Date of submission: November 07, 2026

To, The Secretary Listing Department **BSE Limited** Department of Corporate Services Phiroze Jeejeebhoy Towers, Dalal Street, Mumbai – 400 001 **Scrip Code – 539551 (EQ), 975516, 976418**	To, The Secretary Listing Department **National Stock Exchange of India Limited** Exchange Plaza, Bandra Kurla Complex Mumbai – 400 051 **Scrip Code- NH**

Dear Sir/Madam,

Sub: Transcript of Earnings Call for the quarter and half year ended September 30, 2026.

Further to our earlier letter dated Monday November 02, 2026 in relation to uploading the Audio Recording of the Earnings Call of the Company held on Tuesday, November 02, 2026 for the quarter and half year ended September 30, 2026, please find attached the transcript of the said Earnings Call.

We wish to inform you that the Earnings Call transcript is also available on the website of the Company at: https://www.narayanahealth.org/stakeholder-relations/earnings-call-audio-and-transcripts

Kindly take the same on record.

Thanking you

Yours faithfully
For **Narayana Hrudayalaya Limited**

SESHIAH SRIDHAR
Digitally signed by SESHIAH SRIDHAR
Date: 2026.11.07 13:02:42 +05'30'

Sridhar S.
Group Company Secretary, Legal & Compliance Officer

"Narayana Hrudayalaya Limited

Quarter 2 FY27 Earnings Call"

November 02, 2026

MANAGEMENT: **MR. VIREN SHETTY – VICE CHAIRMAN**
DR. EMMANUEL RUPERT – CHIEF EXECUTIVE OFFICER AND MANAGING DIRECTOR
MS. SANDHYA JAYARAMAN – GROUP CHIEF FINANCIAL OFFICER
MR. R. VENKATESH – GROUP CHIEF OPERATING OFFICER
DR. ANESH SHETTY – MANAGING DIRECTOR OF INTERNATIONAL BUSINESSES
MR. RAVI VISHWANATH – BOARD MEMBER – NHIL
MR. NISHANT SINGH – VICE PRESIDENT – FINANCE AND INVESTOR RELATIONS
MR. VIVEK AGARWAL – DEPUTY GENERAL MANAGER – FINANCE AND INVESTOR RELATIONS

Moderator: Good afternoon, everyone, and welcome to the Quarter 2 FY27 Earnings Call of Narayana Hrudayalaya Limited. We thank you all for joining us today. On the call with us from the management team are Mr. Viren Shetty, Vice Chairman; Dr. Emmanuel Rupert, CEO and MD; Ms. Sandhya Jayaraman, Group CFO; Mr. Venkatesh, Group COO; Dr. Anesh Shetty, MD of the International Business; Mr. Ravi Vishwanath, Board Member of NHIL; Mr. Nishant Singh, Vice President, Finance and Investor Relations; and Mr. Vivek Agarwal, Deputy General Manager, Finance and Investor Relations.

The results presentation and financial statements have already been uploaded on the stock exchanges and are also available on the company's website. Before we proceed with this call, we would like to remind everyone that everything that is being said on this call that reflects any outlook for the future or which can be construed as a forward-looking statement must be viewed in conjunction with the uncertainties and the risks that they face. Please note that this call is for a duration of 1 hour.

We will address questions pertaining to the India business in the first 30 minutes, followed by the international business. Given the limited time available, participants are requested to ask maximum two questions at a time and join the queue for any follow-on questions. We also request participants to avoid chat questions and ask the questions live.

With that, we would like to start the Q&A. I request everyone to now use the raise hand feature to start posing their questions.

First question is from Prithvi Raj. Prithvi Raj kindly announce your company name and go ahead with your question, please.

Prithvi Raj: This is from Unifi Capital. Firstly, on the India business margins. This quarter, the margins are around 25% and it's now almost on par with the best amongst the large players. However, the ARPOB is still at INR55,000 only compared to INR70,000 plus for others. Is there further scope for margin improvement as structurally ARPOBs improve or you think margins can be at this level for quite some time and then you will focus on revenue?

R. Venkatesh: I'll take this. Prithvi Raj, Q2 is generally a strong quarter, as we have seen across financial years. And in this particular quarter, we've seen good growth both from the volume and price mix. So on IP volumes, we've seen 4% increase year-on-year.

OP footfall, we've seen around 12.5% growth. ARPOB, as you said, has increased from INR17.5 million to INR19.5 million (annualised) year-on-year, as we focus more on high-end procedures and greater use of robotics.

What we have seen is that moderate price increases and balanced pricing have driven strong growth in both IP and OP volumes this year. We will continue with the same strategy to ensure we have a balanced growth both in terms of volumes and realizations in the coming quarters as well.

And on the margin side, yes, it has gone up to more than 26%, which is now among the best in the industry, even though our ARPOB remains well below peers. Along with better realizations, we've also had the benefit of operating leverage on the costs where our doctors and nursing costs have come down by 1.9% QoQ, which has added to the margin. And our focus will remain on seeing how we can sustain these margins at current levels.

Prithvi Raj: So is there a further potential for margin improvement because your ARPOB will anyway structurally go up given the gap between competitors. So can we look at around 200 basis points of higher margins as a peak level?

R. Venkatesh: So that is what I was trying to say…

Viren Shetty: I'll jump in here Venkatesh.

R. Venkatesh: Yes.

Viren Shetty: Just to clarify, we don't target any specific margins. The margins you see, which are best-in-class despite an ARPOB that is significantly lower than peers, are a reflection of the huge amount of effort we've put in over the past 10 years in digitization, process improvement, supply chain and addressing every single driver of unnecessary cost in the company.

Our mission has always been to cater to people who cannot afford treatment in most of the other private hospitals and to price our surgeries and procedures extremely affordably. The margin is a reflection of what we do once we end up paying for the very high cost of services balanced out against all the efficiencies we're able to bring in.

So margin expansion isn't the thing that we target. What we're looking for is accessing the largest pool of patients in all the cities that we operate in. Volume growth is what we want to pursue.

Prithvi Raj: And on the recent regulatory news on oncology price cap, etcetera, what exactly you're hearing from the government? And if any price cap that will get implemented, how will it impact Narayana?

Sandhya Jayaraman: Oncology is about 15% of India hospital revenue, and the drugs that have come under the cap are only a part of it. I think the caps will go live from 9th of November, and we'll have a better idea at that point in time.

The only thing we want to call out is that we are not a very margin-focused company and a lot of our focus is on how efficiently we can run a high-volume standardized protocol, cost discipline driven care. So we will support anything that enables transparent and affordable pricing. There may be some ups and downs as this is implemented, which we will work through as we understand it better.

Prithvi Raj: My final question, on the India business is on insurance. If you have to look at your combined ratio, it's as high as 280 percentage. Generally, for the established players in the industry, it's all around 100 to 110 percentage. So how should we look at this trajectory over the next few years? And how long will the losses continue? Is it possible for you to quantify in terms of combined ratio or any other profitable metric that you track?

Ravi Vishwanath: Do you want me to take that, Viren?

Viren Shetty: Yes, please, Ravi.

Ravi Vishwanath: Sure. Prithvi, a couple of things on this. One, the ratios do get a little distorted quarter-by-quarter, Q1 versus Q2, etcetera. I think some of the things that give us confidence in terms of the overall kind of book moving in the right way, right, is -- one is, of course, if we look at the

growth versus last year to this year, the growth has been substantial. I think that gives us confidence.

The other thing that gives us confidence is that the claims ratio, which is the more important kind of metric, right? So one is you have the top line in terms of revenue, that's growing. The claims ratios themselves, if you look at quarter-to-quarter, that has come down significantly and it is trending -- continues to trend in the right direction. Our model, just to remind you, is a little bit different from the traditional models. We are focused largely on building our retail business.

That is something we're doing directly. And that, as you probably know, is something that does take time. While that is happening on the one hand, we are building our SME book and engaging with customers to make sure that we are positioning ourselves as their health partners. We are the first health insurer that is promoted by a hospital. And we want to not just be a transaction in terms of health insurance claims.

We are positioning ourselves as health partners. So across this journey, I think even those partnerships and that engagement has been going well with our customers. And so generally, we feel that this is going in the right direction. It is still too early to give you a time line in terms of what -- when it will break even, etcetera, but it is trending in the right direction when we look at claims ratios. And when we look at actual expenses as well, the entire book is trending in the right direction.

And so we're quite happy about that. We are quite focused on the things that we want to do, which is the retail business that is direct, focused controlled group business and really engaging with customers to make sure they have a great experience, and we use our health care data to help improve their lives and help them get well and stay healthy. So I think in all those areas, it's moving in the right direction.

Prithvi Raj: From our point of view, this journey towards clinics and insurance started 2.5, 3 years back. And back then, there were some committed investments that management has mentioned. And there were some time lines also mentioned. However, this journey is taking too long. And with every quarter or with every year, the losses are actually increasing.

But at least at the management level, do you have any numbers saying you will try till you make certain losses and then you will end up giving up on insurance or you want to just keep pursuing at any cost? So how should we look at it?

Viren Shetty: Prithvi, neither we will give up on insurance nor we will pursue this at any cost. There were a set of strategies we had in mind when we first started out, and some did not work as well as expected. We are adapting and pivoting, and we're keeping the amount of money spent as low as possibly we can.

There was an amount of money we had committed towards spending on the clinics, which have proven themselves to be an extremely valuable resource for all our patients and for doctors to run their evening OPDs. That will continue because its value to the larger network is proven.

With insurance as well, this is a brand-new business started by a company that has no idea how to sell insurance. It takes time. We will spend in moderate amounts to keep our customers very happy to make sure that the claims don't go above and beyond what we had estimated for and to cut the cost in insurance distribution, which is currently a very high priority for the IRDAI Chairman, so that we can break even at a much smaller book than the peer set.

Nishant Singh: Prithvi, just to correct, the numbers have not worsened. The combined loss of the 2 businesses was around INR33 crores last quarter, and this quarter it is INR22 crores. So the losses have come down actually. Even for Cayman, if you look at the insurance losses, the number is down from $3.7 million to $1.1 million. So actually, the trend is lower.

Prithvi Raj: I will come back with questions on the international business.

Moderator: Next question is from Sajal Kapoor.

Sajal Kapoor: This is Sajal Kapoor from Antifragile Thinking. I have 3 questions, but I'm happy to ask 2 and then rejoin the queue. First is regarding the AI and organizational learning, if I may. So I know Narayana has been deploying AI across clinical and operational workflows for some time now.

Question is, where did AI initially create problems, false confidence or unintended consequences? And what have you as the team learned from those failures that now shapes how you deploy AI across the network?

Viren Shetty: Sajal, Viren here. The AI use cases that you may be referring to is maybe what other health care organizations have been adopting. For us, our AI use cases are much more measured and more grounded in practical application. AI in radiology predates LLMs. This is a technology that's fairly proven and is not prone towards making mistakes.

AI-based radiology interpretation is now the gold standard the world over. We've been using it with great success. The rest of our applications use voice bots or just simple data interpretations from the information that we have to generate, say, for example, a set of patients with out of range biomarkers or the OT list and trying to create a more efficient way to populate it.

These will not cause any errors in the overall decision-making. That is a tomorrow problem. We're looking at the lowest hanging fruit that we can use AI to make things slightly more efficient today.

Sajal Kapoor: No, that's helpful. And second is for maybe you, Sandhya, it's related to the ROCE regarding the U.K. and the insurance. So as we know both the U.K. and insurance businesses are at different stages of development.

Over what time horizon should investors evaluate the ROCE of these ventures? And what milestones should we track along the way to distinguish a temporary investment phase from a structurally attractive return profile?

Sandhya Jayaraman: Sure. For the U.K. business, I think a 5 to 7-year time horizon is a good way of looking at the business because we have just entered and there is a journey that we have to achieve on that business. As far as the insurance business is concerned, we are not running a stand-alone health insurance company. It's part of the continuum of care.

It is a way of financing health care for us. A stand-alone ROCE for insurance is not how we would measure ourselves internally. We want to get to a point, where we are not burning cash in insurance, and we are able to deliver the care that we want to deliver to our customers, while taking care of the financing by -- supported by the insurance arm.

So that's really where we have to get to. Of course, there is a journey and we're going through different models to get there. I don't think, even in the longer run, we would want to report ROCE separately for the insurance business.

Sajal Kapoor: Yes. No, absolutely, Sandhya. And just to clarify, I wasn't looking for segmental reporting of ROCE anyway at a consol level. At a group level, currently, the ROCE is not giving us a true reflection. So yes, I completely agree with the strategy around insurance and what you suggest. At some point in future, we should get a higher level of ROCE at an aggregate group level. That's precisely the question.

Sandhya Jayaraman: So at a group level, our ROCE is between 15% to 16%. That's because we've come off a huge investment in Cayman as well as the investment we've made in U.K. and India entering the capex phase. But the dilution, which is coming purely because of U.K. is about 4% to 5% that we will want to bridge over the next 5 years or so. As India also comes off the capex cycle, I think that's when the full effect of the -- all the measures will show on the ROCE.

Moderator: Next question is from Shruti Mimani.

Shruti Mimani: Thanks for letting me ask the question. I'm from Clearstone Family Office. Just wanted to check on India, we have seen growth in revenues as well as margins have been better on the back of cost efficiencies and payer and case mix. But just wanted to check on the IP footfall, which has been around like 60,000 for a few quarters. So just what's happening there? And how do we see that going forward or how that impacts the drivers overall?

Viren Shetty: I'll ask Venkatesh to take this.

R. Venkatesh: Yes. If you look at the numbers, the primary drivers in our Bangalore cluster and Calcutta cluster have done reasonably well in terms of footfall, which generate the major part of our revenues. And when it comes to Bangalore clusters, we're growing steadily quarter-on-quarter.

In the Eastern cluster, there was a transition issue in porting certain categories of government scheme patients in Bengal, which should settle in the coming quarter, after which IP footfalls will gradually pick up.

We expect much stronger footfall growth from the Eastern region in Q3. In the smaller units in the Karnataka cluster, we have been rationalizing our payer mix, which we continue to strive

on, to ensure we have reasonable volumes and good realization, which is again a journey, and we expect these volumes to eventually pick up in the coming quarters.

All in all, we have done in the last few quarters, we've seen good growth in both outpatient and inpatient volumes compared with a couple of quarters ago. And with the strong base and good funnel which have been created over the last 2 quarters across all the regions, we foresee good footfall growth both from inpatient side and outpatient side in Q3 and Q4.

Shruti Mimani: Got it. And that will be in addition to the upcoming beds that we are anyways having in 2 years' time?

R. Venkatesh: That's right.

Shruti Mimani: Right. And just…

Sandhya Jayaraman: And small data point, Shruti, I wanted to add. Our IP footfalls have actually grown 6% quarter-on-quarter and almost 4% year-on-year. So we have been seeing IP growth on a continued basis between quarter. That's just for -- from a clarity point of view, though Venkatesh answered it in detail.

Viren Shetty: As of now, no bed addition.

Shruti Mimani: Yes, correct. And just on international patients, I've seen this quarter, we called out that there was increase in the payer mix also because of that. So what happened there? I just wanted to understand how are we thinking about international in the mix in India?

R. Venkatesh: Yes. See, this is not an area we are specifically targeting. The growth is purely organic and comes mainly from Bangladesh, because of the brand and loyalty we have built there over the last 2.5 decades, supported by easier visa and travel conditions. International patients contribute around 6% to 7% of hospital revenue, but it is not something we specifically target.

And when it comes to the volume, it is subject to a lot of these macro issues, which can fluctuate quarter-on-quarter. So there is no single explanation for the increase, and it can fluctuate from quarter to quarter. But on the whole, our focus has been more on domestic, and we've done well in terms of footfall in domestic, while the international on an organic basis has complemented things.

Moderator: Shruti, I request you to rejoin the queue please, as we have participants waiting. Next question is from Aryan Jain.

Aryan Jain: This is Aryan from Groww Mutual Fund. So I have a couple of bookkeeping questions. So sir, what would be our occupancy ballpark in the India hospital business? And what would be the optimum level we can take it to from here?

Sandhya Jayaraman: Aryan, occupancy is not a metric we focus on. Typically, it's 60% to 65%, but we follow the throughput model because occupancy usually is calculated on midnight beds. And when you're doing more and more efficient turnaround on care, that gets distorted if you only look at occupancy.

One good way to look at our numbers is that we haven't added any capacity and our occupancy has also not increased in the past several quarters. We have been hovering at 60% to 65% in the way it is traditionally calculated.

But you can see the leverage impact of higher throughput going through the facilities, both in terms of the revenue uplift that we have seen, the higher volumes that we are able to process, and the cost leverage we have earned, which flows through into margins. It's coming through because we focus on throughput and not on occupancy.

Aryan Jain: Okay. Understood. And my second question would be -- would you be able to break down the INR 250 million loss of the insurance and clinic business?

Sandhya Jayaraman: I think INR 223 Million, roughly half-half but insurance is slightly higher

Nishant Singh : Health insurance is around INR14 crores and clinics around INR8 crores. Last quarter, insurance was INR19 crores, which has now come down to INR14 crores, and clinics from INR14 crores to INR8 crores.

Aryan Jain: Okay. And just one last one…

Moderator: Aryan, I request you to rejoin the queue, please.

Sandhya Jayaraman: Just one follow-up, Aryan. We are merging the clinic business into the hospital business, so going forward it will be useful to only look at the insurance number. The clinic model is proven successful and merged into the numbers we'll report out for the hospital going forward. For the past several quarters, we have given both the numbers. So I think you will have a view of the trajectory already.

Moderator: Next question is from Japreet Singh.

Japreet Singh: I'm an Individual Investor. So sir, my first question is what evidence today we have that operating or having integrated care insurance gives us an advantage compared to other stand-alone operating hospitals. That's my first question.

Viren Shetty: The advantage of an integrated care model is one in which you don't treat every patient interaction as a one-off. A patient walking into a clinic, a patient coming for a scan or a patient coming for a procedure is not just one interaction or one transaction for us.

We build comprehensive health profiles of all our patients, and we're able to better serve them with annual checkups, with diagnostic scans, with blood tests, with vaccine camps. And this increases the number of interactions our customers will have with us over a lifetime.

So it is superior, we feel, because we are able to do more for our patient rather than just doing surgeries or just doing walk-in clinic appointments. The insurance is part of how all of this gets paid for.

Our belief is that insurance in India will also evolve from just paying for a portion of health care expenses to a plan that combines preventative care, wellness, outpatient benefits as well as inpatient hospitalization in a closed network.

Japreet Singh: And sir, my second question is with the U.K. acquisition entry and the forays in integrated care insurance and expansion coming in India, what is Narayana trying to become going forward?

Viren Shetty: Anesh, are you there?

Anesh Shetty: It's on mute, Viren. I think the question was what is NH trying to become with all these activities happening in India and everywhere else.

Viren Shetty: With our U.K. expansion and those things.

Anesh Shetty: Do you want to take that question now?

Viren Shetty: I think one way to think about it is that we've developed a set of capabilities in India with running highly efficient hospitals. And there is a natural rate of growth that we've experienced within our existing network. We are adding more beds. We are adding more facilities in the hospitals over here. But our ambition is a lot more than that.

And we saw in the U.K. and in the Caribbean an opportunity to expand our skill set and capabilities into a market where for the same amount of work, the realization is much, much larger than what is available in India.

So the thing we're trying to build is a very large integrated health care system across at least 2 or 3 geographies so that we're not exposed to any one country's, let's say, vagaries of whether it is currency depreciation or any sort of macroeconomic risk or be able to cater to different patient profiles across countries and leverage cross-country learnings from one country and then apply it to another.

So there are definite synergies that we've seen with running a very large GCC for all our international operations out of our corporate office in Bangalore. And there are cost savings that have been enacted across not just all our hospitals here, but also across the hospitals we run in the U.K. and Cayman.

Moderator: Next question is from Vinay Nadkarni.

Vinay Nadkarni: Yes. This is Vinay Nadkarni from Hathway Investments. First of all, thanks, Sandhya ma'am, for conducting this within 30 days of the end of the quarter. I appreciate the efforts put in. Now on the U.K. business, I just wanted to have -- is it going as per what you had anticipated when you took it over? I'm just asking from the point of view of dropping revenues quarter-on-quarter and the EBITDA after IFRS?

Anesh Shetty : Thanks for your question. So before answering, Sandhya told me to give you an extra question because you complimented her. The team has put in a lot of effort, as our operations are not only in India and the results have to be consolidated across geographies. They have really put

in a good effort and a lot of systems have been improved to get this at the pace it is happening right now.

So back to your question, Vinay. So I think we are on a good track and very confident with our synergies and cost efficiencies that we planned during the acquisition. So things like implementing software, automation, setting up the GCC, which is just rolled out a few days ago for patient-facing communication is working ahead of plan.

With those things we have direct influence over, we are on plan, in some regards, slightly ahead of plan and confident and happy. There are certain aspects which given it's a new market, a, we are still learning about the nuances and b, a little out of our control with regards to NHS revenue commissioning and external patient acquisition.

So those, as you can see in the results as well, there is some volatility and unexpected small dip that we are seeing. We are still wrapping our hands around that and hope to get the revenue trajectory back to where it was just a few quarters ago.

But when it does, we will see the benefit of our cost efficiencies and the operational changes we've already implemented even though it's early days. It's just that today, it's getting masked out and not flowing into earnings because of the revenue dip on a very low margin base to begin with from where we started.

Vinay Nadkarni: Yes. I'm sure like Cayman, you would turn that place around as well. My other question is on -- see, you are so dependent on your IT systems. With the cybersecurity risk really climbing up, how assured are you of not impacting the businesses if by any chance there is any cybersecurity risk coming across in your business?

Viren Shetty: Yes. It is a huge concern for us. The number of attacks that have been happening recently and the health care organizations have especially large surface area. For example, there was a recent software vulnerability that we were able to patch very quickly. But in the end, this is never ending, and it is something you just have to spend a lot of time and effort towards.

The wrong response to AI-powered attacks on critical infrastructure is to say, okay, let's go back to pen and paper. We cannot go back to those days. We've seen so much efficiency gain. Our patients move through the system much faster.

Our nurses are less hassled at work. There's so much information flowing in our systems that going back to pen and paper is impossible for us. We just need to spend more money and build better systems and obviously hope and pray that bad things don't happen that are well beyond our control. But this is just a reality of any interconnected system these days.

Moderator: Vinay, I request you to rejoin the queue. Next question is from Damayanti Kerai.

Damayanti Kerai: This is Damayanti from HSBC Securities and Capital Markets Limited. My first question is to Sandhya. So we have been discussing you are setting up GCCs to manage the international business. So any impact we should broadly assume due to the currency volatility, say, INR against USD or GBP in your reported consol numbers?

Sandhya Jayaraman: It is not linked to the GCC per se, because it's still a small number in the overall scheme of things of the company. But you could see that when you look at our consol numbers in the OCI, you can see that there is a significant positive movement in the OCI coming in because of currency conversion.

So there is some benefit of the currency because of all the work that we are doing from India for the international markets. But I don't think you'll need to factor something specific on that in the way of forecasting our business numbers.

Damayanti Kerai: Sure. Just to understand, say, operations in Cayman or operations in U.K. costs are in local currency terms, right?

Sandhya Jayaraman: Yes. Revenue, cost, everything is in local currency terms. And even when we are billing from India, we bill in the corresponding currency as per the transfer pricing guidelines of India. So therefore, it is kind of BAU and you don't have to factor anything exceptionally for that.

Damayanti Kerai: Sure. My second question is on India insurance business. So as we have been discussing, it's still in build-out phase. However, I just wanted to understand the team's thought process after recent regulatory development in the insurance sector, like after the announcement by the IRDAI, was there any change in the way you want to progress in your journey for the insurance compared to like when it started some time back?

Viren Shetty: Yes. No change really, but I'll ask Ravi to elaborate.

Ravi Vishwanath: Sure. So the headline Damayanti, as Viren just said, there is no real change at the moment. But overall, we do welcome the IRDAI regulations. I think any move that adds value for the customer is welcome for us. We are the first hospital group to directly promote a health insurer.

So we agree that, for example, hospitals are a good channel to offer health insurance to customers, which is one of the distribution channels to approach to make the process simpler for the customer, reduce cost. And as a hospital, we also have a greater understanding of the customers' health, not just at time of sale, but over their lifetime because these are lifelong policies, and that's important.

And this can, therefore, help us manage risk better and evaluate the portfolio better and bring on some of the synergies that Viren was referring to earlier. As I mentioned earlier, we are focusing on growing our retail business with sales to hospital customers. We expect to remain focused on the same.

Other parts of this, whether we should become an insurance distribution entity, etcetera, it's too soon to say. The final guidelines are going to come out at some point. And once they come out, I think we'll take a call on it. But based on what we are seeing at the moment, we think that the regulations will actually support our current strategy. And so -- and we welcome it in general. We don't, at this point, anticipate any significant changes to our strategy.

Damayanti Kerai: Sure. So Ravi, right now, all the insurance schemes are sold inside the hospitals only, right, hospitals and clinics to the patients who are coming in.

Ravi Vishwanath: We sell to employers and employee groups. On a retail basis, we sell largely, though not exclusively, to people who have a relationship with NH. And that -- hopefully that will continue.

Moderator: Next question is from Prithvi Raj.

Prithvi Raj: This is from Unifi Capital. I have 2 questions on international business. First is on U.K. Anesh, is it fair to assume that your top most priority for U.K. is to increase revenue as well as margins? What are the challenges that you have faced after you acquired this company, which happened a year back?

And could you also elaborate the actions that you have taken, especially on the revenue front? I mean in the past, you have spoken a lot on the cost front, but especially on the revenue front, what are the initiatives that you have taken? And why is it not translating.

Anesh Shetty: Sure. So Prithvi, you are right. Our initial and topmost priority is to improve earnings, which will come from a combination of both reducing our costs and growing revenue, as our earnings are disproportionately low compared with local peers, from a very low base. We have spoken -- as you said, we have spoken about what we're doing on the cost side.

As far as revenue is concerned, there are 3 major channels: NHS, private insurance and self-pay, NHS is a once-a-year contracting relationship. The financial year starts on April 1st, so contracts get reset every March and any change is effective only from 1st April of the following year.

Our goal really is to grow the non-NHS sources of revenue. So this requires a lot of interactions and transactional changes in the business because a lot of the hospitals were not even empanelled by the insurance companies. A lot of our doctors are not recognized by the insurance companies, so because the business was run predominantly as an NHS provider for decades.

So a lot of what we have done is setting up the building blocks to be able to open up those private channels. It does take time. It's a very, very heavily regulated market. These processes take a lot of time, something that would take a few weeks for us in India takes months here for various other reasons.

We have made progress on the building blocks. But as you rightly identified, it's not yet translating into additional revenue into the business, but we hope that will change fairly soon. On the cost side, we have seen good changes.

We've made a lot of changes in our consumables and supply chain strategy. Those results are active in the business. As Sandhya and the colleagues pointed out, we've set up our GCC that's growing quite well. So that is another cost efficiency. And we are making good progress with getting our digital platform regulatory certified with the regulators and compliant.

We think that's about 4 to 5 months away from getting all certifications, and then we'll start the implementation of Athma, which will be a significant change forward. So again, on the cost side, I think things are on track. On the revenue side, there is a learning curve. It is a new market for us. There are some initial building block steps that we are working through, but it will take some time for us to get a better grip of how to acquire private patients and start that.

We are seeing early results. Separately, the NHS did slow down contracting for all providers in the market. This is temporary; the patients are not going anywhere, the waiting lists are only growing. We are confident of that being reversed soon. But the private patients will require some more homework and some more efforts to unlock.

Prithvi Raj: Just a quick follow-up. If I ask for some time period, will it take a year or 2 years for you to at least get back to a decent level of revenue pool?

Anesh Shetty: It depends what decent is, Prithvi. But I don't think it is going to take that long. See, the NHS, like I said, there is seasonality to it. There are both political compulsions to contracting as well as the practical realities of patient waiting list and the activity plans being reset once a year. So I think that is a little more predictable.

With the private sources, we are seeing already small steps flowing in and the percentage of our business from private sources is increasing, which is what we want to see. But as long as we're so heavily dependent on NHS, any small move forward in private will be completely undone and more by even a tiny deterioration in NHS because it's such a big constituent of the revenue pool. But we'll have a much better idea over the next few quarters, and we will ourselves get a better sense about predicting the -- how long these things will take in this market.

Prithvi Raj: Just one final question from my side on your Cayman Islands business. Obviously, hospitals continues to do exceptionally well. On the insurance piece, this quarter, there has been a significant reduction in the losses. And as per the last con call, I think in the month of Jan, there will be further reset of the insurance contracts. Once that happens, starting from Q4, should we expect a further significant reduction in the insurance losses? And shall we look at H2 FY28 for the breakeven?

Anesh Shetty: Sure. If you look at the quarterly trend of insurance losses, approximately, it was $5.4 million 2 quarters ago, $3.7 million in the previous quarter and $1.1 million this quarter. The reduction from $3.7 million to $1.1 million is a huge one.

Obviously, we are seeing significant reductions in the insurance losses as we are repricing and purging poor performing accounts, improving processes, etcetera. But this -- the $1.1 million does have some one-off because it includes the summer school holiday months, when people tend to defer elective care, they'll be on holidays, travel with family, etcetera.

So there is some one-off in that. But directionally, we are seeing our losses come down very rapidly, which is our stated intention. We said that's the direction we're taking. We're not focusing on growth in insurance until we bring the losses down. So it is going according to plan, actually better than planned.

We're very happy with the trajectory there. You are right, in January prices will get reset, but that's for a smaller cohort. The big reset will happen in July 2027. Hopefully, even before that, we'll see negligible losses, and from July onwards we will have exited almost all unprofitable books.

Moderator: Next question is from Devang Patel.

Devang Patel: This is Devang from Sameeksha Capital. My question was on the India insurance business. You earlier mentioned we were trying to build up our SME book. So my question was that generally, we understand corporate is the more competitive part of the insurance business. So what is our current mix of retail versus corporate? And what is the ideal target mix for this.

Ravi Vishwanath: I can take that. When these books start to build, group business will always be a larger proportion just because -- just because it's larger and retail business takes time to build. I would look at it in a couple of ways. I don't think there is an ideal proportion. What matters is at a portfolio level, what is the -- what are the losses -- loss ratios?

Are they in control and in line with what we want? And are we able to provide the services to those customers within our network. I think these are the more important things that we look at as opposed to just a random mix of group versus retail. Initially, of course, it is going to be more group heavy and that will moderate out over a period of time.

Moderator: Devang, does that answer your question?

Devang Patel: Yes. My second question was on ALOS. You mentioned earlier, we are trying to improve throughput. But you are seeing ALOS between 4.3 to 4.5 days. So given case mix, what kind of improvement should one look forward to in the ALOS?

Dr Emmanuel Rupert: Like I mentioned even the last quarter, we want to -- over the next 4 to 6 quarters, we want to come closer towards 4 or 4.1 because we have a higher mix of certain very high ALOS procedures, the transplants, the bone marrow transplants and certain very high-end medical admission patients.

These are very high-acuity medical admissions. So these are some of the things which actually puts us at a number, which is like 4.3 and things like that. But our endeavour is to reduce wherever we have the procedure-driven patients to get that down as much as possible so that we will be closer towards 4, 4.1.

Moderator: Next question is from Shruti Mimani.

Shruti Mimani: Shruti, again from Clearstone. Just on Cayman Hospitals piece, I mean it's been excellent growth. Partly I wanted to understand how have we been able to do this to get to this scale? And naturally, second piece is that given it's a small island, limited population, where can this max out or is there a cap to the revenue growth over time at some point? Yes.

Anesh Shetty: Sure. Yes. Shruti so the -- I mean, the hospital is a several year long story. We've seen this performance for quite some time. Having said that, given that as you identified, it is a small island, you are physically constrained by the size of the market.

And that's where the insurance play, the integrated care play. That's why it was started in Cayman. The current growth you are seeing is a result of the integrated care strategy working out as well as us focusing on reducing costs holistically, not just at the hospital level, but also for the employers at an insurance -- for the entire system cost essentially in that market. And the new hospital did add a few new service lines. It's now about 1.5 years since we started that.

But we've always maintained the best days of growth for Cayman are behind it. Our size is a limiting factor and an anchor on our growth in that small island. We continue to see good growth from non-Cayman sources, that is international patients. But for the Cayman story, the best days of growth are behind.

We now are focusing on securing the patient base we have being a more comprehensive provider for the patients' need and executing on the integrated care strategy, which will allow us to have a non-volatile sort of safe patient and locked-in patient relationship for many decades to come.

Shruti Mimani: Okay. And where are these international patients coming from?

Anesh Shetty: Other markets in the Caribbean. So we are the only tertiary health care provider in English-speaking Caribbean, and we are the preeminent health care brand in that region. So all the other islands and the nearby Latin American countries as well, but principally the other Caribbean islands.

Shruti Mimani: Right. And is there a run rate number that we have for what we're thinking about Cayman Islands hospitals business?

Anesh Shetty: I'm sorry, what do you mean by run rate number?

Shruti Mimani: As in the max revenue at some point that we think…

Anesh Shetty: That's tough to say, and it is not something we guide on.

Shruti Mimani: Just maybe one…

Moderator: Shruti, I request you to rejoin the queue, please as we have participants waiting. Next question is from Sajal Kapoor.

Sajal Kapoor: This is Sajal again from Antifragile Thinking. Just one more for you, Sandhya, if I may, on cash flow and working capital this time. So we know that the U.K. business currently carries approximately INR1,700-odd crores of net debt, while the EBITDA margin has declined from, I think, 8.8% to closer to 7% sequentially. More broadly, how are operating cash flow and working capital evolving across the group at a consol level, particularly the receivables and the cash conversion.

And I'll explain the context where I'm coming from. So historically, if you go back last 10 -- 10 years since the IPO, we have converted roughly 93% of EBITDA into operating cash flow, of course, after working capital adjustments. However, in H1, this appears to have been closer to 88%. And so what explains the shortfall? And how much is the timing related?

And should we expect cash conversion to return to its historical levels by the time we exit this fiscal or we're going to be doing less than 93% over the next 4, 5 years until U.K. operations finally become normalized?

Sandhya Jayaraman: Sure. So the cash conversion for U.K. is not a problem. In fact, NHS is a very good payer; it pays on time and partially in advance. So the cash conversion is not a problem for the U.K. The reason you have seen a slightly lesser cash conversion in H1 is coming from India and Cayman. There has been a slight delay in both India and Cayman in terms of collections.

Typically, Q2 is a good collection quarter, especially with the government payers, but there has been some slowness that we have seen there. But we've also seen slight slowness with the insurance payers as well, similarly in Cayman.

Typically, on a full-year basis, this normalizes: in some quarters collections are a little slow, but we catch up over the next few months. So that's what we are expecting. Our overall cash conversion cycle is not going to be negatively affected because of the U.K. business.

Moderator: Next question is from Rajit Aggarwal.

Rajit Aggarwal: I'm Rajit from Nilgiri Advisors. Just a couple of questions on the U.K. business. If you can provide a few more details on the cost side that led to the decline in EBITDA margins, given that there is a comment also which says the margins reflect near-term separation-related costs. So what was the extent of this impact?

And how long is this supposed -- may last? The second question is on the payer mix. When we started, it was around 7% of revenue. So is it still the same or is it a couple of -- or a few basis points above or lower than 7%?

Anesh Shetty: Sure. So Rajit, to your first question, when we acquired the business, the company we acquired was a division of a larger group that ran 3 business divisions. We only acquired the hospitals. Therefore, all our external vendors, for example, Microsoft or any and every kind of vendor had to -- we had to novate agreements and have essentially fresh agreements with these people.

And naturally, as you can expect, there are certain diseconomies of scale when we went from a larger group to a smaller company, and it was also an opportunity for them to raise prices. So we -- that was what we mean by separation costs where a lot of the day-to-day cost of the business once we separated out the company were higher for us.

Now there is no way to quantify this prior to the acquisition, but we do know what those costs are now, and we are working actively to mitigate that. On the second part of your question, some of the cost changes we are making are already flowing through.

But because of the slight revenue decline that we're seeing quarter-on-quarter, we're not seeing our cost -- any cost efforts flowing into earnings yet. But when the revenue picks back up, that's when we expect these things to start being more visible.

And also on an annual basis, these are initiatives that have just started flowing through this month or a few weeks ago or 1 or 2 months ago. So the annualized effect will flow in as we go. We're comfortable with our execution pace on the cost synergies. We just need -- we have some homework to do and work to do on the revenue front.

On the last part of your question, on private, that is non-NHS revenue, we are seeing an increase. We are not disclosing the exact percentage, but we are seeing small steps towards growing the non-NHS books of business.

Rajit Aggarwal: Right. So just as a quick follow-up, would you be able to share some top line number where these costs or you start to see the EBITDA benefits? Would it be 67% or 70% or something like that?

Anesh Shetty: At a very simple level, we are comparing it to where it was. So even if you go 1 or 2 quarters back, which is just 3 million, 4 million additional revenue for the quarter, we will start seeing these benefits flow in. But more significantly, once -- with time because these are changes we've made very recently. So the effect of them will flow in over a few quarters.

Moderator: Next question is from Vinay Nadkarni.

Vinay Nadkarni: Vinay again from Hathway Investments. Just one question. The doctors and nurses cost has gone down to 26% this quarter. Is it just because of the Q2 effect? Or is this a structural change that we are looking at?

Viren Shetty: Venkatesh, do you want to take that?

R. Venkatesh: Yes. This is -- basically, it largely reflects our operating leverage. If you look at quarter-on-quarter, our revenues have gone up by 9%. And it has gone up mostly on a largely fixed clinical cost base and the nursing cost base. And that is the reason why because of this leverage, we are able to get these costs much lower than what it was in the previous quarter.

That is why these costs have come down by around 1.9%. We continue to work on costs and the disciplines around the cost while we keep growing the volumes and revenues, which will keep giving more and more benefits in the coming quarters.

All in all, the summary of it is because of the operating leverage, which we could gain because of the revenue growth quarter-on-quarter with the clinical cost base and the nursing cost base being the -- largely on the fixed nature.

Vinay Nadkarni: So going forward, should we factor in around 26%, 27% or should we not?

Sandhya Jayaraman: We do not guide on margins, but as you know, quarters are seasonal in health care. Q2 is a higher margin quarter. Q3 is slightly muted. So you should go with the trend you've seen in

health care rather than extrapolate the current quarter. There are also headwinds and tailwinds that keep operating. So you should follow the trend of the industry when you're forecasting.

Moderator: Next question is from Aryan Jain.

Aryan Jain: I'm Aryan from Groww Mutual Fund. So my question was on Cayman. This quarter, our ARPP saw 13% growth. Just wanted to understand what drove this growth?

Anesh Shetty: Yes. Aryan, in Cayman, as we have said before, quarter-on-quarter changes in ARPP, ARPOB or ALOS are not informative. Those are not the metrics to look at. There is a lot of seasonal variation. In relative terms, it is still a low volume base that we're talking about because it's a small island.

A single large patient discharge can distort these meaningfully, so the trend to follow would be volumes.

We disclose discharge and outpatient volumes, and revenue trends are visible over several quarters. It's both insurance and hospital services business in Cayman, any quarter-on-quarter measure would be very, very hard to justify.

Aryan Jain: Okay. Understood. Fair enough. And one last question. So how do we generally manage attrition in India in our India hospital business or doctor level?

Dr Emmanuel Rupert: We don't see too much of attrition at the senior level. We hardly have much of attrition, but we do have a strong program of mentoring and a lot of people do come to us as primary associations at the doctor level. So -- and we have a very strong DNB program across most specialties, especially the tertiary and quaternary specialties.

We have close to around 900 postgraduates in training across the entire network. And we do have a strong mentorship and people joining us and progressing through the one level to another level.

So we do have that reasonably covered. There might be some odd challenges here and there in Tier 2 and Tier 3 cities, but it is generally not something that we worry too much about at the senior level. Nursing has this usual attrition at every level, but we are fairly stable. We do have nursing schools and colleges. We have more than 3,000 nursing students in training.

They have a very strong training program within the existing hospital network. And also with the use of this technology and especially the NAMAH app and the Athma, their nonclinical workload has come down significantly. It's come down by more than 50%, 60%. That makes that burnout and other things far, far lower and they are much more amenable to having a clinical care. So we generally don't have too much of a problem as far as this level.

Attrition does happen over a period of time, as people want to go back to their home towns or move for better opportunities and things like that. But in general, we are reasonably covered.

Moderator: We have a follow-up question from Vinay Nadkarni.

Vinay Nadkarni: Vinay Nadkarni from Hathway. Just had one question before you disable the chat. Just wanted to know, since you are adding almost 635 beds in FY '28, when would you be able to give us rough quarterly additions for the next year?

Sandhya Jayaraman: I'm not sure a quarterly view is the right measure for bed additions. As and when our facilities are ready to be commissioned, we will share that guidance 1 quarter in advance.

Vinay Nadkarni: 1 quarter advance. Okay.

Moderator: Ladies and gentlemen, that was the last question for today. We thank you, everyone, for joining the call and for your continued interest in Narayana Health. We appreciate your participation and support. Should you have any further queries, please feel free to reach out to the Investor Relations team. Have a good day everyone.