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UPGROWTH HEALTHCARE PLAYBOOK 01

Patient Acquisition Funnel Architecture

How to instrument the path from enquiry to consultation attended, and stop reporting a number that cannot see the failure.

HEALTHCARE

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Why this playbook exists

Almost every hospital and clinic in India reports cost per lead. Almost none can tell you what a patient costs counted to the consultation they actually attended. The gap between those 2 numbers is where the budget disappears, and it is invisible on the dashboard the marketing team is judged by.

This is not an argument about attribution software. It is an argument about where the funnel is broken. In healthcare the break is almost never in the campaign. It is in the handover: the minutes and hours between a form being submitted and a human being calling back, and the days between that call and somebody physically arriving. Marketing owns the first half and does not own the second, so the second half goes unmeasured, and the unmeasured half is the one that decides revenue.

What follows is the architecture we use to make that half visible. It is deliberately operational. There is nothing here about brand positioning and nothing about creative. It is a set of timestamps, owners and definitions that a marketing lead and an operations lead can agree on in one meeting, and a reporting shape that survives past the form fill.

Who this is for
Marketing heads at multi-speciality hospitals, clinic chains and single-specialty groups in India. It assumes you already run paid and organic acquisition and that your reporting currently stops at the enquiry. It does not assume any particular CRM.

WHAT IS IN THIS PLAYBOOK

01 The 6 states of a patient enquiry

A funnel only works as a shared language if both teams agree on what each state means and who owns it. Most healthcare funnels fail this test immediately: marketing says lead, the front desk says enquiry, the clinical team says patient, and none of the 3 refer to the same event.

Use these 6. They are deliberately observable, which means each one has a moment you can point at rather than a judgement someone has to make.

State	What it means	Owner
Enquiry received	A form, call, chat or walk-in has been captured with a contactable number	Marketing
First contact made	A human has spoken to the person, not attempted and failed	Front office
Qualified	The enquiry is inside your catchment, specialty and payment model	Front office
Appointment booked	A named date, time and consultant exist in the schedule	Front office
Consultation attended	The person physically arrived and was seen	Operations
Treatment started	The first billable clinical event after the consultation	Operations

The most expensive definition error in healthcare marketing
Counting a lead at Enquiry received and reporting cost against it. That number improves every time you widen targeting, and it improves fastest when the added volume is people who will never attend. It is not a neutral metric. It actively rewards the thing that is hurting you.

Why 6 and not 3

Three-state funnels hide the 2 places healthcare actually leaks. Between First contact made and Appointment booked you lose people to qualification failures you can fix in the media plan: wrong city, wrong specialty, wrong payment expectation. Between Appointment booked and Consultation attended you lose people to reasons operations can fix: the slot was 11 days away, nobody reminded them, or the consultant was rescheduled. Collapse those and both losses look like one number called conversion rate, and nobody can act on it.

The specific mechanics of that second gap are covered in Pain in the Handover, part of our healthcare growth series.

02 The handover, and why it breaks

The handover is the single highest-leverage point in a healthcare funnel and it is almost never owned by anyone. It sits between 2 teams with different reporting lines, different working hours and different definitions of success. That seam is where enquiries die.

The 3 failures, in order of cost

1. **The first-response clock is never started.** Nobody records the time between enquiry received and a human speaking to the person. Without that number you cannot tell a slow week from a bad campaign, and the conversation defaults to lead quality.
2. **Media runs in hours nobody answers.** Health searches concentrate in early mornings, evenings, Sundays and holidays. If your phone cover does not, you are buying impressions that fund the nearest competitor's booking. The real ceiling on spend is the schedule of hours a human answers, which is an operations decision before it is a media one.
3. **Routing is by round robin rather than by intent.** A high-value enquiry for a surgical specialty and a general enquiry about a checkup arrive in the same queue and are treated identically. Both get a worse experience than they should.

> **The exercise that settles the argument**
> Submit an enquiry through your own website on a Saturday evening from a number nobody at your organisation recognises. Time what happens. Do it again on a Tuesday at 11am. Bring both timelines to the next marketing review. This costs nothing, takes 2 days, and has changed more budgets than any audit we have run.

What good looks like

- A named owner for the handover, not a shared inbox.
- A first-response target expressed in minutes for the hours you are open, and a defined overflow route for the hours you are not.
- Ad schedules set to the hours calls are actually answered, with any hour outside that either routed to overflow or given no spend.
- Call recordings sampled weekly. Somebody listens to 20 inbound calls before anyone judges lead quality. That exercise usually reveals the enquiries were fine and the handling was not.

03 Instrumentation: what to timestamp

You do not need a new CRM. You need 9 timestamps and a rule about who writes each one. Everything else in this playbook is downstream of getting these captured consistently.

#	Timestamp	Written by	What it unlocks
1	Enquiry received	System	Volume by source, the denominator for everything
2	First contact attempted	Dialler or CRM	Attempt discipline, separate from success
3	First contact made	Front office	The first-response clock, the single most useful number
4	Qualification outcome	Front office	Media waste by reason, feeds back into targeting
5	Appointment booked	Scheduling	Booking rate, and the length of the wait to the slot
6	Appointment date	Scheduling	The gap between intent and attendance
7	Consultation attended	Operations	The real conversion event
8	No show reason	Front office	Separates fixable losses from unfixable ones
9	Treatment started	Operations	Revenue attribution, and lifetime value by source

If your CRM cannot hold these
Do not buy a new one yet. A shared sheet with 9 columns, filled by the front office for 30 days, will tell you more than a migration will, and it will tell you what to buy afterwards. Most healthcare funnel problems are process problems wearing a software costume.

The 2 derived numbers that matter most

Median and 90th percentile first-response time, reported weekly. Use both. The median tells you the normal experience and the 90th percentile tells you where the losses sit, because the tail is not a rounding error, it is a set of specific people who went somewhere else.

Days from appointment booked to appointment date, by specialty. This is the number that predicts no shows better than anything else, and it is a capacity decision rather than a marketing one. If it is long, more spend makes it worse.

04 Multi-location and multi-specialty routing

A network with 12 centres has 12 markets, and a hospital with 9 specialties has 9 funnels. Reporting them as 1 line produces an average that describes none of them and hides the 2 or 3 that are actually failing.

Route on purpose, or branch performance is noise

When an enquiry can be served by more than 1 location, somebody or something decides where it lands. If that decision is not deliberate, branch-level cost per patient is not comparable across branches and cannot be used to allocate budget. The most common symptom is a branch that looks expensive purely because it absorbs overflow from a busier one.

- Define the routing rule explicitly: nearest, or first available slot, or specialty capability. Write it down.
- Capture the routing decision as a field, so you can separate demand generated for a branch from demand routed to it.
- Report cost per consultation attended by branch and by specialty, never blended, and never as a network average.
- Where 2 branches share a catchment, model the overlap before a third is opened rather than after the second underperforms.

> **A specialty-level warning**
> If 1 specialty converts within days and another takes weeks, a single campaign optimising to conversions will shift budget toward the fast one within a fortnight, because it is the only one reporting inside the attribution window. Nothing looks broken. A blended cost per lead can improve for 2 quarters while the slow, higher-value pipeline empties.

05 The metric set that replaces cost per lead

There is no single healthcare metric. The right headline number depends on what the specialty is judged on commercially, and getting this wrong is how a department reports improvement through a quarter in which it lost every case it competed for.

Specialty	Headline metric	Report beside it
Oncology	Cost per consultation attended	Records received to named clinician response time
Fertility	Cost per cycle started	Repeat cycles, and cycles traced to a patient referral
Dialysis	Cost per patient acquired	Chair utilisation by centre and by shift
ENT acute	Cost per booked appointment	Call answer rate by hour
Audiology	Cost per qualified consultation	Enquiry to appointment lag
Diagnostics	Cost per patient acquired	Tests per patient per year
Preventive	Cost per checkup completed	Utilisation against contracted volume
Orthopaedics	Cost per surgical consult attended	Consult to surgery conversion by procedure

Each row below is argued in full on its own page: oncology, fertility, dialysis, ENT and audiology, diagnostics, preventive health and orthopaedics.

The rule underneath the table

Pick the metric that gets worse when the business gets worse. Cost per lead fails that test in every row above, because you can improve it by buying broader traffic while the department loses cases. Any metric that can be improved by an action that harms the business is not a metric, it is a target for gaming.

Not sure which number applies to you

We run a 30 minute diagnostic that maps your current reporting against the metric your specialty is actually judged on, and shows you which of the 9 timestamps you are missing. No deck, no pitch, just the gap.

Book a 30 minute growth call or write to contact@upgrowth.in

06 The 30 day implementation

This is deliberately short. If it takes a quarter, it will not happen. The sequence matters more than the speed: the definitions meeting has to come first, because every later step depends on 2 teams using the same words.

Week 1: agree the language

- One meeting with marketing, front office and operations in the room. Agree the 6 states verbatim.
- Nominate a single named owner for the handover.
- Run the Saturday evening enquiry test on your own website and bring the timeline to the meeting.

Week 2: start the clocks

- Capture timestamps 1, 2 and 3 for every enquiry, in whatever tool you already have.
- Publish median and 90th percentile first-response time to both teams. Weekly, visible, not on request.
- Pull the answered-hours data and compare it against your ad schedule.

Week 3: close the obvious leaks

- Set ad schedules to answered hours, or fund the cover to extend them. Do not do neither.
- Add qualification outcome as a required field with a fixed list of reasons.
- Listen to 20 recorded inbound calls as a group.

Week 4: change the report

- Replace cost per lead in the headline slot with the metric your specialty is judged on.
- Split reporting by specialty and by location. Retire the blended number entirely.
- Book the first monthly review where operations presents the second half of the funnel rather than marketing guessing at it.

> **What to expect in month 2**
> Reported performance usually looks worse before it looks better, because you have stopped counting enquiries that were never going to attend. That is the point. Tell your leadership this before you start, not after the first report lands.

If you want the number before you start, our patient acquisition cost calculator will get you a baseline in a few minutes, and the wider argument sits on our healthcare marketing page.

Diagnosis before prescription

upGrowth works with hospitals, clinics, diagnostics businesses and individual clinicians on patient acquisition, search visibility and AI search presence. If any part of this playbook described your funnel, the fastest next step is a conversation about which timestamp you are missing.

Book a 30 minute growth call or write to contact@upgrowth.in

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DIAGNOSIS BEFORE PRESCRIPTION

Start with one number, not one campaign.

Before the next campaign, get 1 number: what it costs you to acquire a patient counted to the consultation, per specialty. We will run that diagnostic with you in 30 minutes.

Book a 30 minute growth call

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