Reviewer's report

Title: Can Discrete Choice Experiments inform HR policies in Developing Countries? A Review of their Application and Potential Contribution

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Reviewer: Julie Riise Kolstad

Reviewer's report:

The paper is very well written. The method presented, the discrete choice experiment, is applied relatively seldom in HRH research, but has a great potential for policy oriented research on this area. There exist no similar overview of applications of the method on HRH research. This paper is thus an important contribution and can be a source of information for many HRH researchers.

Major Compulsory Revisions
None.

Minor Essential Revisions
1. There is something wrong with the last part of the following sentence on page 3: “There are still only a small number of studies that have used this methodology to analyse the choices of health workers the care providers.”

2. On page 5, you claim that you included only studies reporting results on doctors and nurses. This is not completely true as you also included a study reporting results on clinical officers. The clinical officers often function as doctors, so in some sense you are right, but this needs to be clarified.

3. Also on page 5 under the heading “Description of Studies”, you mention that you found eleven relevant studies. In the tables reporting characteristics of the studies, however, there are as far as I can see only ten studies. Furthermore, there are only 9 references to these studies.

4. You need to update and write out the references properly!

Discretionary Revisions

1. I think the chapter describing what a DCE is could benefit from a short discussion/description of the process of designing a DCE, like how the attributes can be identified etc. For those who have no experience with this method, such a description can be very informative and give a better understanding of the amount of work that is put in order to make these experiments reflect as much of the reality as possible. In my opinion this is in many ways the critical part of the DCE.
2. On page 5, under the “description of studies” chapter, you say that 15 choice sets are considered as the maximum number of choices to avoid respondents’ fatigue. Yes, a design with a maximum of 15 choices has become the most common practice, but as far as I know, no study has yet been able to prove this empirically.

3. On the middle of page 6 you report that most studies have a range of attribute levels that is not in line with current possibilities in the job market, and you present this as a kind of good thing. I think you should consider putting more weight into this argument; in my opinion this is one of the real strengths of DCEs. In particular for policy makers, it is very important to be able to say something about what will happen if the current setting is changed (by some kind of policy). Because the DCE methodology allows the researchers to expand the number of possible scenarios it is very well fit to inform policies (on the contrary to many revealed preference data sets). On the other hand, it should also probably be added that non-existing job possibilities are difficult to relate realistically to for the respondents.

4. On page 9 you report results from Kolstad (2008), and you comment on the preferences of different sub-groups. Personally I found it interesting that those who were very willing to help other people had a different ranking of the attributes than the rest of the respondents, but you have not commented upon that. Similar findings have been reported in a related study from Ethiopia by Serneels et al. for The World Bank in 2005.

5. On page 9 you provide a tentative explanation for the fact that health personnel from developing countries are more concerned with the salary (compared to the other attributes) than those from developed countries. I think this explanation holds for the nurses, but I am not convinced that it is valid for the doctors also. The doctors in Tanzania earn substantially much more than many other recognised professionals. Here is another possible explanation for the doctors: The medical education in developing countries is often a high status elite education that is closely related to power and status and a further career, most often not in medicine, but rather at the top administrative level of the country and its regions. It could thus be that the doctors in developing countries are a selected group of people that care more about status, power and consequently money than others. I am not saying that this explanation is the best, just that there are many possible alternative explanations here...an area for research?

6. The strengths/possibilities for investigation you mention with labelled designs can also be achieved by allowing for interaction effects in the design.

7. Lastly, you conclude that DCEs are valuable tools for health system researchers. I think it would be nice if you start out with stating that there are ways to deal with most of the technical weaknesses that you have mentioned, especially since the last chapter before the conclusion is about the weaknesses of the method. The main objection to DCEs, the one that it is really difficult to come around, is that of the researchers not being able to know if stated
preferences will be the same as the eventually revealed preferences.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

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

**Declaration of competing interests:**

I declare that I have no competing interests.