



Sales Funnel Conversion in B2B Healthcare SaaS Selling: An Exploratory Study of India's Telemedicine Software Industry

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Abstract

India's telemedicine and healthcare-collaboration software market is estimated at approximately USD 4.1–4.8 billion in 2026 and is projected to grow at a compound annual growth rate of 17–25% over the next several years, driven by government digital-health infrastructure, rising smartphone penetration, and growing acceptance of virtual consultation. Despite this growth, the business-to-business (B2B) sales process by which healthcare software-as-a-service (SaaS) vendors acquire clinic and hospital customers remains under-studied in the academic literature, which has focused predominantly on patient-side adoption and macro-level market sizing rather than vendor-side selling behaviour. This study addresses that gap through an exploratory, single-case analysis of the inside-sales customer-acquisition process at a healthcare-vertical SaaS provider in India, based on structured first-hand observation of daily sales activity over a one-month period. Sales activity was logged across six funnel stages — calls attempted, calls connected, prospects showing interest, demonstrations scheduled, quotations sent, and deals closed — and converted into stage-wise conversion ratios. The findings show that conversion ratios improve progressively through the early and mid funnel (20.8% □ 33.3% □ 44.4% □ 50.0%) but fall sharply at the final quotation-to-closure stage (17.5%), identifying this stage, rather than cold-calling or product demonstration, as the primary point of funnel leakage. Objection analysis further shows that prospect resistance is dominated by incumbent free-tool substitution

(WhatsApp/Zoom, □34% of objections) and scepticism toward the clinical adequacy of virtual consultation (□26%), rather than by price alone. The study proposes four low-cost, operationally implementable interventions — verified lead data, standardised objection-handling scripts, pre-call digital warm-up messaging, and a structured post-quotation follow-up cadence — and situates these within the sales funnel, AIDA, BANT, Technology Acceptance Model (TAM), and Diffusion of Innovation frameworks. As an exploratory, single-respondent case study, the findings are illustrative rather than statistically generalisable, and the paper closes by outlining a research agenda for larger-sample, multi-vertical, and longitudinal replication.

Keywords: sales funnel, B2B SaaS, customer acquisition, healthcare technology, telemedicine, India, sales effectiveness, technology acceptance

1. Introduction

The digitisation of healthcare delivery in India has accelerated sharply since 2020, with government-backed programmes such as the Ayushman Bharat Digital Mission (ABDM) and the eSanjeevani teleconsultation platform normalising virtual care at national scale. This policy and infrastructure shift has created a large and growing addressable market for private vendors of clinic- and hospital-facing telemedicine software. Yet a persistent asymmetry characterises this market: while the "hard" enabling conditions for adoption — policy, connectivity, and legal permissibility — have moved decisively in favour of virtual consultation software, the "soft" conditions of trust and



habitual practice among individual doctors have lagged considerably behind. This asymmetry places a disproportionate burden on direct, relationship-based B2B selling as the primary mechanism through which healthcare SaaS vendors must convert awareness of telemedicine, in the abstract, into adoption of a specific vendor's product.

Despite the commercial and public-health significance of this selling process, the academic literature on Indian telemedicine is weighted heavily toward patient-side adoption, scoping reviews of service typologies, and bibliometric mapping of the research field itself, with comparatively little empirical attention paid to the vendor-side sales process — how healthcare software companies actually convert cold outbound contact into paying institutional customers. This gap is notable given that customer acquisition, not patient-side willingness alone, determines whether the technological capacity documented in the broader telemedicine literature is actually deployed within a given clinic or hospital.

This study addresses that gap by presenting an exploratory, empirically grounded account of the B2B customer-acquisition funnel at a healthcare-vertical software vendor in India, based on structured, first-hand observation of the inside-sales process over a one-month engagement. The study quantifies the sales funnel at each of its constituent stages, computes stage-wise conversion ratios, catalogues the objections encountered at each stage, and identifies the specific point in the funnel at which the greatest proportion of qualified prospects is lost. In doing so, the paper aims to bridge established sales and technology-adoption theory — the sales funnel model, the AIDA framework, BANT lead qualification, the Technology Acceptance Model (TAM), and Diffusion of Innovation theory — with the operational reality of selling clinical software to a professionally conservative, time-constrained buyer.

1.1 Research Problem

While the Indian telemedicine sector's growth trajectory is well documented at the macro level, there is limited empirical evidence on where, specifically, the B2B customer-acquisition process for healthcare SaaS products leaks prospects, and what factors — data quality, buyer scepticism, price sensitivity, or follow-up discipline — are most responsible for that leakage. Without this stage-level evidence, vendors and researchers alike are limited to treating "sales effectiveness" as a single aggregate outcome rather than a diagnosable, multi-stage process.

1.2 Objectives of the Study

1. To document the structure of the B2B customer-acquisition funnel used by a healthcare SaaS vendor in India, from initial outbound contact to deal closure.
2. To quantify conversion ratios at each stage of the funnel and identify the stage of greatest prospect leakage.
3. To catalogue and categorise the objections raised by prospective healthcare buyers during the sales process.
4. To propose theoretically grounded, operationally feasible interventions to improve funnel conversion, and to outline directions for future confirmatory research.

2. Literature Review

2.1 The Sales Funnel Model and Customer Acquisition Cost

The sales, or purchase, funnel model represents customer acquisition as a sequence of narrowing stages — awareness, interest, evaluation, decision, and action — with a measurable conversion ratio linking each pair of adjacent stages (Kotler & Keller, 2016). Within this framework, sales effectiveness is best understood not as a single activity metric (e.g., calls made) but as the composite of stage-wise conversion ratios and the overall input-to-outcome ratio. This framing is closely linked to the concept of Customer Acquisition Cost (CAC): because every stage of funnel leakage raises the effective cost of the customers who do eventually convert, stage-level diagnosis — rather than aggregate activity volume — is the more actionable unit of analysis for both practitioners and researchers.



2.2 The AIDA Model in B2B Selling

The AIDA model (Attention, Interest, Desire, Action) describes the sequential cognitive states through which a communication moves a prospective buyer. In an inside-sales cold-calling context, "Attention" corresponds to the opening seconds of a call, "Interest" and "Desire" are built through the qualification conversation and, more powerfully, through product demonstration, and "Action" corresponds to the prospect's acceptance of a formal commercial proposal. AIDA provides a useful lens for mapping stage-wise funnel data onto underlying buyer psychology rather than treating each funnel stage as a purely mechanical filter.

2.3 BANT Lead Qualification

BANT (Budget, Authority, Need, Timeline) is a widely used heuristic for determining whether further sales investment in a given prospect is warranted. In healthcare-specific B2B contexts, the Authority dimension is particularly salient: outbound calls to a clinic or hospital are frequently intercepted by front-desk or administrative staff rather than the clinical decision-maker, meaning that an apparent "not interested" outcome may reflect a gatekeeping decision rather than an informed refusal by the actual buyer.

2.4 Technology Acceptance Model (TAM)

TAM (Davis, 1989) posits that behavioural intention to adopt a new technology is jointly determined by perceived usefulness and perceived ease of use. Applied to clinicians evaluating tele-consultation software, perceived usefulness centres on whether the technology reduces administrative and scheduling friction, while perceived ease of use centres on whether adoption disrupts an already time-pressured clinical workflow. TAM further predicts that ease-of-use concerns dominate early in the adoption decision, while usefulness concerns dominate once a prospect is seriously evaluating adoption — a pattern with direct implications for how product demonstrations and post-demonstration follow-up should be sequenced.

2.5 Diffusion of Innovation Theory

Rogers' Diffusion of Innovation theory classifies technology adopters into innovators, early adopters, early majority, late majority, and laggards, based on their relative willingness to adopt an innovation ahead of their peers. In healthcare-technology selling, this framework predicts that a minority of prospects will behave as innovators or early adopters — proactively receptive once the value proposition is explained — while the majority will require social proof (evidence of peer adoption) before committing, a pattern with direct implications for how vendors sequence outreach and construct their sales narrative.

2.6 The Indian Telemedicine Sector Context

India's telemedicine and healthcare-collaboration software market was valued at approximately USD 4.1–4.8 billion in 2026, with projected CAGR in the range of 17–25% over the coming years, driven by the Ayushman Bharat Digital Mission, the eSanjeevani platform, rising broadband and smartphone penetration, and an expanding chronic-disease burden. Within this sector, clinic- and hospital-facing B2B software is acquired predominantly through direct, relationship-based selling rather than the digital-marketing-led growth strategies typical of consumer-facing telehealth applications, reflecting the trust-sensitive, professionally conservative nature of the clinical buyer.

2.7 Synthesis and Research Gap

While each of the frameworks above has been independently applied to B2B selling and to technology adoption respectively, few empirical studies combine stage-wise funnel data with adoption theory in the specific context of Indian healthcare SaaS selling. This study contributes exploratory, stage-level empirical evidence to that intersection.



3. Methodology

3.1 Research Design

This study adopts an exploratory, single-case research design, appropriate given the absence of prior stage-level empirical data on B2B healthcare SaaS selling in the Indian context. Exploratory case research is a recognised method for generating grounded hypotheses in under-studied operational domains, with the explicit understanding that findings are illustrative rather than statistically generalisable (Yin, 2018, cited generally in case-study methodology literature).

3.2 Setting and Data Source

Data were collected through structured, first-hand participant observation of the daily inside-sales process at the healthcare vertical of a video-collaboration and healthcare-software OEM operating in India, over a one-month engagement. The observing party was directly responsible for executing the sales process — cold-calling, qualification, demonstration scheduling, quotation preparation, and follow-up — rather than passively observing it, allowing for granular, contemporaneous activity logging rather than retrospective recall.

3.3 Data Collection Instruments

Daily activity was recorded using three structured instruments maintained in real time:

- **Call Log** — date, prospect type (individual doctor, clinic, hospital), call outcome, and qualitative notes.
- **Demonstration Tracker** — prospect identity, product demonstrated, attendee designation, and outcome.
- **Quotation Register** — product/tier quoted, quotation value, date sent, and follow-up status.

3.4 Funnel Stages and Conversion Ratio Calculation

Six sequential funnel stages were defined: (1) calls attempted, (2) calls connected, (3) prospects showing genuine interest, (4) demonstrations scheduled, (5) quotations sent, and (6) deals closed. Stage-wise conversion ratios were calculated as the ratio of a given stage's average daily volume to the preceding stage's average daily volume, using steady-state averages (from the point at which daily activity volume stabilised) to avoid distortion from the initial ramp-up period.

3.5 Objection Coding

Objections raised by prospects during calls and demonstrations were logged verbatim at the point of occurrence and subsequently grouped into five recurring categories through iterative thematic coding, with frequency expressed as an approximate share of total logged objections.

3.6 Limitations of the Design

This design carries the limitations inherent to single-respondent, single-vertical, short-window case research, discussed in full in Section 7.

4. Data Analysis and Results

4.1 Steady-State Daily Funnel

Table 1 presents the average daily funnel volume once activity had stabilised.

Table 1. Daily Inside-Sales Activity (Steady-State Averages)

Funnel Stage	Average per Working Day
Calls attempted	130
Calls connected	27
Prospects showing genuine interest	9



Demonstrations scheduled	4
Quotations sent	2
Deals closed	□0.35 (approx. one every three working days)

4.2 Stage-Wise Conversion Ratios

Table 2. Stage-Wise Sales Funnel Conversion Ratios

Funnel Transition	Conversion Ratio
Calls attempted □ Calls connected	20.8%
Calls connected □ Prospects interested	33.3%
Prospects interested □ Demonstrations scheduled	44.4%
Demonstrations scheduled □ Quotations sent	50.0%
Quotations sent □ Deals closed	17.5%
Overall (calls attempted □ deals closed)	□0.27%

The data reveal a distinctive non-monotonic pattern: conversion ratios rise consistently through the early and mid-funnel (20.8% □ 33.3% □ 44.4% □ 50.0%), indicating that each successive qualification filter is, if anything, more effective than the one preceding it. This pattern breaks sharply at the final transition, where the quotation-to-closure ratio falls to 17.5% — below every preceding stage. This inversion is the central empirical finding of the study and indicates that funnel leakage is concentrated not at the top of the funnel (as cold-calling critiques often assume) but at the commercial-negotiation stage.

4.3 Objection Analysis

Table 3. Objections Encountered, by Approximate Frequency

Objection	Approx. Share
Incumbent free-tool substitution ("we already use WhatsApp/Zoom")	□34%
Scepticism toward virtual-consultation clinical quality	□26%
Deferral ("send details, will call back")	□21%
Price/budget concern	□12%
Data privacy/security concern	□7%

Price sensitivity, while present, accounted for a comparatively small share of logged objections (□12%), suggesting that trust- and habit-based resistance — rather than affordability — constitutes the dominant barrier to progression through the early-to-mid funnel.

4.4 Segment-Level Variation

Demonstration activity was concentrated among standalone doctors and small multi-speciality clinics, which together accounted for approximately 74% of all scheduled demonstrations, consistent with the shorter decision cycle and single-decision-maker structure typical of smaller accounts. Hospital-segment prospects, by contrast, required multi-stakeholder coordination and did not convert to closure within the one-month observation window despite receiving quotations, indicating a materially longer sales cycle for institutional accounts than for individual-practitioner accounts.



5. Discussion

5.1 The Quotation-to-Closure Stage as the Primary Point of Leakage

Read through the AIDA lens, the rising conversion ratios through Attention, Interest, and Desire (calls connected ☐ interest ☐ demonstration ☐ quotation) indicate that the sales process is effective at building buyer conviction up to the point of a formal commercial proposal. The sharp drop at the Action stage suggests that the barrier at this point is not attitudinal (the prospect is not un-persuaded) but transactional — price finalisation, internal approval, and sustained follow-up discipline. This reframes the conventional assumption that cold-calling volume or demonstration quality are the primary levers for improving healthcare SaaS sales outcomes; the evidence instead points to post-quotation process discipline as the higher-leverage intervention point.

5.2 Trust as the Dominant Objection Category

The concentration of objections around incumbent free-tool substitution and scepticism toward virtual-consultation quality (together ☐60% of all objections) is consistent with the sector-level PESTEL asymmetry discussed in Section 2.6: the technological and regulatory conditions for adoption are favourable, but social trust lags behind. This pattern also aligns with TAM's prediction that ease-of-use concerns (articulated here as "we already have a working alternative") and usefulness/legitimacy concerns (articulated as scepticism toward virtual care) dominate the earlier stages of the adoption decision, while price becomes salient only later, closer to the point of commercial commitment — consistent with price objections being logged at comparatively low frequency relative to trust-based objections.

5.3 Segment-Differentiated Sales Cycles

The divergence between individual-practitioner and hospital-segment conversion behaviour is consistent with Diffusion of Innovation theory's distinction between individual and organisational adoption units: individual doctors approximate a single-adopter decision process, while hospitals involve a more complex, multi-stakeholder adoption unit whose extended timeline is not evidence of disinterest but of institutional decision complexity. This suggests that funnel benchmarks and follow-up cadences should be segmented by buyer type rather than applied uniformly.

6. Recommendations

Grounded in the findings above, four interventions are proposed, each mapped to a specific funnel stage:

1. ****Verified, segment-specific lead data**** (targeting the calls-attempted ☐ calls-connected transition), to reduce wasted outreach on inaccurate or gatekept contact records.
2. ****Standardised, trust-oriented objection-handling scripts**** (targeting the connected ☐ interested transition), built around the two dominant objection categories identified in Section 4.3.
3. ****Pre-call digital warm-up messaging**** (targeting the connect rate and initial receptiveness), intended to pre-empt the "already using a free alternative" objection before the live call.
4. ****A structured, segment-differentiated post-quotation follow-up cadence**** (targeting the quotation-to-closure transition), with a distinct, longer-touch cadence for institutional/hospital accounts to reflect their extended, multi-stakeholder decision cycle.

Because Recommendation 4 addresses the stage identified as the primary point of leakage (Section 4.2), it is proposed as the highest-priority intervention, with Recommendation 1 as a complementary early-funnel efficiency measure.



7. Limitations

This study is subject to several limitations inherent to its exploratory, single-case design:

- ****Single respondent, single vertical****: all data reflect one sales representative's activity within one healthcare vertical of one organisation, and may not generalise to other verticals, organisations, or sales representatives.
- ****Short observation window****: the one-month period, while sufficient to observe the calling-to-quotation funnel repeatedly, is short relative to typical institutional (hospital-level) sales cycles; the reported zero hospital-segment closure rate likely reflects the observation window rather than a true structural ceiling.
- ****Manually logged, non-CRM data****: activity was recorded via structured manual logs rather than an integrated CRM system, so reported figures approximate rather than exactly reproduce system-verified counts.
- ****Absence of a comparison baseline****: the study lacks a benchmark (e.g., a more experienced representative's funnel, or funnel data from a competing vendor) against which to assess whether the observed conversion ratios are strong, average, or weak relative to industry norms.
- ****Potential observer effect****: awareness that activity was being logged for research purposes may have marginally influenced logging discipline or follow-up consistency relative to an unobserved baseline.

Given these limitations, the findings should be read as hypothesis-generating rather than confirmatory.

8. Directions for Future Research

Future research should extend this exploratory account through: (1) multi-representative, multi-organisation sampling to test the generalisability of the quotation-to-closure leakage finding; (2) a longitudinal design of at least three to six months to capture institutional-segment closure behaviour that a one-month window cannot observe to completion; (3) integration with CRM-logged, system-verified data to eliminate manual-logging measurement error; and (4) cross-vertical replication (e.g., education- or enterprise-vertical SaaS selling within the same organisational context) to determine whether the trust-dominant objection pattern identified here is specific to healthcare or reflective of a broader pattern in Indian B2B SaaS selling.

9. Conclusion

This exploratory study provides stage-level empirical evidence on the B2B customer-acquisition funnel for healthcare SaaS selling in India, addressing a gap in a literature that has, to date, focused predominantly on patient-side telemedicine adoption rather than vendor-side selling process. The central finding — that funnel leakage is concentrated at the quotation-to-closure stage rather than at cold-calling or product demonstration — challenges the common practitioner assumption that call volume is the primary lever for improving healthcare SaaS sales outcomes, and instead points to post-quotation follow-up discipline as the higher-leverage intervention. While the single-case, exploratory design limits the generalisability of these findings, they offer a grounded starting point for larger-sample, longitudinal, and cross-vertical research into the B2B customer-acquisition process within India's rapidly growing telemedicine software industry.

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