THE SCOPE OF ADULT AND FURTHER EDUCATION FOR REDUCING HEALTH INEQUALITIES

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SUMMARY

As set out in this proposal, a substantial body of evidence demonstrates that a large part of health inequality is accounted for by poor health among people who leave school without any qualifications. The social and employment life chances of those who miss out on this key social transition from school to adult life are greatly reduced.

As such, this proposal is centered on the substantive role of further and adult education in reducing social inequalities in health. This can be broken down into a number of constituent elements:

• Adults with no qualifications will likely need financial support to attend further and adult education institutions and obtain qualifications. Many may also need help with basic literacy and numeracy in order to get to the point where they can study for qualifications. Much of the focus of policy should therefore be on acquisition of skills and qualifications for disadvantaged adults.

• A case can be made for subsidising non-qualification-bearing courses, given the economic, social and health benefits which adult education can confer. In particular, older adults may benefit from non-vocational courses which boost wellbeing by providing mental stimulation and interest as well as opportunities for social interaction.

A successful policy framework is therefore likely to include:

• Financial support for those adults who left compulsory schooling with no qualifications, as they work towards achieving qualifications;
• Provision of literacy and numeracy courses for the substantial numbers of adults who struggle with these key skills;
• Encouraging greater participation in learning amongst older adults; and
• Harnessing the role of further and adult education institutions in overcoming disadvantage, given their community locations and ability to identify and prioritise needs at a local level, and through direct engagement with local communities.

Introduction: participation in adult learning and improved health and wellbeing

This proposal sets out evidence for increasing participation in adult education and learning as a tool to improve health and wellbeing, and to reduce health inequalities. There are a number of ways in which this increased participation could lead to improvements. These include:

• effects due to the development of specific skills;
• generic cognitive development;
• personal development, including enhanced self-esteem and confidence;
• opportunities for social interaction, both inside and outside the classroom; and
• economic benefits such as improved career prospects.

Evidence for the health and wellbeing benefits of adult learning

There is growing evidence of associations between participation in various types of adult learning and improvements in wellbeing, health, and health-related behaviours. Much of this evidence has been obtained by researchers using the rich data available in longitudinal birth cohort studies i.e. where individuals are observed from birth at multiple points in their lives. These sources of information have great advantages over cross-sectional data i.e. where a study of individuals is taken at one specific point in time. This is because they enable the researcher to understand the sequence of events in time – in this case, how health outcomes later on in life relate to earlier conditions and experiences.

However, in the absence of evidence from experiments, which would require adult education to be randomly allocated to a treatment group of subjects, it is still necessary to be very cautious in making inferences as to whether adult education had any causal impact on health or wellbeing outcomes.

Studies have used the 1958 British Birth Cohort to reveal relationships between participation in learning and healthy behaviours. For instance, after controlling for other factors, adults who engaged in at least one academic, accredited course increased their levels of exercise. Those who took at least one vocational, accredited course reduced their alcohol consumption. Other studies have estimated the effect of education on reducing the risk of depression during adulthood. Simulation results suggest that these improvements in mental health could result in healthcare savings worth some £230m annually (see also Kwame McKenzie's proposal in this publication, which argues for a greater focus on mental health and mental capital).

In addition, studies of adults in their 30s and 40s have reported a correlating relationship between measures of participation in learning and outcomes such as life satisfaction and/or psychological wellbeing. A study using data from the 1946 British Birth Cohort showed that, for adults in their early 50s, participation in adult learning was associated with improved verbal ability, verbal memory, and verbal fluency in late midlife, over and above the effect of formal educational qualifications by the age of 26. Furthermore, data from the English Longitudinal Study of Ageing (ELSA), a large-scale survey of adults aged 50 and above, has been used to investigate the impact of learning participation on various measures of psychological wellbeing. It was found that, after allowing for other influences on wellbeing, participation in learning was significantly associated with wellbeing outcomes. Amongst these older adults, it was leisure courses, rather than vocational courses, which appeared to have significant effects (and which could be seen in light of the proposal on 'age friendly environments' by Hal Kendig and Chris Phillipson in this publication).
Evidence for the role of adult learning in reducing health inequalities

The Marmot Review\(^7\) identified education as one of the key social determinants of health. As formal education tends to finish by early adulthood, poor educational outcomes can cast a long shadow over the life course (see Edward Melhuish’s article in this publication for a full review of the implications of early childhood education and care on wellbeing). The Review identified lifelong learning as one of the key interventions to reduce health inequalities. However, the report highlighted the potential pitfalls of such interventions. Investment in post-compulsory learning has been heavily weighted towards higher education among young adults, which disproportionately benefits middle class young people. Interventions that focus only on higher education risk increasing inequalities in health rather than reducing them.

The Review also highlighted the danger of interventions in training programmes that are only available to those in work. While such interventions may narrow inequalities in health among those in employment, they may also increase inequalities between the unemployed and the employed, many of whom do not have any formal qualifications. The Review suggests that lifelong learning needs to be available to the unemployed and economically inactive to have any effect on reducing health inequalities.

Unfortunately, in practice, access to further and adult education has tended to become more difficult in recent years, as funding has focused increasingly on young people and on full-time, rather than part-time, courses. For example, financial support for adult learners (aged 25 and over) with no previous qualifications, working on a level 2 qualification (GCSE A*-C grade equivalent), used to be provided by the government, but is now restricted to younger learners under the age of 24.\(^8\) While financial factors are not usually identified as the most important barriers to adult learning, the cost of learning does impact on learners and is more likely to affect socio-economically disadvantaged groups such as single parent families and ethnic minorities.

Evidence suggests that reductions in financial subsidies for adult learners may restrict an important avenue of social mobility, especially for those without any qualifications. Analysis of the 1958 UK National Child Development Study (NCDS) found that higher qualifications obtained during midlife were associated with lower coronary heart disease risk in both women and men.\(^9\) Men and women who left school without any qualifications during the 1970s were able to 'catch up' to some extent with more qualified people, in terms of lowering their risk of coronary heart disease, if they went on to obtain some qualifications in midlife. Furthermore, the protective effect – of obtaining qualifications in midlife – on coronary heart disease risk was larger for men who left school without any qualifications, compared with men who left school with O- or A-level equivalent qualifications.

Thus the value of education in midlife is greatest for those with the poorest education at the time of leaving school.

Further analysis from this study is shown in Figure 1. This shows the percentage of NCDS respondents reporting poor self-rated health from ages 23 to 50, by the levels of qualifications obtained when they were 20 years old and also later on in life. This shows...
that there were no differences between people who left school without any qualifications and those who obtained some qualifications in midlife in relation to their self-rated health at the age of 23. But as they grew older, significant differences in health appeared until there was around a 3% gap between these groups. However, this apparently beneficial effect of obtaining a qualification in midlife was not visible among those NCDS respondents who left school with at least one O-level qualification. There was no difference in self-rated health between those in this group and those who obtained a higher qualification in midlife. Again then, the benefit of gaining education was only found in those at the lowest educational level.

These results suggest that the health returns on adult education qualifications may be greater among people who left school with no qualifications. However, these results need to be replicated in other longitudinal datasets. Furthermore, there may be considerable selection biases in operation. This means that certain members of the population are more or less likely to be selected within the sample, thereby distorting the results. The concern here is that the association of qualifications with better health may not be causal, but a result of the self-selection of people with certain unobserved characteristics which have a positive impact on health, into later life education. For example, since some people who leave school without any qualifications voluntarily return to education later on in life, there is the possibility that these self-selectors are more dedicated to changing for the better than non-participants. These characteristics may include favourable personality characteristics, such as motivation, that enable them to successfully gain some qualifications later on in life. As these personality characteristics are often hard to specify and even harder to measure in surveys, it is hard to control for them in analysis of multiple variables.

Figure 1: Percentage of National Child Development Study (NCDS) respondents from ages 23 to 50 reporting poor self-rated health, who left school with no qualifications or with one O-level qualification by age 20, by additional qualifications gained in midlife.
Implementation: challenges and examples of good practice

There are several challenges that need to be addressed if adult learning is to play its full role in tackling health inequalities. Firstly, there is the challenge of overcoming barriers to participation. As the policy focus has switched in recent years to young people on full-time courses, participation rates in adult learning have decreased. In addition, participation from disadvantaged social groups, and those without any qualifications, is lower compared to more privileged social groups. There are various barriers to participation in adult learning that course provision and funding should be designed to minimise, especially for disadvantaged groups. These include:

- financial barriers;
- difficulties of access;
- lack of confidence about ability to cope with and complete courses; and
- a perception that the courses are not relevant to needs and interests.

Secondly, there is the challenge of ensuring that the system is sufficiently flexible to meet the actual needs of adult learners. A report on training for job seekers, published by education watchdog Ofsted, found many adult learning providers were not offering demanding courses that were likely to increase their chances in the workplace. Due to the centrally prescribed nature and output requirements of the national funding regime, many providers focused on the achievement of formal qualifications rather than tackling participants’ own often deep-seated barriers to employment, which included a lack of numeracy and literacy skills.

Thirdly, there is the demographic challenge. Britain is an ageing society. Older adults have, on average, the poorest health and the lowest levels of formal educational attainment. A number of major reports – including the Government Office for Science’s *Foresight Mental Capital Report*, and the NIACE Inquiry into the Future for Lifelong Learning – have emphasised the potential role for learning in later life. At present, education funding is heavily oriented towards early life stages. The NIACE Inquiry revealed that, of total public and private funding:

- some 86% goes to the under-25s;
- 11% goes to those aged between 25 and 49;
- 2.5% goes to those aged 50 to 74; and
- just 0.5% goes to older adults aged 75 and above.

It is, of course, entirely reasonable that the bulk of education funding should go to young people who are in full-time study. But, as the NIACE Inquiry argued, there is a good case to be made for a gradual and modest re-balancing of the education budget, shifting slightly in favour of older age groups. This would help to take account of demographic trends and maximise the scope for learning to contribute to a healthy and active old age.

**Example 1: older adults and informal learning**

Amongst the most vulnerable elderly – those living in care homes – informal learning can offer opportunities for social interaction and stimulating personal development. There has not
yet been much evaluation of what works best in this field, but some examples of innovative
approaches and good practice were gathered by NIACE, two of which are included here:

• A charity (First Taste) worked with 14 care homes in the Derbyshire Dales to provide
care staff with the confidence and ideas to support older residents’ engagement in
learning, to re-engage residents with learning and to introduce new technologies to
excluded adults. Each home was offered workshops with supporting handbooks and
learning requirements on a range of educational arts workshops such as gardening,
photography, painting and pottery. An independent evaluation identified a range
of benefits for residents and care staff, which included a reduction of a third in
medications such as anti-depressants and sleeping tablets.

• Younger Bengali women from an East London literacy project (Deesha) assisted older
Bengali women in learning English, through sharing experiences of literacy learning
and emotional and physical support. This led to increased self-confidence (especially
in relation to employment) and volunteering among the younger women, and reduced
feelings of isolation among the older women.

These examples are, in the main, of very informal learning activities. But it is this type of
learning which seems most likely to meet the needs of older adults in care home settings.
One further issue is how to facilitate information sharing. Gloucestershire County Council
introduced the position of Activity Coordinator Facilitator. The main tasks of the person
appointed included provision of support, advice and training across the County’s 176 care
homes. It was also a way to encourage networking and the sharing of good practice.

Example 2: ‘Prescriptions for Learning’

‘Prescriptions for Learning’ is a project that was undertaken in Nottinghamshire and
explored the potential for learning to play a role in improving health. It allowed healthcare
staff to refer individuals to a Learning Adviser, including: patients with mild to moderate
depression; people who are socially isolated and vulnerable; and people who want
something to do, or want to make more of their lives but may be anxious, fearful or unaware
of how to do that. An evaluation of the project found that many of those referred had no
qualifications and had not been involved in any learning since leaving school. The project
was very effective in engaging adults in learning who would not otherwise participate. The
evaluation also reported improvements in patients’ wellbeing, physical symptoms, health-
related behaviours and sleep problems, following participation in courses leading to formal
qualifications, practical skills and leisure opportunities.

Conclusion

Considerable research has been undertaken in the last 10 to 15 years on the benefits of
adult learning. The evidence base is a good deal stronger as a result of this. There is scope
for more research, including experimental studies which would help to address causality,
as well as evaluation and replication of the case study evidence. Research to date strongly
supports the view that adult learning is associated with better health and wellbeing.
Although there are few studies on whether this actually reduces health inequalities, a
policy focus on socio-economically disadvantaged groups, such as those who leave school
without any qualifications, is unlikely to suffer from the risk of increasing inequalities in health. Courses that focus on developing numeracy and literacy skills are key for adult education and employment prospects and are unlikely to be taken up by better off groups in society.

It is likely that the most beneficial forms of provision vary at different stages of the life course. In early adulthood and midlife, the acquisition of qualifications may be particularly important, not least because of the benefits of this type of learning in terms of remaining in employment or getting a job. For older adults, training which maintains skills will continue to be useful, as will courses on planning for eventual retirement. For the retired, especially, non-vocational courses which boost wellbeing by providing mental stimulation and interest, as well as opportunities for social interaction, will be most relevant.

A major concern must be the cutting back of funding for adult learning in recent years, and the declines in participation rates which have followed on from that. Increasing financial barriers for adult learners will be felt particularly acutely among socially disadvantaged groups, with potentially detrimental consequences in terms of health inequality. There is a strong case for the provision of financial support to those without any educational qualifications to attend further and adult education institutions and obtain qualifications. Funding is also important to encourage greater participation in learning amongst older adults. These are key components of an adult education approach to reducing health inequalities.

Note on the authors

Professor Tarani Chandola is a Professor of Medical Sociology within the Cathie Marsh Centre for Census and Survey Research (CCSR) at the University of Manchester. He joined CCSR in April 2010, and in January 2012 took over as head of the Disciplinary Area of Social Statistics. He was formerly at the UCL Research Department of Epidemiology and Public Health. He is the Co-Director of methods@manchester and the Meetings Secretary of the Social Statistics committee of the Royal Statistical Society. His research is primarily on the social determinants of health, focusing on health inequalities and psychosocial factors, and the analysis of longitudinal cohort studies. Much of his research is on stress at work and its effects on health. His current research projects include the MRC-funded FRAILL study (Frailty, Resilience And Inequality in Later Life), the ESRC-funded International Centre for Lifecourse Studies in Society and Health (ICLS), and a work-stress intervention study funded by the NIHR.

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