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Abstract

The main purpose of this study was to explore the impact of downsizing and efficiency measures on two key elements of operational performance - fraud detection and fraud reporting. Qualitative data were obtained from ethnographic observations of two major multinational insurance companies, which were already examined before the Global Financial Crisis, and subjected to an inter - and intra - business comparative analysis of anti - fraud resources. The paper points out a big discrepancy in opinions on the downsizing effects between junior staff and their supervisors. Whereas the latter present them as enabling the business to deal with suspicious claims more quickly, the former offer a contrastingly different view in which the constantly growing pressure often leads to suspicious claims getting approved. By validating the practical implications of a purposefully adapted version of resource - based theory, the paper illustrates the infeasibility of subjecting anti - fraud resources to the same levels of downsizing and efficiency as other business resources. Although the literature on the general negative impact of downsizing on the broadly - defined operational performance is growing, this is the first major study to examine its impact on insurance anti - fraud processes and illustrate their changes following the Global Financial Crisis.

Keywords

Efficiency Measures, Ethnography, Insurance Fraud

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The Impact of Downsizing and Efficiency Measures on Anti-Fraud Resources

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The main purpose of this study was to explore the impact of downsizing and efficiency measures on two key elements of operational performance - fraud detection and fraud reporting. Qualitative data were obtained from ethnographic observations of two major multinational insurance companies, which were already examined before the Global Financial Crisis, and subjected to an inter- and intra-business comparative analysis of anti-fraud resources. The paper points out a big discrepancy in opinions on the downsizing effects between junior staff and their supervisors. Whereas the latter present them as enabling the business to deal with suspicious claims more quickly, the former offer a contrastingly different view in which the constantly growing pressure often leads to suspicious claims getting approved. By validating the practical implications of a purposefully adapted version of resource-based theory, the paper illustrates the inviability of subjecting anti-fraud resources to the same levels of downsizing and efficiency as other business resources. Although the literature on the general negative impact of downsizing on the broadly-defined operational performance is growing, this is the first major study to examine its impact on insurance anti-fraud processes and illustrate their changes following the Global Financial Crisis. Keywords: Efficiency Measures, Ethnography, Insurance Fraud

The Impact of Downsizing and Efficiency Measures on Anti-fraud Resources

While some research shows positive effects of workforce reduction on organizational performance (Bowman & Singh, 1993; Demuse, Vanderheiden & Bergman, 1994), there are also studies revealing its disruptive nature (Bethel & Liebeskind, 1993; Cascio, 1993; Krishnan & Park, 2002). The “mean and lean” attempts to improve productivity through downsizing, defined as an intentional reduction in personnel intended to improve the efficiency or effectiveness of the firm (Freeman & Cameron, 1993), have been regarded as the preferred route since the mid 1980’s (Laabs, 1990). They almost inevitably lead to layoff survivors having to pick up at least some of their departed colleagues’ tasks (Lewin & Johnston, 2000), which can lower their morale (Mishra, Mishra, & Spreitzer, 2009; Petzall, Parker, & Stoeberl, 2000), increase anxiety (Brockner et al., 1986; Brockner, Grover, Reed, & DeWitt, 1992), absenteeism (Cascio, 1993) and impair performance (Fisher & White, 2000; Krishnan & Park, 2002).

By equating downsizing with cutting cost through an across the board reduction of headcount, many executives adopt an excessively short-sighted approach that seems to result in star performers being given incentives to leave, depleting crucial skills in human resources and creating the need for patch-up solutions that newly hired consultants are paid to find (De Vries & Balazs, 1996). In this light, and given the quite well-established literature on downsizing, the reader would be right to ask what new contribution is attempted to be made in this study which examines restructuring in the motor insurance industry. Is there anything new to say? I argue that whilst the general examination of downsizing effects is important, its breadth might be in conducive to gleaning the subtle micro-level details that could come to

light if individual aspects of operational performance, like fraud detection and fraud reporting, were analyzed.

Quite a lot of research has already focused on the types of fraudsters (Clarke, 1989), on their characteristics (Palasinski, 2009) and on how and why fraud is committed (Gill, Woolley & Gill, 1994; Doig, Jones, & Wait, 1999). Dodd (1998) reports that the forms of insurance fraud vary widely - from amateur and opportunistic claimants making false statements through to organized networks engaging in sophisticated scams. According to the Crime and Fraud Prevention Bureau (2000), the most typical forms are: reporting inflated loss value (39%), misrepresenting circumstances (32%), making completely false claims (12%), claiming from multiple insurers (3%), and using less conventional methods (14%).

Researchers have also studied the responses of the insurance industry to fraud. They note that despite some similarities in how fraud is tackled, there are considerable differences in the adopted tactics (Clarke, 1990), in the definition of fraud (Doig, Jones, & Wait, 1999) and in fraud detection methods. The methods may include a voice stress analysis (Horvath, 1982), statistical analysis (Artis, Ayuso, & Guillen, 2002), anti-fraud software analysis (Morley, Ball, & Ormerod, 2006), "suspicion-building" IT toolset (Ormerod, Ball, & Morley, 2012) and claims auditing strategies (Schiller, 2006; Tennyson & Salsas-Forn, 2002). Even before the Global Financial Crisis, however, there was unanimous recognition of fraud as a major problem (Dodd, 1998; Litton, 1990; Ormerod, Morley, Ball, Langley, & Spencer, 2003).

Thus, the complexity of insurance fraud can perhaps be only matched by its impact. According to a report by the Association of British Insurers (2009), its annual cost in the UK alone was estimated at just over £1 billion in 2001, £1.6 billion in 2007 and £1.9 billion in 2009. The same report also highlights that more and more people are being caught trying to commit fraud by lying and withholding relevant information – a 30% increase on 2007. These statistics indicate that insurance fraud has been growing faster than the implementation of effective fraud detection and fraud reporting measures.

Such measures were identified as poor prior to the Crisis. In a major ethnographic study of how the detection of insurance fraud succeeds and fails at two multinational companies, Morley et al. (2006) report that the major obstacles to investigating suspicious claims are organizational factors. More specifically, they note that frontline claims handlers, who are primarily responsible for the detection of fraudulent claims, are usually inexperienced (with the average company lifetime of less than two years), undertrained and overloaded with productivity targets.

Morley et al. (2006) also describe the general business atmosphere at the two companies to be infused with speedy rather than careful claims-processing, where any individual sense ownership for claims is minimal, where feedback is limited and unreflective work is encouraged. For example, they note that the frontline staff, who receive no incentive for reporting their suspicions, are required to strictly stick to a telephone script and complete a checklist of fraud indicators, some of which describe suspicious claimants as aggressive, vague and hesitant. In a separate follow-up study, Palasinski (2009) shows that potential claimants are actually more likely to describe fraudsters as polite, accurate and cooperative, thus demonstrating the incorrectness of the image that the insurance industry still associates with fraudsters. Have such organizational factors changed since then?

The losses suffered by the British and American financial institutions since the Crisis have run at trillions of pounds, leading to banks going virtually bankrupt, being taken over by the state or acquired by other institutions (Dewatripont, Rochet, & Tirole, 2010). Whereas most of the insurance industry in the European model went through the Crisis with relatively little difficulty, some of the more deregulated Anglo-Saxon industry had to be downsized,

nationalized or have its assets put on sale, leading to closures, mass redundancies, pay freezes and dramatic efficiency measures (Schich, 2009).

Given a serious deficit in research on how such major restructuring can affect individual elements of operational performance, like anti-fraud resources, I analyze to what extent the two companies have incorporated the six major recommendations suggested to them in the pre-Crisis study by Morley et al. (2006). The recommendations include:

1. offering incentives for spotting and reporting anomalies,
2. offering increased and more regular training opportunities,
3. developing organizational processes that integrate fraud-detection methods with claims-handling,
4. making modern anti-fraud software more available and
5. offering better training for the effective use of such software,
6. as well as increasing a degree of ownership of claims.

Tracing such changes, I respond to Birati and Tziner's (2000) call for the exploration of potential impact that major organizational changes, like downsizing and new efficiency measures, can have on likely financial results of individual companies rather than on a more general economic climate. Given that downsizing often forces management to identify where they have the greatest competitive advantage and to reevaluate their organizational structures to maximize that advantage (Griggs & Hyland, 2003), I draw on resource-based theory (Wernerfelt, 1984) that played a large role in shaping the direction and contents of my ethnographic observations. The theory has already been proven as an effective tool for assessing both the positive and negative effects of a major restructuring (Chatterjee & Wernerfelt, 1991; Krishnan & Park, 2002). Even though Priem and Butler (2001) criticize the theory for its alleged tautological character, conceptual vagueness and limited prescriptive limitations, Crook, Ketchen, Combs, and Todd (2008) argue that its usefulness in the identification, development, and distribution of value from strategic resources is high.

Although one of the main precepts of the theory is that a sustainable competitive advantage stems from unique bundles of resources that competitors cannot imitate (Wernerfelt, 1984), in this study I adopt a more moderate stance by Barney (1991, p. 117) who interprets such resources as "neither perfectly imitable nor substitutable without great effort." For the purposes of this research, then, the anti-fraud resources are defined as all assets, capabilities, organizational processes, and information helping the business to gain a sustained competitive advantage – the claims handlers' ability and opportunity to detect and deal with insurance claims that they find suspicious, unusual and complex. I propose that the advantage might be potentially achieved by approaching the anti-fraud resources differently from other business resources and by not putting them under similar pressure of downsizing. Whilst this approach may seem quite imitable, the successful identification, testing and preservation of all such anti-fraud resources are complex and demanding. Furthermore, the individual qualitative structure and contents of the resources, which even similar businesses organize in their own specific ways, might still result in unique elements of a winning competitive edge.

Method

I adopted an ethnographic approach, which has been proven to be an effective tool for complementing statistical, interview and questionnaire methods (Hill, 2009). This approach allows for up-close and personal insights through participant observation and, unlike survey

and interview techniques, it has the capacity for illuminating complex social processes and work activities in a live natural environment (Seale, Gobo, Gubrium, & Silverman, 2004).

The procedure lasted for 3 weeks during different working hours at various times and involved a number of diverse and systematic activities, like observing and interacting with junior staff and their supervisors at different departments of the two different multinational insurance companies that were subject to a similar, albeit not restructuring-focused, ethnographic analysis before the Crisis (Morley et al., 2006). To maximize the possibility of drawing comparisons with that analysis, I focused only on the 20 junior staff and 6 supervisors who admitted to having the experience of the pre-Crisis processes and procedures.

I assured them all of anonymity and confidentiality, and encouraged them to express themselves as openly as possible. I advised them that their opinions would not be shared with any staff members and that they were simply meant to enrich my study, which was introduced to them as exploration of business restructuring and anti-fraud practices. Sitting separately with both claims handlers and supervisors, I attended team and managerial meetings, each time carefully observing them, occasionally asking questions about the given activity and always trying to listen to what was going on around me.

During the observations at the two companies, I took regular field notes and samples of documents describing a variety of work procedures that could fall into the category of anti-fraud resources. I have not, however, obtained the permission to make audio recordings so, unable to take classical think-aloud protocols, I made bullet-point notes of what participants said they were doing. All the data could then be subjected to inter- and intra-business comparative analyses of the anti-fraud resources, giving insight into the differences between the two companies and the individual changes they have made since the Crisis (see Tables 1 and 2 in the Appendix).

Results

The perspectives of junior staff

When asked about the changes introduced to their workplace in the last three years, the claims handlers at the two companies were highly critical of them. They complained about constantly increasing workload, closer monitoring and the approach of “a stick” rather than “a carrot”. Thus, they said that more and more performance incentives were being phased out and in their place new key performance indicators were being brought in. As a result, at Company A meeting certain objectives, which used to be rewarded with vouchers and bonuses for referring customers to the affiliated repair garages for example, were now considered part and parcel of the job and required as standard performance. At both companies, new and more complex telephone systems replaced the old ones so that now almost all work activities could be measured more accurately than before. The handlers mentioned that there used to be just a few codes for them to enter to indicate the reason for logging off the phone. Now they complained about too many codes and being under much closer surveillance than before, which most of them commented upon as relegating the matter of identifying and reporting suspicious claims to the bottom of their work priorities.

Whereas at both companies there used to be large white boards listing the teams' overall performance, now at Company A the boards listed individual performance, while at Company B there were now separate boards for performers and underperformers whose names were written down in red for everybody in the office to see. At company B consistent underperformance, which was defined as continual failure to process a target number of

claims over a month, was followed by an action plan and suggested solutions, like having to make up for missed targets by working overtime.

Company A used to put the primary emphasis on the quality of customer service experience so that the handlers had more time for claims-processing and inspection of suspicious cases. Now it was the quantity of processed claims that was most important and even the staff that used to work exclusively as quality controllers were tasked with claims-taking. Whereas at both companies the quality feedback used to be very regular, it was now sporadic and focused on errors rather than on praise. Consequently, just like during the first ethnographic study a few years ago (Morley et al., 2006), at both companies the claims handlers received almost no information on the suspicious leads that they could identify from a list of fraud indicators that were now simpler and shorter than before. Used as a heuristic, a fraud indicator describes a factor assumed to be indicative of potential fraud. While commercial confidentiality does not allow for publishing all such indicators, some of them have been shown to actually facilitate fraud (Palasinski, 2009). It is thus apparent that their simplified and nuance-lacking versions, which are meant to help the downsized fraud departments with quicker approval or repudiation of claims, almost inevitably let the more complex and suspicious cases “slip through the net.”

At both companies, team meetings and “huddles,” during which new procedures, objectives and general feedback were announced, were now much less regular and team communication was by and large reduced to impersonal emails and paper brochures. At neither company could the handlers recall any formal training since the Crisis began. They were also unanimous about having to combine different roles that used to be exclusively allocated to different employees. Thus at Company A, the motor insurance staff were now asked to deal with the notification of household claims. Although they were sent email instructions of how to fill in the household claim form and they could count on the assistance of the team leader, who also took claims when the work volume was high, they received no separate list of household fraud indicators and no household fraud training.

At Company B, the claims handlers now had to deal with additional administrative tasks that used to be given to the back offices that were recently closed and partially offshored. They were also given the responsibility for investigating suspicious claims that used to be allocated to the now non-existent fraud team. Such new responsibility involved checking new claims for very broadly defined “anomalies” and fraud indicators, contacting claimants, brokers, repair garages, GPs and the police about any information that might clarify the circumstances surrounding a claim. For example, if a described accident appeared to be minor and all four passengers tried to claim for whiplash injury or if the claimant insisted on using his own repairer garage and his repair quote seemed to be too high, then the handlers were required to stop dealing with new claims and focus on the suspicious one.

Notwithstanding such new workload, it was not rewarded as, like before the Crisis, there were no incentives for identifying and reporting cases that were eventually classed as fraudulent. On the contrary, the time spent on investigating such cases worked against the handlers and affected their productivity figures that were directly related to their performance assessment. At Company A, the fraud department remained a separate organizational unit, but its members were required not to spend more than the average of 30 minutes on suspicious cases, “unless dealing with unusual and complex circumstances.” When the work volume was high, they were now also asked to work as normal claims handlers, which they reported to take them approximately 25% of their time. Consequently, both the claims handling and fraud staff were observed to take a number of shortcuts to comply with the new company procedures and to avoid missing their new productivity targets. For example, rather than contacting all the available witnesses, they would contact only one or focus on only those whose statements expedited claims-processing. They would also focus on only selective

leads and on sources fitting the version of events that were conducive to setting the claim quickly, referring only the most complex cases, like those involving very serious injury or unusually high cost, to loss adjusters and fraud managers.

At both companies, it was evident that the skills of the staff were grossly underutilized. For example, at Company A one quarter of the experienced claims handlers (comprising around 35% of the junior staff who were employed for more than 3 years) were degree holders, but they admitted not to have received any special training or development track that would tap into their skills. In contrast, there were some of such opportunities at Company B, where one fifth of the experienced staff (comprising around 30% of the junior staff who were employed for more than 3 years) were degree holders. However, most of the opportunities were limited to coordinating a small team and were repeatedly described as not much more financially attractive to make up for the additional administrative responsibilities and greater job uncertainty.

At both companies, most of the staff indirectly complained about an increasingly demoralizing atmosphere of depersonalization, boredom and sterile “brain-cell” killing environment, where critical thinking was discouraged and “robot-like” behavior was rewarded. One can easily notice that their knowledge of the bottom-up processes combined with the analytical skills that some of them could hone during their studies might provide new insights into organizational anti-fraud processes that their supervisors were isolated from. Despite some opportunities to share such knowledge at both companies, for example in the form of a suggestion box or solutions board, there was no system in place that would financially reward good ideas.

Most of the staff I interacted with also admitted that the employee satisfaction surveys that they were required to complete on the computer could be easily traced back to them and hence they could not be really as anonymous as they were presented by the supervisors. On a positive note, compared with the working environment before the Crisis, it was clear that certain organizational processes conducive to tackling fraud improved a little. At both companies, new claims that used to be dealt with by different staff at different stages were now allocated to particular individuals, facilitating communication and creating a much greater sense of ownership. There was also greater access to new and automatically updated software, enabling a much quicker and more flexible look into the history of a given claimant, car or address than it was the case before, yet the training in its usage was reported by the junior staff as minimal.

The perspectives of team leaders and supervisors

When asked about the new changes in the last three years, the team leaders and supervisors at Company A and Company B were respectively quite positive and very positive about them. They spoke of the greater workload in terms of developing the staff, improving the organizational health of the business and increasing its competitiveness on the market. At Company A, they presented the tasking of the motor claims handlers with the notification of household claims as not only adding variety to the job, but also increasing their employability and promotional prospects in general. Lacking any formal training and qualifications in household claims, the supervisors stated that household fraudsters would operate very similarly to motor fraudsters, emphasizing that the best strategy of tackling fraud was using “common sense” and sticking to the same fraud indicators that were already used in motor insurance. They said that they did not see the need to rephrase some of the indicators in household terminology to facilitate their better use as “the slight differences in wording were obvious.”

At Company A, where the fraud department remained a separate organizational unit, they were in agreement that giving the fraud staff the average of 30 minutes on suspicious cases was sufficient. They also presented the tasking of the fraud staff with claims-taking as only occasional and unlikely to take them more than 10% of their time, although the fraud staff described it as regular and consuming approximately 25% of their time. Along similar lines, at Company B asking the claims handlers to deal with additional administrative tasks and adopt the role of fraud investigators was presented as tapping into the handlers' insider's knowledge, which, I was told, would be of greater relevance than relying on the ex-fraud team members who were isolated from direct customer contact. At neither company was the issue of taking shortcuts and conflict with productivity targets mentioned spontaneously, but when I raised it at Company A I was advised that it was one of the main reasons why they kept the claims and fraud departments as separate organizational units. At Company B, I was told that the closer monitoring would not allow for "cutting corners" and hence there was little conflict between investigating fraud and hitting productivity targets as the staff would simply have to follow their basic guidelines.

Most of the supervisors at both companies presented the closer monitoring as enabling the business to provide insurance policy holders with better quality customer service that could be excellent each and every time. They also commented on the performance boards as being now more detailed and personalized, helping them quickly identify who needed extra support and training. The supervisors acknowledged that some of the more experienced claims handlers could now find the greater surveillance uncomfortable, but they also argued that it was simply a matter of getting used to it, and that it was not a problem for new employees who did not work under the "old" system before the Crisis.

Thus, as the supervisors at Company A put it, "pampering the staff with perks simply for doing their job" was no longer justified. At Company B, they argued that giving certain incentives, like those for correctly identifying fraudulent cases could distract the claims handlers from doing their job – indemnifying policy holders. At both companies, the supervisors described their shorter list of simplified fraud indicators as more efficient and effective. They admitted that there was already an established approach of accepting the costs of declines in fraud detection as a trade off for a much more efficient throughput, but denied putting such an approach in imbalance, although the new trade off remained uncalculated.

At Company A, the team leaders and supervisors argued that both quantity and quality were equally important, but given the new set of control measures and closer monitoring, the claims handlers "had now a better opportunity to focus on their productivity" and "work their way up through their motivation and efforts rather than tricks." They also presented the tasking of quality controllers with normal claims-processing as a way of way of diversifying their workload and keeping them up to date with bottom-up processes. At both companies, they explained that error avoidance and increased productivity should be top priorities for the handlers, stating that hitting the set targets would also be recognized during the annual staff appraisal.

At both companies, they described the communication through emails and paper brochures as fast, easy and clear; emphasizing that formal meeting would still be organized if bigger changes in procedures were to be implemented. Additional training for the experienced staff was labeled as "superfluous" or "impractical" as it was stated that the best training, including the anti-fraud training, was the actual practice. Whereas at Company A new starters would be sat among the more experienced staff, which appears to be conducive to fostering an effective learning environment, at Company B they would be clustered together and encouraged to learn from one another with the support of an experienced team leader. The latter approach seems to allow for the sharing and consolidation of errors that might be left unchecked by the busy team leader who was not always available.

With regards to the staff development, the supervisors at both companies emphasized that it was their priority to recruit and retain only the best people, but they denied that graduates would necessarily be any better than school leavers. At Company A, promotional opportunities were presented as “open to anybody with the right skills and attitude,” whereas at Company B they were presented as most available for the internal staff with experience rather than “pretentious and arrogant graduates with no real business knowledge.” At Company A, it was explained to me, every year a few junior staff with top performance scores could qualify for management training, but it was clear that correctly identifying fraudulent claims would not be measured and would not be reflected in the scores. As a result, highly productive individuals with little proven anti-fraud effectiveness or anti-fraud training could end up advising and managing fraud teams. At Company B, I was told, there was no formal promotional track for the staff to join, but everybody was personally responsible for their development and that “people with the right ideas would be automatically referred further.” Nonetheless, I could not get a clearer definition of such a referral or what it would involve.

The supervisors at both companies stated that the changes introduced to the business in the last three years had a very stimulating impact on all the staff, diversifying their roles and developing their skills. At Company A, they stated that the sheer number of the still-ongoing changes would keep their business a dynamic place for many months to come, while at Company B they argued that many of their staff, who had been indirectly complaining of monotony and boredom before, were now tasked with additional duties to satisfy their need for extra stimulation. No clear steps, however, were taken to match the additional duties to the claimants' skills or to assess their impact on fraud detection practices.

At both companies, the supervisors argued that the simplified procedures and guidelines must have had a general positive impact on the work quality “as the staff were now relieved from having to overanalyze a number of common scenarios.” They explained that they were open to suggestions and solutions recommended by the claims and fraud staff, and that although it would be impractical to reward all of them individually, they might play a role in promotion and their creators would be recognized during the annual performance appraisal. The managers also presented themselves as open to criticism and assured me that despite the computerized forms, all employee satisfaction surveys were anonymous and individually untraceable.

Despite heavier workload, new targets and downsizing, at both companies they described the general organizational processes as modernized and streamlined. The improved access to the latest commercially available anti-fraud software was said to offset the possibility that the junior staff, who were tasked with extra duties, might fail to spot fraudulent claims. It was also clear that more resources were invested in fraud screening technology than in training the staff to spot and investigate their suspicious. Such an approach appears to be conducive to limiting financial leakage as it was already observed in the earlier pre-Crisis ethnographic research that it is the front-line staff who are best positioned to spot and investigate anomalies (Morley et al., 2006).

At both companies, the supervisors spoke with confidence about the ability of their staff to use and interpret the data from the anti-fraud software, although every claims handler I had interacted with advised me that they could not fully operate it or that they could only use its basic functions. At Company A, the supervisors told me that there were plans for training their staff to better use such software, but they would not specify their nature or timescale. At Company B, they said that the new anti-fraud technology would allow them to keep only a few very well-trained claims handlers on whose expertise the majority of the future less experienced staff could rely.

Discussion

Following Van Rooy et al.'s (2011) strong recommendation for measuring workforce attitudes, especially during an economic downturn, this study gives insight into contrastingly different stances on the impact that a major downsizing seems to have on anti-fraud resources. Thus, the team leaders and supervisors, most of whom were isolated from bottom-up business processes, did not appear to be fully aware of the effects of the new changes. At both companies, they held a number of unjustified assumptions about tackling fraud, like stating that household insurance fraudsters would operate similarly to car insurance fraudsters and over-relying on anti-fraud software rather than on training their staff. They also seemed oblivious to the fact that the closer monitoring, higher productivity targets and no feedback on even successfully identified fraudulent claims had an apparently demoralizing impact on the staff, some of whom openly admitted that following their suspicions adversely affected their performance figures and was not really an aspect of their responsibility.

It appears most of the recommendations by Morley et al. (2006) have been ignored and many of their opposites have been accepted. The two companies have failed to offer incentives for reporting anomalies, adding new disincentives, making training opportunities even less regular and increasing communication via impersonal emails. It seems that tasking junior staff with many extra duties has also hampered the integration of fraud-detection methods with claims handling. Although better anti-fraud software was now more available, at both companies the experienced junior staff admitted to not knowing how to fully use its potential. On a positive note, however, it must be mentioned that both companies increased a degree of ownership of claims.

It is apparent that most of the analysed efficiency measures, including increased pressure and limited feedback, may not just fail to facilitate the detection and reporting of insurance fraud, but are actually likely to have an adverse effect, which probably impairs very important aspects of operational performance. What the supervisors described as "multitasking," "faster communication," and "closer monitoring," the junior staff often referred to as respectively "growing pressure," "impersonal emails," and "intrusive surveillance." Such juxtapositions between the respective mitigation (Van Dijk, 1992) and extreme case formulations (Pomerantz, 1986) offer a glimpse into two contrasting discursive worlds. Whether or not such a contrast is apocryphal is less significant than the effect it appears to have on relegating the matter of investigating suspicious claims to a place of secondary importance.

The junior staff, however, did not seem to be completely cynical about all the organizational changes, although they showed quite a high degree of change-specific scepticism. Using Stanley, Meyer, and Topolnytsky's (2005) distinction between scepticism and cynicism, which they also find to be closely correlated and potentially causal, it appears that the junior staff were more doubtful about the viability of the changes than about the ulterior motives for implementing them. Could, then, they be closer to the "reality" of the situation than their team leaders and supervisors?

Notwithstanding the considerable differences in their perspectives on that "reality," one must bear in mind that they could be equally valid on the grounds of different value systems and metrics. In other words, given the salience of heavier workload, more intensive performance monitoring, fewer rewards for good performance, removal of team performance metrics, lack of formal training opportunities and reduced focus on customer service, the evaluation of the restructuring by the junior staff was almost unanimously pejorative. In contrast, by emphasizing improved organisational health, increased market competitiveness, greater job variety and capitalising on insider knowledge, the team leaders and supervisors had sound reasons to view the organizational changes in positive terms.

In this light, it might be inaccurate to claim that the junior staff were simply right and “in the loop” and their supervisors were wrong and “out of touch.” The situation might be more complex and heavily dependent on what financial impact rejecting suspicious claims has had in comparison with the pre-downsizing time. Until such data is available (at the time of finishing this manuscript it is not) and is subjected to detailed statistical analyses, which is compounded by the subjectivity and ambiguity of what constitutes suspicious claims (e.g., there were no guidelines on whether non-verbal clues were more important than the logical ones) it is premature to claim that downsizing and efficiency measures must have an inevitably negative impact on anti-fraud resources.

All this study shows, then, is that it is likely to be the case, which lends support to a separate exploration that would take into account the full financial balance sheets. However, extrapolating from the comprehensive model treating downsizing programs the same as any other projected investment by a firm (Birati & Tziner, 2000), the very (surprising) absence of even restructuring-adjusted estimates of fraud-linked leakage can be quite fairly interpreted in terms of insufficient control, high risk and presumptuousness, suggesting that the general effect of the (clearly under-planned) downsizing on anti-fraud resources is probably indeed negative. That said, what I hope to have achieved is to demonstrate that examining individual aspects of operational performance, like fraud detection and fraud reporting, through the lens of resource-based theory can represent an insightful and practical approach shedding unique qualitative light that would be obscured if a traditionally general analysis of downsizing was used. Highlighting the implications from a contextualised resource-based theory, I conclude that the anti-fraud resources apparently should not be subject to the same levels of untested downsizing and efficiency as other business resources. To do otherwise, is to risk too many fraudulent claims to “slip through the net,” unless it turns out that the costs of declines in fraud detection will be a beneficial trade off for a much more efficient throughput, which the senior staff expected, but could not estimate or calculate yet.

Naturally, a few words of caution are due. Even though the junior staff at both companies were almost uniformly critical of the significant changes in their job tasks and routines, it is likely that the newly hired staff, whose perspectives were not analyzed due to the inexperience of the pre-Crisis processes and procedures, could be more positive about the changes. Could they then perform better than the “older” staff? Given the greatly increased complexity of the procedural tasks, as well as the longer and expensive process of training, it would be logical to suspect that at least in the short-run they most likely could not. The question about their long-term performance is complicated by the high call-center staff turnover (Morley et al., 2006), individual differences (Koberg, Chesley, & Heppard, 2000) and how managers respond to the anxiety (Richardson & Denton, 1996), decreased morale (Mishra et al., 2009) and frustration (Luthans & Sommer, 1999) of their workers.

It must also be mentioned that despite the efforts to try to minimize subjectivity, the analysis and conclusions were probably shaped by my individual preconceptions, knowledge and expectations - the elements which Seale et al. (2004) present as an inevitable and natural part of qualitative research. Although alternative definitions and theoretical frameworks could have been used in this exploration (Datta, Guthrie, Basuil, & Pandey, 2010), I hypothesize that they would lead to quite similar conclusions, which also paves the way for confirmatory research. Despite Hammersley’s (1990) criticism of the ethnographic method on the grounds of relatively limited validity and reliability, Borland (2001) argues that the issue of balancing subjectivity and objectivity, representativeness and selective sampling, as well as generalizability and uniqueness has been relevant to social sciences in general. LeCompte and Preissle (1982) even criticize such dichotomous divisions themselves. Given the parallels between the two companies, the described processes and their implications are

likely to be relevant to a wider sector of the downsized and more and more efficiency-driven insurance industry, which should be explored in other research.

Such research might take into account other factors, like layoff survivors' work ethic, role ambiguity and job involvement (Brockner, Grover, & Blonder, 1988), as well as self-esteem (Brockner, Grover, O'Malley, Reed, & Glynn, 1993; Wiesenfeld, Brockner, & Thibault, 2000), organizational commitment and perceived control (Brockner et al., 2004). Exploring the post-Crisis effects of such a major restructuring would also provide us with a fuller longitudinal perspective, which is both a timely and important matter. It appears, however, that insurance managers do not tend implement recommendations from academics, leaving room for future research that might focus on how to enhance cooperation between them. Why it is the case is naturally speculative, but it seems that continuous doubts about academia (Pfeffer & Fong, 2002) and its perception as ivory tower detached from "business reality" (Hershberg, Nabeshima, & Yusuf, 2007) are worth taking into consideration, the message arguably being that there is still scope for narrowing the gap between them.

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Appendix

Table 1

Perspectives on Major Post-downsizing Changes in the Two Companies by the Junior Staff

Similarities

changes generally criticized
 emails and paper brochures described as obstructing communication
 the importance of fraud identification and reporting minimized
 complaints about constantly increasing workload and closer monitoring
 complaints about depersonalization, boredom and routines
 performance incentives phased out
 new key performance indicators brought in
 new and more complex telephone systems replacing the old ones
 less regular and error-focused feedback
 less regular and shorter team meetings
 increased multitasking without sufficient training
 no system in place that would financially reward good ideas
 new claims now allocated fully to particular individuals
 greater access to new and automatically updated anti-fraud software

Differences

no special training or development track for employed graduates at Company A
 boards listing individual performance at Company A
 less emphasis on customer service at Company A
 quality controllers and fraud staff tasked with claims-taking at Company A
 junior staff tasked with household claims at Company A
 junior staff tasked with new administrative tasks at Company B
 junior staff tasked with investigating suspicious claims at Company B
 separate boards for performers and underperformers at Company B
 increased need for making up for missed targets at Company B

Table 2

Perspectives on Major Post-downsizing Changes in the Two Companies by the Team Leaders and Supervisors

Similarities

changes generally approved
 changes described as skill-developing and efficiency-improving
 emails and paper brochures described as facilitating communication
 error avoidance and increased productivity described as top priorities
 increased workload described in terms of improving the staff and business
 closer monitoring described as facilitating better quality customer service
 additional training for the experienced staff described as unnecessary
 performance boards described as early problem-spotting systems
 anti-fraud software described as offsetting reduced time for suspicious claims
 shorter lists of simplified fraud indicators described as more effective
 declines in fraud detection assumed to be a trade off for greater efficiency
 taking shortcuts and conflict with productivity not mentioned spontaneously
 recruitment and retention of only the best people emphasized
 the impact of additional duties on fraud detection remaining unassessed

Differences

household fraudsters assumed to operate like motor fraudsters at Company A
 tasking fraud staff with claims-taking described as only occasional at Company A
 rewarding staff for good performance described as unjustified at Company A
 new starters placed among the more experienced staff at Company A
 plans for training the junior staff to better use anti-fraud software at Company A
 mostly external and formal promotional opportunities at Company A
 mostly internal and informal promotional opportunities at Company B
 tasking junior staff with admin tasks described as smart at Company B
 closer monitoring described as minimizing multitasking conflict at Company B
 rewarding staff performance described as distracting at Company B
 new starters clustered together at Company B
 plans for using anti-fraud software to minimize training of new staff at Company B

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