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Educational Challenges Facing Health Care Social Workers in the Twenty-First Century

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Recent reports (Berkman, 1996; Volland, 1997) suggest that social work practitioners are concerned about maintaining a critical role in the delivery of health care services given the current social, economic, and political environments in which health care services are now provided. How can the professional functions and tasks social workers currently perform in the health care delivery system be expanded or modified to strengthen our claim to a domain of expertise? How do we go about influencing any necessary changes in the perspective of the profession? Fortunately, health care social workers have a rich past of achievements that should not be ignored. These achievements that can be documented as unique to the social work profession and effective in meeting the social and health needs of vulnerable populations need to be identified. Social workers must also search for creative solutions to current social problems in the health arena, which define their expertise and preserve their presence in health care policy decisions and service provisions. This article addresses the challenges that the social work profession faces in the health care service environment, focusing on the education and training direction for current and future practitioners in the health care arena.

Historical Development of Medical Social Work and the Ecological Perspective

While the focus of social work practice in health care is constantly shifting, looking back historically helps find the continuity in practice and theory which serves to formulate a professional identity over time (Fee & Brown, 1997). Medical social work was one of the first specialties in social work practice and contributed to the development of the profession. Since 1850, physicians attached to hospitals sought volunteers and paid workers to provide follow-up care for new mothers and babies to detect the social and environmental conditions that were associated with high infant mortality and rapidly spreading infectious diseases. Observing and articulating the social conditions contributing to poor health status is a competency derived from the practice of home visiting, which soon became a unique social work activity proving useful for more accurate medical diagnoses. Moreover, the casework approach to gathering information from a variety of sources to determine the needs of families with problems became a basic technique in developing medical social services (Lubove, 1965).

Social work practice entered the hospital setting when the desire to improve physician education led to an alliance in 1902 between the Charity Organization Society in Baltimore and Johns Hopkins Medical School. This alliance provided medical students with the opportunity to examine how social and environmental factors affected their patients. The support from this alliance legitimized social work as a component of patient care within a hospital setting. The presence of caseworkers within the hospital environment concerned with social and other influences affecting the health of patients gave the hospital institution a more holistic and benign persona. Beginning in the early 20th century, Dr. Richard Cabot of Massachusetts General Hospital hoped that the activities of the medical social worker would support the development of preventive medicine. A preventive approach could help the community better understand the need to control environmental conditions that undermine health and delay recovery from illness (Lubove, 1965).

Meanwhile, the developing profession of medical social work was eager to identify itself as separate from the nursing profession from which

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many of the early medical social workers had come. By 1915, early medical social workers seized the opportunity to organize a distinct professional identity based on the skill of relating psychic and social conditions to physical and emotional distress (Insley, 1977).

Understanding the effect of community life on the health status and patient condition was the skill that separated hospital social workers from the work of nurses and volunteers. Ida Cannon was among the first medical social workers who sought to standardize the skills and competencies required for hospital social services; such skills and competencies distinguished the professional worker from the volunteer and supported the recognition of medical social work as a distinct identity within professional circles (Lubove, 1965). The effort to develop standards of practice led medical social work to become part of the curriculum at Boston University School of Social Work, which advanced the use of scientific principles in professional social work. By 1916, medical social workers established the first professional social work organization.

Medical social work has traditionally been a component of hospital administration. Abilities to articulate the psycho-social and environmental factors associated with health status and to engage in problem solving with patients were enriched over time by the addition of theoretical frameworks which supported the understanding and identification of patient behaviors, which guided strategies for problem identification and change. The growth of professional schools of social work helped expand and legitimize the role of professional social workers within hospitals and medical teaching centers.

By the 1950's, medical social work became restricted to the hospital. Less emphasis was placed on identifying barriers emerging from conditions in the social environment that patients faced. More focus was placed on the state of the patients' emotional and mental health in coping with their health status and on screening for problems amenable to psychosocial counseling. As hospitals moved into a cost-containing era during the 1970's, strategies to reduce both hospital stays and the potential for re-hospitalization engaged social workers reluctantly in the process of discharge planning, referring patients to post-hospital community services. Discharge planning in many ways was a missed opportunity for the profession to assume an important and significant role within the administration and management of the hospital and to advance their influence within the hospital decision-making environment (Wax, 1968). In some hospitals, social workers lost the task of discharge planning, a basic function of social work practice, to nurses operating as case managers.

The early 20th century is noted for American society's awakening to the problems of rapid urbanization that coincided with an influx of immigrants who were ill equipped to deal with the exigencies of their new environment. This is also a time when diseases spread out of control, threatening large population groups. Social workers had a clear mission to seek out and identify the health and social problems of mothers, infants, and children, which were derived from the social conditions in which they lived.

Social workers who gravitated to the community activist role in health services during the early part of the 20th century were part of the settlement house movement. As early as 1912, social worker Julia Lathrop directed the Federal Children's Bureau, which monitored the well-being of children nationally. Social workers, with the backing of the Federal Children's Bureau, were active in the formulation of the Sheppard Towner Legislation of 1921, and in the Maternal & Child Health (MCH) Title V Federal Legislation of 1935, which provided prenatal care and child health care as a public service of state and local government health departments (Seifert, 1983; Insley, 1977). According to Lesser (1985), former director of the Children's Bureau, the legislative history establishing the Children's Bureau reveals Congress' intent to provide resources to state and local governments

to improve the care of pregnant women and children.

This period represented an exciting time for the social work profession. The federal government provided support for social work activities in state and local health departments through the Maternal and Child Health legislation. Health care and child welfare services were monitored under the Federal Children's Bureau. In 1939, while still part of the Children's Bureau, the Maternal and Child Health programs were separated from the Child Welfare programs to form a separate division for Maternal & Child Health within the Children's Bureau. Public health social work emerged with the formulation of the Maternal & Child Health Program. By moving into the public arena, social work practice in health focused on health promotion and disease prevention, identifying populations at risk for health status problems. A new specialty of public health social work evolved separately from hospital social work (Insley, 1998).

Social workers at the Children's Bureau participated in federal legislation to provide maternity and infant care to wives and partners of servicemen during WWII. Social workers were also instrumental in the initiation of the comprehensive Maternal and Infant Care (MIC) programs, which provided comprehensive care to high-risk mothers in poor urban centers. These programs gave impetus to the expansion of a social work presence in local and state health departments, as well as community based clinics, where their skills in coordination and service integration were valued (Rudolph & Borker, 1987; Davis & Schoen, 1978).

Since these early days, a search for recognition and an identity for public health social work have ensued. The effort to define public health social work as a distinct specialization within the social work profession is modeled on the concept that a profession is identified when there is a scientific base of knowledge and a set of standards by which to claim a domain of practice expertise. In 1950, the American Public Health Association (APHA) and the American Association of Hospital Social Workers published standards stating that all social workers in state and local Title V programs and projects were expected to have a Masters in Social Work from an accredited school; social work content had to be included in interdisciplinary University Affiliated projects funded by the Federal MCH legislation; and all MCH training projects were to include social work faculty (Insley, 1998). For many years these guidelines set the standards for social work practice in public health. Much effort was expended in clarifying, justifying, and implementing these separate standards for public health social work which, in 1981, were finally incorporated with National Association of Social Work (NASW) standards for social work practice in medical settings.

Much of this history took place in an environment of growing professional interest in specialization. In today's world, however, specialization is no longer the panacea it was once thought to be. The current environment of health and social service delivery is multi-disciplinary. Service systems are being integrated to provide a continuum of services addressing a variety of special needs. Social workers are being asked to cross social service systems in their practice, to develop collaborative relationships with community based service systems, to organize wrap-around services across programs to meet client needs, and to maintain clients in the community. Health care workers, mental health workers, and child welfare workers serve the same populations and use similar practice skills. Hospital social workers are no longer hospital based. Increasingly, they practice in the community and the skills envisioned as unique to public health social work are blended with social workers in other fields of practice and with other disciplines as well. The population included in Medicaid and Child Welfare will find all of the helping professions working collaboratively with poor children, single parents, and their families. The ecological perspective used in public health social work practice focuses on the interaction of person and environment which needs to be inte-

grated within all fields of social work practice. Rather than being concerned with differentiating public health, social work as a separate field of practice, the combined skills of all fields of practice need to be focused on the tasks ahead.

The Role of the Social Work Perspective in Public Health

The use of the ecological perspective, which the pioneers of public health social work used so effectively as the theoretical underpinning of public health social work practice, is a competence of social work practice that is unique among the health professions. The ecological perspective emphasizes the importance of being proactive in detecting potential community health risks, engaging in preventive health promotional activities, and building on the strengths and capacities that individuals and communities demonstrate in solving their problems. This proactive stance promotes strategies for empowering individuals, groups, and communities to act on their own behalf to better their lives. Concern with prevention, focus on risk assessment, use of home visiting to empower families to participate in their own health care, knowledge of community resources, and competencies of social work practice are necessary to practice in today's health care environment.

Sensitivity to racial/ethnic, gender, sexual orientation, and class differences in health-seeking behaviors, the ability to plan and engage service systems in program development, and planning for individuals, groups, and populations are distinctive characteristics of public health social work practice. This specific range of skills is unique to public health social workers. The systems perspective that prevails in clinical practice is essential for new paradigms in community building practice so that health status can be better understood in its social, physical, and cultural contexts. Consideration of the transactions between people and their environments needs to continue as an enduring value and principal of social work practice.

Changing Functions and Skills for the Current Health Care Environment

Social work practitioners face a number of problems in the delivery of health care services. These challenges require changes in the way social work is practiced, which will eventually effect the curriculum in educational programs. One of the most serious challenges the profession faces is the deepening complexity and severity of social health problems of a non-medical behavioral dimension. More behavioral problems now require collaboration with other health care and social welfare providers and with community based services in order to promote health, prevent disease, and advocate for political and social action to enhance necessary public resources. Some of the health problems at issue include: the continuing disparity in health status between African Americans and European Americans, and between the poor and affluent populations; the increasing numbers of working poor families and children without health care insurance; the persistence of racism and discrimination in the ability to obtain appropriate health care services; the growing aged population that will almost be equal in size to the young by the year 2010 and whose health care needs are likely to compete for resources with the young and the poor; the increase in sexually transmitted diseases particularly among adolescent women; the increase in violence among youth; the discouraging increase in suicide among African American male youth; the problems of prenatal substance abuse; the persistence of single parent families; the disparity in maternal mortality between African American and European American women; and the ethical and legal implications of the biotechnology and genetic revolution.

A second challenge facing social work practitioners in the changing structure of health care delivery is the disconcerting shift in social values about social justice, community responsibility, and the role of government in society. Health care services have always been intertwined with politics in

the United States. The USA is one of only a few advanced industrial countries that consider health care a private commodity. Social justice and the right to health care continue to be problematic as a public entitlement. Federal responsibility, from which much of the support for public health was derived, is weakening. More and more states are shouldering the responsibility to provide local health care solutions. Moneys for many public health programs deny support for social work services on the state and local level. Some states do not have a social work consultant in their state health departments.

Historically, states are more politically subject to local group pressures which influence how block grant money will be spent on the local level (Davis, 1997). Community health centers, one of the mainstays of medically undeserved areas, are implementing much of the block grant money for preventive services but are inadequate in meeting the needs for primary care. The potential for federal funding to allow expansion of community health centers is unlikely as the number of uninsured and underinsured increases (Alpert, 1998). By the end of this century, most Medicaid recipients will be enrolled in managed care plans. Many of these enrollees will be at community health centers. The allure of potential savings for state government by enrolling their Medicaid populations into managed care plans impedes consideration of the problems of continuity of care as clients come in and out of eligibility, and obscures the possibility that the most seriously ill clients among the Medicaid population will be poorly served, or even discontinued for one reason or another (Alpert, 1998).

The expansion of managed care for Medicaid clients provides an important role for social work practitioners to educate potential consumers about the intricacies of managed care rules and to monitor their continued access to care. Managed care providers have little experience caring for the special needs of the Maternal and Child Health population, or with problems of alcohol and substance abuse which requires on-going supportive non-medical care as well as medical treatment. Most managed care programs have little experience with the severely physically and mentally disabled or with HIV/AIDS patients. Managed care providers are not equipped to provide patients with either long term chronic care, or follow up and surveillance, for severe alcohol, drug, and mental health problems to assure the continuum of care needed. Community based, multi-discipline service systems are emerging under the auspices of local health departments, community agencies, and hospitals to triage the special needs of consumers of health services to appropriate levels of care (Rehr, et al., 1998). Social workers are needed in these programs to ensure a continuum of care.

Consumer choice and consumer protection is jeopardized in the new health care environment. For managed care to provide appropriate services with a standard of quality, consumer rights must be protected. Forty-three states have some form of legislation to protect consumer rights of access and treatment. The social work concern with privileged communication, social justice, and ethics should have a strong voice in this movement. Witkin (1998) suggests that basic human rights need to be modeled in practice, and that social problems need to be reconceptualized as human rights issues.

A third challenge to social work practitioners in the managed care environment is the issue of how the distribution of risk will be monitored across managed care programs so that no one company has responsibility for a major portion of the populations with severe disabilities and complicated behavioral problems. This is an issue that social workers should address from both a policy perspective and an advocacy position. The profession needs to guard against managed care companies limiting services and even enrollment to the chronically ill and physically disabled. In order to participate in this process, social workers need to acquire more knowledge about disease manage-

ment, especially for those chronic conditions, which require surveillance and packaging of services. The skills of care management, which are oriented to the individual, need to be differentiated from case management as a core clinical skill. Case management initiates service plans, and monitors and evaluates them while concentrating on consumer empowerment within a framework of cultural sensitivity (Loomis, 1992). Despite these difficulties, the benefits of managed care need to be sustained, such as changed health care behaviors, reduced emergency use, and decreased use of specialties through encouraging preventive procedures such as mammograms. The provision of managed care for early and continuous prenatal care and childhood immunization needs to continue so that the health status of the covered population is improved.

A fourth challenge facing social work practitioners is the change in the reimbursement and financing structures of health care services. Social workers face a health care system that is market driven and cost sensitive. Services are increasingly being viewed as products. The concept of social work services as a product means that the time frame in which a specific service or a continuum of services can be expected to produce a desired outcome needs to be established, and the cost to achieve this outcome needs to be determined. This task will require social workers, if they have not already performed this function, to develop indicators and standards for critical pathways of care designed for specific conditions within a specific time frame, and to evaluate the accuracy of the intervention to improve or stabilize the problem. However, given the emphasis on cost containment social workers need to be vigilant in maintaining the charitable mission and the values of social justice that define the profession. Advocacy for consumer rights to health care services will be a critical social work function.

Most intended outcomes in social work services require networking with other service systems so that all needs of a client population are covered. Some hospitals are contracting with a variety of community service agencies to provide services for the non-medical behavior problems of the population requiring hospital services. Other hospitals are developing interdisciplinary coalitions with county health departments, community groups, and social service agencies in an effort to develop the concept of the seamless health and behavioral service system. In this current view of health care service delivery as an integrated system, social work practitioners must be vigilant about including the populations most vulnerable to being left out and denied access to care.

Clearly the social work profession cannot by itself provide solutions to the serious and complex health problems discussed here. Many of these problems, rooted in the social pathology of our society, require long term strategies combined with social, political, and economic solutions. Health care services today require the coordinated efforts of all fields of social work practice. All fields of practice should be concerned with the health care provided for children in foster care, women in prison, youth in detention, etc. Professional organizations should be integrated to form a critical mass for advocacy and lobbying for the needs of clients and the recognition of the significant contributions that this profession makes to the health care system.

Professional collaboration, public awareness, and a renewed commitment from society to the concept of community are needed to facilitate the development of skills and competencies that empower populations living in poverty to maximize their potential. Corrigan (1994) cites a vision of community as the bonding of kinship, the sharing of place and locale, and the commonality of goals. Together, these three elements bring a sense of meaning that links diverse groups and forms, within these groups, a sense of belonging and identity which provides mutual benefits and caring for each other. Social work professionals need to have the skills to initiate and develop a sense of community, engage community participation, seek the leaders in the community, help volunteers in community associations, and advocate for services to help these associations grow and develop (Levy,

1998). The movement of hospital clinics into urban centers and the growth of satellite services of hospitals and community health centers need social workers as system managers to create pathways of supportive health care services (Dinerman, 1997).

Models of Education and Training

The professional challenges for the new health care environment outlined above raise important issues about the preparation of social workers for professional practice. For example, who should be educated? For what level of functioning? What values and attitudes should we look for in recruiting students? What competencies do we look for in faculty? What competencies need to be included in the curriculum? How should this curriculum be organized? And finally, how should students who have been exposed to this educational program be evaluated?

Historically, social work education produced the Associate degree, the BSW, the MSW, the PhD and the DSW. The Council on Social Work Education (CSWE) has designated both the BSW and the MSW as preparing students for entry-level practice. Although the MSW is recognized as the more advanced degree, it has lost some of its status as the sole professional degree (Bernard, 1995). Since the introduction of a BSW, there has been confusion about the differentiation of curriculum between the MSW and the BSW degree. One way to handle this confusion is to characterize the BSW as the degree in generalist practice and the MSW as the more specialized educational training. This is based on the belief that, as knowledge and technology about specific problem areas grow, specialization is inevitable (Reid, 1995).

Specialization by fields of practice is the model of social work education that exists in many schools today. Most MSW students specialize in mental health, family and children's services, or health care. Yet only about half of the MSW graduates in these specialties are later employed in their chosen field of practice. A recent study by Teare and Shaefer (1995) found no important difference in the tasks performed by workers in the different fields of practice which would warrant specialized curriculum. They found that, despite student interest in pursuing direct service preparation, over half of all MSW graduates were performing management or supervisory level tasks in a relatively short time after graduation from the MSW program. Bernard (1995) points out that in the near future there will be four BSW graduates to one MSW graduate. More disturbing are data showing that the present emphasis on direct practice in MSW specialization results in a large proportion of MSW graduates leaving social reform and/or delivery system changes as they move into the private sector and private practice, leaving the BSW in the public sector arena. Meanwhile, social workers with BSW degrees have attained management positions in many public systems and are returning to school seeking training in management, supervision, administration, and community organization skills. Currently, there is little emphasis in graduate education on macro practice (Bisno & Cox, 1997).

A significant number of graduates of the MSW programs will be the future administrators, supervisors, and community builders of social health care services. In the future, these leaders will have to be skilled in computer technology so that they are able to identify, analyze, and develop appropriate measures for the health needs of various populations (e.g., see Schopler, et al., 1998). These measures should include cultural, racial/ethnic, and class differences in consumers' perception of health and the utilization of services. Training in measurement needs to emphasize outcome measures as well as measures of performance. The acquisition of good data and the use of these data to advance the goal of accountability and quality assurance standards are a necessary focus for social workers in the future.

Computer skills will also be necessary for the future social worker to assess the cost effectiveness of the services being provided and to develop realistic funding proposals. Social work graduates will have to know what types of data are needed to

assess their service performance and be financially accountable, and be able to use this information to communicate with other professional disciplines and policy makers so that they can influence policy decisions. Future leaders will also have to understand marketing, public relations, and legal contracting. They will need to be able to administer and implement integrated service systems and bring neighborhood organizations into the health care system. While many MSW graduates might continue to choose private practice, they too will have to be well-trained in accountability. Volland (1997) identified three Training Skills Areas that need to be emphasized: Basic Skills of Assessment — written and oral communication; Population Specific Skills — ability to implement effective treatment modalities and understand current policy and regulation; and Autonomy Building Skills — to negotiate systems, program planning, collaborating, team building, and financial management.

Educating the BSW student needs to be focused on high quality direct generalist practice with an emphasis on case management and the tasks of monitoring and educating health care consumers, crossing systems to design wrap-around services, and functioning on teams. The BSW social worker is in a position to implement and monitor use of preventive health care services for the complex behavioral health care problems noted above.

Professional social work education also needs to be restructured with the support of professional organizations, faculty perspectives, and training programs. New collaborative relationships with other schools, colleges, and departments, along with public and private trainers, could be a vehicle to orchestrate this reform. The curriculum in the MSW program needs to be more flexible and responsive to changing demands on the profession. The Council on Social Work Education needs to recognize this and develop methods for students to be given credit for long years of experience in the field of practice. This may require restructuring the way professional education is delivered.

Opportunities for students to design curriculum programs can be developed in ways that meet their career goals and match the needs for social work practice in the future. Rather than specialized fields of practice as the organizing framework of social work education, curriculum clusters should be developed which will educate students for a variety of practice roles. Interdisciplinary collaboration with other schools and organizations might be needed to implement such an educational program. There is much to be gained from interdisciplinary education. CSWE accreditation standards might need to be stretched, but the time has come for social work educators to walk cross campus and develop partnerships with other schools and colleges. The field has a long-standing relationship with schools of public health. It is time to expand these connections to other disciplines, such as schools of management and public administration. There is increasing interest among social work educators in dual degree programs that link schools of social work, management, and public health. Most dual degree programs require separate admission standards, which are a barrier to an integrated program of study.

Graduate education programs, which address the skill needs of the future,
involve forming new types of university, agency, and/or community partnerships where agency personnel participate fully in identifying the knowledge and skills needed in designing the curriculum. Fieldwork assignments can be designed to develop specific skills for the student and serve the needs of the agency. Faculty can be full partners in this endeavor, designing projects that reach specific educational goals. Together, faculty, agency personnel, and students can design and implement evaluation of services by developing measures of performance and outcomes. This model is used extensively in public child welfare programs (Hopkins, et al., 1999).

Funding programs for interdisciplinary education and interagency collaboration can provide a

strong incentive for schools and colleges to cooperate with each other. The Bureau of Maternal and Child Health has awarded grants to three different universities to design inter-professional alignments and interdisciplinary education programs. These three projects are based in different university departments: education, medicine, and a social work department. Each project involves faculty from different disciplines, agency personnel, and students working together towards common educational goals. The program housed in the Social Work Department of the University of Vermont, administered by Kathy Bishop (Bishop, et al., 1993), involves parents, faculty, agency services, and students in a program serving children with special needs.

Partnerships that enhance collaboration between schools of social work and private for-profit corporations and businesses can also enhance the educational program. The techniques private companies use to develop their organizations, supervise their staff, and the way they use technology to increase productivity, accountability, and quality control, are important to social work practice in health care since it is essential to develop indicators for quality control and outcome measures for health care service delivery.

Continued Education

Continued education has an increasingly important role to play in retraining and upgrading the skills of the on-line professional social worker. With more states seeking licensing for social workers, those already in practice will need to review their current skills and learn new skills. Licensing will demand greater accountability concerning effective practice performance. Moreover, continued education credits (CEU's) will be required of practicing social workers. Continued education is also needed to fill in the gaps of knowledge for practitioners so they can grow in their professional roles. There is an increasing trend in providing certification for specific practice roles and functions, particularly in substance abuse, which legitimizes the training provided by continued education programs.

Public health social work has a special role in continued education. During the 1950's, the Children's Bureau sponsored workshops for the purpose of transmitting knowledge and providing opportunities for practitioners to interact on health issues. In 1989, the MCH block grant began funding Sprans grants for workshops of regional and national significance. These workshops transmit knowledge of theory and practice on a wide range of health issues to interdisciplinary health practitioners.

Most schools of social work are providing short-term continuing education workshops in specific knowledge areas such as adolescent health, disability programs, and skills in management supervision, program evaluation, group work, and clinical practice. The results of a need assessment survey of field instructors at Syracuse University School of Social Work reflected a demand for the same type of training.

Syracuse University School of Social Work collaborates with other schools at the university in sponsoring continued education workshops. The Law School collaborates with the School of Social Work to review the implications of child welfare laws. The School of Education collaborates on workshops in child health issues. The presence of participants from other disciplines makes these workshops quite stimulating.

Tracy Soska, Director of Continued Education at University of Pittsburgh School of Social Work, presented an exciting model of continued education on community building practice through the development of a Regional Coalition of Community Builders (Soska, 1998). Funding agencies are interested in community partnerships for self-development and empowerment. At Syracuse, with the support of a local foundation, a community-wide continued education program is being initiated on collaboration in human services

among child welfare, mental health, health care, and education workers. The intent is to use local examples of successful collaborations of urban grass roots organizations and to have volunteers from urban neighborhoods who provide leadership in a series of workshops.

Continued education programs will eventually require follow-up evaluations to assess the effect of education on professional practices. Rooney (1986) discusses evaluation in terms of three levels. Level one is where theory and cognitive learning occur; level two is where workers are able to practice the skills taught; and level three is where workers use these skills on the job. Most continued education programs provide level one training with some emphasis on skill development. With increasing emphasis on licensure, there will be more need for continued education and more demand for accountability in demonstrating the positive impact of continued education on social work practice in follow-up evaluative studies (Dietz, 1998).

Finally, there is a lack of travel funds to attend conferences and reluctance on the part of agencies to give workers the time off. This is because workers' hours are billable, and hence, time off for training means a loss of agency income. Distance learning offers an alternative that will keep continued education alive. There are several forms of distance learning, including telephone conferences offered by the Child Welfare League, and satellite programs that require availability of centralized hook-ups. There are also on-line, web-based programs, interactive television, and videotapes.

Distance learning is rapidly increasing as a form of delivery in graduate social work programs. Even though there is controversy over the merits of this model of curriculum delivery, the discussion is increasingly focused on the most effective model of delivery of distance learning (Forster & Washington, 2000). Remaining issues include accreditation, faculty development, curriculum design, and resources. The applicability of distance learning to continued education is evident. No matter what model of continued education is used, the outcomes of these programs need to be evaluated and the acquisition of new skills resulting from these programs needs to be demonstrated in order to be funded (Thyer, et al., 1997; Conklin & Osterndorf, 1995).

Conclusion

Past achievements of the social work profession in the delivery of health care serves as a guide to the challenges faced by the profession in the current health care environment. The early adoption of the ecological perspective legitimized and supported the development of medical social work. In light of the increasing complexity of social and behavioral problems, the skills and perspectives of the profession need to be broadened and new skills must be developed to continue the significant role of social work in health care.

Social workers in health care need to face the challenge of the changing values regarding consumers' right to health care services in an increasingly managed care environment. Social workers need to assure that the disabled, the chronically ill, the working poor, and children are not left out of health care. The changing structure of financing and reimbursing health care services involves the concept of health care services as a deliverable product. This changing financing structure challenges the value of social justice and the orientation of charitable care held by the social work profession.

The challenges outlined above require changes in the graduate and undergraduate professional curriculum. More emphasis should be placed on generalist practice, case management, computer technology, outcome measurement, and collaboration. Since it is likely that an MSW will end up in a management or supervising position, macro-practice needs to be more developed in the masters level curriculum. There is also a growing interest in

interdisciplinary programs in graduate education.

Continued education will play a more important role in the future to upgrade practitioner skills. As more states mandate licensure, continuing education will be a requirement. Distance learning will be an important vehicle to support an expanding demand for continued education. Accountability needs to accompany this expansion by assessing the impact of continued education on practice.

Social workers face a daunting challenge in devising educational programs of the future that develop the capacities of practitioners to perform many different professional roles and functions. The profession needs to recruit motivated students with the values and ethical perspectives necessary for learning the skills required in adapting to the ever-changing environment of health and social welfare service delivery. Moreover, social workers should broaden the concept of who is included in the fields educational perspective by inviting community volunteers to be part of the delivery of twenty-first century educational programs.

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