

**CASE-STUDY**

**SRI LANKA**

**Palitha Abeykoon**

**Sri Lanka**

## LONG-TERM CARE

## 1

**CASE-STUDY: SRI LANKA**  
*Palitha Abeykoon***1 General background data****1.1 Preamble**

Sri Lanka is an island of approximately 62 000 square kilometres, situated in the Indian Ocean off the southern tip of India. Administratively, the country is divided into eight provinces, 25 districts and over 300 Divisional Secretariat areas.

The country has a parliamentary system of government, with the elected Parliament responsible for legislative functions, and the Cabinet of Ministers, presided over by the Executive President, vested with executive powers. The provinces have their own provincial councils, headed by a governor, and elected representatives.

The population at mid-year 2000 was estimated by the Registrar General at approximately 19 million. One of the most visible features of Sri Lanka's age structure is the increasing proportion of older age groups.

As an indicator of the ageing of the population, the percentage of Sri Lankans over the age of 65 has increased markedly over the last 25 years and is expected to increase from 6.3% to 12.3% in the next 25 years. Correspondingly, there has been a dramatic increase in the prevalence of noncommunicable diseases in the population and, consequently, an increase in the need for long-term care.

Increased hospitalization for diseases such as neoplasms and diseases of the respiratory, genito-urinary, neurological, and digestive systems are indicative of these trends. The number of patients seeking treatment for mental disorders has also increased over the years.

A dramatic increase in hospitalization for diabetes mellitus can be attributed to urbanization, lifestyle changes, and the ageing of the population. In addition to the increase in hospitalizations for these noncommunicable diseases, there has been a substantial increase in hospitalization for poisoning and injury.

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At the same time that the noncommunicable disease burden is increasing in Sri Lanka, the country is still facing problems of malnutrition among children, a moderate communicable disease burden, and poverty. The demographic and health survey conducted in 1993 found that 23.7% of children suffer from malnutrition, 15.5% are acutely undernourished, and 37.6% are underweight.

Sri Lanka has done reasonably well in reducing poverty and maintaining low levels of income inequality over the years. However, poverty is still a concern, with an estimated one-quarter of the population living below the poverty line. The under-5 mortality rate for males was 24 per 1000 live births in the year 2000. Although this is a not high rate relative to Sri Lanka's low per-capita income, it does demonstrate that communicable diseases are still an issue in Sri Lanka.

Due to the ageing of the population and the increasing noncommunicable disease burden, Sri Lanka will witness an increase in long-term care needs in the future. It is clear that policy-makers in Sri Lanka will have to plan carefully for future health and social services, in order to provide enough resources for LTC – together with malnutrition, a moderate communicable disease burden, and limited resources

Presented on the following pages are background data concerning Sri Lanka, derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

This chapter will then describe the health and social service system of Sri Lanka, focusing special attention on describing both the current and future needs for LTC and the existing LTC services. Additionally, some suggestions will be made as to how policy-planners should develop LTC in Sri Lanka.

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<sup>1</sup> For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); UNDP, Human Development Report 2001; US Government. The World Factbook 2002; WHO, World Health Report 2002; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.

## 1.2 Background data from International Data Bases

| <i>Demography (Year 2000)</i>               |        |
|---------------------------------------------|--------|
| <b>Population</b> (thousands)               | 18 924 |
| <b>Land area</b> (sq km)                    | 65 610 |
| <b>Population density</b> (per sq km)       | 288    |
| <b>Population growth rate</b> (% 2000-2005) | 0.94   |
| <b>Urban population</b> (%)                 | 23.6   |
| <b>Ethnic groups</b> (%)                    |        |
| Sinhalese                                   | 74     |
| Tamil                                       | 18     |
| Moor                                        | 7      |
| Borgher, Malay, and Vedda                   | 1      |
| <b>Religions</b> (% 1999)                   |        |
| Buddhist                                    | 70     |
| Hindu                                       | 15     |
| Christian                                   | 8      |
| Muslim                                      | 7      |
| <b>Total adult literacy rate</b> (1997)     | 91.4   |
| <b>Age Structure</b> (%):                   |        |
| 0-14                                        | 8.2    |
| 15-24                                       | 19.2   |
| 60+                                         | 9.3    |
| 65+                                         | 6.3    |
| 80+                                         | 0.8    |
| <b>Projections 65+</b> (%)                  |        |
| 2025                                        | 12.3   |
| 2050                                        | 21.3   |

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**Demography (continued)**

**Sex ratio** (males per 100 females):

|                  |      |
|------------------|------|
| Total population | 0.97 |
| 15-64            | 0.95 |
| 65+              | 0.91 |

**Dependency Ratio:**

|                                               |      |
|-----------------------------------------------|------|
| Elderly dependency ratio in 2000 <sup>2</sup> | 10.9 |
| Elderly dependency ratio in 2025              | 20.4 |
| Parent support ratio in 2000 <sup>3</sup>     | 7.2  |
| Parent support ratio in 2025                  | 10.9 |

**Vital statistics and epidemiology (Year 2000)**

|                                                                 |      |
|-----------------------------------------------------------------|------|
| <b>Crude birth rate</b> (per 1,000 population)                  | 17.3 |
| <b>Crude death rate</b> (per 1,000 population)                  | 6.3  |
| <b>Mortality under age 5</b> (per 1,000 births)                 |      |
| males                                                           | 24   |
| females                                                         | 17   |
| <b>Probability of dying between 15-59</b> (per 1,000)           |      |
| males                                                           | 224  |
| females                                                         | 124  |
| <b>Maternal mortality rate</b> (per 100,000 live births) (1995) | 60   |
| <b>Total fertility rate</b> (children born/woman)               | 2.09 |

<sup>2</sup> Elderly dependency ratio: the ratio of those age 65 and over per 100 persons aged 20–64.

<sup>3</sup> Parent support ratio: the ratio of those age 80 and over per 100 persons aged 50–64.

### ***Vital statistics and epidemiology (continued)***

#### ***Estimated number of adults***

***living with HIV/AIDS*** (2001) 4700

***HIV/AIDS adult prevalence rate*** (%) <0.1

#### ***Estimated number of children***

***living with HIV/AIDS*** (2001) <100

#### ***Estimated number of deaths***

***due to AIDS*** (2001) <100

#### ***Life expectancy at birth*** (years)(2001)

Total population 73

Male 70

Female 76

#### ***Life expectancy at 60*** (years)(2000)

Total population 18.5

Male 17.0

Female 20.0

#### ***Healthy life expectancy (HALE) at birth*** (years)(2001)

Total population 61.1

Male 58.6

Female 63.6

#### ***Healthy life expectancy (HALE) at 60*** (years)(2001)

Total population 13.6

Male 12.5

Female 14.6

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### *Economic data (year 2000)*

#### ***GDP – composition by sector (%)***

|             |    |
|-------------|----|
| Agriculture | 38 |
| Industry    | 17 |
| Services    | 45 |

***GDP (\$PPP) <sup>4</sup>*** \$62.7 billion

***GNI – per capita (US\$)*** 850

***GDP – per capita (\$PPP)*** 3250

***GDP growth (annual %)*** 6

#### ***Labor Force Participation (%):***

|        |      |
|--------|------|
| male   | 56.2 |
| female | 31.8 |

### *Health expenditure (year 2000)*

***% of GDP*** 3.4

***Health expenditure per capita (\$PPP)*** 99

***Health expenditure per capita (US\$)*** 29

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<sup>4</sup>PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries

## **2 General health and social system**

### **2.1 Basic income maintenance and poverty reduction programmes**

Since the 1950s, the Government's poverty strategy has focused upon developing human resources and ensuring a minimum consumption level for the entire population. The main strategy was universal, involving free provision of health and education services to all. This strategy was supplemented by a range of income transfer programmes directed at food security (subsidies for rice and rations) and rural development.

With the introduction of market reforms in 1977, safety net programmes were implemented. These included Integrated Rural Development Programmes (IRDPs), Janasaviya, the National Development Trust Fund, the Samurdhi, and the universal wheat subsidy. In addition to these large national level programmes, a host of minor programmes have been introduced to meet the needs of specific population groups such as schoolchildren, lactating mothers, and internally displaced persons.

Despite the many economic strains faced by the country, spending on social welfare programmes has remained consistent in recent years, at approximately two to three per cent of GDP. Additional detail on these programmes is ~~provided in subsection 2.4.3, entitled~~ *Poverty reduction and social welfare programmes* in Section 2.4.

### **2.2 Organizational structure of decision-making**

The national health policy of Sri Lanka attempts to address health inequities, with special attention to care for the disabled and elderly, noncommunicable diseases, accidents and suicides, substance abuse, and malnutrition. Both short-term and medium-term goals have been established for the performance of health services.

The health services in Sri Lanka function under a Central Ministry of Health. Since the implementation of the Provincial Councils Act in 1989, health services were devolved, with separate provincial-level Ministers of Health in the eight provinces. The Central Ministry of Health is responsible primarily for the protection and promotion of health among the people, and for providing technical support to the Provincial Ministries. In addition, the Central Ministry manages the network of teaching hospitals in the country. The key functions of the Central Ministry include the setting of policy guidelines, medical and paramedical education, management of teaching and specialized institutions, and bulk purchasing of medical requisites.

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### **2.3 Financing of health services**

#### **2.3.1 Health finance**

Health expenditures in 2000 totalled nearly 20 million rupees, which was an increase of 5.8% over the previous year. Allowing for inflation of nearly 10%, however, this figure represents a real decrease in annual expenditure.

The major portion of health expenditures is utilized by curative care services. In 2000, these services utilized 67% of the total public expenditure on health, while community health services accounted for only 9%. Of the balance, 21% was for administration and staff services and 3% was for local and overseas training. There is no separate record of expenditure on long-term care services, but with the completion of the National Health Accounts now in progress, it is likely that at least some of this information may soon become available.

The resources mobilized by the health sector of Sri Lanka have always been modest. Sri Lanka completed its demographic transition from a situation of high mortality and fertility rates to a situation of relatively low mortality and fertility within a period of 50 years, but has maintained total national health expenditure at low levels. Throughout this fifty-year period, total public expenditure on health averaged less than 2% of GDP. This is very low by international comparisons. Table 1, below, gives a breakdown of the Government expenditure by activity.

**Table 1. Government expenditure by activity**

|                                        |    |    |
|----------------------------------------|----|----|
| <b><i>Inpatient</i></b>                | 29 | 37 |
| <b><i>Ambulatory</i></b>               | 16 | 19 |
| <b><i>Prevention/public health</i></b> | 20 | 11 |
| <b><i>Capital formation</i></b>        | 30 | 27 |
| <b><i>Other</i></b>                    | 5  | 10 |

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Sri Lanka has been able to achieve these results and outcomes in health by adopting a resource mobilization strategy that uses available public and private funds in an effective and sustainable manner. This strategy has depended on only two resource mobilization methods:

- general taxation; and
- out-of-pocket household spending.

While the overall policy framework has not changed over half a century, the proportional contribution of these two sources has changed, with household spending increasing its share relative to general taxation. Sri Lanka has been relatively successful in increasing the contribution of private financing. User fees and private insurance have also been used for resource mobilization, but the experience to date has been that these approaches are not as effective as general taxation and direct household spending. The policy structure and framework has not changed significantly in five decades, and any changes have been gradual and incremental.

## ***2.4 Services delivery system***

### ***2.4.1 Organization of health services***

In Sri Lanka, both the public and private sectors provide health care. The public sector provides comprehensive health care for nearly 60% of the population. The private sector provides mainly curative care for an estimated 50% of all ambulatory patients, largely concentrated in the urban and suburban areas. Ninety per cent of inpatient care is provided by the public sector. There are special service units for the armed forces and the police.

In Sri Lanka, Western, Ayurveda, Unanni, Siddha, and homeopathic medicine are practised. This allows people to seek the medical care of their choice. Of these types of care, Western medicine and Ayurvedic medicine cater to the majority of people.

Sri Lanka has an extensive network of health institutions. It is estimated that no one has to travel further than 1.4 km to reach a fixed health facility.

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The network of tertiary care institutions ranges from sophisticated teaching hospitals with specialized consultative services to small central dispensaries that only provide outpatient services. In 2000, there were 558 institutions with inpatient facilities, with a total of 57 000 beds – an increase of nearly 2000 beds since 1999. However, the national rate of beds for inpatient care remained unchanged, at 2.9 per 1000 persons.

### **2.4.2 Public health services**

The main function of the public health service is the prevention of diseases, the promotion of health, and the provision of rehabilitative services – both at home and in institutions.

The programme of preventive work provides for the control of communicable diseases, sanitation, school health, epidemiological surveillance, family health, health education, and the enforcement of the Food Act. These services are delivered to the community through general community health services, as well as through specialized programmes. After the devolution of health services, functions for the control of diseases such as rabies, tuberculosis, and sexually-transmitted diseases were transferred to the provinces.

### **2.4.3 Poverty reduction and social welfare programmes**

The following is a short description of some of the social welfare programmes that have been implemented in the past two decades.

#### ***Janasaviya***

Janasaviya (JSP) was introduced in 1989, and was the Government's primary poverty reduction programme at the time. The original purpose of this programme was to provide income transfers to about half the population for two years, but because of the high cost, it was trimmed and phased over fewer rounds and areas. Monthly cash grants were given to households, mandatory savings transferred to a specified Fund, and social mobilization was undertaken in a massive way, using 6000 mobilizers.

The World Bank provided funds for the Trust Fund in 1991, and this project worked through local NGOs. Both Janasaviya and the Trust Fund aimed at increasing the employment and income levels through rural public works and micro-enterprise development, and by improving the nutritional status of pregnant and lactating mothers and poor children.

### **Samurdhi**

The Janasaviya was discontinued in 1995 after only five rounds. It was replaced by the Samurdhi programme, which then became the Government's main vehicle for poverty reduction. Samurdhi combined the functions of the Janasaviya and the Trust Fund, which were disbanded in 1998.

The Samurdhi programme covered 50% of the population, or 1.8 million families, and had two components. The first provided direct income support in the form of food coupons, and the second aimed at promoting self-reliance and rural entrepreneurship.

This was to be achieved through training, credit, and savings schemes similar to that of the earlier Janasaviya. In 1997, Samurdhi cost the Government seven billion rupees, representing 1% of GDP. This high cost was due to the fact that it covered a large segment of the population.

#### **2.4.4 Emergency relief and public assistance**

Another important vehicle in the anti-poverty strategy involves assistance provided for emergency food relief needed as a result of the disruptions of civil conflict. There is also assistance to social welfare services and institutions that serve the most destitute in the country, particularly the handicapped, orphans, and the elderly with no independent means of support. However, the budgetary allocation for this is distressingly low, because of the reduction of voluntary assistance to these needy people in recent years.

#### **2.4.5 NGO involvement**

An overview of Sri Lanka's poverty reduction programmes and initiatives would not be complete without explicit mention of the multitude of NGO programmes directed at socially and economically disadvantaged groups. In 1995, there were over 30 000 NGOs operating in the country, ranging from very small community-based organizations to large NGOs having several thousand full-time staff.

For example, Sarvodaya, one of the largest NGOs in the country, manages a total programme of over US\$12 million a year and employs over 5000 full-time staff and an estimated 30 000 unpaid workers. While it is difficult to quantify their impact, it is certain that NGOs play an important role in long-term care and serving disadvantaged groups.

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### **2.4.6 Assessment of the poverty strategy**

At least since World War II, successive Sri Lankan governments have given priority to the universal provision of basic health and education and assurance of minimum consumption levels to the population. In 1977, the strategy was expanded to include implementation of market economy reforms and specific safety net programmes. Nonetheless, income transfers have consistently accounted for a large share of government spending over the years and have been a recurrent threat to financial stability.

These policies have helped Sri Lanka achieve levels of human resource development unknown in economies of low per-capita income. There has also been considerable success in poverty reduction. There is virtually no destitution, even in the most isolated areas, and the existing poverty is neither age- nor gender-biased.

However, there is increasing evidence that the costs of these poverty programmes, especially those which are poorly targeted, are no longer sustainable and cannot be justified on the basis of their benefits. Among other conditions, significant pockets of poverty persist; more than one-quarter of the population live below the poverty line; access to safe water and sanitation is inadequate; malnutrition and stunting remain high; and alcoholism, domestic violence, and child abuse are significant social problems.

Recent assessments have indicated that although all Samurdhi beneficiaries are encouraged to develop entrepreneurial skills, the evidence shows that few have the potential for such skill development. With a few notable exceptions, few of the programmes were able to develop real micro-entrepreneurs, as external factors (such as infrastructure, marketing, and overall macro-environment) were found to be of greater importance in determining the success of new businesses.

Targeting has long been a weakness of Sri Lanka's poverty reduction and subsidy programmes. Most poverty reduction programmes have covered 60% of the population and many general subsidies have remained in place. Paradoxically, however, assistance to the most destitute (e.g. orphans and disabled elderly) is distressingly low in Sri Lanka.

It is clear that the Government will need to review its social and poverty policies with a view to reducing the role of infrastructure development in areas with high incidence of poverty and to providing interventions aimed at promoting rural development. It will also be necessary to protect the most vulnerable through safety nets based on self-targeting.

It would appear that Sri Lanka will be seriously undermined in maintaining its record of social performance without a strong underlying economy that provides the resources to implement economic reforms and achieve growth-oriented development goals. Donor support for Sri Lankan development will remain crucial for a considerable period of time.

## **2.5 Human resources and training**

In the past ten years, there has been an increase in the number of health personnel in most categories. The total number of doctors rose from 6990 in 1999 to 7960 in 2000. In a parallel development, the number of persons per doctor decreased from 2720 to 2400 during this same year. The number of nurses per 10 000 people was 76 in 2000. It is estimated that there is a shortage of over 3000 trained nurses in Government hospitals.

Also, there exists a shortage of paramedical (allied health) staff, such as pharmacists, medical laboratory technicians, radiographers, physiotherapists, and ECG technicians. There is also a wide disparity in the regional distribution of all health personnel, with the Colombo district – followed by the Kandy and Galle districts – having comparatively higher numbers of health personnel.

Training programmes address some aspects of long-term care, and the institutional objectives of most of these programmes include objectives that relate to various aspects of long-term care. However, it is the opinion of many teachers that the attention given to develop trainee competences in long-term care is inadequate and unsystematic.

It would be useful to review the curricular segments that relate to long-term care in the various health personnel education and training programmes. However, in such specific programmes of training as rehabilitative services, physiotherapy, public health nursing, and similar areas, the orientation is more adequate and these health personnel are trained in different aspects of long-term care.

The Government of Sri Lanka provides for the training of doctors, dental surgeons, assistant medical officers, nurses, and other paramedical personnel. Doctors and dental surgeons are trained in universities through regular degree programmes. Some other courses in non-degree training are also conducted in the universities. The Ministry of Health conducts all other paramedical programmes in institutions that come under the Ministry.

Postgraduate training is conducted both locally, by the Postgraduate Institute of Medicine, and abroad. The Postgraduate Institute conducts training courses in nearly 40 different specialties in clinical and community medicine.

### **3 Summary of LTC provision**

#### **3.1 History of LTC in Sri Lanka**

Sri Lanka has a long tradition of institutionalized and non-institutionalized care for the sick. Ancient kings built hospitals as early as the 5<sup>th</sup> and 6<sup>th</sup> centuries AD, with most of these hospitals located in Buddhist monasteries. It is most likely that they catered to the needs of the monks and royalty, and to a lesser extent to the common people. The tradition of Buddhist monks taking care of long-term health care needs of their brethren continues today, with nursing for the sick being provided in temples by younger pupils.

There is also a tradition of Vedamahattayas (traditional healing practitioners), who practice a version of Ayurveda (a form of traditional medicine) providing various types of care to those in need. Vedamahattayas have family traditions of specialization including such areas as orthopaedics, nerve disease, mental disorders, and humoral disease. Generally, they have visited homes, provided medical interventions, and motivated relatives of patients to undertake activities beneficial to their health. Although this tradition is fast disappearing with the westernization of health care, it still exists in remote villages.

For the majority of the general population, Sri Lankan cultural norms tend to place the burden of long-term care on the family or village. In the case of monks, LTC is a responsibility of the younger monks ordained by the nikaya sect.

The colonial rulers founded modern institutions for long-term care in Sri Lanka. For example, the Dutch founded the Leprosy Institution and the British started the Institution for Mental Illness. Although they were initially 'institutions of segregation', they later became institutions of long-term care.

Epidemics of polio, internal armed conflicts, labelling of chronic mental illness, the introduction of modern life-sustaining interventions, appliances for the handicapped, the development of specialized institutions, and demographic and other epidemiological changes, have changed the current picture of long-term care in Sri Lanka.

## **3.2 Long-term care services**

### **3.2.1 Governmental**

#### ***The Ministry of Social Services: community-based rehabilitation***

The community-based rehabilitation programme is aimed at people needing care in their communities. During the course of routine visits to families under this programme, a volunteer specially trained in principles of community-based rehabilitation (CBR) identifies people who need care. The volunteer is instructed not to proceed immediately with action, but rather to proceed slowly over a number of later visits. He/she makes several more visits over a period of time, and then, through the completion of a prepared form, tactfully assesses the nature of the disability and the needs of the person.

Following this assessment, the volunteer makes several more visits. This information is passed on to the Social Service Officer (SSO) at the Divisional Secretariat, who assists the volunteer in developing a particular action plan. Should the recipient need medical care, the local Medical Health Officer is consulted and an appropriate referral is provided. Similarly, if additional financial assistance is needed, this will also be provided by the SSO.

The wider spectrum of services will be provided to the needy through consultation with the Divisional Steering Committee, which comprises the Medical Health Officer, the Divisional Education Officer, the Divisional Samurdhi Officer, the Divisional Labour Officer and the Divisional Youth Officer. The SSO chairing this Steering Committee acts as the Secretary to the Committee.

Issues relating to social integration, which involves getting the family members to attend to the needs of the LTC patient, and social incorporation issues are handled by the volunteer. If the patient needs special appliances, NGOs are contacted for funding or the appliances are bought by funds available at the Divisional Secretary from the Provincial Government. The Divisional Steering Committee, while coordinating this service among the different government sectors, also coordinates with all NGOs working in the rehabilitation sector.

This system of community-based rehabilitation operates in 160 of a total of 304 Divisional Secretariats divisions and in 5200 Grama Niladhari divisions. Although the process has been in existence since 1994, its coverage has been limited. The Ministry now plans to start CBR in the North and East provinces, beginning with Jaffna.

The total allocation to the line Ministry for this programme is approximately 13 million rupees. After salaries, etc. are paid, only about 50 000 rupees (US\$ 500) per year remain in the Divisional Secretariats for activities, including training costs.

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However, the provincial governments assume some of the expenses at the divisional level. Furthermore, NGOs operating in specific areas and, in some instances philanthropists contacted by the SSO, pay for appliances such as hearing aids, spectacles, wheelchairs, and crutches.

Data on individuals and families receiving assistance from the CBR are kept at all DDS offices by the SSO at the district level. Since 1994, records indicate that this programme has attended to the needs of some 89 000 individuals, with 32 000 taken off the records after having been provided care. The SSO is also responsible at the divisional levels for providing financial allowances to disabled persons and to patients with leprosy, tuberculosis, and cancer.

NGOs such as Help Age Sri Lanka, Sarvodaya, SIHA, and Plan International are assisting the CBR programme by providing appliances, and printed materials for record keeping and training, and by funding some of the local volunteer training programmes. The volunteers in this programme are individuals respected by the community (e.g., schoolteachers). Some of the volunteers are themselves disabled persons retired from the armed services.

### ***The Ministry of Social Services: Parliamentary Act on the Rights of the Disabled***

Sri Lanka also has a parliamentary act that protects the rights of the disabled (No 28, 1996: the Act to Protect the Rights of the Disabled). The Ministry of Social Services is now revising this act so that it is more comprehensive and requires institutions to be responsive to the needs of the disabled.

### ***The Ministry of Social Services: Parliamentary Act on the Rights of the Elderly***

Parliamentary Act No. 9, enacted in 2000 provides for the establishment of a National Council of Elders with the principal function of protecting their rights. The Council, headed by the Secretary to the Ministry of Social Services, is legally entrusted with ensuring the welfare of elderly individuals rather than making policy recommendations for restructuring human resource policies for the country to harness the full potential of the elderly. The appointment of a Board for the determination of claims for maintenance by elders and the Elders' Welfare Fund are institutions provided for in the Act.

### ***The Ministry of Health***

The Ministry of Health has not been very effective in providing the elements of care listed under LTC. Both at the national and provincial levels, the care provided by the Government is heavily institution-based. Except in situations where home visits are undertaken by midwives providing some antenatal and postnatal care, assistance to people outside the hospitals or field clinics has been minimal.

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In the few instances where social workers from the main psychiatry units located in big hospitals visit families of alcohol dependents, and in some cases psychiatric patients, extension services are grossly lacking in the health sector. A recent development, however, involves clinics for the elderly operated by Medical Health Officers in the field.

A few attempts have been made by the Ministry of Health to link up with the Social Services Department at the national level. However, these efforts have only involved short-lived projects. Medical Health Officers participate as health authorities and resource persons in the CBR programme, in those districts where it is functional. Recently in one district, health authorities have undertaken another project to operate day centres for the elderly with the assistance of volunteers. At these day centers, the elderly are provided with food and other needed medical assistance. The NGO Help Age Sri Lanka has trained the volunteers for this programme.

### *Sri Lanka's Armed Forces*

Sri Lanka's Armed Forces probably have the most elaborate long-term care services in the country. They appear to provide institutional, community based and self-help care to their members who have been affected by armed conflict. An army directorate coordinates these services. However, the release of information about the programme has been restricted.

### *Nongovernmental Organizations*

Many NGOs, such as Help Age Sri Lanka and Sarvodaya, are involved at the national and provincial levels in assisting the Social Services Department's CBR programme. Similarly, there are 155 homes for the elderly, which are run by small nongovernmental associations. The Government finances three such homes, located in Anuradhapura, Mirigama and Jaffna. In addition, several homes for the disabled are maintained by voluntary associations. The Jaipur Project provides artificial limbs to those in need.

### *Help Age Sri Lanka*

One of the few NGOs that has a major impact on LTC is Help Age Sri Lanka. This organization is involved in many activities, such as providing direct monetary assistance to homes for the elderly, eye care services for the elderly, day care centres, eyeglasses, wheelchairs, and walking aids. This institution is also involved in educating school children and medical students about the needs of the elderly. They also help older people to plan their retirement.

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More importantly, however, their contribution to long-term care has been in the area of training personnel in needs assessments, provision of community based services, and gerontological home care. They have also assisted in intersectoral cooperation and income generation programmes for the elderly. Both the Ministries of Social Services and Health have been beneficiaries of such training programmes. Each has received assistance from Help Age Sri Lanka in training community-based volunteers and officers in the CBR and day centre programmes.

### **3.2.3 Private sector**

#### ***Ceylinco Home Nursing Service***

There are several small and large private companies that provide home-based nursing for a fee. The most organized of such companies is a subsidiary of the Ceylinco Group known as Ceylinco Home Nursing Services. This service has established branches in five large towns and employs approximately 400 trained nursing aids. Their monthly fee is US\$250, and they provide a comprehensive service that includes dressing of wounds, colostomy care, catheter care, naso-gastric feeding, insulin injections, and nursing care to prevent bedsores, hypostatic pneumonia, diabetic gangrene, dehydration and accidental falls. Due to their high fees, only high-income groups can afford this service.

There are also a few other small companies that provide similar home-based nursing care services. These agencies generally provide nursing aids on a shift basis, and charge approximately US\$3–5 per 12-hour shift. The quality varies very much among the various agencies. Most of them have employed individuals trained at Help Age Sri Lanka.

The most widespread private sector activity involves the off-hour service rendered by Government hospital employees. Attendants, labourers, midwives, and occasionally nurses, are involved in providing such services. Relatives of persons needing care either contact these employees through personal networks, or the services are offered when a patient leaves a hospital. In some cases, the duration of such services to a patient may extend to years.

#### ***Fee-levying homes***

There also exist a few fee-levying homes for the elderly and disabled. The Mallika Home and the Jayandara Elderly Home are two such institutions. These institutions charge an admission fee of approximately 100 000 rupees (US\$1000) and a monthly fee depending on the comforts provided (minimum 4000 rupees). Some individuals who have obtained such services have transferred their monthly pension payments to the institutions.

### **3.2.4 Private funding**

Private insurance programmes are not yet popular in Sri Lanka. However, packages are available in the form of life insurance with disability coverage. Several commercial banks also offer special savings accounts for the elderly with insurance packages and medical check ups.

## **4 General questions pertinent to LTC development**

### **4.1 Present and future needs for long-term care, and gaps between needs and provision of services**

There has been a decline in the crude birth rate (CBR) in Sri Lanka. At first, this was due to changes in the female age structure and the rise in the age at which people marry. Thereafter, increasing use of contraceptives became the dominant reason. This declining birth rate has contributed to the overall ageing of Sri Lanka's population. There has also been a steady decline in the infant mortality rate (IMR) with improvements in health care, nutrition, and a decrease in poverty rates. Life expectancy at birth has increased significantly.

The rapid increase in the average life span, together with the widening of the gap between the life expectancies of males and females, reflects the dramatic improvement in the survival of those groups that were most vulnerable and exposed to high risks of mortality - namely infants, children in the age group 1-4 years, and women of childbearing age.

#### **4.1.1 Morbidity and mortality**

In Sri Lanka, morbidity data are only available for patients seeking treatment as inpatients in Government institutions. Morbidity data for patients attending ambulatory care services and receiving treatment through private sector services are not routinely collected. Other than limited information collected through surveys and registers maintained by specialized campaigns for tuberculosis, malaria, cancer, and leprosy, and from notifications of communicable diseases, the Indoor Morbidity and Mortality Form (IMMR) is the most reliable source of data.

The IMMR has been in use since 1976, and is based on the 10th revision of The International Statistical Classification of Diseases and Related Health Problems (ICD). Data for the years 1995 and 2000 are presented in Table 2 on the opposite page. There are many instances in which the morbidity data in some hospitals have not been analysed. However, while this is a problem, it is likely that the data based on the hospital morbidity will give an obvious indication of the morbidity pattern in the country.

**Table 2. Trends in hospital morbidity by broad disease groups (1995–2000)**

| <b>International Classification of Diseases (10<sup>th</sup> Revision)</b>      | <b>1995</b> | <b>2000</b> |
|---------------------------------------------------------------------------------|-------------|-------------|
| <i>Infectious and parasitic diseases</i>                                        | 1757.7      | 2431.7      |
| <i>Neoplasms</i>                                                                | 190.1       | 260.2       |
| <i>Diseases of blood and blood-forming organs and certain immune mechanisms</i> | 152.2       | 111.0       |
| <i>Endocrine, metabolic and nutritional diseases</i>                            | 205.8       | 278.4       |
| <i>Mental and behavioural diseases</i>                                          | 261.6       | 2417.0      |
| <i>Diseases of the nervous system</i>                                           | 172.4       | 243.4       |
| <i>Diseases of the eye and adnexa</i>                                           | 276.6       | 299.9       |
| <i>Diseases of the ear and mastoid</i>                                          | 66.6        | 86.8        |
| <i>Diseases of the circulatory system</i>                                       | 925.5       | 1153.8      |
| <i>Diseases of the respiratory system</i>                                       | 2088.7      | 2313.4      |
| <i>Diseases of the digestive system</i>                                         | 739.2       | 1056.7      |
| <i>Diseases of skin and subcutaneous tissue</i>                                 | 529.2       | 566.9       |
| <i>Diseases of musculoskeletal system and connective tissue</i>                 | 627.9       | 621.3       |
| <i>Diseases of the genito-urinary system</i>                                    | 998.9       | 124.8       |
| <i>Pregnancy, childbirth and puerperium*</i>                                    | 2207.3      | 3122.6      |
| <i>Certain conditions of the perinatal period</i>                               | 4986.5      | 9108.9      |
| <i>Congenital malformations</i>                                                 | 52.8        | 54.8        |
| <i>Injury, poisonings, etc.</i>                                                 | 2552.1      | 3345.1      |
| <i>Other abnormal symptoms, not classified elsewhere</i>                        | 1311.6      |             |

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In Sri Lanka, there has been an increase in noncommunicable diseases, which arise with the transition in the demographic profile and with increased life expectancy. This is reflected in the increased hospitalization for diseases such as neoplasms and diseases of the respiratory, genito–urinary, neurological, and digestive systems. There has also been a substantial increase in hospitalizations for poisoning and injury.

The number of patients seeking treatment for mental disorders has increased over the years. In 1970, there was a rate of 177 per 100 000 individuals receiving treatment for mental disorders – as compared with 262 and 247 per 100 000 in 1995 and 2000, respectively. This increase is attributed mainly to demographic changes, but other contributory factors are migration, alcoholism, war, and other forms of violence and stress.

There has also been a dramatic increase in hospitalizations for diabetes mellitus that can be attributed to urbanization, lifestyle changes, and the ageing of the population.

### **4.1.2 HIV/AIDS, leprosy, and trauma**

Although HIV was introduced to South Asia rather late, the disease has already emerged as a serious public health and developmental problem. Sri Lanka has joined other countries in expressing its commitment to combat the expanding pandemic. The current estimates are that, in Sri Lanka, approximately 8500 persons are living with HIV, while the reported number is approximately 400. Sri Lanka is classified as a low-prevalence but high-risk country for HIV infection.

During the last two decades, Sri Lanka has made much progress in eliminating leprosy. The introduction in 1982 of multi-drug therapy, an effective, short-duration chemotherapy treatment, and the launching of the awareness campaign in 1990 to educate the general public, made a major impact. The leprosy strategy is now community-oriented and community-based. The community is educated on early signs and the need for treatment. But more importantly, education efforts are under way to reduce the stigma of leprosy, to encourage acceptance of treated leprosy patients as normal members of society, and to educate people as to how leprosy patients should be cared for in their homes.

Trauma is another major issue that often leads to the need for long-term care. Road traffic accidents, and victims of war and conflict, have been increasing in the past decade. The numbers of these victims who need long-term care have become a major health concern for the country.

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### **4.1.3 Likely target population for LTC, given current trends**

Because of the lack of availability of statistics, it is rather difficult to make an accurate estimate of the population needing or receiving long-term care. However, the following indicators for the year 2000 suggest a large hidden population needing such care.

- Of 415 confirmed HIV-positive individuals, 132 have developed AIDS. However, epidemiologists estimate 6000 HIV cases in Sri Lanka.
- Approximately 50 000 patients with psychiatric disorders received treatment in government hospitals.
- Eight thousand new tuberculosis cases were detected in the year 2000.
- Another 50 000 were exposed to poisoning (most of the cases were suicide attempts).
- Similarly, 173 233 cases of asthma, 60 633 cases of ischaemic heart disease, 83 000 cases of hypertension, and 23 559 cases of liver disease (mostly following alcohol use) were reported in the year 2000.
- Additionally, 520 000 cases of traumatic injuries were reported (mostly accidents and injuries related to violence). A significant population of individuals have been disabled as a result of the armed conflict that has continued for almost twenty years.

More generally, with the reversal of the population pyramid, more and more older people are joining the population of Sri Lanka. It has been estimated that by 2050 the average age in Sri Lanka will be 50 years.

## **4.2 Developments in Long-term care**

LTC encompasses personal care, household chores, life management, provision of assistive devices, adoption of advanced technologies, and home modifications and assistance in basic housing and subsistence needs. Access to acute and chronic care of persons who are not fully capable of self-care on a long-term basis – whether performed by themselves or provided by friends, family members, formal care givers, traditional care givers, and volunteers – are also important aspects of LTC.

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In the Sri Lankan context, however, LTC activities seem to comprise the main agenda for rehabilitation, primarily in the Community Based Rehabilitation Programme of the Ministry of Social Services and in the Ministry of Defence. Therefore, 'rehabilitation' in Sri Lanka seems not to be limited just to medical and technological interventions for rehabilitation, but to extend beyond these interventions to incorporate all aspects of LTC.

Another area of work that seems to overlap with LTC is elderly care. Given the demographic changes expected in the future, there is more discussion about elderly care than about long-term care in general. It appears as though these two concepts, which have received attention from both politicians and professionals, are masking the realization of the goal of developing a policy on long-term care provision.

Another factor that seems to affect the conception of care needs is the idea of an inevitable sociological change from extended families to nuclear families, which for most professionals leads to thinking of institutions as becoming the providers of most care. The problem is that, in Sri Lanka, the care provided in institutions is more bureaucratic and mechanical, rather than being based on humanitarian and moral concerns. Furthermore, it is rather difficult administratively for most State-funded institutions to deploy community-oriented extension programmes.

### **4.3 Concluding remarks**

Sri Lanka reflects current trends among most developing countries, facing the prospect of an increasing need for long-term care services that will exceed the experiences of industrialized countries. The ageing of the population will, of course, be the single most important contributor to this need. Current demographic and epidemiological profiles – particularly in relation to chronic diseases and conditions such as tuberculosis, mental illness, road traffic injuries, and violence – will dramatically increase the demand for LTC in the coming decades.

For these reasons, the country faces a number of questions that need to be addressed in a systematic manner, and cost-effective alternatives need to be identified. These efforts must be undertaken within a context in which:

- available resources are extremely limited;
- the structure of the family is in a state of flux;
- cultural and ethical values are shifting; and
- health and social welfare systems are in evolution.

## LONG-TERM CARE

The following are some of the priority actions that must be set in motion in Sri Lanka.

### ■ *Development of a rational LTC policy*

The current policy indication is that the primary responsibility for providing LTC belongs to the family and relatives, with the informal help of the community. The government will only intercede in the event of a serious superimposed illness or in extremely dire circumstances.

The concept that LTC is predominantly a social responsibility and that the government should take a formal, principal role and support informal caregivers has not been established in Sri Lanka. At the policy level, there needs to be support for the view that the responsibility for LTC should be balanced between society and the family.

### ■ *Development of a set of priority areas for LTC in relation to the other needs of the population*

This action must take into account different age groups, disease conditions and service delivery systems. With regard to service delivery systems, it appears that most countries are now moving towards developing community health care.

### ■ *Identification of the roles of government, the private sector, and NGOs, as well as the community and volunteers*

Specifically important will be the stewardship role of the Government in facilitating and creating the infrastructure necessary for nongovernmental sector agencies to provide an increasing quantity of services.

### ■ *Re-evaluation of the current and future role of the family and the community in LTC and development of ways to augment these roles*

- ***Development of the human resources capacity needed to undertake LTC at the desired level, by full-time or part-time health and social services staff, as well as such informal sector staff as volunteers***

This also requires a policy basis, after a careful consideration of the tasks – both professional and specialized, as well as caregiving tasks – that need to be performed by various persons who provide LTC. Policies in this case also have to be cognizant of efficiency and cost-effectiveness requirements, particularly in devising an appropriate personnel mix.

- ***It is important to devise an LTC policy that is sustainable over a long period of time.***

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