Emergency Health Care Overseas
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Many older people travel the world believing that holiday health insurance will ensure optimal quality emergency evacuation, medical care and repatriation. It may, but much depends upon local facilities at location of injury, or illness. Quality and availability of resources vary markedly between regions, countries and localities. Climatic season and transportation infrastructure also affect evacuation and repatriation. Older people are more likely than the young to become ill while abroad, are likely to be hospitalised for longer and require medical repatriation.[1]. Elderly tourists should be aware of the quality of health resources they may meet in time of need. They should investigate and consider the quality of service, speed of response and ease of repatriation when planning their holiday. Travel health professionals should draw attention to these preparations in pretravel clinic consultations.

The quality of emergency health care likely to be met by the older traveller, who is more likely than a younger travel companion to need medical aid while abroad, varies markedly from country to country. The quality and availability of emergency evacuation, aid staff, resources and equipment may determine whether the ill or injured will survive an unfortunate medical mishap or accident which occurs abroad. The old are especially likely to need these services and emergency aid and repatriation should be considered by all older travellers when organising an itinerary and an informed decision made as to whether they should accept the risk of poor medical aid in time of need. Emergency health care in the frequently visited tourist destinations listed is addressed in this chapter.

Tourist Destinations

North and Western Europe
Eastern Europe and Danube cruises
Mediterranean coastlands
Baltic and Black sea cruises
Caribbean islands
Middle East
North America
South America
West Africa and African safaris
Asia and Far East
Australia and New Zealand

Europe

Many tourists travel within and along the coasts of Europe and ill Britons can now often obtain speedy, high quality care in countries within the European Union. The EHIC card covers emergency health care in the 27 members of the EC and a few other states. Standard of resources and medical care however varies within European boundaries. Britons using this service must present a EHIC card entitling them to free medical treatment within the European Economic area. Insurance organisations may not reimburse treatment claims if it has not been produced at the point of treatment.[2] The member countries of the European Union (2011) are:

Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom and reciprocation includes Canary Islands, Azores, Madeira and French Guyana, Guadeloupe, Martinique. The European Health Insurance Card (EHIC) allows individual access to state-provided healthcare in all European Economic Area (EEA) countries and Switzerland at a reduced cost, or sometimes, free of charge. Applying for the card is free and it is valid for five years. Presenting the EHIC CARD entitles the bearer to treatment necessary during the trip, but does not allow travel abroad specifically to receive medical care. However, renal dialysis and management of pre-existing or, chronic, conditions that arise while abroad are all covered by the EHIC. It allows access to the same state-provided healthcare as a resident of the country being visited. However, many of thee countries expect the patient to pay towards cost of treatment.

France. Linked closely by rail and sea to the UK**,** is the country most visited by Britons. There is no great difference in quality of care between private and public hospitals in France and little difference in price. Treatment, whether private or public, is not free at point of delivery. Patients pay the full bill and are then reimbursed later. Being treated in private clinics in France does not mean avoiding waiting lists as they do not exist, but going private does not mean footing the entire bill .3.

Germany. East German general practice under communism was tightly controlled in large polyclinics. City doctors are now encouraged to run single handed practices as in West Germany. Visitors pay the GP and claim a refund if they have produced an EHIC card. In **Germany, Poland Slovenia, Hungary, Slovakia, Austria, Czech Republic, Spain, Portugal and Italy** GPs usually work single handed ,are unlikely to have practice nurses and do not practice gynaecology. Health centres in Spain and Portugal employ salaried doctors. Home visits are infrequent, with out of hours work done by co-operatives working out of hospitals, or health centres. In France, Spain and Germany, it is now advantageous for travellers who suffer acute cardiac problems to undertake immediate by-pass surgery abroad, rather than return to the UK to be wait listed.4

Spain. A network of private and state health institutions and EC reciprocal health care ensure Britons can expect as good and often better health care in emergency than in the UK. Travel health insurance companies now organise clients requiring cardiac intervention, stent insertion and by-pass surgery to receive this in Spain for prompt efficient service. In Spanish hospitals along the tourist dominated Mediterranean coast, there are dedicated English translators on call to ease linguistic problems.

Italy. The country ranks second on the WHO list of countries for top quality health care services. However, many public hospitals are overcrowded and underfunded, although medical facilities are adequate for emergencies. Visitors are expected to pay full hospital charges and then claim reimbursement from their insurance provider. In case of emergency, most general and regional hospitals have emergency rooms (pronto soccorso), open 24 hours a day.

Greece. Greece's public health system provides free or low cost health care for those who contribute to Greek social security. Although medical training is of a high standard, the health service is one of the worst in Europe, largely because of under-funding. Public hospitals are inundated with patients. Standards of hygiene are high however and hospital virus infection almost non-existent. In Greece GPs are replaced by internists, who are physicians doing primary care work. A large hospital on Corfu, a favoured tourist island, has recently been completed. In some hospitals patient eating resources have to be provided by relatives, which present a problem for an ill unaccompanied tourist. Hospital and A&E departments are often manned by private doctors.

Malta and Cyprus. In Malta and Cyprus, favoured holiday spots for Britons of retiral age, most GPs work privately. A large central regional hospital has been completed recently in Malta. In the Maltese state and private sector, diabetes is managed in secondary care and GPs may not even arrange x-rays to check for fractures. In Cypriot and Greek towns, hospital and A&E departments are manned by private doctors.

European river cruises

British tourists visit the European community on land tours and transit many countries in east and west Europe on river cruises. Small ships, without on-board doctors, cruise along the rivers Danube and Rhine and are popular with aging and often ailing tourists. They are reassured by the thought that reciprocal health arrangements will provide for emergency health care. The majority of countries neighbouring the Danube in its long course are members of the EC, with a few exceptions such as Serbia and Croatia and Albania. The standard of available emergency medical care and facilities varies greatly, with cross border travel.[5]

In Western Europe, high quality resources equate with those in the NHS and are immediately available. In eastern European countries, struggling health care systems may not provide the urgent care the ill traveller requires. Immediacy of assistance may also be a problem, as rivers run through many rural areas far from population centres, where ambulance transfer may be unavailable. Private health insurers therefore may not be able logistically, to provide optimal care for tourists in emergency. Insurance companies can only provide what is available from local resources and the patient may have to augment financial agreements, with "informal arrangements"-bribes.[6]

Romania This is a poor Balkan country and new European Community member. It is shedding a culture of Communist corruption, when bribery affected every administrative system, including health care. Medical care in Romania is generally not up to Western standards, and basic medical supplies are limited, especially outside major cities. The country's health care system is so underfinanced, that it faces imminent collapse. Even large university hospitals often lack surgical gloves, antibiotics and medication, forcing patients to pay for them. Buildings are in need of repair with rusting surgical instruments, dilapidated examination beds, cracked, damp walls and dirty toilets common. Private medical providers

meeting Western quality standards are available in Bucharest and other cities but can be difficult to locate.

Doctors are still accustomed to receiving bribes and low average monthly medical wages encourage bribe-taking. Patients pay more to get good clinical and nursing attention.[6]Transparency International, ranked Romania as the second most corrupt country in the 27-member European Union in 2010, behind Bulgaria. A World Bank report concluded that "informal payments" amounted to £200 million annually. Ethically practising doctors observe that the bribery culture is so established that, when bribes are refused, patients mistakenly believe it a sign that illnesses are incurable! Bribery will be required from the ill tourist and costs range from £75 for appendicectomy to £4000 for surgery, with prices posted on blogs and Web sites.

Considerations

- Potential health risks within Romania include hepatitis A, polio, typhoid, and rabies – Travellers to Romania should ensure they are up to date on all routine and hepatitis immunizations. Dental treatment, tattoos and injections should be avoided when within the country and its neighbours.

- Travellers seeking medical treatment should choose provider carefully as quality care is scarce and endeavour to get treatment at a well-equipped centre by travelling to county or capital hospital, where staff may speak English. Visitors must tip medical personnel to guarantee that sufficient attention is given to their medical conditions.

Hungary. Hungary transformed its healthcare system to a decentralised model and now has EC reciprocity. All citizens are covered, regardless of employment status. Patients make co-payments on certain services, including pharmaceuticals and dental care.[7] GPs contract with the Hungarian Insurance Fund and provide a prescription and referral service [8]. In hospitals, the fee-for-service payment scheme encourages hospitals to treat for financial gain.[9]. The system often sees doctors doing nursing duties. Apart from out-of-pocket payments for pharmaceuticals and dental care, 'gratitude 'payments-bribes- by patients, continue to play an important role.[10]

Consideration. Unaware tourists unprepared to offer bribes will receive inferior care.

Bulgaria. The Bulgarian healthcare system is slowly catching up with Western European nations. Citizens have access to a free national health service. Medical equipment in many establishments is in poor condition, often more than 20 years old and the health care system is in a critical state. Medical staff is trained to high standard, receive low wages and operate inadequate and outdated machinery. Hospitals and clinics may not have the equipment and facilities expected in Western Europe. Dentists work privately and pharmacists offer affordable, unregulated treatment and medicines. Transparency International, ranked Bulgaria the most corrupt country in the European Union in 2010. There are a growing number of private hospitals and clinics and state clinics and medical services in all major towns and cities. Nursing care can be sparse, and knowledge of English limited.[11]

Consideration.

- Doctors and hospitals may expect immediate payment in cash for health services. “Informal and gratitude “payments are often expected for simple medical and nursing attention.
- Dental treatment, tattoos and injections should be avoided if possible when within the country.
- Visitors should purchase comprehensive private travel medical insurance which should include medical evacuation to Britain.

Serbia. Serbia has weathered years of political and economic turmoil, ethnic strife and civil war. The country has a well-developed network of primary/secondary care centres, but the system is inefficient and underfunded with equipment and facilities out of date, staff underpaid and demoralised. A European Agency study found that only a third of hospitals had functioning sterilisation equipment and 75% of the medical equipment in health facilities was more than 10 years old. Conditions are improving but vary across the country and medical care is limited. Physicians in Serbia are well-trained, but hospitals and clinics lack equipment and supplies and in large parts of rural Serbia, ambulance service may be unavailable. In acute emergency, best option is Military Medical Academy Belgrade.[12]

Consideration.

- Health workers routinely accept” on the side” informal payments from patients and supplement income with private practice. Patients have to buy hospital supplies “out-of-pocket”, even for items such as bandages and catheters.
- Venous injections and acupuncture should be avoided if possible when within the country.

Croatia. Large parts of the country were devastated by recent war and medical facilities vary widely across the region, with best resources along the Dalmatian coast. Here Medical Tourism facilities are well established. Privatisation of primary health care (except for emergency and public health services) is under way, with about one third of primary care doctors specialists in general medicine, General practitioner-led primary health care is central to the newly organised health care system. Patients have a free choice of primary care doctor the gatekeeper to secondary care in polyclinic or hospital. Those in work and their families have access to state health care, which is covered by government-subsidized medical insurance. Over-all, facilities are good with free emergency aid available for the tourist in emergency. Major population centres have decent private health care facilities. Zagreb is best served with a large general hospital. [13]

Albania. Healthcare in Albania is mainly public/state and only partly private. The rural population and especially those in the north-eastern part of the country have a lower standard

of living and of healthcare than elsewhere. There are plans to privatise parts of the healthcare system, to improve existing infrastructure and to build new institutions. Currently there are shortages of medicines, medical equipment and hospitals are dilapidated. The qualifications of medical personnel have not been carefully regulated and nurses and doctors can still expect "informal payments " to ensure patient attention.300 healthcare centres have been refurbished and some hospitals and polyclinics in cities have also been renovated and some modern diagnostic and treatment equipment installed. Assistance from the European Community has distributed medical equipment to 500 healthcare centres and 2,200 clinics and there has been privatisation of pharmacies. A few private facilities are available to tourists in Tirana but quality of care for the ill elderly tourist away from the capital is problematic with emergency transportation a further difficulty.

Consideration. Health care and resources vary markedly across the country and emergency aid may be delayed.

- Dental treatment, tattoos and injections should be avoided when within the country. Travellers seeking medical treatment should choose provider carefully as quality care is scarce

- Tourists must tip medical personnel to guarantee that sufficient attention is given to medical conditions

Switzerland Although not a member of the EU, the country has reciprocal arrangements and the EHIC card can be used in emergency giving access to good facilities.

Summary

Medical and nursing care resources and facilities vary greatly in countries bordering the Rivers Danube and Rhine, particularly in the Balkans. The river based tourist may meet care as good as, or better than, within the NS, or be exposed to conditions closer to those met in an undeveloped country of the third world. Cruise ships without crew doctor or nurse, pass through many rural areas where health care is limited and falls far short of that available in the big cities. Tourists should remember that they cannot wholly escape the use of local health care resources in emergency. Private health insurance can only provide the best that is available locally and repatriation may be tenuous and lengthy. The public healthcare systems in Central and Eastern Europe have often been declining during the past decade and are underfunded, lack solid infrastructure and are unable to keep professional medical staff in the country.

Mediterranean and Adriatic Coasts

Elderly vacationers now holiday and reside for part of the year in large number along the Mediterranean littoral, the Adriatic and on many of their off-shore islands. Many of the countries along the shores are within the European Community and offer good and relatively standardised health care to travellers who become ill or are injured.

In developing regions and those out-with the EC bloc, standards vary and can be very poor. Tourists often only become aware of inadequacies in health facilities and support when overtaken by a medical or traumatic crisis and can suffer from delayed, or poor, intervention in emergency. Chance can also determine whether the patient under duress is exposed to state established or private health care. The response to an emergency may be delivered by a private or state sponsored ambulance, which will decant the patient into the respective health care sector, with each providing very different standards of provision and support. Linguistic difficulties and cultural differences can also create problems for those in medical need.

In general, the developed countries of the region operate private and state funded medical care, with tourists protected by travel health insurance benefiting from exposure to the former. EC reciprocity ensures that the uninsured will receive emergency care equivalent to that of the countries citizens. The EHIC card does not cover the cost of repatriation. Away from mainland Italy, France and Spain however private health care may predominate and place the uninsured at risk from an inadequacy or absence of care for foreign visitors. [14]

Spain, Italy, France, Portugal. British visitors are assured of good health support along the coastal fringe. Reciprocity ensures access to health care for all UK residents in emergency. Private care predominates in the south of Italy and in Adriatic resorts. There are many English-speaking and foreign doctors in resort areas and major cities. In Portugal nursing care and post-hospital assistance are below what most northern Europeans anticipate. In mainland Greece and its islands there are variable standards of care with patients transferred between islands and mainland by ship and air

Morocco, Algeria, Tunisia, Libya and Egypt. There may be scant or absent universal health care for citizenry and private health care predominates. State institutions may be embryonic, inadequate and offer services far below standards across the sea. Quality of resources deteriorates with distance from major population centres and may be rudimentary in the rural scene. Tourists can expect good private facilities in major cities and some emergency state provision, but in developing townships rural and small and new tourist venues, good care may be distant. Immediate first aid and casualty evacuation facilities may not exist. [15] Recent revolutions in Tunisia and Egypt bring even more uncertainty to availability very variable health care within these countries and the war in Libya has ravaged its health care system.

Morocco. The country has inadequate numbers of physicians and hospital beds and poor access to water and sanitation. The health care system includes 122 hospitals, 2,400 health centres, which are poorly maintained and lack adequate capacity to meet demand for medical care. Tourists located far from major centres and venturing into the hinterland should be aware there are few immediate response vehicles, and access to any good hospital may be hours away. Travel health insurance can only provide what is available and local provision may be non-existent, with transfer to a unit with good facilities some time away. In emergency, road traffic accident and bodily trauma exposes the traveller to admission to local facilities, where hygiene standards may be questionable.

Consideration.

- People travelling without travel health insurance cover may expect a modicum of emergency provision, but ambulance transfer, medication and surgical intervention must be paid for as well as the hotel element of hospitalisation.
- Emergency fluid and blood transfusion brings risks from contamination, HIV infection and hepatitis

Algeria. In Algeria a system of almost free national health care exists. Hospitalisation, medicines, and outpatient care are free to all. Most health services are provided by the public sector, although a small private sector has been expanding.

Libya. Before the civil war, Tripoli and Benghazi offered good private health care with some free health provision for the general populace providing a medium quality health care system, with equipment and medicines badly affected by the international trade embargo. A network of small hospitals serves littoral areas of Tripolitania and Cyrenaica. Small units with limited facilities exist in Derna and Tobruk which before the war were being visited by cruise ships. The revolution has had adverse effects on the universality of health care in the country, devastated facilities and increased variation in quality of care between east and west, rural and city areas. Rebel factions have been entering hospitals and shooting patients

Egypt. Holiday resorts extend from El Alamein to Alexandria along the Mediterranean and up the River Nile. A good transport system brings within reach, Cairo and Alexandria and prime hospital facilities in state and private sector. Dysfunctional administration and transportation make access to hospital facilities problematic and emergency journeys prolonged and resources even more constrained. Public hospitals are open to tourists. Standard of care is good in Cairo and Alexandria but varies in other parts of the country. Health care provision is lacking in remote rural areas, particularly in Western Desert oases. The 2011 revolution has brought political uncertainty with adverse impact on the health care scene.

Israel. The Health care system is reputed to be one of the most advanced in the world. The State has maintains a system of socialized health care. Providers in the Israeli system consist of a mixture of private, semi-private and public entities. Cruise ships calling at Haifa can off load ill patients and expect good local and centralised care.

Syria. Years of civil unrest and embargo had severe adverse effects on provision and quality of health care which was well-developed in the cities, involving state and private hospitals, many public and private outpatient clinics and different sorts of health centres. The health

system for rural areas was limited with few services and the country has had problems with tuberculosis infection. Syrian Health Care

Hospital bombings have brought Syria's medical system to risk of collapse. Syria's medical infrastructure is under severe threat of destruction, with more than half of the country's hospital's already destroyed or damaged in the civil war. Systematic assaults on medical professionals, facilities and patients are breaking Syria's health-care system and making it nearly impossible for civilians to receive essential medical services.

ln two and a half years of civil war, 37 % of Syrian hospitals have been destroyed and a further 20 % severely damaged, WHO figures reveal. Many health workers are currently imprisoned, and 15,000 doctors have fled abroad. Of the 5,000 physicians in Aleppo before the conflict started, few remain. Civilians have to recourse to primitive field hospitals, run by untrained local volunteers, often using basic medicines. Medical volunteers have to smuggle in medical aid and medications in to areas besieged by the regime, or armed rebels,

Turkey. Turkey has a complex health care system of variable quality, especially in most state hospitals. Private hospitals have raised the quality of physicians and medical equipment. Most hospitals and doctors are concentrated in cities and big towns. Private health insurance is well developed in major centres and most popular tourist resorts. A scant health service exists in rural areas with large distances between emergency aid locations and poor transportation facilities in the hinterland.

Albania. has a health care system in transition. It offers basic primary health care system, but many facilities were damaged in conflict up to 1997 and deficits are present in expertise, skills and management. Facilities remain publicly owned with the exception of licensed private pharmacies and dentists. (See European River Cruises.)

Croatia, **Greece, Italy** See comment on EC countries.

***Summary*.**

When **t**ravelling round the Mediterranean coast, the tourist will be exposed to considerable variation in standard and quality of care available in emergency. It is important to carry the EHIC health card to access reciprocal services where they apply and acquire travel health insurance protection for extra protection for general travel in the region. Distances to good private and state emergency care may be considerable and ambulance transportation limited.

Baltic and Black Sea Cruising

Large and small ship cruising round the Baltic and Black Seas attracts elderly travellers. If illness or trauma befalls passengers, there is recourse to the ship doctor who will off-load seriously ill or injured patients at the next port of call or by helicopter rescue to the nearest land hospital. Most of the shores of the Baltic belong to the EU countries Denmark, Sweden, Germany, Lithuania, Latvia and Estonia which have reciprocal emergency health arrangements with the UK. Travel health insurance cover will be required for repatriation if needed.

Russia. Most ships sailing the Baltic Sea call into St. Petersburg and the traveller will be dependent on the Russian health care system. Russia has a very low standard of compulsory state funded healthcare compared to Western Standards. Healthcare is theoretically free and available to all citizens but patients say doctors, nurses and surgeons routinely demand payments - even bribes - from those they treat. Medical staff is adequately trained; however there is a lack of funding and medical equipment. Old Soviet ways still prevail leading to inequality. Russia has more physicians, hospitals, and health care workers than almost any other country in the world on a per capita basis, but since the collapse of the Soviet Union, the health of the Russian population has declined. Medical care in Russia is among the worst in the industrialized world. A 2000 World Health Organization report ranked Russia's health system 130th out of 191 countries. There are private medical facilities in the cities.

Case History. *A 70 year old lady on an inland tour from a cruise ship berthed in Leningrad ate infected ice cream and became ill. Vomiting and with diarrhoea the hotel doctor dispatched her in the middle of the night in a van to an infectious disease unit in the city. It was surrounded by high walls with an electrified fence and entry gates. Admitted to a ward and prostrated by loss of fluid and electrolytes she was stripped, placed under a shower and hosed down with cold water. None of the staff spoke English and she had been admitted without money, passport and day clothes. A doctor prescribed mist. mag. Trisil et pulv. given to the patient on the hand of a nurse and forced into her mouth at regular intervals. Told by signs that her group had continued on their tour, she had a dreadful, neglected few days before making a recovery. The nurses expected bribes for bed-making and provision of bedpans. Only the intervention of the tour group leader eased her discharge.*

Consideration

- Adequate travel health insurance is a must for visitors but will only provide the best available care which can be of poor quality.
- "Informal payments" may be expected for basic nursing care.
- Health facilities vary greatly within cities and across the country

Bulgaria, Georgia, Romania, Russia, Turkey, and Ukraine. These countries border the Black Sea, with health care provision for tourists akin to that described previously and often of very low standard. The Crimean coast has long been renowned for its health spas and there is a thriving medical tourism industry. Travel health insurance is vital to access private facilities and ensures speedy repatriation. (See comments by country)

Caribbean islands.

Air/cruise holidays bring many elderly travellers, to Caribbean Islands. About 20 million tourists visit the islands annually most arriving by ship.[16] and a hundred ships cruise round

them in the European winter season. They can disgorge 12,000 passengers daily on the quays of large and small islands and overburden medical resources. Although each ship carries a medical and nursing staff, if serious medical or traumatic incident occurs on board, the patient will be disembarked at the next port of call whenever possible. [17]Local medical and onward repatriation facilities may be incapable of meeting demand.[18]Medical care can also be of the variable standard Some islands have modern hospitals with good diagnostic and investigative expertise, but there may be a dearth of nurses, doctors, infrastructure and resources.

Health care provision differs from island to island depending upon size, population, and wealth and is usually provided to visitors on a private basis. There is an increasing tendency for elderly tourists, faced with high premiums and illness exclusions for current medical problems, to travel without travel health insurance cover. They travel uninsured for conditions most likely to befall them and in emergency, face high medical costs if requiring medical attention or hospitalisation. In emergency seriously ill patients may be transferred from islands to the USA for continuing treatment and be faced with exorbitant fee demands.

Disease infection risk for tourists is not high in the islands. However Dengue fever and malaria infections are increasing .**Guadeloupe and Martinique** confirm an increasing number of cases of hepatitis which is a special risk in **Dominican Republic**. HIV/AIDS remains a problem on many islands Malaria had been eradicated (except in Haiti and Dominican Republic), but there has been a resurgence in tourist frequented islands. **Jamaica, Puerto Rico and Cuba** have recently seen cases and deaths, with reports from **Cayman Islands, the British and American Virgin Islands**,

Cruise ship passengers particularly run the risk of norovirus infection and the afflicted old person may become dehydrated, debilitated and require island hospitalisation. Infected tourists from Dominica were quarantined on arrival in Glasgow in 2007. Badly debilitated sufferers will be disembarked en route, or at departure ports in Jamaica, Puerto Rica and Barbados where they may be quarantined and hospitalised with or without their consent.

Cruise ships carry many elderly passengers who suffer heart attacks and strokes on board and have to be hospitalised at next port of call. Cardiac medical emergencies are most likely to result in premature disembarkation. Many tourists also suffer from trauma during a sojourn in the islands. Road systems are often embryonic, poorly maintained and suffer urban congestion. The unfortunate victim may find that ambulance response may be non-existent, or delayed and accident and emergency facilities limited and f short in resources. A shortage of water and poor hygiene is evident inland from many of the ports. In island interiors and hinterland people are poor, live frugally in shanties. Local restaurant and café cuisine and ice cream can be infected. Small coastal resort eating places may offer barracuda and amberjack on the menu and there is a risk of cigatuera poisoning from a neurotoxin in fish which feed off reefs.

Elderly tourists sunbathe on beaches and suffer from sun over-exposure, coral abrasions, swimming and sailing accidents. Quad biking, horse riding and off-road 4x4 vehicle pastimes

tempt the senior tourist into unwise activities not contemplated in the home scene. Raft, river and rapid- running result in skin abrasions, lacerations and fractures on islands .Older people, who would never consider such activity in UK, abandon inhibition and in holiday spirit expose themselves to physical hurt ,a major cause of tourist morbidity.

In **Barbados**- a prime tour destination for Britons- one million tourists were studied revealing 704 emergency admissions with 26 deaths.14% were due to falls, 4.2 % due to road accident and 300 injuries required emergency medical evaluation/management per million tourists /year.

Case Histories:

1. *In the hinterland of Grenada, two vehicles in front of a hired car were involved in head-on road accident. One passenger was knocked unconscious and had a serious head injury. Many miles and hours from the nearest hospital, emergency aid was distant and over bad roads. There was no ambulance facility. A taxi driver had to be bribed to carry him to the emergency unit in the island capital, the only route to urgent medical care.*
2. *A cruise ship reversed passage to carry a passenger with a severe myocardial infarction back to Barbados, which had better medical facilities than the nearer small island and the next destination. After a top speed six hour sail, the patient died en route to the hospital after disembarkation. Immediate intensive care hospital attention might have saved him.*

Most islands have medical facilities which expect payment at the time of service, and there can be delays in accessing insurers if communications are poor. The islands usually have radiographic facilities but may not have MRI scanners and have limited laboratory services. To access these may mean a journey to another island, or to the mainland of North or South America. Serious cases in Trinidad are often transferred to Venezuela and in the American Virgin Islands, such as the tourist Mecca of **St .Thomas**, to the USA. Uninsured or inadequately insured patients may face unanticipated very expensive hospital and medical costs. The EHIC card is applicable in all French overseas departments (**Martinique, Guadeloupe, and French Guiana**) as they are part of the EEA, but not in Aruba

Very ill patients who are transferred to small islands may face prolonged delay in air transfer to units with better facilities, due to dearth of land and air transport and weather vagaries. Hurricane, landslide, volcanic eruption and tremor make roads impassable on many of these islands, which are mountainous or subject to flooding. The possibility of prolonged evacuation to modern medical and nursing facilities if injured or ill is not considered by British tourists, accustomed to prompt NHS ambulance transfer and emergency response.

Considerations

- Pretravel consultation should bring potential health care shortcomings to the attention of travellers to the Caribbean.

- High technological cardiac care and rehabilitative resources are unlikely to be available in many islands, a consideration for travellers suffering from chronic ill health.
- Island pharmacies have a limited range of pharmacological products. Replacement medications may not be available in the Caribbean.
- Water and food contamination should be kept in mind on small islands and in island hinterlands. Tourists should anticipate infection problems and remember the adage that ingested food should be boiled, cooked, peeled or rejected if they are to avoid food and water borne infection.
- Influenza and Pneumococcal immunisation, Hepatitis A vaccination is recommended and yellow fever vaccination is necessary for those calling in to Venezuelan ports.
- Antimalarial prophylaxis is necessary for those travelling on ships with landfalls in Central and South America.
- Dental treatment is best avoided to decrease risk of hepatitis.
- Safety of vehicular transport and availability of seat belts should be considered.
- Local evacuation, hospital and emergency resources need consideration.

Summary

A visit to Caribbean islands is associated with low health risk, but trauma, or illness can expose the tourist to lower standards of evacuation, immediate and continuing care than that expected in the UK.

Middle East

Sun, sand and antiquities attract elderly tourists to the Middle East. Along the eastern littoral of the Mediterranean and the Red Sea there has been a proliferation of holiday resorts. Sanitation and health care resources are not always commensurate with expansion of tourist facilities. In this part of the developing world access to clinics, hospitals and health professionals can be limited and the quality of resource and emergency care variable. From Sharm el Sheik to Damascus, Eilat to Dubai aged tourists embark on the cultural trail through this developing world. New hotels and beach facilities are often dependent upon primitive infrastructure and the services of personnel living in squalor. The risk to western visitors from infection and trauma is high and when overtaken by illness or injury, immediate health care may be unavailable or inadequate. (See previous section on the Mediterranean littoral.)

Facilities, resources and access can be problematic or absent in this part of the world. Recent terrorist attacks in popular resorts have exposed weaknesses in emergency response and casualty care systems. State run hospitals and clinics are often under-resourced and of

variable standard with private establishments scarce and expensive. Sea cruisers and elderly people wandering historic sites are exposed to trauma on poor roads, water sports accidents, injury from terrorist explosions and illness from ingestion of infected water and food. Passengers disembark for tours of the Pyramids and ancient Greek, Roman and Phoenician cities. Day time temperatures spiral to high extremes in the Middle East and archaeological sites become arid ovens by midday, which can desiccate the unwary. Older people are at greater risk of stroke in this situation. They can also become confused when dehydrated and may not react rationally to fluid loss, electrolyte imbalance and fail to recognise the need to rehydrate.

The local population may have primitive sanitation scant water supply and vegetable and fruit produce may have been fertilised by" night soil". Water in hotels and restaurants may be contaminated and the risk of gastro-enteric infection is high. River cruises along the River Nile bring a high risk of enteric infection from contaminated water and elderly people run a greater risk from dehydration in high ambient temperatures. Tourists forget that the on-board water may have been drawn from the river. Most passengers forget or ignore the risk of infection from salads, ice and unbottled water ingested on board and the attrition rate of illness is high. In high ambient temperatures dehydration and electrolyte imbalance can result from the resultant diarrhoea with older people likely to be more severely affected. Treatment will depend on the facilities of a local hospital limited in human and equipment resources.[19]

Case histories. *On a bus tour round the sights of Jordan only a few of the elderly tourists were fit to continue the tour one day as most had developed severe gastro-intestinal illness. The probable cause of infection was chicken they eaten at a barbeque lunch organised at an isolated scenic site perched on a hill in the desert. Hygienic preparation of the meal was difficult for the local providers in a waterless location as there were no toilets or hand washing facilities. The tourists ate infected poultry resulting in none of the infected being able to travel onward .Two required hospital care due to dehydration and prostration.*

An elderly lady was visiting the Valley of the Queens in Egypt on a broiling hot, cloudless, day, with reflections from the amphitheatre of rocks and sand escalating ambient environmental temperature. She became dehydrated, confused and was stumbling about. When given a bottle of expensive water she squandered the fluid by pouring the content of the bottle over over-heated feet rather than down her throat.

Exploration of historic sites usually means traverse of rough, unpaved locations and manoeuvres over rocks, and crudely hewn walkways. A stumble may result in fall and fracture with hospitalisation in the arthritic and older people with poor balance. Emergency aid may be distant, evacuation problematic and health professional help variable and limited. Cruise ships plying their trade in local waters tend to be small with very limited health facilities and doctors from the former soviet empire. They are restricted in passenger health support and off load the ill and injured at the nearest health facility, which may not meet western standards of care. Passengers rarely realise the limitations of small ship cover and the likelihood of immediate disembarkation to a local health facility if medical mishap occurs.

Exposure to the warm waters of the Red Sea and Persian Gulf can bring trauma within and out with the water and from over-exposure to fierce sun. If injury occurs immediate casualty care response may be rudimentary and evacuation difficult and prolonged. Reusable needles syringes and equipment can pose a threat of hepatitis B and HIV infection and blood supplies may be suspect in some locations. The sporty often also fail to arrange the additional health insurance cover advisable for their physical activities. Older tourists also undertake sub aqua diving and para gliding, riding and other sporty pursuits at these venues forgetting that the small print in their insurance policies will exclude such activity and they will not be covered in the event of accident.

Considerations

- UK health professionals should advise on potential health risks and remind of differences in emergency support likely to be encountered.
- Tourists should ensure adequate health insurance protection and remember that cover only provides the best health care available which may not meet tourist expectations.
- Travellers should be aware of health hazards they might meet, take precautions, particularly against gastrointestinal infection and seek appropriate vaccination.

Summary

There is a high risk to health in travel through the Middle East from trauma, infection particularly gastro-intestinal disease and civil unrest. High ambient temperatures bring the risk of dehydration and sun burn. Quality of emergency care facilities varies from country to country and within the country. Good medical aid may be distant and evacuation difficult and lengthy. There are good private facilities in the main tourist centres but these are sparse in the hinterlands and rural locations. Private travel health protection is paramount.

North and South America

United States of America

Case History. A 68 year old woman had a severe stroke on a cruise ship sailing in the Caribbean, with a home port in Florida. She had suffered a mild stroke 2 years previously and was not covered by her travel health insurance for any recurrence or symptoms of cardio and cerebro-vascular disease. On admission to hospital in the USA she was very ill and required lengthy intensive health care and rehabilitation. The admission contract made with the family made them responsible for all financial costs. Treatment, hospital management and repatriation expenses bankrupted them.

This is not an uncommon case with ill travellers who are hospitalised in America. The need for all visitors to have comprehensive and adequate health insurance is crucial and should be emphasised at pretravel clinic consultations. Tourists should only venture there certain of personal health insurance protection with close scrutiny of small print clauses and exceptions to cover. Failure to secure health cover, or travel with insufficient protection or exclusions for past medical conditions may prove disastrous. Ill tourists to the United States are exposed to very high fees inherent in the private health care sector.[20]

The case history illustrates a problem faced by many Americans. The U.S. only holds 37th place in the WHO list of top countries for quality health care services, despite being the highest spender. 45 Million US residents have no health coverage at all. 25 million people who are underinsured spend more than 10% of their income on out of pocket medical costs. Underinsured, they are particularly vulnerable, as are unwary tourists. Until a health catastrophe occurs, visitors are often unaware of exposure to health risk.

Canada. Health care in Canada is delivered through a publicly-funded health care system, which is mostly free at the point of use and has most services provided by private entities. A system of high quality, for residents, visitors have to make private arrangements in emergency, with costs not dissimilar to the USA and adequate insurance cover is essential. Canada is a very large country with vast distances between towns and villages in the interior. Doctor's surgeries can be a hundred miles apart and distance and weather can delay immediate access to emergency health care for tourists to the hinterland. [21].

High quality emergency medical care is available in North America providing the patient is insured. In the absence of this protection there can be very long waits to access A. & E. units and fees can be extortionate if hospital admission is required. In rural areas distance can delay urgent admission especially if weather conditions prevent emergency flights.

South America draws the adventurous traveller, with unique cultural and scenic attractions enticing the tourist to Chile, Bolivia and Peru The intrepid traveller needs to journey in robust good health to overcome the rigours of the route. Diverse geography, large distances, tenuous communications, high altitude, temperature extremes, infection and trauma can affect the tourist who should anticipate health problems.[22]

Case history. In an elderly group of travellers in Chile, a man developed a myocardial infarction and a lady a rasping cough which went on into pneumonia. In pain he waited three hours to see the only doctor and as the sole ambulance was in use, he had to be transported by bus back to Calambra hospital 31/2 hours away. After several hours waiting to be seen there and an ECG., which confirmed the infarction, he was advised that facilities were so inadequate in the hospital that he should return to his hotel. He had travelled 7 hours to have the diagnosis confirmed but remained untreated. He was eventually repatriated back to the UK by air. The woman deteriorated despite antibiotic therapy. With poor investigative local resources she was forced to abandon her holiday and return to Santiago. UK tour operators did not provide the on-going support that they inferred and intercontinental communication between insurance companies, tour operators and patients was desultory and anxiety provoking, adding psychological trauma to the scene.

Medical emergency and evacuation problems are likely to prevail in impoverished, undeveloped and distant tourist locations in rural parts of South America. Even with adequate

health insurance cover, protection can only provide what is available. Accessibility and quality of service varies across the regions. State of the art private facilities may be located in the big cities, but an embryonic health service with limited facilities is likely in the rural scene. Land evacuation is protracted and sometimes impracticable. Prompt air evacuation is not assured for cardiac and respiratory conditions as helicopter and small aeroplane transfer is rarely practicable.

A trip across the continent traverses the backbone of the Andes. Such a journey requires preplanning, physical stamina and endurance to accomplish successfully. It is now being undertaken by middle aged and elderly people some of whom are frail and chronically ill. Travel agencies do not adequately inform customers of the physical and psychological ardour of this itinerary. Most are poorly informed about the risk of prolonged travel at altitude, when much of the time spent in Bolivia and Peru will occur at 4,000 metres altitude and higher. Older and chronically ill, at risk, travellers contemplating such a trip should seek a pretravel health consultation.

Chile and Bolivia. Geothermal areas are unguarded. Unwary visitors get scalded from superheated mud pools and fall through silica encrustment into boiling water and steam caverns. First aid attention may be a day of car travel away. Tourists rarely appreciate the health risk of Acute Mountain Sickness (AMS) and fail to recognise headache and vomiting threatens the onset of pulmonary and cerebral oedema and death. Those with chronic cardiac and respiratory problems are over-challenged and may be precipitated into cardiovascular and respiratory failure. Adverse health effects are compounded for those travelling over the border from Chile in to Bolivia, with average travel altitude over3500 metres and passes climbing to 5000 metres and more.

Onward travel in a developing country with poor hygiene facilities exposes the traveller to gastroenteritis and added fluid and electrolyte loss can add to dehydration. Sanitation can be basic, hand washing difficult and food exposed to flies and contamination. The thin air at high altitude poorly screens the sun’s harmful ultraviolet light rays and solar burn is a constant. Roads are very bad, vehicle related trauma is far more frequent than in the UK with emergency aid often many hours away.

Recommendations

- Travellers should be aware that if affected by AMS. in these remote areas will face a long, rough trip to lower altitude with evacuation taking up to 24 hours. This delay could prove fatal.

- Prophylaxis with a carbonic anhydrase inhibitor reduces the likelihood of Acute Mountain Sickness.200 mg. of acetazoleamide should be taken 24 hours before exposure to an altitude of 3000 metres and continued daily while at high altitude.

- Be aware that some policies from insurance companies exclude cover if one ventures above 12,000feet.

- Consider that first aid and medical care will be delayed and limited, which may be a decisive factor in survival following infection, medical mishap or trauma.
- Precautions are required against enteric infection.
- Uvl screen filters should be used.
- Tourist transport often carries oxygen in cylinders for people with AMS. It is a wise precaution to ensure there is a cylinder on board before departure.
- Big towns such as Sucre have private medical clinics and La Paz has good access to well-equipped private medical units for those who have travel health insurance protection.

Peru. A 2000 World Health Organization report ranked Peru health system 130th out of 191 countries. Lake Titicaca is a magnet for many tourists at over 3,000metres altitude. Acute mountain sickness may prevail and its storm-tossed waters can cause motion sickness. Proceeding eastwards and down from the altiplano mosquitos can be a problem. The tourist mecca of Cusco-3,000 metres altitude-is mosquito free, the train however travels down the gorge into the jungle with exposure to malaria transmitting insects. Tourists in shorts with bare arms are often bitten at the ruins in Machu Picchu, in the local town and on the train. They fail to consider prior antimalarial medication or the use of mosquito repellents.

Considerations At pretravel health consultations:-

Health professionals should:-

- deter those with chronic conditions e.g. COAD, the frail elderly, the anaemic, a history of deep vein thrombosis and pulmonary embolism, from setting out on such a trip

Travellers should:-

- Consider pretravel health consultation.
- Seek prophylaxis for malaria and altitude sickness
- Carry, Mosquito repellent protection, anti-motion sickness medication, lip salve, first aid kit, water sterilising tablets, large water bottle.
- Anticipate long, arduous land and air journeys
- Assume water, salads, uncooked food to be contaminated unless certain of source.
- If past history includes heart attack, stroke, COAD, immuno-suppression, carefully consider the wisdom of travel.

Summary

The tourist will find good health care in Canada and the USA. The private sector is very expensive and adequate health insurance is a vital prerequisite to North American travel, Uninsured, emergency health care may be delayed and of variable quality. Private South American health care is of variable quality and emergency care may be inferior, limited or far distant. This is a high health risk part of the world. The older traveller and particularly those with pre-existing illness should consider risk of gastro-intestinal infection, trauma, malaria, acute mountain sickness, solar irradiation and the fatigue of long distance travel in arid , harsh environment. Medical aid may be a day away with no prospect of emergency air evacuation and land transportation is scarce.

West Africa

The west coast of Africa was long known as the Whiteman's Grave because of the high death rate from tropical disease. Countries once shunned by Europeans are now visited in increasing numbers by those intent on accessing winter sunshine. Tourists, apparently protected by comprehensive travel health insurance, often assume that urgent health care needs will be met in medical emergency overseas, as speedily and efficiently as within the NHS. An adverse medical event due to trauma and disease in countries in West Africa however, may expose patients to limited resources and health care and delayed treatment. Insurance companies can only provide the best locally available medical and nursing care. Evacuation and treatment may not equate with that in the developed world. Poor communications, climatic extremes, bad roads and limited transportation threaten delay in emergency hospital access. 23.

Paucity of health professionals, hospitals, and institutional resources determines poor quality of health care provision. Facilities are best in the cities, but up-country and small ports of call often have a rural hinterland, with difficult and distant access to major cities. Traditional medicine, dependent upon herbs and ancient and voodoo practices often, form part of the primary health care Cruise ships are disgorging passengers into countries fringing the West African coast Standards of emergency care vary considerably from country to country, are often rudimentary and may only be available in the main cities and not in ports.

Common diseases in sub-Saharan countries include cholera, typhoid, pulmonary tuberculosis, anthrax, pertussis, tetanus, chicken pox, yellow fever, measles, infectious hepatitis, trachoma, malaria, and schistosomiasis.

The Gambia - A country with one of the world's lowest per capita income rates, its health care system is rudimentary. There is one teaching hospital in Banjul the capital staffed by consultant specialists mainly from Cuba. There is also an MRC unit in Bakau which specialises in tropical diseases. Both of these are near coastal tourist areas, but are extremely busy, crowded and sleep two patients per bed when under pressure. (24) A few private clinics with limited facilities provide emergency care for the ill or injured tourist, but have scant investigative or intensive care capacity. The nearest treatment centres are in Dakar, Senegal many hours, drive plus a ferry crossing, away, with transport at a premium and roads often

impassable in the wet season. [1] The alternative evacuation route is to Europe, a six hour flight, not a viable alternative for a patient with a heart attack, infarction or respiratory emergency, as airlines will not fly individuals for a week or ten days after these critical medical incidents. As in all West African countries, malaria is rife.

Senegal, This country is one of the first ports of call for ships leaving the UK on cruises to South Africa and the Far East. If passengers become ill on the Atlantic crossing they may be disembarked here. Private clinics and a few state hospitals are under-resourced, under-doctored and medications may be difficult to acquire. Large disparities still exist in health coverage, with 70% of doctors, and 80% of pharmacists and dentists, living in the nation's capital city, and only 0.1 physicians and 0.4 hospital beds per 1,000 people.

Major health problems include measles and meningitis along with water-related diseases as malaria, trypanosomiasis, onchocerciasis, and schistosomiasis.

Cape Verde Islands. These islands are a port of call for cruise ships on transatlantic crossings. Health facilities are very limited, and some medicines are in short supply, or unavailable. There are hospitals in Praia and Mindelo, with smaller medical facilities elsewhere. Brava and Santo Antão islands no longer have functioning airports so air evacuation in medical emergency is impossible. Malaria occurs in Cape Verde, with risk is mainly limited to the island of Santiago, and highest risk from July to December.

Ghana. Ghana has Government funded health care, with hospitals and clinics also run by religious groups and a few “for-profit” clinics playing a role. Urban centres are well served; however, rural areas often have no modern health care. Patients there rely on traditional African medicine, or travel great distances for care. Ghana experiences the full range of diseases endemic to the region. Private and state facilities are available to tourists in Accra, but are generally poor in the rural scene. As with most West African countries, there is a high health risk from road traffic accident and emergency aid may be delayed, casualty units far distant with limited resources for transfusion and surgery. Travel health insurance companies can negotiate reasonable care for patients in emergency and there are good air connections to Europe.[25]

Sierra Leone is recovering from a vicious civil war when the infrastructure was damaged. Hospitals and clinics are decayed. Money buys access to what health support is available. Ambulance transfer is rare. This is a hazardous place for pedestrians and vehicles and the risk of accidental trauma is high. Emergency admission to a local medical unit is best avoided, but air evacuation depends upon a few direct flights to Europe. Transport is scarce, the roads often dirt tracks and communication between centres fragmented. The few hospitals and clinics are grossly overburdened with the demands of a malnourished destitute population. The country suffers from epidemic outbreaks of diseases including yellow fever, cholera, Lassa fever and meningitis.

Ivory Coast (Cote d’ivoire). In the Ivory Coast there are sharp regional and socioeconomic disparities in health care. There are 12 physicians per 100,000 people. Access to potable water and waste disposal systems is limited in rural areas. The health care system is unable to

meet the health care needs of the population, with continuing low ratios of doctors and nurses to patients. Chronic shortages of equipment, medicines, and contribute to overall poor service delivery. In rural areas, health care remains a under the guidance of lineage elders and traditional healers. Malaria, yellow fever, sleeping sickness, yaws, leprosy, trachoma, and meningitis are endemic.

Cameroon. Health care for tourists is available in big cities in Cameroon. Simple blood samples are usually analysed in the country, but complex ones go to France. Health care activities are either run as government services, or private services managed by various churches. Modern equipment is needed, with many clinics using outdated equipment. In 2004, there were 7 physicians, 36 nurses, per 100,000 people. Principal diseases are Malaria, HIV Aids, tuberculosis, sleeping sickness, cholera, dysentery and meningitis. Malaria is prevalent in the coastal region, and the forests. Other serious water-borne diseases are schistosomiasis and sleeping sickness, spread by the tsetse fly. Cameroon lies in the yellow fever endemic zone.

Benin. The population depends upon traditional medical practices- voodoo doctors -when in clinical need. There are a few conventional clinics and hospitals accessible to tourists. There were only 6 physicians and 20 nurses per 100,000 people in 2004. Most serious epidemic diseases have been brought under control Yaws has been almost totally eradicated in the north. Yellow fever has almost disappeared. Cholera cases are now rare.

Sao Tome and Principe. These are small islands lying on the equator off the coast of Africa, an attractive port of call for cruise ships. Medical care is extremely limited. The main health facility is the Ayres Menezes Hospital, located on the island of Sao Tome. Most doctors and hospitals expect payment in cash, regardless of whether the traveller has travel health insurance. Serious medical problems require air evacuation to a country with state-of-the-art medical facilities. Flights are limited and rarely fly direct to Europe. Malaria remains a health risk.

Gabon. In Gabon health facilities remain inadequate, particularly outside the Libreville area. The government provides nearly all health care services. The internationally known Albert Schweitzer hospital is located in Lambaréné. Evacuation and repatriation for the ill or injured tourist is likely to be delayed and emergency care extremely limited Malaria, sleeping sickness, tuberculosis, and other infectious diseases are widespread,.

Togo. Medical services include treatment centres with services free except at the clinic at the hospital in Lomé, where patients pay a nominal fee. About 61% of the population have access to health care services. In recent years there have been significant decreases in mortality caused by smallpox, yellow fever, and sleeping sickness. Yaws, malaria, and leprosy continue to be major medical problems

Namibia. Namibia is a country with high levels of inequality in access to health care resources. The main tourist centres have reasonable private health facilities, but tourists safari up country where health units and resources may be unavailable or limited and evacuation can be prolonged 26 Drinking water outside main cities and towns may be contaminated.

Malaria risk exists in the entire northern third of the country from November to June and along the Kunene river and in Kavango and Caprivi regions throughout the year.

Summary

Health services in West Africa:-

- are poorly developed and do not meet the needs of all residents
- vary markedly from country to country
- are particularly poor in rural and coastal areas away from cities.
- may not meet the needs of the ill or injured tourist
- Hospitals and clinics are poorly resourced
- Transport to hospital may be unobtainable
- Yellow fever immunisation is mandatory
- Maximal antimalarial precautions are required
- Travel health insurance will not necessarily bring access to optimal emergency care.
- The risk of traffic related trauma is very high
- Air and land evacuation may not be possible in emergency.

East and South Africa. At the southern end of the African coast line is Capetown, port of call for many cruise ships and ill passengers are off loaded here. The health system consists of a large public sector and smaller private sector. Health care varies from the most basic primary health care, offered free by the state, to highly specialised hi-tech health services available in the private sector. The public sector is under-resourced and over-used. The enlarging private sector, caters for foreigner visitors and medical tourists seeking top-quality surgical procedures at relatively affordable prices. The private sector also attracts most of the country's health professionals. Medical tourists looking for top-quality surgical procedures at relatively affordable prices are visiting in increasing numbers.

Kenya. Access to health care varies widely throughout the country, with quality and resources varying markedly between rural and urban communities. Most facilities are located in Central Province, and few in the border provinces of Western Valley and Nyanza. Prevalence of communicable disease in Kenya is a major factor with HIV, malaria and tuberculosis rife.[27] A large percentage of the population does not seek care despite being ill. 90% of the population in sub-Saharan Africa use traditional medicine as their source of primary healthcare.[28]

Stark disparities are apparent in levels of care, and facility to facility in different regions. Top of the service spectrum are Teaching Hospitals such as Kenyatta National Hospital (KNH) in Nairobi. The next best level of care is found in provincial hospitals, with uneven distribution of health workers between urban and rural areas. Contrast in levels of care is seen in KNH, which offers public and private wards, attended by the same doctors. A patient in the public ward, can expect to spend long hours waiting to be seen, and may be expected to share a bed with another patient. Patients are grouped in large, open, chaotic rooms and afforded no privacy which compares badly with the private ward of the hospital. While both public and private patients receive a reasonable level of care at KNH, the disparity between services offered there and elsewhere can be substantial. The provincial general hospital in Nyeri, for instance demonstrates a major drop in quality of care and resources such as morphine, a basic analgesic [29] can be in short supply.

Zimbabwe. Zimbabwe's health-care system is collapsing. Hospitals face dire shortages of doctors and medical supplies and are unable to undertake basic operations because of shortages of anaesthetics, sutures, and essential supplies. The country is battling one of the world's highest rates of infection of HIV/AIDS, estimated to be killing more than 3000 people weekly. Elective surgery has been abandoned in the central hospitals and even emergency surgery is often dependent on the ability of patients' relatives to purchase drugs, suture materials, and supplies of blood from private sellers. Ambulances are grounded for want of fuel and spare parts. [29] Harare, now has regular outbreaks of cholera.

Considerations.

- Elderly people should be advised to avoid travel in the country until the health care system reaches minimal standards of provision.
- The health care and transportation systems have disintegrated and emergency aid is problematic.
- Travel health insurance cover cannot provide protection in the absence of resources.

Zambia. Services to Zambian nationals are free at rural health centres and urban hospitals The public health care sector suffers from a severe shortage of doctors, medicine, medical equipment and supplies. Zambia has one of the highest rates of HIV infection, even in hard-hit sub-Saharan Africa. There are limited private facilities for tourists. Malaria and tuberculosis are major health problems and hookworm and schistosomiasis afflict a large proportion of the population

Namibia. This is a popular safari destination .The country is arid, distances between health centres can be considerable and health care variable. (See previous note on Namibia)

Tanzania. Medical treatment is free or highly subsidized in company clinics and hospitals. Tanzania's national health care system stresses primary care at an affordable cost, but faces an acute shortage of health care workers. Low pay, poor working conditions and limited

training programs contribute, worsened by the burden of treating HIV/AIDS and malaria patients, Health standards in Tanzania have declined and care is poor. The public system serves the vast majority of the population, but is chronically underfunded and understaffed. The wealthiest 20% of the population uses the private system, the route followed by the insured ill tourist.[30.31]

South Africa. Medical facilities are good in urban areas but can be limited elsewhere. Tourists on safari may find themselves distant from medical aid. Private facilities are good where they exist. Kruger National Park, Mpumalanga and northern KwaZulu-Natal are low risk malaria areas during December-April. Swimming and paddling in stagnant or slow-moving water as there is a risk of contracting bilharzia. (See comment on West Africa)

Considerations.

- Safari travel means long hours in four wheel drive vehicles in a dusty, dry wild environment, in areas where malarial mosquitos thrive.
- Safari visits depend upon early morning and late afternoon trips at a time when mosquitos are active.
- Dry and non- air-conditioned camping environs make for dehydration and water sources may be infected.

There is a high risk from infection and trauma and emergency medical aid may be distant of variable quality and ambulance evacuation n on-existent.

Central and east African countries which offer wild animal safaris are high risk destinations for elderly travellers. Infection, trauma, dehydration are likely to befall the older person who may find that emergency medical care is distant and not of optimal quality. Ideally safaris should only be embarked upon by those in robust health. Pretravel health consultation is advised for those with pre-existing health conditions, and vaccine prophylaxis and antimalarial precautions should be taken.

Summary

With the exception of South Africa the tourist will meet some of the poorest health facilities in the world if requiring emergency aid. Health professional staff are scarce, training variable, resources often basic or absent. Scarce transport and bad roads create difficulties in casualty evacuation. Blood supplies may be contaminated and emergency aid units far distant .Elderly travellers, particularly vulnerable to heat and trauma should be aware of the limitations of health care in the region and that travel health insurance protection in the region can only supply aid from what is locally available and is subject to severe limitations in treatment and health care.

Asia Far East and Antipodes

China.

China is undertaking reform of its health-care system to make it more affordable for the rural poor. Chinese medical schools provide training in Western medicine and also instruct in traditional medicine, but relatively few physicians are competent in both areas. In urban hospitals, there may be separate departments for traditional and Western treatment. In county hospitals, however, traditional medicine receives greater emphasis. It depends on herbal treatments, acupuncture, acupressure, moxibustion (the burning of herbs over acupuncture points) and "cupping" of skin, with heated bamboo believed to be most effective in treating minor and chronic diseases. Traditional treatments may be used for more serious conditions as well, particularly for such acute abdominal conditions as appendicitis, pancreatitis, and gallstones, a consideration for foreign visitors who become ill far from major hospital centres.

Western style medical facilities with international staff are available in Beijing, Shanghai, Guangzhou and a few other large cities. Hong Kong has excellent private facilities. Many other hospitals in major Chinese cities have so-called V.I.P. wards or gaogan bingfang. with reasonably up-to-date medical technology and skilled physicians. They provide medical services to foreigners and have English-speaking doctors and nurses.

India A universal health care system is run by the constituent states. Government hospitals, some of which are among the best hospitals in India, provide treatment at taxpayer expense hospitals, either free or at minimal charges. There is a large private sector in cities and tourist areas .Emergency transportation to hospital can prove a daunting procedure in much of rural, India, a consideration elderly tourists should keep in mind. (See chapter 13)

Japan. The Government provides healthcare services, with the patient accepting responsibility for 30 % of the bill. Japan has excellent hospitals and clinics, and provides highly-technical, state of the art equipment. Patients are free to select physicians or facilities of their choice. Due to large numbers of people visiting hospitals emergency access is an issue in some units and a particular problem in Tokyo. In 2007 14,000 emergency patients were rejected at least three times by Japanese hospitals before getting treatment .Some healthcare in Japan is provided free for expatriates and foreigners. The Japanese have no 'family-doctor' system and medical ethics and bedside manners are not strong points with health professionals.

Malaysia The country offers a comprehensive network of hospitals and clinics, with 88.5 % of the population living within three miles of a public health clinic or private practitioner. (See chapter 13 and medical tourism)

Nepal. The health-care delivery network in Nepal is poorly developed. Government-operated health-care delivery system consists of hospitals and health centres with very basic facilities. Health-care practices in rural areas often depends upon the medicine man or shaman as well as Ayurvedic treatment Allopathic (modern) medicine and quality of care is poor. There are private medical facilities in Kathmandu. Diarrhoeal disease is a major public health problem. There is high risk of road accident trauma. Evacuation may be difficult and protracted with

limited air transport and tenuous road movement. In the higher valleys, patients may have to be carried to hospital on a Sherpa's back.[32-33]Infection risk is considerable with high endemicity of malaria, food and water borne disease such as typhoid and paratyphoid fever, giardiasis, amoebiasis, helminthiasis, rabies and hepatitis B. There is also a risk from the effects of high altitude inducing acute mountain sickness.

Considerations

- Malaria prophylaxis
- Prophylaxis with acetazolamide for high altitude exposure
- Assumption that all water is contaminated and use of water sterilising tablets.
- Consideration of limited emergency care and protracted evacuation and hospital access

South East Asia

IndonesiaThe level of health care in Bali, much visited by tourists, varies from local clinics and hospitals, to foreign run clinics such as SOS International. Small urban clinics can handle simple injuries. Each district in Bali has a hospital located in the main town, however, Sanglah hospital in Denpasar is the only one capable of dealing with major operations and patients are transferred here from elsewhere on the island.

Thailand. The health care system relies heavily on specialized medicine. The Thai Government has developed a universal health care programme whereby everybody gets treatment at public hospitals for a standard fee per visit. If foreigners have a medical problem while in Thailand, a few hospitals of good reputation, cater for foreign patients, with Bumrungrad Hospital being popular. Bangkok General Hospital and its affiliates Samitivej Hospital and Bangkok Nursing Home Hospital, are also commended. Certain hospitals have been actively seeking medical tourists to visit Thailand and now up to 60% of patients at Bumrungrad Hospital and 40 % at Samitivej Hospital are foreigners. (See chapter 13 on medical tourism)

Summary

Large variations in health care occur across south east Asia with some countries having excellent resources and catering for medical tourism. Congested roads and poor transportation result in high road traffic accident risk and trauma in many countries. Emergency transportation can be limited. Travel health insurance cover essential. There is a high likelihood of gastrointestinal infection and malaria in many of these countries.

Antipodes

Australia. Australia has a highly commended medical care system. The Australian Government has signed Reciprocal Health Care Agreements (RHCA) with the government of the United Kingdom which entitles British visitors to limited subsidised health services for medically necessary treatment while visiting Australia. This covers any ill-health or injury

which occurs while in Australia and requires medical attention. The Royal Flying Doctor Service provides an excellent service to rural many rural areas.[34] but emergency aid can be delayed due to adverse weather.[35] A resident of UK is entitled to the following for any ill-health or injury requiring treatment:-

- free treatment as a public in-patient or outpatient in a public hospital
- subsidised medicines under the Pharmaceutical Benefits Scheme
- Medicare benefits for out-of-hospital medical treatment provided by doctors through private surgeries and community health centres.

Medical treatment can be accessed through private doctors' surgeries and community health centres. Doctors at these practices charge for their services by charging Medicare direct or presenting a bill for payment by the patient which is then reimbursed by Medicare. If treated as a public patient in a public hospital, treatment is free on display of passport or reciprocal health care card to staff at the hospital. Medicare will not cover:

- medicines not subsidised under the Pharmaceutical Benefits Scheme
- dental work and allied health services
- accommodation and medical treatment in a private hospital
- accommodation and medical treatment as a private patient in a public ambulance services
- home nursing
- physiotherapy, occupational therapy, therapy, eye therapy, chiropractic services, podiatry glasses and contact lenses, hearing aids

New Zealand. The New Zealand health system functions on the Anglo-American model of care, with emergency care in the pre-hospital setting being conducted by paramedics. There are reciprocal arrangements with the UK. and WHO rates the system highly.

The World Health Organization has ranked the health systems of 191 nations. France and Italy took top spots and Australia, New Zealand, Canada and the UK rating highly with Germany on most measures of performance, including quality of care and access to it.

Arctic and Antarctic

80,000 tourists per year visit the Falkland**s** and Antarctica. A significant number visit the Arctic on cruise ships varying in size from small, ice-strengthened vessels, to massive cruise liners, which combine several days cruising around the Falklands with South Georgia and Antarctica, Greenland, the Svalbard peninsula and Spitzbergen. Larger cruise ships to the region have the health facilities of modern luxury ships. Small ones may not have an on-board doctor .Irrespective of size they will off load ill or injured passengers in the Falkland Islands if cruising southern seas and to Svalbard and the main land in the Arctic. Helicopter rescue is limited by range in the Arctic and patients have to be air evacuated from Svalbard to Norway and from Greenland to Denmark for intensive care. The nearest mainland countries to Greenland and Svalbard, they have good health facilities with UK, reciprocation. [27]

Antarctica The Falklands Islands provide an emergency medical service for cruise ships and intrepid travellers visiting via South America The water supply is safe and there is a

reciprocal health agreement between the UK and Falkland Island Governments which allows free medical treatment for UK residents in the Falklands. This does not cover dental care Medical services are based in the 27 bed, well-equipped King Edward VII Memorial Hospital (KEMH) in Stanley. The islands have 4 general practitioners with extended skills, two consultants, 28 nurses a radiographer and modern digital plain X-ray equipment, excluding CT and MRI scanner. The pharmacy is l stocked with UK pharmaceuticals but tourists are advised to bring enough of their regular medication to cover the e duration of visit.36 Given the small size of the hospital, the restricted range of diagnostic facilities available and e limited ability to manage intensive care patients, coupled with the lack of complex treatments such as kidney dialysis, it is normal to stabilise a critically ill patient and then transfer then to a larger hospital. KEMH has an agreement with the Clinica Aleman in Santiago and every tourist must be insured to cover this potential cost. "Aerocardal" transport charges in the region of US$ 30,000. Fees of the Clinica Alemana are comparable to a private hospital anywhere in Europe ($40,000 US). The RAF normally will not consider transferring a tourist as a patient even if they are UK passport holders. During the tourist season, October-March, doctors are accustomed to dealing with overseas hospitals, transfers and insurance companies. Ships leave from Stanley to cruise the Antarctic peninsula and islands, a four day sail away from the nearest aid in the Falklands .Air evacuation is not practicable and emergency care will depend on ship resources.

The Arctic,**Greenland and Svalbard** There are small village clinics in Greenland villages and Svalbard has a small hospital unit. Serious conditions have to be evacuated by small fixed wing aircraft, an expensive undertaking. Local Governments are now insisting that visitors have repatriation insurance in place before arrival

C*onsideration* The standard of medical care in the Falklands is broadly similar to the UK but tourists must bear in mind the limitations imposed by the size of the hospital, range of specialists and the limited range of diagnostic equipment available. In the Arctic resources are very limited and evacuation often delayed and very expensive.

Case History

On a sea crossing from the North Cape of Norway to Greenland an elderly woman was wheel chair dependent and required help from her husband with all basic needs. The husband had a severe heart attack and had to be airlifted by helicopter, operating at its maximal range, to the nearest hospital in Norway. Bereft of assistance in daily living the care of the wife became a major problem for crew who were not allowed to touch passengers far less offer intimate care and a harassed medical/nursing staff struggling to support with passengers with norovirus infection. She had to be airlifted to the mainland by small aeroplane in an exercise which had to be funded by the patient as she was uninsured.

Summary

Elderly potential travellers to Antarctica and the Arctic should organise a pretravel health consultation. Travel health insurance protection is essential with adequate cover for repatriation. They should be aware that emergency aid may be many hours and in bad weather days away.

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