



AN INDUSTRY BRIEFING FROM GRAIL

What's Changing in Your Capital Story

Your next €10M of capital. The device-sale number you sign. The thesis your board can recite back. Three questions that look separate, but are actually one. A briefing for CFOs at mid-market European medtech firms.

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FOR

European mid-market
medtech finance leaders

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Thursday morning, board pack due next Thursday

Every CFO at a mid-sized European medtech firm has had the same Thursday morning. Four things on the screen at 8:30. The notified body queried the MDR technical file on Wednesday and moved the CE-mark window by six months, which puts your Q3 device-sale revenue at 92% of plan. Your best DACH regional sales lead took a headhunter call last week. Your Head of R&D wants €2M next quarter for clinical-evidence and regulatory-submission tooling, and his one-page says "regulatory infrastructure investment." Your sponsor's partner forwarded a trade-press piece yesterday on AI-native competitors winning hospital tenders, with a single line: "curious to hear your thinking on AI and commercial productivity before Monday."

You have signed fifteen forecasts for this board. The pattern used to be simple. Hold the device-sale plan, grow service attach into the install base, close the quarter clean, keep the auditor happy on service-revenue recognition. The business was understandable.

Something changed. Your device-sale forecast is drifting and your team cannot reconstruct the regulatory-gate-plus-tender-pipeline story in the same meeting. Your clinical-evidence and regulatory capital is running through functional budgets as a compliance line. Your AI-native competitors are quoting on outcome-share and evidence-bundled pricing while your rate card is per device, and hospital procurement teams with their own AI tools are putting both quotes side by side. Your Controllers are closing faster than they ever have. The audit committee is asking about traceability on the agentic tooling. The close is clean. The story underneath it is not.

The job has not changed in fifty years. The bar has risen on every measure of doing it, simultaneously, and the contradictions you have been navigating since you took the seat are suddenly re-openable. The CFOs who treat them as engineering problems run the offensive play. The ones who treat them as permanent trade-offs lose capital-allocation authority to functional heads within eighteen months.

This briefing covers what is happening in your sector, what it means for the finance function you run, and the three questions your team should answer before the next board pack.

Mid-market medtech just lost the equation that priced the sector for a decade

Every device your engineering team ships with AI-augmented clinical decision support raises its usefulness to the hospital by thirty to sixty percent. Your ARPU on those accounts stays flat, because your rate card was built for a world where devices were what you sold and service contracts were how you protected the cycle. The AI-native entrants in your segment are not making this mistake. They quote on clinical outcomes, on evidence dossiers bundled into the sale, on subscription tiers where the installed-base telemetry is part of the contract. Hospital procurement teams are now AI-equipped themselves. They run HTA and total-cost-of-care comparisons where your per-device price sits next to their outcome-share quote. You are running one pricing mechanic. They are running three. Across your installed base the mechanical difference shows up as tender-win compression, and it is already moving the quarterly device-sale prints.

The regulatory environment is turning underneath the sector at the same time. MDR compliance cost is hitting mid-market harder than large-cap competitors. Only thirty-eight percent of SME medtechs say MDR gives them fair market access. HTA and JCA are extending to Class IIb and III devices in 2026, which means the hospital dossier now demands health-economics evidence that your commercial team has never had to build. A single Head of Regulatory Affairs departure delays a submission by twelve to eighteen months. The knowledge walks out. And the AI tools that could extend your RA capacity are emerging at vendor level but have barely reached production in mid-market medtech.

Your device usefulness is rising. Your revenue per installed unit is not. That is not a product-marketing problem. It is a pricing decision the finance seat has not yet claimed.

The sector is repricing underneath everyone at the same time. Hospital procurement has moved from clinical-champion adoption to evidence-based evaluation, and the firms that treat this as a commercial-messaging problem rather than a pricing-and-evidence-moat problem are walking into a board conversation they will not win. The winners are already routing AI capital through the capital-allocation page, not through the functional budget.

Your capital, your forecast, and your narrative are feeling it every day

Your capital allocation. Your Head of R&D's €2M request for clinical-evidence and regulatory-submission tooling is sitting in the functional budget, routed through the same mechanism you use to sign off on lab equipment and software licences. Treat it as the largest single capital-allocation decision you will make this decade, deserving the same discipline you bring to M&A. The finance seats that ship this as a capital line to the board, with alternatives analysis and an ROIC hurdle, keep authorship for the next ten years. The ones that sign the requisition hand authorship to functional heads by default.

Your forecast. The team built the annual plan on 12% device-sale growth. The Q3 print came in at 4%. Your Head of FP&A cannot reconstruct the account-level story because the regulatory-timing signal lives in RA correspondence, the tender-conversion signal lives in commercial CRM, the service-attach signal lives in installed-base telemetry, and the HTA-evaluation signal lives in procurement dossiers her team has never had access to. The plan is exposed, because the data architecture underneath it was built for monthly reconciliation, not for continuous reconstruction of the revenue story across regulatory gates that move.

Your rate-card architecture. The board voted on a commercial plan that assumed AI-augmented devices would price like the legacy portfolio. They don't. Your AI-native competitors are on three pricing mechanics. You are on one. The rate card that ran clean from 2018 to 2024 is now the reason your tender-win rate is drifting on the accounts where HTA evaluation is sharpest. Rate-card architecture is a capital-allocation question about where the evidence moat gets built, not a commercial-messaging question.

Your controller and FP&A bench. The journal entries, reconciliations, service-revenue recognition entries, standard variance decomposition, and first-draft board-pack generation that used to train a junior controller into a Senior Controller into a VP Finance are now running on agents. The Q1 headcount win is real. The 2031 succession bench is empty. The finance function that cuts the junior layer without rebuilding the entry pathway has a cheaper quarter this year and no internal CFO candidate in five.

Your economic thesis. Your board has asked for the strategy-day preview. Your sponsor's partner has asked for an AI-and-commercial-productivity note. Your chair has asked how the firm stays ahead of AI-native competition on hospital tenders. Three audiences, three different documents, each drafted by a different team. None of them are anchored in the same data. The CFOs pulling ahead write the thesis once and let the three audiences draw from the same architecture. The ones behind them are editing three decks and hoping the numbers match.

You do not have three scorecard problems. You have one.

Your sector is repricing from below because AI-native entrants bring three pricing mechanics to the hospital tender while the rest of the market is on one. Your finance function is stretched because forecast credibility, capital-allocation authority, and the economic thesis are each being managed as a separate programme, each drawing on a different data layer, each drafted by a different team. Same force, two altitudes. But there is a third thing happening that most mid-market medtech CFOs have not named yet, and it is the one that matters most.

Capital allocation without forecast credibility is guessing. Forecast credibility without a narrative is scorekeeping. A narrative without a data architecture underneath it is marketing. The finance seat that holds all three holds one integrated asset, not three separate programmes. Every capital-allocation question, every forecast-credibility gap, every narrative weakness is a symptom of the same missing layer: the capital-intelligence infrastructure that ties clinical evidence, regulatory timing, tender pipeline, service attach, and installed-base telemetry into one source feeding all three conversations.

This is the ERP decision of this decade. Every medtech CFO in your cohort is making it right now, whether they see it or not. The ones who personally owned the 1993–1998 ERP decision kept capital-allocation authority for the next twenty years. The ones who signed the IT requisition because "that was an IT decision" watched the CIO take a board seat and the next CFO hire come from outside. The service-attach architecture decision of the 1980s had the same shape: the mid-cap manufacturers who built the recurring service layer personally compounded it into the installed-base economics every mid-market medtech now depends on. The shape repeats. The asset under decision is different. The cost of getting it wrong in 2026 is compressed into eighteen months instead of five years.

The €2M your Head of R&D wants for clinical-evidence and regulatory-submission tooling is not a submission line. It is the largest single capital-allocation decision you will make this decade, and the one place where tightening a forecast, defending a tender, and authoring the next exit story are literally the same line item on the same page.

You have twelve to eighteen months. The CFOs who own this decision personally run the offensive play. The ones who do not become the CFO the board replaces when the successor walks in with a thesis.

What most firms are doing. What the winners are doing instead.

Every medtech CFO has had the AI conversation. Most are making the same four decisions. A smaller group is making different ones. Default looks cleaner for three quarters. Winners compound from month fifteen.

THE DEFAULT PATH

Route AI capital through the functional budgets

Sign R&D and RA requisitions separately. Compliance line in the annual plan. Functional heads own the roadmap within eighteen months.

Hold the rate card, ship AI features into the device

Usefulness rises thirty to sixty percent. ARPU per installed unit flat. Tender-win rate drifts three to five points. Gross margin compresses.

Run the forecast on a rolling spreadsheet

Monthly cadence. Three scenarios take a week. Below-plan quarters produce no regulatory-gate-plus-tender story until the post-mortem.

Cut the controller layer for the Q1 win

Headcount down fifteen to twenty-five percent. Empty succession bench in 2031. External CFO hire the year after.

THE WINNERS' PATH

Route AI capital through the M&A hurdle

One page of alternatives against tuck-ins, service expansion, working capital, buyback. Board sees one capital line with five options and one choice.

Migrate pricing to three mechanics

Service-subscription on AI-augmented lines, outcome-share on clinical endpoints, evidence-bundled pricing where HTA dossiers are part of the sale.

Rebuild the forecast as a live driver graph

Ten scenarios in an afternoon. Below-plan quarters produce the gate-plus-tender story in the same board meeting.

Redesign the junior pathway around judgment

New hires pair with agents on scenarios, capital exposure, governance. Bench rebuilds faster than it would have grown.

The default path shows a cleaner Q1. The winners' path has visible friction for three quarters and compounds from month fifteen. The difference is whether the CFO is authoring the capital or administering it.

Capital Allocation. Forecast Credibility. Value-Creation Narrative.

Three questions every medtech CFO is tracking. The first is the crux. The other two are how you earn the right to answer it.

01 · CAPITAL ALLOCATION

Where does the next €10M actually compound?

R&D envelope expansion? Clinical-evidence and regulatory infrastructure? Sales force productivity rebuild for AI-equipped hospital buyers? Service and installed-base expansion? Tuck-in acquisition of an AI-native evidence tool? Working-capital extension on stretched hospital DSO? Today's default: budgets split along functional lines, the CFO signs the totals, and authorship slides to whichever function shouts loudest. The question is not which tool. The question is whose decision this is.

02 · FORECAST CREDIBILITY

Why did device-sale revenue print below plan, and what is the gate-plus-tender story?

Your board voted on 12% device-sale growth. Your firm is printing 4%. Your Head of FP&A cannot walk the audit committee through the account-level story because the regulatory-timing signal sits in RA correspondence, the tender-conversion signal sits in commercial CRM, the service-attach signal sits in installed-base telemetry, and the HTA-evaluation signal sits in dossiers the finance team has never seen. Three scenarios used to take a week. They now run in an afternoon. The bar has risen on what credible means.

03 · VALUE-CREATION NARRATIVE

What does this firm do that compounds faster than peers?

Your board wants the strategy-day preview. Your sponsor wants the AI-and-commercial-productivity note. Your chair wants the how-we-stay-ahead answer. Three audiences, three documents, three teams, and the numbers underneath them do not match. The CFOs pulling ahead write the thesis once and refresh it continuously from the same data architecture that runs the forecast. The three audiences read excerpts of the same document.

What the firms winning this play are actually doing

Four concrete moves any medtech CFO can start this quarter. Each addresses one lever. Pulled together, they become one capital-intelligence asset the firm runs on.

1**Capital: route the clinical-evidence and regulatory decision through the M&A hurdle**

Your Head of R&D's €2M request is a capital-allocation decision. Treat it like one. Present the alternatives on one page: clinical-evidence and submission-tooling build, installed-base telemetry infrastructure, tuck-in acquisition of an AI-native evidence vendor, service-expansion capex, working-capital extension. ROIC-scored against the same five-year horizon you use for M&A. Name what you are choosing not to fund to protect the thing you are funding. That is the sentence that keeps authorship at the seat.

2**Forecast: rebuild the device-sale forecast as a live driver graph**

Your revenue model should draw from live regulatory-gate timing, live tender pipeline, live service-attach telemetry, live installed-base usage, and live HTA-evaluation signals, as one graph rather than five spreadsheets stitched together. Three scenarios compress from a week to an afternoon. Below-plan quarters produce the gate-plus-tender story in the same board meeting, not in the post-mortem. The forecast stops being a deliverable on a cadence and becomes a live artefact the CFO invests in continuously.

3**Pricing: migrate from one device-sale mechanic to three**

Service-subscription pricing on AI-augmented device lines. Outcome-share or gain-share pricing on clinical endpoints where AI touches measurable hospital value. Evidence-bundled pricing where the HTA dossier and installed-base telemetry are explicitly part of the contract. The per-device rate card holds the base. The three new mechanics convert the thirty to sixty percent usefulness uplift into recurring revenue and tender-win protection on the accounts where AI-native competitors are already quoting. Finance authors the migration plan. Commercial builds against it.

4**Narrative: write the economic thesis once, refresh continuously**

Three sentences on one page. What does this firm do that compounds faster than peers? What capital gets starved to protect it? What gets fed? Refresh the thesis continuously off the same driver graph that runs the forecast. Sponsor-monthly excerpts the thesis. Audit-committee prep excerpts the thesis. Strategy-day deck excerpts the thesis. Three audiences, one artefact, four registers. The CFO authors the narrative. The board recites it back.

The only firm that joins capital authorship to working infrastructure

The medtech CFO has four places to go. None can do what we do.

The big finance transformation practices will sell a twelve-to-twenty-four-month close-acceleration programme staffed by a partner and analysts billing hours. Their audit arm constrains governance advice. Their billable-day model requires selling substrate that agents commoditise. They ship a tighter close, not authorship of the moat.

The finance-tech vendors will sell platform licences and a long implementation. Your moat has to sit on firm-owned infrastructure or it becomes a vendor asset at renegotiation. The CFO who builds capital intelligence on a vendor stack builds it for the vendor.

The FP&A and planning specialists will sell a point solution for one layer. None can run the capital-allocation-plus-narrative conversation the seat requires.

The medtech regulatory and evidence-tech vendors will sell substrate tooling at the validated-process layer. That layer is where CFO authority is thinnest. A cleaner submission workflow, the same authorship gap on the capital decision above it.

The market offers four things you have already said no to. GRAIL is the fifth option.

WHAT YOU GET

Senior advisory that speaks board-room, not deck-room

Working infrastructure your team uses the same week

Custom agents built on your book, your pipeline, your data

The start of a capital-intelligence layer your FP&A owns

No vendor lock-in at any phase of the engagement

WHY IT MATTERS

Founded by operators who have carried CFO-adjacent seats

Business first, technology second

Three weeks from first meeting to working infrastructure

Your team keeps the infrastructure, you own the IP

Every next step earned by what just shipped, never assumed

Three sessions with your finance leadership. Working infrastructure from week one.

We start with your finance leadership team because the change cannot outrun the team's personal understanding of what is possible. Three workshops. Each delivers standalone value. Each earns the right to the next.

WORKSHOP 01

How to think

Walk through what is happening in your sector and inside your finance function. Build the first piece of infrastructure in the room: a live driver agent on your real device-sale model, running against your real regulatory-gate timing, tender pipeline, and installed-base telemetry. Your leadership team leaves with a shared view of what to do next and the first piece of working infrastructure already in their hands.

WORKSHOP 02

Your finance infrastructure

A half-day build. Your Controller, Head of FP&A, Treasurer, and Head of IR each leave with five to ten pieces of working infrastructure tuned to their function. Close-cycle agents. Continuous scenario generation against regulatory gates. Covenant-monitoring intelligence. Tender-pipeline conversion tracking. Board-pack narrative drafting. Infrastructure your team is using the same week.

WORKSHOP 03

Ready to run

Refined infrastructure based on real use. The rollout plan to the wider finance organisation. The capital-allocation-thesis document for the next board meeting. The pricing-migration roadmap for the commercial team. The CEO and sponsor conversation with numbers they can check: ROIC alternatives, scenario ranges, moat measurement.

Three weeks. No IT project. No board approval needed to start. The infrastructure your finance function is already running on when we finish.

For your next forecast review

The questions where your finance leadership cannot agree on an answer are the ones worth an hour on the agenda. Ask these honestly.

Your Head of R&D wants €2M for clinical-evidence and regulatory-submission tooling. Is it in the functional budget as a compliance line, or on the capital page as one option among four? If the former, what would it take to move it before the next board cycle?

Your board voted on 12% device-sale growth. Your print is 4%. Can your team walk the audit committee through the gate-plus-tender story in the same meeting, or does it take a post-mortem? If the latter, what data architecture is missing?

Your AI-native competitors are quoting on two or three pricing mechanics. You are on one. What is the twelve-month plan to migrate from one rate card to three, and who on your team is authoring it?

Your sponsor, your chair, and your CEO have each asked for a different AI-and-commercial document in the last ninety days. Are they excerpting the same thesis, or are your teams drafting three documents that do not reconcile?

Of the junior controllers and FP&A analysts you are cutting to agents this year, how many are the people who would have made your 2031 succession bench? What are you doing instead to build that bench?

If any of these produces a disagreement in your finance leadership, that is the conversation worth having before the board asks.

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