Secretariat of the Commission of the Bishops' Conferences
of the European Community

Joint Answer to the
CONSULTATION FROM THE COMMISSION REGARDING COMMUNITY ACTION ON HEALTH SERVICES
(SEC (2006) 1195/4, 26 September 2006)

Caritas Europa and the Secretariat of COMECE welcome the present consultation regarding Community action on health services, as it gives stakeholders, including civil society and church-related organisations, the opportunity to express their views on this important issue.

Churches and Caritas organisations are major providers of social and healthcare services in many Member States. They have considerable experience in providing these services according to the needs of society. The way in which they provide such services depends upon the prevailing legal framework within the Member States of the European Union.

A. General Comments

I. Special characteristics of social and healthcare services

In the field of person-related services, such as social and healthcare services, the close relationship between the service provider and the beneficiary is vital. The nature of these services requires a particular relationship of trust. It should be taken into account that the recipients of these services are not in a comparable situation to other consumers: Unlike other services, social and healthcare services touch directly upon the physical and mental well being of the beneficiaries. Furthermore they have an active role to play in the care process. We take the view that the special characteristics of social and healthcare services should be clearly recognised in European policy approaches and where appropriate in European Community legislation.

The exclusion of health services as well as social services from the scope of the Services Directive enables the European Commission to take stock of the special characteristics of social and healthcare services before proposing political or legal action. Given the complex nature of social and healthcare we would like to underline that the Consultation on Community Action on Health Services can only be a first step in a long stock-taking exercise before the European Commission will be in a position to propose Community Action.

We should like to emphasise that the European Commission announced in its White Paper on Services of General Interest (2004) a Communication on social ***and*** health services, which we saluted as the right approach to ensure coherence in the political and legal treatment of social and health services. However, the European Commission decided in 2006 to separate the processes in the light of the debate on the Services Directive. Accordingly, the European Commission published in April 2006 the Communication on Social Services of General Interest and in September 2006 the Communication concerning the Consultation on Community Action on Health Services. Despite the decision to treat social and health services separately these two fields remain interlinked, in that they share the same characteristics and should thus be governed by the same principles.

Therefore we invite the European Commission to consider this answer collectively with the answer given on 16 January 2007 and with other Christian organisations to the related consultation on Social Services of General Interest, which is hereby attached.

We also draw your attention to the separate response of Eurodiaconia and CEC-KEK, who share similar concerns, to this Consultation regarding Community action on Health Services.

Like social services, health services should not be primarily looked at from a mere economic point of view, for instance as a possible resource for increasing exportations (as some employers organisations recently advocated). **On the contrary, health care is and must remain a substantial part of the national social welfare systems[1], which have to be organised in a way as to avoid protectionism.**

Besides facilitating cross-border cooperation where appropriate, action at EU level should also aim at:

- securing a level-playing field allowing **non-profit social and health service providers** to benefit from **non-discriminatory access** to cross-border health care; for instance by adopting European Statutes for associations and mutualities, as for-profit providers may already benefit from such an European Statute and the administrative simplification which goes together with it;
- **simplifying administrative requirements** in the case of cross-border provision of health services; this objective is likely to be facilitated by the above-mentioned Statutes.

The Communication regarding Community action on health services raises some preliminary questions illustrating the aspects on which the consultation is based (cf. paragraph 2.1, end of page 4). We wish to respond to these questions by reinstating some of the principles which are at the core of the every day work of Churches, Caritas or other church-related service-providers.

II. Shared values and principles

We wish to reaffirm that "**shared values and principles** for health services on which citizens can rely throughout the EU"[2] do already exist and must be endorsed and guaranteed by any future Community initiative. These values and principles have already been proclaimed by the *Council Conclusions on Common values and principles in EU Health Systems*. We believe that **any future legislative or non-legislative initiative should build up and expand on these principles.**

i. As recognized by the EU Charter of Fundamental Rights, the protection of physical and mental health is a basic right of everyone. As suggested by the Communication, the national policies must aim at creating a healthy environment and lifestyle, insisting on prevention in their programmes.

ii. The "Common values and principles" prompt a patient-centred healthcare provision, which is responsive to individual needs. We stress that **the provision of health services is by definition person-oriented** and has to correspond to the individual needs of each patient. Taking into account this assumption, we add that home should be the setting of first choice for care and treatment, in accordance to the needs and wishes of the beneficiaries.

iii. In the meaning of the "Common values and principles", "**universality**" means that no-one is barred access to healthcare. In our understanding, "universality" means that **all people must have access in due time to an affordable high quality health care system,** for prevention, cure and care, including long term care.

[1] As also stated by the *Council Conclusions on Common values and principles in EU Health Systems* of 1-2 June 2006, hence the "Common values and principles", pp. 34 and 37.

[2] Communication, p. 4.

iv. We affirm that the health care system must be based on collective insurance and/or on a tax-paid ground which is financed under the principle of solidarity. This seems also to be suggested by the “Common values and principles”.

III. Enabling patients to make informed choices

As the Communication points out, patients must be in a position to identify, compare and choose, in accordance with the provisions of their national law, between providers recognised in other countries. The plurality of service providers is an indispensable pre-requisite for the choice of the patients. In order to enable patients to make their choice any legislative or non-legislative measure taken by the Member States or the European Union should therefore not infringe upon the diversity of service providers.

We insist that a future common information and cooperation system should allow every patient to exercise his/her **free and informed choice of the service provider** in conformity with his/her ethical convictions, among all the providers who are capable and competent to offer (within the national legal boundaries) the service he/she needs. The success of medical care depends essentially on a supportive environment which corresponds to the ethical convictions of the patient.

Moral choices and preferences made and promoted by service providers should be part of their information and communication policies and documents shared with potential patients. Seeking information should not be left only to the initiative of the patients (which would deprive the most disadvantaged people from access to relevant sources of information) but should rather be facilitated by a structured system and regularly updated.

IV. Ethical dimension of EU action on healthcare

The Communication makes a timid reference to the need for clarity regarding ethical aspects of health care. We should like to highlight that the freedom of Member States to decide about what care they consider appropriate and ethically acceptable to provide must be ensured. Even though they are considered by the Court of Justice as services, and even if provided for remuneration, **health services are not purely economic services**. They are meant to serve life, from its conception to its natural end. They bear significant ethical implications; therefore a certain specificity must influence their legal and economic status.

The necessity to avoid barriers to the free provision of services, as stated by the Court of Justice, may not infringe upon the respect of fundamental ethical choices of each Member State. In order to create a legal framework in which every citizen can make his/her ethical choices, Member States are entitled to decide which health services they deem admissible and opportune. This concerns not only restrictions to cross-border provision of services but also the use of services abroad or their remuneration. The Court has clarified that such barriers can be legitimate for “overriding reasons of general interest”. The concept of “general interest” should be understood as also incorporating the public policy (*ordre public*) principles proper to each Member State. National legislations restricting or prohibiting the use or the provision of special services in the health sector on ethical grounds must be protected. Such ethical issues may not be harmonized under Article 95.

In its Communication, the European Commission refers to fertility treatment as an example of the Member States’ ability to take different decisions for what they consider appropriate to provide. It is possible that other areas of ethical concern and need for legal certainty (cf. questions 6 and 7 of the consultation) may arise in relation to issues such as abortion, morning-after-pill, surrogate motherhood, euthanasia. It is indispensable that the competence of Member States to legislate in these areas be respected by the EU. According to Article 152 EC-Treaty, any harmonisation of the laws and regulations of the Member States in the field of health issues is excluded. This may not be undermined with regard to ethical issues by treating health

services purely as services and by regulating according to Article 95. Any EU action - be it of legislative or non-legislative nature - must not infringe on the right of the Member States to determine the legal treatment of areas of ethical concern.

B. Answers to specific questions

Q. 1: what is the current impact (local, regional, national) of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

As rightly pointed out in the Communication, the present impact is rather limited, except in specific cases; however, this impact is likely to increase in time because of the expected growth in intra-European mobility. It has to be ensured that cross-border healthcare and specialisation does not impede accessibility for patients to local healthcare. Access to good health care includes access to extensive information about health care and local supply. Proximity is often essential for the affordability of health treatments. Proximity is also necessary to facilitate family visits. Distance treatment is especially a problem for disadvantaged people; they might not be able to afford such a treatment and they will not be embedded in their local surrounding and family life.

Q. 2: what specific legal clarification and what practical information is required by whom (eg: authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

Any future legislation or interpretation on this matter should take better account of the non-ambiguous reference made by article 86.2 of the Treaty to "general economic interest". We understand that the Court of Justice has developed the notion of "overriding reasons of general interest" for specific purposes within the internal market. However, consistency should be ensured between the notions of, on one side, "general economic interest" in the field of competition law and, on the other side, of "overriding reasons of general interest" within the internal market.

Q. 3: which issues (eg: clinical oversight, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different types of cross-border healthcare described in section 2.2 above?

National authorities should take any appropriate initiative to contribute to the accessibility, quality and financial sustainability of healthcare systems. This includes patients' rights, training and other requirements for care professionals.

The exclusion of health services from the services directive has to be respected. Member States must have the right to impose regulations upon service providers which are justified by reasons of general interest.

This responsibility of authorities logically depends on the type of cross-border care considered: it mostly applies to care services provided inside the State concerned, be it by a national or by a non-national provider.

Q. 4: who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?

Safety of cross-border health care is a common responsibility of patients, health care professionals and insurers, and Member States. One should also not overlook the importance of non-judiciary dispute settlements, as is already the case in some Member States: Courts should always be the ultimate option in matters where professionals' liability is at stake.

Q. 5 : what action is needed to ensure that treating patients from other Member States is compatible with the provision of a balanced medical and hospital services accessible to all (for example, by means of financial compensation for their treatment in "receiving" countries) ?

There does not seem to be a case for action at EU level in this respect. Many such cases seem to have been satisfactorily settled by bilateral cooperation.

Q. 6: are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of healthcare providers not already addressed by Community legislation?

As already pointed out, the ethical dimension of healthcare provision should carefully be considered (cf. part A, point IV above). Article 152 EC-Treaty is the relevant legal base. It may not be undermined by article 95.

Another problem which deserves attention is the need to avoid the "brain drain" of care professionals from the new Member States by providing them with the environment and equipment they need to practice in their country of origin.

Q. 7: are there other issues where legal certainty should also be improved in the context of each specific health protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest in order to facilitate cross-border healthcare?

We regret the way this question has been formulated, as it confuses the reader by presenting the facilitation of cross-border health-care as a case for increased legal certainty, whereas legal certainty and facilitating cross-border healthcare are two different issues. Legal certainty may have an intrinsic value, which is not the case for the facilitation of cross-border healthcare.

Q. 8: in what ways should European action help support the health systems of the Member States and the different actors within them? Are there areas not identified above?

The High-level Group on health services and medical care is an interesting tool for exchanging information and enhancing coordination.

As the Communication points out, the Open Method of Coordination is currently used to support Member States in the reform of health care and long-term care borne by their social protection system. However, we have insist that, in spite of the announced intentions, the "Health" strand of the National Strategic Reports on social protection and social inclusion has not been elaborated by the Member States in proper consultation with civil society and stakeholders. We underline that an effective improvement of the health and long term care systems cannot be achieved without the contribution of non-state actors, who have direct knowledge of the social reality and can thus suggest concrete measures to best respond to social and health needs. The European Union could then help support the national health systems and the different actors within them by strongly encouraging Member States to open civil dialogue on health issues as well.

Q. 9: what tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

Until the political debate on health services reaches a point of mature reflection, we would consider it too early for the European Community to adopt legislation. We take note that there exists already binding European case-law in this field; if further legal clarity is needed, this may be achieved by a comprehensive Communication on the application of such a case-law.

As already stated in the reaction to the abovementioned consultation on social services of general interest, whatever the option adopted at European level, any incoherence between related initiatives should be avoided. In particular, the general interest nature of both, social and healthcare services must be taken into account.

Brussels, 8 February 2007

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Caritas Europa
Created in 1971, Caritas Europa is one of the seven regions of Caritas Internationalis, the worldwide confederation of 162 Catholic relief, development and social service organisations working to build a better world, especially for the poor and oppressed, in over 200 countries and territories. Caritas Europa is the umbrella organisation of the European network of 48 Caritas member organisations, working in 44 European countries. Caritas Europa focuses its activities on policy issues related to poverty and social inequality, migration and asylum within all countries of Europe and issues of emergency humanitarian assistance, international development and peace throughout the world. With regard to all these issues, the organisation develops policies for political advocacy and lobbying at European level as well as at national level. The organisation is strongly involved in supporting the activities of its member organisations and those in the wider Caritas Internationalis confederation.

***The Commission of Bishops' Conferences of the European Community (COMECE)** has 24 member bishops who represent the Episcopates of the Member States. COMECE maintains a permanent secretariat in Brussels. The work of COMECE follows three main objectives: to monitor and analyse the political process of the European Union, to inform and raise awareness in both the church and society of the development of EU policy and legislation, and to promote reflection based on the Church's social teaching on the challenges facing a united Europe.*

Annexe

Caritas EUROPA

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Conference of European Churches
Conférence des Églises Européennes
Konferenz Europäischer Kirchen

COMECE
Secretariat of the Commission of the Bishops' Conferences of the European Community

EURODIACONIA
European Federation for Diaconia
Europäischer Verband für Diakonie
Fédération Européenne de la Diaconie

Joint response to the Social Services of General Interest Questionnaire

Churches, Caritas and Diaconal organisations in Europe welcome the European Commission's efforts to define the specific characteristics of social services of general interest offering the recognition of the specificities of these services and their importance in fostering social cohesion and inclusion in society. We also welcome the endeavor to safeguard and uphold the quality and accessibility of social services of general interest through a clarification of how Community law influences the provision of these services.
We welcome the Commission's involvement of church and civil society in this process as we, churches, Caritas and Diaconal organisations, find ourselves to be stakeholders in the joint effort to uphold the European social model as we engage over 1 million professionals and volunteers in the broad field of social services.

Field 1 – Description of social services

1. Please indicate whether the description of the social services as provided by the Communication (see above under "scope") is appropriate and adequate, also with a view to social security schemes responding to the criteria deriving from the *Poucet and Pistre* case law.

- *We welcome the Commission's work to define the scope and the special characteristics of social services as well as its reference to social cohesion, which we see as a key objective of social policy.*
  We particularly appreciate the description of social services as being both preventive and curative and the importance given to both social security schemes and person-oriented services.

- *We think a clearer formulation should be adopted in order to avoid any misunderstanding: "statutory and complementary social security schemes" are not in themselves "social services" (as described in the communication). But social services act in the implementation of social security schemes and as such contribute to the common good, which is one of the reasons they must be treated differently from other services in the market.*

- *The recognition of social services as being rights-based and guaranteeing the fundamental rights of the individual is reflected in their person-oriented approach. Churches and diaconal organisations share this principle. In the Christian understanding, human dignity does not depend on productivity, economic contribution or life situation, but resides in people created in the image of God with equal worth.*

- *We regret the decision not to address health services in the Communication contrary to the announcement in the White Paper on services of general interest of* "a Communication on social services of general interest, **including health services**" *(our emphasis). Social and health services share the same characteristics and on a practical level it is difficult to make a distinction between the two. Therefore we ask the Commission to pay special attention to the close links between health and social services.*

2. If you consider that the description could be improved or other (type of) services should be added, please provide for concrete drafting suggestions.

- *In line with the above considerations, the Communication should refer to "*services ***implementing*** statutory and complementary social security schemes*" instead of the current wording which defines "statutory and complementary social security schemes" as a category of social services.*

Field 2 – Pertinence of the characteristics

3. Please indicate whether the characteristics identified by the Communication are pertinent to gauge the specific features of social services of general interest as compared to other services (of general interest)?

- *We believe the characteristics are generally sufficient to gauge the specific features of social services of general interest.*

- *However, the characteristics of social services as operating on the principles of solidarity and social justice is pertinent to gauge two specificities of social services **if** by this we consider that risks are not individual but structural. This view necessitates public responsibility in ensuring provision of and in regulating social services. As such they are key elements in the operation of social security schemes.*

4. Please provide, if needed, for concrete drafting suggestions for the formulation of the characteristics as they are currently presented by the Communication.

5. Are there characteristics to be added? Please provide for concrete drafting suggestions and examples of services concerned by these characteristics.

- *When we define person-oriented social services we must realise that they often address not only the physical and mental needs but also the spiritual aspect of care for each human being. Being person-oriented and addressing individual needs also means recognising that the religious dimension of life is of importance to the majority of people. We would therefore appreciate a definition which also allows this aspect to be included.*

  A drafting suggestion could therefore be: "person-oriented social services often address not only the physical and mental needs but also the spiritual aspect of care for each human being."

  We also suggest adding "religious traditions" along with the "local cultural traditions" so that the text reads: "They are strongly rooted in (local) cultural ***and religious traditions.****"*

- *A central characteristic of many social services is that they work with the capacity of the user and assist him/her to become independent – in this respect they are fundamentally different from other services provided against consideration.*

- *Social services of general interest often include an element of advocacy in order to defend the interests of the beneficiary and to work for social justice in society*

  A drafting suggestion would therefore be: "they often include an element of advocacy."

6. Please provide as a maximum 3 relevant examples of social services representing one or more of the (additional) characteristics which could be taken as good example for the special nature. Please indicate which concrete element of the characteristics is clearly deducible from the example chosen.

Debt counselling
This service is provided by churches and diaconal organisations to prevent indebtedness of families and single persons and to help them to consolidate their debts. This is a relatively new social service of growing importance meeting the challenges of private insolvencies, which is of primarily preventive character, needs a very high level of personal trust and continued companionship over several years and includes an important advocacy function on behalf of debitors.

Rehabilitation measures and integration measures for disabled people
These services help disabled people to (re-) integrate into society, for example with special vocational training. They are often long-term measures, which need high investments, for example in specialised "sheltered workshops". Such "sheltered workshops" can only be competitive on the market with additional financial support, because their workers are people with special needs. If they were primarily regarded as "economic activities", they would not be able to fulfil their special task to integrate handicapped people into work, becoming more independent and participating in public life.

Hospice services

These services offer assistance to dying people in hospitals and specialised hospices, as well as in families and private environments. The professionals in the services most often work alongside volunteers offering attendance, practical help and very often pastoral care. For many recipients, a common value-base and/or religious background of the service provider is very important in this situation, as they want to be sure to be allowed to die according to their own convictions. This is an area where an integrated provision of health services and social services is an important quality factor and where values and religious traditions play a vital role.

7. How could these characteristics relate to the exclusion of specific social services from the scope of the Services Directive (Art. 2(2)(j) read together with the relevant Recital 27) as politically agreed on 29 May 2006 (Doc. 100003/06)[1] ?

Because of the characteristics and special nature of social services we need a legal environment where we can make sure that these services are safeguarded. The services directive goes some way to recognise that these characteristics justify a specific approach to social services.

Field 3 – Use of characteristics by Member States

8. Please give a definition of what the "general interest" is in your country, and specify in which way (at national, regional or local level) it is defined or is intended to be defined in the future.

We believe that in the field of social services the definition of the General Interest must take into account the welfare state principle where it is based on constitutional rights.

9. How can the characteristics be used by the Member States, at national, regional or local level, when defining the particular general interest mission of a social service and determining the arrangement for its performance and organisation?

10. Have there been problems in the past with giving a concrete mandate to fulfil the particular general interest mission of a social service?

Field 4 – Use of characteristics at EU level

11. Please indicate how (e.g. in a binding way or not), in your view, the organisational characteristics could/should be used at EU level (e.g. agreed checklist) in order to verify whether for a specific social service the applicable Community rules are respected?

As is recalled in the Communication it is the responsibility of the member states to define which services are of general interest.

[1] Text available at the following website: http://ec.europa.eu/internal_market/services/services-dir/proposal_en.htm

We welcome the Commission's efforts to assist in clarifying the specificities of social services of general interest.
However, even if the characteristics given in the Communication are shared among member states the list cannot be legally binding or exclusive.

Field 5 – Experiences with the application of Community law

The Communication and its Annex provide for a further clarification on the conditions of application of Community rules and principles to social services in particular in the following fields:

- Public procurement
- Public-private partnerships
- Freedom to provide goods and services and freedom of establishment
- State Aid

12. Please indicate whether difficulties (may) still arise and if so in which legal areas and for which type of social services.

In some member states regulations are applied unnecessarily in order to comply with Community rules even when this is not required. This is particularly the case when member states use tendering procedures to contract social service providers when this, in fact, is not required. We would therefore like to call for a clearer communication on the application of Community rules.

A difficulty that may arise in the future is the unintentional effects of applying Community law to the field of social service in a way that will impede on the ability of services to fulfil their mission of general interest. If using tendering procedures it is essential to have criteria of selection which do not only focus on price but which take into account other criteria that will enable the service providers to offer services that live up to the characteristics as defined in the Commission's communication.

It also has to be taken into account that continuity is an important characteristic and quality element of social services of general interest. Continuity also underpins the confidence in the social protection system of the Member States. This point should be taken into account when considering public tendering procedures.

13. Please provide for concrete examples and experiences to illustrate these difficulties.

14. Please give an indication on the debate in your country/organisation on how these difficulties should be addressed (e.g. clarification of the non-applicability of state aid rules to different social services of general interest).

Field 6 – Social security schemes responding to the criteria deriving from the *Poucet and Pistre* case law

15. Please indicate whether the questions in the Fields 2, 3 and 4 could also have significance with regard to social security schemes responding to the criteria deriving from the *Poucet and Pistre* case law.
16. Please indicate whether there is a need for further and specific clarification on the application of Community rules as enumerated in Field 5 with regard to these social security schemes.

Field 7 – Future steps at Community level

17. Which expectations do you have concerning future steps at Community level?

We expect that the area of social policy will continue to be a competence of the Member states.

However, if steps were to be taken towards a legislative initiative at EU level, the specificities of different sectors of services of general interest need to be taken into account whilst a piecemeal approach must be prevented to avoid developing conflicting approaches across different sectors of services of general interest.

We also expect more impact assessments of where current and future EU legislation affects policy areas outside the remit of its competence (such as social policy).

18. In case further steps should be considered, what could be the content, but also the advantages or disadvantages of these, including in particular intensified exchange of information, open method of co-ordination, Commission's Communications but also a Framework Directive for social services?

As Europe is widening its cooperation in the economic field we are concerned that the social dimension will suffer. However, we believe that subsidiarity must be the guiding principle for constructing social protection also in the future. ***We do welcome a strengthening of the open method of coordination*** *in the field and welcome any ways that it could be made to have greater impact through bench-marking and ways it could involve more stakeholders.*
We would also welcome the Commission initiating a debate on minimum standards within the Member States.

We also encourage dialogue with civil society and churches (taking into account art. I-47 and art. I-52 of the Constitutional Treaty as well as declaration 11 of the treaty of Amsterdam) including the open method of coordination at the national level and the debate on the future of the social dimension of Europe at the EU level as these organisations have played and play a strong role in providing social services, in fostering social inclusion and in advocating for the weakest in society.

19. Please indicate the expectations with regard to the monitoring and dialogue procedure in the form of biennial reports announced by the Communication.

Brussels, January 16 2007

Caritas Europa

The Church and Society Commission of the Conference of European Churches (CEC)

The Secretariat of the Commission of Bishops' Conferences of the European Community (COMECE)

Eurodiaconia

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Caritas Europa
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The Church and Society Commission (CSC) *is one of the commissions of the Conference of European Churches (CEC). The CSC links CEC's 126 member churches from all over Europe and its associated organisations with the European Union's institutions, the Council of Europe, the OSCE, NATO and the UN (on European matters).*

Its task is to help the churches study church and society questions from a theological social-ethical perspective, especially those with a European dimension, and to represent common positions of CEC member churches in their relations with political institutions working in Europe.

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Eurodiaconia *is a federation of 34 members - churches, non-statutory welfare organisations and NGOs in Europe - operating at national and international level. Our members are rooted in Christian faith within the traditions of the Reformation as well as in the Anglican and Orthodox traditions. We network diaconal and social work of institutions and church communities and co-operate with civil society partners.*
Our Mission: We link our members to serve for solidarity and justice. Our strategic aims are to ensure quality of life for all in a social Europe, to link institutions of diaconia, social initiatives and churches in Europe, to be and to enhance a network of competence.