



Diagnosing Funnel Leakage in B2B Healthcare SaaS Inside Sales

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Abstract

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This paper examines the structure and bottlenecks of a business-to-business (B2B) inside-sales conversion funnel for healthcare software-as-a-service (SaaS) products, based on a thirteen-week participant-observation case study conducted within the Healthcare vertical of a video-collaboration OEM operating in India. The study decomposes the outbound sales funnel into three discrete stages

— calls attempted to calls connected, calls connected to demonstrations scheduled, and demonstrations scheduled to quotations sent — and computes stage-wise conversion ratios rather than relying on a single aggregate conversion figure. Findings indicate that the connect stage, constrained primarily by the quality of outbound contact data rather than by pitch quality or persuasive skill, accounts for the overwhelming majority of funnel attrition (an estimated 70–75 percent loss), while the demonstration-to-quotation stage — once a physician had actually viewed the product — converted at a comparatively high rate (60–65 percent). This pattern suggests that the binding constraint on funnel performance in this context is access to a decision-maker's attention, not the ability to persuade once attention is secured. The paper situates these findings within established sales-funnel, technology-adoption, and lead-scoring literature, and argues that funnel-leakage diagnosis should precede any investment in persuasion training or script redesign when the connect stage is the primary bottleneck. Practical recommendations — verified segment-

specific contact data, a healthcare-specific objection-handling framework, and lightweight lead-scoring — are proposed and sequenced into a phased implementation roadmap. The study's single-case, single-vertical design limits statistical generalisability, and the findings are presented as an illustrative, theory-informed case rather than a representative sample of B2B healthcare-SaaS sales performance.

Keywords: inside sales; sales funnel; funnel leakage; lead conversion; healthcare SaaS; tele-consultation; B2B sales; cold calling; technology adoption

1. Introduction

Inside sales — the practice of selling remotely through phone, video, and e-mail rather than through in-person field visits — has become the dominant go-to-market model for business-to-business (B2B) software-as-a-service (SaaS) companies, owing to its lower cost per contact relative to field sales and its compatibility with high-volume outbound prospecting (Kotler & Keller, 2016). Within this model, a prospect is typically moved through a defined sequence of funnel stages — from initial contact, to a connected conversation, to a product demonstration, to a formal quotation, and ultimately to a closed deal — with the conversion rate at each stage serving as a diagnostic of process efficiency.

Healthcare technology occupies a distinctive position within this general model. The buyer — typically a practising physician or hospital administrator — is simultaneously a time-constrained professional, a subject-matter expert, and a comparatively conservative adopter of new clinical workflows (Rogers, 2003; Davis, 1989). Selling tele-consultation software into this buyer segment therefore combines the structural challenges of generic B2B inside sales (data quality, access to decision-makers, funnel measurement) with a healthcare-specific adoption barrier: scepticism about whether a virtual consultation can match the clinical reliability of an in-person visit.



This paper reports findings from a thirteen-week participant-observation case study conducted within the Healthcare vertical of an India-based video-collaboration original equipment manufacturer (OEM) that markets a cloud-based virtual-clinic platform to doctors, clinics, and hospitals. During the study period, outbound calling activity, demonstration scheduling, and quotation issuance were logged daily, providing an empirical basis for a stage-wise funnel analysis. The central research question addressed is:

what is the primary bottleneck in the inside-sales conversion funnel for B2B healthcare SaaS — does it stem from contact-data quality, from persuasive/pitch skill, or from buyer-side technology scepticism — and at which specific funnel stage does it operate?

Answering this question matters practically because the appropriate managerial response differs sharply depending on where the bottleneck sits: a connect-stage bottleneck calls for investment in data quality, while a demonstration-stage or quotation-stage bottleneck would call for investment in persuasion training, pricing strategy, or product positioning. Conflating these would misallocate scarce sales-enablement resources.

2. Literature Review

The classical personal-selling process — prospecting, pre-approach, approach, presentation, handling objections, closing, and follow-up — provides the foundational sequence against which modern inside-sales funnels are typically mapped (Kotler & Keller, 2016). Building on this, the marketing/sales funnel concept treats the movement of prospects from awareness through interest, consideration, and intent to purchase as a series of discrete, measurable stages, each with its own conversion ratio.

2.1 Funnel-Leakage Theory

A recurring theme in sales-operations literature is that a multi-stage sales process should be diagnosed the way an engineer diagnoses a leaking pipe: by measuring volume lost at each joint rather than only the volume that emerges at the end. An aggregate calls-to-quotation conversion rate, taken alone, offers little diagnostic value, because different stages are typically constrained by different mechanisms — data quality at the connect stage, for instance, versus persuasive skill at the demonstration-to-close stage. Decomposing the funnel into stage-wise ratios is therefore treated in this paper as a methodological requirement rather than a stylistic choice.

2.2 The AIDA Model

The Attention-Interest-Desire-Action (AIDA) model describes the sequence a prospect moves through before taking a purchase-related action. Within a cold-calling context, the Attention stage corresponds to the first few seconds of a call — the point at which the large majority of calls are typically lost — while Interest and Desire are built primarily during a live product demonstration, and Action corresponds to the prospect agreeing to receive, and subsequently accepting, a formal quotation. Where a sales process shows strong conversion from demonstration to quotation but weak conversion from call to connect, the AIDA framework locates the constraint firmly at the Attention stage rather than at Desire or Action.

2.3 Diffusion of Innovation and the Technology Acceptance Model

Rogers' (2003) Diffusion of Innovation theory classifies adopters of a new technology along a continuum from innovators through early adopters, early and late majority, to laggards, and argues that adoption speed depends on an innovation's relative advantage, compatibility with existing practice, complexity, trialability, and observability. Physicians who have already experienced competitive pressure from patients seeking virtual care tend to behave as early-majority adopters, receptive once relative advantage is made concrete, whereas physicians expressing strong scepticism toward remote consultation more closely resemble late-majority or laggard profiles, requiring greater compatibility and observability — for instance, evidence that peer institutions are already using the platform successfully — before adopting.



The Technology Acceptance Model (TAM) (Davis, 1989) complements this by positing that adoption intention is driven primarily by perceived usefulness and perceived ease of use. For physician buyers, perceived usefulness concerns whether the platform can reduce outpatient-department (OPD) load or extend reach to remote patients, while perceived ease of use concerns whether patients — often elderly or less technically confident — can reliably join a virtual consultation. Literature on healthcare-technology adoption specifically argues that physicians' willingness to adopt digital tools is shaped less by feature richness than by perceived clinical reliability, ease of workflow integration, and peer or institutional validation.

2.4 CRM and Lead-Scoring Theory

Customer relationship management (CRM) literature emphasises that leads are not homogeneous in conversion probability, and that systematically scoring leads on dimensions such as engagement, authority, and expressed need allows a sales team to prioritise limited selling time toward higher-probability opportunities (Kotler & Keller, 2016). Where a sales operation works leads strictly in the order they appear on a calling list, irrespective of prior engagement signals, this literature would predict a lower overall funnel efficiency than one that prioritises leads dynamically.

2.5 SPIN Selling and Consultative Questioning

Rackham's (1988) SPIN Selling framework — Situation, Problem, Implication, and Need-payoff questions — argues that complex B2B sales are won less through a scripted pitch than through a structured questioning sequence that helps the buyer articulate their own problem and its consequences before the seller proposes a solution. This consultative approach is particularly relevant to demonstration-stage conversations, where understanding a physician's current patient-follow-up situation, surfacing specific pain points, and only then presenting the product as an answer to a self-articulated need is theorised to outperform an opening feature-list pitch.

2.6 Synthesis and Research Gap

Taken together, this literature suggests that inside-sales performance in a healthcare-SaaS context is jointly shaped by (a) data-quality and access constraints at the top of the funnel, (b) a healthcare-specific trust or scepticism barrier operating primarily at the connect-to-demonstration stage, and (c) persuasive and consultative-questioning technique operating primarily at the demonstration-to-close stage. However, much of this literature treats these mechanisms abstractly or examines them in general B2B contexts rather than in a healthcare-SaaS setting with granular, stage-wise empirical funnel data. This paper contributes an empirically grounded, stage-disaggregated case that tests where, specifically, these mechanisms bind in practice.

3. Research Methodology

This study adopts a descriptive, single-case, participant-observation design. Data were collected by the researcher while embedded as a sales-team member within the Healthcare vertical of the case company's Inside Sales function over a thirteen-week period (25 May to 25 August 2026). This design was selected because it allows direct, first-hand observation of the sales process at a level of granularity — individual call outcomes, objection language, and scheduling friction — that would not be accessible through a survey or secondary-data approach alone.

Primary data consisted of daily activity logs recording calls attempted, calls connected, demonstrations scheduled, and quotations sent, supplemented by a qualitative log of recurring objections encountered during calls. These daily figures were aggregated into average-per-day metrics and converted into three stage-wise conversion ratios: calls attempted to calls connected, calls connected to demonstrations scheduled, and demonstrations scheduled to quotations sent. Secondary data — company product collateral and publicly available industry and market-sizing reports — were used to establish sector context.

The connect-rate figure is reported as an estimated range rather than an exact count, since it was not captured as a discrete logged target during the study period; it is derived from the typical connect experience described by the researcher and cross-referenced against the qualitative log. This is disclosed transparently as a measurement



limitation rather than presented as an exact statistic.

As a single-case, single-vertical, single-researcher design, this study does not aim for statistical generalisability across the broader inside-sales organisation, other verticals, or other firms. Its purpose is analytical and illustrative: to demonstrate, with real operational data, how a stage-wise funnel-leakage lens can localise a conversion bottleneck that an aggregate conversion figure would conceal, and to generate propositions that could be tested more broadly in future, larger-sample research.

4. Case Context

The case company is an India-based audio-visual and video-collaboration OEM that designs and manufactures both hardware and software under a single-vendor model, serving enterprise, education, healthcare, government, and retail customers across more than thirty countries. Its healthcare-focused software offering is a cloud-based virtual-clinic platform enabling appointment booking and both on-site and remote video consultations between doctors and patients, sold alongside a complementary digital-engagement platform used in a healthcare configuration.

The Indian telemedicine and healthcare-collaboration software market was estimated at approximately USD 4.1–4.8 billion in 2026, with a projected compound annual growth rate in the range of 17–25 percent over the following five to ten years, driven by government digital-health infrastructure, rising broadband and smartphone penetration, and growing institutional acceptance of virtual consultation. Within this market, the case company's healthcare software sits in the video - collaboration / tele-consultation sub-segment, competing against both dedicated consumer-facing telemedicine platforms and generic video-conferencing tools repurposed for clinical use. The sales function studied here follows a high-volume outbound-calling model: sales personnel are assigned daily calling targets against a shared, company-provided contact database, with performance measured on connects, demonstrations scheduled, and quotations sent.

5. Results and Analysis

5.1 Average Daily Funnel Activity

Table 1 summarises average daily inside-sales activity over the study period. On a typical working day, approximately 200 outbound calls were attempted, of which an estimated 60–70 resulted in a genuine connected conversation; of these connected conversations, 2–3 progressed to a scheduled live demonstration; and of the demonstrations scheduled, roughly 0–1 progressed to a formally issued quotation on that same day (quotations were also issued on a lagged basis following earlier demonstrations).

Funnel Metric	Average per Day	Notes
Calls Attempted	~200	Fixed daily target
Calls Connected	~60–70	Estimated range; not a fixed logged target
Demonstrations Scheduled	~2–3	Logged downstream outcome
Quotations Sent	~0–1	Logged downstream outcome

Table 1. Average Daily Inside-Sales Funnel Activity

5.2 Stage-Wise Conversion Ratios

Converting the daily averages in Table 1 into stage-wise ratios (Table 2) reveals the specific shape of the funnel. The connect rate on cold calls is by a wide margin the single largest point of attrition; the connected-to-demonstration ratio is comparatively low but represents the stage at which healthcare-specific scepticism is most directly encountered; and the demonstration-to-quotation ratio is, by contrast, the strongest link in the funnel.



Funnel Stage	Approx. Conversion Ratio	Interpretation
Calls Attempted → Calls Connected	25–30%	The majority of attrition occurs here, driven largely by contact-data quality (outdated numbers, gatekeepers, unavailability) rather than lack of interest.
Calls Connected → Demonstrations Scheduled	8–9%	Of doctors reached, only a small fraction agree to a demonstration on the first call, largely due to time constraints and initial scepticism toward remote-consultation software.
Funnel Stage	Approx. Conversion Ratio	Interpretation
Demonstrations Scheduled → Quotations Sent	60–65%	The strongest conversion point in the funnel: once a physician sees a live, healthcare-specific demonstration, a majority progress to requesting formal pricing.

Table 2. Stage-Wise Sales Funnel Conversion Ratios

5.3 Data Quality as a Determinant of Connect Rate

Although a formal statistical correlation could not be computed in the absence of per-call data-quality tagging, the qualitative log consistently associated lower connect rates with calling blocks drawn from older or less-verified segments of the contact database, and comparatively higher connect rates with segments sourced more recently or cross-verified through secondary means, such as a hospital's own published directory. This observational pattern provides the empirical basis for treating contact-data quality, rather than pitch quality, as the primary lever available for improving the top of the funnel.

5.4 Objections and the Locus of Scepticism

The most frequently recorded objection concerned whether a virtual consultation could match the clinical reliability of an in-person visit — a concern rooted in professional caution rather than simple disinterest. This objection operated predominantly at the connect-to-demonstration stage: physicians who voiced this scepticism but nonetheless agreed to view a demonstration typically converted to a quotation at a rate consistent with the overall demonstration-to-quotation ratio, suggesting that a live demonstration was substantially more effective than the initial cold call at resolving this specific concern. This is consistent with the Technology Acceptance Model's emphasis on perceived usefulness and ease of use being best communicated experientially rather than descriptively, and with the Diffusion of Innovation prediction that observability — seeing the product in use — accelerates adoption among more sceptical adopter segments.

5.5 Week-Wise Stability of the Bottleneck

Tracking activity across the study period shows a ramp-up during the first two weeks of onboarding and product training, a stabilisation from the third week onward once daily calling targets and pitch delivery reached a steady state, and a modest tapering in the final week as remaining leads were handed over. Within the steady-state period, connects, demonstrations, and quotations moved roughly in proportion to calls attempted, indicating that the underlying stage-wise conversion ratios were relatively stable week-on-week rather than improving materially with accumulated experience. This is a substantively important result: it suggests that, within this study's time frame, practice and experience alone did not shift the funnel's structural bottleneck, reinforcing the conclusion that the



connect-rate constraint is a data-quality issue rather than a skill-acquisition issue that would be expected to improve with more repetitions.

6. Discussion

The central finding of this study — that funnel attrition is overwhelmingly concentrated at the connect stage rather than at the demonstration or quotation stages — has a direct managerial implication that a purely aggregate conversion metric would obscure. If overall calls-to-quotation conversion were reported as a single blended figure, a plausible but incorrect managerial response would be to invest in additional persuasion or objection-handling training. The stage-wise decomposition presented here indicates that such an investment would target a stage of the funnel that is already performing comparatively well (60–65 percent demonstration-to-quotation conversion), while leaving the dominant source of attrition — the connect stage — untouched.

This pattern is consistent with funnel-leakage theory's core prescription: diagnose stage-by-stage, because different stages are governed by different mechanisms. It also refines the Diffusion of Innovation and Technology Acceptance Model literature's application to healthcare-technology sales specifically. Those frameworks correctly predict that physician scepticism is a real and theoretically grounded barrier; however, this study's data suggest that scepticism, once physicians are actually reached and offered a demonstration, is a resolvable barrier — the true unresolved barrier is access, i.e., the connect stage itself, which precedes any opportunity to address scepticism at all.

The absence of any material week-on-week improvement in the connect ratio, despite accumulating calling experience and pitch fluency, further supports interpreting the connect-stage constraint as structural (rooted in the quality of the contact database) rather than behavioural (rooted in caller skill). Were the constraint primarily behavioural, an upward trend in connect rate would be expected as the caller's technique improved over the thirteen-week period; no such trend was observed.

These findings also speak to CRM and lead-scoring theory. In the absence of a lead-scoring mechanism, all contacts in this case were worked in list order regardless of any prior engagement signal, meaning that calling effort was not differentially allocated toward higher-probability contacts. Given that the connect stage is where the bulk of attrition occurs, even a lightweight mechanism for flagging previously-connected or previously-engaged contacts for repeat outreach — rather than treating every contact as a fresh, equally-probable cold call — would be expected to raise effective connect rates without any change to calling volume.

7. Recommendations

Based on the findings above, four recommendations are proposed, sequenced by expected impact and implementation complexity.

- Invest in verified, segment-specific contact data (e.g., professional-network directories, verified hospital/clinic listings, or paid healthcare-professional databases) in place of bulk-sourced contact lists, since data quality — not pitch quality — is the primary lever for improving the connect-stage ratio identified in Section 5.2.
- Develop a short, healthcare-specific objection-handling framework that explicitly addresses the clinical-reliability concern identified in Section 5.4, using credible reference examples (e.g., large-scale institutional or government tele-consultation programmes) to accelerate the connected-to-demonstration conversion.
- Introduce a brief pre-call warm-up sequence (e.g., a short message via e-mail or a professional messaging channel) roughly 24–48 hours before a scheduled calling batch, so that the cold call is not the prospect's first exposure to the product or brand.
- Implement a lightweight lead-scoring mechanism — even a structured spreadsheet before a full CRM — that flags previously-connected or previously-engaged contacts for prioritised follow-up, addressing the CRM/lead-scoring gap identified in Section 6.

These recommendations are deliberately sequenced to address the connect-stage bottleneck first, since it accounts



for the largest share of funnel attrition and has the fewest cross-functional dependencies, before addressing the comparatively smaller gains available at later funnel stages.

8. Limitations

- The study reflects the experience of a single researcher within one vertical of one organisation over one time period, and does not claim statistical representativeness of the broader inside-sales organisation, other verticals, or other firms.
- Daily activity figures were recorded through informal logs rather than a CRM system; the calls-connected figure in particular is reported as an estimated range rather than an exact count.
- The funnel analysis extends only to the quotation stage; final deal-closure data and post-sale outcomes were not accessible and fall outside the scope of this study.
- The association between contact-data quality and connect rate is based on qualitative observation rather than a formal statistical test, since per-call data-quality tagging was not available.
- The study period does not capture potential seasonal variation in physician availability or institutional procurement cycles that may occur at other times of the year.

9. Conclusion and Future Research

This study set out to identify the primary bottleneck in a B2B healthcare-SaaS inside-sales conversion funnel and to determine whether that bottleneck stems from contact-data quality, persuasive skill, or buyer-side scepticism. Stage-wise decomposition of thirteen weeks of operational funnel data indicates that the connect stage — not the demonstration or quotation stage — accounts for the overwhelming majority of attrition, and that this constraint is more plausibly structural (contact-data quality) than behavioural (persuasive skill), given the absence of improvement over the study period despite accumulating experience. Healthcare-specific scepticism toward tele-consultation, while real and theoretically well-grounded in the technology-adoption literature, appears to be substantially resolved once a physician actually views a live demonstration, positioning access to a decision-maker's attention — rather than persuasion once that attention is secured — as the central constraint on funnel performance in this case.

Future research could extend this analysis in three directions: first, by tracking the funnel through to deal closure rather than stopping at the quotation stage, to determine whether the demonstration-to-quotation strength observed here persists through to final conversion; second, by incorporating exact CRM-logged figures in place of estimated ranges, to permit formal statistical testing of the data - quality-to-connect-rate relationship; and third, by replicating this stage-wise analysis across other verticals (e.g., education, enterprise, retail) served by the same or comparable healthcare-SaaS OEMs, to establish whether the connect-stage bottleneck identified here is specific to healthcare sales or a more general feature of B2B inside-sales funnels.

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