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WHO-FIC Primary Health Care Linearization

A report on process and progress

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Abstract To assist health professionals in recording disease, functioning loss and performed interventions in all primary health care domains, a WHO-FIC primary health care linearization is envisioned. This WHO-FIC primary health care linearization propagates joint use of the WHO-FIC reference classifications, as well as the integration of relevant elements from related or derived classifications. This poster describes the work done on this linearization to date.

Introduction

A key work area of the Family Development Committee (FDC) is to develop the WHO-FIC as an integrated and comprehensive suite of classifications, including in its application (FDC-SWP 02 Integration of the Family). Earlier discussions about the primary health care use case within the WHO-FIC with the WONCA classification working group (WICC) date back as early as the Brasilia WHO-FIC meeting (2012).[1] Those discussions resulted in work done by a task group that advised on how the ICD-11 MMS and ICPC-2 currently relate. The output was a selection of items in ICD-11 MMS that was deemed relevant for primary care, as currently in the ICD-11 Maintenance Platform (aka orange browser).

However, the WHO-FIC primary health care (PHC) scope goes well beyond general practice. There should be a set of elements of classifications that comes as a package that can assist a health professional record disease, functioning loss and intervention – universally applicable – in the realm of all PHC domains. Therefore, developing a WHO-FIC PHC linearization offers the opportunity to propagate joint use of the WHO-FIC reference classifications, as well as integrating relevant elements of related or derived classifications. Importantly, this can be seen as anticipating the alignment of the WHO-FIC classifications.[2]

Primary Health Care

In essence, primary health care covers any primary access point to health care. But it cannot be limited to just that, because then only *access* to health care is defined. We have used the Alma Ata Declaration definition of Primary Care, as the declaration is still valid and reads as follows:

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."[3]

Based on that, essential health care can be considered to:

- Provide good value for money in many settings.
- Address a significant disease burden.
- Be feasible to implement in a range of LMICs.

A PHC linearization should then cover all three perspectives of primary care.

Common domains where primary health care is delivered (this is not an exhaustive list):

Antenatal care	Community based rehabilitation	Dental care
Physio-therapy	Family medicine	Occupational therapy
Pharmacy	Community nursing	Social care
Dietetics	Speech therapy	School nursing

Use case

The PHC linearization gives the health professional the ability to register or document all elements of essential care that a health professional collects or performs through observation, communication and examination. This can be recorded at a granular level within each of the reference classifications (ICD-11 MMS, ICHI, ICF), or at a higher category level (sub or reference set), or potentially a combination of both. The goal of a WHO-FIC PHC linearization is to help a health professional in both high and low resource settings record disease, functioning loss and interventions in the realm of all primary health care domains using the suite of WHO-FIC classifications and thereby providing comparable data.

We foresee an exemplary use case for a PHC linearization in antenatal care, in both low and high resource settings, where there is a practical need for documentation / registration that will benefit from a complete toolkit / tick-box. The reasons for women to come into contact with antenatal care will probably be universally applicable, but the method of recording may be different in different resource settings. For example:

*A female patient comes into first time contact with antenatal care with **nausea**. Patient reported **being pregnant**. This was confirmed by **urine dipstick test** during visit. First-time check-up was performed; **blood pressure** and **weight measurement**. Patient was **enrolled in pregnancy monitoring program**. She was **given advice and support developing healthy home behaviors** and a **birth and emergency preparedness plan**. Patient was **advised on strategies how to cope with nausea**.*

MD90 Nausea or vomiting
QA41 Pregnant state
QA42.Z Supervision of normal pregnancy, unspecified
NT1.AC.ZZ&XJ59 - Test of genitourinary and reproductive functions by Urine dipstick and urine microscopy
PZA.AB.ZZ - Whole body measurement
ITA.AB.AF - Measurement of blood pressure
SM1.PN.ZZ - Advising about self care
VE1.PP.ZZ - Counselling about lifestyle behaviours
VC1.PP.ZZ - Counselling about safety-related behaviours
SDJ.PM.ZZ - Education about handling stress and other psychological demands

Approach

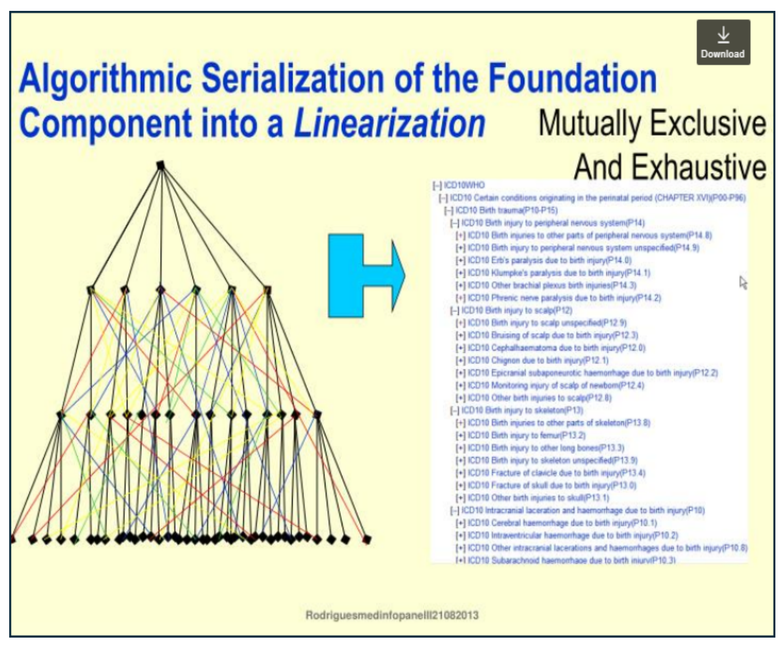
As the WHO-FIC PHC linearization uses the WHO-FIC reference classifications as a starting point, we focused on these firstly, trying to identify PHC-relevant elements in ICD, ICF and ICHI.

→For ICD-11: selection was actually done by the ICD-11 task force primary care, in the ICD-11 foundation: 1054 codes.
→For ICHI: list of essential interventions as defined by World Bank (Disease Control Priorities document Version 9): 140 codes (including preliminary mapping to ICHI);
→For ICF: it was advised during the FDC midyear meeting 2019 to select all groups of second level codes (188 codes / block codes), excluding the anatomical and structures component.
→For WHO-FIC extension codes: selection of Essential in vitro diagnostic tests: 62 codes; Assistive devices: 136 codes. These were chosen because they are common to both ICD and ICHI.

→Next steps include:
1) identifying information gaps left by the selections from the reference classifications;
2) examining if any missing information elements are present in the reference classifications, or if related classifications from the WHO-FIC could provide these (such as ICNP, ICPC, etc.);
3) resolving issues where concepts can be captured in multiple classifications but which are not fully comparable, like in ICD-11 and ICPC; and
4) validating the entire selection by cross-checking it against actual patient records from relevant PHC domains.

Linearization

To ensure further development and secure digital use of the PHC linearization, all elements (from chapter to block to category) need to have a unique reference ID (URI). That will facilitate the PHC linearization to be a 'true' tabulation in the sense of mutual exclusiveness and exhaustiveness, including residuals. The product then might even qualify as a derived classification.



Conclusions & Way forward

This year, 2019, marks the re-start of the work on a primary health care linearization. During FDC sessions in the Banff meeting a further plan of action will be discussed as well as timelines to develop this work further. People are still welcome to contribute to this challenging FDC work item.

[1] R. Jakob et al. ICD-11 Primary care. Poster C307, WHO-FIC Network meeting Brasilia, 2012. [2] See also: S. Tu et al. Toward a Harmonized WHO-FIC Content Model. WHO-FIC Network meeting Banff, 2019. [3] WHO. Declaration of Alma-Ata. Alma-Ata, 1978.