Academic Journal of Psychology and Education (AJPE)
Volume.14, Number 1; January-2023;
ISSN: 2836-3760 | Impact Factor: 7.87
https://zapjournals.com/Journals/index.php/ajpe/index
Published By: Zendo Academic Publishing

CHALLENGING DEFICIT DISCOURSES IN UK PHYSICAL EDUCATION CURRICULA: A HEALTH EDUCATION PERSPECTIVE

[1]Macdonald, D.

Article Info

Keywords: physical education curricula, health discourses, critical discourse analysis, holistic health, risk promotion, public health goals, PE teachers, deficit discourses.

Abstract

This critical analysis examines the health discourses in physical education (PE) curricula across England, Northern Ireland, Scotland, and Wales through a critical discourse analysis of the curriculum documents provided to PE teachers. The study reveals that all PE curricula, with the exception of England, conceptualize health and wellbeing holistically; however, there are complex health landscapes within the curricula. The health discourses move from supporting and enabling pupil health and wellbeing to health-related learning, often associated with public health goals of promoting physical activity. While public health discourses presented in a way that suggests young people will develop knowledge and skills to support their health, a closer look highlights that they may be more associated with discourses of risk and promoting 'healthy' behaviours to avoid 'ill-health.' This study suggests that PE teachers need to challenge deficit discourses that teach students how to be healthy rather than allowing them to learn about themselves and their health.

Introduction:

Physical education (PE) is considered an essential aspect of the school curriculum to facilitate physical activity, health, and wellbeing among children and adolescents. In this regard, this paper aims to critically analyse the health discourses evident in PE curricula across England, Northern Ireland, Scotland, and Wales. The study uses a critical discourse analysis of the curriculum documents provided to PE teachers, which highlights the health and wellbeing of students. The analysis shows that, except for England, all PE curricula conceptualize health and wellbeing holistically; however, the analysis also finds complex health landscapes within the curricula. The discourses move from supporting and enabling pupil health and wellbeing to health-related learning, often associated with public health goals of promoting physical activity. While public health discourses presented in a way that suggests young people will develop knowledge and skills to support their health, a closer look highlights that they may be more associated with discourses of risk and promoting 'healthy' behaviours to avoid 'ill-health.' The study concludes by suggesting that PE teachers need to develop a critical understanding of the health discourses within their PE curriculum and challenge deficit discourses that teach students how to be healthy rather than allowing them to learn about themselves and their health.

[1] Moray House School of Education and Sport, Institute for Sport, Physical Education and Health Sciences, University of Edinburgh, Edinburgh, UK

CURRICULUM AND HEALTH DISCOURSES IN PHYSICAL EDUCATION

Curricula are written for a specific purpose, often representing the official voice of the state and governing what should be taught (Rossi et al., 2009). They have traditionally been developed in the form of a 'detailed specification of knowledge/content' that outlines what (valued) knowledge young people should learn (Priestley, 2011, p. 221). However, recently, there has been a shift towards the development of curricula that focus more on what young people should *experience* and *do* as a result of their learning (Priestley, 2011). From this perspective, the learner is positioned at the centre of the learning process, developing twenty- first- century skills and competencies for citizenship, thus ensuring economic development and national competitiveness (Sinnema et al., 2020). This was seen in our aforementioned 'mapping' research (Gray et al., 2021), where UK curriculum discourses linked PE with a public health agenda to promote active lifestyles (and thus ensure a healthy and productive labour force). Priestley (2011) suggests that this is indicative of neoliberalism adopting the language of education while maintaining 'technical- instrumental' goals (p. 224). This form of learning can also be explained using Foucault's concept of governmentality (Foucault et al., 2008) where, through the creation of institutions, policy and practices, power can be exercised to target particular groups— in this instance, teachers and pupils. Individuals come to internalise these practices to the extent that they begin to govern their own behaviours (and the behaviour of others), as autonomous individuals, self- regulating for the good of the state (Lupton, 1999). Education policies are therefore not value- neutral, they are a mechanism to convey, through discourses, particular messages about what and how children and young people should learn, influencing their beliefs, values and practices within society (Hardley et al., 2020; Rossi et al., 2009).

The discourses evident within policy, therefore, are manifestations of ideologies represented through language, a way of both representing reality and producing social action (Blanchet- Garneau et al., 2019). Thus, health discourses within PE convey messages about what it means to be healthy and *how* to be healthy. Multiple and competing health discourses exist within the context of PE. For example, research has previously suggested that the health- related teaching of many PE teachers is strongly influenced by a biomedical conceptualisation of health— a deficit perspective related to the presence or absence of physical illness (Burrows & Wright, 2007). Such views are typically informed by 'scientific' research endorsed by health 'experts' and conveyed through public health messages by media and governments (Johnson et al., 2013). Against this backdrop, discourses of risk and prevention often dominate with an emphasis on educating pupils about 'risky' health behaviours and teaching them 'appropriate' practices to minimise risk and prevent ill health. This is in contrast to strengths discourses— influenced by social liberalism (Spratt, 2017)— evidenced in, for example, the health and PE curriculum in Australia (McCuaig & Quennerstedt, 2018), where the focus is on developing resources to lead a healthy life.

Drawing from the work of Antonovsky and his concept of salutogenesis, this strengths- based approach views health as a continuum between health- ease and dis- ease, asking the question, 'what creates health rather than only what are the limitations and the causes of disease' (Antonovsky, 1979, p. 12). Salutogenesis recognises that to lead a healthy life, individuals draw from a range of personal (i.e. mental, social, emotional and physical) and sociocultural resources to shape meaningful and coherent experiences. Importantly, resources are always context dependant, related to, for example, gender or social class (McCuaig & Quennerstedt, 2018). Individuals draw from these resources to support their health when they have what Antonovsky (1979) termed a 'Sense of Coherence' (i.e. when they see the meaningfulness, comprehensibility and manageability of their situations). Thus, the role of the teacher from a salutogenic perspective shifts from 'fixing' health or reducing risk to considering the mental, social, emotional and physical resources young people draw on to support and promote their health.

Whilst this strengths- based, holistic, contextualised and relational conceptualisation of health and wellbeing has grown in prominence over the last decade and encouraged debate about the role of PE in teaching young people about health, there remains little evidence of its impact on practice (Alfrey & Welch, 2021). Even in Australia, where the health and PE curriculum explicitly adopts a strengths- based approach, there are concerns that teachers' experiences and reading of the curriculum will result in a perpetuation of health- related knowledge that focuses on what the individual needs to do to be healthy (Alfrey & Welch, 2021). Indeed, research continues to suggest that health discourses in PE are more commonly influenced by neoliberal ideals (Macdonald, 2011); for example, discourses of 'health *as* citizenship', where the role of PE is to create socially responsible and economically productive citizens who protect their own and others' health and wellbeing (Lupton, 1999; McCuaig & Tinning, 2010). However, discourses of health *as* citizenship, alongside an emphasis on individual behaviour, have been criticised for positioning health as a 'moral responsibility' (Gard & Kirk, 2007). They have also been criticised for their focus on the body, where body size and shape are viewed as indicators of both health and moral character. This exemplifies discourses of healthism, whereby individuals are deemed responsible for improving their own health through 'increased awareness along with personal control and change' (Crawford, 1980, p. 368). Such emphasis on personal responsibility— the 'theoretical glue' that binds choice and coercion together (Gard & Kirk, 2007, p. 30)— again reflects neoliberal ideals and is reinforced through public health messages encouraging individuals to voluntarily 'self- regulate' in order to 'become' healthy, responsible citizens (Burrows & Wright, 2007).

To summarise, PE has a role to play in educating young people— from across the four nations of the UK— about health. However, the numerous and complex ways in which health is conceptualised can make curriculum writing, interpretation and enactment challenging. This complexity was highlighted in our analysis of the UK PE curriculum documents, where multiple and shifting discourses were evidenced both within and across contexts (Gray et al., 2021). Thus, a more critical analysis of the health discourses within UK PE curricula is warranted to interrogate those discourses and consider what influence they might have on teacher and pupil subjectivities and practices.

METHODOLOGY

The researchers involved in this study brought insights from each of the four home nations of the UK, facilitating multicultural dialogue around curricula. This was important because each devolved government within the UK has responsibility for the development and delivery of their own localised education and health policy (Bevan, 2010; Raffe et al., 1999). As such, there are significant differences in the structure and content of national curricula across the UK, driven by differing political agendas and a desire to forge a distinct path and educational identity (Andrews & Mycock, 2007; Wyse et al., 2012). Although it is important to recognise and acknowledge the broader political context of the curricula that were the focus of this study, it is beyond the scope of this paper to explore this more fully. However, an in- depth discussion of the issues associated with this is provided elsewhere (see Gray et al., 2021) and— for those less familiar with the landscape of PE curricula in the UK— a brief overview of each context can be found in Appendix A. We now provide an outline of the methodological process followed in this study, beginning with a discussion of critical discourse analysis.

Critical discourse analysis

To explain how discourses work to influence individuals and societies, Rossi et al. (2009) refer to the concepts of ideology and hegemony. Drawing from the theorising of Fairclough (2003), they claim that the ideological work of those in power, (re)produced through discourse, is 'real, not imagined' and leads to the 'constitution of subjects' (p. 79). Importantly, they also highlight that ideologies are more effective when they are normalised, that is, where a particular ideology or discourse dominates over others to the point that it becomes taken- for- granted and seen as 'common sense'. When this occurs, the ideology is said to be hegemonic— exerting power by appearing

'natural' and justified, so that individuals willingly comply with and reinforce ideological power structures (Spratt, 2017). The work of Foucault is also useful in understanding how (curriculum) discourses work to exert power. He defines discourses as a set of 'truths' that circulate within society, constituted through privileged forms of knowledge (Foucault, 1973). Discourse, therefore, becomes the embodiment of power and knowledge (or power/knowledge)— a way of conveying certain truths that guide ways of knowing, communicating and acting on the world (Johnson et al., 2013)— organising and regulating social life (Mullet, 2018). However, although dominant discourses make it difficult to see, think or behave in alternative ways, the theorising of Foucault helps us to understand that power does not always operate in hierarchical ways— individuals can exercise power to resist dominant discourses (Foucault, 1988), making it possible for alternative forms of power to emerge (Willig, 2008).

Critical discourse analysis is an analytical approach that enables us to identify, describe and interpret discourses and to examine the ways in which language is purposefully used to produce and regulate social actions (Mullet, 2018). It aims to uncover the underlying ideologies within discourse and attempts to reveal the role of discourse in the (re)production or resistance of social dominance and power (Rogers, 2004). Thus, it is especially useful in understanding the role of language in constituting power relations and can work to reveal such relations and highlight inequalities. Rossi et al. (2009) note that there is no one approach to carrying out a critical discourse analysis. Rather, approaches are selected based on their relevance to the research purpose (Van Dijk, 2001). Van Dijk (2001) also suggests that there can be no complete discourse analysis, so researchers have to make choices about what needs to be analysed (Rossi et al., 2009). Whilst there may be differing approaches to critical discourse analysis, Mullet (2018, p. 120) suggests that these are characterised by:

a problem- oriented focus, an emphasis on language, the view that power relations are discursive, the belief that discourses are situated in contexts, the idea that expressions of language are never neutral, and an analysis process that is systematic, interpretive, descriptive, and explanatory.

From this position, Mullet (2018) developed an analytical framework for critical discourse analysis which we adapted to suit our own research purposes (see Table 1), focussing on the following five stages.

Stage 1: selecting the discourse

In our initial 'mapping' research (Gray et al., 2021), we developed an analysis framework by drawing from existing literature (e.g. Evans & Penney, 2008; Jung et al., 2016; McEvilly et al., 2014) to identify the core discourses that are known to circulate within the field of PE. As researchers, therefore, we brought to the analysis process a pre- established understanding of the prevalent discourses in PE and the ways in which they work to produce and regulate social action. From this initial framework, we extracted three conceptualisations of health that guided our analysis for the present study: public health, health and wellbeing, and health *as* citizenship. Similar to our 'mapping' research, this new 'health' discourses framework was used to guide a preliminary analysis of the health discourses within the Scottish policy documentation. While the focus of this analysis was primarily on identifying discourses from our framework, we remained open to the possibility that we may uncover health discourses not previously accounted for in the existing PE literature. Resultantly, this initial analysis led to the identification of an additional discourse, the discourse of 'care'. As such, we added this to our 'health' discourses framework to guide our analysis (see Table 2).

TA BLE 1 General analytical framework for critical discourse analysis adapted from Mullet (2018)

Stage of analysis	Description	Example
Stage 1	Select the discourse	Select health discourses evident within physical education

Stage 2	Locate and prepare data sources	Select the curriculum texts for analyses
Stage 3	Code texts and identify overarching themes	Identify the major themes and subthemes using qualitative coding methods
Stage 4	Analyse the external relations in the texts	Examine social relations that control the production of the text and the reciprocal relations (e.g. How do social practices relate to discourses in the text? How does the text in turn influence social practices?)
Stage 5	Interpret the data	Interpret the meanings of the major themes and external relations identified in stages 3 and 4

TA BLE 2 'Health' discourses framework

Discourse	Description	Example
Public health	Health conceptualised as *physical* health promotion with physical activity understood as a means of risk reduction/prevention (exercise as medicine)	Investigates heart rate zones and how these zones relate to fitness and health and wellbeing (Scottish Government, 2017, p. 37)
Health and wellbeing	Health conceptualised as physical activity for enjoyment and holistic wellbeing (involving the physical, mental, social and emotional)	I can make meaningful connections with others, valuing safe, healthy and equitable relationships in a range of contexts (Welsh Government, 2020, p. 84)
Health *as* citizenship	Health conceptualised as a process for imparting values and ethics, teaching and encouraging inclusivity and responsibility for self and others	I can interact pro- socially in different groups and situations, and actively advocate for other individuals and groups (Welsh Government, 2020, p. 83)
Care	Health conceptualised as schools' and teachers' responsibility to protect, support and nurture health and wellbeing	The overarching curriculum framework requires that teachers should help pupils to: respect themselves, understand their rights and responsibilities (Council for Curriculum, Examinations and Assessment, 2007ab, p. 5)

TA BLE 3 Key documents for analysis

England	• Physical Education Programmes of Study: Key Stages 1–4,[1] National Curriculum in England (Department for Education, 2014)
Northern Ireland	• Key Stage 1 and 2[2] Statutory Requirements for Physical Education (Council for Curriculum, Examinations and Assessment, 2007a)
	• The Statutory Curriculum at Key Stage 3[2] and the Key Stage 3 Statutory Requirements in Physical Education (Council for Curriculum, Examinations and Assessment, 2007b)
	• The Key Stage 4[2] Physical Education Non- Statutory Guidance (Council for Curriculum, Examinations and Assessment, 2008)
Scotland	• Curriculum for Excellence: Health and Wellbeing—Principles and Practice (Scottish Government, 2009a)
	• Curriculum for Excellence: Health and Wellbeing—Experiences and Outcomes (including physical education) (Scottish Government, 2009b)
	• The Benchmarks for Physical Education (Scottish Government, 2017)
Wales	• The New Curriculum for Wales Guidance (Health and Wellbeing Area of Learning and Experience) (Welsh Government, 2020)

1
In England, Key Stages 1– 2 pupils are aged 5– 11 and Key Stages 3– 4 pupils are aged 11– 16.
2
In Northern Ireland, Key Stages 1– 2 pupils are aged 6– 11 and Key Stages 3–4 are aged 11– 16.

Stage 2: locating the data sources

As with our earlier 'mapping' research, we selected and analysed those curriculum documents that talk directly to PE teachers about how to organise, enact and assess PE curricula in schools (see Table 3). It is important to note at this point that curricular policy around PE within England is very limited, particularly in comparison with that of the other home nations. Whilst we recognise that health- related teaching and learning may take place elsewhere in schools in England— such as within personal, social, health and economic education (Department for Education, 2021)— we decided to focus firmly on PE curricula within this study. As such, within our analysis, there is at times limited reference to the English context, which is indicative of the limited health discourses evident within the PE curriculum in England— owing, at least in part, to its brevity.

Stage 3: coding texts and identifying overarching themes

During this stage, one member of the research team led the process and carried out an analysis of the health discourses across all of the curriculum documents identified within Table 3. Analysis occurred through documents

being read and re- read, with text being selected, coded and categorised to identify the main health discourses within each curriculum document and the various ways in which these discourses are articulated (see Table 4). Notes were also taken to consider, for example, the meanings, purposes and implications of these discourses for policy enactment.

Stages 4: analysing the external relations in the text

At this point, it is important to acknowledge our stance as critical researchers and the transformational motives that drive our work (Mullet, 2018). As previously mentioned, all researchers were involved in the development of the analysis framework, and so brought to the process their knowledge of the discourses and their relationships with various social practices. This was important given that texts cannot be understood or analysed in isolation, but always in relation to other texts or wider social contexts (Fairclough, 2010). Thus, collectively, we were able explore the knowledge or 'truths' embedded within each discourse and understand the implications of this for 'health practice' in PE. To do so, the themes, extracts and notes were shared among the research team, who engaged in an open, dialogical and critical analysis process. For example, a discussion took place around the practice of monitoring physical activity for health (a public health discourse), which was explicit in the Scotland and Northern Ireland curricula. Issues were raised in relation to how this practice can produce normative exercise behaviours, as well as the potential outcomes of such behaviours, both positive and negative. There was also evidence of health *as* citizenship in all contexts, which led to a detailed discussion around the wider purpose of health learning in PE.

Stage 5: interpreting the data

During this stage, we brought together our findings from stages 3 and 4, placing them into the broader context of 'health within the UK PE curricula'. We also focussed on the points of similarity and difference across the home nations, a process that further supported our understanding and interpretation, serving as a useful means of policy learning (Gray et al., 2021). This stage of analysis revealed that discourses of health within each context were not constant or static but shifting and varied. In order to make sense of this complex landscape, our interpretation was organised, initially, around three key themes: (i) contrasting conceptualisations of health; (ii) developing 'healthy' citizens; and (iii) caring contexts (see Table 4). However, during our analysis we also identified a specific (internal) linguistic device used in each curriculum. That is, a certainty of language that describes what learners 'should' or 'will' learn/experience. Thus, a fourth theme was established:

(iv) the certainty of health- related learning. Each theme is presented and discussed below.

KEY THEMES

Contrasting conceptualisations of health

Our analysis revealed that, in those contexts where PE is explicitly connected to the broader aims of the national curriculum (i.e. Northern Ireland, Scotland and Wales), a discourse of health and wellbeing is prevalent. For example, in Northern Ireland, the overarching aim of the curriculum is to:

promote the spiritual, emotional, moral, cultural, intellectual and physical development of pupils at the school and thereby of society; and prepare pupils for the opportunities, responsibilities and experiences of life by equipping them with appropriate knowledge, understanding and skills. (Council for Curriculum, Examinations and Assessment, 2007b, p. 2)

And in Wales:

The fundamental components of this Area are physical health and development, mental health, and emotional and social well- being. It will support learners to understand and appreciate how the different components of health and well- being are interconnected, and it recognises that good health and well- being are important to enable successful learning. (Welsh Government, 2020, p. 73)

Meanwhile, in England, there is a notable lack of reference to any discourse of health beyond one of the aims of PE being to ensure that all young people 'lead healthy, active lives' (p. 260).

Interestingly, the health and wellbeing discourses within the curricula of Northern Ireland, Scotland and Wales are often associated with developing skills and capacities to enhance health and wellbeing (rather than avoiding risks to protect health and wellbeing). For example, in Wales, young people will become 'healthy, confident individuals who: have the skills and knowledge to manage everyday life as independently as they can' (Welsh Government, 2020, p. 25). In Northern Ireland, young people will be provided with learning opportunities to 'develop and sustain safe, caring relationships' (Council for Curriculum, Examinations and Assessment, 2007b, p. 3).

To some extent, these statements reflect the salutogenic perspective (Antonovsky, 1979) highlighted earlier, whereby young people draw from personal and social resources to develop skills and capacities, enabling them to lead a healthy life. McCuaig and Quennerstedt (2018) emphasise that to successfully enact such an approach and contribute to the holistic health of pupils, attention must be paid to the socio- cultural factors that shape individuals' 'Sense of Coherence'. However, it has been acknowledged that this can be challenging (Alfrey & Welch, 2021), exacerbated when health is articulated in varied ways in different curriculum documents. For example, in Northern Ireland, although the wider curriculum context presents discourses of health and wellbeing, there is limited reference to how PE contributes to health in key stages 1 and 2, and a public health discourse dominates in key stage 4. This shift towards a public health discourse can similarly be seen in the Scottish curriculum as pupils progress through secondary school. In Wales, although we do not see the same shifts across age groups, the situation remains complex as teachers have to carefully consider how they work with all five Statements of What Matters (see Appendix A) if health and wellbeing are to be successfully embedded within PE.

Navigating, interpreting and enacting curricula are extremely complex, and some have suggested that the challenges associated with this task can lead to a form of paralysis, where rather than encouraging curriculum and pedagogical innovation, teachers resort to 'practice as usual' (Petrie et al., 2021). Within PE, this often results in a narrow— and deficit— conceptualisation of health, demonstrated through practices associated with 'fitness for sport' or 'physical activity for physical health'. In this respect, it should be noted that teachers do not read curriculum from a neutral or passive position, they bring with them their own biographies, beliefs, knowledge and social contexts which influence how they both interpret and enact curricula (Ball & Bowe, 1992). The omnipresence of public health messages related to the importance of increasing physical activity for health is difficult for teachers to ignore, especially given that they are also present within each curriculum, where pupils are encouraged to manage their own health behaviour, through for example, monitoring and assessing their diet and physical activity levels. For example:

I can apply my knowledge and understanding of a balanced diet and nutrition to make choices which will allow me to maintain my physical health and wellbeing. (Welsh Government, 2020, p. 78).

While presented as a means by which pupils can improve their (physical) health, this narrow view of health, and practices of self- monitoring, have the potential to lead to PE experiences that can have a negative impact on health, for example, low self- esteem or anxiety (Gray et al., 2015). Narrow conceptualisations of health— and discourses around risk and normality— can lead to the belief that 'being' healthy is a social and moral necessity, where it is both unhealthy and wrong to deviate from the norm (Lee & Macdonald, 2010). Healthism discourses are therefore also linked to the neoliberal imperative that all members of society should be responsible individuals who look after their bodies so they can contribute effectively to society. Given our analysis, it may be that despite all of the UK curricula— with the exception of the English curriculum— introducing health (and wellbeing) as

holistic, they are in fact interpreted and enacted quite differently, potentially on account of the contrasting (and contradicting) discourses of health circulating within and around curricula.

Developing 'healthy' citizens

While above we allude to an implicit relationship between being 'healthy' and being a 'good' member of society, in the curriculum documents we analysed, this connection was often explicit. For example:

… the learning and experience in [Health and Wellbeing] can support learners to become enterprising, creative contributors ready to play a full part in life and work. (Welsh Government, 2020, p. 73).

Indeed, in Wales and Northern Ireland, the connections between health and wellbeing and citizenship are explicit throughout the curriculum documents, influenced by the fact that the four purposes (Wales) and the curriculum objectives (Northern Ireland) guide the way in which each curriculum is organised (see Appendix A). The influence of the four capacities in Scotland is more subtle, but references to notions of citizenship remain clear:

Engages respectfully and confidently with others. Contributes relevant ideas, knowledge and opinions, communicating clearly in a consistent and sustained way, supporting and justifying points with evidence or detail. (Scottish Government, 2017, p. 26).

Reference to citizenship in the curriculum in England is less explicit, although there is brief mention of taking part in sport and other activities to build character, fairness and respect.

There is a clear message in each context— albeit more explicit in some than others— that a purpose of the curriculum, and by association PE, is to develop values and skills that are necessary not only for health, but also for functioning in and contributing to society. While it is difficult to challenge the notion that young people should learn to contribute positively to society, it also seems clear that such references to citizenship are somewhat associated with neoliberalism, where schools become a site for building human capital and contributing to economic productivity (Savage, 2017). Indeed, drawing on the concept of governmentality, Ayo (2012) highlights the way that policy can be used to create a specific type of subject, by encouraging individuals to make certain choices and self- regulate, bringing about 'voluntary' compliance. Evidence of this can be seen in the curricula of the home nations, each of which highlights the role of the individual and their decision- making to develop values, attitudes and relationships. Within this context, improving health and wellbeing becomes a way of maintaining social order, within the school immediately, but also society more broadly. This perspective also supports the assumption, especially in Wales and Scotland, that health and wellbeing are a prerequisite for successful learning, thus contributing to the success of the school, and therefore the economy. Savage (2017) suggests that, while there are important links between education and the economy, this view has the potential to overtake other key issues. For example, it may move attention away from the personal and social determinants of health or undermine health outcomes as educative in their own right— rather than solely a prerequisite for successful learning (Spratt, 2016). Importantly, while discourses of health *as* citizenship are significant in each context, they do not dominate, which potentially reduces the risk of teaching health exclusively *as* citizenship or *for* academic achievement.

Caring contexts

As we have already highlighted, the PE curricula in Northern Ireland, Scotland and Wales are all positioned within wider curriculum contexts that feature the discourse of health and wellbeing. Interestingly, from this broader policy perspective, there is an emphasis on the role of the learning environment to *encourage*, *provide opportunities and support* young people's health and wellbeing. This focus on a 'supportive' and 'encouraging' learning environment reflects discourses of care, highlighting the role and responsibility of the school in nurturing young people's health and wellbeing (Noddings, 2005; Spratt, 2016). For example, in Northern Ireland, the curriculum states that schools should *provide opportunities* for learners to develop as individuals and in society more broadly. In Wales, teachers are provided with curricular guidance to consider ways in which they should *support* their pupils, paying close attention to identifying their specific needs and the range of experiences that

will promote their health and wellbeing. The role of the curriculum and teachers in supporting health and wellbeing is also highlighted in the Principles and Practices document in Scotland, which states that:

Everyone within each learning community, whatever their contact with children and young people may be, shares the responsibility for creating a positive ethos and climate of respect and trust— one in which everyone can make a positive contribution to the wellbeing of each individual within the school and the wider community. (Scottish Government, 2009a, p. 3)

In her analysis of the Health and Wellbeing curriculum in Scotland, Spratt (2016) identifies the prevalence of discourses of care. She refers to the work of Noddings (2005) and states that in caring relationships, the carer and the cared- for should be equals, where the cared- for are listened to, their needs met, and their rights protected. However, Noddings (2012) acknowledges that in schools teachers are in a position of power, which can influence this notion of care. In this context, the carer can adopt a more dominant role and the cared- for becomes dependent, with limited control over their care, which may reduce their capacity for self- care (Spratt, 2017).

Spratt (2017) also cautions that policy discourses of 'care' may be co- opted within the contexts of neoliberalism and school accountability. She contrasts health and wellbeing *for* learning vs. learning *for* health and wellbeing and argues these conceptualisations are underpinned by differing ideologies. Health and wellbeing *for* learning leans more upon neoliberal ideals of individual responsibility and accountability, where positive pupil health and wellbeing may benefit schools (and society) through improved academic performance, behaviour or higher attendance, something that we previously alluded to in relation to *developing healthy citizens*. Spratt (2017) claims that, in this context, schools are driven by an outcome agenda where potentially coercive 'caring' approaches may be adopted to align pupil subjectivities with government objectives. This contrasts with learning *for* health and wellbeing which sees health and wellbeing as educative in its own right and draws upon social welfare ideals of human flourishing. This resonates with Noddings' (2012) differentiation between the needs *assumed* by the school and curriculum and those needs *expressed* by pupils. Noddings (2012) acknowledges the difficulty teachers face in balancing these needs, but notes that a truly ethical, caring relationship requires that teachers listen and attend to pupils' own beliefs about what they need. Importantly, the policy documents in Northern Ireland, Scotland and Wales do make reference to, for example, empowerment and catering for individual needs. However, there is also some emphasis in the broader curriculum within which PE is positioned on the roles of teacher, school and community care and responsibility.

The certainty of health- related learning

As previously mentioned, while the focus of our analysis was to interrogate the relationship between the texts and wider social relations, in our reading of the curriculum documents, we became drawn to a specific (internal) linguistic device used to influence curriculum interpretation and enactment. In each document, there appeared a level of certainty in the language used, suggesting that there is an expectation that all pupils will be successful in the same health- related learning. For example, in England, the overarching aim of the PE curriculum is 'to ensure that *all* pupils … lead healthy and active lives' (Department for Education, 2014, p. 260, emphasis added). In Northern Ireland, Wales and Scotland, this certainty is evident in the 'first person' approach used to describe what pupils *should* learn in PE. For example, in Wales, the descriptions of learning are presented as 'I can' statements that describe what pupils should be able to do through their learning experiences. For example:

I can explain the importance of a balanced diet and nutrition and the impact my choices have on my physical health and well- being. (Welsh Government, 2020 p. 78)

The certainty attached to the knowledge and skills that *will* be learned is somewhat juxtaposed with earlier (care-oriented) curricular statements about *providing opportunities, enabling* and *supporting* that seem to position teachers as facilitators— rather than directors— of learning. This certainty also reflects what Biesta (2020) describes as 'learnification' of education, which although intended to put the learner at the centre of the teaching

and learning process, often fails to make explicit the specific purpose of learning. Learning then implicitly becomes tied up in a 'common sense' view of what education is for, resulting in a focus on the development of specific knowledge, skills and social competencies, valued by and serving the interest of some groups over others (Biesta, 2009).

The prescription and detail offered in relation to what pupils *should* learn also has the potential to lead to a very operational approach to teaching and learning, where curriculum enactment is reduced to a 'tick box exercise' to ensure that all of the requirements of the curriculum have been met (Hardley et al., 2020). According to Biesta (2009), focusing on what must be learned— in the absence of attention to the purposes of education— may limit opportunities for autonomous thinking, doing and being, which serves to further contradict some of the intentions of these curricula which expressly focus on developing self- regulating or 'lifelong' learners. Such prescription in terms of what *will* be learned has drawn criticism, not only due to the narrow nature of this knowledge, but also because, presented in this way— that is, the responsibility of the individual— it neglects the social and structural inequalities that impact on health (Spratt, 2017) and the social and cultural contexts that give personal meaning to how the concept of health is constructed and enacted (McCuaig & Quennerstedt, 2018; Petrie & Thompson, 2021). The certainty of the language used in the curricula we analysed seems to assume that all pupils will experience the curriculum and develop their health in the same way. This is problematic given that not all pupils have access to the same resources for health and it can be challenging for those whose cultural and/or social contexts conceptualise health in different ways. Thus, this form of inflexible, prescriptive, classed and neoliberal curriculum is incoherent with the diversity of the pupil population and inconsistent with the uncertainty of life (Rossi et al., 2009).

CONCLUSION

In summary, the curricula across all four UK home nations reinforce the role that PE can play in developing pupils' health- related learning (albeit implicitly in the Welsh context). Moreover, with the exception of the curriculum in England, all PE curricula conceptualise health and wellbeing holistically, taking into account social, emotional, mental as well as physical wellbeing. However, our analysis has identified a complex and shifting health landscape in each curriculum, where teaching and learning moves from notions of supporting, providing opportunities and enabling pupil health and wellbeing, towards a more concrete (and measurable) concept of health- related learning, often associated with public health goals related to promoting physical activity for health (and, to a lesser extent, developing 'healthy citizens'). Furthermore, although much of the public health discourse is presented in a way that suggests young people will develop knowledge and skills to support their health, closer scrutiny reveals that it may be more associated with the avoidance of risk, promoting 'healthy' behaviours to avoid 'ill health' and to ensure that young people contribute positively to society.

Importantly, we are not suggesting that developing pupils' capacities to improve their physical health and contribute positively to society is a bad thing. Rather, that this focus has the potential to lead to a particular view of health and wellbeing, where the role of the PE teacher becomes that of health promoter, as opposed to health educator. In the case of the former, teaching focuses on 'fixing' pupils' health, encouraging them to make the 'right' choices (Petrie & Thompson, 2021). This is a narrow and potentially damaging perspective, especially for those pupils who find it difficult to make what are seen as the 'right' choices within their personal, social and cultural context. Health and wellbeing curricula, and PE curricula, can and should support young people to become physically healthy and valued members of society. However, they should also contribute to young people's wider wellbeing and personal growth where, through education, they have the freedom to learn about themselves and *their* health and understand the ways in which *they* can lead a life of personal value, meaning and purpose (Spratt, 2016; Thorburn & Stolz, 2017). The scope that each curriculum has to nurture this form of health is unclear. It is somewhat clouded by the various discourses that circulate— with some being more dominant

and/or pervasive than others— which inevitably influence teachers' readings of these curricular documents. While none of the curricula are intended to be prescriptive, there is some evidence to suggest that teachers may feel obliged to teach health in a particular way, perhaps also influenced by their own understandings of what health is and is for. Indeed, we argue that further research is needed to develop a better understanding of the pedagogical guidance that teachers are offered in relation to teaching health in the context of PE.

Finally, to challenge narrow and prescriptive views of health, and encourage broader, more flexible readings of curricula, we suggest that a critical understanding of curriculum is necessary, potentially facilitated by involving pupils in the curriculum- making process. Such an approach has the capacity to encourage teachers to think about health (and PE), not as something that is normative or fixed, but as fluid, dynamic and socially and culturally bound (Petrie & Thompson, 2021). Understanding health from different (pupils') perspectives may support teachers to respond to the call from McCuaig and Quennerstedt (2018) to pay greater attention to the sociocultural factors that contribute to the health and wellbeing of young people and to create learning environments that are understood by the pupils as meaningful and coherent. This may also contribute to a PE curriculum that is more socially just, by shifting the focus away from the individual, towards recognising, understanding and challenging the social and structural inequalities that impact on young people's health. We also propose that a more critical and holistic perspective on health and health- related learning may be facilitated by cross- border and collaborative discussions between PE teachers. Indeed, the purpose of this research is to lay the foundations for our future work *with* PE teachers from the four nations of the UK, where we will provide them with space to work together to understand and problematise the dominant discourses that persist in PE and begin to imagine alternative conceptualisations of the subject. Longer term, we hope that this will enable teachers to develop the collective capacity and authority to rightfully influence and drive future policy developments (Penney, 2008).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study were derived from the following resources available in the public domain: Physical Education Programmes of Study: Key Stages 1-4, National Curriculum in England. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/381344/Master_final_national_curriculum_28_Nov.pdf. Key Stage 1 and 2 Statutory Requirements for Physical Education in Northern Ireland. Available at: https://ccea.org.uk/key-stages-1-2/curriculum/physical-education. The Statutory Curriculum at Key Stage 3 and the Key Stage 3 Statutory Requirements in Physical Education in Northern Ireland. Available at: https://ccea.org. uk/downloads/docs/ccea-asset/Curriculum/The%20Statutory%20Curriculum%20at%20 Key%20Stage%203.pdf. The Key Stage 4 Physical Education Non-Statutory Guidance in Northern Ireland. Available at: https://ccea.org.uk/downloads/docs/ccea-asset/Curriculum/Physical%20Education%20Non-Statutory%20Guidance%20for%20Key%20Stage%204.pdf. Curriculum for Excellence: Health and Wellbeing–Principles and Practice. Available at: https://education.gov.scot/Documents/health-and-wellbeing-pp.pdf. Curriculum for Excellence: Health and Wellbeing–Experiences and Outcomes (including physical education). Available at: https://education.gov.scot/Documents/health-and-wellbeing-eo.pdf. The Benchmarks for Physical Education (in Scotland). Available at: https://education.gov.scot/improvement/documents/hwbphysicaleducationbenchmarkspdf.pdf. The New Curriculum for Wales Guidance (including Health and Wellbeing Area of Learning and Experience). Available at: https://hwb.gov.wales/storage/b44ad45b-ff78-430a-9423-36feb86aaf7e/curriculum-for-wales-guidance.pdf

REFERENCES

Alfrey, L., & Welch, R. (2021). Australian health and physical education Teachers' philosophies and pedagogies of health. In J. Stirrup & O. Hooper (Eds.), *Critical pedagogies in physical education, physical activity and health* (pp. 103– 115). Routledge.

Andrews, R., & Mycock, A. (2007). Citizenship education in the UK: Devolution, diversity and divergence. *Citizenship Teaching and Learning*, *3*(1), 73– 88.

Antonovsky, A. (1979). *Health, stress, and coping*. Jossey- Bass.

Armour, K., & Harris, J. (2013). Making the case for developing new PE- for- health pedagogies. *Quest*, *65*(2), 201– 219. https://doi.org/10.1080/00336 297.2013.773531

Ayo, N. (2012). Understanding health promotion in a neoliberal climate and the making of health conscious citizens. *Critical Public Health*, *22*(1), 99– 105. https://doi.org/10.1080/09581 596.2010.520692

Ball, S. J., & Bowe, R. (1992). Subject departments and the 'implementation' of National Curriculum policy: An overview of the issues. *Journal of Curriculum Studies*, *24*(2), 97– 115. https://doi.org/10.1080/00220 27920 240201

Bevan, G. (2010). Impact of devolution of health care in the UK: Provider challenge in England and provider capture in Wales, Scotland and Northern Ireland? *Journal of Health Services Research and Policy*, *15*(2), 67– 68. https://doi.org/10.1258/jhsrp.2010.009174

Biesta, G. (2009). Good education in an age of measurement: On the need to reconnect with the question of purpose in education. *Educational Assessment Evaluation and Accountability*, *21*, 33– 46. https://doi.

org/10.1007/s1109 2- 008- 9064- 9

Biesta, G. (2020). Risking ourselves in education: Qualification, socialisation, and subjectification revisited. *Educational Theory*, *70*(1), 89– 104.

Blanchet- Garneau, A. B., Browne, A. J., & Varcoe, C. (2019). Understanding competing discourses as a basis for promoting equity in primary health care. *BMC Health Services Research*, *19*, 764. https://doi.org/10.1186/ s1291 3- 019- 4602- 3

Burrows, L., & Wright, J. (2007). Prescribing practices: Shaping healthy children in schools. *International Journal of Children's Rights*, *15*, 83– 98. https://doi.org/10.1163/09275 5607X 181685

Cale, L., Harris, J., & Hooper, O. (2020). Debating health knowledge and health pedagogies in physical education.

In S. Capel & R. Blair (Eds.), *Debates in physical education* (pp. 256– 277). Routledge.

Council for Curriculum, Examinations and Assessment. (2007a). Statutory requirements for physical 7education at key stage 1 and key stage 2. Available at: https://ccea.org.uk/key- stage s- 1- 2/curri culum/ physi cal- educa tion

Council for Curriculum, Examinations and Assessment. (2007b). The statutory curriculum at key stage 3, rationale and detail. Available at: https://ccea.org.uk/downl oads/docs/ccea- asset/ Curri culum/ The%20Sta tutor y%20 Cur ricul um%20at%20Key %20Sta ge%203.pdf

Council for Curriculum, Examinations and Assessment. (2008). Physical education: Non- statutory guidance for key stage 4. Available at: https://ccea.org.uk/downl oads/docs/ccea- asset/ Curri culum/ Physi cal%20Edu catio n%20Non - Statu tory%20Gui dance %20for %20Key %20Sta ge%204.pdf

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal Health Services*, *10*,

365– 388. https://doi.org/10.2190/3H2H- 3XJN- 3KAY- G9NY

Department for Education. (2014). The National curriculum framework document. Available at: https://assets.publi shing.servi ce.gov.uk/gover nment/ uploa ds/syste m/uploa ds/attac hment_data/file/38134 4/Master_final_natio nal_curri culum_28_Nov.pdf

Department for Education. (2021). Personal, social, health, economic (PSHE) education. Available at: https:// www.gov.uk/gover nment/ publi catio ns/perso nal- socia l- healt h- and- econo mic- educa tion- pshe/perso nal- socia l- healt h- and- econo mic- pshe- educa tion

Evans, J., & Penney, D. (2008). Levels on the playing field: The social construction of physical 'ability' in the physical education curriculum. *Physical Education and Sport Pedagogy*, *13*(1), 31– 47. https://doi.org/10.1080/17408 98070 1345576

Fairclough, N. (2003). *Analysing discourse*. Routledge.

Fairclough, N. (2010). *Critical discourse analysis: The critical study of language*. Routledge.

Foucault, M. (1973). *The birth of the clinic: Archaeology of medical perception*. Routledge.

Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), *Technologies of the self: A seminar with Michel Foucault* (pp. 16– 49). University of Massachusetts Press.

Foucault, M., Senellart, M., & Burchell, G. (2008). *The birth of biopolitics: Lectures at the Collège de France, 1978– 79*. Palgrave Macmillan.

Gard, M., & Kirk, D. (2007). Obesity discourse and the crisis of faith in disciplinary technology. *Utbildning & Demokrati: Tidskrift för Didaktik och Utbildningspolitik*, *16*(2), 17– 36.

Gray, S., MacIsaac, S., & Jess, M. (2015). Teaching 'health' in physical education in a 'healthy' way. *RETOS: Nuevas tendenies en Educacion Fisica Deportes y Recreacion*, *28*, 165– 172.

Gray, S., Sandford, R., Stirrup, J., Aldous, D., Hardley, S., Carse, N., Hooper, O., & Bryan, A. S. (2021). A comparative analysis of discourses shaping physical education provision within and across the UK. *European Physical Education Review*, 1– 19. https://doi.org/10.1177/13563 36X21 1059440

Hardley, S., Gray, S., & McQuillan, R. (2020). A critical discourse analysis of curriculum for excellence implementation in four Scottish secondary school case studies. *Discourse: Studies in the Cultural Politics of Education*, *42*(4), 513– 527. https://doi.org/10.1080/01596 306.2019.171046

Johnson, S., Gray, S., & Horrell, A. (2013). 'I want to look like that': Healthism, the ideal body and physical education in a Scottish secondary school. *Discourse: Studies in the Cultural Politics of Education*, *34*, 457– 473. https://doi.org/10.1080/01596 306.2012.717196

Jung, H., Pope, S., & Kirk, D. (2016). Policy for physical education and school sport in England, 2003– 2010: Vested interests and dominant discourses. *Physical Education and Sport Pedagogy*, *21*(5), 501– 516. https:// doi.org/10.1080/17408 989.2015.1050661

Kirk, D. (2010). *Physical education futures*. Routledge.

Lee, J., & Macdonald, D. (2010). 'Are they just checking our obesity or what?' The healthism discourse and rural young women. *Sport, Education and Society*, *15*(2), 203– 219.

Lindsey, I., Metcalf, S., Gemar, A., Alderman, J., & Armstrong, J. (2020). Simplistic policy, skewedconsequences: Taking stock of English physical education, school sport and physical activity policy since 2013. *European Journal of Physical Education*, *27*(2), 278– 296. https://doi.org/10.1177/13563 36X20 939111

Lupton, D. (1999). 'Developing the "whole me"': Citizenship, neo- liberalism and the contemporary health and physical education curriculum. *Critical Public Health*, *9*(4), 287– 300. https://doi.org/10.1080/09581 59990 8402941

Macdonald, D. (2011). Like a fish in water: Physical education policy and practice in the era of neoliberal globalization. *Quest*, *63*(1), 36– 45.

McCuaig, L., & Quennerstedt, M. (2018). Health by stealth— Exploring the sociocultural dimensions of salutogenesis for sport, health and physical education research. *Sport, Education and Society*, *23*(2), 111– 122. https:// doi.org/10.1080/13573 322.2016.1151779

McCuaig, L., & Tinning, R. (2010). HPE and the moral governance of p/leisurable bodies. *Sport, Education and Society*, *15*(1), 39– 61. https://doi.org/10.1080/13573 32090 3461087

McEvilly, N., Verheul, M., Atencio, M., & Jess, M. (2014). Physical education for health and wellbeing: A discourse analysis of Scottish physical education curricular documentation. *Discourse: Studies in the Cultural Politics of Education*, *35*(2), 278– 293. https://doi.org/10.1080/01596 306.2012.745736

Mullet, D. R. (2018). A general critical discourse analysis framework for educational research. *Journal of Advanced Academics*, *29*(2), 116– 142. https://doi.org/10.1177/19322 02X18 758260

Noddings, N. (2005). *The challenge to care in schools* (2nd ed.). Teachers College Press.

Noddings, N. (2012). The caring relation in teaching. *Oxford Review of Education*, *38*(6), 771– 781. https://doi.org/10.1080/03054 985.2012.745047

Olfson, M., Blanco, C., Wang, S., Laje, G., & Correll, C. U. (2014). National trends in the mental health care of children, adolescents, and adults by office- based physicians. *JAMA Psychiatry*, *71*(1), 81– 90. https://doi.org/10.1001/jamap sychi atry.2013.3074

Penney, D. (2008). Playing a political game and playing for position: Policy and curriculum development in health and physical education. *European Physical Education Review*, *14*(1), 33– 49.

Petrie, K., Pope, C., & Powell, D. (2021). Grappling with complex ideas: Physical education, physical literacy, physical activity, sport and play in one professional learning initiative. *The Curriculum Journal*, *32*(1), 103– 117. https://doi.org/10.1002/curj.82

Petrie, K., & Thompson, K. (2021). H/health education in primary schools: Teachers, learners and initiating change. In J. Stirrup & O. Hooper (Eds.), *Critical pedagogies in physical education, physical activity and health* (pp. 74– 87). Routledge.

Priestley, M. (2011). Whatever happened to curriculum theory? Critical realism and curriculum change. *Pedagogy, Culture & Society*, *19*(2), 221– 237. https://doi.org/10.1080/14681 366.2011.582258

Quennerstedt, M. (2019). Physical education and the art of teaching: Transformative learning and teaching in physical education and sports pedagogy. *Sport, Education and Society*, *24*(6), 611– 623. https://doi.org/10.1080/13573 322.2019.1574731

Raffe, D., Brannen, B., Croxford, L., & Martin, C. (1999). Comparing England, Scotland, Wales and Northern Ireland: The case for 'home internationals' in comparative research. *Comparative Education*, *35*(1), 9–25. https://doi.org/10.1080/03050 06992 8044

Rogers, R. (2004). An introduction to critical discourse analysis in education. In R. Rogers (Ed.), *An introduction to critical discourse analysis in education* (pp. 1– 19). Lawrence Erlbaum Associates Publishers.

Rossi, T., Tinning, T., McCuaig, L., Sirna, K., & Hunter, L. (2009). With the best of intentions: A critical discourse analysis of physical education curriculum materials. *Journal of Teaching in Physical Education*, *28*, 75–89.

Savage, G. (2017). Neoliberalism, education and curriculum. In B. Gobby & R. Walker (Eds.), *Powers of curriculum: Sociological perspectives on education* (pp. 143– 165). Oxford University Press Australia and New Zealand.

Scottish Government. (2004). *A Curriculum for Excellence*. Scottish Government.

Scottish Government. (2009a). *Curriculum for excellence: Health and wellbeing, experiences and outcomes*. Scottish Government.

Scottish Government. (2009b). *Curriculum for excellence: Health and wellbeing, principles and practice*. Scottish Government.

Scottish Government. (2014). *Significant Aspects of learning [online]*. Scottish Government. Available at: https:// educa tion.gov.scot/nih/Docum ents/hwb9- signi fican t- aspec ts- of- learn ing- in- pe.pdf Scottish Government. (2017). *Benchmarks: Physical education*. Scottish Government.

Sinnema, C., Nieveen, N., & Priestley, M. (2020). Successful futures, successful curriculum: What can Wales learn from international curriculum reforms? *The Curriculum Journal*, *31*, 181– 201. https://doi.org/10.1002/ curj.17

Spratt, J. (2016). Childhood wellbeing: What role for education? *British Educational Research Journal*, *42*(2), 223– 239. https://doi.org/10.1002/berj.3211

Spratt, J. (2017). *Wellbeing, equity and education*. Springer.

Thorburn, M., & Stolz, S. (2017). Embodied learning and school- based physical culture: Implications for professionalism and practice in physical education. *Sport, Education and Society*, *22*(6), 721– 731. https://doi. org/10.1080/13573 322.2015.1063993

Van Dijk, T. A. (2001). Principles of critical discourse analysis. In M. Wetherall (Ed.), *Discourse theory and practice* (pp. 300– 318). The Open University.

Welsh Government. (2020). *Introduction to Curriculum for Wales guidance [online]*. Welsh Government. Available at: https://hwb.gov.wales/ curri culum - for- wales/ intro ducti on/

Willig, C. (2008). Foucauldian discourse analysis. In C. Willig (Ed.), *Introducing qualitative research in psychology* (2nd ed., pp. 112– 131). McGraw Hill.

World Health Organization. (2013). *Health 2020: A European policy framework and strategy for the 21st century*. WHO Regional Office for Europe.

Wyse, D., Baumfield, V., Egan, D., Gallagher, C., Hayward, L., Hulme, M., Leitch, R., Livingston, K., Menter, I., & Lingard, B. (2012). *Creating the curriculum*. Routledge.