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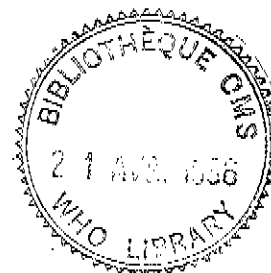
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DES/PHC/85.7
 ENGLISH ONLY

CONSULTATION ON PRIMARY CARE CLASSIFICATIONS

Geneva, 11 - 15 November 1985

REPORT



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1. INTRODUCTION

1.1 Purpose and Scope

The World Health Organization convened a Consultation on Primary Care Classifications in Geneva from 11 to 15 November 1985. The consultation brought together physicians, epidemiologists and statisticians with experience in primary health care, health management and classification issues. The draft International Classification for Primary Care (ICPC) which was the result of a WHO Working Party to Develop a Reason for Encounter Classification was reviewed and discussed in the light of its applicability and utility for national and international purposes and its relevance to health care management in view of the Strategy Health for All by the Year 2000. The recommendations of the consultation should assist WHO to decide on further steps to be taken in this area. The report of this consultation would also serve as a working document at the meeting of the Heads of WHO Collaborating Centres for the Classification of Diseases to be held in Tokyo in 1986.

1.2 Opening of the Meeting

1.2.1 The consultation was opened by Dr J. Hamon, Assistant Director-General, on behalf of the Director-General of WHO. Dr Hamon emphasized the importance of the consultation in terms of the need for information support to health systems management based on the primary health care approach.

In referring to the Alma-Ata Conference on Primary Health Care (PHC) held in September 1978 he indicated the needs of WHO Member States in managing, monitoring and evaluating their health strategies in pursuit of the goal of Health for All by the Year 2000. A sound classification of primary health care should particularly assist in determining the main health problems affecting the population so that better and more efficient health care could be provided. As a result Member States were striving to develop community-based programmes based on primary health care, and to monitor and evaluate these programmes at the local, national, regional and global levels. The periodic evaluations had demonstrated an evolving need for information support. The first monitoring cycle in 1983 had shown that not only developing countries were facing difficulties in obtaining the necessary information but also developed countries were often unable to set objectives and formulate policies as their information bases were inappropriate for such purposes. It was recognized that much information required on issues such as health status, life style, health economics, service needs, community support, and resource allocation were lacking or inadequate. Developed countries for instance were improving slowly, but certain indicators were not necessarily showing improvement. For example some European countries had realized that the life expectancy at the age of 35 years was showing a declining trend. Reasons for this decline were not known and could only be determined with the support of a sound information system using relevant classifications. In developing countries, it was often realized that people by-passed peripheral services, to make their first contact with referral hospitals. The very limited resources allocated to health meant that countries had to struggle with allocating resources to primary health care particularly when, as was the case in some countries, hospitals and salaries were consuming 80-90% of the health budget. Furthermore, in those countries where national expenditure on health was as low as a few dollars per capita per year, there was often a much larger expenditure by individuals in terms of travel costs for seeking health advice and for purchasing drugs.

With these facts in mind, Dr Hamon stressed the need for the participants' input and advice on supporting the health information systems with an appropriate classification for primary health care and particularly to react to the applicability and utility for national and international purposes of the draft ICPC.

1.2.2 The consultation designated Dr R. Wells as Chairman, and Professor S. Banoub as Rapporteur.

1.2.3 The draft ICPC was reviewed and discussed in the framework of information needs of Member States related to the managerial process for national health development based on the PHC approach, and WHO activities in the field of health classifications as well as activities in the area of general medicine at the country level. The various contributions are summarized in the present report.

2. INFORMATION NEEDS OF THE MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT (MPNHD)

The managerial process for national health development, was focussed strongly on Health for All and primary health care priorities and was therefore identified as a key mechanism in support of those processes.

The decision-making process, involving all relevant components of the MPNHD requires relevant information. This information may come from various sources and in the absence of relevant and objective data, individual judgement of knowledgeable and responsible people may be the only source of information. In that context it was stated that it was better to obtain approximate answers to the right questions than to use apparently precise data of doubtful relevance.

The potential users of information, when applying MPNHD in support of strategies for health for all, may be top-level policy makers, executive decision makers, health care managers and health care personnel, research workers, educators and trainers of health personnel, people involved in health matters in other sectors than health, and the public at large.

Selectivity was, therefore, the keynote in deciding what information should be collected to support MPNHD. Each of the above-mentioned users may require different types of information, or the same kind of information presented in different ways. Not all the categories of information carry the same weight or have the same importance in the various stages of the managerial process.

The types of information commonly required when applying managerial process in support of strategies for Health for All were:

- (a) Policy Information including relevant information on national socioeconomic and health policies.
- (b) Information on the availability, accessibility and utilization of various types of health care.
- (c) The information on main health problems of population groups and where relevant, design or selection of interventions.
- (d) Information on resources.
- (d) Information on health manpower, including the number of non-professional primary health care workers, indicating their urban/rural distribution.
- (f) Information on health care costs and information on administrative structure and the capacity of the country, including the structure of central and regional governments, and local community organisations.

It was accepted that all of the potential information needs for the managerial process could not be considered for inclusion in the present elaboration of primary care classification.

3. WHO ACTIVITIES IN THE FIELD OF HEALTH CLASSIFICATIONS

3.1 WHO International Classifications in the Fields of Diseases, Procedures in Medicine and Impairments, Disabilities and Handicaps

The Sixth Revision of the International Classification of Diseases (ICD) was the first to be coordinated by WHO and was mainly a classification of causes of death prepared by statisticians and epidemiologists. Over successive revisions greater emphasis had been placed on morbidity, and clinicians became increasingly involved in decision-making concerning the content of the classification, though there was no change to the basic structure. The clinical input to the Ninth Revision which came into use in 1979 was considerable. However, there was still a great deal of criticism of ICD-9 which was used all over the world in a wide variety of clinical and statistical settings and could not, therefore, meet all the demands placed upon it. During the preparation of the Ninth Revision it had already been obvious that no single classification could meet all those demands and the concept was developed of producing a family of different but sometimes related classifications for different purposes.

The International Classification of Procedures in Medicine (ICPM) and the International Classification of Impairments, Disabilities and Handicaps (ICIDH) were therefore developed and presented to the International Revision Conference for the Ninth Revision of the ICD held in 1975. The Revision Conference recommended publication of these two classifications as supplements to and not as integral parts of ICD-9. The World Health Assembly in 1976 endorsed that recommendation and approved their publication for trial purposes.

The ICPM, particularly the drugs and surgery sections, had been used in several countries. However the whole classification had not been adequately tested. The rapid progress in surgical and other methods and techniques meant that an internationally agreed classification was not amenable to frequent revision and agreement because of the costs involved and the length of time necessary for consultation.

The ICIDH had been mainly used in European countries partly because of the difficulty of translating the concepts into other languages and cultural settings. Some terms were included in both the impairments axis of ICIDH and in ICD and a study was being carried to see whether a rationalization of the two schemes was possible.

3.2 Lay Reporting in Information Support

3.2.1 There had been increasing interest in the use of lay reporting techniques in both developing and developed countries. A WHO meeting in 1971 recommended a practical method of recording signs, symptoms and complaints. The ICD-9 Revision Conference discussed the problem, found that a lay reporting scheme was necessary and recommended that WHO should become increasingly involved in this activity. After several consultations and field trials, mainly in collaboration with countries of the WHO South-East Asia Region, the booklet *Lay Reporting of Health Information* was published in 1978 to be used as an example requiring adaptation to meet local needs.

3.2.2 An interregional meeting on Lay Reporting in Information Support to Health for All Strategy Management held in Manila, Philippines, from 8 to 15 October 1985, brought together 22 participants with a wide range of experience in both developing and developed countries in response to the information needs of WHO Member States in the achievement of the goal of Health for All by the Year 2000. The status of information support in Member States and the role of WHO and other international agencies in making available essential sets of minimum information for the management at the local, intermediate and national levels of the health systems based on primary health care were reviewed. The role of lay reporting in this context was also assessed.

Newly-emerging needs for information for a PHC-based health system were recognized, and hence the need for a new approach that unified information support, health service management and community sources of information based on lay reporting in the expanded sense of community-based information.

It was considered that the concept of lay reporting solely as a classification of medical problems may have retarded the application of the term to cover a much broader community-based information mechanism. There were significant constraints in the playing of this potentially important role for lay reporting. These included lack of political commitment, lack of commitment by senior management, insufficient understanding of the required community framework, and technical constraints (training, instruments etc).

It was only in the past few years that some countries had started to reorientate their health services from problem and person-based to community-based. The PHC approach implied continuity and coordination of care but most activities were still managed as distinct programmes each dealing with individual problems and episodes of illness.

Radically new approaches in terms of collection, processing and analysis were clearly required to reorientate existing epidemiological and statistical services to a responsive information support for PHC-based health systems. The interregional meeting recommended that one country from each region should further investigate lay reporting by the standardization of simple and meaningful procedures to make the necessary information available and facilitate the transmission of relevant information to higher levels. A further meeting would then be convened to evaluate the outcome of these studies.

3.3 Applications of ICD to the Field of General Medicine

3.3.1 In 1972 the World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians (WONCA) prepared the International Classification of Health Problems in Primary Care (ICHPPC) based on ICD-8 though not completely compatible with it. This was updated to be completely compatible with ICD-9 as ICHPPC-2.

3.3.2 A more recent development was the work of the WHO Working Party to Develop a Reason for Encounter Classification which was presented for the consideration of the meeting as the draft International Classification of Primary Care. Whether this classification should become a part of the family of classifications, and if so its place within that family, were aspects to be decided by the meeting.

4. ROLE OF CLASSIFICATIONS IN HEALTH INFORMATION SYSTEMS BASED ON PRIMARY HEALTH CARE

A health care classification should include coded descriptions of situations, events, or health problems, using commonly known terms of reference, to ensure unified data gathering and to allow the comparability of information at the local, national, and international levels.

Use of such a classification needs the following actions to yield a positive outcome:

- Reliable and accurate data gathering
- Processing and analysis of data to provide meaningful information
- Proper dissemination of information through appropriate and timely reporting
- Use of the information for decision-making.

The use of information in decision-making is essential to the strengthening and continuous development of a sound health information system. Classifications must therefore serve the purposes relevant to their objectives.

4.1 Components of Health Information Systems

A sound health information system should include the following components:

- Demographic and socio-economic information
- Health status, including morbidity, mortality and disability
- Health status determinants, including water supply and basic sanitation, nutrition, immunization, and attitudes to health
- Health service facilities and their utilization
- Health manpower
- Organization, management and financing of health and health care.

The data may be gathered routinely, on a sample basis, on a periodic basis, or through ad hoc surveys designed to address specific problems.

4.2 Basic Criteria for Producing an International Classification for Primary Health Care

4.2.1 Relevance to primary health care (PHC)

Since many of PHC encounters are problem-oriented, the content of an international classification for PHC should differ substantially from that traditionally contained in the ICD. The ICD is mainly built on an anatomical-pathological basis, requiring a great deal of diagnostic back-up, and is best used for mortality and hospital morbidity. An ideal primary health care classification should include the presenting health problems or reasons expressed by the patient which may be interpreted as provisional diagnoses by the health provider. Other information on PHC such as health education, nutrition, water supply, and basic sanitation, as well as all procedures other than sickness care should be covered by the classification.

Different levels of health providers such as illiterate or literate community health workers or general practitioners or specialists with free access to diagnostic procedures and referrals to other specialists would be potential users of a PHC classification. For this reason, an international classification should be flexible enough to cope with these variations. However, greater flexibility would jeopardize the unification of a classification system suitable for international use. Therefore, a simple classification should be produced that is relevant to the majority of countries, with a built-in capability of subclassification or more sophistication. This seems to be more reasonable than building a sophisticated model, and asking developing countries to modify it if necessary.

4.2.2 Appropriateness for generating the necessary information

A classification for PHC should provide the information that is essentially adequate for the planning and management of PHC and the health care system in general. The information output of such systems should cover the consumer characteristics, provider characteristics, service need and work load, the facility, utilization statistics, information on morbidity and mortality, and the relationship to other levels of care.

4.2.3 Simplicity and low cost

Internationally, the majority of health systems which could be users of such a classification are suffering from inadequate resources, and are struggling with the constraints of financing the strategy of Health for All by the Year 2000. Therefore, data gathering systems should be as simple as possible, in order to be used by the majority of primary health care providers, spending the least amount of time, with the minimum amount of paper work. Moreover, data processing and analysis should also be simple and consume as little human and financial resources as possible. A high-cost sophisticated system which may be professionally and technically appealing, would limit its application to developed countries, and may lead to frustration and rejection by the majority of countries. This could result in development of many national or local systems, yielding incompatible data.

4.2.4 Compatibility with other classifications

For the purpose of continuity of care and follow-up of cases, a primary health care classification should be compatible with the ICD which is mainly used for mortality and hospital morbidity.

4.2.5 Testing and evaluation

After a careful design and before introduction such a classification should be field tested and evaluated in different health care settings to assess not only its feasibility but also its relevance to health care management.

5. 4-P CLASSIFICATION

The consultation was provided with details of this comprehensive classification for primary care encounters which had recently been submitted to seven Arabic speaking countries and introduced in Kuwait.

5.1 Structure

This classification uses four variables (4-P) relevant to primary health care namely:

- Problem : the main presenting health problem encountered by the attendant or the consumer (not the patient), coded from 000 to 353.
- Procedure : the procedure used to deal with the problem coded by two digits from 01 to 56.
- Provider : the category of the main provider, one digit from 1 to 9.
- Place : the place where the health care is provided namely a primary care centre, home, institution such as a school or factory, or mobile unit, or a hospital outpatient or emergency room.

5.2 Potential Uses

The potential uses were seen to be in primary health care settings within comprehensive health systems especially in developing countries, in outpatient departments and emergency rooms in hospitals where there is a difficulty in using ICD-9, and by lower-level health care workers, through the development of modified simple or short lists of health problems.

5.3 Expected Information Output

It can yield comprehensive information on morbidity, namely incidence and prevalence of 353 diseases and health problems by age, sex, ethnic groups, and geographical regions. This will enable monitoring and assessment of community health status, and evaluation of the outcome of programmes such as expanded immunization, maternal and child health, and other disease control programmes. It also allows defining and prioritizing health problems such as reason for visit, utilization of services, performance by each provider within the primary health care team, patient disposition and referral to the other levels and facilities of the health care system, including the follow-up of cases, and range of coverage of primary health care outside the health facility.

The system would also provide most of the basic data used in planning, monitoring and evaluation of primary care at the intermediate and central levels.

5.4 Discussion

The meeting took note of the philosophy and structure of the 4-P classification and was informed of the existence and use of other general classifications intended for use in primary care settings including that developed by the Royal College of General Practitioners in England.

6. DRAFT INTERNATIONAL CLASSIFICATION OF PRIMARY CARE (ICPC)

6.1 Evolution and Status of the Classification

The draft ICPC which was elaborated by the WHO Working Party to Develop a Reason for Encounter Classification was presented. The classification had originally been entitled the Reason for Encounter Classification (RFE-C). The reason for encounter had been selected for study as, in the interaction between the patient and the provider, most of the time is taken up in finding out exactly why the patient considers the visit to be necessary.

Evolution of primary care classifications had taken place in the previous 20-30 years mainly in the United Kingdom since the advent of the National Health Service in 1948. ICD-6 which came into use at that time and the subsequent ICD-7 were incapable of classifying accurately almost 50 per cent of what was seen in the primary care setting by physicians and appropriately trained providers. There had been only a slight improvement in this percentage with use of the present main chapters of the Ninth Revision, though it was pointed out during discussion that use of the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (the V Code of ICD-9) would have decreased that proportion.

A minimum set of data elements was therefore required to identify the needs of the patient, the provider, the setting, and the disposition in order to provide knowledge of the history and evolution of disease, provide advice and care, and to monitor patient responses to that advice and care. It was envisaged that the draft ICPC could also be used to obtain the information necessary for the design of curricula for health personnel and help to evaluate the performance of the provider. The setting of priorities for resource allocation and the organization of health services would also be possible. Cross-tabulation of the data items could provide utilization information for manpower planning, planning of services and perhaps even more fundamental changes to health services.

Most of the information on the feasibility of the reason for encounter element of the classification came from the extensive field trials which had been carried out in nine countries and five languages. Over 90,000 encounters had been recorded of which over 60 per cent fell into the first component of the classification (symptoms and complaints) and some five to seven per cent in the diagnosis component, the remainder being scattered through components 2-6.

The biggest problem in developing the field trial version of the classification had been the construction of the alphabetical indexes in the various languages. It was already clear that a culture specific thesaurus of lay terms would be needed for each country that would need to be developed by the country itself. Also, the provider should not use the classification without adequate training.

Efficacy studies were currently being carried out in which the encounter form contained the classification in the form of a checklist. This reduced recording and coding time to less than 30 seconds and made the system more acceptable to the provider, particularly if it could be linked to billing.

The draft ICPC was partly derived from existing and tested systems in that the classification used in the United States National Ambulatory Medical Care Survey was used as the basis for the symptom/complaint component and ICHPFC-2 provided the framework for the diagnosis component.

A pilot study for a transition project showing how the patient statement evolved into assessments and dispositions had recently been completed and the first analyses were available.

One example of the use of the data in planning was the adoption of the draft ICPC by an international airline to monitor the health status of 30,000 employees worldwide. The recording of personnel demand for health services and provider determined assessment linked with staff performance and work patterns would show areas of higher occupational stress and risk of morbidity.

6.2 Structure

It was emphasized that this classification was to be used by primary care providers appropriately trained in its use. The following important aspects of the encounter between the patient and the provider could be classified:

- (i) reason for encounter as expressed by the patient;
- (ii) provider's assessment/diagnosis of the patient's health problems;
- (iii) interventions undertaken or the process of care.

Thus, three of the following four elements of the patient's problem-oriented registration (SOAP) could be coded using the draft ICPC:

- S - SUBJECTIVE - the patient's reason for the encounter.
- O - OBJECTIVE - this element is the one which cannot be classified using the draft ICPC.
- A - ASSESSMENT - this element is the provider's diagnosis.
- P - PLAN - this represents the process of care/intervention undertaken by the provider.

In this manner, the draft ICPC provided both a homogenous and simple framework for primary care providers appropriately trained in its use. The simplicity of the draft ICPC was based on its two-axial structure: 17 chapters in one axis, each with an alpha code, and 7 identical components with rubrics bearing a 2-digit numeric code as the second axis (Figures 1 and 2).

Figure 1 - CHAPTERS AND COMPONENTS

Chapters and their Alpha Codes

- A - Generalized and Unspecific
- B - Blood and Blood-forming Organs and Lymphatics (Spleen, Bone Marrow)
- D - Digestive
- F - Eye
- H - Ear
- K - Circulatory
- L - Musculoskeletal
- N - Neurological
- P - Psychological
- R - Respiratory
- S - Skin
- T - Endocrine, Metabolic and Nutritional
- U - Urological
- W - Pregnancy, Child-bearing, Family Planning
- X - Female Genital (including Breast)
- Y - Male Genital
- Z - Social Problems

Components

1. Complaint and symptom component
2. Diagnostic and preventive component
3. Treatment, procedures and medication component
4. Test results component
5. Administrative component
6. Referral and other reasons for encounter
7. Diagnosis/Disease component (Infectious diseases, Neoplasms, Injuries, Congenital anomalies, Other)

Table

Figure 2 - Format of International Classification of Primary Care (ICPC). The Chapters and Components form two axes. Relations with other classification systems are indicated.

COMPONENTS	CHAPTERS													Relation with other classification systems				
	A-General	B-Blood, blood forming	D-Digestive	F-Eye	H-Ear	K-Circulatory	L-Musculo-skeletal	N-Neurological	P-Psychological	R-Respiratory	S-Skin	T-Metabolic, Endocrine, Nutr	U-Urinary		W-Pregnancy, Childbearing, Family Planning	X-Female genital	Y-Male genital	Z-Social
1. Symptoms and complaints																		RFE-C
2. Diagnostic, screening prevention																		ICPC-Process (Process code for primary health care)
3. Treatment, procedures, medication																		ICPC-Process (Process code for primary health care)
4. Test results																		ICPC-Process (Process code for primary health care)
5. Administrative																		ICPC-Process (Process code for primary health care)
6. Other																		ICPC-Process (Process code for primary health care)
7. Diagnoses, disease																		ICHPPC, Defined WHO Tri-axial Classification

The following components are employed when the ICPC is used in its four possible modes:

- Reason for Encounter mode Use Components 1-7
- Diagnosis/Disease mode Use Component 1 and 7
- Process Mode Use Component 2-6
- Comprehensive Mode Use Component 1-7

COMPONENTS

6.3 Conclusions and Recommendations

Participants discussed this classification and made the following recommendations:

6.3.1 The meeting concluded that the proposed classification did not reflect the concept elements, or components of primary health care as described by the Alma-Ata declaration and as endorsed by the World Health Assembly.

6.3.2 However, from the classification as presented it seemed that possible uses were:

- (a) Assessing and monitoring the consumers' demand of care as determined by their own reasons for encounter.
- (b) Facilitating appropriate training of physicians and other health providers, reviewing their curricula and training programmes to respond to the demands of consumers.
- (c) Assisting in classification of survey findings on morbidity and health problems in the community.
- (d) Assisting in making decisions in resource allocations in the light of consumers needs.
- (e) Contributing to the knowledge and research on the natural history of disease and developments of its symptomatology.

6.3.3 The draft classification used the name "International Classification of Primary Care". In the light of the above mentioned discussions, participants concluded that the name as such did not reflect the content and uses of the classification. To be addressed as "primary care" the classification needed to be usable for the whole spectrum of primary care. On the other hand, to be labelled "international" it should meet the requirements of a majority of Member States to be endorsed through the protocol of WHO. It is recommended that the name be changed to reflect the provisional nature of the classification and its relationship to general medicine.

6.3.4 Furthermore, the participants felt that this classification could not replace the International Classification of Diseases (ICD) but could supplement it.

6.3.5 The meeting recommended that WHO should continue to collaborate in further testing and evaluation of the classification.

6.3.6 The meeting was informed that as WHO was not prepared to publish the classification at its present stage of evolution, WONCA, or a similar group, should consider its publication, with an appropriate acknowledgement of the involvement of WHO, to enable further development, particularly for health services research endeavours.

6.3.7 The participants expressed their concern that there remained an unmet need for a PHC classification which could assist countries, particularly developing countries, in the management and evaluation of their health systems where these had been based on the primary health care approach. WHO was, therefore, asked to consider a way of filling this information gap.

Appendix

LIST OF DOCUMENTS

- DES/PHC/85.1 - Agenda, Scope & Purpose
- DES/PHC/85.2 - List of Participants
- DES/PHC/85.3 - List of Documents
- DES/PHC/85.4 - Draft International Classification for Primary Care
- DES/PHC/85.5 - Position Paper - Present and future status of the draft International Classification of Primary Care (ICPC) (Previously Reason for Encounter Classification) - by Professor Maurice Wood
- DES/PHC/85.6 - International Classification for Primary Care: its rationale and applicability - by Dr Samir N. Banoub

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