children, and older adults to prevent a nutritional disaster. In the middle term, starting the rehabilitation of health-care facilities and recovery of agriculture in the regions hit by the flood is crucial. Finally, as the country is gradually restored, long-term measures should start by focusing on the reinforcement of the Bangladeshi health infrastructure. To this end, flood-resistant hospitals and other necessary facilities must be constructed, supply chains strengthened, and adaptation to climate change integrated into national health policies. Through these comprehensive actions, the immediate health crises can be mitigated, and the basis for a more resilient future can be set.

I declare no competing interests.

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Transparency in national health expenditure estimates

Accurate estimates of national health expenditure are indispensable for ensuring effective formulation of health policies. These estimates constitute one of the most important statistics for a country's health-care sector. However, in many countries, the methods used to make these estimates often lack transparency, according to domestic scholars, policy makers, and international observers; substantial difficulties might be encountered when conducting cross-country comparisons due to the absence of detailed information on the data and estimation strategies used.[1] Examinations of national health expenditure data published by the Organisation for Economic Co-operation and Development and WHO frequently reveal a paucity of detailed estimation methods that hinders efforts to replicate the estimates or, at the very least, ascertain with confidence the components included in these figures.[1]

Among all components of national health expenditure, out-of-pocket health-care expenditures are the most difficult to estimate, and estimations of these expenditures are often the least transparent.[2] In many cases, estimation of national out-of-pocket expenditures is not done by departments responsible for health policy formulation, such as ministries of health. Consequently, the methods used for these estimations might not even be fully understood by a nation's health department.

In Taiwan, for example, the national out-of-pocket figure announced by the Ministry of Health and Welfare was estimated by the Directorate-General of Budget, Accounting, and Statistics (DGBAS), the agency responsible for national income estimation. This figure represented 31·4% of the national health expenditure in 2022.[3] The high proportion of out-of-pocket expenditures in Taiwan frequently sparks discussions regarding the adequacy of Taiwan's globally recognised National Health Insurance system in terms of the financial protection it offers.[4] However, the DGBAS has not disclosed the details of the methods it uses to make these estimations, including breakdowns of expenditure categories. This lack of transparency might have contributed to misguided debates surrounding health policy.

Another example is the 2024 decision by Taiwan's Ministry of Health and Welfare to incorporate an additional NT$101·4 billion of private-sector long-term care expenditure into the national out-of-pocket figure estimated by the DGBAS.[3] This inclusion led to a substantial increase in the current health expenditure from 6·1% to 6·8% of gross domestic product in 2021.[3] Unfortunately, the Ministry of Health and Welfare did not disclose the methods or provide specific details regarding this estimate. Without transparent disclosure of methods, scholars and health policy makers are unable to assess the accuracy of such estimates, which can result in misguided health policy design and unproductive academic or policy research.

We strongly advocate for the public disclosure of national health expenditure estimation methods, both domestically and internationally, to facilitate informed health policy development and enable meaningful international comparisons.

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Utilising available isoniazid-resistance tests in new patients

Multidrug-resistant (MDR) tuberculosis (defined as resistance to both rifampicin and isoniazid) is rising globally.[1] In many countries, the diagnostic algorithms in new patients with tuberculosis start with the WHO-recommended molecular first-line tuberculosis diagnostic and rifampicin-resistance test, Xpert MTB/RIF.[2] If rifampicin resistance is negative, the patients are offered first-line tuberculosis regimens. Further drug-sensitivity testing is done if rifampicin resistance is detected.[2] Although able to help detect and manage MDR tuberculosis, this strategy might be unable to prevent MDR-tuberculosis development. Diagnosing and managing mono-isoniazid resistance and rifampicin resistance is essential to prevent MDR tuberculosis development.

In India, the country with the highest MDR tuberculosis burden,[1] among the first-line tuberculosis drugs, isoniazid had the highest prevalence of resistance, and rifampicin resistance was almost invariably associated with isoniazid resistance.[3] Any isoniazid-resistant prevalence was nearly four times that of MDR tuberculosis among new patients, which decreased to about two times among previously treated patients.[3] Many new patients with isoniazid resistance could have later developed rifampicin resistance, increasing the proportion of MDR tuberculosis among previously treated patients. Similarly, the global prevalence of any isoniazid-resistant tuberculosis was three times more than that of MDR tuberculosis among new patients with tuberculosis, which decreased to about one and a half times among previously treated patients.[1,2]

Genomic analysis studies reveal that isoniazid resistance overwhelmingly develops earlier than resistance to other antituberculosis drugs. When rifampicin resistance is detected, pre-existing resistance to multiple additional medicines often exists.[4] These data indicate that undetected isoniazid resistance among new patients with tuberculosis could be an important source of MDR tuberculosis. The addition of isoniazid-resistance testing in new patients with tuberculosis to the existing initial rifampicin-resistance testing protocol could help detect the prevalent mono-isoniazid resistance and any proportion of mono-rifampicin resistance.

Besides a fluoroquinolone-containing treatment for isoniazid-resistant, rifampicin-susceptible tuberculosis, WHO has also endorsed low-complexity molecular tests for detecting isoniazid resistance that are technologically suitable for peripheral-level use in low-resource settings.[5] These isoniazid-resistance tests mostly remain underused at the point-of-care level. These tests require instruments different from Xpert MTB/RIF, and they can rapidly detect resistance to second-line antituberculosis agents; they are, therefore, preferred for placement at MDR tuberculosis treatment sites.[5] However, besides the MDR tuberculosis treatment centres, these isoniazid-resistance tests also need to be used at the peripheral level on all new tuberculosis-positive samples to detect and manage the mono-isoniazid resistance and rifampicin resistance to prevent MDR tuberculosis.

High-resource countries and low-resource countries, with the support of global health agencies, could immediately utilise the available isoniazid-resistance tests for universal testing in new patients with tuberculosis to prevent MDR tuberculosis, an airborne drug-resistant disease that could create lasting negative effects for generations to come.

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Combination strategies in advanced hepatocellular carcinoma: the CARES-310 trial

We read with great interest the final report of the CARES-310 trial by Shukui Qin and colleagues.[1] This trial strengthened the role of camrelizumab plus rivoceranib as a new first-line treatment option and achieved the longest median overall survival for any systemic treatment in global phase 3 trials for patients with unresectable hepatocellular carcinoma. However, we have several concerns with the interpretation of this paper.[1]