



WHO Collaborating Centre
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WHO Family of International Classifications (FIC)

NEWSLETTER

2018 WHO-FIC Annual Network Meeting

**Better Health Information for
Universal Health Coverage: 40 Years after Alma Ata**

The 2018 Annual Meeting of the WHO Family of International Classification (WHO-FIC) Network will be held at the Imperial Palace Seoul hotel in Seoul, Korea, from Monday the 22nd until Saturday the 27th of October 2018. As per established practice, participation is by invitation only. WHO-FIC committee and reference group meetings are planned from Monday until Thursday. The WHO-FIC conference will take place on Friday October 26th.



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This year's meeting theme "Better Health Information for Universal Health Coverage: 40 Years after Alma Ata" was chosen to commemorate the 40th anniversary of the [Declaration of Alma-Ata](#), emphasising the importance of protecting and promoting the primary health care. As the role of health information continues to grow in the modern era, it is possible to achieve both meaningful classification of health information and better healthcare for the public with help of information technology.

The meeting is hosted by the Collaborating Centre for the WHO-FIC in the Republic of Korea. All information concerning the meeting, such as the timetable, venue and accommodation (and afterwards; the meeting archive), can also be found on the meeting website:

<http://www.whofic2018.com/>

Editorial

Kind readers of the WHO-FIC Newsletter, due to some technical difficulties, we decided to present this newsletter one last time in its 'old' look. However, as you may have noticed, the 'feel' has changed: in an attempt to modernise and to consume less paper, we have decided not to bring printed newsletters to the annual meeting, but to guide everyone to the online edition instead. As a bonus, this digitalisation makes it possible to add direct hyperlinks throughout the document.

In this volume of the WHO-FIC newsletter, we have contributions regarding FDRG news, Personal Factors in ICF, an update on ICHI, and the development of ICPC-3.

I wish everyone a pleasant (digital) read. Please continue to let us know about your WHO-FIC news so we can spread the word!

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FDRG News

ICF Practical Manual and e-Learning Tool

Members from the EIC (Education and Implementation Committee) and the FDRG (Functioning and Disability Reference Group) collaborated on and finalised the ICF Practical Manual in 2013 when it was made available initially as an exposure draft and then became available online as Version 0.9 [here](#).

The Manual is targeted at anyone who might be interested in learning more about the ICF and is designed to be used alongside the ICF in its [latest version](#).

The Practical Manual provides guidance on how to apply the ICF concepts and framework in practice, for example in: Coding and statistical use, Clinical documentation, Education, Social Policy and Programmes, Advocacy and Empowerment. The ICF Practical Manual shares many examples of how the ICF has been used. It has also been made available along with many other ICF Education resources on the website www.ICFeducation.org and ranks as one of the most accessed items on that site.

The Manual is about 100 pages in volume and divided in short chapters covering all the topics mentioned before. The main concepts are summarised in easy to read textboxes at the side of the text, allowing for a quick orientation of the reader as shown in the example regarding the environment in the top right corner.

The environment may have a significant effect on a person's functioning and it is essential to record the degree to which it enables or disables the person.

As the Manual tries to cover all possible applications of the ICF, it serves well as an introductory resource, for example in undergraduate courses of health, social and education sciences. Those professionals that are already familiar with the ICF might use it as a quick reference when questions arise.



The manual is also a great companion to be used in conjunction with the new ICF e-Learning tool available at <https://www.icf-elearning.com> and in the process of being translated into various languages. The e-learning tool has a "Learning" and a "Quiz" component and is therefore designed for independent study and self-assessment.

WHODAS 2.0

The WHODAS 2.0 is a generic assessment instrument for health and disability that can be used across all diseases, including mental, neurological and addictive disorders. Being directly linked at the level of the concepts to the International Classification of Functioning, Disability and Health (ICF), it is well suited to describe Functioning in both clinical and general population settings. One of the limitations is the age range it can be applied to, having only evidence in people over the age of 15 (Kimber, Rehm & Ferro, 2015) and some reports of a WHODAS Child Version being used in mental health (Scorza et al., 2013). The Functioning and Disability Reference Group is interested in these initiatives and has received the task to develop a measure that can be used in the younger population. Under the leadership of the current co-chairs of the FDRG (Matilde Leonardi & Haejung Lee), an international initiative was started to develop and test a non-disease-specific functioning and disability assessment tool for children and youth that could be used in clinical, educational and social settings as well as for international

epidemiological studies. The tool will be developed, tested on and validated with children with different conditions, using neurological conditions as the paradigm as they represent the most relevant challenges and certainly the largest group of children with disability worldwide. Research groups interested in participating in this initiative or already having done work related to this are welcome to contact the co-chairs of the Functioning and Disability Reference Group.

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Personal Factors in ICF: Responding to the challenge

Background

Personal Factors (PF) are recognized within the Biopsychosocial model on which ICF is based as important elements modulating human functioning (ICF p.19). Currently they are not classified but users frequently circumvent the missing systematisation by annotating them whenever relevant for the specific use and context.

Outside and within the WHO-FIC the long standing issue of addressing PF classification is recurrently being brought on the stage. The relevant literature related to the PF issue has been recapitulated in a poster presented at the 2015 WHO-FIC yearly meeting (Leonardi et al.). The poster mirrored a position letter published by the same authors in *Dis & Rheab.* (Leonardi et al. 2016) and concluded by urging FDC and FDRG to take the challenge presented by a group of ICF experts and users in a recent paper (Simeonsson 2014) by opening a discussion starting from the points raised in the poster/paper.

Contextual factors looked through ontological eyes

The first characteristic that jumps to the eye when considering the contextual factors with an ontological perspective (= analyses of the qualities of the represented concepts and their relation) is the great heterogeneity of nature and relation, not only among the domains of the unclassified PF, but also among the already classified EF. These for example group together objects (resources and instruments both consumed and used) and processes further

specified in their relation by the attribute (facilitator or barrier).

The concepts that are exemplified in ICF as PF are grossly heterogeneous (see box 1 of poster by Leonardi et al.) and this problem has been repeatedly recognised in the literature (Heerkens 2012, Muller & Geyh 2014). The list of PF includes elements that are already classified in other UN systems (socio-economic status, education attainment, profession/work experience) or WHO ICD (coexisting health conditions and familial predisposition to specific diseases). Several key categories border Body functions & structures (gender, fitness, physical complexion, sexual orientation) and especially in the cloudy area of the psychological aspects the mental functioning (b125 and b126: temperament and personality functions, disposition and intra-personal functions) the inclusion among the mental functions might be matter of debate. Other categories such as habits and lifestyles may include both elements classified in established or developing classifications (ICHI targets) and elements currently outside any classification (e.g. hobbies and preferences in a wide range of areas from recreation to food to travelling, personal preferences, will).

It is apparent that the PF conundrum will never be appropriately addressed if the composite nature of the different concepts currently gathered under the PF umbrella is not sorted out and the relation that each isolated category might entertain with the other components is clarified. This sorting process needs to be guided firstly by stating clearly what the use cases are for PF. There are several lists already produced of possible PF to be used in specific settings and processes (primary care – Postma et al 2018, Occupational therapy – Heerkens et al 2017, etc.). In the various use cases the impact a specific concept might have on functioning and the resulting rubric of relevant PF might be quite different.

Preliminary pruning work could be conducted by FDC and FDRG isolating those PF that are already systematised in other classifications. **The expected outcome** should be the proposal of a different phrasing to be included in the ICF introduction for the description of PF.

The **ontological approach** such as that exemplified by the mapping to SUMO of the ICF categories might be applied to create order in this area without the pretention to build a probably impossible classification of PF, but giving wider range to the ontological investigation of ICF concepts that is both timely and needed.

The resource limitation that has been repeatedly called as a barrier for the work that FDC, FRDG and ITC could take jointly in the direction of the ontological reordering of ICF should not be an obstacle for the assembly of a small group of FDC, FDRG and ITC members that could tap and promote the work of doctorate students analysing the ICF

conceptual model with various methods including SUMO mapping.

A seeding group has gathered and produced a poster (n° 79) to be presented at the forthcoming annual WHO-FIC network meeting in Seoul. The poster is authored by Andrea Martinuzzi, Vincenzo della Mea, Huib ten Napel, Cassandra Linton, Jun Nayaka, Olaf Kraus de Camargo, Ann Helene Almborg, Brooke Macpherson, Lyn Hanmer, Haejung Lee, Matilde Leonardi: thus expressing the co-chairmanships and secretariats of the involved committees and reference groups. The required expertise on terminology and ontology is represented in the group.

The goals of such team work could be expressed by a multistep process:

- Clearly define relevant use cases for ICF PF;
- Identify concepts that are already classified in other systems both within and outside WHO-FIC product suites but not within ICF;
- Single out relevant concepts not classified elsewhere and not present in ICF that can still be considered as modulating elements for individual functioning (e.g. free will);
- Identify concepts that are already present in ICF and clarify the relation these categories entertain with the other categories describing that person's functioning (e.g. heart function and running; craving and eating; visual acuity and driving).

This work could take advantage of the preliminary work being done for EF and could provide a structured response to the call for action concluding the poster presented at the 2015 WHO-FIC meeting, but could also result in a propaedeutic exercise for a wider ontological ICF revision.

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ICHI update: 11 years in development

The International Classification of Health Interventions (ICHI) is one of the three reference classifications in the WHO-FIC Family. The development of ICHI began in 2007. 2018 is a significant year for ICHI development. ICHI has several clear use cases, including international comparisons, adoption by countries without an interventions classification, a base for redevelopment of existing classifications, use for monitoring Universal Health Coverage and the Sustainable Development Goals, as well as a tool for health system management, quality and financing.

ICHI's three axis structure (Target, Action, Means) was finalised in 2010. Content development began in 2011 and has continued since then. Extension codes have been introduced based on the ICD-11 model and now play a key role in allowing flexible additions of detail where required: examples include: additional descriptive information about the intervention, therapeutic products, assistive products, medicaments, and pathology tests. ICHI contains some 8,000 intervention stem codes.

ICHI includes all types of health interventions: diagnostic, medical, surgical, mental health, primary care, allied health, functioning support, rehabilitation, traditional medicine and public health.

Consistency between the three WHO-FIC reference classifications has been a key principle of ICHI's development. Body functions, activities and participation domains, and environmental factors from the ICF are included as targets in ICHI. These are used to describe investigative and therapeutic interventions that focus on the functioning of body systems, interventions to support people in activities and participation, and interventions that address environmental factors (e.g., assessment of or changes to the physical or social environment, provision of assistive products). It will be possible to use the three classifications together: ICD to describe health conditions,

ICF to describe a person's functioning, goals and need for assistance, and ICHI to describe interventions delivered. The user-friendly ICHI browser can be accessed at <https://mitel.dimi.uniud.it/ichi/#>. The browser includes interventions, axes and extension codes, as well as an introduction to ICHI, coding guidelines, and user guidance. A simple, logical syntax has been adopted to link ICHI stem codes and extension codes, interventions performed together, and packages of interventions. As well as using it to access the classification, users can sign up to the ICHI platform and provide comments and suggestions to contribute to the development of ICHI.

In 2018, some 25 ICHI tests have been undertaken by a wide range of interested parties. These tests were supported by an ICHI Training Manual. The general feedback from the tests has been positive. Some 1300 comments were added to the ICHI platform and over 600 of these have resulted in changes to ICHI, with the review process ongoing.

To promote interest in ICHI, a brochure was released at the 2017 WHO-FIC annual meeting. This can be viewed [here](#). ICHI is managed by an ICHI Task Force, chaired by Lyn Hanmer and Richard Madden. Robert Jakob represents the WHO. The Task Force includes members from several collaborating centres which have supported ICHI development over the years.

Next steps: In 2019, there will be formal tests of ICHI as a prelude to a pre-final version and input from member states. A release of ICHI in preparation for implementation (using the ICD-11 model) is planned in late 2019 or early 2020.

Please have a look at ICHI. Even better, try the ICHI Beta-2 version to code or map interventions in your own circumstances. Feel free to make comments on the ICHI platform.

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The ICPC-3 development

Introduction

The International Classification of Primary Care (ICPC) is the most widely used international classification for systematically capturing and ordering clinical information in primary care. It is developed and updated by the World Organization of Family Doctors' (WONCA) International Classification Committee (WICC). The most recent version is ICPC-2, which was revised in 2017 (ICPC-v2.7). ICPC has been designed to cover the core content of primary care at a level of granularity sufficient to describe and support the routine of general practitioners and to compile statistics for primary care. The unique characteristics of ICPC are the

body system chapters, the reasons for encounter, the processes, and the diagnoses organised in an episode of care model over time.

ICPC is formally recognised by the World Health Organization's Family of International Classifications (WHO-FIC) as a classification system for primary care. It is mapped to the International Classification of Diseases (ICD). This allows communication between the two classification systems and complementary usage. Ongoing cooperation between WONCA and the WHO-FIC network exists for the revision of ICD-10 to ICD-11 and harmonisation with ICPC.

The relation between ICPC and ICD

Whilst ICPC is a full classification system in its own right, it is enhanced by being mapped to ICD. ICPC and ICD therefore are complementary rather than in competition – a meaningful level of detail. This mapping allows ICPC to be used as the primary care lens into ICD. The reason for doing so is that the granularity of ICD is often too high and complex for its practical use in primary care. For example, the single code of 'sinusitis' in ICPC has 16 concepts and subclasses in ICD. This level of detail is often unnecessary for primary care.

Similarly, in many cases ICD does not contain higher-level overarching codes or codes aggregated at a higher level which are often more meaningful for primary care. ICPC therefore provides the higher level terms to ICD and by doing this allows for a more meaningful aggregation of ICD-data at primary care level. For example, in ICPC the most frequent cancers of the digestive system (colon cancer, stomach cancer, and pancreatic cancer) have their own individual codes, and there is one code which captures other digestive cancers. This is not possible to do with ease with ICD. With 12 classes and sub-classes of digestive cancer and in the case of colon cancer ICD being split into many subclasses; what is missing is the higher-level code of 'large bowel cancer'. Users will sometimes want to separate certain problems contained in a high-level overarching code or in aggregated codes into a more specific code. Expanded codes through ICPC-ICD mapping allow such users to be more specific, for example enabling the recording of diseases of low prevalence but of high clinical importance.

Why a new ICPC-3?

Since the development of the present version of the ICPC, a lot has changed in health care and especially in primary care. Health care is being transformed to deliver care and services in a person-centred manner and is increasingly provided through community and home-based services that are less costly and more convenient for individuals and caregivers. At present, the ICPC is not covering these new requirements, and therefore needs further elaboration of content to be able to adhere to changes in health care.

Examples of these requirements are:

- The need for social health determinants; determinants that are influenced by actions and encounters that occur outside the traditional health care delivery settings, such as environmental factors, work, socio-economic position, etc.
- The need for gathering and exchange of information about prevention, functioning, risk factors and lifestyle.
- There is also a need for more classes (infectious diseases) especially in tropical countries and for classifying social problems (violence, problems related to refugees etc.).

These subjects become more and more important because in an integrative health paradigm the focus is shifting from a purely medical perspective to a person-centred perspective, where functioning in a social context is the overarching concept.

In parallel to patient-centeredness, we also encounter the development of primary care teams in which in some cases there is a strong relation with public health, meaning that public health interventions sometimes are inclusive in primary care settings. A common understanding of patients functioning is required here as well.

Furthermore the demand for international comparisons of primary health care data is ever growing, with a focus on the efficiency, structure and quality of health systems. The different adaptations of primary care classifications used in different countries are generally not built on a common foundation, and therefore they do not provide a basis for such comparisons.

The way classifications are being developed and maintained nowadays, and the different formats for electronic application, but still also for manual processing, requires a more sophisticated and responsive approach as well. WICC and WONCA have been thinking and discussing about a new “fit-for-purpose” Primary Care classification for several years and want to bring this into a new phase. We are aware that “one size does not fit all purposes”. That is the reason why we also focus on an interface terminology that facilitates efficient and effective sharing of morbidity data with providers that use other classifications.

Goals of the new ICPC-3

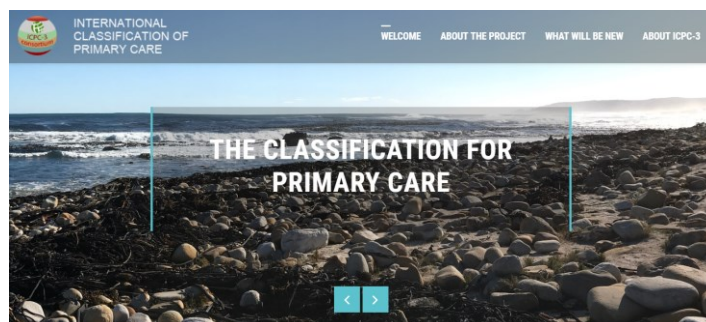
1. To further develop the primary care Content Model as the basis of the content of the new ICPC: The content of primary care cannot be covered by a single classification. Therefore the primary care content model contains linkages to several standardized terminologies and classifications. It will identify the basic properties needed to define any primary care concept through the use of multiple parameters relating to its definition, and meta-information such as structural context in the classification and versioning

information. The ICPC content model will be closely connected to terminologies and classifications such as ICD-10, ICD-11, ICF, ICHI, SNOMED-CT, etc. Because they serve different purposes, classifications like ICPC and ICD both require their own specified content model, but will be harmonized where possible.

2. To offer a new version of the ICPC based on a novel approach for classification development, i.e. a content-model: This novel approach takes into account all desired uses of ICPC in international and different national settings, and is consistent with the principle of interoperability within the Framework of International Classifications and Terminologies.
3. To offer an Interface Terminology with a coding Tool based on the content of the new ICPC to support registration at the source, i.e. the Electronic Patient Record.
4. To bundle and extend knowledge on ICPC development to secure future maintenance of ICPC within concurring developments and marketing of ICPC-products.
5. To create a stable financial model to support continuous development and maintenance of ICPC and the Interface Terminology.

Collaboration in the WHO-FIC

Collaboration is needed to support the principle of continuity of data within and between health-care providers, but also supporting the use of ICPC, or ICD within a country, without losing the possibility to collect or exchange information for different purposes, such as direct patient care, research, reimbursement, aggregation or disaggregation, etc.



<http://www.icpc-3.info/>

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