It is a new experience for Japanese nurses to demonstrate their abilities as members of multidisciplinary teams caring for the elderly. Our questions are as follows:

1. How can we best prepare nurses to work in multidisciplinary teams?
2. How are nurses prepared to assume active roles in political, social, and financial areas to create the infrastructure required for the care of the elderly?

SCENARIO RESPONSE 1

Long-term Care for the Elderly in Australia

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While Australia is a relatively new country in the international context, it too is undergoing a comparatively rapid rate of aging. Currently 12% of the Australian population (18 million) is age 65 or older, a percentage that places the country in the low to mid-range of population aging in the developed world. However projected rates of growth of this group in the next decade are high (1.8% per annum), ranking only behind Japan and China (3%)—with most other developed nations running at rates below 1%. The population growth rate in the frail and vulnerable over age 80 group in Australia is high at 3.9%, with a projected 3% increase by the year 2005.

Thus Australia and Japan have similar aging growth rates and face similar issues in organizing and allocating resources for care of the aged, but the situation in Japan is more serious. In 1996, the mean length of hospital stay for patients age 65 or older was 7.3 days, compared to 4.3 days for all other age groups—extremely short when compared to the Japanese experience of up to 6 weeks.

In Australia, government awareness of the significance of these changes in population aging and the likely effect on service provision to the aged has spearheaded restructuring and adjustment in care services to the elderly over the last decade to meet the challenges of care in the 21st century. Nurses in Australia care for the elderly in a range of settings including acute-care hospitals, community programs, and long-term residential facilities in urban, rural, and remote environments. In 1995, 195,692 registered and enrolled nurses were in the country, 20% of whom practiced in aged care. As in Japan, nurses strives to maintain a meaningful voice for care of the aged in the midst of rapid change.

Historically the majority of aged Australians have remained at home and have not required long-term residential care. For those requiring support and care, arguably the most significant policy development in Australia in the last decade has been the shift in the balance of care from intensive modes of residential care (for example, nursing homes) to more home and community care. A major impetus for this shift came from the 1986 Report of the Nursing Homes and Hostels Review which strongly criticized the emphasis on institutional care, the inadequacy of assessment procedures, and poor coordination in funding and services. By 1993, as a result of reform, only 7% of citizens over age 65 were in residential care, with 17% of the aged identified as requiring some help with self-care, mobility, or communication. Of the aged living at home 94% received care from informal care networks comprised of family and friends.

These outcomes have been achieved within a universal national health care system using a three-tier model of aged care comprising nursing homes, hostels, and a range of services to support aged people living in the community. Currently 121 regional Aged Care Assessment Teams provide services and nursing home referrals across the country. Protective mechanisms within the system, for example scaled charges related to income, and specialist services for indigent Australians and people with dementia, ensure equitable access to services. Recently the 1997 National Aged Care Strategy initiative further streamlined residential care by merging hostel and nursing-home care. This provides a continuum-of-care system responsive to differing dependency levels within a single facility.

Over a decade beyond the universal transition to university nursing education in Australia, three major issues in nursing the aged remain and are not dissimilar to issues facing our Japanese colleagues: (a) elevation of the profile and reputation of aged care nursing within the nursing profession in order to attract and retain excellent clinicians; (b) maintenance of an appropriately trained nursing presence at every level of care; and (c) the inclusion of the profession of nursing as a core stake-holder in aged care policy creation and operationalization. Australia faces a further challenge of how to provide specialized aged-care services to people in rural and remote locations.

Nursing the aged is complex and challenging. Yet it is rare to see working with the aged presented in this way in Australian undergraduate programs unless faculty with clinical preparation in aged care are instructors. No universal guidelines for including aged-care content in undergraduate curriculums in Australian exist, and the pool of nurse leaders in the specialty of gerontology is small. Additionally, for nurses working in the aged-care sector, the post-registration baccalaureate is usually the terminal degree.

Conversely, Australian nurses been successful in creating and developing graduate education, practice, and research initiatives congruent with government aged-care policy. In response to both the 79% increase since 1988 in the proportion the 65 to 79 year old group who are frail, disabled, and living in the community—and the increase in demand for special residential care services—specific graduate nursing programs in aged care are proliferating and attracting students.

The most common form of preparation in aging is the graduate certificate, with an option to continue for a master's degree, which attracts RNs currently working in aged care. Eventually the master's in nursing will become the entry-to-practice standard in aged care, as has already occurred in our other specialties. As Australia creates a critical mass of educated aged-care clinicians, we can expect to see rapid progress in the role options available to nurses. Several university-based aged care programs have become major sites for aged care research and clinical practice, serving as examples of what is possible for nurses in the health care system when we can provide theory-driven, empirically-tested, cost-effective care.

In Australia hands-on personal care is provided by non-nurses at one end of the aged care spectrum. At the other end of the spectrum, we are creating a skilled workforce of nurses capable of rigorous and compassionate care of the elderly whose roles

and reimbursement are not expanding commensurate with their education. Advanced practice roles similar to those of US nurse practitioners have yet to evolve. Recent union-based, industrial responses to the erosion of the role of nurses have focused on the issue of deregulation and privatization in aged care which will result in proprietors no longer being required to prove that the money claimed for patient care is actually spent on care.

Nurses with strong core attitudes of valuing the aging experience and aged people and who have a comprehensive clinically-focused education in aging and skills as research consumers are in the position to become effective multidisciplinary team members. We need to advocate with clarity and persistence for recognition of the unique, measurable contributions of nursing to the well-being of the aged. This can be done through committee membership, outcomes research, and nurturing of a new generation of nurses committed to aged care.

Involvement in multidisciplinary teamwork earns nurses (especially when we are able to demonstrate excellent assessment skills) respect from colleagues in other disciplines. Such involvement also keeps the question of who is best prepared to provide quality patient care at the forefront.

Reference

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SCENARIO RESPONSE 2

Long-term Care for Elders in Brazil

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For Brazilian elders, the informal care, given by relatives, neighbors, friends, or community institutes had been the most important social support, but these kind of caregivers are gradually decreasing. When women, who traditionally were the main caregivers for children and elders, assumed an important role in the work force, the necessity of paid caregivers emerged.

In Brazil, we have a public-health care system, called *Sistema Único de Saude* (SUS). Analysis of SUS's data about hospitalizations shows that the number of admissions in the 60 and older age group—197.2 admissions per 1,000 inhabitants—is greater than for the other age groups; the time spent in hospitals is also greater—about 7.1 days per hospitalization.

Because of the increasing elderly population, related problems about the health care system must be discussed. The financial pattern proposed by SUS for payment to hospitals does not cover the necessities of this group's patients, which usually have more than one disease or health problem. Because the payment is not enough to cover all their needs, the elderly patients are often discharged too early, which leads to frequent returns to the hospital. Moreover, most of our general hospitals do not have rehabilitation programs or specialized nursing or medical teams to care for the elderly.

To establish a National Policy for the Elders, in 1994 the Brazilian government promulgated Law 8842. This law's health care chapter intends the following: (a) to guarantee health care for elders, at all levels; (b) to prevent diseases, promote, protect and recover elders' health, creating programs and prophylactic measures; (c) to adopt and to apply rules for geriatric institutes or similar, to be controlled by supervisors of the health care system; (d) to create rules for hospital geriatric services; (e) to develop cooperation networks between the state and city health offices and the geriatric reference centers and to improve training activities for multiprofessional teams; (f) to include geriatrics as a clinical field in admission tests for physicians' employment by government, state, and city public services; (g) to conduct studies seeking the epidemiologic shape of some elders' diseases, for prevention, treatment and rehabilitation issues; and (h) to set up alternative health services for the elderly.

Although legislators are foreseeing a wide plan for elders' care, the structural problems concerning health care in Brazil, regarding both human and material resources, have made application difficult.

There are few gerontologic specialized physicians or nurses in Brazil. Education programs still do not focus on aging problems and few hospitals have a geriatric ward.

To change this and to improve and spread knowledge on this matter, nursing schools have been including gerontology in their curriculums. We believe that a more satisfying and economical way to prepare nurses for elder care is organizing a kind of specialty course for newly graduated nurses, strongly based on practice, that we call "residence."

Since the 1960s, most of the world's elderly people live in developing countries such as Brazil, and statistical projections show that this is the age group increasing most in developing countries. According to the World Health Organization, Brazil's elderly population will increase 16 times, while the total population will increase only 5 times for the period from 1950 to 2025. In 1991, elders were 7% of Brazilian population (11 million elderly). In 2025, they will be about 15%. Such an increase means that in 2025 we will have more than 32 million people aged 60 or more, and we will have the sixth most elderly population in the world. This population age increase is the world's fastest, compared only to Mexico and Nigeria.

These significant changes of the population pyramid have begun to cause some predictable social, cultural, and epidemiologic consequences, which we are not yet prepared to face. In Brazil, in 1930, two-thirds of the population lived in rural areas. Now, more than three-fourths live in urban areas. Typical migrants are young people who go to cities looking for better jobs leaving their kinsfolk in the country. For elders, who have lived all their lives in a big family, with a strong social and cultural solidarity provided by the young, these changes can be difficult, causing a lack of motivation, hopelessness, and depression.

Rural out-migration has led to a concentration of the elderly in the less developed regions of our country. In urban areas with small nuclear families, there is reduced support for elders and an increasing number of divorces that induces solitude and worsening of some health problems. University centers must