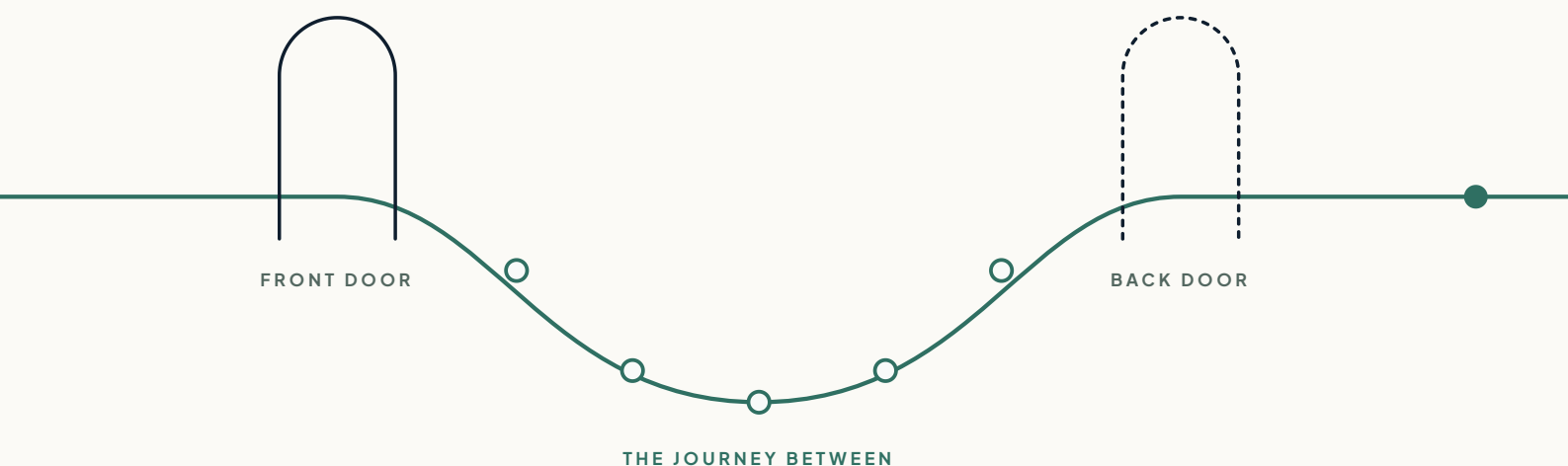


The Digital Front Door— and the Forgotten Back Door

Why healthcare needs an intelligent journey
between them



Echo Health AI

Perspectives on connected care

September 2026 · Australian focus

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EXECUTIVE SUMMARY

Everyone is fighting for the front door

A battle is emerging over healthcare's Digital Front Door. Booking platforms have consumer reach. Practices hold the clinical relationship. Health systems carry responsibility for access, capacity and cost. AI assistants may increasingly meet healthcare intent before a person reaches any healthcare service at all.

Who owns the Digital Front Door? is a fair question. But access is not an outcome. A person can enter healthcare digitally and still be routed to an unnecessarily intensive setting, arrive unprepared, fail to complete an investigation, disappear into a referral gap or return later through a more expensive part of the system.

This paper argues that the Digital Front Door should become the beginning of a continuous, intelligent care journey: one that understands intent, routes appropriately, prepares people for care, orchestrates what happens next and continues after the encounter.

It introduces the **Digital Back Door**: the infrastructure that turns a completed encounter into a completed care pathway, and that keeps asking one question — **did it happen?**

It describes **Practice Intelligence** as the capability that moves an organisation from asking *what happened?* to asking *what needs to happen next?* — for the patient, for the practice and across thousands of journeys.

And it takes an economic position. The aim is not the cheapest encounter. It is the lowest appropriate total resource cost of a safe, effective and completed outcome, always inside the boundary of clinical appropriateness.

The next generation of digital healthcare should be judged by whether it helps people reach an appropriate outcome.

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ABOUT THIS PAPER

A position paper. It sets out an argument and an architectural proposition; it does not report outcomes of any Echo One deployment.

Citations are Harvard author–date. Industry journalism frames the market debate and is not used as clinical evidence. The people described are illustrative characters, not patients.

01 / THE BATTLE FOR THE FRONT DOOR

Who owns the first interaction?

In September 2026 the trade press observed that the general-practice digital front door, long dominated by booking engines, ‘seems quite suddenly up for grabs’ (Knibbs, 2026). That is journalism rather than evidence, but it names a structural question the sector has circled for years.

Who holds the relationship at the moment a person decides they need care? Four kinds of organisation now have a credible claim, and each holds something real.

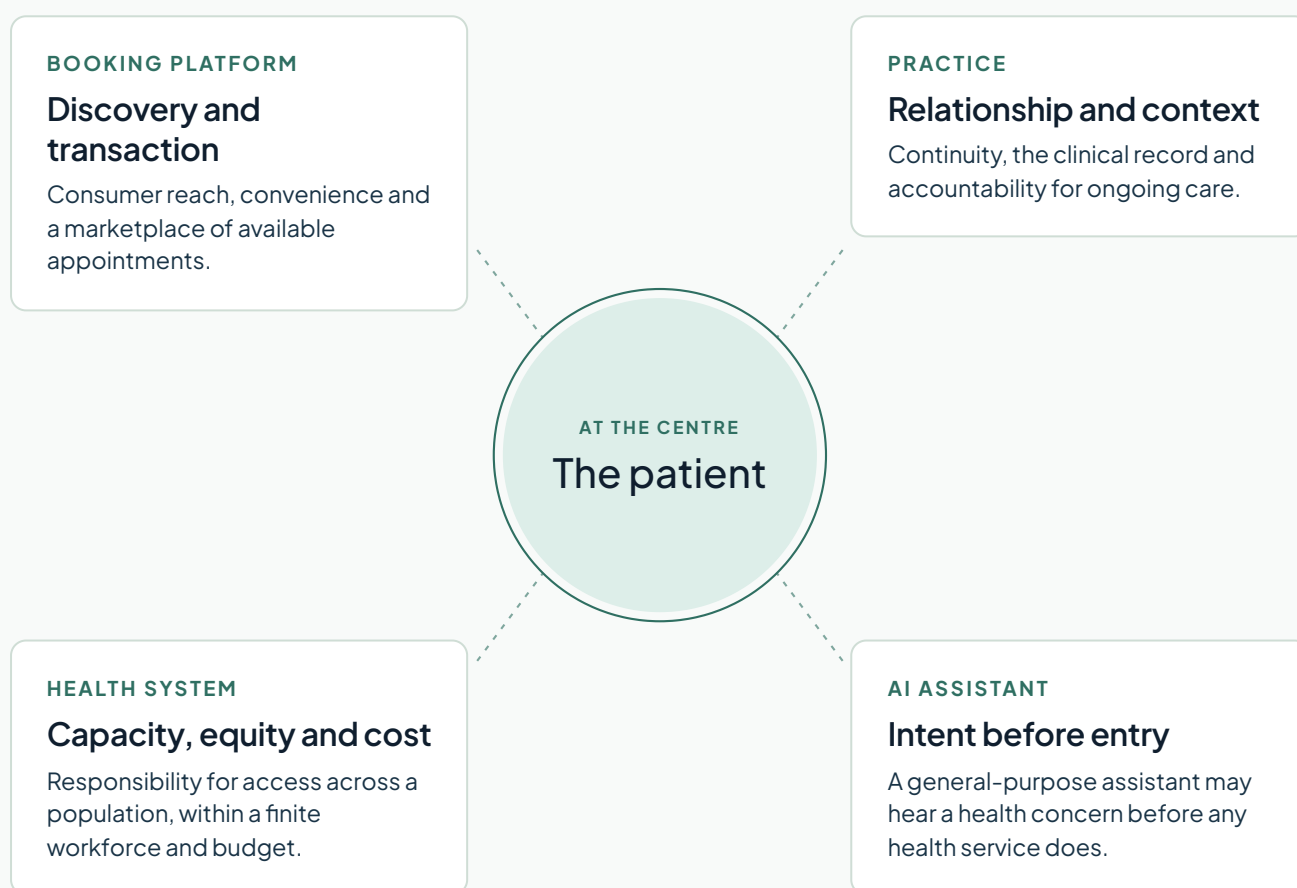


Figure 1. Four contenders for the first interaction, arranged around the person they all serve. Each holds part of the journey; the figure deliberately implies no winner.

If AI hears intent, platforms control discovery, practices hold the relationship and health systems carry much of the cost — who should decide where the person goes next?

01 / THE BATTLE FOR THE FRONT DOOR

Four contenders. Four different incentives.

Booking platforms made access easier and more transparent. They can also become intermediaries between a patient and their practice, and their natural measure of success is a completed booking.

Practices hold continuity and longitudinal context — the history that makes a request interpretable — but have not always had the digital reach to meet people where they start.

Health systems must think beyond filled appointment slots to workforce constraints, equity of access and the total cost of care across a population.

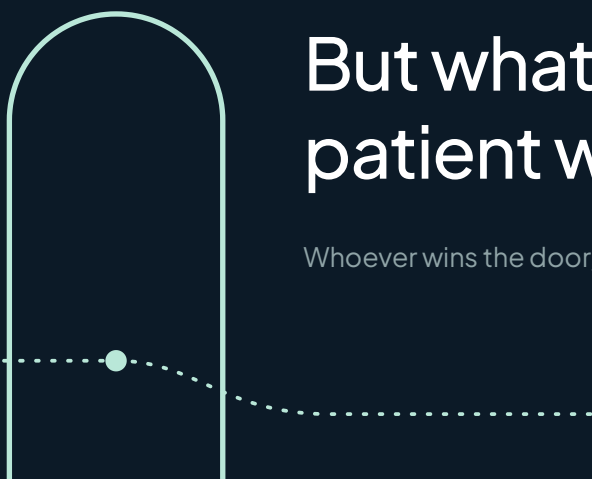
AI assistants may move the front door upstream. The first healthcare interaction can now be a sentence typed late at night, before anyone has decided it is a healthcare interaction at all.

The front door may no longer be a destination. It may be a conversation.

THE MORE IMPORTANT QUESTION

But what happens after the patient walks through it?

Whoever wins the door, the patient still has to reach an outcome.



02 / BEYOND ENTRY

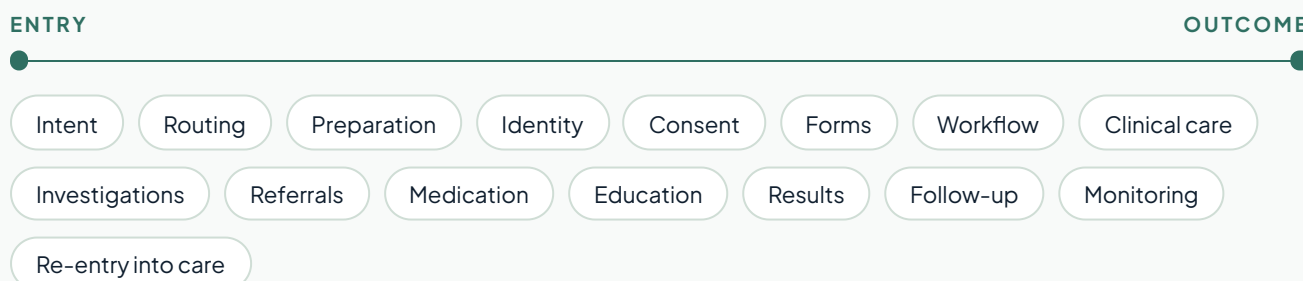
Winning the door is not connecting the journey

Appointment confirmed completes a booking transaction. It does not complete healthcare. The measure of a front door that matters to a patient is not whether they got in, but whether they reached the care they needed.

Emerging evidence is encouraging but thin. In a prospective study of a symptom-assessment tool embedded in a Portuguese provider's app, clinicians who read the report before the consultation said they felt better prepared; the authors, most of them from the tool's manufacturer, note that real-world evidence on clinical integration remains limited (Pimenta et al., 2026).

The important word is *integrated*. Value arises when information gathered at the front door becomes useful inside the care process, rather than being retyped, re-asked or lost at the next hand-over.

The Digital Front Door addressed **access**. The next generation must address **flow**: what happens between a person expressing a need and that need being met.



Between entry and outcome. An interactive journey, not a single transaction. Each step can succeed or quietly fail.

THE DIGITAL FRONT DOOR ADDRESSED

Access

Can I get in?

THE NEXT GENERATION MUST ADDRESS

Flow

Will I get what I need — and will someone notice if I don't?

Digitising entry into healthcare does not digitise the journey through healthcare.

FIGURE 2 / ONE PATIENT, ONE JOURNEY

The patient does not experience a collection of systems. They experience their care.



Figure 2. An illustrative journey from a changed mole to a completed specialist pathway. Left: one continuous line, as Larry experiences it. Right: the separate records that each see part of it. None sees the whole — or where it began and ends.

03 / ROUTING

Routing is not diagnosis

DIAGNOSIS

What condition does this person have?

A clinical judgement, made by an accountable clinician from history, examination and investigation.

ROUTING

Given what we know, what is the safest and most appropriate next step?

A navigation decision under uncertainty. It must be able to clarify, escalate and hand to a clinician.

A front door that decides where a person goes next is making a consequential decision, but it is a different decision from a diagnosis. Keeping the two apart is what allows routing to be useful without claiming clinical authority it does not hold.

Australia regulates medical-device software according to its intended purpose; the use of AI is not, by itself, the regulatory trigger (TGA, n.d.). What a routing tool is designed and claimed to do therefore matters as much as how it works.

Intelligent routing should preserve the ability to clarify, reconsider and escalate — and when it is uncertain, it should fail towards a person, not away from one.

When routing should hand to a person

Possible urgency or red flags · uncertainty the system cannot resolve · a person who asks for one · a request outside what the pathway was designed for. Routing that cannot hand over safely should not be routing at all.

The aim is not to remove judgement. It is to place judgement where it adds value.

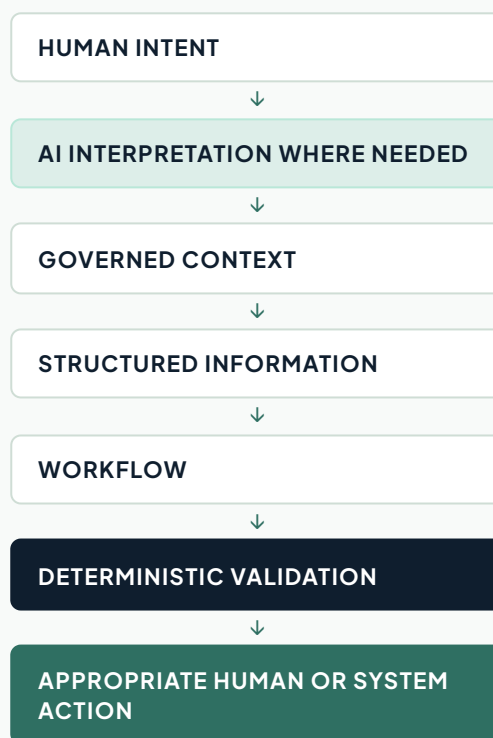


Figure 3. Model reasoning is one step in a governed sequence. Its output is interpreted, validated and acted on by systems and people that remain accountable.

Reasoning interprets. **Context** grounds. **Workflow** orchestrates.
Deterministic systems execute. **People** retain accountable authority.

04 / INTELLIGENT ALLOCATION

Right care is also a resource-allocation problem

Every routing decision allocates something scarce: a GP's time, a nurse's skill, a specialist's list, a hospital bed. Doing this well means holding five questions together — and never letting the last one override the first.

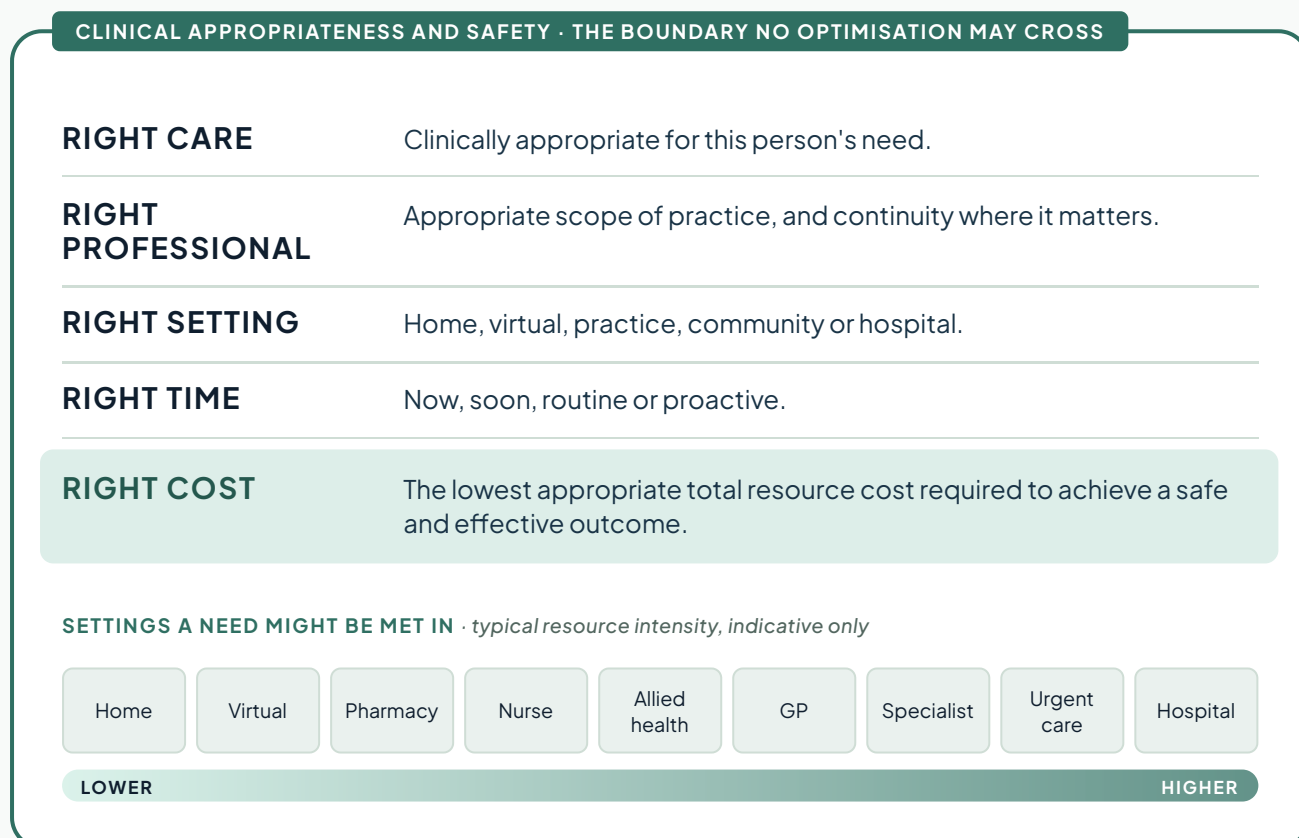


Figure 4. Cost is optimised only inside the boundary set by clinical appropriateness and safety. The settings are not interchangeable: each is right for some needs and wrong for others. Right cost chooses among appropriate options — never outside them.

Right cost does not mean cheapest. The least expensive transaction can create a more expensive pathway if it delays necessary intervention, sends someone back through the door twice, or pushes a person towards a setting that cannot meet their need.

The objective is the least intensive appropriate resource capable of safely meeting the person's need.

04 / INTELLIGENT ALLOCATION

Where and when care happens has economic consequences

The Australian Institute of Health and Welfare estimates the scale of hospital care for conditions that timely and adequate care in the community might have prevented (AIHW, 2025).

788,000 potentially preventable hospitalisations in 2023–24	\$7.7_{bn} in admitted-patient expenditure — 8.5% of the total	3.14_m hospital bed days
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READ WITH CARE

These figures are **not a savings pool**. AIHW notes that they do not represent total savings, because costs in community care would rise to support better prevention and management. The estimates also cover hospital stays only, not care in general practice. They illustrate scale, not recoverable savings.

What the figures do demonstrate is more fundamental: **where and when care occurs has economic consequences**. A need met early in an appropriate setting uses different resources from the same need met late in an intensive one — and usually means a different experience for the person.

Continuity appears to matter. In an Australian linkage study of NSW adults aged 45 and over, modestly higher continuity of GP care was associated with a lower probability of acute potentially preventable hospitalisation (Nguyen et al., 2025) — an observational association, not proof of cause.

The objective is not the cheapest encounter. It is the lowest appropriate total cost across the pathway.

05 / THE MISSING MIDDLE

Forms are not forms

After routing comes the part of healthcare that rarely features in front-door strategy: preparation, identity, consent, history, patient-reported information, appointment constraints, the encounter itself, investigations, prescriptions, referrals, payment, education, results, monitoring and follow-up.

Much of this is neither glamorous nor suited to unconstrained AI. It is workflow. And much of it depends on asking a person for information at the right moment.

That is what a form really is. Not a document to be filled in, but **a structured interaction at a particular moment in a care journey.**

People do not naturally speak in database fields. Conversation — sometimes assisted by AI — helps them say what they mean; deterministic systems then validate and structure what is known, so the information can be relied on downstream.

MOMENTS WHERE THE JOURNEY NEEDS TO KNOW SOMETHING

☐	Reason for visit	before routing	☐	Referral-specific information	what the next service needs
☐	Consent	before care, and again when it changes	☐	Home monitoring	readings between visits
☐	Preferences	language, access, support people	☐	Post-treatment outcome	how it went, in their words
☐	Patient-reported information	symptoms, history, goals	☐	Follow-up	did the plan work?

Figure 5. Forms as moments on the journey. Each asks for something the next step needs, and each is an opportunity for the person to clarify or correct what the system believes.

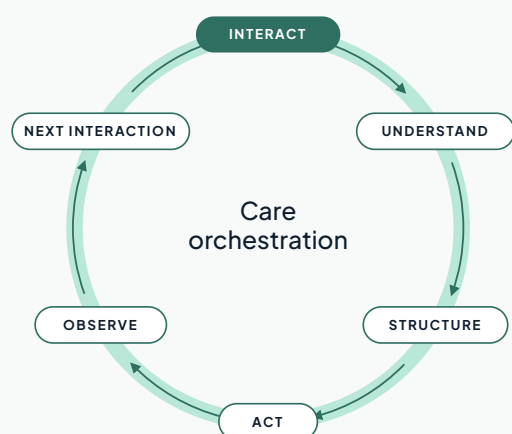
Conversation helps people express themselves. Structure makes the information usable. Workflow gives the information consequence.

05 / THE MISSING MIDDLE

Workflow is the journey

The form captures structured information. Workflow determines what happens because of it. Much of that is known in advance: identity can be checked, permissions enforced, required fields validated, availability queried, referrals tracked, results marked as reviewed and tasks escalated when they become overdue.

None of that needs a model to guess. AI earns its place where ambiguity cannot economically be resolved by fixed logic — interpreting what someone meant, noticing what is missing, drafting what a person will review. Where conditions are known, rules are cheaper, more predictable and easier to audit.



AN EXAMPLE, AFTER LARRY'S PROCEDURE

INTERACT

Day-three check-in: 'How does the wound look?'

UNDERSTAND

He writes that it is redder and sore. AI helps interpret the free text.

STRUCTURE

Recorded as a reported change, with his photo, against the procedure.

ACT

A rule creates a same-day task for the practice nurse.

OBSERVE

The nurse calls, reviews and records the outcome.

NEXT INTERACTION

A follow-up check is scheduled — or the loop closes.

Figure 6. The interaction-workflow loop. A form starts it; workflow gives it consequence. The model assists understanding; a rule creates the task; a clinician decides.

Use reasoning where meaning is uncertain; use rules where conditions are known.

06 / THE FORGOTTEN DIGITAL BACK DOOR

The consultation may be over. The care is not.

An ordinary consultation can end with pathology, imaging, a new medication, a referral, a procedure, monitoring, education or a planned review. Each is a promise about the future.

The **Digital Back Door** is the infrastructure that turns a completed encounter into a completed care pathway. It is where healthcare moves from *what happened?* to *what is supposed to happen next?* — and then to the question that matters most: **did it happen?**

This is not a new concern. Australian-led systematic reviews found that between a fifth and three-fifths of inpatient test results were not followed up (Callen et al., 2011), with similar gaps in ambulatory care, though those studies were all from the United States (Callen et al., 2012). Referring clinicians often do not know whether a patient reached the specialist (Mehrotra, Forrest and Lin, 2011).

Margaret, 84, goes home after a hospital stay, with her daughter Louise helping. Her plan holds five promises about the future. Each is someone's next action; none is guaranteed to happen.

DISCHARGE PLAN *illustrative*

Margaret, 84 · going home with Louise

- ☐ **Medicines**
One new, one stopped
- ☐ **Blood test**
Kidney function, 1 week
- ☐ **Specialist**
Review within 6 weeks
- ☐ **GP**
Visit within 2 weeks
- ☐ **At home**
Watch for swelling

Five promises. Who checks each one?

Availability is not action

Information is moving more freely. From 1 July 2026, in-scope pathology and diagnostic-imaging reports must be uploaded to My Health Record by default, subject to exceptions and approved extensions (ADHA, 2026).

That is real progress. But a result can be available and still need review, communication and action; an electronic alert alone does not guarantee timely follow-up (Singh et al., 2009). The question is moving from *can information move?* to *can the system recognise when expected action has not occurred?*

Interoperability makes information available. Continuity gives it consequence.

FIGURE 7 / THE DIGITAL BACK DOOR

The encounter ends. The care does not.

SETTING	MARGARET'S PATHWAY AFTER DISCHARGE	DID IT HAPPEN?	WHO KNOWS?	WHO OWNS THE NEXT ACTION?
HOSPITAL	Encounter and discharge Summary sent; plan agreed with Margaret and Louise.	?	?	?
COLLECTION CENTRE	Pathology and imaging Kidney function in one week.	?	?	?
HOME	Medication New medicine started; one stopped.	?	?	?
SPECIALIST ROOMS	Referral Specialist review within six weeks.	?	?	?
LABORATORY	Result The blood test result arrives.	?	?	?
GP CLINIC	Review A clinician reviews it in context.	?	?	?
PHONE	Patient communication Margaret and Louise are told what it means.	?	?	?
TELEHEALTH	Follow-up GP review, in person or by telehealth.	?	?	?
HOME	Monitoring Is she well, and is anything changing?	?	?	?

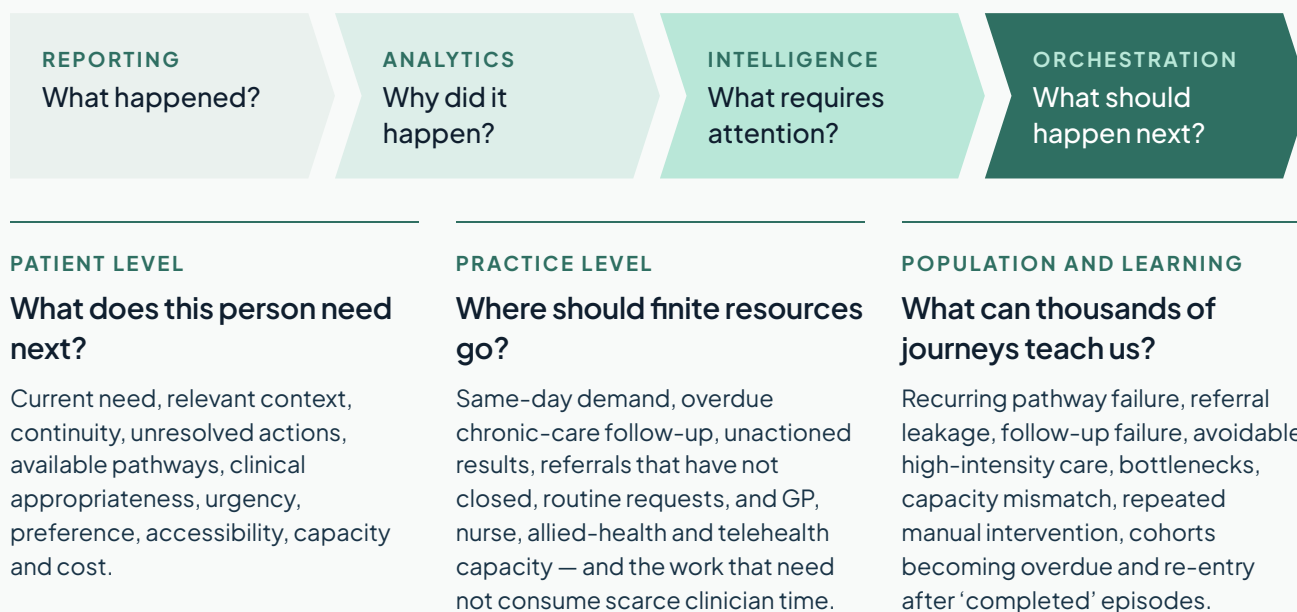
Without back-door infrastructure, each answer depends on someone remembering to check.

Figure 7. Nine expected steps after one hospital discharge (illustrative). The Digital Back Door asks the same three questions at every step, and raises the matter with a named owner when the answer is *no*, *nobody* or *unclear*.

07 / PRACTICE INTELLIGENCE

From dashboards to decisions

Most practice analytics is retrospective: appointments, billings, utilisation, missed appointments and recalls. It answers *what happened?* That is necessary, and not enough. In this paper, Practice Intelligence means the capability to move from *what happened?* towards *what needs to happen next?* — not a better report, but better-directed action.

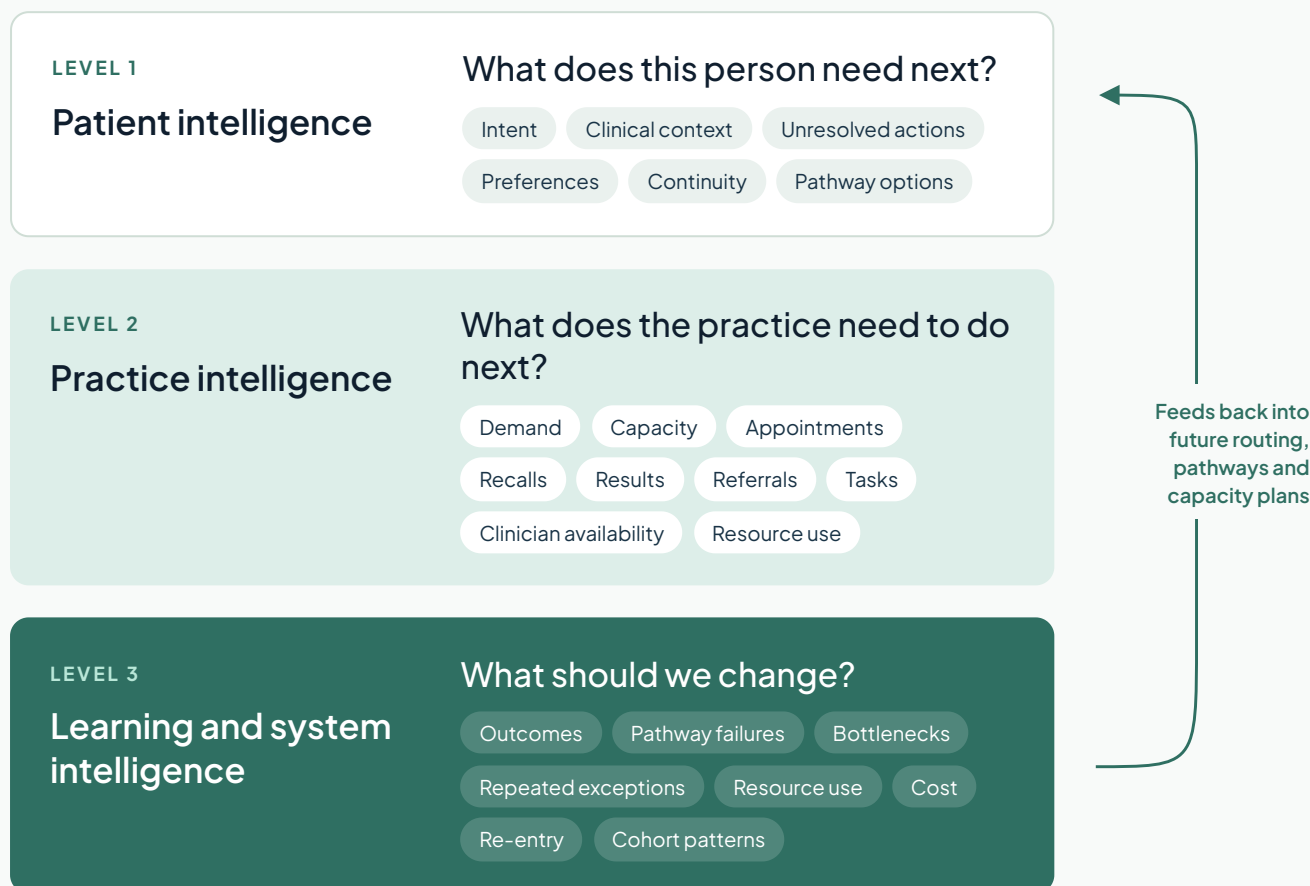


If success is measured as appointments booked, a front door is incentivised to turn every need into an appointment. Sometimes the right outcome is the usual GP. Sometimes it is nursing, pharmacy, allied health, specialist care, urgent care or hospital. Sometimes it is an administrative workflow; sometimes, escalation.

A dashboard displays the system. Intelligence should help the system improve itself.

FIGURE 8 / PRACTICE INTELLIGENCE

Not a dashboard. A learning loop.



Each level asks a different question of the same underlying journeys. The patient level serves one person now. The practice level directs finite capacity this week. The learning level looks across thousands of journeys for patterns no single encounter can reveal — and changes the pathways, rules and capacity that the first two levels work within.

That last step is what distinguishes intelligence from reporting. The idea is not new: the learning health system describes organisations that routinely turn their own practice data into improvement (Friedman et al., 2010), and AI is renewing interest in how that loop is governed (Steel et al., 2025).

Evidence note. The three-level model is an architectural proposition for how practice data could direct action. It is not a demonstrated causal effect on outcomes or cost.

08 / ECONOMICS

The economics of the whole journey

The useful economic question is not only *what did this interaction cost?* but *what did it cost to complete the journey to an appropriate outcome?*

NOT THE TARGET

Cheapest encounter

Fewest clinician minutes

Maximum digital containment

Maximum number of appointments

Lowest transaction cost



OPTIMISE TOWARDS

Appropriate completed care outcome

Safe · effective · completed · at the lowest
appropriate total resource cost

Each metric on the left can be improved while care gets worse. An encounter can be cheap because it failed to address the need. Digital containment can rise because people gave up. Appointment volume can grow because the same problem keeps coming back.

A larger productivity opportunity lies in reducing the avoidable work that fragmentation creates. Australian GPs report wanting to provide more preventive care, yet only one in three say they have the time (RACGP, 2025). Clinician time lost to rework is time not available for care.

WHERE FRAGMENTATION COSTS

- Avoidable duplication
- Repeated data capture
- Failed referrals
- Missed follow-up
- Inappropriate use of scarce resources
- Delayed intervention
- Administrative rework
- Unnecessary escalation
- Preventable deterioration

Each failure may be small. At scale, the system pays for the gaps. Eliminate unnecessary transactions while protecting necessary care.

Evidence note. The size of these costs varies by setting and is not well measured in Australian primary care. This is an economic proposition rather than a demonstrated saving.

09 / INTELLIGENCE WITH RESTRAINT

Intelligence without unnecessary autonomy

A model can interpret an ambiguous request and notice missing context. But once identity, permission, appointment type, follow-up interval or transaction rules are known, probabilistic reasoning is usually unnecessary — and a deterministic mechanism is cheaper, more predictable and easier to audit.

The question is not only *can AI do this?* but *should it have authority to do this, what evidence justifies that authority, and what safer mechanism exists where reasoning is not needed?* Australian regulators and professional bodies frame the same obligations around intended use and accountable clinicians (TGA, n.d.; ACSQHC, 2025; Ahpra, 2024). Ahpra is explicit that practitioners must apply human judgement to any output of AI.

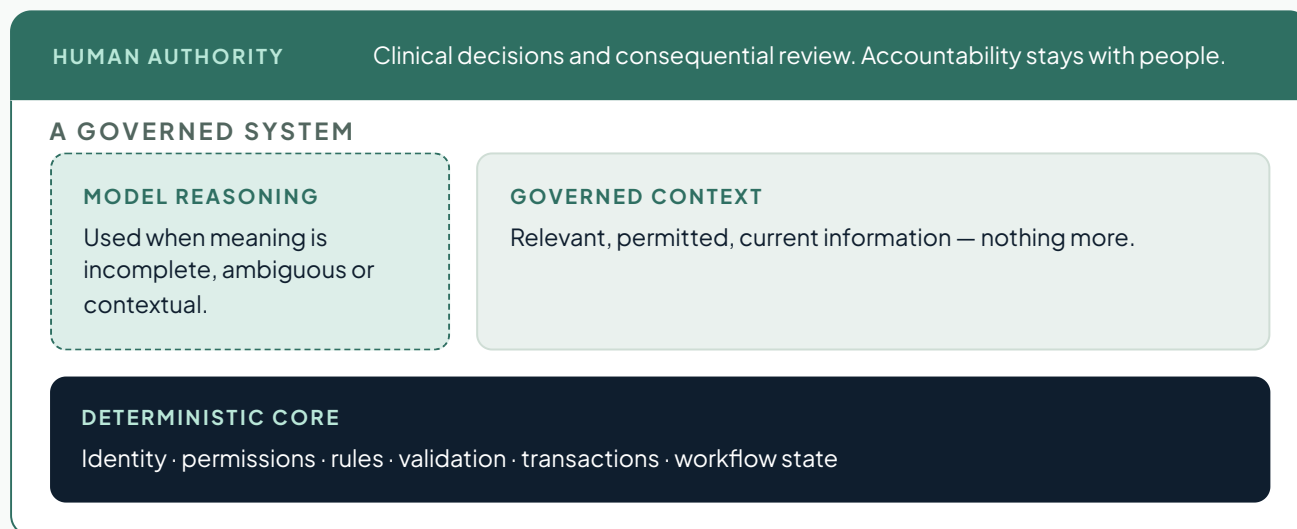


Figure 9. AI embedded in a governed system, not in control of one. Model output is a proposal: it is validated by the deterministic core and, where consequential, reviewed by a person before anything happens.

The deterministic system handles the known path. The model helps people reach it.

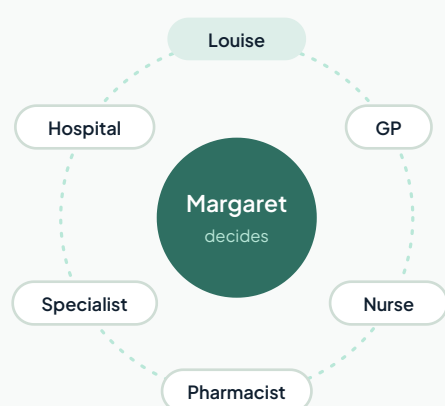
Automation bias — over-reliance on automated advice — is a documented risk in clinical decision support, and grows with workload and verification complexity (Goddard, Roudsari and Wyatt, 2012; Lyell and Coiera, 2017). Designing for review, not rubber-stamping, is part of restraint (see also Echo Health AI, 2026).

AI should expand understanding without making accountability disappear.

10 / PATIENT AGENCY

The patient cannot disappear inside optimisation

Routing, allocation and efficiency can make a person sound like freight moving through a logistics network. That would be a mistake — clinically, ethically and practically.

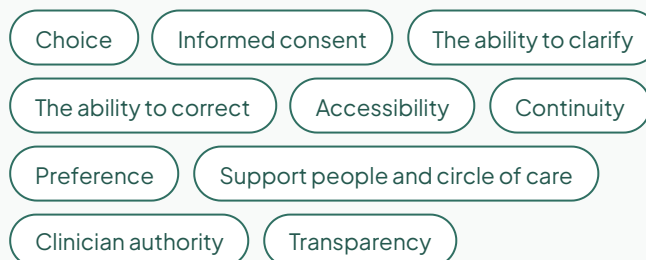


The circle of care. Support people are part of the journey — with the patient's consent, and never in place of it.

People should understand why information is requested, be able to correct a misunderstanding, know what is expected after an encounter and have a reasonable way to notice when something promised has not happened.

Healthcare already asks patients to do work of their own — the ‘burden of treatment’ (May, Montori and Mair, 2009; Eton et al., 2012). Research on digital triage in English general practice warns that digital routes can make requests flow faster while limiting patients' ability to influence how they access care (Brenman et al., 2026). Digital continuity should reduce the burden, not quietly transfer clinical responsibility to the person least equipped to hold it.

WHAT MUST BE PRESERVED



“

The patient can participate in closing the loop. They should not become the loop-closing mechanism.

There are no doors. There is a journey.

A person may move from home to general practice, to pathology, back to the GP, to a specialist, to hospital, to pharmacy and home again. At each transition one organisation may regard its part as complete. The patient does not.

Continuity requires enough context for each interaction to begin where the previous one ended. Seen from the patient's side, the front door and the back door were never separate things.

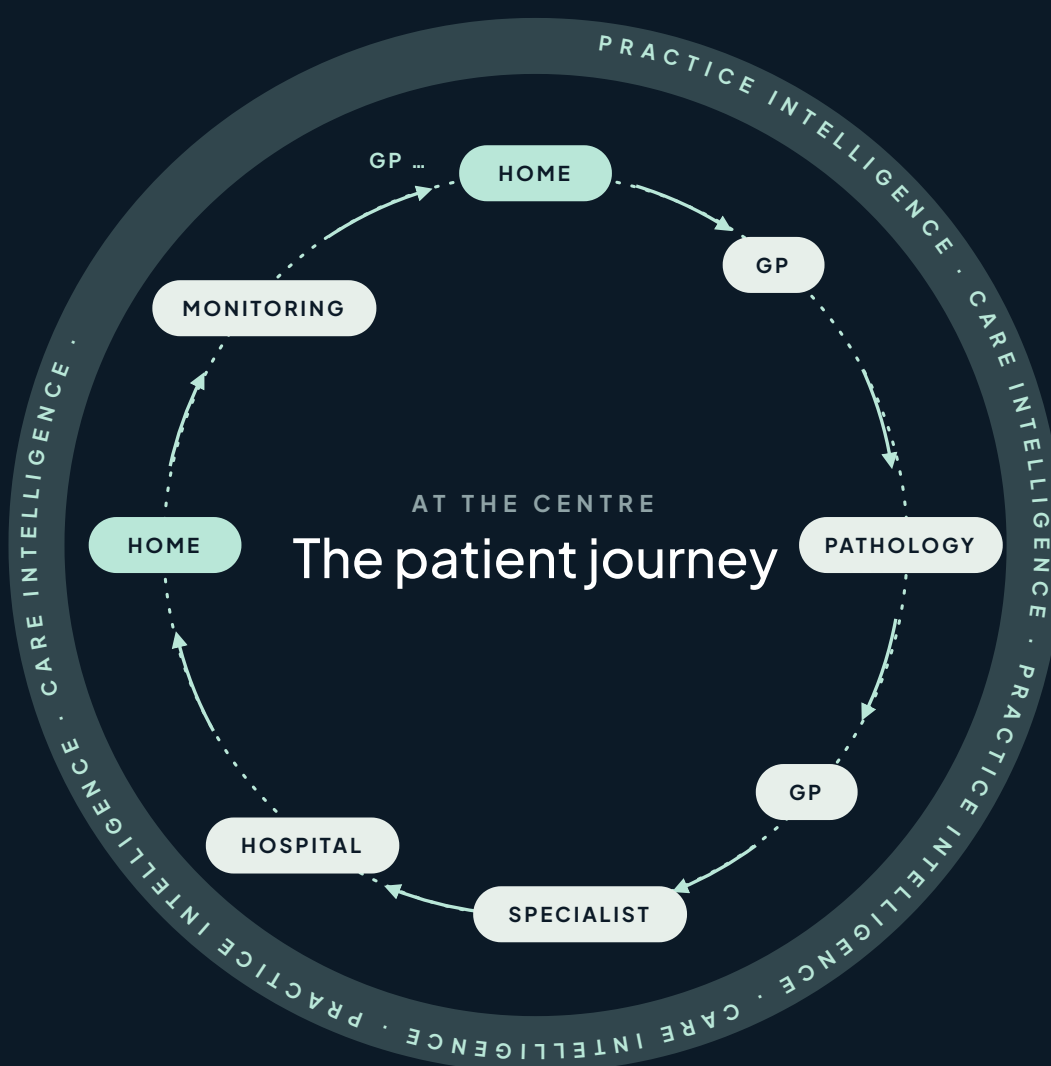


Figure 10. The journey as a loop, not a line. Every transition is both an ending and a beginning; the outer ring is the intelligence that carries context across them.

The back door of one service becomes the front door of another.

12 / WHAT GOOD LOOKS LIKE

Eight questions for health leaders

- | | |
|--|--|
| 01 Who encounters patient intent first — and what happens to it? | 02 Are we optimising for bookings, or for appropriate care? |
| 03 Can relevant context carry forward to the next step? | 04 Are our forms part of workflow, or digital paperwork? |
| 05 Can we see our Digital Back Door? | 06 Do we know when expected care has not happened? |
| 07 Are we allocating finite resources intelligently, inside the boundary of safety? | 08 Does the organisation learn from its journeys? |

A Digital Front Door strategy that cannot answer these questions may solve access while leaving the larger care-delivery problem untouched.

CONCLUSION

Ownership of entry is not ownership of the patient

The battle for the Digital Front Door is real. Booking platforms have reach. Practices hold the clinical relationship. Health systems carry responsibility for access, capacity and cost. AI assistants may increasingly meet intent before healthcare does. But whoever holds the door, the patient's need is met — or not — on the journey behind it. Digital health should make that journey easier to navigate and more likely to end in appropriate care.

Route well

Safest appropriate next step, not the nearest booking.

Prepare people

Context gathered once and carried forward.

Reason where needed

Intelligence where ambiguity requires it.

Govern the known path

Deterministic workflow where conditions are known.

Close loops

Know whether expected care happened.

Learn from failure

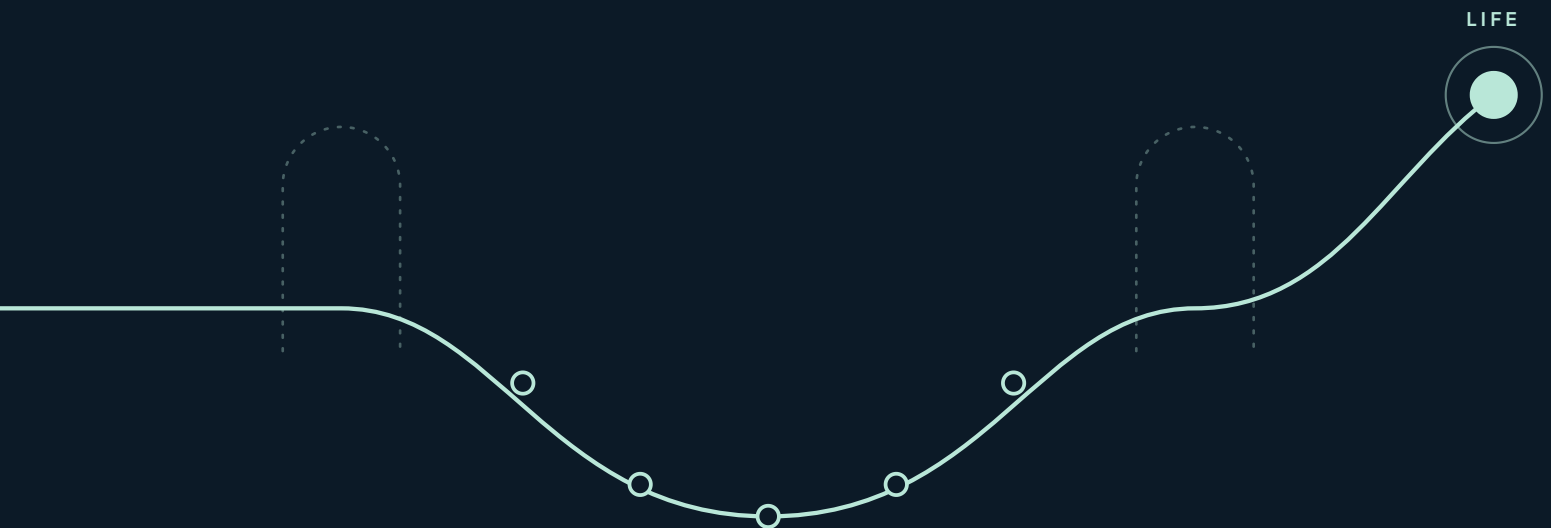
Change pathways, not just reports.

Allocate wisely

Finite resources towards appropriate, completed outcomes.

Keep people in charge

Patients choose; clinicians decide.



BACK TO WHAT MATTERS.

The future of digital healthcare is
not about who owns the door.
It is about who can connect the
journey.

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EVIDENCE NOTE

Australian authoritative sources and peer-reviewed research are used where available. Where Australian data were not found — for example on referral completion and test-result follow-up in primary care — international evidence is used and labelled as such. Industry reporting frames the contemporary debate about the front door and is not used as clinical evidence.

Potentially preventable hospitalisation expenditure is presented as evidence of scale, not as recoverable savings. The Digital Back Door, the three levels of Practice Intelligence and the intelligent-allocation model are architectural propositions, not demonstrated causal effects. Where a study was led by a product's manufacturer, or relies on self-report, the text says so.

Government web pages are cited as published at the time of writing; readers should check the current version, particularly for regulatory and My Health Record requirements.



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The Digital Front Door—and the Forgotten Back Door. White paper, September 2026. Published at echo-one.health/resources.

This paper sets out an argument and a direction. It is not clinical advice, does not describe regulatory approval and makes no claim about outcomes of any Echo One deployment. The characters and journeys are illustrative; no patient information is used.

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