The 4th WHO-FIC Asia-Pacific Network Meeting

(Summary)

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Venue: Act City, Hamamatsu

Contents

Day One

1. Opening and Welcome

Dr. Kenji Shuto opened the meeting at 9:07 by introducing Dr. Tsuneo Sakai and his hospital, Seirei Hamamatsu General Hospital. The WHO-FIC Asia-Pacific Network (APN) meeting had been called in Hamamatsu so that the participants would be able to visit Dr. Sakai's hospital.

Mr. Satoshi Ono welcomed the participants. At the time of the meeting, the International Classification of Diseases, Revision 10 (ICD-10) had been seeing more and more use across the world. Japan sought to improve the ICD, and was appreciative of WHO for making efforts to revise it. Dr. Shuzo Yamamoto was asked to give some opening remarks on behalf of the Japan Hospital Association. He praised the WHO-FIC APN for its role in furthering medicine by encouraging the sharing of information using ICD, and expressed his hopes for a successful meeting.

Dr. Bedirhan Üstün expressed his pleasure at being in Hamamatsu and explained that the meeting was very important. Nine days after the meeting, WHO would be holding one of the first editorial meetings for the revision of ICD-10. Dr. Üstün believed that it was important to come to Japan before that meeting as Japan was the epicenter of the ICD revision movement. He commended the Asia-Pacific Network for being a model organization for other regions.

Each participant then introduced themselves before the meeting moved on to the adoption of the agenda.

2. Adoption of the Agenda

The meeting had been called to discuss future activities for the WHO-FIC APN and primary healthcare activities. Dr. Üstün explained that the theme for the WHO-FIC for the year had been primary healthcare. Primary healthcare was a leading concern for WHO for the last 30 years as it was the principal service providing healthcare to 80% of the world. WHO had renewed its focus on primary healthcare, and Dr. Üstün hoped that health information needs regarding the topic could be made more explicit. He asked that each country identify its primary healthcare needs. WHO's challenge was to

make the ICD able to meet the requirements of the primary healthcare situation in each country.

Day one of the APN meeting would formulate the problems concerning primary healthcare in the region, and day two of the meeting would come up with solutions.

3. Report on Activities

3.1 Health Information Management

Ms. Yukiko Yokobori of the Japan Hospital Association gave a presentation on the status of education on health information management around the world. The Japan Hospital Association had conducted a survey on the topic, with the goal of working to encourage further ICD implementation. A total of 17 countries participated in the survey. Ms. Yokobori reported on 9 countries from the survey whose data was relevant to the meeting.

Australia was using ICD-10, ICD-10-AM and ACHI. The country had universities and medical institutions which provided education on health information management.

Fiji used ICD-10-AM for both mortality and morbidity coding, and ACHI for procedure.

Malaysia used ICD-10 for both mortality and morbidity coding. There were 400 Medical Records Officers (MRO) in Malaysia who received two weeks training on coding, but no certification.

In Papua New Guinea ICD-10 was used.

The Republic of Korea used ICD-10 for mortality and KCD-4 for morbidity. For procedure ICD-9-CM was used. 20 universities and 60 junior colleges were providing education on health information management. Approximately 10,000 people had been certified in the country.

In Singapore, ICD-9 was used for mortality, ICD-9 and ICD-9-CM for morbidity and ICD-9-CM for procedure.

Thailand used ICD-10-TM for mortality, morbidity and procedure.

In Vietnam, ICD-10 was used for mortality and morbidity. The country had no professional coders. Short training courses on health information management were offered at some universities.

In Japan, ICD-10 was used for morbidity and mortality and ICD-9-CM for procedure. Certification was provided by five medical organizations including the Japan Hospital Association. 18,752 people were certified in health information management.

The conclusion of the study was that a wider survey was needed. Ms. Yokobori believed that it was necessary to study all 126 WHO member countries using ICD in order to judge what improvements could be made.

Questions and Comments

Dr. Üstün thanked Ms. Yokobori for her presentation and complimented her for taking the initiative to complete the successful survey. He suggested that the members take inspiration from the study and establish a permanent knowledge base, perhaps utilizing the internet, with up-to-date information on the health information management situation in each country.

3.2 Basic Policy on Future Activities

A presentation was then made on the WHO-FIC Asia-Pacific Network basic policy on future activities. The APN was two-years, eleven months old. The network consisted of three working groups, mortality, morbidity and functioning, and health information systems. Dr. Shuto emphasized that the network placed a high importance on a functional approach. He explained the types of WHO-FIC activities: 1) normative functions, such as ICD revision and the standardization of healthcare; and 2) supportive functions, such as education and implementation. The WHO-FIC had been established to take the lead in health information classification, and thus carried out exclusive activity regarding standardization. However, in terms of implementation, such as for research and other activities, the WHO-FIC cooperated with other groups outside of the WHO-FIC network.

Dr. Shuto postulated that going forward the WHO-FIC should split into a governing body and an academic group. The governing body should be made up of representatives from each country and should make all major decisions. It should be exclusive, as opposed to the academic body which would be open to anyone wishing to further health information management. The group would work on quality assurance for health data, the statistical analysis of data, and research for health policy making.

The sharing of information was important to the development of the APN. Dr. Shuto asked that everyone check the website of the network frequently. He also mentioned that he hoped that a database could be built for research, and he requested that the meeting discuss country visits as well as a "Facebook" approach to data sharing.

4. APN – Mortality Group

Dr. Wansa Paoin presented a report on the APN Mortality Group. For 2009-2010, the group aimed to compare and analyze data in the Asia-Pacific region on mortality, synthesizing results to draw new conclusions. In order to achieve this, the group had three work plans which consisted of country visits, mortality data mining, and death certificate quality analysis.

Concerning country visits, the group had visited the Republic of Maldives and Union of Myanmar, and planned to visit three other countries. In the Republic of Maldives the group had found that the country used ICD-10 for mortality data. The quality of data collected was fairly good, but an assessment of the country's death certificates produced an average quality level of around 35%. Dr. Paoin stated that the group would work with the country to improve the quality of their certificates.

In Myanmar, data collection was not being carried out very well. The cause of death was recorded on death certificates less than 50% of the time. However, the group found that the country had adequate capability to implement better data collection. A pilot project had been carried out to use ICD for deaths occurring outside of hospitals.

The group had discussed with both countries about tools for enhancing death certificate quality. In addition to helping the countries improve the quality of verbal autopsy, the group had also recommended the use of IRIS software.

Next, Dr. Paoin presented on the group's data mining efforts. The group was using three types of data mining to analyze information, which it drew from a WHO data pool. Dr. Paoin explained that they had organized data from each country into clusters, keeping statistics on the top 10 causes of death in each location. Cluster-0 contained countries in which the leading causes of death were cancer, cardiovascular and cerebrovascular diseases. Cluster-1 held countries with cardiovascular and cerebrovascular diseases as the top causes of death. Cluster 2 comprised countries having infectious diseases, malnutrition and traffic accidents as their leading causes of death, and Cluster-3 included countries where the leading causes of death were infectious diseases and traffic accidents.

Comparing the data, the group had been able to produce five best rules for the top five causes of death for each country. These included points such as "If CA lung is found, cerebrovascular disease will also be found 100% of the time." Dr. Paoin noted that the group did not necessarily know the reason behind any of the rules, but regardless, the exercise had shown that different data analysis techniques could produce solutions to mortality data problems.

The third work plan for the group involved death certificate quality assessment. Quality was assessed in terms of causes of death and general quality. The group had developed a medical certificate audit form and was assessing the correctness, detail of description and general quality of data for death certificates, assigning a score of 0-4 to each category. Zero meant that a category was incompatible with WHO ICD cause of death standards and 4 meant that a category was compatible with WHO ICD cause of death standards, and that the group had a strong confidence in the accuracy of the content of the category.

Questions and Comments

Dr. Boonchai Kijsanayotin noted that when the group was planning to go to other countries, they had run into problems concerning funding and coordination. He suggested that WHO actively advocate cross-region information sharing given how difficult it was for groups in individual countries to do this on their own. Dr. Üstün answered that he understood that working across regions was difficult, and that any single country initiative was doomed to fail. He believed that the answer lied with the APN. He suggested that the APN work to facilitate such trips. He also proposed that

the group in Thailand hold a meeting with WHO and other groups doing similar work and see what synergies could be formed to further mutual goals.

5. APN – Morbidity and Functioning Group

Prof. Syed Aljunid presented on the morbidity and functioning group. The group focused on how coded morbidity data could be used for policy formation and decision making. The group was implementing a case-mix system in Indonesia and Mongolia and was discussing moving into other developing countries as well. In Indonesia, the group was working with all 850 public hospitals, and had held four case-mix tariff workshops between January and April 2009. In Mongolia, the group carried out a case-mix system project in December 2009. It had conducted 10 workshops on coding, costing, and case-mix systems within the country. In October, the group would be holding the 4th International Case-Mix Conference in Kuala Lumpur. The group had also held workshops in Australia, and planned to do so in Japan.

For 2010, the group planned to carry out morbidity training in less developed countries. It would develop open source software for healthcare training, and hoped to launch an open source grouper. The group was also working to facilitate distance learning about coding.

Questions and Comments

Prof. Richard Madden expressed his excitement for the open source grouper, but asked if users would be restricted to using ICD-9-CM in the grouper. Prof. Aljunid responded that some programming would need to be done before other systems could be used.

Dr. Shuto raised a question about using ICF for morbidity data. Prof. Aljunid answered that the use of ICF had been requested within the group as a more objective way of measuring disability. Dr. Üstün exclaimed that putting data coming from ICF into case-mix groupings would help to encourage the use of the system. Prof. Madden raised the point that using the ICF may help Australia to develop its methods for complex rehabilitation, and suggested that there were possibilities for collaboration. Prof. Helena Britt argued that ICF was too complex for the average doctor. Australia had been testing Duke profiles, and had found them easy to use. She hoped that they would be developed to help everyone achieve a better understanding of disability.

Dr. Üstün informed the group that Dr. Halfdan Mahler had once famously said that ICD was only useful in primary healthcare as a doorstop. For a coding system to be useful to primary healthcare providers, it needed to be easy, cheap and cheerful. Mrs. Vera Dimitropoulos suggested that going forward, severity algorithms could be developed to have a more functional aspect. Dr. Üstün replied that functioning and severity were independent, although related, constructs, and that he was hesitant about the idea, noting that DIGs or Duke profiles may not always differentiate appropriately.

Dr. Üstün presented an update to the meeting regarding ICD revisions. The revision group had approached WONCA to ensure that the ICD-11 primary healthcare edition and WONCA's ICPC-3 revision would be nearly identical, or at least symmetrical. He encouraged the group to think about how the topics they were discussing could link into the revision process.

6. WHO Strategy for Primary Healthcare

In the period building up to the APN meeting, there had been a great imperative for WHO to focus on primary healthcare. Dr. Margaret Chan, Director-General of WHO, had stated that a return to a focus on primary healthcare would be essential to achieve the Millennium Development Goals. WHO was aiming to implement four reforms: universal coverage reform, service delivery reform, leadership reform, and public policy reform.

Dr. Üstün explained to the meeting the meaning of primary healthcare. It involved not just health, but a multifaceted system to support the development of healthy people. WHO was interested in engaging in primary healthcare for a number of reasons. First, it had been shown that a majority of patients sought medical treatment at primary healthcare facilities, 50% compared to the 1% that goes to hospitals for regular healthcare. Additionally, the position of WHO had been shifting toward primary healthcare since the 1960s and 1970s due to the influence of charismatic figures such as Halfdan Mahler and Henry Labouisse.

Dr. Üstün noted once again that Dr. Mahler had said that ICD only had use in primary healthcare as a doorstop. He also reminded the participants that they had come out of the last APN meeting with the decision that they would try to find a way to use the data being produced in primary healthcare for public health policy. In light of this, WHO-FIC had met with WONCA to develop a classification system which could be

used in primary healthcare, the International Classification of Primary Care (ICPC). Dr. Üstün believed that the system would be widely adopted if the information about it was simplified and put into a way that anyone could easily understand.

The mortality rate in countries with good primary healthcare systems was better than in those with poor primary healthcare systems. Dr. Üstün requested that the meeting focus on how they could continuingly advance measurements of primary healthcare, as improvements to it would come about through solid analysis.

As an example of the importance of primary healthcare, Dr. Üstün presented the difference that reducing the budget for it had made on Indonesia. A 2% reduction in the budget for primary healthcare between 1996 and 1999 corresponded to a 14% worsening of the infant mortality rate. He further noted that better primary healthcare raises the life expectancy at all ages except ages 80 and above.

Question and Comments

Prof. Madden asked about how culture plays into primary healthcare. He wondered how WHO had been taking into account the problems of indigenous populations when thinking about primary healthcare. Dr. Üstün answered that perhaps there would need to be special attention given to these groups in order to counteract some of the historical inequalities that had led to chronic health problems in such communities.

Dr. Shinsuke Fujita proclaimed that it would be more cost-effective and better for the public if the medical community focused on changes that improved the lives of the people rather than health system improvements.

7. Country Presentations

7. 1 Australia

Prof. Britt presented on primary healthcare in Australia. The average Australian visited their General Practitioner (GP) 8 times per year. 50% of GPs used electronic systems, and of those, 21% utilized a program to classify diseases under ICPC-2. In general, GPs only used ICPC-2 for problems managed. In response to this situation, ICPC-2 Plus had been developed, an electronic system which allowed for GPs to enter in terms and have them automatically categorized in ICPC-2 or ICD-10-AM.

7. 2 Cambodia

Dr. Khemrary Khol reported that Cambodia was focusing on improving its healthcare system through district-based healthcare. To this end, the country was utilizing outreach activities, health centers and referral hospitals to implement primary healthcare. 87% of new healthcare cases reported in 2008 came from primary healthcare locations. Information on these cases was collected through health center registers, medical records and outreach registers. This information was then turned into electronic data at each district office and sent to the Department of Planning and Health Information. The country was working to create health information guidelines to facilitate the collection of data to be used in planning going forward.

7. 3 China

China had implemented a three-tier health network, a rural health workforce and a rural cooperative medical center to strengthen primary healthcare, particularly in rural areas. Dr. Qin Jiang informed the meeting that two 10 year plans had been developed and carried out, and 11 key indicators of health had been developed for implementation by local governments. The country was aiming to achieve two objectives by 2010: 1) develop a valid and safe health information system; 2) improve the healthcare systems in developed areas to be equivalent to those of middle-income countries. The government was requiring the mandatory information coding of records by doctors, providers or coders. At the time, only paper-based information was collected, but there were plans to put electronic information systems into place.

7. 4 Hong Kong, China

Dr. Ting Hung Leung presented on primary healthcare in Hong Kong, China. In 2008, 27% of outpatient visits occurred in the public sector while 73% occurred in the private sector. At the same time, the public sector provided various services for community based care and preventive care. Regarding the collection and maintenance of primary care health information, a Clinical Management System was being utilized by the public sector for the storage and retrieval of patient data. For the private sector, all

practitioners were required to maintain patient records, but were not required to submit the records to the government. Regarding the coding of patient records, a clinical vocabulary table was being used that allowed practitioners in the public sector to input diagnoses directly into the Clinical Management System. In addition, ICPC-2 was also adopted for diagnoses coding in the public sector. However, there was no standardized approach for coding of diagnoses in the private sector. A working group had been set up to develop a territory-wide electronic health record (eHR) sharing system, with the aim to have it ready by 2014.

7. 5 Japan

The Japanese medical system did not have a definition of, or any statistics on, primary healthcare. Dr. Fujita therefore presented his personal data on the subject. He noted that most doctors in Japan specialize in organ specific medicine, with only a few going into primary healthcare. About 4% of patients sought treatment at a primary healthcare facility in 2007. Dr. Fujita reported that primary healthcare practitioners' groups in Japan were organizing and aiming to improve the quality of primary healthcare.

Dr. Sukil Kim asked about the classification of clinics. He understood that clinics were not classified as primary healthcare facilities in Japan. Dr. Fujita answered that this was the case, and that it was one reason why statistics for primary healthcare usage were so low.

7.6 South Korea

Information in the South Korean system was primarily collected from facility records and aggregated at the national level. Prof. Ok-Nam Kim reported that multiple data monitoring systems had been developed. Among these was the Korean Tuberculosis Surveillance System, which utilized electronic data and ICD codes to fight against tuberculosis. Additionally, the country was collecting data on discharged patients and had collected the data on a national patient survey website, where it was being used to manage facilities.

Dr. Kim added some information on primary healthcare. 96% of healthcare in South Korea was carried out at primary healthcare facilities. 6.4% of South Korean GDP was expended on healthcare, and the number was rising.

7.7 Malaysia

Prof. Aljunid presented on primary healthcare in Malaysia. Most health services in Malaysia were provided by independent practitioners who were not heavily controlled by the government, and thus it was hard to collect data on primary healthcare. Publicly, Malaysia had invested a lot into building the primary healthcare system, and had created a three-tier system comprising of main health centers, sub-health centers, and midwife clinics. On the private side of primary healthcare, Prof. Aljunid noted that private clinics saw 60% of the patients in Malaysia. The clinics provided medical services and prescription drugs. There was no communications link between private care facilities. New records were created every time a patient visited a new facility. Patient data was only collected at the healthcare facility level, and the data was aggregated at the district, state and national level. ICD was used in all public facilities, and ICPC was used in some private clinics.

7.8 Papua New Guinea

Prof. Britt presented on behalf of Papua New Guinea. She noted that health information management in the pacific islands region was not very well developed, but there were many networks which had been formed to help pacific island countries improve the situation: 1) a Pacific Senior Health Officials Network had been established to carry out senior-level policy exchange to improve healthcare in member nations; 2) a Health Information Systems Knowledge Hub had been built to carry out reviews of the health programs being implemented in each country; 3) The Pacific Health Information Network carried out information sharing and workshops to assist island countries with healthcare services health management; and 4) the National Centre for Health Information Research and Training had been formed to advance education on ICD-10.

7.9 Thailand

80% of the health professionals in Thailand worked in the public sector. Dr. Kijsanayotin noted that it was hard to talk about the private sector as there was not

much data being collected on it. The average primary healthcare facility in Thailand was a Primary Care Unit (PCU). There were more than 10,000 PCUs in the country, and many of them were staffed only by medical assistants or nurses. PCUs frequently collected data on patients. It was reported that PCU staff spent 40% of their time on data management. The units were keeping administrative and clinical data and using it for medical record keeping and for administrative uses.

8. Closure of Day One

Dr. Üstün closed day one of the meeting at 17:19 with a request that the meeting start the following day with talk of how WHO could meet the needs of the primary healthcare situations of each country.

Day Two

1. Opening of Day Two

Dr. Üstün opened day two of the meeting at 9:10.

2. Using WHO-FIC in Primary Care

Prof. Madden presented on the work of the family development committee, which had been working for 10 years to facilitate the use of ICD classifications in primary care. He summarized the definition of primary care for the meeting as the first level of contact for individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, constituting the first element of a continuing health care process.

A number of classifications, such as ICD and ICF, had relevant terms for primary care, but only IPCP had been designed for the topic. Neither ICD or ICF were fit for classifying Reason For Encounter (RFE), whereas ICPC was designed to use the language of patients and clinicians to label RFE.

Prof. Madden also discussed intervention and medicines, and suggested that both should be "opened" to ICPC, in other words, the classification should be connected to ICHI and ATC, the systems designed for each topic respectively. ICPC could serve across an episode of care, and could be the key to many other WHO-FIC classifications fit for purpose.

Questions and Comments

Dr. Ting Hung Leung asked about how a system could be built which could be integrated into all levels of care. Prof. Madden responded that if ICD-11 included information on primary care, information would be able to flow seamlessly from first encounter to more granular levels of detail later on.

Dr. Kijsanayotin asked about the transfer of data between ICD and ICPC. Prof. Britt responded that WONCA had tried to map data between the two classifications, but this had provided them with results that they felt were unusable. Prof. Madden added that starting an episode of care with ICD was not possible in his opinion, as there would not

be enough information at that stage to populate the classification system. It was important to create a system that allowed for a flow of data between the classification systems appropriate for each stage of care.

Dr. Jiang enquired about the coverage of social issues in the ICPC, for topics such as food security and endemic disease. Prof. Britt answered that ICPC had some classifications for social issues and that a revision was being carried out to expand its treatment of such issues. Prof. Madden mentioned that he felt that ICPC was not yet fit for use with social issues; it had been developed by an organization that did not define primary care as including a wide-variety of such issues. He welcomed the discussed revision.

3. Reactive Panel Discussion

3.1 Response from WONCA

Prof. Britt noted that it is often assumed that WONCA had defined episodes of care. This was not the case. Rather episodes of care were meant to be a reflection of the patient's experience. A patient with a headache this year, a migraine the next and a brain tumor the following year may not feel they had experienced three medical problems. Rather, the patient would feel that there is continuity between the three; this was the reason for thinking about care in terms of episodes.

The idea behind RFE was the need to classify patient visits in terms of patient needs. There may be many reasons why a patient would visit a medical facility, and these reasons may not always include illness. It may also be for such reasons as a checkup, a renewal of prescription or a service. It was necessary to have coding which could accurately describe such varied reasons.

Prof. Britt confirmed that WONCA agreed with Prof. Madden about opening ICPC to ICD. As for linking ICPC to ATC, WONCA believed that a lot of work needed to be done in the area of prescription. In the Australian medical system, prescriptions were linked back to diagnosis, but not the other way around. Prof. Britt cautioned that linking ICPC to ATC may not be the way to improve the situation.

Questions and Comments

Dr. Kijsanayotin raised the point that each system had problems in being sufficient for some things and inadequate for others. He suggested that SNOMED allowed for the most granular descriptions of care, and urged WHO to not become set in the mindset of ICPC. Prof. Britt stated that Australia was looking into how SNOMED could be used in primary care. She hoped that a situation could be created in which GPs would not have to learn SNOMED, but could enter information as they understood it and have it converted to whatever classification system necessary. The meeting discussed wide-spread misunderstanding of SNOMED as a classification system.

3.2 Response from the Japanese Primary Care Societies

Dr. Fujita presented on primary care trends in Japan, noting that since 1990 Japan had entered a period of aging, depression, and rising medical costs. He showed the meeting a map of the Chiba region comparing the number of hospitals in the areas within it to their average life expectancy. Life expectancy was not connected to the size of the hospitals in an area but the number of hospitals available for use.

The introduction of medical insurance after World War II had increased life spans in Japan dramatically. Medical costs did not grow much until 1990, but had been on the rise since then. Dr. Fujita noted that this was due to the aging population and an increase in deaths since the period, suggesting that death was the reason for the increase in cost. The average death in Japan cost 3 million yen.

Ambulance calls had steadily increased since World War II, up to the point of 5.5 ambulance calls per death. Dr. Fujita speculated that this showed anxiety over healthcare in the country. Time to emergency room figures had also been increasing. He noted that at Chiba University Hospital, over 60% of patients who used ambulances were mild cases. Frequent use of ambulances and usage of an ambulance for a mild problem suggested high anxiety over healthcare. Dr. Fujita hoped that primary care services could act as gatekeepers alleviating the concerns of patients before they felt the need to go to the hospital. If primary healthcare could serve such a role, medical costs could be kept down and patients would feel more secure.

Questions and Comments

Dr. Üstün suggested that the theme of the morning session was the journey from what the patient experienced to how that was classified. He noted that many in the meeting

had stated that it was important to keep things simple and patient-orientated lest they get lost in too much unusable detail. Dr. Kijsanayotin agreed, commenting that there are many facts in every episode, and what is important is to extract meaning from those facts.

4. Implementation of ICD in Primary Care Units

Dr. Paoin presented on how PCUs were utilizing ICD. He started by explaining that coding was primarily done only when staff members of PCUs had free time, and thus was not necessarily carried out meticulously.

An evaluation of ICD-10 usage in PCUs had been carried out in 2007, finding error rates of 70-90%. The most common type of error was invalid coding. The reason for the high rates of error was found to be a lack of information – there were no ICD books available for PCUs, and on average no training was carried out. Coding was done through the use of a diagnosis list, but the practitioners doing the coding were not always able to find the correct term.

There was resistance in Thailand regarding the use of ICPC-2, as practitioners were wary of using two systems, especially when it was not easy to convert data between ICD-10 and ICPC-2. Thus a project was started to make ICD-10-TM easier to use in PCUs. The project had eliminated complexity by clearing up confusing code descriptions and disposing of non-user friendly words and symbols. The first version of ICD-10-TM for PCU was released in August 2009, and three-day training sessions were subsequently carried out in each province. PCUs were encouraged to use full ICD-10-TM once they became familiar with ICD-10-TM for PCU.

The project had shown success, and Dr. Paoin suggested that given the results, he believed that ICD and ICF should be the first classification systems introduced to developing countries. Following the establishment of familiarity in the two systems, others could be introduced.

Questions and Comments

Dr. Robert Jakob asked about changes that had been made to the code in simplifying it, and assured Dr. Paoin that WHO was discussing cleaning up any unspecific or confusing code descriptions in the ICD-11 revision. Dr. Paoin responded that in

simplifying the code they had eliminated the asterisk sections of code but left the rest intact.

5. Summary of the Morning Session

Dr. Üstün presented the meeting with 10 principles from the morning session for approval:

1. A Primary Care classification must be short and simple.
2. There should be no redundancy between coding systems. ICD-11 and ICPC should be compatible.
3. Classification rubrics in primary care are heterogeneous ranging from; there may be many different factors important to each case. There needs to be a proper decision of what factors are to be defined in classification.
4. Primary care does not exist on its own, but within an overall health system. Primary care should not be approached as if there is no secondary or tertiary care. This must be considered when designing the PC Classifications and appropriate collaboration systems built between pris mary, secondary and tertiary care systems.
5. It is important that Primary Care Classification revision be well coordinated for different types of providers and consumers. There needs to be efficient sharing of information between all stakeholders.
6. The Primary Care Classifications should be based on established terminologies/ontologies. This will be the basis for linking with health records and assuring quality assurance. This underpinning systems will enlight how different coding systems interact with each other.
7. There must be incentives for the users of Primary Care Classification. Primary Care Practitioners will classify if they are given reasons to do so, and classification systems should be developed with this in mind. One incentive for use of the system may be the management guidance.
8. In many countries it is not possible to have a second layer of coders in addition to the practitioners. Methods should be developed for primary care providers allowing code themselves.
9. PC classifications should be tested in the real world to identify issues of feasibility, reliability and these tests should be used to improve their user-friendliness.
10. PC classifications should be of at least two levels of complexity: (a) resource poor settings; (b) resource rich settings.. PC Classification systems should be usable electronically and on paper.

Questions and Comments

Mrs. Dimitropoulos declared that she believed that at the end of the road they would need coders to make sure that definitional concepts were correct. Concretely deciding on definitions before proceeding with system development was extremely important. Additionally, she didn't think that the group needed to shy away from complex definitions within the database. The interface of the system should be simple for doctors, but the database itself may be highly sophisticated. Dr. Fujita offered his opinion that the most important thing was the ability to use data for the improvement of medical practices. If the data could help healthcare providers to improve their practice, that would be incentive enough.

Dr. Üstün went around the room asking each country for input.

Dr. Leung answered for Hong Kong, China and raised a number of issues. He stressed that it was important to develop a system that protected patient confidentiality. Additionally, he preferred that the system be implemented in such a way as to provide electronic information on prescriptions, summaries of patient information, and test results. Such functions would lead to the improved practices and provide incentives for the use of the system.

Dr. Jiang emphasized that for China it was very important that a system be developed allowing for real-time coding by providers, given that doctor handwriting could sometimes be very difficult to interpret.

Dr. Khol stated that in the case of Cambodia, there needed to be established a simple classification system for the local level. The use of this data, and more complex coding, would be better implemented only at the hospital level.

For the Australian delegation, Prof. Britt answered that she agreed with Dr. Fujita that it was vital to create a system allowing for a better patient experience.

Dr. Kim declared that classification systems should be developed to suit users in each country, and this included creating localized translations of the terms of the classification system.

Dr. Fujita said that the key issue for Japan would be who would be doing the coding.

For Malaysia, Prof. Aljunid said that given conditions in the medical field of the country, it was unlikely that ICPC would be introduced any time soon, and it would be further difficult to introduce the two new systems of ICD-11 and ICPC-3. Dr. Üstün clarified that he envisioned the two classifications to be so similar that they were basically the same.

6. ICD 10 Training Tool

The meeting moved on to a presentation about some initiatives WHO was taking to facilitate ICD usage. Dr. Jakob first discussed a questionnaire which had been created to evaluate ICD-10 usage, and asked that any countries which had not inputted their data do so.

Following discussion of the questionnaire, Dr. Jakob explained progress WHO had made in creating a tool for ICD-10 training. The tool had been designed to help users create and utilize data. WHO assumed that those with and without medical backgrounds would need to code data, and that people with and without medical backgrounds would need to use that data. The organization estimated that data was primarily being used for public health mortality and morbidity studies, casemix groupers, quality and patient safety studies, and primary healthcare evaluations. In order to assist with these usages, 2,000 screens had been created for 40 hours of training, and course versions had been designed to suit different user types, such as certifiers. The text of the tool had been extensively reviewed, and was at the time ready for its first overall review.

The tool would be available at a low price and have extensive free distribution. It would be available electronically and on a CD-ROM, and Dr. Jakob estimated that it would be launched by the Annual Meeting of the WHO-FIC Network in Seoul. Dr. Jakob thanked everyone who had contributed to the project.

7. Discussion on Future Activities

7.1 Recommendations from the Morbidity and Functioning Group

Dr. Shuto presented on the recommendations of the Morbidity and Functioning Group for future APN activities.

The group suggested that there be mid-year meetings between the different groups in the region, as well as a meeting before the Annual Meeting of the WHO-FIC in Seoul. Dr. Kim suggested that mid-year meetings be held in different countries around Asia.

Conversation moved to who would host the next meeting of the APN. Dr. Paoin pointed out that given the suggestion to hold the next meeting the following April, it was vital that they choose a host soon. It was decided that all interested members would explore the decision in their home countries and report their situation to Dr. Shuto as soon as possible.

Dr. Shuto asked the meeting if the following April would be acceptable for the next meeting. Dr. Jakob explained that April was being recommended in order to try to connect different meetings to each other so that members of different groups would be able to reduce the amount of times they had to travel. Prof. Madden asked if it would not be better to hold the next meeting in April 2011 so that there would be ample time to make progress on APN issues. Dr. Üstün did not believe that April 2010 was too soon.

Dr. Shuto concluded that the venue for the next meeting should be selected from Thailand, Australia or China and that a decision should be made before the Seoul meeting whether the meeting should be held in April 2010 or April 2011.

Participants discussed funding for international training programs and meetings. Meeting participants asked Dr. Üstün if he could approve funding. He responded that he could help to enable funding, but could not personally approve it after a certain amount. Above that amount, those wishing to receive funding would need to fill out a project proposal and apply for funding.

Prof. Aljunid brought up the idea of creating an initiative to introduce ICF in selected countries. It was requested that Prof. Aljunid submit a proposal for what activities would be carried out. The proposal would then be circulated for approval. Prof. Aljunid explained that he had received two requests from groups in Malaysia and Iran on using ICF for disability compensation purposes. He suggested that training programs be organized for the groups.

Dr. Paoin asked about using APN letterhead when contacting groups in other countries. Dr. Üstün answered that if their plans were in line with the work plan, he would write to the group in the country Dr. Paoin wished to contact telling them that Dr. Paoin's group would be paying them a visit as an officially sanctioned operation of the WHO-FIC APN.

7.2 Strategic Plan for Work

Dr. Shuto asked Australia to comment on further activity in pacific island countries. He informed the meeting that Japan was eager to work with pacific island countries in the future and was prepared to offer funding to help them. Prof. Britt responded that she would communicate the message to those in charge of maintaining contact with pacific island countries.

Dr. Shuto asked participants to contact him if they had any suggestions on how to improve the website of the APN. He also requested everyone to continue to cooperate with the research being carried out by the Japan Hospital Association.

Discussion moved on to the use of a "Facebook-like" group to facilitate communication within the network. Dr. Üstün explained that WHO would provide funding for the creation of a networking site if countries were interested. He would write a proposal on the matter. Dr. Kijsanayotin suggested that rather than creating something new, the network form a closed group on Google or another website. Dr. Üstün stated that he would look into different options and make a proposal.

The meeting discussed efforts to encourage the involvement of non-attending countries. Dr. Paoin suggested that groups discuss the work of the network with other countries at other international meetings. Dr. Shuto said that a practical way to invite non-attending countries was to support the work of the mortality group and morbidity and functioning group in reaching out to new countries. He did not see a need to form a separate group to pursue the issue; for the time being he felt that supporting the two groups was a good first step. It was decided that further communication would be carried out on the issue at a later date.

Dr. Shuto moved the topic of discussion to continued support for the mortality and morbidity and functioning groups in their academic activities. Dr. Kijsanayotin asked

about funding for new research. Dr. Shuto responded that the network was not a legal corporation and thus could not raise and provide funding. Money would have to come from WHO. Dr. Üstün reminded the meeting that any work requiring funding would need to be part of the APN work plan which was approved by WHO.

Dr. Shuto closed the discussion on future activities, stating that he would be in contact with those in the network for further conversation. Dr. Üstün reminded that WHO had asked each country to put their information into the ICD-10 PLUS platform. That information was being entered into auditing software to produce a list of improvements for the ICD-11 revision. A workshop would be held a few days after the APN meeting with managing editors from each TAG to discuss the list and develop an alpha (non-public) draft of the ICD-11 revision. The following May, the alpha draft would be distributed and there would be a one year period in which the beta draft would be developed. That draft would be open for public improvement. Steps would be taken to merge together ICD-11 and ICPC-3.

8. Closure of the Meeting

Dr. Üstün made closing remarks on behalf of WHO. He thanked everyone for coming to the meeting and for all of their hard work. He expressed particular gratitude to the work group chairs. He expressed confidence in the group's ability to work together in the future. He thanked the Japan Hospital Association for their support in forming the network. He also thanked the Ministry of Health, Labour and Welfare and the organizers of the meeting.

Dr. Shuto thanked all the participants for their attendance and closed the meeting at 17:07.

Appendix: List of Participants

Australia

Prof. Helena Britt	Director, Australian GP Statistics and Classification Centre, Australian Institute of Health and Welfare & University of Sydney
Prof. Richard Madden	Professor of Health Statistics, Director of National Centre for Classification in Health, University of Sydney
Mrs. Vera Dimitropoulos	Assistant Director, National Centre for Classification in Health, University of Sydney

Cambodia

Dr. Khemrary Khol	Chief, Bureau of Health Information, Department of Planning and Health Information, Ministry of Health

China

Dr. Qin Jiang	Deputy Director, Research Center for Classification of Health Intervention and Payment System, China Health Economics Institute, Ministry of Health, P.R. China
Dr. Zhi-Guo Zhang	Staff, Research Center for Classification of Health Intervention and Payment System, China Health Economics Institute, Ministry of Health, P.R. China

Hong Kong, China

Dr. Ting Hung Leung	Head, Surveillance and Epidemiology Branch, Centre for Health Protection, Department of Health, Hong Kong SAR
Mr. Wing Kai Kwan	Statistician, Health Statistics Section, Surveillance and Epidemiology Branch, Centre for Health Protection, Department of Health, Hong Kong SAR

Japan

Mr. Satoshi Ono	Director, Vital and Health Statistics Division, Statistics and Information Department, Ministry of Health, Labour and Welfare
Dr. Kayo Takimura	Director, ICD Office, Vital and Health Statistics Division, Statistics and Information Department, Ministry of Health, Labour and Welfare
Dr. Kenji Shuto	Aide of the Minister, Health Sector Reform Office, Minister's Secretariat, Ministry of Health, Labour and Welfare
Ms. Emiko Oikawa	Technical Advisor, ICD Office, Vital and Health Statistics Division, Statistics and Information Department, Ministry of Health, Labour and Welfare
Mr. Tsutomu Ishiyama	Chief, ICD Office, Vital and Health Statistics Division, Statistics and Information Department, Ministry of Health, Labour and Welfare
Dr. Shuzo Yamamoto	President, Japan Hospital Association
Dr. Toshio Oi	Vice-President, Japan Hospital Association/ Chairman, Japan Society of Health Information Management
Dr. Tsuneo Sakai	Vice-President, Japan Hospital Association/ Chairman, the 35th Annual Meeting of the Japan Society of Health Information Management
Mr. Kazuhide Yamaguchi	Special Adviser, Japan Hospital Association
Mr. Naoichi Yokoyama	Director-General of the Secretariat, Japan Hospital Association
Ms. Yukiko Yokobori	Head, Distant Training Division, Japan Hospital Association
Dr. Shinsuke Fujita	Associate Professor, Chiba University Hospital

Republic of South Korea

Dr. Sukil Kim	Associate Professor, The Catholic University of Korea, College of Medicine
Prof. Ok-Nam Kim	Research Professor, The Catholic University of Korea, College of Medicine

Malaysia

| Prof. Syed Aljunid | Professor, United Nations University, International Institute for Global Health |

Thailand

Dr. Wansa Paoin	Chief Knowledge Officer, Faculty of Medicine, Thammasat University
Dr. Boonchai Kijsanayotin	Medical Informatics Officer, Bureau of Policy and Strategy, Ministry of Public Health
Ms. Maliwan Yuenyongsuwan	ICD officer, Bureau of Policy and Strategy, Ministry of Public Health

Vietnam

| Dr. Ha Thai Son | Hospital Information System Manager, Administration of Medical Service-Ministry of Health |

WHO

| Dr. Bedirhan Üstün | Coordinator, WHO, Classifications, Terminologies, Standards |
| Dr. Robert Jakob | Medical Officer, WHO, Classifications, Terminologies, Standards |

Secretariat

| Mr. Koichi Nishikawa | Chief Examiner, Distant Training Division, Japan Hospital Association |
| Mr. Hajime Kikkawa | Chief Examiner, Distant Training Division, Japan Hospital Association |

Observer

| Dr. Makoto Anan | Vice Chairman, Japan Society of Health Information Management |
| Dr. Sotaro Suzuki | Vice Chairman, Japan Society of Health Information Management; Special Adviser, Fujisawa City Health &Medical Center |