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Gender budgeting as a tool for safeguarding women's health

Report[1]
Committee on Equal Opportunities for Women and Men
Rapporteur: Ms Ingrida CIRCENE, Latvia, Group of the European People's Party

Summary

The Committee on Equal Opportunities for Women and Men believes that gender budgeting should be an essential element in member states' health policies, and that the Committee of Ministers should promote gender budgeting also in the health field. Gender budgeting is an application of gender mainstreaming in the budgetary process. It means a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures in order to promote gender equality.

The Assembly should thus recommend that the Committee of Ministers ensure that member states apply Recommendation CM/Rec(2008)1 on the inclusion of gender differences in health policy, in particular the recommendations relating to the incorporation of gender mainstreaming into national health policies and strategies, including the collection of gender-disaggregated data and the use of gender impact assessments. The Committee of Ministers should also encourage member states to go further and to apply gender budgeting to the national health policies and strategies in order to allocate the budgetary resources in the health field in a fair and efficient way for both women and men.

1. Reference to committee: Doc. 11836, Reference 3545 of 29 May 2009.

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A. Draft recommendation[2]

1. Gender budgeting is an application of gender mainstreaming in the budgetary process. It means a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures in order to promote gender equality. The Parliamentary Assembly recalls its Recommendation 1739 (2006) on "Gender budgeting" in this context.

2. The Assembly welcomes the adoption by the Committee of Ministers of Recommendation CM/Rec(2008)1 on the inclusion of gender differences in health policy. In this recommendation, the Committee of Ministers made clear that a key determinant of health is actually gender (which is a social construct) as opposed to sex (which is a biological attribute), in that many differences and inequalities between women and men's health status stem from social, cultural (including religion) and political arrangements in society.

3. The Committee of Ministers put the question in the context of protection of human rights, and recommended that member states make gender one of the priority areas of action in health through policies and strategies which address the specific health needs of men and women and that incorporate gender mainstreaming. Unfortunately, however, gender budgeting as a specific tool for safeguarding women's health was not given adequate consideration.

4. There is, in fact, increasing evidence from all fields of health research that risk factors, clinical manifestation, causes, consequences and treatment of disease may differ between men and women. This means that, in turn, prevention, treatment, rehabilitation, care-delivery and health promotion need to be adapted according to women's and men's differing needs. Gender budgeting can make a crucial contribution to the actual delivery of healthcare which responds to these needs.

5. As in all fields of gender budgeting, it is essential that gender-disaggregated data be collected in member states in the health field, and that gender impact assessments be made. With these two tools in hand it is then possible to effectively move on to the step of gender budgeting, i.e. allocating the budgetary resources in the health field in a way which is fairer to women and men – and more efficient.

6. The Assembly believes that gender budgeting should be an essential element in member states' health policies, and that the Committee of Ministers should promote gender budgeting also in the health field.

7. The Assembly thus recommends that the Committee of Ministers:

7.1. ensure that member states apply Recommendation CM/Rec(2008)1 on the inclusion of gender differences in health policy, in particular the recommendations relating to the incorporation of gender mainstreaming into national health policies and strategies, including the collection of gender-disaggregated data and the use of gender impact assessments;

7.2. encourage member states to go further and to apply gender budgeting to the national health policies and strategies in order to allocate the budgetary resources in the health field in a fair and efficient way for both women and men;

7.3. instruct the competent committees to consider following up Recommendation CM/Rec(2008)1 with a recommendation on gender budgeting in the health field.

2. Draft recommendation adopted unanimously by the committee on 27 April 2010.

B. Explanatory memorandum by Ms Circene, rapporteur

1. Introduction

1. The Council of Europe has already done significant work in the gender budgeting field. The Parliamentary Assembly adopted Recommendation 1739 (2006) on gender budgeting in March 2006, on the basis of a report by our colleague Ms Anna Čurdová (Doc. 10764). This report included an expert paper by Ms Elizabeth Villagómez on the role of parliament in promoting and applying gender budgeting.

2. Gender budgeting – as a concrete tool in the framework of gender mainstreaming – has been the focus of several intergovernmental meetings as well, most recently the Conference on State Budgets: A Key Factor in Real Equality Between Women and Men, which was organised by our "sister" committee, the Steering Committee for Equality between Women and Men (CDEG), in Athens in May 2009.[3] On this occasion, a handbook on "Gender budgeting: practical implementation" was launched, which makes concrete proposals to governmental and non-governmental actors on how to use gender budgeting as a practical tool.[4]

3. The Council of Europe's Informal Network on Gender Mainstreaming dealt with gender budgeting in September 2005. The same network focused on gender mainstreaming in health in September 2006. Committee of Ministers Recommendation CM/Rec(2008)1 on the inclusion of gender differences in health policy also touched on this subject. However, I feel that the link between the two subjects remains to be made, which is why I tabled a motion for a resolution on gender budgeting as a tool for safeguarding women's health in February 2009 (Doc. 11836).

4. It is my intention to briefly outline gender budgeting principles in this report, and then to explain how the application of these principles in the health field could help to save many women's lives – and thus make our societies both more cohesive and more prosperous.

2. The principles of gender budgeting

5. Even though knowledge on gender budgeting is becoming more and more widespread, please allow me to briefly cite some paragraphs of Ms Čurdová's 2006 report, which explain the gender budgeting concept in a very exact and succinct way.[5]

> *"2.1. Definition*
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> *The Council of Europe's Steering Committee for Equality between Women and Men (CDEG) defines gender budgeting as 'an application of gender mainstreaming in the budgetary process. It means a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures in order to promote gender equality.'*
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> *This gender perspective is based on application of the gender mainstreaming principle in the budgeting procedure. This entails treating women's priorities and needs on an equal footing with men's and assessing the gender impact of budgetary policies, while making the budgeting process gender responsive at all levels and restructuring revenues and expenditures with the ultimate aim of achieving gender equality.*
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> *2.2. Principles*
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> *Public budgets are not neutral in their effects, since they are used to implement specific policies with implications for society and the economy. It is through the public budget that the political authorities shape social and economic development, decide priorities for action and determine needs-based redistribution criteria for society. These policies accordingly affect men and women in different ways, in terms of both revenue and expenditure.*
>
> *The aim of gender budgeting is not to draw up separate budgets for women, but to take better account of social realities. By stepping up the collection and analysis of gender-disaggregated data and giving an improved insight into the real added value generated by resources earmarked for women and for men, gender budgeting allows more equitable distribution of financial costs and benefits, while fostering more effective use of public funds.*

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3. In which I had the honour to participate as a Chair and panellist.
4. Copies are available from the Council of Europe Secretariat.
5. "Gender budgeting", report by the Committee on Equal Opportunities for Women and Men (Doc. 10764), pp. 3-4.

2.3. Objectives

Gender budgeting has three main objectives. First, it seeks to ensure that budget policies are equitable and to foster a reduction in inequalities and equality of opportunity, taking better account of the differing needs of women and men within the economy and society.

The second objective is to encourage more effective use of public spending, in keeping with predefined objectives, as regards the distribution of resources and services targeting men and women. Gender budgeting accordingly aims to improve the quality and the efficiency of public services in line with the differing needs of male and female citizens.

The third objective is to give people a better grasp of public revenue and expenditure and, hence, ensure greater transparency of public policies implemented by national, regional and local authorities."

3. Gender mainstreaming in the health field

6. In its Recommendation CM/Rec(2008)1 on the inclusion of gender differences in health policy, the Committee of Ministers made clear that a key determinant of health is actually gender (which is a social construct) as opposed to sex (which is a biological attribute), in that many differences and inequalities between women and men's health status stem from social, cultural (including religion) and political arrangements in society. The Committee of Ministers noted that gender inequalities can result in problems of access to health services, including to information, and that the lack of resources to promote gender sensitivity in health care providers could constitute structural barriers to quality of health care. This is why the Committee of Ministers pushed for more gender mainstreaming in the health field, since the recognition of gender differences and inequalities would add to the efficiency and effectiveness of health policies and health care services for both women and men.

7. The Committee of Ministers put the question in the context of protection of human rights, and recommended that member states make gender one of the priority areas of action in health through policies and strategies which address the specific health needs of men and women and that incorporate gender mainstreaming. They recommended the promotion of gender equality in each sector and function of the health system including actions related to health care, health promotion and disease prevention in an equitable manner, and encouraged the development and dissemination of gender sensitive knowledge that allows evidence-based interventions through systematic collection of appropriate sex-disaggregated data, promotion of relevant research studies and gender analysis, as well as the establishment of monitoring and evaluation frameworks on progress on gender mainstreaming in health policies.

8. I am aware of the fact that this recommendation is still very new, and that it is thus premature to expect all of its recommendations to already have been implemented. However, I feel that one of the most practical tools of gender mainstreaming, namely gender budgeting, is missing in the recommendation.

4. The potential benefits of gender budgeting in the health field: a case study – Cancer

9. The incidence of oncological diseases worldwide is growing. What is alarming is the fact that among these cases many are malignant tumours located in sites that are easily accessible for examination (e.g., cervical cancer, breast cancer, oral cavity cancer, etc.). They are referred to as visually detectable tumours. The mortality rate of visually detectable tumours is 3.5 times higher in women than in men.

10. According to the Eurobarometer survey "Health in the European Union" conducted by the European Commission in 2006, 29% of inhabitants answered that they have a long-standing illness or health problem. Each year 275 000 women develop breast cancer, and 88 000 women die with this diagnosis. Breast cancer is the main cause of death in women between 35 and 59 years of age. Increasingly younger women in the EU are developing mammary gland tumours. Some 35% of women who have developed breast cancer are younger than 55 years of age, and 12% have not even reached the age of 45 years.

11. When comparing standardised breast tumour mortality rates for women up to 64 years of age in the EU and in the Baltic states, the mortality rate is higher in the Baltic states. These rates might have been lower if timely diagnostics and adequate treatment had been provided. Thus it is imperative to draft national strategies for the prevention and early diagnosis of chronic non-infectious diseases.

12. The second most widespread tumour affecting women up to 45 years of age is cervical cancer. The greatest incidence of cervical cancer is found in women who are between 35 and 64 years of age. Main cause of cervical cancer is the human papillomavirus (HPV) infection, but there are also other factors contributing to development of this type of tumour. An HPV infection increases the risk of developing cervical cancer by 20 to 175 times. Cervical screening programmes are especially important for timely identification of this disease.

13. When comparing indicators in the EU member states, one comes to the conclusion that in post-communist countries the mortality rate is higher; that fact can be attributed to delayed diagnosis and treatment**.** Controllable risk factors for malignant tumours are smoking, alcohol use, a sedentary lifestyle, excess weight, unhealthy food, chronic infections and delayed diagnosis. This attests to the importance of education and awareness raising in maintaining good health.

14. One of the reasons for incomplete data on oncological diseases is insufficient accessibility of health-care services. This can be attributed to the distance between one's place of residence and the health-care service institution (health-care coverage), the qualification of medical personnel, patient co-payment, queues, and lack of information. Issues of health care accessibility are analysed in the EU survey EU SILC (Survey on Income and Living Conditions), which confirms the importance of these factors.

15. Since health care is regarded as a human right, the principle of gender equality should be applied to it as well.

16. One measure of society's health that is used worldwide is an indicator of premature deaths, or years of potential life lost (YPLL). It characterises premature mortality and preventable causes of death; it is also used to evaluate socioeconomic losses sustained by the state. Such causes of death might have been averted by taking preventive measures; therefore, these data facilitate prioritising issues related to the health of society. Years of potential life lost is an estimate of the average years a person would have lived if he or she had not died in an accident or from a disease. Years of potential life lost is an informative fact-based indicator of society's health.

17. The number of potential years of life lost due to death from external causes or acute cardiovascular diseases is five times higher in men than in women. An analysis of budget use for health care in member states of the Council of Europe shows that often emergency care is given priority, and that is easily understandable from the point of view of saving lives. An emergency situation most often involves cardiovascular diseases and external causes (traffic accident, suicide, homicide, drowning, alcohol poisoning, etc.).

18. In view of the fact that breast cancer ranks first as a cause of death and YPLL in women, budget allocation benefits improving the quality of life for men. Considering the use of the health care budget from the point of view of gender equality, it is important to discern a link between macroeconomics and effective use of money spent. As we know, "gender budgeting" does not require two separate budgets.

19. In order to improve use of the health-care budget, it is absolutely necessary to draft a national strategy based on data analysis and the financial resources of the budget.

20. With regard to improving female health and preventing possible causes of death in women, a specific programme is needed for women of reproductive age. The goal is a healthy woman who does not require a part of the national budget for medical treatment or disability benefits and who, being healthy, takes an active part in generating the gross domestic product and in paying taxes.

21. From the point of view of gender equality, it is essential to involve women themselves as decision makers in the whole process of drafting the budget. The result is crucial for all decision makers – for parliamentarians and members of government, for employers in order to strengthen macroeconomics, and for society as a whole in the context of the demographic situation.

22. Since the primary causes of female oncological mortality are breast cancer and cervical cancer, drafting a goal-oriented programme for preventing these pathologies is a striking example of gender budgeting. In order to ensure effectiveness of budget contributions, there are various prerequisites: a precisely formulated goal and a predicted result that can be statistically demonstrated. To obtain a scientific basis**,** there is a need for precise analysis of data according to a unified methodology and for sufficient time and factual materials to analyse pilot projects**.** This is the framework for long-term planning of effective budget use.

23. In applying this framework to the most dangerous and lethal oncological diseases in women – breast cancer and cervical cancer – the European Commission has adopted guidelines for breast and cervical cancer screening. On the basis of these guidelines, member states of the Council of Europe should draft

concepts and strategies for ensuring screening programmes for the target group of women, that is, women of reproductive age. It should be noted that screening is effective only as a co-ordinated health care policy, not as a decentralised screening enterprise.

24. Such screening includes diagnosing cervical cancer by performing a PAP smear once every three years for women 25-70 years of age; mammography once every two years for women 50-69 of age; and starting at 50 years of age, an annual faecal occult blood test. In view of the fact that the rate of incidence of cervical cancer is increasing, vaccination against HPV – the most common cause of cervical cancer – is now being widely introduced.

25. According to data of the European epidemiological surveillance (Eurosurveillance 2008), the following countries have assessed the cost efficiency of introducing vaccines against HPV before including this type of vaccination in their immunisation programmes: Slovenia, Belgium, France, Canada, the United States, the Netherlands, Denmark, Great Britain, Germany, Australia, Ireland, Norway and Switzerland. The most common reasons why countries did not assess cost efficiency was the lack of financial resources and the confidence that it is enough to rely on similar research conducted in other countries.

26. The research by Eurosurveillance shows that the main factors for introducing vaccination against HPV in Europe were a favourable cost-efficiency ratio and the expected epidemiological influence upon pre-cancerous lesions and the cervical cancer itself. The European Centre for Disease Prevention and Control (ECDC) concludes that vaccination against HPV is a cost-efficient strategy. Several publications mention that the first benefits of this vaccination will be evident after a couple of years.

27. In 5 to 10 years' time, it could be possible to reduce by 30% a high-risk HPV infection, by 40% to 50% pathological changes in a PAP smear and by 50% to 60% explicit cervical intraepithelial neoplasia. If vaccination of girls started at the age of 12, the number of cervical cancer-related cases would decrease by approximately 66%, and the number of deaths would decrease by approximately 67%. In total, approximately 1 889 years of life per 100 000 women could be saved. If the average salary is taken into account, the economic effect in each member state will be different. Nevertheless, it undoubtedly is a cost-efficient long-term strategy.

5. Conclusions

28. In view of the fact that the state budget is an instrument of macroeconomic policy, it is important to find the correct mechanism and methodology for introducing a gender-based budgeting strategy. It would help to save considerable costs and would significantly improve the quality of life not only for women but also for their relatives.

29. Since the 1995 4th World Conference on Women in Beijing, basic principles of gender equality are being adopted as a strategy and applied in more than 40 countries all over the world. The government – specifically the ministry of finance – plays the most important role in preparing the budget, and in doing so it co-operates with other ministries. The second most important ministry in planning health-care expenditures is the ministry of health, which formulates a national strategy and national policy. It is also very important to ensure that principles of gender budgeting are understood by officials at all levels of the civil service.

30. When drafting a research-based plan and calculating its efficiency, it is very important to keep in mind the need to achieve a "measurable result" and to assess its suitability for a given strategy. Usually, when the budget is prepared, officials give lip service to "gender neutrality", but in practice the budget tends to discriminate against women's interests. This is because "gender neutrality" is not the same as "gender equality" or "gender sensitivity". The government's duty is to protect the weakest and to prevent any form of discrimination. This can be done successfully by involving the NGO sector. A good example is the United Kingdom Women's Budget Group, which regularly conducts analysis of the United Kingdom budget and actively lobbies the parliament for higher allocations for women's health care.

31. The report of the Task Force on International Innovative Financing for Health Systems, co-chaired by United Kingdom Prime Minister Gordon Brown and World Bank President Robert Zoellick, was completed on 29 May 2009 at the 3rd task force meeting held in Paris. All task force members agreed to the final report and a set of recommendations that includes a range of innovative financing options which countries and other stakeholders can choose to support. One of the main recommendations of the task force report is Recommendation No. 6: "Strengthen the capacity of governments to secure better performance and investment from private, faith-based, community, NGO and other non-state actors in the health sector".

32. The World Health Organization, the United Nations and the World Bank also emphasise the importance of gender budgeting and point out that by investing in women's health, governments significantly promote social development. Back in 1994, the Vienna Statement on Investing in Women's Health in the Countries of Central and Eastern Europe recognised the introduction of screening for breast and cervical cancer as a priority.

33. An audit of the observance of the gender equality principles should be applied not only to specific ministries but to all social services, and it should include issues such as the accessibility of specific services, safety, the school system, foodstuffs and sports activities. These principles should be incorporated into national legislation, and the law should define the audit methodology, the system for data compilation, analysis and monitoring. Such streamlining of national legislation has begun in Belgium, Austria and Spain.

34. In 2001, the Organisation for Economic Co-operation and Development (OECD), the United Nations Development Fund for Women (UNIFEM) and the Nordic Council of Ministers held a Conference in Belgium on Strengthening Economic and Financial Governance through Gender-Responsive Budgeting. In March 2005, the Council of Europe's Committee of Ministers approved the Plan for Gender Equality (Order APV/526/2005) with regard to informative and statistical systems and introducing gender-responsive fiscal and budgetary policies.

35. Pursuant to the strategy for preventing the incidence of breast and cervical cancer and reducing the death rate from these diseases, all Council of Europe's member states should conduct data analysis in accordance with a uniform methodology and by following the existing WHO guidelines. They should develop and implement national strategies which include organised screening for tumours; early diagnosis of cancer would improve the effectiveness of treatment and the quality of life.

36. One of the main requirements is to raise public awareness by introducing health education in schools and promoting a healthy lifestyle; it is also important to raise awareness about the importance of self-examination. Comprehensive informative and educational campaigns, as well as health promotion measures, are vitally significant. The quality of services and their accessibility should be the cornerstone of these strategies. In drawing up national health care budgets, national anti-cancer strategies should be regarded as priorities.

6. Recommendations

37. As we have seen from the above, there is increasing evidence from all fields of health research that risk factors, clinical manifestation, causes, consequences and treatment of disease may differ between men and women. This means that, in turn, prevention, treatment, rehabilitation, care-delivery and health promotion need to be adapted according to women's and men's differing needs. Gender budgeting can make a crucial contribution to the actual delivery of health care which responds to these needs.

38. As in all fields of gender budgeting, it is essential that gender-disaggregated data be collected in member states in the health field, and that gender impact assessments be made. With these two tools in hand it is then possible to effectively move on to the step of gender budgeting, that is allocating the budgetary resources in the health field in a way which is fairer to women and men – and more efficient.

39. I believe that gender budgeting should be an essential element in member states' health policies, and that the Committee of Ministers should promote gender budgeting also in the health field.

40. The Assembly should thus recommend that the Committee of Ministers:

– ensure that member states apply Recommendation CM/Rec(2008)1 on the inclusion of gender differences in health policy, in particular the recommendations relating to the incorporation of gender mainstreaming into national health policies and strategies, including the collection of gender-disaggregated data and the use of gender impact assessments;

– encourage member states to go further and to apply gender budgeting to the national health policies and strategies in order to allocate the budgetary resources in the health field in a fair and efficient way for both women and men;

– instruct the competent committees to consider following up Recommendation CM/Rec(2008)1 with a recommendation on gender budgeting in the health field.