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Strengthening Geriatric Care in Sri Lanka: Challenges and Opportunities for an Integrated Primary Healthcare Approach — A Narrative Review

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ABSTRACT

Background: Population ageing presents growing challenges for healthcare systems, particularly in low- and middle-income countries where the demand for chronic disease management, rehabilitation, community-based support and long-term care is increasing. Sri Lanka is experiencing a substantial demographic transition, creating an urgent need to strengthen services for older people within its publicly funded healthcare system.

Objective: This narrative review examines the challenges and opportunities for strengthening geriatric care in Sri Lanka, with particular emphasis on integrated primary healthcare, continuity of care and the implications for health policy and service delivery.

Methods: A focused narrative search of publicly accessible scholarly literature, national policy documents, demographic reports and international guidance was undertaken to inform the review. Sources relating to population ageing, healthcare utilisation, integrated care, long-term care and primary healthcare reform were examined. International evidence was considered alongside Sri Lankan research to identify approaches potentially adaptable to the national context.

Discussion: Sri Lanka has an established public healthcare system and a policy foundation for elderly healthcare. Nevertheless, demographic ageing increases the need for coordinated management of multimorbidity, functional decline, medication-related problems and long-term care requirements. Important priorities include strengthening primary healthcare capacity, improving referral and discharge pathways, developing multidisciplinary teams, supporting family caregivers and establishing sustainable community-based services. The World Health Organization's Integrated Care for Older People framework provides a useful basis for person-centred assessment and individualised care planning. Implementation requires appropriate workforce development, financing, information systems and intersectoral collaboration.

Conclusion: Strengthening geriatric care in Sri Lanka requires a coordinated, equitable and person-centred approach linking primary healthcare, hospitals, rehabilitation and community-based support. A phased model adapted to local resources could improve continuity of care and provide relevant lessons for other countries experiencing similar demographic transitions.

Keywords: Geriatric care; population ageing; integrated primary healthcare; older adults; health systems; long-term care; Sri Lanka.

1. Introduction

Population ageing is one of the most significant demographic and public health developments of the twenty-first century. Improvements in healthcare, nutrition, sanitation and living conditions have contributed to increased life expectancy in many countries. However, population ageing also increases the importance of preventing disability, managing chronic diseases, maintaining functional ability and providing continuing support for people who experience limitations in daily living. These challenges are particularly important in low- and middle-income countries (LMICs), where demographic transitions may occur alongside resource constraints, changing family structures and limited formal long-term care services.

The World Health Organization (WHO) emphasises that healthy ageing should be understood in terms of developing and maintaining the functional ability that enables wellbeing in older age, rather than simply the absence of disease (WHO, 2015). This perspective has important implications for healthcare delivery. Older people may experience several interacting health conditions, reduced mobility, cognitive changes, sensory impairment and social difficulties that cannot be adequately addressed through isolated, disease-specific interventions. Consequently, health systems need approaches that integrate preventive, curative, rehabilitative, psychological and social support.

Sri Lanka provides an important context for examining these challenges. The country has developed an extensive publicly funded healthcare system that provides a broad range of preventive and curative services. Nevertheless, its demographic structure is changing rapidly. According to the Department of Census and Statistics, people aged 60 years and above constituted 18.0% of the population in the 2024 Census of Population and Housing (Department

of Census and Statistics, 2026). This demographic change has implications for service planning, workforce development, healthcare expenditure and the organisation of continuing care.

The health needs of older people extend beyond the treatment of individual diseases. Multimorbidity, frailty, reduced mobility, falls, cognitive impairment, depression, nutritional problems and medication-related complications may coexist and affect independence. A recent multicentre study involving older adults attending medical clinics in Sri Lanka examined the relationships between multimorbidity, medication use and outcomes including falls, physical activity and cognitive function, illustrating the importance of considering these problems together rather than in isolation (De Zoysa et al., 2025).

Primary healthcare has an important role in responding to these needs through prevention, early identification of health problems, chronic disease management, medication review, rehabilitation and coordination of referrals. However, effective geriatric care also requires functional links between primary healthcare institutions, hospitals, specialist services, community organisations and long-term care providers. Where these services operate without adequate coordination, older people and their families may face difficulties navigating the healthcare system and maintaining continuity of care.

Sri Lanka has recognised the importance of responding to population ageing through its National Elderly Health Policy, approved in 2017. The policy identifies comprehensive healthcare, trained personnel, rehabilitation, long-term care, community participation and integration of elderly healthcare into primary healthcare as important priorities (Ministry of Health, Sri Lanka, 2022). More recently, policy dialogue on healthy ageing has emphasised the need to strengthen a primary healthcare-centred health system capable of responding to the changing needs of older people (Perera and Samarakoon, 2025).

Despite these policy developments, the practical organisation of integrated geriatric care remains an important area for health system planning. Strengthening services requires attention not only to the availability of clinical interventions but also to coordination, accessibility, workforce competencies, financing, family support and the continuity of care across settings.

Against this background, this narrative review examines the challenges and opportunities for strengthening geriatric care in Sri Lanka, with particular emphasis on integrated primary healthcare. It explores the healthcare needs of older people, the current policy and service context, barriers to effective service delivery, and relevant international approaches. It also proposes a practical framework for connecting primary healthcare, hospital services, rehabilitation and community-based support, with lessons potentially applicable to other LMICs.

2. Methodology

2.1. Review design and scope

A narrative review approach was adopted to examine the health-system implications of population ageing in Sri Lanka and identify opportunities for strengthening integrated geriatric care. This approach was selected to facilitate a contextual discussion incorporating empirical research, demographic information, national policy documents and international guidance.

The review was guided by three questions:

1. What are the principal healthcare needs of older people and the major challenges affecting geriatric care in Sri Lanka?
2. How can primary healthcare be better integrated with hospital, rehabilitation, community-based and long-term care services?
3. What feasible strategies could strengthen the accessibility, continuity and quality of geriatric care in Sri Lanka?

2.2. Information sources and search approach

A focused narrative search of web-indexed scholarly literature and publicly accessible institutional sources was undertaken to inform this manuscript. Relevant material was sought through scholarly records accessible via PubMed and other indexed literature services, together with official publications from the WHO, the Ministry of Health of Sri Lanka, the Department of Census and Statistics, and the Asian Development Bank.

Search concepts included population ageing, older adults, geriatric care, primary healthcare, integrated care, multimorbidity, healthcare utilisation, rehabilitation, long-term care and Sri Lanka. Combinations of these terms were used to identify relevant publications and policy documents. Reference lists of selected sources were also considered where additional relevant literature could be identified.

Priority was given to sources providing direct evidence about Sri Lanka, authoritative national statistics, relevant policy information and internationally recognised frameworks for integrated care. International publications were considered where their findings or recommendations had potential relevance to health systems with comparable resource constraints.

This was a focused narrative search rather than a comprehensive systematic database search. No claim is made that all eligible studies were identified or that a formal systematic screening process was completed.

2.3. Source selection and synthesis

Sources were considered according to their relevance to the review objectives, the credibility of the issuing organisation or publication, and their contribution to understanding geriatric healthcare needs and service organisation. Particular attention was given to demographic evidence, healthcare utilisation, multimorbidity, national elderly health policy, long-term care and WHO guidance.

The literature was synthesised thematically under five areas: healthcare needs associated with ageing; organisation of geriatric services in Sri Lanka; challenges affecting integrated care; opportunities for strengthening primary healthcare; and policy and management priorities.

International recommendations were interpreted in relation to the Sri Lankan health system. The proposed integrated-care framework represents a synthesis of policy and clinical principles rather than a model whose effectiveness has already been demonstrated through implementation in Sri Lanka.

3. Healthcare needs of older people in Sri Lanka

3.1. Demographic ageing and implications for health services

Sri Lanka's ageing population creates a need to reconsider how healthcare services are planned and delivered. The 2024 census reported that 18.0% of the population was aged 60 years and above, highlighting the growing importance of age-responsive healthcare and social support (Department of Census and Statistics, 2026).

The implications extend beyond an increase in the number of older patients attending healthcare facilities. As people live longer, health services must address the interaction between chronic disease, functional limitations, social circumstances and the availability of support at home. Some older adults remain independent and require mainly preventive and routine healthcare, whereas others need intensive clinical management, rehabilitation or continuing assistance with daily activities.

Healthcare planning should therefore avoid treating older people as a homogeneous group. Services should be responsive to differences in functional ability, socioeconomic circumstances, geographical access, family support and individual preferences.

3.2. Multimorbidity and functional decline

Multimorbidity is an important challenge in geriatric care because several chronic conditions may require simultaneous treatment and monitoring. Multiple appointments, complex medication regimens and conflicting clinical priorities can create difficulties for older people, their caregivers and healthcare professionals.

Sri Lankan evidence supports the importance of examining these issues together. De Zoysa et al. (2025) investigated multimorbidity, medication use and associated outcomes among older adults attending medical clinics in four tertiary hospitals. Such research provides a basis for considering medication safety, falls risk and functional assessment as connected components of geriatric care.

A disease-focused model may fail to address the cumulative effects of several conditions on mobility, cognition, nutrition and independence. A more comprehensive approach should assess both diagnosed diseases and their consequences for daily functioning. Primary healthcare teams can contribute through regular monitoring, early identification of deterioration, medication reconciliation and timely referral for specialist assessment or rehabilitation.

3.3. Healthcare utilisation and accessibility

Access to healthcare is influenced by more than the geographical presence of a health facility. Mobility limitations, transport costs, waiting times, health literacy, social support and the ability to navigate referral pathways may affect whether older people obtain appropriate care.

Wickramarachchi, Siop and Perera (2022) examined healthcare utilisation among 880 urban-dwelling older adults in Sri Lanka. Their findings demonstrated variation in patterns of doctor visits according to individual characteristics, highlighting the importance of understanding the factors influencing service use rather than assuming that the availability of services guarantees equitable access.

Although the study focused on urban residents, its findings reinforce the need for locally relevant assessment of barriers affecting different populations. Rural, estate-sector, economically disadvantaged and socially isolated older adults may experience different challenges. Further research is required to establish how these barriers vary across districts and population groups.

4. Current policy and service context in Sri Lanka

4.1. Existing policy commitments

Sri Lanka's National Elderly Health Policy, approved in 2017, provides an important foundation for strengthening healthcare for older people. As described in the Ministry of Health's National Health Policy Review, the policy emphasises comprehensive healthcare, trained human resources,

rehabilitation, palliative care, long-term care and integration of elderly healthcare into the primary healthcare system (Ministry of Health, Sri Lanka, 2022).

These priorities recognise that the needs of older people cannot be met through hospital treatment alone. Preventive services, community participation, family support and coordinated continuing care are also necessary.

The existence of a national policy, however, does not by itself demonstrate the extent to which its provisions have been implemented. Assessment of implementation requires evidence on service coverage, workforce availability, financing, referral arrangements and health outcomes. Further evaluation is needed to identify which policy commitments have been translated into routine practice and where additional investment or organisational changes are required.

4.2. The role of primary healthcare

Sri Lanka has a long-standing primary healthcare foundation, and reforms have sought to strengthen primary healthcare towards universal health coverage. Perera et al. (2019) highlighted the importance of accelerating primary healthcare reform in response to demographic ageing and the burden of non-communicable diseases.

For older people, primary healthcare can provide a continuing point of contact for preventive services, chronic disease monitoring, functional assessment and coordination of care. It can also help identify people who may benefit from rehabilitation, caregiver support or specialist review.

However, effective primary healthcare requires more than first-contact consultations. It depends on appropriate clinical protocols, trained personnel, reliable access to medicines, functioning referral pathways and mechanisms for communication between providers.

A stronger primary healthcare role should therefore complement, rather than replace, specialist and hospital services. Older people with complex conditions must retain timely access to specialist assessment while receiving coordinated follow-up closer to home whenever appropriate.

4.3. Long-term care and community support

Long-term care becomes increasingly important when older people experience persistent limitations in physical or cognitive functioning. Such care may involve assistance with daily activities, nursing support, rehabilitation, supervision and help for family caregivers.

The Asian Development Bank's *Country Diagnostic Study on Long-Term Care in Sri Lanka* examined the policy and regulatory environment, service provision, workforce capacity and financing of long-term care (Asian Development Bank, 2021). The study provides an important foundation for understanding the need to develop a more coordinated approach to long-term care.

Family members remain important sources of support for many older people. However, reliance on informal care alone may become difficult when family members are employed, live at a distance or have their own health or financial constraints. A sustainable system should recognise family contributions while developing appropriate formal services, caregiver education and respite support.

The relationship between healthcare and social care is particularly important for older people with substantial functional limitations. Hospital treatment may address an acute illness, but a safe return home may depend on rehabilitation, suitable living arrangements, access to assistive devices and reliable caregiver support.

5. Major challenges in strengthening geriatric care

5.1. Fragmentation and limited continuity of care

Older people with multiple health conditions may receive care from several providers and institutions. Without adequate coordination, clinical information may not follow the patient, medication changes may not be communicated clearly, and follow-up arrangements may be inconsistent.

Hospital discharge is a particularly important transition. Older patients may require medication reconciliation, rehabilitation, wound care, mobility support or follow-up for chronic diseases. If these needs are not communicated to the next provider and caregiver, recovery may be compromised and avoidable healthcare use may increase.

A coordinated system should establish clear responsibilities for discharge planning, referrals and follow-up. These arrangements should be proportionate to the patient's needs, with more intensive coordination for people experiencing frailty, multimorbidity or limited social support.

5.2. Workforce capacity and multidisciplinary care

High-quality geriatric care requires healthcare workers who understand the interaction between medical conditions, functional ability, psychological wellbeing and social circumstances.

Relevant competencies include assessment of mobility and falls risk, recognition of cognitive and mood problems, medication review, nutritional assessment, rehabilitation planning and communication with caregivers. These competencies can be incorporated into continuing professional development for doctors, nurses and other healthcare personnel.

Multidisciplinary care may involve medical officers, nursing officers, pharmacists, physiotherapists, occupational therapists, nutrition professionals, mental health professionals and social care personnel, depending on local availability.

A major implementation challenge is determining how such services can be organised where specialist personnel are limited. A feasible approach would combine training for existing primary healthcare teams with clear referral pathways to professionals who can provide additional assessment and support.

5.3. Resource constraints and age-friendly environments

Resource limitations may affect the availability of rehabilitation facilities, suitable equipment, accessible consultation areas and trained personnel. Older people with impaired mobility may also experience difficulties using facilities that lack appropriate seating, clear signage, accessible toilets or safe movement between service areas.

Age-friendly care does not necessarily require extensive new infrastructure in every facility. Improvements may include safer walkways, priority arrangements for people with functional limitations, accessible information, appropriate seating and better organisation of patient flow.

However, physical modifications must be accompanied by appropriate clinical processes. An accessible building alone cannot provide integrated care without adequate assessment, communication, follow-up and referral arrangements.

5.4. Medication safety and clinical complexity

Older adults may use several medicines prescribed by different providers. This creates opportunities for duplication, drug interactions, inappropriate prescribing and difficulties following treatment plans.

Medication review should therefore be an important component of integrated geriatric care. Healthcare professionals should reconcile medicines at transitions between settings, assess whether each medicine remains necessary, and consider the patient's renal function, cognition, mobility and ability to manage the regimen.

Clinical decisions must be individualised. Reducing medication numbers should not be treated as an objective in itself; the purpose is to optimise treatment according to expected benefits, potential harms and the preferences of the older person.

5.5. Limitations in long-term care and caregiver support

The need for continuing assistance may increase when older people develop substantial functional limitations or cognitive impairment. However, the availability, affordability and coordination of long-term care services require further development and evaluation in Sri Lanka.

Family caregivers may require education, emotional support, practical advice and assistance in navigating health and social services. Without adequate support, the responsibility of care may become difficult to sustain.

A comprehensive strategy should include community-based services where feasible, respite support, caregiver training, rehabilitation and appropriate residential care for people whose needs cannot be met safely at home.

5.6. Information systems and evidence gaps

Integrated care depends on timely information about diagnoses, medicines, functional status, referrals and follow-up. Inadequate information exchange can contribute to duplication, missed appointments and discontinuity between hospital and community services.

Sri Lanka would benefit from evaluating practical ways to improve communication across service levels, including standardised referral documentation, shared care plans and appropriate digital records.

Research gaps also need attention. Further studies should examine service coverage, functional outcomes, patient experience, caregiver burden, workforce competencies, costs and differences in access between geographical and socioeconomic groups. Without such evidence, policymakers may find it difficult to prioritise interventions or assess whether reforms are improving outcomes.

6. Opportunities for an integrated primary healthcare approach

6.1. Adapting the WHO ICOPE framework

The WHO Integrated Care for Older People (ICOPE) framework provides a useful foundation for strengthening person-centred assessment and care planning in primary and community settings. Its second-edition guidance describes pathways for identifying declines in intrinsic capacity, assessing individual needs, developing personalised care plans and monitoring implementation (WHO, 2025).

Intrinsic capacity refers to the combination of an individual's physical and mental capacities. Relevant domains include mobility, cognition, vitality, vision, hearing and psychological capacity. The ICOPE approach also recognises social support and caregiver needs.

For Sri Lanka, the framework could be adapted to existing primary healthcare services rather than introduced as a completely separate programme. A phased approach could begin with a small set of feasible assessment procedures and referral pathways, followed by expansion according to local capacity and evaluation findings.

The framework should be used flexibly. Screening and assessment procedures must be appropriate to the training of personnel, available referral services and the preferences of older people.

6.2. Introducing routine comprehensive assessment

Older people attending primary healthcare institutions could benefit from assessment that considers more than the presenting complaint. Depending on local resources and individual need, this may include:

- Chronic disease status and recent changes in health.
- Current medicines and potential medication-related problems.
- Mobility, falls risk and activities of daily living.
- Nutrition, sensory difficulties and cognitive concerns.
- Psychological wellbeing and social support.
- Caregiver needs and the person's own care priorities.

Assessment should lead to an appropriate response rather than becoming a documentation exercise. Identified problems should be linked to practical interventions, follow-up or referral.

Comprehensive geriatric assessment may be especially valuable for older adults with complex needs. However, it should be implemented in a way that is proportionate to available resources and does not create unnecessary barriers to routine care.

6.3. Strengthening multidisciplinary teamwork

Integrated care requires clear roles and effective communication among healthcare professionals. A practical model could establish a designated clinician or care coordinator for older adults with complex needs, supported by available nursing, pharmacy, rehabilitation and community services.

Multidisciplinary discussion need not require every professional to be physically present at every consultation. Depending on the complexity of the case, coordination may occur through scheduled meetings, telephone communication, referral documentation or secure electronic systems.

The central objective is to ensure that relevant professionals work towards shared goals and that older people and caregivers understand the agreed care plan.

6.4. Establishing stronger referral and discharge pathways

Clear referral and discharge arrangements could improve continuity between primary healthcare and hospitals.

A standardised discharge summary should communicate the principal diagnosis, relevant investigations, medication changes, rehabilitation requirements, warning signs and planned follow-up. Where possible, responsibility for arranging follow-up should be explicit.

For patients with complex needs, primary healthcare teams should receive timely information and have a clear route for seeking advice from specialist services. Conversely, specialist services should be able to refer patients back to primary care when continuing management can be provided safely at that level.

6.5. Developing community-based support

Community-based services can complement facility-based care by supporting prevention, rehabilitation, caregiver education and follow-up. Their organisation should reflect local needs and available resources.

Possible approaches include targeted home visits for older adults with substantial mobility limitations, community rehabilitation, caregiver education and referral to relevant social support services. Community organisations and trained volunteers may contribute to social engagement and identifying unmet support needs, provided their roles are clearly defined and appropriate confidentiality and safeguarding arrangements are maintained.

These services should not substitute for necessary professional assessment or treatment. Instead, they should provide an additional link between older people, families and the formal health system.

6.6. Improving age-friendly healthcare facilities

Hospitals and primary healthcare institutions can strengthen their responsiveness to older adults through practical improvements in accessibility and service organisation.

Potential measures include accessible entrances and toilets, safe walking areas, appropriate seating, clear signage, understandable health information and arrangements to assist patients with mobility or sensory limitations.

Staff education should reinforce respectful communication, shared decision-making and recognition of the differing needs of older adults. Care should avoid age-based assumptions and should support the person's autonomy and preferences wherever possible.

7. A proposed framework for integrated geriatric care in Sri Lanka

Drawing on Sri Lankan policy priorities, evidence on healthcare utilisation and long-term care, and the WHO ICOPE approach, this review proposes a framework organised around five connected components.

Component 1: Community and primary healthcare. Primary healthcare institutions provide health promotion, preventive care, chronic disease monitoring, initial assessment of functional concerns and identification of social support needs.

Component 2: Comprehensive assessment and personalised care planning. Older adults with identified needs receive further assessment appropriate to their circumstances. A care plan records clinical priorities, functional goals, medication considerations, rehabilitation needs and follow-up arrangements.

Component 3: Hospital and specialist services. Patients requiring specialist investigation or acute treatment are referred through defined pathways. Discharge planning connects hospital care with continuing primary and community services.

Component 4: Rehabilitation, long-term care and caregiver support. Physiotherapy, occupational therapy, community services, family caregiver education and formal long-term care are linked to the care plan according to need and availability.

Component 5: Governance, workforce and information systems. Health authorities support implementation through workforce development, resource allocation, referral protocols, information sharing, monitoring and evaluation.

These components should operate as a connected pathway rather than as separate programmes. The older person and their preferences should remain central to decisions across all settings.

Table 1. Proposed priorities for strengthening integrated geriatric care

Priority area	Proposed action	Suggested monitoring indicators
Primary healthcare	Introduce feasible functional and clinical assessment procedures	Proportion of eligible older adults assessed
Workforce	Provide training in geriatric assessment and coordinated care	Number of staff trained; competency assessment results
Medication safety	Strengthen medication reconciliation and review	Proportion of selected high-risk patients receiving medication review
Referral coordination	Standardise referrals and hospital discharge communication	Proportion of discharges with documented follow-up plans
Rehabilitation	Improve access to appropriate rehabilitation services	Referral completion and functional outcomes
Community support	Develop targeted home and caregiver support pathways	Service uptake and caregiver-reported needs

Priority area	Proposed action	Suggested monitoring indicators
Long-term care	Strengthen planning, quality standards and links with health services	Service availability, quality indicators and unmet care needs
Governance and data	Establish monitoring and evaluation arrangements	Completeness of reporting and use of indicators in service planning

Note: These are proposed indicators for future implementation and evaluation, not reported results from an existing Sri Lankan programme.

8. Policy and implementation recommendations

8.1. Strengthen primary healthcare as the coordinating platform

The Ministry of Health and relevant provincial authorities should consider how geriatric assessment and follow-up can be incorporated into existing primary healthcare services. Implementation should begin with locally feasible procedures and clear referral pathways rather than creating parallel services without adequate resources.

8.2. Develop a competency-based workforce strategy

Training should address functional assessment, multimorbidity, medication safety, communication, rehabilitation and caregiver support. Continuing professional development should be supported by practical protocols and access to specialist advice.

8.3. Improve transitions between hospital and community care

Hospitals should strengthen discharge planning for older people with complex needs. Clear documentation, medication reconciliation and agreed follow-up arrangements should connect hospital teams with primary healthcare providers and caregivers.

8.4. Develop sustainable community and long-term care services

Policy planning should consider the availability, quality, affordability and financing of long-term care. Family caregivers should be recognised as partners in care, while access to professional support and appropriate residential services should be developed according to need.

8.5. Improve information systems and accountability

Standardised indicators should be developed to monitor service coverage, continuity, patient experience, functional outcomes and equity. Information systems should support appropriate communication between providers while protecting confidentiality.

8.6. Evaluate implementation before scaling up

Pilot programmes could be introduced in selected settings representing different service contexts. Evaluation should assess feasibility, acceptability, resource requirements, equity and clinical or functional outcomes. Lessons from implementation should inform subsequent adaptation and expansion.

8.7. Strengthen research and international collaboration

Research priorities include national and subnational assessments of unmet geriatric care needs, caregiver burden, service utilisation, workforce capacity and long-term care financing. Collaboration with regional and international research groups may help identify adaptable approaches while strengthening the local evidence base.

9. Discussion

The evidence and policy context reviewed in this article indicate that strengthening geriatric care in Sri Lanka requires a shift towards coordinated services that address clinical, functional and social needs together. Population ageing increases the importance of maintaining independence and preventing avoidable deterioration, while multimorbidity and functional limitations create demands that extend beyond individual clinical encounters.

Sri Lanka's existing public healthcare network and policy commitments provide a foundation for developing integrated services. The challenge is to translate these commitments into practical arrangements that connect primary healthcare, hospitals, rehabilitation and long-term care. The 2021 Asian Development Bank country diagnostic study highlights the importance of considering long-term care provision, workforce capacity, regulation and financing alongside clinical services (Asian Development Bank, 2021).

Evidence on healthcare utilisation among older Sri Lankans also demonstrates the value of examining how individual characteristics influence service use (Wickramarachchi et al., 2022). This reinforces the need for service planning that recognises differences in accessibility, social support and healthcare requirements. However, existing studies do not provide a complete national assessment of all barriers to integrated geriatric care. Further research is needed to establish the extent and distribution of unmet needs.

The WHO ICOPE framework offers a useful international reference because it combines assessment of intrinsic capacity with personalised care planning and follow-up. Its adaptation could help shift the focus from isolated disease management towards maintaining functional ability and responding to individual priorities. Nevertheless, the framework should not be assumed to produce improved outcomes automatically. Its effectiveness in Sri Lanka would depend on appropriate training, accessible referral services, continuity of care and realistic resource allocation.

A phased implementation strategy is therefore preferable to an ambitious model that cannot be sustained. Initial implementation could focus on selected primary healthcare institutions, with links to referral hospitals and available rehabilitation services. Evaluation should establish whether the approach is acceptable to older people and healthcare workers, whether it improves continuity, and what resources are required for wider implementation.

International relevance lies in the broader challenge faced by health systems seeking to respond to ageing within limited resources. Sri Lanka's experience may provide lessons for other LMICs concerning the use of existing primary healthcare structures, the integration of family and community support, and the development of sustainable care pathways. However, transferability will depend on differences in health financing, workforce capacity, family structures and social protection systems.

10. Limitations of the review

This review has several limitations. First, it uses a focused narrative search rather than a systematic review methodology. The search was not designed to identify every relevant publication, and the possibility of selection bias cannot be excluded. Second, the availability of published Sri Lankan research varies across topics, and some areas of service delivery may be insufficiently documented. Third, international evidence may not be directly transferable to Sri Lanka because of differences in healthcare organisation, resources and social circumstances.

Finally, the integrated-care framework and implementation recommendations presented here are proposed approaches derived from the literature and policy context. They have not been tested as a single intervention in Sri Lanka. Further empirical research and evaluation are necessary to determine their feasibility, costs and effects on patient outcomes.

11. Conclusion

Population ageing creates an important challenge and an opportunity for Sri Lanka to strengthen the organisation of healthcare for older people. Although the country has an established public healthcare system and a policy foundation for elderly healthcare, effective responses require closer coordination between primary healthcare, hospitals, rehabilitation, community services and long-term care.

An integrated, person-centred approach should prioritise functional assessment, chronic disease management, medication safety, multidisciplinary collaboration, effective referral pathways and support for family caregivers. The WHO ICOPE framework provides a useful basis for adapting these principles to primary and community care, provided implementation is tailored to local resources and service capacity.

Progress will require coordinated policy leadership, workforce development, sustainable financing, better information systems and systematic evaluation. By strengthening continuity of care and focusing on the needs and preferences of older people, Sri Lanka could develop a more responsive and equitable model of geriatric care while generating lessons relevant to other countries experiencing population ageing.

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