MEETING OF THE WHO COLLABORATING CENTRES FOR THE FAMILY OF INTERNATIONAL CLASSIFICATIONS

10 – 16 October 2009
Seoul, Republic of Korea

D002p

International Classification of Primary Care

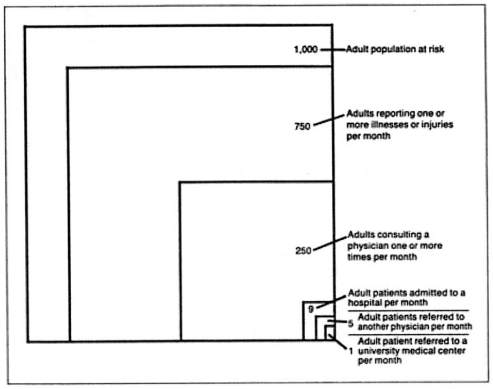
GC Miller, H Britt, J O'Halloran
Family Medicine Research Centre, Australia

Abstract The International Classification of Primary Care (ICPC) is compact, containing only 1400 classes. However it is comprehensive, covering multiple aspects of primary care. It is based on the epidemiology of primary care – classes are developed based on: Frequency of occurrence in primary care; Public Health importance; Prognosis/outcome; Value of interventions. ICPC-2 is a member of the WHO Family of International Classifications.

Introduction

The Scope of Primary Care

- A large proportion of the world's medical care is provided by primary care
- Primary care is expanding rapidly, particularly in developing countries and in eastern Europe
- Primary care physicians manage a very wide spectrum of patient problems: physical, psychological, social and functional
- Good primary care = good population health (Starfield)



Monthly prevalence estimates of illness in the community and the roles of physicians, hospitals, and university medical centers in the provision of medical care (adults 16 years of age and over). *(White et al 1961)*

History of ICPC

The International Classification of Primary Care (ICPC), developed by the ICPC Working Party, broke new ground in the world of classification when it was published in 1987 by WONCA. For the first time primary health care providers could classify, using a single classification, three important elements of the health care encounter; reasons for encounter (RFE), diagnoses or problems, and process of care.

Since publication ICPC has gradually received increasing world recognition as an appropriate classification for general/family practice and primary care, and has been used extensively in some parts of the world, notably in Europe and Australia.

In 1998 Wonca published a revised version of ICPC (ICPC-2) with inclusion and exclusion criteria attached to the classification rubrics, and a mapping to ICD-10. A revised electronic version was released in 2000.

ICPC is designed for use in paper based statistical collections and in electronic information systems for both encounters and episodes of care. It has inclusion and exclusion criteria in addition to paper based and electronic indexes to guide appropriate usage. Maps are provided from other classifications such as ICD-10 so that ICPC may also be used as an 'organising principle' for data collected in those classifications.

An agreement has been reached between Wonca and the International Health Terminology Standards Development Organization to Map SNOMED CT to ICPC-2

Methods & Materials

ICPC-2 Structure

ICPC has a biaxial structure with 17 **chapters** on one axis and seven **components** on the other. **Chapters** are based on body systems with an additional chapter for psychological problems and one for social problems. Each chapter is identified by a single alpha code which is the first character of all rubrics belonging in the chapter (Figure 1). Each chapter is divided into seven **components**, identified by a range of two digit numeric codes not always uniform across chapters.

Chapters

Components	A	B	D	F	H	K	L	N	P	R	S	T	U	W	X	Y	Z
1. Symptoms, complaints																	
2. Diagnostic, screening, prevention																	
3. Treatment, procedures, medication																	
4. Test results																	
5. Administrative																	
6. Other																	
7. Diagnoses, disease																	

A General
B Blood, blood forming
D Digestive
F Eye
H Ear
K Circulatory
L Musculoskeletal
N Neurological
P Psychological
R Respiratory
S Skin
T End/met/nut
U Urinary
W Pregnancy
X Female genital
Y Male genital
Z Social

The structure of ICPC represents a move away from the combined anatomical and aetiology based structure of ICD. For example, where ICD includes a separate chapter for neoplasms, one for infections and infestations, and another for injuries, such problems are distributed among chapters in ICPC, depending on the body system to which they belong. Regrouping of the rubrics (eg for all neoplasms in all body systems) can still be undertaken across chapters if analysis of totals is required.

Conclusions

ICPC is a classification which reflects the distribution and content of aspects of primary care. It was designed as an epidemiological tool to classify data about three important elements of the health care encounter ie reasons for encounter (RFE), diagnosis or problem, and the process of care. ICPC was designed for the collection and analysis of patient data and clinical activity in the domains of General/Family Practice and primary care. This collection and analysis can occur at the level of an individual patient for clinical care, at the practice level for recall, clinical audit and activity analysis and at the regional, State and National level for health services research and statistics. It can be used to classify terminologies and other classifications in electronic health records to facilitate decision support and patient safety systems.

ICPC is maintained and updated by the International Classification Committee (WICC) of Wonca. Local support is given by individual members of the Wonca International Classification Committee.

The full revision cycle is currently 11 years however mapping to other classifications may be reviewed at shorter intervals to adjust for changes in other classifications and changed usage. WICC has been active since 1972 and currently has 40 members from 23 different countries. WICC is partially funded by Wonca and the participation of some members is supported by their national governments.