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**A new view on
hospital and health
systems strategy**



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Executive summary



In any industry, most organizations define themselves in terms of their function (what they do) and their form (how they do it). Ideally, form follows and enables function. Traditionally, hospitals and healthcare systems have thought of their function in terms of the mission: Are they a safety-net provider or an academic medical center focused on educating physicians? Similarly, hospitals have thought of their form as a set of assets: a regional footprint, a network of facilities on a campus, or an ambulatory surgery center.

In this regard, hospitals and health systems tend to look at function and form more narrowly than their counterparts in other industries, which define their function as the way that they attract customers (their value proposition) and their form as their capabilities (their distinctive strengths) as well as their assets. A retailer, for instance, will think of its function as the mix of products that attract purchasers, and those products will change as its customers change their tastes; the retailer's form is not just assets such as real estate and inventory, but also the design skills and merchandising capabilities that support that function.

A mission can unite an organization behind a common purpose — but it can also become disconnected from the needs of the market or devolve into a laundry list of “nice to have” objectives. Describing an organization's function through its mission alone can lead to vulnerability. When customers migrate to new services or competitors (for example, wellness clinics in retail chains), reliance on a strong mission alone can leave the organization unprepared. Instead, a health organization will gain a greater benefit from defining its function the way companies in other industries do — as a distinctive value proposition, based on a nuanced understanding of the community's needs. Similarly, there are benefits to thinking about the health organization's form in terms of capabilities and operating models, rather than just assets. By broadening their thinking about form and function, hospitals and health systems can untether themselves from the past, unlock new opportunities, and remain viable and vital during these tumultuous times.

Introduction

“Five years from now,” said the CEO of a major academic medical center at a recent hospital conference, “our organizations will look very different. They will operate with different incentives, different business models, and different footprints.” He added that as the industry evolves from volume to value, both the function and the form of hospitals and health systems will change.

Although we hear many health systems acknowledge that these changes are coming, most of them are inadequately prepared. In fact, we see many systems attempting to solve tomorrow’s problems with yesterday’s tactics — an “arms race” to acquire physicians; “across the board” cost cuts that don’t deliver results; and massive spending on marketing, IT, and facilities without a clear case for return on investment (ROI). Some systems are moving with a purpose and a clear set of priorities, but many others appear to be stuck, as if waiting for their competitors, regulators, and payors to tell them how to define themselves. With a different way of thinking about function and form, hospitals and health systems can regain control of their destiny.

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Health system form and function: The traditional view

Most hospitals and health systems have a mission — a notion of what they are and what they aspire to be. The mission often reflects the reasons why a particular hospital came into existence in the first place: to serve the unmet needs in the community, to lead the fight against a terrible disease, or to educate and develop new generations of physicians. The mission unites and inspires organizations toward great achievements.

However, over time, even the noblest mission can become a liability in two important ways. First, it can gradually become disconnected from the needs of the community, especially as those needs evolve. For example, a hospital may invest in supporting a service line it considers essential, and for which it was once the only provider in a given community. Since then, higher-quality alternatives may have emerged nearby, offered by more scale-effective competitors. The viability of this once essential service would now need to be reexamined.

Second, if the mission does not prioritize strategic objectives, it can become a repository of “nice to have” activities, championed by local supporters but not really needed. These missions often sound like laundry lists of everything that an organization could provide: teaching, research, and leadership in every possible service line, across the entire care continuum and at every severity level. Such a scattershot view of the organization’s function can lead it to fragment its efforts and become a “jack of all trades, master of none.”

Hospitals and health systems can also be overly constrained in their thinking about their form. Traditionally, hospitals have defined their form as their assets — land, buildings, medical technology, and physician practices. This point of view is limiting in two ways. First, it is not always necessary to own assets to realize ongoing benefits from them; for example, an increasing number of hospitals don’t own their land or buildings. Second, competitors can replicate assets and the advantage that they confer.

As a result of this way of thinking about their mission, many health systems today are characterized by a form and a function that are suboptimal, rooted in the past, and yoked to their legacy assets. This problem manifests itself as a lack of focus; indeed, three of the most common categories of healthcare providers — community hospitals, academic medical centers, and multihospital systems — are all struggling with problems of focus.

- *Community hospitals*: This is probably the most prevalent type of hospital in the United States, with variants including safety-net hospitals and faith-based healthcare providers. Originally founded to be “all things to all people,” community hospitals now find themselves undifferentiated and serving as providers of last resort. Their slim profit margins — at best 2 to 3 percent — make them particularly vulnerable.
- *Academic medical centers (AMCs)*: These entities essentially impose a research and teaching “surcharge”; as a result, they are among the most expensive care settings. (An AMC CEO admitted recently that 85 percent of the care delivered by his organization could have been delivered in a community hospital.) As payors and consumers become more price-sensitive, some AMCs will struggle to command their premium, and payors may steer patients away from them, especially for “commodity” services such as laboratory tests.
- *Multihospital health systems*: After several waves of consolidation, the multihospital system has become one of the more common healthcare subsectors. Close analysis, however, suggests that few of these entities are really “systems” in any meaningful sense. Instead of explicitly trying to bring complementary facilities and practices under one roof, and realize synergies accordingly, these systems operate as confederations of semi-independent hospitals, with each having its own view of its mission and with few benefits from their integration.

Case for change

While the healthcare industry has been subject to many shake-ups over the past few decades, now is a most propitious time to reopen the conversation about hospital form and function. The current industry transformation is particularly disruptive, as the center of gravity shifts from volume to value, from inpatient to outpatient, and from physician to consumer. Health reform has made the situation even more dynamic, expanding coverage without sufficient direct steps to address affordability, patient accountability, or provider shortages.

The three struggling healthcare models will find it hard to survive in the new era. **Community hospitals** will have to continue providing uncompensated care — as much as US\$53 billion by 2019 by some accounts. Meanwhile, they will see their disproportionate share hospital (DSH) subsidies disappear at the same time that states cut Medicaid budgets and physician shortages persist. **AMCs** may find themselves locked in an “arms race,” building outpatient pavilions and acquiring physician groups while payors and employers seek to lock them out of “narrow” networks. And **multihospital health systems** will struggle to differentiate themselves, perpetually at risk of being “stuck in the middle.”

The market and the regulators are placing unprecedented demands on hospitals and health systems in terms of transparency, accountability, quality, ROI, and value. So how can they break out of the cycle and gain a new perspective on strategy?

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Health system function: A new perspective

For a hospital or health system that seeks a relevant and vital positioning in its market, the function has to be “market back.” In other words, it has to be based on a clear and well-articulated understanding of the customers the hospital wants to serve, and of the unique value proposition it can provide these customers.

Before laying out a menu of possible value propositions, it is important to address a key concern. Many healthcare providers feel that they do not have the luxury of choosing their customers — or saying no to others based on their service area, socioeconomic status, or diagnosis. In fact, the term “customer” is controversial in some health organizations for this reason. However, there is merit to defining the target customer as someone you want to attract and win over — even if you have to serve everyone who walks in the door. Choosing a target customer is not about saying no; it is about selecting a center of gravity and aligning the bulk of your organization’s resources behind it.

What function could a hospital serve, based on its target market? In the hospital and health system sector, we believe there are seven key value propositions. These reflect the buying behaviors of healthcare customers — both individual (including families) and institutional (including commercial payors, employers, and public-sector payors).

All customers want quality care, but they still make real choices about where they seek care. Health systems differentiate themselves along three dimensions — care, access, and cost (*see Exhibit 1, page 11*).

Hospitals and health systems that differentiate on the dimension of care offer cutting-edge research in a particular clinical area, or best-in-class outcomes for a particular treatment. This orientation is found in organizations with the following value propositions:

- *R&D Leaders* attract customers who want the best available treatments, including experimental treatments that are sometimes on the leading edge of medical science and may not be available

elsewhere. Organizations that follow this clinical innovation model (such as the Cleveland Clinic) invest in research and build strong service-line offerings. They generally tell a compelling story in the market and can attract patients from all over the world. For some of these patients, they will provide a second opinion — or a last resort when all other options have been exhausted.

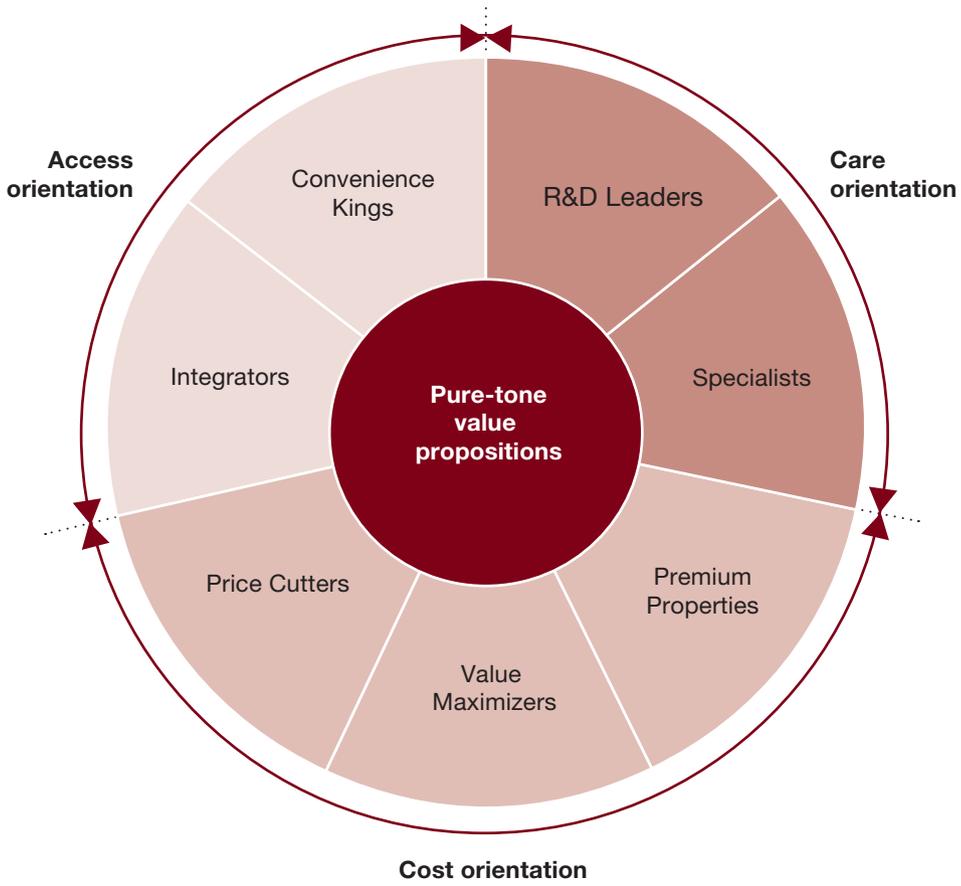
- *Specialists* attract customers who are looking for a provider with a single-minded focus on their condition, and a track record of excellence. Organizations such as MD Anderson (a world leader in cancer treatment) have picked one or a few clinical areas, and used every bit of their attention and scale to deliver consistent and quantifiably superior results. Customers who choose these hospitals and health systems have done their homework — going beyond reputation and word-of-mouth.

Among the many health systems that fill a more basic need — namely, local access to good-quality care, eliminating the need for patients to travel long distances — there are the following value propositions:

- *Convenience Kings*, such as St. Vincent Health in Indiana, offer a full range of clinical services in their community-based facilities. They provide enough service offerings to meet most of the needs of their patients close to home and in one facility. For the rest (including exotic tertiary and quaternary care), they might designate one of their hospitals as a center of excellence — or partner with a specialist institution.
- *Integrators* create value by “connecting the dots” of an otherwise fragmented healthcare environment. They coordinate the care for their patients across the continuum, offering better outcomes and often a superior experience. Many add a financing element to achieve better alignment of incentives. One example of such a health system is Geisinger in Pennsylvania, which offers its patients a high level of service at every point in the process — from diagnosis to surgical procedures to discharge to a follow-up prescription drug regimen. Geisinger’s systematic approach to integration makes its delivery system more valuable than the sum of the parts. At its best, it simultaneously delivers great quality, value, and experience.

A third group consists of organizations that have prospered as consumers take a larger role in making healthcare choices and paying for them. These health systems have approached the problem of healthcare costs unilaterally, with three solutions that translate into three different value propositions:

Exhibit 1
Seven value propositions for health systems



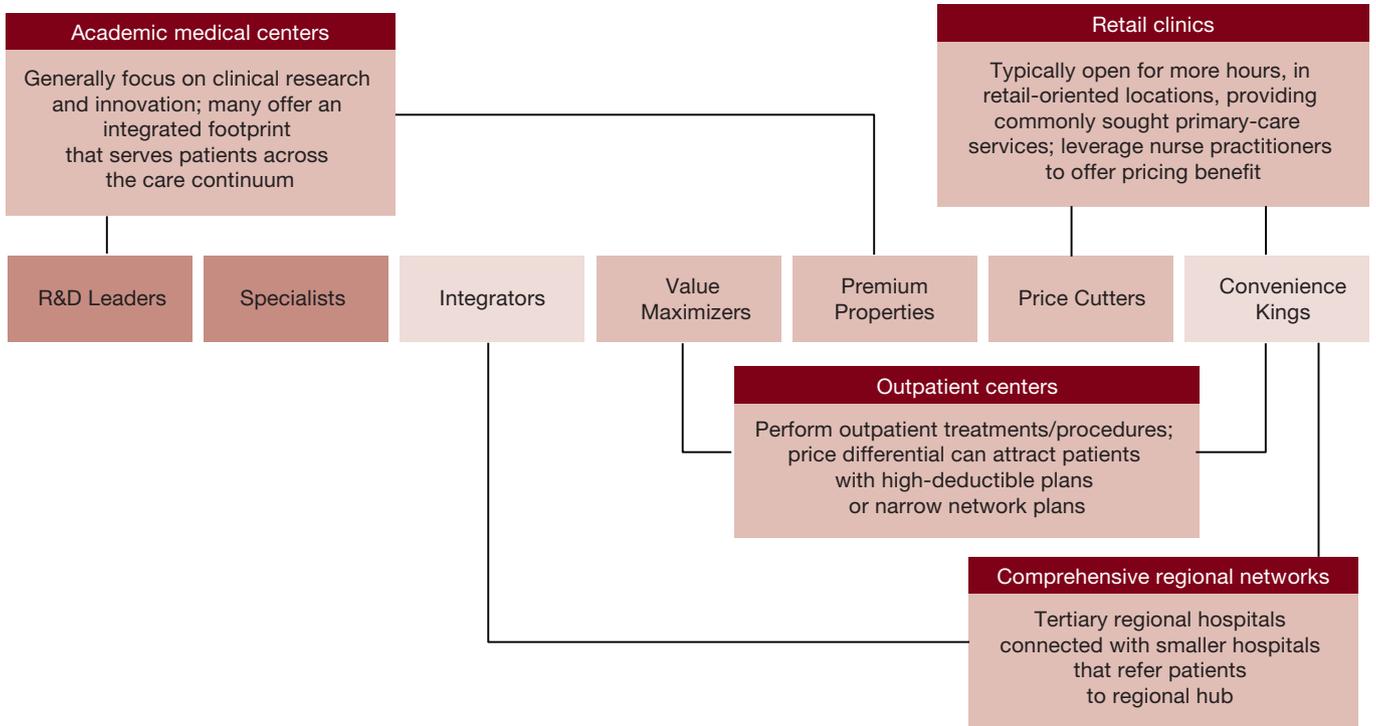
Source: Strategy&

- *Premium Properties* serve consumers who want the greatest comfort, privacy, convenience, amenities, and service levels money can buy. Henry Ford Hospital in West Bloomfield, Michigan, is an example of a facility that provides high-end accommodations. An increasing number of hospitals are also designating “luxury wings” in their facilities. It remains to be seen how successful the premium model will be under the roof of a community hospital.
- *Price Cutters* operate on the other end of the spectrum — offering the lowest price point for a particular procedure, while maintaining a reasonably robust standard of quality. Though the idea of price shopping for healthcare may seem unusual, it is becoming more common in areas where the consumer is responsible for footing the entire bill — such as cosmetic surgery. Comparison shopping for LASIK procedures is also commonplace, and some hospitals in emerging economies, such as Bumrungrad International in Thailand, have been successfully attracting price-sensitive medical tourists from around the world. As healthcare continues to become less affordable for many families, it seems likely that some U.S. health systems will adopt the low-cost “reverse innovations” developed by emerging-economy hospitals such as Aravind Eye Care System in India, which has substantially reduced the time and expense needed to perform cataract surgery.
- *Value Maximizers* do not promise “everyday low prices.” Rather, they focus on maximizing overall value, defined as offering the best possible outcome and experience at the lowest possible cost. By reducing complexity, shifting care settings, and removing waste, these hospitals seek to create pricing transparency and help their customers get everything they need, while eliminating unnecessary extras. Steward Health Care in New England has adopted this approach, and we expect that many others will follow suit — if they can build the requisite capabilities to make it work.

Few healthcare institutions play only one function and fit perfectly into any of these value propositions. Indeed, in the real world, it is far more common to find hybrids — value propositions that actually represent a successful blending of functions (*see Exhibit 2, page 14*). For instance, an R&D Leader may also cultivate a premium pricing position. Another successful hybrid approach might mix the frugality of a Value Maximizer with the accessibility of a Convenience King. As healthcare executives consider the function of their organization, they will be much more likely to pursue hybrids rather than pure-tone models, and they should; the goal is to find the mission and strategic focus that fits them and their market best.

Successful hybrids need to be coherent. They can adopt different goals, but those goals should reflect internally consistent and complementary value propositions that make use of a single set of capabilities. These coherent multifunctional entities are the Swiss Army knives of healthcare — but you will not find a Swiss Army knife with a blade that doesn't fit into its case. The best hybrid healthcare systems are designed and managed with a similar attention to integration.

Exhibit 2
Hybrids of value propositions



Source: Strategy&

Health system form: A new perspective

To implement their strategy, health systems need to think about their current and potential capabilities. By capabilities, we mean a health system's ability to consistently and repeatedly achieve a specific business (or sometimes clinical) outcome through a combination of people, processes, technologies, and know-how. For instance, a hospital might have the capability to deliver measurably better outcomes for a set of cardiology procedures. Another hospital might have the ability to enable patients to recover from major surgery several days faster than they would at other hospitals.

Capabilities provide a much better strategic focus than assets; as noted earlier, assets can always be sold or reproduced by competitors. And once ingrained into an organization's culture and practices, capabilities are extremely hard to replicate. Individual capabilities can also be linked into an inimitable system that allows an organization to perform its function more effectively and efficiently than competitors. A variety of capabilities systems can support the value propositions described in the previous section (*see Exhibit 3, page 17*).

This emphasis on capabilities does not mean giving the asset portfolio short shrift; it remains central to the form of the healthcare organization. Combined with a capabilities system, the asset portfolio enables the healthcare form to serve its function. For example, there are several distinct, viable types of portfolios of offerings. Their definitions have been established and tested by analyzing past M&A activity and looking for operating models that are more likely to create value.

- *Scaled portfolio systems* operate a portfolio of care delivery assets, typically across a broad geographic footprint. This model drives value creation by sharing capabilities (through facilities such as electronic medical records, revenue cycle management, or regulatory compliance) across the portfolio to generate economies of scale and lower cost. In addition, these entities can identify clinical best practices and protocols through their learning experience within the network and apply them throughout the system.

Combined with a capabilities system, the asset portfolio enables the healthcare form to serve its function.

- *Geographic cluster systems* concentrate care delivery assets in a contiguous market, typically close to where patients live. This model drives value creation by enhancing market power and building mutually beneficial physician referral relationships within the network.
- *Hub-and-spoke systems* position a care delivery facility as a central hub and build a network of “feeder” care delivery facilities around it. The feeder facilities are typically tertiary or quaternary care hospitals, which refer only complex cases to the central hub. These systems create value by generating learning curve benefits at the hub (for example, by giving physicians opportunities to perform procedures like relatively complex heart transplants) as well as by operating all assets within the network at maximum utilization.
- *Innovation systems* offer a distinctive product or service. Innovation can take place across any dimension of care delivery, from clinical care to patient experience to care financing. The intellectual capital obtained by codifying innovation may be exported and monetized at other health systems — for instance, through co-branding.
- *Location-based hospitals or systems* are embedded in local communities. This is perhaps the most common operating model, especially dominant in rural areas, but also the most exposed to profitability pressure. Value creation comes from channeling demand from the captive local population, and providing more cost-effective ways to satisfy it.

Exhibit 3

Pure-tone value propositions

R&D Leaders	<p><i>Strategic focus:</i> Attract patients through leadership in clinical service and research</p> <p><i>Capabilities might include</i> recruitment and continued development of the world's top medical students and physicians; building partnerships with top medical schools; an oversight role in major clinical trials; information exchanges among top physicians around the world; staff rotations among facilities; close governance and transparent reporting of hospital's own experimental treatments and procedures; a franchising ability to extend the brand</p>
Specialists	<p><i>Strategic focus:</i> Achieve and advertise measurably better outcomes of care in a particular clinical area</p> <p><i>Capabilities might include</i> deep expertise in a chosen clinical area, namely by attracting specialist physicians and being on the leading edge of treatments relating to a disease; excellence in national (or international) claims-based marketing; the ability to generate referrals through a continuously improving network</p>
Convenience Kings	<p><i>Strategic focus:</i> Serve as a one-stop destination by offering an integrated portfolio of clinical services and access points</p> <p><i>Capabilities might include</i> footprint optimization, including the skills to build out the primary-care footprint and to allocate physical space; partnership-development expertise, especially with retailers that can serve as walk-in clinics, and with physicians willing to make home visits; statistics-based staffing techniques; expertise in online care support; the use of innovative payment models such as concierge medicine (which often takes the form of annual retainer)</p>
Integrators	<p><i>Strategic focus:</i> Deliver better results in individual and population health by coordinating care across a variety of settings through the right tools, information, and financing</p> <p><i>Capabilities might include</i> end-to-end healthcare delivery; world-class skills in wellness and post-acute care; use of powerful "care managers" with the authority to coordinate care at different phases of illness; the rapid resolution of problem situations caused by service fragmentation</p>
Premium Properties	<p><i>Strategic focus:</i> Provide the very highest standard of care with the goal of enhancing the patient's experience and satisfaction</p> <p><i>Capabilities might include</i> a hospitality-like focus on customer comfort (including the maintenance of luxury facilities); delivery of highly personalized service; emphasis on holistic patient care, including alternative medicine; continual creation and delivery of "high tech" services; the recruitment of highly regarded physicians</p>
Price Cutters	<p><i>Strategic focus:</i> Offer a subset of services at a dramatically lower price</p> <p><i>Capabilities might include</i> special skills in evaluating input costs, including through moves such as performing a procedure in a lower-cost geography or lower-intensity setting; reverse-innovation of technology; the "de-skilling" of procedures so that physician assistants and nurse practitioners can handle more aspects of care and more parts of procedures</p>
Value Maximizers	<p><i>Strategic focus:</i> Achieve the optimal balance among quality, experience, and cost of care</p> <p><i>Capabilities might include</i> a highly sophisticated financial approach, including an ability to "variabilize" fixed costs and adjust the service-line portfolio to changes in demand; skills to convey a "high value, not cheap" message to the market; a method for targeting value-conscious customer segments (such as small businesses)</p>

Source: Strategy&

Putting it all together

For health systems ready to consider their form and function, several key questions must be answered:

- What are the current market dynamics that have to be reflected in your function and form? How will they evolve and what are the implications for you?
- What is your starting point in terms of assets and capabilities?
- What are the function and form choices available to you? What value propositions, capabilities systems, and asset portfolio choices would be the most coherent? In other words, which would align most effectively with one another?

Market dynamics

Demand for care is driven by such factors as the demographic, economic, and public health characteristics of a population. It is also driven by the willingness and ability to pay for care, and the propensity to utilize care. Demand for care is currently in flux, as utilization shifts from inpatient to outpatient and post-acute care, reimbursement rates stagnate, and rate increases are contingent on meeting quality and care standards set by payors. (See “*Operating Models and Transition to Risk-Based Reimbursement*,” page 22.)

Similarly, the supply of care is driven by the availability of clinicians and healthcare facilities; by the cost of labor, supplies, and technologies to deliver care; and by the competitive dynamics in a particular market. The supply of care is also in a state of change. For instance, there has been an oversupply of hospital beds and specialists, along with a shortage of primary-care physicians, for some time now. In healthcare, the strategy used on the supply side has great influence on demand. For example, a primary-care-heavy model offers the potential to steer future healthcare utilization early, and supply of convenient ambulatory surgical care centers can mitigate hospital inpatient demand.

Assets and capabilities

The internal strengths of a hospital or health system include both assets and capabilities. Advantaged assets, such as a well-located facility, can be differentiating, but the distinction may not be sustainable.

Moreover, choosing the right capabilities to focus on has a critical flipside — coming to terms with the fact that the hospital and health system will be merely competitive or undifferentiated for the remaining capabilities. No hospital or health system can be great at every capability — nor should it try.

Coherent combinations

At a high level, the external assessment shows the kind of value propositions that the market has an appetite for; the internal assessment serves as a reality check on an organization's ability to deliver. For instance, the analysis of external and internal factors might prompt a health system to transition from an “illness” focus (acute and emergency care) to a “wellness” focus (preventive and chronic care). Or certain factors might prompt a system to redesign the patient experience, build deep expertise in a clinical specialty, create a set of more affordable clinical offerings, or serve a particular population more effectively.

Once again, certain choices will be more viable and coherent than others. For example, a health system in a market dominated by high-cost medical centers may offer a value proposition that blends high value and convenience. To serve this function, the system may have to evolve its capabilities system to deliver most of its community care to the value-conscious population segments. The most appropriate operating model would follow a scaled portfolio template.

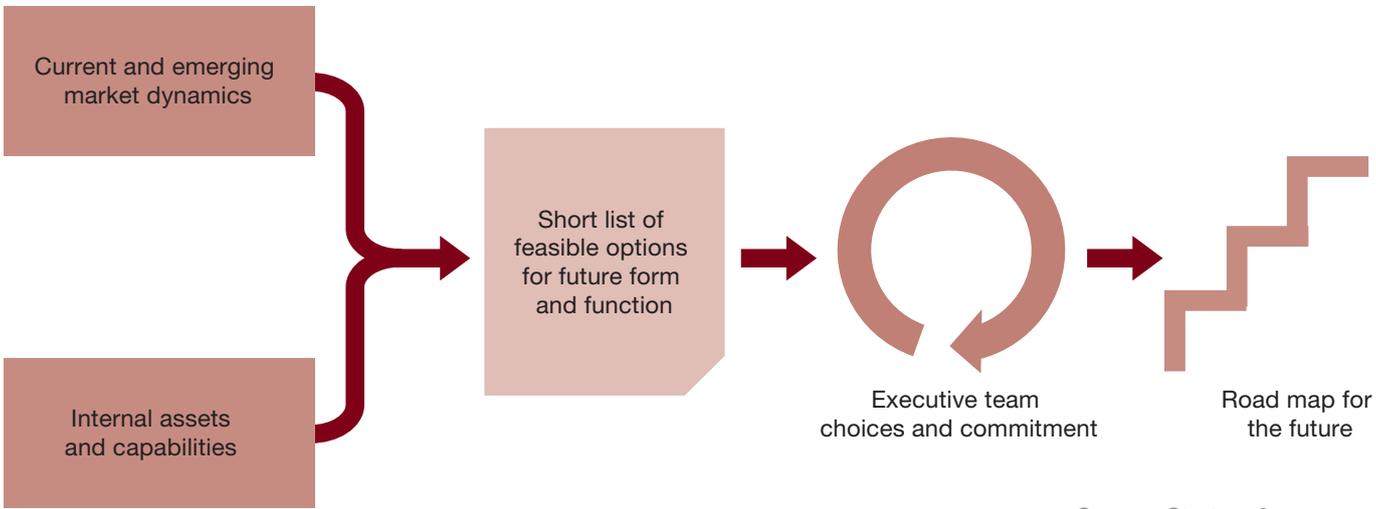
Similarly, a regional health system that serves as both payor and provider of care may choose an “integrator” value proposition — characterized by strong capabilities in coordinating care seamlessly across multiple sites and modalities, from pre-primary care delivered through retail channels to post-acute care delivered at home. Such a system might adopt a hub-and-spoke operating model.

Getting started

In defining the right function and form for a healthcare organization, the destination is well worth the journey and there are major

milestones along the way (*see Exhibit 4, next page*). Organizations emerge from this process with a more sober understanding of their own strengths and market realities, a clear sense of priorities, a renewed commitment to the mission, and greater alignment around the future direction.

Exhibit 4
Strategy development approach



Source: Strategy&

Operating models and transition to risk-based reimbursement

During the next few years, risk in healthcare will be transitioning downstream from payors to providers. Providers are, in general, ill equipped for this transition of risk.

At the same time, payors are unwilling to move significant profits downstream, commensurate with risk movement. Collaboration of types not seen before between the two parties is required to overcome these hurdles.

So far, those collaborations are meeting with limited success. Characteristics of the early plays that trouble us include:

- A brute-force approach to redesigning the care delivery model (in which payors are setting top-down budget targets for providers)
- Mechanisms (such as variants of accountable care organizations and patient-centered medical homes)

that do not envision how to scale to a full enterprise level

- Parsed approaches to data sharing (thus weakening the core ingredient to ultimate success)

We believe that payors and providers will need to proceed deliberately with the appropriate risk-sharing approach, depending on a provider's operating model and capabilities. For instance, geographic cluster systems may be generally well positioned to assume the total healthcare-cost risk across a particular population, given the breadth of their footprint throughout the community and their capabilities in providing services across the continuum of care. Innovation systems that specialize in a distinctive product or service may find it more appropriate to assume risk at the activity level (such as bundled payments) than at the population total-cost-of-care level.

Conclusion

This is a moment of structural transformation for healthcare. It is fraught with risk. Hospitals and health systems that fail to make difficult choices about their form and function are likely to find themselves marginalized, undifferentiated, and “caught in the middle,” with few options for the future. But for the health systems willing and able to make disciplined, coherent choices, the future is much brighter. These more forward-looking health systems have a high likelihood of surviving and of playing an expanded role in the well-being of their communities, the nation, and, in some cases, the world.

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