Meeting the current and future health-care needs of Sri Lanka’s ageing population

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ABSTRACT

Sri Lanka is one of the fastest-ageing countries in the world. This rapid demographic transition is expected to result in one quarter of the population being elderly by the year 2041. Profound challenges face the country as a result, especially with respect to planning adequate elderly-oriented services in the social-care and health-care sectors. In response to this need, many initiatives have been put in place to promote and protect the welfare of older people, and these rights have been inscribed in law. Within the health sector, despite the wealth of policies and initiatives in recent years, it is clear that the existing health infrastructure and systems still require strengthening, reorientation and coordination, to meet the needs of the growing population of elderly individuals. Lessons learnt from the successes in reducing the maternal mortality ratio can be applied to strengthening preventive services at the community level, to ensure active healthy ageing in Sri Lanka. Engagement of specialist medical officers of health and general practitioners to provide preventive and curative primary-care services would reduce current pressures on higher-level services. Expansion of dedicated elderly-care wards and units at the tertiary level would restructure care towards changing patient demographics. The key to success in these strategies will be increasing the proportions of the medical, nursing and allied professional cadres who have been trained in geriatric medicine. Such capacity-building in the care of the elderly will allow a move towards provision of multidisciplinary teams that can manage the complex physical, social and psychological needs of the older patient.

Key words: ageing, elderly care, geriatrics, multidisciplinary care, Sri Lanka

BACKGROUND

Sri Lanka is one of the fastest-ageing countries in the world, with the proportion of the population aged 60 years or older projected to increase from 12.5% currently to 16.7% in 2021.¹ Although this demographic transition is affecting many countries, the speed of change is particularly dramatic for Sri Lanka. An estimated one in four Sri Lankans will be elderly by the year 2041. The trend is, in part, a result of investments in education and health for the past several decades. Low fertility rates and extended life expectancies are expected to continue, putting financial pressure on the working-age population.¹ This is starkly illustrated by the changing dependency ratio in Sri Lanka – i.e. the number of dependent children and elderly individuals per 100 working-age people. There were 55 dependents per 100 working-age people in 2001. This number is expected to rise to 58.3 by 2031 and, following a rapid increase in old-age dependency, is projected to increase significantly after 2041.¹

As a result, Sri Lanka faces profound economic challenges, for example in provision of pensions. Social structures are also in flux; while the cultural norm has been to care for older relatives within the extended family, factors such as more women working outside the home and migration of working-age adults to urban centres and abroad, are disrupting this traditional support system. Putting robust systems in place to accommodate the greater demands for elderly-oriented social care and health care will be crucial to the country’s ability to manage its fast-restructuring population within financial constraints.

The need to respond has been particularly urgent in recent years, owing to Sri Lanka being in a period of “demographic bonus”, i.e. where the proportion of the population that is of working age remains significantly larger than that of dependents. This has given Sri Lanka a window of opportunity to align service provision with future needs.¹²

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In the past two decades, many initiatives have been taken to respond to the social needs of the growing population of older people. The Protection of the Rights of Elders Act in 2000 led to the establishment of the National Council for Elders, comprising representatives of the ministries of social services, health and finance, as well as experts and voluntary organizations that are engaged in providing services for elderly individuals. Its principal function is the promotion and protection of the welfare and rights of older people. The implementation and funding authority, the National Secretariat for Elders, reports to the National Council for Elders and is situated within the Ministry of Social Empowerment and Welfare. In 2006, the National Charter for Senior Citizens and National Policy for Senior Citizens Sri Lanka were adopted. In 2011, amendments were made to the existing Act and the Protection of Rights of Elders (Amendment) Act was enacted, which provided more rights to older people.

The National Secretariat for Elders has provided grants to establish elders’ committees throughout the country; at the district, divisional and village levels in 2012, there were there were 17 200 and 10 000 committees, respectively. These committees encourage the participation of elderly individuals in decision-making processes at grass-roots level and are a mechanism to ensure that policies and programmes for the elderly are effectively implemented to suit local needs.

The activities of the National Council for Elders include financial assistance for services, including day-care centres, psychological counselling programmes and training for carers of the elderly. Other initiatives include home-care services, provision of assistive devices for elderly individuals with disabilities, financial assistance for those in need, free legal advice service, and support for income-generating activities. The Government of Sri Lanka has taken legal measures against public institutions not providing accessible facilities for disabled persons, including disabled elderly individuals. In addition, any institution providing residential care for elderly people must be registered with the National Secretariat for Elders. Identity cards enable elderly people and their caregivers to receive benefits, such as a discount on the cost of medicines, higher interest rates for fixed-term deposits in banks, and priority in obtaining public and private-sector services.

Preventive health services are implemented through medical officers of health and their field staff at the district level; additional medical officers focus on mental health and prevention of noncommunicable diseases. The Ministry of Health initiated Healthy Lifestyle Centres in 2011, to address the lack of a structured screening service for noncommunicable disease at the community level. The main objective of Healthy Lifestyle Centres is to reduce the risk of noncommunicable diseases in 40–65 year olds, by detecting risk factors early and improving access to specialized care for those with a higher risk of cardiovascular disease. There are numerous other public health programmes at the community level on prevention of disease and promotion of health for the elderly, such as the national Vision 2020 community programme for eye care and cataract surgery.

The World Health Organization Global Network of Age-friendly Cities and Communities was established to foster the exchange of experience and mutual learning between cities and communities worldwide. In an age-friendly city, policies, services, settings and structures support and enable people to age actively by: (i) recognizing the wide range of capacities and resources among older people; (ii) anticipating and responding flexibly to ageing-related needs and preferences; (iii) respecting the decisions and lifestyle choices of elderly individuals; and (iv) protecting those who are most vulnerable and promoting their inclusion in and contribution to all areas of community life. Sri Lanka’s first age-friendly city was established in the Wellawaya area of Monaragala district.
and a 2013–2018 strategy is under way. The first phase of the programme has been completed and involved a baseline assessment of all primary health-care facilities for age-friendly design and signage, human resources, tools and technologies, and interventions available for prevention and control of noncommunicable disease. Subsequent ongoing activities include advocacy and training, including training of volunteers, and enhancing the age-friendliness of services.

**REORIENTING THE HEALTH-CARE SYSTEM TO MEET THE NEEDS OF THE AGEING POPULATION**

Despite the wealth of policies and initiatives in recent years, it is clear that the existing health infrastructure and systems in Sri Lanka still require considerable strengthening and reorientation to meet the needs of the growing population of elderly individuals. Although local data on care for the elderly are scarce, studies that exist indicate that many health problems in the elderly go undetected, owing to a lack of awareness, time, knowledge and human resources at all levels of care, from the community to the hospital (see Box 1).

According to the World Bank Sri Lanka Aging Survey, which was done in 2006 among Sri Lankans aged over 60 years, elderly individuals rely substantially more on public-sector services for their health care than do non-elderly individuals; 70% of health-care visits by elderly people were to government facilities, compared with 44% for the overall population. A 2008 World Bank report on the challenges facing Sri Lanka in addressing the rapidly ageing population noted the lack of organization of public health services to provide integrated, continuing care for older patients at the primary-care level. The report noted that most elderly individuals lack access to a regular doctor, and there is no infrastructure to ensure regular screening for illness and disability. Furthermore, as noted in the *Health Strategic Master Plan 2016–2025*, many cross-cutting issues of health services for older people are suboptimal. A national plan has been under development by the National Secretariat for Elders and is currently being finalized. The health-related action points of this plan have been developed in parallel with the national *Strategic Framework for Development of Health Services 2016–2025*.

Clearly, more elderly-oriented improvements to the public health services and related welfare systems are needed, including establishment of long-term care and respite care. Key to continuing improvements in services will be building capacity for care of the elderly in the community and education of all cadres within the health workforce, to sensitize health systems to the needs of the elderly and to build multidisciplinary teams that specialize in care of older patients.

**Strengthening services at the community level**

A key way forward would be to apply the lessons learnt from Sri Lanka’s impressive success in reducing maternal mortality to address community-based care of the elderly. The significant

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**Box 1. Local data on health and elderly people**

The recently published *National Survey on Self-reported Health in Sri Lanka* comprises data collected throughout 2014 from 25,000 housing units (i.e. excluding those living in institutions) covering all districts in the country. Although the data are based on self-reports and not confirmed by clinical diagnosis or tests, it is the first island-wide household survey on health. A total of 55.2% of respondents aged 60 years or older reported having at least one chronic illness. In respondents aged 65 years or older, 18.1% reported having diabetes, 30.4% reported hypertension, 6.6% reported having asthma and 8.9% reported having arthritis. Notably, of those not reporting hypertension, only 19.4% had had their blood pressure checked; of those reporting they did not have diabetes, only 24.1% had had their blood glucose levels checked; and of those reporting no heart disease, only 30.9% had had their cholesterol levels checked.

Data were also collected on respondents who had experienced an accident within the previous 3 months that had required treatment at a hospital or medical clinic. A total of 19% of men and 13% of women aged 60 years or older had experienced such an accident – higher proportions than for respondents in younger age groups. For men and women aged 60 years or over combined, the most frequent types of accident were those occurring in the home (50.4%) and road traffic accidents (28.5%).

A preliminary study done among 150 patients aged 65 years and older admitted to the National Hospital of Sri Lanka detected depression in 40%, cognitive dysfunction in 73%, 6/60 or worse visual acuity bilaterally in 34%, hearing impairment in 8.3% and unprovoked falls in 23%, while 57.6% were unable to, or took longer than 30 s to, perform a “timed up and go” test. These problems were detected by the use of screening tools to detect the specific problems of the elderly and would have been missed during routine assessments in a general medical ward.

In patients aged 65 years or older attending routine family-physician clinics, targeted screening enabled detection of dementia in 14.5%, depression in 17.1% and a significant percentage with impaired activities of daily living.

A study to determine the incidence of home accidents during a period of 1 month found the incidence among those aged 60 years or above was 10.9 per 100, and these were mostly falls.

In a study of community-residing elderly people in Colombo district, the presence of more than two chronic diseases, dizziness, history of falls within the previous year, and poor mobility were each significantly associated with falls. Individuals with a disability had a higher risk of falls than those with no disability.
reduction in the maternal mortality ratio was achieved largely via a strong community health network, with the midwife family health worker playing a pivotal role at grass-roots level. It is therefore essential to replicate this success by having an officer to coordinate the welfare of elderly individuals in each community. The family health worker cadre could be expanded to provide assessment, prevention and rehabilitation services at the community level for the elderly population. Reorientation of the role of family health workers to include responsibility for the elderly population may increase the popularity of this profession. Applications for family health-worker posts have been dwindling and an expanded job definition with new opportunities for training and professional development may increase the appeal of this career option.

As described earlier, the work of the National Secretariat for Elders has resulted in the formation of a network of thousands of village elders’ committees throughout the country. The leaders of these committees are a powerful resource in the development of community services for elderly people. Sri Lanka scores well in equitable provision of government health services for all ages. There are at least 246 divisional elders’ committees and 19 district-level committees. Elders’ committees are linked with their local-level health authorities, especially with the medical officer of health and their staff for health-related activities and with social service officers for welfare needs. Continued strengthening of these community health services for older people would be the best way to ensure not only equity but also accessibility of services for older persons, especially those with limited mobility. The use of this already existing strong community network, together with the voluntary sector and the extended family, represents a very cost-effective strategy for scaling up a health-care system for older people in the community.

To strengthen this service provision, guidelines need to be developed for screening and treatment of diseases in elderly people. In addition, more education is needed to inform the public on the health needs of the elderly population, the services available and ways of accessing them. Communities need more awareness programmes for different target groups, to minimize the generational gap between elderly and younger age groups.

**Strengthening the primary health-care level**

Strengthening primary care is essential to scaling up services for elderly people. Preventive health services are provided through 338 health units, known as medical officer of health areas. The services are delivered by a team of field officers and led by a medical officer. The duties of the medical officer of health are broad and have a strong focus on maternal and child health, which restricts the time available to focus on elderly members of the community. A solution would be to follow the model of the Healthy Lifestyle Centres, whereby a new cadre of medical officers was created, who were specifically charged with coordinating activities related to noncommunicable diseases at the district level. A similar cadre of medical officers of health for elderly care could coordinate the work of the family health workers working in the elderly community.

An additional weakness at the primary health-care level is the absence of a system of general/family practitioners in the public sector. Primary medical care in the state sector is provided at hospital outpatient departments and central dispensaries. Private general practitioners are often medical officers working in the state sector who work as general practitioners after office hours, in solo practices. No qualification or training in family medicine is required to set up in general practice and there is no set procedure for referral from primary to secondary or tertiary care. There is some evidence that family medicine is an increasingly attractive option among doctors and undergraduates. Given the growing demands for both preventive and curative services for the elderly population, it is timely to rethink the health infrastructure to include general practices to manage curative services in the community and reduce pressures on higher-level services.

In addition to the state provision at the community and primary-care levels, many nongovernmental organizations and private-sector organizations are involved in providing elderly-care services. This points to a clear need for systematic monitoring and evaluation of existing and new services. In the future, periodic reviews will be necessary to map the provision of care and to develop an evidence base on best practice, to ensure a sustainable health-care programme.

Reorientation of tertiary care: the importance of a multidisciplinary approach

Elderly patients in Sri Lanka are currently treated by general physicians in general medical wards. It has proved difficult to build dedicated elderly-care units with specialist staff, owing to financial constraints, although further development of such services is planned. Such elderly-care units require both specialist multidisciplinary staff and assistive infrastructure such as ramps and accessible toilets, for which it has been difficult to obtain funding. In busy general medical wards, there is a rapid turnover of patients and a high demand for beds. Rehabilitation of elderly patients after acute illnesses is difficult in these wards, since staff lack the time to engage with elderly patients and work with them to improve mobility. Since regular wards also lack links with social services, the community-liaison aspect of rehabilitation that is essential in elderly care is lacking. Multidisciplinary teams for this purpose are currently only available in stroke units and some orthopaedic wards. Reorientation of tertiary care to the increasing number of elderly patients should include the provision of dedicated beds for the elderly in each general medical ward, plus development of multidisciplinary teams trained in elderly care to work in general medical wards.

The elderly patient poses many challenges to the physician. Clinical presentation in elderly individuals can be very nonspecific; patients may have several noncommunicable and degenerative diseases and may be taking multiple medications. An interdisciplinary/multidisciplinary service is therefore an absolute necessity to manage these complex physical, social and psychological needs. Evidence of the effectiveness of this approach to elderly care – mainly from high-income countries but also from some low- and middle-income
countries – supports the use of multidimensional packages, including pharmacological and psychosocial interventions; collaboration between different members of the primary-care team; involvement of patients and families together with a stepped-care approach and clear referral pathways; and appropriate supervision, depending on an individual’s response to intervention and their severity of disease.23

In the Sri Lankan context, delivery of care by an interdisciplinary team consisting of a geriatrician/physician, nurse, physiotherapist, occupational therapist and social worker is needed to provide a comprehensive package to the elderly patient. Other team members such as dietitians, speech and language therapists, podiatrists and tissue-viability nurses also have a vital role. Instead of compartmentalized service provision, a holistic approach needs to be implemented at all levels of service provision, for a better programme of elderly care. As with all aspects of service provision, financial constraints are a challenge. Nevertheless, much progress could be made via partnership with other Member States in the region and collaborative capacity-building initiatives. All countries need to acknowledge that, in order to meet the challenge of their ageing populations, diverting resources towards care of the elderly is an investment rather than a burden. A healthy, economically active, elderly population will be an asset in a society with a shrinking workforce.

Social workers are crucial to the success of the multidisciplinary approach to care of the elderly, since they can ensure the delivery of the patient’s post-discharge care plan within the community. The cadre of social workers are currently attached to the administrative sector within the Ministry of Social Services. To enable smooth functioning of a multidisciplinary team, a social worker should be recruited in each hospital. It is vital to establish this link between social services and the curative sector at the levels of both service provision and government ministries.

To strengthen multidisciplinary and multisectoral collaboration at all levels, a technical advisory committee has been established by the Ministry of Health, Nutrition and Indigenous Medicine, to advise on programme planning and policy-making. In addition, a Ministry of Health, Nutrition and Indigenous Medicine steering committee for elderly care is responsible for relevant policy decisions. Periodic reviews are conducted to share best practice pertaining to elderly health care at all levels.

Education and research in geriatric medicine

Strengthening clinical capacity at the community, primary care and hospital levels, and mainstreaming the multidisciplinary approach to care of the elderly, requires investment in training. The Sri Lanka Association of Geriatric Medicine was formed in 2014 by a group of energetic doctors committed to elderly care, with a vision to ensure active healthy ageing in Sri Lanka. The mission of the association is to ensure promotion of geriatric education among the medical fraternity and the public, in order to facilitate the development of elderly-friendly environments in health-care institutions and in the community.

In 2013, the Postgraduate Institute of Medicine at the University of Colombo started a diploma in elderly medicine, as a first step in establishing an academic specialty in geriatric health. This step was taken in direct recognition of the fact that specialist training to enable early intervention and prevention of future morbidities is likely to promote efficient utilization of health resources.24 It is a full-time course in which the medical officers selected for the diploma by a competitive screening test are given 1-year release from their work stations by the Ministry of Health. The training is proving popular with applicants. However, since a new field of training with new opportunities usually attracts more trainees, incentives may be necessary in the future if the popularity of the course decreases. In addition, a doctor of medicine programme in geriatric medicine is due to be launched this year by the Postgraduate Institute of Medicine.

It is vital that training of nurses in geriatric medicine takes place simultaneously, to enable teamwork in the delivery of care to the elderly. Elderly care is included in the basic and post-basic nursing curricula. There are currently plans to increase training for physiotherapists, occupational therapists and social workers.11

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