



MEETING OF HEADS OF WHO COLLABORATING CENTRES
FOR THE CLASSIFICATION OF DISEASES

Canberra, Australia
10-16 October 1995

REPORT

1. Opening of the meeting

Dr Bruce Armstrong, Director of the Australian Institute of Health and Welfare (AIHW) and Head of the Australian Centre, introduced Professor Janice Reid, Chair of the Institute. Professor Reid explained the structure of the Australian Centre with headquarters at the Institute in Canberra and benefiting from the expertise of the National Reference Centre for Classification in Health (NRCCH) in Brisbane, the National Injury Surveillance Unit (NISU) in Adelaide, and the National Coding Centre (NCC) in Sydney. Professor Reid pointed out the great value of the role of WHO in the development of classifications. She welcomed the participants to the first meeting of collaborating centres to be hosted by the Australian Centre and wished them well in their deliberations.

The meeting was then opened by Dr H.R. Hapsara, Director of the WHO Headquarters Division of Epidemiological Surveillance and Health Situation and Trend Assessment (HST), on behalf of Dr Hiroshi Nakajima, Director-General of the World Health Organization and of Dr S.T. Han, Regional Director of the WHO Regional Office for the Western Pacific. In his opening address, Dr Hapsara emphasized the importance of renewing approaches to health statistics in order to enhance their generation, especially broadening their use, and improving the quality of data produced. He acknowledged the classification of diseases as an important tool for ensuring the quality of data. He outlined WHO's current activities in relation to the ICD as well as future ICD-related functions at the global, regional and country levels and noted that these would have to be carried out in the context of diminished human and financial resources.

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2. Election of officers

Dr J. Donovan of the host centre was appointed Chairperson. Professor B. Smedby and Mr G. Pavillon were elected as Vice-chairpersons. Ms E. Taylor was elected rapporteur assisted by designated participants for specific agenda items.

3. Consideration and adoption of the agenda

The Agenda was adopted as presented with the addition of items 6.5 for short lists, 6.6. for copyright, and 9.3 for other studies.

4. Reports of activities

4.1 Reports of activities of the WHO Collaborating Centres for Classification of Diseases

The Australian Centre (ESS/ICD/C/95.5) reported on its activities in three areas: the Australian Institute of Health and Welfare (AIHW) had undertaken to carry out a number of tasks in relation to the revision of the International Classification of Impairments, Disabilities, and Handicaps (ICIDH) including seeking comments on the overlap between the ICD and the ICIDH; the establishment of a multidisciplinary reference group, including representatives of people with a disability, to comment on the work of the Handicap working group; and involving other Australian agencies with a view to trialing a new draft ICIDH. The AIHW study of apparently inadequate causes of death where queries might be addressed to certifying physicians had continued.

The National Reference Centre for Classification in Health (NRCCH) had established a comprehensive research programme in primary health care settings. In cooperation with the Brisbane office of the Australian Bureau of Statistics (ABS) the NRCCH had evaluated software with a view to coding multiple causes of death in ICD-9. A training course had been held for data items and definitions required for morbidity coding and for ICD-9-CM.

The National Coding Centre (NCC) is dedicated to improving the quality of coding within Australian health services through the development of national coding standards and quality improvement processes applicable to medical record documentation and coding. The NCC had established a National Committee for the Implementation of ICD-10 and a companion procedure classification. The NCC is preparing mapping from ICD-9-CM to ICD-10 and intends to develop an Australian version of ICD-10 for morbidity purposes.

As the Centre Head was unable to attend the meeting, the report of the Sao Paulo Centre (ESS/ICD/C/95.6) was presented by the Secretariat. During the year under review the Centre had completed the alphabetical index to the Portuguese-language version of ICD-10 and the classification will come into use in Brazil in January 1996. Didactic materials for training coders in the use of ICD-10 had been developed and a number of mortality and morbidity courses had been held. The microcomputer-based Underlying Cause of Death System had been translated into Spanish and introduced in Cuba. Other activities of the Sao Paulo Centre are reported on under agenda items 8.1 and 9.3.

The new Head of the Beijing Centre, Dr Dong Jingwu, reported on an impressively wide range of activities (ESS/ICD/C/95.7). These included cause of death statistics, hospital morbidity statistics and training. In May 1994, ICD-9 was published as the national standard on classification and coding and put into effect by the China National Bureau of Technical Surveillance. At the same time, the Centre was continuing the work of translating and proof-reading of the Chinese-language version of Volume 1 of ICD-10.

The past year had been one of significant activity and major change for the London Centre (ESS/ICD/C/95.8). Professor Michel Coleman had been appointed Deputy Chief Medical Statistician and had taken over from Dr Fox as Head of the Centre. A new joint centre had been established with the Office of Population Censuses and Surveys (OPCS) retaining responsibility for mortality and the National Health Service Centre for Coding and Classification (NHSCCC) becoming responsible for morbidity, procedures and other health service activities. Work on the TENDON computer-based training package had been completed in January 1995. The new Automated Cause Coding System (ACCS) was in routine use.

The Paris Centre (ESS/ICD/C/95.9) had worked extensively on the development of the alphabetical index to ICD-10 in French as well as on the French-language version of the International Classification of Diseases for Oncology, Second Edition, 1990 (ICD-O-2). Preparatory work had begun for the implementation of ICD-10 in public hospitals in 1996 and for mortality in 1997. Work was also well advanced on the French version of the TENDON training software. A protocol had been prepared for an international multiple cause study. Five countries were able to participate according to the protocol and a first report is presented under agenda item 9.2. Other Paris Centre activities are reported under agenda item 8.1.

The Arabic Centre (ESS/ICD/C/95.10) had continued its commitment to support the ICD, answering coding queries and giving specific advice. A training manual on clinical coding incorporating the latest WHO guidelines and principles had been developed. Translation into Arabic is planned. A questionnaire had been sent, through the WHO Regional Office for the Eastern Mediterranean, to establish the current status on the use of the ICD and seeking guidance on how the Centre could assist countries in classification-related activities. The results of the questionnaire were not yet available.

The Moscow Centre (ESS/ICD/C/95.11) had completed the main work on Volumes 1 and 2 of ICD-10 and these had been sent to press. Volume 3 would be sent to press during the last part of 1995 or early in 1996. Comparability tables had been prepared between the ICD-9 and ICD-10 short lists for general and perinatal mortality. A three-character version of ICD-10 with inclusion and exclusion terms had been published. Work had also been carried out on the applications of ICD-10 to oncology and to mental and behavioural disorders: clinical descriptions and diagnostic guidelines.

The Centre for the Nordic Countries (ESS/ICD/C/95.12) had contributed to an international collaborative study on multiple cause analysis as well as to work on the revision of the ICIDH. The Nordic Classification of Surgical Procedures (NCSP), developed by a NOMESCO working group, will be implemented in Denmark on 1 January 1996, in Finland during 1996, and in Sweden on 1 January 1997. The Nordic Centre is engaged in a project for Nordic coordination within the area of Diagnosis Related Groups (DRGs). The project, which includes development of conversion tables between ICD-10, the NCSP and ICD-9-CM as well as DRG definitions based on ICD-10 and NCSP with a corresponding grouper, will be finalized before the end of 1995. The Nordic Classification for Accident Monitoring is being updated with modules for violence and suicides. A third edition will be published in 1996. The third edition of the Bibliography of Literature on the ICD and other health-related classifications was published in 1994; 663 new items had been added making a total of 1,482.

The Collaborating Centre for North America (ESS/ICD/C/95.13) had seen the retirement of its Head, Robert A. Israel and the departure of a number of key personnel but the Centre had also gained new personnel. Work in the United States had focused on continuing to upgrade the automated mortality processing systems MICAR and SUPERMICAR, disseminating mortality data and ICD-9-CM on CD-ROM, preparing for the implementation of ICD-10 for both morbidity and mortality, improving the quality of medical certification of cause of death, the development of guidelines for external cause of injury coding and considerable activity related to the ICIDH. Part of the activity related to ICD-10 was the development of a new procedure classification by the Health Care Financing Administration. During discussion of the Centre's activities, the Centre Heads emphasized the need to ensure that the new procedure classification was designated in a way that did not imply that it was a part of the international ICD-10 published by WHO. Canadian activities included an ICD-10 implementation study, development work related to the revision of the Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP), and the servicing of numerous requests for verbal and written information and presentations (in English and French) on ICD-10. An important event was the transfer of the Nosology Reference Centre from Statistics Canada to the Canadian Institute for Health Information (CIHI). Other North American Centre activities are described under Agenda items 6.2, 7.4, 8.1 and 8.2.

No report was received from the Caracas centre.

The Office of the ICD, Japan (ESS/ICD/C/95.15) reported on the introduction on 1 January 1995 of a new revision of the Japanese Standard Classification of Diseases consisting of a list of four-character subcategories without inclusions, and of Japanese tabulation lists for mortality and morbidity. A new Japanese medical certificate of cause of death with an additional line in Part I had been introduced at the same time. The Japanese version of the Instruction Manual to ICD-10 was published in March 1995. It also contains the list of three-character categories, the new Japanese medical certificate of cause of death and tabulation lists for morbidity and mortality. The Japanese index will be completed by March 1996.

The Dutch WCC report (ESS/ICD/C/95.16) noted that the Classification and Terminology Committee for Health (WCC) is about to become part of a new centre of coordination for the standardisation of information supply in the health care sector. The WCC had decided in 1994 to direct its activities more to the organization of standardisation than to the research and development of classifications and definitions. When necessary, the latter activities will be decentralised with the WCC secretariat activities confined to the provision of information and advice. Classification-related standardisation topics will primarily be confined to ICD, ICIDH, classifications of procedures and classifications of medicines. In discussion of the report, it was noted that the WCC had been very involved in developing national, specialised classifications and, in particular, in the semantic aspects of classification. Work on specialty expansions of ICD-10 for ENT and internal medicine was noted as was activity carried out to standardise concepts and definitions in the area of "chronicity".

The meeting was provided with an update regarding ICD-related activities in New Zealand by a representative of the New Zealand Health Information Service of the Ministry of Health. It was noted that the Australian ICD-9-CM was implemented in New Zealand on 1 July 1995 for morbidity. That implementation was preceded by a train-the-trainers course and eight regional courses. A "help desk" was established to assist with queries following implementation and coding audits are planned. A move to case-mix funding for hospitals using the Australian DRGs is expected. Mortality coding by ICD-9 is centralised and automated coding is being investigated. An orientation to medical certification of cause of death is provided annually to all fifth year medical students in the three New Zealand medical schools. Implementation of ICD-10 in New Zealand will be linked to that in Australia.

4.2 Report on ESS Unit activities on ICD

ESS Unit (ESS/ICD/C/95.4) reported that the greatest part of its resources had been devoted to the finalisation of the alphabetical index to the French-language version of ICD-10. A diskette version of the three volumes of the English-language version of ICD-10 had been prepared in both WordPerfect 5.1 and ASCII formats and was available from the WHO Distribution and Sales Service. Work had continued on the development of the three character versions of ICD-10 in both English and French. Technical advice had been provided in the development of adaptations of ICD-10 to neurology, rheumatology and orthopaedics and paediatrics in English and to oncology and dentistry and stomatology in French. There had also been involvement with the WHO Division of Mental Health in the preparation of the multi-axial classification of childhood and adolescent mental disorders and the preparation, in collaboration with the Executive Committee of the World Psychiatric Association, of an Educational Programme for the use of the Mental and Behavioural Disorders chapter of ICD-10. Plans were also well advanced for two further specialty-based adaptations of ICD-10 for hereditary diseases and external causes, the latter in collaboration with a NOMESCO Working Group.

5. Implementation of ICD-10

5.1 - National (language) versions

A paper from the WCC (ESS/ICD/C/95.37) provided the meeting with an update on the translation, publication, and implementation of the Dutch ICD-10 in the Netherlands.

A paper from the WHO Regional Office for Europe (ESS/ICD/C/95.47) summarised the results of a survey to ascertain the present status, plans, and problems for European countries in the implementation of ICD-10. At the time the report was prepared, replies had been received from 60-70% of the member states in the region. The survey indicated that:

- . about half the countries in the region have or will have the ICD-10 in their national language by the end of 1995;
- . by 1995, only 6 countries (out of the 35 responses received) were using ICD-10 for morbidity and only 5 countries were using ICD-10 for mortality;
- . the majority of remaining countries plan to implement ICD-10 for mortality coding during 1996-1997 and for morbidity coding from 1997; and
- . bridge coding studies are planned in about one quarter of the countries in the region.

Particular problems mentioned repeatedly by individual countries included:

- . a lack of funds for printing manuals;
- . the need to coordinate the introduction of ICD-10 with national experts and specialists; and
- . the need to look carefully at training issues especially where there is insufficient expertise within the country.

In order to maintain a current status report on implementation plans for ICD-10, the meeting updated the summary table included in the report of the 1994 Caracas meeting. The revised table is appended to this report as Annex 1.

Those countries represented at the meeting which had already implemented ICD-10 were invited to share their experiences and to highlight any particular problems that had been encountered.

Thailand's implementation of ICD-10 was planned by a working group that identified staff for training, formulated the training curriculum, produced the teaching materials and recruited trainers. Three staff attended the international TENDON training course in 1992 and subsequently trained eight other people. Staff working in social insurance hospitals were the first priority for training followed by the hospitals of the Ministry of Public Health and their hospital executives, doctors, and other health professionals. Problems had arisen because of the different academic backgrounds of the participants and the fact that some lacked a medical background. After implementation the trainers became supervisors and had to be well prepared to answer questions by letter and telephone and to operate a "hot line" service for questions concerning disease coding. At the beginning of ICD-10 implementation, only the three-character level of the classification and the instruction manual were available in Thai. The absence of an alphabetical index caused some problems in the early stages.

On 1 January 1994, Denmark implemented ICD-10 for both mortality and morbidity, moving directly from ICD-8 to ICD-10. Some minor problems were encountered at the time of implementation and for the first six months there were many questions referred to a "hot line" staffed by two doctors. There was some coding imprecision in the first few months indicating a need for more guidance. Annual coding guidelines are produced and circulated as is a quarterly newsletter with information regarding coding and registration problems. It was noted that in Denmark, most hospitals report electronically, on line, and by the end of a given month about two thirds of the month's records are available for preliminary statistics. Two months later final statistics are produced.

It was reported that emphasis is being put on using the data and on providing feedback to hospitals and departments on their activities, waiting time, etc. This is being done, in part, in an effort to improve the quality of data. It is hoped to evaluate the results in a few years.

Implementation of ICD-10 for morbidity was accomplished in England on 1 April 1995. Between January and March every hospital coder received training (either basic training to ICD-10 or updating training). Prior to the implementation there was a significant communication effort which included clear and frequent communication regarding all aspects of the planning and preparation. The communication network included liaison officers nationwide who served to filter information out to all users. A central "help desk" proved invaluable in dealing with the frequent queries and problems during the first four months of implementation. There are plans to publish the most frequent questions addressed to the help desk along with the answers and this material will be shared with the Secretariat and the other collaborating centres.

Based on experience to date, the meeting noted the value of communication prior to and throughout the implementation process as well as the need for support such as "help desks" to respond as quickly as possible to specific problems. Ongoing training and communication as well as the sharing of experiences between countries was also encouraged.

5.2 Training

A report from the Beijing Collaborating Centre (ESS/ICD/C/95.27) detailed experiences related to the popularisation of ICD in China including: getting support from government at all levels; the translation of the classification into Chinese; the challenges related to training health workers with limited knowledge of the ICD; and the lack of direct economic benefits for ICD coders who are, nonetheless, very dedicated to their task. The efforts and significant advances made in China over a relatively short period of time were recognised by the meeting participants.

With respect to ICD-10 training, participants were reminded of the ICD-10 training courses held in England (in 1992 and 1993) to train international trainers. It was noted that although ICD development is the role of WHO Headquarters and ICD-10 implementation support is the role of the Regional Offices, the Secretariat has been able to provide some training courses (using the TENDON training software developed in the United Kingdom) at regional and even subregional levels with the assistance of a former head of a collaborating centre. As more countries move toward ICD-10 implementation, however, requests for additional training support and the available expertise are now in conflict and the assistance of collaborating centres was welcomed.

General discussion on training issues ensued, including discussion of training and training material needs, and the utilisation of the TENDON software. It was noted that the software is being translated into French and Swedish. Experiences in use of the English software have indicated that it was most effective in a classroom environment but that it could also be used for self-training as long as a contact person was available for support. A variety of training needs were identified including the rather urgent need to train staff from WHO regional offices.

In response to an offer from the London Centre to investigate the possibility of offering additional TENDON training courses for trainers, the meeting recommended that WHO regional offices identify the need for these as well as the need for further translation of TENDON. The London Centre undertook to further explore the possibility of making available to other centres and to the Secretariat a variety of additional ICD-10 training and support materials on diskette. It was noted that the printing costs of these materials would thus be incurred locally. This offer was gratefully endorsed by the meeting.

In relation to United States plans for ICD-10 mortality training, the increasing use of automatic coding of literal text for mortality statistics, largely based on software developed in the United States, was noted and the meeting was advised that the United States will be hosting the first-ever international users group meeting in 1996. The meeting will be for technical experts experienced in the use of the software. Computer-assisted coding software was also discussed in relation to both its availability and utility. These two issues were considered important enough to be added to future agendas.

6. Family of classifications

6.1 Classification of medical procedures

A report (ESS/ICD/C/95.38) was presented by the WCC regarding a classification structure to which every national classification of procedures can be linked. Such a structure would enable international comparability through mapping between coding systems or grammars. The WCC report summarised the history of European activities relating to draft standards for the development of procedure classifications, which resulted from WHO's decision not to produce an international procedure classification. The report noted that the structure is being developed through the EFCC (European Federation of Classification Centres) and funded by the European Union. The co-owners of the classification structure will be the partners of the EFCC but it was emphasized that the intention is to distribute the structure without generating a profit. A limited mapping has been done as a pilot study to relate different classification systems to the structure.

The meeting was informed of the development of the Nordic Classification of Surgical Procedures (NCSP), a project developed over five years to gain agreement between the five Nordic countries. The general structure of the classification involves five positions: anatomical system; anatomical site or organ; type of procedure; and technical specification (the latter occupying two positions). At the second position, provision has been provided for re-operations on each body system. In addition to surgical procedures, the classification includes diagnostic endoscopies and some investigative procedures. The classification will be published first in English and will be used in Finland and Denmark from 1996 and Sweden from 1997. Country-specific classifications in other areas, such as imaging, nursing and allied health, are being developed. A maintenance plan has been developed for the NCSP which will be coordinated through the Nordic Centre.

Based on the Nordic report and information provided to previous meetings, general support was expressed for the concept of a multiaxial structure for procedure classifications.

6.2 International Classification of Impairments, Disabilities, and Handicaps (ICIDH)

The North American Center reported (ESS/ICD/C/95.46) on its activities in 1994 and 1995 centred on informing and educating users about the ICIDH and coordinating North American participation in the international revision of the classification. At the request of the Secretariat, an overview of ICIDH revision activities and future plans was provided by the WCC (ESS/ICD/C/95.36) but it was recommended that, for future meetings, separate reports should be provided by each of the participating centres.

The Secretariat noted that ICIDH activities will be incorporated into the WHO Mental Health Division but Dr. Michel Thuriaux will continue to be involved even though the main focus of his activities will be on emerging, viral and bacterial diseases. Concern was expressed regarding the decision to place ICIDH within the Mental Health Division. The Secretariat stressed that, although there is a new focus on emerging diseases, HST Division will continue to provide taxonomic and statistical input to the ICIDH revision process.

The Paris Centre reported that there is a separate collaborating centre in France for the ICIDH but that there is coordination between the two groups and that the Centre Head would attend the upcoming ICIDH revision meeting. The Nordic Centre reported that it had undertaken efforts to look at cross-cutting issues in the overlap between ICD and ICIDH. A Swedish translation of the ICIDH had been finalised and the classification as a whole will be circulated for comments by the Swedish Board of Health and Welfare. The Australian Centre reported a high degree of interest in collaboration during the

revision process and the need for consistency in data collection in this area. The London Centre noted an increasing interest in the ICDH in the United Kingdom. The NHSCCC thesaurus was offered as a reference source in the revision process since it contains the concepts in use in this area within the United Kingdom.

6.3 Non conventional methods

The Secretariat provided some background on this topic which is also referred to as lay reporting. It was noted that the booklet on lay reporting which was published by WHO in connection with ICD-9 was intended to serve as an example and not a product to satisfy needs in all locations. The meeting heard about current lay reporting activities in India where there is a continuous sample survey and in Myanmar where midwives have an important role in data collection. The usefulness of such data based on lay reporting in terms of comparability with ICD-based reporting was questioned. It was emphasized that there is a need to ensure relevance for local purposes. The Secretariat was requested to produce a paper relating to guidelines for lay reporting for presentation at the next Centre Heads meeting.

6.4 Specialty-based adaptations

A report (ESS/ICD/C/95.39) was provided on development by the WCC of a manual describing the issues surrounding specialist adaptations of ICD-10 with particular regard to the ability to map to the core classification. The intention of the manual is to assist health professionals develop projects within their own specialities. There was discussion regarding the presentation of specialty classifications where not all ICD-10 categories are to be utilised. The basic principles imposed by WHO for national versions and specialty-based adaptations of ICD-10 were that:

- . no changes should be made to the existing three and four character classification;
- . no use should be made of unassigned three or four character codes;
- . expansions or extensions should be limited to the fifth character and beyond; and
- . no change in assignment of terms should be made.

6.5 Short lists

The Nordic and Paris Centres described the work of EUROSTAT on the development of short lists for mortality, the aim of which is comparability of data between European countries. It was noted that the Nordic countries also have their own short list and they are working to ensure comparability between the two lists, as far as possible. It was stated that there are also plans to develop a EUROSTAT short list for morbidity.

Concern was expressed about the relationship between the WHO short lists and national short lists and the effect of multiple lists on the comparability of mortality data. This is particularly relevant because of the need to provide stability during the changeover period from ICD-9 to ICD-10.

There was discussion about how well the WHO short list reflects different mortality patterns internationally (e.g. tropical diseases in Nordic countries) and it was noted that WHO recommends the development of country-specific short lists utilising as many WHO short list categories as possible.

There was a range of views regarding the need for region- or country-specific short lists given the international collection of data at a more specific level (i.e. ICD-10 four character codes). The North American Centre noted that mortality short lists based on ICD-10 to meet WHO reporting requirements, and separate lists to meet United States requirements, will be available in January 1996. These will be made available to other centres through the Secretariat.

6.6 Copyright

As a follow-up to the Caracas meeting, the Secretariat presented details (ESS/ICD/C/95.22) of all translation rights agreements that had been completed to date for the main ICD-10 as well as for the various specialty-based adaptations. The Secretariat undertook to keep the Centre Heads informed in a timely manner of any future agreements that were reached. It was noted that there are two areas in WHO Headquarters dealing with copyright issues: HST deals with classification development and the Division of Publishing, Language and Library Services (PLL) is responsible for giving permission for the development of national language versions and specialty adaptations. WHO is not always aware of national language versions being developed and sometimes specialty classifications have been developed in parallel with the development of the core classification. Language versions in the six WHO official languages (English, French, Spanish, Russian, Chinese, Arabic) are prepared under the auspices of WHO. For non-official languages, the country itself is granted the copyright. The meeting was informed of the need for licences for the mapping of ICD-9 to ICD-10.

The North American Centre noted that the United States had negotiated a licence with WHO to use ICD-10 for government purposes. The Secretariat noted that similar agreements had been negotiated with other Member States. The Secretariat discussed a recent meeting regarding the possible issuing of licences to a major private software company for the WHO language versions (English and French) in countries where WHO retained the rights. The meeting was unclear whether major software companies had negotiated with other countries for national language versions.

7. Maintenance and updating

7.1 Updating between revisions

A paper (ESS/ICD/C/95.43) was presented by the North American Center regarding the ongoing annual updating of ICD-9-CM for use in the United States. The ICD-9-CM Coordination and Maintenance process was described and the intent to use this process with ICD-10 in the United States was noted. A similar annual updating process for the Australian ICD-9-CM was also noted.

There was considerable discussion regarding the international updating process for ICD-10 which had been accepted by the World Health Assembly as part of the report of the Revision Conference. The specifics of the process defined to date, as detailed in the report of 1994 Caracas meeting were reviewed (see Annex 2). It was noted that collaborating centres would serve as the first level filter for any ICD-10 updating requests. As the ICD is a global issue, it was emphasized that updates should be limited to those determined by necessity rather than desirability and it was noted that there may be a need to make compromises. With respect to the criteria for making updates, it was agreed that these would be defined more fully once some practical examples had been dealt with. As a beginning, updates should be restricted to those that are substantive and important for statistics at the international level. It was noted that once any update has been accepted it will have to be included in all statistics, softwares, etc. and that this may be expected to require significant effort. With ICD-10 having already been implemented in several countries, the first requests for ICD-10 updates might be anticipated for the 1996 Centre Heads meeting. These should therefore be received by the Secretariat by the end of March 1996.

The question of whether a decision by Centre Heads would be binding was discussed. The Secretariat explained that while the World Health Assembly had formally approved ICD-10, it would not expect to ratify updates. Decisions by Centre Heads would be taken as advisory rather than binding on WHO.

7.2 Reference system

A reference system had been established at the time of the introduction of ICD-9 for the exchange of coding queries between the Collaborating Centres and WHO but had fallen into disuse after a relatively short time. Some formal process would be required for the transmission of requests for code assignments for ICD-10 as well as for proposals for updating between revisions. It was noted that it may become necessary to have separate criteria and processes for morbidity and mortality. The Secretariat agreed to prepare draft instruments for consideration at the next Centre Heads meeting. Since ICD-10 was introduced in England and Wales for morbidity a number of queries had been received and the London Centre agreed to provide details of these to the Centre Heads and to the Secretariat. With respect to future queries and suggestions for updates, the meeting agreed that each collaborating centre should submit documentation in their original language with an English translation, if necessary.

7.3 Rule 3

The issue of individual interpretation of "direct sequel" or "direct consequence" in the application of rule 3 was addressed by the meeting along with the change in the rule between ICD-9 and ICD-10. It was noted that in developing programs for automated coding and underlying cause selection, such relationships must be predefined. It was agreed that consistent interpretation of rule 3 has an important impact on the international comparability of underlying cause of death. Examples of changed trends through the introduction of the ICD-10 rule 3 were provided (see ESS/ICD/C/95.45 and ESS/ICD/C/95.28). Despite the assistance provided by ICD-10 through examples, it was agreed that there was a need for international collaboration in order to develop some broad criteria with the goal of providing as much standardisation as possible to ensure comparability. The North American Centre provided the Secretariat with a number of written questions that required clarification to assist them in the application of rule 3.

7.4 Dagger and asterisk system

It was noted that, although an international working group was established at the Caracas meeting to review the application and usefulness of the dual coding of etiology and manifestation through the use of dagger and asterisk codes and to provide guidelines for its use in ICD-10, the group had not been convened. As background, a paper presented by the Nordic Centre (ESS/ICD/C/95.32) gave an overview of the dagger/asterisk system and its use and implementation, particularly in the Nordic countries. The review revealed that the number of studies on the use of the system in ICD-9 are few and that very little has been reported in the way of implications and benefits. The Nordic Centre concluded that further discussions are necessary and that guidelines are needed as to the extent of instructions needed and

ways of handling the dual system technically. Issues identified for further discussion included methods of presenting dagger and asterisk codes in the tabular list of national versions of ICD-10 where the system has not been adopted.

The North American Center reported (ESS/ICD/C/95.40) that the United States continues to object to the dagger/asterisk system and does not find the system useful. Examples were provided of how the ICD-10 dagger/asterisk system will be modified for the United States clinical modification of ICD-10 to allow the use of a single code wherever possible.

There was considerable discussion regarding the future of the dagger/asterisk system with a wide divergence of opinion on the topic. It was suggested that the availability of computerised systems may make the dagger/asterisk system less relevant in the future as there will be other methods of data retrieval. It was agreed that further study was required and that the topic should remain on the agenda for upcoming meetings. On the issue of the presentation of dagger and asterisk codes in national language versions, the Secretariat agreed to report back at the 1996 meeting.

8. Improvement of health information

8.1 Improvement of medical certification of cause of death

A paper (ESS/ICD/C/95.26) presented on behalf of the Sao Paulo Centre described how that centre has participated since the 1980's with a committee in the Study and Prevention of Maternal Mortality in the city of Sao Paulo. The paper also described the more general impetus for establishing these committees, which date back to the 1930's in North America. The purposes of the committee are both statistical and remedial in the sense of identifying why and how individual maternal deaths occurred, through investigation, and then attempting to promote institutional change and practice change to prevent future deaths.

The starting point of each investigation is the death certificate for each woman aged 10-45, from which deaths due to external causes, cancers, and certain other causes have been removed. Most of the investigated deaths turn out to be maternal deaths even if not reported as such on the death certificate. The benefits of these committees are reported as twofold: they alert physicians to the magnitude of the problem, which they may otherwise ignore because of relatively low frequencies of deaths, but probably high rates of morbidity; they improve reporting, especially from complications that are often not stated as due to pregnancy, delivery, or occurring during the puerperium.

Results of this project demonstrated the importance of better educating physicians on how to complete death certificates and it was noted that the Sao Paulo Centre has produced booklets, in Portuguese and Spanish, to help physicians understand how to complete death certificates correctly.

The Paris Centre (ESS/ICD/C/95.30) reported on work to improve the quality of French mortality statistics by investigating deaths that are examined (with or without autopsy) by a medical examiner, usually in a forensic institute. The medical certificate of cause of death is not always completed and in such cases the cause of death does not find its way into the national statistics. The study in the greater Paris area covered each death during 1990 and a summary form was completed giving both demographic data and the cause of death. These data allowed a "corrected file" for greater Paris to be constructed. The results were then extrapolated to provide estimates for France as a whole. The correction index for deaths from natural causes was minimal. The differences, however, are more appreciable for violent deaths. These are mainly comprised of homicides and drug-induced deaths which are the only two causes for which INSERM receives very inadequate reports.

The Paris Centre presented a description (ESS/ICD/C/95.31) of a new death certificate to be trialed while legislative modifications are taking place. The new death certificate will conform to the international model. Two methods of presenting the certificate are to be piloted in France using sample case histories. One method of presentation has the certificate printed with examples on the same document, the other provides multiple certificates in a booklet format which will include completion instructions. The pilot aims to determine, with physician involvement, the preferred certificate format before a new certificate is introduced in 1996. A further evaluation will be made in 1996, focusing on results from both old and new style certificates, in order to ensure that the effects of ICD-10 implementation in 1997 do not contaminate the results. In terms of evaluation criteria, it was suggested to assess the number of certificates where the general principle applies. In France this is currently approximately 65% and an increase to 75% would be hoped for if the new approach was effective.

It was reported that similar work is happening in England, where OPCS is testing a new layout for the death certificate. This has been designed for easier completion and is accompanied by new guidance notes. It is being tested in five hospitals and five general practices. Some 2000 deaths have now been recorded using the new layout. The point was made that testing whether the form is easier to complete is relatively non-problematic; testing whether the quality of death certificate information is improved as a result is much harder. This may be approached by OPCS by evaluating the percentage of deaths ascribed to non-specific causes.

Additional methods were suggested including: assessment of the number of reported conditions and of what types of modification rules are invoked to reach the underlying cause of death; analysis of the distribution of causes of death recorded in Part 1 as opposed to Part 2 before and after implementation of a new form; and analysis of the rate of enquiry concerning death certificates, which should reduce with improved quality of certification.

It was noted that Denmark is also addressing the issue of death certificate redesign but uses a different certificate, including details of the circumstances surrounding the death and autopsy results.

The Office of the ICD, Japan (ESS/ICD/C/95.35) described changes now made to the death certificate and some early statistical results based on ICD-10. Instructions are now provided on the certificate to indicate that symptoms and mode of dying are not to be entered and conformity with the 1990 World Health Assembly recommendations had been achieved by the addition of a fourth line to Part 1. The adoption of the ICD-10 Rule 3 has produced expected changes in the data, particularly in terms of pneumonia and cerebrovascular disease. There have also been reductions in the areas of heart disease, hepatitis, cirrhosis and an increase in diabetes mellitus. It was not clear whether this last was due to the adoption of Rule 3 or to the presence of the additional line on the death certificate. It was reported, however, that a 14% increase in diabetes deaths had been experienced in the United States when a fourth line was introduced in 1989.

A paper (ESS/ICD/C/95.45) from the North American Centre described the re-engineering of the United States death registration system. This issue is being addressed particularly due to the rapid development of automation which facilitates moving from paper to electronic records. It was noted that private software companies have already moved into the area of software provision for birth registration. The National Center for Health Statistics (NCHS) decided to seize the opportunity in death registration to set standards for systems. This will have the benefit of improving the quality of data by facilitating greater consistency. It will also improve timeliness and reduce the effort required from NCHS.

A broad specification has been developed which includes the requirement for systems to be at the level of the certifier and to meet the needs of legitimate key players, including their varying needs in terms of speed of access to the data. It must also support differing circumstances surrounding death. It should be interactive and contain prompts and edits. It was noted that the role of hospital records in relation to cause of death was considered but the link was found to be less than was hoped for. The records do not contain sufficient information to substitute the certificate.

It is planned that the electronic verification of consistency will be performed by using a central server to convert text to code and perform cross checks. The MICAR/TRANSAX/ACME system is now PC-based but although this provides the facility for immediate coding and editing this scenario would present problems in terms of updating. The server would overcome this issue with edits and queries performed on-line.

In discussion, it was explained that the death certificate in Denmark will be designed so it can be scanned using optical character readers. The death certificate is a legal document, however, and paper copies are also necessary. It is hoped to store this information on CD-ROM by mid-1996 and an update will be provided at a future meeting. In France, there is a two-part registration process and some of the information comes from the National Bureau of Statistics. Once the new certificates become a legal document in France, they will be required to be archived for in excess of ten years. Sweden recently introduced a two-tier system similar to the United States proposals in terms of supporting differing speeds of access, but has no evaluation results yet. In the United Kingdom, the situation is different in that clinicians write the death certificate but registration is electronically captured via distributed registration software owned by OPCS. The data are submitted to OPCS on disc and coded by OPCS using Automated Cause Coding (ACCS) software. Australia advised that much standardisation of recording practices has been achieved but some inconsistencies still remain. Data is supplied mostly on disc to one coding bureau which works with and through state registrars in making enquiries. Registrars have recently agreed to warehouse their data centrally; this will give easier access to the data as the eight separate states will not have to be approached by the central office. This should also improve consistency of coding of causes of death.

The effects of changes to the death certificate on mortality data were considered to be significant and it was agreed that ways should be sought to annotate data provided to WHO by governments, with details of changes and their likely effects so that these could be taken into account when using and publishing the data. It was noted that Sweden, France, Japan, the United States, Australia, the United Kingdom, Denmark, and Brazil are all modifying or planning to modify their death certificates. A strong suggestion was made that a series of informative articles based on the meetings' discussions and papers be prepared and published in both the WHO World Health Statistics Quarterly and, if possible, in the International Journal of Epidemiology. The London Centre agreed to coordinate development of a series of articles.

8.2 Improvement of morbidity data

The North American Center presented an evaluation of ICD-10 for morbidity reporting in the United States (ESS/ICD/C/95.41). The evaluation was designed to assess whether ICD-10 was a significant improvement for morbidity as well as for mortality, and hence whether the investment in its implementation was justified. ICD-10 was compared in detail with ICD-9-CM. The document outlined the type of recommendations made for modifying ICD-10 for use in the United States. Recommendations included removing certain guidelines and rubrics considered not suited to morbidity coding or considered redundant. Also, since a procedure classification is being developed, ICD-10 categories representing procedures (such as O80-O84 Delivery) were recommended for deletion. A number of new four-character codes were recommended for addition to provide further clinical detail. Complete copies of the current draft proposals for modification of ICD-10 were provided and comments were welcomed. The full evaluation report should be completed by the end of 1995 and copies will be provided to the Secretariat for comment. Once approved by the relevant authorities, the "ICD-10-CM" is expected to be implemented in the United States in the year 2000.

It was pointed out that the addition of four-character rubrics violated an agreed principle for modification of the ICD. The North American Center acknowledged this concern but indicated that the United States government agreement with WHO permits the addition of such codes when it is not possible to achieve objectives through other means. Such proposals for changes would be limited to a minimum. It was suggested that any changes adopted by the United States could be proposed as updates to the full ICD in due course. A question was raised regarding whether changes in the morbidity codes would also be incorporated in the United States software for automatic cause coding of mortality data, since this could produce unexpected effects for other countries expecting to use the next version of this software. The North American Center expected this to be discussed by the proposed users' group for the automatic system.

The North American Center also presented a tentative proposal (ESS/ICD/C/95.42) to modify ICD-10 poisoning codes (T36-T50) to identify the circumstances through an additional digit for the purpose of morbidity reporting. The intent was to improve compliance with the rules for reporting external causes of injury, since this was a public health problem of considerable importance. Codes for external causes of injury were reported to be perceived by many as unnecessary since they did not affect cost reimbursement in the United States.

In discussion of the proposal, it was pointed out that audit studies show that physicians often fail to record the relevant detail for this coding. A variety of methods of recording pharmaceutical products were reported by meeting participants, for example the Nordic countries use an additional pharmacological code, updated annually, for poisoning and drugs. All 4-digit codes except x.0 and x.9 in the range T36-T50 had been deactivated, and the extra code for the drug involved had to be assigned in order to complete the coding of a case. It was pointed out that the American Hospital Formulary contains similar detail and can be mapped to ICD-9-CM codes, but cannot be used by hospitals in making claims for reimbursement, hence the need for additional codes. The proposal had aroused controversy because it deviates from the reporting of other external causes. The Australian Centre mentioned plans to include a classification of devices as well as drugs into hospital information systems, in order to permit surveillance of adverse reactions to them.

The North American Centre reported (ESS/ICD/C/95.44) on the development of guidelines for morbidity reporting of external causes of injury. There is currently no national requirement for injury E codes. A few states had required this, and many more did so now that more space was provided on the relevant forms. The aim was to improve and standardise the reporting of such causes of injuries and to encourage their reporting nationally. An important example of the public health relevance of such codes was in the Indian Health Service, where such data had enabled preventive developments such as the building of new roads to reduce accidents. Comments were invited on new guidelines that had been developed for coding these diagnoses: these were attached to the paper.

The Nordic Centre suggested choosing the E code relevant to the main condition if there were more than one. The London Centre recommended using successive fields for the codes for main diagnosis and any associated E code. Participants were referred to pp 29-30 of document ESS/ICD/C/95.16 on the utility of ICD-10 for accidents in the Netherlands, both for in-patients and out-patients. The Nordic Centre added that the Nordic Medical Statistics Committee (NOMESCO) had developed codes for out-patient and emergency room applications. A third edition was being prepared with WHO Headquarters, and a report would be given at a subsequent meeting of Centre Heads.

9. Special studies

9.1 Bridge studies

The Nordic Centre presented the results of a Danish study of bridge coding of 5,000 death certificates between ICD-8 and ICD-10 (ESS/ICD/C/95.33). Denmark had never used ICD-9. The study examined the previously untested assumption that central coding of all death certificates by three coders with many years' experience produced data

of high quality and consistency. The study showed that there was unexpectedly large instability in the coding of underlying cause of death which could not simply be related to the change in ICD revisions. This suggested that retraining of the coders would be helpful, and that the eventual use of automatic coding would improve consistency. The short list of causes used for mortality statistics would also need to be completely revised.

It was asked whether other countries had plans for bridge coding between ICD-9 and ICD-10. Some were planned and in addition those countries using automatic encoding under ICD-9 and retaining the natural language text would be able to carry out bridge coding retrospectively.

The Australian Centre reminded the meeting that this study demonstrated that the quality of data was only known when it was tested; that automatic coding might give the wrong answers, but would at least be consistent, and that original text should be preserved by Centres using automatic coding, both to enable revision if errors in the software came to light, and especially to allow bridge coding with future revisions.

9.2 Coding, tabulation, and analysis of multiple causes of death

A paper presented by the North American Centre (ESS/ICD/C/95.21) described issues, considerations and examples in the use of multiple cause of death data in United States Government statistics. The important work in France and Sweden in this area was recognised. As background, the point was made that international death certification was designed to obtain underlying cause of death only and not all co-morbid conditions present at the time of death and the certificate was designed as a questionnaire to lead physicians to the underlying cause accurately. This all had the effect that all other conditions reported by physicians to arrive at an underlying cause of death were lost.

The paper described what the United States does in the area of multiple cause of death statistics. It covered the history of the system and the evolution of the software. Since 1968 multiple cause coded data had been produced as a part of routine statistics, using electronic software (ACME and TRANSAX). This had not reduced costs but the benefit had been greater consistency in selection practices. The NCHS are looking for international collaboration with anyone using TRANSAX software. This is due to the fact that the logic in the software has an effect of losing detail. This happens when the move is made from the entity axis to record axis codes. Examples of this were provided. Basically entity axis codes represent all conditions reported by the clinician, record axis codes are the subset produced as a result of the application of the TRANSAX logic. Table 1 of the paper was discussed and a key example drawn from it showing four times as many death certificates on which diabetes is mentioned as there are where it is listed as the underlying cause of death.

The main objective of the paper was to form a United States perspective on what they thought could be done by WHO and the Collaborating Centres in establishing standards for publishing multiple and underlying causes of death. Research in this area is covered in the paper. Responses were that the data should be regularly published, that international presentation standards would be useful, though underlying cause of death needs to remain the primary focus for tabulation. Also, the entity/record axis code differentiation was considered useful, but in need of modification. There should be international recommendations regarding regular tabulation of multiple cause data. There should also be international rules for creating these data. TRANSAX was considered a useful start in this area but help was deemed necessary to make it more so. Lastly the maturation of this data set, with 3 or more conditions being recorded on significant numbers of certificates, argues strongly for international guidelines to promote the use and comparability of these data.

The main Nordic comment on this paper was that they did not support TRANSAX without modification as the international standard. Since 1987 certification in Sweden had been done to reflect all diagnoses and their sequence. A 1983 test of TRANSAX decided against its use due to the decrease of information beyond an acceptable level. Sweden used the modifications prescribed by the ICD instead and found ACME worked better on that basis than when used in conjunction with TRANSAX. Sweden did agree however that TRANSAX could become an acceptable international standard if the logic was changed. A formal, workable definition of multiple causes of death was also required.

It was noted that this analysis had been of great help in identifying inconsistencies in selection of underlying cause of death.

A paper (ESS/ICD/C/95.28) from the London Centre described the implications of an automated cause coding system (ACCS) for mortality in England and Wales. The paper did not address multiple cause coding as such, but was relevant to that issue.

United States software is embedded in the ACCS. The system was introduced as part of a wider change in the handling and analysis of death registration, including dissemination of registration software to allow electronic capture of data in the field. The clinician writes the death certificate, and passes it to the next of kin or other "informant" who passes it to the registrar, who then collects demographic data from the informant and compiles the whole into a draft death entry. This is now largely automated and discs are sent centrally, where the coding is carried out. There was no opportunity for peripheral data capture to help the physician improve the quality of certification.

The paper contained a diagrammatic representation of the system, which was explained. The comment was made that there was no access to the reason for rejects. The system is something of a black box therefore. Rejects are entered manually. Manual and automated systems were not run in parallel so an equivalent to bridge coding is not available.

The paper also described how in 1983 OPCS contravened Rule 3 and allowed many more associations between immediate and underlying causes to be made. The effects of this are demonstrated within the paper showing age-standardised death rates per million population (not per 100,000 as printed).

In 1993 the United States software was implemented, and so an automatic reversal of Rule 3 occurred as the software incorporates the standard WHO approach. The data showed associated increases and decreases at the 1983 and 1993 points, and this is graphically demonstrated in the paper.

The Paris Centre presented preliminary findings from a collaborative study of multiple cause analysis of mortality (ESS/ICD/C/95.29). Brazil, France, Latvia, Russia, and Sweden had contributed data to date. Tables showed what information had been coded as well as ratios of mentions to underlying causes for various groups of diseases. Thirteen ways of tabulating the data, of which seven might become routine, were proposed. The latter were:

- . mean number of conditions in Part I and in Part II
- . mean number of conditions reported by, age
- . mean number of conditions coded, by age
- . proportion of certificates with a single imprecise cause, by age
- . proportion of certificates with 799.9 as a single cause, by age
- . ratio of mention of a cause to selection as underlying cause, by cause
- . nature of injury and poisoning for violent deaths, by code

The Paris Centre proposed extending the descriptive analyses to more countries, preferably at least one per centre. A further extension would be to study differences in international mortality by comparing analyses with multiple causes to traditional analyses with a single underlying cause. That would need a small group of motivated countries.

The Secretariat pointed out how such tables immediately highlighted international variations in certification practice. The Nordic Centre welcomed the first results of the international collaboration, which provided valuable insight. They asked for more detailed analyses.

They noted that Denmark and some other countries would not be able routinely to separate "coded" from "reported" conditions. The Secretariat suggested it would be valuable to tabulate the number of reported causes in Table 3 separately for violent and non-violent deaths, since violent deaths often generated large numbers of causes.

9.3 Other studies

A Sao Paulo Centre cross-sectional study (ESS/ICD/C/95.23) of the classification of diseases in mental health carried out in Sao Paulo, Brazil was presented to the meeting. The aim of the study was to determine the prevalence of mental disorders in an epidemiologic catchment area. Prevalence was obtained by means of a WHO questionnaire, the Composite International Diagnosis Interview (CIDI) applied by non-physicians. Cases were classified according to both DSM-III-R and ICD-10 by computer program. From the study it would seem that F17.2 (Tobacco dependence) is more inclusive in ICD-10 than in DSM-III-R. Also F00 (Organic brain syndrome) was applied to many people with low literacy and to manual workers. This seems to arise from the fact that parts of the CIDI are not adequate for all cultures. Preliminary results show a high prevalence of depression and the grouping of mood disorders to be adequate.

A paper (ESS/ICD/C/95.24) was presented on behalf of the Sao Paulo Centre which dealt with the question of the utility of the HIV disease (AIDS) codes in ICD-10. Each country using ICD-10 has the option of using either the coding structure provided in the classification (i.e. five three-character categories and their corresponding fourth character detail) or using two codes, one which is general (B24, Unspecified human immunodeficiency virus [HIV] disease) and the other which describes a disease complication of AIDS.

The project involved the application of the ICD-10 codes to almost 1300 surveillance records of new cases treated in a hospital during 1994. The results showed that for cases of AIDS, not deaths, the published ICD-10 coding structure was not adequate to reflect many important complications, such as diarrhoea and nervous system disorders. The conclusion was that double coding is preferable to using the ICD-10 structure, at least for reflecting the information on medical records.

A paper (ESS/ICD/C/95.25) from the Sao Paulo Centre on statistical implications of the change in definition of the perinatal period with adoption of ICD-10 was presented. The definition of stillbirth had been widened from commencement at 28 weeks of gestation to 22 weeks. The paper expressed concern that the change would destroy comparability of perinatal statistics.

The Secretariat noted that more than 80% of questions on perinatal mortality related to definitions, and greater clarity could be useful. It was important that perinatal mortality remain an indicator for international comparisons. It seemed there had been a misunderstanding, and that while ICD-10 recommended collection of stillbirth data from 22 weeks or 500 grams, it still proposed that publication for international comparisons be from 28 weeks or 1000 grams. It was agreed the Secretariat would write to the Sao Paulo Centre with this explanation.

10. Other business

10.1 Improving the functioning of the meeting

Delegates were reminded of the difficulty for the Chair, the Secretariat, and all delegates if papers were not distributed sufficiently early. It was suggested that papers ideally needed to be distributed at least six weeks before the meeting through the Secretariat in WHO Headquarters, or by direct mail or fax to all participants at least four weeks before the meeting. If these deadlines could not be met, Centre Heads should make every effort to fax papers before the meeting, in addition to bringing sufficient copies personally. It was agreed that these arrangements would greatly facilitate preparations for the meeting.

It was also agreed unanimously that all participants should receive an agenda showing which papers were to be discussed under each agenda item.

It was agreed WHO could arrange translation of papers from its official languages into English if submitted sufficiently early.

A suggestion that the report of the meeting be circulated more widely, for example to all countries, was supported. The Secretariat undertook to identify a suitable distribution list.

It was agreed the report should be accompanied by an "Action list" to improve follow-up of decisions of the meeting.

The value of coordinated publication of reports of collaborative research had been mentioned earlier in the meeting. This would broaden the impact of work of the Centres; it was suggested for the multiple cause projects and for those relating to improvements in medical certification of cause of death. Coordinated publication would require an agreeable editor and at least one Centre being willing to lead a group of centres.

Terms of reference of the Heads of Centres meetings were not widely known. They had last been agreed at the Sao Paulo meeting (SES/ICD/C/91.26). A copy was distributed to delegates. It was noted that when votes were taken at the meeting, only Centre Heads or their designate had a vote; WHO Regional Office representatives did not.

Since each Centre represented either a language group or geographical area, Centre Heads were reminded of the need to communicate with their "constituent" countries.

10.2 The role of WHO Headquarters

In his address to participants at the opening of the meeting, Dr. Hapsara had acknowledged the classification of diseases as an important tool for ensuring the quality of data. The meeting endorsed this view. While collaborating centres willingly continue to carry out their responsibilities, the meeting stressed the need for continuing coordination and cooperation in the area of ICD activities from WHO Headquarters. Concern was expressed regarding maintaining and enhancing support in this area.

10.3 Female genital mutilation

A recent WHO Technical Working Group on female genital mutilation had been surprised to find no reference to these practices in ICD-10. A definition and four categories of female genital mutilation were provided to the meeting. The Centre Heads were asked to review both the definition and the classification and to inform the Secretariat, as soon as possible, of any observations they may have and to make recommendations concerning their possible inclusion in the first round of updates to ICD-10.

10.4 Euthanasia

The Australian Centre asked for advice on how this should be coded, and the North American Centre indicated it also might need this advice in the future. The Secretariat indicated it was a procedure, and the underlying cause of death was the condition for which it was performed. The WCC noted that an extra category of unnatural assisted death had been derived for the Netherlands, and agreed to circulate a document on this.

11. Date and place of next meeting

The location of meetings since 1986 was reviewed. The Office of the ICD, Japan will host the next meeting in Tokyo from 15-21 October 1996. The Kuwait Centre indicated that it was not yet ready to host a meeting, so the 1997 meeting will be hosted by either the Moscow Centre or the Nordic Centre.

Action SummaryAll Centres

- provide requests for ICD-10 updates to the Secretariat by the end of March 1996;
- send comments on the guidelines for morbidity reporting of external causes of injury attached to paper ESS/ICD/C/95.44 to the North American Center;
- send papers for the next meeting to the Secretariat at least six weeks in advance of the meeting or by direct mail or fax to all participants at least four weeks before the meeting. If these deadlines cannot be met Centre Heads should make every effort to fax papers before the meeting in addition to bringing sufficient copies personally;
- inform the Secretariat of any observations on the definition and classification of female genital mutilation and make recommendations concerning their possible inclusion in the first round of updates for ICD-10;

London Centre

- provide the Secretariat and other Collaborating Centres with details of the most frequent questions and coding queries addressed to the ICD-10 morbidity help desk together with the answers that were given;
- explore the possibility of making available to other Centres and the Secretariat a variety of additional ICD-10 training and support materials on diskette;
- supply Centres and the Secretariat with details of the ICIDH concepts contained in the NHSCCC thesaurus;
- coordinate development of a series of articles on the effects of changes to the death certificate and other system changes on mortality data.

North American Center

- make United States ICD-10 mortality short lists available to other centres through the Secretariat;
- provide the Secretariat with a copy of the full evaluation report on ICD-10 for comment.

Dutch WCC

- provide the Secretariat and Centre Heads with a copy of the document on unnatural assisted death.

Secretariat

- identify, with the Regional Offices, the need for further TENDON training courses as well as the need for translation of TENDON in other languages;
- include ICD-10 mortality training and computer-assisted coding software on future agendas;
- produce a paper relating to guidelines for lay reporting for presentation at the next Centre Heads meeting;
- keep Centre Heads informed in a timely manner of future translation rights and publication agreements;
- prepare draft instruments for the transmission of requests for code assignments for ICD-10 as well as proposals for updating between revisions to be considered at the next Centre Heads meeting;
- respond to North American Centre's written questions on the application of Rule 3;
- report on the use (or otherwise) of the dagger and asterisk system in national language versions of ICD-10 to the next meeting of Centre Heads;
- write to the Sao Paulo Centre regarding ESS/ICD/C/95.25;
- for future meetings provide all participants with an agenda showing which papers will be discussed under each item;
- identify a suitable distribution list to ensure a wider dissemination of reports of Centre Heads meetings.

Proposed Implementation Dates of ICD-10

(update of report page 11 of Caracas meeting, WHO/ESS/ICD/C/94.33)

CENTRE	COUNTRY	MORTALITY	MORBIDITY
Caracas*	Venezuela Spanish-speaking Latin America	1995 or 1996 Mainly 1996	1997 1996-1998
North America	USA Canada English-speaking Caribbean	1998 1998 1995?	2000 Before 2000 1996
Kuwait	Kuwait Arabic-speaking countries	1996** ?	1996 ?
Paris	France Other French-speaking countries	1997 or 1998 ?	1996** ?
Australia	Australia New Zealand	1998 1998	July 1998 July 1998
Nordic	Denmark Sweden Norway Finland Iceland	1994 1997** 1996 1996 1996**	1994 1997** 1997** 1996 1997**
Japan	Japan	1995	1996
London	England & Wales Scotland Northern Ireland	1998 1998** 1998**	1995 1996 1996
Sao Paolo	Brazil Other Portuguese- speaking countries	1996 ?	1996 ?
SEARO Region	Thailand Others***	1993 ***	1995 ***
Moscow	Russia	1997	1997
Beijing	China	2000+	2000+
Dutch WCC	Netherlands Other Dutch-speaking countries	1996** ?	1998-2000** ?

- * not represented at 1995 meeting nor reported on progress
 ** change, usually deferral, from report to Caracas meeting
 *** interest expressed by some countries for selective introduction
 from 1997

Extract from ESS/ICD/C/94.33

9. Updating between revisions

It was agreed that there are a number of types of situations which could generate requests for updating and that each of these might require a different type of solution. These included: new conditions which, as medical knowledge evolves, would merit assignment to a temporary code in the U section of ICD-10; new descriptions or synonyms for conditions already assigned to an ICD-10 category which might be added to the index; requests to further subdivide existing categories for retrieval of specific conditions, which might be handled through a temporary code in the U section which could later be added back into the existing category for statistical purposes; conditions with newly recognised etiologies which might warrant a change in their assignment in ICD-10 (or in a later revision); and correction of errors in ICD-10 assignment.

As ICD-10 is now coming into use, the method of putting the updating process into operation was discussed in detail. It was agreed that anyone using the classification could propose or request an update. Such requests, with the support and cooperation of WHO Regional Offices, should be collected and screened by one of the Collaborating Centres. Proposals should be forwarded to the Secretariat and to the other Collaborating Centres, along with a recommendation from the originating Centre, for comments and review at the next Heads of Centre meeting before a final decision is taken. It was noted that some proposals, based upon incomplete knowledge or understanding of the classification, could be responded to directly by the Centre and would not require further action. The importance of mechanisms to ensure open communication between Centres, countries, WHO Regional Offices, etc. was stressed.

In discussing a timetable for handling update requests, reference was made to the report of the Beijing Heads of Centres meeting (SES/ICD/C/92.32) which stated: "Requests received by October of a given year would be considered at the next Centre Heads meeting (usually held in March or April of the following year). After providing an early preliminary response to the requesting authority, the Secretariat would review proposals and seek advice from Collaborating Centres and other expert consultants. The Secretariat would prepare and disseminate a summary of responses and recommendations prior to the Centre Heads meeting. Updates accepted at the Centre Heads meeting would be disseminated to national authorities as rapidly as possible to allow implementation from 1 January of the following year."

Although Centre Heads meetings are not always held in March or April, the timetable was deemed to continue to be appropriate by replacing the October deadline with one six months prior to the next Centre Heads meeting.

With respect to dissemination of updates to ICD-10, this continues to be an issue for further research and testing. Electronic dissemination through bulletin boards was mentioned as a possible addition to published notices in the World Health Statistics Quarterly, newsletters from Collaborating Centres, reports of Centre Heads meetings, etc. The issue of common implementation dates of updates and

common interpretation of ICD-10 internationally was stressed. It was also noted that feedback should be provided to those requesting updates, either to indicate acceptance of their proposal or non-acceptance with an explanation of the reasons why.

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Documents

ESS/ICD/C/95.1	Draft Agenda
ESS/ICD/C/95.2	List of Participants
ESS/ICD/C/95.3	List of Documents
ESS/ICD/C/95.4	Annual Report of ESS Unit Activities on ICD
ESS/ICD/C/95.5	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases, Australia, 1995
ESS/ICD/C/95.6	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases in Portuguese, Brazil, 1995
ESS/ICD/C/95.7	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases, China, 1995
ESS/ICD/C/95.8	Annual Report of the WHO Collaborating Centre for the Classification of Diseases, England, 1995
ESS/ICD/C/95.9	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases in French, France, 1995

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ESS/ICD/C/95.10	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases in Arabic, Kuwait, 1995
ESS/ICD/C/95.11	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases, Russia, 1995
ESS/ICD/C/95.12	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases in the Nordic Countries, Sweden, 1995
ESS/ICD/C/95.13	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases for North America, USA, 1995
ESS/ICD/C/95.14	Annual Report of the Activities of the WHO Collaborating Centre for the Classification of Diseases, CEVECE, Venezuela, 1995 (not received)
ESS/ICD/C/95.15	Annual Report of the Activities of the ICD Office, Statistics and Information Department, Ministry of Health and Welfare, Japan, 1995
ESS/ICD/C/95.16	Annual Report of the Activities of the WCC, Dutch Classification and Terminology Committee for Health, The Netherlands, 1995
ESS/ICD/C/95.17-20	Not used
ESS/ICD/C/99.21	Issues, Considerations and Examples in the Use of Multiple Cause-of-Death Data in U.S. Government Statistics
ESS/ICD/C/95.22	Licences Granted for the Translation of ICD-10 and Specialty-based Adaptations by ESS Unit
ESS/ICD/C/95.23	Classification of Diseases in Mental Health: A Cross-Sectional Study in Sao Paulo, Brazil
ESS/ICD/C/95.24	Evaluation of ICD-10 Use in AIDS in Sao Paulo, Brazil
ESS/ICD/C/95.25	The Change in the Definition of Perinatal Period from ICD-9 to ICD-10: Statistical Implications, WHO Collaborating Centre for the Classification of Diseases in Portuguese, Sao Paulo

- ESS/ICD/C/95.26 Maternal Mortality Audit System in Sao Paulo, Brazil
- ESS/ICD/C/95.27 Some Practices on Popularizing and using ICD in China
- ESS/ICD/C/95.28 The Implementation of an Automated Cause Coding System for Mortality in England and Wales
- ESS/ICD/C/95.29 The Collaborative International Study on Multiple Causes Analysis, WHO Collaborating Centre for the Classification of Diseases in French
- ESS/ICD/C/95.30 Contribution of a Forensic Institute for the Knowledge of Mortality Causes in a French Region
- ESS/ICD/C/95.31 Improvement of the Medical Certification in France
- ESS/ICD/C/95.32 Use of Dagger-Asterisk Codes in ICD-10: Review and Recommendations, WHO Collaborating Centre for the Classification of Diseases in the Nordic Countries
- ESS/ICD/C/95.33 Bridge Coding Between ICD-8 and ICD-10 of 5000 Death Certificates, Danish National Board of Health
- ESS/ICD/C/95.34 ICD-10 in Morbidity Coding in Danish Hospitals 1994-95
(not received)
- ESS/ICD/C/95.35 Improvement of Medical Certificate of Cause of Death After Changing the Form of the Japanese Medical Certificate
- ESS/ICD/C/95.36 Activities of the ICIDH Revision, 1995, The WCC, Dutch Classification and Terminology Committee for Health, Zoetermeer
- ESS/ICD/C/95.37 Note on the Dutch Version and Implementation of ICD-10 in the Netherlands
- ESS/ICD/C/95.38 Note on the EFCC-Project Development of the Common Reference Model for (Surgical) Procedures, The WCC, Dutch Classification and Terminology Committee for Health, Zoetermeer

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- ESS/ICD/C/95.39 Note on the Specialty-Based Adaptations of ICD-10 in Dutch
- ESS/ICD/C/95.40 Review and Comment Concerning the Dagger/Asterisk System in ICD-10, WHO Collaborating Center for the Classification of Diseases for North America
- ESS/ICD/C/95.41 Report on ICD-10 Evaluation for Morbidity Reporting in the United States
- ESS/ICD/C/95.42 A Proposal for Combining the ICD-10 Poisoning Codes for Morbidity Reporting, WHO Collaborating Center for the Classification of Diseases for North America
- ESS/ICD/C/95.43 Report on the Updating Procedure for ICD-10, WHO Collaborating Center for the Classification of Diseases for North America
- ESS/ICD/C/95.44 The Development of Guidelines for Morbidity Reporting of External Cause of Injury, WHO Collaborating Center for the Classification of Diseases for North America
- ESS/ICD/C/95.45 Re-engineering the U.S. Death Registration System
- ESS/ICD/C/95.46 International Classification of Impairments, Disabilities, and Handicaps: Recent Activities, WHO Collaborating Center for the Classification of Diseases for North America
- ESS/ICD/C/95.47 Review of the ICD-10 Implementation of the WHO European Region, WHO Regional Office for Europe, Copenhagen
- ESS/ICD/C/95.48 Report of Meeting