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Longueville Media Pty Ltd
PO Box 205
Haberfield NSW 2045 Australia
www.longmedia.com.au
info@longmedia.com.au

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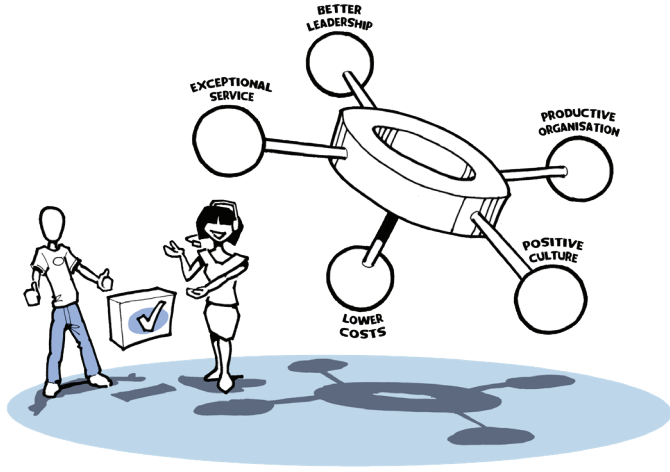


CASE STUDIES WITH REAL TANGIBLE RESULTS

Many books have been written about how to improve service, leadership, and culture, but very few attempt to link theory and ideas with actual, specific outcomes. Some may make general claims of a significant increase in productivity or efficiency, but do not provide supporting data.

We believe it is important to provide this data, so, in addition to the examples and case studies provided in previous articles and chapters, we have included several case studies here that describe in concrete terms the astonishing results achieved when progressive leaders have reconceived service delivery, leadership, and culture to create more positively viewed and productive service organisations.

CASE STUDY 1: INSURANCE CLAIMS

CONSUMER SATISFIED ✓ INSURER SATISFIED ✓ REGULATOR SATISFIED ✓

Imagine if you had to claim on your personal insurance. It could be that you have been injured and are unable to work and therefore need to claim for loss of income. It could be that you have had a serious illness, which has made it difficult or impossible for you to work, and you need financial help in the form of a trauma payment or total and permanent disability cover. It could be that you have been diagnosed with a terminal illness, or that someone in your family has died. I think you would agree, each instance is an extremely challenging life event. It is also why many people take out insurance policies. It gives peace of mind that, should the unthinkable happen, they will have support for themselves and their families at times of significant financial and emotional stress.

MAKING AN INSURANCE CLAIM SHOULD BE STRESS FREE

When people are dealing with challenging life circumstances, and at a point when they may feel vulnerable, making an insurance claim should be simple, stress-free, and lead to an outcome in days, not months. The Australian Securities and Investments Commission (ASIC) states that: 'For consumers, the intrinsic value of an insurance product is in the ability to make a successful claim when an insured event occurs'.[76] We agree. Many people chase the lowest insurance premiums; however, the only time you know whether your insurance policy and company is any good is when you make a claim.

76 Report 498, 'Life insurance claims: An industry review', Australian Securities and Investments Commission (ASIC), Oct 2016.

There is agreement amongst the regulators that the consumer experience during the claims process must be improved. Various reports and codes have highlighted the areas that need improvement, such as the experience at the time of claim, removing the complexity and confusing nature of the claims process, and addressing the unacceptable time period a claim can take to be settled.

In Australia, since 2019, the Australian Prudential Regulation Authority (APRA) and the Australian Securities and Investments Commission (ASIC) have released a series of publications and an online tool allowing policyholders – for the first time – to compare life insurers' performance in handling claims and disputes.[77] This information includes claims handling timeframes and dispute levels across all policy types[78] aimed at making it easier to compare life insurers' performance in handling claims and disputes.[79]

Speaking at the Australian Financial Services Council Life Insurance Summit, Emma Curtis, ASIC Senior Executive Leader – Insurers, Financial Services and Wealth group, said, 'What I would do is call on the industry to help us regulate you better collaboratively and … help steer the industry towards consumer-centric outcomes'.[80]

77 APRA and ASIC publish world-leading life insurance data, press release, Australian Prudential Regulation Authority (APRA), 29 Mar 2019.

78 APRA sets expectations for improvements to claims handling, press release, Australian Prudential Regulation Authority (APRA), 12 Oct 2016.

79 APRA and ASIC publish latest data on life insurance claims and disputes, news release, Australian Prudential Regulation Authority (APRA), 20 Oct 2020.

80 'Industry needs to collaborate with regulators: ASIC', Chris Dastoor, MONEYIMANAGEMENT, 21 April 2021.

REDUCE COSTS AND IMPROVE SERVICE BY MAKING THE CONSUMER THE FOCAL POINT OF REFORM

Change must happen. That much is clear. The challenge for leaders is how to make changes that result in real improvement for consumers while reducing the cost of delivery and compliance.

In our experience, when we observe leaders using conventional approaches to improve their claims services and comply with new regulations, changes take too long to implement and often involve expensive investment in IT. Inevitably, technology project costs escalate, the time required to deliver increases, and, often, despite this extra expense and time, the results delivered fall well short of expectations or, worse, lock in inefficient operating models into 'IT concrete', making future changes even more difficult and expensive.

Sound organisational theory, practical methods, and leadership tools, are required to make changes that result in real improvement for consumers while ensuring the cost of delivery and compliance reduce.

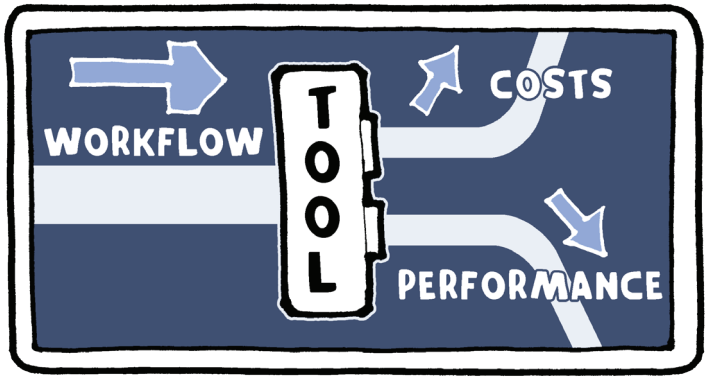
In a particular financial services organisation, the executive leadership wanted to improve their claims service by allowing greater flexibility in how consumers could interact with their organisation, reduce decision and payment time frames, reduce costs, and meet new industry-standard regulations.

Over several years a number of change initiatives had been undertaken to achieve these goals; for example, educating consumers on the claims process and how to navigate it when they initiated a claim, implementing case management, hiring senior claims assessors, effecting several restructures, and implementing targets and service level agreements.

Despite hefty investment and long time scales, each of these initiatives failed to achieve the anticipated results. Instead of reduced decision and payment timeframes, both, in fact, increased. Costs also increased, instead of reducing. These issues were hindering the organisation's ability to meet the new regulation standards. As a result, claims leaders had requested additional resources, citing an increase in the number of claims being placed

on the service as the cause of the increased timeframes. Additional staff were hired, but, once again, performance didn't improve.

In a further attempt to improve the claims service and reduce costs, the executive turned to technology. There was a technology-first philosophy firmly embedded in the organisation, and multimillion-dollar projects were undertaken. The first was to implement a digital workflow tool. Countless hours were spent mapping the current claims processes and digitising them. A plethora of triggers were implemented in the tool, which would route or divert claims to various specialists based on rules. A new claims performance dashboard was also created, which used the workflow data to generate reports on the types of claims received, claim durations, team members' productivity, adherence to targets and service level agreements, and costs.



Unfortunately, after the implementation of the digital workflow tool and claims performance dashboard, performance continued to decline and costs increased. As is typical in many service organisations, the decision was made to invest in more technology to solve the problem, which further compounded the situation.

A progressive leader from the organisation contacted us for help. They could see an endless spend on technology wasn't proving to be the answer to their problems. We explained that, in our experience, applying technology to already ineffective work designs predictably leads to frustration, failure, and lament.

What needed to change first was the way in which the work was designed, organised, and managed. And, critically, that change should be consumer led, not technology led. We suggested that the consumer was put at the centre of any reform, and the consumer's perspective should be the focus for improving the insurance claims services.

We worked with leaders of the claims area to help them take a consumer's perspective and learn first-hand what was happening in their service. Through an experiential exercise, they learnt what creates value for consumers and how well the organisation's claims services were designed to deliver value. Studying a variety of different claim types, this new first-hand knowledge revealed:

- The typical and predictable consumer demands placed on the service, and how well their services were designed to deliver value for each of those demands

- The amount of unproductive activity (cost) inherent in the current organisational systems and structures and, more importantly, the causes of these costs

- The impact the organisational systems and structures had on productive behaviour and activity

- How people experienced their work, their leader, and the claims area

- Shared mythologies underpinning the existing culture

We asked the leaders to establish what mattered to consumers when it came to using the organisation's claims services. When talking to colleagues, the leaders found that there were a lot of assumptions about what consumers wanted. Customer experience (CX) experts and subject matter experts (SMEs) had held workshops to brainstorm what they thought were the consumers wants and needs. They also researched what other claims providers

were doing. Together, this had formed the basis of what they assumed consumers needed. No one, though, had thought to engage with consumers directly to gain a true understanding of what creates value for them through learning their circumstances, needs, and issues.

We suggested that previous claimants be contacted, which revealed that what mattered to consumers was that they were eligible, the length of time it took for them to get a decision, that they got the right amount of money, what choice they had about when and how they received their payment, that they were able to deal with the same person, and that the organisation didn't cause them further stress and anxiety at their time of need. The leaders learned that the direct feedback from consumers conflicted with the previous CX and SME assumptions. For example, working to the CX and SME assumptions, consumers had previously been advised of service levels, not how long it would take for them to receive payment; they would deal with multiple people, not a single person; and every eligible claim was paid on the same date and in the same way, without variation.

It was also learned that consumers wanted to lodge claims in different ways. For example, a small cohort wanted to use a form, others wanted to do it online, and the biggest cohort wanted to do it over the phone. Again, these actual wants and needs conflicted with the previous assumptions. It had been assumed that *every* consumer would want to claim online, lodge documents online, and would want to see the progress of their claim online too. It became apparent that forcing consumers to transact online had frustrated a large percentage of people at their time of great need.

Next, the claims leaders looked at the number of claims received per week in a control chart. (See chapter 16, Are you running your organisation through the rear-view mirror?) There was a mythology in place that the number of claims received was on the increase; however, the control chart revealed that, in fact, the number of claims received per week had remained stable.

Looking at the claims performance dashboard reporting, it showed that claim durations were increasing but were still within agreed service level limits. Clearly, from a consumer's perspective, the claim would start when they first contacted the organisation, and end when they received a decision and their payment. But the claims leaders learned that within the claims team, the clock started only when all claim information was received from the consumer. It could take several weeks and lots of to and fro between the consumer and the claims team to receive all information. Consumers had to provide various proofs of identity, complete multiple forms, and provide supporting evidence, all of which, from a consumer's point of view, was part of the timeline, but not from the organisation's perspective. Once all initial claim information had been received, and the claim had been started, each time the consumer was asked for further information, the

clock stopped until it was received, at which point the clock restarted. When asked why this was done, people in the claims team said that they were aware that the average time frame for a claim had increased and, therefore, they were focused on trying to make the numbers look better.

Via the claims performance dashboards, leaders could easily find out how much it cost to do a certain activity, how people were tracking against targets and service levels, and the status of each claim. However, when we asked them to find out how long claims took, end to end, from when a consumer first contacted the organisation until their claim was paid, they were unable to obtain that data. This data had to be extracted from various IT databases and placed into a control chart. It was a shock to the claims leaders when a true reflection of performance from a consumer's point of view – end-to-end resolution of the claim – was understood.

After learning the true duration for claims, we asked the leaders to follow claims through the various specialists involved in completing a claim. They found that working to service level agreements and targets, each of these specialists picked up a claim from their work queue, completed their portion of the work, then either passed it onto the next specialist or passed it back to the previous specialist if there was a discrepancy.

The leaders learned that:

- Consumers were asked for further information up to 20 times per claim
- Claims were handed to different specialists multiple times
- The same documentation was checked multiple times by different people
- Decisions were checked multiple times by different people

- There was a lack of clarity and agreement on the authority associated with each role

- Power structures had developed because managers would overstep their authority

- Claims team members and managers had become overly reliant on standard processes and complicated compliance regimes, had become overly risk averse, and had outsourced decisions to external parties such as Legal and Risk teams

- Over 90 per cent of the activity in the process did not directly contribute to settling the claim and was, therefore, unproductive activity

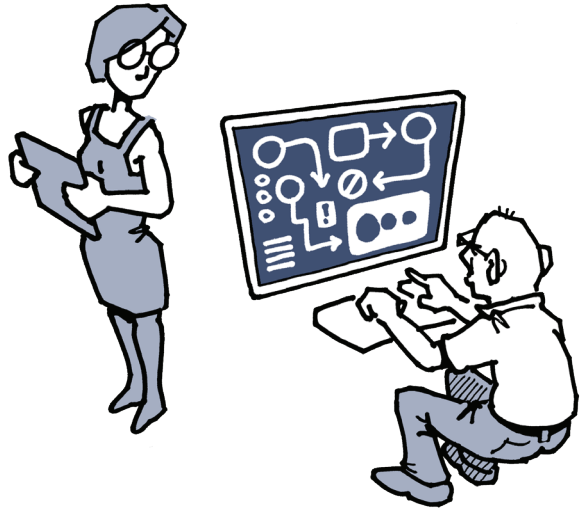
- Claims were diarised to service level agreement (SLA) timeframes and not worked on until the SLA was close to being breached

- Even a simple and straightforward claim would take months to complete

When observing the normal functioning of the claims work, some of the leaders asked colleagues whether they felt comfortable ignoring some of the red tape or not perform certain activities that, to them, obviously added no value. Each time their colleagues said they couldn't, because the policies, systems, processes, rules, or the design of IT tools didn't allow for that judgement or discretion. The executives quickly learned that no one, not team members, team leaders, or even claims managers, had the authority to change a system.

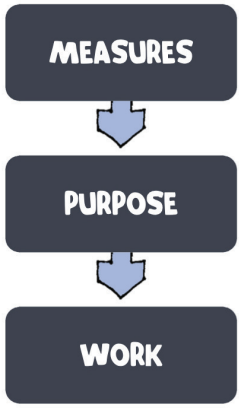
The leaders asked members of the claims teams what their managers paid attention to and were told that managers fixated on managing people's activity – how many things they did, how long it took them to do each task, what was in their queue, and so

on. This had created a burgeoning and bureaucratic measurement system. Employees were regularly monitored and surveilled using technology to feed the measurement system.



Rather than starting with a purpose defined from the intent of the claims service ('Pay me what I'm entitled to'), a de facto purpose of make the numbers was evident. A singular focus on making the numbers capped performance, and drove unproductive behaviour and activity, because work was undertaken where the only intent was to make the bosses happy.

The claims managers paid attention to things that mattered to them – and what they paid attention to got done. The impact was that more people in the claims teams focused on making the numbers, instead of on achieving the purpose the claims service had been set up to accomplish. The following diagram illustrates how this relationship operated in practice.



Targets, incentives, work states, standards

Make the numbers

Case manage; diarise & wait; follow the process; specialise & functionalise; stop the clock

As a result of these experiential learning experiences, the claims leaders couldn't un-see what they had seen with their own eyes and un-hear what they had heard with their own ears. We asked the leaders to reflect on the following:

1. Why is it like this?

2. What is the effect on people claiming at a difficult time in their life?

3. How much is this costing the organisation?

The claims leaders had learnt that their current organisational systems and structures caused high levels of failure demand, lots of unproductive activity, increased backlogs of work, and unneeded operational expense. The learning process that had been undertaken from the consumer's perspective had diagnosed significant and previously hidden improvement opportunities in how to effectively service consumers at a time of great need, work more efficiently, better meet regulation, and reduce operating costs. Therefore, the decision was taken to redesign both the organisational systems and structures to improve the service.

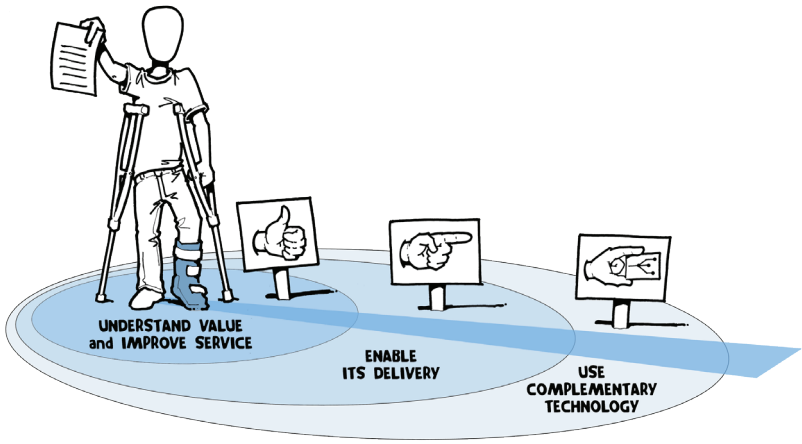
We advised that the most effective approach, and certainly a less costly one than those taken to date, was to redesign the claims services using the following steps:

1. Determine what creates value for people claiming and how best to service them, and use that information to set the context for improvement

2. Organise and enable people to deliver outcomes more effectively, supported by productive organisational systems and structures

3. And, only then, apply the minimum required technology that complements the more effective organisational systems and structures, enhances cognitive processes, and automates simple and repetitive tasks

It was our experience that adopting this unique three-step approach would enable the organisation to achieve improved claim outcomes in months, not years. And in doing so, service to consumers would quickly improve, and, at the same time, delivery and compliance costs would plummet.



The real-life results were compelling. After applying this three-step approach, a productive structure was designed and implemented. (See chapter 17, Designing productive structures.) As a result, excess managerial layers were removed, people at all levels gained a clearer understanding of what was expected of them, people were enabled to use their full capabilities in exercising judgement and discretion in roles that freed them to work productively (see chapter 15, Turning intention into productive reality), and a far more productive working environment was created, so that each person understood where each other's authority started and finished. (See the section It is better to build relationships based on authority rather than power, in chapter 17, page 195.) Existing organisational systems were diagnosed, redesigned, and implemented. (See chapter 14, Liberating people and organisations from stultifying systems.) Leaders worked to change and sustain culture by using three leadership tools: leadership behaviour, organisational system design, and symbols (See chapter 18, A cure for that déjà vu feeling of cultural resistance.)

Rather than having separate functions to pass work between each other to process life insurance claims, teams with the required skill sets were formed. Each team had the capability and authority to use judgement and discretion to complete the minimum

required work, for example, claim assessment. Technologists worked alongside their front-line colleagues taking new insurance claims to understand what creates value for consumers. This created a shared body of knowledge that related back to consumers and the way consumer work was done. The technologists were able to see first-hand that much of the organisation's IT tools were hindering their colleagues from creating value for consumers. Many of the business rules in the process were embedded in the tools, and forced people to follow the process, no matter how unproductive some of the steps were. With this knowledge, the technologists could understand and identify where technology could complement human activity, rather than control it. The IT leaders focused on creating the capability so that when a productive organisational system was designed and implemented, the technology could change and adapt with it. As a result:

- Their processing time for life insurance claims, from claim notification to decision, reduced by over 80 per cent
- Over 96 per cent of the previous steps for life insurance claims were removed, as they were revealed to be unproductive activities from a consumer's perspective
- Their processing time for medical insurance claims, from claim notification to decision, reduced by over 45 per cent
- Over 65 per cent of the previous steps for medical insurance claims were removed, as they were revealed to be unproductive activities from a consumer's perspective
- The spend on IT for meeting new regulations was less than a tenth of what had been originally budgeted

From a consumer's point of view, at a time when people are experiencing challenging life circumstances, and at a point when many feel vulnerable, a simple and straightforward service is of

critical importance to them, and they have been vocal in their praise of the improved service.

Progressive leaders can make this example the new norm for the service industry, rather than the exception. After all, this three-step approach can be applied to any process-based service, including financial services, planning and development, repairs, social care, health, installations, allocations, and repairs and maintenance. Imagine! Satisfied customers and significant quantifiable savings in cost and processing times just waiting to be realised.