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Abstract
The importance of health while moving towards Universal Health Coverage (UHC) is emphasized as a priority agenda of the government of Bangladesh. The country is committed to move progressively towards Universal Health Coverage by 2032, which is documented by the Health Care Financing Strategy (HCFS) of Bangladesh in 2012 with some other policy documents. Though Bangladesh has succeeded considerably in achieving most of the MDG targets, it lags far behind in reaching the targets of many health indicators. High absenteeism of providers, shortage of some crucial manpower, malfunctioning equipment, inappropriate distribution of drugs, improper doctor-nurse ratio, hard to reach areas, income and regional inequity, high prevalence of certain communicable diseases, growing burden of non-communicable diseases and high out-of-pocket expenditure for services are the major challenges of health sector of Bangladesh, should be overcome to achieve Universal Health Coverage.

Key words
UHC, MDG, absenteeism, inequity Sensing

Introduction

The Health, Nutrition and Population (HNP) Sector of Bangladesh has started implementing the Universal Health Coverage (UHC) in order to bring the segments of population who are still uncovered or underserved under the coverage of healthcare services, provide the necessary packages of services, improve the quality of services, and ensure provision of required services without any out-of-pocket expenditure at the point of service delivery. The country needs successful implementation of the UHC since there is high inequity in the use of health care services, high financial burden for the recipients of services, and low quality of service provision. It will not be an easy task for the HNP sector to adequately implement it due to a number of bottlenecks. Several preconditions have to be fulfilled before and during implementation of the UHC. This paper is an attempt to discuss the importance of UHC, the challenges to be overcome, and the preconditions to be fulfilled for successful implementation of the UHC.

UHC is a dominant agenda in Sustainable Development Goals (SDGs) and in post- Millennium Development Goals (MDGs) of global health (HEU, MoHFW, 2015). As national income has increased considerably around the countries in the world along with the burden of non-communicable diseases, demand has also increased for quality of care and affordable health services. Many countries today are actively pursuing to achieve Universal Health Coverage. The efforts have stirred interest and guidance from international organizations, such as the World Health Organization and the World Bank, and led to new platforms for developing countries to learn from each other (Bristol N., 2014).

Universal coverage is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma-Ata declaration in 1978. Achieving both the health related Millennium Development Goals and the next wave of targets beyond 2015 will depend largely on how countries succeed in moving towards universal coverage (WHO, 2016). The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments for health care or loss of income when a household member falls sick. In attaining this goal, it is important to recognize that there is no single model for achieving UHC; each country has to design its own path and develop homegrown solutions based on the needs of the population and the capacity of its health system.

Countries as diverse as Brazil, France, Japan, Thailand, and Turkey that have achieved UHC are showing how these programs can serve as vital mechanisms for improving the health and welfare of their citizens, and lay the foundation for economic growth and competitiveness grounded in the principles of equity and sustainability (Araujo and Maeda, 2014). This

success has inspired the leaders of the South Asian Association for Regional Cooperation (SAARC) countries too. The SAARC in its Kathmandu Declaration stated that it was looking towards achieving Universal Health Coverage among all its member nations, adding that it was targeting the elimination of poverty. The leaders recognized the importance of achieving UHC, improving health regulatory systems, preparedness for emerging and remerging diseases, and the challenges posed by anti-microbial resistance and non-communicable diseases.

The Government of Bangladesh (GOB) is constitutionally obligated (Bangladesh Constitution, Part II, Article 15) to provide the basic necessities of life, including food, clothing, shelter, education and medical care to its citizens. Hence, in various policy documents of Bangladesh, such as Vision 2021, 7th five Year Plan, The National Health Policy-2011, HPNSDP (2011-2016), National Social Protection Strategy, the importance of health in moving towards UHC is emphasized as a priority agenda of the government. The government of Bangladesh is also committed to move progressively towards Universal Health Coverage by 2032, which is documented by the Health Care Financing Strategy (HCFS) of 2012. However, poverty, lack of knowledge, and other barriers keep many people from accessing services essential to maintain health and making healthy life choices. One major barrier is finance; a large number of health services in Bangladesh are obtained through out-of-pocket expenditures made at the point where health services are received or medicines are purchased. Globally, such expenditures account for about 32% of total expenditure on health (Xu K et al 2010), but for Bangladesh, it makes up 64% of total health expenditures (HEU, MoHFW, 2015). Such high out-of-pocket expenditures on health can lead to loss of productive assets (selling items or property to pay for medicines) and threaten economic survival, especially in countries with high rates of catastrophic illnesses, such as Bangladesh (HEU, MoHFW, 2012). It was this concern that has led to the inception of the Universal Health Coverage.

The paper is based on secondary data. The sources are various policy documents of MoHFW, WHO, academic journals, internet, workshops, books and newspapers. The sections of this paper cover the objectives of UHC, challenges and prospects of UHC in Bangladesh and finally it summarizes the entire discussion and puts forwards some recommendations.

Objectives of Universal Health Coverage

Universal Health Coverage (UHC) is defined by WHO as 'ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services'.

Hence, Universal Health Coverage (UHC) embodies three related objectives:

- **Equity in Access to Health Services:** Equity is paramount. Hence, this objective stems from the doctrine that health is not a privilege, but a basic right, and thus everyone had a right to healthcare services, not just the ones who could afford it or pay for it. In other words, those who need the services should get them, not only those who can pay for them. The most vulnerable people should have access to the health services they need without restrictions.
- **Maintaining Quality of Health Services:** The second objective of UHC is that the quality of health services should be good enough to improve the health of those receiving services. This may mean improving the quality of provider, increasing provider per patient, increasing other inputs, maintaining right input mix or simply including more services to a basic healthcare package.
- **Financial-risk protection:** The third objective is to ensure that the cost of using care does not put people at risk of financial hardship that is to reduce the incidence of catastrophic health expenditure. Catastrophic health expenditure is defined as out-of-pocket spending for health care that exceeds a certain proportion of a household's income with the consequence that households suffer the burden of disease. A household is said to have been impoverished by medical expenses when health-care expenditure has caused it to drop below the poverty line. One major objective of the UHC is to prevent this from happening.

The priority of UHC is to ensure access to the key interventions targeting the health related Millennium Development Goals – births attended by a trained health worker, family planning, vaccinations, and

prevention and treatment of diseases such as HIV, malaria and tuberculosis – while considering how to address the growing problem of non-communicable diseases.

The World Bank Group is committed to UHC as a means of making sure that no family is forced into poverty because of health care expenses. It aims to help countries build healthier, more equitable societies, as well as to improve their fiscal performance and the country competitiveness-towards the goals of ending extreme poverty by 2030 and to close the gap in access to quality health services for the poorest 40 percent of the population in every country. To measure progress toward these goals, the World Bank Group has two overarching targets (Araujo and Maeda, 2014):

- For financial protection, by 2020, the proposed target is to reduce by half the number of people impoverished due to out-of-pocket health care expenses. By 2030, no one should fall into poverty because of such expenses.
- For service delivery, the proposed target is to ensure that at least four out of every five of the people in the lowest income groups in every country have access to essential health services.

The successful implementation of the UHC package requires an efficient health system that provides the entire population with access to good quality services, health workers, medicines and technologies. It also requires a financing system to protect people from financial hardship and impoverishment from health care costs. Access to health services ensures healthier people; while financial risk protection prevents people from being pushed into poverty. Therefore, UHC is a critical component of sustainable development and poverty reduction, and a key element to reducing social inequities.

Performances of Health Sector in Bangladesh

Bangladesh has made significant progress in recent times in many of its social development indicators particularly in the health sector. The country has made important gains in providing primary health care since the Alma Ata Declaration in 1978. Health indicators show steady gains in many respects and the health status of the population has improved. Life expectancy at birth has increased from 64.9 in 2002 to 71 in 2013 (WB, 2013). Total fertility rate (TFR) has reduced from 3.0 to 2.3 births per woman; contraceptive prevalence rate (CPR) has increased from 58.1 percent to 62.2 percent, use of skilled birth attendant during delivery has increased from 16 percent to 42 percent, use of antenatal care (ANC) at least 4 times during pregnancy has increased from 16 percent to 31 percent, the proportion of births delivered at health facilities has increased rapidly from 12 percent to 37.4 percent, postnatal care (PNC) within 48 hours (at least 1 visit) of delivery has increased from 16 percent to 34 percent, infant mortality (IMR) has declined from 65 deaths per 1,000 live births to 38 deaths per 1,000 live births, proportion of children received the measles vaccine by age 12 months has increased from 70 percent to 80 percent, prevalence of stunting among children under 5 years of age has decreased from 51 percent to 36 percent from 2004 to 2014 (BDHS, 2014). Bangladesh has achieved its MDG 4 target for under-5 mortality of 48 deaths per 1,000 live births by 2015 (Table-1). The Millennium Development Goals (MDGs) have played an important part in securing these progresses.

Table 1: Trends in selected health indicators in Bangladesh during last 10 years (2004 to 2014)

Indicators	BDHS 2004	BDHS 2011	BDHS 2014
Under Five Mortality Rate	88	53	46
Infant Mortality Rate	65	43	38
TFR	3.0	2.3	2.3
Maternal mortality ratio (MMR)		194 (BMMS 2010)	-
Contraceptive prevalence rate (CPR)	58.1	61.2	62.4
Antenatal care coverage (at least 4 visits)	15.9	25.5	31.2
Percentage of delivery by skilled birth attendant	16	32	42
Institutional Delivery	12	29	37.4
Postnatal care within 48 hours (at least 1 visit)	16	27	34
Proportion of 1-year-old children immunization against Measles	70	84	80
Prevalence of stunting among children under 5 years of age	51	41	36

Source: NIPORT, BDHS, 2004, 2011, 2014

Current Challenges of Health sector of Bangladesh

Though Bangladesh has considerably succeeded in achieving most of the MDG targets, many public health challenges still remain. The HPNSDP results framework sets target for some crucial health indicators by 2016. But in most cases, especially for receiving ANC (at least 4 times), PNC within 48 hours (at least 1 visit), delivery assisted by skilled birth attendant and prevalence of stunting among children under 5 years of age, data from BDHS 2014 show that Bangladesh lags far behind in reaching these targets (Table 2).

Table 2: Current situation and HPNSDP targets of some selected crucial indicators on Bangladesh

Indicators	**BDHS 2014**	**Target by 2016**
Under Five Mortality Rate	46	48
Infant Mortality Rate	38	31
TFR	2.3	2.0
Maternal mortality ratio (MMR)	194 (BMMS 2010)-	<143
Contraceptive prevalence rate (CPR)	62.4%	72%
Antenatal care coverage (at least 4 visits)	31.2%	50%
Percentage of delivery by skilled birth attendant	42%	50%
Postnatal care within 48 hours (at least 1 visit)	34%	50%
Proportion of 1-year-old children immunization against Measles	80%	90%
Prevalence of stunting among children under 5 years of age	51%	38%

Source: NIPORT, BDHS, 2014 and MoHFW, HPNSDP, 2012

Though Bangladesh has been making progress in reducing the gap between the poorest and the richest women in the use of facilities for delivery, still inequity remains. In BDHS 2014, 15 percent of births in the past three years of the women in the lowest wealth quintile were delivered in a health facility compared with 70 percent of births in the highest wealth quintile. This translates to a ratio of about 1 to 5. In the effort to achieve equity in delivery in a health facility, the HPNSDP sets a ratio of less than 1 to 4 between women in the lowest and the highest quintiles (BDHS, 2011). The corresponding ratios in the 2004 BDHS was 1 to 15. Considerable inequity in the use of any antenatal care during pregnancy also exists between the poorest and the richest women in Bangladesh (Table 3).

Table 3: Trends in percentage distribution of receiving any ANC and institutional delivery by wealth quintiles during last 10 years

Wealth Quintiles	Received any ANC (%)		Institutional delivery (%)	
	2004	2014	2004	2014
Poorest	33.7	57.5	2	15
Second	46	69.4	3.2	22.6
Middle	58.3	89.8	5.5	33
Fourth	66.5	88.4	11.9	42.7
Richest	84.1	95.3	30.3	69.5

Source: NIPORT, BDHS, 2004 and 2014

Significant regional inequity exists in health service delivery in Bangladesh. HPNSDP targets delivery by a medically trained provider to reach 50 percent by 2016. But this target is achieved only in urban areas and in Khulna division, other regions and rural areas lags far behind in reaching this target (Table 4).

Table 4: Trends in percentage distribution of delivery assisted by medically trained personnel by location of the households and divisions during the last 10 years

Location of households and division	**BDHS 2004**	**BDHS 2014**
Urban	29.6	60.5
Rural	9.4	35.6
Barisal	11.4	36.7
Chittagong	11.7	43.9
Dhaka	14.9	43.5
Khulna	21.4	58.2
Rajshahi	10.6	41.6
Sylhet	11.1	37.9
Total	16	42

Source: NIPORT, BDHS, 2004 and 2014

There is continuing high prevalence of certain communicable diseases, and the growing burden of non-communicable diseases. Moreover, out-of-pocket expenditure for health care accounts for 64% of total

health expenditure. There has always been a constant wide gap between the out-of-pocket expenditure as a percentage of total expenditure on health and government expenditure as a percentage of total expenditure on health (Figure -1).

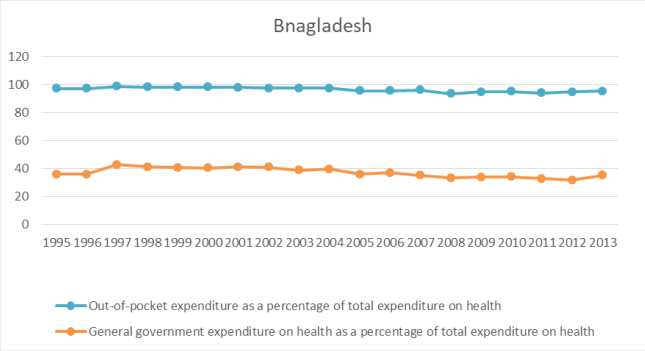

Figure 1: Gap between the out-of-pocket expenditure as a percentage of total expenditure on health and government expenditure as a percentage of total expenditure on health in Bangladesh, source: The World Bank indicators

Per capita total expenditure on health is increasing at an increasing rate from 1995 to 2013, while the per capita government expenditure on health is not in the same rate and the gap between the two is ever widening (Figure 2).

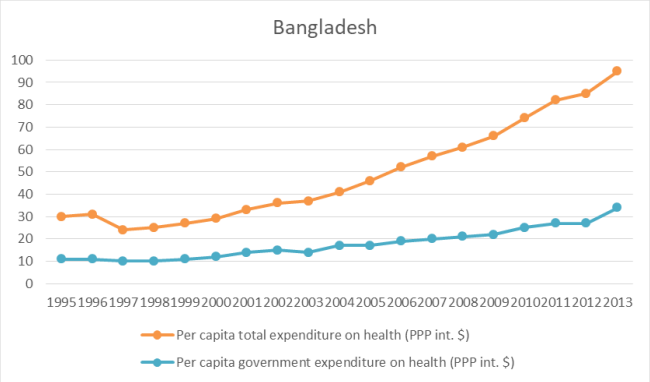

Figure 2: The gap between per capita total expenditure on health and per capita government expenditure on health in Bangladesh, source: The World Bank indicators

Currently around 4.5 percent of the total government expenditure is spent on health. According to the Abuja declaration 15 percent of the total government budget should be allocated for the health sector. The Health Care Financing Strategy of Bangladesh (2012-32) suggested to increase the budgetary allocation for the health sector to at least 10 percent of the total government budget. The government expenditure grew in the last few years at the rate of 17.6 percent per year. Using this growth rate the total spending in the health sector is calculated and the estimated spending on health will be 790 billion taka in 2012 assuming that the government will allocate 10 percent of the budget for health (Figure 3).

On the other hand, the actual expenditure on health has grown at the rate of 12 percent during the period of 2005 to 2014. Using this growth rate the future expenditure on health has been estimated. The figures show that the estimated actual spending on health will be 248 billion taka in 2021. Therefore, there will be huge financing gap between what government should spent for health care and what will be spent on health if the government do not increase the budgetary allocation for the health sector. The trends of the amount that government should spend on health and what is actually spent on health show that the financing gap shall increase gradually over the period of 2015 to 2021 (Figure 3).

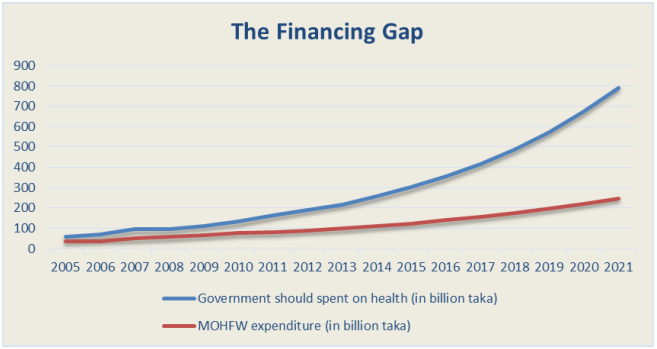

Figure 3: The Financing Gap (2005-21), Source: MoF

There are 5 doctors and 2 nurses per 10,000 population, making the nurse-doctor ratio in Bangladesh only 0.4. This falls short of the WHO standard of 3 nurses per doctor and the nurse-to-doctor ratio are among the lowest in the world (Ahmed et. al, 2011). WHO has declared Bangladesh as one of the 58 crisis countries facing an acute human resource crisis. The density of formally qualified registered Health Care Providers (HCP), i.e. doctors, nurses, and dentists, in Bangladesh is 7.7 per 10,000 population, and constitute only about 5% of the total health workforce. The number is approximately 2.3 workers per 1,000 population as the threshold density for the health system to perform optimally, Bangladesh has an HCP density of only 0.58 (0.3 physicians, 0.28 nurses and midwives, and 0.02 dentists). There are around 5 physicians and 2 nurses per 10,000 population. The equal nurse-doctor ratio in Khulna and very low nurse-doctor ratio in Sylhet is also associated with better health indicators in Khulna and worse health indicators in Sylhet. There is also a

bias towards urban areas in the distribution of HCPs. The doctor to population ratio is 1:1500 in urban areas and 1:15000 in rural areas. There is also substantial variation among different divisions, with Dhaka having the highest density of physicians followed by Chittagong, while this trend is reversed for nurses. The male bias among doctors is another problem hampering women's access to appropriate health services.(cited in https://d5nxst8fruw4z.cloudfront .net/atrk.gif?account=ZDBVh1aon800ov).

A study by Jahan et al. (2015) revealed that there was shortage of some crucial manpower in the surveyed facilities. The posts were mostly vacant. Moreover, there was the problem of high absenteeism, and even if the doctors are present they do not remain in the facility for more than 2-3 hours. In addition to this, certain proportion of equipments remains out of order and some essential items to provide maternal, neonatal and child health services (MNCH) are absent. They also found from observation of the research team, input data, service statistics, and discussions with community leaders and eligible clients, that quality of services was low. Using all the methods huge shortage of manpower, especially nurse and doctor, absence of qualified doctor, shortage of other inputs, improper input mix, not-in-order equipments were the major limitations at the facilities.

The slum population, whether slums are legally created or not and whether its dwellers live on the formal sector occupations or not, should get the basic amenities of life, including healthcare, for the benefit of the entire population of cities. A recent study showed that per capita income in the slums is almost close to the per capita income in the country, however high inequity of income exists in the slums, more importantly, level of use of healthcare is much lower than the urban (formal) areas. Several factors constraint the demand and supply side of the healthcare, nevertheless, limited access to healthcare is their serious constraint to use of healthcare. This is also an important factor to have reduced the demand for healthcare from the qualified sources. Effective measures are needed to increase both demand and supply of services and thereby the equilibrium use of healthcare and obtain positive comparative statics (Jahan et al. 2015).

Prospects in achieving UHC in Bangladesh

The government of Bangladesh is firmly determined to address these challenges and committed to move progressively towards Universal Health Coverage by 2032, which is documented by the Health Care Financing Strategy (HCFS) of 2012. It envisions strengthening financial protection, extending quality health services and providing population coverage. To achieve this, three strategic objectives were proposed: generate more resources for health, improve equity (by pooling resources and allocating them in an equitable way; and enhance efficiency. The HCFS 2012-2032 outlines a path towards financial protection for health to reduce the current high levels of out-of-pocket payments and catastrophic impact of seeking health care in Bangladesh. The strategy will be implemented in three time bound periods – short term, medium term and long term. Short term will be completed up to the end of the third sector wide program Health, Population and Nutrition Sector Development Program (HPNSDP) in 2016. The Government will start the SSK pilot - a subsidized health protection scheme for Medium term will cover up to 2021 coinciding with the time period of vision 2021 of the Government. The Vision 2021 envisages that Bangladesh will be a middle income country by 2021. SSK for the BPL population will be scaled up. The mechanism for the formal sector will expand and coverage for the informal sector will increase through voluntary subscription to the Social Health Protection Scheme. In the long term, spanning over 20 years up to 2032, the country aims to achieve Universal Health Coverage meaning ensuring access to quality health services and financial protection for its citizens through a complete inclusion of the informal sector in the Social Health Protection Scheme. Under the HCFS 2012-2032, the government of Bangladesh has determined a pathway for the health financing indicators to follow so they may reach the Universal Health Coverage target level by 2032 from the current levels in a systematic process.

Many countries working toward UHC already rely on locally specific, routinely collected service statistics to measure their health system's performance and standard demographic and economic surveys contribute occasional snapshots of trends in health status measures and economic development. At the same time, establishing new global goals, indicators, and targets could have a critical impact on governments' commitment to successful implementation of global declarations. In this line Bangladesh is also developing a UHC monitoring tools based on its own epidemiological and demographic

profile, health system and health financing, level of economic development and the population's demands and expectations.

A combined methodology reviewing strategic documents, reports and policies, analysis of health information tools and discussion with different stakeholders was used to develop the monitoring tool. Most of the impact indicators are Millennium Development Goals (MDG) indicators; the indicators identified cover all six domains of health systems: 1. Human resources, 2. Service delivery, 3. Medicines and Technologies, 4. Information, 5. Governance 6. Financing.

Successful implementation of UHC will depend on several measures to be adopted soon.

- It is now a common knowledge that absenteeism of providers is extremely high in the primary health care facilities. Since the providers will have to play the crucial role in achieving UHC, absenteeism of them has to be drastically reduced. In order to reduce absenteeism, the size of the facilities have to be expanded so that all providers have sufficient office space to work fulltime. Accommodation of the providers have to be increased substantially. Gradually the facilities needed for proper education of children and communication should be made available in each upazilas. The complementary inputs such as anesthesiologist, nurse, equipments etc. should be supplied adequately so that the providers can perform their duties without much difficulties. Alongside these, a disincentive mechanism should also exist which should be used in the cases of severe and prolonged absenteeism and irregularity in service.
- New positions for trained senior nurse and nurse/midwife should be created so that in absence of doctors they can perform the scheduled services.
- The supply of essential commodities for effective services should be ensured on the regular and full time basis. All UHCs should have the capacity to conduct pathological tests like blood glucose test and urine test in functional form. Adequate supply of basic logistics and drugs should also be present in the facility always. In addition, supply of utility services like electricity, water and gas should always be available.
- The existing BCC campaign should be intensified to be more effectively deliver the important messages especially related to MNCH services. The messages for BCC should include: what are danger signs of pregnant mothers, when should pregnant mothers be transferred to health service facilities, what is nearest suitable health service facility, and how to contact with service providers on regular and emergency basis, what are the specific duties of husband and mother-in-law towards pregnant women and the need for planning to make required money readily available. The message should be communicated using all the available modes through counseling sessions at the CCs and higher facilities, satellite clinics, billboards, posters, leaflets, and messages though mobile.
- Role of local community and local level planning should be increased
- Overall infrastructural development is needed especially in hard to reach areas such as in hilly, haor, coastal, chor and island areas.
- Interim facilities such as mobile, motor cycle for doctor and ambulance, palki, van for patients should be ensured
- In the hard to reach areas, number of facilities more or less equivalent to the UHFWC and CC should be larger than that of in the mainstream plain land. In the haor area, one UHFWC cannot cover one union due to inaccessibility and remoteness. In the unions, there several UHFWCs should be established. Similarly the number of CCs should also be large compared to that of in plain land. In rainy season, the mobile clinics can also be very useful.

Unless these measures are adopted, the implementation of UHC will achieve limited amount of success.

Conclusion and recommendations:

The country needs successful implementation of the UHC since there is high inequity in the use of health care services, high financial burden of the recipients of services, and low quality of services. Several preconditions have to be fulfilled for successful implementation of the UHC.

The initial challenge is to find innovative approaches to UHC, including expanding the health care workforce quickly at relatively low cost, or reducing absenteeism

in workplace, and directed to reaching underserved areas, while striving to ensure quality and effectiveness of care.

A research study conducted by the IHE (2015) showed that high absenteeism is present in all types of facilities in remote areas. In the light of this finding, for UHC to be implemented in Bangladesh, the presence of providers and support staffs related to MNCH services should be ensured for 24/7. Another recommendation is that each facility should have at least one female doctor to provide MNCH services. In addition, new positions for trained MNCH senior nurse, nurse/midwife and Community Health Worker (CHW) should be created so that in absence of doctor they can perform the scheduled services. The vacant posts should also be filled up.

To ensure a smooth transition towards UHC, proper mechanisms should be developed to provide incentives to providers especially in remote areas. However, in order to avail the advantage they will be required to serve in the remote area for a specific period (at least for 3 years). There after they will be transferred to the mainland facilities. Proper accommodation facility is also needed to be ensured. In order to expand the MNCH services and to ensure that each service required patient get the service on due time, one or two female residents of each village should be trained up as SBA. They will get hands on training on techniques to provide basic service and will do referrals if necessary.

Correspondingly, Bangladesh is moving toward introducing demand-side interventions through the introduction of third-party payers, which requires investments in new technical and institutional capacity with potential increases in administrative costs and complexities. The decisions initiated at this early stage of UHC can have long-term repercussions on the development of the health system.

To counter the demand side barrier to UHC, proper counseling should be provided at household level and each household member should be counseled on an individual basis. In addition, BCC materials should be developed involving knowledge on UHC. Consumers should be motivated to go to doctors instead of local pharmacy or quacks for seeking care related to mother and child issues. Also a huge barrier for patients seeking healthcare services in the rural areas of Bangladesh is the remote areas of their residence and the lack of proper or any transportation to carry them to the facilities.

It may be instructive for Bangladesh to examine the experiences of other countries who have constructed highly fragmented health systems, as the country is considering introducing social health insurance as the financing vehicle for expanding coverage, which could result in preferential coverage for formal sector workers and exclusion of households in the informal sector, which is not desirable for a comprehensible health coverage package.

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