

## Leading article

# Ageing and the health sector in Sri Lanka

*Meeting the challenges calls for fresh thinking and focused strategies*

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A rapid increase of the child and youth population in Sri Lanka was a major socio-economic issue during a greater part of the last five decades. Population ageing is expected to draw much public attention in the first half of this century. The phenomenon of population ageing is brought about by a rise in life expectancy and a fall in fertility. This transition from high birth rates and death rates to low mortality and fertility rates alters the proportionate share of different age segments of the population.

In Sri Lanka, the proportion of the population under 15 years of age to the total population declined from 41.5% in 1963 to an estimated 24.8% in 2000. On the other hand, the share of those aged 60 years and over has increased from 5.4% to 10.0% during the same period. This is the result of a rise in life expectancy at birth from 61.7 years in 1962 to 73.7 years in 2000, and the fall in the number of children for every woman in the reproductive ages from about 5 to the current level of about 2. The favourable decline in mortality and fertility has been achieved through the effective implementation of primary health care and family planning, and other social development programs.

Before considering people over 60 years of age, it is important to look at the changes in the population age structure in middle life. For instance, the population aged 45 to 59 years is expected to increase from 2.98 million in 2000 to 4.64 million in 2025. The growth of this segment of the population has important implications for the health sector. It is in this age group that some of the degenerative diseases begin to surface. The huge increase in the absolute size of population aged 45 to 59 years will increase the number of those seeking health care, even if the disease prevalence rates of this age group remain unchanged (1). Meeting the health care needs of this growing population is essential as they form the most experienced workforce in terms of skills acquired on the job. Effective screening and diagnostic methods, and the application of therapeutic technologies need to be put in place, to ensure that a large majority of this population could live healthily, and contribute productively to economic development.

The population aged 60 years and over is expected to increase from 1.92 million in 2000 to 4.45 million by 2025, and is the fastest growing segment of our population. In relative terms, its share to the total population will increase from 10.0% to 19.7% from 2000 to 2025. The process of population ageing needs to be looked at in the context of

rising life expectancy. At present, the life expectancy at birth in Sri Lanka is about 74 years for females and 70 years for males. This is expected to rise to 78.5 and 73.5 years respectively by 2025. Given the current level and pattern of mortality, a man reaching 60 years can expect to live on an average, 21 more years, while a woman reaching that age can expect to live 23 more. The corresponding life expectancies in 1946 were 15.7 years for both sexes. So a person reaching 60 years today, would be looking forward to at least another ten years of active life. Labour force is about 63% for those aged 60 to 69 years. Thus a large majority of those aged 60 to 70 years are relatively healthy, and physically and mentally able to contribute to economic activity. Hence health care and social support for the elderly need to be directed more at those aged 70 years and over, whose number would more than double during the next 25 years from 830 000 in 2000 to 2.0 million in 2025.

If people aged 60 to 69 years are excluded, the proportion of those aged 70 years and over in the total population is only 4.4%, and will increase to 9.1% by 2025. This places the problem of population ageing in clearer perspective and makes it easier for health planners to address the real issues (2).

The transition from high to low levels of mortality has also brought about an inflation of morbidity, which can have significant implications for ageing populations. In the 1940s, when life expectancy in Sri Lanka was about 40 years, sickness was commonplace, but mostly of brief duration. In the low mortality setting of today, the application of effective diagnostic and therapeutic technologies has diminished the probability of premature death among those who are ill, and thereby increased the absolute level of morbidity. And population ageing is likely to increase its disease burden. It has been argued that when modern medicine succeeds in saving marginal lives, it increases the real burden of morbidity and disability in low mortality populations, thereby adding substantially to the duration of sickness, as illness episodes are prolonged (3). This in turn increases the cost of health care. Consequently, population ageing in Sri Lanka can significantly alter the costs and benefits of health care.

Another important demographic feature in population ageing is that, women will outnumber men due to their higher life expectancy. The sex ratio (men: 100 women) of those aged 60 years and over will fall from 98.7 in 2000 to

89.5 in 2025. This fall would be even greater for those aged 70 years and over, from 97.4 to 84.8. Thus the proportion of older widowed women in the population will increase in the future. This has important implications for the health sector. For it has been observed in developed countries, that marital status is an important factor in determining whether a patient is admitted to an institution or cared for at home. Living with a spouse in old age ensures regularity in habits, diet and life style, and promotes health. Home health efforts, in particular primary health care, should be directed at enabling the elderly to lead independent lives with their family for as long as possible.

In a Sri Lankan household study, elders' self-assessment of their health status showed that only 1.3%, comprising 0.6% of men and 2.3% of women, were bedridden. Those reporting sick comprised 36.6%. They were not seriously ill, but suffered from minor ailments (4). This study also revealed that the elderly tend to ignore illness that does not interrupt or disorganise their normal activities of living. Anthropologists who have observed non-western populations, note that people who would be sick by modern standards continue to work and live normal lives, although if they were to live in a modern western society, would interrupt routines in response to such conditions (5). Thus with rising standards of living in Sri Lanka in the coming decades, there would be a greater demand for health care among the elderly.

Given the rapid absolute increase in the elderly population in Sri Lanka, it is likely that the number of disabled elderly also will increase in the future. Although in the more developed countries heart disease and cancer are the major killers, only a small proportion becomes disabled because of them. However, in countries such as Sri Lanka, lack of nutritive food and the spread of communicable disease can result in disablement of the elderly. Hypertension, hearing impairment, dementia, diabetes and urinary incontinence cause disability that may not be visible. Hence every effort should be made to prevent or minimise disablement of the elderly. Preventive strategies include awareness programs, early treatment and community services for rehabilitation when required (6).

By the year 2030 a large proportion of Sri Lankans would be living in urban areas: according to United Nations projections, more than 40% of the total (7). Growth of the urban population is likely to result in greater environmental pollution, shifts in occupational patterns, and changes in consumption and life styles. These require preventive strategies to minimise the negative effects of urbanisation on the health of the population.

With over 50 years of free education, the elderly of the future will be more literate and better educated. Moreover, a significant proportion will be living in urban areas

and will have fewer living adult children than the current generation of elderly. These changes will also have important implications on the needs of the elderly for care.

As we move into the first few decades of this century, it is very likely that there would be further improvements in mortality at advanced ages. This is already occurring in developed countries. More than half of female and a third of male deaths in developed countries occur after age 80. In 19 developed countries the average annual improvements in male mortality for the age group 80 to 89 years increased from 0.48% during 1950s and 1960s to 1.2% during 1970s and 1980s. The corresponding increase for females was 0.8% to 1.88% (8). Thus the fall in mortality of the elderly will further increase the demand for health care services. Related to reduction in mortality of the "old-olds" is the ageing of patients. Infants and old people have the highest incidence of sickness and hospitalisation. At ages above 70 years, rates of sickness and hospitalisation tend to be substantially higher than in the 0 to 4 age group. This pattern is much the same in both developed and developing countries. In Japan, the incidence of medical treatment for the age group 70 and over is almost 40% higher than that for the age group 0 to 4 years. These differentials in the incidence of sickness by age at the base and the apex of the population age pyramid imply that actual health care needs would be different to what conventional indicators suggest. For example, the conventional index of ageing (those aged 65 and over/those aged 0 to 14 x 100) for Japan for the year 1986 was 50.5. In contrast, the comparable index of ageing for patients for the year 1986 was 107.0 (9). Thus the ageing of patients in Sri Lanka in the future, resulting from improvements in survival at advanced ages, would further increase health care costs.

From the foregoing discussion it would be evident that population ageing is an inevitable outcome of a positive demographic trend resulting from social and economic advancement. So it is important to promote, through health education programs, healthy life styles among the young and the middle-aged. For cultivation of lifelong healthy personal habits offers the best prospects for a healthy old age. The most significant are those concerned with diet, exercise, avoidance of tobacco and alcohol, occupation and sleep. Regular mental and social activities are important in maintaining good health and functioning in later years. With increasing longevity families with four living generations will increase in Sri Lanka. But decrease in the number of children, and their dispersion due to migration and urbanisation, would result in a fewer number of siblings being available for home care. Therefore, opportunities should be provided for "young-olds" to take care of the "old-olds" at home. It is important to teach adults to manage health and sickness in the household. This should include knowledge about nutrition and sanitation, and training about how to treat some forms of sickness without

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professional help, so as to assist the body's natural ability to recover from illness. It may also be important to provide appropriate training for out-of-school youth to take care of the elderly at home, while waiting for suitable employment. It is equally important to develop and expand community based health care facilities to serve the increasing numbers of old patients as an alternative to home care.

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## Economist on the LTTE (2)

Sri Lanka's giant neighbour, India has its own separatist worries, especially in the northern Muslim-majority state of Kashmir. It does not want borders in its neighbourhood redrawn along ethnic lines. The Indian government regards Mr Prabhakaran's rise with horror. A battle for Jaffna could send refugees across the Palk Strait to Tamil Nadu, an Indian state with a much bigger Tamil population than Sri Lanka's. Victory in Jaffna could lead to greater Tiger infiltration of Tamil Nadu and the stirring of latent separatism there.

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