Editorial

WHO ICD- 11 Showcasing of Traditional Medicine: Lesson from a lost opportunity

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International Classification of Diseases

(ICD) and its importance?

International Classification of Diseases (ICD) is a WHO initiative which aims to classify various disease conditions, injuries and causes of deaths occurring globally. ICD was required for providing a uniform nomenclature and diagnostic definitions to various clinical conditions as an eventual help to the health policy makers, planners, researchers, epidemiologists, insurance providers and health care delivery administrators for enabling them to understand the global and local health trends without any linguistic perplexity or dilution related to the ultimate meaning of a disease condition. ICD has proven its worth in all such areas of health concern for over five decades. The real strength of ICD however lies in its dynamicity allowing its repeated revisions as per the emerging needs. A recent release of 11th edition of ICD is a clear testimonial of this dynamicity of ICD (1,2).

Importance of uniform nomenclature of morbidities and causes of mortality is beyond any doubt. It gives an opportunity of relevant data collection from any corner of the world and yet interpretable at any other completely unrelated part of the world. Such uniform data collection is important regionally and also globally in order to identify the regional and global morbidity trends for their wider applications.

ICD-11 will now be presented at World Health Assembly in May 2019 for its formal adoption by the UN member states and will be made effective from 1 January 2022. The period between release and ultimate execution of ICD-11 is expected to allow the member states to prepare themselves to use this new version by making its effective regional translations and adopting appropriate strategies in their own morbidity monitoring systems. Eventually, this period will also be utilized to train the health care professionals to make an effective use of the new ICD.

ICD-11 took more than a decade of repeated consultations and suggestions by stake holders at various levels to give it an edge over the previous versions. ICD -11 is largely compatible with electronic data keeping and presents simplified coding structures for providing ease in data keeping. Besides this, it has also added a few new chapters particularly one on traditional medicine(TM) and another on sexual health. Gaming disorder has also been added as a new clinical entity into the section on addictive disorders. It is this new chapter on Traditional Medicine at ICD- 11, where we are presently concerned with.

At this point, this seems highly praiseworthy seeing WHO giving a voice to millions of people using TM worldwide as in the absence of any such representation at global morbidity data platform, actual contribution of the traditional medicine in global health care scenario was largely unknown and ignored. Despite a reported 82% global population using some form of traditional health care (3), the absence of meticulous data was detrimental to measure its real impacts on the society. Eventually, in the absence of persuading data, it was largely neglected at the health related policy making platforms on the matters of resource mobilization needed to tap its fullest potential.

WHO initiative on including TM in ICD therefore deserves all praises.

Inclusion of Traditional Medicine in ICD: A long due initiative

After being pleaded for long time at various global forums, it is the first occasion that TM is given a full cognizance at WHO for its roles played in global health care perspectives. To authentically evaluate the TM's role in global health care scenario, this was imperative to know the impacts it created upon the people through a careful monitoring of the morbidity areas where it predominantly acted upon. Such evaluation however was not possible unless a dual and parallel morbidity monitoring involving the traditional as well as conventional morbidity reporting was adopted all through the process of data collection. Such dual morbidity screening eventually required keeping TM and conventional morbidity understanding side by side facing each other in order to generate a common pool of understanding about disease process.

This is highly gratifying to see that this cumbersome task of putting two completely different paradigms of health into a common set of understanding was ultimately achieved by WHO. Although this achievement currently refers to Traditional Chinese Medicine (TCM) alone, this keeps open its doors to accommodate many other thriving traditional health care philosophies prevailing globally. Ayurveda , at this juncture , comes as a natural choice to be the next entrant to ICD.

Highlights of the current version of TM at ICD-11: A solo showcasing of Traditional Chinese Medicine

WHO has long recognized the importance of TM and emphasized its due utilization within the conventional health care frame work to ensure a comprehensive and inclusive health care availability to all. Alma-Ata declaration 1978 further augmented the cause of TM by proposing the member states to extend the use of TM in the primary health care. Since then much has been done and achieved but the gaps still existed. Recognizing the missing gaps between the policy and practices pertaining to TM, WHO in its ICD -11 press release reiterated -

"Although millions of people use traditional medicine worldwide, it has never been classified in this system."

Inclusion of TM in ICD -11 was one strongest measure which could have been taken to ensure giving the due of TM in terms of resource allocation in accordance of the services offered and priority areas covered by the respective health care systems.

Now while welcoming this long due initiative ultimately taken in cognizance by WHO, giving a high end legitimacy to traditional health care world over, there are also the grievances about non inclusion of many other prominent traditional health care systems practiced in the world. By TM, ICD -11 largely refers the TCM prevalent in East Asia inclusive of China, Korea and Japan.

A look at the brief description of 26th chapter of ICD - 11may disappoint many seeing that the chapter in its present form talks only of TCM under the ambit and scope of TM and has no representation of any other traditional health care practice having their substantial share in net traditional medical practices seen globally. The brief description about chapter 26 pertaining to the Traditional Medical Conditions (module 1) in ICD- 11 says –

"This chapter refers to disorders and patterns which originated in ancient Chinese Medicine and are commonly used in China, Japan, Korea, and elsewhere around the world. This list represents a union set of harmonized traditional medicine conditions of the Chinese, Japanese, and Korean classifications. For an extended list of traditional medicine conditions, please refer to the International Classification of Traditional Medicine (ICTM). Key Definitions in ICTM: A disorder in traditional medicine, disorder (TM1), refers to a set of dysfunctions in any of the body systems which presents with associated manifestations, i.e. a single or a group of specified signs, symptoms, or findings. Each disorder (TM1) may be defined by its symptomology, etiology,*

*course and outcome, or treatment response. 1 Symptomology: signs, symptoms or unique findings by traditional medicine diagnostic methods, including inspection such as tongue examination, history taking (inquiry), listening and smelling examination, palpation such as pulse taking, abdominal examination, and other methods. 2 TM Etiology: the underlying traditional medicine explanatory style, such as environmental factors (historically known in TM translations as the external contractions), emotional factors (historically known in TM translations as the seven emotions), or other pathological factors, processes, and products. 3 Course and outcome: a unique path of development of the disorder (TM1) over time. 4 Treatment response: known response to traditional medicine interventions. In defining a disorder (TM1), symptomology and etiology are required. Course and outcome, and treatment response are optional. A pattern in traditional medicine, pattern (TM1), refers to the complete clinical presentation of the patient at a given moment in time including all findings. Findings may include symptomology or patient constitution, among other things. 1 Symptomology (as above). 2 Constitution: the characteristics of an individual, including structural and functional characteristics, temperament, ability to adapt to environmental changes, or susceptibility to various health conditions. This is relatively stable, being in part genetically determined while partially acquired. The use of the ICD-11 TM Chapter is optional for those who would like to record epidemiological data about traditional medicine practice. This chapter should not be used for mortality reporting. * 'TM1' refers to Traditional Medicine conditions - Module I. The (TM1) designation is used throughout this chapter for every traditional medicine diagnostic category in order to be clearly distinguishable from conventional medicine concepts."*

Taking this description into the account, this seems that in its current form, the chapter deals with TCM as its module 1 but has a plan and provision of including other forms of traditional medical practices under the domain of other modules. An indication to this thought is seen at International Classification of Traditional Medicine (ICTM) where a proposal of inclusion of different traditional health care systems under different modules was made. Such modules included (1) East Asian/Chinese–based traditional medicine, (2) Ayurveda, (3) Homeopathy, and (4) other TM systems with independent diagnostic conditions (4).

Unfortunately, the brief description about TM in ICD -11 does not really read out this very intention of ICTM and hence keeps the speculations open for what actually is encompassing under the current domain of TM by WHO.

How TCM succeed to find a place in ICD- 11 ?

Inclusion of TM in ICD was the culmination of continuous yet strategic efforts of stakeholders who had powerful voice at UN and also had a strong native system of health care different to conventional health care. Traditional Chinese Medicine fundamentally forms the basis of all traditional health care practices prevailing in East Asian Region with small regional differences to accommodate local traditions. China, Korea and Japan share a common pool of traditional health care knowledge which is predominantly TCM. There cultural similarities help them coming together in regard to the issues which are of common interest and traditional health care prevalent in this region comes as a natural cohesive bond among them. Incidentally China and Japan have a strong foothold at UN and hence are in a position to push their policies related to TCM. This however is one side of the story and the success of TM being placed at ICD has much more reasons leading to this effect.

History of TM at WHO begins from 1972 when a Department of Traditional Medicine (DTM) was initially established. DTM was established with a distinct objective of spreading the TM practices worldwide. With 1978 Alma-Ata declaration, the idea of inclusivity of TM in mainstream health care further augmented through proposing the member states to extend the use of TM in the primary health care. In 1991 Standard International Acupuncture Nomenclature was published by WHO. In

1999 UN started a debate within its member nations for its concerns about high cost of technology oriented heath care and inequitable health care in large part of the world. In 2003 the issue was handed over to WHO to find a solution and here traditional Chinese Medicine was recommended as the possible intervention. Under the leadership of Choi Seung – hoon , a project was started to study the feasibility of utilizing TCM as the possible mean to defray the escalating health care cost globally. The project initially involved countries from East Asia and Australia but was subsequently joined by US also. This project basically worked on three issues namely (1) Standardization of Acupuncture points (2) Standardized term set, and (3) Assignment of diagnostic codes.

As an outcome to the project, WHO in 2008 published Standard Acupuncture Point Locations in the Western Pacific Region (5). Almost simultaneously the other component of standardizing the terms related to TCM was also attempted and in 2007 WHO brought out another publication titled as WHO International Standard terminologies on Traditional Medicine in the Western Pacific Region (6). With this ground work which has attempted to establish a uniform understanding of TCM terminologies, the symptom complex presented as disease in TCM were now been attempted to be standardized as a diagnosis. 'International Classification of Traditional Medicine (ICTM)' resulted as an outcome which was subsequently elaborated with regional descriptions of the TM diagnosis and their appropriate codes. China, Japan and Korea (CJK) were three countries who contributed heavily to this stage of development. As a consequence this classification is largely referred as ICTM-CJK. ICTM upon its development was primarily thought to facilitate the uniform data collection related to TCM either in a standalone model or as a supplement to WHO ICD. The ultimate objective however was to link it to the WHO family of International Classifications (WHO –FIC) . Moving ahead from this task, CJK have taken the responsibility to develop a dual coding system for the conditions treatable by TM in order to facilitate the cross system comparison of epidemiology, diagnosis and management on the basis of readable diagnosis. This has finally paved the way for including TCM in ICD. This is easy to infer that TCM inclusion in ICD- 11 is the outcome of a long and continuous process with clear objectives of identifying the role of TM in national and global health care. This is noteworthy to see that this forward momentum of TCM did not stop here and in furtherance to what has been done at TCM pertaining to the standardization of its terms and diagnosis , attempts have now been made to standardize its interventions too (7)

Efforts of Ayurveda for its inclusion in morbidity studies

Ayurveda, the Indian traditional health care system makes a point here for not finding a legitimate place in ICD- 11 despite it having a distinct chapter on TM. Ayurveda, being a formally recognized and practiced health care system in Indian subcontinent, benefitting a large population through its interventions, makes a strong and valid point of its inclusion whenever and wherever TM is being talked of.

Advocating the inclusion of Ayurveda in ICD has more reasons to plead besides it being a popular health care system of the orient. Ayurveda has very distinctive approach of its own physio-anatomical and pathological understanding of heath and disease which makes it a strong candidate for a differential treatment in reference to the health care policy making. We however have learnt from the ICTM-CJK model that to reach at this point we need to reach at consensually standardized Ayurvedic technical terminologies and the disease patterns on the very basis of its own *dosha –dushya* ideology.

Attempts to standardize its terminology for their uniform application begin late in Ayurveda and efforts have rarely been made to refine such attempts by popularizing them among the real stakeholders. Central Council for Research in Ayurvedic Sciences (CCRAS), an overburdened apex organization dealing with research in Ayurveda has attempted for it in a ritualistic fashion without any clarity about its real use by the researchers and epidemiologists in Ayurveda. Minimal attempts have been made to reach at consensual agreement on defining the terminologies and

neither any training was proposed to train the end users for using such comprehensive system of Ayurveda disease coding. (8) As may be predicted, this attempt of CCRAS could not generate any conspicuous sign of awareness among the people responsible for data keeping in Ayurveda . Only in the recent past, in wake of the developments made by the TCM counterparts and as a prelude to find a place in upcoming ICD revision, some refreshed revival attempts have been made by CCRAS in this direction. One significant among them was the development of National AYUSH Morbidity and Standardized Terminology Portal (NAMSTP) (9). This portal is designed as a web based platform aiming to collect the morbidity data related to various sectors of AYUSH from various parts of the country. As per the stakes claimed by CCRAS, '*this portal has a potential to revolutionize morbidity data statistics collection and may have a huge impact on the future policy making decision by bringing to light, the contributions of various AYUSH systems in the health care delivery system of the country'*. The key features of the portal are reported to be the morbidity codes and standardized terminologies related to all AYUSH systems for their unambiguous reporting, electronic data submission through individual institution login ID and also an integrated electronic health records (EHR) system for detailed data collection from individual institutions (10) .

While keeping a note about the proposed ambitious outcomes of this nascent activity of CCRAS, since its formal launch (on 2nd Ayurveda day Oct 17, 2017) by Indian prime minister, what we see in almost one year of its existence is nothing truly noticeable. Most ironical part of the story is that still, most AYUSH institutions in the country dealing with health care in their respective systems are unaware about any such initiative taken by the Ministry of AYUSH or CCRAS. If this impedance continues , the data accumulated in the due course will only be reflective of the one accumulated at the CCRAS or other research council's peripheral units alone which will not truly be reflective of real morbidity status dealt by various systems in the country.

There are further cautions about the uniform acceptability of the definitions adopted while making of NAMSTP. More cautions are about the ease of operation of a sophisticated data entry system by the real end users which may require thorough training and awareness programs to clear their doubts on regular basis.

Conclusion

ICD has versatile usage in terms of morbidity and mortality related epidemiological monitoring. Eventually this comes as an imperative tool for policy makers in the health care segment for its provision of the data related to the disease burden. This gives an opportunity to think pragmatically in terms of proportionate resource allocations for the purpose of comprehensive and collective health care inclusive of morbidity prevention and management.

For long time in recent past, traditional health care could not be treated fairly in terms of resources allocation due to the ambiguity related to their contribution in net health care. This was gradually realized that such contributions however cannot be measured unless a parallel is drawn between traditional and modern health care for the purpose of contribution quantification. As most traditional health care systems have their own set of terminology to understand health and disease process, linking such terminologies with a more accepted scientific terminology was highly desired. Developing a dual system of understanding a disease process was therefore of utmost importance. Through the continuous efforts made in the area initially by standardizing the traditional health care terminology and subsequently by developing the morbidity codes by keeping the specific TM diagnostic conditions in parallel to modern diagnosis, TCM found its way into ICD-11 . Ayurveda being utilized by an equally large number of native population, also requires to be treated fairly in terms of resource allocation proportionate to its contribution in health care and for that it needs to find a legitimate place in ICD. Very recently, we have seen some momentum in India towards this objective of which development of NAMSTP seems to be a good initiative. What more desired is to make such moves popular among the end users so that they can practically be employed in

data collection . A consensus among stakeholders regarding the definitions employed to explain the terminologies is also highly desired. Adoption of such consensus documents by WHO and their publication by WHO office could be the most pragmatic way towards the global acceptance of such activities. This is what was done by TCM and which has paved a way for their positioning in ICD-11. Ayurveda although has lost this opportunity of entering into ICD this time but there seems no harm learning from the mistakes to save the future. Moving pragmatically with a strategic mindset, Ayurveda surely can reach at a state compelling enough to find a seat during the next revisions of ICD.

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