



**WORLD HEALTH ORGANIZATION**

WHO/GPE/CAS/C/02.75

Distr.: LIMITED

ENGLISH ONLY

**MEETING OF HEADS OF WHO COLLABORATING CENTRES  
FOR THE CLASSIFICATION OF DISEASES**

Brisbane, Queensland, Australia

14-19<sup>th</sup> October 2002

**Title:** Report of the WHO-Wonca Joint Working Group on the relations between ICD-10, ICF and ICPC-2

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**Purpose:** For discussion

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## Report of the WHO-Wonca Joint Working Group on the relations between ICD-10, ICF and ICPC-2

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### Summary

*The WHO/Wonca joint working group on the relation between ICD-10, ICF and ICPC-2 met in 2002 in Amsterdam and in Copenhagen.*

*Within the terms of reference the working group reports to the Wonca International Classification Committee (WICC) and to the Heads of Centres (HOC) through the Family Development Committee (FDC).*

- *First the potential confusion with regard to several terms and concepts was cleared because a common terminology for the purpose of the report had to be established.*
- *ICPC-2 can be used in three modes in primary care: as a reason for encounter classification, as a diagnostic classification and as a process classification. ICPC-2 does not cater for the classification needs in community based "primary health care".*
- *The working group recommends that the ICPC-2 will be included in the FIC as the reason for encounter classification. In the reason for encounter mode all seven components of ICPC-2 are involved which allows WHO to use ICPC-2 concepts in future updates of ICD-10 and its derived classifications. It allows Wonca to describe the terminological relations in the ICD-10/ICPC-2 thesaurus for the part of the diagnostic concepts involved in both classifications e.g. components 1 and 7 of ICPC-2.*
- *The diagnostic components of ICPC may cover the need for a primary care diagnostic classification of health data, especially those needs of family doctors.*
- *The working group recommends that the FDC and the WICC will work together towards a common solution for a diagnostic primary care classification.*
- *The relation between ICPC-2 as a diagnostic classification and ICD-10 is now in a stage where practical work can be done by several participants. A further customisation of the four language ICD-10/ICPC-2 thesaurus will allow others to be involved.*
- *The coding of process with ICPC-2 is not meant to be anything more than superficial and its use depends to a considerable extent on national conditions. It is unlikely that primary care providers other than family doctors, such as nurse practitioners and barefoot doctors, will find the coding of process of ICPC-2 (nor the ICN for that matter) sufficiently geared to their professional needs.*
- *The working group considers ICF an important tool to describe problems of functioning in primary care patients and recommends focusing first on the relation of ICF with ICPC-2 in its diagnostic mode.*

*The working group concludes that further co-operation in the collaborative effort between the two stakeholders (WHO and Wonca) is important and can be based on this report.*

## Preamble, terms of reference and interorganizational structure

### Preamble

The Family Development Committee (FDC) within its work plan will analyse the possible classifications for use in primary health care with the goal to present recommendations for adoption of new member(s) of the family to cover coding of *reasons for encounter* and *diagnoses*.

At the meeting of the FDC in Copenhagen, April 2001, one day was used for a meeting with representatives of the World Organization of Family Doctors (Wonca) and its Wonca International Classification Committee (WICC) to discuss possible future co-operation on the use

of ICPC-2. A joint paper on this issue was presented to the 2001 Meeting of Heads of WHO Collaborating Centres for the Family of International Classifications (FIC). The meeting asked the FDC to form a joint working group with Wonca/WICC with the task to find out whether ICPC-2 should be a candidate for a related membership of FIC with special emphasis on covering the needs of family practice. The meeting too agreed to the need for a primary care adaptation of ICD-10 for classification of diagnosis in primary care settings.

The first meeting of the WHO-Wonca working group in March 2002 in Amsterdam resulted in an interim report that was discussed in the Trieste meeting of the FDC. The working group had a second meeting in May 2002 in Copenhagen and decided how to finalize its report after a very productive discussion. The report on this discussion, its recommendations and a proposed work plan for the completion of the task will be discussed by WICC in Sydney (September 2002), and by the FDC at the WHO HoC meeting in Brisbane (October 2002).

Parallel to this co-operation between the Committee and Wonca, the FDC will analyse the relations between the two reference classifications of the FIC and other possible candidates for membership of the FIC for use in primary care.

## Terms of reference

The FDC together with WICC has given the following terms of reference to the WHO-Wonca Joint Working Group on the relations between ICPC-2 and the FIC.

1. The working group shall thoroughly *analyze the ICD, ICF and ICPC concepts* of reason for encounter, health problem, health condition, diagnosis and functioning and describe which fields the classifications cover within the context of WHO FIC.
2. Based on this analysis the working group should consider the possible *use of ICPC-2 as a classification for family practice concepts* within the WHO FIC.
3. The working group shall propose a *mapping between ICPC and ICD* and – if found necessary – *a mapping between ICPC and (selected) ICF categories* that will ensure a transparent mapping 1:1 and n:1 from fine granularity to coarser granularity.
4. Also the working group should consider the possible application by WICC of a *primary care adaptation of ICD-10*.

## Interorganizational structure

There are two stakeholders for a collaborative effort to clear the relationship between ICD-10 and ICPC-2: WHO and Wonca.

The technical advisory groups are the Heads of WHO-FIC Centres (HoC) and the WICC. The Family Development Committee (FDC) is in this case the committee for the preparation of the recommendations on the ICD-10/ICPC-2 relationship.

The WHO-Wonca joint working group is a group that has to report to the WICC and to the HoC through the FDC.

## Conclusions on the analysis ICD, ICF and ICPC concepts

The analysis the ICD, ICF and ICPC concepts (see annex 1) points out the existing confusion about terms and concepts. In order to solve this from the Wonca perspective, it was decided that the term *contact* would not be used anymore, and would be replaced by the term *encounter*, which is a core concept in ICPC, as is *episode of care*. All synonyms of a diagnosis or health problem or part of a health issue or condition refer to a single concept: the diagnostic description given by the episode title. The CEN standard on continuity of care<sup>1</sup> will be used as a reference, and the (forthcoming) Wonca International Dictionary for Family Practice (Wonca Dictionary) has been revised accordingly.

A similar confusion exists with regard to *classification, nomenclature, thesaurus* and *controlled medical vocabulary*. A classification is an ordering principle of a domain. ICD-10 is the ordering principle of health problems in the domain of medicine at large; ICPC is the ordering principle of the domain of family practice and primary care and can be used in three modes (see also annex 1: terms 2):

- (a) as a reason for encounter classification, for which all of its seven components can be used,
- (b) as a diagnostic classification, for which only components 1 and 7 can be used, and
- (c) as a process classification, for which only components 2-6 can be used.

ICPC relates only to ICD-10 as a diagnostic classification: the classes of ICD-10 then serve as a nomenclature to ICPC and its alphabetical index as a terminology.

The essential difference between the two classifications is, in this respect, that ICPC is based on the prevalence of health problems in primary care, whereas the ICD-10 has a broader diagnostic range. In ICPC only common conditions have a separate class, whereas less common conditions are included in rest groups. Each of these groups includes conditions of a substantial number of ICD-10 classes. These ICD-10 classes therefore define the content of the ICPC rest group at issue. This perspective is included in more explicit terms in the Wonca Dictionary.

The reason for encounter is used as the best available approximation of the patient's perspective on his health problem and represents his request for care resp. his reason to seek care from a primary care provider e.g. family doctor. It serves as a classification, and the terminology is derived from empirical data, especially with regard to the designation of patients' requests for an intervention in all chapters. A nomenclature so far is not available. The approach is quite similar to the Reason for Visit Classification that originally served the development of the reason for encounter classification, which was developed by the WHO, tested in a large international field trial, and later included in ICPC. The coding of reasons for encounter appeared to be largely independent of the primary care provider's professional background. In the field trial, nurses proved to be as able to document and code reasons for encounter as family doctors were. ICD-10, through the ICD-10/ICPC-2 thesaurus, could well relate to reasons for encounter from the first and the seventh component: symptoms/complaints and 'disease' labels. It needs further work to assess to what extent classes in chapter Z of ICD-10 could be used to document patients' requests for an intervention.

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<sup>1</sup> CEN prENV 13940, Health Informatics – System of concepts to support continuity of care, May 2000

## Use of ICPC-2 as a classification for family practice

The WHO-Wonca joint working group recommends that the ICPC-2 will be included in the FIC as the RFE classification. In the RFE-mode all seven components of the ICPC-2 are involved. This allows the WHO to use ICPC-2 concepts in future updates of ICD-10 and its derived classifications. This allows Wonca to describe the terminological relations in an ICD-10/ICPC-2 thesaurus for the part of the diagnostic concepts involved in both classifications, e.g. the components 1 and 7 of the ICPC-2.

The coding of process with ICPC-2 is not meant to be anything more than superficial, and its use depends to a considerable extent on national conditions with regard to the daily work of family doctors, resp. primary care providers. It is important to anticipate on future international classifications of procedures with regard to their potential use as a terminology and a nomenclature for ICPC-2 in the process mode. It is unlikely that primary care providers other than family doctors will find the ICPC-2 process mode sufficiently geared to their professional needs.

The ICPC-2, components 1 and 7, may cover the need for a primary care diagnostic classification of health data also, especially those needs of family doctors. Primary (health) care in different countries differs considerably in organizational structure while the frequency distribution of diseases in large parts of the world differs from the distribution underlying ICPC-2 in its current form. It is, however, Wonca's intention to cater for the coding needs of family doctors working under different conditions, by providing additional classes on the basis of its mapping to ICD-10. These will minimally contain the diseases used in the World Health Report, Tabular List, p 72-76. Such a selection will be made available on the basis of the ICD-10/ICPC-2 thesaurus that now is available.

Although ICPC-2 reflects the paradigm of medicine under primary care conditions, it does not preclude use by others than physicians and other health personnel working in that role. Especially nurse practitioners may find ICPC-2 (if necessary adapted to their needs as in developing countries) useful.

The working group recommends that the FDC and the WICC will continue to find a common solution for a primary care classification for family practice, viewed upon as personalized care. Community based 'primary health care' is considered to be a different field to be classified<sup>2</sup>.

## The relation between ICD-10, ICPC-2 and ICF

See also annex 3.

Considerable time was spent on the assessment of the working version for four languages of the ICD-10/ICPC-2 thesaurus, prepared in Amsterdam. Although still several technical and taxonomic problems are to be solved, it was concluded that this working version is suitable for

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<sup>2</sup> "WHO definition of primary health care: Primary health care is essential health care made accessible at a cost the country and the community can afford, with methods that are practical, scientifically sound, and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Related sectors should also be involved in it in addition to the health sector. At the very least it should include education of the community on the health problems prevalent and on methods of preventing health problems from arising or of controlling them; the promotion of adequate supplies of food and of proper nutrition; sufficient safe water and basic sanitation; maternal and child health care including family planning; the prevention and control of locally endemic diseases; immunization against the main infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs." (J.M. Last (ed.), A Dictionary of Epidemiology, Fourth Edition, IEA, Oxford 2001)

distribution to all members of the Wonca International Classification Committee (WICC) representing close to 30 countries resp. languages, and the WHO Heads of Centres. After some additional editing, the chair of WICC will be responsible for distributing the thesaurus to the WICC members, and Martti Virtanen will make it available to those Heads of Centres who, at this moment, wish to be involved in the technicalities of the proposed thesaurus. In the Netherlands, Willem Hirs and Henk Becker will act as ‘mail box’, to which suggestions can be mailed automatically once a user has installed the program. WICC anticipates that it can efficiently involve its members from the different language areas by adding available translations of ICPC-2 and of ICD-10 to the core of the existing system.

The relation between ICF and ICPC-2 was discussed in some detail. WICC considers ICF as an important tool to describe problems of functioning in primary care patients. Active work to operationalize the relation between the two systems has already started. Body functions chapter of ICF appears to be best related to the ICPC-2 codes for ‘limited function and disability’ (last two characters of code are ‘28’) in the 17 chapters of ICPC. They follow the localization of ‘Body functions’ of ICF. The ‘Body structures’ chapter of ICF will be assessed in WICC from the perspective of the organization or localization as available in ICD-10.

‘Activities and participation’ chapter of ICF appear to be best related to specific diagnostic classes in ICPC, based on the preferential mapping of the clinical consequences of a disease, and the limitations in activity and participation it most likely will cause. ‘Environmental factors’ chapter of ICF appear to be an element that would be best served by a freestanding relation to ICPC as an additional classification. The important potential of ICF to support patient centred communication between primary care providers, e.g. physicians, nurses, nurse practitioners, and physiotherapists was acknowledged. WICC wants to focus first on the relation of ICF with ICPC-2 in its diagnostic mode; in a later stage, it would be worthwhile to assess the potential of ICF as a reflection of the patient’s perspective in relation to reasons for encounter.

The working group recommends that selected code sets will be developed for specific disease groups, common in ICD-10 and ICPC-2.

## **Primary care adaptation of ICD-10**

The working group considers the ICPC-2 components 1 and 7 as a possible candidate for a primary care adaptation of ICD-10. More work is needed to move the ICPC into that direction, for example a solution is needed for

- those ICPC-codes that are more detailed than ICD-10,
- the ICPC-2 keeping pace with updates of ICD-10 and relevant modifications,
- the ICPC-2 handling of dagger/asterix and tumours (anatomical sites and neoplasms).

## **Conclusions and work plan**

A good start for further work on the relations between ICPC-2 and the family of international classifications has been made. A clear demarcation has been achieved between the several functions of ICPC-2 and the elements considered for future inclusion in a WHO Family of International Classifications. The relation between ICPC-2 as a diagnostic classification and ICD-10 in the available translations appears to be best developed, and now in a stage where practical work can be done by several participants.

A proposal for a shortcut between ICPC-2 classes and one single preferential ICD-10 class to improve the inclusion of the available mapping in electronic patient records has to be further discussed. The Wonca Dictionary will be further adapted to the available standards. A further customization of the four language ICD-10/ICPC-2 thesaurus, will allow others to be involved.

## Annex 1: Analysis the ICD, ICF and ICPC concepts

The analysis is based on definitions and/or use of the terms in ICD-10<sup>i</sup>, ICF<sup>ii</sup>, ICPC<sup>iii</sup>, Wonca Dictionary<sup>iv</sup> and RVC<sup>v</sup>. The group has discussed the various terms and made comparisons between the uses of these terms in the classifications relevant for registration and statistics in primary health care.

### Terms (1)

*Encounter.* The term is used to describe a meeting or contact between a person (patient) and a health care professional. The Wonca Dictionary has this definition:

ENCOUNTER. Any professional interchange between a patient and a health care provider be this provider a single professional or a health care team. One or more health issues (problems or diagnosis may be dealt with at each encounter. When more than one health issue is addressed during one encounter, this encounter relates to more than one episode of care.

The term ‘encounter’ in Wonca terminology does cover all types of contacts between a health care provider and a patient, see the conclusions on page 2. It has, in the context of family or general practice, been given a specific and limited meaning.

*Contact.* The term ‘contact’ is generally used in the health sector in many countries, but is not specifically defined as a meeting or communication between a person and a health care provider, and for instance it may include «indirect contact» such as telephone communications. However, the meaning of the word seems to generally function as an unambiguous «international» term.

*Visit.* In medical professional language, depending mostly on the country/linguistic area, this term can cover two different concepts:

A professional call by a physician (or other health care provider) to treat a patient (e.g. at the patient's home)

A call upon a health care provider for consultation or treatment.

The Wonca Dictionary does not define ‘visit’, but refers to ‘encounter’ indicating that the terms may be considered synonyms.

The Reason for Visit Classification for Ambulatory Care (RVC) does not explicitly define a visit, but as it is originally classifying ‘reasons for seeking ambulatory medical care’ it seems that it cover (only) situations, where a person presents himself at an ‘office visit to a non-Federal, office-based physician’, but with the intention later to cover also other settings.

*Conclusion:* The terms ‘Encounter’, ‘Contact’ and ‘Visit’ are widely used in primary and ambulatory care and in classifications used in these settings. However, not all the terms cover clearly defined concepts, and an analysis of the classifications using the terms shows that they are

not synonyms. This should be kept in mind when discussing parallel use of various classifications.

## Terms (2)

This section deals with the terms used to describe the concepts classified in various classifications dealing with morbidity.

*Health problem.* In ICPC-2 ‘health problem’ is defined as the provider’s assessment of the patient’s health problem. The Wonca Dictionary has this definition:

HEALTH PROBLEM: any concern in relation to the health of a patient as determined by the patient and/or the health care provider....

ICD-10 uses the term (related) ‘health problems’, but does not have any definition of the concept. ICF and RVC do not use the term. However, the RVC in its disease module lists the most important diseases as such.

*Health condition.* The term ‘health condition’ is an umbrella term covering any state of health such as diseases, disorders, injuries, etc. ‘Health condition’ is the preferred term in ICF, which only very seldom uses more specific terms. ICD, ICPC-2 and RVC do not use the term.

*Diagnosis.* In medical terminology the term means either (a) the act or process of identifying or determining the nature and cause of a disease or injury through evaluation of patient history, examination, and review of laboratory data or (b) the opinion derived from such an evaluation. The definition in the Wonca Dictionary is:

DIAGNOSIS: the determination of the nature of a disease, a medical name given by the physician for the health problem presented by a patient, family, or community. This may be limited to the level of symptoms. The term covers both the process and its outcome and, in the case of a patient, represents the formal medical establishment of an episode.

*Disease.* ‘Disease’ is a definite morbid process or condition with characteristic symptoms and signs, which may affect the whole body or any of its parts; its aetiology, pathology and prognosis may be known or unknown.

In ICD diseases are organized into categories of diseases, and as stated in ICD-10: *The ICD is used to translate diagnoses of diseases and other health problems from words into an alphanumeric code, which permits easy storage, retrieval and analysis of the data*<sup>3</sup>.

ICF does not classify diseases.

The RVC has a disease module (see above).

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<sup>3</sup> ICD-10, vol. 2, page 2.

*Conclusion:* ‘Health condition’ is an umbrella term used as the preferred term in ICF, but not in other classifications. ‘Health problem’ is used in ICPC-2 to distinguish the provider’s conclusion from the patient’s reason for seeking care. The terms ‘Disease’ and ‘Diagnosis’ are not synonyms. ICD and ICPC organise diseases in categories containing 1-to-n diseases and the diagnosis is used as a key to classify a given condition.

### Terms (3)

A diagnosis is the name of a disease given by the health care professional (the physician) and is the result of the professional’s analysis, is not the same as the patient’s reason for contacting the health care service. This has been discussed in a paper<sup>vi</sup> presented at the HoC meeting in Washington. At the same meeting the US Reason for Visit Classification was presented. The definitions of the terms ‘encounter’ and ‘visit’ has been discussed under Terms (1).

*Reason for encounter.* The term ‘Reason for Encounter’ is defined in ICPC-2 (p. 2) as

“.... the agreed statement of the reason(s) why a patient enters the health care system, representing the demand for care by that person.”

They may be symptoms or complaints (headache or fear of cancer), known diseases (flu or diabetes), requests for preventive or diagnostic services (a blood pressure check or an ECG) a request for a treatment (repeat prescription), to get test results, or administrative (a medical certificate). These reasons are usually related to one or more problems which the doctor formulates at the end of the encounter as the conditions that have been treated, which may or may not be the same as the reason for the encounter.

As ICPC uses the same categories and codes for different purposes only the context indicates if a category is used as ‘reason for encounter’, as ‘treatment’, as ‘diagnosis’ etc. This puts special demands in presentation of data in ICPC format. Also the user (the individual physician) must be careful to clearly distinguish the registration of the patient’s reason for encounter from the professional interpretation of the patient’s condition and the translation of the diagnosis to a category in the classification.

*Reason for visit.* The term ‘Reason for visit’ as used RVC is defined as

The patients’ stated reason for seeking ambulatory medical care

This is further emphasised in the coding guidelines:

The reason for visit should be coded exactly as recorded, that is, no interference regarding what the patient really meant to say should be made.

RVC is developed as a «single purpose» classification and the codes can only be used for registration of reason for visits. The categories are organised in 7 modules covering the same areas as the components of ICPC.

*Conclusion:* ‘Reason for encounter’ and ‘Reason for visit’ are identical concepts. However, there are minor differences between ‘encounter’ and ‘visit’ – see Terms (1). ICD-10 and ICF do not classify ‘reason for encounter’ and ‘reason for visit’.

## **Health classification developed for primary care**

The Family of International Classifications does not include members specially meant for use in primary care. To meet the demands for classifications to cover the need for such classifications primary care adaptations of ICD has been developed in some countries, and Wonca has developed ICPC specially meant for family/general practice.

### **Disease classifications**

In Sweden and Germany adaptation of ICD-10 has been developed for use in family medicine and in other ambulatory health care settings.

ICD-10-SGBV<sup>vii</sup> is a special German adaptation of ICD-10 for use in the ambulatory sector of the German health care system. The adaptation makes a compromise between the needs and demands of the health insurance companies and the medical profession. To accomplish this two extra axis have been added to the codes indicating laterality and certainty of the diagnosis. Both family doctors and specialists can use the classification.

ICD-10-SGBV does not classify reason for encounter/visit, functioning, activities and participation.

*ICD-10-SGBV nationally meets the demands for a classification of diseases in primary care (general as well as specialist out patient care). It has very specific national characteristics, but presents only minor problems related to mapping to ICD-10.*

ICD-10 adaptation for primary care, Sweden<sup>viii</sup> is based on the Swedish translation of ICD-10. The classification uses four and five character codes. In most cases the fourth character is ‘-’ indicating that ICD-10 have sub-categories, which are not used, but also four character codes from ICD-10 are used where appropriate. In many cases two or more ICD-10 codes are merged into one ICD code. To distinguish such codes from the corresponding ICD-10 code the code is extended with a ‘P’ as a fifth character.

The Swedish ICD-10 adaptation for primary care does not classify reason for encounter/visit, functioning, activities and participation.

*The Swedish ICD-10 adaptation for primary care meets the demands for a classification of diseases in primary care. It has no specific national characteristics, but presents some problems related to mapping to ICD-10.*

## ICPC-2

ICPC-2 is a classification developed by Wonca International Classification Committee to cover all classification needs in family/general practice. In one classification the physicians have the possibilities to code the three central elements of their work: reason for encounter, diagnosis or problems and the process of care.

Diseases are coded by use of components 1 or 7. The same components are used (together with the other components) to code reason for encounter. This means that only the context can tell you which of the two concepts a given code does actually cover.

The ICPC-2<sup>4</sup> includes in its first and seventh components a mapping between all ICPC-2 codes and all ICD-10 codes, with the exclusion of the chapter on external causes. Because both ICPC-2 and ICD-10 cover all health problems and because the number of categories in ICD-10 is larger, optimally each code in ICPC-2 should be mapped to one or more ICD-10 codes and those ICD-10 codes should be mapped back to the same ICPC-2 code. Additionally each ICD-10 code should be mapped to one and only one ICPC-2 code and that code should be mapped (among others) to the ICD-10 code at issue. Since ICPC-2 is not a list of upper level ICD-10 headings this straightforward mapping is not always possible. The relations in the mapping are often more complicated and reflect the special requirements of a primary care classification. As ICD-10 is not a classification of 'reason for encounter' the mapping cannot cover components 2-6 of ICPC-2. Because ICPC-2 is not a classification of external causes mapping cannot cover chapter XX of ICD-10.

ICPC-2 does not classify functioning, activities and participation, but gives guidelines for coding of severity of disease and functional status based on COOP/Wonca charts.

*ICPC-2 meets the demands for a classification of health problems incl. diseases in primary care. It has no specific national characteristics. It presents some problems related to mapping to ICD-10. The contextual presentation indicates that a selection of the available codes can be used to classify a disease.*

## **Reason for encounter/visit classifications**

Two classifications have been developed for coding the reason for encounter/visit.:

RVC classifies 'reason for visit'. It is rather detailed classification organized in modules suitable for ambulatory care. The classification is used for coding elements of the patients' personal appearance in the office of the physician.

*RVC meets the demands for a classification of reason for encounter/visit in ambulatory care. The classification does not include so called 'indirect' visits, but this may be changed.*

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<sup>4</sup> I.e. the March 2002 update of the electronic version of ICPC-2, in: Family Practice 2002; 19: 543-546; see also <http://www.fampra.oupjournals.org/content/vol19/issue5> (forthcoming) (see also vol 17/issue 6)

ICPC-2 classifies 'reasons for encounter'. It is a rather detailed classification covering several aspects of encounters between patients and providers.

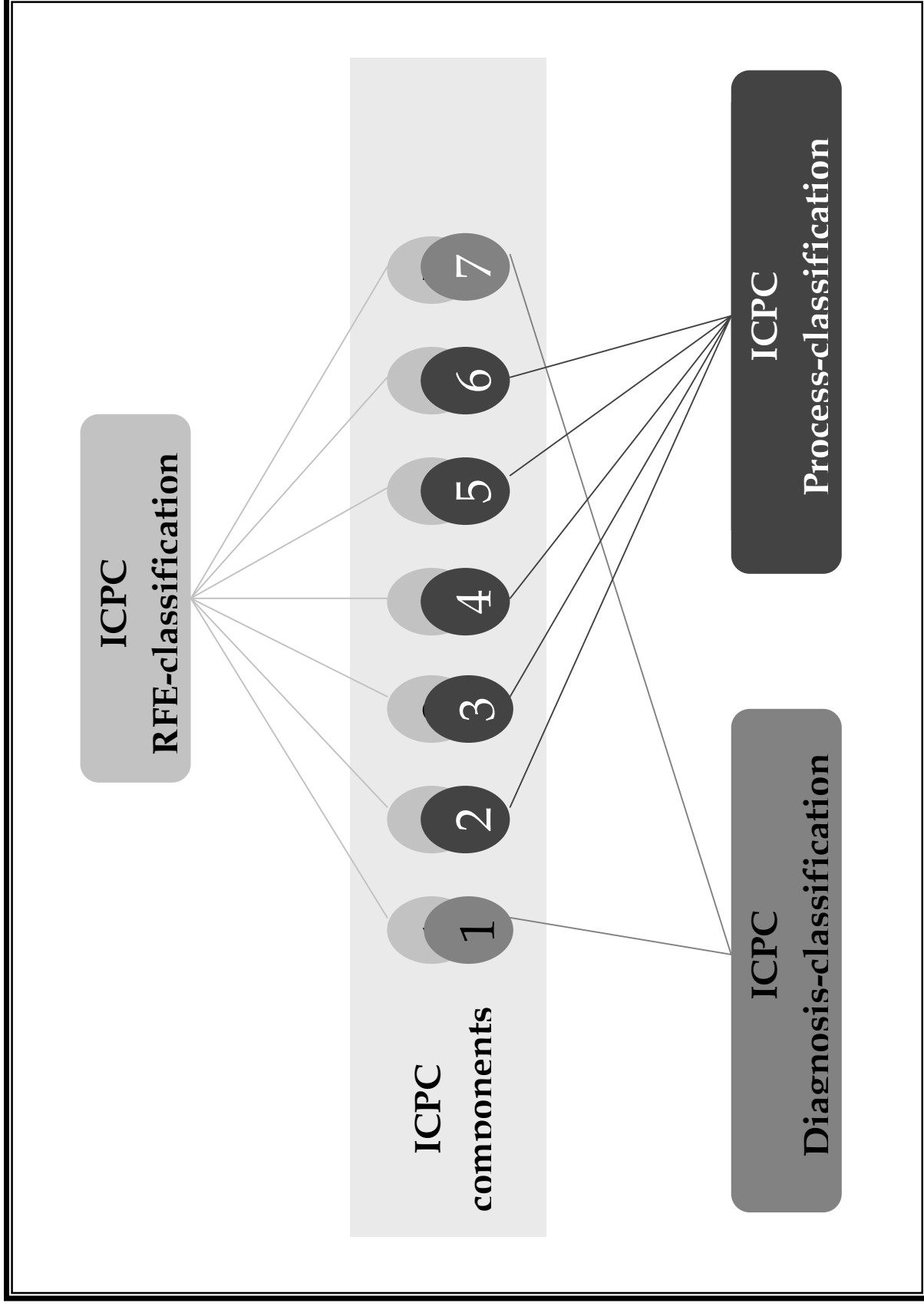
As several components contain codes that can be used also for coding diseases or processes of care, the contextual dimension is essential in the understanding and use of the classification as 'reason for encounter' classification.

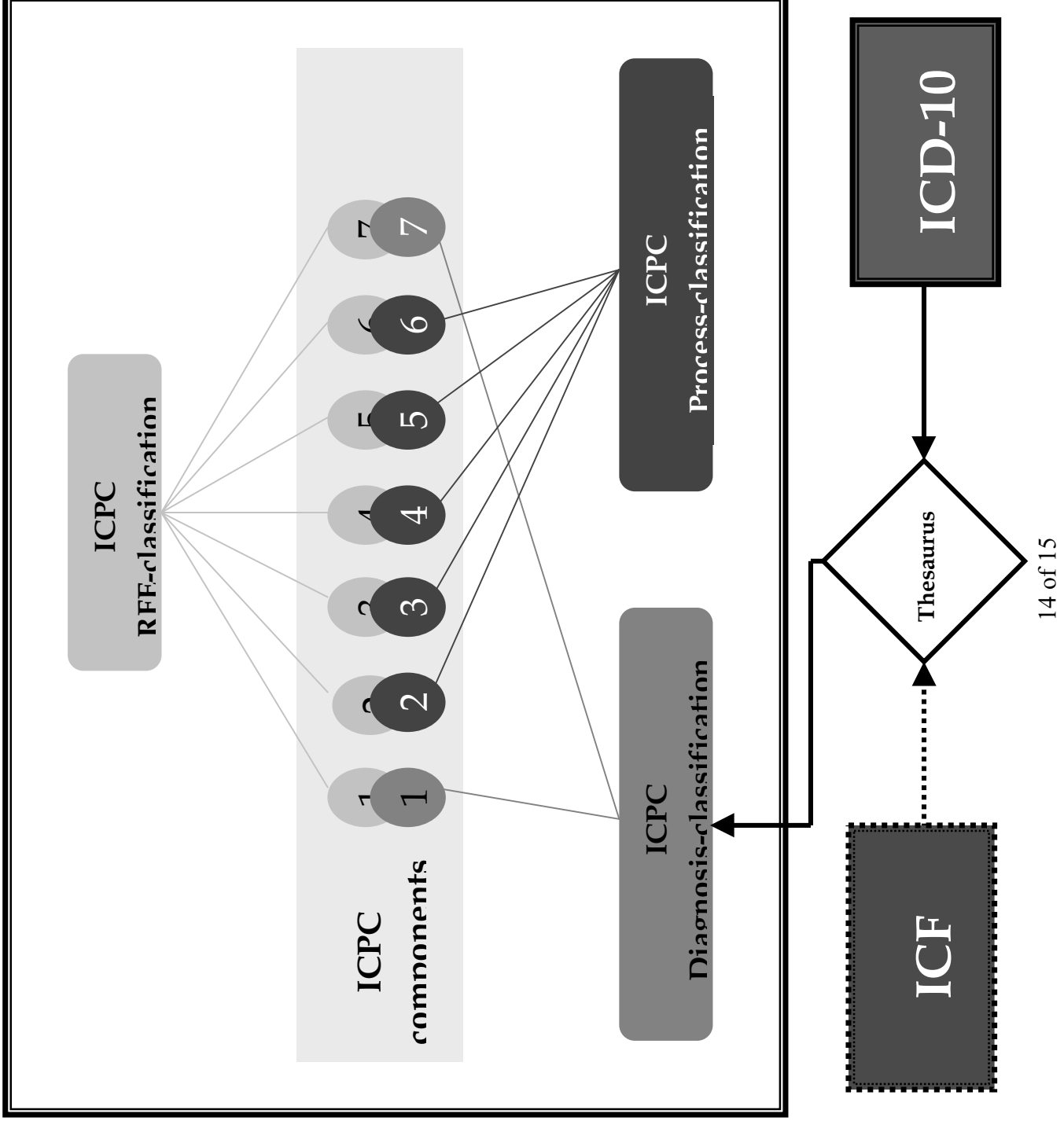
*ICPC-2 meets the demands for a classification of reasons for encounter/visit in primary care. The classification includes all types of encounters.*

### **Classifications of functioning**

ICF is the only available classification of functioning. Although some concepts in ICPC and RVC refer to functional problems they are not overlapping the concepts classified in ICF.

*ICF probably meets the demands for a classification of functioning in primary health care, but specific guidelines for appropriate use will be necessary.*





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- i International Statistical Classification of Diseases and Related Health Problems, 10th revision, vol. 2, World Health Organization, Geneva, 1993, section 2.1, p. 2.
- ii International Classification of Functioning, Disability and Health, World Health Organization, Geneva, 2001
- iii International Classification of Primary Care, ICP-2, Wonca International Classification Committee, Oxford Medical Publications, 1998
- iv Wonca International Dictionary for Family Practice, ed. Niels Bentzen, Wonca International Classification Committee
- v A Reason for Visit Classification for Ambulatory Care, Data Evaluation and Methods Research, Series 2, Number 78, National Center for Health Statistics, February 1979
- vi Conceptual and terminological differences and similarities between ICD-10 and ICPC, A discussion paper by Niels Bentzen, Martti Virtanen and Gunnar Schiøler, WHO/GPE/CAS/C/01.53
- vii ICD-10-SGBV A Special Adaptation for the Outpatient Sector of the German Health Care System, M. Schopen, WHO/GPE/ICD/C/99.34
- viii Klassifikation av sjukdomar och hälsoproblem 1997, Primärvård, Socialstyrelsen, Stockholm, Sweden