Executive summary

Major diseases and health problems

Two thirds of women in Germany self-assess their health as being either good or very good; a slightly lower figure than for men. Self-reported health figures decrease with age with just under half of women aged 65 years and older rating their own health as being either good or very good. Over the course of the last 20 years, the figures for self-assessed health of older women in particular have seen a significant increase. Between 1994 and 2016, the proportion of 60- to- 69-year old women reporting either good or very good subjective health has increased by almost 13 percentage points. Positive developments were also seen in women's average life expectancy, which has been rising for many decades and has itself increased by 4.3 years since 1991. It currently stands at 83.3 years, which is 4.8 years higher than for men, but the gender gap is narrowing.

Today cardiovascular disease is the main cause of death for women and accounts for around 40% of all deaths. Cardiovascular disease nonetheless continues to be seen as a disease that affects mainly men, and women often underestimate their risk of contracting it. Improved treatment and healthier behaviour have led to a decrease in coronary heart disease mortality and incidence rates in both women and men. For most cancers – the second leading cause of death among women – incidence rates and mortality rates have also decreased. One exception is lung cancer, where the observed increase in women has been related to the increase in female smoking rates during the last decades of the 20th century. Its wide spread and increasing prevalence has caused diabetes to become another important women's health concern. Women are less likely than men to have undiagnosed diabetes and are less likely to suffer from the disease's late effects. However, female diabetes patients face a greater risk of developing cardiovascular conditions than men. Other conditions that also affect women more frequently include musculoskeletal disorders – particularly osteoarthritis, osteoporosis and rheumatoid arthritis – as well as a number of mental health conditions such as depression, anxiety disorders and eating disorders. While more women than men attempt to commit suicide, death by suicide figures for women are lower. Benign gynaecological diseases have a major impact on women's quality of life and how they feel about their bodies. They include endometriosis, uterine fibroids and uterine prolapse. While common, there is little reliable data on the prevalence and influencing factors of these conditions as well as on the health care provided. In addition, relevant infectious diseases for women specifically include the human papilloma virus (HPV), chlamydia and toxoplasma infections.

During the final stages of the report, the new coronavirus SARS-CoV-2 was spreading at great speed throughout the world. International findings indicate possible gender differences in corona infections and COVID-19 mortality, the extent and causes of which will need to be investigated in more detail. In those countries where gender-disaggregated data are available, men more often die from COVID-19 and develop more severe symptoms.

Health-related behaviour

Women's behaviour is often more health-conscious than men's. Not only do women smoke less frequently daily or occasionally, they are also less often heavy smokers (smoking 20 or more cigarettes per day). Women do not drink as much alcohol as men, are not as often afflicted by alcohol abuse or alcohol dependence. Women also eat more balanced diets: compared to men they more often eat healthy foods such as fruit and vegetables and drink water more frequently. As regards physical activity, women are less likely than men to cycle or walk as part of their daily routine (e.g. to work). Women are also less likely to engage in leisure time sports activities than men. However, no gender difference was detected as regards work-related physical activities in paid or unpaid jobs, such as lifting and carrying in nursing or house and gardening. Lifestyle factors such as diet and exercise behaviour affect body weight. While a smaller proportion of women are more overweight than men (53.0% and 67.1% respectively), obesity affects both genders equally (23.0%). From a public health perspective, it is specifically obesity with its wide spread and the concomitant health risks which is one of the most important health concerns affecting women. Being underweight, at the other end

of the spectrum, is much less common (2.3%) and the women affected are mostly young. Pressure in society to be slim can lead to an internalisation of the dominant ideals of beauty and lead women to become dissatisfied with their bodies. One quarter of underweight women consider themselves to be 'just right' and one third of normal-weight women consider themselves to be 'too fat'. Factors such as age, education, employment status and family form lead to evident differences in women's health behaviour. This shows that sociocultural conditions, gender roles and corresponding role expectations have a crucial impact on health behaviour. Here, the gender differences observed for tobacco consumption are caused, on the one hand, by different socio-cultural behaviour patterns which was because smoking for women was a social taboo for a long time. On the other hand, women and men biologically react differently to tobacco smoke substances. And women, due to their higher sensitivity to tobacco smoke, are at greater risk of developing tobacco-related diseases.

Prevention and health care

Health promotion is aimed at increasing resources for maintaining good health; and prevention is aimed at avoiding illness. Cancer screening examinations are an important prevention measure and aim to detect cancer at the earliest possible stage and therefore, ultimately, reduce disease mortality. Around half of all women take part in early detection examinations for cervical cancer at the recommended intervals, and around three-quarters in mammography examinations. Within a year around one fifth of women in Germany participate in at least one behavioural prevention measure related to diet, exercise or stress management/relaxation – a higher proportion than men. Compared to men, a greater proportion of women also take part in occupational health promotion schemes for back health, nutrition and stress/relaxation. However, young women, women with lower education and single mothers do not make as much use of behavioural preventive measures. And health insurance funded workplace health promotion measures are mainly offered in companies that employ more men. In this way the expansion and target-group-specific design of measures could contribute towards greater gender equality and reducing differences in health opportunities which are conditioned by social inequalities.

Higher participation rates by women are not only evident with regard to prevention and health promotion measures, but also in the utilisation of health care services. Around 91% of women and 84% of men take advantage of outpatient medical services within a year, around 17% of women and 15% of men receive hospital treatment. The higher rates for women, particularly at a younger age, are attributed, on the one hand, to the use of gynaecological and obstetric services, and, on the other, to a different perception of health and a greater willingness to seek and accept medical assistance. The utilisation of rehabilitation services, self-help group participation and the use of medicines, both prescribed and self-medicated, is also higher among women than among men. The different ways in which medication affects women and men needs to be highlighted. Differences evinced during therapy should be taken on board as well as during research to make sure that drug therapy is safe for women.

Gender differences are also apparent in long-term care: around two thirds of those in need of long-term care are women, partly because of their longer life expectancy, and care for close relatives is predominantly carried out by women. Bearing the responsibility for the care of others as part of the female gender role is also compounded by the fact that women make up the majority of employees in the health care professions. This is particularly evident in occupations such as medical and practical assistance or geriatric care, where women account for 98% and 85% respectively. Nevertheless, women remain under-represented in top-level professional positions (e.g. senior physicians and chief physicians).

Health during the course of life

The essential foundations for health in one's later years are laid during childhood and adolescence. At this stage in life apparent health differences between girls and boys can already be observed. In childhood, girls are healthier and present fewer medically conspicuous issues than boys. For example, conditions such as bronchial asthma, hay fever and mental health problems are less frequent among 7- to 10-year-old girls than boys. In adolescence, which is altogether also a healthy life phase, we see a switch in health in relation to gender. Adolescent girls suffer from pain, sleep disorders and dizziness more frequently than boys. They also more

frequently present signs of eating disorders, as well as depression and anxiety symptoms. Girls report experiencing stress and being dissatisfied with their body and appearance much more often than boys. During puberty, they also tend to orientate towards role models for health and health behaviour patterns, which can comprise both positive and negative aspects. For example, compared to boys, they do less exercise but eat more fruit and vegetables.

Many women of working age are faced with the task of reconciling work with raising children or caring for relatives. In many cases, the self-assessed health of women who work is slightly better than that of non-working women; including when these women are mothers of children of school age or minors. However, when conflicts between family life and work arise, they can have a detrimental impact on health. Young mothers, single mothers, unemployed women and women caring for relatives are exposed to specific health burdens. A family, social and labour policy with a long-term focus could help women to develop a balance between gainful employment and looking after their families and therefore promote the health of women in mid-adulthood.

While it is clear that more older women tend to live alone than men, there is no gender difference between the degrees of experiencing loneliness. Almost half of all women aged 65 years and older rate their health as being good or very good. As a trend, subjective health increases over time. Around half of women aged 65 years and older have joint, bone, disc or back problems, and about one in three women report cardiovascular conditions or eye diseases. They therefore often take several drugs (polypharmacy). Dementia and depression, the most common mental illnesses at later stages in life, usually only affect women in old age (85 years and older). Around half of older women aged 65 years and older have signed a living will (Patientenverfügung) or a power of attorney (Vorsorgevollmacht), and more than one in three a full power of attorney (Betreuungsverfügung).

Health of women with a migration background

Almost 25% of women in Germany are considered to be from a migration background, i.e. they themselves or at least one parent does not have German citizenship by birth. The average age in this group is 36 years, roughly ten years lower than the average age of women without a migration background. Women with a migration background are a highly diverse group. Migration-specific factors (country of origin, length of stay and reason for migration) and sociodemographic factors (education, income and family situation) influence their living circumstances in Germany as well as their health and health behaviour. On average, women from a migration background are less frequently affected by chronic physical diseases such as diabetes, but are more likely to suffer from symptoms of depression. Compared to women without a migration background, they do not consume risky amounts of alcohol, but they are also less likely to do exercise. Differences in the utilisation of healthcare services and the quality of treatment are mainly due to language barriers. The data basis on the health of women (and men) with a migration background remains inadequate with gaps particularly in the area of health services research.

Sexual and reproductive health

Sexuality is a core element of health, and sexual and reproductive health cover a wide range of related issues which are interlinked manifoldly. Sexuality is mostly played out in long-term relationships. Throughout life, stability and fidelity in a partnership are highly valued. Following the sexual revolution of the 1960s and 1970s, restrictions have decreased and this has led to new freedoms for individuals. Nevertheless, within the context of sexual self-optimisation, both sexes appear to be feeling a new pressure to be sexually competent and successful.

The female reproductive phase is the period between the beginning (menarche) and the end of menstruation (menopause). Almost half of all girls have their first menstrual period at the age of 12. Women in Germany on average have their last menstrual period at just under the age of 50. Since the early 2000s, fewer and fewer women have received hormone therapy during the climacteric period. Reproductive behaviour in Germany is characterised by a low birth rate and having one's first child relatively late in life. The majority of women use some form of contraception. While younger women mainly use condoms or the pill, with age, more and more women use contraceptive coils. Since 2001, abortion figures have dropped. Most terminations of pregnancy take place within twelve weeks of conception according to the regulation of consultation.

Around a quarter of childless women of reproductive age are involuntarily childless. In 2018, almost 107,000 treatment cycles of artificial insemination were carried out, with a sharp increase over the last 15 years. 787,523 children were born alive in Germany in 2018. 30.5% of clinic births in 2017 were Caesarean sections. After a strong increase in Caesarean section rates in the 1990s and 2000s, a slight decline is now being observed and numerous initiatives now promote physiological birth.

Health effects of violence against women

In Germany, 35% of women have endured physical and/or sexual violence after the age of 16; mainly at the hands of partners or ex-partners. Socio-economic status does not determine the likelihood a woman will suffer violence; certain groups of women such as women attempting to end a relationship and women with disabilities, are more at risk than others. About half of all female victims of violence suffer injuries of varying severity as a result of physical or sexual violence. Among the physical and psychosomatic sequelae of violence against women are chronic pain, respiratory diseases and gynaecological conditions. The resulting psychological conditions specifically include depression, post-traumatic stress disorder, eating and anxiety disorders, as well as anxiety symptoms, stress symptoms and suicidal tendencies. Women who have experienced physical, sexual and/or psychological violence during their lives rate their own health status worse than women who have not. In Germany, there is a network of support institutions for women affected by violence. However, supply and access difficulties were observed selectively. Health care professionals play a particularly important role in detecting cases of violence and providing support. The Istanbul Convention on preventing and combating violence against women and domestic violence came into force in Germany in February 2018. It calls for comprehensive measures for intervention, prevention and support for affected women.

Health of women with disabilities

Around five million women and girls (12% of the female population) have an officially recognised disability, of which 3.8 million have a severe disability. Women with impairments and disabilities are a heterogeneous group facing highly diverse health situations and needs. On average, they rate their health status as worse and face higher levels of psychological stress than women without impairments or disabilities; potentially also because they are more exposed to violence and discrimination. Women with impairments and disabilities have a greater need for and also make greater use of healthcare services. At the same time, the lack of barrier-free services limits their access to health care, a fact that also applies to gynaecological treatment. For women with disabilities, enjoying a self-determined sexuality, being in a partnership and parenthood and society's acceptance of these roles remain important goals. This particularly applies to women living in supported living situations. In addition, there is a great need for sexual education and appropriate counselling. Highly relevant is also protection against (sexual) violence: women and girls with disabilities suffer violence much more often in their lives and experience sexual assaults two to three times more often than women with no disabilities. Not least, a pillar for the prevention of sexual violence is sexual self-determination. In order to develop targeted measures, the data situation on the health of women with disabilities should be improved.

Women's health in a European comparison

At over 83 years, the average life expectancy of women in Germany is as high as the average for EU member states. For women in Europe, cardiovascular diseases are the most frequent cause of death, followed by cancer. Results of the Global Burden of Disease study show that in the WHO European Region, ischaemic heart disease causes the greatest burden of disease among women. Risk factors that can be influenced are common: more than 44% of the women in EU Member States are overweight or obese. As for binge-drinking among women, at just under 19% Germany ranks second among the EU member states. However, at around 22%, the proportion of women who are physically active at levels that promote health is more than twice as high in Germany as the European average. The EU member states face similar challenges: demographic change, the associated increase in chronic illnesses and the need to support health-promoting behaviour and create health-promoting living environments. An EU-wide comparison of women's health data can help us to learn from each other.

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