A Critical Theory of Adult Health Learning

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Abstract: In providing an analytical review of theoretical dimensions of health that contribute to learning, and vice versa, this paper forms the basis for an emergent theoretical framework for adult health learning. The proposed theory fills a knowledge gap around adult health learning, by integrating critical theory with critical adult education processes, to increase awareness and action on the broad determinants of health. Given the great number of health professionals writing about learning, this new theoretical framework will help to further conceptualize the political and power-ridden dimensions of learning for health.

The State of the Problem

A colleague of mine is fond of saying that everything is health and health is everything. Without naming it, she is espousing the theory of social determinants of health (SDOH; Laverack, 2007), that our health is affected by factors such as the environment, race, food security, gender, work, geography, education, and relationships. This theory acknowledges that in addition to biology, we are as healthy as our environment and that any effort to address health has to take this larger socio-economic environment into account rather than focusing exclusively on individual lifestyle choices. SDOH and health promotion theories (Ottawa Charter, 1986) and accompanying strategies encourage the community to be involved in a collective process of large scale change that will positively affect health (Ledwith, 2001).

Yet, as effective as these SDOH and health promotion theories are at pointing to the contributing factors affecting health they do not fully integrate a systematic adult learning component or address the specific ways that change can come about. The critical theory of health and adult learning that is addressed in this article includes a role for adult educators as facilitators of change that surpasses individual choices of behavior, and which refuses to limit itself to working with extant sources and policies to make minor changes, rather than to revolutionize learning for health. To build this theory, I craft and analyze extant bodies of knowledge in health, critical theory, and adult learning, and use them to build a new learning theory premised on the idea that health can be achieved by the people themselves through “critical analysis and action” on the many environmental influences that determine their health (Labonté, 2005, p. 2).

Insights from Health Theory

I begin with some of the related literature in health promotion, which has drawn attention to the many ways that health in a community is determined by factors beyond the individual (Raphael & Bryant, 2002). These factors include societal structures that influence an individual’s sense of control and well being. Health promotion, by and large, is a multidisciplinary response to the narrow health education perspective that dominated up until the 1980s. Health promotion theorists continue to work to inform the public about these social determinants of health since it has become increasingly evident that the SDOH determine the health of individuals and communities (Raphael, 2008b, p. 2). Health promotion makes it clear that in order to address health we need to engage the public in a participatory and comprehensive process of identifying the SDOH, addressing them and creating change. Given adult education’s strength in community development and activism, adult learning would seem to be a ready contributor to health promotion. Without an applied learning focus, which utilizes the discourse, strategies and expertise of adult educators, health promotion will continue to be rooted in theoretical concepts and unattainable goals.

One of the key determinants of health within the SDOH framework (Raphael, 2008b) is education. Simply put, the better our educational level, the better our health. We know from studies of participation that people with higher levels of education and health are more likely to participate further in higher education, and they are more likely to engage more in lifelong learning pursuits (Feinstein & Hammond, 2004). Well educated citizens are also more likely to volunteer and to participate in the life and governance of their communities (Mundel & Schugurensky, 2008). Furthermore, the better one’s education the more likely he or she is to have a regular body mass index (BMI) and live a longer life (Townson, 1999). Beyond the benefits of education, we now know that the mere fact of engaging in lifelong learning contributes to health. According to a report from The Center for
Research on the Wider Benefits of Learning “Participation in adult learning contributes to positive and substantial changes in health behaviours and small improvements in wellbeing” (Feinstein et al., 2003, p. iv; Feinstein & Hammond). This is good news for adult educators who have known this fact intuitively for sometime but now have it verified.

Yet, despite the insights of health promotion theory, much of the health and learning literature still focuses on western medicine, illness and patients (e.g., Bartlett & Windsor, 1985) and on dated strategies to encourage adults to work on their individual lifestyle choices. The arena envisaged in a critical theory of adult learning is much larger—it is the community which embraces a much larger constituency and which includes the whole community in assessing their health. Consequently, a health promotion approach moves the focus from reliance on health education literature to community engagement in health promotion activities such as community kitchens, faith-based health programs, and environmental campaigns. Yet, while the health promotion literature suggests change, it does not go far enough in embracing an adult learning model.

The type of health and learning approach that is envisaged here is beginning to emerge in a practical way in the small town in which I live in northeastern Nova Scotia. In an intercommunity and interagency partnership, health promotion advocates are coming together with librarians, builders, sustainability advocates, and citizenship groups to build a centralized learning centre tentatively called the People’s Place which will include a town library, space for literacy programs, nonprofit group meetings and youth gatherings, as well as a health education resource centre, community kitchen, and community food security space. This is an integrative approach that sees health as an important aspect of life in the community and as one that is intricately tied to health and learning. And it is here that health promotion advocates and community developers find common vision and create new alternatives for healthy communities. They are bolstered by the fact that the province of Nova Scotia has actually created a Department of Health Promotion in addition to its Department of Health at the provincial government level.

Critical Theory

The critical social sciences help to probe the rationale or the philosophy of practice that undergirds effective health education that engages the determinants of health and which helps learners move beyond the basic teaching and learning processes. The Marxian informed perspective of critical theory allows us to replace an individually centered framework with a broader based, social and political approach (Alman, 2000). A centerpiece of this theory, as Brookfield (2005) notes is its learning tasks that show that not only is the content of learning reformed, but so are the structures that undergird it. Brookfield names the learning challenges of critical theory as “learning to challenge ideology, contest hegemony, unmask power, overcome alienation, learn liberation, reclaim reason, and practice democracy” (p. 2). These learning tasks are integrated into this proposed theory of health and learning, along with understandings of gender and race. For the engaged adult educator, these are all teaching tasks for increased community health. Below, I draw on salient aspects of critical theory to illustrate the links to health.

Challenging ideology. Ideologies (Eagleton, 1991) such as individual-focused health education, doctors as all-knowing purveyors of health, and citizens as consumers of expert medicine, have come to dominate the Western world. These might be framed more succinctly as the ideology of the medical model. This ideology has become hegemonized so that citizens see themselves as grateful yet unknowing and docile beings, subject to the machinery of hospitals and evidence-based medicine, in which their health needs are commodities to be bought and sold. A marker of the effectiveness of this ideology is the degree to which the general public supports and depends on it, and blames their ill health on personal and moral failures. A revised theoretical approach, rooted in health promotion, challenges these hegemonies and works with learners in participatory ways to reclaim health. It also broadens what we learn (e.g., how to quit smoking) to the larger global structures, corporate capitalism, financial regimes, environmental degradation, and corporate downsizing, all of which limit human agency and perspective, and which contribute to the unequal distribution of disease and access to health care (Marmot & Wilkinson, 2006). As an example of how to address these ideologies through collective action on the social determinants of health one only has to think of the breast cancer test scandal in Newfoundland to see how the hundreds of women who received inaccurate results, took control of their health, contested the infallibility of the medical system by suing it, and demanded better equipment and testing procedures. They started a citizen’s movement that insisted on accountability and professionalism, and which encouraged them to take control of their own health. Of course, this is not the first time anyone has challenged systems or ideologies; Ivan Illich (1976) was challeng-
ing health care in the 1970s but this recent example shows how that movement has taken hold with groups of affected citizens.

Challenging class. An ideology rarely succeeds unless it has the support of people and institutions around it. And in this case, the medical paternalistic model of health has been bolstered by social class issues, which as Mojab (2005) points out, are a major factor in all world events. Social class affects our identity and how we cope with the world; when class is entwined with issues of race and gender, the situation becomes more complex. In terms of health and learning, class affects who has access to health and education, who controls health and education, and who will benefit most from changes in health and education. Improved social class translates into a higher standard of living, better paying job, and access to health care services. And, social class is often a direct result of the situation one was born into.

Griff Foley (2005), an adult educator and social movement theorist influenced by Marx, notes that there are preferred and embedded ways of learning for the higher social classes, namely higher education. For the lower social classes the preferences and choices are limited and are more likely to be in the community. It is no wonder then that many of our efforts in adult learning are in the community, and employ informal and nonformal learning strategies. Our historical roots as educators are with the people and the struggling classes, providing us with the expertise to address social class and its effects on health. Of particular concern for us is that citizens within the lower social and economic strata have more difficulty accessing services including formal education, and consequently may have greater need for adult learning in informal settings. Standard health education models, which are frequently premised on schooling, are insufficient.

Unmasking power. Classic theories of power are a strong part of critical theory. These theories address the constraints against advancing in the existing system and the struggles that citizens have to resist the holders of power such as medical officers, departments of health, and government officials (Freire, 1970). Embedded within these classic notions of power are systems of privilege that limit access to the determinants of health. And it would be a naïve citizen who did not realize that power is an integral part of the medical system, medical knowledge and of health education in particular. Yet, less apparent are the holders of power outside the health system in the complex array of factors that affect health such as employment, environment, and education. Within education, the holders of power are those who set standards for literacy, grant access and award diplomas, and establish the curriculum for schools and universities, as well as teach. It is not coincidental that these holders of power have typically been educated and socialized through liberal education models.

Traditional health education settings such as public health clinics, had health educators delivering smoking cessation or weight reduction programs; the primary task of these professionals was to transfer knowledge to the community. In a community led process such as a critical theory of health and learning proposes, the power is distributed among the group of participants so that the facilitator (who could be a health professional such as a nurse) would engage teachers and learners in a participatory process to look beyond disease or negative behavior to issues such as the impact of a box store on a small town with multiple family run businesses. The community health process would look at the effects of unemployment, minimum waged and part time jobs, and loss of markets for locally produced food. In this case, the power moves from the health professional and from the medical field to the community and its reservoir of knowledge and ability. The focus is on learning and change. Those with formal educational preparation for the health professions, e.g., pharmacists, respiratory technologists, and physicians, might indeed be called on to teach others and contribute their knowledge but they would be one source among many.

Gendering and racializing learning. An integral part of this critical theory of adult learning is how it incorporates also an understanding of the effect of gender and race on adult learning and the health of communities. It is no accident that the people on First Nations reserves in Canada have the lowest health outcomes of all citizens (Townson, 1999). And it is no surprise that they also have the lowest education levels and greatest levels of poverty, which are major determinants of health. Hence the ongoing interest of First Nations in moving beyond traditional health education such as alcohol and tobacco cessation programs and on to health promotion initiatives which address factors affecting their health namely disease, poverty, education, and environmental degradation. This shift represents a return to an ecological and holistic view of health, which is consistent with their cultural outlook.

Implications for Teaching and Learning

Any effective model of critical adult learning for health has to take into account adult education’s expertise with grassroots learning, and our knowledge of
the integration of creativity, the arts, the body, and activism into the teaching and learning process. All of these factors contribute to an integrative framework that contributes to the transformative potential of the theory. How we can accomplish some of this transformation is difficult to itemize and explain. However, I will attempt here to address two of the key pedagogical strategies for teaching and learning.

Working in a Participatory Mode

Though to an adult educator this may sound very basic, the use of a collective model is endemic to all social learning processes. Groups bring with them the insights of all the members and when facilitated well can harness this insight into change. In my town right now, a group of us adult educators have started a process of community health impact assessment (CHIA) in which we will meet collectively to assess how changes in the provincial budget will have positive and negative effects on the health of our community. Participatory processes are an integral part of social movement learning (see Foley, 2005).

Infiltrating Higher Education

Adult educators have a role in infiltrating how education is done in professional health programs. Through our graduate degree programs we have an opportunity to change how teaching and learning by modeling creative strategies ourselves, by introducing the concepts of power, hegemony, class and gender to our students and by encouraging the interruption of the exclusive use of lectures and top down instruction. A common complaint is that much of the teaching at present in professional schools does not leave room for discussion or multiple modes of learning. Although some such as Bryan, Kreuter, and Brownson (2008) have come up with a list of ways (tips) for educating those in health professions, which they align with adult education theory, what is being encouraged here is less about teaching tips and more about philosophy. When critical perspectives are encouraged then there are challenges to taken for granted ideas such as the medical model or the expert in charge. In a first year public health program, the professor might have students go out into the community and interview seniors, asking them about their health needs and involving them in creating solutions.

Conclusion

There is evidence that this critical theory of health and learning is slowly being implemented, though it has not been identified as such. Some very strong voices can be heard such as Irv Rootman’s (2004) on the connection between literacy and health, and Denis Raphael’s (2008a) on the need for a decided stress on health promotion. Yet, it is not clear that the learning dimension has been highlighted. Now is the time for us to come together as people concerned about our health to create viable community models of living. This article has provided a critical and theoretical framework that strengthens their pedagogical and emancipatory practices and which encourages health for all (see English, in press).

References


