HOC
HEALTHY OUTBACK COMMUNITIES

Beyond the Pilot

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Lessons from building a place-based system of care in remote Western Queensland

A lessons-learned reflection • Reference period July 2023 – May 2026

Contents

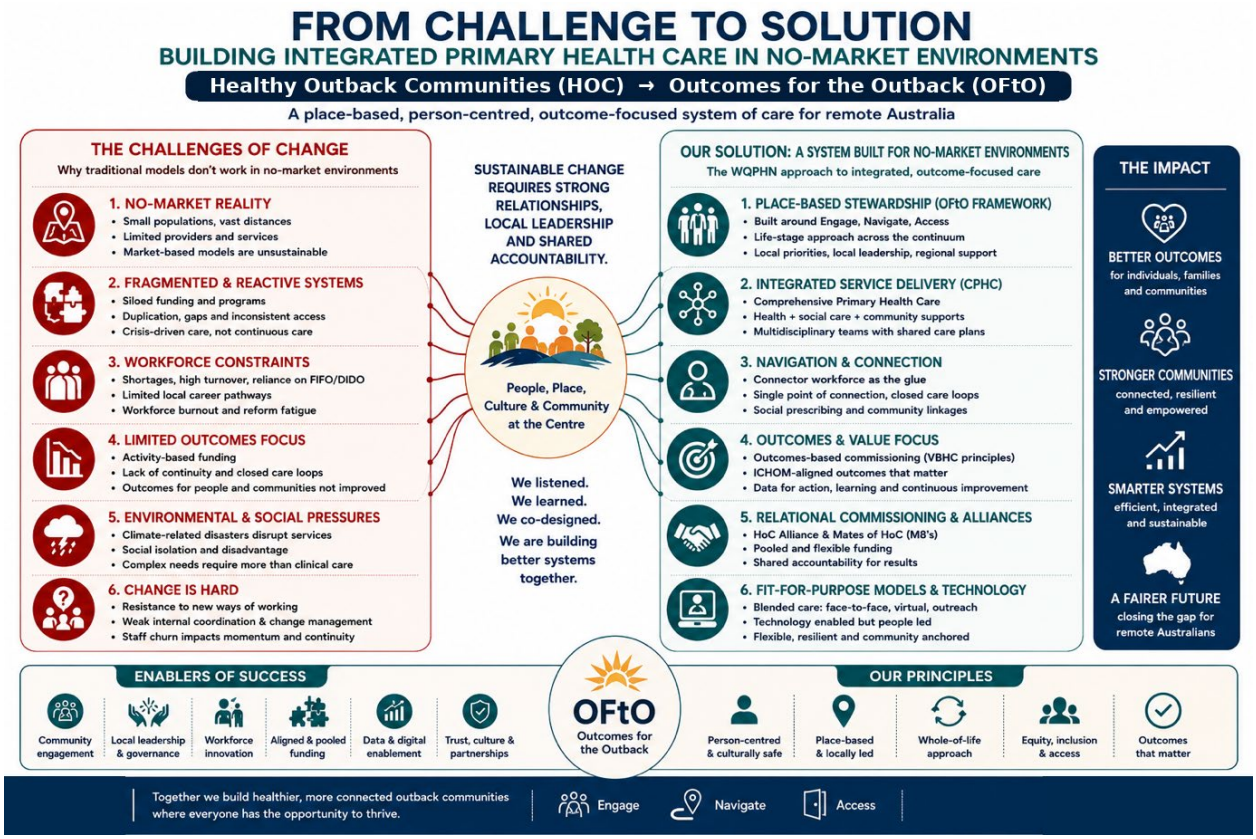

Figure 1. From challenge to solution — why conventional models do not hold in no-market environments, and the system of care HOC was built to put in their place.

About this paper

A lessons-learned reflection prepared to support institutional learning and forward decision-making — not to attribute fault or audit performance. It draws on internal program documentation, operational reporting, the outputs of the Longreach and Winton workshops, structured reflection with implementation staff and Alliance partners, and comparable remote-health reform evidence. Population data: ABS 2021 Census and QGSO regional profiles (ASGS 2021). Prepared in line with recognised good practice for lessons-learned and program-evaluation reporting.

Executive Summary

Healthy Outback Communities (HOC) is Western Queensland Primary Health Network's attempt to redesign comprehensive primary health care around place, relationships and continuity, rather than around episodic, activity-funded service delivery. It was conceived as the practical proving ground for Outcomes for the Outback (OFtO) — the region's outcomes-based commissioning framework — and was designed for the operational realities of Australia's most remote communities, where in many places there is no resident GP, no pharmacy and no Aboriginal and Torres Strait Island Community Controlled Health Service. These are not gaps at the margin of a working system; they are the baseline.

Between 2023 and 2026 HOC moved that ambition from concept into live operation. Within twelve months of its public launch, integrated, multidisciplinary care anchored by locally embedded Connectors was running in three of the most remote communities in the country. The pilot demonstrated something that had not previously been shown at this scale in Western Queensland: that integrated comprehensive primary health care, social prescribing, relational commissioning and outcome-focused stewardship can function in thin and no-market environments — and that communities will engage with them.

It also showed, honestly, where the harder lessons lie. Geographic expansion advanced more slowly than the original ambition envisaged. Delivery concentrated in one cluster of communities; a managed, comprehensive, community-by-community rollout schedule did not exist for much of the period; the evaluation design proved heavier than the operating team could sustain; and the program depended on a small navigation workforce whose continuity carried real challenge. None of these are unusual in transformational reform under extreme-remoteness conditions. They are, however, precisely the conditions that make the lessons worth recording.

> **In short:** HOC turned a model of care into operational reality and built the foundations — the model, the evidence, the Alliance and a sequenced roadmap — for a disciplined, stewardship-led next phase. The central task now is execution: scaling what worked with the discipline and investment the first phase showed are essential.

This paper sets out what HOC is, where it started, what it achieved, what constrained it, and what was learned. It is written as institutional reflection — to inform the next phase of HOC and to contribute to the wider conversation on remote-system reform, value-based commissioning and comprehensive primary health care across remote Australia.

1. Why HOC Exists

Remote and very remote Australia experiences a persistent, structural failure of the health system — not an occasional shortfall, but a steady-state condition. It is driven by market failure, workforce maldistribution, fragmented and short-cycle funding, and commissioning models designed for metropolitan settings and then applied, largely unchanged, to places they were never built for.

The consequences are measurable and well documented: avoidable hospitalisations, worsening chronic disease, life expectancy well below the national average, declining mental health and social and emotional wellbeing, and the slow erosion of community resilience. The system's usual response — more assessments, more disconnected programs, more short-term interventions — tends to add activity without adding continuity. Activity-based funding compounds this by rewarding throughput rather than prevention, navigation or follow-through.

HOC was designed to address the architecture of this problem rather than its symptoms. The proposition was simple to state and hard to deliver remote communities do not need a better version of programs that have already been tried. They need a place-based, community-enabled system of comprehensive primary health care built around relationships, continuity and local capability.

> *Wellbeing in remote communities is social as much as it is clinical. Continuity, trusted relationships and local navigation capability are foundational infrastructure — not optional add-ons to a program.*

2. What is HOC?

HOC is not a program or a service line. It is a place-based, life-stage system of care that puts the person, their family and their community at the centre, and organises support around them. It sits inside OFtO and its three thematic domains — Engage, Navigate, Access — applied across the life course. Engage builds presence and trust; Navigate provides local coordination and continuity through the Connector workforce; Access delivers timely, culturally safe clinical and social care. Together they create connected care journeys rather than isolated occasions of service.

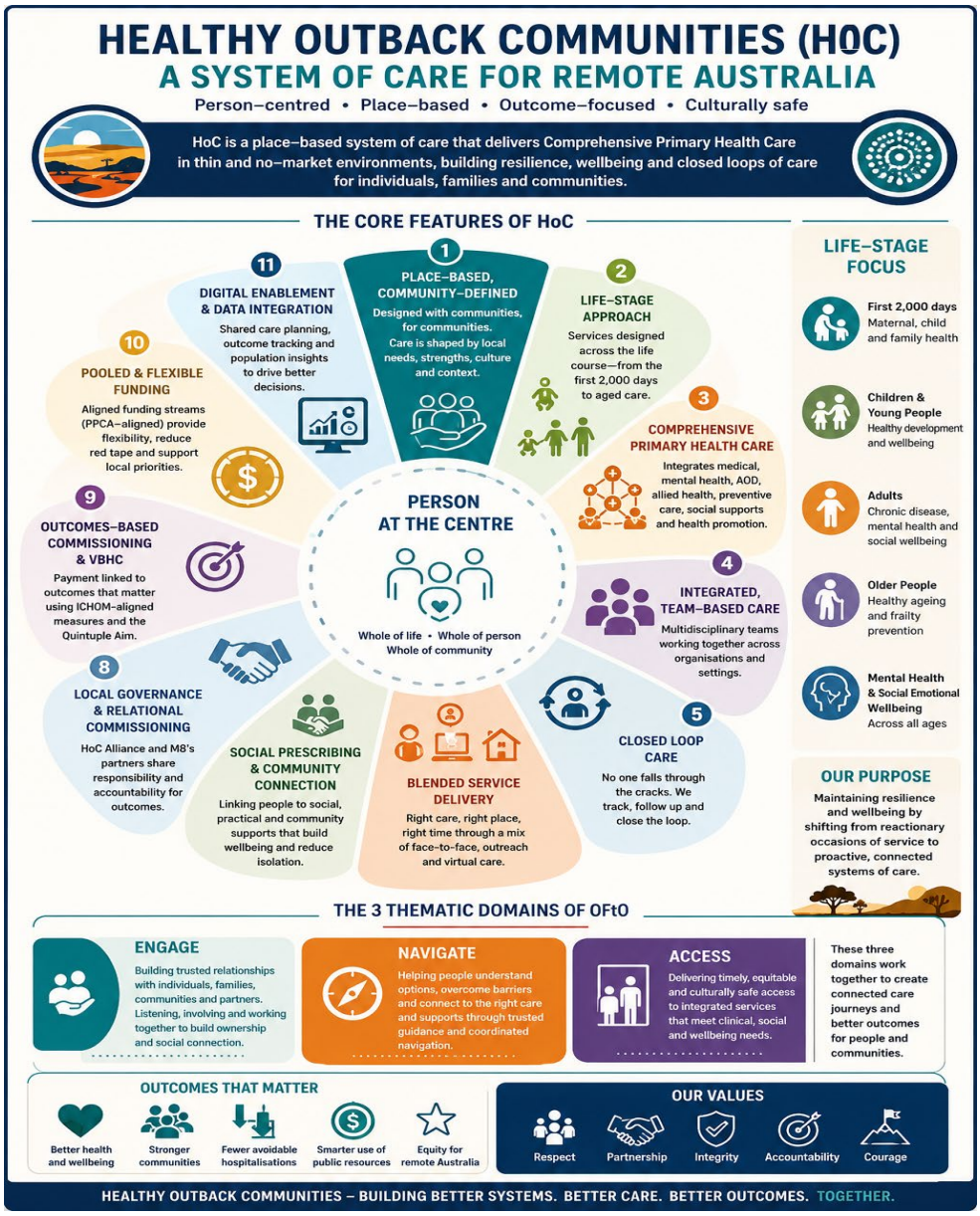

Figure 2. The HOC system of care. Interconnected features organised around the person, the family and the community, expressed through the Engage, Navigate and Access domains of OFtO. Where the features operate together, the model works; where a critical feature is missing — particularly the Connector — integration weakens.

The model's components are deliberately interconnected: the Connector holds the relationship; the virtual and hybrid hub (to be transitioned to the HOC Chronic Conditions Clinic) provides access; the wellbeing plan anchors continuity; social prescribing addresses the social determinants; and the Alliance governs the whole.

A defining feature is the focus on closed loops of care. Referrals, assessments and interventions are tracked, followed up and linked back into ongoing planning, so that people do not fall through the cracks between fly-in visits and disconnected services. This is the most important operational difference between HOC and conventional remote delivery, where care is too often a sequence of one-off encounters.

3. The Journey, 2023 to 2026

HOC moved from concept to operation quickly. The initiative was established in 2023, a substantive risk register was developed early, and the model launched publicly in Windorah in April 2024. Within a year, integrated care was live across the Barcoo cluster — Jundah, Stonehenge and Windorah — supported by two resident Connectors and the virtual Health and Wellbeing Hub. Boulia was engaged through the virtual hub, initially without a resident Connector.

A regional evaluation workshop in Longreach in early 2025 brought partners together and confirmed both the genuine achievements of the pilot and the structural pressures it was navigating. Notably, delivery continued past the original funding horizon — itself a signal of embedded relationships, partner commitment and community demand. Scale-up planning was re-initiated in 2026 and culminated in a regional Alliance workshop in Winton in April 2026, which produced the first sequenced, community-by-community rollout plan and secured in-principal agreement on outcome-based payment and ICHOM-aligned measurement for diabetes and mental health.

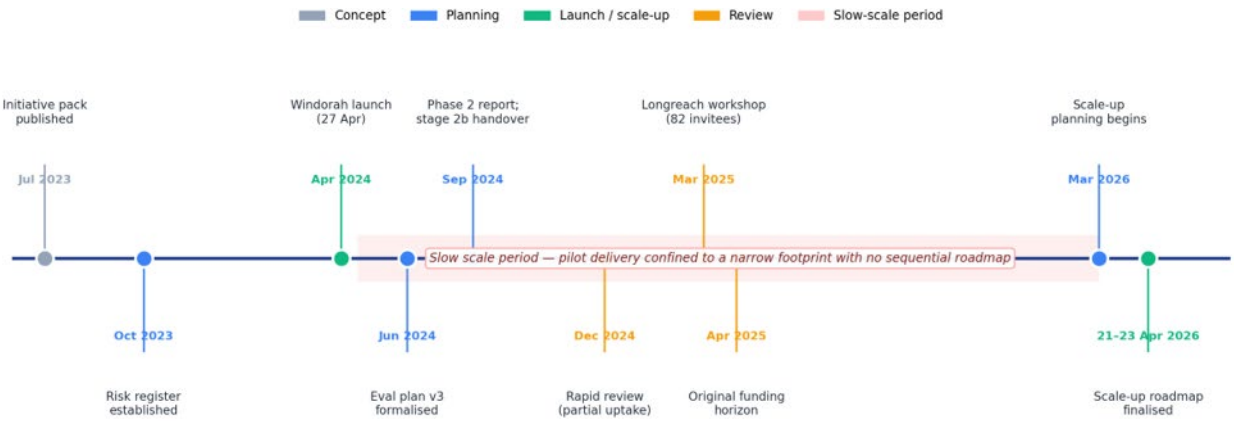

Figure 3. HOC chronology, 2023–2026. Rapid establishment and launch, a concentrated delivery period across a narrow footprint, and a return to sequenced scale-up planning in 2026.

The pattern matters more than any single date. HOC established itself rapidly and delivered real integrated care — but in a concentrated footprint, and without a managed expansion schedule for much of the period.

The 2026 HOC Regional Scale-Up roadmap is the structural correction to that and marks the transition from pilot innovation toward scalable regional stewardship.

4. What Worked

Within a deliberately limited footprint, HOC generated real, sustained operational activity — and, more importantly, a set of strategic assets that now underpin the next phase. What the activity showed matters more than any single count: the model engaged people who had previously gone without coordinated care, held them in continuing relationships, and turned community knowledge into action.

People engaged Hundreds of residents entered coordinated care who would otherwise have had no continuing pathway.	**Care delivered** Medical, nursing, wellbeing and combined consultations were delivered repeatedly, not as one-off visits.	**Continuity built** Personal wellbeing plans were created and reviewed, anchoring care over time rather than at a single point.
Determinants addressed Social prescribing connected people to transport, housing, digital access and community support.	**Issues resolved** The majority of community issues logged were actioned or resolved, closing real gaps on the ground.	**Footprint proven** Live, Connector-led delivery operated in the most remote communities, with virtual reach beyond them.

Beyond the activity itself, six strategic achievements stand out — each now a foundation for the next phase.

- Integrated care, made real. HOC demonstrated that integrated comprehensive primary health care can operate effectively in thin and no-market environments — shown in practice, not asserted, in three of the most remote communities in the country.
- The Connector as infrastructure. Where Connectors were embedded locally, engagement rose, continuity strengthened and multidisciplinary pathways functioned. Where they were absent, virtual access alone did not sustain engagement. This is the pilot's single most consequential finding.
- Social prescribing, embedded. HOC introduced structured social prescribing into remote Queensland's health architecture, formally extending care to isolation, digital access, and social participation.
- Relational governance. The HOC Alliance and the Mates of HOC concept created multi-agency governance foundations — a shift from transactional procurement toward shared accountability for outcomes.

- National positioning. Engagement with national bodies positioned HOC within wider conversations on value-based and remote-area care, strengthening the credibility of the regional approach.
- A foundation to scale from. The 2026 HOC Regional Scale-Up roadmap, agreed ICHOM measures and in-principal outcome-based payment framework marked the formal transition from pilot to a scalable stewardship model.

5. Constraints

An honest reflection names the conditions that shaped the pace as clearly as the achievements. The points below are structural observations, not attributions of fault; several were foreseen in the 2023 risk register, and most are characteristic of transformational reform in extreme-remoteness conditions. They are recorded here because lessons are only useful when the conditions that produced them are named plainly.

5.1. Expansion lagged the original ambition

Live, Connector-led delivery reached the three Barcoo communities; the virtual health and wellbeing hub services extended to Boulia; the broader target footprint was not operationalised within the pilot period. The causes were layered — workforce shortages, funding cadence, evaluation load, variable partner readiness and role-clarity gaps — and together they showed that this kind of reform needs stronger operational scaffolding than first assumed.

5.2. A more detailed rollout schedule developed over time

HOC was guided by a phased approach from the start, but a detailed, community-by-community delivery schedule took time to mature. The refreshed roadmap now provides that level of detail; sustaining disciplined monitoring against it is a central operational focus for the next phase.

5.3. Virtual care alone was not enough

The virtual health and wellbeing hub delivered real value where paired with a face-to-face clinical consultation and resident Connector. Where it stood alone, utilisation faded. The planned move to hybrid chronic-conditions clinics — in-person care with optional virtual follow-up — is the correct structural response, and reflects exactly what the evidence showed.

5.4. Evaluation outgrew operational capacity

The evaluation design was analytically thorough but operationally heavy. Several instruments remained underpopulated and the mid-point evaluation slipped its timeline. The lesson points clearly toward a minimum viable dataset and a developmental evaluation model suited to thin-market settings.

5.5. Coordination, role clarity and organisational embedding

Internal reflection consistently identified unclear roles, light project-management scaffolding and fragmented internal communication. At times HOC was understood as a project rather than an embedded way of working — which limited the organisational ownership transformational reform requires. These issues were progressively recognised and are being addressed.

5.6. Workforce continuity and Connector sustainability

Turnover across the HOC management and implementation team and the wider remote health system affected relationship continuity and momentum. The Connector role — HOC's most distinctive innovation — also carried the highest single-point-of-failure risk, making its sustainability a standing governance priority.

5.7. Reform challenges and climate disruption

Parts of the agenda challenged established practice, and reform fatigue and business-as-usual pressures were observable — as in most large-scale transformation. Repeated flooding and road isolation across the period further disrupted engagement and scheduling, underscoring that in remote Australia, climate resilience and health-system resilience cannot be planned apart.

6. Lessons Learned

The following eight lessons synthesise the operational and strategic learning of the pilot. They are framed as transferable institutional insights — forward-looking, practical, and intended to guide the next phase of HOC and to inform commissioning, alliance design and remote-system reform more broadly.

LESSON 1

Navigation workforce is infrastructure

In remote systems, a trusted local navigation workforce is infrastructure in the same sense as roads or telecommunications. Its absence cannot be substituted by virtual access, program activity or administrative coordination. Fund it and protect it accordingly.

LESSON 2

Virtual care must be paired with local presence

Virtual delivery adds real value when anchored by a resident Connector and an in-person start. Hybrid models — face-to-face care with optional virtual follow-up — are the right design for chronic conditions, mental health and continuity-dependent care in remote Australia.

LESSON 3

Stewardship outperforms competition in thin markets

Market mechanisms do not function where there is no market. Continuity, workforce stability and population health gains require active regional stewardship — alliance governance, pooled planning, relational commissioning and shared accountability — rather than competitive tender.

LESSON 4

Evaluation must match operational capacity

A theoretically complete evaluation the operating team cannot sustain yields partial evidence and avoidable frustration. Specify, resource and protect a minimum viable dataset from the outset, and use developmental evaluation suited to thin markets.

LESSON 5

Reform is organisational change, not service change

System reform cannot sit only at the service-delivery layer. It requires internal adaptation, change management, workforce engagement and stewardship capability. Organisations leading remote reform must invest in their own transformation as deliberately as in the program.

LESSON 6

Clear sequencing strengthens delivery

HOC was guided by a phased intent from the outset, but the pilot showed that a more detailed, community-by-community delivery schedule — with visible status by site — helps a place-based program move steadily and tell its story clearly. The refreshed roadmap brings that level of detail, and sustaining it is a practical priority going forward.

LESSON 7

Throughput metrics under-measure remote value

Preventing disengagement, holding continuity, reducing avoidable deterioration and improving navigation create substantial value without generating high billable volume. Commissioning must be built around what matters — person-defined outcomes, wellbeing, equity and lived experience.

LESSON 8

Climate and health resilience are inseparable

Recurrent flooding and isolation confirmed an implicit design assumption: in remote Australia, climate resilience and health-system resilience must be planned together, across commissioning, workforce design and operations.

7. Commissioning for Value

Value-based health care and the Quintuple Aim have long been part of WQPHN's approach, and HOC reaffirmed their relevance: throughput metrics alone do not capture value in remote communities. The next phase is about staying committed to that direction and deepening it — continuing to apply ICHOM-aligned measurement for diabetes and mental health, PROMs and PREMs, and progressing the move toward blended and outcome-based payment. The five aims below remain the lens through which performance and investment are considered.

1	2	3	4	5
Person experience *Care that matters to people and family*	**Population health** *Prevention, wellbeing, less deterioration*	**Provider experience** *Sustainable workforce, meaningful work*	**Health equity** *Closing gaps, culturally safe access*	**Efficiency & sustainability** *Value-based, outcome-focused care*

Figure 4. The Quintuple Aim, a continuing part of WQPHN's approach — the lens guiding outcome measurement and the ongoing shift toward outcome-based commissioning.

8. Where HOC is Heading

The next phase is not about expanding a pilot. It is about operationalising a validated model of care at scale, with the commissioning architecture, workforce investment and stewardship capability the first phase showed are essential. Six priorities define the direction — each building directly on what the pilot demonstrated.

▶ Scale the Roadmap

Execute the agreed community-by-community rollout with monthly monitoring and clear status by site.

▶ Embed Connectors

Recruit and embed resident Connectors in each phase. Coverage cannot move without local navigation workforce.

▶ Operationalise Hybrid Care

Stand up chronic-conditions clinics combining in-person care with optional virtual follow-up.

▶ Right-size Measurement

Run a minimum viable evaluation set — issues register, hub reporting, provider survey and community reference cycle.

▶ Commission for Outcomes

Apply ICHOM measures and staged outcome-based payment across future contracts.

▶ Close the Community Loop

Keep the community voice visible through regular reference groups and insight reports.

9. What Success Would Look Like by 2029

Looking beyond the lessons of the pilot, it is worth naming the practical destination the next phase is working toward. By 2029, success would be characterised by:

- Resident Connectors embedded across participating communities.
- Hybrid chronic conditions clinics operating routinely across the region.
- Outcome measurement integrated into commissioning and service delivery.
- Communities actively participating in governance and local stewardship.
- Demonstrable improvements in continuity of care, navigation and wellbeing outcomes.
- Outcome-based commissioning established as the primary mechanism for investment and accountability.

10. Conclusion

Over three years, HOC grew from a pilot initiative into something more durable: a practical implementation platform for OFtO, a live test of stewardship-based commissioning, and an emerging comprehensive primary health care system designed specifically for remote Australia.

The pilot confirmed what its design always assumed. Relationships matter. Navigation matters. Continuity matters. Social cohesion, workforce stability and active stewardship matter. And it confirmed, just as clearly, that remote-system reform cannot rely on fragmented programs, episodic funding, virtual substitution, or commissioning frameworks built for metropolitan markets.

The central lesson is straightforward. Remote Australia does not need more disconnected programs. It needs regional stewardship, integrated commissioning, community-enabled navigation, workforce continuity, social prescribing, closed loops of care, and shared accountability for the outcomes that matter to people and communities.

> **HOC has built those foundations.** The HOC Scale-Up roadmap, the agreed measures, the outcome-based commissioning framework and the Alliance governance provide what is needed to build the next chapter. The open question is whether the discipline, investment and organisational commitment that scaled stewardship requires will be sustained — and on that, the pilot has made the case.

The next phase of HOC is therefore not about scaling a pilot. It is about helping shape the future operating model for comprehensive primary health care in remote Australia — with the stewardship capability and sustained investment that Western Queensland's communities have long deserved.

Better systems. Better care. Better outcomes. Together.

Healthy Outback Communities • Outcomes for the Outback