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

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14-20 October, 1997

**WHO Long-term Strategy for the Development and Management
of Health-Related Classifications**

Note: this revised long-term strategy is based on a first draft prepared by the secretariat taking into account the recommendations of the annual meeting of Heads of WHO Collaborating Centres for the Classification of Diseases held in Copenhagen, Denmark from 14 to 20 October 1997

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WHO Long-term Strategy for the Development and Management of Health-related Classifications

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EXECUTIVE SUMMARY

In the introduction to this document, the history of the ICD is briefly reviewed and the basis for WHO's responsibilities in maintaining and updating the ICD, as provided in the WHO Constitution, is noted. The objectives of the long-term strategy are to assist WHO to identify changing needs for the ICD (and related classifications and tools) and the Organization's ability to respond to them into the 21st Century. The strategy builds on recommendations of the 1989 International Revision Conference, the Forty-third World Health Assembly in 1990, annual meetings of Heads of WHO Collaborating Centres for the Classification of Diseases (particularly the meeting in October 1997), and the expressed needs of Member States and other users of the ICD.

In a review of current status, the growth of the use of the ICD for a variety of purposes and the growing use of information technology, including the Internet, are described in relation to changing resources at WHO and their impact on traditional ICD-support mechanisms. The importance of the ICD to HST and other WHO programmes as well as to national health information systems is addressed.

A number of strategic issues affecting the long-term strategy are identified, including:

- the family of classifications and the level of HST involvement in the development and maintenance of family members;
- the future of the core classification (the ICD-10) and its immediate derivatives in terms of periodic updating and ongoing maintenance and support;
- the promotion and expanded implementation of ICD-10 worldwide;
- the role of the WHO Collaborating Centres for the Classification of Diseases; and
- the resources required.

A plan of action until the year 2010 has been developed. It focusses on three following main areas which are seen to be of high priority in the short term:

- promoting and implementing ICD-10;
- updating the ICD-10 (and related classifications and tools); and
- activities related to the family of classifications.

In addressing these areas, specific activities are identified for action and follow-up and the roles and responsibilities of HST, the Regional Offices, and the Collaborating Centres are explored. The Heads of the Collaborating Centres, after discussing a draft of this long-term strategy, committed themselves to working in partnership with WHO to achieve a common workplan. In implementing this strategy, further discussion will be required between HST and the Collaborating Centres and between HST and other areas within WHO. In order to carry out the plan of action, there is a requirement for the commitment of additional resources (both human and financial) to support and enhance WHO's classification activities which are the foundation for much of its work and are critical to the development and enhancement of health information systems at the national, regional, and international levels.

I. INTRODUCTION

A. Background

The International Classification of Diseases (ICD) is a statistical classification used for the quantitative study of illness, related morbid conditions, and death. The importance of such a systematic classification was recognized as early as the 17th century in the work of John Graunt in the analyses of the London Bills of Mortality and in the early 18th century in the classifications of de Lacroix (Sauvages), Linnæus, and Cullen. However, the present form of the ICD can best be traced stemming from the work of William Farr who became the first medical statistician of the newly-established General Register Office of England and Wales in 1837. Farr proposed principles for a uniform statistical classification of mortality that have, in many instances, persisted to this day in spite of the several changes in governance and in form which have subsequently taken place in the classification. The concept of a uniform classification attracted the attention of the International Statistical Congress and its successor, the International Statistical Institute, under whose ægis the classification evolved based on work by Farr, d'Espine, Bertillon, and others. Over time, the responsibility for the development, maintenance, and improvement of the ICD passed from the International Statistical Congress and the International Statistical Institute (ISI) to a Mixed Commission comprised of representatives of the ISI and the Health Organization of the League of Nations, and finally to the World Health Organization.

The basis for WHO's responsibilities for the ICD and related health classifications can be found in the Organization's Constitution. Chapter II, Article 2 lists, *inter alia*, the following subparagraph functions¹:

- c) to assist Governments, upon request, in strengthening health services;
- f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;
- q) to provide information, counsel, and assistance in the field of health;
- s) to establish and revise as necessary international nomenclatures of diseases, of causes of death, and of public health practices.

B. Objectives

In view of WHO's constitutionally-mandated functional responsibilities to the support of health statistical services including the development, maintenance and use of relevant statistical classifications, this long-term strategy is developed to assist in the Organization's distribution of scarce resources to carry out those ICD activities necessary for the fulfillment of health statistical objectives, both of the Organization itself and of Member States. *The International Statistical Classification of Diseases and Related Health Problems* is virtually universal in its acceptance as

¹*Basic Documents, Forty-first Edition*, Geneva, World Health Organization, 1996, pp 2-3.

a standard statistical tool, essential at the international, national and local levels for the quantification of mortality, morbidity, and related health problems.

The classification is at a threshold as the 21st century approaches; new demands for information, and new technologies for capturing, storing, retrieving, and disseminating information suggest this as an appropriate moment in the "life" of the ICD to step back and take a fresh look at the process of developing, maintaining and supporting it. This plan will assist in the identification of changing needs and WHO's ability to respond to them.

C. Approach

The current strategy builds on the recommendations of the International Revision Conference², the decisions of the Forty-third World Health Assembly in 1990, discussions at recent annual meetings of the Heads of WHO Collaborating Centres for the Classification of Diseases³, evaluations by the secretariat of the status of various current and ongoing ICD-related tasks, and the requirements of Member States and other users of the classifications. A draft version of this strategy was developed and presented to the October 1997 meeting of Heads of Collaborating Centres. At that meeting, it served as a basis for discussion⁴. This version of the strategy takes into account those discussions and subsequent recommendations to the secretariat.

II. REVIEW OF CURRENT STATUS

As noted in the introduction to ICD-10⁵, the ICD has had an impressive history of development. While early revisions had been concerned only with causes of death, the scope of the classification had been extended at the Sixth Revision in 1948 to include non-fatal diseases. This extension has continued through the current version. In addition, there have been publications, on a trial basis, of supplementary classifications of procedures in medicine and of impairments, disabilities, and handicaps. Recognizing the expanding uses of the ICD, it was realized during the preparation of the Ninth Revision that the ICD alone could not cover all of the

²*International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*, Volume 1. Geneva, World Health Organization, 1992, pp. 11- 28.

³*c.f.* Meeting of Heads of WHO Collaborating Centres for the Classification of Diseases, Tokyo, Japan, 15-21 October 1996. Unpublished document WHO/HST/ICD/C/96.54. Geneva, World Health Organization, 1997.

⁴*c.f.* Meeting of Heads of WHO Collaborating Centres for the Classification of Diseases, Copenhagen, Denmark, 14-20 October 1997. Unpublished document WHO/HST/ICD/C/97.65. Geneva, World Health Organization, 1997.

⁵*International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*, Volume 1. Geneva, World Health Organization, 1992, p. 11.

needed health information and that a more practical concept might envisage a "family" of disease and health-related classifications to address different public health requirements, using the ICD at the three-character level as the central, or core, classification.

On a world-wide basis, there has been a growth of uses for the ICD, spreading from the original need to classify causes of death on to indexing and retrieval of hospital records, to hospital and general morbidity studies, as well as a rapidly emerging need for additional classifications needing coordination and compatibility with the ICD, such as the aforementioned classifications of procedures in medicine and of impairments, disabilities, and handicaps. This growth of uses and of classifications has also produced a tremendous growth in the number of users requiring support.

The infrastructure within WHO for supporting these additional applications has not kept pace with the demands nor has there been sufficient accommodation made for the increased diversity and complexity of the day-to-day work brought about by technological advances such as electronic dissemination of products on diskette, CD-ROM, and on the Internet as well as applications of ICD computer-based training. Completion of the actual revision of the ICD and publication of the volumes in English and French does not signal the completion of the related activities within HST. In addition to the work related to various language versions and applications of the classification, there is also much work to be done in support of the implementation and ongoing maintenance and periodic updating of the classification itself. In fact, resource constraints and other emerging health priorities have necessitated reductions in the WHO staffing levels for all of these activities. While there are many complex reasons for this to have happened, it is nevertheless a fact that ICD-related work was supported from the period 1948 to the early 1980's by a staff of eight, while today this staff consists of fewer than two full-time equivalents.

During that same period, the number of WHO Collaborating Centres for the Classification of Diseases has grown from the original centre in London to additional centres in Paris, Caracas and Moscow and then further expansion to Washington, São Paulo, Beijing, the Nordic countries, Canberra, and Kuwait; along with the Office of the ICD, Japan and the Dutch Centre for the Standardization of Informatics in Health Care (CSIZ) as regular participants at annual meetings. While it is correct that the expanded number of centres is a resource to WHO, especially in support of language or country specific applications of the ICD, it is also true that the expansion of the network has resulted in additional burdens for WHO staff through heightened ICD awareness in Member States with concomitant increases in new applications and expanded uses. For example, there are now over thirty national versions in use in addition to the English and French versions which are the responsibility of WHO Headquarters. Additionally, there has been an exponential increase in the use of the ICD for morbidity purposes, especially in French-speaking countries.

While it is difficult in retrospect to evaluate the need for a staff of as many as eight persons in the former ICD unit in the earlier years, it is not so difficult to see that the current level

of staffing is not adequate for the tasks. If some of the funds realized by the Organization from the personnel reductions had been left with the programme, it might have been possible for adequate amounts of alternative support to have been obtained through contractual services or other external sources of expertise, but this, too, is difficult to assess after the fact.

It is, however, possible to identify currently essential ICD-related activities (Annex 1), determine how, where, and when these should be carried out, and to prioritize them. On this basis, human and financial requirements can be estimated and a long-term strategy can be developed to rationalize programmatic needs with resource allocations.

It has been previously indicated that the antecedents to the present ICD were entrusted to WHO at its establishment and embodied in the WHO Constitution as a normative function. However, that does not imply any greater or lesser importance for the ICD than other constitutional functions. Clearly, ICD activities must remain relevant to the overall strategies of the Organization and be an integral part of its programmes at all levels.

The ICD and other health-related classifications (i.e., the "family of classifications") are an essential component of the Health Situation and Trend Assessment (HST) Programme which has responsibility for global health situation analysis and projection, strengthening of country health information (including health information systems which incorporate the ICD) and partnerships and coordination of epidemiology, statistics, and trend assessment. These classifications and the HST mortality database also contribute to global epidemiological surveillance, a function of the Emerging and other Communicable Diseases Surveillance and Control Programme. The ICD-based information also supports other technical programmes at WHO Headquarters and Regional Offices such as the Expanded Programme on Immunization; Health and Environment; Information System Management; the Special Programme of Research, Development and Research Training in Human Reproduction; and the Special Programme for Research and Training in Tropical Diseases. Epidemiological and statistical analyses, many of them heavily dependent on data related to causes of death, injuries, and illnesses derived from the ICD, contribute significantly to the formulation of the WHO health-for-all policy and strategy for the next century.

III. STRATEGIC ISSUES

During the review of the draft version of this strategy at the meeting of Heads of Collaborating Centres in October 1997, there was a general strategic discussion. The conclusions of this discussion were summarized as:

- the ICD programme is vitally important to a diverse range of customers and is used on a day-to-day basis;
- the world is changing rapidly with many impacts on health and health information and these will place many new demands on classifications;
- much will need to be done over the next few years if the position of ICD is to be maintained and protected; and

- improved ways of working must be found if success is to be achieved. These include:
 - working more effectively and efficiently together;
 - managing and coordinating the programme so that promises are delivered upon;
 - working with others who have the right skills and a common agenda; and
 - acquiring and developing new resources and skills.

It was agreed that HST, Collaborating Centres, Regional Offices, and national and specialty groups must work in partnership and commit themselves to a common work plan. In developing such a work plan, there are some concepts which must be further refined and some specific issues which must be addressed. These are developed in some detail below.

A. The Family of Classifications

1. Defining the concept(s)

In order to consider the entire scope of ICD-related activities that are relevant to current and future international and national needs, it is first necessary to define the family of classifications that should be included in the scope of work of WHO and of the Collaborating Centres.

The concept of a family of classifications was originally seen as a dynamic group of health-related statistical classifications based on the core ICD, dependent on definitions or statistical practices inherent to the ICD, or linked in some other fashion to the ICD. While this was a useful concept to establish WHO interest, involvement, and, in some instances, control of many health and health-related classifications, an amorphous and changing web of classifications requiring WHO involvement does not lend itself to assessment and planning for future WHO activities. Therefore, as an essential step in the development of a long-term plan, criteria for inclusion of a classification into the family and an explicit statement of WHO responsibilities for each class of "family" membership is required.

The Heads of WHO Collaborating Centres for the Classification of Diseases have previously provided some criteria for family membership⁶. They proposed that a classification can be accepted into the family of disease and health-related classifications when:

- it is supported/requested by a large number of Member States and/or an authoritative international organization
- it is of importance to WHO activities
- it is not in conflict with the ICD or other classifications in the family

⁶Meeting of Heads of WHO Collaborating Centres for the Classification of Diseases, São Paulo, Brazil, 9-15 April 1991. Unpublished document SES/ICD/C/91.26. Geneva, World Health Organization, 1991.

Subsequently, Centre Heads have discussed additional criteria such as ease of use, validity, and quality of input data but these additional criteria have not been formally proposed or adopted.

The general scheme of the family, as illustrated in the report of the ICD-10 Revision Conference (Annex 2), classifies disease and health-related classifications into five groups:

1. ICD three-character core classification and direct derivatives (i.e. ICD four-character classification, and short tabulation lists)
2. Specialty-based adaptations.
3. Information support to primary health care
4. Other health-related classifications
5. International Nomenclature of Diseases

Since all ICD-related activities stem from the core classification, each of the other family group's degree of relationship to the core classification should be one of the primary determinants of the required level of WHO/HST involvement and/or support.

Specialty-based adaptations - Specialty-based adaptations draw directly upon the existing three- and four-character structure of the ICD, but more detail is often given by means of fifth- or sometimes sixth-character subdivisions. Specialty-relevant sections or categories which may have been scattered throughout the ICD are usually brought together in one compact volume. Appropriate definitions, a glossary of terms, and an index are frequently part of such an adaptation.

Information support to primary health care - Definitions and methods of data collection and analyses at the local level in support of primary health care, including lay reporting and other community-based health information schemes have been closely linked to the ICD but are not directly linked to or derived from it.

Other health-related classifications - These classifications typically include health problems, impairments, disabilities, handicaps, reasons for encounter with the health care system, and medical and surgical procedures. While not directly based on the ICD, these classifications may have a link with a diagnosis classified in the ICD.

International Nomenclature of Diseases - This is a multi-volume publication⁷ which is related to, but not derived from, the ICD. The ICD is a statistical classification which groups similar conditions into mutually-exclusive categories in a hierarchical fashion, while a medical nomenclature is an exhaustive set of titles comprised of each known morbid condition. The concepts of classification and nomenclature are closely related because a nomenclature is often

⁷*International Nomenclature of Diseases*. Geneva, Council for International Organizations of Medical Sciences and World Health Organization, multiple volumes, various years.

arranged systematically and also serves as a primary source for the vocabulary used in a statistical classification.

When the issue of the family of classifications was again discussed by the Centre Heads in October 1997, there was agreement that this was a high priority for the short-term but one that could not be accomplished during that meeting. The Heads of Centres believed that the parameters for inclusion in the family of classifications must be revisited and refined by the Collaborating Centres and HST within the coming year and that once this was accomplished the adoption of guidelines for prioritizing work on family members could be undertaken. These tasks have, therefore, been included in the plan of action section of this paper where guidelines are proposed for determining the level of WHO/HST effort with regard to the various members of the family of classifications. It should be recognized, however, that newly-proposed classifications or changing circumstances might require deviations from the guidelines after appropriate consideration and decision by the Director, Division of Health Situation and Trend Assessment.

2. International classification of medical procedures

During the development of the Ninth Revision of the ICD, in response to requests from a number of Member States, WHO had drafted a classification of therapeutic, diagnostic and prophylactic procedures in medicine, covering surgery, radiology, laboratory and other procedures. Various national classifications of this kind had been studied and advice sought from hospital associations in a number of countries. The intention was to provide a tool for use in the analysis of health services provided to patients in hospitals, clinics, outpatient departments, etc. The Revision Conference recommended that the provisional procedures classifications should be published as supplements to, and not as integral parts of ICD-9, that they should be published in some inexpensive form, and that after two or three years' experience they be revised in the light of users' comments. WHO published the International Classification of Procedures in Medicine (ICPM) in 1978. It was adopted by some countries and used as a basis for national classifications in some other countries. The ICPM was never revised.

The Revision Conference for ICD-10 in 1989 reviewed work done by the secretariat on a tabulation list for procedures that had been developed to serve as a guide for national presentation or publication of statistics on surgical procedures and which could also facilitate intercountry comparisons. The aim of the list was to identify procedures and groups of procedures and define them as a basis for the development of national classifications, thereby improving the comparability of such classifications. The Conference agreed that such a list was of value and that work should continue on its development, even though any publication would follow the implementation of the Tenth Revision. Questions have been raised since the time of the Revision Conference, however, about plans to update the ICPM or to develop a new international procedure classification. There is a perceived need for a classification for countries which had prepared national-language versions of the ICPM and now need an updated classification.

This issue was raised at the 1997 Centre Heads meeting in view of the fact that a number of countries and regions have already developed their own procedure classifications and the shortage of resources in HST. The meeting also considered the Galen-in-use project which plans to offer a multilingual common reference model for describing procedures and mapping national classifications to this common framework. The meeting recommended that no work should be done on an international procedures classification at this time. The needs of countries with no modern classification of procedures were seen to be important, however, and it was agreed that mechanisms need to be found to make some or all of the new national classifications available to a wider range of countries. WHO Regional Offices as well as the Collaborating Centres were seen to have a role in facilitating this process.

3. Clearing-house function

At the time of the International Conference for the Tenth Revision of the ICD, it was recognized that specialty-based adaptations of the ICD and health-related classifications would likely become numerous in the future and the recommended role of WHO as a clearing-house for information about these classifications was considered to be extremely important. This is seen to be particularly true with respect to facilitating the dissemination of information about national (language) initiatives, including those related to the classification of medical procedures.

B. The Future of the Core Classification and Its Immediate Derivatives

1. *Updating the classification*

Following the recommendation at the International Conference for the Tenth Revision of the ICD for an updating process, there have been discussions on this topic at successive meetings of the Heads of WHO Collaborating Centres for the Classification of Diseases. Prior to the 1997 meeting, there had been agreement on some aspects of the updating mechanism for ICD-10, such as the time lines for submission, evaluation, and agreement. Various methods of dissemination had also been addressed. Discussions at the Centre Head meetings had also identified a range of types of updates that might be requested. For the first time, some proposed updates were officially discussed at the 1996 Centre Head meeting. The only changes that were approved, however, consisted of corrections of errors identified in the alphabetical index submitted by the secretariat. Although approved, these changes have not yet been officially disseminated.

Until October 1997, a formal mechanism for processing, accepting, and promulgating ICD-10 updates had not yet been officially adopted. This activity was, therefore, included as part of the plan of action in the draft version of the long-term strategy presented to the Centre Heads meeting and some suggestions were provided for consideration. Papers from the Nordic and North American Centres prepared for the meeting included additional suggestions particularly related to the use of the ICD-10 for mortality. There was agreement at the meeting about the importance of the updating activity as a high priority, short term task. In fact, a subgroup of the meeting, working from the suggestions in the draft strategy, discussions at previous meetings, and

suggestions in the papers from two of the Centres, developed a proposal which was presented back to the meeting and adopted. The newly-approved updating mechanism for ICD-10 appears as Annex 3 to this paper. The meeting also went on to approve the first official updates to ICD-10 as presented by the secretariat and provided guidance for their dissemination.

Clearly, all aspects of this updating process have not yet been fully explored, and the complexities of keeping all interrelated parts of the family of classifications in synchrony is an issue to be examined. Yet, the decisions related to a possible ICD-11 are contingent on the success or failure of the updating process. All timetables of work and resource allocations during the next five to 10 years are dependent on the evaluation of this mechanism. The International Conference for the Tenth Revision of the International Classification of Diseases recommended an updating mechanism, and also recommended that the next revision conference be held in 1999. These recommendations were approved by the Forty-third World Health Assembly. Based on the Assembly's endorsement of the Revision Conference's actions, an ICD-11 revision would come into force in 2003. This does not now appear reasonable if the traditional approach is followed, but not enough is yet known to determine if interim updates will obviate the need for a revision *per se* rather than a reprinting incorporating the modifications which had been approved up to that point.

When this issue was raised at the 1997 Centre Heads meeting through the draft long-term strategy, it was agreed that there should be an evaluation of the updating mechanism after three years and this evaluation has, therefore, been addressed in the plan of action section of this paper. It was further agreed that discussions regarding ICD-11 should be deferred until the completion of this evaluation and consideration of the results by WHO and the Centre Heads.

2. Maintaining/supporting the classification

It has been previously indicated that, within the family of classifications, the ICD three-character core classification and its immediate derivatives should receive the highest priority. However, the classification, and the ways in which it is distributed, maintained, and revised are in transition. Its uses and applications are also changing at an accelerated pace. It is no longer appropriate to use the same mechanisms of support as have been used since the inception of the classification over one hundred years ago.

As noted in the section above, this plan does not assume that the classification will remain essentially static during a given "revision cycle" of, say, ten or fifteen years. Rather, it is assumed that the updating mechanism will keep the ICD relatively up to date and error free. This mechanism will introduce necessary changes while resisting pressure for highly parochial or trivial modifications, a task which requires careful examination of statistical as well as classification issues. The efficient dissemination of the updated material is a challenge that must be given immediate, high priority attention. In addition, it is assumed that printed versions of the ICD will become less important and that the medium of choice for distribution of the classification and its associated products will be electronic. Because of these assumptions, a large body of prior

experience in dealing with ICD matters and their associated timetable probably will no longer be applicable. On the other hand, new approaches will hopefully bring efficiencies and improved timeliness of products - but there will be a cost as well to bring the ICD and related health classifications into the 21st century.

An important consideration for WHO health-related classifications for the immediate and longer range future is the medium on which the classifications and related material are distributed. Electronic versions, in the form of floppy disks and CD-ROMs, are already in use and are often the preferred medium rather than paper-based products. These forms of storage of information or similar but technologically-improved storage media will probably continue to replace the use of paper versions. However, distribution on media of these types is relatively easily controlled by WHO for purposes of copyright protection and for revenue-producing sales. Just as with printed products, the Organization can establish policies regarding free distribution of items, reduced pricing for, say, developing countries, pricing for other Member States, and pricing for non-governmental or commercial uses. It can negotiate terms for uses which incorporate the classification(s) into software or other proprietary data systems as part of the copyright protections. At the same time, recognition must be given to the fact that the development of WHO's health-related classifications often is partially dependent on technical and resource support of some Member governments, NGOs, and other outside agencies and organizations. Accordingly a clear statement of pricing policy for electronic products should be rationalized and publicized as part of the overall strategy for the ICD. This policy should make allowance for the fact that the ICD is an international standard and required for specified applications.

Another essential consideration for WHO health-related classifications for the immediate and longer range future is access to electronic products either for viewing or for downloading from the Internet. The Internet has become a common and convenient vehicle for the rapid sharing and transfer of information on a world-wide basis. Many ICD products lend themselves well to this process as part of the goal of widespread dissemination and use of the classification and publication on the Internet not only promotes this dissemination and use but also provides an avenue to make updates, clarifications, interpretations, etc. available to users on a timely and efficient basis. Therefore, Internet publication seems like a highly desirable objective, but equitable access policies must be developed first.

To protect the copyright and to address revenue concerns, Internet availability of the ICD should not result in a way to get around the pricing schedules and policies for printed or electronic media items. This suggests that Internet availability should be based on password access for those previously given authorized access, password access for those who pay an appropriate fee while on line (e.g., by payment via credit card - a common practice for many other Internet services), or free for those materials and demonstrations that should not be associated with a fee (such as, say, errata, updates, and descriptive material.).

3. *Classification-related tools*

In association with the core classification and its immediate derivatives, there is a set of closely related tools which support and enhance the quality and utility of ICD data. These include items such as:

- (a) conversion and equivalence tables;
- (b) bridge coding exercises and comparability ratios;
- (c) training materials and software (e.g., TENDON);
- (d) automated encoding and coding-assisting software (e.g., MICAR, LUCID);
- (e) data presentation methods (e.g., tabulation lists);
- (f) analytical methods (e.g., multiple cause of death analysis).

When planning core classification activities, these and similar tools which support the use and interpretation of the classification should be given similar priority as the work on the basic classification itself. However, the actual tasks may be appropriate for development by one or more of the Collaborating Centres with coordination by HST, rather than all being undertaken centrally.

Once developed, tools supporting the use and interpretation of the core classification and its immediate derivatives should be evaluated and, where appropriate, advance plans drawn up to keep them in synchronization with changes in the classification(s) and with technological and methodological advances.

Most, if not all, of the developmental work for these tools lends itself to decentralization to Collaborating Centres or other appropriate institutions, requiring for the most part only coordination from WHO. If undertaken on a voluntary basis but with sufficient advance notice, the Collaborating Centres can make significant contributions while providing important support to Headquarters. At the same time, such activities strengthen the capabilities of the Centres and assist them in their own staff development.

C. **Other Key Issues**

1. *Promoting and implementing ICD-10*

Once a new revision of the ICD and the associated tools have been developed, one of the important roles of WHO is to facilitate and/or assist with the ICD implementation among existing ICD users. Another role is to expand the use of the classification to additional countries and/or from mortality application only to both mortality and morbidity applications. Promoting and implementing ICD-10 worldwide was, in fact, seen by the Centre Heads at their 1997 meeting as the first high priority, short term task. The Centre Heads expressed concern about the many parts of the world, including countries in Africa and Asia, where the ICD is not currently used.

The promotion and implementation roles do not rest with HST alone but rather rest, to a large extent, with the WHO Regional Offices. Some of these offices deal with a large number of countries and may also deal with a wide variety of national languages (for many of which there are no Collaborating Centres). A few of the Regional Offices have established an internal level of competency in this regard while others have established a roster of individuals who can be brought in to assist them on a periodic basis. Other offices have, in the past, relied on resources from HST and the Collaborating Centres. As the quantity of classification expertise available at HST has diminished and the resources available through or from the various Collaborating Centres for the classification of diseases may also be limited, the Regional Offices who have not built up their own bases of expertise may have difficulty fulfilling these roles.

The ICD is only one component of a national health information system and, with the increasing technical complexity of both the classification itself and the informatics support to health information systems, a coordinated, team approach to providing assistance to countries has become necessary. Such an approach necessarily involves several areas within WHO including the Regional Offices.

2. WHO Collaborating Centres for the Classification of Diseases

The network of WHO Collaborating Centres for the Classification of Diseases, with responsibilities for languages and/or geographical areas, are an essential component in WHO's classification-related activities. As stated earlier in this paper, the number of Collaborating Centres has increased significantly. There now remains only one of the WHO regional official languages which is not covered by a Collaborating Centre - German. A potential candidate has been identified to fill this gap and an observer from that organization attended the most recent Centre Heads meeting. There was strong support at that meeting for proceeding quickly to designate a German-language centre. The need for additional centres remains to be evaluated further.

The Heads of the Collaborating Centres have met annually for more than 25 years. These meetings have provided the opportunity for the Centre Heads to provide advice to WHO on classification matters, something that has been particularly important through the development and dissemination of ICD-10. In addition, the meetings provide an opportunity to share knowledge and experience between centres in a variety of technical areas.

Although there have been discussions at various times about procedures for the governance and functioning of these meetings of Heads of Collaborating Centres, the meetings still need streamlining, especially in view of the continuing expansion of topics requiring discussion and resolution by Centre Heads. In spite of frequent past agreements on the part of Centre Heads to complete written material by an agreed date, papers continue to be submitted too late for pre-meeting circulation in a timely manner. This unnecessarily prolongs discussions at meetings and may result in inadequate or inappropriate consideration of important items.

A number of suggestions have been proposed to deal with these problems. For example, in order to maximize use of available meeting time and to allow thorough discussion of important issues, it has been suggested by some participants that concurrent "break-out" sessions, each devoted to a key issue, be utilized during Centre Heads meetings. This, however, might result in the exclusion of one or more Centre Heads from discussions of importance to them, especially in the case of Centres represented by just one person. Alternatively, subcommittees charged with the exploration of important issues could prepare background papers and recommendations during the period between meetings, working preferably by e-mail. By use of this mechanism, a wide range of input from outside experts could also be gathered, which would not be immediately available at meetings. Subcommittee reports could be reviewed by the full group during the meeting. In this way, more efficient use of meeting time would result in wider participation by all attendees at the meeting.

When this issue was raised at the 1997 Centre Heads meeting during discussion of the draft long-term strategy, the response was the creation of a working group of Centre Heads to develop new procedures for the meetings. The proposal was brought back to the meeting and adopted. The result appears as Annex 4 to this paper.

3. Succession planning

There is presently no provision in HST for training of staff to assume ICD responsibilities in the future. When the incumbent Technical Officer leaves his post it will be too late to begin a succession plan. ICD-related skills are not commonly found in the work force, even amongst otherwise highly-trained professionals, and the requisite on-the-job training takes years. In addition to the unique technical skills required for ICD-related work, there is a special need for strong linguistic skills in English and French because of HST's responsibility for ICD support in both of these languages.

Unless the Organization takes steps to prevent it, there will be, in the foreseeable future, a severe loss, not only of nosological and linguistic skills, but also of almost all traces of institutional memory of ICD issues, practices, and processes.

IV. A PLAN OF ACTION FOR ACTIVITIES THROUGH THE YEAR 2010

The time period to be covered by this plan is assumed to be, as a minimum, from the date of acceptance of the plan through the year 2010. This period of time will encompass the dates when key ICD events might occur if no major changes in schedule and approach are made. By including these dates within the planning period, the impact of any proposed changes can be evaluated. On the other hand, too long a period might require significant "mid-course" corrections resulting from uncertainties and changes in the longer range future while too short a period would not permit appropriate advanced planning.

A. Promoting and Implementing ICD-10

At the 1997 meeting of Heads of Collaborating Centres, the first high priority, short term task was seen to be the promotion of implementation of ICD-10 worldwide. Although a few countries have already implemented ICD-10 in full, others have been delayed by the complexity of implementation posed by the need to adjust automated coding systems, develop new extended classifications, map linkages to ICD-9, and put new national medical procedure classifications in place. There are still, however, many parts of the world where ICD is not currently used. In some of these areas, promotion of the ICD itself and of a health information infrastructure are important activities for HST and the Regional Offices.

1. Finalization of the three-character version

In order to increase the utility and use of ICD-10 around the world, HST should proceed as quickly as possible with the finalization of the three-character version (in English and French). In addition, HST should investigate the development of basic software which would facilitate morbidity data collection. Such activities would, no doubt, require some additional funds to support the necessary development work.

2. Review of pricing policies and distribution activities

HST, in consultation with Centre Heads, should work out with the WHO Division of Publishing, Language and Library Services (PLL) a pricing and distribution plan for current and future ICD materials that would allow, in addition to traditional printed versions, controlled access via the Internet as well as the use of other forms of electronic media for new and updated materials.

3. WHO Regional Office involvement

WHO Regional Offices which do not already have expertise in the area of classification should establish a pool of such expertise, either within their staff or through the development of a pool of external resources that may be contracted periodically (including persons employed in national ministries or agencies). The expertise should encompass a broad knowledge of the ICD and the associated tools, the ability to develop and deliver training, and the ability to assist with development and implementation of associated data collection systems. While ICD-related tools such as materials and software may be available from HST, the human resources should be the responsibility of the Regional Offices. With such expertise in place, Regional Offices will be better positioned to contribute to the ongoing maintenance of the classification based on the needs of countries within their region.

While knowledge of the ICD itself requires specific technical expertise, there are additional needs such as statistical knowledge and informatics knowledge which may be necessary to provide the most appropriate assistance to countries. This cannot be expected to be provided

by an individual. Instead, Regional Offices must be positioned to provide a coordinated, team approach to ensure ICD implementation as part of an overall health information system.

B. Updating the Classification

1. The updating mechanism

Now that an updating mechanism for ICD-10 has been formalized, it must be operationalized under the coordination of HST and with the cooperation of Collaborating Centres, something which will require a substantial commitment of resources. Users of the classifications must be encouraged to contribute to this updating through the agreed upon routes as described in Annex 3. The results of the updating must be widely disseminated to ensure that they reach all users. The following are some specific activities that must be undertaken:

- There should be widespread communication and publication of the process for submitting requests for change(s) to ICD-10 (including the contact information for the Collaborating Centres and their areas of responsibility).
- Changes that are accepted at Centre Heads' meetings must be disseminated electronically with a clear indication of their effective date. A revised classification should be made available in English and French on diskette and CD-ROM, with details of the actual changes available via the Internet.
- Changes introduced into ICD-10 must also be reflected in all language versions, adaptations, and any associated tools.

In addition to changes to ICD-10 which require international agreement through the updating mechanism, there may be minor modifications which are introduced in national versions of the classification. Such modifications should be distributed by Member States to WHO/HST and to the Collaborating Centres for information.

An issue that must be considered in the updating of ICD-10 is the relationship between the content of ICD-10 itself and the content of other members of the family of classifications, particularly the specialty adaptations. One phase of the ICD-10 updating mechanism that cannot be overlooked is that of assuring consistency between the family members. Similarly, proposed modifications to family members must be evaluated in terms of their impact on ICD-10.

2. Evaluation of the updating mechanism

At their 1997 meeting, the Heads of Collaborating Centres committed themselves to work with HST in the development of an evaluation plan for the updating mechanism by the end of their

1998 meeting. The evaluation itself should be carried out after three years of experience using the updating mechanism as formalized at the 1997 meeting.

3. Future revisions of the classification

At the 1997 Centre Heads meeting it was recommended that no consideration should be given to ICD-11 until after the evaluation of the updating mechanism was undertaken and the results considered by WHO and the Centre Heads.

When consideration is given to ICD-11, one of the following approaches might be recommended to the Director-General:

a) Continuation, with refinements if necessary, of the updating process, with planned reprintings and electronic updates of the ICD based on the previously approved updates. Using this approach, a new CD-ROM version of the classification could be issued annually. The details of the updates would be highlighted on each version of the CD-ROM and on the Internet. The naming convention for the ICD could be modified to show the periodic updates followed by cyclical formal reprintings, perhaps by a designation such as "ICD Tenth Revision, Updated through 1998"; "ICD Tenth Revision, Updated through 1999"; ... ; "ICD Eleventh Revision"; etc. These might be referred to in abbreviated form as "ICD-10, 1998 Edition"; "ICD-10, 1999 Edition"; ... ; "ICD-11"; etc.. This kind of change in process would probably eliminate the need for the traditional Revision Conference but would require the agreement of Member States.

or

b) Reverting to the traditional approach of essentially freezing the content of the ICD through some set period of time, soliciting suggestions for change, and producing a new Revision, as in the past. This approach would require the Director-General to solicit approval of Member States to change the target date for implementation of ICD-11, since the World Health Assembly's target date would no longer be feasible.

4. Review and evaluation of classification-related tools

A review and evaluation of the ICD-related tools should be undertaken in collaboration with the Centre Heads. Timetables for these need to be established by HST with input from Centres and voluntary assignments given to appropriate Centres or institutions. Interim reports on work on these tools should be given at annual Heads of Centres meetings.

C. The Family of Classifications

1. Parameters of the family

HST, in consultation with the Centre Heads, should revisit and refine the parameters for inclusion into the family of classifications by the end of October 1998 (see also Section III.A.).

2. Prioritizing work on family members

Once the parameters for inclusion in the family of classifications have been adopted, HST, in consultation with the Centre Heads, should adopt operational guidelines for prioritizing work on health-related classifications. As a first step in that process, the following guidelines are proposed for consideration:

Guidelines for prioritizing work on components of the Family of Classifications

- Tasks related to the ICD three-character core classification and its immediate derivatives are considered to be "critical" or "highly desirable" and must be given higher priority than any other task involving another member of the family.
- Work on *speciality-based adaptations* must be undertaken by organizations external to HST. The responsible organization must agree in writing to follow HST-specified principles in preparing the speciality classification and any other copyright restrictions imposed by WHO. They must, as part of the principles, agree to WHO review before publication and abide by any WHO objections.
- Priority for approval of HST staff involvement in the development of *speciality-based adaptations* should be given as follows: (1) the work is to be undertaken primarily by another WHO Division or Unit; (2) the work is to be undertaken primarily by an NGO; (3) the work is to be undertaken primarily by an international professional society; (4) the work is to be undertaken primarily by a nationally-recognized professional society; or (5) the work is to be undertaken by any other organization or group whose professional competence is acceptable to WHO. This prioritization carries no implication of descending levels of competence; rather, it is a reflection of the increasing level of WHO/HST staff support that might be required to produce an internationally acceptable end-product.
- Work on other *health-related classifications* must be undertaken by organizations either external to HST or in collaboration with HST. Any links to the ICD must be in conformity with HST-specified principles in preparing the classification and with any other copyright restrictions imposed by WHO. The responsible organization must, as part of the principles, agree to HST review before publication and to abide by any WHO objections.

Work on an international procedure classification or framework would fall into this category (see also below).

- All work on members of the Family of Classifications must be reported to Heads of WHO Collaborating Centres at least on an annual basis, and Centre Heads should be given the opportunity to furnish advice and to recommend approval prior to final WHO approval. Centre Heads' recommendations should focus on the links with the ICD; other areas of comment should be in the nature of suggestions only.
- *Information support to primary health care* should be on an information-exchange basis with no measurable HST ICD-related resources being involved.
- Communication between the *International Nomenclature of Diseases* and HST should be maintained but little other activity should be required, except, perhaps, at times when the ICD updates or revision is in progress.

Any deviations from these guidelines should be approved by the Director, Division of Health Situation and Trend Assessment (HST) only after consideration is given to programmatic needs within the Organization and input from the Heads of WHO Collaborating Centres has been received and reviewed.

3. International classification of medical procedures

A number of countries and regions have already developed their own procedure classifications in a manner relevant to their health care systems and any case-mix activities. The development of a universally-relevant international classification of medical procedures that could be kept current in the face of almost daily changes is not considered practical. Mechanisms need to be found, however, to make some of the new classifications available to a wider range of countries where they may be relevant. WHO Regional Offices could assist in facilitating this process. In addition, WHO Collaborating Centres are seen as an important resource for assisting countries in the development of national procedure classifications relevant to their needs.

HST should request Regional Offices to contact Member States to determine their needs in relation to medical procedure classification. This contact should not, however, imply that an international procedure classification will be provided. Once information about national needs is available, a decision should be taken by WHO with respect to proceeding further on the development of a taxonomic approach for the classification of medical procedures and the preparation of guidelines for the establishment of national procedure classifications (something which has already been included in the plan of work for the 1998-1999 biennium).

4. Clearing-house function

Based on its own activities and on information provided by Collaborating Centres (particularly during annual meetings of Heads of Centres), national and international organizations, national governments, and Regional Offices, HST should serve as a clearing-house for information on the Family of Classifications and related activities. Such information might be made more widely available through the use of the Internet (including the publication of the reports of Centre Heads meetings).

D. Roles, Responsibilities and Resources

It is clear that WHO must retain a core role in the development and maintenance of the ICD. First, it is the ICD proprietor, and must retain ultimate responsibility for approval of updates, technical standards and copyright issues. Second, WHO must promote the ICD family globally, and assist or facilitate implementation of ICD-10. Third, the ICD is an essential infrastructure within WHO for the description of the global health situation and trends. Fourth, there is the need to coordinate the activities of Collaborating Centres for the Classification of Diseases and the ICD-related activities of the Regional Offices.

Although the Collaborating Centres play an important role in carrying out the essential ICD work programme, there is a clear need for expanded resources within HST for ICD work, and for the provision of support from other areas of WHO, notably with information technology and publications responsibilities.

1. Minimum ongoing staffing and resourcing

There are several levels of support which WHO might choose for the provision of human and financial resources for health-related classifications. Obviously, each level carries with it concomitant programmatic implications. The resources needed for each level and its programme implications must be worked out in detail by HST for presentation to WHO senior management. However, the current status of one Technical Officer and part time secretarial support for ICD-related activities, does not permit WHO to meet expectations of many Member States and other users.

A minimum level of resources to maintain a set of reasonable permanent functions (see Annex 1) would require at least a staff consisting of one full-time technical officer, one full-time support person, and one full-time secretary along with adequate regular budget resources to enable the recruitment of consultants to carry out planned activities during each biennium.

Other specific activities already planned for the period September 1997 - December 1999 (see Annex 5) clearly require enhancements to the minimum recommended support level.

In light of the special linguistic requirements of the ICD work within HST, any replacements or enhancements of staff should be fluent in English and French.

2. Succession planning

WHO should develop a succession plan in order to train new staff to assume ICD responsibilities when the inevitable replacement of the present incumbent becomes necessary. This may be accomplished by on-the-job experience to be gained by support staff working under the guidance of the incumbent Technical Officer. At their October 1997 meeting, Centre Heads expressed strong concern at the risks involved in the current reliance on a single Technical Officer and urged WHO to address this matter as soon as possible.

3. Provision of informatics support

The move to the use of technology such as CD-ROM and the Internet has increased the complexity of maintaining the necessary databases, making updates, tracking changes, etc. Such maintenance must be carried out with direction and coordination from subject matter experts in HST. In addition, however, dedicated informatics resources are necessary. These must be provided by the WHO Division of Information System Management (ISM) or funds must be made available to purchase such services.

4. Enhancement of classification-related networks

At their 1997 meeting, the Centre Heads recommended the establishment of appropriate communication networks and proactive mechanisms for anticipating issues. One of the ways that this could be accomplished is through expanding the range of groups with whom HST staff are in regular contact.

HST should develop and maintain contacts with groups working not only on classifications, including members of the family, but also on their application especially through various forms of automation. Examples of these are the work on LUCID ("The Ultimate Interactive Codification of Diagnosis") and the various "Galen-in-use" projects such as GRAIL ("GALEN Representation and Integration Language) and SPET ("Surgical Procedure Editing Tool").

5. WHO Collaborating Centres for the Classification of Diseases

It was recommended at the 1997 Centre Heads meeting that a German-language Collaborating Centre should be designated in the short-term as a natural and necessary extension of the existing network. In the longer term, it was seen as a medium priority that a mechanism be developed for deciding on the need for additional centres.

6. Governance and Functioning of Centre Head Meetings

The 1998 meeting of Centre Heads should be conducted on the basis of the new procedures developed at the 1997 meeting (see Annex 4). Based on the success of the new communication proposals and meeting rules, the duration of subsequent meetings should be reviewed at the 1998 meeting.

V. CONCLUSION

This document has attempted to highlight the importance of the ICD and associated classifications and tools both to WHO and to Member States. A number of strategic issues which pertain to the development and management of the ICD itself and to other health-related classifications are identified. A plan of action for the next decade or so is proposed.

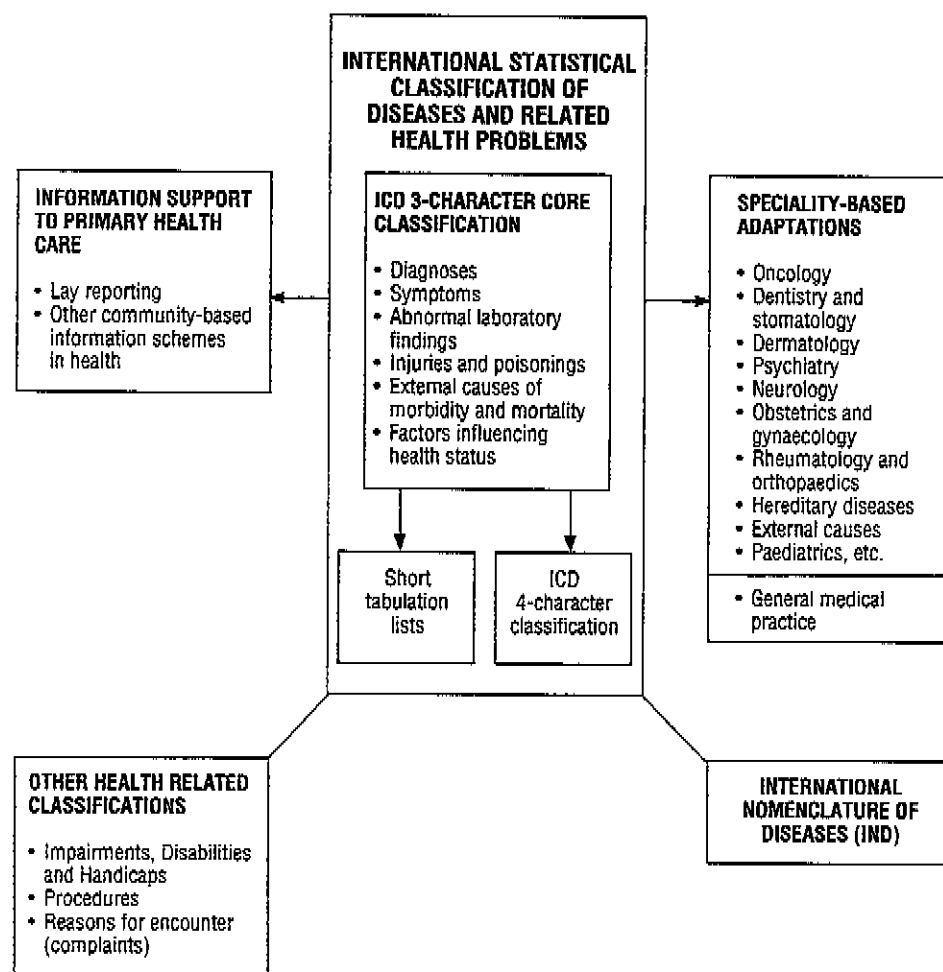
A draft version of this long-term strategy was discussed at the 1997 meeting of the Heads of WHO Collaborating Centres for the Classification of Diseases. These discussions resulted in a number of actions and recommendations from the meeting and these have been incorporated into the present paper. At their meeting the Centre Heads committed themselves to working in partnership with HST, Regional Offices, and national and specialty groups on a common workplan.

In implementing this strategy, further discussion will be required between HST and the Collaborating Centres and between HST and other areas within WHO. There is also a requirement for the commitment of additional resources (both human and financial) to support and enhance the Organization's classification activities. These activities and their outcomes are the foundation for much of the Organization's work and are critical to the development and enhancement of health information systems at the national, regional, and international levels.

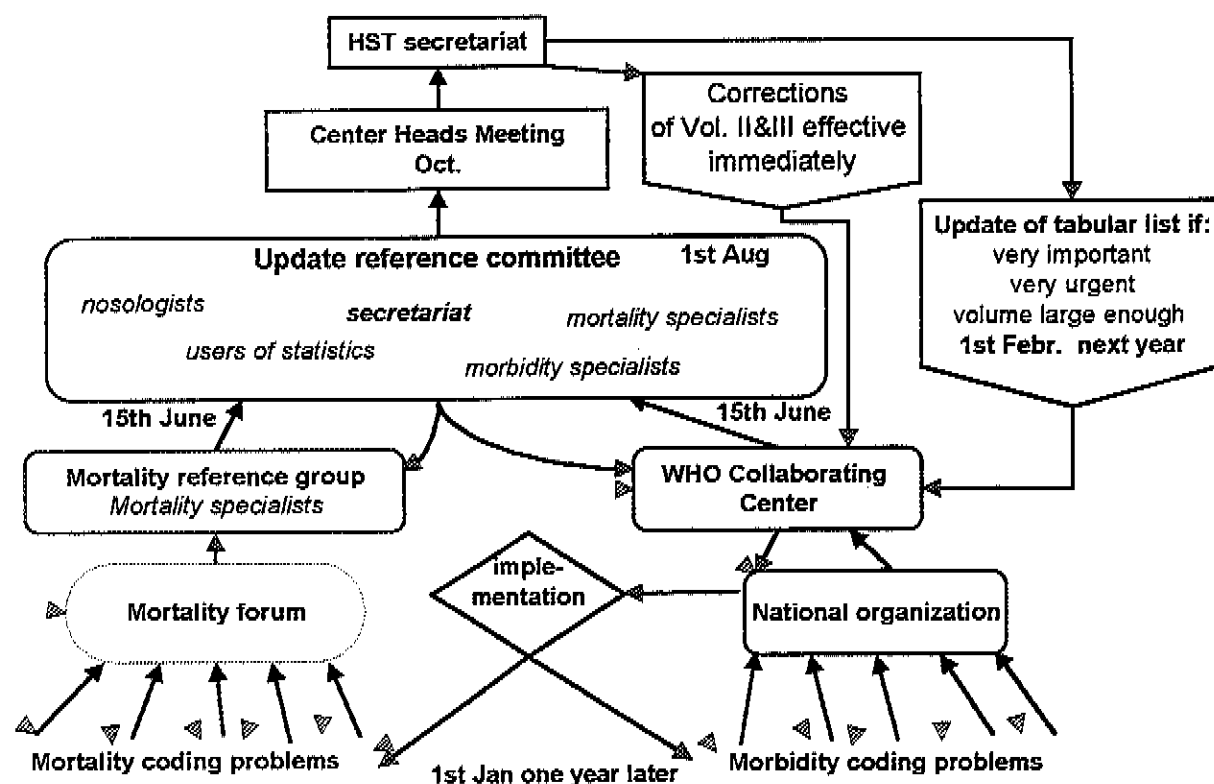
PERMANENT ICD-RELATED FUNCTIONS

- Organization, facilitation, and follow-up to annual meetings of Heads of WHO Collaborating Centres for the Classification of Diseases.
- Administration of the mechanism for the periodic updating of the ICD and other members of the family of disease and health-related classifications. Receipt of proposed updates through the Collaborating Centres. Formulation of HST recommendations on each proposal for discussion and decision at the annual meetings of Heads of Centres.
- On the basis of the outcome of the Centre Head meeting, updating of the mainframe alphabetical index databases in English and French. Updating of the diskette and CD-ROM versions of the ICD in English and French and promulgation of the details of the agreed changes on the ICD Internet homepage. Notification to responsible groups of changes as they affect national language versions and specialty-based adaptations (e.g., ICD-O).
- Other maintenance of the ICD Internet homepage: listing of national language versions, implementation dates, updating of FAQs (frequently asked questions), etc.
- Support to the WHO mortality database.
- Support to users of the classifications.
- Further development and support to specialty-based adaptations
- Consultation with PLL on issues related to translation rights, copyright, and royalties.
- Administration of the Nomenclature Regulations with the Legal Counsel.
- Planning of activities and identification of budget requirements.
- Support to senior management for relevant activities of the WHO Executive Board and the World Health Assembly.

Family of disease and health-related classifications



Updating Mechanism for ICD-10



Recommendations in the draft WHO long-term strategy document (WHO/HST/ICD/C/97.39) and in papers from the North American and Nordic Centres regarding the updating of the ICD were reviewed. It was agreed that issues for updating might take two basic forms:

- updates to the classification itself, i.e. correction of errors and additions
- clarification of application and interpretation (of the classification and its associated rules) to establish international practice

After discussion, a mechanism for review of issues was developed that incorporated elements from each of the suggestions. The mechanism is illustrated in the diagram above.

The following points were discussed by the meeting and agreed:

- Updates suggested should only relate to the ICD-10 and not to national versions (although they may come from national versions).
- Updates, once agreed, should be applied to all language versions (if applicable) and specialty adaptations and should be reflected in related tools, as necessary.

- Two separate bodies should be established: an Update Reference Committee (advisory to the secretariat and the Centre Heads, generally carrying out its activities by electronic means such as e-mail and facsimile); and a Mortality Reference Group (with decision-making powers regarding application and interpretation, working electronically and meeting once annually, if necessary)
- The Mortality Reference Group will make decisions on the application and interpretation of the ICD as it relates to mortality and will refer updates/changes to the Update Reference Committee.
- Mortality problems arising through the Mortality Forum (an electronic newsgroup) requiring decisions on application and interpretation will be referred to the Mortality Reference Group.
- Morbidity problems should be directed to the Collaborating Centres and then to the secretariat for distribution to Update Reference Committee members.
- There should be representation from the Mortality Reference Group on the Update Reference Committee (particularly to address proposed changes to Volumes 1 and 3 that would effect application and interpretation).
- Collaborating Centres and the secretariat may nominate representatives to the Mortality Reference Group and the Update Reference Committee (nominations are not compulsory). Nominations from the Collaborating Centres should be made to the secretariat by November 20, 1997.
- There should be a balance between morbidity and mortality expertise in the membership of the Update Reference Committee. The membership should include clinicians, nosologists and users of statistics based on the classification (e.g. epidemiologists, statisticians and researchers) but should not exceed 20 members.
- Once the Mortality Reference Group and the Update Reference Committee are operational, the replacement of members should be staggered to ensure continuity and balance.
- The Update Reference Committee will be coordinated/chaired by the secretariat.
- The secretariat will appoint a chairperson for the Mortality Reference Group.
- The Update Reference Committee will be responsible for developing criteria for acceptance of changes to the ICD. These criteria will be established as part of the Committee terms of reference and will be tested by the Committee.
- Recommendations made to the Centre Heads will be based on issues for which the Update Reference Committee has reached agreement by consensus. Where consensus is not possible, the issue may be referred to the Centre Heads for resolution.
- Decisions from the Mortality Reference Group should be available from the WHO ICD-10 home page (directly or through a link) using the most suitable accessible technology. The decisions may be available from several sites (mirror or replicate sites) but, if so, they should all be updated concurrently.

- Corrections of errors (e.g. typographical, spelling, inconsistency between versions) should be announced on the ICD-10 home page immediately. If a correction will have an impact on statistical collection, however, it should be treated as part of the annual update process and introduced with other updates.
- Updates to Volume 1 of ICD-10 (and their associated index changes) should not be implemented immediately. For mortality statistics (which are based on a calendar year), updates become effective for deaths from the first of January of the second year following the October Centre Heads meeting (i.e. 15 months later). For morbidity statistics (which may be based on a fiscal/financial year), implementation dates will be dependant upon update mechanisms within individual countries. To avoid confusion, it was recommended that updates approved at the Centre Heads meeting not be made available until the following February.
- To be considered at an October Centre Heads meeting, recommendations from the Update Reference Committee and the Mortality Reference Group must be submitted by the first of August.
- If the Mortality Reference Group is to meet, it should meet by the end of June to allow finalization of recommendations by the first of August.
- Although there will be an ongoing updating process, annual updates to the classification are not essential. Updates will be disseminated when they are sufficiently important or urgent, or when there is a sufficient volume to make dissemination worthwhile (based on the impact on language versions, specialty adaptations, and associated tools). Updates will not be issued more frequently than annually. The secretariat will have discretion in making recommendations to the Centre Heads for implementation (including recommendations regarding the timing of such implementation).

Procedures for Meetings of Heads of Collaborating Centres for the Classification of Diseases

The meeting reviewed the references to the governance and functioning of Centre Heads meetings contained in Annex 5 of the document "WHO Long-term strategy for the Development and Management of Health-related Classifications" (WHO/HST/ICD/C/97.39). The meeting agreed on new rules for the governance and functioning of Centre Heads meetings as set out below. These would subsume all previous decisions from the 1990 London, 1991 Sao Paulo and 1995 Canberra Centre Heads meetings.

Participation/invitations

The number of Collaborating Centres and the number of participants have grown significantly and the meeting therefore adopted the following rules for participation:

- The secretariat of the meeting is assumed by HST. Other WHO Headquarters and Regional Office staff may attend as part of the secretariat and will be invited by HST.
- The Heads of Centres are by definition members of the meetings. Invitations to Heads of Centres will be sent by the host Centre. Each Centre Head may designate (to the organizers) other individuals as part of their delegation but Centres should limit their participation to four representatives (including the Centre Head).
- The host Centre is free to invite, in addition, persons from its own national offices or the geographical area of the Member States where the Centre is located.
- The secretariat may, in consultation with the host Centre, invite representatives of Member States, national classification centres and nongovernmental organizations in official relations with WHO, as well as individual experts as participants or observers, subject to their technical competence in relation to matters to be discussed and according to the WHO rules laid down for the attendance of such representatives or observers.

Voting

Only the Heads of Centres or, in their absence, their nominated representatives have the right to vote. There is only one vote for each Centre.

Timing/periodicity/duration of meetings

The timing of meetings in October as well as the one-year interval between meetings were still considered appropriate.

The merits of shortening the meeting to fit within a working week (no more than 5 days) were agreed in principle.

In order to facilitate report writing, the following procedures should be tested: submission, by the authors, of short abstracts of annual reports and one-paragraph summaries of other documents in electronic version. The secretariat would then only need to write the report on the business of the meeting and discussions following document presentations (see below).

For 1998, the current duration and format should be retained, recognizing the need for continuing significant development of the work program and the unknown level of success that the new communication proposals and meeting rules will have. The duration of subsequent meetings should be reviewed at the 1998 meeting.

Agenda/documents/report/communication

The host of the forthcoming meeting should take lead responsibility for development of the agenda, in consultation with the secretariat and other Centre Heads:

- The emphasis of the agenda could change from year to year, with each year considering progress on the work plan and implementation of ICD-10, but the work plan only being revised every second year. This would allow more time in the intervening years for consideration of scientific and analytic papers.
- A theme would be set the previous year for the next year's meeting.
- Documents can be commissioned on specific themes, e.g. work-plan-related evaluations of tools (bridge-coding, tabulation lists), data quality, etc. but self-selected topics of documents will also be allowed.

The host of the previous meeting should take on responsibility for following up on business from the previous meeting together with the secretariat. The basis for this follow-up should be the "Action Summary" accompanying the report from the previous meeting.

The host of the forthcoming meeting should take on responsibility to review documents in consultation with the secretariat:

- Documents should be reviewed with regard to their treatment at the meeting: information only, discussion, or decision.
- On the basis of document review the secretariat will prepare the annotated agenda in consultation with the Head of the host Centre.

Documents should be provided to the secretariat in an agreed upon readable electronic format to the extent possible.

Collaborating Centres requiring translation of their documents by the secretariat need to submit them earlier than the normal timetable.

Centres distributing documents directly should ensure that these reach participants no later than two weeks prior to the meeting.

Documents not submitted according to the timetable shown below will not be considered at the meeting.

The report of the meeting should be sent to participants no later than two months after the meeting and should be made available through the ICD-10 home page.

Reports from at least three annual meetings, starting with the 1996 report, should also be available on the ICD-10 home page.

Starting with the 1998 meeting, the secretariat should aim to make all documents from the meeting available on the ICD-10 home page after the meeting.

Timetable

Theme discussion	Previous meeting
Call for documents	No later than 8 months prior to the meeting
Submission of abstracts	No later than 5 months prior to the meeting
Draft agenda	Shortly after submission of abstracts
Recommendations from Update Reference Committee to secretariat	No later than 2 months prior to the meeting
Submission of documents to organizers (host Centre and secretariat)	No later than 4 weeks prior to the meeting (see also below)
Distribution of documents to participants	To reach participants no later than 2 weeks prior to the meeting. Centres wishing to distribute documents via the secretariat need to submit these no later than 6 weeks prior to the meeting.
Annotated agenda	Distributed at the meeting
Distribution of report	Available to participants no later than 2 months following the meeting

**OTHER SPECIFIC ACTIVITIES PLANNED FOR THE PERIOD SEPTEMBER 1997 -
DECEMBER 1999**

- Development of three-character versions of ICD-10 in English and French for countries that do not have the infrastructure necessary to support the full four-character version.
- Revision of ICD-O-2 (ICD-O-3).
- Development of ICD-O-3 in French.
- Development of an International Classification of External Causes of Injuries.
- Finalization of Application of ICD-10 to Neurology (ICD-10-NA) and work on the French-language version.
- Revision of ICIDH in cooperation with the Division of Mental Health and Substance Abuse (MSA).
- NGO focal point for International Association of Cancer Registries (IACR) and World Organization of Family Doctors (WONCA).
- Facilitation of TENDON training courses in English and in French as requested by the Regional Offices.
- Preparation of guidelines for physicians and others certifying causes of death.
- Participation in the development of a taxonomic approach for the classification of medical procedures and the preparation of guidelines for the establishment of national procedure classifications.