Protecting the health of travellers from the UK and Ireland

A position paper prepared by the Executive Board of the Faculty of Travel Medicine of the Royal College of Physicians and Surgeons of Glasgow

ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW

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Contents

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The Faculty of Travel Medicine of the Royal College of Physicians and Surgeons of Glasgow is committed to advising the public on travel medicine related matters through all media channels.

Executive summary

The number of travellers from the UK and Ireland has increased markedly in recent years. Their destinations and the type of activity undertaken while on international travel put them at risk of injury and disease. There is evidence that this now causes a considerable medical and economic burden, both during travel and on return to their home.

A significant proportion of the illnesses and injuries are preventable. Pre-travel health advice may identify hazards associated with different activities and provide means of mitigating or eliminating risk. This may be through education, formal instruction, the provision of physical measures to reduce environmental exposures, or use of medical measures such as drugs or immunisations.

Those travellers who do become ill on return would normally present to their primary care practitioners. The diseases in such returning travellers can be quite different from those seen in normal practice, and may lead to delays in diagnosis and treatment with subsequent increased morbidity.

Travel advice may be given by medical practitioners, nurses or pharmacists. There is no formal structure for provision of travel medicine services, and current arrangements have evolved over time rather than been developed following a detailed planning process.

No formal training or academic qualifications are required in order to provide a travel medicine service. There is no licensing or validation of the quality of care delivered by travel medicine advisors.

Travel Medicine is not currently a recognised medical specialty in the UK or the Republic of Ireland. Professional leadership and best practice guidance has been provided by the Faculty of Travel Medicine of the Royal College of Physicians and Surgeons of Glasgow since its foundation in 2006.

Issue

Within the UK and Ireland there is a lack of structure and delivery of travel medicine services, absence of a formal training pathway to a recognised professional standard, and lack of assurance of practice against defined standards.

Recommendations

1 The standards of medical care given to travellers before, during and after travel should be as high as those practised in every other field of medicine.

2 Standards of best practice should be outlined and national guidelines adopted where appropriate.

3 Formal training by a suitably accredited provider should be mandatory for all health professionals offering medical advice to travellers.

4 The governance of Travel Medicine should be provided by the Faculty of Travel Medicine by means of its continuing professional development programme.

5 Assurance of the competence of travel medicine providers should be reviewed by national authorities, with consideration given to the financial remuneration arrangements and licensing.

6 The travelling public should be educated to recognise the standard of service that should be expected of providers, and how this is delivered.

Introduction

Travel medicine has been defined as a specialism that deals with the health of travellers who visit foreign countries. It crosses disciplines and is concerned not only with prevention of infectious diseases during travel but also with personal safety and reduction of environmental risk. It differs from tropical medicine, because it focuses primarily on pre-travel preventive care of individuals and less on the diagnosis and treatment of illness acquired overseas. However, travel medicine specialists should be able to recognise and either treat or refer common syndromes in returned travellers [1].

Current travel trends

International travel from the United Kingdom and Ireland has increased rapidly over recent decades. The categories of traveller and their reasons for travel are varied, and the activities undertaken complex.

Over the past six decades, tourism has experienced continued expansion and diversification, becoming one of the largest and fastest-growing economic sectors in the world. In 2012 UK residents made an estimated 50.3 million visits abroad, unchanged from 2011[2]. Despite a continuing economic downturn, the holiday market held relatively steady in 2012 with holiday visits down only 1% whilst those made for other purposes increased. It would appear that the economic downturn has had a more significant effect on travel trends than international conflict and infectious disease threats and there are grounds for believing that once there is a return to economic growth that there will be a further dramatic rise in the numbers of travellers.

The World Tourist Organisation estimates international tourist arrivals worldwide will increase by 3.3% a year to reach 1.8 billion by 2030 [3]. International tourist arrivals in the emerging economy destinations of Asia, Latin America, Central and Eastern Europe, the Middle East and Africa will grow at double the pace (+4.4% a year) of that in advanced economy destinations.

Holidays are by far the most common reason for travelling abroad from the UK and Ireland although those visiting friends and relatives account for 20% of the total visits abroad. Other reasons for travel may include business trips, international sports, medical tourism and humanitarian aid. Most travellers still go to countries in Europe and other developed areas of the world. However, there is a rapidly increasing number of people travelling to remote and less developed countries. With continued growth in travel to diverse locations, there will undoubtedly be an increase in the need for adequate pre-travel advice for travellers from the UK and Ireland.

Patterns of illness in travellers

There is no systematic prospective collection of information on illness related to travel, either for people who become sick or injured whilst overseas or for people who develop disease on their return. This is true for both the UK and Ireland and for all other countries.

There are limited data collected from travellers who receive pre-travel advice from selected international clinics (GeoSentinel), occasional studies conducted on defined groups, and observational research based on reported cases of disease following travel.

Within the UK, Public Health England (formerly the Health Protection Agency) publishes periodic reports on travel-related disease. The last full review of illness related to foreign travel was published in 2007 based on data from 2004/2005 [4]. Since then there have been reports which focus on specific issues of travel-related disease: people visiting friends and relatives (2008) [5], and traveller's diarrhoea (2010) [6].

However, there are indicators that overseas travel is associated with a significant burden of disease and injury, and a corresponding economic impact:

- In 2012 the Association of British Insurers reported that 56% of travel insurance claims were made for medical reasons [7].
- The Foreign and Commonwealth Office reported 6193 deaths of British nationals overseas for a 12 month period spanning 2012/2013 [8].
- In 2012 there were 1378 cases of malaria reported in the UK, all of which were travel-related.
- Gastrointestinal disease is reported in up to 60% of travellers to some destinations [9], with the risk of infection being higher in those areas of the world with poor water supplies and sanitation [6].

Specific studies have also identified variable morbidity from trauma (especially road traffic accidents) [10] and psychiatric disease (including suicides) [7]. Data from medical repatriation companies suggest that accidental injury is the commonest cause of morbidity in younger age groups, whilst cardiovascular disease accounts for most of the illness occurring in older groups. Vaccine-preventable diseases cause a relatively small number of infections [11], despite the emphasis given to vaccine delivery in many pre-travel health care settings.

Travellers are also recognised as the means by which many new and emerging infectious diseases move around the globe [12]. The introduction of novel pathogens may have profound consequences for both the health systems of receiving countries and longer term economic effects. Examples from the last 20 years include HIV/AIDS and the spread of multi-drug resistant bacteria. In the last decade there have been significant public health problems caused by travellers with SARS, and more recently H1N1 influenza and MERS-CoV [13, 14, 15]. These episodes led to the World Health Organization revising and updating the International Health Regulations in 2005 (implemented 2012) to take account of travellers with novel infectious diseases.

A relatively new phenomenon is that of medical tourism, with patients travelling to different countries to receive medical care (including surgery) before returning to their homeland. There is increasing evidence that this is associated with the spread of difficult-to-treat multi-drug resistant bacteria, acquired in the host health care environment, when the patient returns to their home [16].

Delivery of travel medicine services

The delivery of travel medicine services in the UK has developed in a piecemeal fashion. Groups such as the Armed Forces, international industrial companies, non-governmental aid and humanitarian organisations have for many years recognised the benefits of correct preventative medicine and adopted good practice as a "given" in their arrangements. Travel medicine for the wider public (tourists, migrants, business, student groups and those visiting friends and relatives [VFRs]) form a large and rapidly expanding disparate group, for which there is no universal provision and for which a variety of providers may make arrangements, but with no co-ordinated approach and no guarantee of comprehensive (or consistent) advice or care. It has been estimated that 50% of travellers who might benefit from correct travel health advice and management fail to achieve this, and travel unprepared with the resultant risks and costs of morbidity and mortality [17].

The position is worsened by the fact that there is no mandatory accreditation and training of practitioners, no required qualifications and, unlike other health care in the UK which is free at point of access, some vaccines are free of charge yet others, including prescriptions for malaria chemoprophylaxis, are not. The only existing mandatory programme for registration, training, standards and audit in travel medicine is in relation to the provision of Yellow Fever vaccination. The approval and monitoring of such centres is a requirement, consistent with international health regulations [18].

The provision of travel health advice and care can be obtained in several different ways:

- Primary care. General practitioners provide the bulk of services, often delegating the duties to nurses who may or may not have received specialist training.

- Some areas in England and Wales are exploring the opportunities provided by the newly introduced Clinical Commissioning Groups. One of the ideas in current circulation is of a generic "immunisation clinic" for an area which would take referrals from local GP practices, and which would be staffed by nurses with specialist (but as yet undefined) training.

- Private clinics. These offer a "one stop" travel health service with advice, vaccine and malaria chemoprophylaxis provision, often providing appointments out of office hours and in central positions (e.g. at railway stations or airports). A wide range of travel health advisors can be employed ranging from the inexperienced to the highly qualified. This service is often provided within the context of a private clinic offering other non-NHS services (e.g. aesthetic procedures).

- Pharmacists. Travel medicine services are increasingly being offered by community pharmacists as a non-NHS service provision.

- Specialist clinics are available in many major cities (e.g. the Hospitals for Tropical Diseases in Liverpool and London). These are staffed by NHS employed consultant infectious disease specialists and nurses who have usually received training in travel medicine.

- Occupational Health departments. These include NHS trusts, industry, and the armed services. They provide travel health advice, vaccines and medications for their staff travelling overseas as part of their employer's duty of care [19].

- Non-governmental organisations (NGOs) or charities. Services for volunteers and employees of these organisations encompasses pre-, during and post-travel advice and support, and are most often managed by experienced staff who have received specialist training.

Education and training in travel medicine

Medical practitioners who practise travel medicine are currently drawn from a range of different professional backgrounds and possess different higher qualifications. They include general practitioners, consultant physicians specialising in infectious diseases or tropical medicine, consultant medical microbiologists, consultants in public health, and specialists in occupational medicine. Nurse practitioners have equally varied backgrounds, and the Royal College of Nursing has published standards that it expects specialist nurses to attain [21]. In 2012 the Faculty of Travel Medicine published standards for the Practice of Travel Medicine in the UK and Ireland; however the lack of specialty status means that these remain guidelines for "best practice" as opposed standards for quality of care that can be monitored and enforced [22].

No formal higher specialist training pathway or certification of completion of specialist training exists for the discipline of travel medicine as it is not a specialty recognised by the General Medical Council, Irish Medical Council, Nursing and Midwifery Council, or General Pharmaceutical Council. Currently there is no mandatory requirement to possess a professional higher qualification in order to practise travel medicine in the UK and Ireland.

Professional groups
Travel Medicine organisations exist both in the UK and Ireland and elsewhere, but these are predominantly peer-support groups that offer membership solely on the basis of payment of subscription fees. Such groups can lobby in specific-interest areas and offer advice, but represent consensus or even majority opinion, rather than patient-centred best practice.

Academic accreditation
The International Society of Travel Medicine (predominantly comprised of clinicians based in the USA) does offer an examination of academic knowledge (the Certificate of Travel Health) which has been benchmarked against the Faculty of Travel Medicine examinations, and found to be comparable to the part 1 examination for Membership of the Faculty of Travel Medicine of the Royal College of Physicians and Surgeons of Glasgow [20]. In the UK, the Diploma in Travel Medicine was established in 1995 at the University of Glasgow, and subsequently transferred to Health Protection Scotland in 2000 and the Royal College of Physicians and Surgeons of Glasgow in 2010. It was the first academic training programme leading to a recognised qualification in travel medicine anywhere in the world, and continues to attract large numbers of international students.

Professional accreditation
The Faculty of Travel Medicine was founded in 2006 at the Royal College of Physicians and Surgeons of Glasgow, and uniquely amongst Royal Medical Colleges is open to both nursing and pharmacy graduates as well as doctors. It remains the only organisation in the world which for travel medicine provides professional leadership, facilitates education and training programmes, sets standards of best practice, and organises continuing professional development in conjunction with the respective professional bodies. Over 400 members have been admitted on the basis of their professional and academic record in the area of travel medicine or by examination. Since 2012 the normal route to membership is attained by passing the membership examinations.

Public information
Much of the travel health information available on the internet is unvalidated and potentially misleading. Within the United Kingdom, authoritative websites dealing with health issues include those administered by the National Travel Health Network and Centre (of the Department of Health) [23], and Health Protection Scotland [24]. The Foreign and Commonwealth Office gives guidance with respect to wider travel-related issues that impact on health such as personal security, country-specific information on logistics and consular advice [25]. Many other websites lack professional oversight and credibility, but may appear superficially convincing and authoritative. Without specific training for medical professionals and education of travellers, the ease of access to unvalidated information means that there is an ever increasing risk to travellers from either misleading or wrong advice.

References

1. Hill DR, Ericsson CD, Pearson RD, et al. The Practice of Travel Medicine: Guidelines by the Infectious Diseases Society of America. Clinical Infectious Diseases 2006; 43:1499–539
2. World Tourism Organisation. UNWTO Tourism Highlights, 2013 Edition
3. World Tourism Organisation. UNWTO Tourism towards 2030
4. Health Protection Agency. Foreign travel-associated illness, England, Wales, and Northern Ireland - 2007 report. HPA 2007
5. Health Protection Agency. Foreign Travel Associated illness – a focus on those visiting friends and relatives. 2008 report. HPA 2008
6. Health Protection Agency. Foreign travel-associated illness - a focus on travellers' diarrhoea. 2010 report. HPA 2010 viii
7. Travel insurance statistics 2012 **https://www.abi.org.uk/News/Industry-data-updates/2013/07/Travel-insurance-statistics-update**
8. Foreign and Commonwealth Office. British Behaviour Abroad Report 2013. FCO London 2013
9 Steffen R. Epidemiology of Traveler's Diarrhea. Clin Infect Dis. (2005) 41 (Supplement 8): S536-S540. doi: 10.1086/432948
10. Foreign and Commonwealth Office. British Behaviour Abroad Report 2013. FCO London 2013. Available at: **https://www.gov.uk/government/publications/british-behaviour-abroad-report-2013**
11. Boggild, AK. Castelli, F. Gautret, P. et al Vaccine preventable diseases in returned international travellers: Results from the GeoSentinel Surveillance Network. Vaccine. 2010 28; 28(46): 7389-95
12. Chen LH, Wilson ME. The role of the traveler in emerging infections and magnitude of travel. Med Clin North Am. 2008 Nov;92(6):1409–32, xi.
13. Khan K, Arino J, Hu W, Raposo P, Sears J, Calderon F, et al. Spread of a novel influenza A (H1N1) virus via global airline transportation. N Engl J Med. 2009 Jul 9;361(2):212–4.
14. Kraaij – Dirkzwager M, Timen A, Dirksen K, et al. Middle East respiratory syndrome coronavirus (MERS-CoV) infections in two returning travellers in the Netherlands, May 2014. Euro Surveill. 2014;19(21):pii=20817. Available online: **http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20817**
15. Ruan S. The effect of global travel on the spread of SARS. Math Biosci Eng. 2009 Jan;6(1):207-8.
16. Chua KY, Grayson ML, Burgess AN, et al. The growing burden of multidrug-resistant infections among returned Australian travellers. Med J Aust 2014; 200 (2): 116-118.
17. Angell SY, Behrens RH. Risk assessment and disease prevention in travelers visiting friends and relatives. Infect Dis Clin North Am. 2005 Mar;19(1):49–65.
18. World Health Organisation (WHO) International Health Regulations. 2005
19. UK Government. Health & Safety at Work etc Act 1974
20. International Society of Travel Medicine (2013) Certificate in Travel Health®. The body of knowledge for the practice of travel medicine. Accessed 11 September 2013 at **https://www.istm.org/WebForms/Members/MemberResources/cert_travhlth/body.aspx**
21. J Chiodini, L Boyne, A Stillwell, S Grieve (2012) Travel health nursing: career and competence development, RCN guidance. RCN: London
22. JH Chiodini, E Anderson, C Driver, VK Field, GT Flaherty, et al. (2012) Recommendations for the practice of travel medicine. Travel Medicine and Infectious Diseases 10(3):109-128
23. NaTHNaC (2013) National Travel Health Network and Centre. Available at **http://www.nathnac.org/travel/** [accessed 11 September 2013]
24. Health Protection Scotland (2013) TRAVAX. The A to Z of Healthy Travel. Available at **http://www.travax.nhs.uk/** [accessed 11 September 2013]
25. Foreign and Commonwealth Office (2013) Travel Advice. Available at **https://www.gov.uk/foreign-travel-advice** [accessed 11 September 2013]

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