



## OUR POSITION

# Safe and responsible use of Artificial Intelligence across the care economy

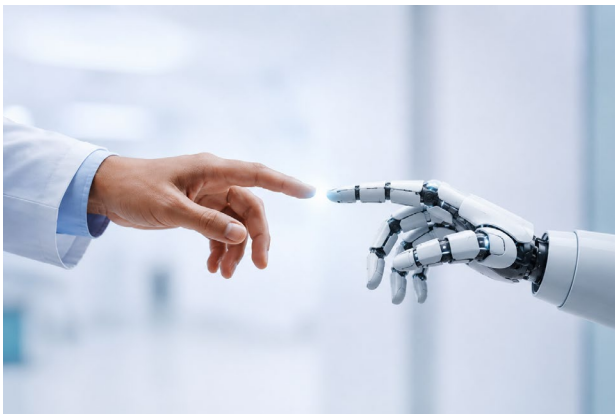
### BACKGROUND

Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, community, and aged care providers. Our members operate over 90 hospitals in each Australian state and in the Australian Capital Territory, providing around 30 per cent of private hospital care and 6 per cent of public hospital care, in addition to extensive community and residential aged care. CHA Members also provide approximately 13 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care services.

CHA not-for-profit health, community and aged care providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care. CHA champions reforms aligned with the healing ministry of Christ and the work of Catholic congregations around the country.

The aim of our position statements is to outline CHA's policy and advocacy priorities on key issues that are essential to the mission and values of its members.

A more in-depth analysis of our policy positions is available through our government submissions.



### POSITION

Artificial intelligence (AI) is rapidly emerging as a transformative technology across Australia's healthcare system. Applications of AI now span the full care continuum, from ambient AI scribes in primary care, to AI-powered imaging tools in cancer diagnostics, and predictive algorithms in complex surgical planning.

Operationally, AI is supporting more efficient hospital management, with new tools being applied to bed allocation, rostering, and patient discharge. Whilst beyond the clinic, AI is reshaping medicines and pharmacogenomics research from 'petri dish to patient',<sup>1</sup> with tools helping to accelerate drug discovery pipelines and support translation into clinical settings.

This list is not exhaustive. The sheer breadth of application reflects the scale of AI's potential to reshape how care is delivered, organised, and experienced across Australia.

Yet for all the potential benefits, AI technologies also pose novel risks that could cause significant harm to patients, providers, and the health system itself. AI models may, for example, entrench inequities through biases in their training data, while decision-making may appear increasingly opaque due to 'black-box' systems.

Public perception around AI varies too, and there is notable scepticism amongst healthcare professionals regarding its safety, reliability, and use in clinical practice. There are also concerns of job displacement across the care economy, alongside worries that these technologies are eroding the fundamentally human encounter of care.

#### Key principles

This paper calls for a multi-faceted approach to AI in the care economy that is grounded in Catholic principles and ethical standards, arguing that:

1. AI is "a profoundly human reality"<sup>2</sup> and must always be directed toward the flourishing of the human person, judged not by profit or efficiency alone, but by whether it serves the common good.
2. it must always be human intelligence, with its conscience and freedom, that guides technical innovations and responsibly determines their use.<sup>3</sup>
3. the therapeutic relationship must remain a moral encounter between persons.
4. the benefits of AI should be justly distributed across the care economy, with a preferential concern for those at most risk of exclusion.

## What is Artificial Intelligence (AI)?

Artificial intelligence (AI) is a term that encompasses a broad and evolving set of scientific disciplines and technologies.

There is no single or universally accepted definition of AI, but rather a series of approaches and perspectives that each attempt to illuminate different aspects of what these technologies are and do.

Functionally, AI is understood as a tool “that enables computers and machines to simulate human learning, comprehension, problem solving, decision-making, creativity, or autonomy”.<sup>4</sup>

In practice, AI encompasses a broad spectrum of functions, from simple rules-based systems that perform defined tasks using fixed logic, through to more adaptive systems that iterate from data, and agentic AI tools that are capable of autonomous action across complex tasks.

When applied to healthcare, this means AI can be trained to detect abnormalities in medical images, predict which patients are at risk of deterioration, transcribe and summarise clinical consultations, or identify promising drug candidates from vast molecular datasets.

Whilst these ‘functional’ approaches are useful, they tell us little about what happens when AI enters the complex social and institutional environment of healthcare.

A sociotechnical framing helps to address this gap, recognising that AI is not deployed in a vacuum but rather influences, and is influenced by, the social contexts in which it operates, with potential unintended consequences.<sup>5</sup>

The Catholic Church’s teaching on AI, expressed in the 2025 doctrinal note *Antiqua et Nova* and Pope Leo XIV’s 2026 encyclical *Magnifica Humanitas*, aligns with this perspective, whilst frameworks such as the Rome Call for AI Ethics help to translate these principles into practice.

As *Antiqua et Nova* observes, the very use of the word ‘intelligence’ in connection with AI “can prove misleading” and “risks overlooking what is most precious in the human person”.<sup>6</sup>

Moreover, AI possesses “sophisticated abilities to perform tasks, but *not the ability to think*”. Put differently, whilst AI can process vast amounts of data, identify patterns, and generate outputs, it does not understand what it produces, and it cannot exercise judgement.

*Magnifica Humanitas* reaffirms these points, stating that “we must avoid the misconception of equating this type of ‘intelligence’ with that of human beings”.<sup>7</sup>

It adds that “[s]o-called artificial intelligences do not undergo experiences, do not possess a body, do not feel joy or pain, do not mature through relationships and do not know from within what love, work, friendship or responsibility mean.”

Ultimately, the capacity to recognise the vulnerability and dignity of a patient, to be present in suffering, and to exercise moral judgement in the therapeutic relationship are all reflected in the human side of the healing vocation, and they are not replicable by any machine.

## What is Artificial Intelligence (AI)? (cont.)

This is important, because the ways in which we define AI shape how we govern it, alongside how we integrate it into care, and how we understand the limits of what it can and should do in a health system, all of which needs to be grounded in the dignity of the human person.

## How is AI currently being used in Australian healthcare?

AI technologies are being adopted across a wide range of healthcare settings in Australia, though the pace, scale, and maturity of adoption varies considerably. There are five broad areas of application discussed here. Further details can be found in **Appendix B**.

### Hospital settings

The most mature applications of AI in Australian healthcare can be found in hospital settings, where various tools are already integrated into routine workflows and are augmenting particular clinical functions.

For example, ambient AI scribes such as Heidi Health's AI scribe capture and process clinician patient conversations, converting them into structured clinical documentation, including progress notes, referral letters, and other outputs using speech recognition and language models. These outputs all require the clinician to remain ultimately responsible for their content.<sup>8</sup>

In medical imaging, AI-enabled diagnostic tools, including Australian start-up Harrison.ai, support decision-making for radiologists interpreting X-rays, CT scans, and MRI across public and private services.<sup>9</sup>

And whilst AI-assisted imaging is not new, the current generation of deep learning tools has expanded significantly in scope and capabilities, for example by operating across multiple imaging modalities.

Recent examples include Computer Aided Detection tools such as Medtronic's GI Genius, which uses AI imaging to improve adenoma detection rates in endoscopy,<sup>10</sup> and AI-powered MRI-based detection methods that support neurologists to identify drug-resistant focal epilepsy.<sup>11</sup>

### Operations and administration

AI tools are supporting a range of administrative and operational functions across health and aged care settings. Tools such as Microsoft Copilot are increasingly being used to support administrative tasks including meeting documentation, email drafting, and content review.

Alongside this, AI tools are being applied across hospitals to improve bed management, scheduling, rostering, and coordinating emergency departments.

Whilst predictive analytics and risk-stratification tools are also emerging as valuable resources for improving allocative efficiency.

The Adelaide Score, for example, integrates objective vital signs and laboratory data to predict the likelihood of safe hospital discharge, supporting clinicians and bed managers in making timelier and evidence-based decisions about patient flow.<sup>12</sup>

## How is AI currently being used in Australian healthcare? (cont.)

More broadly, AI agents and workflow automation tools are being applied to handover prompts, documentation triggers, and coordination tasks that have traditionally relied on manual processes and institutional knowledge.

### **Community and aged care**

AI is playing a growing role in aged care and community-based services, though adoption is generally less mature than in acute hospital settings.

AI-powered wearable devices equipped with predictive algorithms can monitor vital signs and detect early symptoms of deterioration, enabling earlier intervention and supporting models of care in the home.

Alongside this, AI-enabled communications tools are helping to address workforce shortages, for example by enabling connectivity between specialist expertise in metropolitan areas and local and regional teams.

These platforms can also manage high-volumes of inbound and outbound calls, automate scheduling, and set reminders and follow-ups. Such capabilities may help to ease the administration burden on stretched aged care services, particularly following the new Aged Care Act.

Finally, purpose-built AI hardware is beginning to address practical barriers to AI adoption in aged care settings with limited or variable digital infrastructure. One example is Heidi Remote,<sup>13</sup> a portable device designed for audio capture and transcription without the need for continuous internet connectivity. This should benefit regional, rural, and remote settings, where connectivity may be limited.

Yet the use of such devices also raises important questions about patient privacy and data protection, particularly regarding where audio data is stored, who has access to it, and how patients are informed of its use.

### **Consumer-facing AI**

Consumer-facing AI health tools, including ChatGPT Health and Amazon One Medical, are emerging as sources of health information and advice for the public, with 1 in 10 Australians using ChatGPT for health information.<sup>14</sup> They may also be used as a substitute for professional care, with potential consequences for patient safety.

These tools often operate entirely outside of clinical governance frameworks, raising unresolved questions about regulation, responsibility, and patient safety.

Their growing use is a challenge for healthcare providers, who must increasingly account for the fact that patients may present having already received AI-generated health advice of variable quality and reliability.

Clinicians will therefore need sufficient AI literacy to recognise and respond to this, including understanding how these tools work, their limitations, and how to discuss their use with patients.

### **Emerging and frontier applications**

AI is reshaping medicines and pharmacogenomic research in Australia and globally, accelerating drug discovery pipelines and translation into clinical settings.<sup>15</sup>

## How is AI currently being used in Australian healthcare? (cont.)

Moreover, multi-modal clinical decision support systems, integrating clinical notes, imaging, pathology, and structured data, are beginning to emerge as tools for holistic patient assessment.

Finally, AI analytics, including polygenic risk scoring, are supporting advancements in precision medicine approaches. These applications are the least mature in terms of clinical deployment but are advancing rapidly.

## How are Catholic Health Australia (CHA) members using AI?

Several CHA members are actively developing and deploying AI technologies across their services, whilst also leading the way on ethical and governance standards.

St Vincent's Health Australia has piloted an AI voice bot through its Hospital-in-the-Home program in Victoria,<sup>16</sup> and has developed an AI-powered breast cancer risk prediction tool through the BRAIx program,<sup>17</sup> in partnership with the University of Melbourne, Australian Institute of Machine Learning, and BreastScreen Victoria.

Villa Maria Catholic Homes recently undertook a three-year trial with Deakin University's Applied Artificial Intelligence Institute, using HomeGuardian technology to predict and prevent falls among older people and people with disability.<sup>18</sup>

Likewise, Calvary have previously deployed a digital AI assistant in its Covid Care at Home virtual hospital service in 2022.<sup>19</sup>

Cabrini Health worked with Heidi Health to implement an AI scribe across its emergency department (ED) and inpatient short stay.<sup>20</sup>

Following a successful pilot in which ED care was completed an average of 24 minutes earlier, and clinicians saved an average of 31 minutes on clinical documentation, Cabrini extended the program to 12 months, with 97 per cent of clinicians reporting that they wanted continued access to the tool.

Finally, Mercy Health has become the first Australian health and aged care provider to sign the Rome Call for AI Ethics. In parallel, Mercy released its AI Strategy for 2025-28, grounded in the principles of the Rome Call for AI Ethics and the AICD AI Governance Framework. They are also developing a framework to support Catholic organisations in adopting and embedding the Rome Call's principles.<sup>21</sup>

## What are the potential benefits of AI for the care economy?

AI holds immense potential to reshape the entire care economy in Australia. The clinical opportunities are vast, and the integration of AI technologies offers benefits across diagnostics, monitoring, operations, and research.

Perhaps the clearest current opportunity lies in diagnostics, where AI can support improved accuracy and reduce error, for example by identifying patterns and anomalies that might otherwise be missed by the human eye.

AI is also increasingly being integrated into monitoring systems to support enhanced, real-time tracking via wearable devices.

## What are the potential benefits of AI for the care economy? (cont.)

These tools enable healthcare professionals to identify patients at risk of deterioration, in need of triage, or available for early supported discharge.

As discussed, AI also supports streamlining administrative tasks, with the potential to improve efficiency whilst reducing costs and enhancing patient outcomes and experiences. For example, AI can free up a clinician's time to spend on patient care by automating documentation, scheduling, and coding processes.

This may promote workforce wellbeing, retention, and longevity, as it offers the potential to reduce the administrative burden that contributes to clinician burnout.

AI may also improve allocative efficiency within hospitals, optimising patient flow, and reducing length of stay. These capabilities enable patients to be transitioned into appropriate care settings in a timely manner, with the potential to improve outcomes whilst easing pressure on acute capacity.

Strategic integration of AI within acute hospital environments therefore presents a critical opportunity to use finite resources more sustainably.

This is important at a time when private hospitals and other acute providers are facing growing viability challenges, driven by increasing patient complexity and the escalating cost of care delivery.

### **Alignment with the ministry of Catholic healthcare**

The Catholic Health Ministry is grounded in the belief that healthcare professionals are called not merely to treat illness, but to be “guardians and servants of human life”.<sup>22</sup>

If deployed responsibly, and for the common good, AI has the potential to enhance the capacity of healthcare professionals to fulfil this vocation by improving diagnostics, reducing administrative tasks, supporting clinical decision-making, and enabling clinicians to spend more time on the human encounter, which is at the core of our models of care.

From a Catholic perspective, the potential operational benefits of AI can also be understood through the lens of stewardship. This emphasises the responsible use of resources, a better prediction of patient need, and the reduction of waste across the care economy.

AI also holds promise for expanding access to care for those who are marginalised, isolated, or under-served within our communities. It offers the potential for earlier intervention for those most at risk, who often present later and with more complex needs. This includes more culturally appropriate care – such as language translation – that can reduce the barriers faced by people from culturally and linguistically diverse backgrounds.

However, these benefits should be understood as potential rather than guaranteed, and their realisation will depend on how AI is governed, implemented, and evaluated. Ultimately, the promise of AI depends less on what it can do, and more on whether we have the wisdom to direct it well – asking not only *what* we are optimising, but for *whom*, and *at what cost* to our collective humanity.

## What are the potential risks of AI to the care economy?

Despite the potential benefits, the increasing use of AI across the Australian care economy introduces a range of risks that must be identified, understood and mitigated.

Many AI tools, for example, operate through opaque decision-making processes, leading to some describing these as 'black-box' systems.<sup>23</sup> This creates difficulties with understanding how and why a particular decision or set of decisions have been made. Such opacity poses challenges to clinical accountability, informed consent, and the ability of healthcare professionals to trust AI decision-making.

Alongside this, AI can undermine the clinical encounter itself, as patients who arrive having already consulted a tool may hold pre-formed expectations about their diagnosis or treatment – positioning AI as an unauthorised third party in the room – that, where they conflict with clinical judgement, can erode the role of the clinician and complicate the therapeutic relationship.<sup>24</sup>

This is compounded by the risk that consumer AI tools can incorrectly be used as substitution for professional care, and propagate mis- and dis-information. AI systems may produce errors or 'hallucinations', whereby outputs are presented as truth when they are in fact incorrect.<sup>25</sup>

In clinical settings, such errors – particularly in diagnostics – can have severe consequences, ranging from misdiagnosis, to delayed treatment, adverse drug reactions, and inappropriate clinical decisions.

Concerningly, AI errors may contribute to a growing mistrust in the expertise and judgement of healthcare professionals themselves, a trend that has become increasingly common since Covid-19.<sup>26</sup> Moreover, AI-generated health content at scale could also shape what populations believe is normal, possible, and desirable in healthcare.

Furthermore, AI algorithms can inadvertently perpetuate existing biases within training data, leading to inequitable outcomes for different patient groups. In skin cancer screening, the imaging datasets most widely used to train AI diagnostic tools tend to significantly overrepresent lighter skin tones, and perform worse for darker skin tones.<sup>27</sup>

These risks may be compounded by organisations using multiple AI systems across a single patient pathway ('AI stacking'), leading to cascading errors or biases. This creates systemic risks that existing clinical governance frameworks are largely unprepared for, including privacy breaches.<sup>28</sup>

The processing of large volumes of sensitive patient data across AI systems heightens the risk of privacy breaches. To neglect data security is not merely a technical failing but a moral one that is a betrayal of the trust at the heart of the Catholic health ministry. Where this trust is broken, patients may disengage from care altogether at the very moment where they need it most.

AI adoption also raises broader workforce concerns. Over-reliance on AI tools may diminish the diagnostic and decision-making skills of healthcare professionals over time, while the automation of certain clinical and administrative tasks raises legitimate concerns about job displacement across parts of the health workforce.

## What are the potential risks of AI to the care economy? (cont.)

At the same time, there is a risk in failing to engage with AI at all, particularly as it may benefit organisational sustainability, workforce retention, and the capacity to deliver high-quality, person-centred care.

### **Challenges to the Catholic ethic of care**

For Catholic health and aged care providers, these risks carry a particular ethico-moral dimension.

A fundamental concern is that AI reduces the human person to a sum of their data points and algorithmic outputs, treating illness, ageing, and death as technical failures to be overcome, rather than defining elements of the human condition that require accompaniment, compassion, and presence.

As Pope Francis argued, fundamental respect for human dignity demands that we refuse to allow the uniqueness of the person to be identified with a set of data.<sup>29</sup>

Pope Leo XIV reinforces this, warning that – when AI systems present themselves as neutral and objective – they risk obfuscating the exclusion of the vulnerable behind a “veneer of neutrality”, which makes injustice harder to see and to challenge.<sup>30</sup> This carries particular weight in the care economy, where the people most dependent on AI-assisted decisions are often those least able to contest them.

Moreover, as *Antiqua et Nova* makes clear, AI cannot – and should not – replicate the empathy, compassion, and morality embedded within the therapeutic relationship. If AI were used to replace the human encounter between patient and carer, then this would risk “worsening the loneliness that often accompanies illness”,<sup>31</sup> particularly if the use of AI undermines human communication.

In aged care settings, this concern is acute – particularly for people living with dementia, where AI monitoring and surveillance tools raise profound questions about consent, dignity, and the risk of masking or enabling elder abuse.

For Catholic providers whose mission centres around serving the most vulnerable, deploying AI tools with pre-built biases risks entrenching inequities. Catholic providers should commit that no AI tool is deployed in a Catholic facility unless its impact on the most marginalised cohort using that service has been formally assessed – directly operationalising the preferential option for the poor.

Moreover, Catholic teaching emphasises that technological progress should promote, rather than replace, human labour.<sup>32</sup> Catholic providers therefore have a particular pastoral and moral responsibility to their own staff to treat them “as persons and never as mere resources”,<sup>33</sup> and to ensure that AI-driven change is just rather than merely efficient.

Finally, Pope Leo XIV has warned that the concentration of power around AI in the hands of a small number of private actors poses a structural threat to democracy, solidarity, and the common good.<sup>34</sup> In particular, when data and infrastructure are controlled by a few, the ability of communities and governments to shape how AI is used – and for whose benefit – is severely compromised.

## How can Catholic ethics support the safe and responsible use of AI across the care economy?

Catholic principles and ethics offer a distinctive lens through which to underpin the safe and responsible use of AI in health and aged care.

The Church's teaching on AI, expressed mostly clearly in *Antiqua et Nova*, and *Magnifica Humanitas*, offer moral guidance to complement AI governance frameworks, with the aim of ensuring that these technologies serve and promote the human person, and the common good.

Nonetheless, the Church's engagement with these questions is still deepening, and the principles set out in this paper should be read as a starting point, rather than a settled or exhaustive framework.

With that being said, *Antiqua et Nova* does provide a useful account of what human intelligence is, what the therapeutic relationship demands, and why moral agency cannot be delegated to machines, even when they have been designed to imitate human cognition.

The clinical encounter is particularly important here, as it is viewed as a moral event between embodied and relational persons. Moreover, it is grounded in the assumption that one must have the capacity to be present in suffering, can exercise one's conscience, and uphold the irreducible dignity of the patient.<sup>35</sup>

Alongside this, core Catholic principles help to translate these insights into practical guidance for how health systems should govern, use, and make decisions about AI.

First, human dignity should be the central pillar for evaluating any technology. Catholic teaching draws upon principles of solidarity and the common good to assess whether the benefits of AI across the care economy are distributed equitably, and the harms are minimised.

Second, subsidiarity – the principle that people and communities should be able to participate in the decisions that affect them – ensures that decisions about the use of AI are not imposed from above, or by commercial interests, but are instead shaped by the clinicians, patients, and other groups directly affected by such changes.

Well-designed AI can advance subsidiarity by giving people access to better information through which they can participate more meaningfully in decisions about their care.

Yet participation also requires that people understand when and how AI is being used in their care. The question of patient consent therefore sits at the heart of this principle.

Notably, whilst transparency and informed understanding remain essential, a blanket requirement for explicit consent in every instance risks limiting the broader benefits of AI adoption and may inadvertently disadvantage those who have consented.

Catholic providers must navigate this tension carefully, balancing respect for individual autonomy with their broader responsibility for the common good of all those in their care.

This extends to procurement too, and before any contract is signed, providers should ask who owns the data, who may profit from it, and whether the arrangement serves the common good.

## How can Catholic ethics support the safe and responsible use of AI across the care economy? (cont.)

Catholic social teaching also calls for discernment – the practice of pausing, reflecting, and seeking wisdom before acting – which should be central to making significant decisions about AI adoption. This is a habit of moral attention that should be embedded in governance culture.

Finally, the focus on the preferential option for the vulnerable ensures fairness, as it asks whether AI works for the people who need it most, rather than those with the resources to access it.

These principles can be operationalised through several possible frameworks, with one example being the *Rome Call*. This introduced the idea of ‘algorithethics’, the embedding of ethical considerations into AI systems from the outset.<sup>36</sup>

Whilst not a teaching document, the *Rome Call* offers a practical bridge between Catholic ethics and governance structures, helping to ground secular frameworks in the language of human dignity.

For example, the Rome Call’s six principles align with the ‘six essential practices’ set out in the Australian Government’s Guidance for AI Adoption.<sup>37</sup> Similarly, it shares several overlapping points with the Australian Institute of Company Directors (AICD) AI Governance Principles framework,<sup>38</sup> alongside guidance published by the Australian Commission on Safety and Quality in Health Care (ACSQHC).<sup>39</sup>

Currently, most existing governance structures across Australia’s care economy fail to routinely account for AI-specific considerations. For example, approval pathways vary across clinical and research domains, and there is little clarity around who is responsible for assessing AI-related risks.

Catholic healthcare providers are well placed to address these issues. Their shared mission and values create genuine opportunities to collaborate on the safe and responsible use of AI, including through joint procurement, communities of practice, and shared governance frameworks.

Moreover, Catholic care providers across Australia operate within a structured ethical framework, namely the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia (‘the Code’).<sup>40</sup>

The Code provides a strong foundation upon which AI-specific governance can be built, as it already sets out the ethical commitments that guide how Catholic providers should evaluate, adopt, and oversee the use of these technologies.

Its emphasis on the primacy of human dignity, for example, offers a substantive test for most AI tools, asking whether a given tool respects and promotes the dignity of the person it is supposed to serve.

Similarly, the Code’s commitment to the integrity of the therapeutic relationship reinforces the view that AI tools must not erode the relational and moral character of care, however beneficial their application might be.

The principle of *primum non nocere* (the obligation to first do no harm) encourages Catholic providers to consider the potential harmful effects of AI, some of which are outlined in the previous section.

## How can Catholic ethics support the safe and responsible use of AI across the care economy? (cont.)

For example, they may consider whether an AI tool or system entrenches – rather than addresses – existing inequities, or poses risks of displacing workers without a just transition.

Finally, clinicians and their organisations have a growing responsibility to develop sufficient AI literacy that will be needed to recognise, critically evaluate, and – where necessary – correct AI-generated health information that patients may present with.

Catholic health and aged care providers, alongside professional colleges and membership organisations such as CHA, are well placed to lead on this, and have a particular responsibility to do so as these technologies continue to develop rapidly.

Taken together, these principles offer a distinctive Catholic approach for the safe and responsible use of AI across the care economy. For a more comprehensive list of principles and suggested principles, please see **Appendix A**.

## What this means for CHA members

This paper is intended as a starting point for CHA members as they navigate the opportunities and risks that AI presents. Whilst the governance landscape continues to evolve, there are several practical steps that Catholic health and aged care providers can take now.

- 1. Establish governance** – appoint a named individual accountable for AI adoption within your organisation, and ensure that AI-specific considerations are integrated into existing clinical and corporate governance frameworks.
- 2. Apply discernment** – before adopting any AI tool, pause to ask whether it serves the mission, respects human dignity, and has been evaluated for its impact on the most vulnerable people in your care.
- 3. Assess equity impact** – no AI tool should be deployed unless its impact on the most marginalised cohort using that service has been formally assessed.
- 4. Invest in data foundations** – AI is only as good as the data that underlies it. Investing in data quality, interoperability, and governance is a precondition for responsible AI adoption.
- 5. Build AI literacy** – support clinicians and staff to develop sufficient understanding of AI tools to use them well, explain them to patients, and recognise their limitations.
- 6. Engage collaboratively** – CHA members share a mission and a values framework that creates a genuine opportunity to develop common approaches, including joint procurement, shared governance frameworks, and communities of practice.
- 7. Monitor regulatory developments** – the Therapeutic Goods Administration's (TGA) approach to AI as a medical device is evolving, and CHA members should ensure that their procurement and governance processes reflect this.
- 8. Advocate for good governance** – CHA members have a responsibility to call for robust AI governance that serves the common good, not merely commercial interests.

# Appendix A – Principles for the safe and responsible use of AI across the care economy

Principle	Suggested approach
<i>Ground AI governance in ethical integrity and Catholic ethics</i>	<ul style="list-style-type: none"> <li>• Adopt a structured governance framework, such as the Australian Institute of Company Directors (AICD) AI Governance framework, as the organisational backbone and embed Catholic ethical standards to underpin operational decision-making criteria.</li> <li>• Align with the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia and the ACSQHC Guidance on AI in Healthcare.</li> <li>• Appoint a named individual accountable for each AI system, with appropriate AI literacy.</li> <li>• Treat workforce impacts as a governance pillar, not a downstream risk.</li> <li>• Monitor TGA guidance on AI as a medical device and ensure procurement processes account for regulatory classification of AI tools used in clinical settings.</li> </ul>
<i>Extend ethical compliance across the supply chain</i>	<ul style="list-style-type: none"> <li>• Require AI vendors and technology partners to demonstrate alignment with recognised AI principles – such as those set out in the <i>Rome Call</i> – as a condition of contractual agreement. This includes paying attention to the condition of workers who sustain AI systems, especially those engaged in data labelling and content moderation.</li> </ul>
<i>Treat equity as a design principle from the outset</i>	<ul style="list-style-type: none"> <li>• Assess AI systems at every stage for their impact on marginalised populations, including Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, older Australians, people of diverse sexual orientation and gender identity, people living with disability, and those in regional, rural, and remote areas.</li> <li>• No AI tool should be deployed unless its impact on the most marginalised cohort using that service has been formally assessed.</li> </ul>
<i>Ensure transparency and explainability</i>	<ul style="list-style-type: none"> <li>• AI systems used in Catholic-provided care must be sufficiently explainable that clinicians can understand what the system does, its known limitations, and how its outputs should inform clinical reasoning.</li> <li>• Where a system cannot be adequately explained, its use in clinical settings should be reconsidered.</li> </ul>
<i>Protect informed consent and human agency</i>	<ul style="list-style-type: none"> <li>• Patients should be informed when AI is being used in their care, should understand what role it played in a clinical decision, and should have recourse to question AI-assisted decisions.</li> <li>• Whilst explicit consent may not be required in every instance, transparency is essential.</li> <li>• Decisions regarding patient treatment must always remain with the human person.</li> <li>• Catholic providers must ensure that AI tools are evaluated for whether their design, defaults, and outputs are consistent with the sanctity of human life and the dignity of the human person.</li> </ul>
<i>Promote the flourishing of the patient and the clinician</i>	<ul style="list-style-type: none"> <li>• AI should support the clinician's capacity for professional judgement, moral agency, workforce wellbeing, and vocational fulfilment.</li> <li>• The act of healing takes place within a therapeutic encounter between persons, and AI must serve, not erode, the conditions that make that encounter possible.</li> </ul>
<i>Invest in data quality, privacy, and sovereignty</i>	<ul style="list-style-type: none"> <li>• Invest in data quality, completeness, and interoperability as a precondition for AI adoption, particularly in aged care settings where data foundations remain underdeveloped.</li> <li>• Protect patient data and privacy as an ethical, rather than just legal, principle.</li> <li>• Ensure that organisational data practices respect Aboriginal and Torres Strait Islander data sovereignty, so that Indigenous communities retain meaningful control over the collection, use, and interpretation of their data.</li> </ul>
<i>Exercise responsible stewardship through proactive engagement</i>	<ul style="list-style-type: none"> <li>• The risks of adopting AI poorly are real, but so is the risk of failing to engage at all where the conditions for responsible adoption can reasonably be met.</li> <li>• Responsible stewardship requires that Catholic organisations engage actively and critically with AI, rather than defaulting to inaction.</li> </ul>
<i>Account for the environmental footprint of AI</i>	<ul style="list-style-type: none"> <li>• AI systems consume significant energy and water resources. CST's commitment to integral ecology – reinforced by Pope Leo XIV's calls in <i>Magnifica Humanitas</i> to account for AI's environmental costs – demands that these costs are assessed and, where possible, minimised.</li> </ul>

# Appendix B – Examples of AI use across the care economy

AI Technology Type	Australian Examples	Functional Role	Regulatory Status & Adoption	Status
<b>Ambient AI / Digital Scribes (LLMs + ASR)</b>	Heidi Health, Nuance DAX Copilot	Converts clinician-patient conversations into structured clinical notes, summaries, referral letters, and coding suggestions. Used in GP, outpatient, and hospital settings. Evidence shows significant reductions in after-hours documentation and clinician burnout. Clinician remains accountable for all outputs.	TGA reviewing for medical device status when AI extends beyond passive summarisation. Increasing uptake across primary care and hospital departments. Raises governance, consent, and medico-legal questions.	<b>Deployed</b>
<b>Medical Imaging AI (CNNs / Deep Learning)</b>	Harrison.ai Radiology; emerging applications in MRI-PET for epilepsy detection	Image recognition and classification for X-rays, CT scans, and MRI (e.g., lung nodules, fractures, or focal cortical dysplasia). Provides decision support for radiologists, not autonomous diagnosis. Can reduce interpretation time and improve detection rates.	Listed on ARTG as AI-enabled medical devices (Class IIb). Deployed across Australian public and private radiology services, supporting more than half of Australia's radiologists. Outputs require clinical validation.	<b>Deployed</b>
<b>Predictive Analytics &amp; Risk Stratification (ML on structured data)</b>	The Adelaide Score; early warning systems embedded in EMRs	Predicts discharge readiness, patient deterioration risk, and escalation needs using vitals, pathology, and observations. Prospective hospital implementation demonstrates improved patient flow, reduced length of stay, and cost efficiency. Also used for cancer prognosis and treatment response prediction.	Likely classified as a medical device when informing clinical decisions or care planning (TGA risk-based classification). The Adelaide Score demonstrated safety and efficacy in prospective trials published in the ANZ Journal of Surgery (2025). AI augments rather than replaces clinical judgement.	<b>Deployed</b>
<b>Conversational AI / Virtual Care Assistants (LLMs + NLP)</b>	Virtual care symptom checkers, remote chatbots, patient navigation tools	Patient check-ins, symptom triage, appointment support, and care navigation. Used in virtual hospitals, remote monitoring programmes, and home-care contexts. Aims to improve access and reduce burden on clinical staff.	Classified as software with therapeutic intent only if providing diagnosis or treatment suggestions. Purely informational tools may be excluded. TGA guidance evolving. Increasing deployment in telehealth.	<b>Deployed</b>
<b>Hospital Operations &amp; Workflow AI (AI agents, ML)</b>	NexusMD ED agents, bed management systems, scheduling optimisation tools	Automates coordination tasks including alerts, handover prompts, documentation triggers, bed allocation, and rostering. Aims to optimise patient flow, reduce bottlenecks, and improve operational efficiency in emergency departments and wards. One Victorian ED reported a 30% improvement in consultation efficiency.	Not necessarily classified as diagnostic or therapeutic devices. Regulatory treatment depends on whether outputs influence clinical choices. Mostly assistive rather than autonomous. Governance and explainability remain key considerations.	Emerging
<b>Cancer Care AI (ML classification &amp; prediction)</b>	Risk stratification models, treatment response prediction	AI-driven risk stratification, prognosis estimation, and treatment response prediction for various cancers. Supports personalised treatment planning and clinical decision-making in oncology.	Used mainly in research, clinical trials, and specialist cancer centres rather than routine care. When outputs guide treatment decisions, likely classified as medical devices.	Emerging

## Appendix B – Examples of AI use across the care economy (cont.)

AI Technology Type	Australian Examples	Functional Role	Regulatory Status & Adoption	Status
<b>Genomic &amp; Laboratory Analytics AI (ML on genetic/lab data)</b>	AGRF + Allelica polygenic risk scoring, genomic variant interpretation tools	Uses genomic data and machine learning to quantify disease risk (e.g., polygenic risk scores for cancer, cardiovascular disease). Supports precision medicine approaches and early intervention strategies.	May be regulated if intended for clinical decision support (e.g., predictive cancer risk assessment). Growing interest in precision medicine applications. TGA evaluating regulatory frameworks for genomic AI tools.	Emerging
<b>Remote Monitoring &amp; Wearables AI (Embedded ML)</b>	AI-enabled wearables and remote monitoring devices for vitals tracking	Detects trends in vital signs, alerts for escalation needs, and supports chronic disease management. Increasingly used in hospital-at-home programmes and post-discharge monitoring.	If tied to clinical decision endpoints, may be regulated as medical devices. If purely informational, may be excluded. Growing integration with virtual care models. Privacy and data governance considerations important.	<b>Deployed</b>
<b>Aged Care AI (Falls prediction, behavioural monitoring, workforce ML)</b>	SmartGuard, Cura, AI-assisted rostering tools	Predicts falls risk in residential aged care using movement, vital signs, and behavioural data. Monitors patterns associated with dementia-related distress. AI-assisted rostering tools support workforce planning and care continuity. Aims to improve resident safety and reduce preventable adverse events.	Falls prediction tools with clinical decision outputs likely classified as medical devices under TGA risk-based framework. Behavioural monitoring raises significant consent, dignity, and surveillance concerns. Regulatory guidance for aged care-specific AI tools is still developing.	<b>Deployed</b>
<b>Mental Health AI (NLP, predictive analytics, digital therapeutics)</b>	Mindset Health, Osana, suicide/self-harm risk screening tools embedded in EMRs	Supports mental health triage, symptom screening, and care navigation. Predictive tools assess risk of deterioration, self-harm, or hospital readmission. Digital therapeutics provide structured, AI-guided therapeutic content. Used across community mental health, telehealth, and inpatient settings.	Digital therapeutics with therapeutic intent likely classified as medical devices. Risk screening tools embedded in clinical workflows subject to TGA oversight. Significant ethical considerations around bias, consent, and the limits of algorithmic assessment in mental health contexts.	Emerging
<b>Medication Safety AI (NLP, rule-based ML)</b>	MedChart, pharmacy dispensing AI, adverse drug event detection tools embedded in EMRs	Detects potential adverse drug interactions, flags dosing errors, and automates dispensing checks. Supports pharmacist review and clinical decision-making. Increasingly integrated into EMR workflows across hospitals and aged care settings.	Likely classified as medical devices when outputs directly inform clinical decisions. Widely deployed across Australian hospital and aged care pharmacy settings. Governance and accountability frameworks for automated safety alerts still maturing.	<b>Deployed</b>
<b>Palliative Care AI (predictive analytics, NLP)</b>	Palliative care prognosis tools, Goals of Care decision-support tools	Supports prognosis estimation and care planning in the last months of life. AI tools assist clinicians in identifying patients approaching end of life and initiating Goals of Care conversations. Some tools use NLP to analyse clinical notes for prognostic signals.	Emerging area with limited Australian-specific deployment. Tools informing clinical decisions likely require TGA classification. Raises profound questions about human dignity, the therapeutic relationship, and the appropriate limits of algorithmic involvement in end-of-life care, directly engaging the ethical framework of this paper.	Emerging

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