PRO-HEALTH 65+
Health promotion
Prevention of risk
Action for seniors

Co-funded by
the Health Programme
of the European Union

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Mobilising the Potential of
Active Ageing in Europe

Participation in educational activities of older Europeans in poor and good health. Comparative analysis in selected European countries

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IAGG-ER 8th Congress 23rd-26th April 2015

Dublin A

Plan of the presentation

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- Subject of the research
- What we do know from previous studies
- Methodological concept of the research
- Results – an engagement in educational activities of older persons in poor and good health
- Discussion
- Conclusions and recommendations

Subject of the researach

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1. Learning activities in older age >generally less researched subject (**A**)

2. Poor and good health in older age > based on prevelance of multimorbidity (**B**)

3. Relations between A. and B.

Good and poor health concept

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- **Good health** > successesfull ageing concept

One of main domains of the concept of successful ageing is that good physical and mental health, disease avoidance, functional ability and high cognitive capacity are preconditions for continuing life engagement (Rowe & Kahn 1997).

- **Poor health** > multimorbidity

Health of older people is generally characterized by suffering from, often multiple, diseases. Mostly they are chronic and do not exist as a single health problem, rather as multimorbidity. Epidemiological studies indicate different scale of multimorbidity prevalence in older age, with variations attributable most likely to methodological biases. In many reports its range is assessed as more than 50%; e.g. from 55 to 98% (Marengoni at al 2011), 67% (Salive 2013).

Knowledge from the previous studies – learning activities in older age (LA)

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- Main factors of educational activities in general: human capital and LLL are driven by employers' needs and motivation of employees based on labour market status
- LA after retirement is influenced by reached level of education and the past learning history (during employment period)
- LA in older age is stimulated by employment or similar working activities
- LA is connected with leisure and social environment conditions and possibilites however **still determined by human capital**
- Preferable form of LA in older age > more informal („happy" education)
- LA is connected with higher wellbeing

Knowledge from the previous studies – learning activities and health

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- General relationship: human capital and health – mutual relationship
- LA and health in older age have not been yet sufficiently researched; only general conclusions:
  - seniors are educationally active under two main conditions: when they are healthy and well educated
  - physically and mentally healthy people are socially active in a wide variety of activities

Pictures from the the literature

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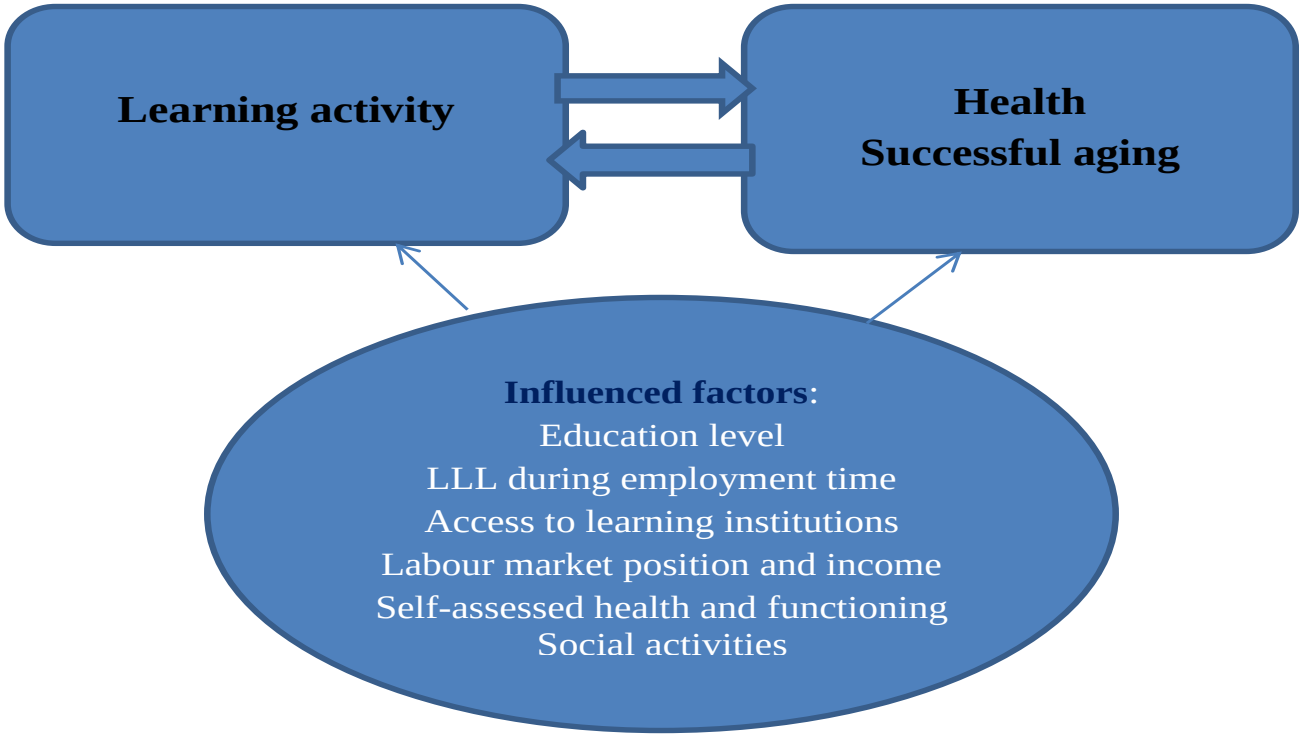

Main research questions

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- The pathways of the impact of possible learning determinants at older age depending on morbidity,
- The determinants of learning activities at older age in morbidity groups depending on employment status.

Data & methodology

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- The Survey of Health - Ageing and Retirement in Europe (SHARE)
- Years 2010/2011 (wave 4, release 1.1.1)
- Respondents - individuals 50+ from 16 European countries
- The analysis of educational activities covers 57391 persons
- Multivariate analysis based on the country pooled regression model (logit) controlling for country differentials
- Comparison of AME between morbidity groups

Model applied

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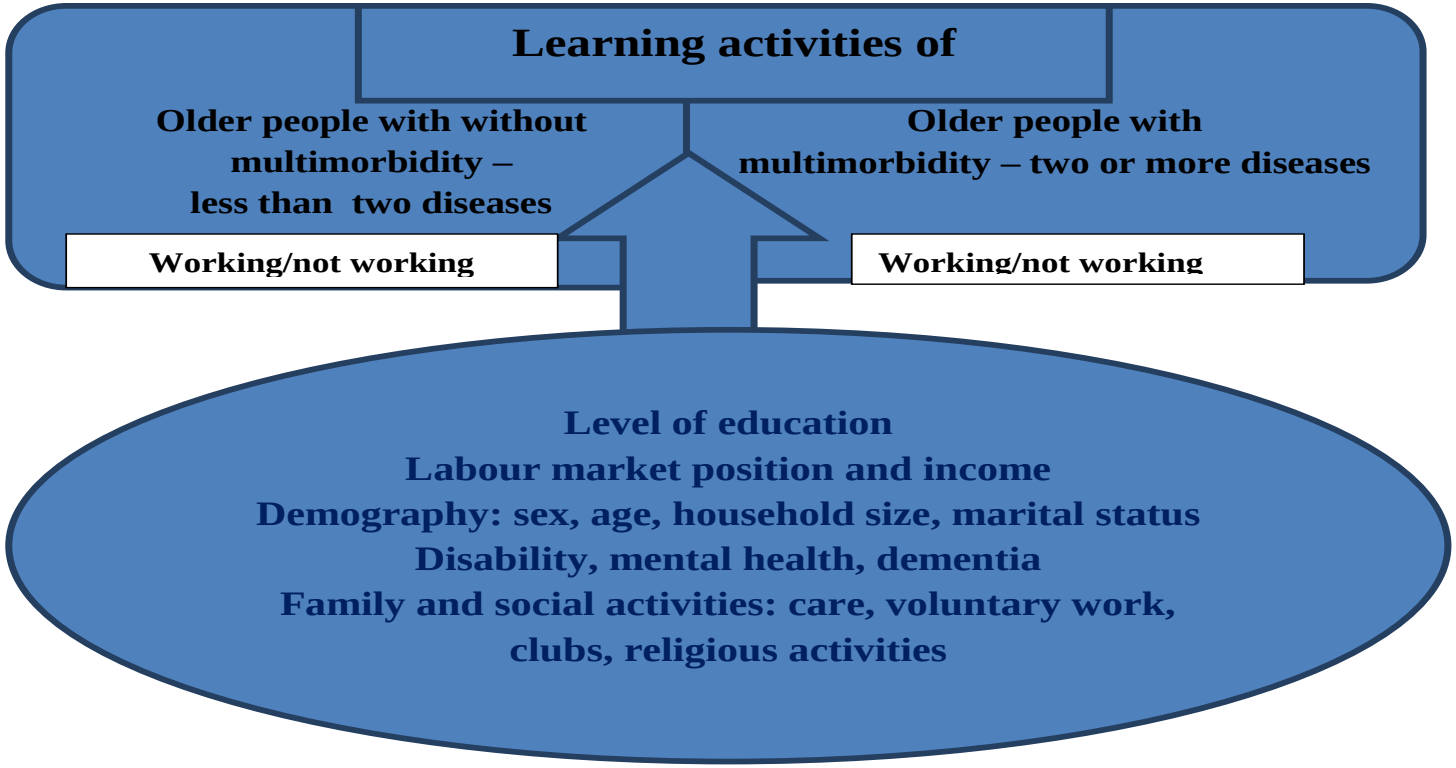

Indicators

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- Participation in educational activities is formulated by the question: if an individual *has attended an educational or training course in the past twelve months*.
- Good and poor health is indicated by morbidity, measured binominaly - less vs. two or more than two illnesses from the list of illnesses specified in the survey, excluding dementia as a chronic diseases of mental character and separating illnesses from risk factors.
- Health status is indicated by: ADL - limitations in activities of daily living, dementia and prevalence of mental disorders
- Determinants of educational participation include: human capital (education), demographic factors (age, sex and size of the households), socio-economic status (labour market position, income) and other activities of social character (care provision, voluntary work, religious activity, clubs and sports)

Frequency of taking-up educational activities in older age in European countries

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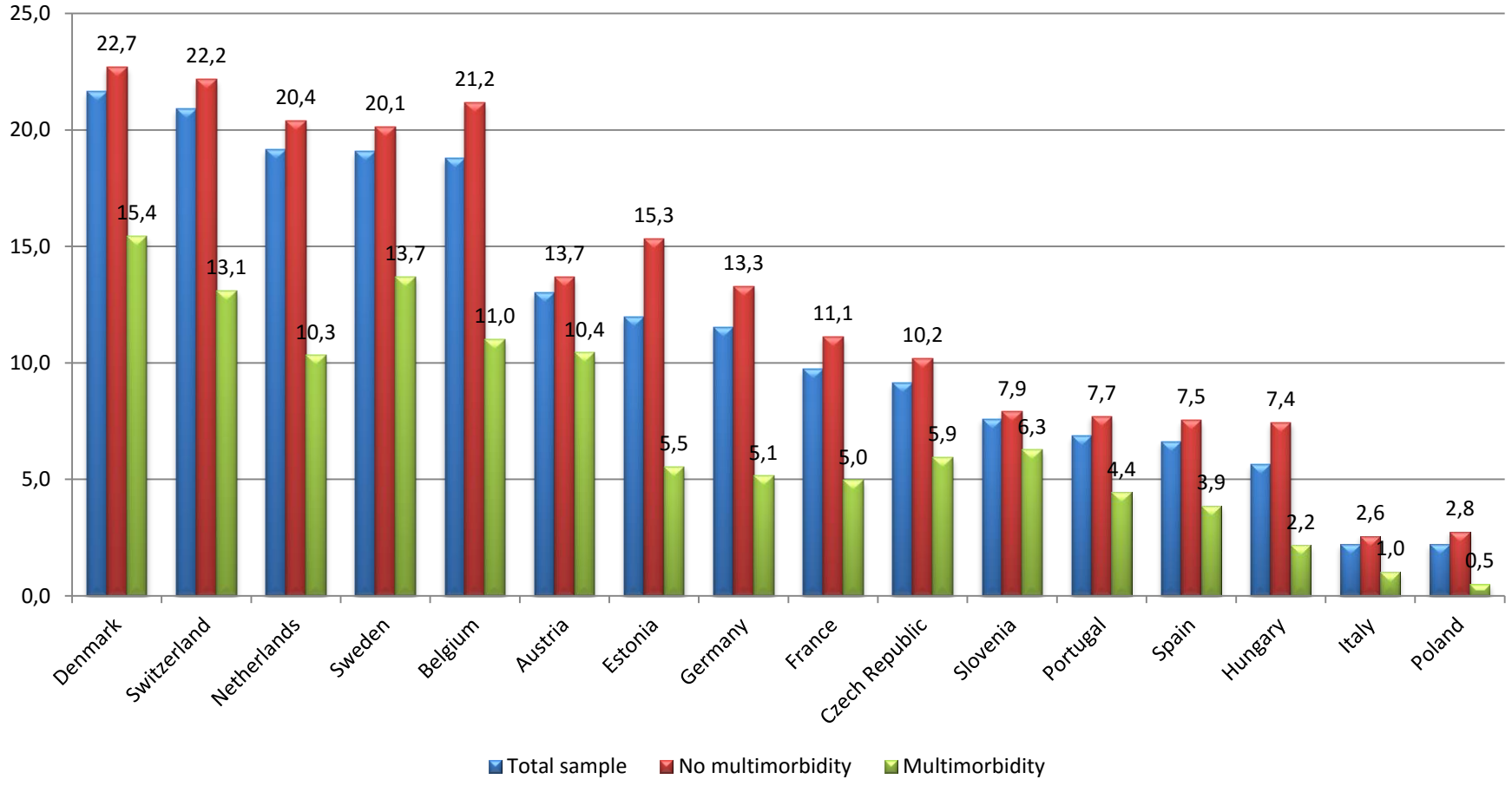

Source: own calculations based on SHARE 2010/2011

Educational participation in European countries

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- High differences between countries: Nordic – every fifth elderly participating, Western Europe - moderate participation, Southern Europe - lower participation, differences in Eastern Europe
- Reasons could include variations in welfare regimes that relate to investments in human capital over the life course (LLL), availability of infrastructure, tradition, financial opportunities.
- Poor health is a strong limitation of participation.

Factors significant for educational participation of the older population

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In good health (less than two morbidities)	In poor health (two or more morbidities)
Demography – being female (+++), being 75+ (---)	Demography – being female (++), being 75+ (--)
Human capital – secondary (+++) and higher level of education (+++)	Human capital – secondary (+++) and higher level of education (+++)
Employed (+++), unemployed (+++)	Employed (+++), unemployed (++)
Income: third (++) and fourth quartile (+++)	Income: fourth quartile (+)
Social and care activities: informal caregiving (+++), participating in sports and clubs (+++), volunteering (+++), religious activity (+++)	Social and care activities: participating in sports and clubs (+++), volunteering (+++), religious activity (++)

Factors significant for educational participation of working/ non-working older people

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Working		Non-working	
No multimorbidity	**Multimorbidity**	**No multimorbidity**	**Multimorbidity**
		Health – dementia (--)	
Demography – being 65+ (-)	Demography – being 65-74 (-)	Demography – being female (---), being 65+ (---), being married (-), 2 pers. HH (-)	Demography – being female (-), being 65+ (---)
Human capital – secondary (+++) and higher level of education (+++)	Human capital - secondary (+) and higher level of education (+++)	Human capital - secondary (+++) and higher level of education (+++)	Human capital – secondary (+++) and higher level of education (+++)
Income: second (+), third (+++), fourth quartile (+++)		Income: second (+++), third (+++), fourth quartile (+++)	Income: second (+), third (++), fourth quartile (+++)
Social and care: informal caregiving (+++), participating in sports and clubs (+++), volunteering (+++)	Social and care: participating in sports and clubs (++), volunteering (+++)	Social and care: informal caregiving (+++), participating in sports and clubs (+++), volunteering (+++), religious activity (+++)	Social and care: participating in sports and clubs (+++), volunteering (+++), religious activity (+)

Discussion
limitation of analysis

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- Imprecise definition of educational activity in the survey - the type of activity not specified (formal/informal)
- Intensity of activity not analysed
- Educational participation rates of older people by countries are significantly different (follow different welfare state regimes and culture) and it seems that more precise explanations on participations in good and poor health could be analysed by specific group of countries

Conclusions

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- The analysis confirmed existence of significant relation between educational activity and health at older age.
- Poor health strongly limits educational activity, however human capital and further occupational work are always important determinants of participation, even in poor health
- Educational activities are usually accompanied by other type of activities: e.g. volunteering, caregiving, religious practice.
- Types of determinants in poor and good health are similar.
- Only if working are compared with non-working, the types of determinants depending on multimorbidity differ.

Reflection

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The analysis points to high differentiation of the level of learning activities of older people in European countries, which depends not only on individual factors analysed in the paper, but also on a number of **macroeconomic** and **institutional factors**, including employment rate, character of welfare state (welfare state regimes), corporate responsibility for human capital investments via life-long learning during the cycle of professional career and local governments' capabilities to integrate older people.

The meaning of external factors is high, especially for the population characterized by multimorbidity as in fact most if not all older people are.

Investment in ageing oriented health care and educational policies are of similar importance.