Long-term Care of Older Persons in Sri Lanka
Acknowledgements

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<th>Full Form</th>
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<tr>
<td>ADLs</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td>AMO</td>
<td>Assistant Medical Officer</td>
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<td>AT</td>
<td>Assistive technologies</td>
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<td>CA</td>
<td>Counseling assistants</td>
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<tr>
<td>CO</td>
<td>Counseling Officers</td>
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<tr>
<td>CBO</td>
<td>Community based organization</td>
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<td>CHN</td>
<td>Community Health Nurse</td>
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<td>EPF</td>
<td>Employees Provident Fund</td>
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<td>ETF</td>
<td>Employees Trust Fund</td>
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<td>GBD</td>
<td>Global Burden of Disease project</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GN</td>
<td>Grama Niladhari (local government officer)</td>
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<tr>
<td>GNI</td>
<td>Gross National Income</td>
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<td>GPs</td>
<td>General Practitioners</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HLC</td>
<td>Healthy Lifestyle Centre</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>IADLs</td>
<td>Instrumental activities of daily living</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<tr>
<td>MOH</td>
<td>Medical Officer of Health</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NCCP</td>
<td>National Cancer Control Programme</td>
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<tr>
<td>NCDs</td>
<td>Non-communicable diseases</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NSE</td>
<td>National Secretariat for Elders</td>
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<td>NSE</td>
<td>National Secretariat for Elders</td>
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<td>PGIM</td>
<td>Post-Graduate Institute of Medicine</td>
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<td>PHI</td>
<td>Public Health Inspector</td>
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<td>PHM</td>
<td>Public Health Midwives</td>
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<td>PHNS</td>
<td>Public Health Nursing Sisters</td>
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<tr>
<td>SLAGM</td>
<td>Sri Lanka Association of Geriatric Medicine</td>
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<tr>
<td>ESCAP</td>
<td>Economic and Social Commission for Asia and the Pacific</td>
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<td>USD</td>
<td>United States Dollar</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WWC</td>
<td>Well Woman Clinics</td>
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Executive summary

Sri Lanka has one of the fastest ageing populations in South and South-East Asia because of early progress in reducing fertility rates and increasing life expectancy. The proportion over 60 years has increased from 6.6 per cent in 1981 to 13.93 per cent in 2015, and is predicted to rise to 28.6 per cent by 2050 (United Nations, 2015). This pace of ageing is faster than that found in developed countries and is happening while the country is at an earlier stage of economic development. The country is also experiencing a growing epidemic of NCDs.

Older people contribute in social, emotional and economic ways to their families and communities, but their ability to contribute can be impaired by illness and disability. Investment in a long-term care system (LTC) is needed to prevent loss of function, care for older persons, and reduce the impact of disability on older persons, their families, and communities, and on the health and social welfare systems.

This report brings together findings from a review of relevant past and current national policies and programmes, relevant Sri Lankan research data and policy analysis, and international documents on healthy ageing and LTC. Several key informants have also given their views.

The 2015 WHO World Report on Ageing and Health defines LTC as: “the activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity” (WHO, 2015). LTC may include medical care, nursing care, and daily life care. It also includes consideration of how modifying domestic and public environments can mitigate the impact of disability.

Sri Lanka has a strong, government-funded health care system, which has been especially effective in improving maternity and child health indicators at low cost, and preventing and treating infectious diseases. The need to re-orient the system towards the detection and management of chronic conditions and ageing-related health problems has been recognized. A new Shared Care Cluster System is being piloted. There has been increasing investment in hospital infrastructure but there is also a need to strengthen community level prevention and care services. It is also essential to integrate planning for LTC for older persons with responses to the NCD epidemic, to vision impairment, and to mental health problems.

Sri Lankan demographers and the Government recognized the implications of rapid population ageing in the 1990s. There has been a gradual development of a strong, rights-based, legislative framework and relevant social services and health policies. These have been developed through consultative processes involving a range of stakeholders. Implementation has been slow, but there has been much progress since 2000. Much inter-disciplinary research has been conducted and there is a rich evidence base to inform planning and implementation.
The World Bank national survey on ageing conducted in 2006 found that 40 per cent of older persons live with their spouse and children; 37 per cent only with their children; 10 per cent only with their spouse; and 6 per cent live alone (Ostbye, Malhotra and Chan, 2009). Those living alone or with only their spouse are more vulnerable and more likely to need help. Less than 1 per cent of older persons in Sri Lanka are estimated to live in residential nursing homes.

While the current cohort of older persons has benefitted from the progressive health, education and social welfare policies during their lives, many have little or no income and depend financially on their children. Currently, most LTC is provided at home by family members. This situation is gradually changing as a result of smaller families, greater involvement of women in the workforce, greater migration rates and changing expectations.

Family caregivers need support. Home nursing care services, with availability of day care, rehabilitation and respite care services, can greatly assist families to continue to care for older family members at home. The most vulnerable older persons, who may be living alone or with only their spouse, and destitute older persons, need to be identified and prioritized for LTC services. Most Sri Lankan older persons and their families are reluctant to accept residential care, but the need for residential care is increasing and there will need to be greater investment in day care and residential care. This needs to be accompanied by regulation and close monitoring to prevent abuses.

The amendment to the Protection of the Rights of Elders Act in 2011 directs that local government divisions establish Elders’ Committees. Older persons’ organizations at the community level have many benefits and could contribute to LTC services. They enable social participation, which is health promoting, and mutual support; can provide opportunities for income generating activities and savings schemes; health promotion through peer educators; and a collective, representative voice. They also facilitate easier access to screening for vision impairment and chronic diseases, especially hypertension and diabetes. Older people themselves can provide many LTC services if supported and coordinated.

Community based organizations, Shramadana societies, faith based groups and women’s groups can also play important roles in LTC. Inter-generational activities can ensure that there is ‘someone for everyone’ by pairing young people with older people, with mutual benefits. Development NGOs can be encouraged to mainstream ageing in their work in the same way they mainstream gender.

In planning LTC services it is important to have a gender perspective. There are more older women than older men, and they have a higher prevalence of disability, especially in the oldest age groups. Most older women today were not engaged in formal sector employment when they were younger and so are more likely to have an inadequate income. It is usually women who provide care for older family members.

The private sector also has a role to play and there is scope for the development of small and medium sized business to provide home-based LTC services for those who can afford it.
Decisions need to be taken about the workforce for LTC, especially at the community level. This includes re-formulating position descriptions, pre- and in-service training, deployment and support. The Divisional Directors of Health Services, Supervising Public Health Midwives and Public Health Nursing Sisters will also require in-service training for the role of supervision and coordination of home nursing care, and collating data for monitoring quality of care and planning. Developing a strong LTC system includes development of an integrated health information system. Patient held health records can contribute to continuity of care and health care workers, social workers, older persons themselves and caregivers should be encouraged to record their activities and observations.

The National Secretariat for Elders, the National Council for Elders, and the Ministry of Health Unit for Youth, Elderly and Disabled have been working closely together. There are many champions for healthy and active ageing in Sri Lanka from different backgrounds. There is now a need for a high level, intersectoral coordinating mechanism to build on the excellent work already conducted and to ensure resources are allocated to enable implementation of services in an equitable way. The coordinating mechanism will need to bring together a broader range of relevant stakeholders from within the Ministries of Health and Social Services, as well as other sectors, including the Finance Ministry, transport, industry, civil society, academia, and the private sector.

Despite these achievements there remains a need to raise awareness of the implications of population ageing more broadly among the relevant sectors. Ironically, the success of the health system in Sri Lanka in relation to women and children’s health and infectious diseases may contribute to a reluctance to change.

Sri Lanka has many lessons to share with the region from the experience of developing policies and plans for LTC, and about the challenges of implementation at scale.
Introduction

It is increasingly urgent to develop new strategies and policies to address the need for long-term care (LTC) for older people in the Asia-Pacific region. This report is a contribution to the ESCAP project: “Strengthening National Capacity for Promoting and Protecting the Rights of Older Persons”. The goal is to increase the knowledge of policy makers and key stakeholders on trends of demographic change, and policies and good practices to address the challenges and opportunities of population ageing in the region.

The number of older people in the region is expected to increase from 438 million in 2010 to more than 1.26 billion by 2050. The 2012 Bangkok statement on the Asia-Pacific review of the Implementation of the Madrid International Plan of Action on Ageing highlights the limited capacity to meet the rising need for care services for older people. ESCAP aims to provide guidance and facilitate the exchange of lessons learned and good practices on health care and LTC for older people in the region.

The 2003 WHO report, *Key Policy Issues in Long-term Care*, states that LTC policies need to reflect each country’s unique conditions, which have to be understood in much more depth and complexity. The 2015 WHO *World Report on Ageing and Health* has a chapter on responding to the need for long-term care systems. This report presents information about rapid population ageing in Sri Lanka and responses to the growing need to build an effective and affordable LTC system for older people. The report analyses the history of the development and implementation of relevant policies and programmes, and the current challenges and gaps.

THE DEMOGRAPHIC TRANSITION

As countries develop, with improvements in living conditions and health care, death rates fall, especially child and maternal deaths, and the population grows. After a lag, birth rates also fall as more children survive and parents reduce the number of children they have. The gap between death rates and birth rates results in continuing growth of the population. Later, the birth and death rate stabilize at a new lower rate, and the population stabilizes at a greater size before eventually declining. This results in a greater proportion of older people and a smaller population of children. Women have longer life expectancies than men in most countries so there is a greater proportion of women over 60 years than men. In European countries the proportion over 60 years increased from 7 per cent to 14 per cent over a century. Many Asian countries are making the same transition in only 25 years.
CONTRIBUTIONS MADE BY OLDER PEOPLE

Older people make important contributions to the economy and well-being of their families and communities. They undertake child-care and domestic tasks enabling younger members of the family to go out to work (Andrews and Hennink, 1992). They bring in income through casual work, grow vegetables, and look after animals. They volunteer, give advice to their adult children, and pass on traditional skills and knowledge to the young. Like women’s domestic work, the economic contribution of older people is not included in national accounts, so is not sufficiently appreciated. When older people become disabled or ill they may no longer be able to contribute in these ways and someone in the family might need to stay at home to care for them. However, even frail older people who depend on others often play important roles in the lives of their families through the love, comfort and sense of continuity that they provide.

DEFINITION OF LONG-TERM CARE FOR OLDER PEOPLE

The 2015 WHO World Report on Ageing and Health defines LTC as:

*The activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity (WHO, 2015).*

‘Intrinsic capacity’ means ‘the composite of all the physical and mental capacities of an individual’. Loss of intrinsic capacity may be gradual, or marked by recovery of some functions, and it may be possible to prevent deterioration. ‘Functional ability’, means ‘the health-related attributes that enable people to be and to do what they have reason to value’. It is made up of the intrinsic capacity of the individual, environmental characteristics, and the interactions between them (WHO, 2015). LTC can be achieved both through preventing or minimizing loss of intrinsic capacity, and, when intrinsic capacity has been lost, through providing the environmental support and care needed to maintain functional ability at a level that ensures well-being (WHO, 2015).

A system for LTC includes family members, friends and neighbours, volunteer caregivers, as well as multi-disciplinary teams with paid caregivers, occupational therapists, physiotherapists, podiatrists, community nurses, doctors, and care managers and coordinators. LTC systems include counselling, wound care, incontinence services, low vision services, rehabilitation, provision of mobility aids, respite care, end-of-life care, and support for caregivers. These services may be delivered at community level or in residential care homes. LTC should also help to reduce the risk of catastrophic out-of-pocket health care expenses. LTC systems also include the provision of information, training of caregivers and planning their deployment, accreditation, and financing. The WHO report calls for a revolutionary re-alignment of health and social care systems (WHO, 2015).
Methods

This report is informed by:

- Review of relevant past and current national policies and programmes
- Review of international documents on healthy ageing and long-term care
- Review of relevant research, policy analysis publications, and newspaper articles in both the peer-reviewed literature and grey literature
- Consultations with key informants (Appendix 1)
- Analysis of experiences from the healthy ageing projects undertaken by the Burnet Institute in Nuwara Eliya district since 2004.
1 Findings and discussion

Sri Lanka context

Sri Lanka is a small island country south of India, with a population of 20.3 million people, and a current annual population growth rate of about 0.5 per cent (United Nations, 2015). 70 per cent are Buddhists; 13 per cent Hindu; 10 per cent Muslim and 7 per cent Christian. It is one of the most densely populated countries in Asia, and one of the least urbanized with less than 20 per cent of the population living in urban areas (United Nations, 2014). But there is now a growing trend of internal migration, especially to Colombo and the urbanized Western province.

Sri Lanka recently transitioned from a low income to a middle-income country. In 2011, GDP growth was 8.3 per cent. The GNI per capita is currently USD$10,770 (World Bank, 2014). Textiles, tourism, tea, rice production, vegetables and other agricultural products are important sectors of the economy. Remittances from overseas workers are the most significant contributor to foreign exchange. The labour force participation rate is 53.3 per cent; for women this is 34.7 per cent, and for men, 74.6 per cent (Department of Census and Statistics, 2014). Tax revenue, which was 19 per cent of GDP in 1990, had fallen to 10.2 per cent of GDP by 2014 (Karunanayake, 2015). Literacy rates are high with 92.6 per cent of men and 89.7 per cent of women able to read (Department of Census and Statistics, 2012a). However older people, especially women and those in plantation and rural communities, have lower literacy rates. The civil war, between 1983 and 2009, affected social and economic development, especially in the north and west.

1.1 Trends in population ageing in Sri Lanka

In the decades after independence in 1948, the Government of Sri Lanka invested in health and education, which led to early progress in reducing fertility rates, maternal and infant mortality, and increasing life expectancy. As a result, Sri Lanka has one of the fastest ageing populations in South and South-East Asia. Female life expectancy is 79.6 years; male life expectancy is 72.4 years (United Nations, 2015).
For many decades the proportion of the population over 60 years was small and fairly stable, increasing from 5.4 per cent in 1946 to 6.6 per cent in 1981. By 2015 the percentage had doubled, with 13.9 per cent of the population now aged 60 years or over, and this is predicted to rise to 28.6 per cent by 2050 (Department of Census and Statistics, 2012a and United Nations, 2015). The richer countries of the world have a higher percentage of older people but these countries aged at a much slower pace (with a doubling in the percentage over 100 rather than 25 years).

The age group above 60 years of age is increasing rapidly, but in 2014 only 1.3 per cent were estimated to be 80 years or older. However, this ‘oldest-old’ age group, will also soon start to increase rapidly.

This transition is occurring while Sri Lanka remains a lower middle-income country with a GNI per capita of $10,770. However, Sri Lanka has a high proportion of the population (42.6 per cent) in the 25–54 year old age bracket (Institute of Policy Studies of Sri Lanka, 2014). This means that the country is benefitting from a demographic dividend. The dependency ratio (number of children less than 15 years plus the number of people over 60 years per 100 persons in the working ages) is currently low, so conditions are favourable for economic growth. But the increase in older people is outpacing the decline in the dependency of children, so total dependency of the population is expected to grow significantly from the mid-2030s. Hettige and others have pointed out that the assumption that all those above 60 years of age are dependent is inaccurate, since the majority of 60–70 years olds continue to work in the informal sector and contribute to the economy (Hettige, 2014).
Figure 2. Dependency Ratios 2001–2051, Sri Lanka

![Graph showing dependency ratios from 2000 to 2050 for child dependency, old age dependency, and total dependency.](image)


1.2 Living arrangements of older persons

The World Bank national survey conducted in 2006 found that 40 per cent of older persons live with their spouse and children; 37 per cent only with their children; 10 per cent only with their spouse; and 6 per cent live alone (Figure 3). Those living alone or with only their spouse are more vulnerable and more likely to need help. Less than 1 per cent of older persons in Sri Lanka are thought to live in residential nursing homes. A small 1992 study in Kandy showed similar findings, suggesting there has so far been little change in living arrangements (World Bank, 2008).

A 2012 survey of a random sample of 1,125 older persons in Nuwara Eliya district also found that 6 per cent of older persons were living alone; 8.3 per cent of older women and only 3 per cent of older men (Burnet Institute and The Fred Hollows Foundation, 2013). Of those living alone 60.6 per cent were widowed; 18.5 per cent were 75 years or over. 86 per cent of those living alone needed no help with activities of daily life, and 77 per cent needed no help or only some help with one instrumental activity of daily life. 54.5 per cent of those living alone reported that they had been very often or always lonely in the previous two weeks, compared to 9 per cent of those living with others. 42 per cent of those living alone felt they were ‘very much’ or ‘extremely’ affected by being dependent on others for their needs, compared to 14.7 per cent of those living with others. Older persons living alone were as likely as older persons living with others to report that their overall quality of life was good or very good (49 vs 47 per cent), and were a little more likely (16.9 per cent) to say that their quality of life was poor or very poor, compared to 10.4 per cent of those living with others. 19 per cent lived in a...
household with six or more members in addition to the older person. They reported similar quality of life to those in households with between one and four members. Perera provides a useful analysis of the risk of deprivation and vulnerabilities of older persons in different living arrangements in Sri Lanka (Rajan, Risseeuw, and Perera, 2011).

1.3 Financial situation of older persons

Poverty is a major underlying cause of older persons becoming dependent. Those over 60 today experienced high rates of unemployment in the 1970s and 80s (Rajan, Risseeuw, and Perera, 2011). Many older persons continue to work in the casual, informal sector, often in low paid jobs that require physical effort, for as long as they are able to. Older women are much less likely to be employed outside the home than men; 16.5 per cent of women aged 60–64 are earning compared with 67 per cent of men aged 60–64 (World Bank, 2008). Increasing
prices of basic goods and services are especially difficult for older people with very low incomes.

Older persons in poor households may benefit from the national poverty alleviation Samurdhi programme, although this is poorly targeted (Glinskaya, 2003). Gaminiratne in 2004 studied retirement benefits and argued for a means tested retirement scheme, as a universal pension benefit scheme would not be affordable to the country in the medium to long-term (Gaminiratne, 2004). The 2008 World Bank report on ageing in Sri Lanka has a chapter analyzing formal income support programmes including pensions and relevant safety net programmes (World Bank, 2008). Hettige has made the point that estimates of the proportions of economically active older persons, and of those who depend on others, is a major gap in the data on older persons, and is not yet collected in census data (Hettige, 2014). However, there is increasing recognition of the need to do more to ensure income security in old age and debate about how to do this.

A national consultation on pensions was held in Colombo in October 2015. A study presented at the consultation reported that in Sri Lanka only 20 per cent of older persons receive a pension from the public sector; 5 per cent through the informal sector, and a further 5 per cent receive a small pension through the Ministry of Social Welfare (Daniel, 2015; ESCAP, 2015; ESCAP and IPS, 2015). Half the population of older persons receives no pension. It was noted that a comprehensive national pension fund would be more equitable and result in less fragmentation, with greater mobility between sectors and job categories, and should ensure basic income security for both older women and older men. Sustainability will be a major challenge. In the same consultation, the need for the social security system to become stronger and more sustainable was noted (Senewiratne, 2015; ESCAP and IPS, 2015). It was noted that most old age income support schemes are employment based, so women who have not been employed outside the home lack access to income support in old age. The many informal sector workers, such as fishermen or farm workers, have not had the ability to contribute regularly to these programmes.

Some experts advocated for the Government to create a national pension policy framework (Wettasinghe, 2015). It was pointed out that once they retire at 60, older persons have an average 21.6 years more of life expectancy, and that in all other South Asian countries, the retirement age is higher than the healthy life expectancy. A gradual increase in retirement age to 65 years of age was recommended, reporting that there are 24 pension schemes in the country, but no common policy frameworks. The Department of Pensions spends LKR 14 billion a month on public sector pensions, but nearly 82 per cent of older persons do not receive any pension benefits. Some have been calling for a superannuation fund to be created, and for an independent regulator for pension schemes. The Pensions Department, plans to review pension schemes in other countries to inform a comprehensive pensions framework (Wettasinghe, 2015; ESCAP and IPS, 2015).

The Employees Provident Fund and the Employees Trust Fund are contributory lump-sum retirement benefit schemes. Poor families rarely receive a large lump sum so it is often soon spent on a motor-bike, TV, or wedding, leaving older persons without an income. In the 2013
Nuwara Eliya survey, only 25 per cent of older persons said they had saved for their old age; 69 per cent thought that a regular payment would be better than a lump sum at retirement, while 26 per cent preferred the lump sum (Burnet Institute and The Fred Hollows Foundation, 2013). One quarter were in debt, and for half of them this caused a lot of concern.

The National Secretariat for Elders (NSE) has a responsibility to relieve the poverty of older persons. Older persons who do not have sufficient income to sustain themselves can apply to the Maintenance Board to claim maintenance from their children. Under the Protection of the Rights of Elders Act, the Board will investigate and decide on the payment of maintenance. The Board received only 70 complaints from older persons needing support during 2014. Since June 2012 there has been a Public Assistance Programme for older persons over 70 years receiving less than LKR 3,000 income per month. They now receive LKR 2,000 per month, which amounts to LKR 66 (USD$ 0.50) per day. A total of 386,080 older persons were receiving this assistance in the first eight months of 2015 (this represents 40 per cent of all older persons over 70 years), an increase from 254,000 in 2013. The NSE also runs a Sponsorship Scheme for Sri Lankans to sponsor a destitute older person who will then receive LKR 250 per month.

Civil society organizations have noted that it is common for private, commercial and state banks to debar those who are above 60 years from obtaining loans. HelpAge Sri Lanka has partnered with the NGO Berendina to empower older persons through microfinance activities to address this gap (Perera, 2015).

1.4 Common health problems of older people and barriers to care

Older people’s health problems in low income settings are characterized by chronicity, co-morbidity, preventable disability, consequences of earlier health hazards, poor nutrition, and increasing vulnerability, but also resilience. They have a wide range of risk factors for chronic conditions, some originating early in life. Poor maternal nutrition contributes to low birth weight, which in turn predisposes to high chronic disease in adulthood (Barker, 2007). In old age immunity is reduced increasing risk for infectious diseases, especially reactivation of tuberculosis, and cancers (Meydani, Ahmed and Meydani, 2005; Moore and others, 2010). Poor oral and dental health, poverty, a desire to give their food to their children or grandchildren, and lack of access to a variety of foods combine to cause nutritional deficiencies (Perera and Ekanayake, 2011; Meydani, Ahmed and Meydani, 2005). In highland areas damp and chilly conditions increase risk of pneumonia. Long exposure to indoor air pollution and occupational hazards can result in chronic respiratory diseases. High parity contributes to urinary incontinence. Poverty and stress may lead to drinking and smoking. Social isolation is a significant risk factor for morbidity and mortality (Grant, Hamer, and Steptoe, 2009; Holt-Lunstad, Smith, and Layton, 2010).

The prevalence of cardiovascular disease is increasing more rapidly in South Asian countries than in any other region of the world (Moran and others, 2014). Stroke is common in South Asia, including Sri Lanka, but public and health care provider awareness of stroke risk factors
and management is low (Wasay, Khatri and Kaul, 2014). One in five adults in Sri Lanka has diabetes or pre-diabetes and one-third of those with diabetes are undiagnosed (Katulanda and others, 2008). Complications may be more common in South Asia than in richer countries because of poor management, lack of knowledge for self-management, and barriers to access to health care (Perera, De Silva, and Perera, 2013). Incidence of cancer is also increasing, especially breast and cervical cancer among women, and lung and oral cancer among men (Moore and others, 2010).

Common conditions that affect quality of life are often neglected. These include, in particular, vision impairment; hearing loss; incontinence; pain and restricted movement associated with arthritis; fatigue associated with anaemia; sexual health problems; falls; and violence or neglect, which are often hidden (Lowenstein, 2009). Depression, anxiety and dementia are common – but may not be thought of as health conditions requiring treatment or care (Patel and Prince, 2001).

Older people often experience barriers in accessing health care services. These include poverty, isolation, lack of mobility, lack of transport, queues and long waiting times, health care provider attitudes, user fees and the cost of drugs. Their health care seeking behaviour is often influenced by lack of information about health and services, a belief that their symptoms are a ‘normal part of ageing’, and a reluctance to spend money on themselves. Treatment for chronic conditions is expensive and the economic impact on poor and vulnerable populations is great (Engelgau and others, 2011). A certification process for ‘Age-friendly hospitals’ could be developed following the model of the successful ‘Baby-friendly hospital’ accreditation scheme.

1.5 Health care system

Successive Governments in Sri Lanka have been committed to providing health care services free of charge at the point of delivery financed through tax revenue. The 2016 budget speech continues this commitment. Sri Lanka has achieved excellent health outcomes, with high levels of healthcare use and patient satisfaction, despite low levels of government expenditure on health (Rannan-Eliya, 2010; Rannan-Eliya and others, 2014). There are, however, provincial and district disparities in health indicators, with the north and the east, and the estate sector, having worse indicators.

In 2010 government services provided 96 per cent of inpatient care and 45 per cent of outpatient care (Rannan-Eliya, 2010). There are no official charges for inpatient or outpatient services. However, patients are often expected to purchase medicines and supplies from the private sector when the government dispensary is out of stock. There is good public confidence in government hospitals (Perera, S., 2014). The private sector is predominantly curative and has been growing, but is becoming more expensive.
CURATIVE CARE SERVICES

In addition to the National Hospital in Colombo there are 20 teaching hospitals, several specialist hospitals (cancer, maternity, infectious diseases, mental health, children’s hospital, chest diseases), three Provincial and 18 General hospitals, and 60 Base hospitals (Perera, S., 2014). There are also 473 divisional hospitals, most with fewer than 50 beds, and 474 primary medical outpatient care units with non-specialist doctors. Doctors in government service are allowed to work in private practice after 4.00 pm. There are many private general practitioners GPs.

PREVENTIVE SERVICES

The central Ministry of Health, Nutrition and Indigenous Medicine (MoH) is primarily responsible for the protection and promotion of people’s health, including setting policy guidelines, medical education, and management of teaching and specialist medical institutions. Each of the eight Provincial Councils has a Director of Health Services and there are Deputy Directors of Health Services at district level. The Divisional Directors of Health Services (often called Medical Officers of Health) are responsible for preventive health care for a population of 60,000 to 80,000, through 341 government community health services. Their team includes Public Health Inspectors (PHI), Public Health Nursing Sisters (PHNS), and Public Health Midwives (PHM). They undertake public health prevention activities such as maternal care, immunizations, and dengue prevention. Good monitoring and surveillance systems, use of parent held child health records, high female literacy, good health seeking behaviour, well trained staff and clear job functions have contributed to the success of the maternity and child health programme.

HEALTH CARE SYSTEM REFORM

Much work has been done to plan for health care system reform to meet the major challenges of responding equitably and efficiently to the increase in NCDs, mental health, injury prevention and ageing-related conditions. There is recognition of the need to change from management of acute episodes to continuing, personalized care that supports self-management of chronic conditions (Perera, S., 2014).

Most of the cost of chronic NCDs is currently borne by patients (Engelgau and others, 2010). Cancer and acute myocardial infarction are predominantly publicly financed, while expenditures for diabetes, asthma, and other types of heart disease are mostly paid for by patients (Engelgau and others, 2010). Although patients visit free government clinics, they have to purchase drugs, and they are losing confidence because of lack of availability of medicines and investigations. Some medicines, such as statins to prevent heart disease, are not equitably distributed (Engelgau and others, 2010). The clinics close at 4.00 pm so many patients have to access private care after this, although they will often see the same doctor. The central MoH receives a larger allocation of the health budget to pay for the costs of the larger hospitals, and
there has been a steady decline in the proportion of the health budget given to Provincial Councils. The central MoH is responsible for procurement of drugs for the whole country, and recruitment, basic training, and deployment of major categories of health staff. There are problems with the way that drug needs are estimated at provincial level (Perera, S., 2014).

The development emphasis has been mainly on capital improvements for larger hospitals. This has contributed to bypassing of primary level curative institutions, which is possible because there is no requirement for a referral from the primary care level. In 2008, bed-occupancy rates were nearly 85 per cent in higher-level facilities and below 50 per cent in lower-level facilities (Engelgau and others, 2010).

In 2008 the MoH policy analysis unit undertook expert consultations and analysed service gaps (Perera, S., 2014). There was consensus that the existing model should be expanded rather than setting up a parallel structure for NCDs at primary level, with service linkages between the primary health curative and preventive health delivery organizations. There was also commitment to eight principles:

- Improved accessibility of care
- Continuity of care
- Responsiveness to community and patients’ needs
- De-institutionalizing care – promoting care at community level
- Fostering other sectoral involvement
- Accommodating home based care
- Supporting self-management through improved health literacy
- Continued quality improvement and patient’s safety

To achieve this they identified the need for:

- Outpatient management of chronic diseases, with an appointment system to reduce long queues from 5.00 am, standardized care guidelines, lifestyle modification guidance, and a personal patient-held health record
- Training to improve knowledge, attitudes and competencies of hospital staff to manage chronic diseases
- Attention to referral and back referral practice
- Ensuring basic emergency care available
- Improving availability of essential drugs for NCDs and of basic lab tests
A Shared Care Cluster System is now being trialled in four districts. This consists of a unit with an apex hospital providing specialized care, together with its surrounding primary care curative institutions with a defined catchment area. Curative services have not previously had a defined catchment area. About 500 post-intern doctors who are assuming duties in primary level curative institutions have been given an orientation on the guidelines and tools.

WELL WOMAN CLINICS

Well Woman Clinics (WWC) were introduced in 1996 to screen peri-menopausal women for breast and cervical cancers and NCDs including diabetes and hypertension. In 2013, there were 983 WWCs held fortnightly or once a month. Trained Medical Officers screen women and refer to hospital outpatient clinics. Follow up is carried out by the area public health midwife (PHM). PHMs in Nuwara Eliya have suggested that the Well Woman Clinics could include advice, support and services for older women with continence problems and could routinely train women to perform pelvic floor exercises. A total of 152,685 women attended WWCs around the country in 2013 but only 42 per cent were over 35 years. There is scope to greatly increase the popularity and coverage of the WWCs for older women.

HEALTHY LIFESTYLE CENTRES

In 2011 the MoH adopted a policy of establishing healthy lifestyle centres (HLCs) for detection of NCDs and promotion of healthy lifestyles for ‘people between the ages 35 to 65 years’ (Ministry of Health, 2011). While it is important to prevent NCDs and promote healthy ageing throughout the life course, the limit of 65 years is artificial and is an inadvertent consequence of the WHO target for NCDs to ‘reduce premature mortality by 20 per cent’. In Sri Lanka the age that defines a premature death is 65. There is evidence that NCDs increase in incidence with age and that many older people with diabetes and high blood pressure are unaware of their condition and that health promotion is effective among older people. It is important to advocate with the NCD department at WHO to take efforts to reduce inadvertent ageism in national NCD responses resulting from this target. In early 2016 the MoH decided to remove the upper age limit for the HLCs. The HLCs are encouraging more people to be screened for NCDs and providing important health messages (WHO, 2014b).

SPECIALIST SERVICES

There were 1,577 specialist consultants nationally to that date in Sri Lanka, and a further 1,987 consultants were needed (Moramudali, 2015). The out-migration of specialists is an area of concern in Sri Lanka and the Ministry of Health is planning to expand the cadre of consultants. The Board of Studies of the Post-Graduate Institute of Medicine (PGIM) and the specialist Colleges play a major role in regulating the numbers of specialists.
DEVELOPMENT OF TRAINING IN GERIATRIC MEDICINE

There are currently no board-certified geriatricians working in Sri Lanka, but some general physicians have recognized the need to develop the speciality.

A Speciality Board in Elderly Medicine was established by the PGIM in 2009, consisting of general physicians who have trained overseas in geriatrics. A one year full-time diploma course in geriatric medicine had been initiated in 2013 by the PGIM, with the third group currently being trained. One expert noted that there were not yet posts for the diploma graduates, and that there should be more community level training included in their course. A five year MD course in geriatric medicine had been developed and was expected to commence in early 2016, with four to five trainees starting each year. This will include short rotations in relevant sub-specialities and one or two years of overseas training. In addition, four of the eight medical schools in Sri Lanka have begun to include geriatric medicine in the undergraduate medical curriculum.

The Sri Lanka Association of Geriatric Medicine (SLAGM) was founded in 2014 to improve knowledge and awareness of active and healthy ageing, with a membership of over 100. SLAGM is undertaking Continuous Medical Education programmes in collaboration with the Ceylon College of Physicians to improve knowledge among the medical profession. A Diploma in Gerontology has been developed for graduates working in the health and social services Ministries, and a Diploma in Palliative Care is planned. There are also plans to develop a Post-Graduate National Training Centre on Ageing.

There are currently no hospitals for geriatrics and no geriatric nursing training at community level. A National Steering Committee was established in 2013 to develop 10 – 13 underutilized district hospitals to be geriatric hospitals.

Developing the clinical specialty of geriatrics cannot directly address the challenge of LTC for older persons in Sri Lanka. However, geriatricians and the SLMAG can be valuable allies in raising awareness of health officials to reorient the health system towards the rights and needs of older people, stimulating research, contributing to the training of other cadres of health and social care providers, and championing improved links between hospital and community care.

AYURVEDIC CARE

In planning LTC systems it is important to take into account the traditional system of Ayurvedic medicine, which is widely respected and practiced in Sri Lanka, especially among older people. The MoH has a Department of Ayurveda, which establishes and maintains hospital and dispensary services; conducts examinations and research; and registers Ayurvedic practitioners. Ayurvedic medicine has its own medical council in Sri Lanka. The Institute of Indigenous Medicine of the University of Colombo runs training programmes and also publishes the Sri Lanka Journal of Indigenous Medicine.
Ayurvedic medicine is based on concepts of universal interconnectedness, the body’s constitution, and life forces. Ayurvedic physicians prescribe individualized treatments, including compounds of herbs or proprietary ingredients, and diet, exercise, and lifestyle recommendations. For older people Ayurvedic medicine is affordable, familiar and trusted. There have been few well designed clinical studies, but there is some evidence that Ayurvedic medicine is effective for arthritis, injuries and diabetes. More clinical trials are needed (Medagama and Bandara, 2014).

Many older persons attend both an Ayurvedic and an allopathic practitioner. Allopathic health care providers should ask their patients about Ayurvedic treatment they may be receiving, because of the possibility of interactions with other medicines. It is important in health promotion to advise older persons not to postpone the investigation of serious symptoms when using Ayurvedic medicine. It is likely that the concept of integrative medicine, which combines allopathic treatment with evidence-based complementary therapies, will be valuable in Sri Lanka in the future. For example, cinnamon has been found to be effective at lowering blood sugar for diabetics (Medagama, 2015).

PALLIATIVE CARE

LTC staff need to have communication and clinical skills in palliative care if older persons are to be supported to die at home with dignity. There are currently no designated palliative care units in public or private hospitals and a lack of both training and guidelines for palliative care. The College of General Practitioners has trained 300 doctors, but undergraduate medical and nursing training should include palliative care. Injection morphine and pethidine are on the essential drugs list and available in all hospitals. Oral morphine is only available from cancer hospitals, and is not always available. The national cancer control programme (NCCP) has a palliative care team, and a national Steering Committee is to be formed, but palliative care policy needs to be integrated with NCD, healthy ageing, and LTC responses (Kumar, 2015).

1.6 Social welfare system

Since the post-independence period, Sri Lanka has had a history of strong social welfare policy. The Government implements a range of schemes that focus on providing safety nets for vulnerable groups such as the disabled and older persons. The Ministry of Social Empowerment and Welfare oversees the Department of Social Services, the National Secretariat for Persons with Disabilities, the National Institute of Social Development, the NSE, and the Counselling Division. The Samurdhi welfare programme directly targets poor and vulnerable households.

The NSE has the responsibility to protect the rights of older persons. Activities include support for Day Care Centres, issuing of identity cards, a Maintenance Board, social welfare payments, establishment of Divisional level Elders’ Committees, pre-retirement seminars, issuing of intra-ocular lenses, registration of relevant organizations and services, renovation
of homes for older people, training of social welfare staff and home based care givers, and access to low cost home care services. The National Institute of Social Development is a degree awarding Institute, under the Ministry of Social Services. It trains professional social workers, counsellors and conducts an 18 month Diploma course in Gerontology.

In 2005 the Government approved the establishment of Social Care Units in all Divisional Secretary Divisions. These provide an integrated, comprehensive social care package as a safety net. The programme is a joint venture implemented by the Ministry of Social Services, the Ministry of Child Development and Women’s Affairs and the Provincial Councils. The Units are staffed by a Social Services Officer, Counselling Assistants, an Elders’ Rights Promotion Officer, a Social Development Assistant, a Women’s Development Officer, and a Child Rights Promotion Officer, Early Childhood Development Officers and a Relief Sister. These Units could play a valuable role in providing LTC services.
2 Evolution of the development of legislation, policies, and programmes relevant to long-term care for older persons

The need to re-orient the health and social systems towards the rights and needs of older people, including the provision of LTC, has been recognized in legislation and policies in Sri Lanka for many years.

2.1 Key national legislation and policies

1982 National Committee on Ageing established in the Department of Social Services

1993 National Policy for the Elders formulated

1997 The recommendations of the Sri Lankan Presidential Task Force on Health Sector Reforms included Care of the Elderly as a priority focus area. Priority tasks suggested by the Task Force were:

- Assess needs of older persons;
- Produce manuals for training of primary health care workers and health volunteers;
- Improve network of Day Care centres;
- Screening of older persons at divisional level;
- Appoint community health nurses;
- Improve facilities at hospitals for older persons;
- HelpAge proposal to use religious places as day care centres;
- Plans to improve the existing facilities of homes for older persons;
- Increase awareness in the community about caring for older persons

1997 Annual Health Bulletin noted an increase in hospital admissions for diabetes and cardio-vascular disease, and the need to prioritize prevention and treatment efforts.

1998 The Department of National Planning published the Government’s “Six Year Development Programme 1999–2004”. “Thrust areas” identified for Social Services included “provision of community based care for vulnerable groups such as elders.”

1998 The National Population and Reproductive Health Policy presented strategies for the care of older persons:

(a) Encourage the private sector, NGOs, CBOs and the local community to provide community care and services to older persons
(b) Initiate social security schemes for older persons not already covered by EPF, ETF, etc.
(c) Provide incentives to families to care for older persons at home
(d) Provide appropriate training for out of school youth awaiting employment to enable them to take care of older persons at home.
Protection of Elders Rights Act No. 9 of 2000. The Act provided for the establishment of a Statutory National Council and the National Secretariat for Elders within the Ministry of Social Services, a Maintenance Board for determination of claims of older persons, a National Fund for older persons, the introduction of an older persons’ identity card, the establishment of Elders’ Committees at local government level and Day Care Centres, and the introduction of a pension scheme for older persons aged 70 and over who do not get any kind of assistance and who have no family or relative to look after them.

First consultation process for integrated responses to ageing by Ministry of Health and Ministry of Social Empowerment and Welfare (Perera, 2005).

The National Charter for Senior Citizens and National Policy for Senior Citizens of Sri Lanka was approved by Cabinet: “The mission of the Charter for Senior Citizens is to ensure and reinforce the values of independence, dignity, participation, self-fulfilment, and a good quality of life in the diversity of their situations in a caring, accepting and respecting community” (Government of Sri Lanka, 2006).

The Director General of Health Services attended the High-level Meeting on the Regional Review of the Implementation of the Madrid International Plan of Action on Ageing (MIPAA) in China and a background report was prepared.

‘Mahinda Chintana’ – Vision for the future: The development policy framework of the Government of Sri Lanka, Department of National Planning and Ministry of Finance and Planning. This policy framework recognized that “The main challenges in the health sector include (a) responding to a changing disease and demographic pattern, (b) human resource management, (c) improving responsiveness and (d) addressing the needs of vulnerable groups. The demographic and epidemiological transition is leading to challenges of aging, a growing burden of non-communicable diseases (NCD) and lifestyle diseases. The percentage of the population over 60 years of age is expected to grow from current level of 11 per cent to 16 per cent by 2020 and to 29 per cent by 2050. Therefore, the health problems of the aging, including more NCDs, will be the main challenge in the future.”

The main outcome from the National Scientific and Policy Forum was a policy decision to pilot primary health care strengthening to address population ageing.

The National Action Plan for the Protection and Prevention of Human Rights 2011 – 2016 was developed.

A consultative process, supported by WHO, led to the multi-sectoral National Action Plan on Ageing 2011 – 2015. However, the plan has not yet been approved by Cabinet.

The Protection of the Rights of Elders (Amendment) Act, No. 5 was passed.

The new Government’s National Budget Speech included funding for:

- “Increase of the LKR 1,000 allowance granted to elderly people to LKR 2,000 from January 2015
- Elderly Clubs will be set up in all Grama Niladari areas to create an enabling environment for elderly people to spend their leisure time watching TV, reading and being engaged in other facilities available at day centers; Medical clinics will also be organized at these centres
- Allocation of LKR 250 million to provide financial assistance to reputed social organizations, which promote elderly care
- LKR 200 million will be allocated to rehabilitate elderly homes at Saliyapura, Katharagama, Mirigama and Jaffna.
- Allocation of LKR 100 million to provide financial grants to film producers and artists to make films and tele-dramas promoting success stories of traditional family values towards elders.”

The Youth, Elderly and Disabled Unit of the Ministry of Health prepared a draft Policy on health for older people for consultation.
The National Charter for Senior Citizens and National Policy for Senior Citizens of Sri Lanka 2006, is an excellent and comprehensive policy document. However, many experts have pointed out that there has been little progress in implementing the policy and the National Action Plan on Ageing because of the lack of effective coordinating mechanisms (Wijisinhe, 2012). There is now a need to use the National Charter for strong advocacy for LTC across government.

2.2 Protecting the rights of older persons

The National Charter is a rights-based policy, and there are several mechanisms to protect older persons’ rights. There is an Elders’ Desk at the Legal Aid Commission that has several functions (Government Information Centre, 2009):

- To provide free legal advice regarding maintenance, accident claims, loss of property, pension and fundamental rights of destitute older persons.

- To lead a counseling service centered on ‘Elders’ Homes’ and ‘Day Centres’ in view of educating Grama Niladharies (GNs), Social Service Officers and school children on older persons’ rights and older persons’ law.

- To launch joint programmes in collaboration with the National Secretariat for Elders and the People’s Bank.

- To help protect the rights guaranteed to older persons under the Protection of Elders Rights Act No.9 of 2000.

The Attorney-at-Law who heads the Elders’ Desk coordinates with the NSE, conducts awareness programmes and advises destitute older persons about their rights.

In 2012 a consultation on the Rights of Elders was organized by the Human Rights Commission (Wijisinhe, 2012). This clearly stated that ensuring care for older persons should be the responsibility of government. It called for:

- a mandatory contributory pensions scheme, a state pension for all older persons, and government monitoring of private pension schemes.

- raising the age of retirement to 65, allowing voluntary retirement earlier with lower pension provision.

- GN Divisions (local government) to maintain ‘vulnerability indices’ to monitor the situation of older persons and other vulnerable groups and share with appropriate government officials for action.
• one Elders’ Rights Protection Officer in each Divisional Secretariat, responsible for coordinating information and action, and ensuring maintenance for destitute older persons.

• more and better training of counsellors with nationwide deployment

• all older persons to be provided with identity cards and a campaign to ensure card holders receive their benefits.

• legal assistance and advice to be available for all older persons when needed.

• raising awareness and encouraging volunteers.

3 Delivery of long-term care for older people in Sri Lanka

Developing delivery service strategies for LTC requires integration of health care and social welfare services, with reorganization of the programmatic infrastructure and a coordinating mechanism. Most LTC is delivered by family members at home, but the need for home-based care services is increasing. These could also reduce hospitalization and provide care after discharge from hospital.

3.1 Family support and care

STRONG CULTURAL NORM OF FILIAL CARE

In Sri Lanka adult children have traditionally cared for their ageing parents if they became frail and dependent. As in other countries in the region, it is common to hear that there is a cultural and religious imperative for adult children to care for their ageing parents (Balasuriya, 2011). Practical care is usually provided by women. Commonly, both men and women contribute financially to the older generation when needed. Amarabandu has described the traditional roles in agricultural communities of the nuclear family, the extended family and the village in the care of older persons (Amarabandu, 2004). The youngest son, who inherits the family home, and his wife, were expected to look after the parents in their old age. Other children in the family help by providing financial support and other items. Older persons without children were looked after by another close relative or others from the village.

Discussion of inheritance and assistance with writing a will is important because of the conflicts and expensive legislation that often happen in families when an older person dies intestate (Gamburd, 2013). This is relevant to LTC because uncertainty about inheritance can cause anxiety for sons and daughters-in-law providing LTC for the older generation. On the other hand, some older persons worry that if they transfer land titles to their children before they die their children may not be willing to care for them if they become dependent (Gamburd, 2013).

A small study was conducted in Peradeniya in central Sri Lanka to explore older people’s attitudes towards future LTC. Only 20 per cent of the 364 older persons interviewed at a government hospital in Kandy were willing to consider accessing care outside the family, and these tended to be those with little or no family support, depressed, and living far from a hospital (Liu and others, 2013). The 2008 World Bank report noted that “Old people regard institutionalization as a last resort” (World Bank, 2008). The Protection of The Rights of Elders Act states that “Children shall not neglect their parents willfully and it shall be the duty and the responsibility of children to provide care for, and to look into the needs of, their parents.”
FACTORS INFLUENCING CHANGING TRENDS IN FAMILY SUPPORT AND CARE

The significant changes in traditional family structures and roles have implications when planning policies for LTC for older people. There have been several useful anthropological and sociological studies in Sri Lanka of the dynamics of family relationships, care-giving, and inheritance (Watt and others, 2013; Thennakoon, 2014; Gamburd, 2015; Weerathunga, 2014a, 2014b; Rajan and others 2011). These explore how traditional beliefs and practices are being influenced by rapid socioeconomic changes, and it is important to consider their conclusions in predicting future needs for LTC and the policies that will be needed.

Weerathunga, analysed the patterns of wealth transfers, the different attitudes of the generations, and the impact of migration. Watt and others (2013) studied caregiving expectations and challenges in Southern Sri Lanka, and Gamburd (2015) undertook an anthropological study on the south-west coast in 2009 enquiring about migration and intergenerational family obligations. These studies all identify strong values around caring for older persons in the home, but identify challenges to this arrangement in the future.

SMALLER FAMILIES

Early reductions in fertility rates have resulted in smaller families with fewer adult siblings to care for ageing parents. Average household size decreased from 5.2 in 1981 to 3.9 in 2012, and this trend is likely to continue (Department of Census and Statistics, 2012c). Sri Lanka has the smallest average household size in South Asia, with smaller households in rural than in urban areas (De Silva, 2005).

WOMEN WORKING OUTSIDE THE HOME

High rates of school attendance for both girls and boys, modern influences, and economic pressures mean that more women are working outside the home. In 2007, the percentage of women who worked in the previous year was 17 per cent for those aged 15–19 and 53 per cent for women aged 40–44 (Department of Census and Statistics, 2009). Watt and others found that households where both the adult child and their spouse worked outside the home, households where older persons had a disproportionate amount of household work, and economically stressed households, faced the greatest challenges in caregiving (Watt and others, 2013). One expert interviewed raised the point that LTC policy needs to consider and address the particular issues of those whose work requires them to move frequently, such as government doctors, police and defence forces, who face particular difficulties in caring for older family members.
HIGH RATES OF MIGRATION

There are high rates of internal and overseas migration, and this is likely to continue; half of the youth in Sri Lanka say they would like to migrate to a developed country (De Silva, 2014). The majority of overseas migrant workers are in the 25–29 year age group and until the early 2000s most were women; the sex ratio is now more equal (Ministry of Foreign Employment Promotion and Welfare, 2013). Women commonly earn more than they could if they remained in Sri Lanka and send money home to the family. According to a study, villagers often believe that if a woman’s remittances support the whole family this overcame the migrant’s duty to care for a dependent family older person. People seem to look at the issue in terms of a network of family support, with changes in the economy leading to changes in traditional family roles and responsibilities. Some respondents noted that the care from a paid worker would not be the same as the care a family member would provide, and did not trust a paid worker in the same way as family. Some suggested that poor or unmarried relatives could care for older persons within the family, rather than a migrant woman giving up her job and her pay, but also noted that it is now difficult to find such relatives that are not already working. Even returning temporarily when an older person becomes sick is a problem because when a migrant worker breaks their contract to return home early they have to pay their airfare and the recruitment agency (Gamburd, 2015).

Migrant workers are important to the national economy; in 2010 remittances from overseas workers accounted for 49 per cent of export earnings (Ministry of Foreign Employment Promotion and Welfare, 2013). It is interesting that the 2013 national report on migration analyses the social implications of women migrating overseas for work, and discusses the impact on their children’s education and well-being, but does not mention the impact on older people in the family (Ministry of Foreign Employment Promotion and Welfare, 2013). This is likely to be considerable, both in terms of the child-care the older generation perform when the mother is missing, and the lack of care for dependent older women in the family. Gamburd concluded: “The reallocation of obligations is likely to cause tension, stress and conflict as family members work together to meet the challenges posed by an ageing population in a globalizing world.”

INTERGENERATIONAL RELATIONSHIPS

Watt and others found that both older persons and caregivers described a sense of duty and role modeling of parental caregiving that is passed down through generations (Watt and others, 2013). Older persons saw financial autonomy as important for maintaining the balance in their relationships and feared losing their independence, yet wanted to know that their children would support them. Weeratunga (2014b) found that many children who live with their parents receive some benefits from the parents, despite the commonly held belief that it is the parents who benefit through gaining access to care. She concludes from her research that “overall the changes in the family role and functioning have led to a reduction in the well-being of Sri Lankan older people. Moreover this gap has not been filled by pension and
social protection schemes in Sri Lanka, which remain limited. It is crucial that this area is addressed by policy makers and planners”.

As in many countries there is debate about the appropriate balance between families and the government in providing care and support. This is likely to continue to change and further social studies will be important to track and understand the changes and their effects.

SUPPORT FOR FAMILY CAREGIVERS

Family members who care for older relatives also need support and to have their rights protected (Muangpaisan and others, 2010). Wiener (2003) has usefully reviewed the evidence about the effects on the health and well-being of family caregivers. Most carers are women, but husbands and sons are sometimes caregivers and may face specific difficulties. Caregivers’ mental and physical health is often affected. They may become socially isolated, suffer stress, lack sleep, be exploited, lack privacy, and be unable to earn outside the home, or to save for their own old age. Health care providers may be reluctant to ask caregivers how they are coping because they feel helpless to change their situations (WHO, 2003). Their training should address this issue and the importance of providing support to caregivers. It is important that respite care is available, and that there is training, recognition and laws guaranteeing unpaid leave to provide care. As internet access becomes more common, even in poorer families, there is potential to provide support and information online.

3.2 Community–based care

THE ROLE OF COMMUNITY ORGANIZATIONS AND NGOS

Sri Lanka has several national NGOs, and international development NGOs also work in Sri Lanka. They could play valuable roles in advocating for LTC services, in coordinating delivery of community home care services, and in fostering inter-generational activities. Currently few of them include a focus on older people. HelpAge Sri Lanka, an affiliate of HelpAge International, has been advocating for the rights of older persons for many years and supports a range of activities (HelpAge International, 2010). HelpAge operates an eye hospital in Colombo providing free cataract surgery to older people and a dedicated training unit for caregivers. They also work with Elders’ Committees. Berendina is a national NGO that supports Elders’ Clubs, income-generating activities for older people, and a few Elders’ Homes. Sarvodaya Suwasetha Sewa Society maintains four homes for older persons. Some religious organizations such as the All Ceylon Buddhist Congress, Young Men’s Christian Association, and Young Men’s Muslim Association provide welfare services to older persons.
OLDER PERSONS’ COMMUNITY ORGANIZATIONS

Community organizations for older persons can contribute to LTC in a number of ways (Holmes and Joseph, 2011). Social participation helps to protect against chronic conditions, depression and loneliness (Holmes and Joseph, 2011; Malhotra, Chan and Ostbye, 2009). Older persons enjoy themselves together through dancing, playing music, reading poetry, drama and watching films. It is easier and more efficient for health and social welfare services to reach older persons when there is a common meeting place. Members give each other support when bereaved or in need. Income generation activities and savings schemes can reduce poverty, and older persons learn new skills. They are better able to participate in and contribute to their communities. Inter-generational activities can ensure that there is ‘someone for everyone’ by pairing young people with older people, with mutual benefits. Older persons could also organize themselves as volunteer carers to their peers and provide respite care to family caregivers. Groups of older persons could prepare meals for dependent older persons at a low cost as an income generating activity. Activities that help others have been associated with better cognitive function among older persons (Maselko, 2014). Older persons’ organizations provide greater visibility for older persons, a collective voice and opportunities to influence local government officials and politicians.

FIGURE 4. THE CLUSTER MODEL FOR ELDERS CLUBS AND COMMITTEES
The 2011 Amendment to the Protection of the Rights of Elders Act included the directive “to establish an Elders’ Committee in every GN Division, Divisional Secretary’s Divisions, Administrative District and Provincial Council area.” The NSE provides LKR 7,500 for each Divisional Level Elders’ Committee. However, progress is slow. In 2014, 1,000 GN Division Elders’ Committees were supported, amounting to 7 per cent of the country’s 14,151 GN Divisions (Ministry of Social Services, 2014).

NGOs, including PALM Foundation, HelpAge Sri Lanka, Berendina, and Sarvodaya have played a role in establishing community level older persons’ organizations. PALM Foundation, a local NGO in the hill country, has promoted a cluster model, in which the two leaders of each community Elders’ Club in a GN Division form the GN level Elders’ Committee. The median number of older persons in a GN Division is 142, which is a large number for a single Club, and older persons prefer a Club that is in their own village. The community level Elders’ Clubs link with existing Community Based Organizations, Shramadana Societies, Women’s Groups, Youth Clubs, temples and church groups, helping to ensure sustainability.

**DAY CARE SERVICES**

The NSE supports day care centres. They provide financial assistance of LKR 25,000 (USD$175) to each centre for the purchase of items such as furniture, crockery, and kitchen equipment. In 2014 the NSE supported 63 day centres (Ministry of Social Services, 2014). Some Provincial Councils also support day care centres.

HelpAge Sri Lanka and some small local charitable organizations, such as the Sri Lankadhara Society, run day care centres for older persons. They typically provide services for a small number of poor or destitute older persons in a single location.

Dr Shiromi Maduwage, of the MoH Youth, Elderly and Disabled Unit, explained that the Sri Lanka Standards Institute has developed standards that cover all older persons’ nursing homes, but there are not yet any standards for Day Care Centres. A strong regulatory framework with national guidelines and monitoring is needed to ensure that good quality services are provided. Day care centres need to be established across the country.

**THE ROLE OF THE PRIVATE SECTOR**

There has so far been relatively little recognition by the private sector of the opportunities that arise from the ageing of the population and the growing need for home care services (Dasanayaka, 2006). A study has analysed the products and services offered by Sri Lankan businesses and entrepreneurs to older people, and recommends policies and strategies for new innovative business thinking (Dasanayaka, 2006). The 2016 Budget speech included financial support for the establishment of new micro, small and medium enterprises. There should be encouragement for entrepreneurs to provide affordable home care services for older persons.
There is some private provision of home nursing care. The Sri Lanka Red Cross Society has a fee-paying service, Red Cross Home Nursing Pvt Ltd (Red Cross Home Nursing Care, 2014). This costs about LKR 1,000 (USD$10) per day. There are several private home nursing care agencies in Sri Lanka, which often have their offices in front of large hospitals. Some private residential care homes also provide a home care nursing service. Most of these are in or near Colombo.

One expert interviewed pointed out that the allied health professions of podiatry, occupational therapy, and physiotherapy are important for home care services for older persons, but outside Colombo the numbers are small.

### 3.3 Residential care

Currently only about 1 per cent of Sri Lankan older persons live in residential care. The Director of the National Secretariat for Elders reported that there are about 300 Elders’ Homes in the country with about 10,000 residents; most are in the Western and Southern Provinces, with few in the north, east or central highlands (Appendix 2). The number of Elders’ Homes are insufficient for current needs for residential care for destitute older persons and older persons who have no family to care for them.

**SUNDAY TIMES. “OLD, ABANDONED AND PENNILESS”. AUGUST 07, 2011**

‘Applications are pouring in at Elders’ Homes, and thousands of applicants are on a waiting list. The Little Sisters of the Poor, in Darley Road, Colombo 10, is a home for elders, run by nuns of the Roman Catholic Church. The home, which is managed almost entirely on charity, can accommodate up to a maximum 98 persons. “But we get more than 300 applications a year,” Sister Irene Bernadette, who is in charge of administration at the home, told the Sunday Times. “This is the case at all elders’ homes. Children of elderly persons plead with us to find accommodation for their parents, but we are helpless.”


**CHARITABLE RESIDENTIAL CARE FOR OLDER PERSONS**

Most residential care homes are run by local voluntary social service organizations, which are often faith-based. For example, the Sarvodaya Suwasetha organization maintains four residential nursing homes for ‘destitute and abandoned’ older persons and the Catholic Grace and Compassion Benedictines have three homes for ‘frail elderly’. Some seek contributions from donors, and receive alms donated on the anniversary of a loved one’s death. Two-thirds have 30 places or fewer, while 18 per cent have more than 50 places (World Bank, 2008.) Some are for women only. The Social Services Departments of Provincial Councils provide financial support and supervision. To apply for a place older persons or their family members make an application to their GN (local government official), which is then endorsed by the Divisional Secretary at the Divisional Secretariat. The management of the home keeps a waiting list.
Some of these Elders’ Homes do have fee-paying places. However, they may fear that they will lose their status as a charity if they charge for their services. Gamburd (2011) describes an underlying tension between ‘the need for shelter and the sense of shame’ after talking with older persons in a nursing home in the south. There is a strong class-related stigma associated with needing residential care. Poor older persons are seen as deserving of charity. She notes that the middle classes prefer to hire a servant to look after older persons at home. These attitudes are apparent in the descriptions at many of the Elders’ Home websites, such as: “Most of the people who living here are the innocent parents who has no protection and kindness from their children and relations.” and “They are from disadvantaged homes or rejected by their families and children or left destitute due to the death of husband or too poor and weak to look after themselves.”

**PRIVATE SECTOR RESIDENTIAL CARE**

There is a growing number of private fee-paying LTC residential homes in Sri Lanka (Appendix 3). Some are also aiming to attract older people from richer countries (Sirimanna, 2015). Most are in or near Colombo, and are small, caring for about 10–30 older persons. The cost of residential care is between LKR 25,000–50,000 (USD$ 176–352) per month, in addition to a non-refundable admission fee and a deposit. Most also provide respite care and post-hospital discharge care, and some will provide nursing care home visits or loan out commodes and mobility aids.
4 Workforce for community long-term care

There are several questions to consider in relation to which cadres of workers will provide different aspects of LTC. Is a new specialist cadre needed, or can LTC tasks be added to the position descriptions of existing cadres? What type and level of qualifications and training are needed for different tasks? How can LTC providers be supported and retained in rural, remote, and underserved areas?

It has been well recognized by some stakeholders that LTC will require well coordinated local teams of primary health care providers, working with Social Welfare Officers, Social Development Assistants, and Elders Rights’ Promotion Officers. In 2005 there were discussions about the need for an integrated response of the health care system to rapid population ageing (Perera, 2005). The report included a table showing how the staff of the different Ministries could be coordinated from national to community levels (Table 1).

<table>
<thead>
<tr>
<th>Level</th>
<th>Ministry of Health Preventive</th>
<th>Ministry of Health Curative</th>
<th>Ministry of Social Empowerment and Welfare</th>
<th>Ministry of Public Administration and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>Director, Youth, Elderly and Disabled Unit</td>
<td></td>
<td>Director, National Secretariat for Elders</td>
<td>Additional Secretary</td>
</tr>
<tr>
<td>Provincial</td>
<td>Provincial Director of Health Services</td>
<td>Provincial Director Social Services; District Medical Officer, Base Hospital</td>
<td>Provincial Secretary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provincial Director of Health Services</td>
<td>Medical Superintendent Provincial Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District</td>
<td>Deputy Prov Director Health Services</td>
<td>District Social Services Officer</td>
<td>District Secretary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>District public health staff</td>
<td>District Medical Officer, District Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divisional</td>
<td>Divisional Director of Health Services</td>
<td>Medical Officer Peripheral Unit</td>
<td>Elders Rights Protection Officers</td>
<td>Divisional Secretary</td>
</tr>
<tr>
<td></td>
<td>Medical Officer of Health</td>
<td>Medical Officer Rural Hospital</td>
<td>Social Welfare Officers</td>
<td>Samurhdi Niladari</td>
</tr>
<tr>
<td>Community</td>
<td>Public Health Nursing Sisters, Midwives and Inspectors</td>
<td>Medical Officer Central Dispensary</td>
<td>Grama Niladari</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health volunteers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Perera (2005)
Although the number of doctors and nurses has been increasing, Sri Lanka lacks sufficient doctors, nurses and allied health professionals, including physiotherapists, pharmacists, ophthalmic technologists and occupational therapists, to meet the growing need for LTC. Of countries in the region, Sri Lanka, has the highest rate of out-migration of doctors and the third highest of nurses (Ministry of Foreign Employment Promotion and Welfare, 2013).

As described above, the Shared Care Cluster System has been developed to improve the detection and management of chronic conditions. However, it does not address the issue of the need for LTC and home care visits. There are different views, yet no consensus, about which cadres of workers will visit older persons in need of home health care services, or coordinate a range of LTC services. One expert noted that this has been discussed since the late 1980s.

The following discussion explains the pros and cons of different cadres visiting older persons in need for home health care services.

**PUBLIC HEALTH MIDWIVES**

Public health midwives (PHMs) are the most numerous primary health care providers, tend to be recruited locally, and work closely with families through their home visits. They have an 18 months training programme, with 12 months in the nursing training school, and six months in the field and hospital wards. Each Community Health Unit has 20–25 PHMs, one or two Public Health Nursing Sisters, a few Supervising PHMs, a Supervising Public Health Inspector, and 5–6 Public Health Inspectors. Each PHM serves a defined population of 2000–4000. The number of PHMs per 100,000 population has grown little since 1980.
It has been noted that “The success of the Sri Lankan primary health care system lies in its ability to produce vital healthcare skills in rural areas whilst also retaining grass root level primary health workers in remote regions of the country. The system has contributed to the dramatic reductions in both child and maternal mortality in the country and has helped fill the gap that had existed in health care availability in rural areas” (De Silva, 2011). In addition to reproductive health services the PHMs are also involved in health promotion activities and educating the community regarding health and health related activities.

The chief arguments made against PHMs taking on a role in providing home nursing care for older persons is that they already have a heavy workload, and have not been trained in general nursing.

If PHMs are given this role it will be important to identify the various home nursing care tasks, such as counseling, preventing and managing chronic ulcers and wounds, falls prevention, rehabilitation after stroke, incontinence care, and management of medicines. Their job description will need to be modified, and a mechanism developed for referral for home nursing care from a physician. The training programme for PHMs will need to be substantially modified and in-service training organized for existing PHMs. The Divisional Directors of Health Services, Supervising PHMS and Public Health Nursing Sisters will also require in-service training for the role of supervision of home nursing care by PHMs, and collating data for monitoring quality of care and planning. Existing data will need to be analysed to estimate the need for older persons’ home nursing care and the associated time commitment required, in order to determine the appropriate number of households to be allocated to each PHM. The numbers of PHMs would need to be greatly expanded to cope with their new role.

Yet some key informants said that it has become increasingly difficult to recruit new PHMs. It is also important to consider gender. All PHMs are female. There are more older women than older men, and it is likely to be more important to older women than older men that the person providing home nursing care is of the same gender. Nevertheless, there may be some older men who would prefer to have nursing care of a personal nature provided by a man. A recent pilot study of introducing the new task of addressing intimate partner violence for PHMs was found to be effective and provides some useful lessons about introducing new roles for PHMs (Jayatilleke and others, 2015).

**COMMUNITY HEALTH NURSES**

Nurses in Sri Lanka are trained at one of the 12 government nursing schools for three years or have studied a BSc Nursing degree course. There are also some private nursing training institutes with courses of one to two years. Some nursing courses now include community health nursing and geriatric nursing.

At the Kotelawa Defence University the Faculty of Allied Health Services has a nursing training school where the curriculum includes a comprehensive Community Health Nursing module. However, although there have been some small community health nursing projects, larger scale implementation has not happened because of the great shortage of nurses in hospitals.
One expert suggested that the Angoda National Institute of Mental Health community care provides a useful model for LTC. There is a link in the field between the Medical Officer of Health (MOH), the Medical Officer of Mental Health, the Psychiatric Nurse, and the Occupational Therapist. With this model there would be one CHN per MOH area, working under the Public Health Nursing Sister.

Because they go from home to home, the PHMs could identify where there are older persons in need of LTC and tell the CHNs.

**ASSISTANT MEDICAL OFFICERS**

Historically, Assistant Medical Officers (AMOs) have played an important role in rural and peripheral health care. There are currently approximately 2,000 AMOs. Their training course was discontinued in 1995 (De Silva and others, 2013). AMOs with an AMO certificate need to complete eight years of service before being recognized and registered as a Registered Medical Officer with the Sri Lanka Medical Council. There has been controversy about the training and registration of this cadre of workers between the Sri Lanka Assistant Medical Officers and Registered Medical Officers Association, and the Government Medical Officers’ Association.

**ALLIED HEALTH PROFESSIONALS**

Experts emphasised the need for the allied health professions of physiotherapy, podiatry, and occupational therapy to be expanded and involved in the LTC system. There are 325 government physiotherapists in Sri Lanka and more are in private practice. There are degree courses in physiotherapy at the large universities and at several private training institutes, and a Higher National Diploma course at the School of Physiotherapy and Occupational Therapy affiliated to the National Hospital. Most physiotherapists work in hospitals and there is a lack of trained physiotherapists in the country (Ministry of Health, 2013). There is a Government Physiotherapists’ Association and the Sri Lanka Society of Physiotherapy. There needs to be a major increase in the number of physiotherapists working both in hospitals and at community level to meet the challenge of population ageing.

There is a three year diploma course for occupational therapists at a single School of Physical Therapy and Occupational Therapy in Colombo. There are 57 trained occupational therapists deployed in hospitals, but not at community level.

**VOLUNTEER CAREGIVERS**

The MoH Unit for Youth, Elderly and Disabled have begun a programme of short training courses for volunteer home-based attendants from the community who are attached to selected MOH areas. It is, reported that, a caregiver’s certificate is under consideration. A programme
is planned to train those over 55 as caregivers. Experts suggest that retired nurses and PHMs could become caregivers and use their knowledge.

COUNSELLING ASSISTANTS AND COUNSELLING OFFICERS

There are 96 Counseling Assistants (CAs) under the Ministry of Social Empowerment and Welfare and seven Counseling Officers (COs) of the (then) Ministry of Child Development and Women’s Affairs working across the country. There is potential for them to contribute to LTC. Their capacity and work has recently been reviewed by the Institute for Health Policy (Institute for Health Policy, 2013). Most of the CAs and COs are women. They serve an average population of 133,000 and encounter marital, family, educational and psychological problems. The CAs dealt with many serious psychosocial problems at community level and were committed to their own professional development and improving the services they provide.
5 Leadership, governance and coordination of long-term care

5.1 Role of government

The NSE plays an important role in leadership and governance in relation to LTC. Their mission is: “[t]o encourage participation of elder persons in social development and to ensure their independence, care, participation, self-fulfilment, dignity and to protect the rights of elders through awareness programmes”. Organizations and individuals providing services for older persons must register under the Protection of the Rights of the Elders Act with the NSE.

Under the 13th Amendment to the Constitution, Provincial Councils are tasked with maintaining welfare centres for older persons, providing grants to improve the quality of charitable homes for older persons and supporting Provincial level Elders’ Committees (Pathirana, 2014). There is a need for national standards for residential homes for older persons, and national care guidelines. The private health care sector is growing rapidly and there is a recognized need for greater regulation.

5.2 Coordinating mechanism

The excellent policies developed for healthy and active ageing and LTC cannot be implemented at scale in an equitable and efficient way without an independent coordinating mechanism. While some social services staff and health care staff often work well together at the divisional or district level, there are not yet standardized mechanisms in place for coordination of LTC for older persons (Perera, 2005).

Older persons may need regular medical care, regular nursing care, and regular daily life care, so it is important to be able to decide what mix of additional formal services is likely to yield the most benefit (Howse, 2007). Coordinating care has been shown to be beneficial in the UK, where care plans help prevent unnecessary hospital admissions, ensure there are links with long-term care services, and support people to remain at home (Patterson, 2014).

5.3 Long-term care information system

For coordination and to ensure good quality and equitable distribution, a strong LTC information system is needed at every level. Information is needed for evidence-based decisions from individual assessment and management of care needs to administrative decisions, planning, coordination and monitoring.

The Government Health Information System (HIS) in Sri Lanka is still predominantly paper based and manual from point of data capture to data transfer to the regional and central levels (Ministry
of Health, 2015). Data is analyzed at regional and national levels using computer based analytical tools and manual methods. Most private sector health data with the exception of data on immunization, notifiable diseases and maternal mortality, are not reported to the state. There is no formal system to capture health information from General Practitioners.

The MoH has a new HIS Policy, which identifies problems that would need to be addressed in an effective LTC information system. These include inadequate coordination among existing information systems, compartmentalization of the information governance mechanism, limited data sharing, moderate use of information for decision making and insufficient automation leading to relatively modest quality of health information. A new LTC information system would need to articulate with the MoH policy and with the Ministry of Social Services information system, but should be a function of an LTC coordinating mechanism.

It can be difficult when introducing new functions to existing workers to include additional record-keeping. For example, in introducing a new function for the PHMs (addressing intimate partner violence) they were not required to make records because the MOH did not wish to add more paperwork to the PHMs’ duties. However, evaluators observed that this might compromise programme effectiveness and make it difficult to evaluate the programme.

The parent-held child health record contributes to the child health information system. There have been several patient-held personal health records developed and piloted in Sri Lanka, for older persons, for NCDs, and for adults. None of these has yet been distributed nationally. A personal health record where the older person, caregivers, family members, health staff, and social welfare staff can all record their observations, would be of great benefit for LTC and the LTC information system.

**SOCIAL ACCOUNTABILITY**

Community-based monitoring of health care services has been found to be an effective strategy to increase accountability of health care services and could also be used for LTC services.

**THE UNION MOVEMENT**

The need to care for older persons also has major implications for labour laws. The Union movement in Sri Lanka has begun to take an interest in the needs and rights of workers to be able to take leave, not only when children are sick, but when they need to be at home with older relatives. This is particularly an issue of women’s rights. Unions could also advocate for the rights of domestic workers to avoid exploitation if they are expected to care for frail older persons. Unions could also include retired workers in their membership. Mr Bala Tampoe, the late Secretary General of the Ceylon Mercantile Union advocated for this nationally and internationally and used the memorable slogan ‘Elders of the world unite, you have nothing to lose but your pains’ (Cunningham, 2012). This advocacy work should continue at national, regional and international levels.
Enabling environments: Home modification and assistive technologies

The WHO Report on Ageing and Health explains that ‘even for people experiencing decline in capacity, supportive environments can ensure that they can still get where they need to go and do what they need to do. LTC and support can ensure that they live dignified lives with opportunities for continued personal growth” (WHO, 2015).

Assistive technologies (AT) are defined as “the application of organized knowledge and skills, procedures and systems related to provision of assistive products, whose primary purpose is to maintain or improve an individual’s functioning and independence, facilitate participation, and enhance overall well-being and quality of life” (WHO, 2014a). Home modifications, such as improved lighting, hand rails, and removal of obstacles, have been shown to have a large impact on preventing falls and increasing feelings of safety at home. There are technologies that can assist with walking, washing, and remembering to take medications. Basic assistive technologies include walkers, canes, crutches, latrine chairs, dosette medicine boxes, incontinence pants and pads, spectacles, magnifiers, hearing aids, artificial prostheses, and cervical collars. We should also think about access to communication through the internet as an assistive technology, because it facilitates connections with family members that are far away. AT for older persons in Sri Lanka has received some attention, but there is a need for a comprehensive, integrated health and social system approach to increase availability of AT (Marasinghe, Lapitan and Ross, 2015).

Because of the civil war many have lost limbs to mines or other injuries, so Sri Lanka has much experience in making and distributing prosthetic limbs and wheelchairs (Perera, P., 2014). There are several NGOs for the rehabilitation of disabled people. The Sri Lanka Foundation for the Rehabilitation of the Disabled advocates for the rights of disabled people and manufactures assistive technologies, including for older persons. The Colombo Friend In Need Society is the largest provider of artificial limbs in Sri Lanka. They tend to focus more on youth and children than older persons. There are also a few commercial companies that provide orthotic, prosthetic and assistive device services to the public. There is a professional society, the Sri Lanka Association for Prosthetics and Orthotics and a Sri Lanka school of prosthetics and orthotics, established in 2004 funded by the Nippon Foundation.

Affordable hearing aids are not widely available in Sri Lanka. In 2014 the NSE, planned to provide 55 hearing aids to older persons, but had provided only 32 up to September (Ministry of Social Services, 2014). One reason for this low take up is lack of awareness, but if awareness is raised it would be costly to meet the current and increasing needs of older persons.

There needs to be an expansion of the production and distribution of AT and a mechanism to ensure this. There is also scope to provide guidance for home-made AT devices and for older persons and family members to assess and modify their own domestic domains. More links
are needed between those providing assistive devices for the disabled and those working in provision of LTC for older persons (ESCAP, 1997).

Attention also needs to be paid to making environments in the public domain age-friendly, including temples, bus stands, hospitals and government offices. The Age-friendly Environments Programme is an international effort by WHO to address the environmental and social factors that contribute to active and healthy ageing in societies. Wellawaya in Uva province was registered in December 2012 as Sri Lanka’s first Age-Friendly City (Wickramasinghe, 2015). It is not only urban settings that can be made age-friendly; Elders’ Clubs and community organizations can assist in making their communities age-friendly. The traditional Sri Lankan ambalama, or wayside roofed resting place, can be thought of as an age-friendly feature.

IDENTITY CARDS FOR OLDER PERSONS

People over 60 years are eligible to apply for an Elders’ Identity Card from the GN, Divisional Secretariat or the NSE. This can be considered as part of an enabling environment. The cards provide priority for government and private sector services, ability to get additional interest for fixed deposits in the National Saving Bank, and a 5 per cent discount from National Pharmaceuticals Department when medicines are purchased. In 2014 the NSE distributed Identity Cards to 8,934 older persons. There is a need to train service providers and bus conductors in the meaning and benefits associated with the Elders’ Identity Card (Ministry of Social Services, 2014).

INFORMATION AND COMMUNICATION TECHNOLOGIES

New communication technologies have great scope for assisting in many aspects of the LTC system. A new study in European countries, the United States of America and Canada found that ICT-based services for informal carers and paid assistants improve the quality of life of older people and their carers and access to qualified care (Carretero, Stewart and Centeno, 2015). They also generate savings which contribute to the sustainability of the LTC systems. The International Data Corporation reported that at least one million of the population now have a mobile phone or other device, and 22 per cent had a smart phone in 2014 (International Data Corporation, 2015). In the Nuwara Eliya district community survey of 1,125 older persons in 2013, 25.8 per cent of the older persons said that they own a mobile phone; 77 per cent said they have access to a mobile phone. But only 1.4 per cent reported that they had ever used the internet.
7 Predicting need for long-term care in Sri Lanka

For planning purposes it is useful to be able to predict the numbers of older persons likely to need LTC services. There is no simple measure to estimate need for LTC. An older woman with low vision may need care if she is living with a frail husband, but not if she is living in a large household of family members who can help her.

FIGURE 6. FACTORS INFLUENCING DEMAND FOR LONG-TERM CARE SERVICES

One difficulty in predicting demand for LTC is that it is influenced by factors that are also changing rapidly. These include the pace of population ageing, especially among the oldest old, the sex ratio of the older population and their marital status, living arrangements, health and financial status, availability of family support, expectations of older persons and their families, and availability of services. The life history of each cohort of older persons will also affect need in old age. The current cohort of Sri Lankan older persons has benefitted from the progressive health and social welfare policies since Independence, but has also lived through a long civil war. There is great variation between countries in the proportion of older persons that depend on care.

Estimates are often based on assessing the proportion of older persons unable to perform ADLs, such as eating, bathing, getting in and out of bed and using a toilet, or IADLs, such as cooking, shopping, and housework (World Bank, 2015). However, the World Report on Ageing and Health makes the point that this approach results in underestimates of the numbers of older persons that could benefit from care and support (WHO, 2015).
WHO prepared country estimates for current and future LTC needs in 2002 based on changes in population size and structure, and the 1990 Global Burden of Disease estimates for disease and disability prevalence (WHO, 2002a). However, these estimates greatly depend on the weightings given to disabilities and these have changed over time with different methods used to determine the weightings, and there is debate about the meaning and validity of the methods (Nord, 2015). There is a useful discussion of the conceptual difficulties in measuring LTC needs in the WHO paper. The 2011 national census questionnaire included a question about disabilities:

**BOX 1: P14 PHYSICAL AND MENTAL DIFFICULTIES**

Inquire on difficulties in the domains Seeing, Hearing, Walking, Cognition, Selfcare, Communication and mark the correct answer. (1. No difficulty; 2. Difficult; 3. Not possible at all)

1. Seeing (even with the use of glasses if they are used)
2. Hearing (even with the use of hearing aids if they are used)
3. Walking a short distance or up/down about 12 steps in a stairway
4. Cognition (remembering and concentrating)
5. Day-to-day self-care such as getting dressed, washing etc
6. Communication in their own language due to physical or mental reasons

**FIGURE 7. PERCENTAGE OF OLDER PERSONS WITH EACH DISABILITY**

<table>
<thead>
<tr>
<th>Disability</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty seeing</td>
<td>21.8%</td>
</tr>
<tr>
<td>Difficulty hearing</td>
<td>19.4%</td>
</tr>
<tr>
<td>Difficulty walking</td>
<td>11.3%</td>
</tr>
<tr>
<td>Loss of cognitive ability</td>
<td>8.3%</td>
</tr>
<tr>
<td>Difficulty with self-care</td>
<td>4.8%</td>
</tr>
<tr>
<td>Difficulty talking</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

Source: Department of Census and Statistics (2012b)

If we apply the percentages in Figure 8 to the national census population estimates for these age groups for 2014, the total number of older persons of 60 years or over with at least one disability is 866,068 (although they will not all need LTC).
Responses to the census question about difficulty with ‘Day-to-day self-care such as getting dressed, washing etc.’ showed that about 5 per cent had some difficulty or were not able to do it at all. In the 2006 World Bank representative national survey 15 per cent of the sample had difficulty with at least one ADL (World Bank, 2008); in a 2013 community survey in Anuradhapura, 20 per cent (Rathnayake and Siop, 2015); and in the 2013 Nuwara Eliya district survey, 15 per cent (Burnet Institute and The Fred Hollows Foundation, 2013). The reasons for this difference between survey and census data require more analysis.

**FIGURE 8. PERCENTAGE OF OLDER PERSONS WITH AT LEAST ONE DISABILITY BY AGE GROUP AND SEX**

In Sri Lanka, as in other countries, the need for care and support tends to increase in older age groups, and women in the oldest age groups are more likely to need care services than older men of the same age (Leveille and others, 2000). In the 2006 national survey of ageing there was a decrease in prevalence of independence in ADLs, IADLs, and mobility with increasing age for both sexes. The prevalence of independence in ADLs, overall as well as for most individual components, was similar for men and women aged between 60 and 74, but men were more likely to remain independent in the older age groups, especially after age 85. Men were also much more likely to maintain mobility across all age groups (Ostbye, Malhotra and Chan, 2009).

The 2006 national survey found that 20.2 per cent of older persons were receiving support with activities of daily living, 13 per cent among those aged 60-69 and 46 per cent among those older than 80 years (World Bank, 2008). This suggests that about 489,300 older persons, nationally, would be receiving support with activities of daily living.

The proportion of older persons in the older age groups is also increasing in Sri Lanka. The rate of increase in the 70 and above age group is estimated to be about 4.2 per cent, higher than the rate of increase among those in the 60 – 70 age group of about 3.4 per cent (De Silva, 2007). The ‘oldest old’ group (80 and over) is increasing in size at a rate of 3.2 per cent. After 2021 there will be a great increase in the pace of increase in the oldest age group.
8 Reducing the need for long-term care

The aim of public health policies is not simply to increase life expectancy, but to increase the duration of old age that is lived in good health and free of disabilities (‘compression of morbidity’). For this both primary and secondary prevention are important. The prevalence of disability in old age depends on several factors, including the exposure to NCD risk factors of different cohorts of older persons, trends in age-specific disease prevalence rates, adoption of healthier behaviours, and the quality of health care, which may improve as countries develop economically, but may be ‘outrun’ by the pace of ageing. A recent review of longitudinal data concluded that there is a mixed picture in richer countries with less severe disability but more moderate disability, while the picture in low and middle income countries remains unclear (Chatterji and others, 2015). Rannan-Eliya notes that available evidence for Sri Lanka suggests that change in duration of old age lived in good health has not yet been achieved. He argues that the secondary prevention of complications of NCDs needs much more investment because declines in mortality and disability in developed countries have been driven by medical interventions for NCDs, especially heart disease (Rannan-Eliya, 2008). For this it is necessary both to increase detection, and to improve management.

Despite the high levels of family support in Sri Lanka it is obviously going to be difficult to cope with the increasing need for LTC for older persons. Wealthy countries like the UK and Australia are currently experiencing great difficulty in financing their LTC systems, and have had more time to adapt (O’Carroll, 2015). So it is important to invest in reducing the need for LTC, as well as developing and strengthening LTC systems.

Much has been done in Sri Lanka to promote healthy ageing throughout the life course. The impressive progress in MCH and occupational health should be celebrated as contributing to healthy ageing in later cohorts. But specific efforts are needed to ensure that health promotion efforts include those already over 60 years. Sri Lanka is also making public policy efforts to facilitate healthy lifestyle behaviour change such as increasing taxes on tobacco products and reducing sugar and salt in takeaway foods and drinks (Ministry of Health, 2009). The evidence base to inform prevention of NCDs and ageing-related health problems is increasing rapidly (Shrivastava and Misra, 2015).

Secondary prevention is also important. Type 2 diabetes is common among older people and often undetected. Diabetes has many complications that cause disability and reduce quality of life, including, vision impairment, impotence, and chronic ulcers. Even when people do know they have diabetes their diabetic control is poor (Amarasekara and others, 2014b). However, Jayasuriya and others were able to show that an intervention with trained nurses was able to reduce total energy intake and increase physical activity, with better glycaemic control than in the group receiving usual care (Jayasuriya and others, 2015). It is important that policies and protocols for community care and treatment of people with diabetes are culturally relevant and take into account traditional beliefs and practices of the different ethnic groups (Amarasekara and others, 2014a).
VISION IMPAIRMENT

Vision impairment is one of the most common causes of disability and dependency among older persons in Sri Lanka (Vision 2020 Secretariat, 2016). Refractive error and cataract can be treated effectively at low cost with distance and near vision spectacles and cataract surgery. However, there are high rates of untreated cataract and many older persons who need spectacles do not have them. It is important that detection and management of vision impairment and blindness is integrated with healthy ageing initiatives and responses to NCDs.

People with vision loss that cannot be treated need low vision services such as adapting their environment to make the best use of their existing vision, and low vision devices (such as magnifiers) (Berger and others, 2013). There is increasing recognition of the need to decentralize low vision services and adapt them to the needs of older people. The national Vision 2020 programme has built a strong Low Vision centre in Kandy for assessing patients, and providing tailored services. In Sri Lanka, barriers to the extension of low vision services include the lack of appropriately trained personnel to lead their development and introduce a training programme, and a lack of trained personnel.

FALLS PREVENTION

Falls are a common reason for needing LTC because they can result in injuries, fear of falling and reduced mobility (Stel and others, 2004). Older people should be screened for their risk of falling. Factors that increase risk include older age, poor cognitive function, poor balance and lower strength in the legs (Thanthrige, Dassanayake and Dissanayake, 2014). Encouraging physical activity, home assessment and modifications, screening and treatment for vision impairment, reviewing medicines, and preventing osteoporosis are interventions that will help to reduce falls (WHO, 2007).

RATIONAL PRESCRIBING, USE OF MEDICINES AND REGULATION

Many older persons taking long-term medication for chronic conditions need help to take their medication at the right time and at the right dose, to store their medicines appropriately at home, and to ensure that they have a regular supply without interruptions. Older persons often do not receive sufficient information about their medication (Perera and others, 2012). Many older persons are prescribed multiple medicines which may have interactions and side-effects. This increases the risk of falls, and may affect their functional ability. The College of General Practitioners could play a useful role in raising awareness among GPs of the importance of rational prescribing for older persons. However, in recent decades there has been limited regulation of the import, distribution, prescribing and dispensing of pharmaceuticals in Sri Lanka. In July 2015, the National Medicines Regulatory Authority was established after a long delay and is working to address these problems.
THE ROLE OF THE BUSINESS SECTOR

The ‘Silver Sustain’ programme of Velona Pty Ltd is a good example of how businesses can help to prevent the need for and support LTC (Threadworks, 2012). The CEO of this textiles company, aims to ‘ensure that our policies and procedures do not discriminate based on age or gender’ and has developed a system of retaining workers over the retirement age. They have flexible policies that enable those who have to care for older family members to be able to take time off when needed. They encourage older workers not to retire and offer shorter working hours, training and professional development. They recognize that most older workers require better lighting conditions, flexible work and less strenuous roles, and restructure roles as needed. This initiative is worth publicizing. The International Labour Organization developed an international labour standard on older workers in 1980, and have a number of relevant publications at their website (ILO, 1980 and ILO, 2011).
9 Financing for long-term care

The subject of financing mechanisms for LTC is complex. It includes financing support for social care, health care services and daily life care, and needs to take into account pension and social transfer policies to ensure a basic income. Sri Lanka does not currently have a separate financing mechanism for long-term care.

In Sri Lanka it is currently expected, by both the people and their Government, that most of the cost of LTC will be borne by older persons and their family members. There are several reasons why lessons about funding LTC from developed countries may not be relevant to low and middle income countries (Howse, 2007). Financing of LTC needs to take into account both questions of allocative efficiency as well as questions of justice (Howse, 2007).

Both health sector and social services budget allocations will need to increase over time to cope with increasing demand for LTC. A coordinating and monitoring mechanism must also be funded. Advocacy with the Finance Ministry is important and the need for increased allocations should be framed as a cost-effective investment, because availability of good quality LTC will reduce the impact on the economy and health care services of population ageing. Muiser and others present a framework and explore how the financing functions of collection, pooling, and purchasing can support the development of LTC systems based on actual need (Muiser and Carrin, 2007).

Historically, Sri Lanka has been able to provide a wider range of health services with better outcomes at a lower cost than the World Bank has said is possible (Jayasinghe, 1998). However, with population ageing, more costly treatment options becoming available, and raised expectations, there will need to be greater investment in the health sector (Withanachchi and Uchida, 2006). One expert has said that we should change the familiar primary health care advocacy slogan ‘Health for all at low cost’ to ‘Health for all at medium cost’. Real growth in health expenditure averaged 5 per cent between 1991 and 2012. The Government announced in the 2015 budget that it will increase its spending on healthcare from 1.4 per cent of GDP to around 3 per cent, recognizing the challenges of population ageing and the epidemic of NCDs.

Table 2 gives a picture of indicators of spending on health, compared with other countries in South Asia, countries in South East Asia with similar GDP, and a high income country, Australia, showing that Sri Lanka’s Government expenditure on health is higher than in some comparable countries, such as Indonesia, but lower than Thailand’s, which prides itself of having achieved universal access to healthcare.
<table>
<thead>
<tr>
<th>Country</th>
<th>GNI per capita (PPP) 2014*, USD$</th>
<th>Total health expenditure per capita, (PPP), USD$</th>
<th>Total govt health expenditure per capita (PPP), USD$</th>
<th>Total expenditure on health as a percentage of GDP</th>
<th>General govt expenditure on health as a percentage of total expenditure on health</th>
<th>General govt expenditure on health as a percentage of total govt expenditure</th>
<th>Out-of-pocket expenditure as a percentage of total expenditure on health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>10,770</td>
<td>304</td>
<td>134</td>
<td>3.2</td>
<td>43.9</td>
<td>7.4</td>
<td>46.5</td>
</tr>
<tr>
<td>India</td>
<td>5,640</td>
<td>215</td>
<td>69</td>
<td>4</td>
<td>32.2</td>
<td>4.5</td>
<td>58.2</td>
</tr>
<tr>
<td>Pakistan</td>
<td>5,110</td>
<td>126</td>
<td>46</td>
<td>2.8</td>
<td>36.8</td>
<td>4.7</td>
<td>54.9</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>3,330</td>
<td>95</td>
<td>34</td>
<td>3.7</td>
<td>35.3</td>
<td>7.8</td>
<td>60.2</td>
</tr>
<tr>
<td>Nepal</td>
<td>2,420</td>
<td>135</td>
<td>58</td>
<td>6</td>
<td>43.3</td>
<td>11.9</td>
<td>46.2</td>
</tr>
<tr>
<td>Indonesia</td>
<td>10,190</td>
<td>293</td>
<td>114</td>
<td>3.1</td>
<td>39</td>
<td>6.6</td>
<td>45.8</td>
</tr>
<tr>
<td>Thailand</td>
<td>13,840</td>
<td>658</td>
<td>527</td>
<td>4.6</td>
<td>80.1</td>
<td>17</td>
<td>11.3</td>
</tr>
<tr>
<td>Malaysia</td>
<td>24,080</td>
<td>938</td>
<td>514</td>
<td>4</td>
<td>54.8</td>
<td>5.9</td>
<td>36.1</td>
</tr>
<tr>
<td>Australia</td>
<td>42,880</td>
<td>4,191</td>
<td>2,792</td>
<td>9.4</td>
<td>66.6</td>
<td>18.7</td>
<td>19.1</td>
</tr>
</tbody>
</table>


There is limited financing by insurance (2 per cent) and employer schemes (5 per cent of total financing). Private sector financing of health expenditure is dominated by household spending. This ranged from 81 to 88 per cent during the 1990 to 2012 period, while employer sponsored insurance made the next largest contribution (ranging from 5 to 7 per cent). Expenditure on inpatient care has increased over time from 20 to 31 per cent, while outpatient care spending has fallen from 24 to 21 per cent. Spending on prevention fell from 8 to 5 per cent. There has been a trend of an increasing share of health expenditure going to hospitals in recent years, while spending on ambulatory care has decreased (Amarasinghe and others, 2014).

The Institute of Health Policy in Colombo has experience and expertise in health economics and has recently signed a Memorandum of Understanding with the MoH. This might facilitate analysis and recommendations for effective and equitable financing mechanisms for an LTC system.
10 Conclusions

Sri Lanka has much to share with other countries in the region about policy development in relation to LTC for the rapidly ageing population. Policy development and planning on this topic has been inclusive and wide-ranging, with recognition of the central importance of a multi-sectoral approach. The policies and plans are based on values of equity and protection of rights. There have been genuine consultations with a wide range of stakeholders. The WHO country office has been supportive. The process has been useful for networking and raising awareness. There are good relationships between NGOs, especially HelpAge Sri Lanka, government officials, and health professionals. There are new guidelines being developed, communication materials, and training programmes for doctors, community health nurses, social services staff, and local government officials. A multi-level Elders’ Committee structure has been designed that will facilitate representation by older persons.

But it is also important to acknowledge lessons for the implementation of challenges and gaps. Because a large number of sectors, institutions and stakeholders need to play a role in LTC, and they are answerable to different authorities, an effective, intersectoral, coordinating mechanism is essential. It is also vital to have a mechanism for reaching outwards, to inform and help Government, civil society and the business sector to think through the implications of ageing for their work. All can contribute to achieving equitable availability of affordable LTC and support to dependent older persons.

In 2002 a WHO report ‘Long-term care in developing countries: ten case studies’ reported that ‘Sri Lanka is at the very initial stages of developing LTC services’ (WHO, 2004). There has been a great deal of work since then, but the country is still in the early stages of reforming the health care system from one that responds predominantly to acute illness episodes and MCH needs to one that is able to support self-management of chronic conditions, prevent NCDs, and provide integrated LTC services. WHO acknowledges that the necessary changes take years to implement (WHO, 2002b). It takes time for a big ship to change direction. Organizational structures and systems have evolved over decades, and the system is stretched, so there is a lack of time to devote to planning and implementing the reforms that are necessary. The success of the existing primary health care system may paradoxically contribute to reluctance to change. But Sri Lanka is better placed than many countries at similar levels of economic development because it already has strong government-funded health infrastructure and systems.

The unusually rapid demographic transition has wide implications for the nation’s economic development. Investment in an effective, well-coordinated LTC system will help to minimize the range of impacts. It is a feature of the Sri Lankan economy that foreign exchange is disproportionately earned by women as migrant domestic staff, tea pickers, in textile factories, and in tourism. Working women will have additional pressures of caring for older persons within the family and many will no longer be able to earn outside the home. A good under-
standing of the opportunities and challenges of the demographic transition is important for the Finance Ministry.

Older people are forming an increasing proportion of the electorate so are becoming an important constituency for politicians. Elders’ Clubs and Committees facilitate representation of their collective voice.

There have been many champions for enabling healthy and active ageing from many backgrounds. These have included champions within the Ministries of Health and of Social Services, among demographers, social scientists, community health physicians, health economists, clinicians, civil society, and business people. There has been a growing output of multi-disciplinary ageing-related research in Sri Lanka. But many of the researchers are not yet aware of each other’s work. There is now a rich and valuable evidence base to inform not just planning, but implementation. There is a need for a new mechanism to maximize the value of the existing research data, to identify priorities for future research and funding opportunities, and to bring researchers together from different disciplines and subject areas.

Reforming health and social welfare systems to deal with the very different health and social care problems of ageing is a major challenge and will not happen rapidly. Developed countries such as the United Kingdom of Great Britain and Northern Ireland and Australia are facing enormous difficulties in providing good quality LTC to dependent older persons, and they have had longer to prepare because of their slower pace of ageing.

Finally, it is important to note that the demographic trends that will affect the lives of all age groups in Sri Lanka are happening at the same time as climate change. Planning for LTC for older persons needs to take into account these effects, which tend to affect the most vulnerable in society, including older persons, most severely.
APPENDIX 1. INDIVIDUALS CONSULTED

SRI LANKA MINISTRY OF HEALTH

Dr Susie Perera, Director, Organization Development, and Director Policy Analysis and Development, Ministry of Health, Sri Lanka
Dr Shiromi Maduwage, Consultant Community Physician, Ministry of Health
Dr Thilak Siriwardana, Director, Non Communicable Diseases Unit.
Dr Saman Senanayake, National Focal Point for Low Vision services

SRI LANKA MINISTRY OF SOCIAL EMPOWERMENT AND WELFARE

Mr Singapulli, Director, National Secretariat for Elders, Ministry of Social Empowerment and Welfare
Mr Priyantha, District Social Services Officer, Nuwara Eliya

WHO COUNTRY OFFICE

Dr Thushara Ranasinghe, WHO Country Office
Dr Lanka Jayasuriya-Dissanayake, NCD Officer, WHO Country Office

CIVIL SOCIETY AND POLICY INSTITUTES

Mr Samantha Liyanage, Director, HelpAge Sri Lanka
Ms Annie Kurian, Director, Centre for Social Concerns Elders Advisory Group, Better Vision Healthy Ageing Programme.

RESEARCHERS AND ACADEMICS

Dr Aindralal Balasuriya, Medical Faculty, General Sir John Kotelawala Defence University
Professor Saroj Jayasinghe, University of Colombo
Dr Achala Balasuriya, Secretary, Sri Lanka Medical Association of Geriatrics
Professor Lakshmann Dissanayake, Department of Demography, University of Colombo.

PRIVATE SECTOR

Mr Gehad de Zoysa, CEO, Threadworks Ltd (Silver Sustain programme)
Mr Tilak De Zoysa, Businessman; Chairman, HelpAge Sri Lanka
APPENDIX 2. CHARITABLE RESIDENTIAL CARE FOR OLDER PERSONS

WESTERN PROVINCE
There are 117 homes for older persons in the Western Province.

COLOMBO DISTRICT
Srilankadhrara (20 older women), Colombo 6 (also have 8 fee paying, low cost rooms)
Grace Perera Home For Elders, Dehiwala, Colombo
The Rani Violet Elders Home, Moratuwa (26 elders)
Wellawatte Methodist Church Elders’ Home, Wellawatte, Colombo
Mrs Eric Brohier Memorial Home, Welawatte, Colombo
Moratumulla Methodist Church Elders’ Home, Colombo
Rajagiriya Elders Home & Iris Perera Home, Salvation Army, Rajagiriya
All Island Buddhist Association Elders Home, Homagama, Colombo
Sahana Udaya Elders Retreat Home, Sahanoda Foundation, Dehiwala, Colombo
St Francis Home for the Aged, Pamunugama, Negombo
St Jude Elder Care Home, Negombo
St Nicholas’ Home, managed by the Dutch Burgher Union, Dehiwala
St Mary’s Home for the Elderly, Maradana (98 elders)
Good Shepherd Convent Elders Home, Mabole, Wattala
Society of St Vincent de Paul Friendship House, Thalawathugoda Road, Maduwela
Elders Welfare Society, Koralaima
Janadara Elders Society, Moratuwa
Sri Sathya Sai Home for Elders, Watereke, Meegoda
Lady Fareed Home for Elders, Makola
Sanhinda Elders’ Home, Pita Kotte
Little Sisters of the Poor Elders’ Home, Maradana, Colombo
Catholic Social Welfare Homes:
Shanthi Nivasa, 81, St. John’s Way, Colombo 15
Home for the Aged, 46/5A, Puwakkotawa Road, Nayakanka
Home for Elders, Pelawatte, Battaramulla
Home for Elders, Christu Sevana, Ratmalana
Home for Elders, 204, T.B. Jaya Mawatha, Colombo 10
St. Martin’s Home for Elders, Thimbirigasyaya
Home for Elders, Tammita, Negombo
Home of Compassion, Madampitiya, Colombo 14
St. Albert Elders’ Home, Beruwala
Marian Home, Dehiwala
St. Joseph’s House for Elders (The Lawn), Ja-Ela
St. Vincent’s Elders’ Home Nagoda, Kandana
St. Joseph’s Home for Elders, Kotte
Maison Srimathi Indrani-Greyline Marco Home “Sarasum Cottage”, Nayakakanda
Clive de Mel Memorial Home, Piyagala
St. Joseph’s Home, Madapatha, Piliyandala
Home for Elders, Tammita
St. Anne’s Elders’ Home, Wadduwa
Elders’ Home, Pitiropa
St Martin’s home for elders, Kotugoda, Colombo (32 elders over 70 years of age)

KALUTARA DISTRICT
Sujatha Elders’ Home (145 residents at 3 sites), Kalutara
Blessed Joseph Vaz Home (Home for Elders), Nagoda, Kalutara
Marcsri Homes, Kalutara, (Catholic Social Welfare Home)
Sri Lanka, Marcsri Sarana Seva Nivahana, Kalutara, (Catholic Social Welfare Home)
Madupitiya Yasurisu Elders Foundation, Panadura

GAMPAPA DISTRICT
Senehewathi Maatha Elder’s Home, Gampaha
Nimala Maria Elders’ Home, Divulapitiya (Catholic Social Welfare Home)
Sethjeeana State Elders Home, Meerigama

SOUTHERN PROVINCE

GALLE DISTRICT
Wijayarathana Elders’ Home, Rathgama
Muhandiram D.F. Perera Abayasiriwardana Elders’ Home, Mohottivaththa, Balapitiya
D.J. Chandradasa Elders’ Home, Batapola
Amarasheela Elders’ Home, Aluthwala, Ambalangoda
Warusavithana Elders’ Home, Polwaththa, Ambalangoda.
Abesekara Elders’ Home, Elpitiya
Bhikshu Wiwekaramaya Elders Home, Keembeala, Baddegama.
Bonawista Elders’ Home, Rumassala, Unawatuna.
Venrith Elders’ Home, Kaliwella, Galle.
Dharmaraja Elders’ Home, Heenatigala, Thalpe.
Samarasinghe Elders’ Home, Piyadigama, Ginthota.
E. Francis de Silva Elders’ Home, Akkara 20, Pinkanda, Dodanduwa.
Somasiri Jinadasa Elders’ Home, Nalagasdeniya, Hikkaduwa.
Pilana Elders’ Home, Pilan Junction, Pilana.
H. Wimalasena de Soysa Elders’ Home, Balapitiya
Senehasa Elders’ Home, Lokurugoda, Baddegama.
Sri Somadevi Elders’ Home, Kurunduwaththa, Ginthota.
Sujatha Elders’ Home, Nugaudamulla, Kudaudaga-ha, Uragaha.
Sugatha Elders’ Home, Sinharupagama, Balapitiya.
Mishanary Of Therapy, Apeksha Niwasa, Kapuhenwila, Akmeemana
Gaminini Suwasetha Elders’ Home, Andurathwila, Baddegama
Sugatha Elders’ Home, Dedduwa, Haburugala.

MATARA DISTRICT
Thihagoda Elders’ Home, Thihagoda.
Karunaratne Elders’ Home, Karaputugala
Dasa Elders’ Home, Thalalla, Gandara.
Sambodhi Elders’ Home, Wehalla, Dikwella
Aryadasa Elders’ Home, Denuwala, Weligama
Siri Sumanarama Bhikshu Wiwekaramaya, Godauwa, Kottagoda.
Bandara Elders’ Home, Seenipalla, Mulatiyana.
Suwa Sewana Elders’ Home, Walpala, Mathara
Sambodhi Elders’ Home, Pallegama
Devid Jayasundara Elders’ Home, Kapugama, Dewinuwara.
Kantha Surakime Padanama, Malana, Kamburupitiya.

HAMBANTOTA DISTRICT
Rathnayaka Elders’ Home, Bemiaththa, Ethalabeligalla, Beligalla
Sarana Anda Elders’ Home, Dehigahalanda, Ambalangoda.
Mapiya Sewana Elders’ Home, Paramipura, Angunukolapelessa
Liyanaparthiran Elders’ Home, Katurwana
Kusuma Menikpura Elders’ Home, Sooriyawewa
Meththa Nissaranas Elders’ Home, Manajawa, Ambalangoda.

CENTRAL PROVINCE
KANDY DISTRICT
Nikaketiya Elders’ Home, Menikhinna, Kandy
Phimbyahena Elders’ Home, Peradeniya, Sri Lanka
Bopitiya Elders’ Home, Marassana, Kandy
Shamrock Elders’ Home, Nawalapitiya,
Kotikaamba Elders’ Home, Hatharaliyadda,
Godahena Elders’ Home, Dolapithila
Udunuwara Elders’ Home, Gelioya
Mulgampola Elders’ Home, Mulgampola, Kandy
Ambipitya Elders’ Home, Ambipitya,
Mawilmada Saranasewana Elders’ home, Mawilmada, Kandy,
Mahaiyawa Elders’ Home, Mahaiyawa Kandy
Friend In need Society Elders’ Home, Kandy

MATALE DISTRICT
Imbulandanda Elders’ Home, Dumkolawatta, Matale,
L. Warnakulasooriya Elders’ Home, Madawela Ulpatha
Rangiri Dambulu Elders’ Home, Dambulla

NUWARA ELIYA DISTRICT
Chandra Wijerathne Elders’ Home Widulipura,
Hatton Weera Elders’ Home, Hatton,
LONG-TERM CARE FOR OLDER PERSONS IN SRI LANKA

EASTERN PROVINCE

AMARAPURA DISTRICT
Sarana Elders’ Home, Sanundupura, Dehiyaththakandiyaya

BATTICALOA DISTRICT
St. Joseph Elders’ Home, Batticaloa
Nawajothi Elders’ Home, Kaulwanchikudy, Batticaloa
Kattankudy Muslim Elders’ Home, Kattankudy, Batticaloa
Vipulananda Elders Home, Kallady, Batticaloa
Nandavanam Elders Home, Batticaloa

TRINCOMALEE DISTRICT
St. Joseph Elders Home, Uppuveli, Trincomalee

NORTHERN PROVINCE
Siva Poomi Elders Home, Chullipuram, Jaffna (50 elders)
Puttur Methodist Church Elders’ Home, Puttur.
Paramananda Elders Home, Jaffna
Santhom Elders Home, Mannar

NORTH WESTERN PROVINCE
Widyabandu Elders Home, Kirimetiya
D.M. De Silva Memorial Elders Home, Madampe
St. Jhosape Elders Home, Lansigama
Nanda Rajapaksha Elders Home, Mahawewa
Wedihiiti Sarana Padanama, Polpithigama
Suwasewana Elders Home, Minhettiya
Nanda Jayasinghe Elders Home, Othuwvela
Asarana Sarana Elders Home, Ambakote
Dingiri Amma Elders Home, Kobbewehera
J.L. Sirisena Elders Home, Dummalasuriya
Asarana Sarana Elder Home, Makalanegama
Malkanthi Elders Home, Polgahawela
Mee Murthha Elders Home, Yaddigama
Seelawathi Elders Home - Kalugamuwaha
Sirisena Subasinghe Memorial Elders Home, Sandalankawa
Muhandiram Sende Piyasa Elders Home, Giribawa
Reverent Kabalewa Piyabarat Anunahimi
Memorial Elders Home, Gaiyala
C.A. Rathnayaka Memorial Suwasewana Elders Home, Kuliapitiya
Mallawapitiya Elders Home, Mallawapitiya
Sarana Elders Home, Weerapokuna
Nenaruwan Wisum Sewana Elders Home, Rasnayakapura
Jayamanna Memorial Elders Home, Kuliapitiya
Rathanapiyasa Elders Home, Hanhamuna
Neel Hemantha Elders Home, Udubaddawa
Kabalewa Piyabarathi Anu Nahimi Elders Home
Sabaragamuwa province
Home for Elders, Nelundeniya, Warakapola
Wickramasinghe Memorial Home for Elders, Kegalle
Mawpiya Sewana Elders Home, Meepagama, Kalawana
Anomadassi Elders Home, Mawanella

UVA PROVINCE
Amunudowa Lions Club Elders’ Home, Uva
Kailagoda elders’ home, Badulla.
Rideepana elders’ home, Badulla.
Sambodhi elders’ home, Dodamwagawa, Rideemaliyadda, Badulla
Sri Sambodhi Elders Home, Monaragala
Plisarana elders’ home, Moneragala
Kataragama elders’ home, Kataragama.
Sanasuma retired senior citizens’ home, Rideepana, Badulla.
Methodist Church Elders’ Home, Badulla
APPENDIX 3. PRIVATE RESIDENTIAL CARE FOR OLDER PERSONS

Suwasaviya Nursing Home, Horana, Kalutara District, Western Province. A ‘luxury care home’ that offers apartments for long-term care for 12 older persons. Services include respite care, nursing care, physiotherapy, a regular medical clinic, with a doctor on call, and gardens for residents.

Royal Nursing Home, Maharagama, Colombo. Provides long-term residential care, respite care, post-hospital discharge care, and a home nursing service.

Windsor Gardens Nursing Home and Age Care Home, Colombo 5 and Colombo 7 provides long-term residential care.

Rivendale Resort, Assisted Living and Retirement Home, village of Thuduwa, south of Colombo 24 hour basic nursing care. Long-term residential care and respite care.

Cinnamon Care Services Pvt Ltd, Bandaragama, south of Colombo. Offers residential care, respite care, short-term stays and home care services.

Priya Jeewaka care resort, Battaramulla, Colombo. Provides long stay, short stay, convalescence and respite care residential care, with optional nursing care.

Village 60 Plus Pvt Ltd. Four care homes in and around Colombo including a luxury retirement village. Provides day care facilities, and short or long-term residential care.

Happy Heart, Elder Care Home, Mattegoda, Colombo. Provides residential care.

Retirement resort (Pvt) Ltd Negombo, Western Province

Sethma home for the elderly, Kottawa

Certis Lanka Home Nursing & Swift Care (Pvt) Ltd, Colombo 5. Provides home visits by nurse aides through five branches across the country, and mobility aids and commodes.

House of Happiness, Mount Lavinia (8 – 12 older persons at two sites).

Solace Nursing and Rehabilitation Home, Negombo.
References


