REPORT NO.: RES33479

RESTRUCTURING PAPER

ON A

PROPOSED PROJECT RESTRUCTURING

OF

SOCIAL HEALTH INSURANCE PROJECT: IMPROVING ACCESS, QUALITY, EFFICIENCY, AND FINANCIAL PROTECTION

APPROVED ON APRIL 27, 2016

TO

REPUBLIC OF KAZAKHSTAN

DECEMBER 4, 2018

HEALTH, NUTRITION & POPULATION

EUROPE AND CENTRAL ASIA

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Public Disclosure Authorized

ABBREVIATIONS AND ACRONYMS

FM	Financial Management
MOH	Ministry of Health
MSHI	Mandatory Social Health Insurance
PDO	Project Development Objective
PMU	Project Management Unit
POM	Project Operational Manual
SHIF	Social Health Insurance Fund
STEP	Systematic Tracking of Exchanges in Procurement

BASIC DATA

Product Information

Project ID P152625	Financing Instrument Investment Project Financing
Original EA Category Not Required (C)	Current EA Category Not Required (C)
Approval Date 27-Apr-2016	Current Closing Date 30-Jun-2021

Organizations

Borrower Republic of Kazakhstan	Responsible Agency Ministry of Health,Ministry of Health

Project Development Objective (PDO)

Original PDO

The proposed Project Development Objective is to improve accessibility, quality, and efficiency of health service delivery, and reduce financial risks to the population that are caused by serious health problems.

Summary Status of Financing

Ln/Cr/Tf	Approval	Signing	Effectiveness	Closing	Net Commitment	Disbursed	Undisbursed
IBRD-86170	27-Apr-2016	01-Nov-2016	27-Jun-2017	30-Jun-2021	80.00	2.08	77.92

Policy Waiver(s)

Does this restructuring trigger the need for any policy waiver(s)?

No

I. PROJECT STATUS AND RATIONALE FOR RESTRUCTURING

Project Status

1. The Loan was approved on April 27, 2016, in the amount of US$80 million and became effective on June 27, 2017.

2. ***Project Development Objective (PDO)***. The PDO is: "to improve accessibility, quality, and efficiency of health service delivery, and reduce financial risks to the population that are caused by serious health problems".

3. Progress toward achieving the PDO was downgraded from Moderately Satisfactory (MS) to Moderately Unsatisfactory (MU) in July 2018 given the concerns about ability of the Project to demonstrate progress towards achievement of the PDO by the current closing date. Despite significant progress in the implementation of the health reform, the Results Framework (RF), as defined during preparation, cannot reflect this in full. The implementation of the Mandatory Social Health Insurance (MSHI) was originally planned to be executed in one phase but given the challenges that this reform imposed, the Government opted for a two-phase approach. In the first phase, already under implementation, the entire financing mechanism of health services was changed. Since January 1, 2018, budget proceeds, instead of flowing directly to health providers rendering health services under the State Guaranteed Benefits Package based on historic budget, are now channeled through the Social Health Insurance Fund (SHIF), which conducts strategic purchasing and contracts services from public and private providers. Payments in this new system include: per capita and fees for services in the case of primary care, and the use of Diagnoses Related Groups (DRG) in the case of hospital-produced services and fee-for-service for some specific health services. In addition, providers now have autonomy to use part of the received funds to implement adjustments in service delivery and provide incentives to their staff. The SHIF also started collecting contributions from employers as of July 1, 2017, and pooling funds for the second-phase implementation. This second phase will include the collection of contributions from employees and government-subsidized contributions for defined vulnerable population groups, with the provision of an expanded package of health services to the insured to start on January 1st, 2020.

4. The RF needs to be adjusted to better capture this two-phase approach. While the PDO indicators No.1 and 4 (increase in public expenditure share for PHC and functionality of the SHIF) show some progress, activities supporting PDO indicators No. 2 and 3 (outpatient surgeries and technical audit of inpatient services) have not yet been implemented. Lastly, PDO indicator No. 5 (financial risk protection for the bottom 40% of households) requires a minor adjustment to its definition as well as adjustment of the baseline value to reflect the use of the already existing methodology to measure this indicator.

5. Similar to the situation with the PDO indicators, some of the intermediate results indicators show progress (e.g., number of regions implementing disease management programs (DMP), number of competency-based educational programs developed and implemented), while those affected by the two-phase approach need adjustment to reflect the adjusted timeline of the MSHI implementation (e.g., achievement of key benchmarks for a functioning social health insurance system, incentive-based adjustments in the contracting methods, and others).

6. ***Implementation Progress*** is rated as MS given some acceleration in procurement processes observed recently, especially after the implementation of Systematic Tracking of Exchanges in Procurement (STEP). Status of progress in the implementation of activities in each of the components is as follows:

   (a) Component 1. Supporting implementation of the national MSHI (US$16.63 m): The implementation of this component is accelerating, with the main international technical assistance (TA) contract to support the

implementation of the MSHI (US$3 m) currently being negotiated with the selected firm. This TA will help the SHIF expand the scope of its activities, put in place additional tools and processes aimed at improving efficiency and financial risk protection, including provision of institutional support for SHIF functioning, strengthening mechanisms of purchasing pharmaceuticals and health technologies, improving financial control mechanisms and technical audits to be used under the MSHI system. When the second phase of MSHI implementation starts in early 2020, the SHIF will have strengthened the capacity and tools to act as a single strategic purchaser of health services and, consequently, will contribute to the efficiency and financial risk protection aspects of the PDO. Another major TA contract to support the modernization of the MoH information systems and integration with that of the SHIF (US$2.2 m) is under implementation as are several other smaller TA contracts for improvement of health sector regulation and health care benefits packages, tariff setting, and provider payment methods.

(b) Component 2. Strengthening of health service delivery to support implementation of the national mandatory Social Health Insurance system (US$62.94 m): Project activities that contribute to improving accessibility and quality of health care delivery—such as health care standardization, strengthening PHC, emergency care, and public health, roll out of disease management programs, and improving the quality of medical education—are being implemented regardless of the adjusted implementation timeline of the MSHI. These activities are also expected to contribute to the progress towards the PDO. TA to support further development of health infrastructure through a public-private partnership (PPP) approach is at the contract negotiations stage and is expected to be signed within the coming weeks. TA to support the strengthening of emergency medical care is ongoing, and DMP are being rolled out beyond the initial two pilot oblasts to selected polyclinics in the remaining 15 administrative units. Procurement of medical equipment to support the establishment of PHC Excellence Centers, the rollout of the DMPs, and implementation of clinical protocols will be launched in phases starting in a select number of oblasts where the gaps are well defined. Three out of six contracts for strategic partnerships between local and international medical universities have been signed and activities are being implemented. For the remaining three contracts, negotiations are close to completion.

(c) Component 3. Project management, monitoring and evaluation, and communications strategy (US$10.43 m): The Project Management Unit is fully staffed and continues its satisfactory performance. Periodic implementation progress and financial management reports are being submitted to the Bank on a timely basis and found satisfactory. There is a clear understanding of the MoH of the importance of a strong communications strategy and citizen engagement to support the sector reforms, with many tailored communications and awareness-raising activities already being implemented.

7. ***Legal Covenants***. The Project is compliant with all the legal covenants and conditions specified in the Loan Agreement (LA).

8. ***Financial Management (FM) and Disbursement.*** The Project continues to comply with the FM-related legal covenants stipulated in the Loan Agreement, including maintenance of a fully operational automated accounting software, timely submission of the Interim Financial Reports acceptable to the Bank, and internal control procedures documented in the Project Operational Manual (POM). The first audit report covering 2017 was completed by May 28, 2018, and the auditor issued an unmodified (clean) audit opinion of the Project.

9. ***Disbursement.*** With some contracts already being under implementation, US$2.1 m (or 2.6% of the Loan) has been disbursed from the Loan Account since its effectiveness (June 27, 2017). Despite the low level of disbursement, the Project already committed around US$10.6 m and will commit an additional US$11 m under contracts currently being negotiated. The difference between the level of disbursements and commitments is explained by the TA-focused nature of the Project, where payments are made against deliverables produced over a relatively long period

of time. It is estimated that around US$1 m will be disbursed by December 31, 2018, and an additional US$2 m by June 30, 2019, bringing a cumulative disbursement level to US$5 m by the end of FY19 (or 6.25% of the Loan). It is expected that the Loan amount will be fully disbursed by the current Closing Date of June 30, 2021, as the pace of implementation has significantly accelerated.

10. ***Social and Environmental Safeguards***. The Project has been assigned a category "C" and, therefore, has no Social or Environmental Safeguards risks.

11. ***Citizen Engagement*** (CE). To ensure that the improvements in health care are responsive to the population's needs, and to engage users in the reform of the health care system**,** the Project has prioritized the engagement of citizens. Nevertheless, the change in the timeline to implement the MSHI have delayed some of the core CE activities while increasing the necessity for appropriately nurtured activities that are likely to have a significant influence on the outcome of the reform. During the last year, while gaps were addressed in the reform planning, efforts have been made to conduct awareness-building (through an intensive communication strategy), establish citizen feedback processes, and develop a robust CE plan for the remainder of the Project. In addition, a well-staffed national call-center has been established in the MoH and is not only managing incoming citizen complaints but also analyzing the information to support MoH policy inputs in lagging areas.

12. Moving forward, cognizant of capacity challenges and the sensitivity of the reform, the Project will incrementally ramp up, through a staged approach, the improvement of the citizen engagement mechanisms, especially those that support the MSHI reform by: (i) an annual National Multi-Stakeholder Forum; (ii) Citizen Feedback and Monitoring Mechanism; and (iii) a proactive Grievance Redress Mechanism. There are good ownership and clarity on the part of the national counterparts as to the importance of these elements of the Project, and implementation hurdles are slowly being addressed. During a subsequent stage, it is intended to adopt the Community Scorecard methodology for health facilities to use for self-assessment and action-planning to enable improvements required in the competitive environment to be created by the MSHI system.

Rationale for Restructuring

13. The MoH and the World Bank team agreed that the PDO remains relevant and achievable within the Project timeline. Nevertheless, given the adjustment of the plan to implement the MSHI, revisions of some areas of the RF of the Project are needed. While some of the indicators do not require any changes, some other indicators require adjustments to their definitions, target values, and timing of achievement of targets to better reflect the updated, two-phase timeline of the MSHI implementation. In addition, there is a risk that the Loan may not be extended beyond the original closing date due to sensitivity around the introduction of MSHI and wariness of the country authorities towards increased costs associated with extended implementation periods. Therefore, a Project restructuring needs to be processed to adjust the RF in order to reflect more realistic targets, recuperate its relevance and ability to track progress towards the achievement of the PDO.

II. DESCRIPTION OF PROPOSED CHANGES

14. This Level-2 restructuring seeks to:

Revise the Results Framework: Some target values for PDO and intermediate results indicators are revised to reflect implementation progress and improve the measurability of specific indicators to reflect the changes of the timetable for implementing the MSHI. Specifically, the following changes are proposed:

PDO Indicators:

- ***Percent of all surgeries included in the "outpatient elective surgeries" list performed as outpatient surgeries in project-supported hospitals and outpatient facilities.*** The end target of 50% is being reduced to 40% and target values for preceding years are being revised accordingly, including the replacement of the quantitative target value for Year 2 (2018) with the qualitative value of "List of outpatient elective surgeries defined". This is justified as the additional package of services and additional performance-based payment mechanisms that would motivate healthcare providers to modify the structure of delivered care that will be implemented in the second phase of the MSHI reform.
- ***Percent of all contracted inpatient services subject to technical audit (annually).*** The end target of 40% is being reduced to 30% and values for preceding years are being revised accordingly. Similar to the preceding indicator, the SHIF will start implementing technical audits only after the start of MSHI implementation. Therefore, there may not be sufficient time until Project closing to reaching the original target.
- ***Decline in the proportion of the bottom 40% of households incurring out-of-pocket expenditures on health that exceed 10% of total non-food related household spending over a 12-month period.*** The definition of the indicator, as well as the baseline value, are being adjusted in line with the definition and figures received from the Statistics Committee. Specifically, the revised definition should read: "Proportion of the bottom

40% of households spending 10% and more on health services and non-food goods in the health sector out of total expenditure on paid services and non-food goods" with a revised baseline value of 10.5% (2016) instead of 9.3% (2013). This is justified given the marginal differences between the original indicator definition/baseline value and those derived from the institutionalized practice of the Statistics Committee.

Intermediate Results (IR) Indicators:

- ***Percent of the population for whom SHIF received SHI contributions/subsidies and people with access to an insurance package of health services.*** The "*people with access to an insurance package of health services*" part of the indicator is removed because the population will have access to the insured package of health services only starting in 2020. In the remaining part of the indicator, the percentages of population covered in Years 4 and 5 of the Project are increased from 55% and 60% to 82% and 83%, respectively, and target values for preceding years are adjusted to reflect the levels of contributions being collected from some defined categories of population in the period preceding the full implementation of the MSHI.
- ***Achievement of key benchmarks for a functioning social health insurance system.*** The target value for Year 1 "Plan and benchmarks defined" is replaced with "MSHI implementation roadmap approved". This is justified since, as a governmental agency, the MoH follows the requirements of the governmental planning systems, which define the type and contents of the documents developed by governmental agencies. The MSHI implementation roadmap was already adopted by the MoH Order No.764 dated October 16, 2017, and covers all key elements of the MSHI system, including criteria of the full functionality of the SHIF included in the PDO Indicator 4 ("SHIF is fully functional based on predefined criteria"). Furthermore, developing and monitoring new benchmarks would require additional time and resources, which is not justified.
- ***Key adjustments in the contracting methods are adapted to include incentives for providers to improve quality.*** The indicator's values for Years 2 and 3 are made consistent with the adjusted timeline of the MSHI implementation.
- ***Percent of health facilities meeting International Patient Safety Goals (minimum 5 points).*** This indicator is being dropped because of a selection bias and data measurability issue. Specifically, given the voluntary nature of national accreditation in Kazakhstan, only around 200 health facilities out of over 5,000 participate in the national accreditation program annually, with all facilities that receive national accreditation status meeting the Patient Safety Goals. Furthermore, many organizations, especially the private ones, prefer to receive international accreditation or specialized accreditation for services from various international organizations. In terms of data measurability, there is no unified register, which would serve as the basis for calculation of the number of accredited organizations to ensure objective data collection. Therefore, this leads to the fact that the received data will not be reliable, because it is physically impossible to cover all organizations in one survey.
- ***Direct Project Beneficiaries.*** This indicator does not provide any useful information in the context where the whole population of the country would benefit from a well-functioning MSHI system and improvements in the health care delivery system.
- ***Health personnel receiving training.*** The target value of "90" for Year 1 (2017) is replaced with "0" as no training activities were conducted in 2017 due to the postponement of the Flagship Course on Health Financing and Sustainable Development to 2018 due to the unavailability of key lecturers.
- ***Health Facilities constructed, renovated, and/or equipped.*** The target value of "10" for Year 2 (2018) is replaced with "0" because (i) the MoH has decided that the lists of the needed equipment and respective technical specifications would be developed based on recommendations from TA to be provided to support

the MoH in the development of the lists and of the technical specifications, and (ii) the budget allocated to the MoH for 2018 does not include funds for the procurement of medical equipment for health facilities.

- ***Percentage of patients reporting improved health services.*** The measurement methodology of this indicator is adjusted in light with the revised MSHI implementation timeline. Namely, in the first phase, it is proposed to use semi-annual sociological opinion surveys of patients in the country's regions (with a representative sampling) to be launched in 2019. Given the timeline of the survey, the baseline for this indicator will be established in Year 3 (2019) and end-target value in Year 5 (2021) is proposed to be 10 percentage points above the baseline value. Information for years 4 and 5 will be disaggregated by region, gender and socially vulnerable group (e.g. elderly, youth, minority, people with disability).
- ***Increase the transparency, credibility, and effectiveness of complaints handling system.*** The measurement methodology for this indicator is adjusted to the use of semi-annual sociological opinion surveys (with a representative sampling). The collected data will be used to further improve the existing, multi-channel complaints-handling and feedback mechanisms[1] and will be disaggregated by region, gender and socially vulnerable group (e.g. elderly, youth, minority, people with disability) for years 4 and 5.

15. Disbursement Estimates and Implementation Schedule are revised to reflect implementation progress and the revised timeline for MSHI implementation.

[1] Public relations concerning filing and consideration of appeals of individuals and legal entities related to realization and protection of rights, freedoms and legal interests of citizens are regulated by the Law "On the Procedure for Consideration of Appeals from Individuals and Legal Entities" dated January 12, 2007 No. 221. The terms of consideration of complaints on provision of public services are established by the Law of the Republic of Kazakhstan "On State Services". The Rules for recording appeals of individuals and legal entities have been approved (General Prosecutor's Order dated December 18, 2015 № 147).

III. SUMMARY OF CHANGES

	Changed	Not Changed
Results Framework	✓	
Disbursement Estimates	✓	
Implementation Schedule	✓	
Implementing Agency		✓
DDO Status		✓
Project's Development Objectives		✓
Components and Cost		✓
Loan Closing Date(s)		✓
Cancellations Proposed		✓
Reallocation between Disbursement Categories		✓
Disbursements Arrangements		✓
Overall Risk Rating		✓
Safeguard Policies Triggered		✓
EA category		✓
Legal Covenants		✓
Institutional Arrangements		✓
Financial Management		✓
Procurement		✓
Other Change(s)		✓
Economic and Financial Analysis		✓
Technical Analysis		✓
Social Analysis		✓
Environmental Analysis		✓

IV. DETAILED CHANGE(S)

DISBURSEMENT ESTIMATES

Change in Disbursement Estimates
Yes

Year	Current	Proposed
2016	0.00	0.00
2017	0.00	0.00
2018	700,000.00	1,092,328.00
2019	19,600,000.00	10,707,672.00
2020	46,700,000.00	29,300,000.00
2021	13,000,000.00	38,900,000.00
2022	0.00	0.00

Results framework

COUNTRY: Kazakhstan

Social Health Insurance Project: Improving Access, Quality, Efficiency and Financial Protection

Project Development Objectives(s)

The proposed Project Development Objective is to improve accessibility, quality, and efficiency of health service delivery, and reduce financial risks to the population that are caused by serious health problems.

Project Development Objective Indicators by Objectives/ Outcomes

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Improve accessibility, quality, and effeciency of health service delivery and reduce financial risk *(Action: This Objective is New)*								
Increase public expenditure share for PHC + consultation and diagnostic care + outpatient drugs (Percentage)		35.00	35.00	36.00	37.00	38.00	40.00	40.00
Percent of all surgeries included in the “outpatient elective surgeries” list performed as outpatient surgeries in project-supported hospitals and outpatient facilities (Percentage)		5.00	5.00	10.00	25.00	30.00	40.00	40.00
Action: This indicator has been Revised	***Rationale:*** ***The end target of 50% is being reduced to 40% because the additional package of services and additional performance-based payment mechanisms will be implemented in the second phase of the MSHI reform.***							

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Percent of all contracted inpatient services subject to technical audit (annually) (Percentage)		20.00	20.00	25.00	30.00	30.00	30.00	30.00
Action: This indicator has been Revised	***Rationale:*** ***The end target of 40% is being reduced to 30% due to the adjustment in the MSHI implementation timeline.***							
SHIF is fully functional based on predefined criteria (Yes/No)		No	No	No	No	Yes	Yes	Yes
Proportion of the bottom 40% of households spending 10% and more on health services and non-food goods in the health sector out of total expenditure on paid services and non-food goods (Percentage)		10.50	11.70	12.80	13.90	13.50	12.80	12.80
Action: This indicator has been Revised	***Rationale:*** ***The definition and baseline value are being adjusted in line with the definition and figures received from the Statistics Committee.*** ***.***							

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Component 1. Supporting implementation of the National Mandatory Social Health Insurance System *(Action: This Component is New)*								
Percent of population for whom SHIF received SHI contributions/subsidies (Percentage)		0.00	32.00	26.00	26.00	82.00	83.00	83.00
Action: This indicator has been Revised	***Rationale:*** ***The changes are proposed due to the revision of the MSHI implementation timeline and based on data on MSHI payments for the employed population.***							
People with access to an insurance package of health services (Number (Thousand))		0.00	0.00	7,000.00	8,800.00	9,600.00	10,500.00	10,500.00
Action: This indicator has been Marked for Deletion	***Rationale:*** ***This part of the indicator is proposed to be removed because the population will have access to the insured package of health services only starting in 2020.***							
Achievement of key benchmarks for functioning social health insurance system (Text)		No	MSHI implementation roadmap approved	Partial	Partial	Yes	Yes	Yes
Action: This indicator has been Revised	***Rationale:*** ***As a governmental agency, the MoH follows the requirements of the governmental planning systems, which define the type and contents of the documents developed by governmental agencies.***							
Key adjustments in the contracting methods are adopted to include		No	No	No	No	Yes	Yes	Yes

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
incentives for providers to improve quality (Yes/No)								
Action: This indicator has been Revised	***Rationale:*** ***Change: Correct target values for the second and third year to "No".*** ***Rationale: Implementing effective quality incentives before 2020 is not feasible due to the adjustment in the MSHI implementation timeline.***							
Component 2. Strengthening of health service delivery to support implementation of the national mand *(Action: This Component is New)*								
Number of fully functional regional PHC excellence centers (Number)		0.00	0.00	0.00	5.00	10.00	16.00	16.00
Number of regions implementing disease management programs with evidence-based effectiveness, including incentives for health providers and patients (Number)		2.00	2.00	7.00	10.00	13.00	16.00	16.00
Percent of health facilities meeting International Patient Safety Goals (minimum 5 points) (Percentage)		10.00	15.00	20.00	30.00	40.00	50.00	50.00
Action: This indicator has been Marked for Deletion	***Rationale:*** ***This indicator is being dropped because of a selection bias and data measurability issue.***							

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Number of educational programs developed and implemented in medical education institutions based on competence-based approach and professional standards through strategic partnerships (Number)		1.00	2.00	3.00	4.00	4.00	5.00	5.00
Unified register of human resources for health implemented (Yes/No)		No	No	No	No	Yes	Yes	Yes
Direct project beneficiaries (Number)		0.00	100.00	1,700.00	5,000.00	8,200.00	10,000.00	10,000.00
Action: This indicator has been Marked for Deletion	***Rationale:*** ***This indicator does not provide any useful information in the context where the whole population of the country would benefit from a well-functioning MSHI system and improvements in the health care delivery system.***							
Female beneficiaries (Percentage)		0.00	52.00	52.00	52.00	52.00	52.00	52.00
Action: This indicator has been Marked for Deletion								
Health personnel receiving training (number) (Number)		0.00	0.00	900.00	1,900.00	2,800.00	3,400.00	3,400.00
Action: This indicator has been Revised	***Rationale:*** ***Change: Adjust the target value for the first year to "0".***							

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
	Rationale: No training activities were performed in 2017 because the Flagship course on Health Financing and Sustainable Development was postponed to 2018 due to unavailability of key lecturers.							
Health facilities constructed, renovated, and/or equipped (number) (Number)		0.00	0.00	0.00	20.00	50.00	50.00	50.00
Action: This indicator has been Revised	***Rationale:*** ***Change: The target value of "10" for Year 2 (2018) is replaced with "0".*** ***Rationale: Due to unavailability of Republican budget for 2018.***							
Percentage of patients reporting improved health services (Text)		n/a	n/a	n/a	Baseline value established	+5% over baseline	+10% over baseline	+10% over baseline
Action: This indicator has been Revised	***Rationale:*** ***Change: To change the measurement methodology to using semi-annual sociological surveys with a representative sampling.*** ***Rationale: To improve authenticity and efficiency of feedback from the surveyed population.***							
Increase in transparency, credibility, and effectiveness of the complaints handling system (Percentage)		0.00	0.00	0.00	35.00	40.00	60.00	60.00
Action: This indicator has been Revised	***Rationale:*** ***Change: To change the measurement methodology to using semi-annual sociological surveys with a representative sampling. At the end of the Project, 60% of the total number of patients surveyed through a representative sampling are expected to report awareness of the grievance redress mechanism, greater transparency and credibility of the grievance redress mechanism, and experience of having used it / likelihood of using it in the event of a complaint.***							

Indicator Name	DLI	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
	Rationale: To improve authenticity and efficiency of feedback from the surveyed population.							