Reducing learning inequalities matters in closing health gaps

by Ricardo Sabates
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I have been working in the areas of education and international development over the last decade, focusing first on the wider benefits of education and more recently on the role of education in reducing inequalities. My particular interest in the area of inequalities was inspired by the work of Sir Michael Marmot, chair of the WHO Commission on the Social Determinants of Health. Sir Michael Marmot pointed out that a significant proportion of health disparities can be attributed to social inequalities. He argued that it is only by addressing the social aspects of health inequalities that we might have any hope of closing the health gap between the rich and the poor within a single generation.

Numerous studies have suggested that education is linked to benefits beyond income and employment. For instance, individuals with higher levels of education are more likely to demonstrate positive health behaviours, less likely to be engaged in criminal activities, and more likely to be active participants in society. My own research in this field has pointed to the impact of education on the uptake of preventative health care in England, Scotland, and Wales, and to the importance of post-compulsory education in crime reduction in England. All of this research clearly underscores the key role of education.

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I have also examined the role of education in closing health inequalities in the context of low- and lower middle-income countries. For me, the key research question moved from the *absolute* impact of education on wider personal and social outcomes, including health outcomes, to the *relative* impact of education. By this I mean that if education is to be an engine for social justice, it should be of greatest benefit to the poorest individuals, and its effect should be most transformative for that population.

Using data from the Young Lives Project in Ethiopia, my research has quantified the role of educational quality in explaining health differentials (as measured by stunted growth or height-for-age) among children. We identified different groups of children according to the outcomes of educational quality. The first group consisted of children who were enrolled in school, attending regularly, in the correct grade for their age, and learning. Learning was measured by combining results on the Peabody Picture Vocabulary Test and a basic mathematics test and selecting the top 50% of children in the distribution. This accounted for around 20% of children in the sample.

Among the rest of the children who were enrolled in school (about 45% of the sample), we identified three non-exclusive groups: first, children who were not learning; second, children who

were not attending school regularly (missing the whole week of class prior to the survey); and third, children who were more than three years older than expected for their school grade. The comparison group was made up of children who were in school, attending regularly, in the expected grade, and learning.

Differences in the 'quality' of education explained approximately 44% of the health inequalities we observed between children who were attending school regularly, in the expected grade, and learning, as compared with those who were not attending regularly. We found a somewhat smaller difference in health outcomes between children who were enrolled in school but at risk because they were older than their classmates and those who were in school, in the expected grade, attending regularly, and learning (32%), as well as between those who were enrolled in school but not learning compared with those who were enrolled, attending regularly, in the expected grade, and learning (28%).

Overall, this research suggests that there are potential health benefits for children who are in school and learning. Educational quality, in particular high-quality education for poor and marginalised children, has the potential not only to promote learning, but also to improve child health and offer wider benefits to children, their families and their societies. This demonstrates that interventions to improve educational quality should not be treated as discrete, unidirectional measures that produce only educational benefits. Instead, educational interventions can have important knock-on effects in other areas of children's lives.

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