Meritocratic and Fair? The discourse of UK and Australia's widening participation policies

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Abstract

Introduction

Globally, people with the academic and personal attributes to successfully study medicine experience disadvantages associated with sociodemographic factors. Governments have attempted to address this issue via macro-level policies aimed at widening participation (WP) to medicine. These policies differ by country, suggesting much can be learned from examining and comparing international policy discourses of WP. Our question was: how are discourses of WP to higher and medical education positioned in the UK and Australia?

Methods

A systematic search strategy was guided by five *a priori* themes inspired by United Nations Sustainability Goals (2015). Seventeen policy documents (UK n=9, Australia n=8) published between 2008 - 2018 were identified. Analysis involved two over-arching, iterative stages: a document analysis then a Foucauldian critical discourse analysis, the latter with the aim of unveiling the power dynamics at play within policy-related discourses.

Results

Discourses of social mobility and individual responsibility within a meritocracy are still paramount in the UK. In contrast, the dominant discourse in Australia is social accountability in achieving equity and workforce diversity, prioritising affirmative action and community values. Similarities between the two countries in terms of WP policy and policy levers have changed over time, linked to the divergence of internal drivers for societal change. Both nations recognise tensions inherent in striving to achieve both local and global goals, but Australia appears to prioritise community values in working towards 'nation building' while in the UK the focus on individuality and meritocracy at times seem at odds with achieving parity for disadvantaged individuals.

Discussion

WP policies and practices are situated and contextual so caution must be taken when extrapolating lessons from one context to another. The history of a country and the nature of marginalisation in that country must be scrutinised when trying to understand what drives WP policy.

Introduction

Across the world, young people with the academic and personal attributes to successfully study medicine and become doctors experience disadvantages associated with sociodemographic factors such as ethnicity, minority group membership and/or low income.[1] These disadvantages lead to under-participation in medicine and higher education more generally. The reasons for this are often multifaceted, interconnected within a myriad of wider, complex structural and societal issues including: ethnic minority inequalities,[2] parental education,[3] personal aspirations,[4] educational attainment,[5] family and peer influences and expectations .[6]

Governments have attempted to widen participation to education and medicine via macro-level policies, the aim of which is to reduce discrepancies between the rates of participation of different demographic groups of students in higher education generally,[7] and medical education specifically.[8,9] These widening participation policies are then enacted by universities and medical schools via the development and implementation of widening access (WA) processes and tools.[10,11,12] The precise nature of these WA processes and tools varies across different countries, but include: quota systems,[13] outreach programs,[14,15] access courses,[16,17] particular use of selection tools[18] and the use of contextual data.[10] However, students from certain backgrounds remain under-represented in medicine worldwide,[19,20,21,11,12] suggesting these policies are not wholly effective. Related to this, we know little about how policy translates into practice 'on the ground'.[22,23,18,24] Moreover, the focal groups for initiatives also vary, from racial groups,[25,26] indigenous populations such as Aboriginal and Torres Strait Islanders in Australia,[27] rural communities[28] and lower socio-economic groups.[29,5] This adds complexity and means assumptions cannot be made that what works in one context, with one focal group, is transferable to other contexts and groups.

Given this diversity of approaches and focal groups, it is important to understand what underpins WP practices across different countries. This means looking at the ways in which different

governments and national and regulatory agencies approach widening participation to medicine, as how this is conceptualised at a macro level will have a major impact on the ways in which it is understood, implemented and experienced 'on the ground'.[11]

One way of doing this is by analysing how these national-level organisations use language, and the contexts in which language and texts are put to practice.[30] Previous research has explored constructions of discourses linked to widening participation (WP) in higher education both within[31] and between institutions,[32,33] and from the perspectives of the target demographic of WP policies.[34] Findings indicate that although WP discourses in the prospectuses of differing higher education institutions demonstrate a shift toward similar discussions of inclusivity,[32] analysis of institutional policy discourses show less promising circumstances for WP.[33] Other studies have looked at discourses of widening access to medicine. For example, Alexander et al's recent critical discourse analysis of information on UK medical school websites found that these also echo discourses of meritocracy and deficit, and largely omit discourses of workforce diversity and improved health outcomes, and the strengths that non-traditional students might bring to the profession.[35] In contrast, a Canadian study of policy texts on medical school selection identified diversity as an object of value, where social accountability was extolled as the dominant solution to most issues of representation.[36]

We add to this body of literature and offer a new perspective by focusing on widening participation policy itself, exploring texts to identify discourses produced and reproduced that have power implications in relation to WP to higher education and medicine. Our position in doing so is anchored in the Foucauldian view that action and its drivers (in this case, action related to widening participation to medicine) both reflect and reproduce broader social and historical trends.[37] Simply put, a country's position on widening participation will be shaped by its unique social, political and

economic circumstances, and thus much can be learned from examining and comparing international discourses of widening participation to medicine.

Our research question is: how are discourses of widening participation to higher and medical education positioned, both within and between UK and Australian contexts? We explain why we selected these two countries for comparison below. We aim to challenge the current rhetoric of widening participation to medicine via a comparison of related policy produced by organisations within these two countries. Our ultimate objective is to identify and seek explication of the assumptions and underpinnings of widening participation discourses, and how these discourses could be potentially refined, reframed or even dismantled.

Methods

This work is situated within the paradigmatic framework of criticalism, where the goal is to unveil power dynamics within studied phenomena and foster empowerment via description and analysis of these dynamics.[38]

Comparative contexts

Our focus is two Anglophone countries: UK and Australia. These countries have much shared history and culture and provide good systems for comparison as they share a long tradition of policy borrowing, particularly with respect to social inclusion policy and practices.[39] Since the 1950's, the UK and Australia demonstrate similar trajectories in the massification of their higher education systems, with comparable levels of public and private contributions, participation rates, and similar academic structures and quality assurance frameworks.[40] Their governments have recognised the essential role that universities play in the development of and contribution to a global knowledge economy, and the dividends afforded to their nations in becoming international frontrunners in the higher education sector.[41] However, high levels of social disparity in both the UK and Australia mean universities struggle to offer equality of opportunity in a largely meritocratic environment, where entry to higher education is primarily determined by academic success.[41] Both have hierarchically stratified systems, typical of liberal-market systems, where some institutions and courses have higher status than others.[42] In both countries the effects of maintaining a world-class reputation and competing at an international level are regularly at odds with the need for local commitment to inclusion.[43] Both countries have groups which are under-represented in higher education[44] and medicine, groups which are primarily targeted for improving access to the profession.[45,5] However, there are also striking differences between the two countries in terms of more recent political and economic occurrences, as well as in size, population and climate. Australia has major inequities between Aboriginal and Torres Strait Islanders (we recognise this is a contested term but will be

used for the purposes of this paper) and other Australians,[46] whereas the UK's inequities are based mostly on social class issues which inter-relate with inequality on the basis of ethnic background.[47,48,49]

Whilst the UK was weathering the financial, political and social fallout of the global recession of 2008, Australia was one of the only OECD countries that managed to escape largely unscathed, due to government stimulus spending, its proximity to the booming Chinese economy and the mining boom.[50] In the UK, this global economic crisis gave rise to concerns around public expenditure, inevitably impacting upon the higher education sector, which saw a significant increase in tuition fees for students.[51]At the same time, Australian governments were committing to a series of targets as part of Closing the Gap, a strategy aimed at reducing inequalities in Aboriginal and Torres Strait Islanders' life expectancy, mortality, education and employment.[46]

Theoretical background

The work of the French philosopher Michel Foucault provides a theoretical framework for critical discourse analysis (CDA). Foucauldian critical discourse analysis "investigates the rules about the production of knowledge through language and its influence over what we do".[52] Discourses are written and spoken language, 'practices that systematically form the objects of which they speak', and imply systems of exclusion and distribution of power, reproducing and producing new structures.[53] Discourses can be thought of as the flow of knowledge through time and space, constantly reshaping and enabling social reality.[54]

In CDA, texts are interrogated to uncover assumptions implicit within them and locate statements of truth, and institutional relations that embody deeper and more complex systems of discourse.[55,56] In a Foucauldian sense, 'truth' is "a system of ordered procedures for the production, regulation, reproduction and functioning of statements, linked by systems of power which produce it and

sustain it". Foucauldian analysis focuses on identifying these statements of 'truth' to be able to challenge the existing status quo, in an attempt to change the existing political, economic and institutional regime of the production of truth, thereby constituting a new 'politics of truth'.[57]

A singular text or document generally lacks the power and influence to alter discourse or taken-for-granted knowledge, but numerous sources circulating more or less at the same time become potent tools and generators of knowledge.[53,58] In other words, over time, and with enough intertextual repetition, certain truths and knowledges achieve dominance or taken-for-granted status.[59,60]

Put simply, critical discourse analysis (CDA) aims to make transparent the ways in which documents and texts are constituted by diverse and often competing discourses, and to explicate the power dynamics and relationships at play between and within institutions and subjects.[61] CDA lends itself well to the current study, where the goal was to unveil power dynamics within studied phenomena and inspire empowerment via the description and analysis of these dynamics.[54]

CDA is a well-established approach for scrutinising discourses in the field of education and higher education policy,[62,63,64] and has been used in the analysis of educational policies in both UK[61,65] and Australian contexts[62,66]. Foucauldian CDA has also been used with growing regularity in medical education[67], including explorations into discourses of competency-based frameworks,[55] accreditation and curricular standards,[68] and - as mentioned earlier – in respect of medical school selection policies[36] and widening access messages on medical school websites.[35]

Definitions

In this area of research and practice, the terms 'widening access' and 'widening participation' are used frequently and sometimes interchangeability. However, they mean different things. Nicholson and Cleland[12] define widening participation (WP) as "the *policy* that people such as those coming from disadvantaged backgrounds, mature students, students from ethnic and cultural groups and disabled students should be encouraged to take part, and be represented proportionately, within higher education" (p.321). In contrast, widening access (WA) "emphasises more the equality or fairness of the selection processes that act as a gateway to higher education or medicine (p.322). Our focus is more widening participation than widening access. Please note this differentiation is not always clear in the documents reviewed.

Search strategy and inclusion criteria

Our focus was contemporary discourses of widening participation to medicine in the UK and Australia, so the document search and selection were limited to the years 2008 – 2018.

Our source of data was policy documents not academic research papers. Policy documents can be considered "grey literature", literature which is typically not published in academic journals or books and is often excluded from large databases and other mainstream sources.[69] Thus, a systematic review of the academic databases (e.g., Scopus) was not appropriate for document identification. Indeed, systematically identifying grey literature is not a straightforward task.[70] However, material available outside academic processes can make positive contributions to subsequent inquiry and practice because it is contemporary, and in the case of policy documents, influential in terms of being a statement of the government's (or government agency's) position, intent or action in a specific area.

Our approach to this challenge was as follows. First, we located an official international source of agendas that aim to bring nations together in targeting areas of improvement for their people, drawing on the 2015 United Nations 17 Sustainable Development Goals for 2030 to structure document searching. These goals were designed to tackle global challenges, including issues relating to poverty, inequality, education and health outcomes, and the UN Secretary-General calls on all sectors of society to take action, embedding needed transitions in the policies, budgets, institutions and regulatory frameworks of governments, cities and local authorities.[71]

The goals and targets relevant to this study were identified (see Table 1) and used to develop five *a priori* themes to guide document searching and analysis: access to higher education, access to professional careers, health workforce diversity, improved health outcomes, reducing inequality.

….. Table 1 here ….

Second, a systematic search of publicly available documents was conducted using search engines on websites of UK and Australian government pages, regulatory agencies and national organisations linked to higher education and/or health and medicine. Combinations of search terms included: widening access, widening participation, higher education, medical education and medicine. Within the team, we had much knowledge of widening participation and access in Australia and the UK which we drew on to both identify documents and cross-check our corpus. One author (JC) is an internationally recognised researcher and expert in this field, and two are directly implicated in the delivery of participation processes and practices within medicine in Australia (SS, JB). Documents were selected for analysis on the basis that they embodied one or more of the *a priori* themes (see above) in reference to higher and medical education, where sections of each text were coded against each theme using NVivo qualitative analysis software (QSR International, Doncaster, Victoria,

Australia). A total of twenty-nine documents were initially identified for analysis, later reduced to include only those in the higher education field that referred to medical education or medicine as a profession. In terms of health-related texts, we aimed to represent the key organisations pertinent to this study in both the UK and Australia as far as possible. However, we excluded documents that only provided numerical data without discussion of widening participation issues.

The final corpus of texts included policy, guidelines and recommendations from government departments, as well as official, nationally-endorsed non-government organisations, focused on widening participation to medicine and higher education in the UK and Australia. In terms of regulatory authorities, the Australian Health Practitioner Regulatory Agency (AHPRA) is included via its most recent annual report, and the General Medical Council (GMC) is represented via research it commissioned in the form of a research report published in 2012.

Analysis

The first step in analysis was to review documents to ensure their content and context were appropriate to the conceptual underpinnings of the study.[72] This process began by producing a description of each document with the aim of situating the text within the context of the organisation that produced it,[36] via iterative close reading of the texts and surface interpretation to locate relevant information and establish document parameters, making explicit the context of their production, authors, target audience and original sources of information that contributed to the creation of the text.[73] This stage helped us gain understanding and knowledge of the documents and topic[74] and assisted in determining the authenticity, credibility and representativeness of the corpus of texts.[73]

The above laid the foundations for a Foucauldian critical discourse analysis, where the task was to seek an understanding of the meanings conveyed within the texts, by locating statements of truth

and the discourses they serve to legitimise and perpetuate.[36] In short, analysis focused not only on what the content is but also on what it does; what is included and what is not; what is implied and what is asserted. Foucault did not define an explicit or unified theoretical approach to CDA, but provided a number of concepts aimed at exploring how knowledge and power is continually contrived and contested within language, to show how different discourses are made possible, arise, change and disappear.[56] Given this, we drew on the following steps from an earlier CDA study to guide analysis[68]: (1) (further) familiarisation with the texts; (2) analysis of the assembled archive to identify prominent key words and statements; (3) analysis and interpretation of links between identified discourses and the values of widening access to higher education and medicine; (4) description of the effects and implications of both UK and Australian discourses on the potential to advance policy and practice related to widening participation to medicine.

We operationalized this as follows. Documents were managed in NVivo qualitative analysis software (QSR International, Doncaster, Victoria, Australia). One research team member (MC) read the full text of each article and coded recurring statements and concepts. A coding framework was established using a data-driven approach, and related concepts were grouped as discursive patterns. The coding framework evolved iteratively and via regular team discussions. Once each text was coded, we examined how, and for what purposes, discursive trends were used to legitimise certain discursive practices related to widening participation to higher education and medicine.

Reflexivity and Positionality

Within qualitative research it is the researcher who is the primary tool of analysis, and so being continuously reflective about how one's experiences shape the interpretations of organisational intentions and statements is essential.[75] With this in mind, it is important to note the following. Some of the authors (JC, SS) are well-embedded in the UK and Australia medical education communities, others less so (MC, AP, JB). The first author (MC) has a background in collective

advocacy and public health and is a campaigner for social justice. JB is an academic and Aboriginal Australian, who advocates for Aboriginal and Torres Strait Islander health and healthcare education. AP is a medical doctor who trained in India and works in public health education in the UK. JC has a 15-year programme of research examining widening access and selection into medicine in the UK. All authors have "hands on" experience of medical selection. The authors were continuously reflective about how their differing life courses (e.g., country of origin, life stage), education and training (one author was a medical doctor, others came from public health and psychology backgrounds) shaped their interpretations of the documents and their positioning in respect to the context and focus of this study. Perspectives differed but all authors shared a strong belief in the importance of addressing inequality and increasing medical student diversity globally through extending knowledge and changing practices.

Ethics

Ethical approval was not required as this study is based on analysis of publicly available documents.

Results

Seventeen documents were selected for analysis, nine from the UK, and eight from Australia (see Table 2). The first stage of document analysis produced a table explicating the content analysis of each text. This facilitated an understanding of the immediate historical and/or political context in which each of the documents are situated (see Table 3).

…. Tables 2 and 3 about here ….

Foucauldian critical discourse analysis

Two interconnected objects of analysis, examples of statements of truth, and associated dominant and counter discourses are displayed in Table 4 (UK) and Table 5 (Australia).

…. Tables 4 and 5 about here ….

UK

The discourse of social mobility and emphasis on individual responsibility is repeatedly discussed in UK texts, which caution that failure to improve individual skills will result in people being left stranded both socially and economically (UA 2009). It is the dominant discourse again in the progress report FAPC (2012), produced three years later. In this, the professions are positioned as 'world leaders' (FAPC 2012, UA 2009), enjoying an 'unrivalled reputation for excellence and integrity' (UA 2009), but social mobility and its stagnation in Britain is highlighted: 'birth not worth' (FAPC 2012, UA 2009) has shaped access to professional positions in society.

To combat this stagnation, young people from disadvantaged backgrounds with enough ability and aptitude are positioned as deserving 'a fair crack of the whip' and a 'level playing field' (the latter

metaphor mentioned in six of the nine UK documents) in order to fully realise their aspirations, but there is a tension between who is responsible for achieving these changes. Social accountability takes the form of a counter discourse, where the professions can do more in terms of targeted action and addressing barriers (UA 2009) but is ultimately overshadowed by the discourse of social mobility and individual responsibility. Governments are recognised as equalisers of opportunity here (UA 2009), but it is the individual that is attributed responsibility for achieving social mobility - it is 'the job of the citizen to grab those chances' (UA 2009).

The attribution of deficit to disadvantaged groups, which assumes that certain individuals lack certain skills, proficiencies, knowledge, and/or cultural capital, is somewhat at odds with the discourse of individual responsibility, where 'family and social networks can lack the experience and knowledge to help them achieve their aspirations' (FOP 2015). The one Scotland-specific text calls out this perceived deficit model, challenging the system to be more accountable when it comes to supporting disadvantaged learners (BF 2016).

When moving beyond widening participation to higher education to the more specific object of widening participation to medicine, the dynamic between familiar discourses shifts, where social mobility and individual responsibility take a back seat to the more dominant discourse of workforce diversity and improving patient care. Fair Access to Professional Careers (2012) goes further to call out medicine as lagging behind the other professions, where it 'has made far too little progress and shown far too little interest' in widening participation. 'Medicine has a long way to go when it comes to making access fairer, diversifying its workforce and raising social mobility' (FAPC, 2012) is cited repeatedly in texts specific to medicine, and legitimises the discourse of workforce diversity as a key motivator for improving access to the profession. In this text, social mobility is somewhat secondary to the importance of enriching the medical profession and better patient care as the end goal of a

fairer admissions process, where 'widening participation is about inclusion. It is about diversifying the workforce and not about 'letting people in'' (IGP 2018).

The most prestigious of the professions i.e., medicine and law, are accused of not doing enough to broaden access, where they still 'recruit from too narrow a part of the social spectrum' (FAPC 2012). Discourses of both social and economic benefits of expanding the professions are referred to regularly, but 'increasing productivity' (FOP 2015) appears to take precedence over social benefits. Related to this, widening participation is referred to as 'controversial terrain' and credence is given to the 'deeply polarised' excellence versus equity debate (UC 2012). Inequalities are seen as inevitable in access to a 'high stakes' medical degree and maintaining standards of excellence within a league table culture is repeatedly raised. Changes to admissions processes such as the use of contextual data are described as 'problematic for medical schools' where there are 'concerns that it will be used to disadvantage students who are academically able' (SFC 2014). Concerns about maintaining the quality of higher education and strong university reputations within a competitive global market are a real worry, and reinforce the dominance of discourses of academic excellence and international reputation over those of equity and fairness: universities are frequently positioned as critical to the future of the UK and its economic success, and are challenged on their practices and the changes they need to make, despite calls for all stakeholders to take responsibility for improving access to higher education, as 'the blame game has to end' (UC 2012). Most of the UK corpus of texts are produced for and by higher education authorities, and so discourses related to health outcomes have less precedence than in the Australian findings (see next section).

Australia

Similar to the UK, Australia lays claim to an international higher education system (BR 2008), where remaining competitive in a global market must be a priority for the nation. Fears around Australia losing ground here are given credibility, contributing to a counter discourse of higher education as

an economic good in a competitive global market, where the higher education sector 'faces threats' to its position amid a decline in quality. This discourse of higher education as an economic good has less dominance in subsequent texts selected for analysis, where higher education's primacy as a social good begins to emerge in later texts (AOATSI 2012, IPP 2017, FCPC 2017), where the importance of equitable access for all Australians is a priority. Globalism is recognised as having the potential to be destructive because although it 'can drive a push for diversity', it can also 'act to reinforce social division' (FCPC 2017). 'Better communication within a 'competitive collaborative' institutional setting in which universities compete to provide best practice initiatives in a transparent and collaborative model' is proposed as a 'constructive process to achieve equity goals' (IPP 2017). The wider benefits of widening participation to higher education for families and communities are commonly reiterated where universities and other professional bodies are required to respond to community need as part of a 'whole system effort'. The dominance of this discourse of higher education as a social good in community and nation building is firmly established, overshadowing economic rationale behind healthcare decisions, especially in regional, rural and remote communities (HCRRR 2016). This notion of shared responsibility in 'nation building' is extended to Aboriginal and Torres Strait Islander leaders and communities in the quest to make higher education a 'natural pathway' for Aboriginal and Torres Strait Islanders , contributing to 'growing their own' in the creation of a new Aboriginal and Torres Strait Islander professional class (AOATSI 2012).

Accountability for institutions and organisations is key, and parity targets, reporting frameworks and mission-based accountability mechanisms are highlighted as ways of making this happen (AOATSI 2012). In contrast to the UK's dominant discourse of individual responsibility and a bottom-up approach, Australia puts a focus on organisations and higher education providers as being in charge of driving change and 'leading from the top' (AOATSI 2012). Embedding Aboriginal and Torres Strait Islanders perspectives within higher education policy and practice is a big part of nation building and reducing inequalities (AOATSI 2012).

Social mobility takes a back seat in Australia, where workforce diversity becomes the dominant rationale for greater access to higher education for people from disadvantaged groups. For example, 'the Department of Health is committed to reflecting the diversity of the Australian community in its workforce by building an inclusive culture that celebrates differences' (DH AR 2018). Closing the Gap targets[76] that aimed to ameliorate Indigenous disadvantage have clearly had an impact on improving health outcomes. Aboriginal and Torres Strait Islander perspectives contribute to a new focus on increasing participation within the Aboriginal and Torres Strait Islander health workforce, where 'there is growing appreciation of the vital role that all Aboriginal and Torres Strait Islander health workers and registered health practitioners play in their roles as cultural brokers of, and contributors to, health improvements and outcomes in their communities' (AHPRA AR 2018). Workforce diversity is repeatedly and explicitly linked to improving health outcomes for all Australian communities, where stakeholders are urged to collaborate in a climate of accountability to achieve parity in outcomes and access for regional, rural and remote Australians (AMC AR 2018).

Accountability is also an important feature of Australia's approach to recruitment of medical students, where affirmative action procedures are employed to diversify the medical student population and improve access for students from 'marginalised' backgrounds. In contrast to the UK's deficit-based approach to WA, Australian institutions have implemented strategies to streamline and prioritise rural origin students in a concerted effort to ameliorate the poor health outcomes experienced by rural and remote communities (HCRRR 2016). Four of the eight Australian texts are produced by health-related organisations, and similar to their positioning of discourses of higher education, also bring in healthcare as both a social good (dominant discourse) and economic good (counter discourse) when it comes to widening participation to medicine.

The professions are called to account frequently in terms of changing attitudes: they 'need to examine cultural biases, accountability and positions on social diversity' (FCPC 2017) and recognise the value of non-traditional students in tackling entrenched inequality in access. When it comes to widening participation and widening access to medicine the Australian texts go beyond UK discourses of workforce diversity, academic excellence, and equity, paying heed to the notion of micro-class reproduction of privilege and identifying the stratification of learning opportunities as a form of social reproduction. There is 'nothing natural about the culture of prestigious professions', who have 'particular histories that are classed, gendered and raced' (FCPC 2017), where it is who you know and having access to 'hot knowledge' (information gleaned from informal social interaction) that determines success in a medical career. The Australian context also explores the impact that travelling such a great social and cultural distance can have on disadvantaged students in accessing medical education, where 'numerous stresses can accumulate into a collective hidden disadvantage, which can unintentionally discriminate against equity students' (IPP 2017). This counter discourse of extreme social mobility is dominated by the aforementioned discourse of micro-class reproduction in widening participation to medicine, bringing a more nuanced exploration and critical understanding of the tensions at play within the broader discourse of social mobility identified in UK texts.

Discussion

Main findings

Critical discourse analysis (CDA) allowed us to compare and contrast interpretative insights across the two countries. In the UK, social mobility is the construct and discourse that prevails throughout much of the language of participation. By contrast, in Australia, the dominant discourse is social accountability. Broader discourses of widening participation to higher education in the UK begin and remain fairly rooted in paradoxical notions of individual responsibility and deficit over the ten-year period, but when it comes to medicine, these shift towards those of workforce diversity and better patient outcomes. Initially, Australia appears to share the UK's focus on higher education as an economic good, but rapidly prioritises the social benefits of a more diverse workforce and better access to a medical career for disadvantaged groups.

Earlier studies highlighted that, outside Europe, the clearest comparable set of widening participation and access initiatives to those in the UK were found in Australia.[77,78] Our analysis shows, however, that similarities between the two countries in terms of policy and policy levers have changed over time, linked to the divergence of internal drivers for societal change.

We suggest that Australia's recent colonial history, the racism and subjugation suffered by Aboriginal and Torres Strait Islanders, and the consequent poor health and social outcomes they experience, brought to the fore the pressing need to address issues of marginalisation. Australia as a nation began to realise its role to play in improving these outcomes as part of a whole system approach and to recognise the importance of Aboriginal and Torres Strait Islander perspectives and contributions, which in turn supports discourses that aim to create parity of access and outcomes in health and education. This gave rise to a collaborative focus on community building, workforce diversity and patient care in a climate of state and institutional accountability. By contrast, in the UK the global

economic crisis of 2008 prompted a series of welfare reforms amid growing concerns around skills shortages, the continuing decline in social mobility,[79] and the effect this might have on the UK's participation in a knowledge based economy.[51] However, what emerged was not a climate that aimed to bring stakeholders together within a culture of systemic accountability, but a new austerity agenda that gave rise to multiple social concerns and conflicts within societies and institutions.[80]

Both nations recognise tensions inherent in striving to achieve both local and global goals, but Australia appears to prioritise community values in working towards 'nation building' while in the UK the focus on individuality and meritocracy at times seem at odds with achieving parity for disadvantaged individuals. Collaboration is key for both countries' institutions and organisations, but with subtle differences. It is the government that is called to action most often to make changes in Australia whereas as in the UK, responsibility is devolved: universities, medical schools and the professions are frequently singled out in terms of what they could and should be doing differently to widen access.

How to achieve widening participation also differs across the two countries. Affirmative action and diversifying the workforce as a key to improving patient outcomes is a priority in Australia. Whilst the link between workforce diversity and better health outcomes is referred to in UK texts, it is not given the same attention as in Australia. Instead, the deficit model of action is the dominant approach to widening participation to medicine in the UK.

Evidence to support claims and legitimise the discourses they perpetuate also differ subtly across the two countries. Organisations in both countries regularly cite quantitative evidence from other official and widely recognised institutions, documents and reports to support their claims, and represent historically-privileged stakeholders in policy genesis and reproduction. However, although the UK documents include some qualitative evidence to support their claims (of deficit), the

Australian texts put significant emphasis on the importance of narratives and storytelling in illuminating the voices of marginalised groups. We suggest that this is a means to connect with the lived experiences of Australian individuals and communities and is acknowledgement of the place of storytelling in Aboriginal and Torres Strait Islander groups .[81]

Comparison with previous literature

This study contributes to a body of work looking at widening participation and access to medicine. Scholars have, for example, looked at policy enactment,[11] selection methods,[82] graduate entry,[23] learning environments,[2] and the implications of social and cultural capital.[83] We add a new perspective to this body of literature by focusing on widening participation policy itself, exploring policy texts to identify discourses produced and reproduced that have power implications in relation to participation in, and access to, higher education and medicine.

Social mobility is a common theme in UK widening participation to higher education and medicine research,[11,22,84,85] challenging the old social order of class and hierarchy with a 'whatever it takes' attitude, linking an economic imperative with the cultural politics of the 'fairness' agenda. Whilst these ideas are progressive, higher education as an economic good dominates 21st century rhetoric and connects being fair and progressive with a meritocratic, competitive discourse of individual responsibility.[86] In keeping with these wider discourses, the 'level playing field' metaphor for fairness that is repeatedly referred to in the identified UK texts, and supposed to benefit 'those at the bottom', is in reality for a no-holds-barred game of all against all.[65]

In line with the policy documents, the 'level playing field' metaphor appears with significantly less regularity and emphasis in the wider Australian literature, where uplifting the quality of schools in low-income neighbourhoods has been a more long-standing theme.[65] Other research examining

discourses of Australian policy documents related to inequality and social justice find nation-building as a more important and pertinent rationale than position and reputation in a global market.[87]

The concepts of extreme social mobility and micro-class reproduction that play a part in obstructing fair access to education for marginalised groups have also been highlighted in other literature. Social and cultural risk pepper the road to success and denote the sacrifices and dislocation that may be experienced by individuals and their families and communities.[65,88] Being a success story hides a 'cruel optimism', a concept given to the phenomenon of the holding up of hope as a means of obstructing social and political change, rendering desired outcomes unattainable. This may reinforce the structural inequalities that makes 'the good life' harder to achieve for all, where social mobility exists in a world of universal precarity.[89]

Similar discourses with varying degrees of dominance and interconnectedness have been identified within other platforms and contexts when it comes to widening access to medicine.[35,36] However, in both studies, the authors question whether the rhetoric in fact contributes to the maintenance of the specific power relations they seek to address, where institutional power and prestige may continue to be reproduced through the same processes that aim to empower other societal groups.

Implications for future research, policy and practice

Although these findings might be interpreted as suggesting that the UK could look to Australian discourses of achieving parity, transferability of practice and policy are limited by their particular cultural and political context. While acknowledging this, there may be important lessons that can be drawn from this international comparison, particularly given the similarities between the UK and Australia in terms of how their education systems are organised.[45] Although the dominant discourses of widening participation differ, we suggest that both countries may benefit from reflecting on each other's discourse and practices, as to do so may help unveil new and alternative positions. Shifting

from “not seeing” to “seeing” in this way may just help with change. Similarly, both countries may wish to reflect on the likely dominance of socially-privileged stakeholders in policy and practice development, as this may help address (or reinforce) inequities, differences and hidden disadvantage within higher education[90] and medicine.[91]

This would help fulfil the need to consider deep, structural change to put disadvantaged groups at the core of the design and development of policy and policy-related texts via participatory action research (PAR) approaches.

Following extensive consultation and negotiation between organisations, Australia has recently refreshed its Closing the Gap targets to consider a much broader and more nuanced range of policy ideas more in line with Aboriginal and Torres Strait Islander demands of the government.[92] However, the new targets remain focused on reducing socio-economic differences and do little to address power imbalances, thereby perpetuating ideas of Aboriginal and Torres Strait Islander deficit.[93] Conceptualising equity and diversity should explicitly consider the historical disempowerment of marginalised groups, deal directly with a redistribution of power through continued critical reflection on the inclusiveness of policy development, and take into account how this acts upon future discourses of widening participation to medical education.[36] An effective social justice framework requires a transformative reimagining of widening participation as opposed to the current rhetoric of the ‘disadvantaged’ becoming more like the advantaged.[94,95] Alternatively, or additionally, re-conceptualising widening participation as a ‘wicked problem’ may be useful. This framework provides “a means of shifting thinking from erroneous ‘simple’ solutions to thinking more contextually and receptively” (p.1228), and can be used to explicitly recognise that widening participation is a multi-causal, dynamic social problem, where context and stakeholder views are paramount.[96]

Strengths and weaknesses of the study

In using critical discourse analysis to examine and interpret relations of power, the authors of this study are paradoxically implicated in the very same power relations they have attempted to disentangle, and so become an integral constituent of power.[61] However, the principles of critical discourse analysis call for multiple interpretations, and advocates of this framework acknowledge and consider unproblematic that it is a politically contentious activity.[96] In employing this method of analysis, researchers must take an explicit socio-political stance within a post-structural approach to a reality which is contextual and historically specific, and therefore subjected to non-absolutist interpretations. As stated earlier, our positions in respect to WP differ given our respective backgrounds. The composition of research team allowed us to keep a check on selective perception. We provided a clear description of the research process and our rationale for decisions.

The UK and Australia are meaningful comparators because of their shared history and tradition of policy borrowing.[39] Our analysis shows, however, that similarities between the two countries in terms of widening participation policy and policy levers have begun to change over time, linked to the divergence of internal drivers for societal change. This indicates the value of longitudinal and follow-up research to assess change, or lack of change. This brings us to our second point. Our analysis focused on policy documents from a 10-year period (2008-2018) but, in doing so, could not assess what influenced these documents or how they may have been interpreted, transmitted and transformed into policies and guidelines out with this timeframe, and we refrain from making explicit assumptions or conclusions based on this brief timeframe of analysis. These documents can be viewed as a 'snapshot' in time; reflections of and on the past and present situation of widening access to higher education and medicine.[36] Their relevance at another point in time may be less. For example, the documents used in our analysis were published prior to the onset of the 2020 Covid-19 pandemic, China's investments (and relationship) with Australia dropping and the UK's

Brexit from the European Union. The possible impact of these significant events on widening participation will not be known for several years.

Finally, inequality in access to higher education by social background is a global phenomenon. It would be interesting to gain a sense of the trajectory and diversity of policy discourses related to widening participation in countries with different historical, cultural patterns of societal inequalities/levels of inequality, especially those with histories of colonisation.

In conclusion, widening participation policies and hence widening participation and access practices are situated and contextual, bound in time and place. This suggests that the need for caution if extrapolating lessons from one context to another. The history of a country and the nature of marginalisation in that country must be scrutinised when trying to understand what drives widening participation policy – and consider how best to empower marginalised groups and put their perspectives at the core of the design and development of policy and policy-related texts.

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Table 1. Selected United Nations Sustainability Goals and targets

Goals	Targets
Goal 3 – Good health and wellbeing	• Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
Goal 4 – Quality Education	• By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university • By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations
Goal 10 – Reduced Inequalities	• By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status

Table 2. UK and Australian documents identified for analysis

	UK (9)	Documents	Australia (8)	Documents
Government	Department for Business Innovation and Skills	Green Paper - Fulfilling our Potential: Teaching Excellence, Social Mobility and Student Choice (Nov 2015) **(FOP, 2015)**	Department of Health	Annual Report 2017-18 **(DH AR 2018)**
NGO's	Panel on Fair Access to the Professions	Unleashing Aspiration: The Final Report of the Panel on Fair Access to the Professions (2009) **(UA 2009)**	Review of Australian Higher Education: Expert Panel (initiated by Australian Government)	Final Report (Dec 2008) **(BR 2008)**
			The Panel of the Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People (Initiated by Australian Government)	Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People Final Report (July 2012) **(AOATSI 2012)**
	Independent Reviewer on Social mobility & Child Poverty	University Challenge: How Higher Education can Advance Social Mobility (Oct 2012) **(UC 2012)** Fair Access to Professional Careers (May 2012) **(FAPC 2012)**	Australian Medical Association	A Plan for Better Health Care for Regional, Rural, and Remote Australia (2016) **(HCRRR 2016)**
			National Centre for Student Equity in Higher Education	Informing Policy and Practice III 2016 Student Equity in Higher Education Research Grants Program Projects **(IPP 2017)** Fair Connection to Professional Careers (Aug 2017) **(FCPC 2017)**
	The Commission on Widening Access	A Blueprint for Fairness: Final Report of the Commission on Widening Access (March 2016) **(BF 2016)**	Australian Medical Council	Annual Report 2017 **(AMC AR 2018)**

	Medical Schools Council	Selecting For Excellence Final Report 2014 **(MSC SFE 2014)** Selection Alliance Report 2017 **(MSC SA 2017)** Indicators of good practice 2018 **(MSC IGP 2018)**		
Regulatory Agencies	General Medical Council(Commissioned research)	Research Report: Identifying best practice in the selection of medical students (2012) **(GMC 2012)**	Australian Health Practitioners Regulatory Agency	Annual Report 2017-18 **(AHPRA AR 2018)**

Table 3. Content analysis of UK and Australian documents

UK						
Document/Date	**Author**	**Target Audience**	**Type/sources of information**	**Purpose**	**Context**	**Selected sections of text**
Unleashing Aspiration: The Final Report of the Panel on Fair Access to the Professions (2009)	NGO - Panel on Fair Access to the Professions (18 representatives from a range of professions)	Government and the professions	Analysis and evidence gathering from a wide range of sources, followed by formulation of 88 recommendations	Recommendations for action by professionals, government and others – primarily about forming new partnerships for action, with little or no cost to government (given fiscal context)	2008 economic recession Government's white paper – New Opportunities (2009), set out proposals aimed at an economic upturn and ensuring all members of society have a fair chance to benefit. The report also established the Panel on Fair Access to the Professions	Foreword by the Chair (p5-8) Chapter 6.3: Widening participation further (p93)
Research Report: Identifying best practice in the selection of medical students (2012)	Regulatory Agency - General Medical Council (Commissioned research)	GMC, medical schools, Medical Schools Council, departments of health	Modified systematic review of selection literature, realist review of WA literature, website survey, interviews with Admissions Deans, typology evidence assessment	Defines, analyses and critiques evidence on and approaches to selection and WA to medicine, making recommendations for future policy and actions	Commissioned by GMC to examine evidence on selection methods and WA initiatives at medical schools Conceptually underpinned by GMC's Tomorrow's Doctors report (2009) and Good Medical Practice, and the Schwartz report - Fair admissions to higher education: Recommendations for good practice (2004)	Executive summary (p3) Introduction (p6-8) Chapter 7. The effectiveness of widening access initiatives used by medical schools to promote fair access (p49-82)
Fair Access to Professional Careers (May 2012)	NGO - Independent Reviewer on Social mobility &	Government, the professions, employers, Ofsted, universities, statutory	Team took evidence from wide range of sources and organisations,	Stocktake of progress since Unleashing Aspiration (2009), restating case for fair	Builds on Unleashing Aspiration report and the work of the Panel on Fair Access to the Professions	Foreword and summary (p1-7) Introduction (9-11) Chapter 4: Progress

	Child Poverty	regulators, trade unions	including; desk work, call for evidence, b-live survey, evidence hearings, bilateral evidence	access to professions and why it matters	(2009). Change in Government in intervening years, but social mobility 'remained a core social policy point', emphasised in the Government's social mobility strategy document 'Opening Doors, Breaking Barriers: A strategy for Social Mobility (2011)	in the medical profession (p43-49)
University Challenge: How Higher Education can Advance Social Mobility (Oct 2012)	NGO - Independent Reviewer on Social mobility & Child Poverty	Universities, schools, government, careers services	Team took evidence from wide range of sources and organisations, including; desk work, call for evidence, university deep dives, roundtable discussions, survey, bilateral evidence	The aim of this report is to suggest how universities can become part of a wider national effort to advance social mobility, and makes several recommendations, particularly for government	Significant rise in tuition fees under Coalition Government in 2012. Graduates will only have to pay back student loan once they research minimum earning threshold, but proportion of young people applying to university fell for the first time since 2006, especially from those living in most disadvantaged areas	Foreword and summary (1-9) Introduction (11-17)
Selecting For Excellence Final Report 2014	NGO - Medical Schools Council	Medical schools, Health Education England and equivalent bodies in the devolved administrations, Association of UK University Hospitals, General Medical Council, Royal	Gathered information from wide array of sources, seeking out best practice and analysing data to establish what works from access programs in medicine and elsewhere Took an evidence	Sets out plans for future policy development in selection for medicine and makes several recommendations for target audience	Criticisms towards WA to medicine in Fair Access to Professional Careers report (2012) led to summit on what medical schools will do in response GMC became aware of major diversity in selection methods and	Introduction (p1-2) Executive summary (p4-5) Chapter 2. Widening participation (p35-50) Appendix A: Supporting widening participation in medical schools: Best practice indicators

		Colleges, UCAS, Higher Education Statistics Agency	based view of policy development and commissioned research around selection		commissioned the review – Identifying best practice in the selection of medical students (2012)	(p71-74). Research and Engagement (p75)
Green Paper - Fulfilling our Potential: Teaching Excellence, Social Mobility and Student Choice(Nov 2015)	UK Government - Department for Business Innovation and Skills	Higher education stakeholders including statutory and quasi-statutory bodies, higher education providers, students and employers	Consultation contains proposals 'to reshape the higher education landscape to have students at its heart', including plans to drive social mobility via increasing higher education participation by disadvantaged and under-represented groups Invites views and responses from everyone with an interest in higher education	Core aims are to raise teaching standards, provide greater focus on graduate employability, widen participation in higher education, and open up the sector to new high-quality entrants	The cap on student numbers was lifted in 2015 Government's productivity plan - Fixing the Foundations: Creating a more prosperous nation (2015) – aims to improve skills UK Commission for Employability and Skills (UKCES) surveys demonstrate skills shortages and a need for divisive action to rebalance the economy Nation Student Survey (NSS) gives insight into course and teaching quality Research Excellence Framework (REF) already receives significant recognition and funding, and the new Teaching Excellence Framework (TEF) aims to do the same for teaching. The new Office for Students (OfS), based on 2011 reforms, aims to	Foreword (p8-9) Introduction and executive summary (p10-17) Annex A: Equality analysis (p80-87)

					put students at heart of the system. Equality Act 2010 means the Department for Business Innovation and Skills (BIS) is legally obliged to give due regard to equality issues when making policy decisions	
A Blueprint for Fairness: Final Report of the Commission on Widening Access (March 2016)	NGO - The Commission on Widening Access (Scotland)	Scottish government, commissioner for fair access universities, Scottish funding council, local authorities, schools	Issued a Call for Evidence (June 2015), reviewed existing evidence, commissioned a literature review on barriers to fair access, held consultation events and meetings, held expert groups, took presentations from key stakeholders including students, care leavers, experts and practitioners	Proposes 34 recommendations for a system-wide plan aiming to support Scotland to achieve the goal of equal access for those from deprived backgrounds or with care experience	In the 2014-15 Programme for Government the Scottish Government set out its ambition 'that every child, irrespective of social background, should have an equal chance of accessing higher education.' – The Commission on Widening Access was established to advise Ministers on the steps necessary to achieve this	Chair's foreword (p2-5) Executive summary (6-19) Agenda for the future (p68-73)
Selection Alliance Report 2017	NGO - Medical Schools Council Selection Alliance	Medical School Council and UK medical schools	The Selecting For Excellence Final Report (2014) supplied the template for this (first) report from the Medical Schools Council Selection Alliance, citing new developments in widening participation and new policy drivers	An update on the Medical Schools Council's work in selection and widening participation reporting on progress on the implementation of recommendations	Since Selecting for Excellence report (2014) new policy drivers have influenced Selection Alliance's work; qualification reform, 1,500 new UK medical school places, shortage specialities, a changing regulatory environment (TEF), and health and	Introduction (p3-6) Chapter 2: Data monitoringResearch into widening participation (p25)

					disability	
Indicators of good practice in contextual admissions 2018	NGO - Medical Schools Council Selection Alliance	Government, Medical Schools Council, universities and medical Schools	Information based on the understanding of current effective measures as a result of work by the Selection Alliance	Aims to provide an approach to and indicators of what might work best when a medical school considers its approach to contextual admissions	Fair Access to Profession Careers (2012) report, Selecting for Excellence Final Report (2014), establishment of MSC Selection Alliance and its work on contextual admissions all formed the basis of this report	Entire report (p1-11)
Australia						
Document/Date	**Author**	**Target Audience**	**Type/sources of information**	**Purpose**	**Context**	**Selected sections of text**
Final Report (2008)	Review of Australian Higher Education: Expert Panel (Bradley Review) - initiated by Australian Government	Australian Government, Australian Education International, higher education providers, higher education financing system	National consultations, stakeholder meetings, received 450 responses and submissions from individuals, organisations and institutions	To set targets and recommend major reforms to the structure, financing and regulatory frameworks for higher education	The Commonwealth, state and territory governments agreed to work together to halve the proportion of Australians aged between 20 and 64 years without qualifications at the certificate III level and above between 2009 and 2020 – nearly 6.5 million people. This report is one of the activities underway to set the policy framework to address this target	Executive summary (xi-xvii)
Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People Final Report	The Panel of the Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People	Governments, higher education sector – especially universities, schools employers, professional organisations,	Consultation process with the sector - every public university in Australia, Notre Dame in Broome. Met with and received submissions from vice	To provide evidence and make recommendations to the Australian Government on higher education access and outcomes for Aboriginal and Torres Strait Islander	Follows on from Bradley Review (2008) by proposing measures that address the significant gap between Aboriginal and Torres Strait Islander and non-Indigenous	Ministerial Foreword Executive summary (p9-16) Introduction (p1-2) Context (p3-10) What are we trying to achieve? (p11-14)

(2012)	(Initiated by Australian Government)	research agencies, vocational education and training sectors, Aboriginal and Torres Strait Islander communities	chancellors, senior university representatives and Aboriginal and Torres Strait Islander students, graduates and staff	people	Australians' higher education outcomes. Closing the Gap agenda - Government commitment to address Aboriginal and Torres Strait Islander disadvantage and improve lives across six areas relating to health, early childhood development, education and economic participation	
A Plan for Better Health Care for Regional, Rural, and Remote Australia (2016)	Australian Medical Association	The Commonwealth, Government	Policy and research reports	Sets out main challenges facing health care in regional, rural and remote Australia, and what actions are needed by the Government in addressing these	Cites current issues as context; closure and downgrading of rural hospitals seriously affecting future delivery of healthcare in rural areas, distribution of doctors skewed heavily towards major cities, significant infrastructure limitations in rural areas	Entire report (p1-8)
Fair Connection to Professional Careers: Understanding social difference and disadvantage, institutional dynamics and technological opportunities	National Centre for Student Equity in Higher Education	Government, policymakers, communities, schools, all relevant stakeholders linked to higher education	First section examines ten research reports, funded in 2016 by the NCSEHE, which collectively form policy and practice to maximise the access, transition and successful completion of university by	To collate and promote research that continues contributes to an evidence base and inform discussions how student equity policy and programs should be developed	Third publication of the series 'Informing Policy and Practice'. $1.4 million made available by the NCSEHE for 34 research projects undertaken by Australian universities and other research organisations, demonstrating how to	Foreword (p4) Preface (p5-10)

(2017)			students from disadvantaged backgrounds. Second section introduces overviews of Equity Fellows Program		improve participation and success in higher education	
		Government, policymakers, communities, schools, higher education sectors, professions	Sociological, qualitative and statistical research findings from 2016 Equity Fellowship project (2016)	To explore the complex social and educational factors implicated in the underrepresentation of non-traditional students in high-status professions.	Cites both the Bradley Review (2008) and two UK documents (included in this analysis) - Unleashing Aspiration (2009), and Fair Access to Professional Careers (2012) – as key foundations in the production of this report.	Key findings (p6) Chapter 1: About the Fellowship and this report (p7-8) Chapter 2: Research on fair connection to high status professions (p9-18) Chapter 5: Views from the National Consultation (p43-53)
Annual Report 2017-18	Australian Health Practitioners Regulatory Agency (AHPRA)	Government, National Boards, stakeholders in Australia's health sector	Performance data for all National Boards on accreditation, registration, notifications, legal services, compliance, and financial statements	Provide information on delivery of core regulatory functions in order to protect the public, administer national law, endure registrants are qualified, work with stakeholders, uphold professional standards, identify and respond to risk, and use appropriate regulatory force	2017 saw the development and launch of a shared commitment between Aboriginal and Torres Strait Islander health leaders, AHPRA, the National Boards and accreditation authorities. The National Scheme Aboriginal and Torres Strait Islander strategy statement of intent is a commitment to achieve equity in health outcomes between Indigenous and non-Indigenous Australians to close the gap by 2031	The National Boards: Protecting the public: Aboriginal and Torres Strait Islander Health Practice Board of Australia in 2017-18 (p14) Medical Board of Australia in 2017-18 (p16-17) Registration (p37) Community and engagement (p66-67)

Annual Report 2017-18	Australian Government: Department of Health	Government and relevant stakeholders	Evidence based policy, targeted programs and best practice regulation	Reporting on and setting outcomes for health systems, policy, access and support services, regulation, aged care and sport and recreation outcomes	Report prepared in accordance with section 46 of the Public Governance, Performance and Accountability Act 2013 for presentation to parliament. It contains information specific to the Department required under other legislation including the National Health Act 1953 and Human Services (Medicare) Act 1973 Department assisted the Government in developing the $550 million Stronger Rural Health Strategy in 2017-18	Secretary's review (p4-9) Chief Medical Officer's report (p11) Outcome 2: Health access and support services – Program 2.3: Health workforce (p48-50) Part 3: Management & Accountability – Part 3.2: People (p146)
Annual Report 2018	Australian Medical Council (AMC)	Government, community, relevant stakeholders in Australia's health system and services including the Medical Board of Australia and Australian Health Practitioner Agency, Health Professions Accreditation Collaborative Forum, Council of Presidents of Medical Colleges,	Supported by the work of standing committees, expert panels and working parties in monitoring, advising and overseeing the operation of the AMC and its functions	Provided financial statements for the AMC, information on AMC's corporate governance arrangements, performance in carrying out its functions, and important events and activities in 2017-18	Development of a more visible and effective strategy for engagement with Indigenous Australians – leading to the creation of an Aboriginal, Torres Strait Islander and Maori Health Statement that recognises Indigenous peoples as First Nations peoples, and includes First Nations people's perspectives in the work	From the President (p2) From the CEO (p3) Strategic priorities (p9) Promoting Aboriginal, Torres strait islander and Maori health (p3) 2017-18 highlights (p11-12)

		Leaders in Indigenous Medical Education			of the AMC	

Table 4. Foucauldian critical discourse analysis - UK

Object	Examples of Statements of Truth	Dominant discourses	Counter discourses
WA to Higher Education	'Britain remains too much a closed shop society – the glass ceiling has been raised but not yet broken' (UA 2009) 'society will not flourish unless people see that effort and endeavour are rewarded' (UA 2009) 'Reforms are working…Universities are playing their part as powerful engines of social mobility' (FOP 2015) 'There is a very real danger that the Government has under-estimated the extent to which fear of debt is part of the DNA of Britain's least well off families' (UC 2012) 'The introduction of tuition fees have brought to a head public concern about whether access to university is genuinely meritocratic and fair' (UC 2012) 'barriers must be broken down to make access to a professional career more genuinely meritocratic' (FAPC 2012) 'Government can equalise opportunities but in the end social mobility has to be won through drive and ambition – aspiration has to come from individuals themselves' (UA 2009) 'notions of a State that empowers citizens to realise their own aspirations to progress' (UA 2009) 'Social change is primarily driven from below, not above. Families and communities are the foundation stone' (FAPC 2012)	Social mobility and individual responsibility within a meritocracy	Social accountability of the state

	'Britain needs people with the knowledge and expertise to help us compete at a global level' (FOP 2015) 'Prosperity in an increasingly competitive global market relies on our country developing the potential of all those with aptitude, ability and aspiration' (UC 2012) 'Increasing productivity is one of the country's main economic challenges' (FOP 2015) 'Fair access is much more than an altruistic endeavour – avoiding this lost potential is firmly in Scotland's economic and social interests' (BF 2016)	Higher education as an economic good in a competitive global market	Higher education as a social good
	'Innovation and diversity in HE provision is crucial to maintain our international reputation' (FOP 2015) 'Highly selective universities enjoy global reputations for excellence and compete in a global market for students – they have some of the best outcomes for students but lowest rate of attendees from disadvantaged backgrounds' (UC 2012) 'The debate on universities and social mobility has become deeply polarised between greater equity and those who believe standards will suffer unless excellence, not equity, is the guiding principle' (UC 2012)	International reputation and excellence in a knowledge- based economy	Greater equity
	'we reject the notion of positive discrimination which we believe will create new injustices' (UA 2009) 'It is important to help disadvantaged pupils understand their choices because family and social networks can lack the experience and knowledge to help them achieve their aspirations' (FOP 2015) 'It is time to rebalance the focus from the perceived deficit in the individual to what more the system can do to support disadvantaged learners to succeed' (BF 2016)	Deficit model	Affirmative action
WA to medicine	'Medicine has a long way to go when it comes to making access fairer, diversifying its workforce and raising social mobility' (FAPC 2012)	Workforce diversity and improving patient care	Social mobility

	‘Medicine recognises that the skills modern doctors require include far greater understanding of the social and economic backgrounds of the people they serve’ (FAPC 2012) ‘In addition to social mobility, a medical profession with access to the widest possible talent pool is essential for producing the best possible doctors’ (MSC SFE 2014) ‘Medical schools can ensure the fairest and most transparent admissions processes that select the best possible candidates from all parts of our society for the benefit of patient care’ (MSC SFE 2014) ‘Widening participation is about inclusion. It is about diversifying and enriching the medical profession and not about ‘letting people in’’(MSC IGP 2018) ‘As well as social mobility, a second rationale for WA to medicine is to improve healthcare provision by ensuring doctors are as representative as possible of the society they serve in order to provide the best possible care’ (GMC 2012)		
	‘There is great demand for undergraduate places to read medicine and it is vital that excellence is maintained’ (FAPC 2012) ‘Medicine has made far too little progress and shown for too little interest in the issue of fair access’ (FAPC 2012) ‘Contextual data is a key element of an admissions process which sets out to be fair to all and which strives for academic excellence’ (MSC SFE 2014) ‘Contextual data is problematic for medical schools as there are often concerns that it will be used to disadvantage students who are academically able’ (MSC SFE 2014) ‘Aim to make widening access more fair, transparent, and evidence based’ (MSC SA 2017) ‘Medicine is a high tariff subject and therefore inequalities in public education impact on it to a greater degree’ (MSC IGP 2018)	Academic excellence	Equity and Fairness

Table 5. Foucauldian critical discourse analysis – Australia

Object	Statements of Truth	Dominant discourses	Counter discourses
WA to Higher Education	'we must create an outstanding international competitive tertiary education system to meet Australia's future needs' (BR 2008) 'For higher education to truly support nation building, all Australians must be able to contribute to and share in its benefits' (AOATSI 2012) 'higher education and training have a critical role to play in improving the socio-economic position of Aboriginal and Torres Strait Islander people, their families and their communities. It also has an important role to play in driving the nation's social and economic development' (AOATSI 2012) 'The case for equity is socially compelling and becoming a strategic imperative for a knowledge based society of the future' (IPP 2017) 'Globalism can drive a push for diversity and it can act to reinforce social division' (FCPC 2017) 'Promoting access to higher education improves prospects for extended families and communities of equity students as others seek to emulate their success' (IPP 2017) 'The Panel proposes a collaborative approach be developed involving universities, governments, professional bodies, the business sector and communities working together to improve the lives of Aboriginal and Torres Strait Islander people through HE' (AOATSI 2012) 'Better communication in a 'competitive collaborative' institutional setting in which universities compete to provide best practice initiatives in a transparent and collaborative model, is a constructive process to achieve equity goals' (IPP 2017)	Higher Education as a social good in community and nation building	Higher Education as an economic good in a competitive global market
	'By increasing the numbers of Aboriginal and Torres Strait Islander professionals across different fields, all Australians will benefit from access to more diverse expertise, knowledge and skills' (AOATSI 2012)	Workforce diversity	Social mobility

	'The issue of WA and ensuring success for non-traditional students requires a markedly different mindset that recognises the value of these students to the profession, adequate resources, and a will to change' (FCPC 2017) 'Building a class of Aboriginal and Torres Strait Islander professionals who can respond to the needs of their own communities will be vital to meeting Closing the Gap targets' (AOATSI 2012) 'Professions need to examine cultural biases, accountability and positions on social diversity' (FCPC 2017)		
WA to medicine	'The professions have particular histories that are classed, gendered and raced, and a culture that endures through either complete or incomplete professional socialisation and 'micro-class reproduction' (FCPC 2017) 'Numerous stresses can accumulate into a collective hidden disadvantage, which can unintentionally discriminate against equity students' (IPP 2017) 'Should these students have to radically change their dispositions and ways of being in the world to succeed in high-status professions, or should the professions adapt to authentically recognise the myriad strengths that these students bring to the professional table' (FCPC 2017)	Micro-class reproduction	Extreme social mobility
	'Decisions have been driven by economic rationalism without regard to the consequences for local communities and the sustainability of the rural workforce' (HCRRR 2016) 'It is essential that Government policy and resources are tailored and targeted to the unique nature and diverse needs of regional, rural and remote communities' (HCRRR 2016) 'Now is the time to develop comprehensive plans to for healthcare in regional, rural and remote Australia, and to commit to significant funding increases to bridge the gap between city and country' (HCRRR 2016)	Healthcare as a social good in community and nation building	Healthcare as an economic good in a competitive global market

	'The AMA recognises that doctors form rural backgrounds are more likely to return to these areas to practice' (HCRRR 2016) 'The Department of Health his committed to reflecting the diversity of the Australian community in its workforce by building an inclusive culture that celebrates differences' (DOH AR 2018) 'There is a growing appreciation of the vital role that all Aboriginal and Torres Strait Islander health workers and registered health practitioners play in their roles as cultural brokers of, and contributors to, health improvements and outcomes in their communities' (AHPRA AR 2018) 'Increasing recruitment of medical students from a rural background can make a real difference for rural patients' (HCRRR 2016) 'Medical education and training must be responsive to the community – promoting and protecting the health needs of the Australian community' (AMC AR 2018) 'It is by closing the circle from community need, through AMC standards and policies, to practitioner education and capability development, that the AMC aims to achieve a positive impact on health outcomes' (AMC AR 2018)	Workforce diversity for improving health outcomes	
	'The AMA recommends increasing the targeted intake of rural background medical students from 25% to a third of all enrolments' (HCRRR 2016) 'Universities in the Rural Health Multidisciplinary Training programme have implemented strategies to streamline and priorities rural origin med students' (DOH AR 2018)	Affirmative action	