— ADVISORY PROFILE · 2026

Clear evidence for the decisions that *shape* healthcare

Acuvera Consulting GmbH advises boards and executive teams in healthcare delivery, health insurance and medical technology, and health-technology investors and founders.

Acuvera

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— § 00 · SUMMARY

Summary

Acuvera Consulting GmbH is a boutique advisory firm working in healthcare strategy, market intelligence and organisational design. The work is carried out by practitioners who have spent decades in healthcare delivery, and it rests on analysis grounded in peer-reviewed evidence rather than vendor claims.

We advise boards as well as executive teams in three sectors: healthcare delivery, health insurance and medical technology (MedTech). Boards receive independent evidence against which to test management proposals and to exercise oversight. Executive teams receive analysis and design work that carries decisions through to operating practice. We also advise health-technology investors and founders on the evidence that separates demonstrated value from claims.

Our work is organised in four practice areas, each set out as a chapter of this brochure:

01 **Foresight**
Some features of the next twenty-five years are already largely set: an older population, an ageing workforce, a growing burden of chronic disease and dementia, higher health spending and recurring heat. We use these projections to test medium- to long-term strategies before capital and reputation are committed.

02 **Rethinking healthcare delivery**
Rising cost and a shortfall of health workers are structural. We help organisations redesign how work is done, and adopt technology, including artificial intelligence, in service of that redesign.

03 **Re-imagining how healthcare is financed**
Wearables and continuous monitoring are moving risk information towards the insured. We help insurers plan for selection, price prevention and rethink risk pooling, and we help MedTech companies, investors and founders build the evidence that payers and purchasers require.

04 **Preparedness and resilience by design**
Concentrated supply chains and dependent infrastructure expose health systems to disruption. We help providers and payers design continuity of care before it is needed.

Across all four areas the discipline is the same: state what the evidence supports, say where it stops, and design for the conditions an organisation will actually face.

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— § 01 · WHO WE ADVISE

Boards and the executive teams who answer to them

Boards and executive teams need different things from an advisor. Boards need an independent, evidence-based view: an outside reading of management proposals, of the assumptions behind long-term plans, and of the risks the organisation carries. Executive teams need analysis that is carried through to design — operating models, care pathways, products and plans — and the measurement that shows whether a change has worked. We work with both, and we are explicit about which role we are playing in each engagement.

TABLE 1 · SECTORS AND THE QUESTIONS WE HELP ANSWER

SECTOR	QUESTIONS WE HELP BOARDS AND EXECUTIVES ANSWER	CHAPTERS
Healthcare delivery Hospital groups, academic medical centres, ambulatory and specialist providers	Where does clinical and administrative time go, and what can be recovered? Which digital and AI tools have evidence behind them? Can care continue if supply, power or access fail? Does the long-term plan hold against demographic and workforce projections?	1, 3, 4
Health insurance Statutory and private health insurers	How exposed is the risk pool to information-driven selection? How should prevention be priced and rewarded within the limits on health- and genetic-data use? How will projected spending and disease burden affect the book of business?	2, 4
Medical technology MedTech and health-technology companies	Is the clinical and economic evidence sufficient for regulators, payers and purchasers? What is a realistic reimbursement pathway? Which long-term shifts in demand should shape the portfolio?	2, 4
Health-technology investment Venture capital and corporate venture capital funds; start-up founders	Does the evidence support the valuation? Will the tech find resonance amongst consumers, clinicians and/or ancillary healthcare staff? What ecosystem changes are required for adoption? Are the regulatory and reimbursement routes credible? Is the equity story within what the data can support?	2

§ 02 · CHAPTER 1

Foresight: testing strategy against the futures we can already *see*

Much about the next twenty-five years is uncertain. Some of it is not. Foresight separates the two, and uses what is fairly certain to test strategies before they are committed.

Why long-horizon decisions need a different discipline

Hospital campuses, insurance portfolios, device platforms and workforce pipelines commit capital and people for a decade or more. Plans of that length are often built on a single expected future, and they are exposed when that future does not arrive. Foresight replaces the single forecast with two layers. The first holds projections that are fairly certain because the underlying processes are already in motion. The second holds uncertainties that are genuinely open — technology, regulation, reimbursement, capital and geopolitics. The first layer anchors every scenario; the second is varied deliberately, so that a strategy can be tested against more than one plausible future (Fig. 01).

The people who will be old in 2050 are already alive today.

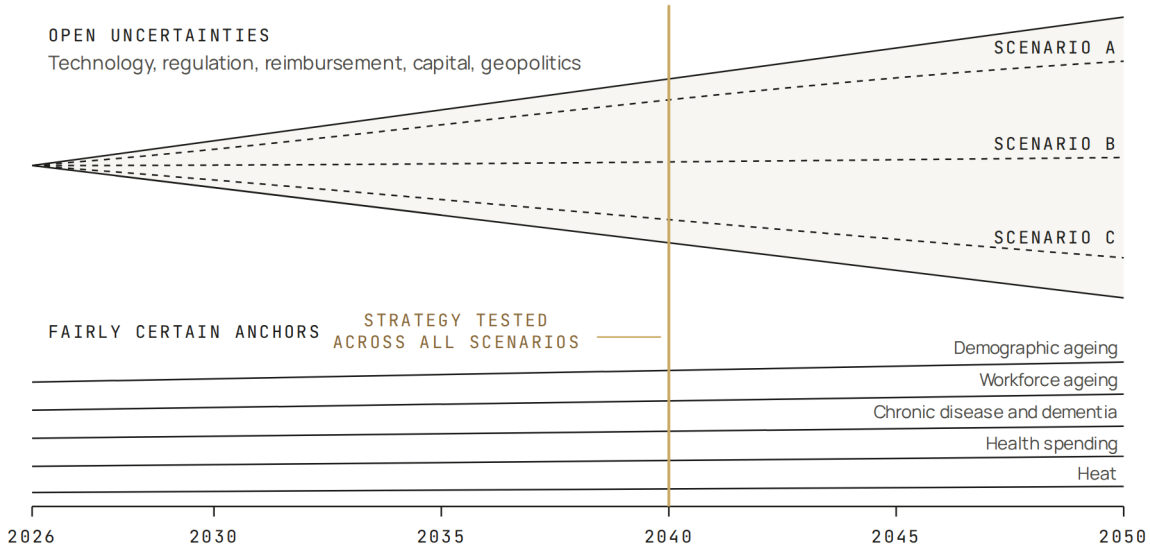

Fig. 01 · Fairly certain anchors and open uncertainties over a twenty-five-year horizon

FIG. 01 · FORESIGHT FRAME · ILLUSTRATIVE, NOT TO SCALE · ACUVERA POV · 2026

What is fairly certain

DEMOGRAPHY The European Commission projects that the EU old-age dependency ratio — people aged 65 and over relative to those aged 20 to 64 — will rise from 36.1% in 2022 to 59.1% in 2070. Put differently, the EU moves from nearly thirty people aged 20 to 64 for every ten people aged over 65 in 2022 to fewer than twenty by 2045.[1]

WORKFORCE Demand grows while the workforce ages. The WHO Regional Office for Europe reported in 2022 that in 13 of the 44 countries reporting data, 40% of medical doctors were aged 55 or older.[2] Globally, a shortfall of about 10 million health workers is projected for 2030.[3]

DISEASE BURDEN The Global Burden of Disease forecasting study projects that total disability-adjusted life-years will increase in every GBD super-region to 2050, largely as a function of population ageing and growth, even as age-standardised rates fall. Globally, the share of that burden due to years lived with disability rises from 33.8% to 41.1% — a shift from premature death towards long-term morbidity.[4] In western Europe, the number of people living with dementia is forecast to rise by 74% between 2019 and 2050.[5]

SPENDING OECD projections indicate that public spending on health will grow on average by 1.5% of GDP by 2045 across OECD countries.[6]

HEAT An analysis covering 32 European countries estimated 67,873 heat-related deaths in the summer of 2022, 50,798 in 2023 and 62,775 in 2024.[7] A separate analysis estimated that the heat-related mortality burden of 2023 would have been 80% higher without the adaptation achieved since 2000 — evidence that planned adaptation changes outcomes.[8]

TABLE 2 · FAIRLY CERTAIN PROJECTIONS USED AS SCENARIO ANCHORS

DRIVER	INDICATOR	VALUE	PERIOD	REF
Demography	EU old-age dependency ratio (aged 65+ relative to aged 20–64)	36.1% → 59.1%	2022 → 2070	1
Demography	EU persons aged 20–64 per ten persons aged over 65	nearly 30 → fewer than 20	2022 → 2045	1
Workforce	Countries (of 44 reporting) in which 40% of medical doctors are aged 55 or older	13	2022	2
Workforce	Projected global shortfall of health workers	about 10 million	2030	3

DRIVER	INDICATOR	VALUE	PERIOD	REF
Disease burden	Global share of DALYs due to years lived with disability	33.8% → 41.1%	2022 → 2050	4
Disease burden	Change in number of people living with dementia, western Europe	+74%	2019 → 2050	5
Spending	Growth in public spending on health, OECD average	+1.5% of GDP	by 2045	6
Heat	Heat-related deaths, 32 European countries	67,873 / 50,798 / 62,775	2022 / 2023 / 2024	7

DALYs, disability-adjusted life-years. Values as published; ranges and uncertainty intervals are given in the cited sources.

From projections to a stress-tested strategy

We work in four steps (Fig. 02). First, we fix the anchors: the projections relevant to the organisation's markets and horizon, drawn from official statistics and peer-reviewed forecasts, with their uncertainty ranges. Second, with the board and executive team, we select the two or three open questions that matter most — for example the pace of AI adoption, the direction of reimbursement policy or the availability of capital — and build a small set of distinct, internally consistent scenarios on top of the anchors. Third, we test each option in each scenario: where it holds, where it fails, and what it would cost to adapt. Options that hold across scenarios are separated from those that depend on one future arriving. Fourth, we set signposts: the indicators that show which scenario is unfolding, and the decisions they should trigger, so that the strategy is revisited on evidence rather than on the calendar.

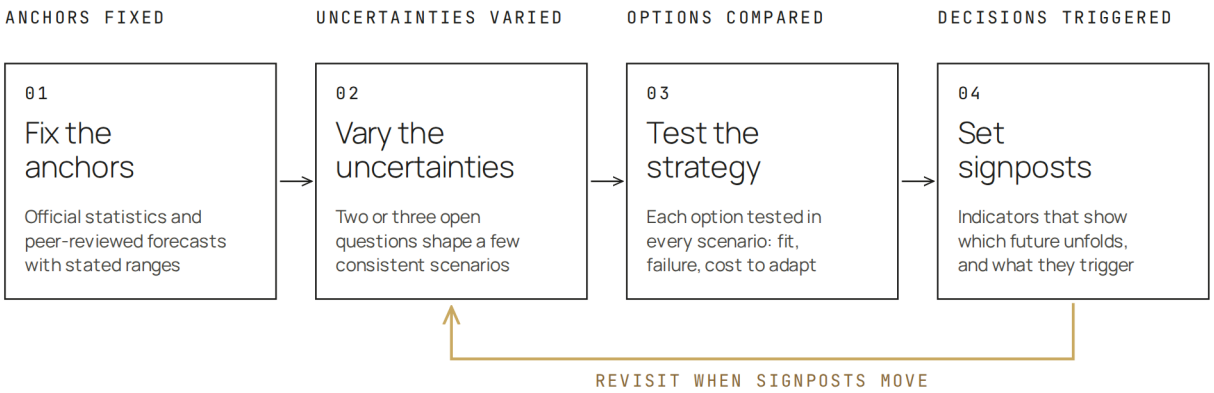

FIG. 02 · FORESIGHT METHOD · ACUVERA POV · 2026

The method has an empirical basis. In three field experiments, the use of multiple scenarios did not raise or lower experts' overall confidence; instead, their judgement of long-range investments shifted according to how each investment fared in each scenario, and after using

multiple scenarios they preferred more flexible options.[9] The Global Burden of Disease forecasts themselves pair a reference forecast with alternative scenarios for the same reason.[4]

What boards and executive teams receive

For boards: a concise foresight briefing for the long-term plan or a major capital decision, showing which assumptions are anchored in projection and which are bets, and which signposts to monitor. For executive teams: a working set of scenarios, the stress-test of the options under consideration, and a monitoring framework that can be refreshed as data change.

- A hospital group can test a campus or service plan against the ageing of its catchment population and of its own workforce.
- An insurer can test product, pricing and reserving strategy against the growth of chronic disease and dementia.
- A MedTech company can test its portfolio against the shift of disease burden from premature death towards long-term morbidity.

No one can forecast the future of healthcare with precision. Much of its shape is nonetheless already visible, and strategies should be tested against it before they are committed.

§ 03 · CHAPTER 2

Rethinking healthcare *delivery*

Rising cost and a shortage of health personnel are structural. Redesigning how care is delivered, supported by present-day technology including artificial intelligence, is the response that lasts.

The pressures are structural

Health systems across Europe and beyond face two pressures at once. Spending keeps climbing: across OECD countries, health expenditure averaged 9.3% of gross domestic product (GDP) in 2024,[10] and the OECD attributes projected further growth largely to technological change, rising expectations of what healthcare can achieve and population ageing.[6] At the same time, the workforce is under strain. A reassessment of World Health Organization (WHO) workforce data projects a global shortfall of about 10 million health workers by 2030, concentrated in lower-income regions and with nursing personnel as its largest component. The same analysis estimates that about 10 million health workers will retire between 2020 and 2030, half of them in high-income countries.[3]

What current technology, including AI, can and cannot do

Several technologies are now mature enough to change how care is delivered: electronic records, remote monitoring, clinical decision support and a widening set of artificial-intelligence applications. The evidence calls for careful reading. A systematic review and meta-analysis identified 31,587 records and included 82 studies; only 25 validated their models on external data, and only 14 compared deep-learning models with health professionals on the same out-of-sample data. In those 14, pooled sensitivity was 87.0% for the models and 86.4% for the professionals; poor reporting limited interpretation.[11] A later scoping review of 86 randomised controlled trials of AI in clinical practice found that 81% reported positive primary endpoints, but these related mainly to diagnostic yield or performance, most trials were single-centre, and the authors called for trials to prioritise patient-relevant outcomes. They cite a 2023 review in which only nine (1%) of 627 registered trials of AI-enabled technologies could readily be identified as published, and note that high sensitivity and specificity need not translate into better patient outcomes.[12]

The capability is real; the benefit depends on how a tool is deployed. The distance between efficacy under study conditions and effectiveness in routine practice is where most of the value is won or lost.

Redesign is where the gains are realised

The clearest opportunity lies in how clinicians spend their time. A direct observational study of ambulatory practice in four specialties found that physicians spent 27% of their office day in direct clinical face time with patients, and nearly two further hours on electronic records and desk work for every hour of direct patient care.[13] In our experience, adding technology to an unchanged workflow tends to add cost and clerical load rather than remove it. The gains — returning clinical time to patients, easing pressure on scarce staff and restraining cost growth — come from redesigning the work around the technology: which tasks are automated, which are reassigned, which are removed, and how the remaining steps connect. Failure rates for large, complex digital health programmes have been persistently high, and most failures have been attributed largely to poor project management.[14]

How Acuvera supports this work

We help provider and payer organisations rethink delivery along these lines. Typical engagements include:

- Measuring where clinical and administrative time is actually spent, and where technology can recover it.
- Appraising specific AI and digital tools against published evidence and the organisation's own data, separating demonstrated capability from marketing.
- Redesigning care pathways and operating models so that automation and task reallocation reduce, rather than add to, the burden on staff.
- Building the measurement needed to test whether changes improve patient outcomes, workload and cost, before and after adoption.

For boards, we provide an independent appraisal of major digital and AI investment cases before approval, and of their results afterwards.

Organisations that redesign how care is delivered, and adopt technology in service of that redesign, will be better placed than those that buy tools and hope. Technology introduced without attention to the people who must use it, and without the workflows that make use of it, tends to become an expensive failure.

— § 04 · CHAPTER 3

Re-imagining how healthcare is *financed*

Rising risk awareness among the insured, driven by wearables and continuous biomonitoring, could renew adverse selection. Insurers will need to adapt their models, and the value of health technology will rest increasingly on evidence.

The information balance between insurer and insured is shifting

Wearables and continuous biomonitoring are giving individuals private knowledge of their own health risk. The Apple Heart Study enrolled 419,297 participants; 0.52% received an irregular-pulse notification, and among notified participants who returned analysable electrocardiogram patches, 34% had atrial fibrillation. The study did not assess effects on health outcomes.[15]

As risk information accumulates with the insured, while insurers in community-rated systems are restricted from pricing on it, the classic conditions for adverse selection appear. When buyers know more about their own risk than the insurer, a competitive insurance market may fail to reach any equilibrium; where one exists, higher-risk buyers impose a cost on lower-risk ones, who end up with less than full cover, and a single pooled contract cannot be sustained.[16] The effect is not automatic. Evidence from the long-term care insurance market shows that private information has several dimensions: some who buy more cover are higher-risk, while others simply value insurance more and are in fact lower-risk. In aggregate, those with more insurance were not higher risk.[17] A renewed wave of adverse selection is therefore a credible risk to plan for, not a certainty.

From symptom-based consultation to early-signal prevention

Continuous monitoring moves the point of clinical contact from the moment symptoms appear to the moment an early signal is detected. That shift changes both the timing and the cost of care: more case-finding, more preventive intervention and far more data to interpret. For insurers it cuts two ways. Earlier detection can raise near-term diagnostic and treatment costs, yet it also offers the prospect of averting expensive late-stage disease. Rethinking the financing model therefore means pricing prevention rather than only illness, governing the data, and deciding — within the legal limits on the use of health and genetic information — how risk is shared rather than selected against. Practical responses include prevention-oriented

products, investment in early intervention, revised risk pooling and reinsurance, and closer partnership with providers and technology firms.

How Acuvera helps insurers rethink financing

- Quantifying a book of business's exposure to information-driven selection, and stress-testing the risk pool against rising consumer risk awareness.
- Designing prevention-oriented products that price and reward early detection within the legal limits on health- and genetic-data use.
- Rethinking risk pooling, underwriting and reinsurance so that continuous monitoring strengthens the pool rather than fragmenting it, and building the measurement to confirm that prevention reduces downstream cost.

For insurers' boards, we provide an independent view of how exposed the book is, and of whether management's product and pricing plans are consistent with that exposure.

MedTech, health-technology investors and founders

The organising discipline is evidence: a study of the twenty top-funded private US digital health companies found that peer-reviewed publications were concentrated among a small number of companies, that healthy volunteers were the most commonly studied group, and that few studies enrolled high-burden populations or measured effects on outcomes, cost or access to care.[18] A later analysis of 224 digital health companies found that 44% had no completed clinical trials or regulatory filings, and that the strength of clinical evidence showed no correlation with the total funding a company had raised.[19]

For MedTech and health-technology companies, the same evidence determines access to payers and purchasers. We help boards and executive teams test whether clinical and economic evidence will satisfy regulators, payers and purchasers, appraise regulatory and reimbursement pathways, and shape evidence plans so that products are both used and paid for.

We also advise venture capital and corporate venture capital funds on health-technology investment. We help investors distinguish demonstrated clinical and economic value from claims, appraise regulatory and reimbursement pathways, and run evidence-based due diligence, so that capital is directed to products likely both to work and to be paid for.

For healthcare start-ups, we help turn clinical promise into the evidence that raises capital and secures reimbursement. Because funding has not tracked the strength of clinical evidence,

founders who can show credible clinical and economic data, a defensible regulatory route and a realistic payment pathway stand out to investors and payers alike. We support start-ups in shaping the evidence plan, the market and competitor analysis, and the financial narrative for a funding round, keeping the equity story within what the data can support.

Better information will reshape both the financing of healthcare and the value of the companies built on it. Insurers, MedTech companies, investors and founders that make evidence the organising principle, and plan for selection rather than ignore it, will be better placed than those that do not.

§ 05 · CHAPTER 4

Preparedness and *resilience* by design

European health systems must plan for major disruption — supply-chain failure, infrastructure loss and conflict. Delivery strategies and facilities can be designed to withstand such disruption.

The threat picture is no longer hypothetical

Two developments make preparedness urgent for European health systems. First, the medicine supply chain is concentrated and brittle. China is the world's largest producer of active pharmaceutical ingredients, with an estimated 40% share of global production, and India, the world's largest provider of generic medicines, procures almost 70% of its active ingredients from China.[20] A single failure can spread worldwide: in October 2016 an explosion at a Chinese plant on which global supply of the active ingredient had come to depend caused a worldwide shortage of the antibiotic piperacillin–tazobactam.[21] Medicine shortages, already common before 2020, were made worse by the COVID-19 pandemic through increased demand, lockdowns, border closures and hoarding.[20]

Second, heightened geopolitical tension raises the possibility that such disruptions coincide with losses of energy, transport or communications. The probability of any single catastrophic scenario is uncertain; the underlying fragility is documented.

Resilience must be designed in, not bolted on

A health system is resilient when it can prepare for and respond to a crisis, maintain core functions while it lasts, and reorganise afterwards if conditions require.[22] That capacity is not summoned during a crisis; it is built beforehand, through decisions about stockholding, supplier diversity, surge capacity and the physical protection of facilities.

Hospitals depend on uninterrupted power, water, telecommunications and medical gases. A scoping review of hospital safety assessments identified structural integrity and the safety of these internal systems as core elements of whether a facility remains safe and functional in a disaster.[23] (The WHO Hospital Safety Index rates structural and non-structural safety and emergency and disaster management capacity.[24]) Preparedness for specific threats has been uneven: surveys of hospitals with emergency departments in Belgium (2014) and the Netherlands (2017) found serious gaps in preparedness for chemical, biological, radiological

and nuclear incidents; in the Dutch survey, 40% of responding hospitals had decontamination facilities and 32% had appropriate protective equipment for triage and decontamination teams.[25,26] Resilience also carries costs, and who bears them matters;[27] the aim is targeted preparedness for identified risks, not open-ended spending.

How Acuvera supports preparedness and resilience

We help provider and payer organisations rethink delivery so that continuity of care survives disruption. Typical engagements include:

- Mapping single points of failure across the medicine and consumables supply chain, and designing supplier diversity, buffer stock and substitution protocols against identified risks.
- Assessing facilities against recognised safety indices and prioritising the hardening of power, water, communications and medical-gas continuity.
- Designing surge and continuity plans — staffing, triage and care pathways — that hold under loss of supply, utilities or access.
- Building the measurement and rehearsal — exercises and drills — needed to confirm that plans work before they are needed.

For boards, we translate these risks into oversight questions: which failures the organisation could not absorb today, what closing the gap would require, and how readiness is tested.

Disruption to European healthcare is no longer a remote contingency. Organisations that design for resilience now, soberly and against identified risks, will sustain care when others cannot.

§ 06 · HOW WE WORK

How we *work*

EVIDENCE FIRST	We ground analysis in peer-reviewed literature and official statistics, state where evidence is thin, and separate what is established from what is inferred.
PRACTITIONERS	Our work is carried out by people who have led healthcare organisations and delivered care, and who understand how decisions play out in the clinic, in the claims department and in the boardroom.
FROM ANALYSIS TO PRACTICE	We carry recommendations through to design, and build the measurement that shows whether a change has worked — before and after adoption.
WHERE WE WORK	Switzerland and the DACH region, the United Kingdom, the Middle East and South Africa.

FOUNDER

Dr Tyson B. Welzel

FOUNDER & MANAGING PARTNER

Tyson Welzel founded Acuvera in 2025. He spent nearly ten years in senior executive roles at Mediclinic Group, including as Group Chief Innovation Officer; as a member of the Group Executive Committee he held group-level responsibility for strategy, digital transformation and innovation. He is medically qualified (MBChB, MMedSc, EMDM, MMan) and has published peer-reviewed research in emergency medicine and disaster preparedness. He has completed the INSEAD International Directors Programme and has sat on three boards, chairing one. His advisory work spans healthcare strategy, market intelligence and organisational design for providers, insurers and health-technology companies.

— ANNEX A

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Healthcare, *human*, by design.

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