



## Adviesaanvraag

Vraagsteller	Regeringscommissariaat Corona
Datum van adviesaanvraag	9/08/2021
Onderwerp	Advice on the extension of the CST/DCC and on ways to increase vaccination coverage in low coverage areas in Belgium
Vraag	-
Reden	

## Adviesverstrekking t.a.v. het Overlegcomité

Datum van adviesverstrekking	18/08/2021
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## 1. Vaccination coverage in Belgium

Overall Belgium has been applauded for achieving very good COVID-19 vaccination coverage rates (i.e. 66,28% fully vaccinated in the entire country).

However, there are important areas and populations with much lower coverage in Belgium, typically located in large cities with high diversity and larger communities with low socio-economical profiles. In particular the Brussels region is lagging behind considerably on vaccination, i.e. 47% of its citizens are fully vaccinated overall, with a large spread between the more and less affluent communes, but even in the more affluent communes, vaccine coverage rates remain relatively low as compared to Flanders (72%) and Wallonia (64%).

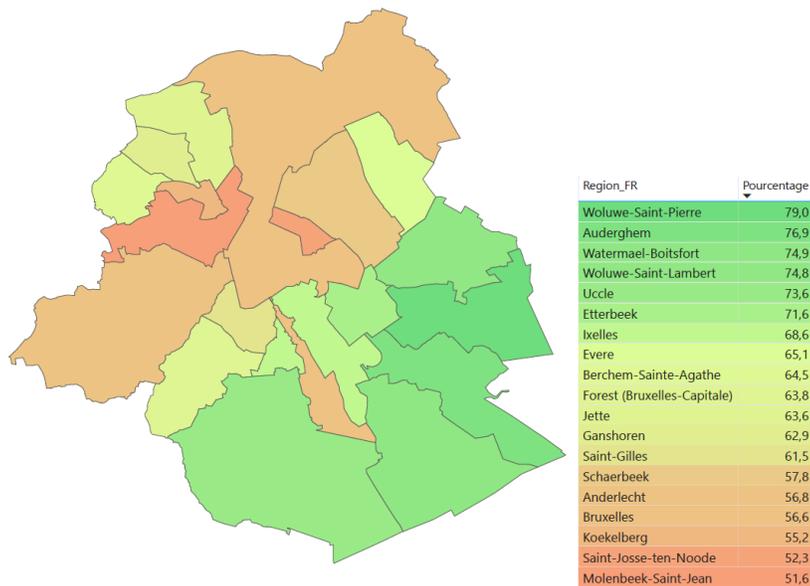


Figure 1. Coverage of first dose per commune (data Inge Neven)

The group of unvaccinated persons is quite heterogeneous and consists of several groups, including:

- (1) persons who are consciously anti-(Covid-19) vaccination mainly because of a deep distrust (this is probably a small group)
- (2) a larger group with people who remain hesitant or doubtful, sometimes mediated by a distorted view on risk perceptions through social media or likeminded peers. Some of them have been overwhelmed by the situation and/or had practical issues with receiving vaccination (e.g. single parents, people lacking time or the priority to get vaccinated). This group includes also those who had prior COVID-19 infection and considers themselves as safe. The sizes and proportions of these group may differ regionally and may evolve over time



## 2. Epidemiological evolution

We refer to the GEMS-report dd. 17/8/2021 and the RAG report dd. 18/8/2021 for a more complete overview of the epidemiological evolution.

We expect for the upcoming weeks a further increase in viral circulation due to returning travelers (with a typical peak near the end of August), increasing number of events and gatherings, reopening of schools, return to work and office, change of season and the virtually exclusive (around 99%) presence of the more contagious delta variant. Careful further follow-up of the net impact on cases and hospitalization patterns is required. High rates of viral circulation may cause disease primarily among the not-vaccinated, but can spread further to fully vaccinated medically vulnerable persons (as levels of protection may vary between individuals and may decrease over time).

Taken together, the situation in Brussels is worrisome, with the lowest vaccination levels, a diverse population with the highest number of people entering from abroad (4,5 people out of 100 inhabitants return to Brussels from abroad, for 3,5 and 2,5 in Flanders and Wallonia respectively). In combination with the start of the new school year, return to work and office, the reopening of the large-scale events and mass-gatherings (since 13/8/21), this may lead to a fast increase in cases, also followed by a stronger increase in the number of hospitalizations than in the other Regions. Brussels will probably become dark red on the ECDC map (14-day incidence above 500) in Week 2021/33, while Wallonia has become red (high positivity) in Week 2021/32. This is to be seen as a threat to public health but may also jeopardize the international reputation of the European capital.

Short term modeling results show that, if the actual epidemiological trend continues, the number of hospitalizations is expected to further increase to averages of 40-50/day for Brussels, Flanders and Wallonia, respectively, leading to an ICU-occupancy rate to reach 15% overall, and to exceed the 25% threshold for Brussels by September 1st. For the moment, 23% of hospitalizations in Brussels are due to people arriving from abroad.

Mid-long term projections suggest that the increase in contacts due to the end of summer and the beginning of the school year may lead to a new wave in cases and hospitalizations in September-November. It is clear that local vaccination coverages as well as contact behavior will strongly influence the size and impact of this wave on the health care system.

In conclusion, the epidemiological evolution is not reassuring, and **urgent measures to ramp up vaccine coverage in the Brussels region are needed** (next to strengthening non-pharmaceutical interventions to reduce the number of infections).

## 3. Attitudes toward CST and mandatory vaccination

The youngest wave of the motivation barometer (see Annex 1 for more details) that took place between August 12<sup>th</sup> and 15<sup>th</sup> (N = 7285; 65% females; 86.9% vaccinated persons; 66.7% highly educated persons; 78.8% Dutch speaking persons) reveals that

- a) unvaccinated, yet previously infected individuals need being addressed through targeted communication efforts to indicate why vaccination is of added value to them;
- b) citizens oppose a generalized introduction of mandatory vaccination but favor a selective introduction among high-risk professions (e.g., health care workers; individuals working with vulnerable people) where it can be justified and, hence, is perceived as legitimate;



- c) citizens oppose a generalized introduction of the CST but favor a gradual extension to high-risk settings (e.g., night life) where its use is perceived as necessary to promote safety.

At a broader level, citizens’ nuanced perspective signals that they are very thoughtful and critical about these topics, thereby wanting to protect the safety of themselves and those around them. If we want to secure that selective mandatory vaccination and CST are accepted by the population, they should be framed as strategies to preserve safety and health instead of means to increase freedom. Increasing vaccination rates may follow as a desirable side-effects of their introduction but should not be casted as the primary driver for their introduction (mandatory vaccination) or extension (CST).

#### 4. Possible interventions (requirements, pros and cons listed in table beneath)

Last month, France announced the extension of the Digital Covid Certificate to domestic activities. Subsequently, vaccination appointments increased by one million (for additional information, please refer to annex 2). At the same time, France is now dealing with substantial social turmoil which suggests that the gap between vaccinated and non-vaccinated people has increased and that some polarization has taken place.

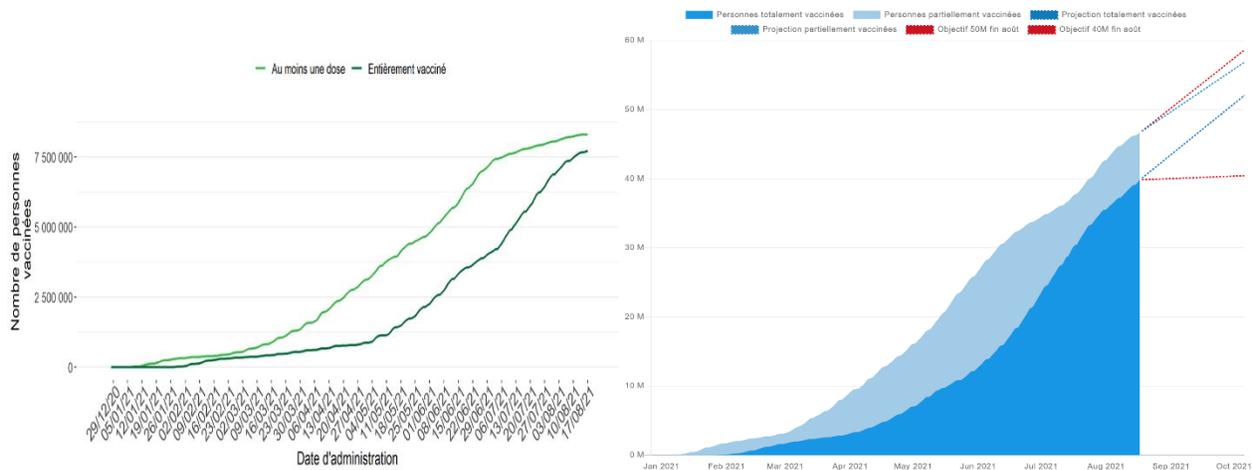


Figure 2. Comparison first-dose vaccinated in Belgium and France

Belgium as a whole is still ahead of France, but since July 12 the gap has gone from 12% to less than 3% today (and the gap is still decreasing). Most importantly, Brussels is not catching up with the rest of Belgium : it went from 45.7% on July 12 to 50.4% today, a gain of 4.7% while Belgium gained 6% in that period. A note of caution here concerns the fact that Brussels comprises a large proportion of bi-nationals and foreigners. Because the statistics of vaccinated people in Brussels do not include people vaccinated in their own country, the figures may be underestimated. Most interestingly, Paris intra-muros (the ‘equivalent’ of Woluwé) went from 66% on July 12 to 81.5% on Aug 12 and 82.6% on Aug 17, and Seine Saint-Denis (the equivalent of Saint-Josse/Molenbeek) went from 52.2% on July 12 to 71.6% on Aug 12 and 73.3% on Aug 17 (see covidtracker.fr).



### 1.1. Interventions to stimulate intrinsic vaccination motivation

- Vaccination out of intrinsic motivation is in general to be preferred especially since Belgium has a long track record of high vaccination coverage.
- We still expect a significant number of Belgian citizens planning to get vaccinated in the coming weeks (e.g. return from holidays) out of intrinsic motivation. Therefore, the current vaccination campaign (including for the 12-15 year old) should be further continued, facilitated and supported.
- With worsening epidemiological figures we expect demand for vaccination also to go up again. Indeed, increasing hospitalizations relate to higher risk perception which would feed into increased vaccination intentions, thus eliciting a naturally unfolding 'intrinsic' dynamic.
- Strong communication campaign (both mass and targeted) needed, focusing on:
  - The large scale population advantages, e.g. by highlighting percentage of non-vaccinated among hospitalized and the relationship between the percentage of vaccinated, the wave peak and 'safely going back to school';
  - Minimal targets to be achieved, e.g. % of vaccination coverage;
  - Providing a solid rationale for those with passed infection to still get vaccinated;
  - Informing about the rare character of side effects;
  - Explaining the phenomenon of breakthrough infections;
  - Presenting age-specific norms of vaccination coverage such that older generations are perceived as models by younger generations;
  - Illustrating if-then scenarios showing the expected epidemiological evolution depending on different levels of vaccination coverage to highlight the effectiveness of the vaccine;
  - Highlighting the favorable position of the country in the international ranking and linking this to the positive response of the population to the vaccination campaign.
- Gradual switch to decentralization, local tailor-based approach (*'bringing the vaccine to the people and not vice versa'*). In addition to already ongoing efforts, specific attention should be given to, for example, low threshold activities, local vaccination booths in universities, secondary and high schools, event venues, testing centers, hospitals, ... and tailored information sessions to help people make their decisions. Finally, one should not only further mobilize the GPs and pharmacists but also encourage the currently, and especially the newly vaccinated people (at least in Brussels) to promote vaccination using adequate motivational framing.

### 1.2. Mandatory vaccination

- A step-wise mandatory vaccination to specific target groups in society may need to be considered as well, e.g. for people working with medically vulnerable persons (health care sector) and those working in sectors where incidence rates remain high.
- The rationale for mandatory obligation of selected groups should rest on the collective benefits with respect to health and safety rather than the constraint. Such a targeted and collectively-framed approach among high-risk professions will be more easily perceived as legitimate, resulting in greater acceptance.
- However, together with the introduction of an obligation and in addition to the legal framework, all efforts to stimulate intrinsic motivation need to be mobilized and exploited (by capitalizing on the success of the vaccination campaign) and the possible collateral damage towards public trust



in the government and other vaccination programs (measles, pertussis, ...) needs to be taken into account.

- Finally, agreements on (large scale) mandatory vaccination at international level may need to be considered for sustainable pandemic control.

### 1.3. Extend application field for CST/DCC

- The role and place of a CST may need to be primarily promoted as an instrument of risk reduction and safety enhancement, rather than an hidden obligation for vaccination or a 'pass to freedom'.
- To avoid the perception that CST is used as a strategy to seduce or even manipulate people, it is therefore critical to use it in high-risk contexts only where its perceived legitimacy will be higher. CST could be useful to open the possibility for organizers of smaller high-risk events (which requires adapting the legal base), provided a clear context is given (e.g. either use of CST or application of remaining measures). In this way, additional areas of society could open up in a safe way.
- Its composition may be critically revised over time and explained well e.g. those with a certificate of past disease should still be motivated to vaccinate, the availability of affordable tests,...
- The use of the CST should depend on the epidemiological situation (e.g., Israel suspended the use of the pass for several weeks when the epidemiological situation allowed it).
- There are issues with its falsifiability (fraud). In addition, this creates difficulties regarding the responsibility for control.
- Its use should be limited in time, depending on milestones achieved in epidemiologic containment and vaccination status.

### Suggested way forward

The epidemiological situation in the Brussels region calls for urgent measures to ramp up vaccine coverage as it jeopardizes its international reputation being the capital of the EU.

Continued investment in **intrinsic motivation should remain the basis and priority**. All possible options for intensified, targeted communication is required, to specific groups, using the communication means and channels of those groups as well as low-threshold vaccination at work, schools, shops, events, ... should be explored. Sufficient means should be devoted

This can be combined with **targeted mandatory vaccination** (e.g.; health care workers, others who work with vulnerable persons, education) and **broadening options to apply the CST for at risk activities** such as mid-sized events, night life, student life, fitness/sports clubs, ... where the motivation should be to reduce the risk and install a safety culture.

Finally, in acute settings (with worsening epidemiological parameters), none of these options should be seen as the definitive or quick solution but rather as a building block, next to clear emphasis on the **maintenance of non-pharmaceutical interventions** (e.g. mask wearing, distancing, testing and quarantine, ventilation,...) in all settings that threaten the safety and health of the population (public transport, work, schools).



## Summary

	Pros	Cons
<b>Stimulate intrinsic motivation</b> Requirements: <ul style="list-style-type: none"> <li>• Strong communication campaign (mass + tailored);</li> <li>• Bringing vaccines to people at work, school, shops,...</li> </ul>	Experience: Belgium has a strong track record of vaccination coverage	Time consuming (as tailor based)
	Most sustainable way, also towards other vaccination programs	
	Probably, still a sizeable number of people willing to get vaccinated after their holidays	has been tried extensively but various suggestions above indicate that there is still potential to be exploited
<b>Vaccination: targeted vaccination campaign and mandatory vaccination</b> (requires adapting the legislative framework (i.e. add vaccination against sars-cov-2 to Annex VII.1-6 RD biological agents of the Codex Prevention and Protection at work. This annex contains a list of companies and employee categories for which certain vaccinations are mandatory)	Focus on specific groups (e.g. HCW, working with vulnerable people)	Limited experience (except compulsory vaccination for HBV for health care workers)
	Targeted introduction among high-risk sectors can be justified to achieve collective goal of low virus circulation.	Very intrusive in one's personal life
	Mandatory for small target groups to be combined with voluntary for general population	Challenges with enforcing, may possibly lead to absenteeism, career re-orientation, and staff drain (cross border) although not doing so may entail the opposite risk and positive experiences with other mandatory vaccines (e.g. HBV) have proven otherwise.
	Targeted implementation minimizes the risk that different groups of unvaccinated groups (see above) join forces	May jeopardize trust in authorities and impact uptake of voluntary vaccination programs
<b>Extended use of CST/DCC</b> (requires legislative framework and availability of affordable tests)		Legitimacy complicated if a geographical distinction is made
	Low cost intervention	Limited experience
	Seems to effectively stimulate hesitant people to take up vaccination (see the case of France)	Falsifiability, controllability, legitimacy of the people carrying out controls (citizen versus citizens).
	Targeted application allows one to framed the CST as an instrument to promote 'risk reduction and safety', leading to greater acceptance and less resistance among non-vaccinated	Motivation may come across as hidden 'obligation'; can be reduced by focusing on the role of CST as an instrument to promote risk reduction instead of increasing freedom.
	Focus on most at risk settings (events, student life, sports clubs, fitness)	May create social polarization (coalition of the discontent; see the French situation) which would be detrimental to the acceptability and further uptake of the vaccine
	Can be used as a 'quality label' but is then best framed in terms of safety (rather than freedom)	Legitimacy of the people doing the controls (citizen versus citizens)
	Introduction in high risk contexts, such as events and nightlife sector, deserve priority	Complicated to make a geographical distinction in its use
Versatile / reversible / limited in time		



## Annex 1. Attitudes toward CST and mandatory vaccination: Evidence from the Motivation Barometer

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August 18, 2021

The youngest wave of the motivation barometer, a long-standing study that charts Belgian citizens' motivation and well-being (see [www.motivationbarometer.com](http://www.motivationbarometer.com)), took place between August 12<sup>th</sup> and 15<sup>th</sup> (N = 7285; 65% females; 86.9% vaccinated persons; 66.7% highly educated persons; 78.8% Dutch speaking persons). Three key findings need being highlighted that are relevant:

- First, in contrast what can be intuitively expected, unvaccinated (instead of vaccinated) individuals have become increasingly demotivated over time (see figure 1). The erosion of motivation is even more visible among unvaccinated individuals who got COVID-infected. These trends are presumably due to (a) a selection effect, with motivated individuals gradually getting vaccinated and (b) previously infected, unvaccinated individuals not seeing a valid reason for their vaccination, making them a critical subgroup for targeted communication.
- Second, a similar discrepancy between vaccinated and unvaccinated individuals is visible with respect to individuals' attitude towards mandatory vaccination (figure 2). While more than 80% of unvaccinated individuals is (strongly) opposing mandatory vaccination, vaccinated individuals have a more favorable but also more nuanced perspective, thereby taking the targeted group into account. Almost 80% (strongly) agrees to oblige health care workers and professions that get in contact with vulnerable persons to be vaccinated, but a far smaller percentage is in favor to introduce mandatory vaccination in the entire population or in youngsters.
- Third, vaccinated persons have a similar nuanced perspective with respect to the use of the Covid-Safe Ticket, thereby differentiating its usefulness by context (figure 3). While the vast majority of unvaccinated persons are against its introduction regardless of context, vaccinated persons are positive about its current use (large scale events, traveling) but 74% also consider it as a (very) useful instrument in night life. Yet, for other contexts, such as catering, work or education, a smaller percentage of vaccinated individuals has a favourable opinion.

Overall, these findings indicate that (a) unvaccinated, yet previously infected individuals need being addressed through targeted communication efforts to indicate why vaccination is of added value to them; (b) citizens oppose a generalized introduction of mandatory vaccination but favor a selective introduction among high-risk professions (e.g., health care workers; individuals working with vulnerable people) where it can be justified and, hence, is perceived as legitimate; (c) citizens oppose a generalized introduction of the CST but favor a gradual extension to high-risk settings (e.g., night life) where its use is perceived as necessary to promote safety. At a broader level, citizens' nuanced perspective signals that they are very thoughtful and critical about these topics, thereby wanting to protect the safety of themselves and those around them. If we want to secure that selective mandatory vaccination and CST are accepted by the population, they should be framed as strategies to preserve safety and health instead of means to increase freedom. Increasing vaccination rates may follow as a desirable side-effect of their introduction but should not be casted as the primary driver for their introduction (mandatory vaccination) or extension (CST).



Figure 1. Shifts in voluntary motivation to adhere to the measures among vaccinated and non-vaccinated individuals since February 2021.

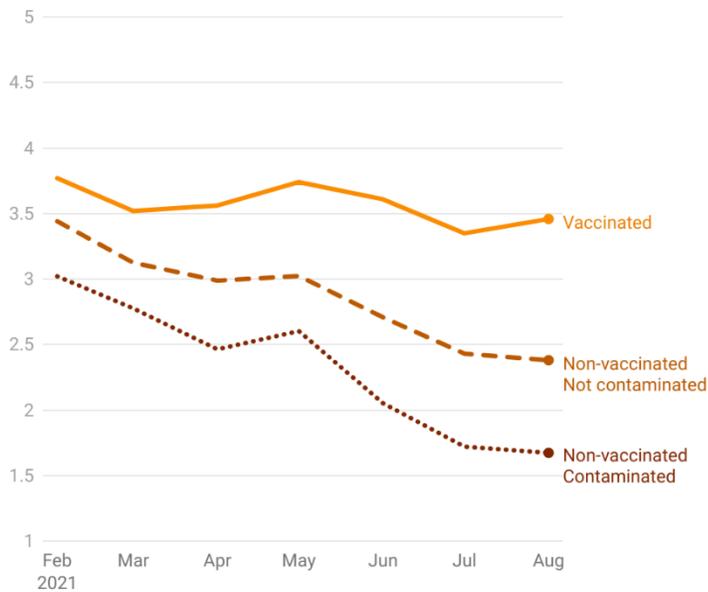


Figure 2. Attitude towards mandatory vaccination as a function of subgroup among vaccinated and non-vaccinated individuals

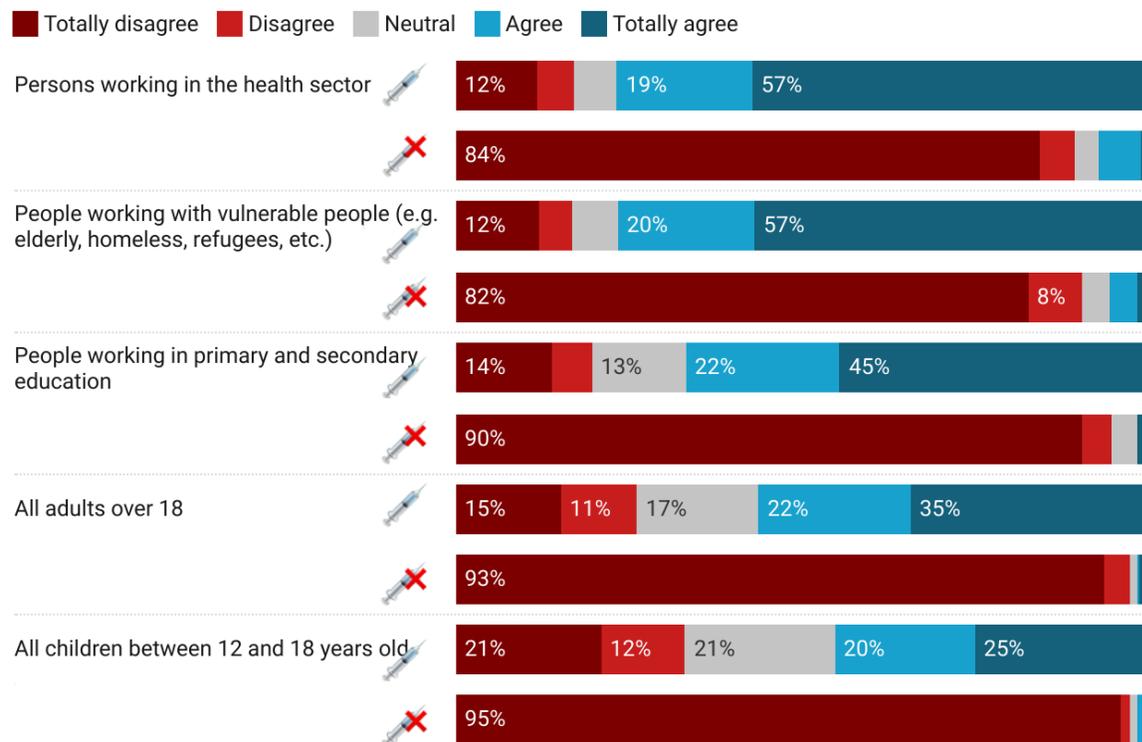
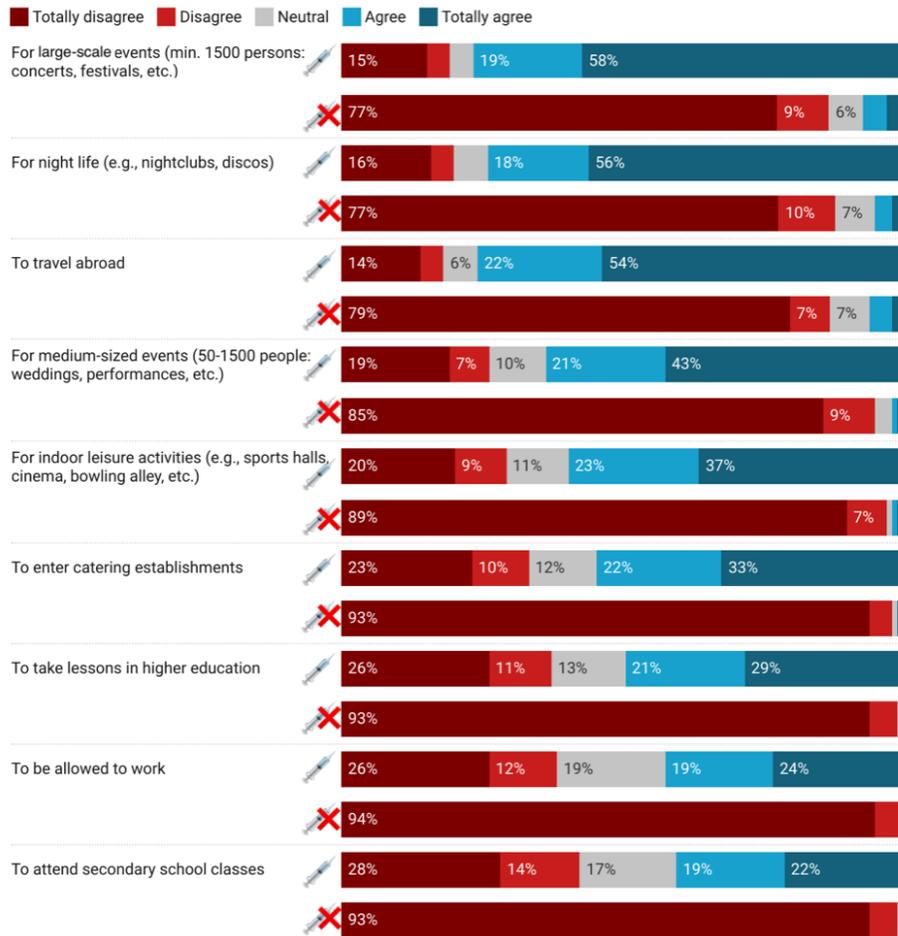




Figure 3. Attitude towards CST as a function of sector among vaccinated and non-vaccinated individuals





## **Annex 2. Which lessons for Belgium and its regions from the French « covid pass experiment » ?**

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*Preliminary draft, August 16, 2021*

### **Introduction**

This short note discusses whether the French ‘covid pass experiment’ announced on July 12 by President Macron holds potentially useful lessons, or not, for Belgium and its regions.

This French policy is much more ‘coercive’ than the Belgian policy pursued so far, which has mostly relied on ‘positive non-monetary motivation’, implying a ‘no mandate/no carrots/no sticks’ approach. Indeed, the only Belgian restriction concerns the requirement of a sanitary pass (showing proof of either vaccination, prior infection or a negative test) for events above 1.500 participants, the other restrictions for Belgian residents only concern travel abroad and are imposed by other countries.

As stressed by our psychologist colleagues, this approach is consistent with studies where individuals are asked to react to potential rewards or penalties and showing non-vaccinated people reacting negatively to mandates, carrots or sticks, leading to the fear such incentives could backfire.<sup>1</sup>

These hypothetical studies are very useful, and Belgium’s aggregate performance so far has been more than satisfactory. However, as is well-known, regional differences are very significant : while Flanders excels in its vaccine coverage, Wallonia is average, and Brussels is a laggard.

Looking at alternative strategies implemented abroad is therefore potentially useful, especially in a context where scientists talk about ‘a race between vaccination and the variants’, and where new, more contagious variants indicate a vaccination target higher than 70%, and possibly up to 80 or 90%. A vaccination strategy should therefore ideally start with an explicit target percentage with a timeline, and an appropriate strategy to reach them.

### **‘Natural experiments’**

Comparing strategies across countries is not easy, because we cannot have ‘everything else equal’, so that ‘comparaison n’est pas raison’.

The ‘gold standard’ in terms of evidence concerns ‘randomized control experiments’ used to authorize vaccines for example. Even that is not perfect : we don’t know yet of course the 10year danger of covid vaccines, especially for a brand new technology like mRNA. But beyond that, we are pretty ‘safe’.

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<sup>1</sup> See The motivation barometer (23 June 2021). *Séduire, persuader et/ou informer ? Comment faire face aux hésitants vaccinaux ?* by Olivier Klein, Olivier Luminet, Sofie Morbée, Mathias Schmitz, Omer Van den Bergh, Pascaline Van Oost, Maarten Vansteenkiste, Joachim Waterschoot and Vincent Yzerbyt, Gent, Leuven, Louvain-la-Neuve and Brussels.

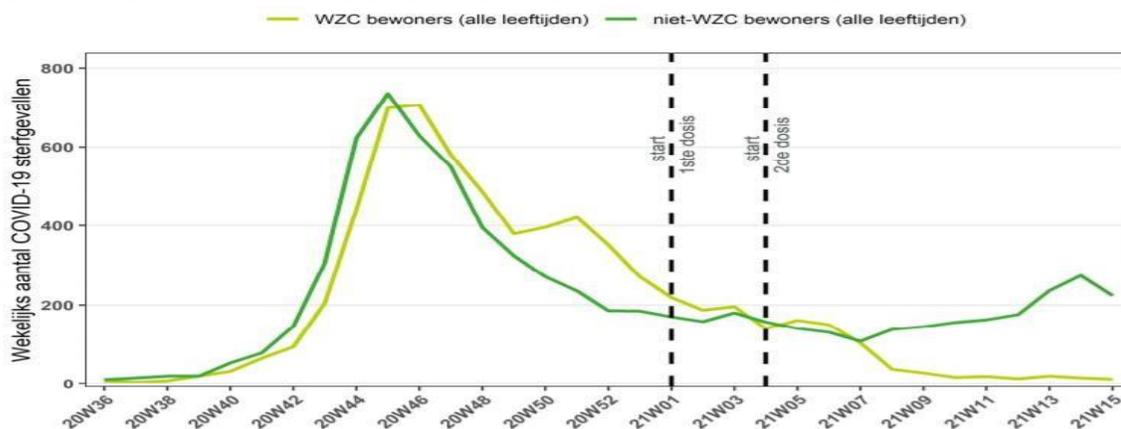


Psychology has a long tradition of running experiments, and economics has developed an experimental tradition too, very much benefiting from and influenced by psychology (focusing more (but not exclusively) on monetary (negative or positive) rewards). The advantage of such experiments is that they pretty well ‘controlled’. Their limit is that they are hypothetical : how much should we trust people when they say how they will alter their behavior in front of a policy which is not enacted ?

In order to address this caveat, empirical economists often look for ‘natural experiments’, namely specific policy changes which give information about ‘actual’ policy. They then try and look at ‘differences-in-differences’, namely they look at how a the difference of a given variable between a ‘treatment group’ and a ‘control group’ evolves over time.

This idea is pretty intuitive. A very convincing example of its usefulness is the following graph published by Sciensano :

**Effect of vaccination on weekly COVID-19 mortality on two groups with highly different vaccination coverage: nursing home residents (light green) and general population, Belgium.**



‘Proving’ that vaccination reduces mortality in Belgium when we vaccinate only retirement home residents and we vaccinate them all is not possible. But randomly vaccinating them is ethically not an option. Moreover, we can exploit specifics of the vaccination strategy, namely the timing of vaccination of different groups, to be pretty confident that mortality decreases sharply around two weeks after the second (Pfizer) dose. Indeed, in the graph we see that mortality in the non-retirement-home-resident population is, if anything, rising in that period while it collapses in retirement homes, meaning that the difference of this difference in mortality grows over time two weeks after the second dose.

Intuitively, comparing vaccination performance over time across countries is more challenging. However, looking at this difference-in-difference is insightful too.

France is not the only country to have introduced covid pass requirements in various settings like horeca, sports or culture : Denmark, Austria, Germany, Israel, Italy, Luxembourg or Portugal have done it for example, and it would be worth looking at them too, while this note only considers France.

France is potentially particularly informative, because it is a very explicit brand new strategy, announced solemnly on French TV by the President on July 12, with a well-defined timetable (it included a vaccination

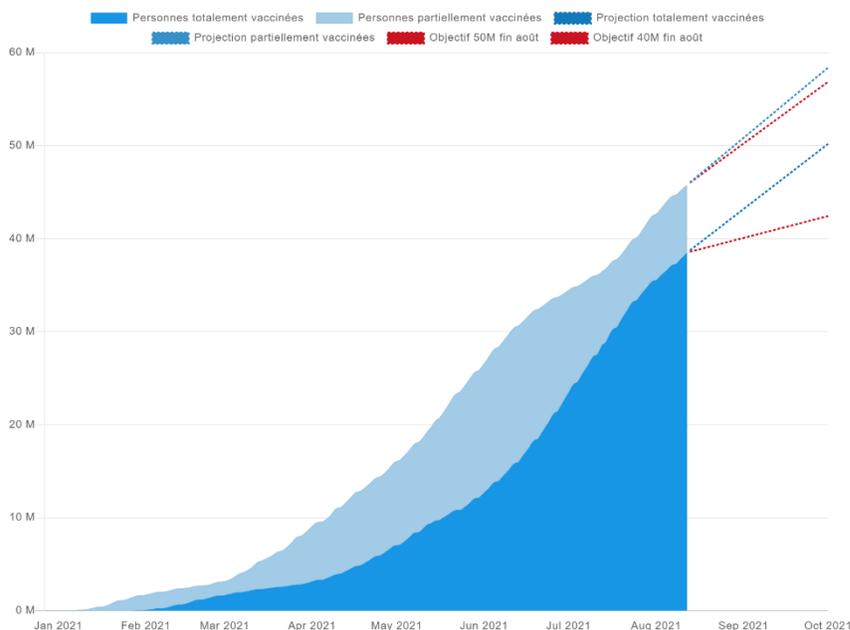


requirement for healthcare personnel, and a sanitary pass requirement in particular in cinemas and museums as of July 21, and in horeca as of August 9).<sup>2</sup>

### The impact of the July 12 announcement in France

The immediate impact of this announcement was a ‘vaccination appointment rush’, with for example almost one million vaccination appointments within 24 hours.<sup>3</sup> This response was stronger than even the defenders of the pass had hoped.

More significantly, the next graph (coming from <https://covidtracker.fr/vaccintracker/> and based on the data from the Ministry of Health) shows an acceleration of the number of people at least partially vaccinated for around three weeks. In this note, we will focus on this indicator, which is the right one at a time where vaccine supply is not the binding constraint any more but it is vaccine hesitancy which is, so that the key hurdle is convincing people to get a first dose.



While the above evidence strongly suggests that Macron’s plan helped raise vaccination rather than slowed it down, it of course does not mean it convinced everybody : every Saturday multiple demonstrations are organized in France by opponents to the policy, totalling more than 200.000 participants each Saturday of August until now. On the other hand, more than 9 million French people have decided to get vaccinated since July 12.

<sup>2</sup> Note that different countries choose different ‘application perimeters’ of the pass requirement but so far they mostly adopt its EU definition, namely proof of vaccination, proof of prior infection or proof of a negative test (whose technique or duration validity can differ however) result.

<sup>3</sup> See [https://www.liberation.fr/societe/sante/vaccination-tous-piques-de-doctolib-apres-les-annoncesde-macron-20210712\\_A7D33PZ4Y5HFPP6ZIW5TZLQZDA/](https://www.liberation.fr/societe/sante/vaccination-tous-piques-de-doctolib-apres-les-annoncesde-macron-20210712_A7D33PZ4Y5HFPP6ZIW5TZLQZDA/)



Moreover, looking now at the geographical dimension and its time evolution, the next two graphs indicate how France has risen spectacularly in the « vaccination ranking » since July 12. The graphs compare, using the Our World in Data website, the latest information to the July 12 numbers for the pre-eastern-enlargement EU countries (or 'EU15', including the UK) plus Israel and the US. The analysis is only preliminary and would be worth refining, but it is already instructive.

Considering France, we see that it was number 16 out of the 17 countries selected on July 12, but number 9 on August 14, thanks to a 14% increase of its total population at least partly vaccinated (from 54% to 68%). Again, this indicates that the Macron plan did not backfire, at least until now (the new vaccination level has somewhat slowed down by now, but it is still at 260.750 on August 12, the last available number ; this slowdown has prompted the French authorities to stop keeping testing free of charge).

This being said, while France does very well with its 14% rise, it is by no means alone : 3 other countries also have a 14% increase, and two of them have the advantage of starting from a significantly higher level than France on July 12 (Portugal and Spain). In fact, there is quite some variability in performance, and we could classify our 17 countries in 5 groups, defined in decreasing position on July 12 :

1. The countries which 'peaked early' : the UK, Israel and the Netherlands, which were in the top 3 on July 12 but are not any more, because they improved only by 1 or 2%.
2. The countries which 'progress moderately from a good basis' : Belgium (+5% and a stable 4th rank) and Finland (+6% and a slightly worse rank).
3. The countries which 'made very impressive progress' and are now the top 3 : Denmark (+11%) and Spain and Portugal (both +14%).
4. The countries that 'progressed very significantly from a low base' : Sweden (+10%) and Ireland and France (both +14%).
5. The countries that 'show slow progress from a weak base' : Luxembourg, Germany, Austria, the US and Greece, all with an increase of 4 to 5%.

Note that Italy, with a gain of 7% and a starting point of 60%, is 'in-between' groups 2 and 5.

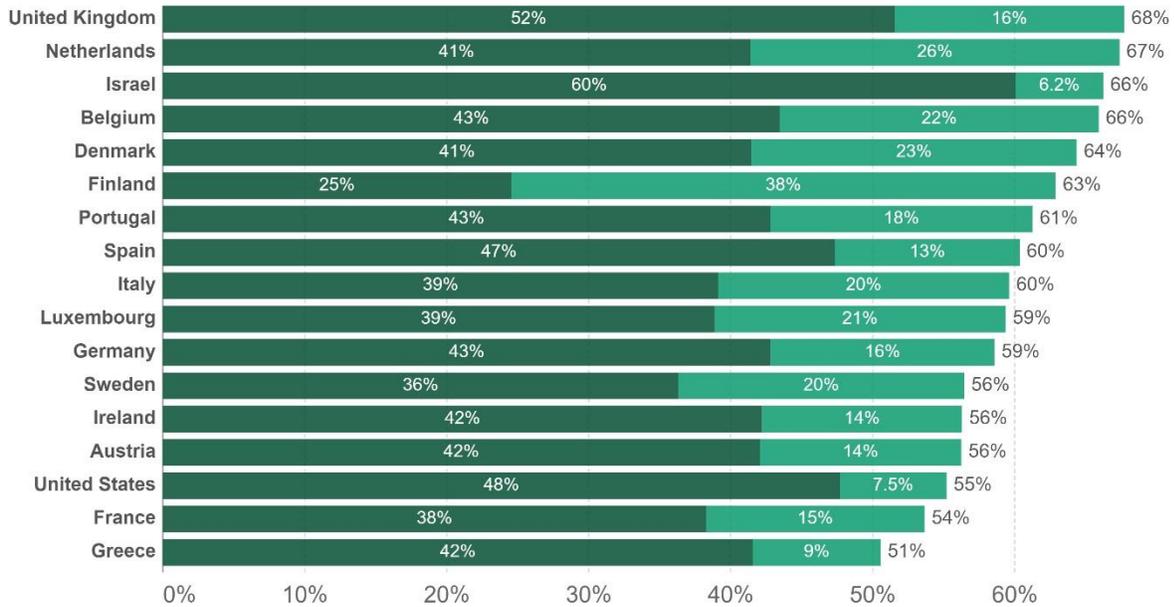
If we want to achieve a vaccination rate of more than 80% because of the delta variant, group 3 is the 'model' and group 5 the one which should be most concerned. Beyond this, group 1 should also be somewhat worried, while the question is to what extent groups 2 and 4 can emulate group 3 (by increasing its progress for group 2 and sustaining it further for group 4).



## Share of people vaccinated against COVID-19, Jul 12, 2021

Our World in Data

■ Share of people fully vaccinated against COVID-19 ■ Share of people only partly vaccinated against COVID-19

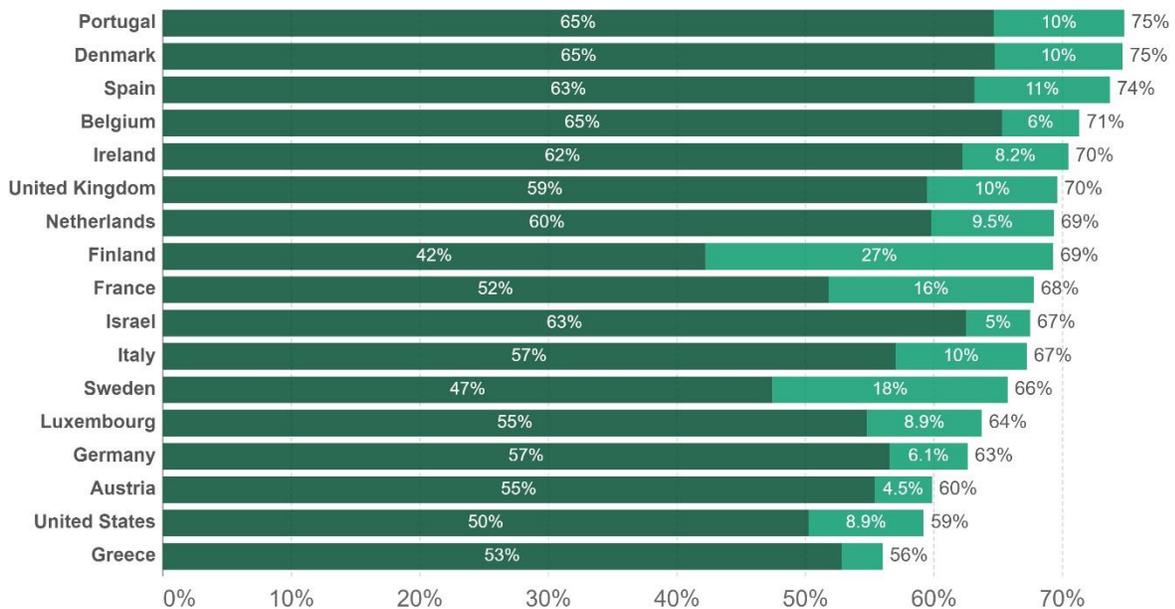


Source: Official data collated by Our World in Data. This data is only available for countries which report the breakdown of doses administered by first and second doses in absolute numbers.  
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## Share of people vaccinated against COVID-19, Aug 14, 2021

Our World in Data

■ Share of people fully vaccinated against COVID-19 ■ Share of people only partly vaccinated against COVID-19



Source: Official data collated by Our World in Data. This data is only available for countries which report the breakdown of doses administered by first and second doses in absolute numbers.  
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## Which lessons for Belgium and its regions ?

When we look at Belgium as a whole, one could argue that the French experiment is in a sense of limited value : yes, it 'turned things around' with its 14% increase but, even if Belgium only improved by 5% in the same period, it is still above France by 3%, and its stable 4th rank means it overtook 3 countries while being overtaken by another 3. The question remains nonetheless about the ultimate target in terms both of vaccination rate and time it would take to reach it.

However, the picture looks very different when looking at the Belgian regions (which moreover do not 'converge' in absolute terms). If we had to position them on the above two graphs :

1. Flanders, which went from 71.6% to 77.8%, would be number 1 in both graphs.
2. Wallonia, which went from 61.6% to 67.0%, would be very similar to Italy, so inbetween groups 2 and 5.
3. The German-speaking community, which went from 59.5% to 62.3%, would be in group 5.
4. Finally, the Brussels region, which went from 45.7% to 50.0%, would be last in both graphs.

This clearly means that the French experiment is not really relevant for Flanders. For Wallonia, note that the country closest to its performance is Italy, which recently decided to 'go the Macron way'. And the performance of the German-speaking community, and especially of Brussels, really requires an adaptation, and France is in this sense clearly worth looking at.

Brussels is, on top of that, already a worrisome region in terms of new cases, with an incidence of 410, almost twice the national average of 213, itself a high number ahead of the beginning of the school year and of Fall weather. Next to the sanitary concerns, the capital of Europe, with its economy partly dependent on intercontinental tourism and business travel, can moreover not afford the economic and reputational loss of being a 'low-vaccination red zone'.

Brussels has specificities in terms of hosting poor communities of diverse origins. Does this make the French experiment irrelevant for Brussels ? No, because first the experiment 'works' for both richer and poorer Departments in France, as the following data show for Île de France :

Department	Per capita income	Vaccination rate	
		on July 12	on August 12
Paris	197	66.0	81.5
Hauts de Seine	160	53.6	65.9
Yvelines	136	47.8	56.7
Val de Marne	110	55.2	68.7
Essone	106	47.4	59.2
Seine et Marne	100	46.2	60.3
Val d'Oise	98	52.0	66.8
Seine Saint-Denis	75	52.2	71.6



Source : <https://www.insee.fr/fr/statistiques/4965285> for per capita income (2018 data relative to nat. average) ; and <https://covidtracker.fr/vaccintracker/> for vaccination rates (Ministry of Health data).

Brussels has both very wealthy communes and very poor ones, and interestingly the French experiment has had a very sizable impact both in rich 'Paris intra muros' (which started at 66% vaccination rate on July 12) and in poor Seine Saint-Denis (which started at 52%). This is encouraging for a Brussels region where all communes need improvement : from a poor commune like Saint-Josse, which has the lowest vaccination rate in Brussels at 39.3%, up to a wealthy commune like Woluwé Saint-Pierre, whose vaccination is only at 61.5% even though it is the highest in Brussels.<sup>4</sup>

## Conclusion

The recent French experiment is not ideal, as it introduces differentiated treatment between different groups of citizens in everyday activities. It runs the risk of alienating some citizens who are understandably surprised by such a 'turnaround' after the earlier promise that 'vaccination will be an individual decision', a promise made by most countries. It was dangerous to make such a promise while at the same time saying the target was to reach 70% vaccination (it would have been much better to say : 'we will only vaccinate volunteers as long as vaccine supply is limited and we will refine vaccine policy as more information about the potential dangers of vaccination accumulate'). When the promise and the target are inconsistent with one another, one has to be adapted. From a public health point of view, the delta variant makes abandoning the target risky, but it is for the public authorities to decide whether or not to take this risk.

In any case, since evidence strongly suggests that the French experiment helps raise vaccination rates significantly, it seems very reasonable to consider it, possibly with fine-tuning in terms of the perimeter of activities for which the sanitary pass is required, for at least three of our four federated entities, and especially Brussels which needs all the help that can be provided.

Introducing different requirements in different regions is of course complicated and subject to 'arbitrage', with some people moving to the next region to circumvent the rule. This, together with the fact that the virus 'does not respect borders' and the significant work-related interregional mobility, could plead for temporary measures applied everywhere in Belgium, even though this can be politically difficult too..

In any case sticking everywhere to the existing policy with only minor modifications seems like a dangerous course of action.

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<sup>4</sup> Sciensano publishes (at least partial) vaccination rates per commune as a % of the 18+ population. The above numbers multiply Sciensano data by the ratio of 18+ population over total population computed from <https://ibsa.brussels/themes/population/structure-par-age>.