UNDERSTANDING BUSINESS PROCESS TRANSFORMATION: AN INSTITUTIONALISATION PERSPECTIVE

Anthony Renner-Micah
University of Ghana Business School, amicah001@st.ug.edu.gh

John Effah
University of Ghana Business School, jeffah@ug.edu.gh

Richard Boateng
University of Ghana Business School, richboateng@ug.edu.gh

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Anthony Renner-Micah
University of Ghana Business School
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John Effah
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Email: jeffah@ug.edu.gh

Richard Boateng
University of Ghana Business School
Email: richboateng@ug.edu.gh

Abstract

This study aims to understand how a health insurance organisation undertake business process transformation to stimulate innovation. A growing interest in digital transformation raises questions about how this can lead to business process transformation in delivering health insurance. This study seeks to understand one of the most relevant phenomena today, digital transformation, which implies fundamental changes in the activities of organisations based on the use of digital technologies and the implication for business process management. This paper, therefore, applies a sociotechnical approach using institutional theory as the analytical lens and qualitative interpretive case study as the methodology. It depicts how various institutions influence the outcome of business process transformation. The findings have implications for research, practice, and policy

Keywords: Business process transformation, Digital transformation, Health insurance, Interpretive case study.

1.0   Introduction

This study aims to understand how a health insurance organisation undertake business process transformation to stimulate innovation. Health insurance information systems typically involve digital infrastructure, data and processes instigated from various points of care, such as payer–provider, pharmacy prescriptions, patient feedback, and responses (Abbas et al., 2015). The health insurance sector provides protection in terms of financing and payment for healthcare services of the insured (Amponsah et al., 2022). These insured members are largely at the bottom of the pyramid and, thus, have been a growing concern to many developing countries in recent times (Adesola, 2010) primarily, within the framework of the United Nation's Sustainable Development

Goal 3, which seeks to ensure universal health coverage (UHC) of all member nations. Ensuring the scheme's growth and ongoing viability through efficient processes spurred on by digital technologies is paramount (Boranbayev & Boranbayev, 2010). Thus, we contend that health insurance serves as a crucial link in the health system that mediates access to healthcare services between healthcare providers, pharmaceutical firms, and the general public. Consequently, health insurance is a strong candidate for business process transformation, warranting increased attention from IS researchers.

Business process and business process management (BPM) has been conceptualised in general as a topic that combines knowledge on how to best manage the (re-)design of specific business processes catering for a variety of goals and contexts (vom Brocke & Rosemann, 2015). Combined, they have proven successful in helping organisations improve and innovate. Despite the importance that business process management has gained over the last several decades, it has come up for criticism. It has been noted to fall short in leading the transformative outcomes that contemporary organisations are seeking. For example, Brocke et al. (2016) argue that one reason for the frequency of BPM project failure is the lack of knowledge about how to address the different contexts sufficiently. In addition, BPM has been primarily thought of as being enabled by enterprise systems or ERPs since these systems have traditionally been considered as providing pre-defined, configurable processes as part of their all-inclusive package offerings. On the above, Rosemann (2014) notes that beyond their compelling narratives, there have been limited methods supporting process innovation. In particular, the author posits that this misfit of BPM capabilities is increasingly profound when examined from the perspective of substantial changes in the global digital space, the opportunity-rich environment, and rapidly emerging digital disruptions. In this regard, with the emergence of new concepts such as digital transformation, concerns have been expressed regarding the future of BPM, where it appears to have increasingly limited itself to identifying, modelling representation, and mining processes (Klun & Trkman, 2018).

Organisations are confronted not only with technical problems like a growing portfolio of IT applications and services but also sociotechnical problems at the heart of how technology is used in business processes to deliver new or changed capabilities. Informed from an IS perspective, there is room for a sociotechnical lens to improve our understanding of business processes (Crick

& Chew, 2017). This is against the backdrop that much of the BPM field work assumes implicitly that business processes are deterministic machines that can be purposefully designed and implemented in the organisation in a top-down process (Beverungen, 2014). Arising from the above, information system scholars have begun looking to business process transformation for answers (e.g., Eom et al., 2022; Kirchmer, 2021, 2022; Svetlana et al., 2022; Weerakkody et al., 2021). In particular, Baiyere et al. (2020) argue that "the context of digital transformation necessitates a rethinking of the dominant assumptions that have characterised how we think of BPM" (Baiyere et al., 2020, p. 256).

The realisation of citizen-centric services in the public sector requires breaking traditional silos and transforming existing institutional structures and processes (Weerakkody et al., 2021). There are many different business processes involved in the operation of health insurance. These include health-insurance underwriting (Mourmouris & Poufinas, 2022), claims processing (Rawat et al., 2021), enrolment, customer service and billing (Renner-Micah et al., 2020c). While attempts have been made at re-designing some inefficient processes within the larger context of BPM in health insurance (e.g., Alahmadi et al., 2014; Rebuge & Ferreira, 2012; Smirnov et al., 2012), it has generally not yielded the expected outcomes. Moreover, these have been largely outside the domain of information systems research. Numerous challenges still underpin the efficient operationalisation of business processes under health insurance (Renner-Micah et al., 2020a). The research problem identified is one of limited empirical research in IS on business process transformation in health insurance. Related to this are the limited theory-driven research and the context gap of business process transformation in developing countries. As a result, there is a need for a study to address this gap, especially one that focuses on digital transformation of business processes (Baiyere et al., 2020). This paper extends the current research focus to examine the question of how a health insurance organisation in a developing country undergo business process transformation and under what institutionalisation context. In addressing the question, the study uses an interpretive case study approach as the methodology (Barrett & Walsham, 2004; Walsham, 2006) and institutional theory (Scott, 2014) to understand how a health insurance organisation went through a business process transformation in a technologically mediated change.

The remainder of the paper is structured as follows: Section 2 presents the literature on health insurance and business process management. Section 3 introduces the theoretical foundation for

the study. The research setting and methodology are described in section 4. The case description is presented in section 5. This is followed by section 6 and section 7, presenting the analysis of findings and discussions, respectively. The paper concludes in section 8, providing the study's implications and suggestions for future research.

2.0   Research Background: Health Insurance and BPM

In many developing and low-income countries, health insurance is increasingly considered a viable funding mechanism for financing healthcare for citizens (Amporfu et al., 2022; Ezenwaka et al., 2022; Wu et al., 2022), especially for the poor or bottom of the pyramid (Nayak et al., 2019). Ghana introduced the National Health Insurance Scheme (NHIS) in 2003 to remove financial barriers to accessing healthcare and provide quality and affordable healthcare to the Ghanaian population (Baltussen et al., 2006). This social model's fundamental tenet is that the production of health services is the responsibility of health care providers such as hospitals, clinics, pharmacies and other care providers while purchasing is institutionalised in the health insurance organisation (payer) to buy health services (Street, 1994). A business process is a series of activities an organisation carries out to achieve a particular outcome. Broadly, organisations can be understood and managed as a system of interrelated processes (Grover & Markus, 2008). Therefore, health insurance business processes and their management entailed some modelling and automation to support the NHIS operations. Figure 1 shows some of NHIS's business processes.

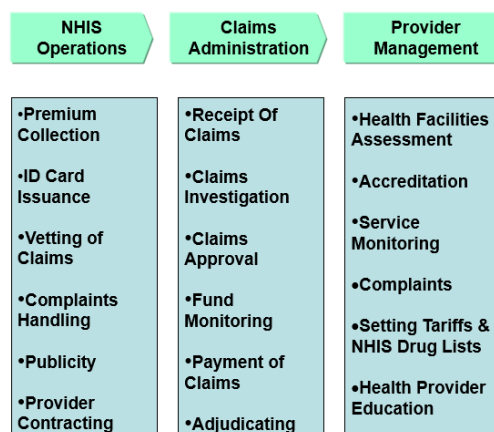| NHIS Operations	Claims Administration	Provider Management
•Premium Collection	•Receipt Of Claims	•Health Facilities Assessment
•ID Card Issuance	•Claims Investigation	•Accreditation
•Vetting of Claims	•Claims Approval	•Service Monitoring
•Complaints Handling	•Fund Monitoring	•Complaints
•Publicity	•Payment of Claims	•Setting Tariffs & NHIS Drug Lists
•Provider Contracting	•Adjudicating	•Health Provider Education

Figure 1.   **Health Insurance Business Processes**

The history of BPM shows that there has been a trend from automating processes to managing processes (van der Aalst et al., 2016). The management of health insurance processes has taken a very identical trajectory. The intended outcome of improving business processes in the case of health insurance, unfortunately, has not always been encouraging. Health insurance is still plagued by process inefficiencies in claims administration, leading to wide-scale fraud and abuse (Amponsah et al., 2022; Dutt, 2020; Owusu-Oware et al., 2018; Singh et al., 2021), the problem of identity management culminating from lapses in the process of identity card issuance (Effah & Debrah, 2018) and member registration process that has been most often chaotic (Renner-Micah et al., 2020a). It is perhaps not a coincidence that van der Aalst et al. (2016) argue that BPM research has frequently focused excessively on specific artefacts, i.e., process models. However, better models do not automatically yield better processes.

3.0   Theoretical Foundation: Institutional Theory

The theoretical lens underpinning this interpretive case study is institutional theory (Scott, 2014). Theory application in IS studies is underpinned by conceptions of the relationship between the social (i.e., human collectives) and technology. According to institutional theory, situated actors act within an institutional framework of rules, norms, knowledge and sedimented discourses. The institutional conditions get reproduced in the course of action, but they may also be modified or transformed by intentional or nonintentional activities. This study draws on selected elements from institutional theory to analyse the phenomenon of business process transformation.

Institutional factors and the institutionalisation process are two ways institutional theory is prominent in organisational studies (Mignerat & Rivard, 2015). The factor approach sees the regulative, normative, and cultural institutions as a means of action in organisations and their environment (Scott, 2014). Conversely, the institutionalisation process explains how institutions emerge, become stable, change, and phase out. Institutionalisation comprises two sub-processes, deinstitutionalisation, and reinstitutionalisation. First, deinstitutionalisation refers to the cessation of previously established institutions due to identified weaknesses (Kwiek, 2012). Second, reinstitutionalisation relates to the process of introducing a new form of institutional order with new arrangements different from the previous (Currie & Swanson, 2009; Scott, 2014).

Researchers can benefit from institutional analysis to better understand how institutions shape the design, implementation, use, and outcome of technologies within or across organisations (Orlikowski & Barley, 2001). Studies in recent years have adopted an institutionalist perspective to examine IT innovation, development, use and implementation (Dang & Pekkola, 2020; Mignerat & Rivard, 2015).

In this study, deinstitutionalisation refers to attempts to remove constraining institutions and logic in BPM, such as using manual or paper-based processes within the health insurance setting. A characteristic of reinstitutionalisation is as an intervention into an existing social order to improve the state of affairs. This study views the development and use of digital technologies within a business process transformation context to improve or alter processes as a case of reinstitutionalisation.

4.0   Research Setting and Methodology

This study is part of a larger research project into digital transformation of health insurance in a developing country. The current study focuses on business process transformation within health insurance from an institutionalisation perspective from a developing country context.

4.1   Methodology

The study uses qualitative research methodology (Myers, 2013) and underlying assumptions of the interpretive paradigm (Walsham, 2006) to understand the phenomenon of business process transformation. A central tenet of interpretivist philosophy is that multiple realities in social contexts are socially constructed and subject to the different subjective interpretations people ascribe to them (Hassan et al., 2018). The setting up and carrying out of fieldwork is the basis of interpretive study and generally attempts to understand phenomena through the meaning people assign to them (Stahl, 2014). The vehicle for interpretive investigations is an in-depth case study, where research involves frequent visits to the field site over an extended period (Klein & Myers, 1999; Walsham, 1995). Case study methodology is particularly useful when the researcher wants

to explore a phenomenon within a complex real-world scenario (Myers, 2013), such as in the health insurance sector.

4.2 Data collection

In line with the interpretive case study tradition (Walsham, 2006), this study obtained data from multiple sources, including interviews, observations, project documents and websites. It included semi-structured interviews with key informants with knowledge and experience with the business process transformation initiative, its implementation, and its outcomes. The key informants' selection was through purposive sampling (Miles et al., 2014) based on the relevance of their role in understanding the phenomenon. Additional insights were obtained through interaction with some of the digital artefacts involved. Data collection took place from December 2021 to September 2022. Interviews lasted between 40 minutes and one hour and were tape-recorded, transcribed, and verified by participants.

No. of Interviewees	Organisation	Interviews
30	Health Insurance Organisation	Director of MIS (1), Deputy Director (2), Regional ICT Coordinators (10), Datacenter Administrators (3), Database Administrators (2), Manager ICT Business Systems (1), District MIS Officers (10), Application Developer (1)
2	Service Provider/Consulting firm	Project Manager (1) Senior Solutions Architect (1)

Table 1   Interviewee profile

4.3 Data analysis

Based on the interpretive tradition, data analysis occurred alongside data gathering (Walsham, 2006). The concepts informing the analysis are from institutional theory. Data analysis was aimed at identifying themes relevant to significant aspects of reinstitutionalisation and deinstitutionalisation as well as outcomes. Using these concepts from institutional theory, the researchers identified themes related to institutions that enabled or constrained business process transformation in health insurance. From the interpretive analysis perspective, the goal is not to

test the theory but to use it as a sensitising device (Klein & Myers, 1999) to allow understanding to emerge from the data. Where necessary, follow-up with the interview participants was undertaken to verify emerging findings or seek additional data following the principle of the hermeneutic circle.

5.0   Case Description

The following section presents the case organisation and the institutional context of business processes and looks at the role of digital technology as a driver of business process transformation. Health insurance is attracting more and more attention in low and middle-income countries as a means for improving healthcare utilisation and protecting households against impoverishment from out-of-pocket expenditures. With an estimated population of 29 million as of 2018, Ghana is classified as a middle-income country. Healthcare financing has gone through a chequered history since its independence in 1957. Past governments have pursued policies and programmes with varying degrees of success to accelerate economic growth and raise living standards. The National Health Insurance Scheme (NHIS) was established under Act 650 in 2003 and later revised under Act 852 in 2012 by the Government of Ghana. There are sixteen (16) regional Offices in the country's sixteen (16) political regions and a total of 166 district offices & 5 registration centres. The scheme is meant to provide essential health care services to a person resident in the country through the District Mutual Health Insurance Scheme (DMHIS) and Private Health Insurance Schemes (PHIS). The scheme's mission has been to secure the implementation of the national health insurance policy that ensures access to essential healthcare services for all residents of Ghana and drive universal health coverage (NHIA, 2021).

The call for process efficiency across the health sector has been rife. The healthcare sector in Ghana, including health insurance, has achieved notable improvements in processes and user experience of services. However, process transformation has taken much longer, and the outcomes have not always been visible. We analyse the interactions and transformations of health insurance processes through the lens of the institutionalisation process.

5.1 Stage One: Pre-Automation

From the inception of NHIS between 2003 - 2008, much of the underlying processes of its operations started with much paper-based workflow between the NHIS, healthcare providers (HCPs) and the insured. For example, member registration was done using printed paper forms. Subsequently, members were issued printed booklets containing biographic information and a photo ID. At the health care providers (HCPs), the NHIS furnished the HCP with a paper-based compilation of the names of health insurance members registered under that health care provider to be used as a guide for verifying eligibility for health services. The health care provider records all medical interactions on a printed paper claim form, including details such as diagnosis and treatment after attending to the NHIS member. Each form had a unique number printed in advance, referenced a specific member, and included the services received. The healthcare provider will usually batch thousands of paper claim forms monthly to be submitted to the NHIS for reimbursement. In terms of the process for submitting claims, healthcare providers monthly send an envelope with claim forms, including a summary form describing the health provider name, the total number of claims being submitted, and the total amount being claimed to the NHIS. Some healthcare providers also send a spreadsheet with the claims data. The contents of the spreadsheet usually vary per provider.

The growth recorded in service utilisation from 2010 presented significant challenges to the predominantly paper-based environment. The time and effort invested in everyday paper-based workflows were longer and more cumbersome. A paper-centric culture, in general, meant that NHIS had to contend with offices filled with boxes of paper claims resulting in retrieval, processing, archival challenges and long delays across the process areas.

5.2 Stage Two: BPM and Automation

With the challenges described in the previous section, the stage was set for a comprehensive strategic plan to guide its operations and streamline its activities to enable it to achieve its utmost objective of providing affordable basic healthcare services. A senior management official who was asked about the objective of this strategic plan had this to say:

"*Based on the issues and challenges with implementing the NHIS programme, we were looking at how the manual NHIS business processes would be modelled and automated to*

support NHIS operations. The goal was one of transformation into a solution-based organisation."

The quest to bring significant improvement in the operation of the NHIS came in the form of business process modelling and the introduction of IT solutions to automate these processes based on the outcome of the business process modelling activities. This started with mapping all business processes into outbound and in-house processes. For example, the member registration process is considered a key outbound process, i.e., the gateway of applicants into the national health insurance program. The process occurred at the local community level through registration agents and the scheme's district offices. Figure 2 shows an example of a modelled member registration process.
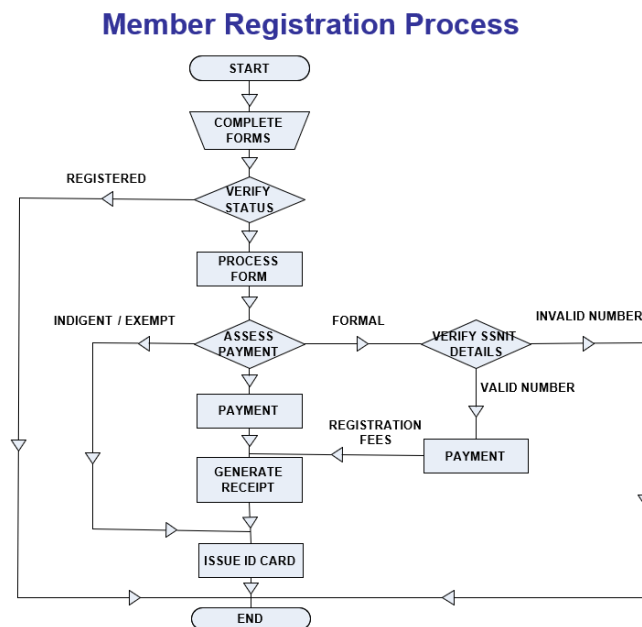

Figure 2.   **Modelled Member Registration Process**

Mapped and modelled business processes were linked with IT solutions for automation. For example, the IT solution linked to the remodelled member registration process allowed fingerprints to be taken and mobile registration kits capable of issuing instant identity cards. Other business process areas, such as health provider management and customer service, were similarly modelled and automated.

5.3   Stage Three: Business Process Transformation

Despite the improvements made to business processes through mapping, modelling and automation, there were nevertheless significant process bottlenecks between 2012 - 2015. These included inadequate insurance claim processing capabilities, challenges with the production and distribution of membership identification cards, lack of data integrity, system slowness and significant downtime due to increased daily transactions resulting in members waiting in long queues at district offices. Health insurance penetration was at an all-time low. While business process management and automation improved individual business processes, the downside was that they were siloed and disconnected. In 2016, NHIS digital transformation was mooted to improve overall business performance and innovation by adopting digital technologies and implementing new ways of managing the business process, organising and executing work. This required the alignment of IS with business needs on the one hand and with transformation goals on the other. Having automated a significant number of business processes, the natural roadmap was to complete the missing components by creating an integrated end-to-end system to address the transformative needs. These were executed under three broad areas of data, infrastructure and people.

5.3.1   Electronic Data Interchange (EDI)

Under an electronic data interchange (EDI) project, islands of information and disconnected processes and siloed applications were brought together under a unified platform improving member management, claim accuracy, reducing errors and frauds, and minimising processing times. A business intelligence (BI) system was introduced, giving a clearer view of the organisational data and enabling a deeper understanding of existing processes.

5.3.2   Infrastructure Changes

Ultimately, processes and services will be impacted without the proper digital infrastructure supporting them. The objectives of the infrastructure changes were to resolve system slowness and significant downtime, thereby increasing system availability, protecting sensitive data, and assuring business continuity and disaster recovery. The infrastructure change also involved migrating from physical servers to a virtual machine architecture with increased storage capacity.

5.3.3 Improving People Skills

In order to effect the kind of transformation that was being envisaged, people's skillsets needed to be improved through training programs to ensure that managers, developers, analysts, engineers, administrators and front-line workers were empowered with the needed skills. In a series of workshops and training sessions undertaken in all regions, front-line workers were trained on the integrated platforms. Datacenter engineers and administrators were trained and sponsored to be certified in various technical disciplines. Senior managers also received training in business intelligence and analytics.

6.0 Analysis of Findings

The case study's findings present some interesting issues for analysis. Based on the research question and institutional theory as a lens, this section draws on the institutionalisation process approach to analyse the case. The notion of deinstitutionalisation is used to explain the existing systems' problems and other inefficiencies and the reason for their replacement. Subsequently, reinstitutionalisation is used to analyse various interventions and their outcome.

6.1 Process of Deinstitutionalisation

From the case description, the focus of deinstitutionalisation was to remove barriers and constraining institutions that had made the operationalisation of business processes ineffective and inefficient across the different stages. In stage one, pre-automation, such barriers and constraining institutions comprised the manual and predominantly paper-based culture. The member registration process involved recording the member registration information on printed paper forms and being issued a printed booklet containing biographic information and a photo ID for member identification to use at accredited healthcare providers. Similarly, the claims process flow consisted of an end-to-end use of printed forms for submission and vetting. Notwithstanding the use of spreadsheets to submit claims by some healthcare providers, there was no standard to this means. Therefore, it was fraught with errors, significantly causing delays in the claims administration process. Existing administrative guidelines and laws governing health insurance administration also legitimised the paper printing and physical distribution culture. The adverse

effects, therefore, resulted in inefficient processes. Consequently, the focus of managing the business process and automation was to remove such constraints and barriers.

While resorting to adopting business process management and automation brought gains in stage two, it nevertheless left barriers and constraining institutions to deinstitutionalise. Automating the member registration process and claims process resulted in improvement but brought unintended consequences. Automation, for example, meant there was, for a period, an increase in daily transactions at the point of registration, at the point of health service utilisation and the submission of claims for this utilisation. This resulted in system slowness, significant downtime, and long waiting queues at various health insurance offices across the country and even at hospitals because the means to authenticate members to determine eligibility to receive services was also impacted. Rather than increasing the uptake of health insurance, it instead stalled. Siloed and disconnected processes as barriers and constraining institutions needed to be deinstitutionalised.

6.2   Process of Reinstitutionalisation

In stage one of the case description, once an inhibiting or series of constraining institutions are identified to be deinstitutionalised, the organisation works towards process automation. The reinstitutionalisation process introduced IT solutions comprising registration kits and an online member registration system to replace manual and paper-based processes. Similarly, under health provider management, the submission and vetting of insurance claims were automated using IT solutions. The IT solution was intended to remove the existing cultural practices by migrating processes online so there would be no need to print and physically work with paper forms. These served as the infrastructure for reinstitutionalisation.

The case for reinstitutionalisation in stage three resulted from the unintended consequences in stage two. This attempt at reinstitutionalisation came with the intention of a business process transformation that sought to transform more areas of operations than before. The electronic data interchange (EDI) project brought together islands of information and disconnected processes from siloed applications unto an integrated digital platform. The infrastructure changes resolved system slowness and significant downtime, thereby increasing system availability, protecting sensitive

data, and assuring business continuity and disaster recovery. As part of the reinstitutionalisation, people's skillsets were improved through training programs to ensure that managers, developers, analysts, engineers and administrators were empowered with the needed skills.

7.0   Discussion

In line with the research question of how a health insurance organisation in a developing country undergo business process transformation and under what institutionalisation context, this section discusses the research findings in terms of an incremental and gradual transformation rather than a complete and radical transformation.

7.1   Going Paperless

Findings from the analysis show that the culture of preference for paper forms and documents persisted across the various stages. Two reason account for this. First, business process mapping, process modelling and the subsequent business process automation seem to be conceived after the information has been physically captured on paper rather than a paperless decision informing the business process management actions. Secondly, existing administrative guidelines and laws governing health insurance administration generally legitimise the paper culture. For example, paper claim forms received from healthcare providers after vetting, approval and payment need to be stored and archived for not less than three years for purposes of future audits. Going paperless therefore remains a distant dream as the absence of laws facilitating e-signature, digital documents, and digital workflow constrain paper culture's deinstitutionalisation(Effah & Nuhu, 2017). Within developing country health insurance information systems literature, a red tape culture based on excessive preference for physical documents has been identified as a source of inefficiencies and process transformation bottlenecks (Renner-Micah et al., 2020b).

7.2   The Context of BPM

A failure to consider the existing regulations and a cultural predisposition that had institutionalised the practice and preference of paper forms over digital alternatives was one of the key reasons why the intended process automation failed to be wholly deinstitutionalised. In a related study, Klun

and Trkman (2018) argue that the field of BPM seems to have restricted itself increasingly to process modelling and needs to embrace new theoretical insights and artefacts within the context of digital transformation. From the findings, process modelling leading to the automation of membership registration process followed a similar path. As observed by van der Aalst et al. (2016), there is a need to recognise that organisations are faced with not only technical challenges but also sociotechnical issues that go to the heart of how technology is used operationally in business processes to deliver the new or changed capabilities. Indeed one of the reasons ascribed for the frequency of BPM project failure is the inability to sufficiently address different contexts (Brocke et al., 2016).

7.3   Continuous Improvement

The findings show that organisations must undergo continuous improvement to achieve business process transformation (BPT). This is revealed in two ways: first, focusing on developing business process management capability that is proactive rather than reactive and considers the opportunity-rich environment and generative capacity of digital technologies from a sociotechnical perspective. This goes beyond the logic of simply modelling business processes. Secondly, the IT infrastructure design and its alignment needs to be in sync with the business process transformation objective to adequately support the business processes. Both of these occur over time through iterations.

Baiyere et al. (2020) have taken this discussion forward and proposed that the three dominant logics emphasised under BPM, i.e., modelling (process), infrastructural alignment (infrastructure) and procedural actor (agency) logics need to be re-examined in the context of digital transformation. The authors propose new logics of light touch processes (process), infrastructural flexibility (infrastructure) and mindful actors (agency). Nevertheless, the IS literature supports the continuous improvement perspective of BPT as an ongoing, cross-functional process-focus change initiative (Müller et al., 2017).

8.0   Conclusion

The purpose of this study was to understand how health insurance organisations undertake business process transformation. The study contributes to both IS and health insurance literature as a first

attempt to offer rich insight into business process transformation of a health insurance organisation in a developing country context. Significant contributions of this study stem from a historical and evolutionary perspective based on national health insurance organisations' account of their quest to transform their business processes digitally.

The study contributes to research, practice and policy. For research, this paper offers theoretical and empirical contributions that a deeper examination of the institutionalisation context can provide vital insights into how business process transformation could be improved. Based on an analysis of the case in the health insurance context, we show that institutional elements constrain achievement of goals that organisations aim to achieve by implementing business process transformation. On the one hand, institutional constraints interact with business process transformation, but at the same time, they motivate action and serve as an important driver for both deinstitutionalisation and reinstitutionalisation. This study is significant for health insurance in general but particularly for those in developing countries where the experience of business process transformation remains limited.

From a practice standpoint, the study is expected to contribute to a deeper understanding of health insurance business process transformation. It explicates actions that have been possible to take and constraints that reduce the ability and motivation of health insurance organisations towards digital transformation. While technology and automation are essential in business process management, ultimately, to achieve business process transformation, the role of human factors cannot be ignored. Moreover, health insurance managers need to implement continuous improvement of processes to ensure that processes are constantly monitored, evaluated, optimised, and aligned in a triad of people, processes, and technology (i.e., infrastructure changes).

For policy, government and policymakers should consider the benefits of going paperless. As organisations and industries become more complex and the world continues to come to terms with pandemics, case in point, Covid-19, this rethink is now more than ever critical to delivering efficiencies, especially within the health system. Organisations and the workforce within them

need access to files and source documents 24/7, anywhere-anytime, as technology drives every aspect of what we do today.

The study is limited by a single case study in one developing country and the use of institutional theory. This implies that other elements may have been blanked out due to these limitations. However, the study findings can be generalised to similar settings in line with interpretive research. Future studies can explore the institutional enablers and constraints of business process transformation in private health insurance.

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