Reviewer's report

**Title:** Competency-based education in the health professions: Implications for improving global health

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**Reviewer:** Eliana Claudia C Ribeiro

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The statement: “Improvements in global health can only be realized through the development of a workforce that has been educated to promote health and to care for those with disease [1],” which the authors agree with, may reveal the idea that professional qualification is not only indispensable but also sufficient in itself, concealing all the other factors involved in improving health conditions.

The authors define the terms competence and competencies in the text, but do so without mentioning the different existing approaches and leaving the reader under the impression that there is one single definition in literature. The sentence "though competence has always been the implicit goal of more traditional education frameworks, CBE makes this explicit by establishing observable and measurable metrics that learners are expected to attain and thus, deemed competent;" may be confusing, leaving the reader under the impression that the proposed model is different because it allows for precision and measurement, which sets the competency model distant from modern cognitive psychology approaches and also, specifically in the healthcare context, from proposals to bring education and work closer. The way it is presented, competencies would be closer to behavioral goals and taxonomy of goals, subjects discussed since the middle of the 20th century.

I believe that educators should be extra careful when they state that what distinguishes the competency model is the emphasis "on the results of education rather than its processes", also made explicit in the sentence: "In CBE, the critical issue is that the learner reaches the specified level of performance in a competency; how he or she reaches that point (the educational process) is secondary.” The implications of CBE for curricular design, pedagogical practices, and requirements for faculty training to recognize the context as essential to structure learning represent significant changes. On the other hand, experience in diversified scenarios imposes new dimensions to pedagogical work. The text is, in this sense, contradictory, for it denies and at the same time highlights the implications of CBE for the curriculum. It is also not clear in the text in what realm of education planning CBE should be included - sometimes in the macro, sometimes in the micro space of a course, or of addressing a health problem, as on the child delivery chart presented. The model presented on Figure 2 (based on author that has to be mentioned), makes it clear that each and all parts of the curriculum are guided by the profile one seeks to achieve; planning for each unit or module always refers to the final profile, based on the possible performance
level for that training phase. As presented by the authors, it seems that each course will define their competencies and not the opposite: how each unit will contribute to building the desired profile of competency.

The presented idea that “Traditional educational programs too often have an insular character in which the expectations of learners are based on what has been taught in the past”, or “Learning objectives, if present, are often ‘retrofitted’ reflect what the faculty desire to teach or deem important which doesn’t always coincide with the needs of society” seems quite vague, as if in traditional models content and practices depended only on the faculty involved in instructional programs. Training institutions were, are and will be subject to the influence of external actors, linked to multiple and contradictory interests in society. “Schools, licensing agencies, and professional societies may each define the competencies differently or use different terminology for similar domains” the authors said, but it is important to reiterate that they may have different notions as to what a competent professional is.

Unquestionably, the educational movement where the idea of competencies stem from is related to the demands of the productive sector in the USA and to broadening efficiency and rationality, notably in the post-war period. These demands are foreign to schools and have been incorporated uncritically by many. Authors such as Gonczi defend the idea that multiple actors should participate in defining competency, recognizing its social character. And one of the major challenges of designing competency profiles nowadays is exactly how these can reflect the interests of society or how can different interests in society be expressed in the profile definition methodology.

This concern is touched upon in the text when the authors refer to a tendency: "curricula designed in resource rich settings may be projected or perceived as ‘gold standards’ for resource poor settings, to the exclusion of other necessary topics that are more likely to address local health needs”. What is not clear is the process suggested by the authors for this tendency not to be reproduced by the competency model.

When the authors state that “First, CBE explicitly maps the specific health needs of the populations to a set of competencies for the workforce to be trained. A CBE program has the potential to improve the health of the community it serves only to the extent that it uses context specific health issues to determine the desired competencies [1]“ they emphasize the idea that the model should be based on contextualized health needs. The question remains as to how one should proceed, specifically in countries where the population does not have a voice to express their needs, to guarantee that their interests will be included in the profile definition. Merely expressing the desire that the profile will reflect their demands does not seem to be enough to face the existing obstacles. Since the text seems to be oriented towards defending the idea that CBE is an adequate alternative for resource poor settings, it is my understanding that the authors should delve deeper into how to overcome these obstacles.

The authors make statements that do not hold, such as "Resource poor settings need health professionals who are not just clinically “competent” but who can provide leadership to set expectations and transform health within their country.
These skills are particularly needed in resource poor settings where healthcare systems have yet to be optimally shaped. A competency-based focus on leadership, policy formation, management, and the direction of interdisciplinary teams is essential for the development of professionals in low resource settings. I understand that the majority of competency profiles currently designed in the developed world include these capacities for all professionals. Furthermore, I believe that all healthcare systems require leadership for the process of continuous improvement. The USA, for example, according to Starfield, has high per capita health expenditure when compared to the most affluent industrialized countries, but health indicators in the country point to some necessary changes in its healthcare model.

**Level of interest:** An article of limited interest

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I have no competing interests’