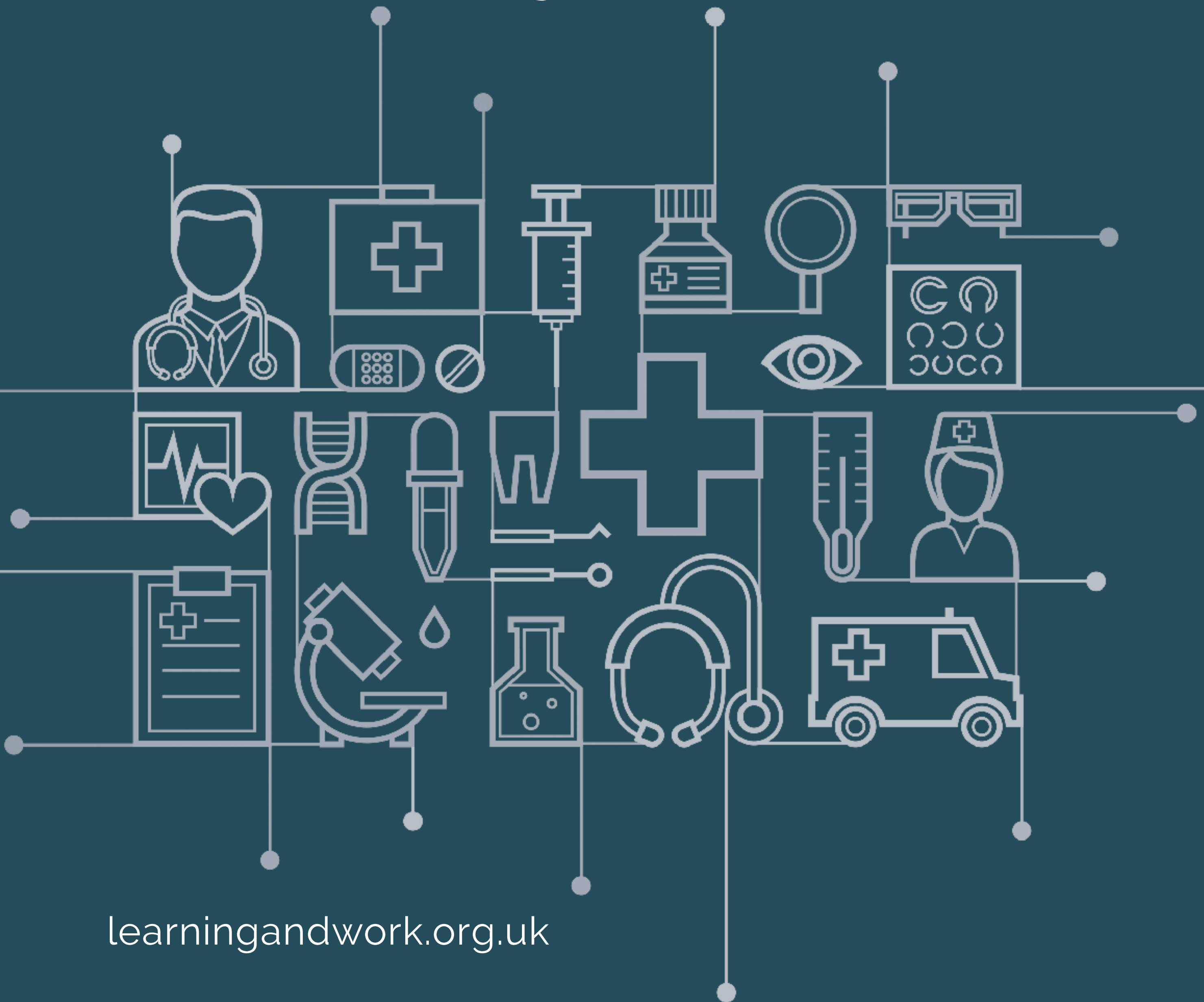
LEARNING AND WORK INSTITUTE

Learning, work, and health: the next 70 years



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Forum for Adult Learning NI

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Foreword

This year the National Health Service celebrates its 70th birthday.

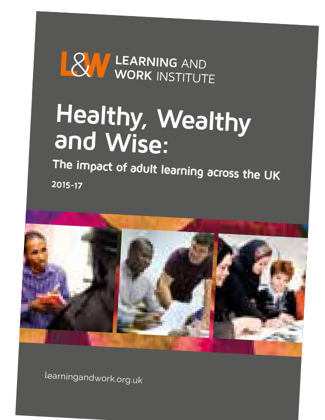
On July 5th 1948 the NHS was born, launched by Aneurin Bevan at Park Hospital in Manchester (today known as the Trafford General Hospital). It was viewed as the pinnacle of a hugely ambitious plan to bring good healthcare to all. Today it has grown to become the world's largest publicly-funded health service.

There is no question that the overall health of the population in England has improved greatly over the past 70 years, but we must also recognise that the **health challenges of 2018 are very different to those of 1948** – we are living longer, and that greater life expectancy brings with it long term health conditions and associated 'lifestyle' illnesses. It follows that the NHS must look more widely in its solutions to ensure that the healthcare of the population continues to improve.

This paper highlights the current challenges in relation to employment and the economy; and how participation in adult learning and access to fair and good work can have positive health benefits both for the individual and society.

In doing so we follow up many of the ideas in an earlier paper. *Healthy Wealthy and Wise: the impact of adult learning across the UK* highlighted international research on the social determinants of health. We have added responses to our recent public survey on attitudes to health, learning and work.

The evidence tells us that we need to address the social determinants of poor health. Prevention is cheaper than cure, and social solutions (such as access to learning and support to work) can also be part of supporting people with health conditions. We outline ways in which we can invest stretched public resources more efficiently and effectively.



We believe that learning, skills and employment support need to be a central part of improving health, reducing demands on the health service, and an integral part of meeting the challenges of the next 70 years.

Stephen Evans,
Chief Executive, Learning and Work Institute

Executive Summary

The National Health Service was always intended as part of a coordinated package of measures linked to inequalities in housing, welfare, work, and learning. However, over the past seventy years, as demands on the NHS have grown, policies for health, learning, and the workplace have been largely uncoordinated.

Our world is very different to that of 1948: we live longer, we smoke less but other 'lifestyle diseases' are still prevalent and cost millions to address. The focus of our health spending is largely on cure and rehabilitation rather than prevention.

And yet learning and work both have a clear role to play in working alongside the NHS to ensure a healthier Britain.

We know there are clear links between learning and health. Many international surveys have shown the increased likelihood of better health for people with higher educational levels. In addition, qualification levels are linked to how we make use of health services, manage our own health and that of those we look after.

Similarly, workplaces are critical to our health. Employed people spend a large part of their lives at work, and increasingly have longer working lives. But some aspects of ill health emerge in the workplace or are exacerbated by it, particularly back problems and mental health issues. Workplaces need to change, and employers need to play their part in supporting the health of the nation.

Generally speaking, work is good for us. But it has to be 'good' work—precarious and insecure employment can be harmful to our health. Those of us excluded from the labour market often face health challenges. Disabled people and those with long-term health conditions are more likely to be unemployed. Alongside the negative health effects of long-term unemployment, there is an underutilisation of talent that our economy needs.

Given this situation, we propose for discussion, six big challenges which, if achieved, would support a greater coordination of health, learning, and work as we move into the third decade of the twenty-first century.

We think that increased access to learning and employment opportunities can help to reduce demand for health services as well as improve outcomes for individuals, the economy and society. Better alignment of health services with learning, skills and employment will help the UK meet its future workforce needs and give everyone, regardless of background, a fairer chance in life. Interconnected issues deserve solutions that are interconnected.

- **Future funding of healthcare needs to better address the social determinants of poor health.** Prevention is better than cure, and social solutions (such as access to learning and support to work) can also be part of supporting people with health conditions. Extra and existing health funding should be appropriately targeted on these through: the NHS Forward View; increased investment in Public Health initiatives that link more closely with other devolved funding such as the Adult Education Budget; a £100m Work, Health and Learning Fund.
- **A coordinated approach** to health and associated services, including adult learning, and employment services, should be adopted locally with multidisciplinary teams to avoid unnecessary duplication.
- **Social Prescribing** to support learning linked to health, work and communities should be extended across the UK. We argue that linking social prescribing with entitlement to a Personal Learning Account would help give people greater choice and ownership over their learning, as well as more flexible help with the cost
- **Person-centred curricula**, using an asset-based approach, to enhance capabilities and existing knowledge, should be adopted, again making use of multidisciplinary teams.

- **Government should accelerate plans to transform how we support disabled people** into work, to stay in employment, and to progress. This should include a commitment to consult on new primary legislation both to reform the benefit system and provide support for employers.
- **Devolution Deal areas should work with government** to set out how they will halve the disability employment gap together and to then develop 'Local Labour Market Agreements' to deliver it. This provides the opportunity for greater flexibility for local areas, underpinned by a clear accountability framework.

In order to investigate this further, in June 2018 L&W polled 3,000 adults across England.

We asked three questions:

- How is your health in general?
- To what extent would you say that you know and understand how to keep healthy or improve your health?
- Which three changes would help you keep healthy or improve your health?

Our survey has shown that many of us have very different views on how healthcare spending should be allocated. For example, older people are more likely to favour investment in hospitals and other curative models. Younger adults, who are currently less likely to be experiencing ill health, favour a more balanced approach including social prescribing and preventative models.

Those people in poorer health are least likely to say they know how to improve their health. Generally speaking, the public seems to think a more balanced range of approaches are appropriate.

This is a critical finding at a time when government has pledged more funding for the NHS. How that plays out is important. The NHS is not an organisation but a set of interrelated services which need to work more closely in partnership with social care, local learning and employment services, and employers themselves.

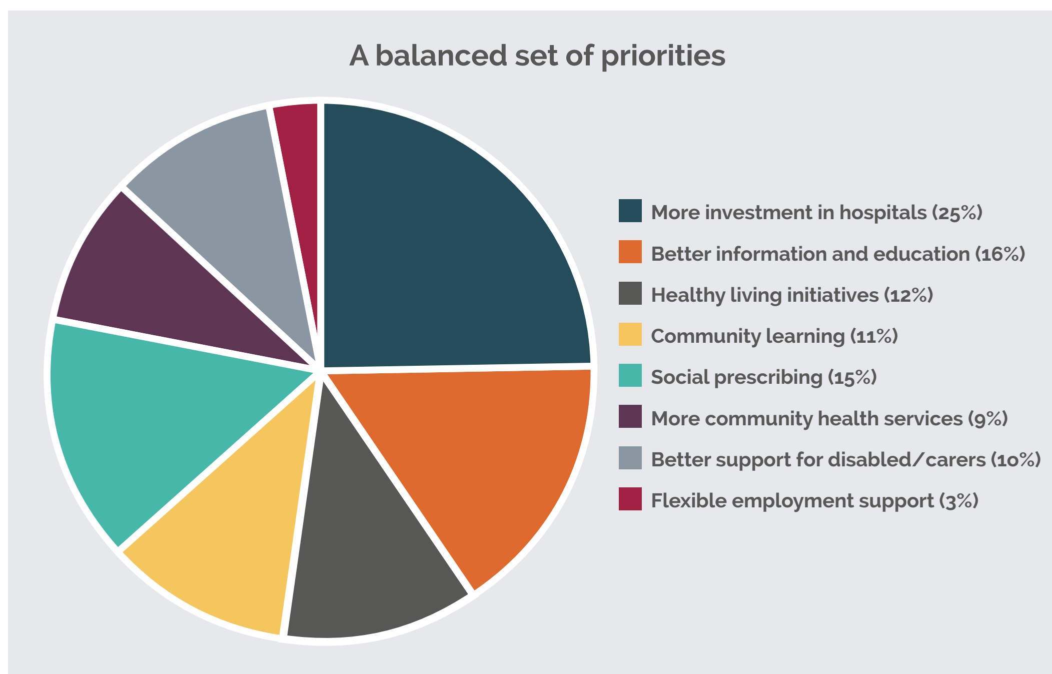


Figure 1: What changes would help you keep healthy or improve your health? (1st mentions)

Where have we come from?

First principles

Seventy-seven years ago, in the darkest days of the Second World War, a civil servant was asked to chair a committee on social insurance. So began the National Health Service's long journey into existence and the national institution it is today.

Hopes were not high in all quarters. The Treasury regarded Sir William Beveridge's committee as 'a tidying up operation' to deal with 'administrative issues rather than issues of policy'. The press had different ideas reporting the committee's work as 'the widest and most comprehensive investigation into social conditions… with the object of establishing economic and social security for everyone on an equitable basis'.[1]

From this 'comprehensive' approach the NHS was born, not as a separate 'health' initiative but part of an integrated solution to 'five giant evils'[2]:

- **Want**, what we would call poverty today
- **Disease**, the effects of poor health
- **Ignorance**, or educational disadvantage
- **Squalor**, the result of insufficient or poor housing
- **Idleness**, due to enforced unemployment or restricted access to work

Beveridge concluded that 'no satisfactory scheme for social security can be devised' without the 'following assumptions':

A. A national health service for prevention and comprehensive treatment available to all members of the community.
B. Universal children's allowance for all children up to 14 or in full-time education up to 16.
C. Full use of powers of the state to maintain employment and to reduce unemployment. (Section 1 of Beveridge Report.)

The elimination of poverty is linked to support for children throughout their **education**, proactive measures to support **employment**, alongside a **national health service**.

A coordinated vision?

The White Paper *A National Health Service* came out in February 1944. Alongside the principles of being 'free of charge' and 'comprehensive', it stated that all citizens 'irrespective of means, age, sex, or occupation shall have equal opportunity to benefit from the best and up-to-date medical and allied services available'. As Nicholas Timmins notes, the White Paper was less clear about *how* this would be done:

> It was now certain that a National Health Service, largely tax-financed, free at the point of use, and comprehensive, covering family doctors, dentists, hospital services and more, would arrive. Its precise form, however, remained far from clear.

Government stressed that the service should promote good health 'rather than the treatment of the bad'. Health promotion was there at the very beginning but was later removed from the remit of the Department

1 Timmins, N. 2017 *The Five Giants: A Biography of the Welfare State*. (3rd Ed.) Collins, London.
2 Cmnd 6404. 1942. *Social Insurance and Allied Services; Report by Sir William Beveridge*, HMSO, London.

NHS TIMELINE

Date	Event
5 July 1948	NHS launched at Park (now Trafford General) Hospital, Manchester
1952	1 shilling prescription charge, £1 flat rate dental charge
1957	Percy Commission report on mental health care recommending community not institutional care, and absorption into wider NHS
1958	Polio & diphtheria vaccinations
1959	Mental Health Act enacted Percy recommendations, repealing the Lunacy and Mental Treatments Acts (1890-1930) and the Mental Deficiency Acts (1931-38
1960	First UK kidney transplant
1961	Contraceptive pill widely available

of Health. For example, the link between smoking and lung cancer established in the 1950s took too long to lead to decisive action from the government. Preventative measures through the taxation system in 1956 would have certainly saved NHS expenditure 'downstream' as smokers made use of future health services.

Equality of opportunity was also a key principle of the 1944 *Education Act*, but what this entailed precisely given the lack of resources and the ambiguity around what constituted 'adequate provision' for adults has been a bone of contention ever since.

The difference between education and health at that time was the former was put in the hands of local authorities while the latter was firmly controlled by Whitehall.

Both education and health have seen many changes and reorganisations over the years, with varying degrees of decentralisation, delegation, and devolution. But, it is perhaps fair to say that they are largely on a twin-track approach. Both are separate too, in varying degrees, to developments in employment policy and the critical importance of the world of work to our health and well-being.

The separation of policy areas on the one hand, and the fragmentation of local and 'national' services on the other has led, despite all the success of the NHS, to inefficiencies and enduring health inequalities.

'Five Giant Evils': the Beveridge Report (1942)

Beveridge regarded focussing on social security alone as 'a wholly inadequate aim'; it had to be addressed as part of a wider programme:

> It is only one part of an attack upon five giant evils: upon the physical Want with which it is directly concerned, upon Disease which often causes the Want and brings many other troubles in its train, upon Ignorance which no democracy can afford among its citizens, upon Squalor. . . and upon the Idleness which destroys wealth and corrupts men.

Although Beveridge noted that Want (or poverty) was probably the easiest giant to tackle, he argued everywhere that a **comprehensive, joined-up approach was vital**. The lack of such cohesiveness had, indeed, formed the very definition of all previous approaches:

> In all this change and development, each problem has been dealt with separately with little or no reference to allied problems.

Not only health, but every aspect of social welfare had suffered similar discordance and incoherence:

> ...social insurance and the allied services, as they exist today, are conducted by a complex of disconnected administrative organs, proceeding on different principles, doing invaluable service but at a cost in money and trouble and anomalous treatment of identical problems for which there is no justification.

The phrase 'with special reference to the inter-relation of the schemes' appears in the opening paragraph. Beveridge placed coordination at the top of his three guiding principles:

> 'The first principle is that any proposals for the future, while they should use to the full the experience gathered in the past, should not be restricted by consideration of sectional interests established in the obtaining of that experience.

Social Insurance and Allied Services; Report by Sir William Beveridge

1962 Hospital Plan – programme to unify 3-part NHS structure – hospitals, GP and LHAs – and build district general hospitals in +125,000 population centres. First hip replacement

1965 Prescription charges abolished

1967 Salmon Report on nursing staff. Cogwheel Report on hospital organisation and problems of tripartite NHS structure. Start of 10-year Whitehall Study into social class-related health gradients, finding inverse ratio of mortality to employment grade. Abortion Act passed

1968 Prescription charges reintroduced. First UK heart transplant.

1972 CT scanners introduced

1975 Discovery of 'endogenous morphine' or endorphins as natural painkillers

Where are we today?

A fragmented system

> The basic challenge of the National Health Service is that it has a limited amount of money to spend and an unlimited number of ways of spending it.
>
> Tim Harford, *The Undercover Economist*

The world today is very different to the one Britons inhabited in 1948. More than ever we are dependent on global trade, competition and collaboration. Thanks to the NHS and advances in all aspects covered by the Beveridge Report, we are living longer, but health inequalities are stubbornly persistent.

As Lord Darzi has recently commented: 'despite a decade of austerity, the quality of care provided by the health and social care system has been maintained or improved. Yet it is also clear that the health and care system is under serious strain.' (IPPR, 2018)[3]

The 2017 NHS review of progress highlighted what it terms '**five paradoxes**':

- We're getting healthier, but we are using the NHS more.
- The quality of NHS care is demonstrably improving, but we're becoming far more transparent about care gaps and mistakes.
- Staff numbers are up, but staff are under greater pressure.
- The public are highly satisfied with the NHS but concerned for its future.
- There is now an underlying consensus about how care needs to change to 'future proof' the NHS, but the ability to do so risks being overtaken by what CQC [Care Quality Commission] has called today's 'burning platform'.[4]

Over time, health has accounted for a larger proportion of public spending. In part this reflects rising demand and an ageing population; in part the relative protection of health spending compared to other public services since 2010. However, with further cuts to other public services increasingly challenging, and economic growth weak by historic standards, we need to find new ways to manage demand for health services and deliver health improvements.

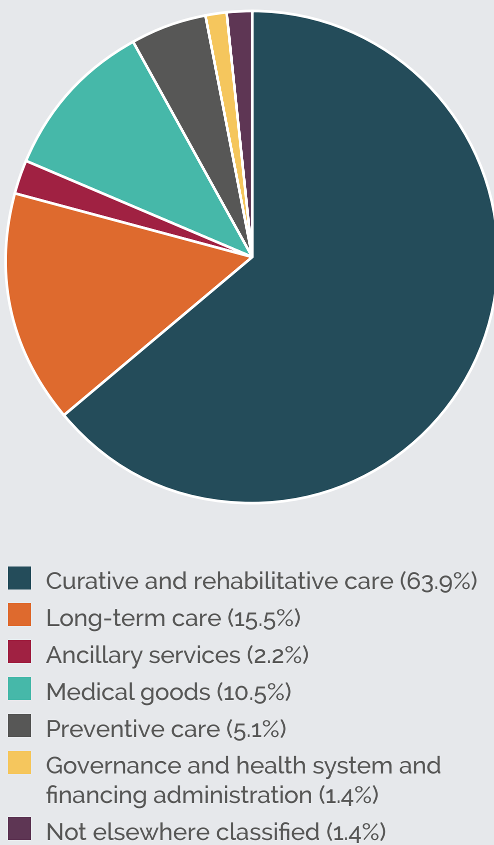
3 Better health and care for all: A 10-point plan for the 2020s The final report of the Lord Darzi Review of Health and Care (2018) https://www.ippr.org/research/publications/better-health-and-care-for-all

4 NHS England (2017). Next steps on the NHS Five Year Forward View. https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/

NHS TIMELINE

Year	Event
1978	World's first test-tube baby
1980	The Black Report into health inequality revealed widespread inequalities due to income disparities. Led to similar studies in 13 countries
1983	Mental Health Act introduced patient consent into treatment unless it is considered urgent ('sectioned')
1986	First AIDS health promotion campaign
1987	First heart, lung and liver transplant
1988	Breast screening introduced
1987	Whitehall Report showed that among British civil servants, mortality was higher among those in the lower grade

Figure 2: Government healthcare expenditure by healthcare function, 2016 UK



Source: Office for National Statistics

1990 NHS Community Care Act – Health Authorities to manage own budgets as Trusts

1994 Organ Donor Register established

1998 NHS Direct launched Acheson Report: 39 policy recommendations for reducing health disparities. Emphasised need to address social and economic determinants of health inequalities.

2000 Established NHS walk-in centres. NHS Plan set 4-hour A&E waiting time target

2002 Primary Care Trusts established (abolished 2013)

2008 Darzi Review – the largest consultation in NHS history – called for patient-centred approaches based on closer working between health and social care organisations

"We need to stop building health centres because they are principally focused on illness not health. The shape of primary care is pretty much unchanged since 1948... and it needs to change. We seem to continue to believe that our health system should be about responding to biomedical conditions not building healthy communities despite the fact we know that our health is 70% driven by social determinants."

Bromley By Bow Centre

Partly due to NHS successes, health care funding has largely focussed on addressing 'downstream' problems such as curative rehabilitative care and long-term care. Preventative care to try to address potential problems 'upstream' have suffered in the funding settlements.

The recent Lord Darzi Review of Health and Care (June 2018) puts forward a ten-point plan for the 2020s. The first point is:

> Invest in health, not just healthcare. This means embracing a 'health in all policies' approach across government and getting serious about tackling obesity, smoking and alcohol consumption.[5]

Admirable as this approach is, the review's recommendations sit largely within the 'health' bubble. There is little mention of the role of learning (beyond public health education) and the importance of workplaces in supporting a healthier nation.

The integration of health and social care is high on the policy agenda. The Five Year Forward View (2014) was, it has been argued, the first NHS document that said NHS structures did not have to be the same everywhere[6]. Healthwatch's preview of 2018 has identified the top five issues for people this year. Third on the list—after mental health services and adult social care—is 'services working better together'.[7]

The £6bn 'health and care' investment in this in Greater Manchester highlights an interest in local solutions through joining-up funding. But this also draws attention to another paradox.

The so-called 'integration paradox' is that although government is investing more in joining up services, it has also run-down some of the services it wishes to integrate with. Austerity cuts to the voluntary sector and local authorities has left them in a position where they lack capacity to contribute.[8]

As we shall see in the following section, these issues remain linked—they are as interconnected today as they were in 1948—the challenges and the solutions remain shared.

5 Better health and care for all: A 10-point plan for the 2020s The final report of the Lord Darzi Review of Health and Care (2018) https://www.ippr.org/files/2018-06/darzi-final-june18-summary.pdf
6 Timmins, N. (2018). Devo Health: some reservations, IPPR.
7 Healthwatch. (December 2017). Mental health tops people's health and care issues for 2018. https://www.healthwatch.co.uk/news/public-set-top-health-and-social-care-priorities-2018
8 Wistow, G. (2018). Hope over Experience: still trying to bridge the divide in health and social care, IPPR.

NHS TIMELINE

2009 NHS Constitution published covering patient rights

2010 Strategic review of health inequalities in England (Marmot Review) – proposes evidence-based strategy to address social determinants of health across the social gradient, pointing out that health inequalities are largely preventable

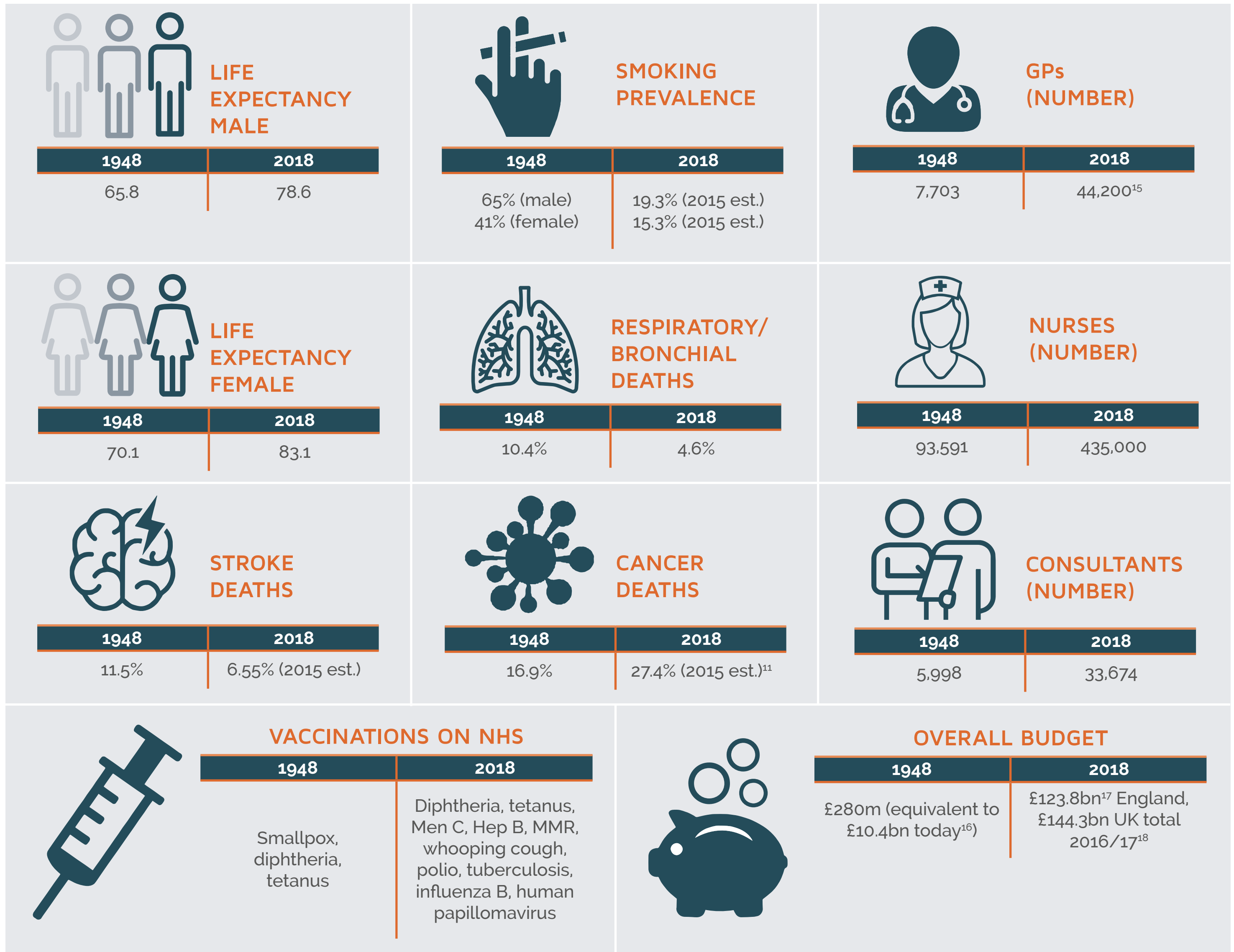
2010 Austerity cuts to local authority social care leads to increased demand on A&E and hospital beds. Opposition calls for National Care Service

2010 Liberating the NHS White Paper promotes competition and the application of procurement law to NHS

2011 Dilnot review of social care

2012 Health and Social Care Act proposes 'choice, decentralisation, and markets' approach

Health: then and now



2013

Public Inquiry into Mid Staffordshire NHS Foundation Trust demands more interventionist approach from Department of Health, but staffing levels reduced to half the number of the 1990s

2014

NHS Five Year Forward View. The programme envisions a radical upgrade in prevention and public health, decisive steps to break down the barriers in how care is provided and moves to hand patients far greater control of their own care

2015

Two-thirds of NHS Trusts in deficit

2016

Public Health England launched the first nationwide campaign to address preventable disease in adults. The One You campaign encourages adults, particularly those in middle age, to take control of their health

2017

NHS 111 Online piloted in 4 locations in England. This new service enables people to use their smartphone, laptop or tablet to access the same healthcare services and advice offered by the NHS 111 telephone service

2018

Prime Minister Theresa May announces new investment for NHS

What people told us

In June 2018, L&W polled a representative sample of about 3,000 people (aged 16 years and over) across England.

Our survey asked three questions:

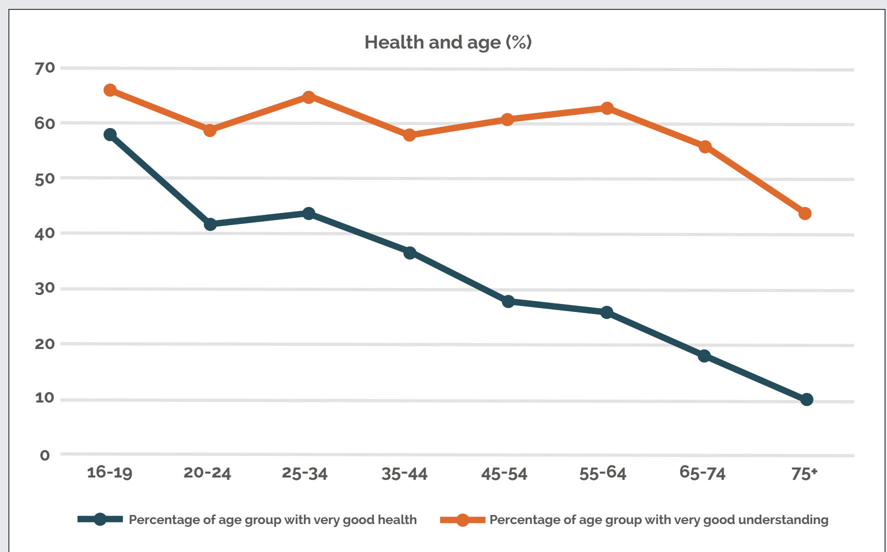
- How is your health in general?
- To what extent would you say that you know and understand how to keep healthy or improve your health?
- Which three changes would help you keep healthy or improve your health?

The survey told us a number of things:

Age matters

As we get older, we are less likely to say we are in 'very good health' or 'good health'. Around 90% of people under the age of 35 feel their health is good or better. This figure declines to 47% of those over 75 years. For people in late working age the figure is around 65%.

Understanding of how to stay healthy or improve our health also declines with age, particularly for those over the age of 75. Only 44% of this age group said they know how to keep healthy 'very well'. In some respects, this is to be expected: as we get older it is harder to keep healthy as our health declines.

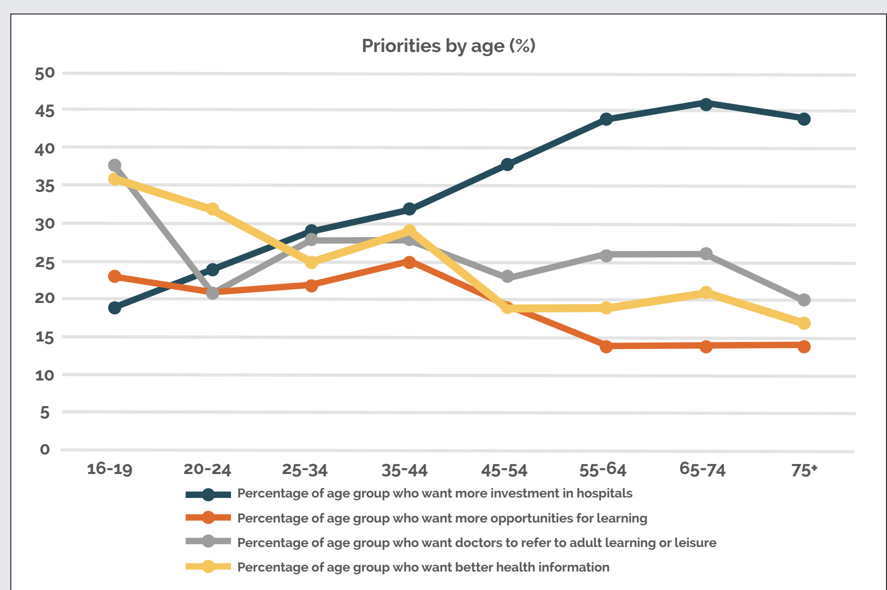


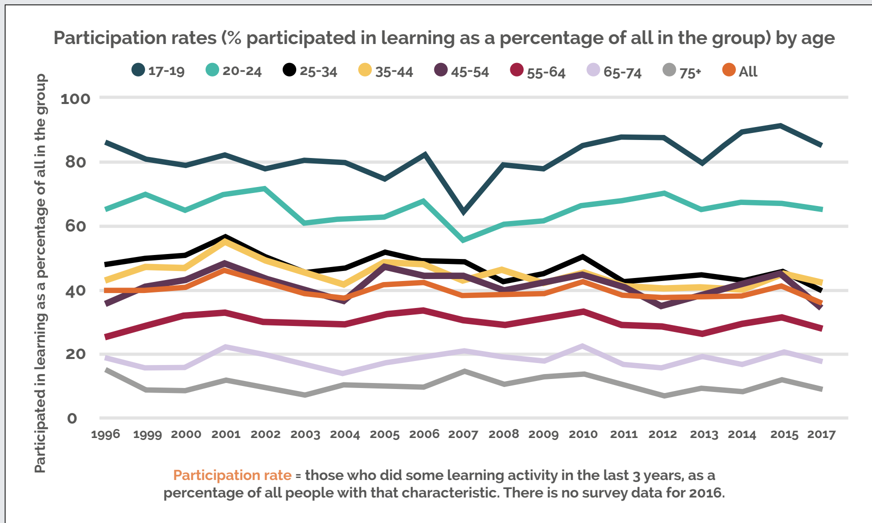
As we get older we are more likely to favour investment in curative models (hospitals and medical care); a higher proportion of younger people mentioned preventative models (social prescribing and community health initiatives).

Taking all priorities that people mentioned, less than a quarter of younger adults (under the age of 25) mentioned more investment in hospitals and medical care. This figure was close to a half of adults over 65.

When asked if they would like 'more opportunities to learn and be active in their communities' about a quarter of adults under 45 agreed.

This figure declines steeply after 55 to around 14%.





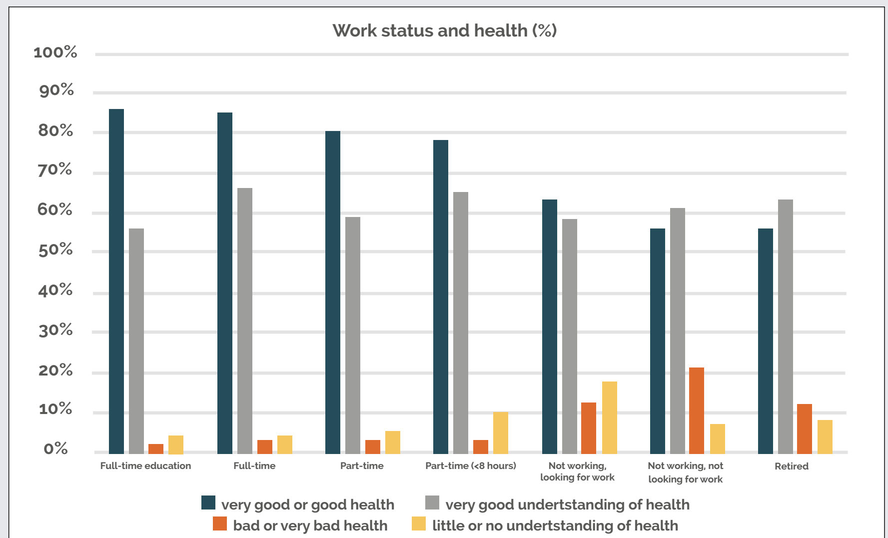
Through our annual participation in learning survey, we know that taking part in learning also declines with age. However, we know from the same survey that as we get older we are more likely to learn for personal reasons (such as staying healthy).

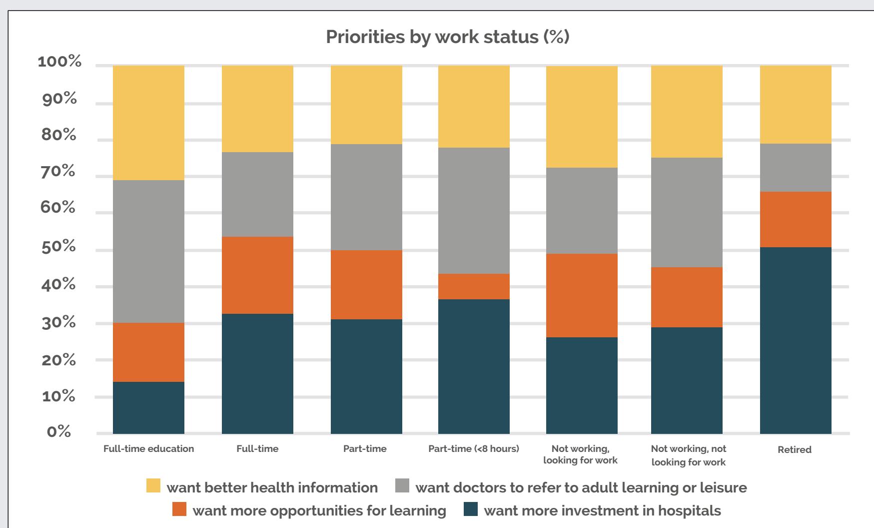
The decline in participation in learning is particularly steep for those over 55. This is precisely the time when our health shows the most marked decline.

Work is important too

Nearly two-thirds (65%) of people who work full-time regard themselves as being in 'very good' health. However, this figure falls to just 46% of those working less than 8 hours a week. Only 3% of those in full-time work felt they have 'very bad' or 'bad health', compared to 21% of those who are 'not working and not looking for work'.

Understanding of health is lowest for those 'not working and looking for work': 17% said they have 'little or no' knowledge or understanding of how to keep healthy.



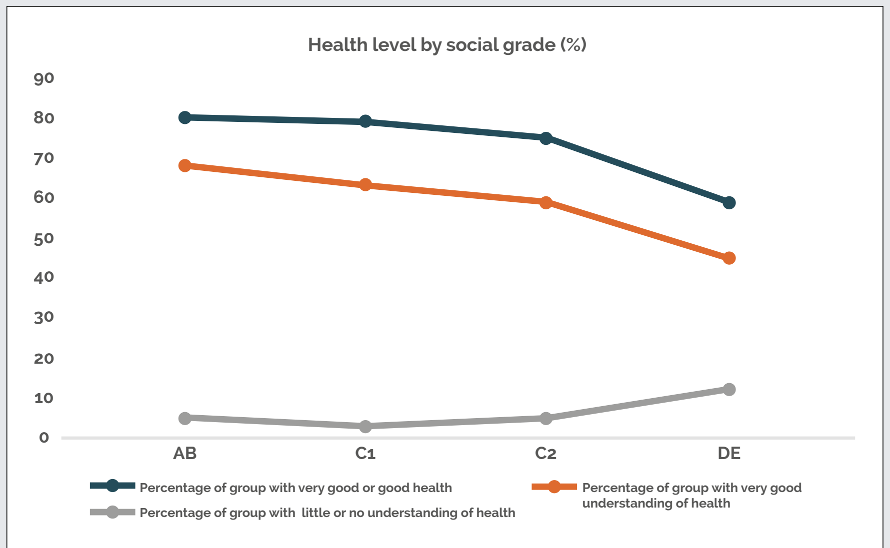


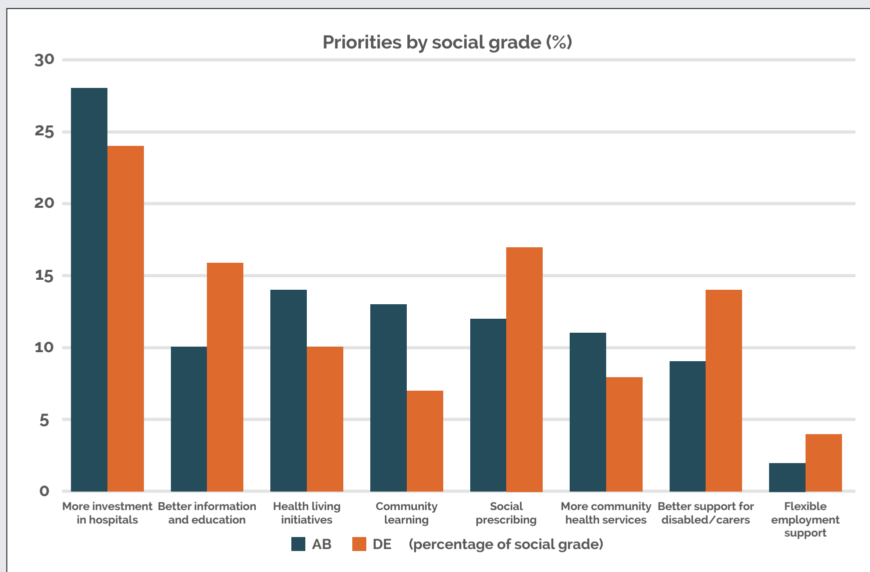
A higher proportion of retired people mention the need for more investment in hospitals (or other medical treatment); the lowest proportion is among those in full-time education. Both of these categories correlate to age groups, where those people in full-time education are likely to be in the younger age groups. Differences between those in full-time and part-time work are negligible except in the category of 'doctors making referrals to adult learning or leisure provision' (such as gym or swimming). For those 'not working but looking for work', the most mentioned area is 'better support for people with health problems and disabilities in work, including more flexible employers' (26%).

Where we are on the 'social gradient' matters

Measures of socio-economic status used in market research is closely related to occupation. AB includes 'higher managerial, administrative or professional' jobs, whereas DE includes semi- and unskilled workers, those in insecure work, and people in receipt of income-based benefits.

In our survey, 80% of ABs consider themselves to be in very good or good health. For DEs this figure falls to 59%. Sixty-eight percent of ABs have a very good understanding of health matters (45% of DEs). In terms of having 'little or no knowledge', 12% of DEs admit to this (4% of ABs).

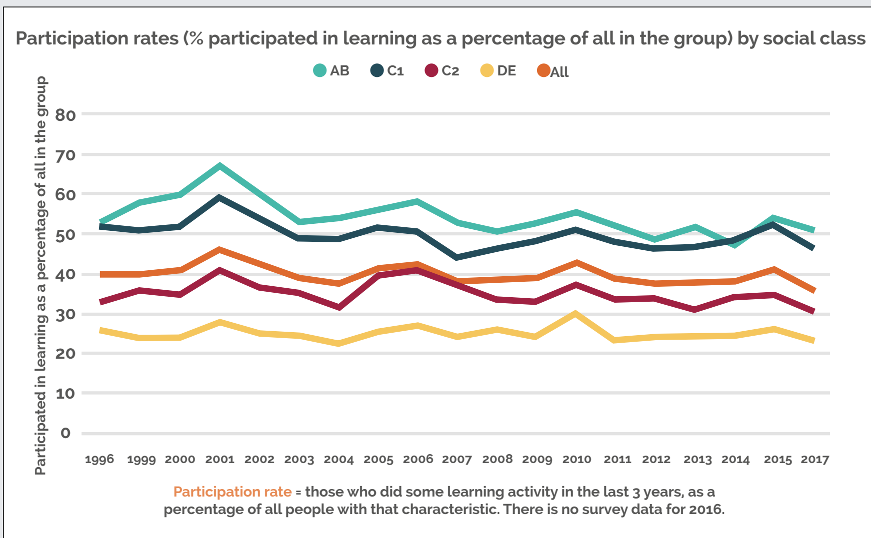




If we compare the first mentioned area that people feel would keep them healthy or help improve their health, the prioritisation made by ABs and DEs has a different balance.

Only 7% of DEs prioritise investment in 'more opportunities for people to learn and be active in their communities' compared to 13% of ABs. A higher percentage of DEs (14%) prioritised better support for disabled people in work, compared to 9% of ABs.

More DEs (16%) prioritised 'better information and education about [their] health', compared to 10% of ABs. Approaches to social prescribing seem to be slightly higher priority to DEs than ABs.



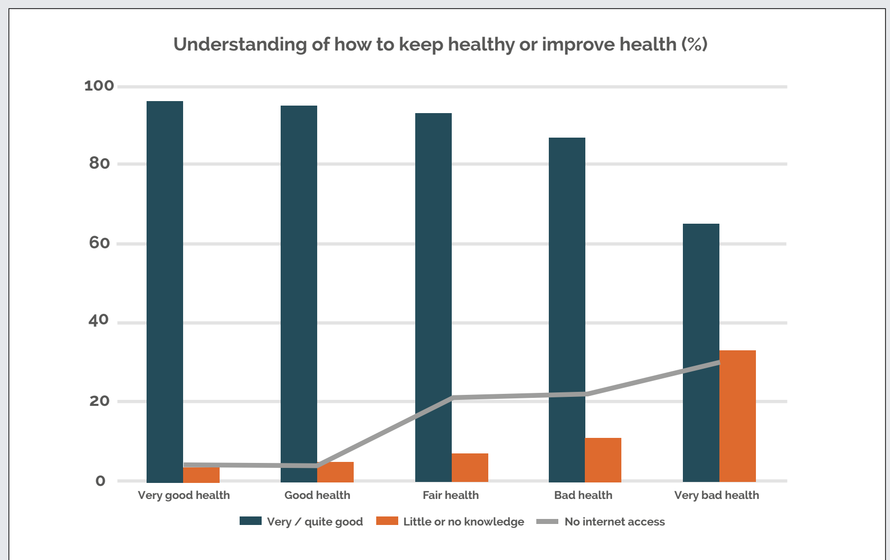
And yet… participation in learning is closely related to socio-economic status. The health divide is broadly similar to the learning divide.

People in good health, have a better 'understanding' of how to keep healthy

Of adults who have 'very good health', 96% said they know and understand how to keep healthy or improve their health very or quite well. Just 4% of this group have little or no understanding of their health needs. This figure rises to one-third of those people with very bad health.

Access to the internet could be a contributing factor and increasingly important as public services, such as the NHS, become 'digital by default'.

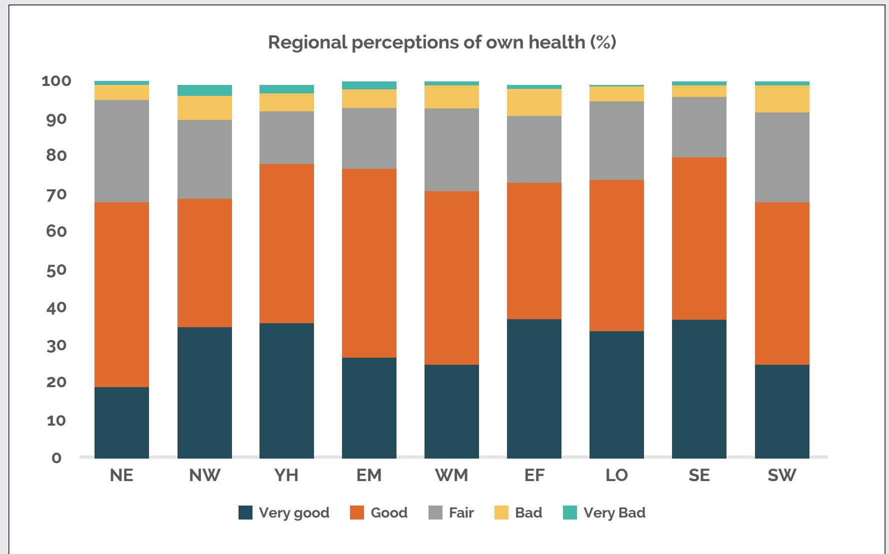
Although gender doesn't seem to be a factor in how healthy we feel, women have more health-related knowledge than men. 95% of females said they know and understand how to keep healthy or improve their health (92% of males). Men are more likely to say they have 'little or no knowledge' (7% of males, 5% of females).



Where we live matters

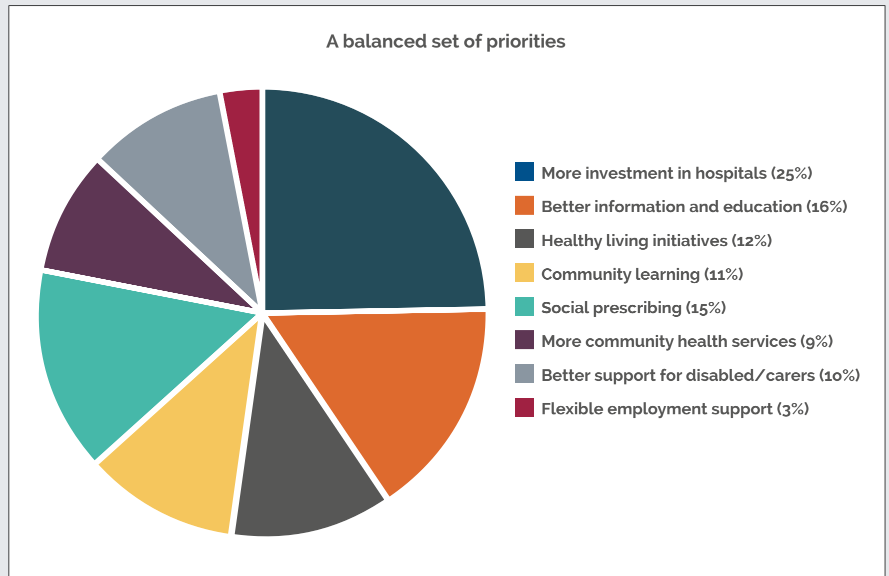
As we have seen, our health is linked to other areas of inequality and deprivation. Many reports have shown that the poorest areas are more likely to have lower levels of education, health, wealth, and quality housing. Our survey could not drill down into these areas, but a number of regional disparities were highlighted.

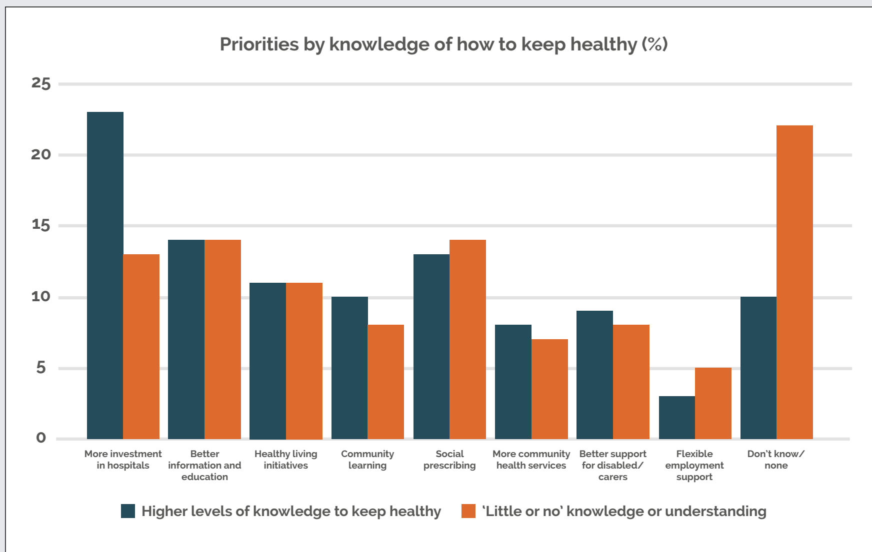
Of those living in the South East (SE) and East of England (EE), 97% feel that they know how to keep healthy or improve their health, compared to the other regions: London (LO-94%), South West (SW-93%), West Midlands (WM-92%), Yorkshire and the Humber (YH-91%), North West (NW-90%), and North East (NE-88%).



What would make things better?

When asked to name three things that would make a difference to help to keep them healthy or improve their health, just over a third of people (35%) mentioned more investment in hospitals and medical treatment. This percentage increases with age, as more people experience poor health, and rely on curative interventions. As a first mention, this figure fell to a quarter of respondents perhaps indicating that most people regard community-based and preventative interventions more important. For example, nearly one quarter (24%) of adults under 45, wanted better information and education about their health compared to 16% of the whole population.





However, people mention a range of possible responses, including an increase in social prescribing by GPs referring to either leisure/gym classes or adult learning classes (15%). 'More opportunities for people to learn and be active in their communities' (community learning in the chart) was prioritised by 11% of people.

Age and work status can determine how we respond when asked to identify the three changes that would help us keep healthy or improve our health. Younger people and those in full-time education are less likely to favour extra investment in hospitals and medical treatment. Those with lower understanding of how to stay healthy are more likely to answer 'don't know' or choose none of the options listed.

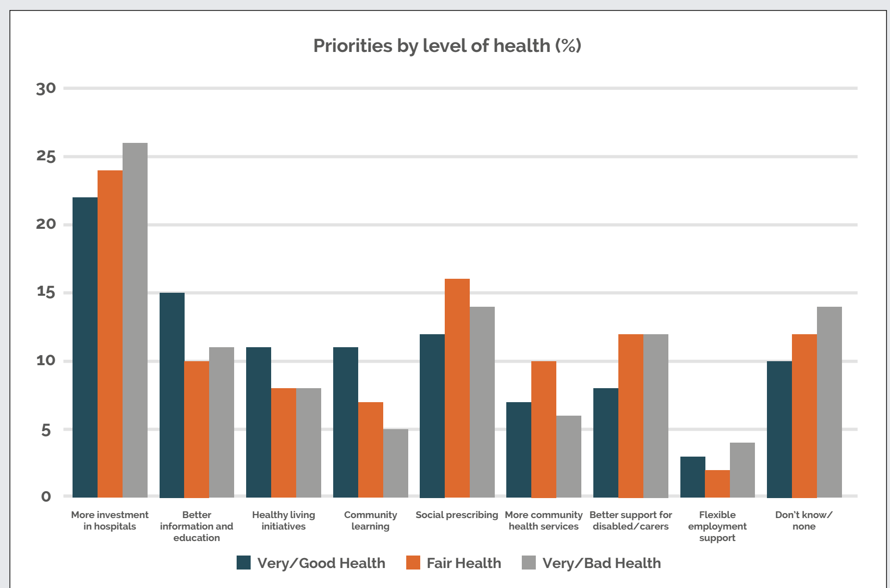
Understandably, people with bad or very bad health were more likely to prioritise extra investment in hospitals / medical treatments. A higher proportion of those in very good or good health favoured more opportunities for people to learn and be active in their communities.

People in very good or good health were more likely to mention:

- more opportunities to learn and be active in their communities
- better information and education about their health
- health professionals supporting healthy living initiatives

People in very good or good health were less likely to mention:

- more investment in hospitals
- social prescribing, where doctors make referrals to gym, swimming, or adult learning
- better support for people with health problems and disabilities in work



Learning, Work and Health

"There is large variation in how many years people can expect to live in good health across the UK. Differences in education, employment opportunities, lifestyle behaviours, social mobility and the wider local environment all have a major impact with males and females in some parts of the UK living 14.1 years and 15.0 years longer in "Very good or good" health than others."

Jodie Withers, Health Analysis and Life Events, Office for National Statistics[9]

> In Britain we have a National Health Service, the evidence shows that low-income is mostly not a barrier to access. Yet we still have inequalities in health.
>
> Michael Marmot, *The Health Gap*.

Both good quality learning and good quality employment are, to use Marmot's phrase, 'protective of health', whereas being learning-poor and being out of work is harmful to health. Learning and fair work are protective because they improve wellbeing, and give us agency. Their absence is harmful because it contributes to poor mental health, social isolation, and poor self-management of health.

Learning and health

> Learning… has clear links to improved health behaviours, such as reduced likelihood of smoking, including through being better able to understand health information provided.
>
> L&W / JRF, *Skills and Poverty*, 2016[10]

As UNESCO's most recent *Global Report on Adult Learning and Education* states adult learning improves health behaviours and attitudes; involvement in education helps develop a greater ability to understand and manage our own health. Learning helps divert individuals away from dependency on health providers and enables the health service to focus on clinical needs and consequently increase efficiency and effectiveness.[11]

Disability-free life expectancy is linked to the levels of education achieved. There are strong links between health, longevity and the time spent in initial and continuing education. As we live longer, the likelihood of having long-term complex conditions is greater. The costs of health and care increase as we age so remaining healthier longer reduces pressures on the health service.

Lifestyles: the way we live in relation to diet, exercise and the use of alcohol can have detrimental effects on our health. Adult learning provides the tools for people to influence their environment and, according to UNESCO, helps to 'make them healthier'. Adult learners develop greater confidence through their learning which helps them to access and understand information, systems and support as well as participate in groups and networks, which facilitate healthier lifestyles.

Mental health and well-being: 25% of adults in Britain will experience a diagnosable mental health condition in any one year and figures are rising, with suicide amongst young men in particular, being the biggest killer in those under 30 years of age.

LEARNING AND HEALTH KEY FACTS

- Disabled people are three times more likely not to hold any qualifications compared to non-disabled people
- 19.2% of working age disabled people do not hold any formal qualifications
- For people aged 30 and above, if everyone without a degree had their death rate reduced to that of people with degrees, there would be 202,000 fewer premature deaths each year. (Marmot, 2010)[12]
- 43% of adults aged 18-65 do not routinely understand health information[13]
- 25% of males (16-74) with no qualifications have life-limiting illnesses (12% males with level 3 qualifications and above).[14]

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9 Office for National Statistics. 2016. Health expectancies at birth and at age 65 in the UK, based on 2011 Census health and disability prevalence data: 2010 to 2012 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthexpectanciesatbirthandatage65intheukbasedon2011censushealthanddisabilityprevalencedata/2010to2012

10 Learning &Work Institute / Joseph Rowntree Foundation. 2016. *Skills and Poverty: building an anti-poverty learning and skills system*. http://www.learningandwork.org.uk/sites/niace_en/files/files/Skills%20%20Poverty%20Sep%2016.pdf

11 Unesco Institute for Lifelong Learning, 2016, 3rd Global Report on Adult Learning and Education, Hamburg, Germany, UIL http://uil.unesco.org/adult-education/global-report/third-global-report-adult-learning-and-education-grale-3

12 Marmot, M. 2010. *Fair Society, Healthier Lives*. https://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

13 CHL Foundation, 2014. What do we know about the format in which people with low levels of health literacy prefer to receive information? A review of the literature http://www.chlfoundation.org.uk/pdf/Lit%20Review%20Fin.pdf

14 Office for National Statistics Longitudinal Study quoted in Marmot. 2010

Adult learning also plays a key role in addressing the Health Literacy challenges faced by people in navigating health systems, making informed choices and managing their health. According to 2012 research 43% of adults aged 18-65 do not routinely understand health information. This figure rises to 61% when an element of numeracy is involved, which shows the importance of basic skills.

Health Literacy is defined by the World Health Organisation (WHO) as '**the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health**'. Health literacy means more than just being able to read pamphlets and successfully make appointments. By enabling people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.

Work and health

Being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for reducing health inequalities. However, jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health.

Michael Marmot, *Fair Society, Healthy Lives*,

The UK has a high employment rate (75%), but 3.1 million Britons are in insecure work, a rise of 0.5 million between 2012 and 2016.[15] This includes zero hours contracts, part-time work and under employment of people with skills and qualifications which are not being used. 6.9 million adults aged 16-64 have a long-term health condition or disability but only 47% of disabled people are in employment.

Of the 3.6 million disabled people who are out of work, nearly half (47%) are neither looking for work nor available for work – this is three times the rate for those who are not disabled. Disabled people are also half as likely to be actively looking for work as their peers who are not disabled.

Disabled people are a diverse group with a range of capabilities and support needs. This includes some people with impairment-specific barriers as well as those with broader and common barriers such as time out of work, low skills, low confidence and lack of work-readiness. Many face multiple disadvantages. Employment rates are lowest for those with more significant impairments, for older disabled people and for those with mental health conditions.

Health and work is a two-way street. For some people access to work will help improve their wellbeing and reduce their dependency on the NHS. In other cases, workplaces cause stress and increase the burden on health services. But all employees and workplaces are not the same. For example, employees in micro-businesses (1-9 employees) are twice as likely to leave work and move onto Employment Support Allowance (ESA) without a period of sickness absence than those in larger businesses.

"Good work supports our good health. It keeps us healthy, mentally and physically. It enables us to be economically independent and gives us more choices and opportunities to fulfil other ambitions in life… too many people are missing the opportunity to develop their talents and connect with the world of work, and the range of positive impacts that come with doing so—including good health and social outcomes."

Ministerial foreword, *Improving Lives: the future of work, health and disability*, 2017

15 Learning and Work Institute (2017) What is driving insecure work. http://www.learningandwork.org.uk/wp-content/uploads/2017/07/What-is-driving-insecure-work-_-July-2017.pdf

> *"It's vital to reduce not only the disability employment gap – important as that is – but also the disability PAY gap. Disabled people in work are paid about £1.50 an hour less than non-disabled people – a pay gap of 14%. …. Poverty is deeply associated with disability, among those in work as well as out of work. Research finds half of all households using food banks have at least one disabled member as do almost half of all households in poverty."*[19]
>
> Liz Sayce, former CEO of Disability Rights UK

WORK AND HEALTH KEY FACTS

- 131m days lost each year for sickness absence, of which 'stress, anxiety and depression' is 15m days
- Absence from work annually costs £13bn in health-related benefits and £2bn in healthcare, sick pay and foregone taxes
- 72% of people entering treatment for alcohol problems were not in paid employment at the start of treatment
- 42% of employees experience at least one period of sickness absence per year (7% are off work for 2 weeks or more)
- 17% of unemployed people report having a limiting long-term condition (9% for employed people)
- Almost half of ESA claimants had 'mental and behavioural disorders' in August 2015
- 47% of unemployed 50-64-year olds have been out of work for a year or more
- 7.2m 50-64-year olds are employed, but 42% of them are living with a health condition or disability
- 46% of long term absentee employees are aged 50 or over

Employment rates are lowest among those with no or few qualifications and skills, people with disabilities and mental ill health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people. When in work, these same groups are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Many are trapped in a cycle of low-paid, poor quality work and unemployment.

Insecure and poor-quality employment is associated with an increased risk of our physical and/or mental health worsening, from conditions caused by work that in turn lead to absence due to illness, and worklessness. The main work-related ill health are common mental health problems and musculoskeletal disorders. Being without work is not good for our health, but while 'good work' is linked to positive health outcomes, jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill.

Some groups are particularly at risk and are, rightly, the focus of increased government attention. Recent independent reviews carried out by Dame Carol Black[16], Matthew Taylor[17], and Lord Stevenson / Paul Farmer[18] focus on the role of employers in addressing access to 'good work'.

The Government is taking forward many of the ideas in the above reviews and initiatives, including rolling out more employment support in health contexts where employment specialists are embedded into local clinical teams. The aim is to support recovery and increase access to paid employment. An integrated approach between health and employment professionals is essential. Such approaches will benefit employers, individuals and the health service in the long-term.

Improving Lives: the future of work, health and disability proposes reform in four interlinked areas:

- Employment support services
- The welfare system
- The workplace
- The healthcare system

The government's ambition is to incentivise the number of disabled people in work by one million over the next ten years.

The focus is on getting people into a job and helping them stay there. In order to do this the move from ESA to Universal Credit is essential. Work coaches, the government argues, will need more training to work with people with health conditions (including mental health) and disabled

16 Black C. An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity. Cm 9336; 2017. Available from: https://www.gov.uk/government/publications/drug-and-alcohol-addiction-and-obesity-effects-on- employment-outcomes
17 Taylor, M. 2017. *Good Work: The Taylor Review of Modern Working Practices*
18 Stevenson D and Farmer P. 2018. *Thriving at work: The Stevenson / Farmer review of mental health and employers*, Department for Work and Pensions. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf
19 Sayce, L (2017). IntoWork17 blog: Shifting direction to reduce the disability employment – and pay gaps, L&W. https://www.learningandwork.org.uk/2017/07/05/shifting-direction-to-reduce-the-disability-employment-and-pay-gaps/

people. The support provided needs to be more personalised; working with employers to address issues around discrimination, improve support and advice on creating the conditions for good work. Statutory Sick Pay will be reformed as part of this process. There will be greater links with schools and colleges around Access to Work schemes. In healthcare there will be particular focus on occupational health services, the role of Work and Health Champions, and reforming the Fit Note system. The government is looking at the role of Personal Budgets in paying for support needs. The size of the mental health support service will increase, so that more employment advisers work in health services.

"All health professionals have an important role to play in both motivating service users to think about work, and in providing interventions which will support the return to work process… Close working with the Trust board, occupational therapy senior management team, borough management teams, local services, commissioners and service users was also found to be vital in delivering services."

Individual Placement and Support, Central and North West London NHS Foundation Trust

Six Big Challenges

We think that increased access to learning and work opportunities can help to reduce demand for health services. Better alignment of health services with learning, skills and employment will help the UK meet its future workforce needs and give everyone, regardless of background, a fairer chance in life. Interconnected issues deserve interconnected solutions.

1. **Future funding of healthcare needs to better address the social determinants of poor health.** Prevention is better than cure, and social solutions (such as access to learning and support to work) can also be part of supporting people with health conditions. Extra and existing health funding should be appropriately targeted on these through:

   - **NHS Forward View.** The NHS will soon set out how it plans to invest its additional resources, an update to its 2014 Forward View. It should state clearly how it will invest in learning and work services, and align with existing services, both to help prevent ill health and as part of the solution for some patients and some conditions
   - **Public Health.** Local Authorities will receive around £3.2bn in 2018/19 for public health. Access to learning, better information and education on health, and support for health at work should be at the heart of their plans for spending this money. They should also lead alignment of public health funding with learning and work programmes, including adult and community learning. There are particularly strong opportunities to do this in Combined Authority areas and where the Adult Education Budget is being devolved.
   - **£100m Work, Health and Learning Fund.** The Government has established a joint Work and Health Unit, looking at how to join up employment and health programmes and policy. It includes a £70m fund to test new approaches. One way to make a reality of public health and NHS commitments could be to widen the remit of this unit to include learning, expanding its budget to £100m with joint investment from DHSC, DWP and DfE[20]. An alternative measure would be a jointly supported **Challenge Fund** enabling joined up bids from local areas for new and innovative approaches.

20 Department of Health and Social Care, Department for Work and Pensions, Department for Education.

2. **A coordinated** approach to health and associated services should be adopted, including adult learning at local levels and integrating multidisciplinary teams to avoid unnecessary duplication. Government departments including Health, must embrace the **demonstrable value of adult learning** and **employment services**, in addressing key strategies and policies, acknowledging that it is the responsibility of more than the education and skills departments. There are emerging examples of adult learning services measuring the impact of their services on health and wellbeing.

   We need more of this and a longer-term, focused approach to building the evidence base, including through greater use of Randomised Control Trials.

BROMLEY BY BOW

The Bromley by Bow Centre is in Tower Hamlets, one of London's and the UK's most deprived areas, with the highest number of hard drug abusers in London, the highest rate of child poverty and one of the lowest levels of green space per head in the UK. 23% of the adult population have no formal qualifications, overcrowding is prevalent and the suicide rate is twice the London average.

The centre was founded in 1984 as an early exercise in holistic thinking between the community and a local GP surgery, involving a preventative rather than curative health model which aimed not simply to treat sick people but to enable them to be well and live a full life in a vibrant community.

Over 30 years a sophisticated partnership strategy has evolved to tackle both the clinical and the wider determinants of health, in a community demand-led environment that identifies itself not as a health centre but as a 'community department store'. A key part of this approach is 'social prescribing', in which healthcare professionals can refer patients to a wide range of locally available community and public services. The strategy is based on three main principles: accessibility, integrated services and long journeys. It practises a theory of change consisting of 'stretch outcomes' in a five-step programme: initial engagement, primary intervention and support, social prescription addressing fundamental challenges including skills and confidence, preparing for work, and ongoing progression and empowerment.

The centre today includes a connection zone, arts space, credit union, park and growing spaces, children's centre, café, employment service, health facility and advice centre. It has championed social enterprise development and its incubation programme has supported 57 local businesses employing over 300 people, with a combined turnover of over £4m. Six GP practices with over 40,000 registered patients make 700 referrals a year to over 40 local services, and 95% of local healthcare professionals report increased health benefits and reduced GP visits as a result of social prescribing.

The Bromley by Bow Centre now supports other major initiatives around the country including Well North Wales and Well North. It has contributed to the Marmot review and is cited as an example of good practice in the King's Fund report *Tackling Poverty, Making More of the NHS in England*.

"A key part of the approach is social prescribing, in which healthcare professionals can refer patients to a wide range of locally available community and public services."

Bromley By Bow Centre, London

"Responses highlighted a lack of conversations and collaboration between GPs, employers, other healthcare professionals, and Jobcentre Plus. They made clear that sharing information regarding work and health between interested parties could improve the care and support provided to someone at risk of falling out of work, or on sickness absence. A more effective joining up of services was also seen as a good way to address wider social needs, like debt or housing problems, which both affect people's health and wellbeing and their readiness for work."

Improving Lives: the future of work, health and disability (paragraph 140)

3. **Social Prescribing** to support learning linked to health, work and communities should be extended across the UK. Investing in learning enables people to invest in their own well-being and ability to manage health conditions as they get older. To achieve this more GPs need to be made aware of the benefits of social prescribing and have up-to-date information from learning providers about what's on offer. We argue that linking social prescribing with entitlement to a Personal Learning Account would help give people greater choice and ownership over their learning, as well as more flexible help with the cost.[21]

Such an approach would lead to greater levels of shared responsibility for investment between employers, individuals and the State. Every citizen would have a Personal Learning Account, setting out entitlements and financial incentives to invest in their own learning. It would also allow local top-ups where other services (such as housing or health) wanted to encourage or support people to learn (perhaps because of particular local skills needs, or the wider health benefits of learning).

Likewise we need greater recognition of the health benefits of good work.

WELL NORTH WALES

While rates of inequality in North Wales are broadly lower than the average for Wales, pockets of deprivation are hidden by proximity to more affluent areas. 12% of the population live in the most deprived quintile, where there is a 25% higher rate of emergency hospital admissions and the mortality rate is twice that of the highest quintile. In addition, there is a life expectancy differential of 7 years, and a poor health and disability differential of 17 years.

Following cross-agency recommendations set out in the 2015 Future Generations & Wellbeing (Wales) Act, the Well North Wales initiative was set up by the Health Board to support the health inequalities agenda in North Wales. This was in recognition of the fact that health inequalities arise from a web of interrelated factors including housing, education, isolation, income, disability, and economic and social status, which largely fall outside the primary scope of NHS Wales.

Well North Wales is an umbrella strategy covering a range of partnership and multi-agency initiatives across North Wales, involving Welsh Government, Learning and Work Institute, the Big Lottery Fund, the Bevan Commission, housing associations, social services, universities, local employers and community stakeholders. It also draws support from the successful Well London project including the Bromley by Bow Centre. Community-based programmes will underpin the development of locally-determined initiatives, supported by the development of a network of health and well being hubs, with a focus on greater integration and inter-agency working.

Each of these fell within the 20% most deprived areas and, significantly, had not previously been targeted for intervention. Service proposals included children and families with complex needs; mobility and chronic disease management; addressing obesity and food poverty; homelessness; mental well being and resilience; and men's health.

Progress in these areas has led to an integrated 'Made in North Wales' social prescription model aimed at improving individual quality of life and alleviating pressure on NHS services and primary care through: more efficient use of health and social services; improving wellbeing and health outcomes; empowering residents to manage their own conditions; maximising community assets; and improved accessibility to community members.

21 Learning and Work Institute. 2016. Power to the People: the case for Personal Learning Accounts. http://www.learningandwork.org.uk/sites/niace_en/files/files/Lifetime%20learning%20policy%20solution%20FINAL.pdf

4. **Person-centred curricula**, using an asset-based approach, to enhance capabilities and existing knowledge, should be adopted. Since 2009 we have researched and trialled a Citizens' Curriculum approach that builds on existing assets and the interests that individuals and communities bring to learning. The approach supports the development of a range of interlinked capabilities: literacy, numeracy, digital, financial, civic, and health.

Such an approach requires cross-disciplinary teams and training for professionals in health, community and employment in relation to adult learning practice. Professionals in adult learning must have an opportunity to work with colleagues in health, community and employment services using partnerships, peer and mentoring approaches.

ROCHDALE BOROUGH COUNCIL

Rochdale Borough Council in conjunction with L&W ran a Citizens' Curriculum pilot in Kirkholt, a large social housing estate with low employment and skills, poor health, drug and alcohol abuse, isolation, domestic violence and a high rate of police call outs.

Facing economic constraints, the council wanted to find ways to reduce the disproportionately high cost in public services of deprived areas like Kirkholt. Research showed that people in Kirkholt wanted to develop better skills and access learning, yet were on average less likely to do so. This contributed to a recognition that causes and effects were not linear but overlapping and complex.

It followed from this that multiple overlapping deprivations could not be addressed by separate, siloed approaches. A 'coalition' was formed involving learning providers, local employers, community groups and an integrated team including health, housing, social, drug and alcohol, and police services. Using coalition resources such as police data, challenging or hard-to-reach learners were identified for high-support engagement in a Citizens' Curriculum pilot. The objective was to overcome traditional barriers to learning, such as fear of academic or formal learning environments, in order to improve learning, health and employment outcomes and make a positive difference to people's lives.

The pilot aimed to raise the local level of engagement in learning to at least the borough average. It offered targeted support to young people, especially the unemployed, lone parents, and those using drugs and alcohol. Training and work placements were made available, and keyworker support for families at risk. The programme also provided peer to peer support from Community Champions, and support to become a Champion in turn.

The pilot demonstrated improvements across virtually all metrics. Participation in learning increased beyond the borough average to 3.8%. Improvements were measured in health and mental health, school attendances, employment outcomes, skills and qualifications, and retention on drug and alcohol programmes.

At the same time there were reduced incidents of domestic abuse, reduced A&E attendances, reduced drug and alcohol use, and a 60% reduction in police call-out rates. A rigorous and validated third-party cost-benefit analysis showed a return of £3.68 in savings for every £1 invested.

Demand for police services in the area has fallen steadily over 3 years and is 13% lower than the area norm. Rochdale has now adopted the approach as part of its wider public service reform strategy, and an integrated follow-up programme has since been set up in Lower Falinge and College Bank, two other deprived areas of Rochdale.

"...adult education networks [should] work with Healthwatch, the Patients Association, trade unions and other representative organisations, who work with adults and family learning initiatives to advocate the health and well-being benefits of adult education to wider public."

Warwick University / The Institutes of Adult Learning, 2017

Figure 3: Rochdale Borough (Kirkholt Pilot). Summary of findings / validated evidence

"The new Work and Health Programme offers a more personalised local approach to supporting disabled people overcome barriers to employment targeting specialist support to those who are least likely to be able to find work in 12 months."

Improving Lives: the future of work, health and disability

5. **Government should accelerate plans to transform how we support disabled people** into work, to stay in employment, and to progress. Recent Government documents provide a start on this, but greater ambition is needed. This includes reforms to the benefit system, increased investment in back-to-work support, and support for employers. Taken together, this should look to tackle inequalities in access to employment as well as the pay penalty that disabled people on average face once in work.

Employers have a key role in taking this forward in adapting workplaces to the needs of a more diverse workforce that in turn reflects their customer base. Enhanced skills only lead to work and income improvements if employers effectively use them in the workplace - improving skills in isolation is unlikely to be effective. Related, learning helps to build adaptability and flexibility, crucial as the world of work changes.

6. **'Devolution Deal' areas should work with government** to set out how they will halve the 'gap' in employment rates between disabled people and non-disabled people, and to then develop 'Local Labour Market Agreements' to deliver it. Based on their equivalent in Canada, these would set out the services the government will devolve to local areas, along with the outcomes local areas will deliver through these. This gives the chance for greater flexibility for local areas, underpinned by a clear accountability framework. In all other geographical areas, local partners should be encouraged and supported to develop governance arrangements that bring together employment, health and other local services so as to better co-ordinate support for disabled people. The Department for Work and Pensions, the NHS and local government should work together to develop a common framework for identifying, engaging, assessing and referring disabled people and those with health conditions.

   The West Midland's recent *Regional Skills Plan* proposes greater collaboration between different parts of the health service, local and national government, including NHS England, the Department for Work and Pensions, and the Department for Health and Social Care. This is being supported by, among other things, a large scale trial funded by the Work and Health Unit.

   Within this collaborative structure the devolution of the Adult Education Budget is seen as having a role in enhancing mental health and well-being through community-based learning provision.[22]

"The shape and content of work and individual health and well-being are strongly related. For the benefit of firms, workers and the public interest we need to develop a more proactive approach to workplace health."

Matthew Taylor,
Good Work: the Taylor review of modern working practices,
2017

WORKING WELL, GREATER MANCHESTER

The Working Well pilot programme operates in Greater Manchester to **help long-term benefit claimants with health conditions to move into and stay in work**. All participants on the pilot are claimants of Employment and Support Allowance (ESA) in the Work Related Activity Group (WRAG), who have completed the two-year maximum time individuals can spend on the Work Programme.

The pilot commenced in March 2014 and took referrals up to March 2016. Since clients can receive up to two years of support in finding a job and up to one year of in-work support, the 'final' cohort of starters will not all complete the programme until March 2019.

All participants will have spent two years on the Work Programme, when Jobcentre Plus refers claimants[23] in Greater Manchester to Working Well. Alongside health conditions the programme focuses on substance abuse issues, debt problems, and / or housing needs. The approach is to seek to address these problems before moving on to help the client focus on employment

The pilot was designed to cover 5,000 referrals from March 2014. Up to the end of the referral period in March 2016, 4,985 claimants had been referred to Working Well and 4,548 had started the programme in Bolton, Bury, Oldham, Rochdale, Stockport, Tameside, and Wigan. All ten Greater Manchester local authorities have drawn up a **Local Integration Plan** for Working Well, setting out the organisations and services that would be involved and the arrangements for their involvement.

Each participant has a **key worker** for two years, as a point of contact and coordinator for the support they need. Key workers' caseloads are kept low, at around 60 clients per key worker, so that they can provide focused, intensive and bespoke support to all their clients.

A **personalised action plan** is developed for each participant, and a bespoke package of support is created in response. The type of support is wide ranging and includes, for example, support with regard to skills, employment, health issues and housing problems.

An early impact assessment assessed the impact of the programme on a range of job and off out-of-work benefit outcomes. L&W investigated the early impact on weeks in work and weeks off out-of-work benefits.

Overall, analysis of different job outcomes suggests that Working Well has not increased the chances of individuals moving into work, but has **lengthened the time in work for those participants who do enter work**.

Department for Work and Pensions, 2018[24]

22 West Midland Combined Authority. 2018. *Regional Skills Plan*. WMCA. https://www.wmca.org.uk/media/2252/regional-skills-plan.pdf
23 Employment and Support Allowance (ESA) in the Work-Related Activity Group (WRAG)
24 DWP, January 2018. Research Report No 946 Greater Manchester Working Well: early impact assessment A report of research carried out by the Learning and Work Institute on behalf of the Department for Work and Pensions

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