The International Classification of Diseases ICD was established following the first International Statistical Congress held in Brussels in 1853. William Farr from London and Marc D’Espine from Geneva were requested to prepare a list of causes of death which could be used in all countries. Its purpose was to enable comparison of mortality statistics between countries. In order to achieve that, reliable estimates of the population in adequate age and gender detail were prerequisite. There was then a need to describe deaths in an agreed manner and finally to ensure comparability of storing data using a common coding system. All the ingredients of a common information system were then in place, but in reality it was a long time (and perhaps we have not yet reached it) before true comparability was achieved.

The need for comparability of data remains today: to monitor the spread of illness; to generate hypotheses on cause whereby the beneficial or adverse affect of diet, alcohol, environmental factors etc can be examined in countries with differing life styles and dietary habits; to assess the burden of illness and evaluate interventions; and to study systems of healthcare delivery with a view to defining the optimum.

**The importance of primary care**

The importance of data from primary care is often underestimated. In the British National Health Service, the fourth practice based morbidity study in 1991/92 showed that 78% of the population made contact with their general practitioner (gp) in one year. Almost all patients with infectious diseases are managed in primary care. Wilson and Bhopal prepared a list of illnesses they considered attributable to infectious diseases. According to that list approximately 5% of deaths, 6% of hospital admissions and 40% of episodes of illness presenting to general practitioners were caused by infection. If information about infections is needed, data from primary care are essential. Health services are driven by the problems which patients present to the doctor at first contact. Even in countries in which the general practitioner does not have an absolute gate-keeper role in relation to access to specialist services, the doctor of first contact is usually a gp. GPs are therefore closest to the totality of illness in the community. They are also in a particularly advantageous position to evaluate the impact of interventions such as initiatives to stop smoking and influenza vaccination programmes. Antibiotic resistance is a particular and topical problem. Almost all our information on antibiotic resistance is based on specimens collected in secondary care. There are virtually no data on resistance in the infections and micro-organisms found in the community.

**European initiatives**

The significance of information from primary care has been recognised at the administrative level in the European Union. For information to be useful it must be gathered in a consistent and structured way. A short review follows of projects undertaken which have been particularly concerned with primary care in Europe.

*International comparison of immunisation schedules*

This project was undertaken by the European General Practice Research Workshop (EGPRW) and was concerned with comparing the different schedules of primary immunisation of children and the differing administrative procedures involved. In conception it was visualised as a first study in a series in which the final goal was an attempt to define the optimum immunisation schedule taking account of issues relating to health care delivery as well as immune responses at different ages. The final goal was never reached because regrettably, the group could not sustain a sufficient level of interest.

*The interface between primary and secondary care*

This study described the administrative structure of the referral process in European countries and was undertaken as a collaborative venture by members of the EGPRW.

*The European study of referrals from primary to secondary care*

Fourteen European countries were involved in the examination of the referral process. Amongst its most revealing findings were the very considerable differences in the number of consultations undertaken each week by gps in different countries, the numbers of these which involved home visits and the delays in the waiting times for patients receiving specialist care after referral by gps.

*Eurosentinel*

This project was led by Dr van Casteren. It was the first European attempt to bring together the activities of sentinel practice networks. Several sub studies were undertaken under the umbrella organisation and it has in effect given birth to most of those which follow.

*European influenza surveillance scheme (EISS)*

Eurosentinel led to much greater collaboration in the field of influenza surveillance. There is now in place a scheme of integrated clinical and virological surveillance in which six European networks participate.
Task profiles of general practitioners
The organisation and function of gps has been extensively described in this project directed by the NIVEL Institute in Utrecht.

The denominator problem
One of the key problems for research in medicine involves the definition of a denominator for epidemiological study. The issues have been thoroughly reviewed within a European concerted action involving the sentinel networks in several countries including Belgium and the UK.

Health monitoring in sentinel practice networks
This project is currently underway. It is similar in intention to Eurosentinel but is focused more on chronic diseases. There are two main strands, the first is concerned with establishing a European centre for harmonising the activities of sentinel practice networks with the emphasis on securing comparable information in different countries. The second is concerned with field studies on diabetes and chickenpox. We hope this project will lead to an extension of sentinel practice activities in Europe.

European enteric infections sentinel surveillance (E-EISS)
This project attempts to establish an equivalent to EISS with regard to enteric infections and is currently being considered for funding by the European Commission.

Vision for the future
In conclusion I would like to propose a long term objective of securing comparable information from primary care networks in European countries. The information from the consulting room will be integrated with patient linked laboratory information about micro-organisms and hospital utilisation data. The basis for information gathering will involve efficient use of information routinely collected as part of the delivery system for health care.

References