term securities. Lower benefits or greater premium ratios may be necessary with declining investment returns. A surplus of liquidity results in higher expenses or reduced benefits for clients due to weaker investment returns. Lack of liquidity may cause claims payments to be delayed and may even result in bankruptcy, which would be detrimental to clients who are most in need. Self-insured programs typically do a poor job of consistently managing their liquidity and do not base it on anticipated claims and expenses. Many people have excessive liquidity, in part because they struggle to identify acceptable investments and/or because they don't fully understand the ramifications.

Worldwide insurance programs vary greatly in terms of their goods, distribution methods, capability for management, institutional maturity, and a host of other factors. A program's growth and effectiveness are also influenced by the socioeconomic context and setting in which the insurance programs developed. Because of this variation, comparing the effectiveness of insurance programs can be challenging and perhaps arbitrary; as in the case of Sierra Leone, any generalizations regarding success should be taken with a grain of salt. Some of the concerns already brought up in this study need more clarification and empirical investigation. There are many various types of insurance products, and this study defines some of the key categories that have been produced. Each offers a sophisticated method of analysis performances. Many also offer extras like features that decide premiums and how claims are computed and processed. For instance, there are differences amongst life products in terms of duration, level and pattern of coverage, methods for paying premiums, underwriting standards, and a number of other factors. Most types of products can use many of the performance measures from this study. But there are a few outliers that should stand out.

CONCLUSION

The results might lead to a greater acceptability of insurance in Sierra Leonean society, which would strengthen the sector's ability to supply high-quality services and provide its citizens with protection against poverty. When insurance professionals consider and implement the recommendations of this research into their strategic business decisions to ensure growth and business sustainability, Sierra Leone communities may experience positive social change in the form of wealth and value creation, as well as socioeconomic infrastructural development. By enhancing businesses' financial capacity to manage their products and provide a steady income stream, this study may contribute to beneficial societal change. The following topics were identified in the study's findings: (a) service delivery quality; (b) public perception; (c) education and awareness raising; and (d) business growth and sustainability. Sierra Leoneans may be aware of the necessity for insurance as a component of financial management to achieve financial independence and minimize unfavorable life eventualities as a result of these themes encircling good transformation. This study will help the expansion and sustainability of the life insurance industry while also enhancing the quality of life for Sierra Leoneans who are eligible for insurance. The ability to create and implement customer satisfaction strategies for business growth and sustainability can be developed by leaders of insurance firms. Three significant challenges for action that might help all life insurance practitioners expand the life insurance industry were identified by the research's findings. These suggestions include improving service quality, developing trust and confidence, and increasing operational effectiveness.

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