



**SA ABORIGINAL  
CHRONIC DISEASE  
CONSORTIUM**

# Healthier Together

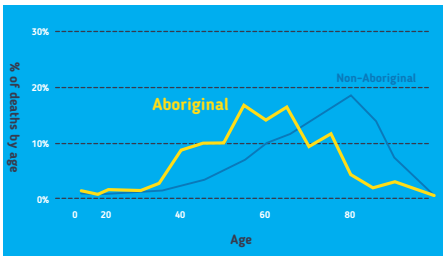
Creating partnerships for success.



# What is the SA Aboriginal Chronic Disease Consortium?

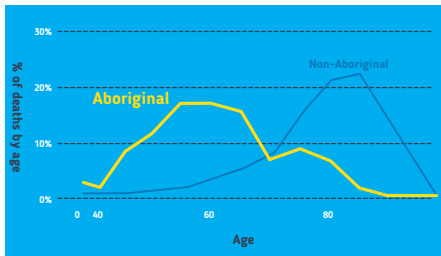
The South Australian Aboriginal Chronic Disease Consortium has been established to improve the health and wellbeing of Aboriginal South Australians. By creating strong partnerships for success, we are working to prevent and detect early heart disease, stroke, cancer and diabetes as well as support those who are living with these chronic diseases. The stark disparities in these chronic diseases are well documented and form a daily reality for many Aboriginal people in South Australia. However, with a more concerted effort across the entire health sector, we have the potential to improve prevention and enhance access to health care services for Aboriginal people.

Deaths from cancer.



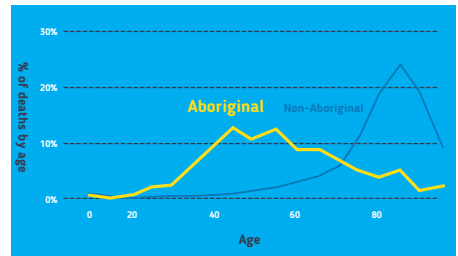
More than half of cancer diagnoses occur before the age of 60, compared to one-third of diagnoses in the non-Aboriginal population.

Deaths from diabetes.



Aboriginal people aged 25 and over are hospitalised for diabetes at much greater rates in South Australia compared to non-Aboriginal people.

Deaths from heart disease and stroke.



The majority of Aboriginal people who pass away from heart disease and stroke do so between the ages of 40 and 70, compared to non-Aboriginal people in their 80s.



The Consortium has been set up to implement the priorities for heart disease and stroke, cancer, and diabetes and is being informed by three chronic disease plans.

-  the South Australian Aboriginal Heart and Stroke Plan 2017-2021,
-  the South Australian Aboriginal Diabetes Strategy 2017-2021, and
-  the South Australian Aboriginal Cancer Control Plan 2016-2021.

## How the Consortium aims to implement all three plans

### 1. LINKING PLANS, STRATEGIES AND PROVIDERS

The Consortium provides an integrated approach to implementing the plans by linking a wide range of providers across the continuum of care, while also reducing duplication. As such, the approach resonates with all conditions simultaneously to help improve outcomes, particularly for people who have all three conditions. It also means that Aboriginal and Torres Strait Islander people's worldview and definition of health are aligned through a holistic outlook where physical, spiritual and environmental elements are interconnected rather than segmented into parts of the body.

### 2. IDENTIFYING COMMONALITIES BETWEEN CONDITIONS

Each of these conditions can be related back to common behavioural factors, including: smoking, low intake of fruit and vegetables, being overweight, lack of exercise and unhealthy levels of drug or alcohol consumption. These kinds of factors are largely preventable, particularly when the impact of other

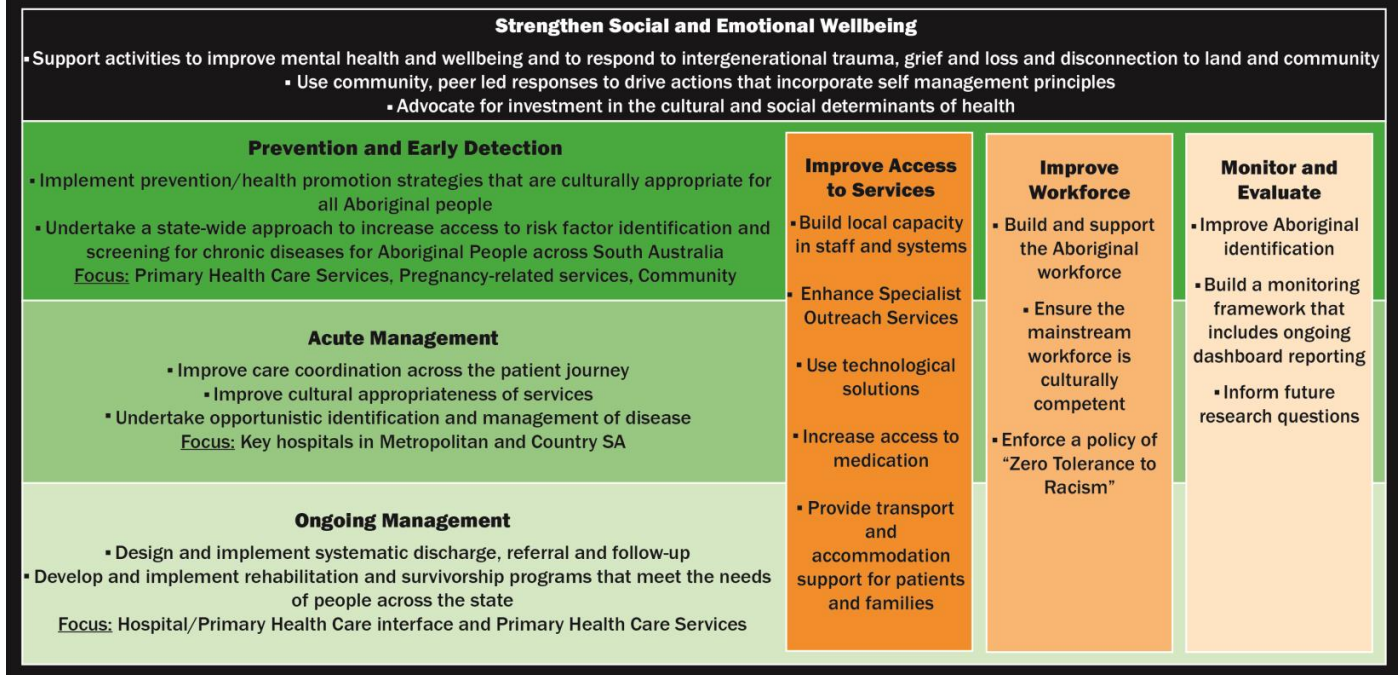
social determinants of health such as poverty, housing and education are also considered. Often, members of the community are carrying a higher level of burden as a result of families trying to cope with comorbidities. This could include any combination of heart, stroke, diabetes, chronic kidney disease and cancer illnesses.

### 3. IMPLEMENTATION THROUGH REPRESENTATION

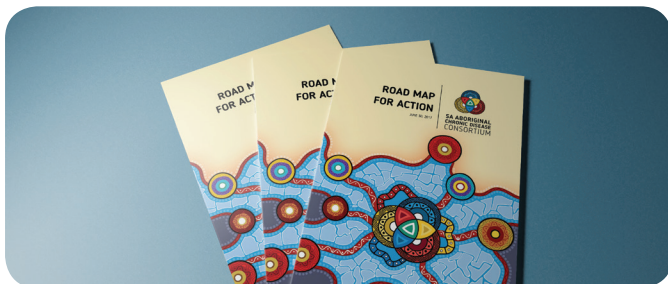
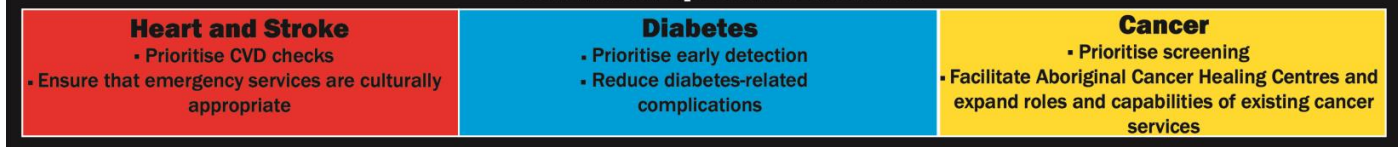
With proper representation in the Consortium, including Aboriginal leadership and co-chair representation on all working groups, we can effectively represent the Aboriginal community. In doing so, the Consortium will continue to build on existing clinical, professional and administrative structures while also prioritising and implementing improvements in collaboration with Aboriginal communities. Through ongoing integrated monitoring and reporting we're helping to deliver quality services to Aboriginal people that are set against targets to quantify the impact.

# Our road map for action, and bringing it to life

## “Across Plan Priorities” - Cancer, Diabetes, Heart and Stroke

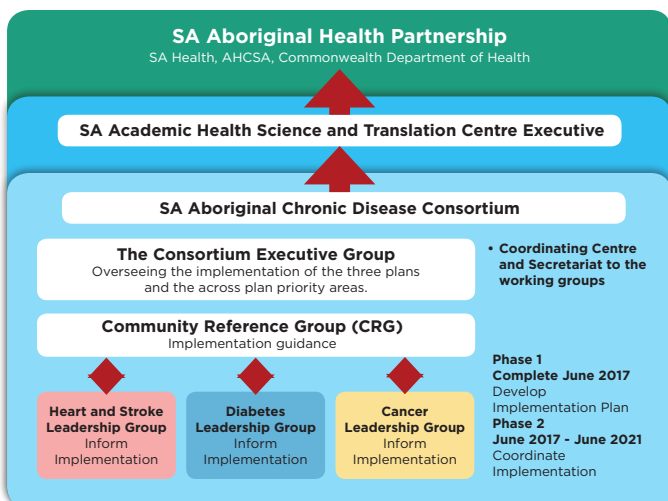


## Condition Specific Priorities



The Road Map has 10 Priority Areas that cover 27 Priority Strategies. Given the wide range of strategies, two approaches will be used by the Consortium Coordinating Centre to implement the Road Map. Firstly, a “Coordination Role” to help ensure that all interested parties are coming together to define and commit. Secondly, an “Influencing Role” to advise, advocate, offer leverage and provide links that support projects.

## Governance structures



### The Consortium Executive Group

The Consortium Executive Group members are the CEOs from each SA Health Local Health Networks, the Aboriginal Health Council of South Australia, the two Primary Health Networks in SA, as well as the co-chairs of the Community Reference Group and the condition-specific Leadership Groups.

### The Community Reference Group

The Community Reference Group has representation from many South Australian Aboriginal communities and are a critical voice in the Consortium. The Group’s role is to provide guidance and advice, to provide high level cultural and community knowledge, review progress and ensure accountability.

### Condition-specific Leadership Groups

There are three condition-specific Leadership Groups – one for diabetes, cancer, and heart and stroke. Experts, clinicians, service providers, non-government organisations, advocates and community members participate on the Leadership Groups.

# Our Vision

To reduce the impact of chronic disease experienced by Aboriginal and Torres Strait Islander people living in South Australia through the delivery of collaborative, appropriate, well-coordinated, evidence based strategies to successfully implement the priorities in the South Australian Aboriginal Cancer Control Plan 2016-2021, South Australian Aboriginal Heart and Stroke Plan 2017-2021, and the South Australian Aboriginal Diabetes Strategy 2017-2021.

# Our Guiding Principles

The “Guiding Principles” underpin the Consortium’s work as it implements all three plans.

- Aboriginal health is everybody’s business
- Aboriginal leadership is essential
- Prioritise community participation
- Culturally safe care is essential
- Aboriginal primary care is a key driver of improved outcomes
- Family must be a focus/partners in care & interventions
- To improve health, the impact of the social barriers must be addressed
- Services must be consistent, available and accessible
- Activities must recognise and respect cultural diversity
- Use partnerships to plan, deliver and evaluate healthcare
- Provide holistic care which recognises comorbidities
- Focus on coordination and continuity of care
- Ensure commitment and accountability



# Consortium Members

- The South Australian Aboriginal Health Partnership
- South Australian Health & Medical Research Institute
- South Australian Academic Health Science & Translation Centre
- Aboriginal Health Council of South Australia (AHCSA) and its member organisations
- SA Health, including the following business units:
  - Transforming Health – Acute Coronary Syndrome (ACS) & Stroke
  - Country Health SA Local Health Network (CHSALHN)
    - Aboriginal Health Directorate
    - Integrated Cardiovascular Clinical Network (iCCnet)
  - Central Adelaide Local Health Network (CALHN)
    - SA Cancer Services
  - Southern Adelaide Local Health Network (SALHN)
  - Northern Adelaide Local Health Network (NALHN)
  - Women’s and Children’s Health Network (WCHN)
  - SA Ambulance Services (SAAS)
- Adelaide Primary Health Network
- Country SA Primary Health Network
- Adelaide-based universities, including
  - University of Adelaide
  - University of South Australia
  - Flinders University
- Non-government organisations, including
  - Cancer Council SA
  - Heart Foundation
  - Diabetes SA
  - Royal Flying Doctor Service (RFDS)
  - Rural Doctors Workforce Agency (RDWA)

## For more information:

**Website:** [www.aboriginalhealthconsortium.org](http://www.aboriginalhealthconsortium.org)  
**Facebook:** [facebook.com/SAAAboriginalChronicDiseaseConsortium/](https://facebook.com/SAAAboriginalChronicDiseaseConsortium/)

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