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Evaluating use of ICPC-2, for ICPC-3 development

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Abstract **In working towards development of ICPC-3 it is important to identify from use of Version 2: rubrics that are rarely used, rag-bags (including –99, –29, other multiple disease rubrics) that are over-utilised, and concepts that have emerged and now need their own rubric. This work is being undertaken for the International Classification Committee (WICC) of the World Organisation of Family Doctors (Wonca).**

Introduction

Use of ICPC internationally
Primary care is expanding rapidly, particularly in developing countries and in eastern Europe.

ICPC is **currently used** extensively by clinicians in 21 countries, less frequently in many others.

Translations currently to:
19 languages:--
Chinese, Czech, Danish, Dutch, English(3), French, Greek, German, Italian, Japanese, Portuguese, Romanian, Russian, Spanish (2), Azeri, Serbian, Finnish, Swedish, Turkish.

ICPC National licences held by:
Belgium, Brazil, Denmark, Finland Norway, Portugal, Switzerland,
Under negotiation: Australia, Canada

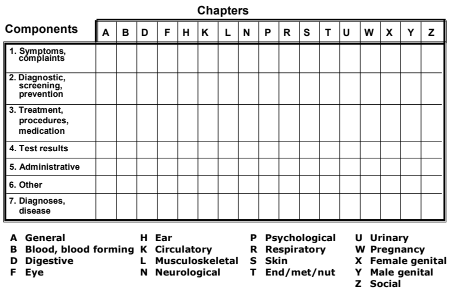
In ICPC, concepts that have their own rubrics are those that arise most frequently in primary care and/or are of public health importance.

Frequency of use varies according to the epidemiology of the country. For example, pig bites are frequent ion Sri Lanka, not in Australia.

In planning the development of ICPC-Version 3, it is important to assess the extent to which ICPC- Version 2 reflects the international epidemiology of primary care. This project assesses the utilisation of ICPC-2 rubrics, use of 'rag-bag' codes and the relationship between these two usages, within each Chapter of ICPC-2

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 which are not always uniform across chapters.

Fig 1: Structure of ICPC



ICPC is a hierarchical classification which does not attempt to provide an individual code for every concept but rather to provide a code for the most important and/or most frequent arising in primary care. The remaining problems, symptoms and services are grouped into unspecific codes which Lamberts et al call 'rag-bag' codes.

Aims of the study:
•To review existing content of ICPC-2 in relation to current utilisation for patient reasons for encounter and problems managed in primary care.
•To identify new content areas in light of changing epidemiology in primary care.

Methods and materials

Data collection
We requested from all countries currently using ICPC in primary care, data about the frequency of use (relative to their denominator) of each ICPC rubric in coding patients reasons for encounter and problems managed.

As part of this request we developed a <u>structured questionnaire</u> to ensure we had understanding of the data source:

- the study population from which the data were drawn
- the data elements to which ICPC has been applied
- method of data collection (computer versus paper)
- coding method – primary v's secondary
- size of PC provider sample
- size of encounter sample

Analyses Phase 1:
On receipt of the data, combine data from all countries and assess, for each countries and for all countries combined:
- the number of codes utilised at least once
- the number used not at all or at very low frequency
- rate of utilisation of codes. international breadth of use
- utilisation of 'rag-bag' codes.

Phase 2:
Evaluate the frequency of use of more specific terms used in conjunction with ICPC-2 in countries in countries using other systems to provide extra specificity with the ICPC-2 code for example interface terminologies or ICD 10.

The aim is to identify concepts used frequently in multiple countries, that are either in 'rag-bags' in ICPC-2, or are difficult to find a place to classify.

Results to date

To date we have **received data** from 6 countries (*number of coded RFEs and problems managed):*
- Austria *(n=27,000)*
- Australia *(n= 285,000)*
- France *(n=41,000)*
- Netherlands *(n=363,000)*
- Portugal *(n=12,000)*

and **interim data** from 4 countries:
- Canada
- Denmark
- Finland
- Germany

We are still a**waiting** data from:
- other European countries
- Africa
- Asia
- South America

Conclusion

Data received to date are somewhat OECD centric. It is essential that this review include data from developing countries where the epidemiology of primary care will differ.

The expected breadth of input will ensure that development of ICPC-3 is undertaken with awareness of the needs of developing countries.