

The New International Classification of Primary Care: Genesis and Implications for Patient Care and Research

Maurice Wood, MD
Richmond, Virginia

In July 1985 in a guest editorial in this journal, Dr. Kerr White called for the restructuring of the International Classification of Diseases. He described the wide variety of "labels" available to clinicians and commented on the lack of information on the causality of disease, which was at odds with the specificity of these labels. He reflected on the work of generalists in the development of classification instruments for primary care and specifically noted the work of Fry of England, Westbury of Canada, and the Classification Committee of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA).¹ He also commented on the work of the World Health Organization (WHO) Working Party, which was asked in late 1978 to develop a patient-oriented classification that would encompass the long-neglected element of patient information, namely, the patient's reasons for making contact with the health care system. The effort was not meant to be another disease classification, but a classification of people problems, and its justification was the presence of well-defined shortcomings in existing classifications for use in primary care.

It was recognized that the new classification developed by the WHO Working Party should be maximally compatible with existing and widely accepted systems; therefore, the International Classification of Primary Care No. 2 (ICHPPC-2 Defined),² which to a large extent is compatible with the International Classification of Diseases No. 9 (ICD-9),³ and the National Ambulatory Medical Care System Reason for Visit Classification (NAMCS-

RVC)⁴ together formed the main body of the instrument. New elements classifying the process of care based on the International Classification of Process in Primary Care (IC-Process-PC) were incorporated.⁵ This new classification was to be designed so that it could be used by physicians and other health care workers with various levels of training in both developed and developing countries. The Working Party, which at that time consisted of four persons, wanted to produce a classification system that would allow users to satisfy three main goals:

1. Define the point at which medical care begins, that is, the reason why a person enters the health care system
2. Gather intelligence on the way in which the health care systems function in different countries and how information is transferred between persons in the community and providers of primary care
3. Provide information and experience that would aid in the development of the International Classification of Diseases, 10th Revision (ICD-10)

It was felt that by the achievement of these goals, the new classification could function as a tool for change. The Working Party understood that it was necessary that any instrument produced should be acceptable to the users of preexisting classifications such as ICHPPC-2, NAMCS-RVC, IC-Process-PC, and that it should be precise, hierarchical, and computer applicable.

To achieve this end, a bimodal system was designed using chapters and components. Chapters were based on body systems, with the exception of three chapters entitled, "General and Unspecified-A," "Psychological-P," and "Social-Z." Each of the chapters contained the same subset of components, seven in number, which together described all of the known reasons why patients would seek contact at the primary care level. Although five of the components were fixed in form, each component would allow expansion or contraction in a hierarchical manner. The component structure allowed existing classifications

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From the Department of Family Practice, Medical College of Virginia, Richmond, Virginia. Requests for reprints should be addressed to Dr. Maurice Wood, Department of Family Practice, Box 251, MCV Station, Medical College of Virginia, Richmond, VA 23298.

or abstracts from them to be incorporated into the instrument. Thus this structure allowed component 7, entitled "Diagnosis and Disease Component," to consist entirely of ICHPPC-2 Defined; the only difference being that the ICD chapters, titled "Infectious Diseases," "Neoplasms," "Injuries Including Adverse Effects," "Congenital Abnormalities," and "Other," did not exist uniquely but were incorporated in the appropriate body system chapter.

Each chapter was given an alpha symbol, and each component was given the same cluster of two-digit numeric codes, which meant that any reason for encounter could be classified by a simple three-digit alphanumeric code. An alphabetic index and a manual for use were developed to standardize the application of the classification in primary care settings.

After the development of this draft format, the Working Party was increased in number to eight by the addition of representatives from the Classification Committee of WONCA. This group then proposed a large-scale international collaborative field trial involving Australia, Barbados, Hungary, The Netherlands, Malaysia, Norway, the United States, Brazil, and the Philippines. The field trial was carried out in five languages—English, Dutch, Norwegian, Portuguese, and Spanish—and each country agreed to produce 10,000 encounters for a target total of 100,000 encounters.

During a nine-month recording period in 1983, 94,470 encounters were entered and analyzed by WHO in Geneva, and these results and the comments by the recording physicians were used to modify the field-trial version of the reason-for-encounter classification to produce a research version of the instrument that could undergo measures of reliability and validity.

The final version of the classification, the International Classification of Primary Care, has 17 chapters, 13 of which are body system chapters, and four of which cover the following areas: "Pregnancy, Childbearing, and Family Planning," "General and Unspecified," "Psychological," and "Social." The seven original components have remained the same.

In 1985 White¹ described this final version as "a matrix that allows clinicians, investigators, and statisticians to follow the flow of both the natural history of ill health and the natural history of medical illness through different phases of differentiation, specificity, management and outcome." The power of the conceptual model involved in this matrix was not fully appreciated until the final version of the classification had been used by practicing physicians in primary care settings, where it could be employed with facility and without disrupting their clinical work.

The International Classification of Primary Care (ICPC) has been proposed for a number of research studies. The

Dutch pilot study⁶ was created to analyze the process of transition from reasons for encounter into diagnoses and then into medical interventions in primary care settings over time. This information is expected to better define, clarify, and interpret the nature of the mechanisms determining this transition. It is hoped that such a research effort would provide a comprehensive system of health information that would be the basis for a new paradigm for understanding the relationships between the health problems of people, as they perceive them, and the expenditures and resources that society allocates to provide the health care services to meet those perceived needs.

This kind of classification system provides an important tool in primary care settings for the comprehensive recording of the patient's reason for encounter, diagnoses and procedures, and some measures of outcome. The analysis of these data can describe the natural history of illness as episodes of care, providing new insights into the work of primary care physicians.

The publication of the International Classification of Primary Care by Oxford University Press is now under way, and it will be available in mid-1987.⁷ The publication consists of a tabular list, a list of abbreviated titles for computer use, a manual for use in four modes—(1) as a reason for encounter, (2) as a diagnostic classification, (3) as a classification of process and procedures, and (4) as a comprehensive mode that incorporates all of the above—and, finally, an alphabetic index or thesaurus, which includes 5,000 synonyms in English.

Planned for September 1987 is an international study of episodes of care using the ICPC. This study will include ten member countries of the European Economic Community (EEC), and through the Ambulatory Sentinel Practice Network (ASPN), the United States and Canada will contribute as one country. ASPN has begun the training of primary care physicians to use ICPC. As this training effort expands and more networks and systems become involved, as White has said, "it will now be possible to call patient problems by their 'right' names," and "have a rational means of linking observations on the submerged mass of the iceberg of disease with the tiny visible tip that preoccupies so much of the medical establishment's efforts." The analysis of encounter data as episodes of care offers a new era of population research in primary care throughout the world.

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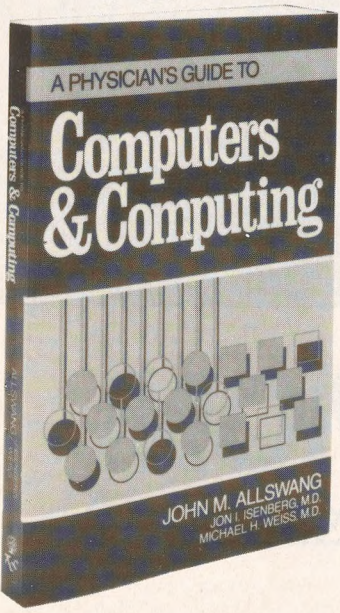
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