KCE REPORT 214Cs

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

SYNTHESIS

IMPACT OF THE KCE REPORTS PUBLISHED IN 2009-2011

Belgian Health Care Knowledge Centre

The Belgian Health Care Knowledge Centre (KCE) is an organization of public interest, created on the 24th of December 2002 under the supervision of the Minister of Public Health and Social Affairs. KCE is in charge of conducting studies that support the political decision making on health care and health insurance.

Executive Board

	Actual Members	Substitute Members
President	Pierre Gillet	
CEO - National Institute for Health and Disability Insurance (vice president)	Jo De Cock	Benoît Collin
President of the Federal Public Service Health, Food Chain Safety and Environment (vice president)	Dirk Cuypers	Christiaan Decoster
President of the Federal Public Service Social Security (vice president)	Frank Van Massenhove	Jan Bertels
General Administrator of the Federal Agency for Medicines and Health Products	Xavier De Cuyper	Greet Musch
Representatives of the Minister of Public Health	Bernard Lange	Brieuc Van Damme
	Bernard Vercruysse	Annick Poncé
Representatives of the Minister of Social Affairs	Lambert Stamatakis	Vinciane Quoidbach
	Ri De Ridder	Koen Vandewoude
Representatives of the Council of Ministers	Jean-Noël Godin	Philippe Henry de Generet
	Daniël Devos	Wilfried Den Tandt
Intermutualistic Agency	Michiel Callens	Frank De Smet
	Patrick Verertbruggen	Yolande Husden
	Xavier Brenez	Geert Messiaen
Professional Organisations - representatives of physicians	Marc Moens	Roland Lemye
	Jean-Pierre Baeyens	Rita Cuypers
Professional Organisations - representatives of nurses	Michel Foulon	Ludo Meyers
	Myriam Hubinon	Olivier Thonon
Hospital Federations	Johan Pauwels	Katrien Kesteloot
	Jean-Claude Praet	Pierre Smiets

Contact

Belgian Health Care Knowledge Centre (KCE)
Doorbuilding (10th Floor)
Boulevard du Jardin Botanique, 55
B-1000 Brussels
Belgium

T +32 [0]2 287 33 88
F +32 [0]2 287 33 85
info@kce.fgov.be
http://www.kce.fgov.be

KCE REPORT 214Cs
METHODOLOGY

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

SYNTHESIS

IMPACT OF THE KCE REPORTS PUBLISHED IN 2009-2011

IMGARD VINCK, MURIELLE LONA, NATHALIE SWARTENBROEKX

COLOPHON

Title:	Impact of the KCE reports published in 2009-2011 – Synthesis
Authors:	Imgard Vinck, Murielle Lona, Nathalie Swartenbroekx
Reviewers:	Raf Mertens, Christian Leonard, Kristel De Gauquier, Dominique Paulus, Marijke Eyssen
Acknowledgements:	Stephan Devriese
Layout:	Ine Verhulst, Sophie Vaes
Publication date:	12 december 2013
Domain:	Methodology (MET)
Language:	English
Format:	Adobe® PDF™ (A4)
Legal depot:	D/2013/10.273/98

How to refer to this document? Vinck I, Lona M, Swartenbroekx N. Impact of the KCE reports published in 2009-2011 – Synthesis. Methodology (MET). Brussels: Belgian Health Care Knowledge Centre (KCE) 2013. KCE Reports 214CS. D/2013/10.273/98.

This document has been published on the website of the Belgian Health Care Knowledge Centre.

LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
SSF	Special Solidarity Fund
CEBAM	Centre for Evidence-Based Medicine
CRT	Cardiac Resynchronisation Therapy
CRT-P	Pacemaker with Cardiac Resynchronisation Therapy
CT	Computed Tomography
EBM	Evidence-Based Medicine
EEG	Electroencephalogram
EMR	Electronic Medical Record
EP	Evoked Potentials
ERP	Event-Related potential
EUnetHTA	European network for Health Technology Assessment
FAGG	Federal Agency for Medicines and Health Products
FANC	Federal Agency for Nuclear Control
FPS	Federal Public Service
GDH	Geriatric Day Hospital
GCP	Good Clinical Practice
HiT	Health in Transition
HIV	Human immunodeficiency virus
HSR	Health Services Research
HTA	Health Technology Assessment
ICD	Implantable cardioverter-defibrillator
IKNL	Integraal Kankercentrum Nederland - Comprehensive Cancer Centre the Netherlands
IMA	Intermutualistic Agency
INAHTA	International Network of Agencies for Health Technology Assessment
INR	International Rationalised Ratio
KU LEUVEN	Katholieke Universiteit Leuven - Catholic University of Leuven
MRI	Magnetic Resonance Imaging

MHD	Minimum Hospital Data
NMR	Nuclear Magnetic Resonance
NCQP	National Council for Quality Promotion
NCHS	National Council for Hospital Services
NIHDI	National Institute for Health and Disability Insurance
OECD	Organisation for Economic Co-operation and Development
P4Q	Pay for Quality
PET	Positron Emission Tomography
PROCARE	Project on Rectal Cancer
QERMID	Quality oriented Electronic Registration of Medical Implant Devices
RHE	Rest Home for the Elderly
RNH	Rest and Nursing Home
UCL	Université Catholique de Louvain La Neuve - Catholic University of Louvain La Neuve
UGent	Universiteit Gent - Ghent University
ULB	Université Libre de Bruxelles - Free University of Brussels (French-speaking part)
VUB	Vrije Universiteit Brussel - Free University of Brussels (Dutch-speaking part)
VVOG	Vlaamse Vereniging voor Obstetrie en Gynaecologie - Flemish Association for Obstetrics and Gynaecology

FOREWORD

A first step in the evaluation process of the actual impact of the KCE reports and its recommendations on policy and medical practices in the field was the independent audit by the Dutch firm *Research voor Beleid* in 2009. This audit was mainly a reputation survey and did not systematically analyse measures or changes that could be attributed to the impact of the KCE. But that did not make the document any less useful and it proved to be an important source of inspiration for our new 2010 management plan.

Needless to say, our political leaders are also interested in the impact of the KCE. Under the current coalition agreement, the Minister for Public Health is obliged to present annually a report to the Parliament on the implementation of KCE reports. To gather the necessary material for that report, all relevant actors were surveyed and a close look was taken at any amendments that were introduced to the legislation and regulations in the wake of the KCE reports and recommendations.

No one expected that every recommendation would be followed. The KCE is and remains a scientific advisory body and policy, after all, does have its own pattern. Yet, it is gratifying to find that today, ten years after the KCE was founded, the advice the KCE issues is rarely, if ever, ignored in debates - at least, when topics the KCE already conducted a study on are being discussed.

The question arises why certain advices are followed to the letter and others not, or far less so. This cannot simply be deduced from the present descriptive research. To answer that question, we will need to delve deeper into and probe the stress area between the putative rationality of *evidence-based medicine* and the interests, values and preferences as they prevail in society. KCE, for its part, is determined to get down to the bottom of this highly relevant issue.

Christian LÉONARD
Deputy general director

Raf MERTENS
General director

SUMMARY

Objective and background of the study

In this study, the KCE describes the impact of the 78 reports published during 2009-2011. The purpose of this document is in first instance a political one. Under the present coalition agreement, the Minister for Social Affairs and Public Health must annually present a report to the Parliament on the extent to which the KCE reports were implemented.

Methodology

The sources that were consulted vary from report to report. The information was mainly obtained from internal and external staff working on the project in question, other contacts, relevant websites and legislation. The media coverage of the reports was documented by means of press articles which the KCE systematically archives. The information obtained was recorded on an individual data sheet per report.

Definition and gradation of impact

Impact manifests itself in various domains. For this particular report, the impact on the political-legislative and economic domain, care organisation, patients and patient organisations, public opinion, the media and the scientific forum was described. The impact on the political-legislative domain was allocated a further gradation: direct impact, i.e., at least one of the recommendations was implemented; indirect impact, i.e., the KCE recommendations featured in the debate on the topic in question but have not been implemented (as yet). The impact of reports containing recommendations aimed at individual health care professionals (mainly practice guidelines) was graded as "not measured". The impact of the methodological reports was given a similar label.

The study limits itself to describing the impact. The reasons as to why recommendations were implemented or not were not explored.

Results

Leaving the 11 reports whose impact was marked as "not measured" aside, about half of the remaining 67 reports can be deemed to have had a direct impact. About one third is currently under discussion. In the case of one of the evaluated HTA reports only, a decision was taken that went directly against the KCE recommendations.

The domains within which the KCE reports can be catalogued (HTA-GCP-HSR-Method) seem to be an objectifiable, determining impact factor. Traditionally, HTA reports are implemented faster than HSR reports. One plausible explanation for this is that the target groups of the HTA recommendations are more confined than for a HSR reports.. Furthermore, HTA report recommendations usually translate themselves into concrete advice on whether or not a particular drug, medical device or specific intervention should be reimbursed. HSR report recommendations are on the whole destined for a number of parties and are, more often than not, the object of several rounds of debate between the stakeholders before they are implemented.

What next?

Aside from being a useful policy instrument, this report is also a valuable tool for the KCE itself as it offers a number of elements which will allow us to enhance our know-how on impact evaluation and improvement. The KCE is also committed to combining forces at European level in this regard.

SUMMARY

TABLE OF CONTENTS

1. CONTEXT

1.1. Introduction: the KCE as partner within Belgium's health policy

Since its foundation - under the Programme Act of 24.12.2002 - and it coming into operation in 2003, the KCE has, thanks to its new, creative and scientific mission, earned its place on the Belgian health care scene. The Knowledge Centre's core business consists of compiling reports which should allow the government to take decisions based on scientific literature, data analysis, advice from experts and findings from all the results combined.

While some of these reports made an indelible impression on the public at large, others impacted on a somewhat smaller scale, assisting care providers in their daily practice. As the numbers of projects increased, demand for advice from the KCE also rose, with the result that the Knowledge Centre has grown into a body that puts its stamp on the decision-making process within the Belgian health care policy. During 2012, it received a sum total of 150 proposals for research projects from institutions and private citizens.

The KCE deals with the following areas of research:

- Analysis of clinical practice and development of clinical practice guidelines: Good Clinical Practice (GCP)
- Evaluation of new medical technologies and drugs: Health Technology Assessment (HTA)
- The organisation and financing of the health care system: Health Services Research (HSR)

The mission of the Institute is essentially limited to supporting the decision-making process; so, the KCE is not involved in the policy decisions and choices ensuing from the formulated recommendations and does not concern itself with the implementation of measures in the field.

In a quest for efficiency within the context of the rationalisation of public expenditure, it is imperative that the result of the KCE activities is evaluated. In that light, it was examined to what extent 78 reports, published between 2009 and 2011, were followed up and implemented in the field. This empirical exercise is unique; foreign agencies, comparable to the KCE, claim that they neither have the time nor the funds to analyse their impact (cf. section 3).

1.1.1. Budget and staff

In 2012, the KCE had access to a total of 9.3 million euro. At the start of 2013, the centre was employing close on 60 people. The research team numbers 39 members, hired after undergoing a thorough selection process. The researchers have varying scientific backgrounds: medicine, economics, law, social sciences, public health and can bank on the support of an administrative team.

The reports are compiled by a team of KCE researchers and, at times, external researchers.

1.1.2. The recommendations

Every study the KCE publishes contains a number of recommendations that should help the government in its decision-making process. It is therefore legitimate to check whether the recommendations were heeded in the field. In other words, the question is: do the reports have an impact? The Dutch consultancy firm *Research voor Beleid* already looked into the impact of the Knowledge Centre[a]. The findings, which date back to 2010, broached on the theoretical understanding of the concept "impact", dealt with the KCE framework of reference and the position of the various stakeholders. On the other hand, the consultancy firm also presented a number of case studies (or impact of reports) within the 3 spheres of activity of the KCE: GCP, HTA and HSR.

The present report takes matters further. It features within the framework of the Coalition Agreement of December 2011 which, in its socio-economic section, provides for a reform of compulsory health insurance and the health care system with a view to making the various actors accountable. In that light, the Minister with competence for Public Health (currently Minister Onkelinx) must report to Parliament every year about the extent to which the reports the KCE published are implemented.

---

[a] Poortvliet E.P.,Vijfvinkel D., Vennekens A., Van Hoesel P., Daue F. Study into the impact of the Belgian Health Care Knowledge Centre, April 2010. http://www.kce.fgov.be/sites/default/files/page_documents/2008-55_hsr_impact_study%20kce.pdf

This overview should allow the KCE to formulate an objective answer to a legitimate request for an evaluation of its activities; on the other hand, the present overview should also provide the information the minister is expected to present to Parliament every year.

2. METHODS

3 years were selected for this particular evaluation: 2009, 2010 and 2011; the 78 reports published during this period were scrutinized. Sometimes earlier reports are quoted because they are of interest in terms of the historical overview of the reports that were discussed more recently.

More recent reports were mentioned if they played an important role as follow-up study.

For every report, both the research questions and the recommendations the KCE formulated were examined. Up and until 2012, the reports did not specify who the recommendations were intended for. In respect of these reports, the addressees of the recommendations were added at the time of the impact evaluation.

Information sources:

- The KCE project leaders of the projects being scrutinized were systematically questioned about their knowledge of the elements of impact. Based on any suggestions they made, external persons were contacted.
- For reports that were by and large or completely compiled by an external team, contact was made with the relevant persons in charge directly. The contacts were interviewed by phone, e-mail or face-to-face.
- Relevant websites were also searched while the website of the House of Representatives and Senate was perused to see to what extent the KCE reports featured in parliamentary questions.
- For every individual report, it was moreover examined which media discussed the KCE reports. The KCE already had an archive of published press articles. At that, the KCE keeps statistics on the frequency at which a report is consulted and downloaded. This gives an idea of the level of interest a particular project generates amongst the public at large.

2.1. Definition of impact

For this particular impact study, "impact" was defined as the extent to which project-specific conclusions and/or recommendations were taken on board. This type of impact is a multi-level one, depending on the target

group (government, patient, care institution, individual care provider, industry…) and the material scope of application (political (a. o. law amendments), scientific (a. o. publications, presentations), public opinion (press coverage)).

It is therefore essential to classify the impact. For this study the following classification was used:

- Economic impact (budgetary)
- Impact on policy and the legislation
- Impact in the field; medical practice
- Impact in the field; care organisation
- Societal impact: patients and patient organisations
- Impact on public opinion and the media
- Scientific impact: further research and national and international publications

Recommendations often impact on several levels. An amendment to the law facilitates amendments to the National Institute for Health and Disability Insurance (NIHDI) regulations/nomenclature, which often impacts on the behaviour of prescribers and patients. Aside from that, changes to the nomenclature invariably have a budgetary impact on the NIHDI. However, that impact is not always calculated. Only in cases where figures were to hand, this type of impact is reported on.

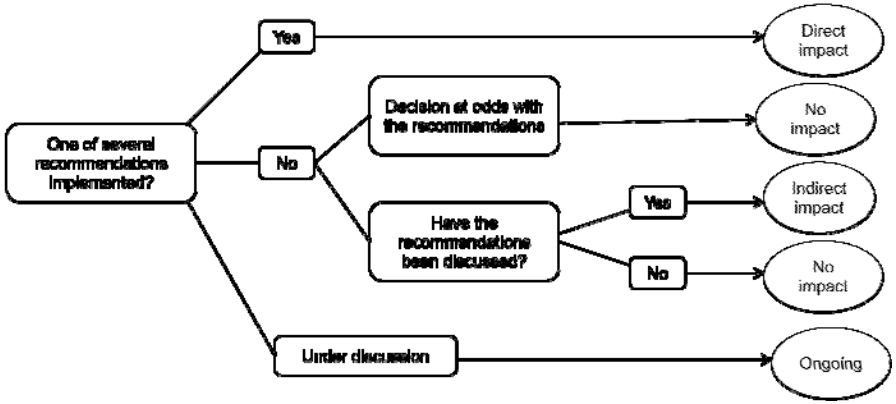
2.2. Degree of impact

The degree of impact was only specified as far as the impact on policy and legislation is concerned.

- Direct impact means that the addressee implemented one or several proposed recommendations (be it in part or in full) in his policy decision.
- Indirect impact means that a policy decision was taken and that the KCE recommendations furthered the debate on the topic but that the recommendations themselves were not implemented.
- Recommendations were marked as having had 'no impact' in cases where they were either not discussed or where the decision went against the KCE recommendation.
- Measuring impact is not a static process. It takes a certain amount of time before certain recommendations are (either or not) implemented. The impact reported represents the state of play at the start of 2013. The final impact of recent reports can often not be determined yet or the reports are still being discussed. The impact of these reports was graded as 'under discussion'.

  In a number of cases, some recommendations have already been implemented while others are still being debated. These reports were marked as having a 'direct impact'.

Figure 1: Framework for assigning degrees of policy impact



2.3. Limitations

A choice was made to only give a factual representation of the impact and not to assess its quality or the reasons why implementation was successful or not. In a number of cases, external elements that often do not lend themselves to objectification, determined to what extent the recommendation was ultimately acted on. Pin-pointing these elements did not come within the scope of this study.

The measurability of the impact is determined by several factors. It goes without saying that the impact of the KCE recommendations destined for players at macro level (e.g. government bodies) is easier to measure than that of recommendations which are mainly aimed at micro level (e.g. individual care providers, patients).

At that, the nature of the recommendations varies according to the type of KCE report (GCP, HTA, HSR).

- Recommendations in GCP and HTA reports are often aimed at a specific and homogeneous target group of care providers (and patients) and deal with a specific type of intervention. They tend to be for immediate implementation. Within the domain of GCPs, some reports formulate clinical practice guidelines for individual care providers while other GCPs formulate advice for policy makers. To what extent individual care providers comply with these clinical practice guidelines was not investigated. To determine whether care providers also implement these recommendations, two types of research are required: surveys amongst care providers, on the one hand, and an analysis of the data (MHD, IMA data, ...), on the other hand, yet these data tend to be a number of years old. On that account, the impact of these GCPs was reported as 'not measured'.
- HSR reports often formulate recommendations at system level, which makes that their implementation tends to have a longer-term perspective.
- And last but not least, the KCE also publishes methodological reports. The impact of these reports is very difficult to assess as they do not instigate direct action within the health care sector but rather provide technical support for internal use within the KCE or for a wider scientific audience. The impact of these reports was also labelled as 'not measured'.

2.4. Update of the report

The reported impact of the respective studies is a state of affairs of the beginning of 2013. The results of this impact study were presented in November 2013 by the KCE to the Commission Public Health of the Chamber. In the mean time for several reports important evolutions have taken place. In this document solely the most important novelties were updated. A systematic update for each report was not carried out. The impact results need to be interpreted accordingly.

3. IMPACT MEASUREMENT OF HTAS AT AN INTERNATIONAL LEVEL

At an international level, HTA agencies are also interested in measuring report impact. The KCE is taking part in discussions on this matter.

3.1. INAHTA

INAHTA (International Network of Agencies for Health Technology Assessment) is an international network of agencies which (among other matters) devotes itself to Health Technology Assessment (HTA). During the 2012 INAHTA annual meeting, the impact of HTA reports was discussed by representatives of HTA agencies from a. o. France, Australia, Germany, Finland, Scotland and Spain. The result of these discussions has been summarised hereafter.

3.1.1. Views on the definition and measurability of impact

There is no uniform definition of the concept “impact” or a set of indicators to measure impact. At that, impact is very much dependent on the local context, the stakeholders involved and the objective of a HTA report. Hence the need to, at the start of any report, define the desired impact, formulate indicators and elaborate a strategy to achieve that impact. Some agencies perform quantitative measurements such as the number of hits, the number of times reports are downloaded or quoted in articles. The majority of the members believed that a combination of quantitative and qualitative measurements is the best way to correctly assess impact.

3.1.2. The INAHTA impact measurement framework

In the past, INAHTA already developed a framework for reporting on the impact of its members' HTA reports on policy decisions at a regional, national and international level.

The majority of the members do not use the INAHTA framework and therefore do not systematically examine and/or report on the impact of their HTA reports. When they do, it is mainly to give account in function of retaining or obtaining (government) funding or to preserve or enhance the quality of their HTAs. Most members do feel however that impact measurement should be a part of the management process.

3.1.3. Constraints

Many members believe that the substantial investment in terms of time and resources constitutes the main constraint with regard to measuring impact. It was furthermore noted that impact is often the result of a combination of factors and that it can in the main not be unequivocally ascribed to the recommendations in a HTA. More often than not, impact is only noticeable in the long term, which means that continuous monitoring is required.

3.1.4. The way to go

On the basis of the above findings, a number of points of action were proposed. It was suggested that reports with a sound impact (analysis) should be put at the disposal of the INAHTA members so that the constraints and challenges could be deduced from these and the elements that facilitate impact identified. Another proposal was to compare HTAs of identical technologies by different HTA agencies for impact in the various health care systems.

An INAHTA working group is preparing a systematic literature review concerning the impact of HTA reports and the methodology to measure this impact which should be ready in 2013. The KCE forms part of this INAHTA working group.

3.2. EUnetHTA

EUnetHTA is collaboration between various European HTA organisations. The KCE took the initiative to establish an impact community of practice within EUnetHTA. The plan is to share experiences on impact measurement and impact enhancement with people in the same field of action.

4. RESULTS

The results reported below focused on the impact at policy level. Further details on the other impact domains can be found in the individual report data sheets.

4.1. Reports on care quality enhancement

The provision of quality care starts with the care provider and presupposes that he is aware of the appropriate diagnostic and/or treatment methods and knows when to apply them. In that sense, clinical practice guidelines are the tool par excellence to assist care providers in their decision-making process. Before an opinion can be given on the overall quality of care in a certain field or on a concrete aspect, information is required. Indicators are instruments that provide information about the degree of quality. The KCE has become an important player in terms of developing quality indicators and clinical practice guidelines on, for instance, cancer treatment.

4.1.1. Indicators of quality care for cancer patients

In 2003, a number of Belgian gastrointestinal surgeons set up the PROCARE project to enhance and harmonise the quality of care for patients suffering from **rectal cancer**. The group presently numbers numerous care providers, including non-surgeons (oncologists, radiotherapists...). In conjunction with the PROCARE Group, the KCE developed practice guidelines (report 69, 2007) and a set of quality indicators (report 81, 2008). In 2011, the KCE, for one, focussed on optimising the feedback to participating centres which allowed them to benchmark themselves against each other (report 161, 2011).

Within the framework of the Cancer Plan, the minister asked the KCE to develop a set of quality indicators for a common form of cancer, **breast cancer** (report 150, 2011), and for a rare form of cancer, **testicular cancer** (rapport 149, 2011), as had been earlier been done for rectal cancer within the framework of the PROCARE project. A final report (152, 2011) formulates recommendations on the establishment of a global care quality assurance system in oncology.

These reports had very little impact at federal level. The indicators are available from the Belgian Cancer Registry but the feedback the Belgian Cancer Registry gives at the request of hospitals is infrequent. In the 2009-2014 Flemish coalition agreement, the Flemish Government set itself the

explicit target though to make quality of care apparent to citizens, i.e. patients. In the Quality Indicators Project, a basic set of quality parameters for intramural care at Flemish level, including breast cancer indicators, was developed in consultation with the sector. The breast cancer indicators being used are mainly based on those the KCE developed.

4.1.2. Clinical practice guidelines for the diagnosis and treatment of cancer

The KCE already developed a series of clinical practice guidelines for the diagnosis and treatment of various types of cancer: **testicular cancer** (report 142, 2010) breast cancer (report 143, 2010), **pancreatic cancer** (report 105, 2009), **upper gastrointestinal cancer** (report 179, 2012) and **cervical cancer** (report 168, 2011). To do so, it systematically collaborated with the College of Oncology. With the help of these guidelines, care providers can choose between various treatment options with full knowledge of the facts.

An effective dissemination of the guidelines is an indispensable first step in terms of giving the guideline the desired impact. Aside from the guidelines being systematically published on the website of the College of Oncology, the KCE guidelines are also regularly presented to the profession. The report on cervical cancer, for instance, was presented by researchers at the conference of the Flemish Association for Obstetrics and Gynaecology (Vlaamse Vereniging voor Obstetrie en Gynaecologie - VVOG) in October 2011. Before long, the KCE guidelines will also be disseminated via EBM Practice Net, an "electronic platform" in the form of a free online knowledge database (www.ebmpracticenet.be) with practice guidelines and general “Evidence-Based Medicine” (EBM) information. Via an Electronic Medical Record (EMR), care providers will have direct access to this scientific information.

The KCE practice guidelines have also been warmly welcomed internationally. The Comprehensive Cancer Centre the Netherlands (Integraal Kankercentrum Nederland - IKNL), for one, based itself on the KCE guideline on pancreatic cancer to develop its own practice guideline. The KCE also regularly cooperates with the IKNL to develop other practice guidelines.

4.1.3. Clinical practice guidelines for the diagnosis and treatment of other complaints

The KCE examined scientific evidence on the diagnosis and treatment of **non-specific neck pain** and recommended that the scientific findings of this research would be used to develop clinical guidelines for physicians, physiotherapists and other care providers (report 119, 2009). Meanwhile, the Scientific Association of Flemish Physiotherapists published the results of this report on its website and in its newsletter.

4.1.4. Guideline for care tailored to the patient and his environment

In collaboration with the federations for palliative care and a number of university teams (KU Leuven, University of Antwerp, UCL and UGent), an in-depth look was taken at the situation of **palliative patients** in Belgium (report 115, 2009). The status of palliative patient should be assigned based on a person's needs rather than on his life expectancy. More often than not, patients want to be cared for and die at home. Care provider training, with a focus on communication skills, and care by a multi-disciplinary team are essential if qualitative palliative care is to be provided. The 3 federations for palliative care were tasked with charting the needs and with looking into putting the KCE recommendations into effect. A model has meanwhile been developed that will be trialled in the field.

4.1.5. KCE recommendations translated into intelligible patient information

The guideline relative to **low risk birth** (report 139, 2010), was sent out to all maternity units in clearly comprehensible text so that it could be incorporated into their own patient information. The maternity units were subsequently surveyed on their experience of these guidelines but the response was insufficient to make a formal assessment.

4.2. Reports concerning the enhancement of the care organisation

Quality of care is very much interlinked with an efficient care organisation. In a number of reports, the KCE took a closer look at the performance of the Belgian health care system, and at how care is organised in the out-patient sector and at hospital level. It also focused on how care in the mental health care sector, care for the elderly and for patients suffering

from chronic illnesses is organised. Not only patients but also care providers reap the benefits of a more efficient system. The KCE looked into the quality of traineeships for trainee physicians and the current work situation of general practitioners. The objective of an optimum health care organisation must also focus on a practicable work situation for care providers and on a positive impact on the continuity of care for patients.

4.2.1. Training and further training

The (non-profit association) Farmaka sent **independent representatives** to general practitioners to provide them with unbiased scientific information. At the request of the Federal Agency for Medicines and Health Products, the KCE assessed the effect of these independent medical representatives on the practice of primary care physicians (report 125, 2010). Farmaka consulted the KCE recommendations for its detailed plan, which it submitted to the Federal Agency for Medicines and Health Products, and more specifically to get inspiration for its criteria to select the elaborated themes and to develop a targeted communication strategy. It is expected that a prospective study, conducted by Farmaka, will produce more detailed information.

The Superior Council of Medical Specialists and General Practitioners, which sets the recognition criteria and accredits traineeships and traineeship supervisors, approached the KCE with the question how it could objectively measure the **quality of traineeships**. In report 130 (2010), the KCE recommends an independent, external, professionalised evaluation and a review of the current quality criteria based on examples from home and abroad. The evaluations could be performed by means of site visits, periodic surveys among candidate physicians and self-evaluation by the traineeship supervisors. This report constitutes an important input for the Superior Council's reflections on the current review of the recognition criteria. Aside from the site surveys, which would call for extra efforts in terms of human resources, most of the KCE recommendations will probably be taken on board.

4.2.2. The organisation of primary care

Improving the work situation of general practitioners has been topic of debate for the past number of years. In that light, the KCE looked into alternatives for the current system of **after-hours primary care** which is extremely taxing on the GP corps (report 171, 2011). In line with the KCE recommendations, standardised funding for after-hours primary care facilities was approved in the agreement between the National Commission of GPs and Sickness Funds. Moreover the number of physicians on call per population segment in the quietest periods has been reduced. Furthermore the Minister presented in November 2013 a plan including a nationalisation of the central after-hours number 1733, the creation of addition after-hours posts and measures ensuring an increased safety for general practitioners on duty.

In conjunction with researchers from ULB and VUB, the KCE furthermore compiled a list of points of action to tackle the **burn-out among general practitioners** (report 165, 2011). The report was presented to the press by the research team, together with the professional association of Flemish GPs and GP groups Domus Medica and the Scientific Society of General Practice in the autumn of 2011 and has since then led to quite a number of round-table discussions in GP circles and syndicates. In February 2012, the report was also discussed by the working group "After-Hours Primary Care" of the Federal Council of the Circle of General Practitioners. Furthermore, the FPS Public Health uses the report as a reference for a possible future project: preventing and tackling burnout among hospital nurses and physicians. The next step will be to put the recommendations made in this report into practice but this will call for wide consultation via the National Council for Quality Promotion and the National Commission of GPs and Sickness Funds. The National Commission of GPs and Sickness Funds has meanwhile committed itself to developing proposals with regard to the recommendations. By the end of 2013, a working group will examine which approach would be practicable for all physicians. Both this report and the report on after-hours primary care (cf. supra) were widely published in the press.

4.2.3. At hospital level

The **move from home to hospital or vice versa**, often causes problems with regard to medication use, such as non-adherence to the treatment prescribed, overdosing, undesirable interactions between medicines, etc. (report 131, 2010). Since the report was presented to the FPS Public Health, medication safety and transmural care have become top of the agenda of the second multi-year plan (2013-2017) “Coordination of Quality and Patient Safety” of the FPS Public Health. The FPS is currently preparing the recommendations that will be forwarded to the hospitals

following this plan. At the end of 2011, the "Flemish Agency for Care and Health" also launched an appeal to take part in a "Medication Plan" pilot project aimed at enhancing electronic data communication (Vitalink project). Finally, a large-scale project, involving hospitals, physicians and the Royal Pharmacists Society of Antwerp (KAVA), was set up in Antwerp which should offer a structural solution to the problem.

Quality rather than quantity, as the saying goes, even though the two can go hand in hand. The KCE demonstrated that the **relationship volume–outcome** can be studied on the basis of the data already collected by Belgian hospitals (report 113, 2009).

In a national prevalence study on **nosocomial infections** (report 92, 2008) and a subsequent study on the impact on mortality and costs (report 102, 2009), the KCE recommends that more resources should be provided for and invested in more specific studies on how to tackle nosocomial infections within the framework of continuous quality enhancement within hospitals. Both studies were used to document and substantiate numerous initiatives with figures. The 5th national Hand Hygiene Campaign is putting the emphasis on the indications "before coming into contact with patients" and "before offering a clean/invasive treatment". New material was developed for this year's campaign. Hospital hygiene is also one of the main themes in the aforementioned 2013-2017 multi-year plan. The national point prevalence studies are repeated on a biennial basis. The attention to infections in rest and nursing homes has also been heightened.

4.2.4. Overall organisation of health care

Further to the report on **measuring the performance of the Belgian health care system (report 128, 2010)**, a platform of representatives of the federal institutions and subsectors was established. Its task is to enhance data collection, define new indicators, ensure a structured communication of the performance indicators and, in time, set priority targets to boost performance. This collaboration resulted in a drastic amelioration of the quality of the data being sent abroad, and more specifically to the OECD. For one, this report proposed that procedures using less radiation should be promoted to ensure that patients would be exposed to less ionising radiation. A collaboration between the National Institute for Health and Disability Insurance (NIHDI) NIHDI- FPS Public Health and the Federal Agency for Nuclear Control resulted in a number of recommendations in the area of medical imaging and in a review of medical imaging. In addition, the FPS Public Health launched an information campaign aimed at the public at large.

The members of the Inter-Ministerial Conference pressed for the project to be extended and its use to be encouraged. Early 2013, a second report on the performance of the health care system in 2012 was published in conjunction with the NIHDI and the Scientific Institute of Public Health. A successor to the reports is currently being prepared.

Ensuring qualitative care in a high-performance health care system is in fact a cross-border concern. The European Directive on the application of patients' rights in cross-border healthcare - which will have to be implemented in national legislation in 2014 - compels Member States to, on request, provide patients with the relevant information on quality and safety standards.

Aside from charting common patient rights in the area of quality and safety of care for patients from every EU health care system, this directive also outlines the legal framework to cover the cost of care in Member States other than the Member State where the patient is covered by social insurance. The implementation of this directive is certainly one major point of particular interest to the Belgian health care policy. In that sense, it is vital to follow up the evolutions of **foreign patient traffic in Belgian hospitals** to ensure that this does not negatively affect the quality, accessibility and affordability of care for the national population. Report 169 (2011) contains a calculation of the number of foreign patients who travel to Belgium for elective care. It also looked at the impact of this on the Belgian health care system. The recommendations formed a direct input for the Observatory for Patient Mobility.

4.2.5. Mental health care

The report on long stay **psychiatric patients in T-beds** is the first in a series of KCE projects in the field of mental health care (report 84, 2008). One important conclusion read that psychiatric hospitals do not try hard enough to reintegrate these patients into society. This contributed to the decision the Inter-ministerial Conference Public Health took in September 2009 to implement article 107 of the Hospital and Other Care Institutions Act. This article allows (psychiatric) hospitals to re-allocate part of their financial resources' budget to ensure that resources and manpower can be

used to further tailor the existing mental health care offer to the needs of and request for help from people suffering from psychological problems.

The report on **the organisation of mental health care for persons with severe and persistent mental illness** (report 144, 2011) more specifically advocated further deinstitutionalisation and care integration. These findings tie in with the initiatives taken within the framework of art. 107 of the Hospital Act. In line with a further deinstitutionalisation, the federal **government will be earmarking 6.5 million euro for nine new projects that will facilitate the transition to transmural care as of 2013.**

One of the basic principles of optimising mental health care is the establishment of care circuits and networks. An important step in this process is developing a consultation position between care providers at patient level. In that light, the **Therapeutic Projects in Mental Health Care** were launched. At the request of Minister Onkelinx, the KCE performed a scientific evaluation of the implementation of the Therapeutic Projects in Mental Health Care programme. It is also thanks to the results of these KCE reports (reports 103, 2009, 123 and 146, 2010) that new rules were introduced on consultation about patients in their home environment. This regulation is a follow-up to the therapeutic projects in which consultation with the treating team on the patient was experimentally developed over a five-year period. It also provides for the remuneration for services such as participation in the consultation the patient, remuneration of the reference person and the organisation and coordination of the consultation process. Even though therapeutic projects can be seen as an instructive experience, it has been established that the mental health care sector is in need of a more structured programme in which primary care can also play a role.

In keeping with this line of reasoning, a decision was taken at the inter-ministerial conference of June 2012 to set up working groups to implement the global reform of mental health care with the following main objectives:

- Cooperation between out-patient centres and residential institutions in the mental health care sector and adjacent sectors from general welfare work and primary health care in a well-defined regional area;
- The early detection of people suffering from mental problems so that care can be provided in patients' immediate environment and that patients receive tailored care in the correct place.

Report 135 (2010) focussed on **mental health care for children and adolescents** and more specifically on **emergency psychiatric care**. The KCE recommended that emergency care should be provided as a coordinated set of activities, available around the clock. In that light, a proposal to plan 15 functional structures for Belgium was tabled. These recommendations were not followed in detail, though a decision was taken to incorporate them into an overall analysis of the mental health care offer for children and adolescents. This should provide policy makers with concrete elements to develop and optimise an integrated mental health care system for both children and adolescents that is built on the existing mental health care offer.

This was achieved via a study of the literature on the **organisation of mental health care for children and adolescents** (report 170, 2011) and the follow-up report "**The organisation of mental health services for children and adolescents in Belgium: development of a policy scenario**"(175, 2012). The results of this last study were clarified to members and experts of the Inter-Departmental Working Group "Task Force Mental Health Care" and the Permanent Working Group "Psychiatry" of the National Council for Hospital Services and were extremely well received. Analogous to the vade mecum "Guide for enhanced mental care via the establishment of care circuits and networks" for Flanders and Brussels, a guide will also be compiled on the mental health care for children and adolescents. The principles of the KCE recommendations will be incorporated into this publication.

4.2.6. Care for the elderly

The demand for **long-term elderly care** continuous to rise. The KCE estimated that, by 2025, 27 000 to 45 000 extra beds for the elderly would need to be created which represents an annual increase of 1 800 to 3 000 beds (report 167, 2011). The KCE therefore indicated that it is essential to anticipate this evolution. The third protocol agreement between the federal and regional governments, which ran until the end of 2012, specified how many spaces could be allocated to rest homes for the elderly (RHEs) and to rest and nursing homes (RNHs). Flanders respected the cap on RHE allocations though it has to be said that 17 890 prior permits on top of that

moratorium were granted. There no longer is any moratorium in place. The proposal from the Federal Government to the regional governments provides for a fixed budget for the years 2013-2014 (36 million euro/year) and takes the trend in volume (a 1.7 % rise) into account. The Communities and Regions have been asked to come up with proposals within this budget by the middle of March 2013. NIHDI also continues to invest in projects on alternative accommodation facilities or assistance for the elderly. The Flemish Government is investing in path counselling for 5 pilot projects.

Medication is not a particularly useful treatment for **dementia in the elderly**. The KCE investigated what alternative forms of treatment are effective and furthermore provided the necessary input for the 2010-2014 Flemish Dementia Plan and the Dementia Flanders Centre of Excellence (report 160, 2011). Wallonia, for its part, set up the "Walloon Action Plan on Alzheimer's and Related Illnesses" (le Programme wallon d'actions Alzheimer et maladies apparentées) in 2011. Eight projects on innovative initiatives for the non-medicinal treatment of Alzheimer's patients were launched. In addition, there are plans in the pipeline to create a Walloon Alzheimer Centre (Centre Wallonie Alzheimer).

4.2.7. The treatment of serious and/or rare diseases

The recommendations regarding **rare diseases and orphan drugs** (report 112, 2009) were well received during the preparations of the Belgian Rare Diseases Plan. A number of the recommendations in this plan have already been implemented or are planned. These relate to the refund of examinations carried out within the framework of genetic screening of DNA samples sent abroad, the establishment of a central register of patients suffering from rare diseases, the support for rare diseases centres of excellence, access to and a speedier refund of certain medication or innovative treatments which have not yet been recognised, commercialised or reimbursed and the establishment of Orphanet Belgium, a national website featuring information on rare diseases.

NIHDI also refers to the KCE reports when considering a new policy on orphan drugs and rare diseases. At the request of NIHDI, the KCE examined the organisational functioning of the **Special Solidarity Fund (SSF)** (report 133, 2010). The SSF is a safety net for patients which ensures that they can receive necessary, albeit expensive, medical treatment for serious, rare illnesses, which are not covered by health insurance, without making a big hole in their own budget. The KCE in first instance emphasised the need to clarify the legal refund criteria. The other recommendations mainly focussed on the procedural level. To avoid any time being wasted, the KCE made a case for a central, direct contact point within NIHDI, where all the data are centralised electronically and where also all applications for a refund of medication to treat rare illnesses and orphan drugs are dealt with. The report was presented to the College of Medical Directors which decides on the individual applications the SSF receives. The issue of establishing a central contact point was broached but left in the middle by the medical directors (or their representatives) of the insurance companies, which this college is composed of. Meanwhile, in line with the KCE recommendations, NIHDI and the Federal Agency for Medicines and Health Products developed a project regarding the 'early access to new drugs'. The project has been presented to the insurance companies and the pharmaceutical sector for discussion.

The issue of orphan drugs and rare diseases is a cross-border one which, on account of the complexity of these diseases and the limited numbers of patients affected by them, calls for a central approach. As a result, the KCE formulated quite a number of proposals for consideration at European level which were discussed by the European Commission representatives.

4.3. The efficient allocation of financial resources: evaluation of medical techniques, interventions, medication, vaccination and screening programmes

An efficient allocation of financial health insurance resources prevents waste. There are plenty of instances where the KCE highlighted medical techniques or medication that did little or nothing to improve people's health. Not or no longer refunding these treatments releases funds that can be used to cover the most useful treatments and keep them accessible to everyone.

4.3.1. Medical imaging

Also in the field of medical imaging the KCE was asked for scientific proof on several occasions. In its report on **PET scanners** (report 22, 2005), the KCE stated that Belgium, with its 13 'recognised' and a handful of 'unrecognised' PET scanners, earned itself the place of international top runner. Ten PET scanners would be enough to ensure proper patient care.

In the wake of this report, only 13 scanners were allowed to operate. As a result of a complaint filed with the European Commission against the not altogether objective programming criteria, Minister Onkelinx asked the KCE to conduct a new study. The idea was to give an overview of the scientifically underpinned applications of the technology and to propose new programming criteria which would be more readily accepted at European level. In its second report (report 110, 2009), the KCE argues that programming should be dispensed with and that the PET scanners arrangement should be based on strictly enforced recognition criteria. At that, only examinations of which the use has been scientifically proven should be refunded.

During 2009, the KCE studied the **programming and financing of Magnetic Resonance Imaging (MRI)** (report 106, 2009). The available data did not allow the KCE to decide on the number of devices needed (programming). Subsequent to that, Minister Onkelinx commissioned a study on dedicated extremity-only MRI scanners which, for one, was to look into the possibilities of replacing the 'ordinary' MRI scanners. The results of this study are expected in September 2013.

In the field of radiology, a thorough general reform is currently being prepared with a view to enhancing cost management. The National Council for Hospital Supplies is to issue its advice on this issue, which is expected to be ready by March 2013. On the basis of this advice, consultation regarding a concrete multi-year plan on more coherent funding, an enhanced infrastructure, greater accessibility and a better quality of care with the profession will begin. A review of the programming of NMR devices linked to a moratorium on CT devices and the establishment of a register for expensive equipment or equipment with a high radiation load are also on the agenda. In addition, a new awareness campaign aimed at the general public and prescribers has been planned and a more optimum dissemination of and feedback about the medical guidelines will also be brought about. Furthermore, within the framework of eHealth, initiatives will be taken to promote electronic prescriptions and reduce double use. With a view to a more evidence-based diagnosis, as is currently the case in the sector clinical biology, the conditions under which radiologists will be allowed to change prescriptions will be specified. As of 1 March 2013, physicians prescribing medical imaging will have to issue highly detailed prescriptions before the health insurance will cover the cost of a radiologist's services.

4.3.2. Medication

The report on **generic and low cost drugs** (report 126, 2010) has led to physicians' prescription quotas being increased as of 2011. The KCE also proposed that pharmacists should be allowed to dispense a generic drug even if the prescription features the original drug unless the physician has explicitly specified not to. Since 1 May 2012, pharmacists are obliged to dispense antibiotics or antimycotics that form part of the cheapest group of medicines, irrespective of what the original prescription states.

The report on the evolution in the use of **statins** and the influence of the refund policy in Belgium (report 141, 2011) brought to light that statins are widely prescribed as a primary preventative drug (to patients suffering from high cholesterol and at serious cardiovascular risk) even though these substances should in fact be prescribed as secondary preventative agents (treatment after a cardiovascular problem has arisen). The KCE advised that information campaigns for the public at large should be launched in which a healthy lifestyle should be highlighted as the first means of prevention. Even though the conclusions were widely published in the press, there has been no word from the government about an organised information campaign. The report also recommended resorting to checks so as to correctly implement the recommendation from the Drug Reimbursement Commission which entails that, in first instance, two significantly cheaper molecules with a proven risk-benefit profile should be used, i.e. simvastatin/pravastatin. The NIHDI publication on control indicators met that demand.

The objective of report 147, 2011, was to critically describe and assess **the drug reimbursement decision-making processes**. At the request of NIHDI and the King Baudouin Foundation, one of the recommendations was followed up, i.e. the recommendation to, during a drug's assessment phase, consider the social values in a balanced manner. A report was compiled on the models to involve citizens and patients in the health care policy; on the other hand, a study is currently being conducted on how citizen consultation can help define preferences and social values. Report 147 had significant scientific impact and was presented at numerous conferences at home and abroad.

Central to projects 127 (2010) and 157 (2011) was the economic evaluation of the **antiviral treatment of chronic hepatitis B** in Belgium. It was recommended that the treatment should be geared towards patients suffering from cirrhosis of the liver or to patients who were very much at risk of developing this condition and to give preference to a treatment with tenofovir over entecavir. These reports had little impact within NIHDI: so far they have not even been discussed.

The report on **pharmacological prevention of fragility fractures** (159, 2011) recommends that this type of prevention should be used to treat high-risk patients, i.e. patients who already suffered a fragility fracture in the past. Persons who are only moderately at risk of sustaining these types of fractures should not be prescribed anti-osteoporosis medication as the possible side-effects outweigh the clinical benefits. The report was presented to and discussed with the National Council for Quality Promotion (NCQP), a body within NIHDI which promotes quality of care and supports initiatives that enhance quality; yet, the impact it had among physicians is difficult to ascertain.

4.3.3. Vaccination

The KCE was asked to provide a scientific background to the debate on the vaccination issue on several occasions.

In the study on **Hepatitis A vaccination** (report 98, 2009) the KCE argued that this vaccine should be funded for every child (between 1 and 12 years of age) travelling to areas where this illness is still prevalent. Vaccinating all adults and infants did not seem to be cost-effective, reason why it its financing was not recommended. On that account, the policy maker decided against the introduction of general vaccination.

Until the present day, the **flu vaccination** campaign mainly targets people working with at-risk groups and people who, as a result of a chronic illness, are more at risk of complications such as people suffering from diabetes, heart-lung and kidney diseases and people with reduced immunity. In addition, the focus also remains on the over-65-year-olds and the people looking after at-risk groups. The Inter-Ministerial Health Conference asked the KCE to take a look at this priority arrangement, so as to further optimise the use of the available vaccines (report 162, 2011). The population group that should be given priority varies in function of what policy makers wish to achieve. If their priority is to reduce the number of flu cases, especially adults under the age of 65 years should avail of vaccination. If a reduction in the number of hospital admissions is envisaged, the vaccination rate amongst people suffering from chronic illnesses should be increased. In the next part of the study, the KCE will examine the cost-benefit ratio of the vaccines, the indirect effects and the influence of other types of flu vaccines. The results should be available by June 2013.

In line with the KCE report on **pneumococcal conjugate vaccination**, the Superior Health Council issued an advice that 3 vaccinations should be administered, instead of the former 4-dose vaccination schedule being adhered to (report 33, 2006). In 2009, 2 new pneumococcal vaccines came onto the market: PCV 10 and PCV13. The KCE report demonstrated that it would be medically desirable and cost-effective to replace the earlier PCV7 programme with PCV10 or PCV13 **(report 155)**. Both communities implemented these recommendations. The Flemish Community took this decision before the KCE report was ever published but its involvement during the research stage of this report leads to believe that its decision was also very much driven by the KCE research results.

The Superior Health Council used the recommendations of the report examining the cost-utility of **vaccination against chickenpox in children and against herpes zoster in elderly in Belgium** (151, 2011) as a keynote to decide against vaccinating all children against chickenpox. This study confirms existing practices. The contribution of the KCE consisted of supplementing the epidemiological aspect with an economic aspect.

4.3.4. Screening

The KCE deemed that **breast cancer screening among women in the age group 40-49-years** would produce more disadvantages than advantages (report 129, 2010). For that reason, the Flemish Minister for Welfare decided not to include this age group in the screening programme. At federal level, Minister Onkelinx insisted that a report on this issue would be compiled as a matter of urgency. In response to the recommendations of the KCE, the department presented the NIHDI Technical Medical Committee with a proposal to amend the reimbursement rules. This proposal is currently under discussion.

Furthermore, it was also examined how **women at risk of contracting breast cancer** should be identified and what imaging techniques would be

the most suitable (report 172, 2011). The subcategories the KCE recommended on the basis of risk factors will be incorporated into a consensus proposal being elaborated by NIHDI. On the basis of this report, a nomenclature change has also been planned.

Population screening for **hepatitis C** has not been recommended (report 173, 2011). In line with this recommendation, no population screening has been organised.

In November 2011, the annual cystic fibrosis week was entirely dedicated to the report on **neonatal screening for cystic fibrosis** (report 132, 2010). The KCE indicated that certain conditions would have to be met if a decision was taken to implement this screening programme. Flemish Minister Vandeurzen and Minister Laanan of the French-speaking Community let it be known that they wish to put this topic top of the political agenda. So far, screening for cystic fibrosis does still not form part of the neonatal screening programme.

For the period from 1 January 2012 up to and including 31 December 2016, the Flemish Community concluded a management agreement with two organisations authorised to carry out a survey of the Flemish population into congenital disorders in new-borns via a blood sample. The current list of disorders to be screened for in this population survey will be assessed. During this assessment, a closer look will also be taken at whether or not neonatal screening for cystic fibrosis should be included in this list.

In March 2012, the French Community organised a seminar where scientific experts, clinicians, practitioners and representatives of the cystic fibrosis association, patients and their family members engaged in consultation. A report is currently being compiled on the basis of all the elements gathered during this seminar; the idea is to evaluate the relevance in terms of public health and the possible benefits of the systematic screening for this disease amongst neonatals, with due regard for the organisational and budgetary aspects.

The Communities used the recommendations in the report on **colorectal cancer screening (report 45, 2006)** as a basis for their screening projects. As of 2014, the Flemish Government will have more than 1.9 million people, i.e. one in three Flemings, screened for colorectal cancer.

4.4. The KCE recommendations as a guide for (dis)investment by NIHDI

In a number of reports, the KCE put forward that there was no or insufficient medical evidence for the added value and cost-effectiveness of a certain treatment or technique. On that basis, NIHDI decided to, under certain conditions, reduce or withhold cover and/or amend the nomenclature.

NIHDI a. o. followed the recommendations made in the reports on **endobronchial valves** (report 114, 2009), **electro-physiological tests** (report 109, 2009), on the **medicines Memantine and Ginkgo biloba for patients suffering from Alzheimer's** (report 111, 2009) and on the **diagnosis and treatment of varicose veins** (report 164, 2011)

The report on **home oxygen therapy** (156, 2011) had a major impact. This report in fact instigated a reform of the system and resulted in a change in the legal reimbursement criteria as of 1 July 2012. Nowadays, as is the case in the Netherlands, a tender-linked reimbursement system prevails. This system, which the KCE proposed, resulted in significant cost savings.

According to a report on the organisation and financing of **chronic dialysis** in Belgium (report 124, 2010), an annual saving of 10 million euro has been entered into the 2013 health budget which is the result of a global review of the specialist therapies that must be offered to patients suffering from kidney insufficiency. On the basis of these KCE recommendations, NIHDI formulated quite a number of proposals in that regard.

The recommendations the KCE made in numerous other reports were not verbatim implemented though they did provide food for thought and resulted in the measure that was taken in the end. As the interests of certain interest groups do have some bearing on the debates, the political decisions that were ultimately taken may have differed from some of the scientifically based recommendations.

In the report on **Tiotropium** (report 108, 2009), a long-acting drug to treat chronic obstructive pulmonary disease, the KCE recommended that this drug should no longer be reimbursed or only up to the level of the alternatives. A proposal from NIHDI to implement a price reduction of that nature met with refusal from the company in question. As a result, NIHDI

decided to no longer reimburse Tiotropium in accordance with section II (a posteriori check) but in accordance with section IV (a priori check by the advisory physician) as of 1 April 2012. This is an indirect incentive for general practitioners to prescribe less Tiotropium. With regard to inhaled anticholergics (tiotropium 88% of the expenditure + ipratropium), a saving of -82% (April 2012), -46% (May 2012), -17% (June and July 2012) in the NIHDI budget was recorded compared to these same months in 2011.

In the file on **interspinous implants and pedicle screws** (report 116, 2009), the KCE advised against reimbursing these techniques for lack of scientific evidence that these techniques are safe and improve the condition of patients in the long run. However, the “pro” votes from practising clinicians and the industry make that these techniques are presently reimbursed.

A request for disinvestment often stems from the finding of overconsumption. **Electroencephalograms (EEGs), Evoked Potentials (EPs)** and **Event-Related Potentials (ERPs) test the diagnosis and follow-up of neurological and psychiatric conditions and have been widely performed and reimbursed** by the Belgian health insurance in the latter years. The KCE queried the use and the cost of these tests (report 109, 2009). It compiled a list of complaints for which EEGs and EPs are indicated. The performance and reimbursement of ERPs was not recommended for lack of scientific evidence. At that, the KCE argued that there is no clinical justification to systematically use EPs of different modality on one and the same patient. However, a recent nomenclature change does provide for the reimbursement of ERPs. For neurologists, a new restriction has been introduced in that patients should only be subjected to 2 EEGs a year unless the patient has been admitted to intensive care or is suffering from active or treated epilepsy. This provision tallies with the recommendation that the systematic repetition of EEGs should be avoided. Yet, its transposition into law lacks in nuance as, in some cases, several EEGs over the period of one year are warranted.

With an annual implantation figure that exceeds the Western-European average by 25%, Belgium proved to be in the lead as far as **pacemaker** implantations are concerned. This high consumption figure cannot be attributed to the Belgian population being more advanced in age or suffering from worse health. Everything therefore pointed to the fact that pacemakers were also used to treat conditions for which there is no hard scientific evidence. In that sense, the KCE recommended that, in the future, new and promising techniques should only be reimbursed once their effectiveness has been scientifically demonstrated (report 137, 2010).

NIHDI immediately suited the action to the word and asked for an evaluation of Cardiac Resynchronisation Therapy (CRT) before covering this treatment in full (report 145, 2010). In line with the former recommendation, CRT electrodes for pacemakers have of late been reimbursed. For reasons of patient safety, the KCE moreover advised to only allow CRT devices to be implanted by "Implantable cardioverter-defibrillator" (ICD) accredited hospitals performing no less than 20 of these procedures a year. The current legislation has opted for compromise and stipulates that the procedure may only be performed in hospitals approved for cardiac pathology E, while every hospital was allowed to implant the device before.

In 2011, NIHDI launched an internet register for pacemaker implantations, "Qermid©Pacemakers". New types of pacemaker implants with cardiac resynchronisation therapy (CRT-P) were added to the QERMID©Pacemakers register and premature replacement can now also be registered. At this moment in time, there is no follow-up registration of complications, outcome, etc. as the KCE had recommended. That having been said, NIHDI has planned an evaluation of the current Qermid registration service for the start of 2013.

Heart revalidation through physical exercise has a beneficial effect on the quality of life of heart patients and reduces the number of hospitalisations and deaths. For that reason, the KCE argued in favour of patients being given a tailored exercise and support programme that runs over several months, in the vicinity of patients' homes, when they are discharged from hospital. In function of a complete review, the file (report 140, 2010) features on the agenda of the College of Medical Directors. The file was already repeatedly discussed at the College's meetings during 2012 and has moreover been extensively discussed with a representation of cardiologists and revalidation specialists. The new provisions on cardiac care programmes (more specifically the insertion of cardiac revalidation in care programmes A) are a recent and new phenomenon that will have a bearing on this file. Discussions will continue in 2013.

The KCE examined the usefulness of **point-of-care devices to monitor blood coagulation values** (report 117, 2009). The number of

complications in patients using the device decreases. Mortality figures for patients who also adjust their medication dosage are lower. Even though the use of this meter does reduce the cost for patients (if NIHDI reimburses it) and the community, the number of patients who would be able to operate the device themselves is probably limited. The KCE recommends that reimbursement should be considered for patients using the device. Following on from this report, a resolutory proposal to introduce a reimbursement system for anticoagulation meters that allow patients to personally determine their "International Rationalized Ratio" (INR) blood values was submitted. This proposal largely adopts the recommendations of the KCE report. The proposal is currently being discussed in the Senate.

4.5. KCE as a partner in the preparation and evaluation of legislation

Often, KCE reports indirectly result in an amendment to the legislation. Every change in reimbursement by compulsory health insurance, for instance, implies an amendment. At times however, the KCE is asked to underpin the preparatory work or to evaluate existing legislation. The KCE's work on the **compensation for injuries from health care** (reports 2, 2004, 16, 2005, 35, 2006, 68, 2007, 107, 2009) are a text-book example of its interaction with the legislator who, when preparing the legislation, invariably took the results of KCE studies into account. The KCE estimated the budget that would be required to compensate victims of medical accidents. The Medical Injury Compensation Act of 31 March 2010 provides for the compensation of victims of medical accidents in cases where no liability on the part of the care provider can be established. One of the prerequisites for compensation is that the accident occurred after 2 April 2010, the date at which the Act was published. On 1 September 2012, the Fund for Medical Accidents began processing the first claim files.

During the parliamentary debates that preceded the vote on the law, proposals were submitted to widen its scope to persons infected with the hepatitis C or HIV virus as a result of contaminated blood transfusions performed prior to 2010. In its report 134 on the indemnification of **blood transfusion victims**, the KCE formulated the recommendation not to ratify the amendment because the proposals that had been submitted could lead to discrimination. This report seems to have convinced Members of the House of Representatives not to defer the vote to a later date. The Act was finally approved in March.

Since 2007 (Verwilghen Act), patients suffering from a chronic illness and disabled persons under the age of 65 years have been entitled to take out a **hospital insurance policy** with a private insurance company provided certain conditions are met. Before extending the measure to after June 2012, the legislator wanted the KCE to perform an evaluation, in collaboration with Assuralia (the Professional Association of Insurance Companies) and patient organisations. The KCE recommendation ensued in the right in question being upheld in the legislation (report 166, 2012).

Three reports on **non-conventional therapies**, published in 2011, created quite a stir in the media, amongst the public at large, in the scientific world and amongst practitioners alike (**Osteopathy and chiropractic: state of affairs in Belgium**, report 148, **Acupuncture: State of Affairs in Belgium**, report 153, **Homeopathy: State of affairs in Belgium**, report 154). The Colla Act was promulgated in 1999 though never fully implemented. This Act provides for the registration of 4 alternative therapies (chiropractic, osteopathy, acupuncture and homeopathy) and for the registration of all the various practitioners so as to offer patients formal safety and quality guarantees. Meanwhile, the debate regarding the possible recognition of non-conventional therapies and who exactly is allowed to practise them continues to rage. The government (FPS Public Health) presented Minister Onkelinx with an advice containing policy guidelines for these 4 practices. This working paper is among other matters based on the KCE reports and on the content of the debates the KCE started in the various chambers. The Council of Ministers approved in the mean time a Royal Decree stating that homeopathy can only be performed by physicians, dentists and midwives, and this as a complementary activity to their basic professional activity. Each homeopathist will need to obtain a university degree or an academic diploma for homeopathy.

Within the framework of the report on **plastic surgery** (report 83, 2008), the KCE was involved in the preparations for the legislative work on guaranteeing quality of care and patient safety. A first concrete measure was a ban on advertising and the manner in which patients must be furnished with information. This legislation was annulled by the Constitutional Court, however, based on the illegitimate discrimination

towards other cosmetic interventions performed by non-physicians, where advertising is allowed. In addition, the Flemish Government introduced a notification requirement for high-risk medical procedures performed in either recognised hospitals or private clinics. Furthermore a law passed in May 2013 stating that invasive medical cosmetic interventions are reserved for certain physicians.

4.6. A closer look at alternative financing

The KCE looked at a number of alternative financing methods within the field of health care.

For one, in terms of hospital financing, it examined whether an **'all-inclusive' hospital financing system** (report 121, 2010), based on the number and type of conditions treated would be a viable option, which did prove to be the case. On demand of Minister Onkelinx a follow-up study was performed regarding a comparison of different financing models (report 207, 2013). Based on the results Onkelinx presented a plan for the reform of hospital financing. A concrete proposition needs to be elaborated by the end of 2014 and approved in 2015.

The KCE also evaluated the **financing of geriatric day hospitals** and their added value to patients (report 99, 2009). Since 2006, geriatric day hospitals have, within the framework of a pilot project, been financed by means of lump-sum funding. The KCE argued that the financing of the geriatric day hospitals should depend on their occupancy rate and the profile of their patients and should not consist of a lump sum. The pilot project has meanwhile been extended until 2015. In the meantime, in the wake of the KCE recommendations, data registration has been improved. To differentiate clearly between geriatric day admissions and other types of admissions, a special variable was introduced.

The report on **the financing of home nursing in Belgium** (report 122, 2010) examined whether the current system of home nursing financing should be adjusted or fundamentally reformed. Discussions about the possible reforms of this financing system are on-going but they are being overshadowed by the current budgetary problems.

The combination excellent quality at an affordable price takes centre stage in almost every KCE report. The report on the feasibility of a **pay for quality (P4Q)** programme dilates upon the systems that link car providers' fees to the quality of the care they provide (report 118, 2009). It found that the majority of the foreign P4Q programmes have a varying and, on the whole, a moderately positive effect on the quality of care and next to no negative effects. The report formulates the conditions that must be satisfied if P4Q is to be applied in Belgium. On the Belgian health care scene, the first steps towards P4Q are now gingerly being taken. Within the framework of the Patient Safety Plan of the FPS Public Health, for instance, it has been mentioned that a move towards the Pay for Quality model is on the cards. The concept is also being tested in a number of pilot projects.

4.7. The assessment of innovative techniques and treatments

Belgian patients should reap the benefits of innovation if they come with genuine advantages, do not entail any risks and if its cost is in proportion to the true added value. It is not easy for policy makers to take all that into account if a new technique or treatment is brought onto the market amid much fanfare and glowing promises. The KCE has clarified matters in numerous files to avoid any hasty decisions being taken, which, in certain cases, could have had dangerous and unnecessarily expensive consequences. Products and techniques that proved to be of benefit to the population were favourably appraised.

The stress area between innovation and patient safety has been scrutinized in the KCE reports on many occasions. During 2011, it was examined what type of pre-market clinical evaluation results manufacturers would have to produce before they are given the green light to bring new **high-risk medical devices**, such as a new type of heart valve or hip prosthesis onto the European market (report 158). The clinical study requirements for medical devices are currently less stringent than those for medicinal products, and the data on the studies that have actually been carried out are not or not easily accessible. At European level, an initiative has been taken to legislate for more stringent requirements. Together with a number of other European HTA agencies, the KCE is trying to steer the debate. Within the framework of this review, the KCE was asked to formulate a proposal for Belgium on the definitions in the Directive under review. At a national level, the KCE is trying to put this topic on the agenda of the Belgian Advisory Committee on Bioethics, a government institution that advises on research problems in the fields of biology, medicine and health care. Minister Onkelinx has already integrated a number of

important points of action on the monitoring and traceability of implants into her Implants Plan.

The KCE took a critical look at a number of new techniques, such as **the remote monitoring of heart patients** (report 136, 2010) and **robot-assisted surgery** (report 104, 2009). Because the safety and added value of these techniques had not been demonstrated at that time, the KCE did not (yet) recommend that they should be reimbursed. The National Council of the Order of Physicians used the KCE report on remote monitoring in an advice on individual reimbursement applications.

As regards robot-assisted surgery, NIHDI decided, in line with the KCE recommendations, to only provide conditional cover for robot-assisted radical prostatectomy. Since 1 October 2009, compulsory insurance has been covering the equipment used for endoscopic robot-assisted radical prostatectomies for patients who received surgery in thereto authorised hospitals. On 1 January 2013, a new agreement came into effect. Under this agreement, the criteria hospitals must satisfy have been broadened.

The KCE also had its doubts about the usefulness of **systematically video-taping endoscopic procedures** for care enhancement or physician training purposes (report 101, 2009). The recommendations do provide a guideline however, especially within the legal framework, in cases where video registration is resorted to.

4.8. The KCE as an international player

The fact that the KCE does not only focus on national policy but also formulates recommendations to be used at a European level is demonstrated by the report on the **orphan drugs**, i.e. medicines for patients suffering from a rare disease, policy (report 112, 2009). One of the recommendations in this report was to establish a European disease and patient register instead of a national one. Getting these types of recommendations implemented at European level is a trickier affair as translating these types of recommendations into action does not come within the direct remit of the Belgian policy maker.

The fact that KCE reports are used as a reference at international level is evident from the study on **self-sufficiency of stable plasma derivatives** in Belgium (report 120, 2009). The French "Inspection générale des affaires sociales" based itself on the KCE report to make their own assessment.

The **Health in Transition reports (HiT)** delves into the various approaches in the areas of the organisation, financing and provision of health care services, and into the role of the main actors within the health care systems. These profile sketches describe the institutional framework, the procedures, the content and the implementation of the health and health care policy; in conclusion, they also highlight the challenges and the areas requiring a more in-depth analysis. The last HiT report on Belgium described the health system and its evolution through to 2007. Its latest version contains up-to-date information and charts the new policy lines and prospects (report 138, 2010). Since this report was published, the KCE has received regular requests for additional information from national and international institutions and enquiries to consider collaboration on other studies.

Also in international scientific literature, the KCE is a respected partner. The report on **transcatheter aortic valve implantation** (report 163), on which an article was published in the renowned British Medical Journal, is one such instance of this.

4.9. Methodological reports

The KCE moreover publishes reports aimed at outlining a theoretical framework or drawing up a methodological guideline concerning a specific topic. In its one hundredth report (2009) for one, the KCE tried to inform policy makers about the use, relevance and pitfalls of **economic evaluations** in the decision-making process. With this methodological report, the KCE attempted to shed light on difficult economic concepts and make study results more accessible to non-economists. Also the internal work processes have not escaped the KCE's attention. To optimise communication with the relevant parties in the field, KCE dedicated a study on the concrete terms of specific “**stakeholder involvement**” techniques (rapport 174, 2012).

5. SUMMARISING FINDINGS

The present report gives a factual description of the extent to which the recommendations in the KCE reports are acted upon. Many reports have a direct impact which translates itself into their implementation in policy decisions. Other reports have a rather indirect impact and help steer the discussions on a certain topic or provide theoretic support to a specific group of users. The underlying reasons as to why certain recommendations were successfully implemented while others were not have not been examined. Leaving the 11 reports whose impact was labelled as unmeasured aside, about half of the remaining 67 reports can be deemed to have had a direct impact. About one third is currently under discussion. In the case of one of the evaluated HTA reports only, a decision was taken that went directly against the KCE recommendations.

The domain of the report (GCP-HTA-HSR-method) has proven to be an objectifiable and determining element insofar as and within the time frame in which recommendations are made. In that light, the reports per domain have been listed in a summary table at the end of this section. The degree of impact (direct-indirect-not measured) was only allocated to the category 'political-legislative'. This does not mean however that the reports are only used and perused by policy makers as the many presentations at congresses, the national and international scientific publications and the continued attention they receive in the press corroborate.

5.1. Impact trend per domain

Measuring the impact of **clinical practice guidelines** on the practice of the care provider in question did not prove feasible for a first version of this impact report as this calls for a specific methodology and a considerable investment in terms of time. However, this does not prevent it being a point of particular attention in any possible sequels to this report. It must be specified however that important initiatives are being taken both by professionals and the Belgian Centre for Evidence-Based Medicine (CEBAM) to centralise and disseminate the information to ensure that the guidelines are as accessible to practitioners as possible. The KCE takes a very active part in these initiatives. For now, this is a first important and necessary step towards achieving that impact. A number of GCP reports, such as the reports on quality indicators or the reports on screening for instance, contain a guideline which is in first instance intended for the policy maker. For these reports, a gradation of impact has been given. Decisions on screening are marked by the stress area between scientific, economic and social interests versus the interests of an individual citizen-patient. The fact that screening also affects a very wide and often vulnerable population group makes an explicit choice for or against screening all the more sensitive. As a rule, the implementation of reports such as these is not something that is accomplished overnight.

The recommendations ensuing from the **Health Technology Assessments** traditionally translate into concrete advice on the use and the reimbursement of an evaluated technology, medical device or medicinal product. In that sense, they are more often than not intended for NIHDI, the professionals and individual care providers. The recommendations that give the go-ahead or advise against reimbursement usually have a direct impact and are in the main implemented quickly. The interaction between what is scientifically justifiable and what is desirable for certain interest groups does sometimes lead to the recommendations being toned down and implemented in some form of compromise. Of all the HTA projects evaluated in this report, only once a decision was taken that directly went against the KCE recommendation. Recommendations regarding reimbursement often go hand in hand with suggestions at procedural or operational level. Enhanced data registration and centralisation of the information are points that are often highlighted as leaving room for improvement. The implementation of these types of recommendations does not only call for an administrative effort on the part of the relevant government department but also for a change in behaviour and mentality on the part of physicians. As a rule, the implementation of recommendations such as these tends to be a lengthy process.

Health Services Research is an all-encompassing term for research into social factors, financing systems, organisational structures and processes which determine their quality and cost and the quality (and quantity) of patients' lives. This diversity in themes also determines the variation in the recommendations and their addressees. But, within this diversity, certain trends come to the fore. HSR reports usually have a direct impact but their implementation path tends to be a lengthy one. Concretely translating recommendations into action in the policy is mostly ensured by working

groups set up by the Minister for Social Affairs and Public Health, in which the relevant interest groups are represented.

The reports that looked at an alternative form of financing of certain domains within health care, have up and until now only been seen as feasibility studies by the policy makers even though the recommendations often paint concrete scenarios. In terms of hospital financing, it is safe to say that consensus has been reached on the need for reform but that there is a lack of initiative in relation to the measures required.

A number of the HSR reports is being gradually implemented or is used as support to document and underpin steps in a policy plan within a specific domain. The trajectory often starts with a feasibility study before being elaborated into one or several concrete scenarios in a subsequent phase. The implementation of the recommendations of these reports will logically take more time but is effective if it provides the policy maker with an answer to concrete questions. The reports on mental health care and the reports preceding the Medical Injury Compensation Act are excellent examples of this.

A proper **methodology** and theoretical framework are two of the cornerstones of a sound scientific report. Indispensable though is that the methodology of the KCE reports is accessible to the people using the reports. For that reason, the KCE has, on several occasions in the past, published a methodological vade mecum to facilitate the reading of its reports. The impact of these reports cannot be measured. These reports are therefore only informative and didactic in nature.

5.2. To be continued…

Leaving the area of reports aside, there is no doubt that other factors, which do not easily lend themselves to objectification, play a role in the either or not successful implementation of recommendations. Whatever way one looks at it, making an impact is not a purely mathematical process. Neither is its evaluation or improvement. In any case, the present report contains quite a number of elements the KCE can use to get down to work on the next issue of its impact report. Investing in tools that do not only measure impact but also examine the factors that influence impact is certainly a meaningful exercise. There is no denying that the people for whom the recommendations are written, and especially the minister, must be involved in this process. Measuring and optimising impact is a concern that transcends national borders. The KCE will, in the near future, join forces with a number of other European agencies who mainly focus on HTAs so as to devise a sound methodology to measure, monitor and evaluate impact.

Summary table

Number	Domain	Project name	Degree of impact	Publication date
160	GCP	Dementia: which non-pharmacological interventions?	Direct	07 July 2011
164	GCP	Diagnosis and treatment of varicose veins in the legs	Direct	04 Oct 2011
150	GCP	Quality indicators in oncology: breast cancer	Direct	17 Jan 2011
113	GCP	The volume of surgical interventions and its impact on the outcome: feasibility study based on Belgian data	No impact	13 July 2009
129	GCP	Breast cancer screening with mammography for women in the age group of 40-49 years	Under discussion	07 July 2010
172	GCP	Identifying women at risk for breast cancer/technical methods for breast cancer screening	Under discussion	04 June 2012
137	GCP	Pacemaker therapy for bradycardia in Belgium	Under discussion	29 Sept 2010
162	GCP	Seasonal influenza vaccination: priority target groups – Part I	Under discussion	01 June 2012
109	GCP	The value of EEG and evoked potentials in clinical practice	Indirect	20 Apr 2009
159	GCP	Pharmacological prevention of fragility fractures in Belgium	Indirect	05 July 2011
161	GCP	Quality Assurance of rectal cancer diagnosis and treatment – phase 3: statistical methods to benchmark centers on a set of quality indicators	Not measured	12 July 2011

Number	Domain	Project name	Degree of impact	Publication date
105	GCP	Scientific support of the College of Oncology: a national clinical practice guideline for pancreatic cancer	Not measured (GCP)	06 Feb 2009
119	GCP	Non-specific neck pain: diagnosis and treatment	Not measured (GCP)	19 Nov 2009
139	GCP	Guideline relative to low risk birth	Not measured (GCP)	18 Oct 2010
142	GCP	Scientific support of the College of Oncology: update of the national guidelines on testicular cancer	Not measured (GCP)	29 Nov 2010
143	GCP	Scientific support of the College of Oncology: update of the national guidelines on breast cancer	Not measured (GCP)	20 Jan 2012
168	GCP	A national clinical practice guideline for the management of cervical cancer	Not measured (GCP)	21 Nov 2011
149	GCP	Quality indicators in oncology: testis cancer	No impact	17 Jan 2011
152	GCP	Quality indicators in oncology: prerequisites for the set–up of a quality system	No impact	05 Apr 2012
99	HSR	Financing of the Geriatric Day Hospital	Direct	09 Jan 2009
102	HSR	Nosocomial Infections in Belgium, part 2: Impact on Mortality and Costs	Direct	04 Feb 2009
107	HSR	Compensation for damage due to health care - Phase V: Budgetary impact of the transposition of the French system in Belgium	Direct	30 Mar 2009

Number	Domain	Project name	Degree of impact	Publication date
123	HSR	Mental health care reforms: evaluation research of 'therapeutic projects' - second intermediate report	Direct	09 Feb 2010
126	HSR	The reference price system and socioeconomic differences in the use of low cost drugs	Direct	02 Apr 2010
128	HSR	A first step towards measuring the performance of the Belgian healthcare system	Direct	05 July 2010
130	HSR	Quality criteria for training settings in postgraduate medical education	Under discussion	09 July 2010
134	HSR	Indemnification of the victims who contracted HIV or hepatitis C through a contaminated blood transfusion	Direct	17 Sept 2010
144	HSR	Organization of mental health care for persons with severe and persistent mental illness. What is the evidence?	Direct	18 Nov 2010
146	HSR	Mental health care reforms: evaluation research of 'therapeutic projects'	Direct	07 Jan 2011
158	HSR	The pre-market clinical evaluation of innovative high-risk medical devices	Direct	30 June 2011
166	HSR	Entitlement to a hospital insurance for persons with a chronic illness or handicap	Direct	28 Oct 2011
169	HSR	Elective care for foreign patients: impact on the Belgian healthcare system	Direct	25 Nov 2011
131	HSR	Seamless care with regard to medications between hospital and home	Under discussion	02 July 2010
103	HSR	Mental health care reforms: evaluation research of 'therapeutic projects' - first intermediate report	Direct	04 Feb 2009
141	HSR	Statins in Belgium: utilization trends and impact of reimbursement policies	Direct	04 Nov 2010

Number	Domain	Project name	Degree of impact	Publication date
115	HSR	Organisation of palliative care in Belgium	Under discussion	22 Oct 2009
122	HSR	Financing of home nursing in Belgium	Under discussion	04 Feb 2010
135	HSR	Emergency psychiatric care for children and adolescents	Under discussion	23 Sept 2010
140	HSR	Cardiac rehabilitation: clinical effectiveness and utilisation in Belgium	Under discussion	27 Oct 2010
148	HSR	Osteopathy and chiropractic: state of affairs in Belgium	Under discussion	30 Mar 2011
153	HSR	Acupuncture: State of affairs in Belgium	Under discussion	27 May 2011
154	HSR	Homeopathy: State of affairs in Belgium	Under discussion	24 May 2011
165	HSR	Burnout among general practitioners: prevention and management	Under discussion	10 Oct 2011
167	HSR	Residential care for older persons in Belgium: Projections 2011 – 2025	Under discussion	10 Nov 2011
171	HSR	Afters-Hours Primary Care: which solutions?	Direct	30 Dec 2011
175	HSR	The organisation of mental health services for children and adolescents in Belgium: development of a policy scenario	Under discussion	12 May 2012
118	HSR	Advantages, disadvantages and feasibility of the introduction of ‘Pay for Quality’ programmes in Belgium	Indirect	16 Nov 2009
120	HSR	How to ensure self-sufficiency of stable plasma derivatives in Belgium?	Indirect	24 Nov 2009
133	HSR	Optimisation of the operational processes of the Special Solidarity Fund	Under discussion	28 July 2010

Number	Domain	Project name	Degree of impact	Publication date
147	HSR	Drug reimbursement systems: international comparison and policy recommendations	Indirect	08 Mar 2011
121	HSR	Feasibility study of the introduction of an all-inclusive case-based hospital financing system in Belgium	Under discussion	25 Jan 2010
138	HSR	The Belgian health system in 2010	Not measured	04 Oct 2010
170	HSR	Organisation of child and adolescent mental health care: study of the literature and an international overview	Under discussion	29 Nov 2011
98	HTA	Evaluation of universal and targeted hepatitis A vaccination programs in Belgium	Direct	09 Jan 2009
111	HTA	Pharmaceutical and non-pharmaceutical interventions for Alzheimer's Disease, a rapid assessment	Direct	02 July 2009
112	HTA	Policies for Rare Diseases and Orphan Drugs	Direct	19 Feb 2010
114	HTA	Endobronchial valves in the treatment of severe pulmonary emphysema: a rapid Health Technology Assessment	Direct	16 July 2009
125	HTA	Impact of academic detailing on primary care physicians	Direct	29 Mar 2010
136	HTA	Remote monitoring for patients with implanted defibrillators. Technology evaluation and broader regulatory framework	Direct	28 Sept 2010
145	HTA	Cardiac resynchronisation therapy. A health technology assessment	Direct	15 Feb 2011
151	HTA	Cost-utility of Vaccination against Chickenpox in Children and against Herpes Zoster in Elderly in Belgium	Direct	24 Jan 2011

Number	Domain	Project name	Degree of impact	Publication date
155	HTA	Cost-effectiveness of 10- and 13-valent pneumococcal conjugate vaccines in childhood	Direct	30 May 2011
156	HTA	Home Oxygen Therapy	Direct	07 June 2011
163	HTA	Transcatheter Aortic Valve Implantation (TAVI): a Health Technology Assessment	Direct	22 Sept 2011
173	HTA	Hepatitis C: Screening and Prevention	Direct	17 Jan 2012
104	HTA	Robot-assisted surgery: health technology assessment	Direct	09 Feb 2009
106	HTA	Magnetic Resonance Imaging: cost analysis	Under discussion	06 May 2009
110	HTA	Positron Emission Tomography (PET) in Belgium: an update	Under discussion	25 June 2009
117	HTA	Use of point-of care devices in patients with oral anticoagulation: a Health Technology Assessment	Under discussion	12 Nov 2009
124	HTA	Organisation and financing of chronic dialysis in Belgium	Under discussion	10 Feb 2010
101	HTA	Video registration of endoscopic surgery: a rapid assessment	Not measured	16 Jan 2009
108	HTA	Tiotropium in the Treatment of Chronic Obstructive Pulmonary Disease Health Technology Assessment	Indirect	02 Apr 2009
132	HTA	Is neonatal screening for cystic fibrosis recommended in Belgium?	Under discussion	15 July 2010
100	HTA	Threshold values for cost-effectiveness in health care	Not measured (methodological report)	14 Jan 2009
116	HTA	Interspinous implants and pedicle screws for dynamic stabilization of lumbar spine: Rapid assessment	No impact	29 Oct 2009

Number	Domain	Project name	Degree of impact	Publication date
127	HTA	Cost-effectiveness of antiviral treatment of chronic hepatitis B in Belgium. Part 1: Literature review and results of a national study.	No impact	07 Apr 2010
157	HTA	Economic evaluation of antiviral treatment of chronic hepatitis B in Belgium: Part 2	No impact	14 June 2011
174	method	Stakeholder Involvement" in KCE working processes	Not measured (methodological report)	25 Jan 2012