EDITORIAL

Falkland Islands

Medicine in the Falkland Islands

R Diggle

A unique healthcare system

The Falklands are a British overseas territory just to the east of the southern tip of South America that came to world attention during the 1982 conflict with Argentina. The archipelago comprises two main islands and some 20 other inhabited islands and upwards of 300 smaller ones, covering an area about the size of half of Wales. Most of the population is centred in the capital, Stanley, and in the military base at Mount Pleasant. The total population, civilian and military, is some 5000, with the deep sea fishing fleets adding another 5000 or so. The islands are situated on the same latitude as Oxford, but due to the lack of the Gulf Stream are cooler than southern England—the climate being more akin to Scotland, where a significant proportion of the early settlers originated from.

The medical services are based in Stanley at the King Edward VII Memorial Hospital which was rebuilt in 1987 after a tragic fire destroyed the previous wooden building. Out of the ashes arose a modern very well equipped facility. The range of equipment and facilities often surprises medical visitors, since Stanley is really only the size of a British village. This is because the hospital is the only medical facility for a large area of the South Atlantic, with referrals coming from as far as Tristan da Cunha, South Georgia, and Antarctica.

Before the 1982 conflict the medical services were very limited mainly due to poor state of the economy. The medical situation was third world in nature with general practitioner (GP) surgeons and GP anaesthetists doing their best with limited facilities. Referrals could be made to the UK, Argentina, or Uruguay but very difficult due to poor communications and lack of money. Overnight the recapture of the Islands brought consultant standard British medicine in the form of the British military medical services. Development of the Islands’ economic structure, with the formation of a fisheries zone, carefully monitored and licensed, has produce 20 years of sustained economic growth to the Islands. Investment in infrastructure, health, and education and maintenance of a sustainable fishery has been the main political priority.

The pattern of illness here is very similar to Britain, although colorectal cancer was particularly common. In 1997 a colorectal screening programme was introduced, with colonoscopies every 18 months to three years for high risk families and a screening fiberoptic sigmoidoscopy at aged 55 for the general population. With a 99% uptake this screening programme appears to have virtually eliminated colorectal carcinoma as a cause of death and morbidity. This programme was started in conjunction with St Mark’s Hospital in London and the Imperial Cancer Research Fund. The gene mutation for two families has been identified and occurs in only one other place in the world (I Frayling; unpublished data, 2002). This raises the hope of effective genetic testing for some families.

The health service has similarities with the British system, but also significant differences. It is a state funded system largely funded by fish licence revenue but also by income tax. Services are free at the point of delivery to Falkland Islands residents and to British residents under a reciprocal health agreement. There are no prescription charges as the cost of collection would exceed the revenue. Four full time and one part time GP provide the general medical services and also undertake a wide range of other medical activities. There is one consultant surgeon and one consultant anaesthetist who are provided by a British locum agency on four month tours of duty. Although the surgical workload is fairly small they are on call permanently, therefore four months is felt to be the maximum reasonable tour of duty. Many of these locums are returning on a regular basis providing a continuity of service, which is audited by surgical and anaesthetic advisors appointed by the Falkland Islands government. These advisors are eminent in Britain but are familiar with providing services in remote areas, thus ensuring that standards are maintained at appropriate levels.

Nursing staff are a mixture of Falklanders who have trained in the UK, contract staff mainly from the UK, New Zealand, or Australia and locally trained staff. Increasing links with British NHS trusts has resulted in two trusts seconding staff, to provide a radiographer, a biomedical scientist, and a dental hygienist.

The GPs provide traditional general practice, but have also expanded their skills to provide accident and emergency services (they have all been trained on the Advanced Trauma Life Support programme), inpatient general medical care, obstetrics, paediatrics, long stay care, and psychiatric care to name but a few. In essence the GPs have to provide everything that is not surgery or anaesthesia. One GP has specialised in endoscopy to copy the colorectal screening programme and an open access service, another has specialised in ophthalmology, two undertake diagnostic ultrasound, two undertake the family planning, two do occupational health, and so on. One of the challenges is keeping up to date and revalidating in all these fields. This wide ranging service is supplemented by visiting specialists recruited mainly from the UK. Thus it might be orthopaedic fortnight or gynaecology fortnight or cataract week.

The service to the outlying farms and settlements is markedly different to the UK. Many farms will be 100 miles away, so consultations will be by telephone and they may be advised to take medication from the “medicine chest” that is provided. A replacement for the chest is then sent in the post. Routine and emergency visits to the outlying settlements are generally by small aircraft along the lines of the well known Royal Australian Flying Doctor Service. The doctor will stay at a farm overnight and consult all the local residents who are also our personal friends. Possibly the ultimate in holistic medicine?

Telemedicine clearly has a major part to play in the Falklands, mainly to seek advice from colleagues in the UK. Radiographs and photographs of skin rashes are commonly emailed for advice. With the installation of new x ray equipment with the Agfa CR Digipan digital processing system it will be possible for all radiographs to be reported on by a consultant radiologist. The main limiting factor in teledermatology is the absence of ISDN lines or broadband communication, although it is likely to be installed within a year or so.

The cost of providing the service is very similar to the British average at £950 per head of population per year. There is no economy of scale but on the other hand we do not need to provide expensive tertiary and secondary level care as we refer these cases to the UK or South America.

Maintenance of standards is critical in such a small system. As previously mentioned, the surgical and anaesthetic services are externally audited, the GP services are due to be audited by the Royal College of General Practitioners later this year, and the laboratory participates in the UK NEQAS system and scores well above average. Clinical governance holds few worries for us as we already have a performance management scheme for all staff. In my opinion
the key to an effective clinical governance system is to ensure that the standards are agreed as being relevant and meaningful by the staff that are to be assessed and that adequate resources are made available to rectify any deficiencies highlighted. The Falkland Islands Government has recognised this and is committing significant sums to staff training.

Health priorities are set by the Chief Medical Officer writing a “Health of the Nation Report” on a regular basis. Recent issues that have been highlighted are smoking, alcohol, dental health, and provision of care to the elderly and vulnerable in society. Working parties chaired by lay persons and including a majority of interested public, including youth, have produced in depth reports that now have to be implemented. Attitudes to smoking in the Falklands are very different to Britain, with a higher rate of smoking and very few smoke-free areas. Attitudes are beginning to change. There is a clear link between alcohol and depression; services to deal with these problems and education to alter society’s behaviour are urgently required. Dental health is poor, partially due to lack of fluoridation of the water supply. The debate to fluoridate is just about to begin. Strangely in most countries poor dental health is associated with poverty, but here it is associated with affluence, with parents providing their children with too many sweets and sugar-containing drinks.

The delivery of healthcare in the Falklands clearly demonstrates that it is possible to have high quality healthcare without large numbers of superspecialists and that doctors, nurses, and other health workers can expand their roles provided that they are supported by access to advice by telephone or email and given adequate training. This model of healthcare is radically different from that of the UK, which is going down the road of increasing specialisation and subspecialisation. There are a number of reasons that the UK has gone down the route it has: Calman training, medicolegal concerns, a generalised blame culture, and league tables. No longer is doing one’s best considered adequate. Although supervision of the medical profession needed revamping, the obsession with surgical results is producing a climate where anything less than perfection is unacceptable, however unreasonable this may be.

My opinion is that the demise of generalists is a very retrograde step. In the long term it will lead to fragmented care and increased costs. Certainly for the Falklands it is going to create a major recruitment problem as there simply will not be the type of GPs, surgeons, and anaesthetists that we require. I believe the only solution is to develop a specialty of rural/remote medicine. Diplomas offered by Aberdeen and the Peninsular medical schools are a welcome step in the right direction, but I believe we must continue to train broadly educated hospital specialists.

The enjoyment of working in a remote place such as the Falklands is the sense of fulfilment in providing a thoroughly good level of service to the community one lives in, most of whom are personal friends or acquaintances. There are frustrations in that anonymity is impossible, and working for a civil service results in inevitable bureaucratic delays compared with the relative freedom of working as an independent contractor.

In the longer term the key to a successful health service is that policy is developed by the professionals in close consultation with the politicians; funding matches tasks and objectives are those that are considered medically desirable rather than politically expedient. In the Falklands the health professionals have a closer and effective relationship with the politicians. Achieving that goal in the UK sadly seems to be remote.

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