



Incidence of gestational diabetes in Australia



What is gestational diabetes?

Gestational diabetes is a type of glucose intolerance, of varying severity, which develops or is first recognised during pregnancy. It mostly occurs in the second or third trimester. Gestational diabetes usually resolves after the baby is born, but can often recur in later pregnancies and greatly increases the risk, both for the mother and baby, of developing type 2 diabetes in later life.



Gestational diabetes affects around 1 in 7 pregnant women

In 2016–17, around 1 in every 7 women aged 15–49 who gave birth in hospital were diagnosed with gestational diabetes (15%, or 40,800 women).

Women with gestational diabetes were more likely to be:

- older—women aged 45–49 were more than 4 times as likely to be diagnosed with gestational diabetes as women aged 15–19 (26% and 6%, respectively)
- born in Southern and Central Asia—incidence among these women was more than twice that of Australian-born women (28% and 13%, respectively)
- socioeconomically disadvantaged—women from the lowest socioeconomic group were 1.5 times more likely to be diagnosed with gestational diabetes than women in the highest socioeconomic group (19% and 13%, respectively).

Compared with the national figure of 15%, rates were slightly higher in the Northern Territory and the Australian Capital Territory (both 17%) and lower in Western Australia (12%).

After adjusting for differences in the age structure of the populations, the rate among Aboriginal and Torres Strait Islander women was 1.3 times the rate for non-Indigenous women (19% and 15%, respectively).



How does gestational diabetes affect pregnant women?

Compared to women with no diabetes, women with gestational diabetes may have different experiences and health concerns during pregnancy and birth.

In 2016–17, these included:

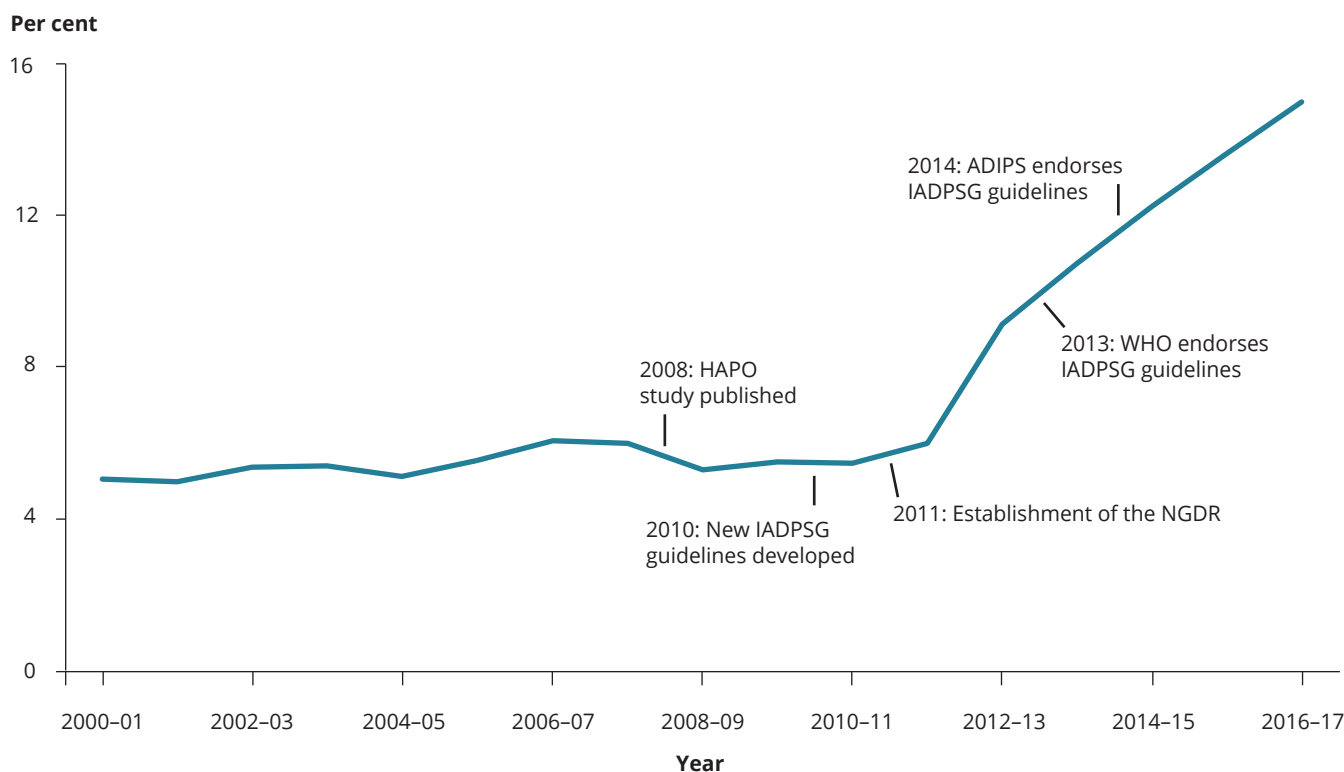
- Pre-eclampsia (4.2% compared with 2.8%)
- Gestational hypertension (4.2% compared with 2.9%)
- Maternal care for excessive fetal growth (6.2% compared with 2.7%)
- Induced labour (43% compared with 30%)
- Caesarean section (44% compared with 37%)
- Pre-term labour and delivery (9.3% compared with 7.5%)

Note: Selected short-term complications. Age-standardised to remove differences in the age structure of the populations.

↑ Changing trends

Between 2000–01 and 2016–17, the rate of women being diagnosed with gestational diabetes in Australia tripled. Steep increases were recorded from 2012–13 across all age groups and all states and territories. Caution should be taken when comparing rates over time, however, as a number of factors, including new diagnostic guidelines are likely to have had an impact on the number of women diagnosed with gestational diabetes in recent years. See the Notes for further information.

Incidence of gestational diabetes in Australia, 2000–01 to 2016–17



1. Age-standardised to the 2001 Australian resident female population aged 15–49.
 2. Population (women aged 15–49 giving birth in Australian hospitals) based on ICD-10-AM diagnosis codes.
- Source: National Hospital Morbidity Database.

Notes: Publication of the Hyperglycemia and Adverse Pregnancy Outcome (HAPO) study in 2008 resulted in the development of new consensus guidelines for the diagnosis of gestational diabetes in 2010 by the International Association of Diabetes and Pregnancy Study Groups (IADPSG). Whilst the guidelines were not endorsed by the Australasian Diabetes in Pregnancy Society (ADIPS) until 2014, establishment of the National Gestational Diabetes Register (NGDR) by Diabetes Australia in 2011 and endorsement of the guidelines by the World Health Organization in 2013, may have had an impact on awareness and screening. The new guidelines were implemented across most jurisdictions in Australia by 2016. A number of studies have shown increased incidence rates to be one of the impacts of the IADPSG guidelines.



How is gestational diabetes treated and managed?

In 2016–17, more than half (56%) of women with gestational diabetes managed their condition through the use of diet, exercise and/or lifestyle management. Around a third (32%) required insulin therapy while 8% were treated with oral hypoglycaemic (blood glucose lowering) medications—5% was unspecified.

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