

The International Classification of Primary Care— An Update

Maurice Wood, MD
Richmond, Virginia

It is now almost 20 years since family medicine became a specialty and the concepts and mechanisms for providing person-centered health care began to be explicated. Remarkable progress has been made over that time in developing training methods, programs, and curricula that have in many cases been based on new information and insights gained from descriptive and cross-sectional research carried out in community-based practice environments. Not unexpectedly, new information has led to new questions, which have become increasingly numerous as the purview and responsibilities of the generalists within health care systems have expanded during the late 1980s.

Recently, Knox¹ has stated that "it has become clear that adequate provisions of health care services and professional development of such services need systems of information much more closely related to reasons why people request and require the services, the diagnoses, problems and morbidity involved and the processes of care provided." Such a system of information was proposed by White² in an editorial in this journal in 1985, when he called for a restructuring of the International Classification of Diseases currently in its 9th iteration (ICD-9.)³ He saw the ICD-9 as "an archaic document incapable of recognizing the web of causality underlying most states of ill health which was at odds with the specificity of its rubrics." White found the ICD-9 largely incapable of reflecting the recent developments in genetics, immunology, or knowledge about the impact of environmental, social, nutritional, psychological, and behavioral factors on disease (Kerr L. White, MD, personal communication, October 22, 1988). The 10th version has been under development since 1979; the changes being proposed are comparatively minor and do not reflect clinical reality. This proposed 10th version has come under intense criticism from clinicians, particularly from those in primary care, as it is not capable of describing the cognitive aspects of their work.

After promulgation by the World Health Organization, the ICD-10 will remain the senior clinical classification until well into the 21st century. It will continue bereft of organizing principles and remain the unstructured combination of chapters with differing nosological approaches, ranging through the anatomical, etiological, and morphological to the demography of groups of patients. It will continue to be disease oriented, focused on the needs of the vital statistician, the pathologist, and to some extent the hospital-based physician, and essentially ignoring the needs of the community-based generalist and those involved in health care delivery.

For these reasons, some countries, including Norway and the Netherlands, are considering not using this 10th revision following its promulgation.

In 1987 in a guest editorial,⁴ this journal reported the publication by Oxford University Press, under the aegis of the World Organization of Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA), of a comprehensive classification and information system titled *International Classification of Primary Care (ICPC)*.⁵ ICPC consists of a tabular list of titles, or "labels," through problems, processes, and procedures to traditional diagnoses, some of which are defined by inclusion criteria. There is a list of abbreviated titles for computer use and a manual for use in four modes, namely, a reason-for-encounter classification, a diagnostic classification, a classification of process and procedures, and finally, a comprehensive classification that incorporates all of the above. Additionally, there is an alphabetic index that includes over 5,000 synonyms in English. There are chapters describing minimum data sets and encounter forms for health information systems incorporating the classification, chapters on training physicians and health care workers to use the system, and, not least, proposals for the analyses of the data product of such a system.

Crombie⁶ postulates that information systems polarize into "working" systems and "academic" systems. The former support clinical problem-solving as it is, and the latter aim at full scientific understanding of the elements of the clinical problem-solving process. Since the ICPC became available in Europe, it has been used extensively

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

as a major element of information systems in academic environments. It has been very well received and has been found easy to use in both everyday clinical practice and academic environments.⁷ To date, it has been translated into six languages—French, Spanish, Portuguese, Dutch, Italian, and Norwegian.

Over the past two years several publications on the use of ICPC in its comprehensive mode in primary care information systems show that it is easy to use in practice, that 60 percent of all patient's reasons for encounter and 60 percent of physician's "diagnoses" are in component 1 (Symptoms and Complaints). Further, it has been shown that physicians are less certain of their problem definition when using component 7 (Diseases) than when using component 1.^{8,9} This difference seems to indicate a need for a better definition for the rubrics in component 7 than the present inclusion criteria allow. That this need exists surfaced at a recent meeting of the representatives of 10 of the 12 countries of the European Economic Community (EEC), which was held at Noordwijk in the Netherlands in September 1988. These representatives decided to use ICPC as the classification of choice for their equivalent primary care health information systems, which they are required to establish by 1992. Papers from the United Kingdom, Belgium, France, and the Netherlands¹⁰ highlighted the variability of primary care physicians' use of diagnostic terms and called for additional inclusion criteria for the rubrics of component 7 and their extension as far as possible to the terms from component 1 when used in a diagnostic way.

Analysis of primary care information systems encounter data as episodes of care over time has shown that the relationships among the patient's reasons for encounter, the physician's diagnostic intervention (process and procedures), and "diagnoses," prescription, and disposition can be used to evaluate the cost and quality of care provided by individual physicians.¹⁰ This evaluation is effected by comparing the individual physician's management of defined clinical entities with the norms set by the group of physicians as a whole. In the United States Wennberg and Gittelsohn^{11,12} have shown that by using hospital discharge data at the county or regional level in a confidential manner, a surgeon's professional behavior can be changed.

The political and fiscal commitment that the EEC has made to the development of health information systems, the minimum basic data sets for primary care, and the selection of ICPC as the primary care classification of choice is in stark contrast to the situation in the United States. Despite the presence of a federal establishment and increasing understanding of the role of the primary physician in controlling the escalating costs of care, coupled with the availability of data on the cost and quality of care provided by primary care physicians in office practice,¹³⁻¹⁷ there is no visible commitment to change the

medicopolitical decision-making process from a top-down approach based on hospital and subspecialist statistics to a bottom-up approach based on data drawn from primary care settings. Yet only in this way can the demands and needs of patients be addressed rather than those of physicians and institutions.

To end on a positive note: perhaps there is light at the end of this tunnel in the shape of a recent report to the Health Care Financing Administration, which contracted with Harvard University to conduct a study of the reimbursement for physician's services under Medicare. The report addressed the use of a resource-based relative value scale that could be budget neutral by providing a more equitable reimbursement for the cognitive services provided by primary physicians and a reduction in the reimbursement for procedural services normally provided by subspecialists.¹⁸ This study and the whole issue of the use of classifications and labeling by physicians is under review by the congressionally mandated Physician Payment Review Commission, chaired by Professor Philip R. Lee of the Institute for Health Policy Studies of the University of San Francisco (Kerr L. White, MD, personal communication, November 11, 1988). Undoubtedly, there will be efforts to maintain the current status and obstruct the implementation of any changes proposed by the Physician Payment Review Commission, but informed advocacy by primary physicians for the resource-based relative value scale and the concomitant need for classifications that reflect the reality of primary care can profoundly influence these decisions at the federal level.

Here—ICPC would come into its own.

References

1. Knox JDF: If it hasn't got a name, it doesn't exist. *International classification, primary care and education*. *Med Educ* 1988; 22: 373-374
2. White KL: Restructuring the international classification of diseases: Need for a new paradigm. *J Fam Pract* 1985; 21:17-20
3. Ninth Revision. *International Classification of Diseases Index. Manual of the International Statistical Classification of Diseases. Injuries and Causes of Death*. Geneva, World Health Organization, 1977
4. Wood M: The new International Classification of Primary Care: Genesis and implications for patient care and research. *J Fam Pract* 1987; 24:569-571
5. Lamberts H, Wood M (eds): *International Classification of Primary Care*. Oxford, Oxford University Press, 1987
6. Crombie DL: The Relation of ICPC with Other Existing ICD-9 Derived Classification Systems. *Proceedings of the Noordwijk Conference, September 8-11, 1988*. The Netherlands, University of Amsterdam, in press
7. Meyer JS, Brower H, Lamberts H: De ICPC als diagnostische classificatie. *Huisarts en Wetenschap*, 1987; 20:13-19, 44-48
8. Lamberts H, Brower H, Groen ASM, Huisman H: Het transitie-model in de Huisartspraktijk. *Huisarts en Wetenschap* 1987; 30: 105-113