



Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

ANNUAL REPORT

2016



We want to be



independent



meticulous



transparent

To achieve a healthcare that is



of high quality



accessible



durable



Patient-based



ABOUT US

Who are we?

The KCE (Belgian Health Care Knowledge Centre) is an independent research centre that provides scientific advice on topics related to the organisation of health care. In general, these topics are proposed by public authorities, universities, professional associations, etc.

The mission of the KCE is to provide rigorous and objective scientific analysis and studies on the basis of which public authorities or healthcare providers can base their decisions regarding health care and health insurance. KCE is therefore expected to offer optimal solutions for care that are both accessible to all and of high quality, in a context of increasing demand and a limited budget.

However, that is where the role of KCE ends. It is not involved in the subsequent political choices or in their implementation, even when this implies that its advices are adjusted by the policy makers to the reality of the field...

KCE is a type B parastatal organisation. This status guarantees total independence from the subsidiary powers, who essentially are the federal authorities (INAMI for 75% and FPS Health and Social Security, together for 25%). In addition, some specific European subsidies cover KCE's involvement in international research networks and projects .

What does KCE stand for?

The Belgian Health Care Knowledge Centre has chosen the acronym KCE, which is a contraction of the words Kenniscentrum (Dutch) - Centre d'Expertise (French)



What do we do?

The KCE mission encompasses five areas of expertise :

- ♦ **Organisation and financing of health care** in the broadest sense (*Health Services Research*)
- ♦ **Evaluation of medical technologies** (*Health Technology Assessment*)
- ♦ The production of **clinical practice guidelines** and their constant adaptation to new scientific developments (*Good Clinical Practice*)
- ♦ Setting up and coordination of the **Belgian non-commercial clinical research programme** (*KCE Trials*)
- ♦ Creation of accurate **methodological manuals** to establish validated working methods for all health care and public health researchers (*Methods*)



In 2016, KCE published 19 reports

Our Board of Directors

Our Board of Directors (hereinafter, the “Board”), consists of representatives of the public authorities and the most important actors in healthcare, health insurance and patient associations, in a balanced composition.



At each Board meeting our new finalised reports are presented. The scientific content is in principle not subject to modification, except on the basis of quantifiable methodological arguments.

The political recommendations, based upon the scientific work, are then discussed, sometimes nuanced, and approved by a simple majority, when voting turns out to be necessary.

Finally, KCE is legally obliged to publish all of its results within one month of their approval by the Board, which is an additional guarantee for our transparency.



Our networks and collaborations

Subcontractors

Despite an in-house team with many skills, the KCE does not always have the necessary internal expertise or the time to perform all of the studies itself. This is why some studies are fully or partially outsourced by public tender to, for example, university teams, specialised consultants or other public services. Also in these cases, the KCE stays responsible for the coordination and the supervision of the project.

External experts and validators

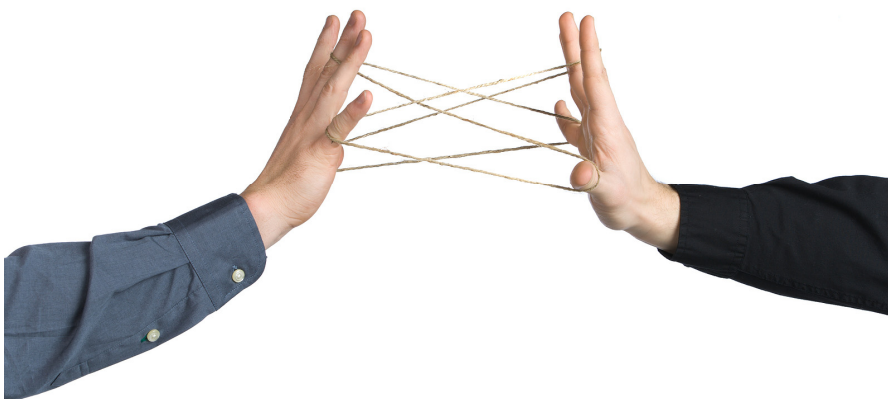
For each of its reports, KCE involves external experts. These people, mostly specialists on the study subject, provide feedback on the research questions, the methodology and the key points to be taken into account for a better acceptance by the field.

Furthermore, all KCE reports are subject to internal and external scientific validation. For the latter, KCE invites three external experts, at least one of whom is foreign. In this way, the KCE benefits from critical, constructive external views on its work, and this contributes to the relevance and the scientific rigour of its reports.

In the course of the years, these collaborations have enabled KCE to build a very rich network with highly specialised national and international experts in a wide range of fields.

The stakeholders

For each of its studies, KCE systematically gathers the opinion of the interested stakeholders. Thanks to these meetings, the communication between the scientific world and the world of decision-makers in the health care sector can be improved and professionalised.



Conflict of Interest Policy

KCE is absolutely committed to its independence and neutrality. Therefore its policy on conflicts of interest is clear and transparent:

- ♦ KCE researchers are not authorised to engage in other professional activities that may give rise to conflicts of interest;
- ♦ All external experts, subcontractors or validators who are involved in a KCE-study have to sign a declaration of possible conflicts of interest, which will be included in the colophon of the report.

International collaborations

KCE has excellent relationships with other scientific institutions conducting similar research in other countries such as NICE (United Kingdom), ZIN (the Netherlands), HAS (France), IQWiG (Germany) or the Norwegian Institute of Public Health (Norway).

Due to its reputation of scientific rigour the KCE receive many requests to participate in working groups on an international level. It is an active member of several international networks such as EUnetHTA, GIN or INAHTA and it is involved in European projects, such as PREFER (IMI). In this initiative, the aim is to develop a method which takes into account the preferences of the patient in the making of new drugs.



Propose a research topic!

For the KCE year programme

Each year, before summer, KCE launches a call for study proposals for the work programme of the following year. Any citizen, organization, institution or policy maker can submit a study proposal between July and September. The work programme is then composed, based upon the following criteria:

- ♦ The potential of the proposed subject to improve health care decisions,
- ♦ The frequency and severity of the health problem and the potential to improve it
- ♦ The feasibility of the study

In order for this evaluation process to proceed as neutrally as possible, all proposals are anonymised.

If you wish to be kept informed on our calls for projects, please register on the website via 'receive news'.



For the clinical trials programme (KCE Trials)

The KCE Trials programme includes three types of calls for study proposals:

- ♦ Within the 'commissioned work stream', the first call is open to any interested citizen. After the selection of the topics, a second call is launched, this time to 'candidate sponsors'. These are the research teams that are interested in actually performing the clinical trials on the selected topics.
- ♦ Within the 'investigator led workstream': only those teams who can also carry out a clinical study themselves may submit a topic.
- ♦ Within the 'international workstream' where Belgian research teams can collaborate with foreign research teams in various ways.

Unlike the classical KCE studies, the calls for study subjects for KCE Trials are not published in a fixed frequency. You can ask to be kept informed on calls and other information from KCE Trials by subscribing on the KCE website.



Our visibility

The main ‘products’ of KCE are its reports. The law provides that all reports should be published on the KCE website within one month of their approval by the Board of Directors. Therefore, the KCE-communication follows the rhythm of these publications, about twenty per year. In addition, a lot of attention is also given to other initiatives, as you will discover below.

The website as our basic tool

For each published report, a specific page is created, with documents that are tailor-made to the degree of interest of each reader:

- ♦ The scientific report describes the performed research, with the methodological details and results. It is always written in English, since it is the language of the scientific community (Belgian and international) and of our research teams, whose members often speak different languages.
- ♦ It is sometimes accompanied by a short report, also in English, which summarises the research work and contains the discussion of the results.
- ♦ A 20 to 30 page summary, which outlines in a clear and fluid language the context of the study, the main results and the final recommendations. The summary is available in French and Dutch as it is addressed to all interested citizens, but above all to health care professionals and the concerned decision-makers.



- ♦ A press release, a two-page text written for journalists that can also serve as a quick introduction to the subject. It is published in French and Dutch.
- ♦ Possibly a short video, when the message is likely to interest a large public. The authors of the study explain the outline of their findings in a language that is clear and accessible to everyone.
- ♦ Infographics, Power Point presentations, etc.
- ♦ Some reports are grouped into thematic pages (Focus) (in Dutch and French). In that way, KCE studies and publications on a particular topic (e.g. pregnancy and birth, preventive medicine, prostate cancer, etc.) can be found, through one click,.

The website also contains our other publications, such as the KCE has read for you's, and calls for study proposals, public tenders, job offers, etc. This information is also systematically sent to everyone who wishes to be kept informed on our activities by registering on our website.

Our website in figures

136.315 visitors (2015: 112.950)

571.834 page views (2015 : 502.444)

6793 video views for a total of 14.212 minutes

Communication with the media

We systematically communicate on each published report towards the general and specialised (medical) press. It is important for us to publicly report on our work. That is why we pay great attention to our press relationships. We try to provide journalists with clear but nuanced information, and we are available to those who wish to explore a subject further.

Our experts are regularly solicited for feature articles or for TV and radio interviews. It shows that the KCE is increasingly emerging as a reliable and competent source in the eyes of the media and the public.



The interest of the media in 2016 in a few figures

750 press articles in the printed press (+ 85 from press agencies)

70 TV-programmes (news, debates and information magazines)

271 radio-broadcasts

Our followers

If you wish to be kept informed on all our publications and activities, please register by clicking on 'receive news'. Today, about 5000 subscribers regularly receive our mailings.

In 2016, we also launched a newsletter, in Dutch and French, specifically for general practitioners (five times a year). In our projects, we often put this professional group at the centre of our projects, but paradoxically GPs seem less aware of our work. At the end of 2016, about 700 GPs had subscribed to this newsletter.

We also expanded our social media presence. Aside from Twitter and LinkedIn, our information is now shared through Facebook, enabling us to broaden our visibility and add immediate interactivity to our communication. Our videos are available on our YouTube channel.

1224 Twitter followers (800 en 2015)

1298 subscribers on LinkedIn (environ 1000 en 2015)

500 'likes' on Facebook

17.490 pages were viewed through social media (17.278 in 2015)



OUR TEAM

The health care domain is very complex. There is no scientific training that comprises all its numerous aspects. That is why at KCE we have opted for a truly cross-disciplinary approach. No research is conducted by a single researcher; on the contrary, each research question is examined from a medical, economic, social, legal and/or ethical perspective, depending on the needs. This is highly appreciated, both by the users of the studies and by the researchers themselves .

Our **45 experts** can be divided into three different categories:

- ◆ researchers with a **clinical** background: physicians, nurses, physiotherapists, dentists, psychologists, all who have acquired complementary skills (usually a PhD) in subjects such as public health, epidemiology, methodology for the development of guidelines, analysis and data management, etc. Some of these experts were or are still clinically active (which enhances their understanding of the field), others have committed themselves to full-time research at KCE.
- ◆ researchers with a background as **health economist**. Thanks to their expertise, we are able to conduct very thorough economic assessments, including Health Technology Assessments (HTA). Their contribution is also essential for our studies on the organization and financing of health care, an area for which KCE is increasingly solicited.
- ◆ researchers with a background in **other human sciences**. Sociologists conduct qualitative studies: they collect data from field experts, patients, stakeholders, etc.) and ensure their rigorous processing. Other researchers allow us to discuss the possible legal or ethical aspects of the varied research questions.
- ◆ **data analysts, statisticians and specialists in scientific information**. They extract from international and Belgian data the pertinent information and figures for our research. They also scrupulously ensure that while using the sometimes very sensitive data, the privacy legislation is respected, that all useful information is identified and that the figures are interpreted correctly. In this way we can collect very precise statistics.
- ◆ specialists in **dissemination and knowledge management**. The first group of specialists adapts the language of our reports to the different target groups and ensures that the message reaches the appropriate audience. Thanks to the second group, all our experts can maintain and develop their expertise, and the quality of our work is guaranteed thanks to meticulous work procedures.



Performant support services

All our experts work in a very horizontal organisation on a human scale where working procedures are well organised and decisions are efficiently taken after deliberation. They are supported by performant support services (ICT, webmaster, library, communication, layout, secretariat, accountancy, etc.).

All together they form a small (63 people) but performant and enthusiastic team



KCE staff members active in 2016

	In FTE*
Chairman	0,2
Management	3,0
General Management	2,0
Programme Management	1,0
Studies	41,4
Physicians, dentists, nurses, physiotherapists...	20,9
Health economists	9,5
Sociologists, lawyers	2,8
Data analysts, statisticians and specialists in scientific information	5,3
Experts in dissemination and knowledge management	2,9
Support	11,3
Secretariat and lay-out	5,3
ICT, website and library	2,0
Legal advice and HR management	2,2
Budget and Accountancy	1,8
TOTAL	55,9

* FTE: full-time equivalent



OUR RESEARCHES

HEALTH SERVICES RESEARCH

for a better health care organisation?

Studies on Health Services Research (HSR) focus on the best way of organising and financing health services in order to guarantee the quality and accessibility of health care, whilst maintaining their economic viability for community and patient.

HSRs are often complex as they have to reconcile the organisational contingencies of health policy with the human context, the opinions and interests of the various professions involved and budgetary factors. Therefore, these research projects are always conducted by transdisciplinary teams.

In general, HSR studies are based on an exhaustive analysis of the scientific literature and of a variety of examples from different countries. The various stakeholders are always closely involved in the main steps of the project. Through its HSR studies, KCE is able to suggest-sometimes radical- reforms for an entire sector.



The integrative methodology of Health Services Research studies was used for two large reform projects on the *organization and reimbursement of psychological and emergency care department services in Belgium*.

This latter project is part of a vast plan for the reform of the hospital landscape launched by Minister of Social Affairs and Public Health, Maggie De Block, for which the KCE has also conducted other preparatory work, such as the development of *governance models for hospital collaborations* and a first attempt to *cluster groups of pathologies according to hospital stay similarity*.





The report on the *improvement of the detection of child abuse by health professionals* attracted major attention from the policy makers and the press. In the meantime, concrete actions in the field have been taken.

Substantial interest was also shown in the report relating to the *compensation of people contaminated with hepatitis C or HIV after a blood transfusion*. Today, these victims are not all equally treated in terms of compensation, which depends on the pathology and the moment of contamination.



A special mention should be made of a joint publication of the KCE and its Dutch colleagues of ZIN (National Care Institute) on *future scenarios for drug development and price setting*. This innovative report, for which some really 'out of the box' thinking has been done, is the result of the work of an international think tank convened by the two institutions. This group has not been afraid to discard some of the paradigms of the current system. It considers medicines as a public good, which should be accessible to everybody without distinction. By organizing this exercise, we participated in a larger, public debate on future drug policies, which is a growing concern worldwide .

In addition, the KCE continues to pursue its fundamental work on the transparency of decision-making with regard to the reimbursement of new treatments. In 2014, the INAMI-RIZIV (National Institute for Health and Disability Insurance) had asked the KCE to what extent it was possible to consider the values that are important to the citizens in the decision-making process.

The methodology developed by the KCE, which is based on multiple-criteria decision analysis (MCDA), was subject to a pilot exercise in 2016 to establish the list of "*unmet medical needs*". This exercise is being closely followed in other countries, since Belgium is a pioneer in citizen and patient involvement in health policy.



The KCE also offers its methodological support to other public authorities in order to help them fine tune their working methods. A study was conducted on the possibility of applying the aforementioned MCDA method for to select priority diseases for *newborn blood screening*, at the request of the French and Dutch Community.

The sixth state reform has transferred the competences for rehabilitation to the Communities. Therefore they urgently need effective tools. The Flemish authorities requested the KCE researchers to perform a study on the *use of the BelRai suite of tools*.

Finally, at the request of the Medical Planning Commission, the KCE analysed the data on the training of *midwives in Belgium and their current workforce*.



HEALTH TECHNOLOGY ASSESSMENT

using public resources for treatments with a real added value



Health Technology Assessments (HTA) analyse the safety and efficacy of a technology, a drug or a vaccine, often in combination with an economic analysis of the cost-effectiveness. The aim of these studies is to establish the proportion of the price of the technology to its health and quality-of-life benefits.

These assessments are most often conducted on products presented as innovative, for which the industry negotiates prices with the public authorities that are often (extremely) high. HTAs can often encounter a strong resistance, as they oppose the idea that “you can’t put a price on health”. On the contrary, we at the KCE are persuaded that it is not ethical to reimburse a health intervention without first confirming in a real-life situation that it brings added value in terms of health, at a reasonable cost for society.

A study on the [*pneumococcal vaccine in elderly people*](#), had the unexpected result that the old vaccine was preferable to the new one because it protects against a greater number of serotypes. In fact, the new vaccine, which is more sophisticated and therefore more expensive, was so effective in newborns that the incidence of serotypes it protects against was drastically reduced in elderly patients. Therefore, this new vaccine became less useful in this population.

There is no doubt, however, on the [*new treatments for hepatitis C*](#): their effectiveness is spectacularly higher than that of older treatments, as is their price... But to what extent can the reimbursement of these treatments be expanded to all people carrying the virus, rather than limiting reimbursement only to patients with serious liver damage, as was the case up to the end of 2016? The KCE recommended the widest reimbursement possible, but also specified a phased approach and a renegotiation of the price in order to keep the health insurance budget under control.



Another innovative technology we examined in 2016 were the *left ventricular assist devices in the treatment of end-stage heart failure or LVADs*. These devices are pumps, designed to support the functioning of a decompensated heart whilst the patient is waiting for a heart transplant. However, some would like them to be used on a wider basis. The KCE-analysis concluded that these devices have a clear clinical benefit, but that they represent a major expense for the health system. Therefore the KCE pleads for a societal and ethical debate on this kind of issues.

Furthermore, we analyzed the *efficacy of biomarkers in ruling out cerebral lesions in mild cranial trauma*. Several cases of mild trauma are subjected to brain scans as a precaution, which are both costly and harmful, due to radiation, even though the risk of intracranial injury is very small. A blood test could limit the use of imaging to situations where it really brings added value.





Caesarean sections are increasing all over the world. In Belgium, for the moment, their share is fluctuating around 21% of all births, with important variations between hospitals (from 12% to 33%)

A 'rapid' HTA: the impact of caesarean sections on the health of mother and baby

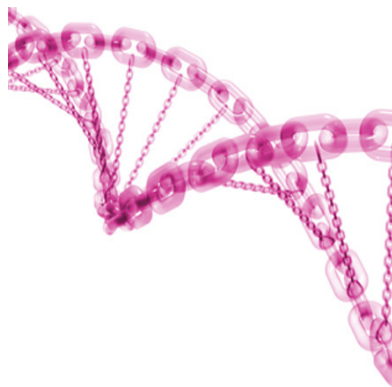
When used in the event of a medical problem in either mother or baby, caesarean sections can without doubt often prevent consequences that sometimes can be very serious. But do the benefits outweigh the risks when the intervention is used for non-medical reasons (which is increasingly the case)? The KCE examined the scientific studies comparing the immediate or long-term consequences of the two ways of delivery.

The main risks concern future pregnancies in particular: one caesarean will often imply more caesareans in the future. The KCE therefore recommends that future parents be well informed and that practitioners be made aware of the potential consequences. In that way we join the WHO that states that caesarean sections should only be conducted when really necessary. As like any other surgical intervention, it is not free from risks. Therefore exposing mother and baby to caesareans is not acceptable, if this cannot be justified by their health status .



CANCER

Promoting good clinical practice and quality of care



Although the overall quality of cancer care in Belgium is good, it still is heterogeneous. For several years, the KCE has been conducting fundamental research to support the continuous improvement of the quality of this care. The final aim is to give every person suffering from cancer access to the best possible care. Over time, this project should lead to a truly integrative system of quality monitoring, including clinical recommendations, quality indicators and a hospital feedback and benchmarking dynamic. These projects are jointly conducted by the KCE, the Fondation Registre du Cancer (Belgian Cancer Registry) and the College of Oncology.

Good Clinical Practice (GCP) studies

In 2016, the KCE developed two guidelines for two cancers that are difficult to treat and for which significant advances have been made in diagnosis or treatment: *rectal cancer* and *ovarian cancer*. These guidelines have recently been added to an already long list of clinical recommendations published over the past few years for cancers of the oesophagus, stomach, pancreas, cervix, colon, prostate, breast, lung, bladder and head and neck.

Medicine is constantly evolving and we cannot expect care takers always to be at the cutting edge of each new development. Guidelines for good clinical practice are tools designed for practising health professionals. They are “summaries”, based on the most recent scientific knowledge, supporting physicians in the treatment of a patient without having to have read the entire scientific literature.

Developing such state-of-the-art tools requires a very meticulous work, of which KCE researchers in particular have expert knowledge. But in order for guidelines to be usable in practice, they must also take account of the Belgian context and the daily reality of medical practice. This is why this type of project is always performed in dialogue with a wide panel of experienced clinicians – a Guideline Development Group (GDG) – that are willing to invest time in the numerous meetings. In that way tools with updated knowledge, that are adapted to the needs of practitioners, are created.

Parallel to this work of continuous updating of knowledge, the KCE launched a discussion on the form and the dissemination of the guidelines: what is the optimal presentation for these tools? How can we make them more user friendly for care providers? How can digital technologies be involved? The result of this exercise will be the subject of a publication in 2017.



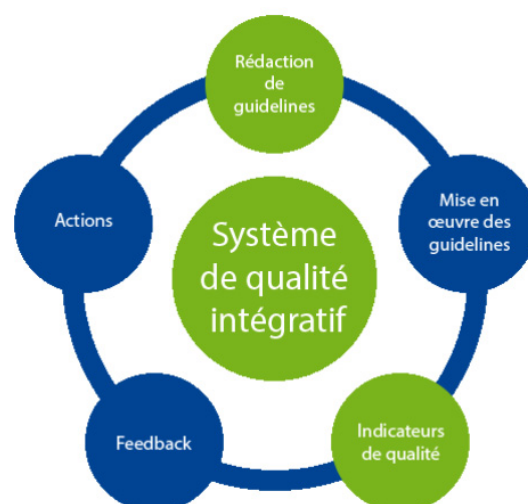
A multi-step system to improve the quality of cancer care in Belgium

Publication of guidelines is only a first step in the improvement of quality of care. In the following phase, quality indicators need to be set up. For this, the KCE identifies sets of quality indicators on diagnosis, treatment and follow-up of patients, in order to enable practitioners to assess the level of quality of their work (feedback) and to adjust the way they render care. This approach has already been applied to five cancer types (rectal, breast, testicular, oesophageal and stomach). In 2016, the KCE identified 23 quality indicators for the *diagnosis and treatment of lung cancer*, still the most lethal cancer.

The Belgian integrative quality system

- ♦ development by the KCE and the College of Oncology of guidelines for a specific cancer type bases on the international scientific literature;
- ♦ on the basis of these guidelines the KCE defines the most relevant quality indicators to assess the quality of the care cancer;
- ♦ for each indicator, the Cancer Registry analyses the results for the entire country and per hospital, using data from several consecutive years;
- ♦ individualised feedback is sent to all hospitals by the Cancer Registry. The results of each individual hospital are compared to those (anonymous) of all Belgian hospitals together, to allow each hospital to situate its practices hierarchically and identify its strengths and weaknesses (benchmarking);
- ♦ adoption of corrective measures by hospitals with

Ideally, this should be a continuous cyclical process, whereby the guidelines are regularly adapted to the most up-to-date scientific data.



Translation of the figure: Integrative quality system; Guideline development; Guideline implementation; Quality indicators; Feedback; Actions



KCE TRIALS

A non-commercial clinical trials programme in Belgium

In November 2015, Maggie De Block, the Minister of Health, requested the KCE to establish and coordinate a non-commercial clinical trials programme in our country, thereby following the convincing example of countries such as the UK, the Netherlands and Germany. These clinical trials research is conducted, such as comparing therapeutic strategies (not necessarily drug-based), studying the effect of existing drugs on populations often excluded from commercial studies (children, the elderly, people suffering from rare diseases) and assessing systematic screening tools or health-promoting strategies, etc.

The KCE Trials team published a first call for study topics in the beginning of 2016. 165 proposals were received, of which 80 were selected for in-depth examination and 11 were finally withheld. For these 11 topics, the KCE Trials team launched a selection procedure for research teams interested in developing and conducting trial protocols with the methodological and financial support from the KCE. This selection is currently in its final phase. In addition, the KCE has negotiated the participation of Belgian teams (and patients!) in three international projects, coordinated by our Dutch colleagues at ZonMw (the Netherlands Organisation for Health Research and Development). The first patient was enrolled at the end of 2016, which was actually the target set by KCE Trials for 2016!



The KCE Trials team: from left to right : Frank Hulstaert, Hilde Nevens, Jillian Harrison, Leen Verleye, France Vrijens



Parallel to the selection procedure of study topics, the KCE Trials team conducted an audit of the clinical research infrastructure at the Belgian university hospitals in order to assess their strengths and weaknesses (gap analysis). To resolve the shortcomings revealed by the audit, a specific customised training programme has been launched. The ultimate objective is to improve the overall quality of the clinical research in our country. The first workshops are held in the first days of January 2017.

An international symposium was organised in November 2016 for the official kick-off of the KCE Trials programme. The opening speech was given by Minister of Health Maggie De Block. An international panel of representatives from different scientific agencies, other organisations in the sector and European institutions shared its vision and working practices with 300 participants from the entire Belgian health care community.



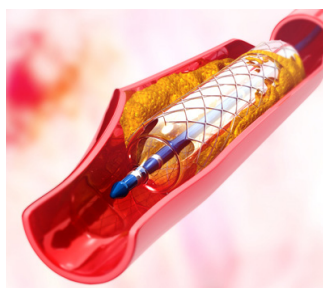
KCE HAS READ FOR YOU

scientific publications read and summarised for you

A major number of public and independent scientific institutions throughout the world (such as NICE, HAS (French National Authority for Health) and the Cochrane Collaboration) conduct the same type of research as the KCE. The results they publish can also be relevant for healthcare in Belgium. The same applies to certain significant publications in peer reviewed journals (the British Medical Journal, the Lancet, the New England Journal of Medicine etc.) or decisions taken by official bodies such as the European Medicines Agency (EMA), the US Food and Drug Administration (FDA) and the European Commission.

KCE researchers, constantly immersed in the international scientific literature, are well placed to identify the articles with a concrete interest for the Belgian medical community in this mass of publications. 'KCE has read for you' provides you with a two-page critical summary of the selected articles. It does not, however, give any clinical or political recommendations.

Four editions of 'KCE has read for you' were published in 2016:



- ♦ a comparison of *bioresorbable coronary scaffolds* and metallic drug-eluting stents (DES) for obstructive coronary artery disease. This was a systematic review published by the Ludwig Boltzmann Institute for Health Technology Assessment, which concluded that the available evidence is currently insufficient to prove that bioresorbable stents are just as effective and safer than DES. The authors recommended a re-assessment in 2018, by which time results from some of the ongoing trials are expected to be available.



- ♦ an assessment of *hyperbaric oxygen therapy (HBOT)* in the treatment of diabetic foot ulcers. The original review from the Cochrane Collaboration concluded that HBOT significantly improved healing in the short term, but not in the long term. These conclusions are in line with those of a previous KCE report published in 2008, which did not recommend HBOT for chronic wounds.





- ◆ an assessment of the efficacy and cost-effectiveness of *seven new immunotherapy drugs used in the treatment of malignant melanoma*. According to a study by the Norwegian Knowledge Centre for the Health Services, all new treatments had ICERs above €100 000 per quality-adjusted life year (QALY). Five of these drugs are already reimbursed in Belgium, but KCE estimated that further research would be useful to confirm the available clinical data and assess the side effects and the impact of these drugs on health related quality of life.



- ◆ an *assessment of two clinical algorithms to identify patients who have suffered mild head trauma* for whom the risk of serious intracranial injury is low and for whom a CT scan could, therefore, be avoided. This article, published in the Journal of the American Medical Association (JAMA) is very complementary to our HTA-report of 2016, in which we investigated the reliability of blood biomarkers, also with the same aim of limiting the use of CT scans.

*Incremental Cost-Effectiveness Ratio (incrementele verhouding tussen kost en effectiviteit): deze waarde geeft de kost weer van een gewonnen levensjaar in goede gezondheid



LIJST VAN DE RAPPORTEN

Rapport **260**: Guideline on the management of **rectal cancer** (*Good Clinical Practice*)

Rapport **261**: The role of **biomarkers** in ruling out cerebral lesions in mild cranial trauma (*Health Technology Assessment*)

Rapport **262**: **Belrai suite of instruments**: an exploratory study on applicability for individual care planning and budget allocation in rehabilitation care (*Health Services Research*)

Rapport **263**: Organisation and payment of **emergency care services in Belgium**: current situation and options for reform (*Health Services Research*)

Rapport **264**: **Left ventricular assist devices** in the treatment of end-stage heart failure (*Health Technology Assessment*)

Rapport **265**: Model for the organisation and reimbursement of **psychological and orthopedagogical care in Belgium** (*Health Services Research*)

Rapport **266**: Quality indicators for the management of **lung cancer** (*Health Services Research*)

Rapport **267**: Multi criteria decision analysis to select priority diseases for **Newborn blood screening** (*Health Services Research*)

Rapport **268**: **Ovarian cancer**: diagnosis, treatment and follow-up (*Good Clinical Practice*)

Rapport **269**: How to improve the detection of **child abuse** in Belgium? (*Health Services Research*)



Rapport **270: Clustering pathology groups** on hospital stay similarity (*Health Services Research*)

Rapport **271: Future scenarios about drug development and drug pricing** (*Health Services Research*)

Rapport **272: Multi-criteria beslissingsanalyse** voor de beoordeling van **medische behoeften**: pilootstudie (*Health Services Research*)

Rapport **273: Financial compensation for persons infected by a contaminated blood transfusion** – an attempt to reduce discriminations (*Health Services Research*)

Rapport **274: Use of pneumococcal vaccines in the elderly**: an economic evaluation (*Health Technology Assessment*)

Rapport **275: Elective caesarean section** in low-risk women at term: consequences for mother and offspring? (*Health Technology Assessment*)

Rapport **276: Economic evaluation of novel direct acting antiviral (DAA) treatment strategies for chronic hepatitis C?** (*Health Technology Assessment*)

Rapport **277: Governance models** for hospital collaborations (*Health Services Research*)

Rapport **278: Health workforce planning and midwifery-specific data** (*Health Services Research*)



BALANCE

ASSETS	31/12/2016	31/12/2015
FIXED ASSETS	224.563,18	308.641,94
I. Formation expenses		
II. Intangible fixed assets	43.695,56	101.251,54
III. Tangible fixed assets	180.867,62	207.390,40
A. Land and buildings	101.797,08	152.695,62
B. Plant, machinery and equipment	69.193,56	45.468,81
C. Furniture and vehicles	9.876,98	9.225,97
D. Leasing and similar rights		
E. Other tangible fixed assets		
F. Assets under construction and advance payments		
IV. Financial fixed assets		
CURRENT ASSETS	14.318.124,87	8.292.877,45
V. Amounts receivable after more than one year		
A. Trade debtors		
B. Other amounts receivable		
VI. Stocks		
VII. Amounts receivable within one year	110.269,69	138.682,65
A. Trade debtors		
B. Other amounts receivable	110.269,69	138.682,65
VIII. Current investments		
IX. Cash at bank and in hand	14.142.714,26	8.097.507,43
X. Deferred charges and accrued income	65.140,92	56.687,37
TOTAL ASSETS	14.542.688,05	8.601.519,39



EQUITY AND LIABILITIES		31/12/2016	31/12/2015
EQUITY		6.193.332,13	6.226.510,89
I. Capital			
III. Revaluation surpluses			
V. Accumulated profits (losses)		6.193.332,13	6.226.510,89
VI. Investment grants			
PROVISIONS AND DEFERRED TAXES			
VII. Provisions for liabilities and charges			
A. Pensions and similar obligations B. Taxes C. Major repairs and maintenance D. Other liabilities and charges			
AMOUNTS PAYABLE		8.349.355,92	2.375.008,50
VIII. Amounts payable after more than one year		50.898,54	101.797,08
A. Financial debts 1. credit institutions, leasing and other similar obligations 2. other loans B. Trade debts C. Advanced received on contracts in progress D. Other amounts payable		50.898,54	101.797,08
IX. Amounts payable within one year		8.298.457,38	2.273.211,42
A. Current portion of amounts payable after more than one year falling due within one year B. Financial debts 1. Credit institutions 2. Other loans C. Trade debts D. Advances received on contracts in progress E. Taxes, remunerations and social security 1. Taxes 2. Remunerations and social security F. Other amounts payable		50.898,54	50.898,54
		1.280.242,33	601.677,82
		301.433,10	
		946.236,00	568.848,16
		183.769,65	173.949,81
		762.466,35	394.898,35
		5.719.647,41	1.051.786,90
X. Deferred charges and accrued income			
TOTAL LIABILITIES		14.542.688,05	8.601.519,39



PROFIT AND LOSS ACCOUNT

PROFIT AND LOSS		
	31/12/2016	31/12/2015
I. Operating income	15.087.864,99	9.083.403,22
A. Turnover		
B. Stocks: increase (decrease)		
C. Own construction capitalized		
D. Intern billing		
E. Other operating income	15.087.864,99	9.083.403,22
II. Operating charges	9.479.125,54	8.723.186,48
A. Purchases and stocks		
B. Services and other goods	2.610.614,60	2.311.434,12
C. Remuneration, social security costs and pension	6.671.457,96	6.214.345,32
D. Depreciation of and other amounts written down formation expenses, intangible and tangible fixed assets	197.052,98	197.407,04
E. Amounts written down stocks, contracts in progress and trade debtors: appropriations (write-backs)		
F. Provisions for risks and charges		
G. Other operating charges		
H. Operating charges carried to assets as restructuring costs		
III. Operating profit (loss)	5.608.739,45	360.216,74
IV. Financial income	0,00	0,00
A. Income from financial fixed assets		
B. Income from current assets		
C. Other financial income		
V. Financial charges	1.778,14	460,12
A. Debt charges		
B. Amounts written down on current assets except stocks, contracts in progress and trade debtors		
C. Other financial products	1.778,14	460,12
VI. Profit (losses) on ordinary activities before taxes	5.606.961,31	359.756,62



VII. Extraordinary income	0,00	0,00
A. Write-back of depreciation and of amounts written down intangible and tangible fixed assets B. Write-back of amounts written down financial fixed assets C. Write-back of provisions for extraordinary liabilities and charges D. Gains on disposal of fixed assets E. Other extraordinary income		
VIII. Extraordinary charges	5.640.140,07	380.940,44
A. Extraordinary depreciation of and extraordinary amounts written down formation expenses, intangible and tangible fixed assets B. Amounts written down financial fixed assets C. Provisions for extraordinary liabilities and charges D. Losses on disposal of fixed assets E. Other extraordinary charges F. Extraordinary charges carried to assets as restructuring costs	5.640.140,07	380.940,44
IX. Gain (loss) of the period	-33.178,76	-21.183,82
A. Profit to be appropriated (+) Loss to be appropriated (-)	6.193.332,13	6.226.510,89
1. Gain to be appropriated (+) Loss to be appropriated (-)	-33.178,76	21.183,82
2. Profit (loss) brought forward		
A. Profit brought forward (+) B. Loss brought forward (-)	6.226.510,89	6.247.694,71
D. Profit (loss) to be carried forward		
1. Profit to be carried forward (+) 2. Loss to be carried forward (-)	6.193.332,13	6.226.510,89



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