KCE

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

ANNUAL REPORT

2017

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We want to be

Independent

Meticulous

Transparent

To achieve a healthcare that is

Effective

Of high quality

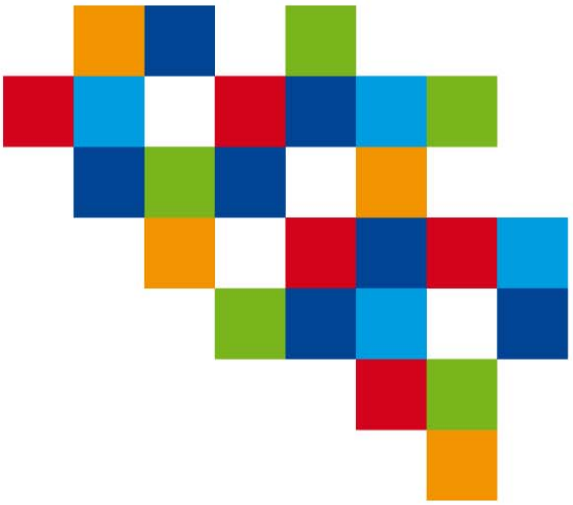
Secure

Patient centered

Accessible

Durable

ABOUT US



KCE

Who are we?

The KCE (Belgian Health Care Knowledge Centre) is an independent federal research centre that provides recommendations to competent authorities and various health care stakeholders based on scientific analysis. These analyses focus on the effectiveness and cost-effectiveness of health interventions, and the organisation, financing and reimbursement of health care. KCE also develops clinical practice guidelines for healthcare providers.
Topics are usually proposed by public authorities, universities, professional associations but any citizen can also submit a research proposal.

The KCE is not involved in the political choices based on the reports it publishes. However, it may be required to intervene in implementation phases when its technical skills are an essential added value.

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 adaption to new scientific developments *(Good Clinical Practice)*
- Setting up and coordination of the ***Belgian non-commercial clinical research programme*** *(KCE Trials programme)*
- Creation of accurate ***methodological manuals*** to establish validated working methods for all health care and public health researchers *(Methods)*

In 2017 KCE published 18 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 independency and transparency.

OUR TEAM

The healthcare 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 **50 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 organisation 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 united and enthusiastic team of 70 people, motivated by the same goal: to provide the studies needed to maintain or improve an effective, safe, quality, accessible and sustainable health care system.

KCE members active in 2017

	In full-time equivalent
Chairman	**0,2**
Management	**3,0**
General Management	2,0
Programme Management	1,0
Studies	**39,9**
Physicians, nurses, dentists, physiotherapists...	19.,5
Health economists	9,6
Sociologists, lawyers	2,8
Data analysts, statisticians and specialists in scienfic information	5,1
Experts in dissemination and knowledge management	2,9
Support	**15,5**
Project facilitator	2,0
Secretariat and lay-out	5,1
Secretariat Trials	1,8
ICT, website and library	2,0
Legal advice and Human Resources Management	2,6
Budget and accountancy	2,0
TOTAL	**58,6**

OUR RESEARCH

HEALTH SERVICES RESEARCH

For better health care organisation

Studies on Health Services Research (HSR) focus on the best way of organizing 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 organizational 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 analysis of the scientific literature but also of grey 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.

Optimise the management of serious trauma

In the area of acute care, there is an international trend towards “integrated trauma systems”. Hospitals must collaborate within these networks, according to their capacity to manage these patients. The most serious injuries are sent as quickly as possible to “Major Trauma Centres”, i.e. centres meeting extremely high requirements in terms of equipment, personnel qualification and availability (24/7). Our Belgian hospitals are already very good, but if we want to set up such an integrated system at home we must first solve serious coordination problems between the various actors . The current reform of the hospital landscape offers the opportunity for this. Taking into account travel times, local geographic specificities, population coverage, the minimum volume of patients to be treated and the availability of existing mobile teams, we estimated that it would be reasonable to have 4 to 7 Major Trauma Centers for the whole Belgian territory.

Health care in Belgian prisons

The responsibility for health care in prison is planned to be transferred from the Minister of Justice to that of Public Health. To prepare for this transfer, we were asked to take stock of the current organization of care and to suggest ways to improve it. Many inmates are in poor health in our prisons, and the care professionals who care for them, often with great dedication, face many problems. Therefore we developed some scenarios in order to enable them to play their caregiving role to the best of their ability, including interdisciplinary teams for primary care, an individual care plan for each newcomer, and continuity of care with caregivers from outside the prison community – also after release, and a strengthening of coordination at the national level. Our country must be able to provide prisoners with health care equivalent to that provided outside the prison, which is also required by Belgian and international legislation. .

What is 'appropriate' end-of-life care?

How is it that some people at the end of their life are treated in a way that does not comply with their wishes? How can we avoid this? Appropriate end-of-life care is care that meets the individual needs of each patient. Some people want to prolong their lives by any means possible, while others prefer to stop all curative treatments and only want comfort care. Thinking in advance about these questions and communicating about what you want is an approach that avoids any such misunderstandings. This is called "advance care planning". Ideally, this should be done with the general practitioner, in agreement with the family, and lead to a written record kept in the medical file. But the work pressures that caregivers often face do not allow them to spend time discussing such issues with the patients. And patients themselves are not always ready to talk about their nearing death, or are no longer in a position to do so. Regardless of the care system – hospitals, nursing homes or home care – listening to patients, talking with them and being present with them should be part of normal daily work .

REFORM OF THE HOSPITAL LANSCAPE

As part of her hospital landscape reform plans, Minister Maggie De Block asked KCE to calculate how many beds we will need in hospitals in 2025. It seems we already have too much capacity in the current situation and that this will escalate in the years to come.

There are too many small maternity wards where only one or two deliveries are performed per day; one-third of these beds will have to be closed by 2025. There is also a need to treat many more patients in day hospitals. The study, however, highlights a deficit of beds for geriatric patients and revalidation, deficits that will further widen if we do not already put in place alternative formulas to hospital care .

Another study identified conditions that would help to increase the use of day surgery. For operations such as cataracts, Belgium is at the same level as other European countries, while for interventions such as removal of the gallbladder, we are far behind. There are also very large variations between Belgian hospitals. Among the various obstacles identified in this study, it is certainly the current, extremely complex, mode of financing surgery which is the main obstacle. That's why we recommend that we introduce a single, transparent system that is more conducive to day hospitalisation. .

DRUGS POLICY

For several years, KCE has been doing substantive work to improve the transparency of decisions regarding the reimbursement of new treatments. This year, *the article 81 convention* system has been scrutinized. This is a parallel procedure for reimbursement access that can be implemented when one wants to make available to patients a drug around which some uncertainties still persist, such as a not (yet) proven efficiency. In return, biopharmaceutical firms generally grant confidential rebates on their price. Our analysis has allowed us to establish that this procedure is being used more and more often but that its long-term benefits to society raise fundamental questions.

The 'BeNeLuxA Collaboration' is the result of the willingness of the Belgian, Dutch, Luxembourg and Austrian governments to collaborate on drug policy. In this context, *the KCE has been asked to study the possibilities of setting up a common Horizon Scanning system for pharmaceutical products. Horizon scanning consists of scrutinizing the drugs that will arrive* on the market, the impact of which could be important – clinically or budgetary – for the health system, in order to anticipate this arrival and to be able to conduct a pre-evaluation. This would help participating countries to identify products on which they could collaborate more closely.

Strategies to improve the medical supply projection model

The KCE has also been asked by the Medical Supply Planning Commission to help define strategies to improve the medical supply projection model. KCE's contribution has been to study this scientific model, to gather the opinions and criticisms of all the actors concerned about the parameters of the current model and to make recommendations to improve those parameters in the future. Representatives of political institutions (federal and federated entities), the health care sector (professional organizations, student associations, doctors' unions, sickness funds, patient associations) and higher education participated in these hearings .

What are the goals of our health system?

Finally, the KCE was asked to compile an inventory of all health goals defined at the federal level, as recommended by the World Health Organization (WHO). There are already a number of them, but they are quite disparate. It is therefore necessary to give them a common thread and a framework, for example via a platform that coordinates the policy of setting objectives.

HEALTH TECHNOLOGY ASSESSMENT

Using public resources for treatments with a real added value

Health Technology Assessments (HTA) analyse the safety and efficacy of a medical technology (drug, implant, vaccine, surgical technique…) often in combination with an economic analysis of its cost-effectiveness. The aim of these studies is to establish the ratio of the price of the technology to its health and quality-of-life benefits. In addition to these clinical and economic aspects, a full HTA study also includes organisational, social, legal and ethical aspects. 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 .

Anticoagulants and atrial fibrilation

Anticoagulants are prescribed, among others, to people with a heart rhythm disorder called atrial fibrillation, in order to reduce their risk of stroke. In recent years, “new oral anticoagulants” or NOAC’s have arrived on the market. Their use is more practical than that of the “old” ones, but their price is also much higher. In addition, our critical analysis of existing data has allowed us to discover that their benefits are not as obvious as they seem to be. Their effectiveness is generally considered superior to that of old drugs … but it is only a few tenths of a percent, and provided that they are correctly used. Indeed, they are often prescribed at doses lower than the recommended doses, but there are no studies proving that these reduced doses are effective. It may thus well be that many patients are not as well protected as one thinks .

Use of external automatic defibrilators by the general public

In Belgium, around 9000 people are stricken each year by an unexpected cardiac arrest, of which 17 to 30% in public areas. Automatic external defibrillators (AEDs) installed everywhere should allow the witnesses of such situations to deliver an electric shock as quickly as possible in order to restore the rhythm of the heart. Should we therefore place more AEDs in public areas? After having analyzed the (scarce) data available, we had to face the facts: the impact of these devices on the mortality for cardiac arrest will be limited, on the one hand because the majority of cardiac arrests occur at home, and on the other hand, because the public is not sufficiently inclined to intervene and because it is difficult to locate existing devices. Since the publication of this report, it has been decided that the “First Aid” will now be taught in schools in the French Community. In Flanders, the project is still under discussion. .

Bevacizumab in the treatment of ovarian cancer

Bevacizumab (Avastin®) is a drug used in combination with chemotherapy in ovarian cancer. It keeps the tumor under control for longer, but because of its serious side effects, it decreases the overall quality of life (short-term) of most patients … without it being possible to prove that it increases their total survival. Only patients whose cancer is metastasized outside the abdominal cavity seem to gain significant benefits, with a more favorable cost-effectiveness ratio. These are elements which we consider important to take into account when deciding whether or not to grant a definitive reimbursement for this indication (it is currently the subject of a temporary reimbursement agreement Article 81 in the specific context of ovarian cancer) .

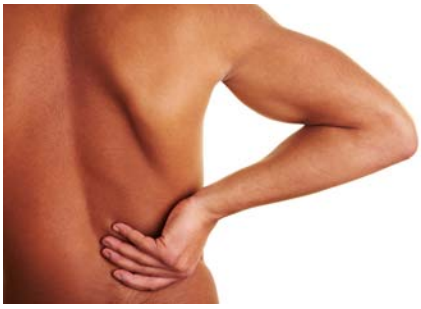
GOOD CLINICAL PRACTICE

Promoting good clinical practice and quality of care

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 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 into account 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) – who 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.

Low back pain and radicular pain: a clinical practice guide and a clinical pathway



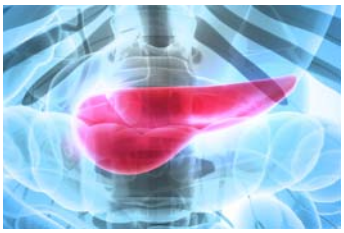
This year saw the culmination of a long-term endeavor: the Clinical Practice Guide for Lower Back Pain and Radicular Pain. From acute lumbago to chronic sciatica, this paper by 31 Belgian experts led by two KCE researchers reviews the body of recent scientific knowledge on this widespread problem. The focus is on de-medicalisation, the importance of staying physically active to promote spontaneous healing, and the (very) limited use of imaging. But probably the most recent element is that people who are at high risk of developing chronic pain should be identified as quickly as possible, so that they can be given a specific approach right away. .

The working group further developed a clinical pathway, which is a kind of "procedure" defining, for a given patient and according to the duration of his pain, the examinations to be performed and the treatments to be proposed in order to progress with him in the most coherent way. To facilitate the use of this necessarily complex document, an interactive online version has also been made available to all concerned practitioners (http://lowbackpain.kce.be/).

What are the preoperative examinations recommended in routine?

Before surgery, it is customary to prescribe a battery of tests, such as blood and urine tests, an electrocardiogram, a chest X-ray or other medical imaging exams. These examinations are supposed to detect possible risks to the health of the patient during or after the operation (operational risk). But are those tests really still necessary, especially when the patient has no particular symptoms? By examining recent scientific data on 15 frequently requested examinations, we have been able to establish which ones are really useful. In order to facilitate the use of these recommendations, we have transposed them into an application that doctors (and patients!) can consult on their smartphone, tablet or PC. To download it: http://preop.kce.be

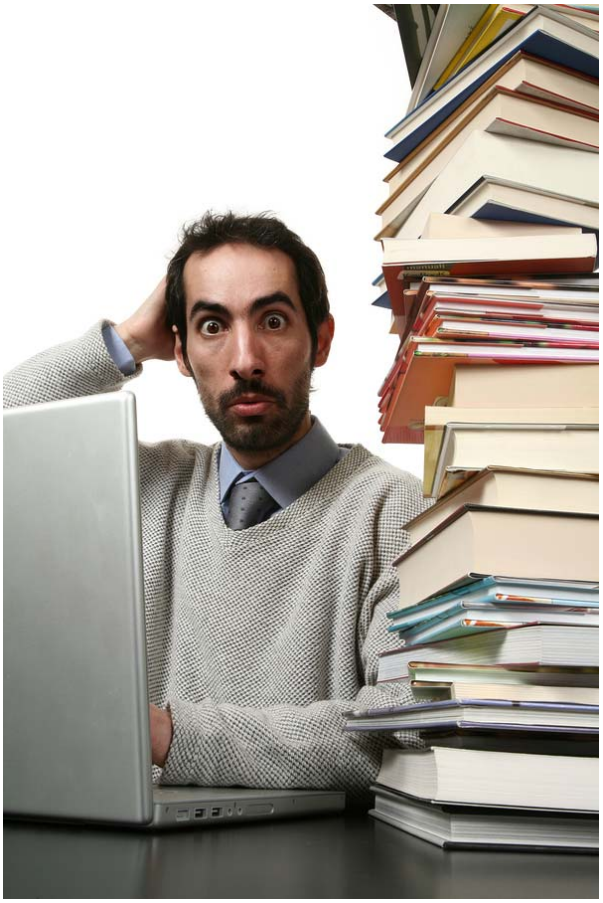
Pancreatic cancer: update of the guidelines



For several years, we have been collaborating with the College of Oncology to develop recommendations for good practice on different types of cancers. Pancreatic cancer had already been the subject of recommendations in 2009, but it became necessary to update them, at least on a few specific questions: the diagnostic tests to be preferred, the need to administer a treatment (radio or chemotherapy) before surgery and the strategy to adopt in case of recurrence.

Our Cancer Clinical Practice Guidelines are the basis for developing quality improvement programs in consultation with the Cancer Registry Foundation and the College of Oncology..

Towards an integrated Evidence-Based Practice plan in Belgium



Good practice recommendations such as those we develop are the basis for evidence-based practice (EBP), which is today the quality standard for care in all Western countries. But in Belgium, many actors are producing such recommendations, without any real coordination or coherence – even if the result is often of good quality. That is why the Minister of Health wanted to launch a “Federal EBP Program”. She transmitted a conceptual note to the KCE and commissioned it to design a federal plan for the management of all EBP initiatives, and this for the first line. The second line could possibly follow later. A first report published in summer 2017 focused on the governance issues of the future program. The second part will be published in early 2018, and will focus on the implementation of the recommendations and on the overall evaluation of the program.

The implementation of the recommendations is indeed a specific concern that the Minister wants to see tackled head on. The vast majority of scientific research resources are devoted to the understanding of diseases and the development of effective treatments, but very few address the means of translating this knowledge into routine practice. Traditional channels of dissemination need to be strengthened by more proactive approaches and take advantage of new communication technologies.

In 2016, we conducted a major survey among healthcare providers to see how well they use and appreciate the guidelines and how they want them to be improved. The results led to the publication of a methodological report entitled “Towards tailoring of KCE guidelines to end-users’ needs”.

It is also on this basis that we developed our first two interactive tools, namely the application on preoperative examinations and the interactive care pathway on lumbar and radicular pain.

KCE TRIALS

A non-commercial clinical trials programme in Belgium

Non-commercial, practice-oriented clinical trials address issues generally ignored by industry, such as comparing therapeutic strategies with each other (eg, two surgical techniques) or investigating the effect of existing drugs on populations rarely taken into account in commercial studies, such as children or the elderly. The KCE focuses primarily on comparative studies.

Countries such as England, the Netherlands or Germany have had such national programs for a long time. The Belgian program was launched at the end of 2015, at the request of Health Minister Maggie De Block, and a first call for study topics was launched in early 2016.

This call resulted in 4 clinical trials to be funded by KCE. Two have already been initiated in 2017: a study with general practitioners on decision support forms for prescribing clinical biology, and a study on the prevention of pressure ulcers by multi-layer dressings in hospitals. For the other two, funding contracts were signed at the end of 2017: one deals with etanercept in early rheumatoid arthritis and the other compares the effects of drug treatment and diet on symptoms of irritable bowel syndrome.

In 2017, a new call (this time investigator-led) has been launched. Among the submitted proposals, many will be implemented early 2018, including the management of depression, the prevention of chronic renal failure, the treatment of cardiac decompensation or localized neuropathic pain. All trials are rigorously monitored to maximize their chances of success..

KCE Trials team, from left to right : Frank Hulstaert, Rasma Kass, Jillian Harrison, Hilde Nevens, France Vrijens, Marianne Devis, Leen Verleye

International collaborations

KCE is also co-funding with its Dutch counterpart ZonMw the VINCA Pediatric Hemato-Oncology trial in Belgium and the Netherlands. More than half of the 40 young patients planned for the Belgian part of the study are already enrolled.

At the end of 2017, another agreement was reached with ZonMw to launch a joint call for comparative study proposals with potential impact for both countries (BeNeFIT). The selection process will begin in 2018. The development of joint selection processes and the exchange of good practices contribute to strengthening the expertise of both teams.

Enhance the overall quality of clinical research in our country

In parallel with the selection process for the study subjects, the KCE Trials team organizes workshops for Belgian professionals wishing to participate in the trials. In 2017, the focus was on the practical aspects of practice-oriented trials and the importance of centralized clinical research units. An international symposium on pragmatic clinical trials was held – bringing together more than 300 participants – as well as several workshops, notably on patient participation (see box), budgeting and health economics.

Finally, a call for tenders was launched for the selection of a trial management software. This tool will enable KCE and participating hospitals to track all ongoing trials in real time.

Patient involvement is essential

Clinical studies should not only answer questions related to medical practice; their results must also (at least in part) provide answers to patients' needs. It is therefore logical that they participate actively in the choice of research priorities, rather than simply being the "objects" of research. KCE Trials places great importance on the patients' point of view; their representatives are involved both in the selection of study subjects and in the follow-up of the trials. They are in the best position to judge the feasibility of a study or the relevance of its results. For example, in the rheumatoid arthritis study, they evaluated the informed consent form and tested the questionnaires for patients. They will also participate in the steering group meetings of the study.

KCE Trials has organized this year a workshop on patient participation with experts from the UK, a pioneering country in this field.

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.

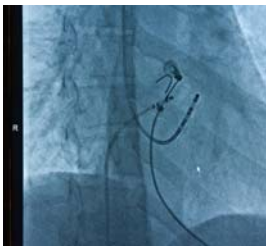
KCE researchers, constantly immersed in the international scientific literature, are well placed to identify the articles with a concrete interest for the Belgian medical community in this mass of publications. KCE has read for you provides you with a two-page critical summary of the selected articles.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

Four editions of *KCE has read for you* were published in 2017:

- ***Compression stocking for preventing deep vein thrombosis in airline passengers.*** Long-haul flights by plane could increase the risk of deep vein thrombosis. Wearing compression stockings during flights lasting more than 4 hours reduces the risk of symptomless deep vein thrombosis. The risk is reduced from 10 per 1000 in passengers without stockings to 1 per 1000 with stockings. Leg swelling is also reduced with compression stockings .

- ***Treatments for Peripheral Arterial Disease: Cost-Effectiveness Analyses.*** Some interventions for the treatment of peripheral arterial disease have been consistently reported as cost-effective: these are supervised (versus unsupervised) physical exercises, percutaneous transluminal angioplasty (PTA) versus femoro-popliteal bypass, PTA with stent versus PTA alone for iliac revascularisation. In patients with critical ischemia, revascularisation (bypass or PTA) is superior to primary amputation.

- ***Repetitive transcranial magnetic stimulation for treatment-resistant major depression: effectiveness and safety***. Compared to a dummy intervention, repetitive transcranial magnetic stimulation (rTMS) leads to a slight short-term improvement in depression. This effect could not be objectified in the long term, as monitoring data are limited to 1 to 6 months. Given the lack of evidence, it is not possible to say that rTMS is as safe and effective as electro-convulsive therapy, but is generally safe and well tolerated.



- ***Efficacy and safety of catheter ablation for people with non-paroxysmal atrial fibrillation*** In patients with non-paroxysmal atrial fibrillation, there is evidence to suggest the superiority of catheter ablation over antiarrhythmic drugs to stop atrial arrhythmias, reduce the need for cardioversion, and reduce the number of hospitalizations for heart disease during the 12 months following the intervention. However, these data must be interpreted with caution as the number of participants and reported incidents is low. There is no evidence of long-term effectiveness (> one year)

NETWORK & COLLABORATION

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, the supervision and the results 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 healthcare 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 collaboration

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, organisation, institution or policy maker can submit a study proposal.

Proposals can be submitted 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 of the health problem
- The severity of the health problem
- The potential to improve it
- The feasibility of the study

Each criterion is individually analysed by members of management and a dozen KCE experts. The results are discussed by all the evaluators and the rejections are systematically justified according to the criteria. At the end of this procedure, KCE's research capabilities are taken into account.

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 via the following link.

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. .

OUR WEBSITE IS OUR BASIC TOOL

It was completely refreshed in 2017, with a more modern, airy and user-friendly layout.

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 .

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.

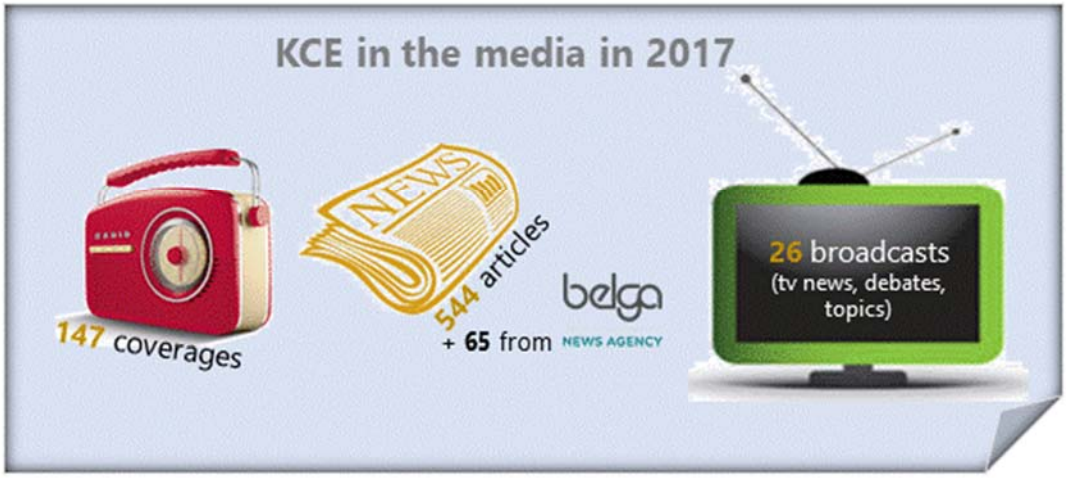
OUR FOLLOWERS

If you wish to be kept informed on all our publications and activities, please register by clicking on ‘receive news’. Today, about 7500 subscribers regularly receive our mailings.

We also publish 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. At the end of 2017, more than 750 GPs had subscribed to this newsletter.

We are also present on social media Twitter, LinkedIn and Facebook, which enables us to broaden our visibility and add immediate interactivity to our communication. Our videos are available on our YouTube channel.

Our visibilty in 2017 showed in numbers



REPORTS PUBLISHED IN 2017

Rapport **279**: Anticoagulants in non-valvular atrial fibrillation *(Health Technology Assessment)*

Rapport **280**: Routine preoperative testing in adults undergoing elective non-cardiothoracic surgery *(Good Clinical Practice)*

Rapport **281**: Towards an inclusive system for major trauma *(Health Services Research)*

Rapport **282**: Proposals for a further expansion of day surgery in Belgium *(Health Services Research)*

Rapport **283**: Horizon scanning for pharmaceuticals: proposal for the BeNeLuxA collaboration *(Health Services Research)*

Rapport **284**: Towards tailoring of KCE guidelines to end-users' needs *(Good Clinical Practice)*

Rapport **285**: Bevacizumab in the treatment of ovarian cancer *(Health Technology Assessment)*

Rapport **286**: Management of pancreatic cancer: capita selecta *(Good Clinical Practice)*

Rapport **287**: Low back pain and radicular pain: evaluation and management *(Good Clinical Practice)*

Rapport **288**: How to improve the Belgian process for Managed Entry Agreements? *(Health Services Research)*

Rapport **289**: Required hospital capacity in 2025 and criteria for rationalisation of complex cancer surgery, radiotherapy and maternity services *(Health Services Research)*

Rapport **290**: Strategies for improving the medical workforce projection model *(Health Services Research)*

Rapport **291**: EBP-Plan *(Health Services Research)*

Rapport **292**: Exploratory steps for the formulation of Belgian health system targets *(Health Services Research)*

Rapport **293**: Health care in Belgian prisons *(Health Services Research)*

Rapport **294**: Static automated external defibrillators for opportunistic use by bystanders *(Health Technology Assessment)*

Rapport **295**: Low back pain and radicular pain: development of a clinical pathway *(Health Services Research)*

Rapport **296**: Appropriate care at the end of life *(Health Services Research)*

FINANCIAL

BALANCE

PART 1 ASSETS	31/12/2017	31/12/2016
FIXED ASSETS	**236 667,34**	**224 563,18**
I. Formation expenses		
II. Intangible fixed assets	**102 198,36**	**43 695,56**
III. Tangible fixed assets	**134 468,98**	**180 867,62**
A. Land and buildings	50 898,54	101 797,08
B. Plant, machinery and equipment	70 437,84	69 193,56
C. Furniture and vehicles	13 132,60	9 876,98
D. Leasing and similar rights		
E. Other tangible fixed assets		
F. Assets under construction and advance payments		
IV. Financial fixed assets		
A. Belangen in rechtspersonen		
B. Vorderingen en effecten		
C. Borgtochten betaald in contanten		
CURRENT ASSETS	**12 896 922,32**	**14 318 124,87**
V. Amounts receivable after more than one year		
A. Trade debtors		
B. Other amounts receivable		
VI. Stocks		
VII. Amounts receivable within one year	**139 573,19**	**110 269,69**
A. Trade debtors		
B. Other amounts receivable	139 573,19	110 269,69
VIII. Current investments		
IX. Cash at bank and in hand	**12 646 218,70**	**14 142 714,26**
X. Deferred charges and accrued income	**111 130,43**	**65 140,92**
TOTAL ASSETS	**13 133 589,66**	**14 542 688,05**

PART 2 LIABIILITIES	31/12/2017	31/12/2016
EQUITY	**6 256 334,98**	**6 193 332,13**
I. Capital		
III. Revaluation surpluses		
V. Accumulated profits (losses)	**6 256 334,98**	**6 193 332,13**
VI. Investmen 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	**6 877 254,68**	**8 349 355,92**
VIII. Amounts payable after more than one year	**0,00**	**50 898,54**
A. Financial debts		
1. Credit institutions, leasing and other similar obligations		
2. Other loans		
B. Trade debt		
C. Advanced received on contracts in progress		
D. Other amounts payable		50 898,54
IX. Amounts payable within one year	**6 877 254,68**	**8 298 457,38**
A. Current portion of amounts payable after more than one year falling due within one year	50 898,54	50 898,54
B. Financial debts		
1. Credit institutions		
2. Other loans		
C. Trade debts	2 004 735,57	1 280 242,33
D. Advanced received on contracts in progress	16 963,00	301 433,10
E. Taxes, renumerations and social security	883 347,33	946 236,00
1. Taxes		183 769,65
2. Renumerations and social security	883 347,33	762 466,35
F. Other amounts payable	3 921 310,24	5 719 647,41
X. Deferred charges and accrued income		
TOTAL LIABILITIES	**13 133 589,66**	**14 542 688,05**

PROFIT AND LOSS ACCOUNT

PROFIT AND LOSS	31/12/2017	31/12/2016
	-	-
I. Operating income	**15 475 241,15**	**15 087 864,99**
A. Turnover		
B. Stocks: increase (decrease)		
C. Own construction capitalized		
D. Intern billing		
E. Other operating income	15 475 241,15	15 087 864,99
II. Operating charges	**11 491 053,23**	**9 479 125,54**
A. Purchases and stocks		
B. Services and other goods	4 388 501,92	2 610 614,60
C. Renumerations, social security costs and pension	6 899 305,21	6 671 457,96
D. Depreciation of and other amounts written down formation	203 246,10	197 052,98
Expenses, intangible and tangible fixed assets		
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)	**3 984 187,92**	**5 608 739,45**
IV. Financial income	**125,17**	**0,00**
A. Income from financial fixed assets		
B. Income from current assets		
C. Other financial income	125,17	
V. Financial charges	**0,00**	**1 778,14**
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
VI. Profit (losses) on ordinary activities before taxes	**3 984 313,09**	**5 606 961,31**

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 and disposal of fixed assets		
E. Other extraordinary income		
VIII. Extraordinary charges	**3 921 310,24**	**5 640 140,07**
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	3 921 310,24	5 640 140,07
F. Extraordinary charges carried to assets as restructuring costs		
IX. Gain (loss) of the period	**63 002,85**	**-33 178,76**
A. Profit to be appropriated (+)	6 256 334,98	6 193 332,13
Loss to be appropriated (-)		
1. Gain to be appropriated (+)	63 002,85	
Loss to be appropriated (-)		-33 178,76
2. Profit (loss) brought forward		
a. Proft brought forward	6 193 332,13	6 226 510,89
b. Loss brought forward		
D. Profit (loss) to be carried forward		
1. Profit to be carried forward (+)	6 256 334,98	6 193 332,13
2. Loss to be carried forward (-)		

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