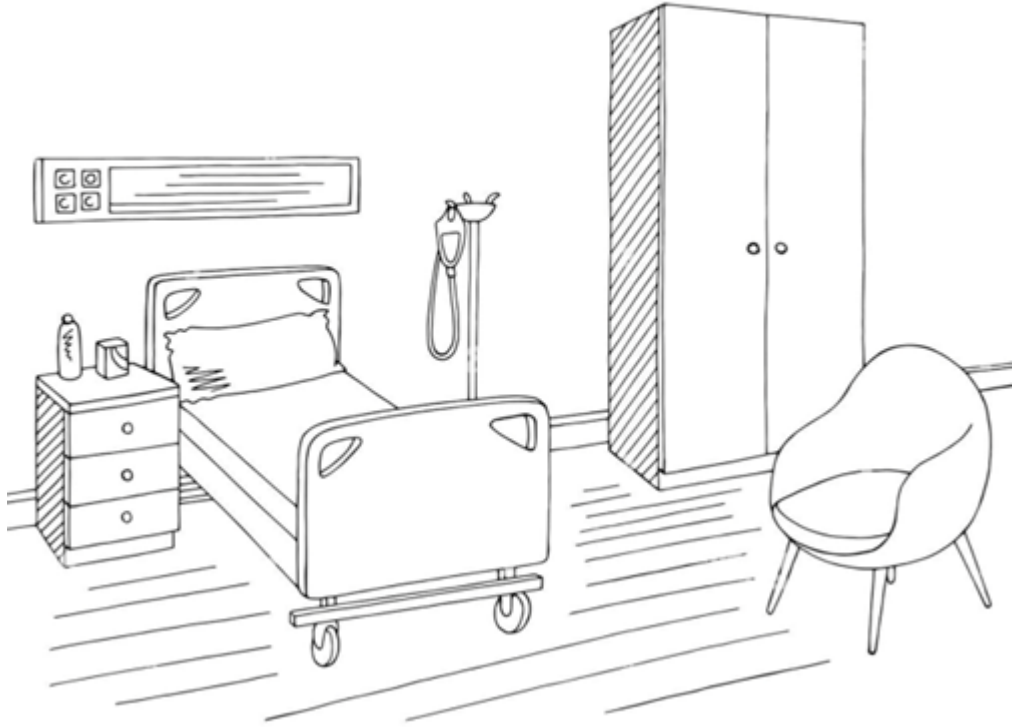


Bangladesh Nationalist Party's

Election Manifesto 2026

Implementation of Selected Health Programs



Professor Dr. Abul Kalam Azad

Introduction

I have felt deeply inspired by the commitment of the Honorable Prime Minister regarding the BNP's election manifesto and the implementation of its electoral promises after the formation of the government. Drawing from my long practical experience in health administration, I have developed a sincere intention to offer some recommendations on how health-related programs can be implemented at the lowest possible cost.

Between 1992 and 1994, I worked on health system reform under a technical assistance project of the World Health Organization. In 2000, I received training on Health Systems at Uppsala and Karolinska Universities in Sweden, which helped me gain direct insight into European health systems.

I have served as a teacher at NIPSOM, a public health educational institution, and as the Director of IEDCR.

While serving as the Director of the Management Information System of the Directorate General of Health Services, I established a robust national health information technology system across the country, which was well-recognized both at home and abroad. Later, having worked as Additional Director General and Director General in the same organization, I gained a comprehensive understanding of the real solutions to the country's widely discussed health problems. Needless to say, limitations of authority prevented me from implementing those solutions.

Due to my deep interest in public health and health systems, I have reviewed and written detailed documents during my participation in various international meetings and conferences, including those of the World Health Organization. Whenever I had the opportunity, I traveled to countries reputed to have good health systems and closely observed the reasons for their success firsthand. I have also delivered lectures both at home and abroad based on practical experience.

Inspired and moved by the resolute path of the BNP's victory and the implementation of its electoral promises, I humbly submit these recommendations to policymakers and relevant stakeholders. If even a single line is deemed worthy of consideration, I will consider my efforts successful.

Sincerely,

Professor Dr. Abul Kalam Azad

Mobile: 01777708000

profakazad@gmail.com

CONTENT

BNP Health Programs — 2

Health Budget — 3

e-Health Card — 5

Primary Health Care — 7

Prevention and Control of Non-Communicable Diseases — 11

A Modern "Secondary Health Care Unit" in Every District — 12

"National Ambulance Pool" and Emergency Health Services Network — 15

Recruitment of 100,000 Health Workers — 16

Automation in the Health Sector, 'National e-Prescription' and 'Prescription Audit' — 17

BNP Health Programs on the Occasion of the 2026 National Election

Introduction

In the introduction to the healthcare section of the BNP's manifesto for the 2026 national election, it was stated that health is not a privilege but a fundamental right of the people. Bangladesh's health sector has been crippled by prolonged neglect, political interference, and a lack of accountability. Seventy-two percent of health expenditures are borne directly out of the pockets of the people, making illness one of the primary causes of poverty even today. Government hospitals are overwhelmed, healthcare workers are demoralized and unevenly distributed, and access to quality care remains an unequal struggle for millions every day. The BNP believes that a healthy nation is productive, self-reliant, and sovereign. In line with the policy of 'Health for All', our goal is to ensure universal health coverage and to provide healthcare to every citizen with dignity and respect. No more impoverishment to pay for medical expenses—quality healthcare will be available at everyone's doorstep.



22 Points

1. Allocation of five percent of GDP to the health sector
2. e-Health Card: An electronic health card for every citizen
3. Guarantee of free, quality primary healthcare
4. Establishment of a modern 'Secondary Health Care Unit' in every district
5. Recruitment of 100,000 health workers
6. Corruption-free healthcare
7. Disease prevention and health awareness
8. Comprehensive maternal and child healthcare
9. Public-private partnership for the treatment of life-threatening diseases
10. Medicine and vaccine supply network
11. Eradication of mosquito-borne diseases
12. Healthy living, sanitation, and nutrition awareness
13. Safe water supply
14. Formation of a 'National Ambulance Pool' and emergency service network
15. Introduction of automation, AI-based 'National e-Prescription' and 'Prescription Audit' in the health sector
16. Formation of a national 'Accreditation Council' in the health sector
17. Emphasis on medical education
18. Dignity, safety, and development of health workers
19. Prevention of violence in the health sector and ensuring the safety of healthcare providers
20. Safe management of medical waste
21. Integrated and modern nutrition program
22. Control of non-communicable diseases caused by tobacco use

Health Budget

Success is possible within the allocated budget itself through proper prioritization and efficiency enhancement

BNP Election Manifesto

The BNP election manifesto states that five percent of GDP will be allocated to the health sector in phases. Every person will receive medical treatment according to their need, not according to their ability.

No Fear of Budget Shortfall

Based on the country's overall GDP size, allocating 5 percent of GDP to the health sector is not currently feasible. Similar to recent years, if the health sector allocation is kept at 5 to 6 percent of the national budget, or slightly increased to 7 or 8 percent, the government will be able to successfully implement many of the manifesto's health commitments.

To achieve this, the government must focus on development in three areas of the health sector:

- Limit expenditure on infrastructure construction
- Improve efficiency
- Reduce corruption

The table below presents the budget of the Ministry of Health and Family Welfare for the 2023-24 fiscal year (in crore taka). The interim government's development budget was insufficient. Therefore, an example from the 2023-24 fiscal year health budget has been provided. In that fiscal year, the total budget was Tk 38,052 crore (5% of the total national budget). Of this, the operating budget was 59.4% and the development budget was 40.6%.

Ways to Limit Expenditure on Infrastructure Construction

A large portion of the development budget is allocated to unnecessary infrastructure construction. The reason is understandable. Infrastructure construction, aside from political and local public aspirations, provides opportunities for contractors and corruption. During the final period of the previous Awami League government, a project proposal for the 5th Health, Population, and Nutrition Sector Program 2024-2029 was prepared. It was a development project. Later, the interim government declared it abandoned.

The estimated budget for this five-year project was: Tk 106,100 crore. Among this, the estimated allocation

Table-1: 2023-2024 FY budget of MOHFW (in crore BDT)

| Division | Budget 2023-2024 FY | | | Revised Budget 2023-2024 FY | | |
|--|---------------------|-------------|--------|-----------------------------|-------------|--------|
| | Operating | Development | Total | Operating | Development | Total |
| Health Services | 17,221 | 12,210 | 29,431 | 13,261 | 9,791 | 23,052 |
| Medical Education & Family Welfare | 5,367 | 3,254 | 8,621 | 4,304 | 2,393 | 6,697 |
| Total | 22,588 | 15,464 | 38,052 | 17,565 | 12,184 | 29,749 |
| % | 59.4% | 40.6% | 100.0% | 59.0% | 41.0% | 100.0% |
| Total health budget is 5% of national budget | | | | | | |

for infrastructure construction was Tk 43,922 crore (41.4%). Most of this infrastructure was intended for the construction of specialized hospitals and the expansion of existing specialized hospital infrastructure. In the next five years, the BNP should focus only on repairing and maintaining existing hospitals and undertake new construction work on a limited scale. Instead, they should bring about a leap forward in the promised primary healthcare services. This will achieve visible change and improve health indicators with limited funds.

Ways to Improve Efficiency

Vacancies in the government health sector must be filled quickly. Measures must be put in place to ensure attendance at workplaces and to assess the quantity and quality of work performed by each officer and employee. A performance-based incentive system must be introduced. The best method is to implement a purchaser-provider model in hospitals and health centers, which will create an automated management system, incentives, efficiency, accountability, team motivation, and spontaneously discourage private practice outside one's own workplace. Details on this matter have been described later in the hospital management section.

Ways to Reduce Corruption

In various areas such as pre-approval of procurement processes, fund release, influencing tender processes, audits, the Anti-Corruption Commission, laws and courts, even honest officers find themselves in danger. Therefore, when given responsibilities as health managers, these officers prefer to stay away from the procurement process. As a result, 100% of the health budget cannot be spent. This is not due to the incompetence of health professionals but rather a flaw in the system. Dishonest officers manage to get away. This systemic flaw must be repaired so that honest officers can avoid unethical expenditures, complete procurements on time, and implement programs.

Procurement of equipment, repair and maintenance, laboratory management, imaging department management, etc., for government hospitals and health centers can be outsourced to the private sector. The government will pay for diagnostic tests at predetermined rates. Such examples are abundant in Bangladesh's private sector and in developed countries. Infrastructure construction in the public sector must be limited, and alternative arrangements for procurement of medicines and MSR (medical supplies and reagents) should be introduced. This has been described in more detail later.

Implementing the purchaser-provider model in hospitals and health centers will automatically reduce corruption.

Increasing budget alone is not enough—intra-sectoral budget priorities must also be set

The example of Thailand can be considered. In that country, 70.5% of total health expenditure is borne by the government. In contrast, the government provides 31% in Bangladesh. In 2008, the Thai government spent 149percapita, which increased to 149percapita, which increased to 364 in 2021 and \$370 in 2022. Not only that, the Thai government has also determined how much should be spent on each sub-sector of the health sector.

Thailand's Intra-Sectoral Health Allocation Ratios

| Category | Percentage |
|---|---------------|
| Preventive & Health Awareness | 23% |
| Outpatient Services | 37% |
| Inpatient & Emergency Services | 36% |
| Patient Rehabilitation | 1% |
| Building & Equipment Repair/ Maintenance | 4% |
| Patient Compensation | 0.1% |
| Healthcare Provider Compensation | 0.004% |
| Total | 100.0% |

E-Health Card

What does the BNP manifesto contain?

Regarding the e-Health Card, the BNP manifesto states that every citizen will be provided with an electronic health (e-Health) card. With this card, when a patient visits any hospital or clinic in the country, doctors will be able to instantly access the patient's previous medical history, test results, and medication information. This will enable doctors to make accurate decisions and, through proper coordination, reduce misdiagnosis, medication duplication, and unnecessary expenses.

What type of card will be used?

From the above description, it is understood that using an e-Health Card will allow access to a patient's medical history and records. This can be achieved through data stored on the card itself, data stored in a back-end data center, or a combination of both. Developing and implementing an advanced, encrypted smart card is costly and time-consuming. The government can implement a progressive plan, initially introducing a basic version and later incorporating advanced technology and funding to implement a more sophisticated e-Health Card. In both cases, a back-end data storage system must be in place. The advanced information technology infrastructure of the Directorate General of Health Services can solve back-end issues at a low cost.

The following questions regarding the e-Card need to be answered:

- Separate health card or national ID card and, in some cases, birth registration card?
- Citizen-based card or family-based card?
- Paper or plastic? App-based e-Health Card, such as those used in Nepal or for various e-services.
- Will the card contain the patient's health data?
- Will there be debit card functionality?
- What will be the arrangement for issuing immediate health cards or providing health services to those without a health card?
- How will data be stored?
- What will be the synchronization method?
- How will personal data protection and information security be ensured?

Cost of manufacturing a smart card (per card)

- Basic NFC/Contactless card: Tk 70 to 150 per card (depending on quantity).
- Advanced encryption card: Tk 200 to 400 for higher security and larger biometric data.
- Card printing and personalization: An additional Tk 10-20 per card for printing and programming including patient name and photo.

Infrastructure and system costs

- Card Reader: A reader for reading data at each clinic. Price: Tk 2,000 to 5,000.
- Central Database and Software: This is the largest expense. Creating a database management and security system for an entire country requires an investment of several crore taka. However, the progress of the MIS department of the Directorate General of Health Services will help reduce costs.

Data Reading Methods

Data from a smart health card can be read in three main ways:

- **NFC (Near Field Communication):** Data is transferred when the card is held near a reader. It can also be read via smartphone. This technology is most commonly used in modern health cards.
- **Smart Chip (Contact Chip):** Data is collected from the chip by inserting the card into a reader, similar to a debit card. This is highly secure and can store patient prescriptions or past diagnostic information.
- **QR Code Scanning:** Data is read directly from the central server by scanning the QR code on the back of

the card. This is the cheapest and easiest method.

- **Cloud Synchronization:** Using the card's unique ID number, all patient information (insurance balance, medical history) is collected in real-time directly from the cloud server via the internet.

A companion mobile app is essential

- A mobile app is an extremely convenient and essential solution for the front-end. Its utility is multifaceted. It is possible to exchange all types of information, including financial transactions. Information can be exchanged from any location without the help of ATM machines or card readers. There is no cost other than the cost of developing the app. Even without a plastic card, all objectives can be achieved using a mobile app. Considering its utility, the plastic card cannot be an alternative to the mobile app.
- Excellent examples of mobile apps include various mobile financial services such as bKash, Nagad, Rocket, Binimoy, or Apple Wallet, Google Wallet, and various banking customer apps. Due to the multifaceted use and convenience of smartphones, even if a plastic card exists, a companion app is essential.
- **Plastic cards are expensive** to produce, distribute, and update. On the other hand, mobile apps are easy to distribute. End users can easily download them from the app store. No card reader is required. To update patient information on a plastic card, service providers must use other devices and platforms, such as mobile phones, tablets, laptops, or desktops. However, on an app-based platform, everything can be done through a single app. Patients will also be able to view their personal information. Updates are easy, and incorporating the latest security features such as blockchain and encryption technology is straightforward.

Health Cards in Different Countries

India: ABHA (Ayushman Bharat Health Account) Card – Digital health record. Debit card functionality.

Nepal: Basic or mobile app-based digital card.

Indonesia: JKN (Jaminan Kesehatan Nasional) – Health insurance card.

Maldives: Husnuvaa Aasandha – Universal health scheme. Primarily uses the national ID card.

Thailand: Instead of a separate physical health card, most healthcare services can be accessed using the national ID card.



In practical terms,

11 of the 22 health programs in the BNP election manifesto can be included under primary health services

According to the BNP election manifesto, the country's primary health services will be modeled after the United Kingdom's National Health Service (NHS). The various health programs outlined in the manifesto can be brought under primary health services:



1. e-Health Card: An electronic health card for every citizen
2. Guarantee of free, quality primary healthcare
3. Recruitment of 100,000 health workers
4. Disease prevention and health awareness
5. Comprehensive maternal and child healthcare
6. Medicine and vaccine supply network
7. Eradication of mosquito-borne diseases
8. Healthy living, sanitation, and nutrition awareness
9. Safe water supply
10. Integrated and modern nutrition program
11. Control of non-communicable diseases caused by tobacco use

Regarding these 11 health programs related to primary health services, the BNP manifesto states:

1. **e-Health Card:** This has been discussed previously.
2. **Guarantee of free, quality primary healthcare:** Primary healthcare will be established as the foundation and pillar of the health system, ensuring treatment is within everyone's reach. Following the model of the UK's National Health Service (NHS) General Practitioner (GP) model, one Primary Health Care Unit will be established in every union of rural areas and one or more Primary Health Care Units in every ward of urban areas. These will provide completely free treatment and medicine for general illnesses related to maternal and child health, as well as mental health services, disability-friendly services, women's healthcare, and elderly care. Each center will have a mini-lab and pharmacy, supplying essential medicines free of charge. Under each Primary Health Care Unit, there will be three peripheral healthcare centers (community clinics). Each center will have three trained community health workers who will regularly deliver preventive health advice and various healthcare services to people's doorsteps.
3. **Recruitment of 100,000 health workers:** Approximately 100,000 new health workers will be recruited to ensure healthcare for all citizens across the country, 80% of whom will be women.
4. **Disease prevention and health awareness:** To deliver healthcare to every home in rural areas, trained health workers will initially identify infectious diseases, diarrhea, high blood pressure, diabetes, malnutrition, and other health problems, increase disease prevention and health

awareness, and provide medical services especially to women, children, and the elderly.

5. **Comprehensive maternal and child healthcare:** Initiatives will be taken to ensure safe delivery as well as comprehensive maternal care, newborn, and child healthcare at the upazila health complex level.
6. **Medicine and vaccine supply network:** Through a phased approach, free primary healthcare medicines will be provided nationwide, life-saving medicines for cancer, stroke, diabetes, and other critical illnesses will be made available at low cost, and locally produced vaccines will be supplied free of charge, bringing rare and expensive medicines within the purchasing power of ordinary people. Fair prices for medicines will be ensured. The state-owned Essential Drugs Company Limited (EDCL) will be restructured, investment will be made in domestic API production and research, and a national pharmacy network managed by trained pharmacists will be established across the country.
7. **Eradication of mosquito-borne diseases:** Year-round, science-based mosquito control and treatment programs will be conducted to prevent life-threatening diseases such as dengue, chikungunya, and malaria.
8. **Healthy living, sanitation, and nutrition awareness:** Widespread awareness will be created among the public regarding healthy living, sanitation, and nutrition. Specialized training programs will be initiated for doctors and health workers.
9. **Safe water supply:** Modern purification systems will be introduced for safe water supply, and reservoirs will be built across the country in phases for rainwater harvesting.
10. **Integrated and Modern Nutrition Program:** The BNP will implement an integrated national nutrition program to

Structure of the UK National Health Service (NHS) GP Practice Team [Updated for 2026]

- Clinical or Medical Team (Comprising Specialist Professionals)
- General Practitioner (GP): Family medicine specialist
- Advanced Nurse Practitioner (ANP): Can diagnose, treat, and prescribe medication
- Practice Nurse: Registered nurse. Manages long-term conditions, vaccinations, and health screening.
- Clinical Pharmacist: Checks for medication side effects. Can change prescriptions or prescribe new medications.
- Physiotherapist
- Mental Health Practitioner
- Physician Associate: Works under the GP, assisting with physical examinations and diagnosis of patients

Holistic Support and Care Team

- Social Prescribing Link Workers: Connect patients with local community groups to address non-medical issues (e.g., loneliness, debt, or claiming benefits)
- Health and Wellbeing Coach: Assists patients in achieving personal health goals and managing long-term conditions
- Care Coordinator: Helps coordinate care for patients with complex needs across the entire health system

Administrative and Management Team

- Care Navigator (Receptionist): Specially trained staff who listen to the patient's problem and determine which specialist would be most appropriate to refer them to
- Practice Manager: Oversees the clinic's daily operations, staff management, and planning

New Conditions for GP Service Delivery in 2026

- Same-day response: Urgent clinical problems must be resolved on the same day
- Abolition of "call back later" practice: Patients cannot be told to call back on another day; a decision or appointment must be provided within the next working day
- Online access: The online consultation system must remain open from 8:00 AM to 6:30 PM

combat stunting among children under five in Bangladesh. This program will operate at three levels: maternal nutrition during pregnancy, treatment of severe acute malnutrition in children, and food and nutrition education. This program will be implemented through coordinated initiatives with the agriculture, education, and food sectors, and will remain integrated as part of primary healthcare.

- 11. Control of Non-Communicable Diseases Caused by Tobacco Use:** Emphasis will be placed on controlling non-communicable diseases caused by tobacco use (cancer, stroke, heart disease, lung disorders, etc.) to protect public health. Necessary legal measures and other activities will be undertaken to control tobacco use.

Promised Primary Health Services

How can it be achieved at low cost and in the shortest possible time?

Current Health and Family Planning Infrastructure of Bangladesh's Unions

Every union in the country has at least one Union Health and Family Welfare Center or Health Sub-Center. Some unions also have 10- or 20-bed hospitals. These have positions for doctors, nurses, pharmacists, lab attendants, ward boys, and security personnel. Each union has at least 3 community clinics. Each community clinic has one Community Health Care Provider. Each union has a government doctor position, and there are field workers from the Directorate General of Health Services and the Directorate of Family Planning. This doctor position was actually created by the previous BNP government. However, they are deployed elsewhere on deputation. Therefore, there is sufficient manpower in rural areas to establish Union Primary Health Care Units or GP Centers and to provide multifaceted integrated health and family planning services. If the vacant positions are filled, initially it will be fine even without creating new positions at the union level for launching health service units or GP centers.

To ensure benefits:

A single administrative authority must be created by integrating all existing government health service structures and manpower at the union level. The government doctor of the union will be the leader. One of the existing health or family welfare centers must be developed into a full-fledged GP Center. It must have a minimum of 10 beds for maternity and emergency medical services. If the relevant union already has a 10- or 20-bed government hospital, that should be selected as the GP Center. The existing manpower of this health center must be restructured, requiring the recruitment of at least one physician (who will also serve as the head of the union health authority), one Diploma Medical Officer, one Practice Nurse, one Midwife, one Health and Wellbeing Coach, one Pharmacist, one Medical Technologist, one Lab Attendant, one Receptionist, and the necessary number of security personnel. It should be noted that a considerable workforce already exists.

The community clinics, and any additional health centers if present, must be converted into branch health centers (branch GP Centers) of the main GP Center.

At each branch health center, at least two health workers must be deployed instead of the current single Community Health Care Provider (the position title may be changed). The referral center for these branch centers will be the union GP Center. If a patient is referred outside the union, the union health authority will coordinate their subsequent care.

Integrated Primary Health Services

All field workers from the two integrated directorates (Health Services and Family Planning) must be brought under the union health authority. This will reduce the shortage of field workers at the union level. Every field worker must be made competent and responsible for providing uniform services through refresher training. A Health and Wellbeing Coach must be appointed or elected under the leadership of the head of the union health authority. Under their supervision, field workers will conduct home visits and provide all types of health awareness, disease prevention, nutritional services, infectious disease prevention and control services, mental health services, and constructive primary healthcare.

Health indicators must be kept updated

Under the transformed primary health services, government field workers must ensure that health indicators, including those of the Sustainable Development Goals (SDG) 2030 and other essential health indicators, are updated annually.

No service without a health card

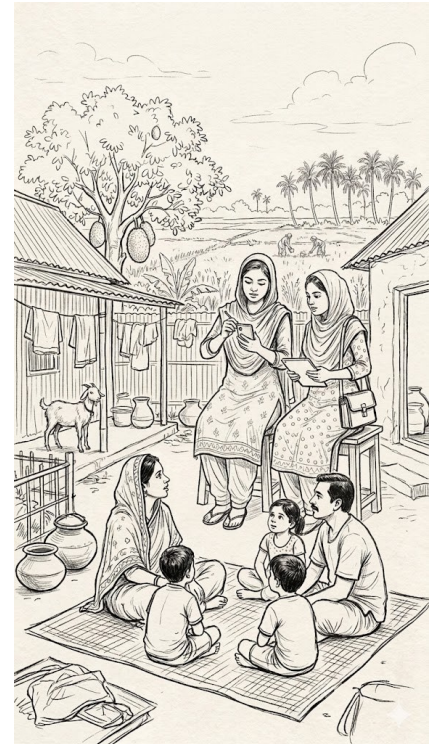
No service should be provided without a health card. There must be an arrangement for issuing an immediate health card.

The concept of providing completely free primary healthcare to everyone must be reconsidered

The idea of providing completely free primary healthcare to everyone, regardless of financial capacity, may be reconsidered. Affluent families should be encouraged to make a small co-payment according to their ability. This will increase the service capacity and quality of the health center. It is desirable to lay the foundation for social health insurance from primary healthcare itself. The co-payment system will discourage people from seeking unnecessary services. Those with health insurance will receive services with a very small co-payment. Those without health insurance will be able to purchase health insurance premiums immediately at the point of care. Those who are not interested in purchasing health insurance will be able to receive services at standard prices. Free health insurance arrangements will exist for the poor. Pregnant and lactating mothers, the elderly, children, and emergency patients will be exempt from co-payment.

Primary Health Services in Urban Areas

In municipalities, primary health service infrastructure and authorities with manpower similar to those in unions must be established for every 25,000–30,000 population. In city corporations, such primary health service infrastructure and authorities must be established based on individual neighborhoods (mahallas). Rather than constructing new infrastructure, it is preferable to start in rented premises or existing/unused government infrastructure. GP practice centers in the UK are often established in rented buildings. Urban primary healthcare infrastructure. A portion of the proposed 100,000 new health workforce must be utilized for establishing these authorities.



Referral from Primary Health Centers to Higher-Level Centers

Patients must be discouraged from going directly to higher-level health centers without a referral from primary health centers. Varying co-payment rates at hospitals can be one way to achieve this. For example, a patient referred from a lower-level health center, upon presenting a referral slip, would pay a co-payment or fee of Tk 5 or 10. Without a referral, the co-payment or fee would be Tk 100.

Coordination of Care for Referred Patients

The union health authority will coordinate all stages of subsequent treatment at the higher-level center for patients referred from lower-level centers, and will keep the patient under direct or indirect observation and support.

Timor-Leste: An Excellent Example of Household Surveys and Ensuring Citizen Healthcare

The country has established a structured approach to home visitation programs for healthcare delivery.

- **Intensive household monitoring:** Annual household visits for close monitoring (annual household health survey; every home).
- **Epidemiological surveillance visits:** In the event of a disease outbreak.
- **Regular routine visits (stratified by population groups):**
- **Population Groups**
- **Group 1:** Healthy individuals. Health workers will conduct household visits twice a year. The individual will come to the health center once a year for a check-up.
- **Group 2:** Pregnant women; individuals at risk for other diseases. Health workers will conduct household visits three times a year. The individual will come to the health center twice a year for a check-up.
- **Group 3:** Individuals affected by non-communicable diseases, mental illness, chronic infections, HIV infection, tuberculosis, etc. Health workers will conduct household visits four times a year. The individual will come to the health center three times a year for a check-up.
- **Group 4:** Individuals with disabilities. Health workers will conduct household visits three times a year. The individual will come to the health center twice a year for a check-up.

Financing for Primary Health Services

Funds can be mobilized from sources such as government allocations, savings resulting from increased efficiency in the health sector, coordination with existing health programs, national health insurance, co-payments, fee-for-service, donations, trust funds, and others.

Prevention and Control of Non-Communicable Diseases

Must be made an integral part of primary healthcare

Introduction

Non-communicable diseases (NCDs) are the leading cause of premature death in Bangladesh. Seventy percent of all deaths occur due to non-communicable diseases. Besides premature death, NCDs cause physical disability and result in significant financial losses. The successes achieved in improving child and maternal health are diminished by NCDs. The nation loses productivity and global competitiveness. A large portion of the population is at risk of NCDs. Among men, 52 percent are smokers. One in every five people has high blood pressure. In 2021, the number of people affected by diabetes was 1.31 crore (13.1 million). In the same year, 75,617 people died from diabetes.

Under primary healthcare, strong, people-engaged public health programs must be adopted to control NCDs:

- Prevention: Lifelong healthy behaviors; healthy dietary habits; physical exercise or activity; a healthy environment.
- Screening: Screening at-risk populations, registering them, and follow-up.
- Control: Keeping those at risk and affected under disease control and monitoring them.
- Sustaining progress: Maintaining and continuously reinforcing healthy habits at both individual and social levels.

Global Examples

- Thailand: Every afternoon, both men and women come out to fields, grounds, petrol pumps, and open spaces. Music plays at a moderate tempo from music players, and everyone dances in rhythm. This is a national initiative for physical exercise.
- Bhutan: Various low-cost specialized exercise devices have been established in parks. People use them, especially the elderly.
- In affluent countries, gyms have been set up in offices, markets, and public gathering places so that people can take advantage of opportunities to exercise wherever and whenever possible.
- In many countries, efforts are being made to create environments in offices and courts where calories can be burned by standing, walking, or other means. Time is allocated for physical exercise during various meetings, seminars, and workshops.

What can be done in Bangladesh?

In Bangladesh, an initiative has been taken for physical exercise to the rhythm of poet Kazi Nazrul Islam's song "Chol Chol." The donor agency JICA had undertaken an initiative in this regard. However, it must be ensured that the elderly and women have adequate opportunities for physical exercise, NCD screening, and control. Arrangements for sports and recreation must be made for everyone regardless of age, gender, or religion. After the Fajr prayer in the early morning, and for people of other faiths according to their convenience, group walking programs can be spread nationwide. The health authorities of unions and urban areas must maintain active systems for statistics on NCDs and risk factors among their enrolled populations, as well as prevention and control programs.

A Modern "Secondary Health Care Unit" in Every District

Unless a purchaser-provider based management system is introduced in government hospitals, no investment will yield benefits

BNP Election Manifesto

With the goal of providing complete, safe, and quality treatment for complex diseases within one's own district, a modern Secondary Health Care Unit will be established in every district. Upazila health complexes will be provided with specialist consultation services, 24-hour ambulance services, and a digital referral tracking system. They will be developed as primary centers for maternal, newborn, child, and reproductive healthcare. District hospitals will be transformed into specialized referral centers, offering services for heart disease, diabetes, cancer, mental health and rehabilitation, kidney dialysis, major and minor surgeries, trauma care, modern laboratory and imaging facilities, and ICU services.

Current State of Upazila and District Hospitals, Medical College Hospitals, and Specialized Hospitals

Upazila Health Complexes

These have 30, 50, or 100 beds. Specialist doctors are posted here. Considering that an upazila's population is at least 500,000, the promised specialist consultation services, 24-hour ambulance services, digital referral tracking system, and maternal, newborn, child, and reproductive healthcare must be ensured. The manpower should be reviewed and restructured. If the quality of services is improved, the majority of patients from the upazila can be treated here. Only a very small number of patients will need to be referred to higher-level facilities.

District Hospitals

Secondary care services are already available in district hospitals. Currently, because the healthcare system in upazila health complexes is insufficient and of poor quality, many patients go directly to district hospitals. The lack of a proper referral system is also a reason for the patient burden at district hospitals. If upazila hospitals are improved, the patient load at district hospitals will decrease. District hospitals face a severe manpower shortage, and existing staff are not properly deployed. This problem must be addressed.

If district hospitals are developed as specialized referral centers as promised—ensuring heart disease, diabetes, cancer, mental health and rehabilitation services, kidney dialysis, major and minor surgeries, trauma care, modern laboratory and imaging facilities, and ICU services—it will be a groundbreaking step in the medical world of Bangladesh and the subcontinent.

In this context, in districts where government medical colleges exist, the medical college hospitals should be integrated with the district hospitals. This will prevent two multidisciplinary specialist hospitals from operating in the same district and will result in cost savings.

Medical Colleges and Hospitals, and Higher Specialized Training Institutes and Hospitals

It would be beneficial for every district to have at least one government or private medical college. This would make multidisciplinary specialist care more accessible at the district level, and the facilities of district hospitals could meet the needs of medical college hospitals. However, the number of seats in medical colleges could be limited to 50. The manifesto states that special emphasis will be placed on the development of government medical colleges and postgraduate institutes to modernize and make medical education contemporary. Currently, there are many deficiencies in these institutions. These must be addressed.

The purchaser-provider model should be introduced in the management of all government hospitals

If the BNP's election promises related to hospitals are successful, it will be a groundbreaking achievement in fulfilling the desired dream of healthcare. However, the conventional hospital management system will not allow 100% success to be achieved. Therefore, the purchaser-provider system implemented in European countries or in countries where national social health insurance is practiced must also be introduced in Bangladesh. In those countries, citizens pay premiums to government health insurance funds. In return, they receive healthcare from designated hospitals, and the health insurance authority pays the bills of the affiliated hospitals. In this scenario, the bill-paying insurance authority is called the purchaser, and the hospital is called the provider.

Even in countries where there is no health insurance but the government bears the cost of citizens' healthcare from the national budget, the government authority assumes the role of purchaser and the hospital the role of provider. Such a system is in place in Thailand.

The current budget allocation system in Bangladesh's government hospitals must be changed, and the purchaser-provider method must be introduced. Under the new system, for every patient a government hospital serves each month, the government or appropriate authority (such as the Ministry of Health) will pay the hospital the amount due. Each service will have a unit price. The total value of all services of all types provided in a month will be paid to the hospital. Detailed resources are available on the application of this method.

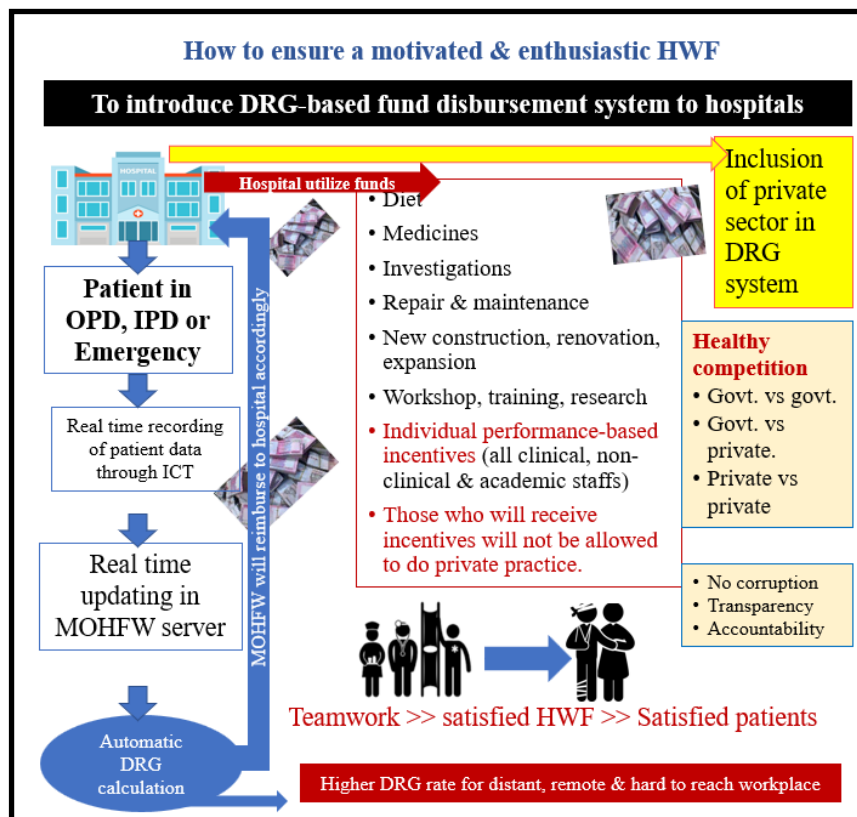
The authority will provide each hospital with an advance budget to cover the operational costs of patient care. This advance amount will be adjusted in the following month. Under the new system, hospital officers and staff will

continue to receive regular salaries and allowances according to the national pay scale. However, from the revenue received in exchange for hospital services, the hospital will fund expenses for diet, medicine, and diagnostic tests; repairs and maintenance; equipment purchase; new construction; renovation and expansion work; and workshops, training, and research. The hospital will have the authority to introduce new services and recruit additional temporary staff on its own payroll.

The prices for services will be set such that after covering expenses, approximately 40 percent of the amount remains with the hospital. This remaining amount will be distributed as incentives to all clinical, non-clinical, and academic staff according to their respective positions, workload, and quality of work. The incentives will be in addition to the basic salary and allowances. Officers and employees receiving these incentives will not be permitted to engage in separate private practice outside the hospital. As a result, they will be more attentive to improving the quality of service at their own hospital. Beyond the regular 8-hour duty, there will be opportunities for 4 hours of overtime work. They will receive additional pay for overtime.

Incentives for remote or inaccessible areas

The rate of incentives will be higher for health centers or hospitals located in remote or inaccessible areas, or for hospitals with fewer patients.



Purchaser-provider model in private hospitals as well

When the purchaser-provider model is introduced, the number of patients in government hospitals will increase. To manage the additional patient load, the government must avoid the costly path of establishing new hospitals or recruiting excessive health manpower through its own funding.

Instead, for patients whose medical expenses are partially or fully borne by the government, the government may advise them to receive treatment from designated private hospitals and health centers. When the concerned private hospital submits bills at government-fixed rates, the authority will verify and pay the bills.

Citizens must use their health cards to receive services from any government or private hospital or health center. The health card will play a crucial role in ensuring correct and appropriate treatment and accurate billing. Expanding the purchaser-provider model to private hospitals will save significant government funds in infrastructure construction, maintenance, repairs, and manpower. The government's management headaches will be reduced. The private health sector will develop. Healthy competition in healthcare quality will be created between government and private sectors, among government hospitals themselves, and among private hospitals themselves. Government doctors and health workers will not be permitted to do private practice in private hospitals or health centers.

Introducing the purchaser-provider model will create a renaissance in hospitals

All healthcare centers must provide the same type of treatment according to established protocols. Counseling must be mandatory. An effective medical audit system must be introduced to control deficiencies or excesses in treatment. If the incentive program under the purchaser-provider model is introduced in Bangladesh's government hospitals, a new wave of work enthusiasm will be created. Every health officer and employee will be active and vigilant in hopes of fair and proper incentives, and will strive to prevent waste, irregularities, deprivation, or misconduct. Service quality and patient satisfaction will increase, leading to a rise in patient numbers. Consequently, hospital income will increase, which will contribute to raising individual incentives. Similarly, officers and employees will collectively speak out against work evasion, corruption, and waste, thereby improving the environment of transparency and accountability. Because even when costs are saved, the amount of individual incentives will increase. However, the purchaser authority must make supervision and audit activities extremely robust to prevent hospitals from providing unnecessary medical services out of greed for higher income, such as unnecessary lab tests or surgeries on patients.

No more government-managed equipment procurement and laboratory operation

Many pieces of equipment in government hospitals lie broken. They are not being repaired. There is no proper maintenance. They cannot be operated due to manpower shortages. These are long-standing complaints. To change this situation, new concepts must be introduced for government-funded equipment procurement, maintenance, and operation in government hospitals. Nowadays, private hospitals no longer need to purchase biochemistry and hematology machines. Manufacturers supply these machines free of charge only on the condition of buying reagents. Moreover, modern-generation machines do not work without the manufacturer's reagents. With the increasing prevalence of artificial intelligence, unprecedented changes will occur in this field. In this context, if the laboratory and imaging services of government hospitals are competitively handed over to private entrepreneurs through legal procedures, they will be interested. They will handle equipment supply, maintenance, repair, and operation. The government will set the price for each test and pay accordingly. The hospital management committee will enforce strict monitoring and punishment to prevent unnecessary tests and low quality for unethical profit.

"National Ambulance Pool" & Emergency Health Services Network

BNP Election Manifesto

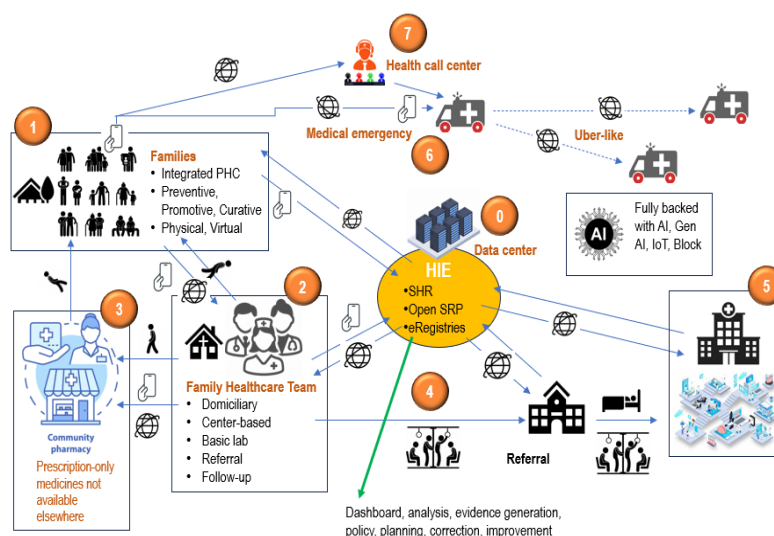
Formation of a 'National Ambulance Pool' and Emergency Service Network: To ensure that no more lives are lost on the way due to not getting an ambulance in time, a National Ambulance Pool/Network will be established, providing 24-hour patient transport and emergency assistance. Alongside this, a modern, technology-dependent national emergency medical service system, 'Emergency Medical Service', will be developed. A national digital call center or helpline and real-time referral system will be launched to quickly access ambulances and emergency medical assistance when needed.

Current Situation

There is no coordinated national emergency medical service in the country. If a person suddenly falls critically ill, calling an ambulance, providing proper medical care in the ambulance, quickly dispatching the patient to the right hospital, and preparing the hospital for admission and treatment before the patient arrives—these matters are like a nightmare in Bangladesh. Moreover, the existing ambulances in government and private sectors do not meet standard norms. Ambulances are not being used efficiently. Somewhere, ambulances sit idle. Elsewhere, ambulances are unavailable during emergencies. Ambulance services are not provided free of charge. Yet ambulance service is an emergency health service, and even wealthy people may not have relatives or money available at the time of an emergency medical need. Sometimes, after an accident, some may even lose consciousness.

How a National Ambulance Pool Can Be Formed

Currently, government ambulances are purchased in the names of various government hospitals. They are primarily used for transporting patients to and from the respective hospital. When there are no patients, they remain idle. On the other hand, another hospital may not have an ambulance available. Also, when a patient is sick at home, they often cannot get an ambulance urgently. To change this situation, all government ambulances must be brought under a national pool. Additional new ambulances will be added through purchase and donations. Private ambulances will also be included on a rental basis. A national authority will manage the ambulance pool. Ambulance services will be provided free of charge for all emergency patients. The ambulance pool will be operated through the national call center described below. Funding for this national emergency medical service and ambulance pool will be secured from government allocations, grants, donor agencies, philanthropic individuals, and revenue generation projects.



A Coordinated National Emergency Medical Service Must Be Launched

The government will form a National Emergency Medical Service Trust. This trust will provide services 24/7 through a National Emergency Medical Service Control Center or Call Center. For this purpose, BTRC's short code 103 is allocated. The call center will receive calls from emergency patients. The patient's GPS location will be identified automatically through information technology, similar to how Uber or Pathao internet apps work. The call center will identify the GPS location of the nearest available ambulance and contact that ambulance, instructing it to proceed to the patient. The call center will simultaneously identify the nearest appropriate hospital and advise the patient to go there. The call center will maintain constant communication with the ambulance and the hospital until the patient is admitted and treatment begins. Under this system, all hospitals must mandatorily follow emergency operation protocols. All government and private hospitals must provide free, life-saving support to emergency patients immediately upon arrival.

Recruitment of 100,000 health workers

80% female

BNP Election Manifesto

Recruitment of 100,000 Health Workers: To ensure healthcare for all citizens across the country, approximately 100,000 new health workers will be recruited, 80% of whom will be women.

Health Workforce Review

There is extensive research and numerous recommendations regarding the health workforce in Bangladesh. Although funds are allocated for salaries and allowances for sanctioned positions in the health sector, approximately 40% of positions remain vacant. Even among similar types of institutions, there is no standard norm regarding the number and types of positions. By coordinating this matter, it will be possible to establish a standard norm by transferring some positions from one institution to another. For this purpose, data and documents should be reviewed over one to two weeks. This will provide an understanding of the actual situation and needs of the health workforce. Consequently, new positions and workforce recruitment plans can be formulated accurately.

Which institutions will the new 100,000 workforce be for?

First, primary health service infrastructure and manpower must be created in urban areas. These positions, along with existing vacant positions, must be filled with manpower. Then, according to the plan, positions should be restructured, additional new positions created, and filled with manpower.



Priority should be given to creating positions for new institutions that do not yet have sanctioned manpower positions.

Immediate Filling of Vacant Positions

If the vacant positions of various health institutions are filled, and officers and employees are inspired and motivated, and office attendance, accountability, responsibility, rewards, and punishments are ensured, significant improvement in the health system will occur very quickly. Applying the purchaser-provider model in hospitals will make the task of inspiration and motivation automatic.

Automation in the Health Sector, Introduction of AI-Based 'National e-Prescription' and 'Prescription Audit'

BNP Election Manifesto

Digital health management (hospital management, medicine supply, procurement, logistics, financial administration, etc.), AI-dependent disease identification, and referral systems will be established in the country's health sector. A National e-Prescription system will be introduced to make prescription and medicine management completely digital and transparent. Prescription audits will be introduced to prevent the misuse of antibiotics and other drugs.

Bangladesh's Readiness

Bangladesh has significant digital readiness in the health sector. In particular, the digital readiness of the Directorate General of Health Services is largely world-class and acclaimed. Below is a list of digital assets of various institutions under different health ministries:

Directorate General of Health Services

- Connectivity
- Data center & Disaster Recovery Center
- Key e-registries (geo-location registry; health facility registry; health provider registry; patient registry)
- OpenMRS+ (Hospital Management System – connecting about 70 hospitals)
- SHR (Shared Health Record – EHR)
- OpenSRP (Open Smart Registry Platform for CHWs)
- eVLMIS (electronic Vaccine Logistics Management Information System)
- Geo-enabled microplanning for routine immunization
- DHIS2 (District Health Information System v2; World's largest deployment)
- HRIS (Human Resource Information System) with biometric office attendance system
- Telemedicine
- Hospital/ diagnostic center /clinic registration system
- Asset Management System
- Procurement portal

Directorate General of Family Planning

- Connectivity
- DHIS2 (District Health Information System – used in about 100 countries)
- FWA e-register
- SCMS (Supply Chain Management System)

Directorate General of Drug Administration

- ADLRS (Automated Drug Licensing and Renewal System)
- PMS (Pharmacy Management Software)
- PharmaDex (Pharmaceuticals Management System)
- eLearning platform
- ADR MS (Adverse Drug Reaction Monitoring System)

Pharmacy Council of Bangladesh

- Pharmacists' registry

Directorate General of Medical Education

- Institution profiles
- Student profiles
- HRIS (Human Resource Information System)
- eLearning platform

CMSD

- Inventory Management System

Health Engineering Department

- Infrastructure development database

Ministry of Local Government and Rural Development

- DHIS2-based Urban Primary Health Care Services Delivery Project Healthcare Management System

Private sector

- A reasonable number of private sector hospitals and clinics have Hospital Management Systems – but lacks interoperability

Security Awareness

Laws on personal and institutional information security will be required. New health technologies, digital apps, and AI algorithms must be brought under licensing. Cybersecurity standards and protocols must be strictly enforced for every digital health platform to prevent hacking or data breaches.