Cost innovation – a value-creation strategy to transform over-priced industries

Brian Leavy

Innovation is typically thought to mean more: more flavors, more options, more features. What makes costovation (cost innovation) so radical is that it flips this understanding on its head and says that sometimes the winning approach is to do less. – Stephen Wunker and Jennifer Luo Law[1]

We know that Indian hospitals, doctors, and administrators have traditionally looked to the West for advances in medical knowledge and we think it’s time the West started looking to countries like India for innovations in health care delivery. – Vijay Govindarajan and Ravi Ramamurti[2]

One of the most exciting developments in the strategy field over the last two decades has been the renewed emphasis on value creation, which brings innovation and entrepreneurship right back to the heart of the strategy development process.

Among the pioneers of this movement are INSEAD professors, W. Chan Kim and Renee Mauborgne who, in the late 1990s, developed the concept of “value innovation” as a new logic for crafting strategic moves aimed at the creation of new market demand.[3] For Kim and Mauborgne, the essence of “blue ocean” strategy lies in the creative deconstruction and reconfiguration of value propositions in compelling ways that can deliver a quantum leap beyond the industry’s current “red ocean” value-cost frontier through raising buyer value and lowering company costs simultaneously. Such value breakthroughs usually require an innovative business model, which is ultimately what makes an effective value innovation strategy so difficult for others to replicate.

The basic value equation is:

\[ \text{Value} = \frac{\text{Customer Benefit}}{\text{Cost}} \]

Looking more closely at this relationship we can see that the blue ocean approach is not the only way to achieve such a quantum leap in value. Putting the primary emphasis on innovative cost breakthroughs is another, and one that remains underutilized in practice.

Brian Leavy is an Emeritus Professor of Strategy at Dublin City University Business School (brian.leavy@dcu.ie), a Strategy & Leadership contributing editor and author of “Value innovation and how to successfully incubate “blue ocean” initiatives,” Strategy & Leadership, Vol.46, No.3, 2018.

Stephen Wunker and Jennifer Luo Law are co-authors of Costovation: Innovation That Gives Your Customers Exactly What They Want and Nothing More © StartupNation.com 2018
Two recent books have valuable insights to offer company leaders and strategists on how they might go about pursuing transformative cost innovation opportunities.

- In *Costovation: Innovation That Gives Your Customers Exactly What They Want and Nothing More* (2018), marketing gurus Stephen Wunker and Jennifer Luo Law highlight the potential of cost innovation in helping to create new market demand and transform the competitive dynamics in any industry sector, and they offer guidance on how to develop such a strategy.

- In *Reverse Innovation in Health Care: How to Make Value-Based Delivery Work* (2018), strategy and innovation researchers, Professors Vijay Govindarajan and Ravi Ramamurti highlight the potential for cost innovations in emerging markets to help transform health care delivery in the West, enhancing patient outcomes, while also making health care more accessible and affordable.[4]

"Cost innovation" strategy – What it is and how to make it work

The notion of cost as a potential target for breakthrough innovation in its own right is still not widely recognized. As marketing consultants Wunker and Luo Law point out in *Costovation*: innovation and cost are still most often seen as “magnetic opposites,” the one in natural tension with the other. They set out to challenge this assumption and show how “innovation and cost-cutting” can become “a powerful duo, capable of reshaping markets and creating long-term competitive advantages.” [See Figure 1 “What is Costovation?”]

Take Planet Fitness, which offers gym facilities for personal fitness with a difference. Basic membership costs around $10 per month. The company is able to offer this ultra-low price because it deliberately forgoes many of the features and facilities included in the industry’s more typical value proposition, including towels, a pool, a basketball court, childcare, steam rooms and saunas, free Wi-Fi and so forth. At the same time Planet Fitness, while “cheaper to run that anything else on the market,” still “ranks first in customer satisfaction – even ahead of luxury giants like Equinox,” and the company is expanding rapidly, with more than seven million members in over a thousand locations across North America.

Planet Fitness is not designed for the fitness fanatic. Its value proposition is targeted at “a customer segment that most gyms rule out as unprofitable – the casual and first-time exercisers.” It delights its core customer base by giving them exactly what they value most and eschewing non-essentials. The company has “made careful, and sometimes difficult, choices to have a simple, low cost offering.” The ultra-low fees make it easier and less intimidating for casual users and first timers to join up, and floor space is primarily devoted to the activities most attractive to them like “rows and rows of cardio machines” rather than “heavy weights” areas, which have little appeal for most of this particular customer base.
Cost innovators like Planet Fitness aim at “purposefully offering less as a way to satisfy more,” by tailoring the offering to what the target customer most values and offering it at the most compelling price possible. It is an approach that is both intensely “customer-centric and low cost at the same time.”

Wunker and Luo Law’s book is replete with other examples, including Consumer Cellular, a telecoms operator with a simple, low-cost value proposition tailored to the needs of senior citizens, Drybar, a popular hair salon chain that provides wash and blow dry only, JamesAllen.com, an online diamond ring retailer, and the Yotel hospitality chain. Yotel rooms are typically located at major international airports, often within airport terminals. The value proposition is spare but offers the time conscious traveler “exactly what they crave – a comfortable bed, an excellent shower, strong Wi-Fi, proximity to their next flight, and fast check-in,” all at a very attractive price. More industries “need a Yotel – a company that excels at offering something at a radically lower price, for a well-defined customer set,” according to Costovation.

To date, many such companies have been pursuing cost innovation strategies based on their own entrepreneurial insights, with little systematic guidance from the
business literature. Costovation sets out to identify patterns that others can learn from and highlights three core traits that successful cost innovators seem to share:

- **A breakthrough perspective.** Cost innovation involves taking a fresh approach to the conventional way of delivering value in any given industry and looking for ways to reimagine it.

  “If you see the market in the same way that your competitors do, then you will solve problems in the same way that they do too.” The willingness and ability to take a “daring new perspective” and to challenge existing assumptions has been a “precondition for every single costovation” that Wunker and Luo Law unearthed in their research.

- **Relentless focus.** Successful cost innovators work hard to ensure that their offer is precisely targeted to neither overserve nor underserve, and are willing to make the difficult choices involved. The ever-present danger is “feature creep” which “affects all businesses, all the time” but the great cost innovators know how to “simplify” their products and services to “what matters most” to their customers and subtract what customers “are willing to make calculated trade-offs for.”

  In the case of Planet Fitness, some trade-offs were likely to have been easier to make than others, such as not having a swimming pool or offering day care, but opting for dramatically smaller free weight sections and deciding not to offer a personal trainer option were probably more difficult calls to make. The cost and complexity of trying to be too many things to too many different customers is the antithesis of cost innovation. The goal is to nail the target customer's job-to-be-done as precisely as possible, forensically eliminating any cost drivers that are extraneous to that requirement.

- **The willingness to blur boundaries.** Many cost innovators have found “rich” opportunities by looking closely at “invisible” elements across the value chain, such as how the product is made, how it is delivered, how it is sold, and how the company partners in the value creation process. Reimagining and reconfiguring the value chain to release trapped value can be a very fruitful target for cost innovation, and Costovation features many such examples, including that of diamond merchant James Allen (see box “Value chain cost innovation at JamesAllen.com”).

### Healthcare – an industry ripe for cost innovation strategies

One of the sectors highlighted in Costovation as most ripe for cost innovation is the healthcare delivery industry.

In *Reverse Innovation in Health Care: How to Make Value-Based Delivery Work*, Vijay Govindarajan and Ravi Ramamurti argue that Western health care providers have

“The blue ocean approach is not the only way to achieve a quantum leap in value. Putting the primary emphasis on innovative cost breakthroughs is another, and one that remains underutilized in practice.”
much to learn about how to pursue imaginative, and urgently needed, cost innovation from pioneers in the developing world, particularly India.[5]

Though the United States continues to be the global leader in medical science, the record in the delivery of health is a very different matter. As Govindarajan and Ramamurti point out, “In 2016, the United States spent a staggering $3.3 trillion, or almost 17.9 percent of GDP, on health care.” Yet the quality of American health care remains uneven at best.[6]

The runaway cost of healthcare delivery remains a major global concern, and over the last decade strategy gurus, Michael Porter and Clayton Christensen, have each examined the sector through their well-known perspectives to understand why management insights that have helped transform other industries and make their offerings more affordable, accessible and reliable over time, have yet to take root in healthcare.

For Porter, the health care delivery sector needs to be redesigned to run more widely on the “principles of value-based competition,” foremost among which are that “the focus should be on value for the patient, not just lowering costs,” that “competition should center on medical conditions over the full cycle of care,” that “high-quality care should be less costly” and that “value must be driven by provider experience, scale, and learning at the medical condition level.”[7] In a similar vein, Christensen believes that the “lack of business model innovation” compared to other sectors “is the reason health care is unaffordable.” The health care industry continues to over-rely on the expensive “all things to all people” general hospital model, with its consultant-intensive, high overhead, batch production mode of delivery, and it underutilizes the two other generic models to be found in most other sectors – the low-overhead, flow production model and the facilitated self-help network.[8]

So where is the catalyst for urgently-needed innovation now most likely to come from? According to Govindarajan and Ramamurti, it will come from the developing world through “reverse innovation” which “refers to the case in which an innovation flows from a poor country to a rich country rather than the other way around.”

Reverse Innovation in Health Care highlights seven exemplars in Indian health-care that are already pioneering value-based competition: Aravind Eye Care System (Eyes), Care Hospital (Knee and Hip Replacements), Deccan Hospital (Renal Care), Health Care Global
Oncology (Cancer Care), LifeSpring Hospitals (Maternity Care), LV Prassad Eye Institute (Eyes) and Narayana Health (Cardiac Care and other specialties). All provide world-class healthcare at ultra-low prices, with Aravind ($30 cataract surgery) and Narayana ($2000 cardiac by-pass graft) being the best known outside of India.

Professors Govindarajan and Ramamurti highlight “a common set of five principles” characterizing these exemplars that operate in a “virtuous cycle” to produce “value-based health care that is high quality, low cost, patient centric, and available to those who seek it.”

- Principle 1: Pursue an inspiring purpose: quality health care for all.
- Principle 2: Configure assets in a hub-and-spoke design.
- Principle 3: Leverage technology.
- Principle 4: Adopt task-shifting.
- Principle 5: Create a culture of ultra-cost-consciousness [See Figure 1.1].

To illustrate these principles the researchers examine the practices of Narayana in action.[9]

Narayana Health was founded by cardiologist, Dr. Devi Shetty in Bangalore in 2001, with a vision to “treat all patients regardless of their ability to pay.” At the time India was estimated to need approximately 2.4 million heart surgeries a year, while only 60,000 were actually being performed nationally due to lack of capacity and affordability.
An inspiring purpose and a commitment to being value-driven. Dr. Shetty made it his personal mission to help make India the first country in the world to be able to “dissociate health care from affluence.” He recognized that charity was “not scalable,” and that his new enterprise would have to be self-financing if it was to be able to grow quickly and help close the gap between national need and capacity. So the model he developed was one in which the patients who could afford to pay full price would subsidize those who could not.

Taking his cue from the manufacturing, retailing and technology sectors, he saw no reason why the relentless drive to lower costs might have to come at the expense of quality. As he sees it, Indian global IT companies like Infosys “are world class, because their quality keeps going up as their costs decrease,” while health care “is a peculiar beast where in spite of all the new technology, costs keep going up all the time.” It is Shetty’s ambition to “buck that trend,” and at the heart of this vision is a commitment to being value-driven.[10]

Process innovation through task shifting and protocol-based operations. Narayana started out as a hospital system devoted to cardiac care, and from its foundation it embraced a “focused factory,” low overhead, flow operational model. The philosophy is that affordable healthcare should be “all about process, protocol and price.” So the treatment process is systematically broken down into a sequence of steps that allows “the highest paid surgeons to do little or nothing that can be done by less-skilled staff.”[11]

Narayana has been a pioneer in the training and use of intermediate-level specialists between the GP and the fully trained cardiologist, and such task-shifting is not confined to the medical and paramedical professionals. At Narayana, the patient’s family is coopted into the treatment process to help directly with post-operative hospital care. This practice not only “frees up nursing staff for other work” but also “eases the transition to reliable, high quality home care, reducing readmissions by 30 percent.”[12]

An obsession with frugality and a culture of continuous improvement. Narayana is obsessive about keeping costs in check and continually looks for innovative ways to reduce them. As Dr. Shetty says, “In health care, you cannot do one big thing to reduce price. We have to do a thousand small things.” For example, Narayana uses generic drugs wherever possible, and digital imaging in its X-ray scans, which is much cheaper than the photographic alternative. It continually takes “a hard look” at everything to see where further opportunities for cost savings that don’t compromise on quality might be found.[13]

This “culture of frugality” has “become the defining spirit of the Narayana enterprise” and extends to all aspects of its operating model, including the cost of building new hospitals, the acquisition and maintenance of its most expensive capital equipment, like PET-CT scanners and MRI machines, its purchasing costs and inventory management and even into the operating theatre itself, where its world-leading use of
“beating heart” surgery for most cardiac by-pass operations reduces the need for expensive heart-lung bypass machines.

Most importantly, it extends right into the mindsets, attitudes and behaviors of the medical professionals themselves. Narayana encourages its doctors “to stop and think about the value of every procedure,” and makes sure that they know the costs involved.[14] It does this through the use of an innovative accounting system that tracks profit and loss on a daily basis. In this way all of its doctors know on any given day how many subsidized operations Narayana will be able to afford the following day and still remain profitable.

A “health city,” a hub-and-spoke system and leadership in telemedicine. One of Dr. Shetty’s more recent innovations is the “Health City” concept, which expands the Narayana Health system to other specialties like oncology, nephrology, neurology and orthopedics. Its goal is reducing the cost of tertiary health care by adding economies of scope to the economies of scale of the cardiac care model. As Dr. Shetty explained, Narayana had “reached a plateau in cost reduction by increasing our volume of surgeries” but “our resources are still underutilized – our machines, sterilization department, blood bank etc. can be used by other hospitals within Health City, and this will drive unit costs even lower.”[15] Health City preserves the focused factory/flow process advantages of the basic Narayana operating model by housing each of the specialties in its own dedicated facility, all co-located on a multidisciplinary campus.

From the beginning, Dr. Shetty realized that his Narayana health system would also have to extend into primary care in order to meet the challenge of bringing cardiac care out into the countryside where the majority of Indian population still lives. While his enterprise was still small, he relied on the use of mobile “outreach camps” to do this.[16] Moreover, to encourage more of those being referred to hospital to follow up, he partnered with a milk cooperative in his home state of Karnataka to found a micro-insurance scheme for the local farmer-suppliers called Yeshasvini.[17] As the enterprise continued to grow, Dr. Shetty was able to evolve his initial mobile camp approach into the establishment of more permanent regional cardiac-care units (CCUs). Narayana has also become a world leader in the use of telemedicine, which allows it to operate these CCUs at ultra-low cost in a very effective hub-and-spoke configuration with its main hospital network.[18]

Narayana is now a global pioneer in the use of technology in health care delivery more generally, which is an integral part of Dr. Shetty’s overall vision.[19] It is currently partnering with leading technology companies like Oracle, Hewlett Packard and others as it seeks to make its culture of learning and continuous improvement ever more data-driven, its operations ever more efficient and its service to its patients ever more responsive, effective and accessible, both financially and geographically.[20]

The “reverse innovation” potential impact of the Indian pioneers

In sum, what all seven Indian exemplars demonstrate is how the value-based principles highlighted by Porter and Christensen as key to transforming any industry to make it more reliable, accessible and affordable can also work in health care, if given a chance, and many of these Indian cost innovations are already spreading to other poor countries in the developing world, especially in Asia and Africa.

How likely are they to make an impact in the West and how soon? Reverse Innovation in Health Care features several examples of Narayana-type experiments already happening in the United States, including those of the University of Mississippi Medical Center, Iora Health and Ascension Health.[21] In the case of Ascension, company leaders have been to India to study the Narayana health care system at first hand, and the two organizations have
recently partnered in the establishment of a Narayana Health City on the Cayman Islands, just an hour’s flight from Miami. While already serving patients in its immediate Caribbean hinterland, the eventual aim is to attract the business of large self-insured US organizations, like Walmart, Home Depot and others.

Whether and when this happen, and to what extent, “time will tell,” but as Govidarajan and Ramamurti put it, for other players in the U.S. health management market, the Cayman Islands may now be “closer” than they think. [22]

---

**Value chain cost innovation at JamesAllen.com**

James Allen (JamesAllen.com) is an online retailer of diamond jewelry whose asset-light business model is able to offer couples a wide selection of engagement rings at a deep discount compared with bricks-and-mortar retailers. The firm operates a “modified drop-ship model” in which it holds no expensive inventory. A couple chooses their diamond from a high quality virtual display on the company’s website, and the order is placed directly with the manufacturer. The manufacturer sends the cut diamond to James Allen for expert inspection before shipping the product directly to the customer. James Allen can then “focus on being more or less a technology company: it can pour its resources into running a website, perfecting its diamond photography” and in this way it is able to “offer among the lowest prices in the industry,” while also being able to “respond faster to new market conditions and trends.”

---

**Notes**


4. All quotes in this Masterclass are extracted from the two featured readings, unless otherwise stated.

   Stephen Wunker is the managing director of New Markets Advisors, a long-term collaborator with disruptive innovation guru, Clayton Christensen, and a former consultant with Bain & Co. Jennifer Luo Law is an associate principal at New Markets Advisors and a former Fulbright scholar.

   Vijay Govindarajan is a globally recognized thought leader in the areas of strategy and innovation. He is the Coxe Distinguished Professor at Dartmouth’s Tuck School of Business and co-author of the New York Times bestseller Reverse Innovation: Create Far From Home, Win Everywhere (2012). Ravi Ramamurti is the University Distinguished Professor of International Business & Strategy at Northeastern University and co-author of Understanding Multinationals from Emerging Markets (2014).


6. Treatment costs are high and unpredictable, hospital readmission rates for Medicare patients run at “a discouraging 15 percent to 16 percent,” U.S. life expectancy is ranked no higher than 43rd in the world, access remains “spotty” and underinsurance is “widespread.” In a “2017
Commonwealth Fund report on eleven industrialized nations the United States ranked “first in healthcare spending and last in overall health-care performance.”

7. Without such realignment, the sector is likely to remain mired in a zero-sum game of “cost shifting” based on bargaining power, with little entrepreneurial impetus to look for overall value breakthroughs. For more on Porter’s value-based principles and their application to the health care sector see Porter, M.E. and Teisberg, E.O. (2006), Redefining Health Care: Creating Value-Based Competition on Results, Boston: Harvard Business School Press.


10. As current group CEO, Dr. Ashutosh Raguvanshi, explains, Narayana strives “to provide the best quality at the lowest cost. That is what we mean by value. We call ourselves a value provider.”

11. For example, in the course of a typical 5-hour cardiac bypass operation at Narayana, the most senior specialist is involved for around 25 percent of the time, with more junior surgeons and nurse intensivists looking after the rest, and “because every motion in the operating suite is choreographed to reduce turnaround time and optimize pay grades,” this allows Narayana surgeons to do “three operations in the time that it takes surgeons at other hospitals to do one.”

12. Family members typically spend three days at the hospital before final discharge and are put to work “tracking vital signs, changing dressings, feeding the patient, cheering on the physiotherapy, and watching for signs that the prescribed anticoagulant drugs were working properly.”

13. For example, the $160 “octopus clamp” that is “routinely thrown away after a single surgery” in the United States, is, following careful sterilization, reused safely up to eighty times at Narayana.

14. According the Dr. Shetty the most expensive instrument in any traditional hospital is “the doctor’s pen” because with the stroke of a pen he or she can say “do that test, do this test,” and too often “they are not necessary.”

15. To give just one example, blood held for transfusions that previously had to be discarded 10 days after its collection as unusable for cardiac surgeries could still be used up to 26 days for bone marrow transplant procedures.

16. A typical mobile unit consisted of a bus with three physicians equipped with ECG machines and emergency medical equipment. Every weekend, the doctors would go from village to village screening the local people, treating “minor issues on the spot” and referring more “serious conditions” to the hospital in Bangalore.

17. For as little as 11 cents per month each member would be covered for hospital treatment up to $2200. By 2017, Yeshasvini had “grown to four million members and eight hundred networked hospitals across the state, and the plan had subsidized more than 100,000 heart operations.”

18. As Dr. Shetty explains: “The beauty of telemedicine” is that “when you hear that somebody is unwell, there is a 99% possibility” that that person “does not require an operation” but rather “requires a medical treatment,” which can often be given on the spot by a general practitioner, backed up by diagnostic imaging and blood testing equipment at the regional CCU, with ready access to the expert advice of the relevant hospital-based senior specialist through videolink. See www.youtube.com/watch?v=Zl8FHjPUjWM&t=237s

19. As he explains: “The thing that addresses the problem of poverty in this world is going to be technology” because while technology “gives the rich people what they have always had” but “just in a better format,” it “will give the poor people what they could never even dream of” and will “make this industry very, very efficient” reducing “mortality and morbidity by at least fifty percent.”

20. Dr. Shetty’s IT partner list is extensive and growing, with Oracle supplying its “cloud-based ERP system,” Hewlett Packard helping to design its current “cloud-based mobile units,” Schiller supplying its “portable ECG machines,” and Stanford Hospital and Accenture working with it to develop a proprietary “decision support system” operable by non-physician ward staff using iPads.

21. For example, the University of Mississippi Medical Center is working on expanding rural access to high quality health care in one of the poorest states, using a telemedicine-based, hub-and-spoke approach.
22. This may take some time as the perception remains among many Americans that “cheap medical care on the Cayman Islands couldn’t possibly equal the quality at a renowned US hospital.” However, as Robert Pearl, former CEO of Permanente observed: “That’s exactly what Yellow Cab thought about Uber, Kodak thought about digital photography, General Motors thought about Toyota, and Borders thought about Amazon.” The pattern in many such disruptions is that the impact may be slow at first and then quite sudden and dramatic.

Corresponding author

Brian Leavy can be contacted at: brian.leavy@dcu.ie

For instructions on how to order reprints of this article, please visit our website: www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com