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Primary Health Network

Homelessness Health Framework

Contents

Introduction

Primary Health Networks (PHNs) play a pivotal role in **improving health outcomes** for people experiencing or at risk of homelessness.

As regional commissioners of primary care, PHNs are uniquely positioned to undertake population health planning, commission services that fill local gaps, build provider capability, and foster cross-sector partnerships to deliver integrated, person-centred care.

Homelessness remains one of the most pressing and complex public health challenges in Australia, impacting physical, mental, and social wellbeing. People experiencing homelessness face significant barriers to accessing timely, appropriate, and continuous health care, barriers that further entrench disadvantage and poor health outcomes.

The Primary Health Network Homelessness Health Framework provides a national approach to addressing these challenges. The Framework outlines principles to assist guide PHNs in designing, commissioning, and supporting trauma-informed health services that are inclusive and responsive to the unique needs of people experiencing homelessness.

The Framework encourages PHNs to embed and coordinate healthcare with housing and homelessness support services through development of inter-agency partnerships and collaboration. This integrated approach serves to strengthen coordination and ensure that vulnerable populations are not left behind in Australia's healthcare system.

Background

Understanding Homelessness in Australia

According to The Australian Bureau of Statistics (ABS) 2021 Census, there were over 122,494 individuals estimated to be experiencing homelessness, representing a 5% increase from the 2016 Census[1]. Around 24,930 of these individuals estimated to be experiencing homelessness in Australia were Aboriginal and/or Torres Strait Islander people, representing one in five (20.4%) of all people experiencing homelessness, despite making up only 3.8% of the overall population.

Homelessness includes more than rough sleeping, and encompasses individuals in temporary crisis accommodation, overcrowded dwellings, or living in inadequate housing conditions. **By definition** homelessness can be broken down into the following categories;

PRIMARY HOMELESSNESS

Is experienced by people without conventional accommodation (e.g.sleeping rough or improvised dwellings).

SECONDARY HOMELESSNESS

Is experienced by people who frequently moved from one temporary shelter to another (e.g. emergency accommodation, youth refuges, couch surfing).

TERTIARY HOMELESSNESS

Is experienced by people staying in accommodation which falls below minimum community standards (e.g. boarding houses and caravan parks).

AT RISK OF HOMELESSNESS

Is experienced by a person when they are at risk of losing their accommodation, often triggered by one or more of a range of factors that contribute to homelessness more broadly.

[1]ABS Census 2021

Homelessness estimates across States and Territories

The Australian Institute of Health and Welfare (AIHW) provides a robust suite of interactive dashboards designed to help inform policy and strategic planning decisions on homelessness and housing. Drawing on 36 authoritative national datasets, these tools offer over 80 customizable dashboard tiles, enabling PHNs to explore region-specific trends, assess service needs, and monitor outcomes. The dashboards provide a base that can be used to support the development, refinement and targeting of integrated health and housing responses across States and Territories.

The dashboards are accessible via this link:
AIHW Housing Data Dashboard | Housing data

Key Drivers for Homelessness

Homelessness can be attributed to inter-related social, economic, and health-related factors. This can include factors such as;

- Lack of access to affordable housing
- Family and domestic violence
- Employment and socio-economic status
- Intergenerational disadvantage
- Mental health
- Alcohol and other drugs
- Other systemic inequities (e.g. race and ethnicity, gender, disability and immigration status, geography, and more)

Obstacles to achieving quality health outcomes for people experiencing and/or at risk of homelessness are wide and varied and often require whole of system approaches to address current and longer term social determinants of health.

[2]Christopher Knaus, “Homeless Australians are dying at age 44 on average in hidden crisis”, 2023
[3]Australian Advance to Zero data (2010-2020)

Health Inequity Among People Experiencing Homelessness

Health equity is the principle that everyone should have a fair and just opportunity to achieve their highest attainable standard of health. However, this ideal remains out of reach for many people experiencing and/or at risk of homelessness—whose challenges often extend far beyond the absence of housing.

People experiencing or at risk of homelessness often have complex and unmet health needs, yet face significant barriers to accessing the care required to address them. These challenges are compounded by a range of interrelated factors, including untreated mental health conditions, financial hardship, limited awareness of available services, lack of transport, and the stigma and discrimination they may encounter when seeking care. Together, these barriers contribute to poorer health outcomes and deepen existing health inequities.

Data informs us that the health outcomes of people experiencing homelessness are significantly worse than those of the general population. People experiencing and or at risk of homelessness face significantly higher;

- **Higher morbidity and mortality rates:** Australian studies have found people who are homeless die on average of 22 to 33 years younger than those who are housed[2].
- **Higher rates of chronic health conditions:** Data indicates that people experiencing homelessness have higher rates of chronic health conditions including; diabetes, cardiovascular diseases, respiratory illnesses, musculoskeletal disorders, dental problems, previous brain injury or head trauma, and blood borne viruses such as hepatitis C[3].
- **Higher rates of mental health conditions:** Data indicates that the prevalence of anxiety, depression, schizophrenia, and post-traumatic stress disorder, are much higher in people experiencing or at risk of homelessness.

Alignment with National Priorities and PHN Program

PHN-funded homelessness activities or services are designed to compliment existing national strategies, including the National Housing and Homelessness Agreement, the National Mental Health and Suicide Prevention Plan, and Closing the Gap targets. The action items in this Framework are tailored to suit the PHN context and have been designed to align with the PHN Program Performance and Quality Framework outcomes, to enable PHNs to embed measurable outcomes and continuous improvement into all aspects of their commissioning and evaluation.

Objectives

The Primary Health Network Homeless Health Framework seeks to provide:

01.

High level guidance to assist PHNs develop and implement PHN-funded homelessness activities and initiatives aimed at improving access to care for people experiencing or at risk of homelessness.

02.

A **structured approach** for PHNs to use when planning, designing, commissioning, and evaluating commissioned homelessness health targeted programs.

03.

Enhanced collaboration across PHNs by providing operational guidance and promoting best practice approaches.

04.

A platform for PHNs to build on **evidence-based models** and **innovative solutions** that enhance access to healthcare for people experiencing homelessness.

Principles

1. **Equity and Inclusion:** Ensure that healthcare services are accessible, equitable, and inclusive for all individuals experiencing or at risk of homelessness, regardless of their location, background or circumstances.
2. **Person-centered care:** Deliver care that prioritises individual needs, preferences, and experiences, with a focus on dignity, respect, autonomy, and an understanding of trauma.
3. **Early intervention:** Support proactive approaches that make homelessness rare, brief, and non-recurring. Employ midstream and upstream interventions to address the root causes of health inequity.
4. **Integrated and Collaborative Care:** Support proactive approaches that make homelessness rare, brief, and non-recurring. Employ midstream and upstream interventions to address the root causes of health inequity.
5. **Cultural Safety and Competence:** Embed culturally safe and responsive practices that meet the unique needs of First Nations peoples and culturally diverse communities.
6. **Data-Driven Improvement:** Use data and evidence to guide decision-making, monitor outcomes, and continuously refine strategies to maximise impact.
7. **Personal choice:** Empower individuals to make informed decisions about their health and wellbeing, fostering autonomy and improving long-term outcomes.

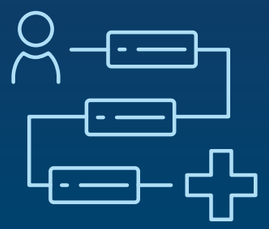
PHN Enablers

1. **PHN Leadership and Governance:** Strong leadership and governance enable PHNs to drive the development and implementation of services that improve access to primary healthcare for individuals experiencing or at risk of homelessness.
2. **Leveraging multiple funding streams:** PHNs can enhance sustainability by drawing on diverse funding sources—such as flexible funding pools, After Hours programs, HealthPathways, and state co-investment. Commissioning strategies may include consortium models, co-commissioning, and outcomes-based contracts to support service integration and innovation.
3. **Collaborative Relationships and Cross-Sectoral Partnerships:** Building and maintaining partnerships across health, housing, and social support sectors is essential to delivering integrated and coordinated care.
4. **Codesign and Co-delivery of services:** Engaging individuals with lived experience and service providers in the co-design and co-delivery of services strengthens engagement and ensures care is responsive to the needs of people experiencing homelessness.
5. **Flexible Funding:** Access to flexible funding supports the development and scaling of innovative, person-centred models of care that address the diverse and complex needs of people experiencing or at risk of homelessness.
6. **Workforce Capacity and Training:** Investing in the skills and cultural competence of the primary care workforce is critical to delivering high-quality, accessible care to vulnerable populations.

Action Areas

Addressing Needs

Quality Care



Improving Access

Coordinated Care

Capable Organisations

1. Addressing Needs

PHNs **identify and address** the needs of people experiencing homelessness in their regions through responsive commissioning.

Strategic planning

Understanding Needs

1.1 PHNs consistently recognise the needs of people experiencing or at risk of homelessness as a core priority within Health Needs Assessments, on par with other population health needs.

1.2 Health is assessed within an ecological framework that considers housing vulnerability, health conditions, and broader social determinants, acknowledging their intersection with homelessness.

1.3 PHNs actively engage with key agencies—including state and territory governments, non-government housing providers, specialist homelessness services, local hospital networks, and local councils—to build a comprehensive understanding of community needs.

1.4 Strategic planning includes targeted consideration of priority groups, such as Aboriginal and Torres Strait Islander peoples, individuals escaping family and domestic violence, youth and families, women, older adults, LGBTQIA+ communities, veterans, rural populations, and people exiting the criminal legal system.

1.5 PHN population risk matrices incorporate indicators of inequity and vulnerability to guide targeted interventions and resource allocation for those most at risk.

Commissioning services

Engagement and co-design

1.6 PHNs build strong relationships with health, housing, and homelessness organisations—including Aboriginal Community Controlled Health Organisations and other key stakeholders—to establish integrated commissioning mechanisms. This may include expert contributions and consortium-based approaches.

1.7 PHNs adopt flexible approaches to engaging with individuals experiencing or at risk of homelessness, tailoring commissioning strategies to meet local needs. This may involve co-commissioning with partners or using consortium models to enhance service reach and impact.

1.8 PHNs ensure people with lived experience are actively involved in the co-design, development, and evaluation of commissioned services. Diverse voices from across homeless populations are prioritised to ensure relevance and responsiveness.

1.9 PHNs provide targeted feedback to communities involved in co-design and consultation processes, fostering trust, demonstrating accountability, and reinforcing community ownership of commissioned initiatives.

Market shaping and development

1.10 PHNs work to build provider capacity and capability, and select appropriate commissioning approaches for the delivering of effective and efficient services. This involves understanding the current market landscape, identifying areas for improvement, and choosing the right commissioning method to achieve desired outcomes.

Procurement

1.11 PHNs identify homelessness as a priority population and procure targeted health responses that improve access and equity within available budgets. This may involve coordinating multiple funding streams where homelessness is a contributing factor and integrated solutions are required.

1.12 Tender selection criteria include a requirement for applicants to demonstrate knowledge and capability in delivering equitable, accessible, and culturally responsive services to people experiencing homelessness.

1.13 PHNs include individuals with lived experience of homelessness on tender selection panels. Where needed, appropriate training and support are provided to ensure meaningful participation and influence in procurement decisions.

Monitoring and Evaluation

Contract management

1.14 PHNs establish, manage, and report on program KPIs to ensure consistent data collection across regions. This includes the use of common indicators and a minimum structured dataset to support benchmarking and evaluation.

1.15 PHNs, primary care providers, and commissioned services implement feedback methods that are accessible and sensitive to the needs of people experiencing or at risk of homelessness, ensuring their voices inform service improvement.

2. Quality Care

PHNs support local health care providers to deliver **quality, culturally appropriate care** to people experiencing and or at risk of homelessness.

Health care provider capability building

2.1 PHNs collaborate with homelessness health stakeholders to build the capability of commissioned service providers through targeted training and professional development. These activities equip providers with the knowledge and skills needed to deliver effective primary care, delivered via online modules, face-to-face sessions, or blended formats.

2.2 PHNs support general practices to offer flexible appointment options, such as walk-in clinics and extended hours. Where bulk billing is not feasible—particularly for individuals without medical identification—PHNs explore additional funding to ensure access.

Supporting and sustaining engagement with services

2.3 PHNs promote shared decision-making and longer contact times to foster trust between frontline health and social care staff and people experiencing homelessness.

2.4 PHNs recognise the need for services that support long-term recovery, stability, and sustained positive outcomes, particularly for individuals with experiences of rough sleeping.

2.5 PHNs support re-engagement strategies for individuals who disengage from or decline services, while respecting their autonomy and right to choose.

Data-driven improvement

2.6 PHNs use data and evidence to guide decisions, monitor outcomes, and continuously refine strategies to improve the Framework's effectiveness.

2.7 PHNs are encouraged to share case studies and implementation examples from their regions or other jurisdictions to support knowledge translation and foster innovation across the PHN network.

Preventing homelessness

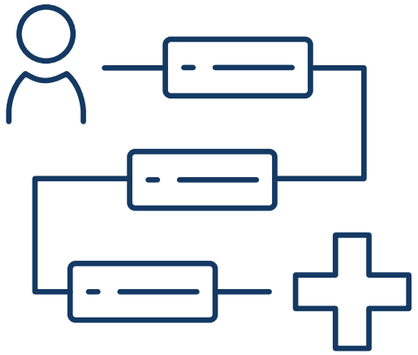
2.8 PHNs focus on implementing models of care that address social determinants linked to homelessness. This includes using assessment tools and early identification strategies in general practice to prevent homelessness before it occurs.

Innovation and improvement

2.9 PHNs seek opportunities to utilise existing service coordination frameworks—such as the Advance to Zero approach—to unite service providers and help communities make rough sleeping rare, brief, and non-recurring.[4]

[4]Pearson, D. (2023). Homelessness is solvable: How we can end it in Australia, Churchill Report.

3. Improving Access



People experiencing or at risk of homelessness can **access health care services** in the PHN region as required.

Primary health care services

3.1 PHNs allocate funding to primary health care services and initiatives that demonstrate improved access and outcomes for people experiencing or at risk of homelessness, in alignment with program objectives.

3.2 PHNs consider commissioning services that are co-located with or partnered alongside existing homelessness services in locations commonly accessed by people experiencing homelessness. Collaborative commissioning approaches are encouraged to maximise efficiency and resource sharing.

3.3 PHNs promote clear and accessible referral pathways to Specialist Homelessness Services, Aboriginal Community Controlled Health Organisations, community health clinics, general practices, and other relevant programs that support access to care.

Barriers to access

3.4 PHNs commission and/or work with partners to co-create sustainable health service models that help address the barriers and challenges people experiencing or at risk of homelessness face when accessing services. Common barriers to accessing primary health care services include;

3.4.1 Competing Priorities: Basic needs such as food, shelter, and safety often take precedence over healthcare.

3.4.2 Cost: Many individuals rely on bulk billing services due to financial hardship.

3.4.3 Mental Health and Substance Use: High prevalence can lead to missed appointments and disrupted care.

3.4.4 Stigma and Trust: Experiences of discrimination in healthcare settings reduce engagement.

3.4.5 System Navigation: Fragmented systems are difficult to navigate, especially for those with complex lives.

3.4.6 Transport: Limited or costly transport options hinder access, particularly in rural and remote areas.

3.4.7 Lengthy Wait Times: Delays in accessing bulk billing GPs or specialists can worsen health outcomes.

3.4.8 No Fixed Address: Challenges in contact, medication storage, and continuity of care.

3.4.9 Limited Appointment Time: Short consultations may not accommodate complex health needs.

3.5 PHNs consider implementing community-focused campaigns to raise awareness of local homelessness health services, using accessible formats and outreach strategies tailored to the target population.

3.6 PHNs adapt communication methods to overcome challenges faced by homeless individuals and populations, improving reach and access to affordable health services.

Priority populations

3.7 PHNs give specific consideration to the access needs of diverse homelessness populations including:

3.7.1 Older Adults: Facing premature aging and increased vulnerability.

3.7.2 Aboriginal and Torres Strait Islander Peoples: Overrepresented in homelessness statistics, especially in rural and remote areas.

3.7.3 People with Disabilities: Psychosocial disabilities impact access to health and housing.

3.7.4 Refugees and Asylum Seekers: Often lack access to government support and basic services.

3.7.5 Multicultural Communities: Face language, cultural, and systemic barriers.

3.7.6 Rural and remote populations: People experiencing homelessness in rural communities may not self-identify as homeless,and face additional barriers to accessing services.

3.7.7 LGBTQIA+ Communities: Experience higher rates of homelessness and service discrimination.

3.7.8 Women: Particularly older women, impacted by domestic violence and economic insecurity.

3.7.9 Veterans: At increased risk due to trauma and mental health challenges.

3.7.10 People Exiting Incarceration: Face significant reintegration and housing challenges.

3.7.11 Youth: Children and young adults represent a substantial portion of the homeless population.

3.8 PHNs note intersectionality and that individuals may belong to multiple priority groups, compounding their health and social challenges and requiring tailored, multi-faceted responses.

Flexible service delivery

3.8 PHNs consider opportunities to improve service integration within their regions by supporting flexible and adaptable models of care. These models are tailored to local needs, funding levels, and service capacity, and aim to reach individuals who may not engage with traditional healthcare settings. Common approaches include:

3.8.1 Outreach Services: Mobile medical vans, street-based care, and outreach health practitioners delivering services in community hubs. These models help build trust and provide care to individuals who cannot or choose not to access clinic-based services.

3.8.2 Shelter Health (Inreach): Health professionals, including GPs and nurses, provide care within crisis accommodation settings, ensuring access to primary care during periods of acute housing instability.

3.8.3 Permanent Housing Inreach: Onsite health services delivered in permanent supportive housing, community hubs, and other stable environments to support continuity of care and long-term health outcomes.

3.8.4 Place-Based Homelessness Health Centres: Development of dedicated health centres focused on homelessness, including support for general practices to expand their roles and build capacity to respond to the complex needs of this population.

3.8.5 Disaster management: PHNs consider climate- and environment-related disaster preparedness, response, and recovery interventions for people experiencing homelessness—particularly rough sleepers and those in regions disproportionately affected by environmental impacts.

3.8.6 After-hours access: PHNs support after-hours services to accommodate the unpredictable schedules and urgent needs of people experiencing homelessness, ensuring timely care outside standard business hours.

3.8.7 **Telehealth:** PHNs promote the use of telehealth while recognising the technological barriers faced by people experiencing homelessness. Strategies are implemented to ensure these individuals are not further disadvantaged by digital exclusion.

3.8.8 Access to Prescription Medications: PHNs work to address the significant barriers homeless individuals face in accessing and adhering to prescribed medications, supporting the development of practical, person-centred solutions to improve medication access and continuity.

Advocacy

3.9 PHNs advocate for homelessness health policy reform and systems change at local, state, and federal levels to improve health equity and service integration for people experiencing or at risk of homelessness.

4. Coordinated Care

People experiencing or at risk of Homelessness receive **holistic, co-ordinated**, and **integrated services** from local health providers

Integration and care coordination

4.1 PHNs commission and/or collaborate with partners to co-create sustainable models of healthcare access for people experiencing homelessness, aligned with best practice approaches such as Housing First.

4.2 Where feasible, PHNs seek opportunities to integrate and streamline activities across other PHN programs and commissioned services to optimise resource use and improve service efficiency.

4.3 PHNs work with partners to develop and promote locally tailored referral pathways specific to homelessness health needs, including integration with platforms such as HealthPathways.

4.4 PHNs collaborate with health, housing, and homelessness services, as well as local communities, to support care coordination and service integration for individuals experiencing or at risk of homelessness.

4.5 PHNs connect with and support the role of case managers supporting individuals experiencing homelessness to break the cycle of homelessness and attend health appointments.

4.6 PHNs and providers recognise the interconnection between health and basic needs, and support holistic service delivery through co-designed, multi-agency, and multidisciplinary care teams.

4.7 PHNs acknowledge the importance of integrating mental health and substance use treatment into broader care models to support recovery and reduce homelessness recurrence.

Strengthening regional partnerships

4.8 PHNs strengthen partnerships with local health, housing, and homelessness providers to improve access to primary healthcare for people experiencing or at risk of homelessness.

4.9 PHNs support the integration of primary healthcare services with housing and homelessness providers through collaborative planning and delivery of care models that address the unique challenges faced by homeless populations.

5. Capable Organisations

The PHN has **processes in place** to ensure comprehensive care for homeless and other vulnerable populations across all activities,

Governance and operational

5.1 PHNs identify homelessness health as a strategic priority, ensuring commitment and accountability across all levels of the organisation, including executive leadership and board governance.

5.2 PHNs implement clear, measurable indicators to assess responsiveness to homelessness health and drive continuous quality improvement. This Framework may be used to guide performance monitoring.

5.3 PHNs ensure representation of homelessness health perspectives on Clinical and Community Advisory Councils, including individuals with lived experience.

People management

5.4 All PHN staff undertake ongoing professional development focused on homelessness, access, and health equity.

5.5 PHNs advocate for and implement human resource practices that support the recruitment and retention of people with lived experience of homelessness across a range of roles within the organisation.

Financial management

5.6 PHNs consider how to sustainably resource homelessness health activities, including the establishment of internal roles and ensuring services are delivered within budget.

5.7 PHNs clearly communicate the costs associated with sustainably delivering homelessness health services and activities across their regions..

Stakeholder relationships

5.8 PHNs actively participate in local, state, and national homelessness health working and advisory groups to inform policy and practice.

5.9 PHNs share knowledge, experience, and learnings with other PHNs through the Australian Health Housing and Homelessness Network (A3HN) Community of Practice.

Conclusion

The PHN Homelessness Health Framework sets a practical path forward for **improving health outcomes** for people experiencing or at risk of homelessness.

By focusing on five key action areas, the Framework assists PHNs to take a coordinated, evidence-informed approach to addressing complex health and social challenges.

Through strengthening of partnerships, integrated service models and data driven planning, PHNs are well positioned to assist address equitable access to primary health services for people experiencing or at risk of homelessness. Guided by national priorities and local needs assessments, this Framework supports the development of sustainable, person-centred solutions that connect health, housing, and social support systems. By investing in these approaches, PHNs can play a critical role in advancing health equity and ensuring that vulnerable populations are not left behind in Australia's healthcare system.

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