

Health, housing and homelessness: How integration and investment saves lives



A3HN Position Paper
February 2026

Acknowledgement of Country

The Australian Alliance to End Homelessness would like to acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the land on which we work. We recognise their ongoing connection to the land, and pay our respects to Elders past, present and emerging.

We recognise that Aboriginal and Torres Strait Islander peoples are more likely to experience adverse health outcomes, housing insecurity, and homelessness compared to non-Aboriginal populations. We support the need for a healthier future that intertwines the wellbeing of Aboriginal and Torres Strait Islander peoples and the land, particularly concerning health, housing and homelessness throughout the country.

Lived experience acknowledgement

We acknowledge the individual and collective expertise of people with lived experience. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of achieving better outcomes for all.

Other acknowledgements

Thank you to everyone who contributed to this report, in particular all of the partners involved with the A3HN and our co-chairs Lisa McKenzie (Institute for Healthcare Improvement) and Nicole Bartholomeusz (cohealth).

Australian Alliance to End Homelessness

Care of: Centre for Social Impact – Flinders University, Room 302, Social Sciences South Building, Flinders University, Sturt Road, Bedford Park, South Australia

info@aaeh.org.au | aaeh.org.au

Recommended citation:

Australian Alliance to End Homelessness 2026, *Health, housing and homelessness: How integration and investment saves lives*. Position paper, Adelaide, South Australia

© 2026 AAEH

This work is licensed under the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License.



Contents

Background	4
Foreword	6
Executive summary	7
Recommendations	9
Recommendation 1: Extend and expand the Homelessness Access Program.....	9
Recommendation 2: Sustain the A3HN - PHN partnership.....	9
1. Introduction	11
Position paper purpose.....	11
Advance to Zero.....	13
2. Homelessness and health intersections	14
Health issues faced by people experiencing homelessness.....	14
Health conditions of people experiencing homelessness captured on by-name lists (single adults).....	15
Healthcare service barriers.....	16
Homeless deaths.....	16
Homelessness, NDIS and disability.....	17
3. What works: Case studies and examples	18
Fund medical care providers to operate within supportive housing programs.....	18
Use HAP funding to establish Advance to Zero communities.....	19
Enable more coordination between PHNs, health services and homelessness organisations through regular homelessness health forums.....	21
Increase funding to support respite housing and care associated with hospitals.....	21
Expand mobile nurse street outreach.....	22
4. Conclusion	24
Appendix 1	25
Case study 1: Brisbane Common Ground, health services within permanent supportive housing.....	25
Appendix 2	28
Case study 2: Effective PHN commissioning for homeless populations: Country to Coast Queensland Advance to Zero communities.....	28
Appendix 3	30
Case study 3: Inaugural homelessness health forum unites Primary Health Networks for the first time under the Homelessness Access Program.....	30
Appendix 4	33
Case study 4: Perth Medical Respite Centre offers dedicated beds for people experiencing homelessness.....	33
Appendix 5	35
Case study 5: Micah Projects Homeless to Home Healthcare After-Hours Service.....	35
References	36

Background

About the Australian Health, Housing & Homelessness Network

The Australian Health, Housing & Homelessness Network (A3HN) was established to bring together leaders from across the health, housing and homelessness sectors to better integrate policy, research and practice, aimed at supporting a health-informed end to homelessness in Australia.

By uniting three key sectors, the network is well-placed to support those addressing the health and housing needs of people experiencing homelessness in Australia.

Who is involved in the network?

The network includes a broad range of stakeholders and leaders across the health, housing and homelessness sectors from all levels of health, including public, primary, secondary and tertiary, as well as mental health and alcohol and other drugs.

Coordinated by the Australian Alliance to End Homelessness (AAEH), the network was formed to ensure the health-informed implementation of Advance to Zero (AtoZ), a national initiative that supports local collaborative efforts to end homelessness, starting with rough sleeping, one community at a time (see: www.aaeh.org.au/atoz)

Through a national forum, the A3HN supports development of policy, furthers research and enhances practice. It enables members to share knowledge, guidelines and models of care, as well as coordinate national advocacy efforts together.

Opportunities to engage with the A3HN include quarterly online community of practice calls, a health stream at the biennial AtoZ Summit, Primary Health Network events as well as the occasional online forum. To learn more and get involved, visit a3hn.org.

About Primary Health Networks (PHNs)

Funded by the Australian Government, Primary Health Networks (PHNs) are independent organisations focused on improving the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes. There are 29 PHNs, covering 31 regions across Australia.

Tailoring their services to the needs of their local communities, PHNs coordinate and integrate local health care services in collaboration with local hospital networks. Typically, PHNs assess the health needs of their region, commission primary care and mental health services to address population health needs and gaps and support primary care and mental health providers in their local area.ⁱ

All PHNs are guided by a set of national priorities and funded through a Commonwealth grant process.ⁱⁱ

About the Australian Alliance to End Homelessness

The Australian Alliance to End Homelessness (AAEH) is an independent champion and catalyst, bringing together individuals, communities, businesses and governments to take action for an end to all homelessness in Australia.

The Alliance supports and amplifies community efforts through driving the Advance to Zero movement, developing solutions towards systems change, building a series of allied networks and working in partnership with people with lived experience to demonstrate that it is possible to make homelessness rare, brief and once-off.



Foreword

Homelessness is a health emergency. Each year, hundreds of Australians die while experiencing homelessness – lives cut short by decades through preventable and treatable conditions.

Research released by the Australian Institute for Health and Welfare in October 2025 found that more than 14,000 people received Specialist Homelessness Services (SHS) support in the last year of their lives between 2012 and 2023ⁱⁱⁱ. SHS clients die at rates 1.4 to 1.7 times higher than those who have never accessed these services.

People sleeping rough or living in insecure accommodation face overwhelming personal, practical, relational and institutional barriers to healthcare. When healthcare is inaccessible, people present to emergency departments later, sicker, and more often, placing strain on the health system and perpetuating cycles of crisis. This burden, both human and systemic, is largely preventable.

The Australian Health, Housing and Homelessness Network (A3HN) was established to change this. By connecting health and housing systems, we can prevent homelessness, improve outcomes and ultimately save lives. We have developed a series of position papers in the past that have, amongst other things, led to the establishment of the Commonwealth Government's Homelessness Access Program (HAP) that for the first time created a dedicated funding stream for Primary Health Networks to improve access to primary healthcare for people experiencing homelessness.

This position paper is an urgent call to action, to change how we plan, integrate and fund the housing, health and homelessness support systems that care for some of the most vulnerable people in Australia. This is literally a matter of life and death.

In the following pages, we set out a series of recommendations grounded in global best practice and our own experience delivering integrated housing, health and homelessness services across Australia.

We welcome cross-sector collaboration on these recommendations and call on the Federal Government to take the lead in meeting this essential need.

David Pearson
CEO, Australian Alliance to End Homelessness

Executive summary

People without stable housing experience significantly higher rates of chronic illness, injury, mental ill-health and premature death. Homelessness is a public health emergency in Australia. Much of this is preventable.

The Australian Health, Housing and Homelessness Network (A3HN) was formed to address this. Through a partnership between the Department of Health, Disability and Ageing and the Central and Eastern Sydney Primary Health Network (CESPHN) as part of the Homelessness Access Program (HAP), the A3HN has established a national community of practice, locally tailored one-to-one coaching to strengthen capability and establish clear pathways for integrating primary care and homelessness, co-authoring the PHN Homelessness Health Framework and delivering in-person forums with an explicit focus on health and homelessness.

Australia now has the foundations of a nationally coordinated, health-informed response to homelessness. Through the Homelessness Access Program and the Australian Health, Housing and Homelessness Network, government investment has enabled national coordination, shared learning and system integration across PHNs and homelessness services – capability that did not previously exist.

This position paper builds on insights from quarterly A3HN community of practice meetings, discussions held at the 2025 National Homelessness Health Forum and previous AAEH events, and a review of literature and best practice examples to outline the reforms required to create an integrated, health-informed national response.

Key insights arising from this work includes that:

- Homelessness is a health emergency: Rough sleepers and those in insecure housing experience chronic illness, trauma, and premature death at much higher rates than the broader population, yet health data rarely records a person's experience of homelessness, rendering these inequities invisible.
- Fragmented funding and short-term programs limit long-term outcomes: Most effective services rely on short pilot funding, limiting long-term planning, workforce stability, and evidence building. Pilot programs are challenged not by their proof of concepts, but by the constraints of short term funding.
- PHNs are system integrators, equipped to improve outcomes for people experiencing homelessness: PHNs are uniquely positioned within communities to coordinate healthcare for people experiencing

homelessness through flexible commissioning and partnerships with local services.

The PHN Homelessness Access Program, established in 2023, has already shown that when PHNs are resourced to commission targeted services, communities can rapidly improve access to primary care and strengthen cross-sector collaboration.

But these gains remain fragile. Most effective programs rely on short-term or pilot funding, limiting stability, workforce retention and system-wide reform. Long-term federal leadership is needed to embed and scale what works.

Evidence from across Australia demonstrates that integrated models – including mobile nursing street outreach programs, multidisciplinary health and specialist homelessness teams, nurse-led clinics in supportive housing, medical respite linked to hospitals and Advance to Zero (AtoZ) collaboration activities – can address inequitable health outcomes by increasing access to primary health care, reduce emergency department use, shorten hospital stays and improve long-term wellbeing.

Commonwealth funding through the HAP has established the knowledge and models needed to eventually end health-related homelessness harms. What is required now is long-term investment, integrated policy and a commitment to treating housing as a core determinant of health. To respond to the current situation, this position paper calls for two immediate actions:

1. Expand the Homelessness Access Program from \$15 million to \$30 million, enabling PHNs to continue to expand their commissioning of evidence-based, locally responsive primary healthcare for people experiencing homelessness.
2. Sustain the A3HN–PHN partnership for a further two years, ensuring national coordination, shared learning and consistency across regions.

This investment has created momentum and early evidence of impact. The opportunity now is to consolidate and scale what is working – embedding prevention-focused, integrated approaches as standard practice, rather than allowing effective coordination and capability to fragment as short-term funding ends.

Early evidence from HAP-funded initiatives demonstrates that integrated, upstream approaches can reduce avoidable emergency department presentations, improve continuity of care and prevent recurring homelessness. Sustained investment would enable these prevention-focused models to move from pilots to business-as-usual.

Recommendations

Recommendation 1: Extend and expand the Homelessness Access Program

Ensure more people experiencing homelessness can access evidence-based, locally responsive primary healthcare by expanding the Homelessness Access Program to \$30 million (up from current \$15 million).

The Federal Government's existing two-year \$15 million investment into the Homelessness Access Program (HAP) has significantly expanded access to primary health care for people experiencing or at risk of homelessness. With 25 Primary Health Networks now delivering targeted services, the HAP is already improving service integration, reducing barriers to care, and strengthening coordinated planning across PHN regions.

The first round of HAP funding is scheduled to end at the end of the 2025/26 Financial Year. Sustained and stable HAP funding – increased to \$30 million – and a longer funding commitment of five years or more will ensure ongoing, long-term impact, greater certainty in program delivery and the opportunity to embed and refine pilot projects that end and prevent homelessness, over time. Determining funding outcomes earlier will allow continuity of programs.

Recommendation 2: Sustain the A3HN - PHN partnership

Embed national coordination, shared learning and consistent approaches between health, housing and homelessness services by sustaining the A3HN–PHN partnership for an additional two years from 2026.

Over the past two years, the Australian Health, Housing and Homelessness Network – Primary Health Network (A3HN-PHN) partnership has provided a coordinated national platform for PHNs, health services and homelessness organisations to collaborate, share evidence and strengthen responses to the health needs of people experiencing homelessness.

Through partnership with the A3HN as subject matter experts, the PHN Homelessness Access Program has built critical infrastructure, including the Homelessness Health Framework, embedding homelessness as a health priority, enabling shared learning across regions and aligning commissioning with the principles of inclusion, access and continuity of care.

Ongoing federal investment will provide the stability and partnership needed to transition this work from pilot activity to sustainable practice across Australia's primary health system.



1. Introduction

Position paper purpose

The purpose of this paper is to provide clear, evidence-informed recommendations for the Australian Government to improve health outcomes and health system coordination for people without stable housing.

This paper highlights the systemic barriers that currently prevent effective healthcare delivery, documents the health inequities faced by this population and showcases models that are already achieving significant results when housing and healthcare systems work together.

It highlights the vital role of Primary Health Networks in commissioning and funding essential primary healthcare services for vulnerable community members and the role of the Australian Health, Housing and Homelessness Network (A3HN) in bringing together cross-sectoral stakeholders, learning and capacity building processes.

This position paper does the following:

- Shares A3HN's two primary recommendations: expanded funding for the Homelessness Access Program and continued support for the A3HN ([see Recommendations](#)).
- Provides an overview of the intersections between health and homelessness, both from a medical perspective and an Australian policy landscape perspective ([see 2. Homelessness and health intersections](#)).
- Provides an overview of insights and feedback gathered at the recent Homelessness Health Forum convened by the A3HN in Canberra in October 2025 ([see 3. What works](#)).
- Shares a series of examples and case studies illustrating the importance of local health funding for the homeless population and the importance of health, housing and homelessness partnerships ([see 3. Case studies](#)).

By drawing these strands together, the paper aims to articulate the reforms needed to ensure that people experiencing or at risk of homelessness can access timely, coordinated and culturally safe primary healthcare.

Ultimately, this position paper seeks to place the unique health needs of people experiencing homelessness as a core agenda within health, housing and homelessness portfolios and shift the national conversation from managing homelessness to preventing and ending it.

Through real life case studies, this paper demonstrates how embedding housing as a core determinant of health, strengthening collaboration across portfolios and ensuring long-term, flexible investment in primary healthcare responses, we can collectively achieve a health-informed, person-centred approach to ending homelessness in Australia.

Defining homelessness

The Australian Bureau of Statistics' (ABS) definition of homelessness describes a person as homeless if they do not have suitable accommodation and live in an inadequate dwelling, have no or limited/non-extendable tenure, and have no control of/no access to (or space) for social relations.^{iv}

In addition, the Australian Institute of Health and Welfare defines a person as homeless if they are living in either non-conventional accommodation, sleeping rough, or living in short-term or emergency accommodation due to a lack of other options, such as living temporarily with friends and relatives

Homelessness is also defined as an umbrella term used to describe four broad population groups. This includes people who are rough sleeping; living in supported accommodations (e.g. refuges and crisis accommodation); living in short-term accommodation without tenure (e.g. boarding houses, hostel, caravan, couch surfing) or living in accommodation in institutional settings (e.g. hospitals, drug and alcohol rehabilitation centres, jail).

Australia's 2021 census estimated seven per cent of people experiencing homelessness across the country were rough sleeping. This means that around 93 per cent were experiencing less visible forms of homelessness, such as couch surfing (sleeping on a sofa at a friend/relative's), living in places of uncertain tenure, like a hostel or boarding house or residing in overcrowded dwellings.^{vi}

Homelessness Access Program

The Federal Government established the Homelessness Access Program in 2023. The purpose of the Homelessness Access Programs is to provide Primary Health Networks with funding to support primary health care access for people experiencing, or at risk of homelessness. Through the program, commissioned services identify gaps and improve service integration within their PHN regions.

The intended outcomes of the HAP are:

1. Increased primary care access for people experiencing homelessness and those at risk of homelessness



2. Increased efficiency and effectiveness of primary health care services for people experiencing or at risk of homelessness
3. Improved planning coordination and support for primary health services
4. Services generally delivered through assertive outreach models or multi-disciplinary hubs.

The grant round included \$15 million in funding, with 25 of 31 PHNs nationally receiving funding in the first round.

Advance to Zero

Advance to Zero (AtoZ) is a groundbreaking national initiative of the Australian Alliance to End Homelessness (AAEH) that supports local collaborative efforts to end homelessness, starting with rough sleeping – one community at a time. Using a range of proven approaches from around the world, communities are supported not just to address individual instances of homelessness, or even reduce overall homelessness, but to end it altogether.

- **Our vision:** To end homelessness in Australia, starting with rough sleeping.
- **Our strategy:** To prevent, reduce and end homelessness, starting with rough sleeping in local communities, by demonstrating that when any future incidents of homelessness do occur, they are rare, brief and once-off – measured by seeking to reach and sustain functional zero.
- **Our framework:** We recognise that homelessness in Australia is both preventable and solvable. We have developed the Advance to Zero framework to help guide efforts to end homelessness based on what's working around the world and what we've learned from efforts so far in Australia. We are seeking to demonstrate that ending homelessness in Australia is possible by generating a groundswell of proof.

2. Homelessness and health intersections

Health issues faced by people experiencing homelessness

People experiencing and at risk of homelessness are among the most socially and economically disadvantaged in Australia. Homelessness is closely associated with adverse health, social, and economic outcomes, and people without stable housing face significantly higher rates of chronic illness and premature death than the general population.^{vii}

Health and homelessness intersect in three overlapping ways:

1. Health as a driver of homelessness

Severe mental illness, cognitive impairment, acquired brain injury and substance dependence can directly contribute to housing instability and homelessness by undermining capacity to maintain employment, tenancies and social supports.

2. Homelessness as a cause and accelerator of ill health

Living without stable housing directly causes and worsens illness, including skin and dental disease, malnutrition, injuries from assault, and exposure-related conditions. Homelessness increases exposure to extreme weather, communicable disease, unsafe environments and sustained psychological stress, accelerating both physical and mental health decline.

3. Homelessness as a barrier to effective healthcare

Homelessness significantly complicates the management of chronic disease – including diabetes, cardiovascular and respiratory conditions – due to instability, lack of medication storage, limited transport and difficulty maintaining continuity of care^{viii}. Poor mental health is widespread and commonly co-occurs with substance use, further limiting engagement with services and contributing to avoidable deterioration.^{ix x}

Jurisdictional data from South Australia illustrates the scale and complexity of this intersection between housing, homelessness and health. Analysis of emergency department (ED) presentations across metropolitan hospitals shows that between October 2023 and October 2024, 1,129 unique individuals experiencing homelessness accounted for more than 4,600 ED presentations, with repeat

presentations common and a small cohort of frequent presenters driving a disproportionate share of demand. This pattern is consistent with national evidence indicating that homelessness is associated with repeated, crisis-driven service use.

Health conditions of people experiencing homelessness captured on by-name lists (single adults)

The table below summarises the prevalence of health, mental health, substance use and acute care utilisation among people experiencing homelessness across three Australian AtoZ communities.

CQ Zero^{xi}	72% of people report having at least one health, mental health or substance misuse issue	57% have a diagnosed mental illness	23% have a traumatic brain injury	30% went to the emergency department 5 or more times in the 12 months prior
Brisbane Zero^{xii}	87% of people report having at least one health or substance misuse issue	66% have a diagnosed mental illness	54% have a serious, ongoing health issue	28% were admitted to hospital 5 or more times in the 12 months prior
Western Australian Alliance to End Homelessness^{xiii}	86% of people report having a mental health condition	26% report they have a serious brain injury or head trauma	58% have a physical health condition	48% have presented to the emergency department for mental health support

Homelessness also increases the risk of violence, victimisation, unemployment and social isolation. These factors, alongside worsening physical and mental health, reinforce a cycle that undermines wellbeing, relationships and housing stability.^{xiv}

Overall, people experiencing homelessness experience a disproportionate burden of severe illness. Common conditions include asthma, liver disease, heart disease, hepatitis C, diabetes, emphysema and HIV-related illnesses.^{xv}

According to the AIHW (2022–23), around 27 per cent of Specialist Homelessness Services clients who were homeless when they sought assistance reported health-related reasons for seeking support.^{xvi}

Healthcare service barriers

People experiencing homelessness have been shown to have higher rates of healthcare service usage, particularly through emergency department (ED) presentations, which are often their first point of medical assistance.^{xvii} They tend to seek assistance later in their illnesses resulting in more severe and complex symptoms by the time they present at hospitals and higher rates of re-presentation at ED.^{xviii xix xx}

Similarly, longer in-patient stays may also be associated with difficult discharges (e.g., difficulty finding a discharge destination to meet the patient's complex needs.^{xxi} A NSW study that analysed 13 years of health records for people experiencing homelessness estimated an average cost of \$82,000 per annum in hospital visits per person. More than a quarter of study participants were categorised as 'high users' of hospital services.^{xxii}

People experiencing homelessness also face a range of barriers in accessing health care, including:

- **Personal barriers:** A focus on meeting immediate needs such as access to food, water and shelter often mean health issues are de-prioritised until they reach a crisis point.
- **Practical barriers:** This includes transport, accessibility issues for people with disabilities, phone, internet and connectivity challenges, medication storage and lack of identification documents
- **Relational barriers:** This includes stigma associated with mental health, fear, distrust or lack of cultural safety of medical and nursing systems.^{xxiii}

These barriers were acknowledged in changes to federal funding that enabled delivery of the PHN Homelessness Access Program.

Homeless deaths

Homelessness significantly drives early and avoidable deaths. According to the Australian Institute of Health and Welfare, people experiencing homelessness face almost double the mortality risk and markedly reduced life expectancy^{xxiv}.

In the period from 2012-13 to 2022-23, around 14,000 people received support from a specialist homelessness service (SHS) in the year before their death – approximately 8,700 males and 5,300 females^{xxv}.

The age-standardised death rate among SHS clients in 2022-23 was about 883 deaths per 100,000 clients, which was around 1.6 times higher than for people who had not accessed a SHS (507 per 100,000). For males the gap was even greater: 1,338 versus 595 per 100,000^{xxvi}.

The age profile of those SHS clients who died shows that nearly half (45 per cent) were aged between 35-54 at the time of death. The median age at death among those who had rough-slept was only 47 years (44 years for females).

When it comes to causes of death, injury and poisoning (including accidental poisoning and suicide) were the most common broad cause, accounting for around 38 per cent of deaths. Among all deaths in Australia, SHS clients made up around one-in-seven accidental poisoning deaths, one-in-nineteen suicide deaths and one-in-twenty-five transport accident deaths.^{xxviii}

In 2022-23, there were around nine potentially avoidable deaths per day among people with a history of SHS support, accounting for around one in eight potentially avoidable deaths nationally.

Homelessness, NDIS and disability

Disability significantly increases the risk of housing instability, while experiences of homelessness can both cause and exacerbate disability through trauma, chronic stress, untreated physical conditions and deteriorating mental health. This means that many people experiencing homelessness have complex and intersecting health and disability needs that remain unsupported by mainstream disability systems.

A 2024 report by Home2Health identifies substantial barriers preventing people experiencing homelessness from accessing the National Disability Insurance Scheme (NDIS).^{xxix} Structural requirements such as having a fixed address, access to identification, consistent phone or email contact and the ability to attend appointments make the NDIS application process largely inaccessible for people without stable housing. Long wait times and out-of-pocket costs for functional and cognitive assessments further compound these barriers, particularly for people with cognitive impairment, psychosocial disability or acquired brain injury. As a result, many people who are likely eligible for the NDIS remain excluded or experience prolonged delays in receiving support.

Without NDIS supports, people experiencing homelessness often rely on crisis-driven health care, including emergency departments and acute mental health services, rather than receiving preventative, community-based or rehabilitative support. The report notes that homelessness services and health services frequently carry responsibility for disability-related support in the absence

of NDIS access, despite not being funded or designed to provide this level of care. This contributes to system strain, service fragmentation and poorer continuity of care for individuals.

Funding from the HAP could directly address this inequality in NDIS access through a range of mechanisms, including:

- embedding NDIS navigators within HAP-funded programs and health services
- developing e-learning modules and resources for staff supporting people experiencing homelessness and
- funding for free neurological assessment services.

3. What works: Case studies and examples

The following section provides further details and case studies, outlining existing programs and projects that support our two recommendations: extending and expanding the Homelessness Access Program funding and extending support for the A3HN.

These examples highlight what has been achieved so far through collaborations, partnerships and how additional funding, resources and expertise could be allocated through HAP funding and supported through PHNs and the A3HN to improve health, wellbeing and housing outcomes for people experiencing homelessness.

Fund medical care providers to operate within supportive housing programs

Medical services are currently provided within many supportive housing programs and have been shown to improve health outcomes and reduce hospital presentations among residents.^{xxx} However, these services are often reliant on inconsistent and insufficient funding sources, leading to reduced certainty in delivery, lower continuity of care and greater difficulty hiring qualified staff who are employed on insecure contracts. Housing providers must re-apply for funding for medical in-reach services on a regular basis and a lack of committed funding for wrap-around services reduced the capacity of community housing providers to deliver housing for high needs cohorts.^{xxxi}

Additional funding for on-site health resources are also cost-effective. A recent study commissioned by the Australian Alliance to End Homelessness (AAEH) found

that for every \$1 invested in Permanent Supportive Housing service costs (including health, tenancy support and other wrap-around support), \$1.44 is saved in government expenditure on health, justice and other public services. Even modest funding amounts can be transformative^{xxxii}. For example, the Launch Housing Southbank Crisis Accommodation is currently supported by two nurses, or 1.8 FTE, with an annual cost of \$305,000.

Case study 1: Brisbane Common Ground as a demonstrable program delivering integrated health and homelessness care

Brisbane Common Ground (BCG), Queensland's first large-scale model of permanent supportive housing, operates through a collaborative between Common Ground Queensland and the tenancy manager, Micah Projects – delivering on-site psychosocial and on-site health support through the Mater Hospital.

This collaboration allows BCG to deliver a health-informed housing model, integrating tenancy management, psychosocial care and medical support. The model demonstrates how embedding healthcare within housing infrastructure can achieve stability, prevent homelessness recurrence and improve health outcomes.

Read the full case study at Appendix 1.

Use HAP funding to establish Advance to Zero communities

Advance to Zero (AtoZ) is a national, community-driven movement aimed at ending homelessness through a coordinated, data-informed, person-centred approach. Built on international functional zero methodologies, AtoZ works by bringing local organisations together around one shared goal: ensuring homelessness is rare, brief and once-off. Rather than focusing on program outputs or siloed service delivery, AtoZ prioritises system-level change by aligning housing, health, community services, government and lived experience advocates around a common framework and way of working.

At the centre of the AtoZ approach is the by-name list (BNL) – a real-time, continually updated list of individuals experiencing homelessness in a local area. Unlike traditional point-in-time counts or static datasets, BNLs allow communities to know every person by name, understand their needs, track their journey through the system and respond quickly when someone's situation changes. This real-time visibility becomes the backbone of coordinated care, enabling case conferencing, prioritisation based on vulnerability and housing allocation that is both transparent and responsive. It transforms homelessness from an abstract policy issue into a manageable, measurable challenge.

Crucially, the AtoZ framework emphasises collaboration, accountability and continuous improvement. Communities track progress using functional zero metrics, which focus on reducing the number of people actively experiencing homelessness rather than simply counting service activity. This helps shift the system from managing homelessness to ending it. Participating communities report strengthened cross-sector relationships, improved data sharing and more efficient resource use. Over time, the approach builds a culture of shared ownership, where services work collectively – not competitively – to ensure that people experiencing homelessness receive coordinated, person-centred support that leads to stable, sustainable housing outcomes.

Case study 2: Effective PHN commissioning for homeless populations: Country to Coast Queensland Advance to Zero communities

Across the Country to Coast Queensland (CCQ) region, more than 4,000 people are without stable housing, many with significant and unmet health needs.

In 2024, CCQ led adoption of the Advance to Zero approach across the Sunshine Coast, Wide Bay and Central Queensland areas, bringing together health, housing and social services. Backbone organisations IFYS Limited and Roseberry QLD lead local collaborations using shared intake and data tools to build a real-time by-name list, enabling coordinated case conferencing and clearer pathways to housing and healthcare.

Now, more than 50 organisations participate in the approach. Together they have identified over 380 people with documented health needs, and have connected 108 individuals to housing and primary care.

Momentum continues to build, but the work faces challenges including large geographic areas, limited service coverage and the need for consistent data input across partners. Providers often extend beyond their funded scope to ensure people can access and maintain healthcare and housing. Trust and strong relationships remain essential for shared data and system improvement. Sustaining this model will require long-term funding, dedicated Advance to Zero backbone teams and ongoing commitment from partner organisations to maintain coordination and drive lasting change.

Read the full case study at Appendix 2.

Enable more coordination between PHNs, health services and homelessness organisations through regular homelessness health forums

In August 2025, the Australian Health, Housing & Homelessness Network (A3HN) hosted the first national Homelessness Health Forum in Canberra, bringing together 22 PHNs, over 35 health, housing and homelessness organisations and government stakeholders. It was the first national opportunity in a decade for PHNs to collectively address the intersection of health and homelessness and advance the Homelessness Access Program (HAP).

The Forum showcased evidence-informed models of care across numerous life stages and highlighted the importance of multidisciplinary partnerships in reducing avoidable hospitalisations, improving continuity of care and preventing recurring homelessness.

Case study 3: The inaugural 2025 Homelessness Health Forum

The Forum built strong national alignment around five priority areas for homelessness health reform: the need for a coordinated national strategy, sustainable long-term funding, integrated and accessible models of care, a national homelessness health dataset and greater investment in prevention and early intervention. Participants also committed to ongoing collaboration through quarterly communities of practice and expressed strong support for continued investment in the Homelessness Access Program as demand grows.

However, significant structural barriers remain, including fragmented policy settings, insecure short-term funding, limited access to specialist services and the absence of integrated national data systems. Workforce shortages and a lack of transitional and medical respite options further limit system capacity. Stakeholders emphasised that progressing reform will require long-term federal investment in the HAP, sustainable funding models, dedicated workforce resources, national data infrastructure and ongoing support for national collaboration led by the A3HN.

Read the full case study at Appendix 3.

Increase funding to support respite housing and care associated with hospitals

Medicare currently funds hospital stays for public patients, covering most medical expenses for Australians and permanent residents. This funding ends once patients

are discharged, even though significant health management needs can persist after discharge, especially for people with complex health needs and without access to a secure home.

Many people who have spent time in hospital, particularly those with severe mental health needs, can face a significant risk of becoming homeless when they are discharged.^{xxxiii} Patients discharged into emergency shelters, insecure housing or homelessness are far more likely to return to emergency departments.^{xxxiv}

Projects like The Cottage or the Better Health and Housing Program in Melbourne, The Medical Respite Centre in Perth and Dunn House in Toronto demonstrate how accommodation supported by case work and healthcare can reduce burdens on more the intensive care segments of the health sector, while also substantially improving health outcomes for residents. Tailored discharge support from hospitals is also necessary to avoid discharge into homelessness.

Case study 4: Perth's Medical Respite Centre

Perth's Medical Respite Centre (MRC), Australia's first dedicated medical respite facility for people experiencing homelessness, opened in 2021 with 20 beds and 24-hour clinical care. Developed in response to frequent early hospital discharges and high readmission rates among people without stable housing, the MRC provides short-term recovery supported by nursing staff, daily GP clinics and hospital-only referral pathways. By offering a safe, medically supported environment, it fills a critical gap between acute hospital care and community living. In its first year, the MRC admitted 152 people, delivering medical care, psychosocial support, health education, and pathways into housing and community services. It reduced emergency department presentations by 46 per cent and inpatient days by 44 per cent, generating an estimated \$2.3 million in hospital cost savings, while operating at a fraction of the cost of hospital admission.

In spite of this, complex health needs and limited housing options created pressure on bed availability and average stays extended beyond the intended 14 days. Challenges with building design, staffing requirements and under-resourced budgets highlight the need for sustained investment, dedicated coordination roles and access to stable housing to support timely discharge and long-term impact.

Read the full case study at Appendix 4.

Expand mobile nurse street outreach

By combining mobile healthcare with assertive homeless street outreach, these teams can make it easier for people experiencing homelessness to get the care

they need while simultaneously helping them to escape the streets and temporary housing permanently.

The most vulnerable population of people experiencing homelessness and those who are at highest risk of avoidable death are those who are sleeping rough. They are also the most likely to experience trimorbidity and face barriers and lack of accessible and appropriate services for their needs. Their lives are saved by direct service provision and as such, these models should be prioritised for HAP funding by the PHNs.

Case study 5: Micah Projects Homeless to Home Healthcare After-Hours Service

The Homeless to Home Healthcare After-Hours Service is a nurse-led outreach and healthcare service that is embedded within a specialist homelessness service in a broader “Housing First” approach to homelessness. It integrates nurses with a community-based assertive outreach team called the Street to Home service in order to enable both housing and healthcare responses to be provided in a coordinated manner. Services are provided to individuals in a continuum of care from the point of working with people who live and receive services on the street, to ongoing care through home visits when a person is housed.

The Homeless to Home Healthcare After-Hours Service was designed to meet a gap in the healthcare market, providing front-line service delivery to homeless people sleeping rough and home visits to people in temporary accommodation or people who are housed, but have experienced chronic homelessness (i.e., homelessness of a period of six months or more) across the Brisbane metropolitan area.

Read the full case study at Appendix 5.

4. Conclusion

Homelessness in Australia remains a profound public health failure – one that cannot be solved by housing or healthcare systems in isolation. This position paper has highlighted the critical intersection between health and housing, the preventable health inequities faced by people experiencing homelessness and the systemic barriers that prevent timely, coordinated care.

Through programs such as the Homelessness Access Program (HAP) and the leadership of A3HN and Primary Health Networks (PHNs), progress is being made toward an integrated, health-informed approach that treats homelessness as a shared social and health responsibility.

The evidence is clear: access to safe and stable housing directly improves health outcomes, reduces hospital demand and creates more equitable communities. Models across Australia and internationally demonstrate the effectiveness of integrated care – from Perth’s Medical Respite Centre and Central Queensland’s Advance to Zero initiative, to Micah Projects’ integrated outreach services. These case studies confirm that when health systems recognise housing as healthcare, the results are transformative: shorter hospital stays, lower emergency presentations, improved recovery and restored dignity for individuals who have been left behind by fragmented systems.

However, short-term funding cycles, program silos and inconsistent data collection continue to constrain progress. Sustainable investment, long-term commissioning and stronger national coordination are urgently needed. This paper calls for an extension and continuation of existing promising changes in Australia’s treatment of health and homelessness – ongoing support for the HAP and for A3HN.

Ending homelessness in Australia will require more than crisis response – it will require sustained leadership, integrated systems and the courage to reimagine how health and housing intersect. The Australian Health, Housing and Homelessness Network (A3HN) will continue to champion this collaboration, advocate for ongoing funding and strengthen the evidence base for change.

Without continued national coordination through the A3HN, the system risks reverting to fragmented, crisis-driven responses – with loss of workforce capability, reduced shared learning and avoidable pressure on acute health services.

Appendix 1

Case study 1: Brisbane Common Ground, health services within permanent supportive housing



Figure 1: Brisbane Common Ground | Source: Micah Projects
| Source: Micah Projects

Context

Brisbane Common Ground (BCG) is Queensland's first large-scale model of Permanent Supportive Housing (PSH), located one kilometre from Brisbane's CBD. Established in 2012, it provides 146 apartments – half for people exiting homelessness (often chronic or rough sleeping), and half for people on low to moderate incomes.

BCG operates through a collaborative partnership that includes Common Ground Queensland (CGQ) (tenancy manager), Micah Projects (on-site psychosocial and health support), QulHN (co-located peer alcohol and other drugs support) and the Mater Hospital (funding for integrated on-site healthcare).

This collaboration allows BCG to deliver a health-informed housing model, integrating tenancy management, psychosocial care and medical support. The model demonstrates how embedding healthcare within housing infrastructure can achieve stability, prevent homelessness recurrence and improve health outcomes.

Outcomes and change

Over ten years (2012-2022), BCG achieved substantial outcomes in housing stability and health improvement:

- **Tenancy sustainment:** The majority of tenants sustained their housing, with average ongoing tenancies lasting nearly six years – remarkable given that over half entered directly from rough sleeping.
- **Improved health and access to care:** Earlier evaluations found significant improvements in tenants' health and healthcare access after 12 months of residence. The presence of on-site healthcare has reduced emergency hospital use and improved preventative care.
- **Reduced service use and cost savings:** A cost-offset analysis found a \$13,100 reduction per tenant in service use in the first year compared to when tenants were homeless, largely due to fewer hospital presentations and crisis interventions.

Challenges

Despite its success, several barriers remain:

- **Funding limitations:** The demand for on-site support—particularly mental health and substance use services—far exceeds available funding.
- **Behavioural and health complexity:** Tenancy breaches often stemmed from health-related issues such as trauma, addiction, or unmanaged mental illness. Sustaining Tenancy Plans helped, but some tenants required more intensive clinical care.
- **Service system fragmentation:** BCG practitioners reported difficulty engaging external health services, especially for tenants with complex, co-occurring conditions.
- **Young and newly homeless cohorts:** Younger tenants (under 24) had shorter tenancies and were more likely to exit unfavourably, highlighting a need for tailored youth-focused health and support approaches.

Resources required

To scale and strengthen the model, a recent study recommended:

- Guaranteed access to health and mental health care – expand partnerships with Queensland Health and community providers to ensure ongoing clinical support.
- Sustained funding for integrated health roles (e.g., nurses, mental health specialists) and on-site coordination.
- Formalised pathways preventing discharge into homelessness, including partnerships with hospitals and corrections to secure step-down housing.



- Data integration across housing and health systems to track long-term outcomes and improve evidence-based interventions.
- Commitment to no exits into homelessness – ensuring alternative housing and health support for any tenant leaving the program.^{xxxv}

Appendix 2

Case study 2: Effective PHN commissioning for homeless populations: Country to Coast Queensland Advance to Zero communities

Across the Country to Coast Queensland (CCQ) region, over 4,000 people are without a secure and stable home, many with complex and unmet health needs. Homelessness and health are deeply interconnected: poor health can lead to homelessness and homelessness in turn worsens health outcomes. Fragmented and siloed service systems make it difficult for individuals to access coordinated care, and a lack of community-level data limits the ability to plan effective services or measure impact.

Recognising these challenges, CCQ identified the need for a joined-up, systems-based approach that integrates health, housing and social supports to deliver lasting change. In late 2024, with PHN Homelessness Access Program funding, CCQ introduced the Advance to Zero approach across the Sunshine Coast, Wide Bay and Central Queensland – the first regional sites in Queensland, joining 26 communities nationwide.

Backbone organisations IFYS (Sunshine Coast Zero and Wide Bay Zero) and Roseberry QLD (CQ Zero) facilitate the local collective effort to end homelessness. They bring together homelessness, housing and health partners to use a shared intake and data-collection tool, supported by consent from each person experiencing homelessness. This information feeds into a shared database to build and maintain a by-name list; a real-time record of every person experiencing homelessness in the community and their housing and health needs.

Partners use the by-name list for coordinated case conferencing, enabling more effective matching of people to appropriate housing and health supports. It also highlights patterns and system barriers, allowing organisations to respond collectively and drive system-level improvements.

Outcomes and change

- All Zero sites are fully launched, with momentum growing across the Sunshine Coast, Wide Bay and Central Queensland regions. Early outcomes include;
- More than 50 health, housing and homelessness organisations are signed on as Zero partners and have received training in the Australian

Vulnerability Triage Tool (AHVTT), Advance to Zero Framework and CSnet database.

- 380+ people have been identified as experiencing homelessness, with their health needs documented in real time in a shared database. Numbers are growing steadily.
- 108 individuals have been connected to housing and primary healthcare through Zero case coordination groups that bring together housing, health and social services to address the needs of individuals and families.
- Emerging system barriers are being identified, providing insights to guide future service and policy improvements, with partners coming together to collectively address these challenges.

Challenges

- Large geographical areas and sparsely populated and under-served communities make coverage challenging in Central Qld. As a result, Zero initiatives have needed to reassess their reach based on available resources and are focusing on key centres.
- Continuity of care and wraparound supports are essential for helping individuals navigate treatment, transition into housing and maintain tenancies and social connections. Providers frequently deliver care beyond their service scope and capacity, such as helping people experiencing homelessness to secure and attend medical appointments, receive and comply with treatment and participate in necessary follow-up appointments.
- Developing robust and actionable shared data dashboards depends on consistent data input from partner organisations as a community-wide effort. Building trust and strong relationships is essential to encourage participation and generate the momentum needed to drive change.

Resources required

- Long-term sustainable funding
- Dedicated Zero 'backbone' teams who drive engagement, collect and analyse data and operate case coordination mechanisms.
- Strong, ongoing commitment from all participating organisations including dedicated leadership, staff time and resources.

Appendix 3

Case study 3: Inaugural homelessness health forum unites Primary Health Networks for the first time under the Homelessness Access Program

Context

In August 2025, the Australian Health, Housing & Homelessness Network (A3HN) hosted the first National Homelessness Health Forum in Canberra – bringing together 22 PHNs, over 35 health, housing and homelessness organisations and government stakeholders. It was the first national opportunity in a decade for PHNs to collectively address the intersection of health and homelessness and advance the Homelessness Access Program (HAP). The Forum showcased evidence-informed models of care across the lifespan and highlighted the importance of multidisciplinary partnerships in reducing avoidable hospitalisations, improving continuity of care, and preventing recurring homelessness.



Outcomes and change

The Forum generated national alignment for the A3HN around five priority areas for reform:

1. **National strategy and leadership:** A shared call for a coordinated homelessness health strategy and a central mechanism (e.g., via National Cabinet) to align policy, accountability and cross-portfolio action.
2. **Sustainable funding models:** Consensus on replacing short-term, fragmented grants with long-term, flexible funding, block funding for non-MBS services, five-year commissioning cycles and dedicated resources for ACCHOs, peer workers, medical respite, and hospital discharge coordination.

3. **Integrated and accessible care:** Clear support for nurse-led clinics, social workers in general practice, new MBS items for case management, streamlined AOD and mental health pathways and step-down accommodation models.
4. **Data, evidence and storytelling:** Agreement on the need for a national homelessness health dataset capturing systemic barriers, supported by lived-experience storytelling and stable funding cycles to build a long-term evidence base.
5. **Prevention and early intervention:** Identification of major gaps in pre-crisis mental health support, youth and family early intervention and housing stability programs.

Participants endorsed ongoing collaboration through quarterly Communities of Practice and confirmed strong national support for continued investment in HAP to meet increasing demand.

Challenges

Despite strong alignment, participants identified significant structural barriers:

- Fragmented policy settings across health, housing, justice, disability and aged care.
- Short-term, insecure funding undermining continuity of care and workforce retention.
- Limited access to specialist services such as psychology, occupational therapy, neuropsychology, dental care and AOD treatment.
- Lack of integrated data systems to track outcomes, systemic barriers and service gaps.
- Insufficient prevention pathways and limited transitional or medical respite options.
- Workforce shortages, particularly in trauma-informed, community-based disability and peer support roles.

These challenges reinforce the need for national coordination and sustained investment.

Resources required

To progress the reform priorities identified at the Forum, stakeholders highlighted the need for:

- Long-term federal investment in the Homelessness Access Program to maintain and scale PHN-led responses.
- Sustainable funding models, including block funding for services outside the MBS and multi-year commissioning cycles.



- Dedicated workforce funding for ACCHOs, peer workers, nurse practitioners, social workers and interdisciplinary teams.
- Investment in data infrastructure, including a national homelessness health dataset.
- Resourcing for prevention, early intervention and housing stability initiatives.
- Support for ongoing national collaboration, including annual forums and quarterly communities of practice convened by the A3HN.

Appendix 4

Case study 4: Perth Medical Respite Centre offers dedicated beds for people experiencing homelessness



Image: Perth Medical Respite Centre | Source, ABC News

Context

Perth's Medical Respite Centre, funded by the WA Department of Health, opened in 2021. It provides 20 dedicated medical beds for individuals experiencing homelessness. The service operates from a building purchased by the East Metropolitan Health Service. This is the first medical respite service of its kind in Australia, with the only other examples much smaller in bed capacity and without onsite medical staff, limiting the acuity of patients who can be admitted.

Residents can stay temporarily, receiving care in a facility with 24-hour nursing care and daily GP clinics to stabilise their health and admission is by hospital referral only. The facility was developed as an acknowledgement that many patients are released before they are fully recovered, particularly those who are experiencing homelessness. Without a stable place to stay, they struggle to access follow-up care, leading to high rates of unplanned hospital readmissions. The Medical Respite Centre bridges this gap, ensuring that people experiencing homelessness can recover in a supportive setting without occupying costly hospital beds unnecessarily.

Outcomes and change

- In the first year of operation, the MRC admitted 152 people with an average length of admission of 20 days.

- Support provided included direct medical care, health education and health literacy, identification and support for psychosocial needs including referral into housing and onto the priority housing list, connections to community-based health services and support to strengthen independent living skills
- Changes in health service use one-month pre and post MRC admission is estimated to save \$2.3 mill in associated hospital cost reductions (approx. \$15,000 per person). This was due to 46% fewer ED presentations and a 44% reduction in total days admitted
- At \$442 per bed day, the MRC is 6.5 times cheaper than in-patient admission (\$2,879 per bed day) and 3.6 times cheaper than the cost of psychiatric admission (\$1,596 per bed day).^{xxxvi}
- The MRC has acted as a circuit breaker for the revolving door between hospital and street, provided opportunity to stay in safe trauma-informed environment

Challenges

- The initial goal of the MRC was a maximum stay of 14 days. Despite this, the average stay length in the first year of operation was 20 days due to the complexity of health care needs and the lack of available housing upon discharge.
- Prioritised pathways for public housing and supported accommodation for MRC residents is necessary to facilitate timely discharge and free up beds to meet growing waitlist demand for the MRC.
- The building design created challenges, especially for AOD detox, women who have experienced trauma/violence (where shared spaces are challenging) and people with mobility needs
- The initial budget was insufficient due to an initial underestimation of resident complexity and staffing needs and requirement for further supports including on-site security, peer support workers and an MRC vehicle.

Resources required

- Sustained financial and human investment to expand and maintain services.
- Dedicated staffing for service coordination, data management, and project leadership.
- Access to affordable housing stock to enable permanent exits from homelessness.
- Ongoing backing from government, PHNs, councils, and philanthropic partners to embed long-term systemic change.

Appendix 5

Case study 5: Micah Projects Homeless to Home Healthcare After-Hours Service

The goal of mobile nurse street outreach programs is to create a single, mobile access point for housing and healthcare services in order to end homelessness and address poor health at the same time. Services can be delivered 24/7 through specially-equipped 24-hour Outreach and Mobile Health vans. The teams are out and about where people are, but can also arrange to meet at safe places.

Collaborative planning and engagement occurs between support and advocacy workers in the Street to Home team. The models enable the establishment of trust and rapport with individuals and families who are homeless as well as vulnerable individuals in housing. Care includes chronic condition management, wound care and referrals to primary healthcare, and follow up care. Benefits of the model include improved health outcomes, proactive early intervention and preventative healthcare, prevention of ED presentations and hospital admissions and economic savings to systems.

An economic evaluation by UQ conducted in (see attached) found that spending \$503,000 and proactively addressing the health and housing needs of Brisbane’s homeless people has saved the Queensland Public Health System between \$6.45-\$6.9 million.

Street to Home - Economic Evaluation

- Street to Home program net value of about \$6.45m per annum
- In-patient admissions reduced by 800, saving the health system about \$3.7m per annum
- Admissions reduced by 1800, saving the health system about \$3.32m per annum

- The cost per episode of care varied between \$141.92 and \$159.24 across the four-year period, with an average of \$150.66.
- Significant cost savings were observed through avoided emergency department (ED) presentations, hospital admissions, and re-hospitalisations, with an average cost saving of \$801,605 per year for avoided ED presentations, \$1,530,786 for avoided hospital admissions, and \$234,192 for avoided re-hospitalizations.
- The program’s return on investment (ROI) was calculated at 438%, indicating substantial economic benefits compared to the initial investment.



Total Annual Funding (A)	Costs of Care (B)	Cost Per Episode of Care (A/B)
\$171,000	\$107	\$159.24
\$170,000	\$107	\$159.17
\$170,000	\$107	\$159.24
\$170,000	\$107	\$159.24
Average	\$107	\$150.66

Number of avoided ED presentations: 800

Value of avoided ED presentations: \$801,605

References

- i. Disability and Ageing Australian Government Department of Health, 'What Primary Health Networks Do' (text, 6 June 2025) <<https://www.health.gov.au/our-work/phn/what-PHNs-do>>.
- ii Disability and Ageing Australian Government Department of Health, 'What Primary Health Networks Are' (text, 15 December 2025) <https://www.health.gov.au/our-work/phn/what-PHNs-are>
- iii Australian Institute of Health and Welfare, 'People Receiving Specialist Homelessness Services Support in the Last Year of Life', Feature Analysis (online, 22 October 2025) <<https://www.aihw.gov.au/reports/homelessness-services/people-receiving-shs-support-last-year-of-life#:~:text=Around%2014%2C000%20people%20received%20s,2013;%20Gordon%20et%20al.>>>.
- iv Australian Bureau of Statistics, 'Information Paper – A Statistical Definition of Homelessness' (2012) <<https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4922.0Main%20Features22012?opendocument&tabname=Summary&prodno=4922.0&issue=2012&num=&view=>>>.
- v Australian Institute of Health and Welfare, 'Homelessness and Homelessness Services Glossary' (2021) <<https://www.aihw.gov.au/reports-data/australias-welfare/australias-welfare-snapshots/glossary>>.
- vi Australian Bureau of Statistics, 2021. [Census of Population and Housing - Counts of Aboriginal and Torres Strait Islander Australians, 2021 | Australian Bureau of Statistics](https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4922.0Main%20Features22012?opendocument&tabname=Summary&prodno=4922.0&issue=2012&num=&view=>)
- vii Pernilla Omerov et al, 'Homeless Persons' Experiences of Health- and Social Care: A Systematic Integrative Review' (2020) 28(1) Health & Social Care in the Community 1 ('Homeless Persons' Experiences of Health- and Social Care').
- viii Institute of Medicine (US) Committee on Health Care for Homeless People, 'Health Problems of Homeless People' in Homelessness, Health, and Human Needs (National Academies Press, 1988).
- ix Public Health Ontario, Homelessness and Health Outcomes: What Are the Associations? (Evidence Brief, Public Health Ontario, 2019) <<https://www.publichealthontario.ca/-/media/documents/E/2019/eb-homelessness-health.pdf>>.
- x Jesse Jenkinson et al, 'Hospital Discharge Planning for People Experiencing Homelessness Leaving Acute Care: A Neglected Issue' (2020) 16(1) Healthcare Policy | Politiques de Santé 14 ('Hospital Discharge Planning for People Experiencing Homelessness Leaving Acute Care').
- xi CQ Zero, (2025), <https://cqzero.org.au/#our-progress-cq-zero>
- xii Brisbane Zero, Individual Adults By Name List Data (2025), <https://www.brisbanezero.org.au/>
- xiii Western Australian Alliance to End Homelessness, VI-SPDAT dashboard (2026), <https://waaeh.org.au/our-work/advance-to-zero/vi-spdats/>
- xiv 'Health of People Experiencing Homelessness', Australian Institute of Health and Welfare (13 February 2025) <<https://www.aihw.gov.au/reports/australias-health/health-of-people-experiencing-homelessness>>.
- xv Chris Hartley et al, 'Homelessness as a Public Health Emergency: Learnings from Crisis' [2025] (FR 443) AHURI Final Report <<https://www.ahuri.edu.au/research/final-report>>.

ts/443> ('Homelessness as a Public Health Emergency').

^{xvi} Australian Institute of Health and Welfare, Specialist Homelessness Services Annual Report 2022-23 (2024) <<https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/clients-services-and-outcomes#reasons>>.

^{xvii} Jane Currie et al, 'Optimising Access to Healthcare for Patients Experiencing Homelessness in Hospital Emergency Departments' (2023) 20(3) International Journal of Environmental Research and Public Health 2424.

^{xviii} Ibid.

^{xix} Stuart J Lee et al, 'Homeless Status Documentation at a Metropolitan Hospital Emergency Department' (2019) 31(4) Emergency Medicine Australasia 639.

^{xx} Jenkinson et al (n 6).

^{xxi} Stephen W Hwang et al, 'Hospital Costs and Length of Stay Among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services' (2011) 49(4) Medical Care 350.

^{xxii} {Citation}

^{xxiii} Andrew Davies and Lisa J Wood, 'Homeless Health Care: Meeting the Challenges of Providing Primary Care' (2018) 209(5) Medical Journal of Australia 230 ('Homeless Health Care').

^{xxiv} Australian Institute of Health and Welfare, 'People Receiving Specialist Homelessness Services Support in the Last Year of Life', Feature Analysis (online, 22 October 2025) <<https://www.aihw.gov.au/reports/homelessness-services/people-receiving-shs-support-last-year-of-life#:~:text=Around%2014%2C000%20people%20received%20s,2013;%20Gordon%20et%20al.>>.

^{xxv} Australian Institute of Health and Welfare, 'People Receiving Specialist Homelessness Services Support in the Last Year of Life',

Feature Analysis (online, 22 October 2025) <<https://www.aihw.gov.au/reports/homelessness-services/people-receiving-shs-support-last-year-of-life#:~:text=Around%2014%2C000%20people%20received%20s,2013;%20Gordon%20et%20al.>>.

^{xxvi} Australian Institute of Health and Welfare, 'People Receiving Specialist Homelessness Services Support in the Last Year of Life', Feature Analysis (online, 22 October 2025) <<https://www.aihw.gov.au/reports/homelessness-services/people-receiving-shs-support-last-year-of-life#:~:text=Around%2014%2C000%20people%20received%20s,2013;%20Gordon%20et%20al.>>.

^{xxviii} Australian Institute of Health and Welfare, 'People Receiving Specialist Homelessness Services Support in the Last Year of Life', Feature Analysis (online, 22 October 2025) <<https://www.aihw.gov.au/reports/homelessness-services/people-receiving-shs-support-last-year-of-life#:~:text=Around%2014%2C000%20people%20received%20s,2013;%20Gordon%20et%20al.>>.

^{xxix} Home2Health., (2024), Access to NDIS & Disability Support for People Experiencing Homelessness in WA. [Access to NDIS & Disability Support for People Experiencing Homelessness in WA. — Home2Health](#)

^{xxx} Laura MacKinnon et al, 'Primary Care Embedded within Permanent Supportive Housing for People Who Use Substances: A Qualitative Study Examining Healthcare Access in Vancouver, Canada' (2022) 30(6) Health & Social Care in the Community <<https://onlinelibrary.wiley.com/doi/10.1111/hsc.13921>> ('Primary Care Embedded within Permanent Supportive Housing for People Who Use Substances').

^{xxxi} Katrina Raynor, 'After a Hopeful Start, Labor's Affordable Housing Fund Is Proving Problematic', The Conversation (Melbourne, online, 15 July 2025) <<https://theconversation.com/after-a-hopeful-start-labors-affordable-housing-fund-is-proving-problematic-260085>>.

^{xxxii} The Centre for Equitable Housing, Per Capita (2024), [Supportive Housing \(SH\) Needs Assessment for Perth and Bunbury, Western Australia - The Centre for Equitable Housing](#)

^{xxxiii} N Brackertz, L Borrowman and C Roggenbuck, Trajectories the Interplay between Housing and Mental Health Pathways (2020).

^{xxxiv} Atsushi Miyawaki et al, 'Hospital Readmission and Emergency Department Revisits of Homeless Patients Treated at Homeless-Serving Hospitals in the USA: Observational Study' (2020) 35(9) Journal of General Internal Medicine 2560 ('Hospital Readmission and Emergency Department Revisits of Homeless Patients Treated at Homeless-Serving Hospitals in the USA').

^{xxxv} Cameron Parsell, F Perales and Ella Kuskoff, Brisbane Common Ground: Analyses of Tenancy Sustainment and Exits at Brisbane Common Ground (UQ, 2022).

^{xxxvi} L Wood et al, Perth's First Medical Respite Centre. Evaluation of the Two-Year Pilot Model (Institute for Health Research, University of Notre Dame, 2024).