Speakers (alphabetical order)

Aftab ALA

King's College Hospital NHS Fundation Trust, UK

BIOSKETCH

Professor Aftab Ala is a Consultant Physician and Professor of Hepatology at the Institute of Hepatology, King's College London. At Kings, he leads the clinical and translational programme in Adult Rare Liver Disease and international Phase 1–3 Clinical Trials. He serves as Chair of the British Association for the Study of the Liver (BASL) Special Interest Group.

A recognized leader in reducing health inequalities, Professor Ala is supported by the National Institute for Health and Care Research (NIHR) and works closely with UK and international charities to reach underserved populations. During the COVID-19 pandemic, his translational research in liver disease and health inequality was funded by the UK government to develop and successfully deliver targeted messaging to underserved communities across the United Kingdom and increase uptake of vaccination through faith communities and centres.

ABSTRACT

The role of Communication in addressing the economic and social sustainability of national healthcare systems.

Effective communication within national healthcare systems which encompasses exchange of health information to educate, inform, influence individual and community behaviours, is fundamental to ensuring economic and social sustainability.

This abstract explores how targeted, culturally attuned health messaging can improve the uptake of healthcare interventions among minority ethnic

populations, thereby enhancing health promotion, supporting earlier disease detection, and reducing longstanding inequalities in access and outcomes.

This discussion draws on works of Aftab Ala et al, focusing on health system improvement, equity, and the role of faith in healthcare. Their research shows how culturally resonant communication through trusted community and faith networks can bridge gaps in trust, access, and engagement, ensuring acceptability and sustainability. Such examples to mitigate against misinformation include COVID-19 testing and vaccination messaging via faith centres, outreach for communicable and non communicable diseases in underserved communities, and faith leaders' involvement in public health interventions.

The outreach studies used culturally sensitive messaging to explore and improved understanding and awareness of chronic diseases e.g. liver disease in UK based Black and South Asian populations to reduce prevalence of the disease and gather lessons for future models in engaging migrant communities.

Similar approaches were used for COVID-19 messaging strategies with the aim of addressing structural inequities that shape exposure, testing, and vaccination. This involved provision of clear, easy-to-understand, accessible and culturally sensitive information about asymptomatic transmission, testing availability, and vaccine safety thereby customising narratives that reflect cultural and religious values.

Ala's framework fosters dialogue to align health system goals with social justice, using co-produced multilingual messaging through trusted messengers and varied channels.

Overall, these innovative studies led the groundworks for a global re-examination of the role of faith and faith leaders in facilitating health-care access and improving outcomes. These approaches can be instrumental in strengthening public health interventions particularly for marginalised populations.

Emili BARGALLÓ

Orden hospitalaria de San Juan de Dios,
Sant Boi de Llobregat,
Spain

BIOSKETCH

Emili Bargalló has a solid professional background in the non-profit sector, covering both public and private spheres, and is specialised in the health, social, and knowledge sectors. His career has developed within organisations guided by a clear and identifiable purpose and values, contributing to the consolidation of robust organisational cultures focused on social impact.

Emili Bargalló stands out for his participation in the governing bodies of various institutions, where they have driven growth through the definition of strategies and the organisation of structures. His management experience includes leading and organising entities in the health sector, with particular emphasis on those dedicated to biomedical research and innovation.

His contributions have had a tangible impact on the growth and sustainability of the organisations with which He has collaborated, demonstrating a capacity to generate value and lasting results.

Since 2010, Emili Bargalló has been linked to the Hospitaller Order of St. John of God in Spain, leading the Barcelona's Research Foundation. In 2015, was appointed as a member of the Province Governing Board and, since 2022, has served as Director of the centres of Territorial Unit I of the Province of St. John of God in Spain, covering Catalonia, Valencia, Murcia, Aragón, and the Balearic Islands.

ABSTRACT

Catholic perspective on the sustainability of western healthcare systems and organizations

The presentation will focus on the sustainability of western healthcare systems and of the organizations that work within them, highlighting both their achievements and their current challenges. We will analyse the situation of health systems by pointing out some of their positive aspects and identifying their main problems, which could lead to a crisis in public perception of the system's real contribution.

The key challenges for the main stakeholders will be identified:

- **Citizens:** Population ageing, the rise in chronic patients, and increasingly high expectations fuelled by easier access to information are generating growing and progressively more demanding needs.
- **Public authorities:** Healthcare spending continues to rise, especially in technology and pharmaceuticals. At the same time, fiscal and debt limits set by Europe restrict funding capacity.
- **Organisations and professionals:** We are facing an increasingly serious shortage of professionals. At the same time, many of them experience burnout. In addition, the professional categories currently in place may be inadequate.

In terms of management, the challenges at the different levels of the system will be addressed. Inequalities between citizens, differences between coverage systems, the various types of public organisations, different models for purchasing healthcare services, as well as the need for integration and digital transformation, are some of the challenges we must face.

Finally, we will address the key factors for the sustainability of healthcare organisations: faithfulness to the mission, sound governance, constant review of what we should focus on, careful management of economic and environmental issues, and the creation of safe spaces where good treatment of users and professionals is part of our identity.

Rok ČIVLJAK

University Hospital for Infectious Diseases,
Zagreb School of Medicine,
Croatia

BIOSKETCH

Prof. Rok Civljak, M.D., Ph.D., is a specialist in infectious diseases, paediatric infectious diseases, and a subspecialist in critical care medicine. He is the head of the Department for Respiratory Tract Infections of the University Hospital for Infectious Diseases "Dr. Fran Mihaljevic", an associate professor at the Department of Infectious Diseases of the University of Zagreb School of Medicine, and a member of the National Hospital Infection Control Advisory Committee, Zagreb, Croatia. He completed his M.D. (1994) and Ph.D. degrees (2014) at the University of Zagreb School of Medicine. Since 1997, he has worked at the University Hospital for Infectious Diseases "Dr. Fran Mihaljevic" in Zagreb. He was awarded by the Croatian Medical Association (2008) and the World Federation of Catholic Medical Associations (2022).

ABSTRACT

Professional and Ethical Challenges in Medicine During Wartime

Wartime conditions impose profound professional, ethical, and personal challenges for healthcare workers, as healthcare systems are often among the earliest and severely affected casualties of war. Healthcare facilities are frequently damaged, disrupted, or deliberately targeted, and healthcare professionals increasingly become direct victims of violence. This presentation examines the historical evolution of wartime medicine and highlights the contributions of healthcare workers during recent armed conflicts. Particular attention is given to the growing pattern of attacks on health services and healthcare workers in contemporary conflicts, reflecting a troubling erosion of medical neutrality.

Despite operating under extreme conditions characterized by insecurity, resource scarcity, and infrastructural collapse, healthcare workers continue to provide essential clinical care, public health interventions, and psychosocial support to civilian and combatant populations alike. These circumstances generate complex ethical challenges, including triage and allocation of limited resources, threats to professional autonomy, dual-loyalty pressures, and the psychological and moral injury associated with care under duress.

The experience of war medicine during the Croatian Homeland War (1991–1995) illustrates both the challenges and resilience of healthcare systems under attack. Developed under conditions of aggression against the Republic of Croatia, wartime healthcare relied initially on highly motivated civilian healthcare workers – often without prior military experience and with limited equipment, transport, and communication resources. Through integration with civilian health institutions, a multi-level system of healthcare was gradually established, ranging from frontline medical support to clinical hospitals and rehabilitation centers. This staged approach achieved favorable outcomes for wounded soldiers and civilians. Notably, there was no major deterioration in the health of the armed forces or significant epidemics during the war, largely due to the dedication and self-sacrifice of healthcare workers within Croatia's integrated healthcare system.

These findings underscore the urgent need for strengthened legal protections, ethical guidance, targeted training, and sustained international advocacy to support healthcare workers during wartime.

Francesca COLOMBO

OECD Health Division, France

BIOSKETCH

Francesca Colombo is the Head of the Organisation for Economic Co-operation and Development's Health Division. She leads OECD work on health, providing internationally comparable data on health, applying economic and data-driven analysis to health policies within a cross-sectoral perspective, and advising policymakers and stakeholders on how to make health systems more resilient and people-centred. Issues Francesca covers in her role include: health systems resilience and value for money; health workforce; health spending and the financial sustainability; measuring of healthcare activities, inputs and outcomes (including the PaRIS initiative developing, standardising and implementing indicators of outcomes and experiences of healthcare); healthcare quality policies; ageing and long-term care; the economics of public health; pharmaceutical policies; and AI and digital health (http://www.oecd.org/health). The results of this work have informed policy-making processes at national and intergovernmental level. Ms Colombo is a member of the NUS-Lancet Pandemic Readiness, Implementation, Monitoring and Evaluation Commission on COVID-19, the World Health Summit Council, the UK Health Foundation's NHS Productivity Commission and served as co-chair of the World Economic Forum Global Future Council on Health and Healthcare and member of the Lancet COVID-19 Commission. She has over 25 years of experience leading international activities on health and health systems.

ABSTRACT

Are health systems sustainable?

Health systems are under intense pressure. Demand for more and better care is rising as populations age. Many systems struggle to provide care that is truly centred on the needs of populations. Tighter fiscal constraints make it both essential and difficult to deliver better health outcomes with limited human and financial resources. As governments face competing priorities, health systems are expected to demonstrate their contribution to broader policy goals, such as the green transition.

Achieving high-performing health systems for all in this context requires a deliberate focus on long-term sustainability, in at least three main dimensions.

First, the financial and fiscal sustainability of health systems must be preserved. Doing so in a context of tight budgets requires a fundamental shift: from cure to prevention, from episodic care to integrated care, from hospital-centred care to caring for people in the community. It also means pooling risks to protect the most vulnerable, while eliminating care that is unsafe, poorly coordinated or ineffective.

Second, health systems need to contribute to wider policy objectives such as environmental sustainability and economic prosperity. This calls for a policy focus on maximising the co-benefits that health policies can generate across other sectors, with an emphasis on policies that promote the health of people and the health of the planet at the same time.

Third, as trust in governments and public services is eroding, health systems play a crucial role in strengthening public trust and supporting the effective functioning of societies and economies. Bringing patients' voices into health system performance measurement and planning helps to accelerate this transformation. Providing care that helps people live well builds confidence in health services and supports broader social trust.

Refocusing health systems around these three sustainability imperatives creates the conditions for durable improvements in the health and wellbeing of patients and populations.

Emilce CUDA

Pontifical Commission for Latin America, Holy See

BIOSKETCH

Currently: Secretary of the Pontifical Commission for Latin America, Holy See; ordinary member of the Pontifical Academy of Social Sciences and the Pontifical Academy for Life; CELAM advisor; professor at Loyola University of Chicago.

She leads the PCAL *Building Bridges Initiative*, connecting the five continents through universities, territorial organizations and international organizations.

She received two Honoris Causa Doctorates: in Liberal Arts from Loyola University of Chicago (2023); in Humanities from the National University of Rosario, Argentina (2022).

She received three Awards: *Highest Award for Contribution to Ibero-American Cooperation* by the Organization of Ibero-American States (OEI), Madrid (2025); the *William H. Sadlier Recognition* by the National Catholic Council for Hispanic Ministry (NCCHM), United States, (2025); the *Iluminis Award for Excellence* by the University of Business and Social Sciences (UCES), Buenos Aires (2025).

She was a Visiting Professor at Boston College (2016), Northwestern University (2011), and De Paul University (2019).

She received a PhD/SDT in Theology *cum laude* from the Pontifical Catholic University of Argentina, lecturing on "Democracy and Catholicism in the United States in the 19th Century". She specializes in Social Moral Theology. She also studied: Philosophy at the University of Buenos Aires; Political Science at Northwestern University; Economics and Business at the University of Business and Social Sciences.

Her most important book: *To read Francisco. Theology, Political Ethics*, Ediciones Manantial, Buenos Aires, 2016 (Published in Italy by Bollati Boringhieri, 2018).

ABSTRACT

Catholic Social Teaching in Healthcare

Christianity is not a religion because it is more than that; it is a theology as a public word "so that all may have a good and abundant life" (Jn 10:10). Health and life are one and the same. Catholicism transformed the Gospel message into a body of doctrine, systematized in the industrial age by Leo XIII, and taken up again by Leo XIV in the face of a civilizational crisis. Healing was the public activity of Jesus Christ, for which he was condemned; and healing is the driving force behind all community organizations dedicated to life at all its stages. Healing the world was the challenge of Pope Francis (cf. Social Catechesis, August-November 2020). According to the Social Doctrine of the Church, health is neither a beginning nor an end, but rather a consequence of social justice as its most sophisticated mediation.

Francis expressed this social challenge as Land-Shelter-Work, summarizing in these three words the minimum conditions for a public health system attentive to human dignity. With this, he reoriented community social discernment based on the four fundamental principles of the Church's Social Doctrine: human dignity; universal access to created and developed goods; institutionalized solidarity; and subsidiarity. The organized community of Catholics, which is the Church, attentive to the physical and mental health of all, translated these principles in the 20th century into: public and financial policies; civil, social, labor, and environmental rights; quality education and healthcare; and social programs for integral development.

Catholic representatives from labor unions, chambers of commerce, and organized communities occupy prominent positions in international organizations, promoting decisions that guarantee health in all its dimensions. However, life is in danger. In light of this, *Dilexi Te* confirms that charity is constitutive of Christianity, and with this, reopens the social dialogue on how charity must be practiced: according to the Church's Social Doctrine. Does a healthy life depend on individual charity, or on the mediation of the rule of law? Answering that question from the perspective of social moral theology is key, because Catholicism is more than a religion.

Federico DE MONTALVO J.

Universidad Pontificia Comillas, Spain

BIOSKETCH

Full Professor of Constitutional Law, Universidad Pontificia Comillas-ICADE
Ordinary Member of the Pontifical Academy for Life
ViceChair of the Spanish Association for Health Law
Former President of the Spanish Bioethics Committee (2018-2022)
Former Member of the International Bioethics Committee, IBC-UNESCO (2014-2022)
Member of the Board of the Chair on Bioethics, Universidad Pontificia Comillas
Advisor of the National Office for Scientific Advice, ONAC

ABSTRACT

The Right to Healthcare As a Fundamental Right: When More Can Be Less

The right to health care may be defined as the right to access benefits and services that enable individuals to preserve the highest attainable level of physical and psychological well-being. States are thereby subject to a positive obligation: to establish a public health system. The State cannot guarantee that individuals will be healthy, but it must provide the institutional and material conditions to prevent and treat illness.

This right began to appear in national and international legal instruments with the constitutional development of the social State and it has traditionally been proclaimed as a social right, not a fundamental one.

What are the consequences of this distinction?

Being proclaimed as a social right, it lacks the direct enforceability characteristic of fundamental rights. Right to health care subject to a legislative power of configuration, The right cannot be judicially enforced until it has been regulated and that it may be subject—depending on context—to limitations. This has generated considerable debate, particularly in times of economic crisis, when public authorities feel compelled to adopt measures limiting public expenditure.

This dilemma concerning the nature of the right is also evident in international law, where proclamations of the right to health care are typically accompanied by expressions such as "the highest attainable standard" (International Covenant on Economic, Social and Cultural Rights) or "available resources" (Oviedo Convention). These qualifications implicitly grant States a broad margin of legislative discretion.

Some constitutional systems have contemplated elevating it to the status of a fundamental right, thereby erecting an insurmountable barrier during times of economic difficulties, under which, once a certain level of health protection is reached, no backward steps may be taken under any circumstances.

The present debate is particularly significant because discussions on universal healthcare—healthcare "for all"— also legal considerations. And what is the difficulty in transforming this right into a fundamental right?

One of the principal difficulties lies in the principle of separation of powers. Economic decision-making in democratic systems belongs to the legislative and executive branches. If the right were transformed into a fundamental right, economic decision-making would shift to the judiciary. Courts would then determine healthcare expenditure. Courts are not designed primarily to sanction to compel public authorities to undertake positive actions. Moreover, courts adjudicate individual cases, focusing on their specific circumstances, whereas legislatures and governments adopt decisions from a broader, systemic perspective.

Can the right be protected while maintaining its nature as a social right?

There are enough legal mechanisms without assuming responsibility for economic policy. In particular, courts may employ standards of rationality: the prohibition of arbitrariness and proportionality.

Yvonne DENIER

Catholic University of Leuven
Belgium

BIOSKETCH

Yvonne Denier studied Philosophy and Applied Ethics at KU Leuven. In 2005, she obtained a PhD in Philosophy with a study on justice and priority setting in health care in the context of scarcity.
She has held visiting positions at the *Internationales Zentrum für Ethik in den Wissenschaften* in Tübingen (Germany), and at the *Hastings Center* in New York. From 2007 to 2024, she has been ethics advisor at *Zorgnet-Icuro*, a large umbrella organisation of > 800 Flemish healthcare institutions (hospitals, nursing homes, and mental health institutions), combining her academic work with the practice of health care ethics policy making. She has years of experience in ethics committees and advisory work at local, national (Belgian Advisory Committee on Bioethics), and international level (WHO, Unesco), as section editor of the international journal *BMC Medical Ethics,* as coordinator of the international intensive course on "Justice and Priority Setting in Health Care" at KU Leuven (5 editions), and as board member of various social profit organizations in health and well-being.

In 2011, she became appointed Professor at the Centre for Biomedical Ethics and Law (KU Leuven) where she teaches 'Healthcare Ethics' in the Master's program in Management and Health Care Policy, as well as 'Foundations of Bioethics' and 'Public Health Ethics & Ethics in Public Policy' in the Master of Bioethics. At the Institute of Philosophy, she is in charge of the international elective 'Ethics of Care'. She also supervises health ethics topics within the Best Bet modules of the Master of Medicine. From AY 2025-2026 on, she will also be teaching 'Philosophy of Medicine' for the Bachelor of Medicine at campus KULAK.

She is programme director of the International Advanced Master of Bioethics and co-director (together with Prof. Dr. Raf Geenens) of Ethics@KU Leuven. At the Centre for Biomedical Ethics and Law, Yvonne Denier coordinates the research line *'Social and organizational ethics in health care'*. This research line takes the bioethical reflection, which for a long time has been predominantly focusing on issues in *clinical ethics* (the micro-ethical level) to the level of *organizational* (meso-ethical level) and *social ethics* (macro-ethical level). Currently, her main research and teaching topics are: *ethical leadership and organizational support for ethical behaviour; moral distress in medicine and health care; ethnic-cultural diversity in healthcare practice; ethics of life style and (clinical) nudging; fair treatment of orphan drugs and rare diseases; the ethics of human enhancement; ethical screening and assessment of health technology innovations; ethical decision-making in the context of increasing scarcity of resources.*

ABSTRACT

Efficiency, Justice and Care. Philosophical Reflections on Scarcity in Health Care

By preserving health, by restoring it if possible, and by caring for the patients when cure is not or no longer possible, supporting them and easing their suffering, health care institutions, services and measures have a major impact on human well-being, opportunities and quality of life. They determine the level and distribution of the risk of our getting sick, the likelihood of our being cured and the degree to which others will help us when we become impaired or dysfunctional. As such, health care is a major determinant in the realization of social justice for all, of which fair treatment, equality of access, based on medical need are fundamental cornerstones.

However, it also turned out that contemporary health care has become very sophisticated and expensive. Since the 90's, issues of scarcity, priority setting, and rationing lie at the center of most current debates on justice in health care. These are pressing issues: one way or another, limits have to be set. As such, the question of what is involved in just health care becomes much more complex. This complexity can be represented as an inconsistent triad, a set of three propositions of which any two are compatible but which together form a contradiction. In the case of health care, the three rival values are: economic efficiency, social justice, and decent-quality care. It seems to be that we can have any two but not all three. Essentially, the central question is the following: how

best to square the proverbial welfare circle. How can resources be matched to needs, or needs to resources in decent, fair and feasible ways?
In this lecture, I will attempt to answer the question how health care can be incorporated into a comprehensive theory of justice, while realising an acceptable balance between efficiency, justice and care.

Ezekiel EMANUEL J.

Perelman School of Medicine, at the Wharton School, University of Pennsylvania, USA

BIOSKETCH

Ezekiel J. Emanuel, MD, PhD, is Vice Provost for Global Initiatives and the Diane v.S. Levy and Robert M. Levy University Professor at the University of Pennsylvania. He holds appointments in the Department of Medical Ethics and Health Policy in the Perelman School of Medicine and the Department of Health Care Management in the Wharton School.

Dr. Emanuel is an oncologist and world leader in health policy and bioethics. He is Special Advisor to the Director General of the WHO, Senior Fellow at the Center for American Progress, and a member of the Council on Foreign Relations. He was founding chair of the Department of Bioethics at the NIH. He served as a Special Advisor on Health Policy to the Director of the Office of Management and Budget and National Economic Council. In this role, he was instrumental in drafting the Affordable Care Act. He served on the Biden-Harris Transition Covid Advisory Board.

Dr. Emanuel is the most widely cited bioethicist in history with over 350 publications. He has authored or edited 16 books. His newest book, *Eat Your Ice Cream,* arrives January 6, 2026.

His numerous awards include election to the Institute of Medicine (IOM) of the National Academy of Science, the American Academy of Arts and Sciences, the Association of American Physicians, and the Royal College of Medicine (UK). He received –but refused— a Fulbright Scholarship. He was a Guggenheim Fellow.

He has been named the Dan David Prize Laureate in Bioethics, recipient of the AMA-Burroughs Wellcome Leadership Award, the Public Service Award from the American Society of Clinical Oncology, Lifetime Achievement Award from the

American Society of Bioethics and Humanities, Robert Wood Johnson Foundation David E. Rogers Award, President's Medal for Social Justice Roosevelt University, the John Mendelsohn Award from the MD Anderson Cancer Center and recipient of the Patricia Price Browne Prize in Biomedical Ethics.

Dr. Emanuel received honorary degrees from Icahn School of Medicine at Mt. Sinai, Union Graduate College, Medical College of Wisconsin, and Macalester College.

Dr. Emanuel earned an MD (1988) and PhD in political philosophy (1989) from Harvard University, an MSc in biochemistry from Oxford University (1981), and BA in chemistry from Amherst College (1979).

ABSTRACT

Designing High Functioning and Universal Healthcare Systems. What the US, China and Other Countries Can Teach Us

Five goals characterize all well-functioning health care systems:

1. **Universal Coverage and Access**

- Auto-enrollment so individuals do not have to initiate action to be covered
- No added premiums, out-of-pocket payments, or other costs for children
- Allow private health care as long as it does not syphon off access to providers and facilities from those in the public system—use funds from the private system to augment the public, universal system

2. **Reasonable Costs**

- Country should have a defined and hard total health care budget that is linked to GDP per person
- Low out-of-pocket payments, at a maximum of no more than 2% of average household income
- No out-of-pocket payments for primary care or children's care
- Out-of-pocket costs should be able to cover all payments for physicians, health center visits, hospital stays and drug costs without forcing families into "medical debt"
- Country should have one budget funding primary care and a separate one for specialist and hospital care

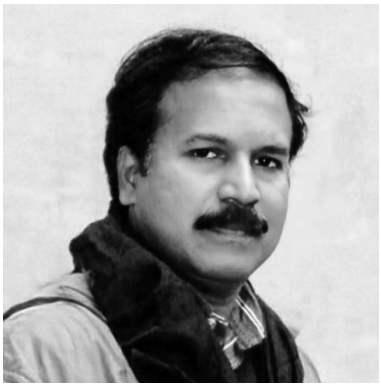
3. **High Quality of Care**
- Recognize biggest improvements in health by targeting children's conditions
- Target most prevalent health problems—e.g. maternal and neonatal/infant conditions, diarrheal diseases, malaria, hemorrhagic stroke, diabetes [Dean T Jamison et al., "Global Health 2050: The Path to Halving Premature Death by Mid-Century," *The Lancet* 404, no. 10462 (2024): 1561–614, https://doi.org/10.1016/S0140-6736(24)01439-9]
- De-emphasize hospital-focused care and emphasize home and community care
- Create and disseminate standardized protocols for common health problems
- Collect and publish standardized data on all outcomes by providers and facilities
- Expand use of AI to facilitate patient access to primary care and ensure care is guideline concordant

4. **Reducing Disparities**
- Focus care expansion on the poor and those in rural areas who are often excluded

5. **Satisfaction**
- Focusing on universal access, minimizing out-of-pocket payments—especially for drugs, primary care access, and children's health care—will produce satisfaction

Two overarching operational principles are associated with the best health care systems: **simplification** and **standardization**. Simple systems are cheaper and allow fewer opportunities for corruption and gaming.

Finally, remember health care accounts for only 10-20% of health outcomes [Five Plus Five," *NAM Perspectives* 7, no. 10 (2017), https://doi.org/10.31478/201710c]. Improvements to the environment should be emphasized through alcohol and sugary beverage taxes, sanitation, provision of nutritious foods, improvements to reduce road accidents, more education, and other structural interventions.



Gifty IMMANUEL

Center for AIDS and Antiviral Research, India

BIOSKETCH

Dr. Gifty Immanuel is a physician-scientist in human virology and global health. He currently directs the Center for AIDS & Antiviral Research in India.

He is a graduate of Harvard Medical School with an MS in bioethics related to infectious diseases. He also holds a PhD in Virology from M.S. University, India, and an MD from Our Lady of Fatima University, Philippines. In addition to his diploma in vaccinology from the Pasteur Institute in Paris, he holds an MSt in theology from Cambridge University.

He has several years of experience in clinical management, research, and the prevention of emerging viral diseases. He is an elected fellow of the Infectious Diseases Society of America and a fellow of the Faculty of Public Health, Royal College of Physicians, UK.

ABSTRACT

Prevention and Education

The WHO defines prevention as a population- or individual-based strategic intervention to minimize the burden of disease and its related risk factors. To attain the salient goal of health care for all that is sustainable and equitable, robust investment in the arena of prevention is essential. Prevention has to be supplemented by rigorous public health education as a tool in health promotion. Prevention is central to global wellness and plays a crucial role in ensuring a healthier future. Prevention should not be viewed only as a medical strategy to provide uniform health care but also as a moral imperative that strengthens the moral fabric of global society.

In addressing global health challenges, prevention encompasses five levels of disease control and mitigation. These interventions include primordial, primary, secondary, tertiary, and quaternary prevention. Within the global burden of diseases, 50% of deaths due to non-communicable diseases are preventable. According to the WHO, effective infection control and prevention strategies can prevent 70% of communicable diseases. In an era of poly-crises, health education and enhanced preventive approaches can reduce disease burden significantly. Transition to sustainable health care requires a multifaceted approach, including education, training, and teaching essential preventive skills.

Prevention remains the capstone of a healthy society. Health literacy through education bridges the gap between understanding complex prevention information and implementing it effectively. Lack of health literacy is a barrier to advancement and the practice of public health. Integrating health education and training is a strategic step in ensuring sustainability and equity.

David JONES

St. Mary's University, UK

BIOSKETCH

David Albert Jones is Professor of Bioethics at St Mary's University, Twickenham, Clinical Professor at the Plunkett Centre for Ethics, Australian Catholic University, and Fellow at Blackfriars Hall, Oxford University (courtesy of whom, profile picture above).

Professor Jones read Natural Sciences and Philosophy at Cambridge, and Theology at Oxford. His doctorate, which focused on the thought of Augustine and Thomas Aquinas, was published as *Approaching the End* (Oxford University Press, 2007). Other publications include *The Soul of the Embryo* (Continuum, 2004) and *Euthanasia and Assisted Suicide: Lessons from Belgium* (Cambridge University Press, 2017, co-edited with Chris Gastmans and Calum MacKellar) in addition to numerous book chapters and journal articles, most recently Slippery slopes down under: the progressive loosening of requirements for voluntary assisted dying in Australia and New Zealand *New Bioethics* November 2025.

In addition to being a Corresponding Member of the Pontifical Academy for Life, Professor Jones is also a member of the Commission of the Bishops' Conferences of the EU (COMECE) Commission on Ethics. In 2009 he was a member of a working party of the General Medical Council which helped draft its guidance on *Treatment and Care Towards the End of Life*. He served as Vice-Chair of the Ministry of Defence Research Ethics Committee from 2009-2024 and, while not formally a member, regularly attended the Moral and Ethical Advisory Group (MEAG) that provided independent advice to the UK government on moral, ethical and faith considerations during COVID (2019-2022). He has provided oral or written evidence to parliamentary, non-governmental, professional and regulatory bodies on over 100 occasions, both in the UK and internationally.

ABSTRACT

Challenging Areas: Elderly

On average, older people have a greater need for healthcare. This creates a challenge for sustainability because of the rising number of older people and a challenge for equity, in that healthcare systems often discriminate against older people.

A root cause of this discrimination is fear. First there is fear of the increasing number and proportion of the population who are older. Then there is fear that modern medicine is extending life indefinitely without adding to quality of life. Behind this is a deeper fear of the decline that can accompany old age, especially loss of independence, loss of bodily control, and most fearful of all, loss of mental capacity. Finally, there is an unacknowledged fear of death. This leads, paradoxically, to calls for medicine to take control of death by intentionally taking life.

Our response to these interrelated fears must be a narrative of hope, the possibility of flourishing even as we decline. This has been called 'graceful senescence'. Ill-health and the requirements of healthcare may impede us from expressing our human dignity and may impede others from showing respect as they would wish. Nevertheless, these constraints can make remaining tokens of respect all the more significant.

It is harder to think what flourishing and grace might mean with dementia. This will involve valuing the memories that remain and expressing habits that embody what we value, such as repetition of familiar prayers or hymns.

Decline involves loss. Nevertheless, in every phase of life, while flourishing involves activity, the Christian life also involve stripping away, dying to self.

If we have hope for ourselves and those we love in old age, accepting the reality of decline and of death while seeking to support flourishing to the end, then equity and sustainability in the healthcare of older people will follow.

Olga Melanie LOMPO

Centre Hospitalier Universitaire Yalgado Quédraogo,
Burkina Faso

BIOSKETCH

Prof. Olga Mélanie LOMPO is a Full Professor of Pathological Anatomy at Joseph KI-ZERBO University and a practicing physician at YALGADO OUEDRAOGO University Hospital in Ouagadougou, Burkina Faso.

She obtained her State Doctorate in Medicine in 1994 from Joseph Ki-Zerbo University. She specialized in Anatomical and Cytopathology at the University of Cocody in Côte d'Ivoire, and subsequently at the University of Nice in France.

Head of the Laboratory of Morphology and Organogenesis at the Doctoral School of Sciences and Health, she also holds the Chair of Research and Action Against Cancer (ReAAC/ORTARChI Chair). Her publications (with more than 400 citations) attest to her scientific impact, particularly in cancer research.

She serves in numerous national and international institutions, including: President of the Francophone Africa Division of the International Academy of Pathology; Special Advisor to the Minister of Higher Education, Research and Innovation; State Representative Administrator on the Board of Directors of CHU-Pala; and member of the National Catholic Bioethics Committee (CNBC).

She is a Dominican Laywoman of the Saint Thomas Aquinas Dominican Lay Fraternity and serves as Assistant Chaplain at Saint Dominique University in West Africa

ABSTRACT

Chatholic Hospitals in Sub-Saharan Africa: Identity, Humanization of Healthcare Facilities, and Contemporary Challenges

Catholic hospitals in sub-Saharan Africa (SSA) represent a historical pillar of healthcare systems, particularly in rural and peri-urban areas where public services remain insufficient. They provide primary care for vulnerable populations. Their identity is based on the values of human dignity, solidarity, and holistic care, translated into a holistic and community-based approach. This approach prioritizes both prevention and treatment, ensures continuity between urban and rural care, and places the individual at the centre of a coordinated pathway encompassing primary healthcare, hospital services, and home-based follow-up.

This vision engages with traditional African understandings of illness, which is conceived as a bodily, social, and spiritual phenomenon. Healing involves the extended family, elders, and community networks, while also integrating traditional practices when appropriate. Humanizing healthcare relies on listening, empathy, compassion, calming environments, and ethical training, placing the patient at the centre.

These pathways involve community health workers, local healers, and participatory prevention, strengthening trust and treatment adherence. However, this model faces significant challenges: chronic underfunding, limited infrastructure, and a shortage of qualified staff. Heavy reliance on donations and international partners creates a persistent financial vulnerability, exposing Catholic hospitals to external risks and threatening the sustainability of services.

To strengthen their role, Catholic hospitals must promote self-financing, diversify their resources, invest in local training, modernize infrastructure, and consolidate lasting partnerships with authorities and communities, thereby guaranteeing equitable access to care and the sustainability of essential services.

Our intervention is structured around three main areas:

- Catholic hospitals in sub-Saharan Africa: Current situation and identity,
- Challenges facing Catholic hospitals in sub-Saharan Africa,

Vision for patient care in sub-Saharan Africa.

Mariana MAZZUCATO

University College London, UK

BIOSKETCH

Mariana Mazzucato (PhD, CBE) is Professor in the Economics of Innovation and Public Value at University College London (UCL), where she is Founding Director of the UCL Institute for Innovation & Public Purpose. She is winner of international prizes including the Grande Ufficiale Ordine al Merito della Repubblica Italiana in 2021, Italy's highest civilian honour, the 2020 John von Neumann Award, the 2019 All European Academies Madame de Staël Prize for Cultural Values, and 2018 Leontief Prize for Advancing the Frontiers of Economic Thought. She is a member of the UK Academy of Social Sciences (FAcSS) and the Italian Academy of Sciences *Lincei*. In 2025, she was appointed Commander of the British Empire (CBE) for services to economics in the King's Birthday Honours List. Pope Francis appointed her to the Pontifical Academy for Life for bringing 'more humanity' to the world.

Her award-winning books include: The Entrepreneurial State: debunking public vs. private sector myths (2013 The Value of Everything: Making and Taking in the Global Economy (2018), Mission Economy: A Moonshot Guide to Changing Capitalism (2021), and The Big Con: How the Consulting Industry Weakens our Businesses, Infantilizes our Governments and Warps our Economies (2023). She advises policymakers around the world on innovation-led inclusive and sustainable growth. Her policy roles include: Chair of the World Health Organization's Council on the Economics of Health for All, Co-Chair of the Global Commission on the Economics of Water, member of the South African President's Economic Advisory Council, Co-Chair of the Group of Experts to the Brazilian 2024 G20 Task Force for the Global Mobilization against Climate Change, and

Special Representative of President Ramaphosa to the 2025 G20 Taskforce 1 on Inclusive Economic Growth, Industrialization, Employment, and Reduced Inequality.

ABSTRACT

The Economics of Health for All

For decades, economic policy has treated health as a cost to be contained or as a by-product of economic growth. The COVID-19 pandemic, accelerating climate breakdown and widening inequalities, laid bare the profound limits of this model.

Drawing from the Common Good and Mission Economy, and work as Chair of the WHO Council on the Economics of Health for All, Professor Mazzucato argues that health and wellbeing must become the explicit goals of economic policy and the guiding principle for how economies are designed, financed, and governed.

Pope Francis, in his closing speech at The Economy of Francesco, spoke of the importance of changing dominant economic mindsets for new visions and models. In 2024, Prof Mazzucato convened a historic dialogue at the Vatican with Pope Francis, to make the case for a fundamental reimagining of economics to serve the common good.

The common good offers a useful framework both for setting shared goals and for working out how to achieve them. Indeed, one big lesson from COVID-19 was that unless economic activity – such as the development of vaccines – is governed for the common good, many people remain excluded from its benefits. The common good offers opportunities to promote human solidarity, knowledge sharing, and collective distribution of rewards.

The Council's full report details four main pillars. Health should be both a core collective and economic objective, not a by-product of growth. Achieving this requires rethinking what societies value and measure (**MEASUREMENT**), moving beyond the GDP towards metrics that capture health, equity, and sustainability. It also demands reframing health financing from short-term cost to long-term investment (**FINANCE**).

Central to this agenda is the role of the public sector (**CAPACITY**). Building the capacity of governments to steer innovation (**INNOVATION**), shape markets, and govern public–private partnerships is essential to ensure that publicly supported innovations are accessible, affordable, and governed in the public interest, with risks and rewards fairly-shared.

John NKENGASONG

Higher Education, Collaboratives and Special Initiatives, Mastercard Foundation, Camerun

BIOSKETCH

Ambassador John N. Nkengasong is a distinguished virologist and global health leader with over 30 years of experience in public health. Currently, he is Executive Director for Higher Education at the Mastercard Foundation, overseeing the higher education and health workforce development portfolios. Previously he was the U.S. Global AIDS Coordinator and the Senior Bureau Official for Global Health Security and Diplomacy (GHSD), leading U.S. efforts to strengthen global health security and manage infectious diseases, including HIV/AIDS.

He was the founding Director of the Africa CDC, where he established it as a key autonomous health agency and coordinated Africa's COVID-19 response, securing vaccines for the continent.

He held critical roles at the U.S. CDC and contributed extensively to global health diplomacy. He holds a B.Sc. from the University of Yaoundé, an M.Sc. from the Institute of Tropical Medicine in Antwerp, and a Ph.D. from the University of Brussels, and leadership training certification from Harvard's Kennedy School. Recognized among Time's 100 Most Influential People in 2021, Ambassador Nkengasong has received numerous awards, including the Virchow Prize for Global Health. He is a member of the National Academy of Medicine and the Vatican Pontifical Academy of Life.

ABSTRACT

Challenging Areas: Epidemics

Global health was founded on the aspiration to improve health for all people, yet persistent inequities continue to undermine this mission. While the field has evolved—from colonial tropical medicine to a complex, interconnected system—structural disparities in access, outcomes, and power remain defining challenges. The contrasting experiences of HIV/AIDS and COVID-19 offer compelling illustrations of how inequity shapes global health trajectories.

HIV/AIDS exposed the devastating consequences of unequal health systems, weak economic resilience, and delayed international response. Countries in sub-Saharan Africa experienced catastrophic loss of life, dramatic reductions in life expectancy, and significant GDP decline before 2003. Yet the HIV response also demonstrates what is possible when political leadership, scientific evidence, community activism, and global solidarity converge. Initiatives such as PEPFAR and the Global Fund catalyzed a historic scale-up of treatment and prevention, contributing to steep declines in new infections and deaths. These successes highlight that targeted, well-governed investment can reverse inequity.

COVID-19, however, revealed that global health inequities persist despite decades of progress. High-income countries secured most of the early vaccine supply, while many African nations waited months or years for adequate access. This disparity underscored vulnerabilities in global supply chains, the concentration of manufacturing capacity, and geopolitical competition. Efforts such as building vaccine production facilities in Senegal represent promising steps toward regional health sovereignty, but the pandemic exposed deep systemic gaps.

Together, HIV and COVID-19 show that inequity is neither accidental nor inevitable—it is the result of governance failures, skewed financing, misinformation, and uneven political will. A new global health order is needed: one that embeds equity, decentralizes capabilities, strengthens regional institutions, and aligns national interests with genuine global solidarity. Only then can the promise of global health—health for all—be realized.

John Y. RHEE

Neuro-oncology & Palliative Care
Dana Farber Cancer Institute
Harvard Medical School,
USA

BIOSKETCH

Dr. John Y. Rhee, MD MPH, is a neurologist, neuro-oncologist, and palliative care specialist at Dana-Farber Cancer Institute and Instructor of Neurology at Harvard Medical School.

He completed neurology residency and chief residency at Mass General Brigham and received his MD/MPH with Distinctions from the Icahn School of Medicine at Mount Sinai, where he was a Dean's Scholar in Global Health. He is an Affiliated Faculty Member of the Harvard Medical School Center for Bioethics, where he teaches a course on narrative ethics.

His research focuses on large language model applications and genomic analysis to better understanding symptom pathophysiology and burden in neuro-oncology, and supportive care interventions in brain tumor patients. His work is supported by the Department of Defense and the American Academy of Neurology. He is a Young Member of the Pontifical Academy of Life, Vatican City, and is Executive Director, Vice Chair, and co-founder of the Hippocratic Society.

ABSTRACT

Challenging Areas: Elderly (Young Members Group)

As of 2020, over 55 million people worldwide are living with dementia, and projections indicate that this will double every 20 years with the aging population. People living with cognitive impairment (PLCI) face unique challenges navigating their daily activities of living and have a greater dependency on those around them.

In this article, we attempt to answer the question as to whether PLCI can still practice virtue. We frame this through a lens of embodiment and dependency informed by an Aristotelean account of hylomorphism. We find in his notions of embodied memory and the moral ecosystem of the polis two ways of understanding how PLCI can still practice virtue.We additionally explore this idea through the works of Alasdair McIntyre, to show how PLCI uniquely contribute to the polis through their radical dependency and vulnerability. We supplement this with recent understanding of bodily or cellular memory as well as disorders of consciousness. Lastly, we acknowledge that even patients with advanced dementia may have moments of lucidity that may allow for inner growth and change, even if not readily evident to an observer. We conclude with some practical considerations of such an argument.

Walter G. RICCIARDI

Catholic University of the Sacred Heart,
School of Medicine,
Italy

BIOSKETCH

Full Professor of Hygiene at the Faculty of Medicine and Surgery and Director of the School of Specialization in Hygiene and Preventive Medicine at the Università Cattolica del Sacro Cuore (Rome).

President

- of the Mission Board for Cancer of the European Commission;
- of the Scientific Committee of the Human Technopole Foundation;
- of the Mission Board for Vaccination in Europe;
- of the Scientific Committee of BBMRI-ERIC.

Co-Director of the World Health Organization Leadership Academy – WHO Regional Office for Europe.

Leading Editor of the *Oxford Handbook of Public Health Practice*.

Associate Editor of the *European Journal of Public Health*.

Member of the Pontifical Academy for Life, Vatican.

ABSTRACT

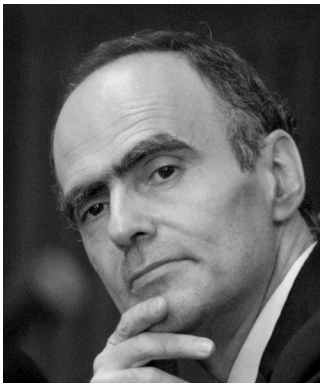
Sustainability of Healthcare Systems from Political Perspective

Sustainability of healthcare systems has become a central political challenge, shaped by demographic transitions, rising chronic diseases, technological innovation, and uneven resource distribution. From a political perspective, sustainability is not solely a financial issue; it is fundamentally about governance, equity, and societal priorities. Governments face increasing pressure to balance universal access with fiscal constraints and growing expectations for personalized, high-quality care. This tension has positioned healthcare as a strategic pillar within broader welfare-state reforms, requiring new policy instruments and long-term planning frameworks.

Politically sustainable health systems depend on effective stewardship, cross-sectoral policies, and adaptive regulatory mechanisms. Population ageing, climate change, and economic volatility require systems capable of anticipating future demand rather than reacting to crises. Political leadership must therefore integrate health in all policies, promote prevention and digital innovation, and strengthen primary care to shift focus from hospital-based, reactive treatment to community-based, proactive care. The role of public–private partnerships and alternative financing models is expanding, yet remains politically contested due to concerns about equity, accountability, and democratic legitimacy.

Moreover, healthcare sustainability intersects with global justice. International disparities in access, pharmaceutical pricing, and workforce mobility reflect geopolitical power relations. Political action must address these systemic inequalities through global governance reforms, resilient supply chains, and ethical frameworks for artificial intelligence and biotechnology.

Ultimately, achieving sustainability requires political commitment to both intergenerational fairness and social cohesion. A sustainable healthcare system is one that maintains financial viability, protects vulnerable populations, supports health workforce wellbeing, and ensures continuity of care in the face of environmental and socioeconomic disruptions. Without strategic political vision and collaborative governance, healthcare systems risk becoming financially strained, socially fragmented, and unable to fulfill their foundational promise of universal, equitable, and high-quality care.



Stefano SEMPLICI

Tor Vergata University,
Italy

BIOSKETCH

Stefano Semplici is a professor of Social Ethics and Bioethics and a member of the Faculty of the Ph. D in Philosophy at Tor Vergata University of Rome. He is a member of the Italian Committee for Bioethics and was the Chair of the International Bioethics Committee of UNESCO (where he was appointed in 2008) from 2011 to 2015 and of the Committee for Bioethics of the Italian Society of Pediatrics from 2014 to 2019.

He is an Associate Editor of the journal «Medicine, Health Care and Philosophy» (since 2010) and was Editor and then Co-editor of the Journal «Archivio di Filosofia/Archives of Philosophy» from 2007 to 2016. He is also a corresponding member of the Pontifical Academy for Life, a member of the steering committee of the Institute for philosophical studies "Enrico Castelli", and of the Editorial Boards and the scientific committees of other institutions, journals, and series. In 2023 he published the book Etica post-pandemica.

ABSTRACT

Fundamental Rights and Justice

Already in the Declarations of the two great revolutions of the eighteenth century, human rights were founded on the recognition of the equality of all human beings. The recognition of their equal dignity in the 1948 Declaration clarified the more profound moral significance of that first move, strengthening its normative scope: the life and liberty of every individual are a good to be respected, protected, and allowed to flourish to the full extent of their potential. This is why social rights (healthcare, education) are as fundamental as civil and political rights.

The reference to human rights is essential in all the most influential theories of justice, albeit with varying roles. The capabilities approach does not contradict the rights-based approach, but instead offers a solution to the problem of the difference between negative and positive rights, between first- and second-generation rights: Martha Nussbaum's list of fundamental capabilities opens with life and health.

The rights that came "before" are often a battleground rather than a catalyst for shared commitment and responsibility. These rights remain fundamental. However, emphasizing the importance of what came "after" in the history of human rights (looking at the social determinants of health and many other basic goods) could be the most effective way today to continue defending the thesis that it is morally and politically imperative to care for the foundations of the "common human". The history of the Catholic Church, up to *Dignitatis Humanae*, is the story of a problematic relationship with civil and political rights. This difficulty has not prevented it from playing a pivotal and even pioneering role with respect to economic and social rights. Continuing to promote these rights means serving the cause of global justice (and bioethics).

William SULLIVAN

Georgetown University School of Medicine, USA

BIOSKETCH

Dr. William F. Sullivan is a family physician with a Ph.D. in Philosophy. Since 2007, Dr. Sullivan has served as an Ordinary Member of the Pontifical Academy for Life. Since 2023, he has held the Joseph P. Kennedy Sr. Chair in Bioethics at the Kennedy Institute of Ethics, Georgetown University, Washington, D.C., USA.

Dr. Sullivan is also a Professor in the Department of Family Medicine, Georgetown University School of Medicine. He is the founding director of the Canadian Catholic Bioethics Institute at the University of St. Michael's College, Toronto, Canada and of the International Association of Catholic Bioethics. Dr. Sullivan's clinical and scholarly focus is on elucidating, practicing, and teaching an approach to health care and ethics, especially with people with intellectual and developmental disabilities, guided by a foundational philosophy.

ABSTRACT

Challenging Areas: Disability and Mental Health

The most basic challenge to the mental health care of people living with disabilities is that these members of our community are doubly disadvantaged: first, because of disparities that people with disabilities often experience in receiving health care adapted to their needs, and second, because mental health care is typically poorly resourced in comparison to physical health care. This two-fold disadvantage is compounded when we consider that, globally, 90% of people with disabilities live in countries where healthcare resources are scarce.

Such disparities ought to be justly addressed. While awaiting large-scale and long-term system changes, however, are there some practical approaches to mental health care and promotion that can meet the health needs of people with disabilities? Can such approaches be implemented sustainably across diverse international contexts? What ethical foundations ought to guide such care?

I will first propose the need for a relational view of health and disability, one that considers human development and flourishing integrally. This reframes mental health care of people with disabilities as promoting positive relationships in which people with disabilities are loved and their capabilities for deciding wisely are affirmed and supported. It also prioritizes mitigating abusive and other such negative relationships.

Secondly, I propose a *method* for deciding ethically that is based on human capabilities that we can affirm in ourselves and support in one another. Such a method will involve people with disabilities in helping to identify and attain concrete possibilities for developing, adapting, and flourishing integrally in safe, supportive, and loving environments, even when health needs are complex and healthcare resources are scarce.

Masahiko TANIGUCHI

St. Mary's Hospital, Japan

BIOSKETCH

Masahiko Taniguchi, MD, FACS is Director of St. Mary's Hospital, a Catholic tertiary-care hospital and regional medical core center in Japan. He is a transplant surgeon specializing in liver and kidney transplantation, with expertise in hepatobiliary surgery. Dr. Taniguchi received his surgical training in Japan and further advanced his clinical and academic experience at the University of Colorado, Division of Transplantation.

Under his leadership, St. Mary's Hospital has strengthened emergency and perinatal care, disaster medical assistance both within Japan and internationally, and international medical cooperation, particularly in collaboration with partners in Asia and Africa. Guided by Catholic social teaching, his work emphasizes equitable and sustainable healthcare, solidarity with vulnerable populations, and respect for human dignity.

ABSTRACT

Japanese Perspective

Japan established its universal health insurance system in 1961, becoming one of the earliest countries to institutionalize the principle of "healthcare for all". This system has ensured equitable access to medical services, contributed to social stability, and provided the foundation for Japan's achievement of the world's longest life expectancy. At the same time, rapid population aging, continuously rising healthcare expenditure, and increasing burdens on healthcare professionals

have exposed structural challenges, raising serious concerns about the sustainability of the universal health insurance system.

This presentation provides an overview of the current state of Japan's healthcare system and examines both the achievements and challenges of universal health insurance—its "bright side and dark side". While the system has successfully promoted universality and equity, it also faces significant structural constraints, including financial pressures and shortages of human resources. These factors underscore the growing complexity of healthcare system design in a super-aged society.

Against this backdrop, the presentation highlights several approaches that characterize Japan's ongoing response to these challenges, including the development of integrated systems spanning healthcare and long-term care, medical digital transformation (DX), work-style reform for healthcare professionals, strengthened regional collaboration, and multidisciplinary team-based care. Through these perspectives, the presentation discusses how Japan's experience may offer practical and ethical insights to the international community.

In conclusion, Japan, as a country that is "experiencing the future" of a super-aged society one step ahead of other countries, bears a responsibility to share with the global community a model of healthcare that is sustainable, equitable, and firmly centered on human dignity. Grounded in Catholic values, St. Mary's Hospital has pursued healthcare practice guided by these principles and, through its continuing journey, stands as a witness to equity, solidarity, and respect for human life.

Sheila TLOU

Botswana Open University, Botswana

BIOSKETCH

Prof. Sheila Tlou is former Co-Chair of the Global HIV Prevention Coalition, Special Ambassador for African Leaders Malaria Alliance, Chancellor of Botswana Open University, Champion of the Nursing Now Challenge, Trustee to Board of Florence Nightingale Foundation, Member of the Board of Trustees of Society for AIDS in Africa, and Advisory Board member for Harvard Global Nursing Leadership Program.

She is former UNAIDS Regional Director and former Minister of Health of Botswana, Professor Emerita of the University of Botswana and former Director of the WHO Collaborating Centre for Nursing and Midwifery Development in Primary Health Care. She holds a PhD in Nursing from the University of Illinois at Chicago and has received over 30 international awards for Leadership in Global Health Equity.

ABSTRACT

Health for Africans: Achievable and Sustainable?

Sub-Saharan Africa is the region with the highest neonatal mortality rate at over 26 deaths per 1, 000 live births. This is far more than the Sustainable Development Goal of reducing preventable deaths of newborns and children under 5 to 12 deaths per 1,000. Leading causes of mortality include premature births, birth complications, congenital abnormalities, and infections, including HIV and Malaria. Despite this health status, there has been a steady decline in mortality rates, all attributed to overall improvement of healthcare services, better nutrition,

access to safe water and sanitation as well as improved immunization. services. If the current trend continues, better infant health is achievable. However, for sustainability, efforts to reduce infant mortality must focus on improving access to overall quality health care, skilled birth attendance and essential maternal and childcare.

Addressing the leading causes of death through targeted interventions can significantly improve survival rates for infants in Africa. Better child health is achievable, and good results can be sustained if driven by strong political will and commitment by leaders in collaboration with communities and development partners. Domestic financing and resource mobilization is critical, coupled with shared responsibility and global solidarity for a health- secure world.

Gert VAN DER WILT

Radboud University Medical Center, The Netherlands

BIOSKETCH

Gert Jan van der Wilt was professor and head of the department of Health Technology Assessment (HTA) at Radboud University Medical Centre in Nijmegen, the Netherlands.

His main research interest is the methodology of researching ethical issues in the context of HTA, with a focus on the interplay between facts and values. He has served on the scientific advisory committee of the Ludwig Boltzmann Institute for HTA (Vienna) and the National Appraisal Committee of the Netherlands.

ABSTRACT

Emerging Technologies in Healthcare Systems

We know, by and large, what novel technologies are currently being adopted in our healthcare systems. Many of those technologies involve some form of Artificial Intelligence (AI). For instance, current developments in human genome sequencing would be impossible in the absence of the unprecedented analytic and computational capacities of current AI. Similarly, developments in automated analysis of medical images would have been impossible in the absence of AI's vast potential for learning, achieving ever more accurate relations between input (the pixels) and output (a medically relevant interpretation of the data).

We also know, by and large, what the performance of those novel technologies is in terms of achieving specified goals such as more accurate diagnoses or more effective control of cancer.

We know much less, however, about the impact of those technologies on our striving to create and maintain a humane healthcare system. This is not due to the fact that relevant analyses are not being conducted. Rather, it results from the fact that such analyses are increasingly fashioned in accordance with a techno-scientific model, comprising specification of moral principles and critical appraisal of relevant empirical evidence. Following the American philosopher, Cora Diamond, I will argue that although such an approach is wide-spread, it does incur the risk of missing something crucially important.

In my paper, I will elaborate this suggestion and specify what it is that we might be missing when we restrict ourselves to prevailing modes of analysis. I will discuss Diamond's concept of ethics and the role of imagination in moral thought. Using a concrete case study I will explore some implications of adopting Diamond's model for the assessment of health technologies.

Robert VITILLO

Dicastery for Promoting Integral Human Development,
Holy See

BIOSKETCH

A national of the United States of America, Msgr. Vitillo is a Roman Catholic priest and a trained social worker with broad expertise in the fields of global health, migration and refugee services, child protection, mental health, social services and human rights.

He previously served as Director of the Catholic Charities agency in the Roman Catholic Diocese of Paterson, New Jersey; in several capacities at Caritas Internationalis, both in Vatican City and in Geneva, Switzerland; as Executive Director of the Catholic Campaign for Human Development at the United States Conference of Catholic Bishops; as Attaché for Health at the Mission of the Holy See to the United Nations and Specialized Agencies in Geneva, and Secretary General of the International Catholic Migration Commission.

He now serves as Senior Advisor for the Research and Reflection Section of the Vatican's Dicastery for Promoting Integral Human Development.

ABSTRACT

Challenging Areas: Migrants

The speaker will review the most recent statistical reports on the numbers of migrants in all parts of the world, with special emphasis on the situation of "forced migrants." He then will focus on "Myths and Realities" related to the health of migrants. "Welcoming the Stranger", as both a religious and civic value will be cited. Catholic Church Teaching and Tradition in response to the needs of migrants

and promotion of their integral human development, in particular their achievement of the right to health care will be reviewed. The Magisterium of recent Pontiffs will be considered, especially that of the late Pope Francis and of Pope Leo XVI. Finally, some suggestions for increased action by the Catholic Church in response to health care needs of migrants will be proposed.

List of Selected Posters

Artificial Intelligence, Algorithms and Health Inequalities
C. Lemos, Faculty of Medicine of the University of Lisbon, Portugal

Augmentative and Alternative Communication (AAC) as a Tool for Equity: Communication, Understanding and Care Involvement in Paediatric Patients with Complex Communication Needs (CCN) and/or Cognitive Deficits in a Dental Setting.
C. Gallo et al., UOSD Community Dentistry, PO Piove di Sacco, AULSS6 Euganea, Italy

Can Healthcare Be Sustainable and Equitable Under Conditions of Exhaustion?
Y. Jin, Committee for Life, Archdiocese of Seoul, Republic of Korea

Challenges of Sustainability and Equity of the Hospital Spiritual Care – A Central European Country (Slovakia) Perspective
J. Glasa et al., Slovak Medical University in Bratislava, Slovakia

Childhood Socioeconomic Disadvantage and Adult Multimorbidity: A Systematic Review and Meta-analysis
P. Broadbent et al., School of Health & Wellbeing, University of Glasgow, United Kingdom

Deuil et Rites dans la Region de l'Ouest Cameroun – Cas du Village Bamendou: Levier ou frein a l'accès aux Soins de santé.
F. Kenfack Jiofackt et al., CNA/YBS, CEO HORSI et Coordinator du RASPAC, Bamendou, Cameroun

Emergenza Sorrisi in Burkina Faso al fianco dei Frati Francescani Minori
F. M. Abenavoli, Emergenza Sorrisi – Doctors for Smiling Children (NGO) – Roma, Italy

Ensuring Equitable Healthcare Access and Sustainability in an Aging World
P. Kordowitzki, Nicolaus Copernicus University, Torun, Poland.

Equitable and Sustainable Access to Advanced Therapies
M. García García, CEU San Pablo University, Madrid, Spain

Faith and Public Health Leadership Dialogue in Service of "Health for All": Evidence and Lessons from Jerusalem
I.Schenker, Impact Vaccination Initiative, Jerusalem

Healthcare for All: Brain Health, Vulnerability, and the Intergenerational Grammar of Care
M. R. Romano, Pontifical University of Southern Italy

Investing in Prevention for Sustainable and Equitable Health Systems: The Role of Digital Transformation
M. Viceconti et al., Department of Industrial Engineering, Alma Mater Studiorum - University of Bologna, Italy

Living Long, Living Unseen: Ethical Challenges of Chronic Disease in Sustainable and Equitable Healthcare
B. Gabric, Lehrstuhl für Theologische Ethik – Moraltheologie, Julius-Maximilians-Universität Würzburg, Germany

"Our Suffering Neighbor": Catholic Health Care & A Moral Obligation to Address Oral Health
S. A. Shibu, Ethics at CHRISTUS Health, Irving, Texas, USA

Predictors of intraoperative blood transfusion in elective surgeries at Different Hospitals of Addis Ababa, Ethiopia. A multi-center Cross-sectional analytical study
Y. D. Denberu et al., Department of Anesthesiology Critical Care and Pain Medicine, College of Health Sciences, Addis Abeba University, Ethiopia

Priority of Vaccination of the Population: Moral and Religious Principles
T. Rashi, Ariel University, Israel


PONTIFICIA | PRO
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