Bridging the gap: Enhancing understanding of insurance contracts to minimize claims rejections

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A B S T R A C T

An investigation to balance the sustainability of insurance companies and successful claims on insurance policies is important towards the economy, as well as for assisting the insured during financial difficulties when their items are damaged or lost. This paper examines some rejected short-term insurances where a misunderstanding of the contract might have caused the insurer to lose out on the claim. Data were collected from cases of courts and insurers on rejected claims due to misunderstandings by the insured. The first test data set was a court case. The second was a graph on the root causes of claims rejections from the insurer. The third was a matrix data set presenting the languages of the insured. The insurers who had refused to pay insurer claims supplied the latter two. Despite the three contexts being widely different, their results show that rejections of claims by the insurers were due to the insured failing to understand the conditions of the contracts, and thus not being able to figure out what could have caused the rejection. Hence, the use of complicated and legal language in insurance contracts results in the insured not fully understanding the contract, which leads to claims being rejected. The paper recommends the use of simple language and pinpointing in layman's form, those aspects that could lead to rejections of claims.

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Introduction

Basically, insurance entails a way that people use to manage risk with valuable items that they own (Feng 2023). When a person buys insurance, they fundamentally purchase a form of protection against unexpected financial losses. The insurance company would pay the insured or the insured-chosen beneficiary if something bad happens to the insured. If one has no insurance and an accident happens, that person may be responsible for all the ensuing costs. Taking an insurance, therefore, provides the insured with peace of mind and expectations that if any injury could happen to their insured item, a worthy compensation would substitute the loss. Many vehicle-selling companies and the financiers of the vehicles being bought insist that the buyer must have an insurance cover for the vehicles they purchase.

Many new vehicle buyers view the choice of an insurance cover as simple, but experienced ones, especially those whose claims were rejected before, know that such a decision-making choice is complex (Pierce and Connolly 2023). In South Africa, it is standard practice that a vehicle that is purchased from a car dealer as new must have cover, usually a comprehensive one.

The condition is that the vehicle buyer cannot take the vehicle out of the building of the seller into the road until that vehicle has an insurance cover that stands in case the vehicle being bought gets into some accident. The seller allows the buyer to decide on the choice of insurance without intervention or interference (Shaheen and Cohen 2013). In some instances, however, the seller can
recommend reputable insurance companies based on their experiences and in an honest gesture, but others may recommend their friends to help them in their commission for increased salaries.

Conducting an inquiry into the equilibrium between the sustainability of insurance companies and the efficacy of insurance policy claims holds significance for both the economy and the provision of financial support to insured individuals in times of harm or loss to their belongings.

This study investigates instances of rejected short-term insurance policies in which a misinterpretation of the contractual agreement may have resulted in the insurer being deprived of the claim.

The study involved the collection of data from court cases and insurers pertaining to rejected claims resulting from misconceptions by the insured parties. The initial textual dataset consisted of a legal case. The second graph depicted the underlying factors contributing to the insurer's denial of claims. The third dataset consisted of a matrix that displayed the languages spoken by the insured individuals. The insurance companies that declined to compensate insurers provided the latter two. Although the three scenarios exhibit significant variations, their findings indicate that the insurers' rejections of claims were primarily attributed to the insured party's lack of comprehension regarding the contractual terms, thereby impeding their ability to ascertain the underlying reasons for the rejection.

Consequently, the utilisation of intricate and legal terminology within insurance agreements engenders a lack of comprehensive comprehension on the part of the insured, thereby resulting in the denial of claims. The study suggests employing straightforward language and identifying, in a manner that is easily understandable, the factors that may result in the dismissal of assertions.

**Literature Review**

Due to the costs involved in buying an insurance and affordability when these are added to the instalment on the vehicle purchase, the vehicle buyer would usually attempt to balance costs and benefits. However, there are often no guarantees on what the insured would get at the end when a loss on the vehicle is experienced because of having not envisioned a specific cause or condition of the loss. When a theft or accident has occurred to the vehicle, the insured must make a claim within strict guidelines, which sometimes could have been said in a casual form, not immediately emphasised to the insured until the rejection time (Mateen, Khalid, Lee et al. 2023). Sometimes, such conditions were not even heard since the conditions are usually read quickly, and they are quite many to process within the time given. From the experiences of the insurance companies, many insurance representatives are fully aware of this. However, what they prefer to do or change is to attract clients for insurance to safeguard earning of commission, but not more about the client.

Sheehan et al (2023) concur that vehicle insurance is bought to protect oneself from various future predicaments regarding the vehicle involved. Some of these aspects that an insurance policy can protect the insured from are the dangerous exposures of normal life, floods, bad roads such as potholed ones and fires to car accidents, including life-threatening illnesses (French and Kousky 2023). Insurance becomes vital because no one can stop a disaster from occurring despite fears that they may not pay when the time for making a claim arrives. However, some good insurance policies can offer financial coverage when these unexpected expenses are required.

The principal intention of taking an insurance is to reduce financial uncertainty and attempt to make accidental loss to be manageable (Gajadien, et al. 2023). It prepares this exchanging payment of a small, known fee, known as an insurance premium, to a professional insurer in exchange for the supposition of the risk of a huge loss, and a promise to pay in case of the occurrence of such a loss. Many insurance companies have experience with the specific causes of rejected claims, and the insured would usually be unaware of such rejections. These insurance companies do not lose, rather, they benefit financially when they reject a claim. Yet, many of them do not close the loopholes in their contracts to give insurance policies in good faith. Business profits and shrewdness, according to Dunn (2023), seem to be the order in the trade in insurance markets.

There are many instances where claims after an accident are rejected because of conditions that were not understood by the insured/client (Lidstone 2022). These only get pointed out to the supposed insured, who had been under the impression that he/she was insured, and which is only emphasised when the claim is rejected. This dejected insured, who had been under the impression that he/she was insured, gets to realise that the insurance company that pledged to insure her/him, had been taking money without verifying the conditions that they mentioned at the time of the claim. Sometimes the insurance argues on the basis that being ignorant of the law is not an excuse which could be taken into consideration on evaluating a claim, and insurers score financial benefits as the payments made by the rejected claim of that insurer is full (or 100%) profit, as the insured receives nothing back (England 2023; Silva and Siscoe 2023). When a vehicle gets into an accident and is written off, that is, it is adjudged to be not fit anymore to get back on the road, it is given an unusable/scrap status. Anything that the insured needs to do to revive such a vehicle requires additional amounts of money. Some of the vehicles are written off even when the insured is still paying instalments at the bank for the purchase of that vehicle. As a result, many people are former vehicle owners who still pay instalments for the vehicles that were written off. That is, they pay for a vehicle that is not there, and they still have to pay for another mode of transport that they use. The question of rejections of insurance claims, particularly those for vehicles, seems to be that the insured did not know what is covered and what is not covered, and the dynamics of the contracts that they signed to be insured.
Good faith: When short-term insurance contracts are signed, most of these contracts are sealed telephonically. The insurer reads the terms and conditions of the contract verbally, and the language of communication during the process is English (Talbot 2023). Yet, most of the insured are not English first language speakers. Whether the insured understood the terms and conditions, as well as the jargon used in the contract, generally remains to be seen when there is a need to make a claim. Even in cases where the policies are concluded/signed through traditional ways using paperwork, Fong (2023) hints that the main interest of most insurance representatives is on making a sale rather than on the insured understanding the conditions or being safe in terms of qualifying for a specific policy. Their target is, therefore, primarily to find a way to convince the applicant to commit to an insurance contract. Huneberg (2019) provides an overview of the insurance law in South Africa, and explains that the law in South Africa emphasises on the importance of ‘good faith’ being upheld in all insurance contracts. The duty of good faith holds that there is a duty on the insured and the insurer to disclose to each other, prior to the conclusion of the contract of the insurance, every fact relevant and material to the risk or the assessment of the premium (Huneberg 2019). When one investigates the duty of good faith, this entails both the insurer and the insured to ensure that all information provided is the utmost truth, and that all information that the insurer needs to know has been provided by the insured. Similarly, the insurer also needs to use due diligence to ensure that the insured has been informed of all the information that they need to know about the policy. This is done to avoid fraudulent claims as well as for the insured to be charged the correct premium based on their circumstances (Le Roux and Lewis 2019).

Given this background, Le Roux and Lewis (2019) argue that it is unfair to expect South African clients, considering the legacy of poor education as well as a lack of literacy, to have a good understanding of what it means to act in good faith when entering an insurance contract. The questions are whether it is just to expect an ordinary South African to properly comprehend materiality around his or her risk profile, even more so to understand what could be considered material by the insurer. In addressing these questions, it is important to note that fair treatment and good faith imply that the client has access to accurate information. Lovin (2011) emphasises that insurers should be clear about their contract terms, for example, the premiums that would be charged, how these will change over time and most importantly, under what conditions a claim could be declined. However, since insurance companies have it on paper that they will explain the terms and conditions of the insurance policy to the clients, Merlin (2020) insists that the insurance policy language is written in legalese, that is, what is practically covered and what is uncovered makes it practically impossible for a lay person to understand what is uncovered at all.

Having looked at good faith, most insurance companies blame clients for not acting in good faith by making fraudulent claims. For example, an insurer may pose an unclear question to the client that may lead the client to misrepresent information unintentionally (de Beer, Mostert and Mostert 2015). The Ombudsman for Short-Term Insurance (2019) explains that most insurance contracts are concluded telephonically, and in some instances, the questions that the insured is asked may not culminate in leading a consumer to misrepresent some information. A simple example that the Ombudsman for Short-Term Insurance (2019) points out is when a claim is rejected because the client did not disclose the colour of his eyes. The ombudsman emphasises that the client may have no knowledge of the different types of eye colour. Moreover, the client may not know where to categorise his eye colour. Therefore, the fact that the client failed to disclose such simple matters that are dependent on the cultural and linguistic background of the client should not be the basis for rejection. Thus, the client cannot be accused of failing to act in good faith during the underwriting of the insurance contract.

The discussion of good faith that is being required from both the insurance and the insured shows that fairness is vital (Baumann and Loi 2023). It requires full transparency and openness from the insurance company, with no hidden agenda or information while the insured should also disclose all the information that the insurance company requires honestly and comprehensively. Some ‘honest mistakes’ do happen from the insured, meaning that the lay insured may misrepresent some facts without knowing. On the other hand, sometimes the insurer seems to deliberately ‘create’ or find faults in the technicalities that are misunderstood by the vulnerable clients that they insure (Linhoff, Mußhoff and Parlasca 2023).

Language barriers in communication: The Ombudsman for Short-Term Insurance (2019) explains that language barriers, especially for first-time insurance consumers, lead to confusion and misunderstanding among consumers. The discourse used in insurance terms denotes certain meanings, but that does not mean that these terms are self-explanatory to the lay person (Merlin 2020). At the sales stage when the client is being provided with the necessary details about the contract, jargon such as ‘principal driver’, ‘regular driver’ and ‘nominated driver’ need to be explained in full to the client before a contract can be signed. De Beer et al. (2015) suggest that there is a need for clients to be educated about the insurance terms and conditions, as well as coverage of the insurance policy in simple and comprehensible language.

In cases where the English language is the client’s first language, the insurer has to ensure that the client is engaged in a language that they will understand. Occasionally, the questions asked to the client, especially when a disclosure is required, need to be asked with the client’s ability to comprehend the question in mind. In this regard, Merlin (2020) concurs with the Ombudsman for Short-Term Insurance (2019) that it is important not to rush through questions as the client may not fully comprehend the question being asked, and answers only a portion of the question, or provide an incorrect response. When claims are rejected due to a lack of good faith, it is important to note that sometimes the client may not have understood the questions that were being asked at the sales stage.

As mentioned earlier, most of the clients who apply for short-term insurance may be caught up in the misrepresentation of information unintentionally because the salesperson did not probe to find out more information about the client. Insurance companies need to
consider their client’s cultural and linguistic backgrounds that influence the way applicants respond to questions. According to Klíma, Růžička and Zima (1976), African language speakers are influenced by cultural standards inculcated in them. For example, the African culture teaches that when being asked a question, one must respond to what has been asked. Any further clarification should be probed. Similarly, it is important to keep in mind that customers’ perceptions, expectations and behaviours can differ significantly between various cultures and demographics (Kurtz 2014:173). As an illustration, the Ombudsman for Short-Term Insurance (2019) provides a scenario where a claim was rejected because the client misrepresented their claim history. However, when the office of the Ombudsman listened to the recorded conversation, they found out that the client was asked if they had submitted any claims in the past three years. The consumer responded with a “yes” and explained the last June incident. The insurance later found out that the client had had two other claims which had taken place in May and July respectively. The client pointed out that after giving the details of the June claim, the sales representative should have probed further regarding the previous claims.

Due to the influence that cultural aspects exert on communication and how language is used, it would be advisable for insurance companies to come up with questions that would allow clients to provide all the required information without undue possibility of being accused of misrepresenting information, which might result in claim rejection. In the case provided earlier on, the sales representative could have asked a direct question such as, How many claims have you had in the past three years? If the client had responded that they had one claim, then it would amount to misrepresentation and a lack of good faith.

**Technicality:** There are cases where a court case is lost on technicality, where the insured loses a claim case because of technicality (Randall, 2007). Wacks (2023) indicates that technicality refers to a point of law or a small detail of a set of rules, as opposed to the intent or purpose of the rules. Technicality never favours the client, as only the insurer has a readily available lawyer to ensure that their loopholes are closed, and only the cases of their client can be flawed to make them vulnerable. Moreover, the insurer has legal support onsite, to cover the back of the insurer when the insured has nothing to guard them. Even after years of court cases that favoured the insurer who won cases of the claims they had rejected, many insurers have not adapted their approaches to cover the aspect of technicality to protect the client. Hence, this makes the insurer strong against the insured, and also keeps the insured in a position of weakness. Therefore, technicality remains a communication weapon for the insurer for protection but leaves the insured vulnerable.

The paper concerns the effectiveness of vehicle insurance companies with regards to the claims that the insured make when their vehicles have been involved in accidents or stolen, or other damage that requires someone to compensate for the loss to the vehicle owner. Its purpose is therefore to investigate some rejected short-term insurance claims where misunderstandings may have occurred regarding the insurance contract by the insured, which might have also caused the insurer to lose out on the claim. It is important to note that this paper’s main focus is rejected claims that may be caused by a lack of good faith caused by the insurer’s failure to use discourse that is clear and understandable to the insured. Language barrier is one of the major causes of claim rejections in South Africa.

**Research and Methodology**

The methodology was based on case studies that served as data to evidence the loopholes in the communication. The first one was a recent court case presented in TopAuto (2023). Data was obtained from one of the big insurance companies in South Africa. One of the authors is employed by the company and permission to use the company data was granted on condition that the company name is not mentioned in the paper. In order to honor the request and protect the identity of the insurance companies used in this research, pseudonyms have been used. Abzubby is the pseudonym that was given to the big insurance company which supplied the second case through a graph demonstrating the loopholes in communication. The third one is based on the outcome from yet another insurance company (pseudonym: INSPIRA), which provided the data but with the condition that their actual identity should not be revealed. The names of the insurers and the insured are therefore withheld for ethical reasons, as anonymity and confidentiality are honoured in this study, and only the details needed for the paper are provided.

**Results**

**Case 1: TopAuto**

TopAuto describes the court case that took place from 2018 between an insurer who had initially rejected a claim against an insured, who took the insurer to court. The case involved a car that was stolen on 22 January 2018. The case was resolved in July 2023, which was a five-year marathon case, thus compromising the insured due to bad faith.

When the claim was submitted in January 2018, the insurer had adjudged the details of the incident of car theft as being inconsistent and then rejected to honour the claim based on the discrepancies shown.

It came out also that the insurer has “...the long-established principles of interpretation of clauses that seek to limit the liability of the insurer” (TopAuto, 2023:3), which was explained by a legal representative of the complainant.

Moreover, while the insurer made a big deal by rejecting the claim, the discrepancies were also found to be negligible, which came after a lengthy legal analysis.
Case 2: Abzubby

The figure above presents the root causes of insurance claims in Abzubby. Relative to the notable causes, most of the causes seem to occur at very low rates. Overwhelming outliers that show extremeness in the causes of claim rejections when insurers are expected to honour the submitted claims are, lack of understanding, and difference of opinion. Coincidentally, these two causes are both related to language, or communication. They are discussed separately below.

**Lack of understanding**: Lacking an understanding means that hearing the information has occurred, but the message was interpreted differently, or misinterpreted. The insurance has said its conditions, and the insurer signed to accept the conditions with the belief that they were able to interpret the message as intended by the insurer. It is surprising that on this aspect, there is an indication that the company error is very minor as compared to the customer’s failing to understand. Therefore, it implies that the customer is at fault in this aspect, even though the misunderstood message was generated by the insurer.

**Difference of opinion**: The difference of opinion is also very notable from the graph, as the second longest bar. It challenges the lack of understanding to about half. For the difference of opinion to be acknowledged, it means the parties are in communication, but do not understand the message the same way. This is a communication gap. In the graph, there is also a company error associated with the difference of opinion, though smaller.

Case 3: Hypotheses Tests

This section investigates the claims that several short-term insurance claims were rejected in South Africa. It seems that some insured clients did not fully understand the terms and conditions of their contracts given that one of the main reasons for failure to understand is due to language barrier between the language used by the insurer and that the insured understands using hypothesis test.

**Test of hypothesis 1**: The first hypothesis focuses on language in understanding the conditions of the contract. The null and alternative hypotheses are:

\[ H_0: \] Native language has no significant impact on clients to fully understand the terms and conditions of their contract.

\[ H_a: \] Native language has a significant impact on clients to fully understand the terms and conditions of their contract.

Level of significance: \( \alpha = 0.05 \)

\[ p-value = 4.527 \times 10^{-23} \]

**Test verdict**: Given the above results, the null hypotheses should be rejected. Under the 95\% level of confidence, native language has a significant impact on clients to fully understand the terms and conditions of their contract.

The data matrix is given as follows:

<table>
<thead>
<tr>
<th>Language</th>
<th>Company Error</th>
<th>Customer</th>
<th>Total</th>
<th>P (Company Error)</th>
<th>P(Customer)</th>
<th>P (Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>10</td>
<td>80</td>
<td>90</td>
<td>4.6%</td>
<td>37%</td>
<td>42%</td>
</tr>
<tr>
<td>Afrikaans</td>
<td>6</td>
<td>31</td>
<td>37</td>
<td>3%</td>
<td>14%</td>
<td>17%</td>
</tr>
<tr>
<td>English</td>
<td>9</td>
<td>41</td>
<td>50</td>
<td>4%</td>
<td>19%</td>
<td>23%</td>
</tr>
<tr>
<td>French</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>0.5%</td>
<td>1.8%</td>
<td>2.3%</td>
</tr>
<tr>
<td>German</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>0.2%</td>
<td>4.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Hindi</td>
<td>1</td>
<td>21</td>
<td>22</td>
<td>0.3%</td>
<td>9.7%</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>186</td>
<td>217</td>
<td>14%</td>
<td>86%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Test of hypothesis 2: The second hypothesis focuses on the impact of language in claims rejections. The null and alternative hypotheses are given as:

\[ H_0: \text{Native language has no significant impact on the root cause of claims being rejected.} \]

\[ H_1: \text{Native language has a significant impact on the root cause of claims being rejected.} \]

Level of significance: \( \alpha = 0.05 \)

\[ p\text{-value} = 1.59 \times 10^{-58} \]

Test verdict: The above conditions of the test lead to the rejection of the null hypotheses. Under the 95% level of confidence, native language has a significant impact on the root cause of claims being rejected.

Both tests attest to the suspicion that language is a significant cause or factor leading to claims of payment being rejected when the stage of the insured to be compensated arrives.

Discussion

In the first case, the insurer may consider minor deviation that is common in daily living as negligible (or legibly small divisions). The discrepancies that the insurer claimed were there, that is, significant, which the insured disputed based on insignificance, came out to show that the insured was correct. There is also an indication of long-established principles of interpretation of clauses. Apparently, this principle was made to limit the liability of the insurer. If this is the case, then the insurance policies may be traps prepared to catch the insured. It, therefore, seeks to maximise the contribution from the insured.

The second case highlights the customer's lack of understanding the message that the insurer has projected, and also the difference in comprehending the message from the insurer. In the two aspects in this case, the company, or insurer, is said to have a slight error. It seems that while the insurer generates the message intended for the insured and the insured finds it difficult to understand it or interpret it as intended, the fault is not attributed to the insurer.

The case of Abzubby shows that the language that insurers use when selling their insurance policies is not fully comprehended by the insured. Data from Abzubby was collected by the company (Abzubby) itself, so the company knows that sentiments could be more on the poor understanding of the language. It is a clear theme that the insured are the ones who did not understand. This theme is partnered with the insurer erring, meaning that the insurer is not held accountable for the lack of understanding of his language by the insured. This is unfair when considering that the insurer benefits financially from failing to pay a claim, as this means that all the subscriptions paid by the insured contribute 100% profit from such an insured.

Then, there is INSPIRA. INSPIRA presents a distribution of its insured customers whose claims were rejected in terms of their language. The tests of hypothesis that were conducted show that it is the lack of understanding of the language used by the insurer, which caused most of the rejections of the claims.

Conclusion

The purpose of the paper was to investigate misunderstandings that could have led to rejections of claims made by vehicle owners during accidents, damages or losses on the insured vehicles and good faith in cases of the insurance contracts. Good faith means that both the insured and the insurer disclose all the aspects related to the issuance of the contract. The insurer in the cases considered in this paper has an upper hand based on a lack of understanding and differences in opinion. Such technicalities leave the insured in a vulnerable state and lower the trust the insured had invested in the insurance contracts and the insurance organisations. Language understanding should not be used for technicalities to deny or reject claims. It is prudent that there is a need for simplification of the language used in the contract such that misunderstandings and misinterpretations can be avoided. Thus, according to good faith, repetition is worth it.

Any good faith insurance company that insures its clients should ensure that the language they use resonates with the client’s vocabulary. The client has their own language that may not be English, and even first language speakers of English sometimes struggle to understand the legal language used by the insurer. The insurer representative is in marketing and selling, and probably being remunerated from the sales made. The insured public is mostly lay with regards to insurance language. When the insurer representatives receive training in insurance terms, they usually realise that they did not know much regarding the contracts even when they had been insured before. They may also realise the weaknesses of the clients who lack the same training. This can then be a way when they become desperate to sign a client to take a short route, that of discussing to give the client an impression that they understand the contract. As this has not been tested, another possibility could be an honest misjudgment by the insurer during contract signing, by not guaranteeing that the insured signs with a full understanding of the contract. Good faith though, requires that each party be honest. The insurer has a bigger role, as the generator of messages on the contract. The clients are from all the languages, but English is used for all of them. The communication culture carries only English, and may miss ways of other cultures to reach the comprehensible state with which these cultures utilise. As the insurer employs all the cultures, they should also ensure that clients of alien cultures from English are addressed to bridge the communication gap.
The study has some recommendations. Any good faith insurance policy should:

i. Entail the commitment by the insurer to the customer's understanding of the conditions of cover in the most efficient way;
ii. Enlist conditions that will lead to rejections in clearer terms; and
iii. Unpacked the ‘long-established principles of interpretation of clauses’ for the insured.

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