

World Health Organization Family of International Classifications 2018

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Authors:

WHO-FIC Family Development Committee – Family paper writing group

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Acknowledgments

Detailed development of this paper was undertaken by a Writing Group consisting of the following members of the WHO-FIC Family Development Committee (alphabetical order):

Keith Denny
Lyn Hanmer
Jenny Hargreaves
Robert Jakob
Cassandra Linton
Brooke Macpherson
Richard Madden
Andrea Martinuzzi
Huib ten Napel
Catherine Sykes.

This work builds on earlier work by Dr John Ashley (United Kingdom) and Dr Willem Hirs (Netherlands), and the predecessor paper 'World Health Organization Family of International Classifications: definition, scope and purpose' published in 2007 and authored by Richard Madden (Australian Collaborating Centre), Catherine Sykes (Australian Collaborating Centre) and T. Bedirhan Üstün (World Health Organization).

This revision was developed with inputs from many members of the WHO-FIC Family Development Committee. Marie Vikdal made significant input to the revision of the Family diagrams (figures 2 and 3).

Introduction

The World Health Organization's Family of International Classifications (WHO-FIC or Family) is a set of products that can be used to support the production of health information nationally and internationally to inform health system financing and resource allocation, evidence-based practice, monitoring of health outcomes and access to services, and the assessment of the health of individuals and populations. The WHO-FIC provides a standardized common language for coding a wide range of information about health and wellbeing, and about interventions delivered to individuals and populations. The classifications have been developed based on sound scientific principles, ensuring that the classifications are internationally and culturally appropriate.

The Family includes three core ("reference") classifications. The oldest of these is the *International Statistical Classification of Diseases and Related Health Problems* (ICD), which is used to classify diseases and related health problems, such as symptoms and injury. Functioning is classified separately in the *International Classification of Functioning, Disability and Health* (ICF) together with environmental factors. The third reference classification, the *International Classification of Health Interventions* (ICHI), is in the final stages of development and classifies health interventions delivered across all sectors of the health system.

Since 1970 WHO's work on international classifications has been supported by a network of WHO-FIC Collaborating Centres and non-governmental organisations. The principal role of the Network is to promote the development, implementation, use, maintenance and updating of WHO reference classifications.

This paper describes the Family and its members, focussing on how the Family is modernizing to meet health information needs in the digital age. The paper is intended for a range of readers; it does not assume prior knowledge of the WHO-FIC or technical expertise. It will be of value to those with an interest in the production and use of high quality statistical information about health, including government officials, policy- and decision-makers, clinicians, researchers, educators, managers and administrators, and health system users.

This paper describes the relationships between the components of the Family, and in particular how the reference classifications relate to each other, and to related and derived members of the Family. The publication of this paper in 2018 coincides with major developments within the Family: ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS), was released in June 2018 and will come into effect on 01 January 2022; an updated version of the ICF was released in June 2017; and ICHI has reached beta stage, with extensive testing planned for 2019. It is hoped that this publication will assist all stakeholders to navigate this significant and exciting phase of availability of improved and practical classification tools, in support of the WHO mandate of promoting and supporting the provision of universal health care internationally.

1. World Health Organization Family of International Classifications – *the Family*

The WHO-FIC, or Family, is a set of integrated classification products that share similar features and can be used individually or jointly to provide information on different aspects of health and health systems. The classifications are designed to cover the core dimensions of death, disease, functioning, disability and health interventions.

The constitution of the World Health Organization states that “Each Member shall provide statistical and epidemiological reports in a manner to be determined by the Health Assembly” (Article 64). In support of the requirement of member states to provide data in a form that can be compared across countries and over time, one of the functions of WHO is to “establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices” (WHO 1995). These international statistical classifications, endorsed by the World Health Assembly for reporting on the health of populations of member states, are the basis of the Family.

The Family consists of three (3) broad groups: reference classifications, derived classifications and related classifications. The reference classifications are international reference standards, from which the derived classifications have been developed to accommodate information needs in specific areas of health. Related classifications cover health domains beyond mortality and morbidity, functioning and health interventions (e.g. medicaments).

The reference classifications within the WHO-FIC are part of the broader UN Family of Statistical Classifications (<https://unstats.un.org/unsd/classifications/Family>). The UN Family also includes other classifications of relevance to health service production and financing.

Purpose

The purposes of the WHO-FIC are to:

- provide a conceptual framework of information domains for which classifications are, or are likely to be, required for purposes related to health and health management;
- provide a set of endorsed classifications for specific purposes defined within this conceptual framework;
- facilitate the storage, retrieval, analysis, disaggregation, interpretation and exchange of data for individuals and populations and the compilation of internationally consistent data;

- improve health through provision of sound health information to support decision making at all levels, including to support financing of health systems (including case mix classification systems and general funding of health services); and to
- stimulate research on health and the health system.

All the above-mentioned uses characterize the WHO-FIC as a set of tools for the monitoring of relevant targets identified within the Sustainable Development Goal number 3 “Healthy lives and well-being for all at all ages” (SDG3). More specifically the WHO-FIC could be a key element in monitoring Universal Health Coverage, one of the most critical of the SDG3 targets.

Characteristics

To achieve these purposes, WHO-FIC classifications must:

- be based on sound scientific, taxonomic and ontological principles
- be culturally appropriate and internationally applicable
- focus on the multi-dimensional (bio-, psycho-, social-) aspects of health
- meet the needs of its different and varied users
- reflect current knowledge while providing relative stability over time
- enable derivation of summary health measures
- provide a platform for users and developers
- be compatible with the use of information from electronic health records and terminologies.

Statistical classifications and clinical terminologies

The use of standardised language supports the generation of data that are consistent and comparable. Classifications and clinical terminologies such as SNOMED CT are such ‘standardized’ languages, but fulfil different roles.

According to the definition of a *terminology* in ISO 1087-1:2000, WHO classifications and clinical terminologies can both be regarded as terminologies. Nevertheless we need to distinguish between classifications and clinical terminologies in terms of their purpose.

The ISO 17115 defines classifications and clinical terminologies as follows (International Standards Organization 2007):

- Classification: ‘an exhaustive set of mutually exclusive categories to aggregate data at a pre-prescribed level of specialization for a specific purpose’.
- Clinical terminology: ‘terminology required directly or indirectly to describe health conditions and healthcare activities’.

A (statistical) classification provides a system for the ordering and hierarchical grouping of concepts in a given domain for statistical purposes. The grouping of

concepts is driven by a purpose for which the classification is designed. Classifications have residual classes ('other specified') to ensure that all cases can be classified; thus, they can accommodate new or unanticipated things encountered in a domain. Classifications also include granular index-terms and rules that guide users to the required concept.

Typically, clinical terminologies are more granular than classifications, to support exchange of concepts at the level of detail required for documentation within a community of practice. A clinical terminology does not need to have mutually exclusive and exhaustive partitioning of a parent class. In health systems, clinical terminologies are designed primarily for the capture, storage, retrieval, translation, and communication of health data, while statistical classifications provide a foundation for collecting, aggregating, analysing, and comparing statistical data.

Statistical classifications and clinical terminologies play complementary roles in supporting health information needs (Fortune et al. 2017). Consistency and relatability between classifications and clinical terminologies are important for healthcare information tools to efficiently support the functioning of the health systems they serve.

With different developers and custodians of the various information products, international agreement processes are necessary for the development and maintenance of linkages between standard terminologies and classifications.

2. Scope and conceptual framework of the Family

What is the scope of the Family?

The Family serves to provide a classification system that has as its scope the range of needs for health data. Broadly speaking, data needs for health include:

- **Data on how healthy people are**
- **Data on factors that influence health**
- **Data on health systems responses.**

All types of these data, locally, nationally and internationally, are needed to implement Universal Health Coverage and support monitoring of the UN's Sustainable Development Goals, for example.

Health for these purposes is defined using the World Health Organization's 1948 definition:

- **A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.**

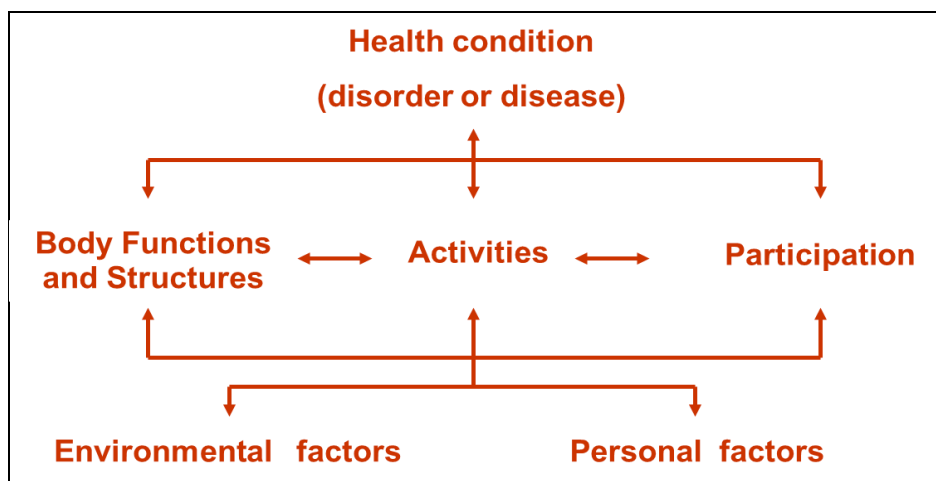
The range of factors that influence health, sometimes called 'determinants', are described by the WHO as follows (<http://www.who.int/hia/evidence/doh/en/>):

- Many factors combine to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact. The determinants of health include:
 - **the social and economic environment;**
 - **the physical environment; and**
 - **the person's individual characteristics and behaviours.**

The ICF provides a framework for the scoping and conceptual basis of the Family

The ICF is the WHO's classification for describing functioning and health at both individual and population levels, and is built upon the WHO biopsychosocial model of health (<http://www.who.int/classifications/icf/en/>) (Figure 1). The model depicts that, in line with the WHO's definition of health, the functioning and health of a person or population is the result of the interaction of health conditions, body functions and structures, and activities and participation in life areas, all influencing each other and influenced by environmental and personal factors.

Figure 1 Interactions between the components of the WHO biopsychosocial model of health



The biopsychosocial model and the WHO-FIC

The members of the Family can be related to the components of the biopsychosocial model:

- The ICD classifies **health conditions** (diseases or disorders as causes of morbidity or mortality). Although not its major role, it also classifies some **environmental factors** (for example, as external causes of injury and poisoning) and some **personal factors** (for example, as reasons for contact with health services).
- The ICF includes classifications of **body functions and structures, activities and participation** and **environmental factors**.
- The ICHI classifies health interventions. It incorporates classifications of **body structures and functions, activities and participation, environmental factors** and **personal factors** into its Target axis.

Thus, the biopsychosocial model provides an underpinning conceptual framework for the Family. This common conceptual framework supports both the complementary use of members of the Family to capture health data, and on-going integrated development of the Family. The framework also allows related classifications to be positioned in the Family, helping to ensure that they play a role in filling conceptual gaps.

3. Structure of the Family

The classifications in the WHO-FIC and the broader United Nations family of economic and social classifications are of three major types. Figure 2 represents the types of classifications in the WHO-FIC.

Figure 2 Schematic representation of the WHO-FIC

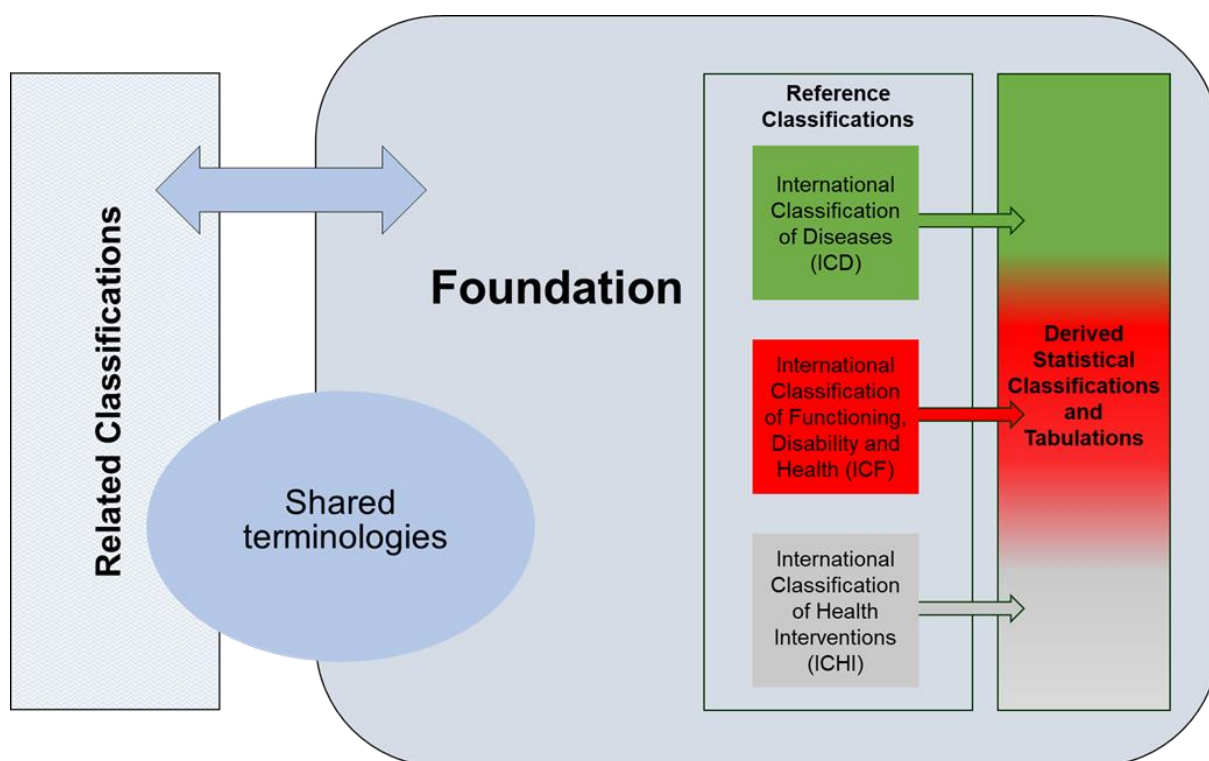


Figure 2 shows the relationships between the classifications in the Family of International Classifications, the Foundation and shared terminologies.

The Foundation, in its simplest form, is a large collection of terms which describe health and health related domains. The formulation of the Foundation is evolving. ICD-11 is the first WHO-FIC classification for which a Foundation component has been implemented.

Derived Statistical Classifications and Tabulations ('derived classifications') draw on terms that may come from one or more of the reference classifications.

Within the Family, related classifications are regarded as complementary to the reference and derived classifications. Related classifications have their own sets of terms, but can also share terms within the Family. For example, the International Classification of Nursing Practice (ICNP) (International Council of Nurses, 2017), a related classification in the Family, could draw on terms from the Foundation in the

same way that the reference and derived classifications could draw on terms from the Foundation. ICNP also uses terms specific to nursing practice which may not be found in the Foundation, but which could be included in the future.

Shared terminologies refers to the use of terms from the same terminologies by more than one of the reference, derived or related classifications.

Figure 3 The WHO-FIC as a bridge linking health and health systems and services.

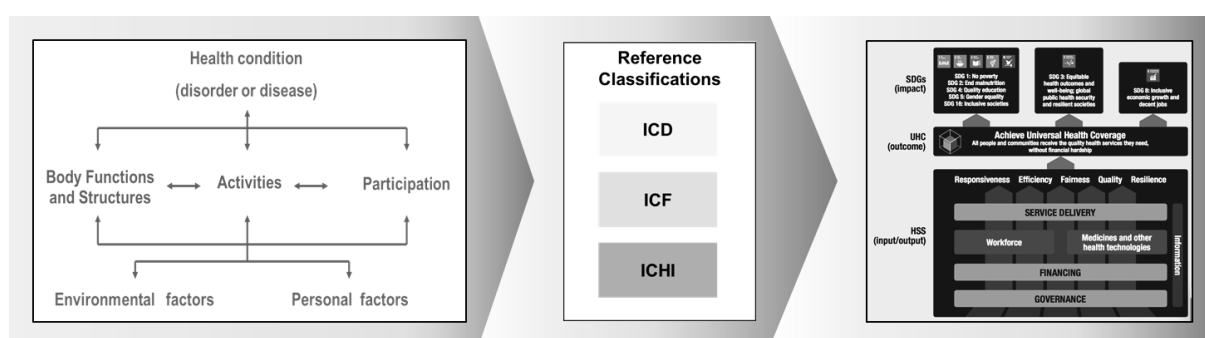


Figure 3 visually depicts the link that the WHO classifications provide, bridging health and functioning, as represented by the biopsychosocial model (both at the personal and population level), with the universe of health services as seen in the context of Universal Health Coverage and the Sustainable Development Goals (source for UHC/SDGs diagram: WHO 2017).

Reference classifications

The three reference classifications of the WHO-FIC are:

- the *International Statistical Classification of Diseases and Related Health Problems* (ICD), which is used to classify diseases and other related health problems, such as symptoms and injury.
- the *International Classification of Functioning, Disability and Health* (ICF), which classifies functioning and health, and
- the *International Classification of Health Interventions* (ICHI), which will classify health interventions. This classification is in the final stages of development with release anticipated by 2020.

These are the classifications that cover the main parameters of health and the health system, such as death, disease, functioning, disability, health and health interventions. They have achieved broad acceptance and official agreement for use and are approved and recommended as guidelines for international reporting on health. They may be used as models for the development or revision of other classifications, with respect to the structure, the character and definition of the categories.

International Statistical Classification of Diseases and Related Health Problems (ICD)

Structure and taxonomy of ICD are determined by a combination of history, relevance and feasibility. ICD needs to accommodate a broad range of settings and uses. All have different thresholds regarding the level of detail that is necessary and achievable. In the development of the classification, an important aspect is the balance between scientific progress and the need for statistical continuity.

ICD began life as the *International List of Causes of Death* in the closing years of the nineteenth century. By the early twentieth century, the list had been adopted by numerous countries and in 1899, its creators initiated a process of decennial revisions to ensure that it remained current in relation to developments in medical knowledge (Moriyama et al. 2011). At the time of writing this document, the most recent revision of the ICD in use is the Tenth (WHO 1989). The Eleventh Revision (ICD-11) was published in June 2018, for use from 2022, and represents a significant overhaul to optimise the classification for today's information technologies.

The original ICD list, as its name suggests, was intended for use in classifying causes of death. It has been widely adopted for this purpose in the compilation and dissemination of vital statistics around the world. From its first revision however, the list was also used by some to derive causes of sickness (Moriyama et al. 2011, p.13). The demand for this latter use grew throughout the first half of the twentieth century and the Sixth Revision (WHO 1948) incorporated a list explicitly for classifying morbidity.¹ Today, the ICD has evolved to a comprehensive classification system for use in mortality, morbidity, casemix, patient safety and quality (<http://apps.who.int/classifications/icd10/browse/2016/en>).

ICD-11

In developing ICD-11, a high degree of flexibility was sought to enable multiple needs to be met from a common base, the ICD-11 Foundation Component. As described in the ICD-11 Reference Guide, the ICD-11 Foundation Component is a structured collection of all ICD-11 entities (diseases, disorders, injuries, external causes, signs and symptoms) (WHO 2018a, Section 1.2.5).²

Each entity in the ICD-11 Foundation Component is defined in a standard way using a structured Content Model. The purpose of the Content Model is to encode the knowledge that provides the basis for the definition of each ICD-11 entity in a systematic way, that determines how more complex terms can be built from simpler terms in the ICD-11 Foundation Component, and that allows different tabular lists to

¹ It was with the Sixth Revision that responsibility for the maintenance of what was renamed as the International Statistical Classification of Diseases and Causes of Death was passed to the newly created World Health Organization (WHO 1948).

² Note that the ICD-11 Foundation Component refers specifically to the ICD-11 implementation. A more general concept of a Foundation for the WHO-FIC is presented in Figure 2 and Section 3 of this paper. The ICD-11 Foundation Component is therefore an example of the implementation of a Foundation for a specific classification.

be built from the ICD-11 Foundation Component. (WHO 2018a, Sections 2.1.14 and 2.10).

ICD-11 for Mortality and Morbidity Statistics (MMS) is the tabular list which forms the classification designed for mortality and morbidity coding. To keep its size manageable, ICD-11 MMS includes concepts with a common level of detail. More detail may be added using a range of extension codes (such as laterality, severity and temporality). ICD-11 MMS can be accessed at <https://icd.who.int/browse11/l-m/en>.

This structure provides a strong base for ICD-11. Importantly, the ICD-11 Foundation Component also allows a flexible way to develop specialist derived classifications consistent with ICD-11.

ICD-11 has been built using a flexible information technology platform, facilitating coding and translation into multiple languages. A comprehensive Reference Guide accompanies ICD-11 (WHO 2018a), which includes both mortality and morbidity coding rules.

International Classification of Functioning, Disability and Health (ICF)

The International Classification of Functioning, Disability and Health (ICF) was first released in 1980 as the International Classification of Impairment, Disability and Handicap (WHO 1980). It was endorsed for international use by the World Health Assembly in 2001 (WHA 2001). The ICF was designed as complementary to the ICD; integrated use of both classifications has the potential to provide a comprehensive perspective on functioning and health.

The ICF provides classifications and codes, a standard language and conceptual basis for the definition and measurement of human functioning and disability (WHO 2001). It conceptualises functioning as a 'dynamic interaction between a person's health condition, environmental factors and personal factors'. In reflecting the model of health embraced by the WHO, the ICF offers a shared perspective for defining and communicating data on functioning and health. Thus, ICF terminology influences the other WHO-FIC reference classifications and can be found in the definition of ICHI targets, as well as in the functioning rubric of ICD-11.

Functioning and disability are used as umbrella terms denoting the neutral and negative aspects of functioning from a biological, individual and social perspective. The ICF, in integrating major models of disability - the medical model and the social model - as a "bio-psycho-social synthesis", provides a multi-perspective, biopsychosocial person-centred understanding of health which is reflected in the multidimensional model. It recognises the role of environmental and personal factors in the experience of functioning, as well as the role of health conditions.

The interactions between the components of the ICF are shown in Figure 1.

Definitions and categories in the ICF are worded in neutral language, wherever possible, so that the classification can be used to record both the neutral and negative aspects of functioning.

ICF is organised in two parts:

Part 1 Functioning and disability

- body functions and structures, and impairments thereof (functioning at the level of the body);
- activities of people (functioning at the level of the individual) and the activity limitations they experience;
- participation or involvement of people in all areas of life, and the participation restrictions they experience (functioning of a person as a member of society).

Part 2 Contextual factors

- environmental factors which affect these experiences (and whether these factors are facilitators or barriers) (WHO 2001);
- the importance of personal factors to the experience of functioning is recognised in the ICF model, but they are not classified or coded.

More information about the ICF is available via the online browser (<http://apps.who.int/classifications/icfbrowser>) and the ICF Practical Manual (WHO 2013).

International Classification of Health Interventions (ICHI)

WHO and the WHO-FIC Network have been developing the International Classification of Health Interventions (ICHI) since 2007 (WHO 2018b). The aim is to meet many use cases including international comparisons, providing a classification for countries that lack one, and supplying additional content for countries that have a national classification focused on medical and surgical interventions. In addition, ICHI can support global initiatives such as the Sustainable Development Goals and Universal Health Coverage, and provide an information base for work on health system performance and patient safety.

ICHI incorporates a definition of “health intervention” that encompasses interventions for health promotion, disease prevention and treatment, rehabilitation, support and palliation provided by all types of providers across the entire health system, ranging from individual clinical interventions, through behavioural and educational interventions to those with broader public health objectives. ICHI covers all parts of the health system, and contains a wide range of new material not found in national classifications. It describes health interventions using the three axes of Target, Action and Means. Users may choose to record a range of additional information such as quantifiers, use of equipment and relationship to other interventions, using extension codes. The ICHI browser gives more information and may be found at: <https://mitel.dimi.uniud.it/ichi/>.

Target

The Target axis contains the entities on which the action is carried out. Targets include: anatomy, human function, person or client, and group or population.

Action

The Action is defined as a deed which is done by an actor to a target during a health care intervention. Actions include: investigation, treating, managing and preventing.

Means

The Means axis contains the entities describing the processes and methods by which the action is carried out. Means include: approach, technique, method and sample.

Derived classifications

Derived classifications are based upon one or more reference classifications, and are often tailored for use at the national or international level or for use in a particular specialty or setting. An example is the International Classification of Diseases for Oncology (ICD-O-3) (Fritz et al. 2000). ICD derived versions for special purposes include primary care, mental health and dermatology, and compacted versions like the Start-up Mortality List.

WHO permission is required for a specialist user group to develop a derived classification. Derived classifications must be made available to WHO for general use.

Related classifications

Related classifications are included in the WHO-FIC to describe important aspects of health and functioning or the health system which complement reference or derived classifications, or are represented and used differently. They may arise from work in other sectors of the WHO, as in the case of medicines (ATC-DDD). Some have been developed by other organisations such as the International Classification of Nursing Practice (ICNP), developed and maintained by the International Council of Nurses (International Council of Nurses 2017), and the International Classification of Primary Care (ICPC-2), developed and maintained by the World Federation of Family Care Physicians (WONCA International Classification Committee 1998).

Related classifications should be as accessible to users as other classifications in the Family.

Custodians of related classifications need to collaborate actively with the WHO and the WHO-FIC Network to increase alignment between their classifications and the Family, to meet evolving client needs in the most efficient form possible.

There is a range of health-relevant classifications that are not currently related classifications in the WHO-FIC. These include the classifications of health care functions and health care providers included in the System of Health Accounts (OECD/Eurostat/WHO 2011). Other health relevant concepts are classified in more

general classifications, including the International Standard Industrial Classification (United Nations 2008) and the International Standard Classification of Occupations (International Labour Organization 2008). Appropriate use of these classifications in association with the WHO-FIC is important to promote international comparability and to avoid possible duplication.

Using the classifications together

One of the challenges within the WHO-FIC is the alignment of classifications, including related classifications, to facilitate effective joint use of the classifications.

The reference classifications contain several similar concepts (such as anatomical terms). There has been an initial effort to align concepts across the three reference classifications, although this process is far from complete. However, it is a vision for the Family to have a structure for common concepts sharing a common ontology. Ontology in this context refers to the underlying logical structure of a classification. Ontology explains how a certain domain can be described in terms of how categories relate to each other and which terms belong to a certain category. The ICD-11 Foundation Component, including all ICD-11 terms, will in time form the basis for a planned common Foundation for the WHO-FIC, as described in Figure 2.

An aim of the Family is to work with custodians of related classifications to reduce, as far as possible, inconsistencies with reference classifications, which could involve change in either the reference classification or the related classification, or both.

A way forward is through:

- involving custodians in the WHO-FIC Network to establish working relations;
- sharing ontological approaches between the member classifications;
- comparing content models to identify the describing entities or parameters and concepts;
- proposing solutions for differences.

Alignment

An aim of the Family is that a concept should be described only once. Concepts from one classification may be used in other classifications, and they should have the same label.

This principle has been followed in the ICF and ICHI, where associated health conditions are not included but sourced from the ICD. Many ICHI Targets are sourced from the ICF. The result is classifications of more manageable size, and avoidance of the need to harmonise going forward.

Development and update cycles

A criterion for inclusion into the Family includes rules/principles for regular revision, for example, updating schedules for reference classifications. A similar regular and transparent update process is needed for related and derived classifications to remain aligned with the relevant reference classification(s).

4. Processes and considerations for adding and deleting classifications to and from the Family

Processes for inclusion of classifications

Unless there is a specific process established for a classification, approval for inclusion in the family is granted by the WHO-FIC Network on the recommendation of the WHO-FIC Family Development Committee (FDC). The FDC should recommend appropriate conditions for approval, including approval term, updating and custodian engagement in the Network.

1. Derived classifications

Derived classifications may have specific approval and review processes. Derived classifications developed outside the WHO-FIC Network, by an expert group drawn from a clinical specialty for example, would need to be assessed against the classification criteria and to have a suitable use case for approval for inclusion in the Family. The approval could set appropriate conditions, for example, in relation to its updating and term of approval.

2. Related classifications

WHO and the WHO-FIC Network welcome approaches from custodians of health and health-related classifications to consider seeking to become a related classification within the WHO Family.

Relevant considerations include the purpose of the classification, the additional classification capacity that it would bring to the WHO Family, the quality of the classification (assessed against the Family's classification characteristics), access arrangements and willingness to work with the WHO and the WHO-FIC Network to improve alignment among the WHO-FIC.

3. WHO-FIC Network promotion of classifications

WHO-FIC will recommend and promote related and other classifications alongside WHO reference classifications as being an international standard for the purpose indicated.

The custodians of related classifications are expected to actively engage with the WHO-FIC Network. Collaboration between WHO-FIC Network members, and mutual use of classifications, should be encouraged and pursued. This allows them to engage with representatives of the WHO-FIC Collaborating Centres, make presentations about the classification, and exchange information and improve relationships between reference, derived and related classifications in a coordinated and systematic way.

The WHO-FIC Network will advise its members of testing of proposed new members of the WHO-FIC and involve them in the testing as appropriate.

WHO will update any documentation to include the new member and post this information on its website.

It is expected that increasing the range of classifications in the Family will mean improved data for international comparisons on a range of health and social service issues.

Considerations for inclusion of classifications

1. Place of the classification within the framework

It is important that additional classifications cover health data elements not adequately covered by the WHO reference classifications. Classifications must include a clear statement about the scope, units of classification and organization of the classification.

2. Technical qualities of the classification

The following technical qualities are considered in decision making about inclusion of a classification in the WHO-FIC:

- each classification should have a hierarchical and/or multi-axial structure such that it is possible to aggregate data from individual codes into larger categories
- classification categories should be exhaustive and mutually exclusive
- the categories should be stable, i.e. they are not changed too frequently or without proper review, justification and documentation (see also 'Development and Update Cycles' in Section 3)
- an entity within a classification that is of importance should have its own category
- categories within a classification should facilitate the description of phenomena in a way that allows unambiguous understanding by others, including statistical users
- each category should have a unique definition
- terms should not be ambiguous and the relationship between terms should be consistent
- the classification should not have categories at the same level in its hierarchy which are too disparate in their population size, i.e. there should be consistent granularity.

3. International accessibility and applicability of the classification

The WHO endeavours to make classifications accessible to the broadest possible cross-section of interested bodies. It is preferable to make classifications easily available in the public domain by publishing in several formats and making them freely available.

- Custodians of classifications may work together with the relevant Committee or Reference Group to prepare guidelines for interpretations of classifications at the applied level and to develop guidance and training materials that make explicit the classification's relationship to the WHO-FIC.
- Availability of the classification in a variety, preferably electronic, formats and as user friendly applications to make the classifications widely used is strongly encouraged.
- Making classifications widely available in many languages and formats such as Braille, large print, machine readable and audio will broaden the sphere of accessibility.
- Classifications in the WHO-FIC:
 - are available, or could be made available, with consistent meaning in the languages of the WHO member states
 - enable data derived from the classification to be of a standard suitable for international comparisons
 - are acceptable internationally
 - are valid for the purposes for which they have been developed
 - can be used reliably, i.e. there is inter-rater reliability and test-retest reliability in coding using the classification, and
 - are supported by appropriate reference material and training.
- The WHO-FIC should be relatively easy to use, unambiguous and well presented.
- All members of the WHO-FIC should be made available for the international common good on the same basis as the reference classifications (<http://www.who.int/about/licensing/en/>).

4. Resource implications

Including a classification in the WHO-FIC should bring added value to users through readily available, internationally endorsed products to support health and related data collection.

When considering a classification for inclusion in the family, resource implications should be taken into account for both its development and ongoing maintenance.

Resources for classifications development and maintenance should be consistent with the WHO framework of engagement on collaboration with non-state actors (FENSA) (<http://www.who.int/about/collaborations/non-state-actors/en/>).

5. Governance

The WHO-FIC Family Development Committee (FDC) aims to develop the WHO-FIC as an integrated, consistent and comprehensive set of classifications. It also aims to make sure that the WHO-FIC has a logical structure so that the classifications needed for each component and setting within the health system can be identified.

WHO and the WHO-FIC Network should be informed of any intention to adapt one of the WHO-FIC reference classifications. The adaptation should be developed in line with the guidelines and principles attached.

Proposals for the possible inclusion of related classifications in the Family are also welcome.

Further information may be obtained from:

Data Strategies and Integration Team
World Health Organization
Avenue Appia, 20
Geneva, Switzerland
Email: classifications@who.int.

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