PERSONAL HEALTH SERVICES—AS DEFINED AND ORGANIZED
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The rational approach to health service organization

In the field of medical care, particularly that area concerned with personal health services, E. Richard Weinerman was both a prodigious worker and a provocative, farsighted conceptualist. We recall him as a man of method for approaching problems. We knew him equally well as the designer of a model for the rational dissemination of information and possible solutions. He began, always, with a premise, based upon philosophical concept. This premise he would connect to the specific task at hand. The task, then, was explored for its practical applications as well as its attendant difficulties. Now, specifics would be threaded back to the premise; but in a manner not merely philosophical, but meant for operational reality. In short, both the concept and the task received continuous exposure and testing, seasoned by time and multiple settings. Ideas and techniques then were rearranged, discarded or expanded to improved forms—and tested anew. Only those that survived this process were accepted and retained.

Organization (he wrote) is the necessary base for technology; rigidity of organization is as destructive to this goal as is planlessness. . . . There has to be a mechanism for translating experience and research into careful planning, that relates the planning directly to the actual program, the experience of which leads back to planning. Finally, we must trust the people and respect their needs as they describe them, and produce those patterns of use that will fit human requirement. (78)

The arduous forum of speeches, lectures, published papers and demonstration projects—this was Richard Weinerman's testing ground. He actively sought it: dating from 1962 there were approximately 146 papers and/or speeches, frequently at the rate of one to two a month. He sought as widely diverse audiences—often hostile ones—as he could; they ranged from medical societies, urban planning groups, local visiting nurses' associations, schools of medicine and public health, organizations for long-term care and care of the aged, numbers of group practices, hospital administrators, and HEW study commissions, to labor unions, radio audiences, and

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NOTE: The numbers in parentheses refer to Dr. Weinerman's List of Publications at the beginning of this volume.
environmental control groups. He spoke his mind. More than that he listened attentively, enthusiastically, and patiently to the critical response of his colleagues. One of his great strengths, indeed, was to listen for something new, thoughtful and honest—from whomever it might be offered—thence to rethink, and not infrequently change his own stand.

He behaved as he believed, demanding logic and rationality. His suggestions for a National Health Insurance Program, and how personal health services would fit into the overall plan, evolved from many years of carefully reasoned problem solving. His ideas did not derive from experimental new models randomly created, but rather from rational answers to a logically organized series of questions.

What, then, were some of these? Dr. Weinerman described the basic problems of primary medical care as being (1) efficiency—solved by timely application; (2) complexity—controlled by organization; and (3) costliness—supported by accessible and available financing.

It simply is not possible in one short presentation to document, let alone pursue historically, each of the many trends in Dr. Weinerman's contribution to our knowledge and understanding of personal health services. Accordingly, I have taken the liberty of selecting those areas that I believe best typify the synthesis of his position on a National Health Insurance Program.

To begin, Henry Sigerist's explication of medical care thoroughly captivated Richard Weinerman. In every paper or address, Dr. Weinerman's opening remarks underscored the interdependence between the ecosystem and medical care. To quote from one:

> The process of planning for tomorrow's health care must be based upon careful analysis not only of the form and content of services, themselves, but also of the underlying social, economic, and medical trends that determine the need and engender the demand for health care. (53)

His conviction about this basis was very firm. I believe it instilled in all of his work that strong and consistently human element which among so many other values, set him apart from others. As he said:

> The twin enemies of health in the ghetto are poverty and despair. These combine to degrade the quality of life, to limit the availability of protective resources, to impair the normal development of infants and children, to intensify the exposure to the most severe risks to health, to distort the emotional context of human intercourse, and to prolong or perpetuate the resulting physical and mental disabilities.

The answers to puzzling problems, the suggested modifications, the courses to be followed—these grew from a comprehensive understanding of
the ecosystem, past, present, and future—not an irrelevant or arbitrary technical assault upon the system. The impact inevitably was substantial, because his solutions were wedded so logically to the changing nature of disease and of the population, to the consequences for medical care and the resources available to medical care. His definitions and organization were contemporary—they combined good timing with a call to looking forward. No one in Dr. Weinerman's hearing could sit back complacently, assured that his, or any, solutions were final. That, too, was one of the rare and appealing qualities of his approach to problem-solving.

**Principles of health service organization**

Personal health services, as he saw the construction, had a number of essential, individual components that fit into a broader group of components. The components tended, for him, to be qualitative rather than quantitative in nature. To omit one set would destroy the rationality of the overall system of organization. The components, or the "ecological model for the health service system" as he qualitatively characterized them in October, 1969, were these:

1. *National responsibility* for policy, priorities, financing, standards, and production of health resources.
2. *Regional organization* for the coordination and administration of self-sufficient networks of comprehensive personal health services.
3. *Local authority* for the operation of primary health services.
4. *Universal coverage* of the population in a single national program.
5. *Comprehensive scope* of services from prevention through rehabilitation, with priorities in the preventive and primary care portion of the spectrum.
6. *Rational coordination* of various types and echelons of service, emphasizing teamwork methods in the function of health personnel.
7. *Professional controls* to assure the maintenance of good standards of quality.
8. *Democratic structure* in policy formation, involving both public and professional representatives at each level of program operation.

The team concept replaces that of the independent practitioner or the autonomous hospital. Functional inter-connections become more important than formal or physical ties. The basic or primary health team—composed of physician, nurse and social aide, in varying proportions—is the most important element of the entire system, requiring first priority for human and material resources. In urban areas, a number of such primary health teams can be grouped in community health centers for efficiency and common use of supporting technical and specialty services. In rural and other isolated areas, the single (but still intact) primary team can serve as the anchor point of the coordinated regional system. Thus, functional rather than physical group practice becomes the key to personalized and integrated serv-
Weinerman's concept of health services

ices. Regional teaching centers and district general hospitals support the all-important primary health units, rather than the pattern now prevalent in most countries of the world in which huge hospitals and large staffs of specialists command the lion's share of resources, professional status, and public esteem.

Emphasis is given in each primary health center to the "out-reach" principle of extending into the community for identification of health hazards, screening of persons at special risk, and health maintenance on the family level. Continuity of long-term care is protected, as the single responsible health team functions throughout the continuum of local health resources such as nursing homes and home care services. Involvement of the citizens at every level of decision-making makes possible the merging of consumer and professional preferences in the evolution of the health service system. (89)

That address, which was delivered just a year ago in Buenos Aires, contained, I believe, Dr. Weinerman's latest organization for personal health services—other than his proposal for National Health Insurance. It also revealed evidence of changes in his own thinking—the type of modifications he so willingly made when he felt that previous ideas had grown outdated.

The "Community Health Center," as he visualized it in earlier work, was separate physically and functionally from the system of primary health care. The latter was associated with hospitals or the physicians' offices—whether private, or preferably in group practice. Here the delivery of care was directed toward a particular patient and his family. Another separate organization involved was the "Community Health Center" which dealt basically with general population groups and their environment.

Dr. Weinerman's definition of "Community Health Center" was as much functional as institutional. It contained those persons working in various community based agencies, such as health departments, visiting nurses' associations, and voluntary health associations. They may have been separate administratively but many of their concerns and activities were mutual. He visualized them as a quasi-integrated whole. Although his "Community Health Center" and the system of primary health care often worked in concert, they did so each in their own well-defined area.

Later, Dr. Weinerman began to see the need for inclusion of other new or traditional health workers from his "Community Health Center" into the primary delivery system. (44,66,72) The justification was aimed, I believe, toward a qualitative control on standards of care. As the definition of comprehensiveness evolved, it was evident that changes would be necessary in methods of organization and kinds of manpower used. Here, he differed from many others in his motivation for these suggestions for change. It was as a method of quality control, not as an answer to manpower shortages (produced by a redefinition of medical care) that he wanted these work-
ers included in the team. He believed that the physician would remain captain of the team (primary for status and political reasons), but that other and new professionals had unique skills not possessed by the physician. (64)

This point of view was also one which had evolved over time. At an earlier stage of thinking he did believe that the professional skills were hierarchical. But as the definition of health care changed, so did the necessary content and skills to meet the care needs and demands. Dr. Weinerman's concepts of the health service organization kept pace and pushed forward.

About this time, Dr. Weinerman also began to see the overview of health care delivery systems in a new light. He felt strongly that medical care systems were a product of the ecosystem, but had not yet empathized the impact which medical care systems themselves had upon those changes in this system. He began to understand and to formulate plans around the way the medical care system—and particularly personal health services—could be employed as an agent of change for active influence rather than passive response.

One method of active influence was through medical education:

The essence of the challenge to the academic medical community is the present imbalance between its technical excellence on the one hand and its growing irrelevance, on the other hand, to the needs of society which supports it.*

He devised and organized the Family Care Unit at Yale, the Family Care Demonstration Project in the Community Health Foundation in Cleveland, Ohio, and influenced many other medical schools and their affiliates to formulate similar programs. The intent was to influence, and train, medical and other students into newer forms of medical care organization. They would then influence others. He described a new type of physician:

The social physician—aware of the changing social order, skilled in the social organization as well as the use of modern technical resources, accepting of the vital roles of non-medical members of the health team, acquainted with the methods of social as well as natural science, oriented in the complex arena of medical care programs, prepared for research into the environmental aspects of illness, and mindful of the unrealized potential of the social application of full medical capacities to the health needs of all of the people. (39)

Another active influence was to rearrange the geographical and political boundaries of primary health care services. He spoke of a necessary shift from the traditional Federal-state-local line of responsibility to one of a
national-regional-community line. As disease and its sequelae know no political boundaries, neither should the system that is trying to eradicate them. The system should respond flexibly to avoid duplication and waste, but caution should be taken to avoid "matters of conflicting authority, program instability, administrative incoordination and the like." (73)

The modern concept of a health service organization

As his latest concept of the "Community Health Center" evolved, it became not just a union, but an "uncoupling and recoupling" of the two previous organizations—not solely as an expansion of his concept of comprehensive care, but as a rational assemblage of knowledge, resources, and finances that would allow us to handle the changes in society and the changes in science. As stated above, he saw the delivery of health care at the primary level to be the greatest intellectual and scientific challenge of the future. (78) At this local level he envisioned the emphasis to be upon "person-health-and team" rather than upon "patient-diagnosis-and specialist." (82)

Every personal health service program must evaluate itself in terms of (1) comprehensive scope of care, (2) elimination of economic barriers, (3) regional coordination of facilities and resources, (4) high standards of quality, (5) integrated education and research, (6) prevention of unnecessary disease, and (7) reduction of economic dependency.

Therefore, organizational and physical separation between the traditionally defined personal health services and public health was no longer a rational model of health care. The development of a science of medical care organizational theory and its application through appropriately designed personal health services would produce the longed-for downward changes in morbidity and mortality.

This concept, I believe, is the basic one behind his proposal for a National Health Insurance Program—a triumphal climax to mesh his philosophical concepts from the teachings of Henry Sigerist into a well-defined operational model.

Financing of health service organization

It is difficult to believe that Dr. Weinerman fully accepted the financial incentives concept that he devised for the National Health Insurance Proposal—but Dr. Weinerman was a pragmatist as well as an idealist. He frequently quoted C. E. A. Winslow:

* See his paper on this subject in this volume.
The art of statesmanship in its essence consists in formulating an ideal and then so dealing with circumstances and with personalities that we approach that ideal instead of receding from it. . . . He who sees only ideals accomplishes little—he who sees only facts, even less. He who grasps both facts and ideals, who molds the actual to the form of a vision, is the man who helps to build a better world.8

Dr. Weinerman had studied and analyzed the relevance of the free market system for medical care organization.9 He questioned its successful application in the role of social planning, its open competition effect upon quality and distribution, and its potential for producing conflict between the consumer and the need for strong centralized power—questions that troubled him even as he wrote the proposals. He understood the necessity for adequate financing as he understood human drives. If financial incentives would begin to move the medical care machinery in a more positive direction, then financial incentives under careful management should be used. However, we should be very mindful of the potential menace of confusing efficiency with effectiveness. The two are not necessarily synonymous. It is my contention that where money is the competitive reward, we can document a long history of sacrificing real effectiveness for commercially-packaged effectiveness. Who is to define what is unnecessary and unessential? Money rewards have a way of being compared and equated with money spent. How much money should be spent in a system to preserve the human element? How much is it worth? Perhaps the end result of an efficient system may lack in its concern for the human element; and the less efficient system may be strong in its concern, management, and preservation of the human element. How or is it rewarded?

E. Richard Weinerman left, as his legacy, our sense of how to approach and solve just such problems. In closing, let me take a quotation from his discussion paper, "Public-Private Partnership: Its Impact upon Physicians and their Professional Associates":

But mostly our people need health services—public or private—and not more tedious documentation or repetitious conference. We have had decades of such substitutes for action: surveys in the 1940's, commissions in the 1950's, and now, in the 1960's planning is the in thing. But we have now long understood the basic concepts necessary for the development of programs for the provision of health services—knowledge enough to support many years of action efforts. I submit that such program experience, constantly assessed through careful evaluation research, is the only effective stimulus for improvements in our current theory and thus for subsequent modifications in our system of health care. The essential unity of theory and action lies at the very heart of this matter of balance in medical care. (87)
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