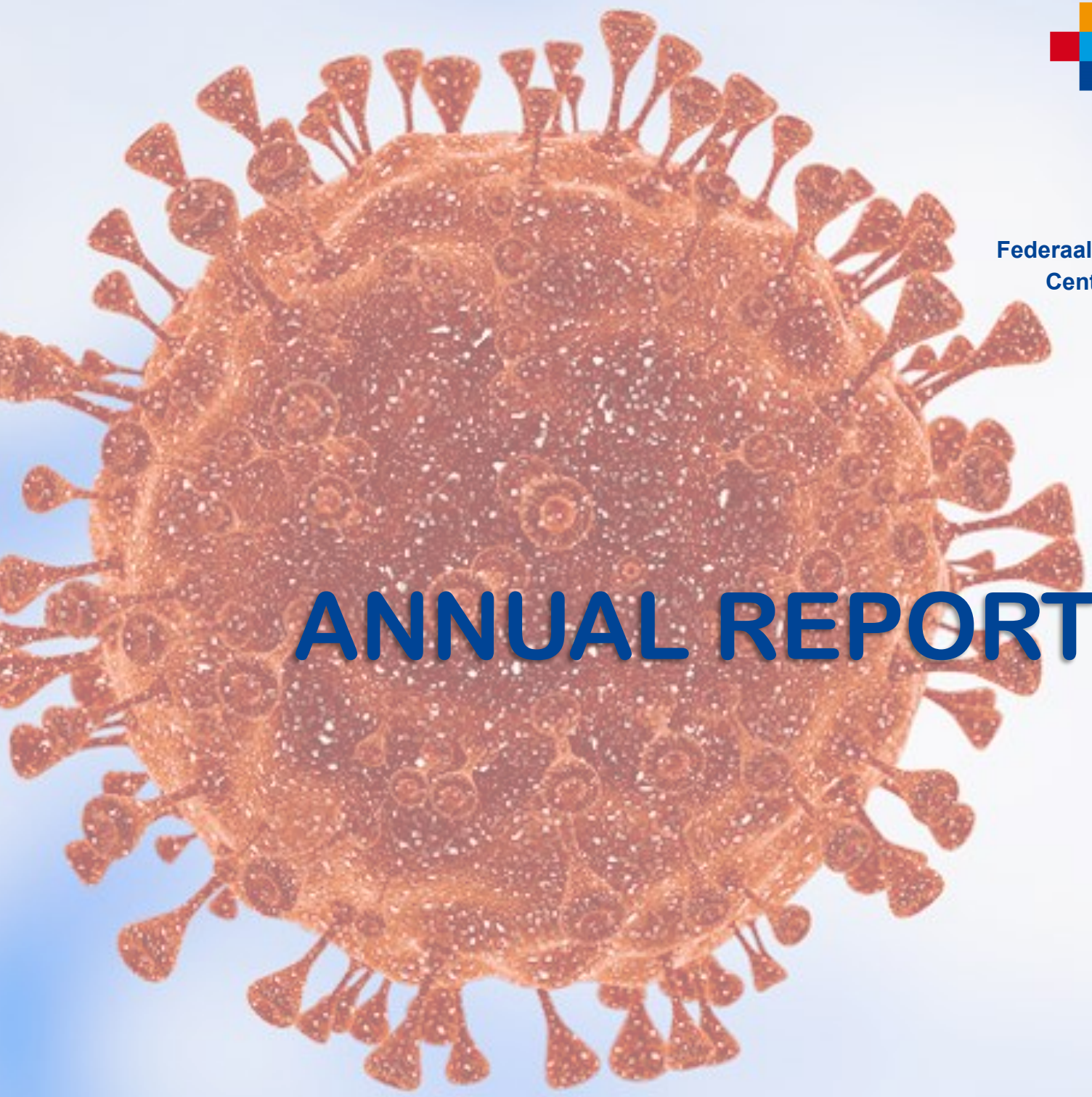


KCE

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

ANNUAL REPORT 2020

[2020, a year in parentheses]

The year 2020 will forever be branded in everyone's memory. For the Belgian and international scientific community, it will retain the bittersweet taste of a colossal challenge but also of a hitherto unseen willingness to pool efforts, at all levels, for the common good. In our country's complex landscape, each institution defined (or redefined) its place by bringing its own piece to the enormous jigsaw puzzle that was unfolding before our eyes.

The Belgian Health Care Knowledge Centre (KCE) is not cut out for working in the spotlight of current affairs. It is a think-tank and expert appraisal body that works in the long term, its role being to provide politicians with tried and tested scientific data that can be used to underpin their decisions. But faced with the coronavirus, our expertise was requested to support the frontline strategic deliberations in the management of the crisis. We thus had to find a way of combining these urgent requests with our basic work, which is more vital than ever in anticipation of the day when our health system can resume its normal course. Our research programme was disrupted as a result.

A series of studies and clinical trials scheduled in the programme were successfully completed as planned, but others had to be postponed until 2021. Parallel to this, a new "COVID-19" research programme took shape as and when requests were made by our political authorities and our colleagues in other institutions. It is this patchwork result that is presented today in our annual report.

Before leaving you to peruse the report, we would once again like to pay tribute to the work of the entire team in conditions that were at times anything but easy. Indeed, since 13 March 2020 the KCE has abided by the official teleworking injunction and a year later, at the time of writing, we are all still confined in our homes. But nobody has thrown in the towel. We have found new ways of being together and of turning our institution into a living entity from within, as we wait to be able to go back to work at Boulevard du Jardin Botanique.

ABOUT US

Who we are

The Belgian Health Care Knowledge Centre (KCE) is an independent federal research centre that focuses on the organisation, financing and reimbursement of health care and on health technology assessment. It also develops guidelines for the clinicians.

The scientific studies it produces are usually requested by public authorities, universities and professional associations, but in fact all citizens, patients or patient organisations can submit a research proposal.

Each KCE study results in recommendations for competent authorities and health care stakeholders. However, KCE has no decision-making power and the policy choices arising from the reports it publishes are not within its remit.

KCE is subsidised by the federal authorities (NIHDI for 75% and Federal Public Services Health and Social Security, together for 25%). In addition, some specific European subsidies cover KCE's involvement in international research networks and projects. The KCE's status as a type B parastatal organisation guarantees its total independence from these subsidiary authorities..

KCE

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

The acronym KCE is a contraction of the words
Kenniscentrum (Dutch)
and Centre d'Expertise (French)

What we do?

The KCE activities encompass six areas of expertise:

- **Health Services Research (HSR)**: the organisation and financing of health care in the broadest sense
- **Health Technology Assessment (HTA)**: the evaluation of medical technologies
- **Evidence-based Practice (EBP)**: the production of clinical practice guidelines adapted to the new scientific developments and participation in the Belgian network of Evidence-Based Practice
- **KCE Trials programme**: the coordination of the Belgian non-commercial clinical research programme
- **"Right to be Forgotten" Programme**: ongoing evaluation of the list of conditions giving rise to a "right to be forgotten" under the Insurance Act of 4 April 2019.
- **Methods**: the creation of methodological manuals to establish validated working methods for health care and public health researchers, primarily focused on KCE research, but often more broadly applicable to research in the domains described above.

Our Board of Directors

Our Board of Directors brings together representatives of the public authorities and the most important actors in healthcare, health insurance and patient associations, in a balanced distribution. It ensures our neutrality and guarantees our independence. At each Board meeting our new finalised reports are presented. The scientific content is in principle not subject to modification, unless objective methodological arguments are put forward. The reports are approved by a simple majority of the votes. 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. More info on our website.

Our external collaborations

We regularly appeal for external expertise – including that of patients – to support us in the design and execution of certain parts of our studies. We also call upon external experts for the validation of each report.

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. However, in these cases, KCE always retains responsibility for the coordination, the supervision and the final results of the projects.

External experts and stakeholders

KCE doesn't work in an ivory tower. For each project, **field experts** are called in. 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 in the field.

Similarly, in each of its studies, KCE also invites **interested stakeholders** for consultations to gather their opinions on the subjects concerned. Stakeholder opinions are always taken into consideration, but are identified as such and are distinguished from the research results.

Each external participant is requested to sign a declaration of a potential **conflict of interest** (see below).

Thanks to these external collaborations, the communication between researchers and caregivers, patients and decision-makers in health care can be improved and professionalised.

Patients increasingly involved in our studies

In 2019, KCE is explicitly committed to involving patients more systematically as partners in its research. They can be involved as ‘experts in experience’ because their personal experience (or their eventual collective knowledge) of the health issues addressed gives them a complementary view to that of the researchers on how to conduct the research and on the relevance of the results. They may also be invited as stakeholders, to represent their interests as patients and users of health services.

Validators

All KCE reports are subject to **internal** and **external scientific validation**.

Internal validation is carried out by two KCE experts not involved in the research, and by the management.

For the **external validation**, 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.

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

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 a conflict of interest;**
- **All external experts, subcontractors or validators who are involved in a KCE study have to fill in and to sign a declaration of interests. The declared interests are mentioned in the colophon of the corresponding report.**

Setting up our study programmes

The KCE has developed well-codified procedures for the rational and objective establishment of its two parallel study programmes: the annual study programme for classical KCE reports and the clinical trial programme KCE Trials.

A third type of programme was launched in 2020 and will be developed in the coming years: the "Right to be Forgotten" programme.

For the KCE studies annual 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.

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 also solicits input from clinicians, patients, and others for its clinical trial topics. But in contrast to KCE's annual study program, the KCE Trials program has no fixed schedule for its calls. You can ask to be kept informed of calls and other information from KCE Trials by subscribing on our website.

You may find more information about the call for clinical trials here

Website traffic in 2020

315092

visitor

591621

page views

56443

consultations of our videos for a total of 93,024 minutes

Our followers

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

2556

followers on Twitter

4911

subscriber on LinkedIn

661

followers on Facebook

OUR TEAM

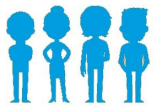
The healthcare domain is very complex. There is no scientific training that comprises all its numerous aspects. That is why at KCE we have opted for a truly cross-disciplinary approach. No research is conducted by a single researcher; on the contrary, each research question is examined from a medical, 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.

The experts

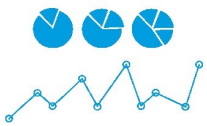
The experts can be divided into five different categories:

- Researchers with a **clinical or biomedical** 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.

- 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 **human sciences**. Some of them conduct qualitative studies: they collect data from field experts, patients, stakeholders, etc.) and ensure their rigorous processing. Others 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 adapt 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.

Some of these experts were or are still academically or clinically active (which enhances their understanding of the field), others have committed themselves to full-time research at KCE.

Performant support services

The researchers are supported by sharp and efficient support services (project coordination, ICT, webmaster, library, layout, secretariat, legal advice and human resources management, accountancy, etc.).

The management

The KCE functions in a very horizontal organisation on a human scale where working procedures are well organised and decisions are efficiently taken after deliberation.

- The management is composed of 4 people:
- a managing director a.i. Marijke Eyssen
- a deputy general manager a.i. Christophe Janssens
- two scientific programme managers a.i.: Irina Cleemput and Sabine Stordeur (detached to the Task Force Vaccination covid-19 since 12/2020)

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.

Active staff members

	Situation at 31/12/2020	Expressed in full-time equivalents
President		**0,2**
Management		**3,8**
General Management		1,0
Studies Management		1,0
Programme Management		1,8
Studies		**44,7**
Physicians, dentists, nurses, physiotherapists,...		25,2
Health economists		6,4
Sociologists, lawyers		3,6
Data analysts, statisticians and specialists in scientific information		6,6
Project facilitator		1,6
Experts in dissemination and knowledge management		2,9
Support		**14,4**
Secretariat and lay-out		6,3
ICT, website and library		1,0
Legal advice and Human Resources Management		3,5
Budget and accountancy		2,0
Total		**63,1**

COVID-19 CONTRIBUTIONS

The KCE has cutting-edge expertise in the analysis of scientific literature or the assessment of new medical technologies. We have therefore offered our services to our colleagues in public institutions who are in the front line of health crisis management. In this way, some of our researchers have drafted studies and opinions on very specific questions posed by other bodies, at national and international level, in a very short time. This work was used by the crisis management groups to develop guidelines and to orient public health decisions. Some of our experts were also invited to participate directly in decision-making bodies in the management of the health crisis.

Specific studies and opinions

Participation in working groups

International contributions

Clinical trials

(See KCE Trials p27)

Specific studies and opinions

- **Medical interventions that spread aerosols**
- **Tromboprophylaxis**
- **Transmission of the coronavirus by children**
- **International comparison of testing and contact tracing strategies**
- **Management of post-intensive care syndrome (PICS) for general practitioners**
- **Outpatient care for Covid-19 patients in the context of saturation in Belgian hospitals**

See also:

- **KCE Report 335** Hospital & Transport Surge Capacity during the first wave of the pandemic

Further studies on COVID-19 are still in progress and will be published in the course of 2021, including a study on the **needs and follow-up of long-term COVID patients**, the interim results of which are maintained on our website (in **French** and in **Dutch**).

Participation in working groups

- **Participation in the Risk Assessment Group (RAG)**

The KCE has been participating in the Risk Assessment Group (RAG) since September 2020. This body is coordinated by the public health institute Sciensano. Its mission is to assess risks and analyse the impact of the measures taken. It is not normally made up of permanent experts and its composition varies according to the issues to be addressed. As Sciensano wants to be able to contact experts rapidly, depending on the specific subjects dealt with by the RAG, three KCE experts have been invited to participate in the meetings on a regular basis. This contribution will be permanent for the time needed to contain the pandemic.

- **Participation in an ad hoc working group on a vaccination strategy against Covid-19**
  (request from the Risk Management Group – May 2020)

The objective of this working group (which is part of the Vaccination Group of the Health Council) was to give an opinion on the vaccination strategy to be adopted against COVID-19 in Belgium, and more specifically to provide political decision-makers with specific recommendations on risk and priority groups, as well as an estimate of the number of doses of vaccine to be provided when a vaccine against COVID-19 would become available. This work was requested by the chairman of the Risk Management Group (RMG). The report “Vaccination strategy against COVID-19 in Belgium”, sent to the Belgian authorities on July 3rd 2020.

- **Participation in the Covid-19 Vaccination Task Force**
  (request from the Covid Commission)

A working group on the implementation of the vaccination strategy against Covid-19 was set up in November 2020. It includes scientists and representatives of the authorities, crisis managers and representatives of the professional organisations concerned. Its mission is to coordinate the vaccination programme against Covid-19. KCE contributes to this mission through the secondment of three experts, two of whom are full-time. One is a member of the core committee and the other is in charge of coordinating communication at the national level.

INTERNATIONAL CONTRIBUTIONS

- **COVID-19 Health System Response Monitor**

The KCE is the Belgian correspondent of the European Observatory on Health Systems and Policies, which is part of the World Health Organisation (WHO). In this context, we have been asked to keep a “crisis diary” for Belgium on an international platform set up to analyse the responses of each country to the epidemic. This initiative will undoubtedly make it possible to carry out interesting analyses a posteriori and to draw valuable lessons for the future.

- **EUnetHTA COVID-19 response – Rolling Collaborative Reviews on COVID-19**

The KCE is part of the European health technology assessment network EUnetHTA. In the context of the COVID-19 pandemic, this network launched Rolling Collaborative Reviews (RCRs) to provide health authorities with rapid and scientifically sound information on the comparative effectiveness of 15 treatments currently used against this virus. The first round of these monthly updated reviews was published in August 2020 and is updated monthly. KCE is covering the generic drugs **camostat** and **nafamostat**.

Some KCE experts also participated in an EUnetHTA Rapid Collaborative Review on some diagnostic tests..

- **Scientific Advisory Board EU-RESPONSE**

The European Scientific Advisory Board EU-RESPONSE is a research and preparedness network for pandemics and emerging infectious diseases (EU-RESPONSE). It is a 5-year multinational project coordinated by INSERM (France). It is funded by the European Union’s Horizon 2020 Research and Innovation programme to design an adaptive European platform for clinical trials for COVID-19 and other emerging infectious diseases (SolidAct Trial) in order to assess the efficacy and safety of medicines. Hospitals from all over Europe may be involved in this framework. A researcher from KCE is part of the independent Scientific and Ethical Advisory Board set up to advise on the structure of the platform EU-SolidAct, and on the priority in which the medicines should be studied.

REPORTS PUBLISHED IN 2020

- Polyvalent immunoglobulins – Part 1 and 2
- Video consultations in the care for patients with a chronic somatic disease
- Bariatric surgery in Belgium: organisation and payment of care before and after surgery
- Organisation of diagnosis and treatment of obstructive sleep apnoea syndrome: an international comparison
- How to better tackle Elder Abuse in Belgium?
- Guideline on the prudent prescription of antibiotics in the dental office
- Evaluation of the reimbursement for hearing aids and implants in hearing loss
- Health System Performance Assessment: how equitable is the Belgian health system?
- Assessing the management of hospital surge capacity in the first wave of the COVID-19 pandemic in Belgium
- Barriers and facilitators for eHealth adoption by general practitioners in Belgium
- Health Systems in Transition (HiT) : Belgium Health system Review
- Performance of the Belgian health system: update of several indicators
- Launch of the Right to be Forgotten program
- Participation in EBP Network

Polyvalent immunoglobulins – Part 1 and 2

KCE Reports 327 & 336

Immunoglobulins, which are produced from human plasma, are invaluable and costly medicines used to treat equally rare and sometimes very serious diseases. There is an ever increasing risk of shortage, both in Belgium and worldwide, which means that strategies must urgently be devised with a view to a better control of their supplies and optimisation of the way they are used. The KCE has been entrusted with carrying out an evaluation of their effectiveness and making an estimate of the quantities our country ought to be able to have at its disposal in the years to come.

Our country recognises eight diseases giving rise to a reimbursement of immunoglobulins, but other countries recognise more. In the first part of the study we went over the scientific evidence supporting the use of Ig in the treatment of these eight diseases, as well as in the treatment of the main other diseases recognised in other countries.

The second part of the research focuses on the situation in Belgium. The aim here is to estimate the quantities of Ig that our country ought to be able to have at its disposal in the coming years, on the basis of current uses and emerging trends, and to draw up recommendations for stocks of Ig to be shared out as equitably as possible in the event of imminent shortage.

Video consultations in the care for patients with a chronic somatic disease

KCE Report 328

The last couple of decades have witnessed a veritable boom in the use of digital technologies, and the healthcare sector has been no exception to this trend. These technologies have been given various names and definitions: remote healthcare, teleconsultation, telemonitoring, tele-expertise, eHealth, mHealth, and so on. The use of these technologies means that medical staff and patients no longer necessarily have to meet in person in the same physical space, which can obviate the need to travel in the case of people with reduced mobility, help curb the problem of crowded waiting rooms, minimise long journeys and reduce waiting periods.

The KCE had been commissioned to study the impact of video consultations on the health of patients suffering from chronic (somatic) diseases, but the Covid-19 crisis broke out whilst this study was under way and reality caught up with the researchers. Remote consultations by phone or video-conference were suddenly accepted and reimbursed throughout the world. The current dynamic should be turned to good account to ensure that this type of “digital” healthcare is introduced to a greater degree, as a useful addition to (but not a replacement of) face-to-face consultations. However, certain conditions have to be met, including, in particular, the patient’s informed consent.

Bariatric surgery in Belgium: organisation and payment of care before and after surgery

KCE Report 329

More than one in three adults in Belgium is currently overweight and 16% are obese. Furthermore, roughly one person in every hundred has had so-called “bariatric” surgery. In 2019 the KCE had already published an initial study on this type of surgery (KCE report 316, 2019), confirming that this operation is more effective than the traditional methods aimed at weight loss. But the study also showed that the effect is only long-lasting if the person permanently alters his eating habits and lifestyle and is subject to long-term medical, nutritional and psychological monitoring.

In this new report, in collaboration with the inter-insurance agency (AIM/IMA), we studied the way this monitoring is carried out in our country and how it could be better organised and financed. Our conclusions are that the way people are taken care of should be more uniform and multidisciplinary and should involve a serious commitment on the part of candidates for the operation. We also recommend that this kind of operation only be carried out in hospitals and by surgeons meeting certain criteria, in particular a minimum annual number of bariatric operations, in order to develop and maintain the teams’ expertise..

Organisation of diagnosis and treatment of obstructive sleep apnoea syndrome: an international comparison

KCE Report 330

The obstructive sleep apnea (OSA) syndrome is quite a common sleeping disorder – one for which nearly 140,000 people are currently being treated in Belgium. The treatment most typically uses a “CPAP” (Continuous Positive Airway Pressure) device, which insufflates air into the respiratory tract whilst the person is sleeping. For its cost to be reimbursed in Belgium, this treatment systematically calls for a night of tests in the sleep laboratory, in a hospital, to confirm the diagnosis, whereupon another night in hospital is most often deemed necessary to adjust the treatment. However, the devices available nowadays make it possible to have the necessary measurements taken in the patient’s home – a situation that affords much greater comfort and guarantees a closer approximation to normal sleeping conditions. This also represents a sizeable cost saving for the healthcare sector.

We therefore suggested a few avenues to be explored for a reorganisation of the way the OSA syndrome is taken charge of and financed, giving priority to home diagnosis as much as possible. Other countries are already organising themselves in this way. We also recommend that a greater role be played by general practitioners, who should be able to prescribe a sleep test and handle the long-term monitoring of the treatments organised. Finally, we are of the view that better use could be made of remote surveillance.

How to better tackle Elder Abuse in Belgium?

KCE Report 331

According to the WHO, the abuse of older persons allegedly affects one in six people aged over 60 worldwide, and only one in every 24 cases is reported. Our report examines the obstacles hampering the detection of problem situations and puts forward a series of twenty-one recommendations to improve the way they are taken care of.

The first of these recommendations is a request directed at the authorities to place a decision support tool at the disposal of all participants potentially involved in the care of the elderly, aimed at providing them with guidance in respect of the questions that might arise and the attitudes to be adopted when faced with any suspected case of abuse. This decision support tool (which is available on our website) also gives a list of tools for the detection of abuse and ill-treatment that have been identified in international literature.

We also took an interest in a little-known – and more often than not involuntary – form of abuse, referred to as “derailed care”. This specifically affects family caregivers who, when they find themselves feeling the effects of overwork, may slip insidiously into a relationship in which ill-treatment takes the place of positive treatment. Few figures are available on this subject but some estimates lead us to suppose that this could be the case in around 15% of family caregivers. In the residential care sector, too, when a lack of time, resources and staff complicates the organisation and when the financing system does not encourage the autonomy of the elderly, positive treatment can transform into institutional abuse.

Generally, we feel it would be desirable for society as a whole – and the authorities at its helm – to be made more aware of the issues of positive treatment, abuse and ageism (age-related discrimination). In the long run, this should promote a change of mentality towards greater inclusion of elderly persons, and the adoption of initiatives designed to support and strengthen the sectors of care and support for the elderly.

Guideline on the prudent prescription of antibiotics in the dental office

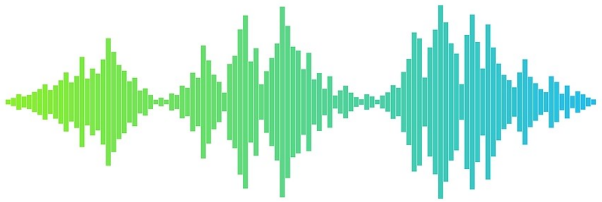
KCE Report 332

Belgium is currently still one of the largest prescribers of antibiotics in Europe (in outpatient care). Around 6% of these antibiotics are prescribed by dentists. We therefore developed a clinical practice guide designed to encourage them to prescribe these drugs in a more reasoned fashion. This work was carried out in collaboration with practitioners in the field and academics. It contains recommendations for the use (or non-use) of antibiotics in a series of everyday situations in dentistry. Thus, for example, in the event of infection at oral environment level, the best approach is to treat the origin of the infection with an appropriate dental treatment, after which antibiotics are rarely necessary.

In fact, the use of antibiotics is rarely appropriate in dentistry. They should be envisaged when an infection appears to be spreading from a distance (swelling of the face or lymph nodes, fever, feeling of discomfort, etc.). When dental implants are fitted, it is also recommended that a single dose of antibiotics be administered before the operation. The same applies to invasive dental operations in people presenting a risk of endocarditis. Conversely, it is not necessary in people who have a knee or hip prosthesis.

The guideline is intended for general practitioners as well, since they sometimes also receive patients suffering from dental problems. When this occurs, it is important for them to refer these patients to a dentist so that the problem is correctly diagnosed and a start can be made on suitable dental treatment. There had hitherto not been any guideline of this kind in Belgium.

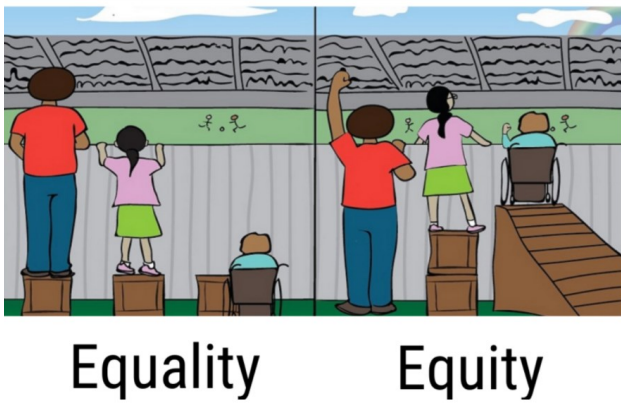
Evaluation of the reimbursement for hearing aids and implants in hearing loss



In our country around 455,000 people use hearing aids due to hearing loss that can range from slight to very severe. Our health insurance sees to it that everyone can have access to the (sometimes partial) reimbursement of the cost of these devices, but the budget that this represents for the INAMI (National Sickness and Invalidity Insurance Institute) has more than doubled in ten years. It is chiefly the costs associated with increasingly sophisticated (partially or wholly) implantable hearing aids that are constantly rising. The question that arises now is whether this type of hearing aid represents a genuine added value vis-à-vis the basic hearing aids already eligible for cost reimbursement. The INAMI therefore asked us to conduct an investigative study on the effectiveness of certain hearing implants and the possible need to extend their cost reimbursement. Unfortunately, we had to record that not enough solid scientific evidence is available on which to substantiate a broadening of the current criteria. However, we did suggest a few adjustments to these criteria aimed at eliminating certain inconsistencies and gradually moving towards a reimbursement based more on physiopathology.

KCE Report 333

Health System Performance Assessment: how equitable is the Belgian health system?



Unfortunately not everyone is in good health and some people need to have recourse to healthcare more than others. In our Belgian system, which is based on solidarity, efforts are made to reduce these inequalities as far as is possible. But when you look at people who have the same healthcare requirements, can we say that the ease with which they can access that healthcare is the same for all of them? In other words, is access to our healthcare system equitable? We used an innovative method in an attempt to answer this question. It emerges from this that for households in a situation of financial insecurity access to healthcare is not equitable, in particular access to specialists and dentists, to the extent that some of them put off this care or do not have recourse to it at all. The main reason is the amount the patient has to pay out of his own pocket or has to pay in advance. For 4% of households, healthcare expenses even represent more than 40% of their total expenses. Protection measures exist, such as the higher reimbursement rates (preferential reimbursement beneficiaries). They do indeed make it possible to reduce these cases of injustice, but protection could be further enhanced as far as the patient's contribution towards the cost of medical treatment is concerned or in the field of additional charges, the amounts of which are increasing.

KCE Report 334

Assessing the management of hospital surge capacity in the first wave of the COVID-19 pandemic in Belgium

KCE Report 335

When the Covid-19 crisis broke out, additional capacity quickly had to be created in the hospitals. The Hospital & Transport Surge Capacity (HTSC) committee was set up at the beginning of March 2020 to advise the Risk Management Group on maximum hospital and patient transport capacity. In June 2020 the KCE was given the task of evaluating how the committee had functioned during the first wave of the epidemic and the way the hospitals responded to the measures it had enacted. The request came from the HTSC committee itself.

Our study showed that the committee was up and running very quickly, taking a series of radical measures to increase hospital capacities in order to cater for COVID-19 patients (for example, the suspension of all non-emergency care). The hospitals found these measures clear, although not always easy to put into practice, and reacted very professionally, in a fine spirit of solidarity. However, it will be important in the future to make provision for a legal framework for these measures (for example the distribution plans) so as to enable the RMG to immediately make their implementation mandatory in the event of future crises.

We also concluded that the committee's composition makes it a preferential platform for the discussion of hospital-related issues. It would therefore be wise to maintain it as a consultative body that can be activated in the event of a crisis situation calling for additional hospital capacity. Ideally its composition should be broadened to include doctors and nurses, so that the frontline players are also represented in it.

Barriers and facilitators for eHealth adoption by general practitioners in Belgium

KCE Report 337

All the federal services are gradually moving into the digital age, and healthcare is no exception. For general practitioners, however, this shift is not always passing off as smoothly as had been anticipated – even though the COVID-19 epidemic has speeded things up considerably. The KCE was asked to identify the factors liable to facilitate the adoption of the eHealth services by these practitioners who play such a pivotal role in our healthcare system.

After listening to the doctors, analysing the INAMI's data and studying the international literature on the subject, we identified a number of avenues for improvement: improving the functioning, interoperability and technical support of the services offered, raising the doctors' awareness, and providing them with training and financial backing.

Beside these conclusions, which all in all are fairly predictable, we also suggest that doctors be involved more closely in the development, testing and implementation of the future new services, alongside the authorities and software developers. After all, a more bottom-up approach, or even a process of joint creation with the developers, would enable them to see to it that the latter benefit from their practical knowledge and to identity the type of services liable to yield added value to their practice in the field.

Health Systems in Transition (HiT) : Belgium Health system Review

HiT report

The Health Systems in Transition (HiT) profiles, published by the European Observatory on Health Systems and Policies, are detailed descriptions of the health systems of each member country, and of political initiatives that are under way. The Belgian report was drafted in collaboration with the KCE and Sciensano.

In order to facilitate comparisons between countries, these reports are based on a common basic structure. They enable political decision-makers, researchers and other stakeholders to gain a detailed view of their own health system, but also to analyse the experiences of other countries with a view to drawing inspiration that could be relevant for their own situation. The objective is to support the drafting of initiatives and health system reforms on an ongoing basis.

The report is comprehensively updated approximately every five years. The major changes and reforms implemented in the meantime are published on an online platform, where the most recent complete version of the report is also available. A summary in French of the Belgian report is also available online on the Healthy Belgium website (towards a healthy Belgium).

A short presentation of the report is also available here.

Performance of the Belgian health system: update of several indicators

Performance report

The last analysis report on the performance of our health system was published in 2019. The 121 indicators contained in this report are also summarised on the Towards a Healthy Belgium website.

Since this publication, a number of indicators have been updated:

- A new indicator on geographical access of maternity services (A-16) was added in October 2020;
- The indicator on the number of patients per nurse (A-8) was updated in October 2020;
- Indicator A-4 on medical care requirements not met for financial reasons (% of individuals included in the survey – self-declared indicator) was updated in December 2020;
- Indicator A-9 on waiting time for an appointment with a specialist (% of the population who have to wait more than two weeks) was updated in December 2020;
- Indicators QP-1 to QP-4 on the doctor-patient relationship were updated in December 2020 (QP-1 = the doctor spends enough time with the patient during the consultation (% of respondents); QP-2 = the doctor provides explanations that are easy to understand (% of respondents); QP-3 = the doctor gives the patient the opportunity to ask questions and express concerns (% of respondents); QP-4 = the doctor involves the patients in decisions concerning care and/or treatments (% of respondents).

Launch of the Right to be Forgotten program

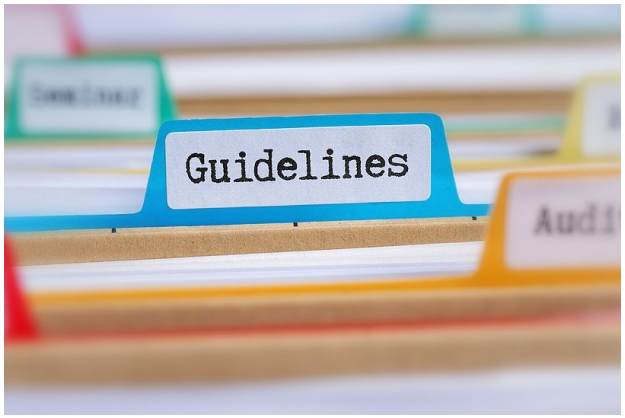
People who have been cancer patients in the past or are suffering from a chronic pathology present a heightened health risk. For this reason, these people may encounter major difficulties in obtaining outstanding balance insurance and, thereby, being granted a mortgage loan and becoming property owners.

In 2006 France started taking steps to facilitate access to outstanding balance insurance for people with a heightened health risk. Belgium drew inspiration from the work being done in France and published the Act of 4 April 2019 also establishing a “right to be forgotten” for these kinds of insurance policies.

From now on people declared as having been cured of a cancer for at least ten years have the possibility of taking out an “outstanding balance” insurance policy without any additional premium linked to this case history. The new law also makes provision for a reduction in the waiting times for other (cancer-related or chronic) pathologies. The KCE is responsible for reassessing the list of these pathologies every two years according to the medical advances made in their respect and the scientific data available on them.

We are already working on two ailments, type 1 diabetes (KCE report 314, 2019) and invasive breast cancer (publication scheduled in 2021). At the end of 2020 we launched a call for subjects with a view to identifying new health problems to be investigated as a matter of priority. This call was aimed at any person or association concerned by a cancer-related or chronic pathology (citizens, healthcare providers, patients’ or consumers’ associations, organisations, political decision-makers, etc.). Twenty-two proposals were submitted and are currently the subject of a selection procedure based on pre-established criteria.

Participation in EBP Network



The KCE was entrusted with the coordination of the prioritisation committee of the Belgian Evidence Based Practice network. The role of this committee is to organise and to accompany the selection of subjects for the activities to be rolled out by the network as a matter of priority. Several types of projects are possible: the development of new guidelines (either by adapting high-quality guidelines adopted in other countries as a basis, or by conducting a review of the literature anew), the updating of existing guidelines, and the implementation of clinical recommendations. In 2020 the call for subjects for the 2021 programme led to the receipt of 26 proposals, five of which were accepted at the end of a scientific evaluation followed by a consensus procedure, and taking into account the available budget: (1) a guideline for the follow-up and revalidation of COVID-19 patients in primary care after hospital discharge, (2) a guideline for the organisation of tele-logopedics, (3) a guideline and implementation plan for low-risk childbirth, (4) a guideline for oncological monitoring at home, and (5) the creation of a list of evidence-based 'red flags' (diagnostic and therapeutic attention points) for podologists.

In addition to these there are also two subjects in reserve which will depend on the budget available: (1) a multidisciplinary guideline for the organisation of tele-consultation and (2) a guideline on the treatment of asthma. Furthermore, some of the projects from 2020 were postponed: the implementation project of a guideline on rehabilitation after a stroke (to 2021) and interventions aiming at the optimization of the prescription of antibiotics in ambulatory care (to 2022).

It also falls to the prioritisation committee to help support previously selected projects. This is the case, for example, with the implementation of the guideline on lumbago and radicular pains (KCE report 287), a project selected in 2018, which comprises three sections: multidisciplinary training of general practitioners, physiotherapists and psychologists, the drawing up of an information tool for patients and the development of indicators to evaluate the impact of the guideline's implementation. The start-up of another 2019 project, i.e. implementation of the guideline on chronic pain, had to be put off until January 2021 due to work overload of the contracting parties linked to the COVID-19 pandemic. As regards projects in the 2020 programme (implementation of guidelines relating to chronic kidney failure and the multidisciplinary handling of stroke), the committee helped provide the candidate contracting parties with information and took part in the setting up of the selection panels.

Lastly, throughout 2020 the prioritisation committee helped in the development of and support to networking of the Belgian EBP network and to the drawing of its strategic plan. In the context of the optimization of the existing prioritisation procedures, it also developed a form that should enable the network's partners to evaluate the prioritisation process.

KCE TRIALS PROGRAMME

KCE Trials is a funding programme for non-commercial clinical trials financed by the Belgian federal authorities. These clinical trials address issues that are usually neglected by industry despite their high societal importance, such as comparing treatment options with each other (e.g. two surgical techniques) or studying the effect of existing drugs on populations that are rarely considered in commercial studies, such as children or the elderly. KCE Trials finances practice-oriented and multicentre comparative effectiveness studies.

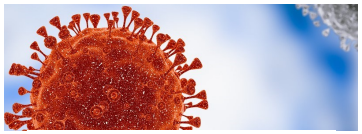
Since early 2020 KCE Trials is supporting efforts against the coronavirus pandemic by selecting and funding non-commercial clinical trials for treating COVID-19.

Despite the turmoil caused by the pandemic and its impact on ongoing studies, KCE Trials programme managed to almost double the number of ongoing trials it funds. In addition to the 4 “COVID-19” trials, 10 new contracts were signed with Belgian and international research teams, bringing the total number of ongoing trials to 30. In addition, 3 trials published their first results.

The KCE clinical trials are:

- **non-commercial**
- **practice-oriented** and focused on current standards of care: unlike commercial trials, these involve patients treated under real-life conditions (in hospitals, in the community and in nursing homes, etc…)
- **comparative**: they compare the efficacy of treatments which have already been used but which have never been directly compared to one another
- potentially able to lead to **cost savings for health insurance**
- **not limited to drugs or medical devices**: they can also involve lifestyle modifications, psycho-therapies, diagnostic tests, surgical interventions, etc.
- guaranteed to **generate databases that are made available for public interest research**, for example to conduct detailed and independent cost-effectiveness studies..

KCE Trials is responsible for the selection and funding of clinical trials, but does not conduct them itself. Hospitals, universities or non-commercial research institution take on the sponsorship and coordination responsibilities. **More info:** https://kce.fgov.be/en/kce-trials



Total budget of the COVID-19 studies

7.5

€ million

1105

randomised patients

33

participating Belgian hospitals

Four COVID-19 trials

A fast-track rolling call was launched in spring 2020 to encourage researchers to propose solutions to the many problems posed by COVID-19. This rolling call resulted in three clinical trials being set up in Belgium and funding for Belgian participation in an international study (DisCoVeRy). The call was initially planned to end at the end of 2020, but the deadline was extended to April 2021 and the scope was extended to include vaccine trials.

- **COV-AID**: A prospective, randomized interventional study to assess the safety and efficacy of interleukin-6 and interleukin-1 pathway blockade in COVID-19 patients with acute hypoxic respiratory failure and systemic cytokine release syndrome. Recruitment for this study has been completed and 342 patients were enrolled in 16 Belgian hospitals.
- **DAWN-Plasma**: Donated antibodies against nCoV in hospitalised patients. The recruitment of this study has been completed, enrolling 489 patients in 21 Belgian hospitals. The protocol has been published.
- **CONFIDENT**: A multicentre randomized trial to assess the efficacy of CONvalescent plasma therapy in patients with Invasive COVID-19 and acute respiratory failure treated with mechanical ventilation. The protocol has been published.
- **DisCoVeRy**: Multi-centre, adaptive, randomized trial of the safety and efficacy of treatments of COVID-19 in hospitalized adults.

First full study results published

In November 2020, the results of our first three completed clinical trials were published in international journals. The results of a pilot study are also available.

ELMO: The effect of evidence-based decision support for ordering laboratory tests in family practice: a cluster randomised trial. Result: the use of an electronic decision support tool integrated into the patient's medical record makes it possible to reduce the volume of laboratory tests prescribed without increasing the risk of diagnostic error.

- **Complete report of the study**
- **Publication in Implementation Science**

KCE-16012: A medical device trial to evaluate the use of a silicone adhesive multilayer foam dressing as prevention for pressure ulcer development in hospitalised patients. Result: The dressings studied reduce the incidence of pressure ulcers of category 2 or higher when used in addition to usual care. The results show a decrease for pressure ulcers at the sacrum.

- **Publication in the British Journal of Dermatology**
- **Complete report of the study**

VINCA*: Comparison of the impact of two vincristine administration methods on vincristine-induced neuropathy in children treated for cancer. Results: The study shows that there is no significant differences between the two routes of administration. This applies to neuropathy as well as to the reported quality of life, medical costs and therapeutic effectiveness. However, differences could be seen in children who were simultaneously given medication (azoles) against fungal infections, where the risk of neuropathy was less with a one-hour infusion. The way in which children process vincristine appears to differ greatly from one individual to another. The researchers hope to be able to better predict which dose and which administration route works best for which group of children. (**Copyright Mediator ZonMw**)

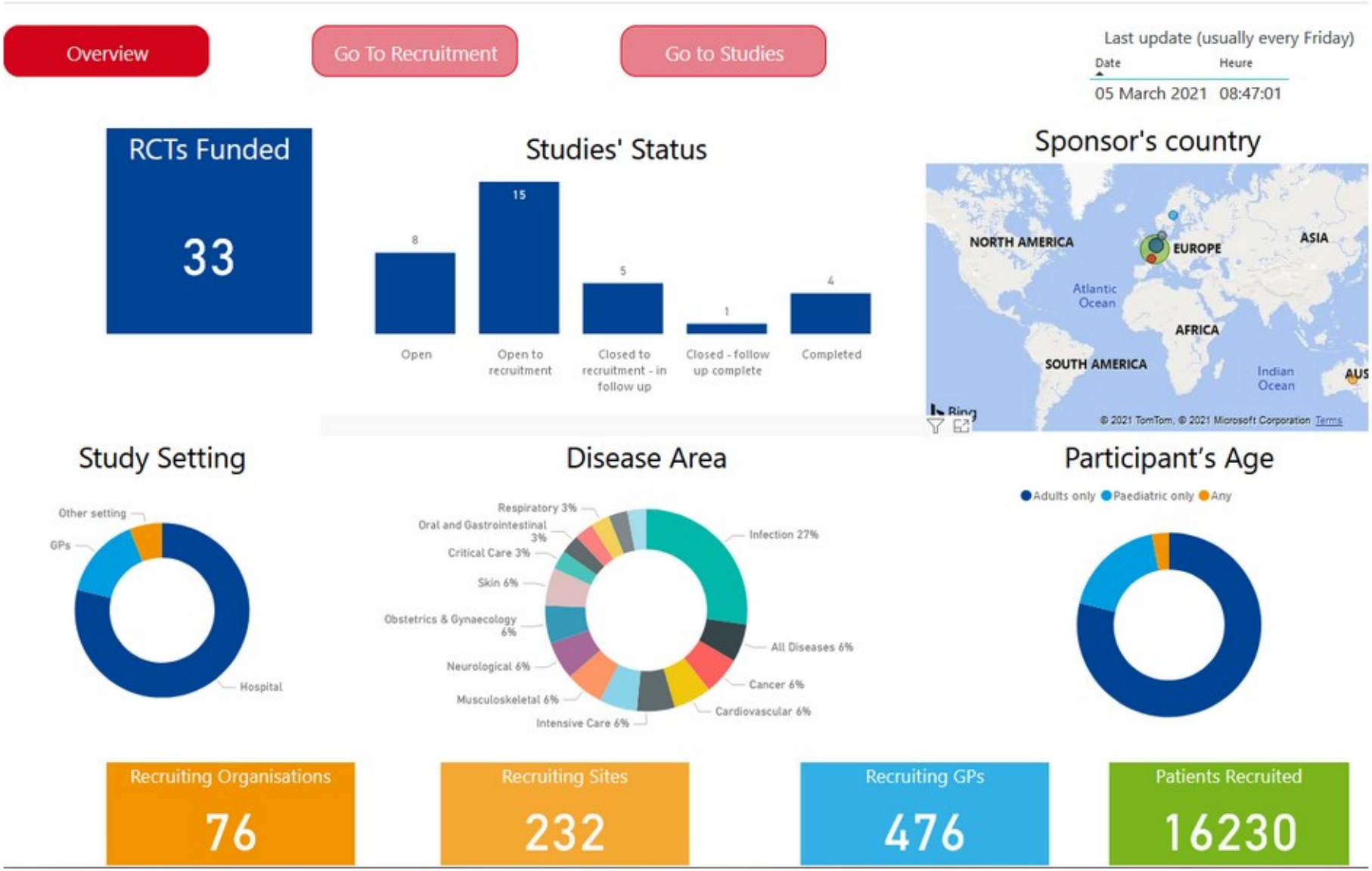
- **Publication in Cancers**

OptiMED: Multidisciplinary medication review in nursing homes to evaluate the appropriateness of prescribing – a pilot feasibility study. Results of the pilot study: the OptiMED intervention seems to show a decrease in the volume of medicines and inappropriate use without affecting patient safety. However, some improvements to the intervention are still needed before a larger scale study can be considered.

- **Report of the feasibility study**
- **Publication in Archives of Gerontology and Geriatrics**

Ongoing studies

We have set up a dynamic dashboard displaying the recruitment status of studies funded by the KCE Trials programme in Belgian hospitals and in other settings (general practice, mental health centres, etc.). This dashboard is updated every Friday, based on the data entered in EDGE Belgium by the recruitment sites .



Figures for the KCE Trials programme at the end of December 2020 :

61	476	16 230	1.7
participating hospitals	participating GPs	total recruited patients	€ million mean budget per trial

Clinical trials in analysis phase

- **DOMINO**: Diet or Medication in Irritable bowel syndrome.
- **PELICAN**: Localized neuropathic pain: a study to compare topical treatment versus systemic treatment.

Clinical trials with completed recruitment

- **CareRA 2020**: COBRA-Slim treatment strategy with or without fast access to TNF blockade for remission induction in early rheumatoid arthritis.
- **Big Bird**: The effectiveness of a blended care program for the discontinuation of benzodiazepines use for sleeping problems in primary care: a clustered randomized trial.

Clinical trials recruiting participants

- **BeNeBio (BeNeFIT)***: (BeNeFIT*): Dose reduction of the new generation biologics (IL17 and IL23 inhibitors) in psoriasis: A pragmatic, multi-centre, randomised, controlled, non-inferiority study.
- **PRECISE (BeNeFIT)*:** (BeNeFIT*): The impact of high versus standard enteral protein provision on functional recovery following Intensive Care admission: a triple blind randomized controlled trial in mechanically ventilated, critically ill patients .
- **BeNeDuctus*:** Multi-center, randomized non-inferiority trial of early treatment versus expectative management of patent ductus arteriosus in preterm infants.
- **ADVOR:** A multi-center, randomized, double-blind, phase IV clinical trial on the diuretic effects of Acetazolamide (Diamox ®) in patients with Decompensated heart failure and Volume OveRload.
- **AGNOHSTIC:** Impact of the use of HYALOBARRIER® GEL ENDO following operative hysteroscopy for improving reproductive outcome in women with intrauterine pathology wishing to become pregnant.
- **BLENDED:** Blended Care Psychodynamic Therapy or Cognitive Behavioral Therapy versus Face-to-Face Psychotherapy for Depression: A pragmatic multicentre randomized controlled non-inferiority trial.

- **BLING III***: A phase III randomised controlled trial of continuous beta-lactam infusion compared with intermittent beta-lactam dosing in critically ill patients.
- **RenoMet:** Metformin as RenoProtector in Non-Diabetic Patients with Progressive Chronic Kidney Disease (CKD stages 2, 3A and 3B): a multi-centre, practice-oriented, repurposing, double-blind, placebo-controlled, randomized clinical trial.
- **ALLTogether1*:** Evaluation of various treatment protocols for trial for children and young adults with acute lymphoblastic leukaemia (ALL) .
- **BENEFICIAL:** A Multicentric, Randomised Controlled Clinical Trial To Study The Impact Of Bedside Model-Informed Precision Dosing Of Vancomycin In Critically Ill Children.
- **GonoScreen:** Efficacité du dépistage des infections sexuellement transmissibles (IST) chez les hommes qui ont des relations sexuelles avec d'autres hommes (HSH).
- **SAFEBOOSC III***: A pragmatic, open label, multinational randomized phase III clinical trial evaluating treatment based on near-infrared spectroscopy monitoring versus treatment as usual in premature infant.
- **IODA:** Feasibility of conducting a pragmatic, randomized trial that compares Immediate versus Optional Delayed surgical repair for treatment of acute anterior cruciate ligament injury.

Clinical trials in the start-up phase

- **KIWI (BeNeFIT)***: Bronchodilators for wheeze in young children presenting to primary care: a randomised, placebo-controlled, multicentre, parallel group trial.
- **DUET (BeNeFIT)*:** Azole-echinocandin combination therapy for invasive aspergillosis. A randomized pragmatic superiority trial).
- **RESET (BeNeFIT)*:** Randomized Evaluation of Surgery in Elderly with Traumatic Acute SubDural Hematoma.
- **ARON:** Impact of clinical guidance & point-of-care CRP testing in children on antibiotic prescription by general practitioners .
- **HYFOIL:** Impact on conception after additional tubal flushing with oil-based contrast versus no additional flushing: a randomised, multicentre, pragmatic trial in women experiencing difficulty conceiving with at least one patent tube at HyFoSy.
- **Foot Drop:** A prospective, multi-center, randomized, parallel-group controlled PILOT trial to compare conservative versus surgical treatment of foot drop from peroneal nerve entrapment.
- **C-EASIE:** Early administration of Vitamin C in patients with sepsis or septic shock in emergency departments: a multicentre, double blinded, randomized controlled trial.
- **SurLym:** Comparison of reconstructive surgery versus no surgery, additional to decongestive lymphatic therapy (usual care), for the treatment of lymphoedema. A multicentre, pragmatic randomised controlled trial.

* Some of these studies (VINCA, BeNeDuctus, BLING III, SafeBoosc, ALL Together1 and DisCoVeRy) are carried out within the framework of international multi-centre collaborations. In these cases, a Belgian hospital takes over the coordination of the research for the whole of Belgium and acts as the single point of contact for the project at the international level. Three other studies are carried out within the framework of the BeNeFIT project (see below).

BeNeFIT

KCE is co-financing certain trials with its Dutch counterpart **ZonMw** within the scope of a joint call called BeNeFIT (Belgium-Netherlands Funding of International Trials). Numerous issues relating to healthcare are in fact relevant for both countries; the development of joint selection processes and exchanges of best practices between researchers helps strengthen the expertise of both teams and obtain results more quickly. The BeNeFIT project currently includes five studies resulting from the first call launched in 2018.

A second call opened in 2020 yielded 41 proposals, which are currently being evaluated.

@KCETrials

OUR INTERNATIONAL COLLABORATIONS

The KCE is part of European and global networks of expertise. Its reputation for scientific rigour has earned it numerous requests to collaborate in working groups at an international level.

International networks

WHO's European Observatory on Health Systems and Policies

European projects

The KCE is an active member of **several international networks** such as:

- **EUnetHTA (European network for Health Technology Assessment),** the European network for Health Technology Assessment with more than 30 states participating. The overall objective of EUnetHTA is to create an effective and sustainable network for HTA across Europe and to help develop reliable, timely, transparent and transferable information to support HTA in European countries. To do this, EUnetHTA produces a repository of methods and processes, and organises the collaborative production of Joint and Collaborative Assessments that can be used by member states.

- **INAHTA (International Network for Health Techology Assessment),** the International Network of Agencies for Health Technology Assessment. It offers its members a forum to identify common interests in the evaluation of health technologies. INAHTA publishes the international HTA database of projects and reports and collaborates on the HTA Glossary project.

- **Beneluxa Initiative on Pharmaceutical Policy,** an association of HTA agencies in the Benelux, Austria and, since 2018, Ireland. Its aim is to facilitate access to quality treatment at reasonable prices for patients in these countries. To this end, its members share Horizon Scanning exercises (anticipating health challenges by £studying new pharmaceutical products entering the market), exchange information, expertise and best practices, and jointly negotiate the prices of new products entering their respective markets (resulting in greater price transparency).

- **IHSI (International Horizon Scanning Initiative),** an international organisation that provides policy makers and payers with data to leverage in price negotiations with the pharmaceutical industry. This data allows health systems to prepare for the arrival of innovative technologies through early technology assessment of new products entering the market .

- **GIN (Guidelines International Network),** an international organisation of organisations and experts involved in the development of clinical practice guidelines. The aim of the GIN is to contribute to the improvement of the quality of care by promoting the systematic development of guidelines and their implementation on an international scale.

- **ECRIN** an international non-profit organisation that networks European scientists involved in clinical research. Its objective is to facilitate transnational multicentre research by providing investigators with support and tools to manage the difficulties associated with the multinational nature of research. Belgium is not (yet) a member of ECRIN but the KCE Trials programme has regular contacts with this structure and its members in the context of international collaborations.

- **HTAi** is the global scientific and professional organisation for health technology assessment. It is a neutral forum that brings together researchers, research agencies, policy makers, industry representatives, academics, healthcare providers, patient and consumer representatives and other stakeholders from 65 countries and 5 continents. HTAi organises an annual international scientific conference and collaborates on the HTA Glossary project. KCE staff members participate in working groups (e.g. the Patient and Citizen Involvement Group) and training courses.

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

The KCE is the Belgian representative to the **WHO's European Observatory on Health Systems and Policies.**

This body supports evidence-based health policies by producing extensive and rigorous analyses of the dynamics of health care systems in Europe, such as the **HiT (Health systems in Transition) country reports**, which are detailed descriptions of each health system.

The Observatory is a partnership between the World Health Organization (WHO) Regional Office for Europe, the governments of Belgium, Finland, Norway, Slovenia, Spain, Sweden and the Veneto Region (Italy), the European Investment Bank (EIB), the World Bank, the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM).

The KCE is responsible for updating the report on the health system in Belgium since 2010 via **The health systems and policy monitor: Belgium.**

A short presentation of the report is also available **here**..

The KCE is involved in several **European projects** such as:

- **PREFER**: is an initiative of IMI (Innovative Medicines Initiative). It is a project that aims to develop a method to take into account the views and preferences of patients in the development of new medicines and reimbursement policies. The project brings together academia and the biopharmaceutical industry, but also patient organisations, HTA agencies (including the KCE), regulators and payers, and small and medium-sized enterprises. The KCE chairs the HTA&Payers Advisory Group and the communication with HTA agencies. It also participates in all working groups and co-chairs the working group on recommendations.

- **PERMIT (PERsonalised MedicIne Trials)**, a project that aims to establish methodological standards for clinical trials in personalised medicine. It was launched in January 2020 under the European research and innovation programme H2020. The consortium includes pan-European research structures (ECRIN, EATRIS, ELIXIR-LU/UNILU), research funders (DLR), HTA agencies (KCE, ISCIII), patient representatives (ETH), competent authorities (ISS) and data protection researchers (TMF).

- **EU-RESPONSE**, a research and preparedness network for pandemics and emerging infectious diseases. It is a 5-year multinational project, coordinated by INSERM (France) and also funded by the European Research and Innovation Programme H2020, to design an adaptive European platform for clinical trials on COVID-19 and other emerging infectious diseases (SolidAct Trial). Hospitals from all over Europe may be involved. A KCE researcher is part of the independent scientific and ethical advisory board set up to advise on the structure of the platform, “EU-SolidAct”, and on which drugs should be studied first.

prefer.
PATIENT PREFERENCES

PERMIT
PERsonalised MedicIne Trials

European Commission

FINANCIAL STATEMENTS 2020

BALANCE

PART 1 ASSETS	31/12/2020	31/12/2019
FIXED ASSETS	**156 693,52**	**131 462,14**
I. Formation expenses		
II. Intangible fixed assets	**34 774,51**	**18 605,01**
III. Tangible fixed assets	**104 713,21**	**104 254,23**
A. Land and buildings	28 154,14	32 176,16
B. Plant, machinery and equipment	42 235,51	46 293,56
C. Furniture and vehicles	34 323,56	25 784,51
D. Leasing and similar rights		
E. other tangible fixed assets		
F. Assets under construction and advance payments		
IV. Financial fixed assets	**17 205,80**	**8 602,90**
CURRENT ASSETS	**18 033 210,38**	**14 341 219,43**
V. Amounts receivable after more than one year	**395,97**	**1 588,11**
A. Trade debtors		
B. Other amounts receivable	395,97	1 588,11
C. Claims from subsidies		
VI. Stocks		
VII. Amounts receivable within one year	**135 761,83**	**161 531,86**
A. Trade debtors		
B. Other amounts receivable	135 761,83	161 531,86
VIII. Current investments		
IX. Cash at bank and in hand	**17 759 339,62**	**14 062 101,35**
X. Deferred charges and accrued income	**137 712,96**	**115 998,11**
TOTAL ASSETS	**18 189 903,90**	**14 472 681,57**

PART 2 LIABILITIES	31/12/2020	31/12/2019
EQUITY	**6 371 052,88**	**6 234 629,60**
I. Capital		
III. Revaluation surpluses		
V. Accumulated profits (losses)	**6 371 052,88**	**6 234 629,60**
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	**11 818 851,02**	**8 238 051,97**
VIII. Amounts payable after more than one year	**0,00**	**0,00**
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. Bails received in cash		
E. Other amouts payable		
IX. Amounts payable within one year	**11 817 403,84**	**8 237 611,09**
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	3 130 160,38	1 667 581,04
D. Advanced received on contracts in progress	1 757 602,93	22 265,00
E. Taxes, renumerations and social security		
1. Taxes		
2. Renumerations and social security	1 001 723,83	1 072 320,49
F. Other amounts payable	5 927 916,70	5 475 444,56
X. Deferred charges and accrued income	**1 447,18**	**440,88**
TOTAL LIABILITIES	**18 189 903,90**	**14 472 681,57**

PROFIT & LOSS

	31/12/2020	31/12/2019
I. Operating income	**24 565 726,86**	**20 760 058,00**
A. Turnover		
B. Stocks: increase (decrease)		
C. Own construction capitalized		
D. Intern billing		
E. Other operating income	24 565 726,86	20 760 058,00
II. Operating charges	**18 509 916,59**	**15 279 116,00**
A. Purchases and stocks		
B. Services and other goods	10 531 809,58	7 110 017,00
C. Renumerations, social security costs and pension	7 882 971,76	8 042 531,00
D. Depreciation of and other amounts written down formation expenses, intangible and tangible fixed assets	95 135,25	126 568,00
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. Opera□ng profit (loss)	**6 055 810,27**	**5 480 942,00**
IV. Financial income	**16,81**	**0,00**
A. Income from financial fixed assets		
B. Income from current assets		
C. Other financial income	16,81	
V. Financial charges	**0,00**	**222,00**
A. Debt charges		
B. Amounts written down on current assets except stocks, contracts in progress and trade debtors		
C. Other financial products		222,00
VI. Profit (losses) on ordinary activities before taxes	**6 055 827,08**	**5 480 720,00**

	31/12/2020	31/12/2019
VII. Extraordinary income	**54 188,74**	**15 304,00**
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	8 602,90	15 304,00
E. Other extraordinary income	45 585,84	
VIII. Extraordinary charges	**5 973 592,54**	**5 476 340,00**
A. Extraordinary depriciation 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	90,00	895,00
E. Other extraordinary charges	5 973 502,54	5 475 445,00
F. Extraordinary charges carried to assets as restructuring costs		
IX. Gain (loss) of the period	**136 423,28**	**19 684,00**

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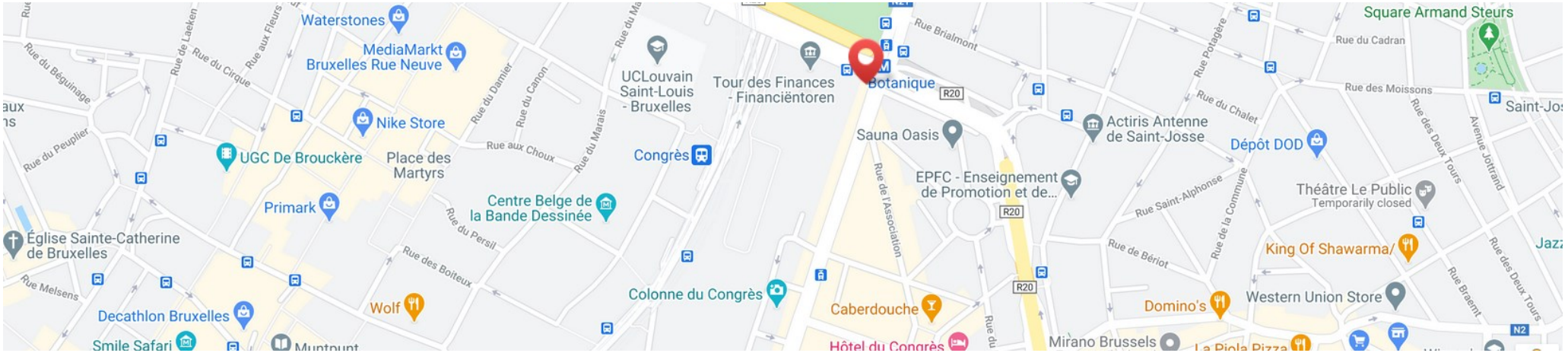

The KCE is a public institution with legal personality, classified in category B as referred to in the Act of 16 March 1954 on the supervision of certain entities of public interest (Parastatal B).
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Privacy protection

We attach the highest importance to the protection of the privacy of the users of its site. Although most of the information is available on or via the website without visitors having to provide personal data, visitors may be requested to provide personal data.

You are protected in accordance with:

- European Regulation 2016/679 of the European Parliament and of the Council of 27 April 2016 (entered into force on 25 May 2018) on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (GDPR)
- the Data Protection Act of 30 July 2018

By consequence:

- personal data are collected and processed solely for the purpose of replying to a request for information submitted by the visitor;
- personal data will not be communicated to third parties nor used for marketing purposes;
- the visitor has the right to consult his personal data and to verify their accuracy and, if necessary, can correct errors. For that purpose, the visitor can contact the webmaster;
- we commits ourself to put in place the best possible security protection to ensure that third parties cannot make incorrect use of the personal data communicated by the visitors of its website