



THE UNIVERSITY OF  
**NEWCASTLE**  
AUSTRALIA

---

# IMPACT OF DIABETES ON WOMEN'S HEALTH OUTCOMES: SURVIVAL, HEALTHY LIFE EXPECTANCY, AND HEALTH RELATED QUALITY OF LIFE

---

**Befikadu Legesse Wubishet BSc (Jimma); MSc (Addis Ababa);  
MPH (Stockholm)**

A thesis submitted in fulfilment of the requirements for the  
degree of Doctor of Philosophy in Health Economics

June 2020

Research Centre for Generational Health and Ageing  
School of Medicine and Public Health, Faculty of Health and Medicine,  
University of Newcastle, Australia

---

## **STATEMENT OF ORIGINALITY**

---

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. The thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

Befikadu L. Wubishet

---

## ACKNOWLEDGEMENT OF AUTHORSHIP

---

I hereby certify that the work embodied in this thesis contains published papers of which I am a joint author. I have included as part of the thesis a written declaration endorsed in writing by my supervisor, attesting to my contribution to the joint publications.

By signing below I confirm that Befikadu L. Wubishet contributed to the development of the research questions, data analyses and interpretation, and writing up and revising of the following papers.

1. Wubishet BL, Harris ML, Forder PM, Acharya SH, Byles JE. Predictors of 15-year survival among Australian women with diabetes from age 76–81. *Diabetes research and clinical practice*. 2019;150: 48-56.
2. Wubishet BL, Harris ML, Forder PM, Byles JE. Age and cohort rise in diabetes prevalence among older Australian women: case ascertainment using survey and healthcare administrative data. *PLOS One*. 2020;15:e0234812.

Professor Julie Byles

### **Published papers**

Wubishet BL, Harris ML, Forder PM, Acharya SH, Byles JE. Predictors of 15-year survival among Australian women with diabetes from age 76–81. *Diabetes research and clinical practice*. 2019;150:48-56 (Appendix G1).

Wubishet BL, Harris ML, Forder PM, et al. Age and cohort rise in diabetes prevalence among older Australian women: case ascertainment using survey and healthcare administrative data. *PLOS One*. 2020;15:e0234812 (Appendix G2).

### **Published abstracts**

Wubishet BL, Harris M, Abbas SS, Lang D, Acharya S, Byles J. PDB19 – Costs of Major Complications of Type 2 Diabetes: A Systematic Review. *Value in Health*. 2017;20(9):A477 (Appendix G3).

### **Papers submitted for publication**

Befikadu L. Wubishet, Julie E. Byles, Melissa L. Harris, Carol Jagger. Impact of Diabetes on Life and Healthy Life Expectancy among Older Women. Submitted to *Journal of Gerontology: Medical Sciences*.

Befikadu L. Wubishet, Melissa L. Harris, Md Mijanur Rahman, Danielle Lang, Julie E. Byles. Impact of diabetes on health-related quality of life: Findings from the 1946–51 cohort of the Australian Longitudinal Study on Women’s Health. Submitted to: *Value in Health*.

Befikadu L. Wubishet, Melissa L. Harris, Danielle Lang, Julie E. Byles. Agreement of Medicare Australia datasets with self-report and hospital admission records in identifying women with diabetes. Submitted to: *Australasian Journal on Ageing*.

### **Conference presentations**

Wubishet, B. L., Byles, J. E, Harris, M. L, Jagger, C. Impact of Diabetes on Life and Healthy Life Expectancy among Older Women. 18<sup>th</sup> National Conference of Emerging Researchers in Ageing, Sydney, Australia (oral presentation).

Wubishet, B., Harris, M., Lang, D., Acharya, S., & Byles, J. Rising diabetes prevalence among older Australian women. 51<sup>st</sup> AAG, Melbourne, Australia (oral presentation).

Wubishet, B., Harris, M., Lang, D., Acharya, S., & Byles, J. Rising diabetes prevalence among older Australian women. Emerging Health Policy Research Conference, Sydney, Australia (oral presentation).

Wubishet, B. L., Harris, M., Abbas, S. S., Lang, D., Acharya, S., & Byles, J. Costs of Major Complications of Type 2 Diabetes: A Systematic Review. 16<sup>th</sup> National Conference of Emerging Researchers in Ageing, Perth, Australia (oral presentation).

---

## ACKNOWLEDGEMENTS

---

First and foremost, glory be to the Almighty God for all the unbelievable miracles in my life. God, You picked me from that small village, and You have been by my side in all of my journey, not only just my thesis. You have always been, and I trust You will be my shield, source of hope, and strength for the rest of my life.

I am very much grateful to my supervisors for their unreserved and continuous support throughout my candidature. Without your committed help, feedback, and encouragement, I would not have written any of the chapters, let alone a thesis. I have been very lucky to have my principal supervisor, Professor Julie Byles. Julie, I can never forget the extremely positive impression I had in one of our first supervision meetings. I remember that I had a preference to postpone the meeting with the interest of reading more before coming for discussion. However, you suggested meeting and I could not believe how you made it easy for me and set the scene for my thesis and gave me all the drawing papers you used. Your inspirational, insightful, democratic, and resourceful supervision has been by my side for the entire period of my candidature. You have been very generous, patient, and understanding with me. Your academic excellence and dynamism have helped more than three dozen of your previous and current students. In my case, even though it took me too long, I realised that you have been working hard to address my numerous special needs. So 'thank you' feels like a very ordinary term to acknowledge you. If I get the opportunity to be a supervisor, you will remain to be my role model for forever, although it feels impossible to be someone like you. I am also very grateful to my other supervisor, Doctor Melissa Harris. Melissa, your guidance and support have been with me, starting from our very first e-mail communication. I cannot find the right words to thank you for the support you provided me during my pre-enrolment communication and until today. You have been very patient, supportive, and understanding of my difficulties and limitations. I have learned many teamwork skills from you, which will help me in my future career and wish to cascade it to others whenever I get the opportunity. To my non-RCGHA supervisors, Ms. Danielle Lang and

Doctor Shamasunder Acharya, you have also been a great addition to my supervisory team. Danielle, your timely feedback to my drafts and your, 'What can I help you with?' checks have had enormous positive contribution, not only to the quality of my thesis, but also to my motivation, confidence to ask for help, and better progress. Thank you for being so keen to check and comment on each draft I sent you. Doctor Sham, you have been very inspirational and generous in sharing with me your wisdom in diabetes and giving me time whenever I needed. I wish and hope to have some means of working together with all or some of you and continue to learn from you in the future.

I am also very grateful to several individuals who had a direct or indirect contribution to my thesis. I have had direct involvement and support from Ms. Peta Forder, Professor Carol Jagger, Doctor Shazia Abbas, and Doctor Md Mijanur Rahman in various roles and parts of my thesis. I would like to thank Mr. Dominic Cavenagh for being very easily accessible and keen to help whenever I had SAS issues. I am grateful to Debbie Booth for her assistance in my literature search and Endnote training and Natalia Soeters, Emily Princehorn, and Linda Smythe for their help in proofreading my thesis. Thank you all and I hope to remain connected and continue working with you all.

I would like to express my gratitude to RCGHA and HMRI staff and peers for extending their hands to help me whenever I have been in need. Thank you Linda, Emily, and Katherine for your excellent administrative support. My special thanks also go to all my Later Life Higher Degree Research group peers. Both the formal and informal conversations we have had helped me to learn so much, stay informed, become stronger and more confident in my research and other demands of life.

I would also like to extend my acknowledgement to my family and friends for their continued moral support and encouragement. My mum and dad, you have been the best parents I can ever have had. You managed to send me to school and then to University, despite all your difficulties and life challenges, making me unique among my childhood friends. However, in the past I have taken all this for granted and I have not yet taken the time to thank you properly. Mum, even if I have not been lucky to show you most of the best things I found in life, I should not forget your early contributions to

the foundation of everything I have got. Zed, you know what? One of the most difficult things for me is to find the best words to thank you enough for your contribution, not only to my thesis, but also in all aspects of my life. You are not only my best friend but also my brother, colleague, counsellor, whatever you name it. Destish, thank you very much for being not only a very understanding and thoughtful brother, but also one of my best friends. I always feel your love, care, support, and even worry for me. Alay, thank you very much for always being a very positive and caring friend. Bet, your mature insights, unreserved concern, and care for me have meant so much both to my life and PhD journey. Tsgi, thank you for the enormous support and lessons I have had from you, but, most importantly, the habit of hard work and courage to stay strong despite all of life's challenges. There are also many lovely people I should thank for their continued support, encouragement, and friendship, including Teke, Dessie, Dinbe, Jo, Mar, Dani, Ale, Tesfish, and Fitse.

I would like to express my highest appreciation to a few individuals and families who have had a great contribution to the betterment of my PhD life in Newcastle. First and foremost, I would like to thank Fr John and his family for their incomparable love and care. I am grateful to Tedy's mum, and her family, as well as Almaz and her family to make me feel as if I am always in my hometown. I also appreciate Kerry for being one of the friendliest and supportive people I have known in Newcastle.

This thesis used data from the Australian Longitudinal Study on Women's Health (ALSWH) and its linked administrative datasets. We would like to acknowledge the Australian Government Department of Health for providing funding for the ALSWH and to the women who participated in the surveys.

I would like to thank the University of Newcastle for offering me this excellent opportunity of studying my PhD with a full scholarship. This research was supported by the Australian Research Council Centre of Excellence in Population Ageing Research (project number CE170100005).

---

# TABLE OF CONTENTS

---

Statement of Originality .....	i
Acknowledgement of authorship .....	ii
Acknowledgements .....	v
Table of contents .....	viii
List of Tables.....	xiv
List of Figures .....	xvii
Abbreviations .....	xix
Abstract.....	1
<b>1 Introduction and background.....</b>	<b>3</b>
1.1 Introduction .....	3
1.1.1 Thesis statement .....	5
1.1.2 Thesis overview .....	5
1.2 Background .....	7
1.2.1 Chronic disease burden.....	7
1.2.2 Definition and epidemiology of diabetes.....	7
1.2.3 Diabetes risk factors.....	9
1.2.4 Diabetes complications .....	10
1.2.5 Impact of diabetes on health care use.....	10
1.2.6 Morbidity, disability, and mortality due to diabetes .....	11
1.2.7 Economic burden of diabetes .....	13
1.2.8 Why a gendered approach to study the health impact of diabetes? .....	13
1.3 Summary .....	14
<b>2 Literature review .....</b>	<b>15</b>
2.1 Introduction .....	15
2.2 Data sources for diabetes case ascertainment .....	15
2.2.1 Biological measures (the ‘gold standard’) .....	15

2.2.2 Self-report .....	16
2.2.3 Administrative data .....	19
2.3 Impact of diabetes on health outcomes .....	23
2.3.1 Impact on survival .....	23
2.3.2 Impact on health expectancies .....	25
2.3.3 Impact on health-related quality of life .....	29
2.4 Gaps in literature.....	31
2.5 Summary .....	32
<b>3 Study methods.....</b>	<b>33</b>
3.1 Introduction .....	33
3.2 Data sources description.....	33
3.2.1 Australian Longitudinal Study on Women’s Health .....	33
3.2.2 Linked data sources, consent, and data linkage process.....	41
3.3 Data analysis strategies.....	44
3.3.1 Diabetes case ascertainment using the ALSWH survey and linked health care datasets.....	44
3.3.2 Further examination of cases identified from only one source .....	59
3.4 Analytical techniques used in this thesis .....	68
3.4.1 Survival analysis .....	68
3.4.2 Healthy life expectancy estimation.....	69
3.4.3 Health-related quality of life estimation.....	70
3.5 Ethical considerations .....	71
3.6 Summary .....	72
<b>4 Predictors of 15-year survival among Australian women with diabetes from age 76-81</b>	<b>73</b>
4.1 Abstract .....	73
4.2 Introduction .....	74

4.3 Methods .....	75
4.3.1 Study population and data sources .....	75
4.3.2 Variables/Measurements.....	76
4.3.3 Diabetes status.....	76
4.3.4 Survival time.....	76
4.3.5 Causes of death.....	77
4.3.6 Other predictor variables for survival .....	77
4.3.7 Statistical analysis .....	78
4.3.8 Ethical approval.....	78
4.4 Results .....	79
4.4.1 Baseline characteristics .....	79
4.4.2 Survival .....	81
4.4.3 Causes of death.....	82
4.4.4 All-cause mortality and its predictors .....	82
4.5 Discussion.....	85
4.6 Conclusion .....	88
4.7 Summary .....	88
<b>5 Agreement of data sources .....</b>	<b>89</b>
5.1 Abstract .....	89
5.2 Introduction .....	90
5.3 Methods .....	92
5.3.1 Data sources and study sample .....	92
5.3.2 Potential predictors of disagreement .....	96
5.3.3 Statistical analyses .....	96
5.4 Results .....	96
5.4.1 Diabetes prevalence.....	98
5.4.2 Agreement.....	100
5.4.3 Validity measures.....	101

5.4.4 Factors affecting agreement .....	102
5.5 Discussion .....	105
5.6 Conclusion .....	108
5.7 Summary .....	108
<b>6 Diabetes case ascertainment and prevalence .....</b>	<b>109</b>
6.1 Abstract .....	109
6.2 Introduction .....	110
6.3 Methods .....	112
6.3.1 Study design and data sources.....	112
6.3.2 The ALSWH Survey dataset .....	113
6.3.3 Medicare Benefits Schedule (MBS) dataset.....	113
6.3.4 Pharmaceutical Benefits Scheme (PBS) dataset .....	113
6.3.5 Hospital admissions dataset .....	114
6.3.6 Cause of death dataset .....	114
6.3.7 Diabetes case definition.....	114
6.3.8 Explanatory variables .....	115
6.3.9 Statistical analyses .....	115
6.4 Results .....	115
6.4.1 Case ascertainment.....	115
6.4.2 Baseline characteristics .....	118
6.4.3 Prevalence .....	120
6.4.4 Predictors of having diabetes .....	120
6.5 Discussion .....	124
6.6 Conclusion .....	127
6.7 Summary .....	128
<b>7 Healthy life expectancy .....</b>	<b>129</b>
7.1 Abstract .....	129
7.2 Introduction .....	130

7.3 Methods .....	132
7.3.1 Measures.....	132
7.3.2 Statistical analysis .....	134
7.3.3 Sensitivity analysis.....	134
7.4 Results .....	135
7.4.1 Baseline characteristics .....	135
7.4.2 Impact of diabetes on health status, transitions, and healthy life expectancy...	137
7.4.3 Impact of diabetes and other covariates on life expectancy.....	141
7.4.4 Sensitivity analysis.....	144
7.5 Discussion.....	145
7.6 Conclusion .....	149
7.7 Summary .....	149
<b>8 Health related quality of life.....</b>	<b>150</b>
8.1 Abstract .....	150
8.2 Introduction .....	151
8.3 Methods .....	153
8.3.1 Study design and participants .....	153
8.3.2 Diabetes case ascertainment .....	153
8.3.3 Outcome variables .....	154
8.3.4 Covariates.....	154
8.3.5 Statistical analysis .....	156
8.3.6 Covariance structure selection .....	156
8.4 Results .....	157
8.4.1 Baseline characteristics .....	157
8.4.2 Impact of diabetes on health-related quality of life .....	159
8.4.3 Sensitivity analysis.....	166
8.4.4 Relationship between diabetes ascertainment source and health-related quality of life .....	167

8.5 Discussion .....	173
8.6 Conclusion .....	176
8.7 Summary .....	176
<b>9 Discussion and conclusion .....</b>	<b>177</b>
9.1 Discussion .....	177
9.2 Conclusion .....	185
<b>References .....</b>	<b>187</b>
<b>Appendices.....</b>	<b>209</b>
Appendix A: Permission for re-use of article and licence agreement for Chapter 4 ....	209
Appendix B: Licence agreement for Chapter 6 .....	210
Appendix C: Supplementary Material for Chapter 3 .....	213
Appendix D: Supplementary Material for Chapter 4 .....	218
Appendix E: Supplementary Material for Chapter 7 .....	219
Appendix F: Supplementary Material for Chapter 8.....	220
Appendix G: Published articles .....	226

---

## LIST OF TABLES

---

Table 3.1: Timeline of the main ALSWH surveys for the 1973–78, 1946–51, and 1921–26 cohorts .....	36
Table 3.2: Schedule of surveys for the Australian Longitudinal Study on Women's Health (age in years and number of participants in each cohort).....	37
Table 3.3: Summary of variables used in the different studies of the thesis .....	40
Table 3.4: Prevalence of diabetes across the surveys in the 1921–26 and 1946–51 cohort women .....	46
Table 3.5: Medicare Benefits Schedule services and corresponding item numbers included in diabetes case identifying algorithms.....	48
Table 3.6: MBS item numbers that have been in use during the period 1996 to 2015 ..	49
Table 3.7: ATC-5 codes for diabetes medications used in the identification of patients with diabetes from the Pharmaceutical Benefits Scheme dataset .....	51
Table 3.8: Total available hospital data coverage period and potentially suitable data lookback period across states .....	53
Table 3.9: Total number of women having diabetes-related admissions and number of admissions across states .....	54
Table 3.10: Diabetes status across the data sources and their combinations .....	56
Table 3.11: Detailed presentation of the number of women with diabetes identified by one or more of the data sources .....	57
Table 3.12: Number and percentage of women with diabetes initially identified from each data source .....	58
Table 3.13: Number and percentage of women with diabetes initially identified from single data sources only and a combination of them .....	58
Table 3.14: Number of times the women in the 1921–26 cohort reported diabetes....	59
Table 3.15: Causes of death for women who reported diabetes only once in the 1921–26 cohort .....	59
Table 3.16: Number of diabetes services used by the 1921–26 cohort women identified from the MBS dataset only .....	60
Table 3.17: Causes of death for women identified from the MBS dataset only and had only one service use in the 1921–26 cohort.....	60
Table 3.18: Number of diabetes medications used by the women identified from the PBS dataset only in the 1921–26 cohort.....	61
Table 3.19: Causes of death for the women identified from the PBS dataset only and used diabetes medication only once .....	61

Table 3.20: Number of times the women in the 1946–51 cohort reported diabetes....	62
Table 3.21: Causes of death for the women who reported diabetes only once in the 1946–51 cohort.....	62
Table 3.22: Number of diabetes services used by the 1946–51 cohort women identified from the MBS dataset only .....	63
Table 3.23: Causes of death for the women in the 1946–51 cohort identified from MBS dataset only and used diabetes medication only once .....	63
Table 3.24: Number of diabetes medications used by the women identified only from PBS dataset.....	63
Table 3.25: Summary of the number of women with and without diabetes and those excluded from the analysis .....	64
Table 3.26: Summary of the limitations of each of the data sources used for diabetes case ascertainment .....	65
Table 4.1: Baseline characteristics of women with no, prevalent and incident diabetes .....	80
Table 4.2: Cox-proportional hazards models for the effect of diabetes and other predictors on all-cause mortality .....	84
Table 6.1: Number and percentage of the total number of women with diabetes identified from each of the four data sources in the 1921–26 and 1946–51 cohort women.....	117
Table 6.2: Univariate association between predictors and having diabetes among the 1921–1926 and 1946–51 cohort women.....	119
Table 6.3: Multivariate association between predictors and having diabetes among the 1921–1926 and 1946–51 cohort women.....	122
Table 7.1: Baseline characteristics of the women with and without diabetes in the 1921–26 cohort .....	136
Table 7.2: Association of diabetes and other covariates with transitioning between good health, poor health and dead states among the 1921–26 cohort women .	139
Table 7.3: TLE, HLE, and unhealthy life expectancy of the women with and without diabetes in the 1921–26 cohort at age 70 and 80 with respect to baseline general health status.....	140
Table 7.4: TLE, HLE, and unhealthy life expectancy of the women in the 1921–26 cohort at age 70 and 80 with respect to the presence of diabetes and other life expectancy predictors among in the 1921–26 cohort women.....	142
Table 8.1: Comparison of covariance structure types for the Proc Mixed procedure .	157

Table 8.2: Baseline (1996) characteristics of the women with and without diabetes in the 1946–51 cohort. ....	159
Table 8.3: Factors associated with changes in physical functioning scores among the 1946–51 cohort women over eight surveys i.e. between Survey 1 (at age 45–50) and Survey 8 (at age 65–70). ....	163
Table 8.4: Factors associated with changes in general health scores among the 1946–51 cohort women over eight surveys i.e. between Survey 1 (at age 45–50) and Survey 8 (at age 65–70).....	164
Table 8.5: Factors associated with changes in social functioning scores among the 1946–51 cohort women over eight surveys i.e. between Survey 1 (at age 45–50) and Survey 8 (at age 65–70).....	165
Table 8.6: Factors associated with changes in mental health scores among the 1946–51 cohort women over eight surveys i.e. between Survey 1 (at age 45–50) and Survey 8 (at age 65–70).....	166
Table 8.7: Association between the source of diabetes case ascertainment and change in physical functioning score between Survey 1 and Survey 8. ....	172
Table 8.8: Association between the source of diabetes case ascertainment and change in general health score between Survey 1 and Survey 8. ....	172
Table 8.9: Association between the source of diabetes case ascertainment and change in social functioning score between Survey 1 and Survey 8. ....	172
Table 8.10: Association between the source of diabetes case ascertainment and change in mental health score between Survey 1 and Survey 8.....	173

---

## LIST OF FIGURES

---

Figure 3.1: Number of women with diabetes identified from one or more of the data sources among the 1921–26 and 1946–51 cohort women.	<b>Error! Bookmark not defined.</b>
Figure 3.2 Proportion of the total number of women with diabetes identified by one, two, three, and four of the sources among the 1921–26 (N=3520) and 1946–51 (N=3064) cohort women.	58
Figure 3.3: Women in the 1921–26 cohort identified as having diabetes after assessment of corroboration of sources.	61
Figure 3.4: Women in the 1946–51 cohort identified as having diabetes after assessment of corroboration of sources.	64
Figure 3.5: Summary of cohorts and sample sizes in the five studies i.e. Chapter 4 to Chapter 8.	67
Figure 4.1: Determination of eligibility of the women for the study.	79
Figure 4.2: Kaplan-Meier survival curves of older women (aged 76–81 in 2002), according to diabetes groups.	81
Figure 5.1: Flowchart of included and excluded women for Medicare vs hospital admissions data agreement study	98
Figure 6.1: Number of women with diabetes identified from one or more data sources among the women in the 1921–26 and 1946–51 cohorts for the period 1996–2016.	116
Figure 6.2: Derivation of study eligible populations from the 1921–26 and 1946–51 cohort women.	117
Figure 6.3: Percentage of diabetes cases identified from different number of data sources for women in the 1921–26 and 1946–51 cohorts for the period 1996–2016.	118
Figure 6.4: Comparison of age and cohort rise in diabetes prevalence among the 1921–26 and 1946–51 cohort women for the period 1996 to 2016.	120
Figure 7.1: Lasagne plot for women with no diabetes (n=8875) showing pattern of self-reported health status i.e a percentage of women in good health, poor health, missing, and dead across Survey 1 (at age 70–75 in 1996) to Survey 6 (at age 85–90 in 2011)	138
Figure 7.2: Lasagne plot for women with prevalent diabetes (n=974) showing a pattern of self-reported health status i.e a percentage of women in good health, poor	

health, missing, and dead across Survey 1 (at age 70–75 in 1996) to Survey 6 (at age 85–90 in 2011). .....	138
Figure 7.3: TLE, HLE and unhealthy life expectancy for women with and without diabetes .....	141
Figure 7.4: HLE and unhealthy life expectancy at age 70 years and over among the women in the 1921–26 cohort in the .....	143
Figure 7.5: Percentage of women’s TLE at age 70 years and older spent in good health with respect to diabetes status and presence of different combinations of life expectancy predictors in the 1921–26 cohort.....	144
Figure 8.1: Directed acyclic graph for covariate selection .....	155
Figure 8.2: Flowchart of eligible population derivation among the women in the 1946–51 cohort. ....	158
Figure 8.3: Mean scores of the SF-36 domains among women with and without diabetes from Survey 1 to Survey 8. ....	161
Figure 8.4: Mean physical function scores of the women over time by source of diabetes ascertainment from Survey 1 (at ages 45–50) to Survey 8 (at ages 65–70). ....	168
Figure 8.5: Mean general health scores of the women over time by source of diabetes ascertainment from Survey 1 (at ages 45–50) to Survey 8 (at ages 65–70). ....	169
Figure 8.6: Mean social functioning scores of the women over time by source of diabetes ascertainment from Survey 1 (at ages 45–50) to Survey 8 (at ages 65–70). ....	170
Figure 8.7: Mean mental health scores of the women over time by source of diabetes ascertainment from Survey 1 (at ages 45–50) to Survey 8 (at ages 65–70). ....	171

---

## ABBREVIATIONS

---

Abbreviation	Descriptor
ABS	Australian Bureau of Statistics
AIHW	The Australian Institute of Health and Welfare
ALSWH	The Australian Longitudinal Study on Women's Health
APDC	Admitted Patients Data Collection
ARIA+	Accessibility/Remoteness Index of Australia Plus
ARR	Adjusted risk ratio
ATC code	Anatomical Therapeutic Chemical code
AusDiab	The Australian Diabetes, Obesity and Lifestyle Study
BMI	Body Mass Index
CI	Confidence interval
CoD	Cause of death
DALY	Disability-adjusted life years
DFLE	Disability free life expectancy
EQ-5D	EuroQol-5 Dimension
HALE	Health adjusted life expectancy
HbA1c	Glycated haemoglobin
HLE	Healthy life expectancy
HRQOL	Health-related quality of life
ICD	International Classification of Diseases
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
IDF	International Diabetes Federation
MBS	Medicare Benefits Schedule
NDI	National Death Index
OR	Odds ratio
PBS	Pharmaceutical Benefits Scheme
PPV	Positive predictive value
NPV	Negative predictive value
RR	Relative risk
TLE	Total life expectancy
WHO	The World Health Organization

---

# ABSTRACT

---

**Background:** Diabetes is one of the major chronic diseases posing a huge health and economic burden to patients, families, and health care systems in almost all corners of the world. Mainly due to its association with numerous complications and comorbidities, diabetes negatively affects patients' health outcomes, such as health-related quality of life (HRQOL), survival, and healthy life expectancy (HLE). Therefore, quantifying the impacts of diabetes based on methods that enable accurate identification of patients has important policy and practice implications.

**Aims:** The thesis aimed to: 1) demonstrate a robust method of diabetes case ascertainment through simultaneous use of multiple data sources; and 2) assess the impact of diabetes on survival, HLE, and HRQOL.

**Methods:** The participants in this thesis were the 1921–26 and 1946–51 birth cohorts of the Australian Longitudinal Study on Women's Health (ALSWH). ALSWH is a population-based prospective longitudinal study among Australian women that is largely focused on women's health and its determinants. The data sources used in this thesis were the ALSWH survey data and linked administrative datasets, including the Pharmaceutical Benefits Scheme (PBS), the Medicare Benefits Schedule (MBS), Admitted Patients Data Collection (APDC), and the National Death Index datasets.

**Results:** The findings revealed that Medicare Australia's datasets (PBS and MBS) had a moderate to substantial level of agreement with both the survey and hospital admission data in identifying women with diabetes. This thesis revealed that diabetes is one of the chronic conditions for which the validity and completeness of case ascertainment can be improved through the simultaneous use of multiple data sources. Women with diabetes had shorter survival compared to women without diabetes, but even those women with prevalent diabetes had a median survival of nearly 10 years at ages 76–81 years. Diabetes was associated with reductions in total life expectancy (TLE), HLE, and the proportion of remaining life years spent in good health at all ages after 70 years. Low

education, having three or more comorbidities, and obesity were also associated with reductions in TLE and HLE and increased unhealthy life expectancy. Women with diabetes had significant reductions in HRQOL scores over time compared to women without diabetes.

**Conclusions:** The findings of this thesis indicated that the validity and completeness of diabetes case ascertainment can be improved through simultaneous use of multiple data sources. Diabetes had a larger negative impact on women's HLE than their overall survival. Lower educational status, multimorbidity, and obesity were also negatively associated with women's health outcomes. These findings suggest a need for interventions aimed at diabetes prevention; and further improvements in the care of women with diabetes to improve their quality of life and promote healthy ageing.