ITIJ’s Assistance and Repatriation Review 2013 offers an up-close-and-personal account of today’s global assistance industry. It provides an in-depth look at the provision of assistance in the modern world and how international assistance providers have evolved to meet new challenges and provide streamlined assistance in the most inaccessible of places. Such places include remote oil and gas fields, and in this Review we assess the development of emergency medical assistance services for those working at these sites. We also ask a veteran flight nurse for her pre-flight checklist in an article that explores how to ensure optimum care coordination; and we look at how best to manage cost effective repatriation decisions.

The assistance industry has come a long way in a short number of years, but what are some of the key differentiators for those operating in today’s global industry? We analyse today’s core competencies and see how add-on services and the development of mobile platforms are making some assistance companies stand out from the crowd. We also look at assistance ‘black holes’, which poses some poignant questions about whether promises of ‘global reach’ really can be kept.

Sarah Watson
Editor, ITIJ

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When it comes to repatriating international patients, a range of important decisions need to be made regarding the unique medical and logistical factors attributable to each case. **Dr Cai Glushak** talks through the complex issues facing those on the front line of this decision-making process, providing valuable insights into how to manage cost-effective repatriation decisions.

The decision-making process surrounding the medical repatriation of a patient is a complex and multifactorial function. It is, essentially, at the top of the travel assistance pyramid in terms of complexity, because it involves virtually every aspect of the assistance service, including coverage determination, medical risk and cost-benefit analysis, patient and cultural preferences, aeromedical expertise, and logistical co-ordination. Because any weakness in this interlinked chain can throw off a very delicate operation, repatriation planning should only be handled by the most experienced co-ordinators and clinical staff who have undergone didactic training and received one-on-one supervision before being allowed to independently manage such services.

It is also worth clarifying here that medical repatriation is differentiated from medical evacuation in that it is, generally, the final step in managing a patient who has fallen ill and been treated abroad, but who cannot get home safely without medical assistance. Hence, as compared to an evacuation, repatriation should rarely be an emergency procedure and can be planned carefully to achieve a satisfactory medical, as well as financial, result. Depending on how ‘repatriation’ is defined, it could involve anything from a simple upgrade of seating on a commercial flight to accommodate a severe ankle injury, to a fully equipped air ambulance with a critical care team.

**All things considered**

Though the repatriation services offered in any given case obviously depend on the nature of the patient’s coverage or personal resources, a quality assistance company will use dedicated medical personnel with expertise in acute and aeromedical care to weigh – first and foremost – the medical needs of the patient. They will determine whether ongoing care in situ is necessary and adequate, the risks of air travel and patient displacement at a given stage of their medical care, the special medical precautions necessary to safely transport a patient home, and their ongoing needs for admission or follow-up care once at their final destination. Subsequently, there may be different repatriation options available in any given patient case, depending on how far the patient has progressed in their recovery from an acute illness or injury. For example, a patient with significant pneumonia might be able to travel home immediately with supplemental oxygen and a nurse to administer antibiotics and assist with activities of daily living en route in an upgraded
cabin. Alternatively, this same patient might be discharged from hospital after a further two days to recover locally at home with one follow-up doctor visit in a week, and be able to travel home with simple wheelchair and luggage assistance in an economy seat. While the former choice might have the patient home sooner, the cost of this option would likely far exceed that of the ‘wait and recover’ approach, which might also be less burdensome to the patient.

Conversely, when a patient is receiving care in a costly medical system such as in the US and it is anticipated that they will remain in hospital for many weeks, yet could be made perfectly stable for transport home in an air ambulance, such a patient could be transported home with a qualified aeromedical team at great cost savings to the insurer and great satisfaction of the patient and family (who are often anxious to be back at home in familiar surroundings while their loved one continues to receive care in a local facility). An air ambulance cost of €60,000 to 80,000 from Chicago to Europe, for example, would be a wise expense compared to continuing with a four-week hospital stay that may cost $150,000 in addition to ongoing accommodation expenses for the family.

The challenge comes in making accurate predictions of the length of hospitalisation or likelihood of downstream complications compared to the immediate costs and risks of earlier medical repatriation. Again, such decisions rely on the honed clinical expertise of the assistance staff, supported by clinical prediction tools and treatment criteria. This is especially needed when making the more theoretical, though financially important, decision about an ongoing hospital stay versus the possibility of trip curtailment if a patient has been discharged as they are no longer acutely ill. Let’s say Mr Jones has been admitted to hospital in Orlando, Florida for a transient ischemic attack (mini-stroke) and has made a complete recovery, but he has multiple stroke risk factors and is in atrial fibrillation – an irregular heart rhythm that predisposes to a stroke. The patient is now on anti-coagulation medication, feels fine and wishes to complete his three-month holiday before returning to Manchester, UK. He will need a weekly blood test to check his medication level for at least one month, but little else if all goes well. His 90-day major stroke risk has reduced with treatment, but remains over 10 per cent. In addition, anticoagulation now poses the risk of bleeding. Do we recommend trip curtailment and repatriation with minimal assistance for Mr Jones and his wife because he now has a 10-per-cent risk of a costly hospitalisation? We would have to book their flight tickets and reimburse them for their three months of pre-paid rent, and likely have a complaint about wrecking their holiday plans. The ultimate decision will be a function of the risk tolerance of the underwriter, presumably considering the preferences of the insured. One approach, then, would be to leave some choice to the traveller, indicating that if he chose to continue his holiday, he would not be covered for complications...
For those of us practising medicine in the US, not responsible for the patient’s outcome. Under the microscope to prove that its decision was a patient to stay in the original site of care will be environment. An assistance company that ‘forces’ result of the natural progress of the disease or the to differentiate whether a poor outcome is the ideal, once home, it can be extremely difficult be unkind – when the medical result is less than completing treatment (such as urgent surgery). It is likely risky to repatriate them home before know they are receiving adequate care and that system, even though informed assistance personnel being treated in a local, less sophisticated medical in the face of a prolonged hospitalisation or recovery after a ‘semi-urgent’ operation – is often enough to having to remain isolated in a foreign country in at about 32 weeks gestation from previously unthinkable: we repatriated a premature infant born at about 32 weeks gestation from a neonatal ICU in Los Angeles to an excellent neonatal unit in the UK using a highly skilled transport team. At 35 weeks gestational age, the ‘premie’ was anticipated to need four to six more weeks in the ICU at a cost of €8,500 per day. We deemed a repatriation to be safe and more cost effective, so set in motion the process of arranging an air transfer. This could not have been accomplished without first convincing the treating neonatologist of the capability of the aeromeds and the receiving neonatal facility through conference calling that involved all entities and the assistance company medical officer. Naturally, the family relied most heavily on the treating neonatologist’s opinion about the planned transport. After our discussions, he was quite comfortable with our proposal and readily convinced the family of the soundness of the proposed repatriation using an incubator and neonatal intensivist and nurse. Meanwhile, we had to facilitate passport and visa preparation for the newborn (the parents had to arrange for a photo related to his atrial fibrillation, but that in other respects his protection would apply.

**Difficult decisions**

One cannot complete a discussion on repatriation decision-making without confronting the growing medico-legal realities inherent in this industry. Patients from highly developed medical systems may have exaggerated concerns about the risks of being treated in a local, less sophisticated medical system, even though informed assistance personnel know they are receiving adequate care and that it is likely risky to repatriate them home before completing treatment (such as urgent surgery). Unfortunately, the retrospectives will often be unkind – when the medical result is less than ideal, once home, it can be extremely difficult to differentiate whether a poor outcome is the result of the natural progress of the disease or the poor medical care given in an inferior medical environment. An assistance company that ‘forces’ a patient to stay in the original site of care will be under the microscope to prove that its decision was not responsible for the patient’s outcome. For those of us practising medicine in the US, Canada or other high-cost, developed medical systems, we confront the question of the ‘medical’ benefit of repatriation when the patient is already benefiting from a high level of medical care. In such circumstances, it is difficult to justify a repatriation for its medical advantages in the acute phase of an illness or before the condition has been definitively treated and the risk of deterioration eliminated. The odds are we can safely deliver even the most complicated patients home with sophisticated medical planning in the majority of cases; but a percentage of such patients will have their medical condition deteriorate.

Take a typical difficult medical risk/cost-benefit choice: can we justify repatriating a patient with a symptom, but ‘stable’ abdominal aortic aneurysm from a qualified Florida hospital to Germany, knowing that if the aneurism ruptures in flight, there is essentially no hope of survival? On the other hand, an operation in Florida will involve a two-week stay in hospital with potential complications (especially as such patients often have co-morbidities) at a gross unadjusted cost of at least €200,000. Can we justify the risks associated with repatriation when the patient is already receiving excellent medical care? This remains a very difficult industry challenge, especially as the costs in such developed medical systems continue to rise, and we are obliged to medically justify any decision to interrupt acceptable care in favour of taking on the risk of transporting a patient overseas to his or her native medical system.

In fact, we find that patients who fall ill in the US often express reservations about returning to their home country in the midst of an acute illness, often citing the inferior care they feel they will receive upon returning home, and asking why we insist they return home before they are fully recovered. Conversely, the prospect of a protracted stay – having to remain isolated in a foreign country in the face of a prolonged hospitalisation or recovery after a ‘semi-urgent’ operation – is often enough to convince a patient of the merits of returning home for ongoing care.

**A common goal**

If well planned, an able assistance organisation may reach a mutually acceptable plan for repatriation of a complicated patient through careful planning involving the treating and receiving physicians, the aeromedical organisation and the patient/family. Regarding the latter, it is important to be realistic about the risks and set realistic expectations while being able to offer some benefit through early repatriation. Recently, we accomplished the previously unthinkable: we repatriated a premature infant born at about 32 weeks gestation from a neonatal ICU in Los Angeles to an excellent neonatal unit in the UK using a highly skilled peri-natal transport team. At 35 weeks gestational age, the ‘premie’ was anticipated to need four to six more weeks in the ICU at a cost of €8,500 per day. We deemed a repatriation to be safe and more cost effective, so set in motion the process of arranging an air transfer. This could not have been accomplished without first convincing the

Patients from highly developed medical systems may have exaggerated concerns about the risks of being treated in a local, less sophisticated medical system in the ICU without medical devices obscuring the infant). All of this required meticulous planning, including for the nervous parents to meet up with the team on arrival in the UK (the air ambulance did not have room for a family member). The end result was an uncomplicated transport and a happy couple very grateful to be back home with family and friends to comfortably attend to their delicate newborn. The client/family was happy and the infant received uninterrupted, sophisticated neonatal care at all times – all at a conservative estimated cost-saving of at least US$350-400,000 in gross hospital charges. Assistance company choices do not always support both ideal clinical results and great cost-savings, but a skilled assistance team relying on refined, clinical decision-making and superb communications skills will result in the most cost-effective results for both travellers and underwriters, while minimising legal and customer relations risks.

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As the emergency medical assistance industry evolves, those operating in this international marketplace have developed and diversified their products and services to meet the needs of clients, partners and today’s travellers. In the midst of this fast-paced development, global assistance providers tell David Kernek how they’re aiming to stand out from the competition.
Assistant companies operating in today’s world have developed into high-tech, highly specialised operations with a global reach that continues to expand. How they have achieved this, and how they deliver assistance whilst going above and beyond client and partner expectations, differs from company to company, but all seem to agree that there are a number of features that are key to delivering stand-out assistance services in the modern world.

**Customisation and personalisation**

Assistant companies the world over emphasise the need to provide excellent customer service, and today this means adding value, customising your service offering, and personalising your operations on a scale never seen before. The one-size-fits-all era is ‘definitely over’ for the assistance industry, says Abasse Asgaraly, new business development director at Zurich World Travel Protection: “Constant and large-scale customisations have become a mandatory requirement for winning and retaining customers.”

Customising the assistance service offering and providing added value starts at the very beginning of the customer journey. “We try to ensure the traveller’s peace of mind by hooking up with them right from the planning stage, through their travels and then all the way home,” says Paola Bianchi, international business division director for Europ Assistance in Paris. “It is a very high level of customisation tailored to each client and their needs.” The need for differentiation and customisation is one of the most important challenges in the travel insurance and assistance industries, she says, and one faced by all assistance companies around the world: “Many of the basic covers, such as cancellation and medical expenses, offered by insurance companies are more or less comparable, so we are meeting the challenge by adding new, added-value services.”

A number of factors have helped assistance companies, large and small, to reach out to customers and business partners – from the harnessing of new technological abilities, to managing their in and outsourcing processes – but what is most important when comparing assistance companies today is not who can offer their services at the best price, but who can provide the best service to customers while being mindful of insurers’ bottom lines. Rob Upton, sales and marketing director at CEGA, says that consistently adding value – both in terms of helping the traveller and controlling costs for clients – enables providers to stand out in a competitive market. At his company, key to this is integration – using their expertise and technology, in a hands-on manner, to manage the whole end-to-end process, thus making the whole customer experience as seamless as possible. With many of their clients, they are even integrating sales, risk management and claims data onto the same IT platform they use for assistance, and empowering personal case managers who, as well as assisting in an emergency, will be able to give the traveller advice on other benefits available under their policy, even making immediate claims payments where appropriate.

“Most insurers have now grasped the importance of looking at the value of an assistance company as a whole. It’s no longer about which company can meet a basic service-level agreement at the lowest price; it’s about customer satisfaction and being able to demonstrate a real, tangible impact on claims spend,” says Upton. “The savings made by a good assistance company through a combination of experienced staff, medical and logistical case management, and an effective cost containment strategy that includes fraud detection and recoveries has become far more important to insurers than small variations in case fees.”

Can larger assistance companies provide high levels of personalised service, though? Upton insists that company size and the ability to provide a personal service are not incompatible. “Scale has many advantages, not least an increased buying and negotiating power, and an ability to absorb unforeseen peaks in activity or to divert resources when necessary. But larger players in the assistance market still place great emphasis on personal service. We operate small, specialist teams that focus on individual clients or small groups of similar clients. This gives each team a detailed understanding of the client’s market, ensuring expert personal advice.”

UK-headquartered InterGlobal Assistance, which operates in partnership with New Zealand’s First Assistance, cautions, however, that the outsourcing process often favoured by larger assistance companies does not always lend itself to a truly personalised service, especially when it comes to claims costs. “We realised that this crucial part of the claims process is where the product is really tested and where claims costs can be significant,” says David Bull, InterGlobal’s operations manager. He says the company’s in-house approach to delivering assistance means that a completely personalised service can be provided by a small team of skilled and dedicated people. “They are able to build relationships with our customers, which is something we do not believe can be easily replicated by a large company, especially those using outsourcing suppliers,” says Bull. Paola Bianchi agrees that a key challenge for assistance providers today is to optimise the trade-off between an international organisation and client proximity. “A large company can provide the same level of care as a local one if they take into account proximity and have knowledge of the different areas,” she states. “That is essential if we are to be competitive.” Each of Europ Assistance’s subsidiaries is specialised in their respective area, she explains, so they know the cultural specifics and the languages spoken. “We are assisting individuals, which means that everyone needs a customised answer, so our services cannot be standardised,” Bianchi concluded.

Similar sentiments are echoed by Patrick Corbett, managing director of Travel Guard EMEA, who has no doubts about the compatibility of global operations and tailored services. “Global...”
capability is essential as it means you have the language skills, the geographical presence on the ground and the cultural expertise to help your customers when they need you the most.” His company staffs a global medical team across four of its assistance centres: Houston (US), Shoreham (UK), Kuala Lumpur (Malaysia) and Buenos Aires (Argentina), which are fully integrated from a systems perspective, meaning the medical personnel work as a team to help customers wherever and whenever required. “However, this global capability must work hand-in-hand with locally based expertise,” states Corbett, “Every local team in Travel Guard is empowered to tailor their operations and service to best suit the local culture. This means we are able to take full advantage of local/regional knowledge and expertise without sacrificing the quality or timeliness of delivery.”

This personalisation of services on a truly global scale is especially important for business travellers, who are increasingly heading into riskier and more remote territories. “The increased risk makes it very important for assistance organisations to have close working relationships with clients, and a deep knowledge of the destination country in order to establish medical treatment, stabilisation, and evacuation protocols for handling difficult and challenging cases,” says Corbett.

Paola Bianchi agrees that this customised approach is crucial for corporate business, and explains how her company has adapted to cater for these clients. “[Business travellers’] needs are often greater than those of leisure travellers, so we have a special product for them that’s flexible in terms of duration, covers all areas for all destinations and includes a special website feature giving online medical information and advice,” she says. “Our Global Corporate Solution includes medical services and clinics in remote sites, security assistance in special risk areas, monitoring and reporting in the event of political situations creating the need for evacuation, and rehabilitation and health services when the customer returns.” Such rehabilitative services are a niche area of development for global assistance companies offering comprehensive, added-value elements for customers. Abasse Asgaraly explains: “We are seeing an increase in post-traumatic stress disorder cases, especially from defence contractors and their employees after assignments in war zones such as Iraq and Afghanistan. Assistance companies are now required to better manage back-to-work support and long-term disability assistance.”

Moving with the times
Changing traveller demographics, especially the movement of business travellers into higher-risk areas, has led to many global assistance companies enhancing their security services. Pre-travel advice based on the latest security threats, and the provision of effective assistance services in remote regions, are de rigueur for the major assistance players of today. Assistance companies, says Abasse Asgaraly, are being ‘compelled’ to offer timely intelligence to HR and risk managers. Proactive steps, he says, can be taken before events impede action to protect clients and their assets. One company that has also recognised the need for enhanced security services is AXA, which acknowledges that as travel trends continue to evolve, especially with many parts of Europe seeing an increasing trend in business travel, this provides new opportunities for employee tracking and repatriation services. James Barwell, AXA’s head of global underwriting and proposition development,
Online and security services are increasingly being requested, another new avenue for assistance companies as more business people are travelling to riskier destinations.

Such added-value services are an increasingly common aspect of assistance provision, but the challenge remains in encouraging customers to fully utilise the services on offer. By doing this, assistance providers not only save themselves time and money, but the benefits for the organisations providing these assistance services for their employees are also significant. "It’s important when assisting organisations with their travel risk management programme that their policy is not just fit for purpose from a duty of care perspective, but also encourages employee buy in," says Aria Assistance’s corporate travel head Randall Gordon Duff, "Whether it’s ensuring travellers book travel through their designated travel management centre or go through a mandatory medical or security pre-deployment process, benefits and processes that encourage employee participation are essential and could range from softer travel-orientated perks such as business class lounge access through to ensuring ease of compliance via technology and financial assistance for travel booking, ticketing and overseas expense submission.”

But it’s not just business travellers for whom global assistance provision has been enhanced and developed. Major catastrophic events, such as the 2011 Japanese earthquake and tsunami, the Arab Spring in the Middle East and North Africa and the war in Syria, says Asgaraly, have heightened the awareness among travellers and expats of the need for adequate insurance and assistance protection. And global assistance companies have worked hard to meet this need, even as traveller demographics have evolved.

Monitoring market changes and responding to them is essential, says Barwell, and an assistance company’s global scope allows it to see how economic circumstances impact customer needs, for example. In fact, travel behaviour has been evolving since 2009-10 in the face of economic pressures, he explains: “In some countries, the continuation of economic turmoil means trip lengths are shortening and destinations are coming closer to home. Staycations are being taken, which again change the services required under the umbrella of assistance. In many cases, information before travelling is seen as increasingly important alongside the response while travelling.”

Global assistance providers also continue to adapt to the growing desire and ability of older people to travel. “The ageing population in many countries is adding a very new dimension to the provision of emergency medical and travel insurance services,” says Asgaraly. “Policyholders do not accept long paragraphs of exclusions. They want insurers and their service providers to adapt their products to the new demographic reality. Ageing does not mean people cannot travel and continue enjoying an active life. Customers want products to be adapted to their new needs and lifestyle.”

And as these and other travellers’ appetites for adventure seemingly know no bounds, so assistance companies have to be proactive in meeting evolving client needs and improving services to meet changing travel trends. “For example,” says Upton, “the recent rise in the accessibility and popularity of climbing trips and expeditions to the Himalayas has prompted CEGA to invest time in perfecting our assistance capabilities in this area, ensuring that we’re able to support the increasing number of cases, and have robust local contacts to facilitate cost control and offer real-time knowledge of local resources.”

Global reach has never been greater for assistance providers, and at the same time a more personalised service tailored to today’s traveller is becoming the norm. Whether providing assistance companies are now required to better manage back-to-work support and long-term disability assistance.
almost boundless opportunities to advance customer and traveller satisfaction. The differentiation value of concierge add-ons is emphasised by AXA, which last year underlined the point by buying White Concierge, a UK-based company with an approximate six-percent share of the European market. Its international team of specialists and the services they offer – from mass market to high-net-worth requests – can be accessed by more than two million consumers. “As an added-value benefit, concierge provides much more positive connotations over many other insurance-based add-ons, which provide customers with support only when something bad happens,” says Stuart Boon, sales director of White Concierge. “Concierge is vastly different, with specialist agents working to continually delight customers and generate new and exciting ways to gratify their travel, business and lifestyle ambitions.” Boon says that concierge providers must have the strength to make a recommendation based on knowledge and experience. “Every call is personal, and we build trust and empathy to ensure a personal solution is created for each request. The level of detail each case receives is so minute it’s almost surgical, with customers experiencing splendid little touches that make all the difference to them, whether it’s cultural subtleties or the benefits of complimentary upgrades and VIP treatment,” he says.

But what’s the best way to provide this plethora of services and to stay in touch with assistance customers? In this age of technology, it seems that smartphones are key. “Smartphone access to emergency contact centres is a must-have feature for assistance providers,” says Asgaraly. “Mobile devices combine ease of access and use compared with the old model, in which insured clients needed to check their policy and then find the emergency contact numbers. Mobile devices will become the tool of choice for travellers and expatriates in accessing their insurance and assistance services.”

At MAPFRE, there’s a strong emphasis on technology: “Technology is a vital part of what we offer, and a key driver of growth in our business strategy,” said a spokesperson for the company. Apps are at the heart of its assistance systems, with the AMA application used to manage assistance and claims, the FUTURA app automating the assistance process, localising the most appropriate resources via GPS and automatically assigning services through mobile devices, and the MAiassist smartphone app allowing the user to automatically request particular assistance services at the touch of a button. Technological bells and whistles are essential in today’s market, agrees David St Clair, operations director at Aria Assistance, but they’re not the total answer. As the global industry will agree, although technology plays an ever-more important part in the supply of assistance services, nothing will replace human contact in the quest for ultimate customer satisfaction. “We have embraced modern technology … ID protection solutions, motor breakdown apps, online reference tools and a fully managed corporate traveller portal providing health and security advice; but when someone has broken down in their vehicle, or suffered an illness abroad, they want to be able to talk to a person who can only show empathy, but can also provide some guidance and reassurance as well as immediately providing assistance,” says St Clair. “Although we have a greater reliance on our technology, we still rely on the human interface first and above all.”

So, while even traditional assistance services, such as roadside assistance, are being made to fit the digital era, personal interaction remains a priority. At the same time, technology is making assistance providers think in a very different way, bringing innovation to the industry. “Technology is really the new frontier in assistance, not only in cases of repatriation from remote areas, but also in daily life,” says Bianchi, “Innovation is part of our DNA. Because people are living longer, we provide Alzheimer bracelets and phone-based services that elderly people with chronic diseases might need. Of course, these services and solutions vary from country to country because national regulations and health programmes are different.”

It is technology that is broadening the reach of assistance services and creating the platforms on which to drive the industry forward to meet the travel and health-based needs of people today. Various challenges face international assistance providers in each area of the globe, but core competencies that can be provided on a global scale are meeting many of these head on. To stay ahead of the competition, assistance companies today have to have a truly global reach, but be able to customise their services to provide a personal approach for each client, whilst remaining cost effective. Value-added services and innovative assistance add-ons are certainly enabling assistance companies to tailor their approach to different clients, and are helping them to stand out from the crowd.
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All things considered

Dutch assistance company ANWB describes a mission it undertook for a patient needing a transfer from French Polynesia to the Netherlands. The team worked in collaboration with First Assistance in New Zealand to complete the medically and logistically complex repatriation.

The notification
On the evening of 3 February 2013, we were phoned by a ship’s physician on a large cruise ship that was sailing in the middle of the Pacific Ocean somewhere between Central America and New Zealand and that was due to arrive on the morning of 7 February in Nuku Hiva, one of the small Marquesas Islands in French Polynesia. One of the cruise passengers had serious heart complaints and had been admitted to the ship’s medical ward. This was a mini-clinic that can offer adequate first-aid help, but for more complicated procedures, a patient must debark as soon as possible and be taken to a hospital. This patient needed a heart operation, and the immediate question was where to go. The ship’s physician considered New Zealand or Australia as the most viable options. We opened a file and agreed to stay in contact via email.

The preparation
The customer was well insured – in addition to her health insurance, she and her husband also had an ANWB/Unigargant travel insurance policy. We immediately went to work by finding the exact location of the patient. There is a 10.5-hour time difference between the Netherlands and Nuku Hiva, where there is a small airport and a small hospital. Further investigation, though, revealed that that this ‘hospital’ was actually an extensive first-aid post with 26 beds for emergencies. Since it was unclear whether or not a cardiologist worked there, however, we couldn’t take the risk of sending the patient there. Thus, we continued searching for the best place to offload the patient for treatment at the best facility. Tahiti is the biggest island in the region and is a three-hour flight from Nuku Hiva, with an 11-hour time difference with the Netherlands. The island has a French hospital with a cardiology ward, so our medical service immediately tried to find out if they could contact a cardiologist at this hospital. The capital city of Papeete has an international airport; there are flights to such locations as Auckland, Sydney and Los Angeles, which are respectively eight, nine and 13 hours away by plane. There are also private jets and air ambulances available for rent, which is what we needed.

Then we looked at the ship’s cruise schedule. The ship had left Mexico and was sailing via French Polynesia to New Zealand. Since it wasn’t due to arrive at Tahiti until 10 February, we spoke with the medical service and by email with the ship’s physician to ask if waiting to dock in Tahiti was a better option than a more stressful evacuation from Nuku Hiva. Sadly, the patient’s condition was so poor that those three days could make an enormous difference, so we went ahead and planned to meet the patient in Nuku Hiva. We saw that the ship was due to arrive at the island on 7 February at 7.30 a.m. (local time). We knew that the ship wouldn’t dock at a pier, but would instead lie at anchor nearby. This was an important detail, because passengers would have to be taken by tender from the ship to the shore, and this could be an obstacle for our patient. Thus, we had to arrange not only for a plane and an ambulance, but also for a boat so that the patient and her husband could be the first to disembark before the other passengers (about 1,500 of them) left the ship and the quay became too crowded. Communication with the ship was fantastic. Although it was the middle of the night in the Pacific Ocean, the receptionist on duty immediately gave us the information we had requested. They also understood that the clients would never be able to take all of their seven pieces of luggage with them, so they assured us that both passengers would take one piece of luggage and one piece of hand luggage each. The ship would transport the rest of the bags back to the UK, where they would then be forwarded to the customers’ home address.

We were also asked if we could pay the bill for the ship’s clinic. We immediately arranged for a payment guarantee to the cruise company and sent this to its main office in the UK. Together with our medical team, we made a plan: we decided to have the evacuation take place in phases. We would first take the patient off the ship by boat and keep the clinic on Nuku Hiva on standby in case of an emergency. If there was no need to use the clinic, we would take the patient and her husband to the aircrport, where they would be flown by an air ambulance to Papeete. Once there, the patient would be admitted to hospital for an examination and to stabilise her condition.

The repatriation of a patient from a cruise ship in the middle of the Pacific Ocean back to Europe

The customer was well insured – in addition to her health insurance, she and her husband also had an ANWB/Unigargant travel insurance policy. We immediately went to work by finding the exact location of the patient. There is a 10.5-hour time difference between the Netherlands and Nuku Hiva, where there is a small airport and a small hospital. Further investigation, though, revealed that that this ‘hospital’ was actually an extensive first-aid post with 26 beds for emergencies. Since it was unclear whether or not a cardiologist worked there, however, we couldn’t take the risk of sending the patient there. Thus, we continued searching for the best place to offload the patient for treatment at the best facility. Tahiti is the biggest island in the region and is a three-hour flight from Nuku Hiva, with an 11-hour time difference with the Netherlands. The island has a French hospital with a cardiology ward, so our medical service immediately tried to find out if they could contact a cardiologist at this hospital. The capital city of Papeete has an international airport; there are flights to such locations as Auckland, Sydney and Los Angeles, which are respectively eight, nine and 13 hours away by plane. There are also private jets and air ambulances available for rent, which is what we needed.

Then we looked at the ship’s cruise schedule. The ship had left Mexico and was sailing via French Polynesia to New Zealand. Since it wasn’t due to arrive at Tahiti until 10 February, we spoke with the medical service and by email with the ship’s physician to ask if waiting to dock in Tahiti was a better option than a more stressful evacuation from Nuku Hiva. Sadly, the patient’s condition was so poor that those three days could make an enormous difference, so we went ahead and planned to meet the patient in Nuku Hiva. We saw that the ship was due to arrive at the island on 7 February at 7.30 a.m. (local time). We knew that the ship wouldn’t dock at a pier, but would instead lie at anchor nearby. This was an important detail, because passengers would have to be taken by tender from the ship to the shore, and this could be an obstacle for our patient. Thus, we had to arrange not only for a plane and an ambulance, but also for a boat so that the patient and her husband could be the first to disembark before the other passengers (about 1,500 of them) left the ship and the quay became too crowded. Communication with the ship was fantastic. Although it was the middle of the night in the Pacific Ocean, the receptionist on duty immediately gave us the information we had requested. They also understood that the clients would never be able to take all of their seven pieces of luggage with them, so they assured us that both passengers would take one piece of luggage and one piece of hand luggage each. The ship would transport the rest of the bags back to the UK, where they would then be forwarded to the customers’ home address.

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If the patient could not receive sufficient help here, we should arrange a further evacuation to New Zealand or Australia. We contacted our First Assistance agent in New Zealand for the practical implementation of our plans. However, we remained responsible for the co-ordination. On the 5 and 6 February, we were in continual contact by email: ANWB, First Assistance, the staff on the ship and the agent on Nuku Hiva discussed all of the practical matters pertaining to this patient case. Thanks to First Assistance, the ship's physicians had email contact with the air ambulance physician and the cardiologist in Papeete and they were able to exchange information about the medical situation. The cardiologist thought he would be able to provide the care needed in Papeete. The preparations went perfectly, and everyone was ready for the patient’s arrival. However, the patient’s condition grew worse. The ship’s doctor sent an email saying that the ship was going to sail faster so that they would be able to arrive on Nuku Hiva six hours earlier: at 1:00 a.m. They wanted us to pick up the patient immediately after docking. After a rapid exchange of emails among all of the parties involved, it was determined that the air ambulance could not land or take off at these small airstrips in the dark. It left Papeete before dawn, therefore, arriving on Nuku Hiva at daybreak. An important point when compiling a dossier is the contact with the clients themselves. You really can’t arrange this sort of operation without consulting the client, but we had never spoken with them! We had sent frequent emails to the ship with our plans and updates of the situation, and we had asked if the clients were aware of what was being arranged for them. But it turned out that we didn’t need to worry: the husband was slightly deaf and preferred not to be on the phone with unknown people ‘so far away’. He had excellent contact with the public relations official on the ship and was well informed of the plans.

The evacuation and hospital admission

The agent on Nuku Hiva had direct contact with the ship about its exact time of arrival, and with the ambulance and taxi service, the customs officials and the extra tender boat. The nurse from the ambulance was taken to the ship by tender to collect the patient, and the ship’s physician also left with the patient in order to personally supervise her trip by ambulance to the airport. Once the patient had arrived at the airstrip, the air ambulance physician took over. The hospital bed on Nuku Hiva was cancelled, and the patient was flown directly to Papeete.

In Papeete, the patient was admitted to hospital and operated on immediately. Her condition improved considerably, and she continued to gain strength in the days that followed. Her recuperation went so well that we were informed a few days later that further treatment in New Zealand wouldn’t be necessary and that we should focus on repatriating the patient to the Netherlands. We sent this positive news to the ship’s physician, who was already aware of the developments since he himself had been in touch with the physician in Papeete.

The repatriation

After consulting the cardiologist, our medical service gave advice for transport: the patient could fly on a scheduled flight with extra oxygen and under the supervision of an intensive care nurse. We chose the best connection: on 20 February, the patient and medical team would board a direct flight from Papeete to Paris with Air France, and from there, transfer to Amsterdam. Air France/KLM worked well with us and were able to provide extra oxygen onboard. We booked a business class ticket for extra space and comfort (a 23-hour flight!) and a wheelchair at the airports because we knew that the patient had not yet been out of bed. We booked two nurses as a supervisory team; given the length of the flight, they could relieve and help each other. And there would then also be time to give attention to the patient’s husband, who had been doing his best throughout this ordeal and was probably exhausted.

On 10 February, we received a mail from the ship’s physician stating that the ship had docked at Papeete and that he had visited the patient. He was pleasantly surprised by the excellent quality of the hospital and the medical treatment received there.

The transfer of information to the hospital staff took quite some time because so much had happened!

On 16 February, the nurses flew with Air France to Papeete, where they arrived (given the large time difference) the following day. They checked into the hotel where the patient’s husband was also staying. In the days that followed, they recovered from their jetlag, concerned themselves with the patient’s husband and tried to improve the patient’s limited mobility when they visited her in the hospital. The patient was given extra physiotherapy and they took her outside in a wheelchair so that she could walk around a little. After speaking with the cardiologist and the husband, the nurses asked us to arrange a hospital admission in the Netherlands. They also reviewed the patient’s case history from the boat through to her treatment in Papeete, and they gave a detailed explanation of the flight home – in person and in Dutch, which made everything easier. Then the big day arrived. Early in the morning, the patient and medical escorts drove by ambulance and taxi to the airport in Papeete. The patient was brought onboard in a wheelchair, and the extra oxygen was next to her seat.

The plane first flew to Los Angeles, where it had a long stopover. During this stopover, the group waited in the business class lounge, where there were comfortable armchairs, and drinks and snacks were available.

At the airport in Paris, the group was brought (the patient again in a wheelchair) to the KLM plane for the last leg of the flight to Amsterdam. At Schiphol Airport, an ambulance and a taxi were waiting to take the group to the hospital in the patient’s place of residence. The transfer of information to the hospital staff took quite some time because so much had happened! Finally, our nurses said their goodbyes and went home; after a return trip of 30 hours, everyone needed some rest.

Author

Eric Grootmeijer is ANWB’s network manager, an ARC Europe area manager, and veteran of the assistance business. He joined ANWB Emergency Centre, Holland’s first assistance organisation, in 1977 and occupied various positions there. He then set up ANWB’s Innsbruck office, where he co-ordinated the ‘plaster cast flights’ during ski seasons, an ANWB invention. He has led the medical and travel assistance department and has also been an ANWB retail branch manager.
It goes without saying that some countries or regions of the world are, generally, more difficult in which to provide assistance – especially countries that are the location of recurring conflict. Sasha Gainullin offers his experience on how best to manage assistance provision when local resources are limited and logistics extremely challenging.

It is easy to imagine certain countries that could be considered assistance ‘black holes’. Take Pakistan for example: there are numerous travel advisories against visiting parts of the country, so anyone brave enough to risk getting caught up in the violence and political activity occurring in these restricted areas would be doing so at their own peril. But what about travel to Punjab or Islamabad – to visit relatives, attend to business, or visit the World Heritage Site of Taxila? Visitors to these parts of the country would be covered by their travel insurance, but if illness or accident strikes or the traveller finds themselves inadvertently caught up in conflict, can their assistance provider deliver what’s expected in terms of client and insurer expectations? Pakistan is in many ways a developed country, but healthcare standards vary, cultural and language barriers are an issue, and there is a lack of dedicated emergency air ambulance provision – all of which make this a difficult place to deliver efficient and appropriate healthcare. At the same time, assistance companies helping clients in the country need to make billing or payment arrangements and organise repatriations with hospitals unfamiliar with dealing with assistance companies or relaying information to foreign assistance company medical directors.

So, is assistance provision in countries such as this beyond the reach of many of the assistance companies who market themselves as having a ‘global reach’? And can those ‘international’ assistance companies offering ‘worldwide’ assistance really be effective or efficient enough in their care delivery to meet insurer and customer expectations in such places? And just what can companies specialising in remote or conflict zone assistance provide that others aren’t as able to?

Understanding global reach
The term ‘worldwide policy’ has become a marketing norm in the travel insurance industry, but may mislead the buyer into believing they are purchasing a policy with truly worldwide assistance capabilities, when in actual fact there are a number of factors that could drastically limit such worldwide assistance provision. Let’s be realistic, there are some places in the world that cannot be easily reached because of their remoteness, lack of communication infrastructure, or other known dangers.

Most underwriters of travel insurance plans that contain international medical assistance provision use policy language to manage their liability by excluding coverage for travel into parts of the world deemed too dangerous; for example, they will exclude cover for travel to areas named by certain governmental travel advisories as ‘places to avoid’ due to current risks associated with that region. By
relying on these authoritative sources, underwriters are able to judge themselves from any obligation to respond to medical events or to pay claims in countries from Algeria to Yemen, as specified in their policy wording. Policy terms and conditions should, thus, reflect and make clear any limitations that could affect the company’s ability to respond to emergencies in remote or otherwise restricted areas.

However, there is an element of personal responsibility that goes beyond ‘buyer beware, read the fine print’ and speaks to common sense expectations of what an assistance company can provide. But there must be a balance between honest disclosure by the insurer and an assumption of personal risk by the insured. At the same time, an assistance company that claims to be able to respond in extreme circumstances must have a proper structure to support its activities. The best companies have employees posted in and around the locations where their clients are located. No such specialist assistance company can post employees in all of these locations, so they must have the ability to get there, either by proxy or in-person, within 24 hours. Having a network of regional managers who liaise with pre-approved local operatives is an effective way to cover the company’s geographic assistance obligations. Once the injured party makes contact, the assistance organisation is obligated to deliver on the promises in the travel insurance policy. The best way to accomplish this is through employees who are properly trained – from the call centre all the way through to the dispatching of qualified personnel to the location where the individual is situated. This goes for mainstream as well as specialist assistance providers, but it is especially important for assistance providers working in hazardous areas to ensure they have well trained staff in situ who also have good local knowledge. Many assistance companies are very good at delivering benefits in areas that have adequate infrastructure, but lack the ability to respond in other areas because they do not have qualified, trained personnel inside ‘black hole’ locations to the extent that certain specialist assistance providers do.

Black hole situations

Even assistance companies with offices in troubled countries or specialist assistance providers with experience of working in war zones can face scenarios that could be considered ‘assistance black holes’. These usually happen in geographical regions that could be deemed more generally as ‘assistance black holes’ or they could occur in larger scale disaster situations. Let’s look at an example. This is an actual case study, although details have been changed to protect patient privacy:

On a beautiful spring day somewhere in the Middle East, a bus load of Indian contract workers swerved to avoid a car. The bus rolled over, killing one person, and injuring 10 others. Ambulances arrived quickly, taking the crash victims to neighbouring public hospitals or missing, the phones are out, and Mr Singh doesn’t speak the language: his case represents an assistance black hole.

Black holes abound when delivering emergency medical assistance in remote and dangerous places. Language barriers are often the first obstacle, while locally available medical care may not be adequate to treat a patient’s condition; and poor infrastructure can cause transportation bottlenecks. Patients can get stuck in the wrong medical setting because of administrative delays and cumbersome bureaucracy with regards to their travel documents. Telephone and Wi-Fi deserts, along with unreliable electricity sources, can shut down communications. The insurance policy may exclude payment for the specific cause of the medical condition or death. Credit cards are not widely accepted in some areas, and getting cash to settle medical bills can be problematic: banks are often closed without notice and wire transfers can take weeks. The local and cultural norms of healthcare delivery may dictate treatments that are not in the best interest of the patient, while the absence of an adequate follow-up and treatment plan after discharge may compromise the patient’s full recovery.

These challenges can’t be eliminated, but facing them directly and in person can provide surprisingly efficient solutions. The best way to prevent black holes from swallowing an assistance case is through the training and placement of knowledgeable and empowered employees along each step of the process. This begins with the first call and continues until the patient is fully recovered. Most assistance companies use local subcontractors in these out-of-the-way locations and, as a result, their services tend to be uneven or inadequate in extreme situations, as specialist – as well as local – knowledge is often key to streamlined and effective case management. Because of the necessary attention to detail for each case, there are only a handful of specialist (often low-profile) – assistance companies adequately covering these regions.

When a medical event occurs, the first point of contact is usually the assistance company’s call centre. Injured and anxious in a foreign land, the client needs information, comfort and solutions. Too often, the call centre is staffed with powerless, linguistically challenged, untrained people who merely take messages. “May I have a phone number where you can be reached? Someone will get back to you shortly,” is often the response received on that first call to an assistance company. Customers need to talk to well-trained people capable of assessing the caller’s level of need and providing immediate information and reliable solutions – even for the most remote
often don't accept credit cards, bank wires, or medical providers in remote and dangerous places. Bottled water, and extra phones. Because most with portable generators, car chargers, batteries, part of daily life. Agents prepare accordingly, for local agents, power cuts, Internet blackouts, the hospital. They know when the power usually up and weaving together financial and information systems. These local professionals bridge potential challenges can turn into black holes, but they don't have to.

In the field
Having experienced, locally knowledgeable health professionals in place before a medical event occurs is key. Assistance companies that subcontract patient care to outside organisations are often playing on-call roulette by relying on third parties to manage their cases. The best approach is to employ workers directly, train them professionally, and place them in the call centres and the communities where their clients live and work. By empowering employees both operationally and financially, they can make real-time, life-saving decisions in the immediate best interest of the patient. They should be expected and encouraged to comfort, advise and intervene bedside, and ensure the patient’s follow-up plan upon discharge is thorough enough to assure enhanced medical outcomes. These field agents have a keen understanding of where deficits in medical services exist in their region, and who the best medical providers are. They act as minders, finders, helpers and fixers by navigating the local landscape. First, they make contact with the patient, and provide a personal assessment. Based on local experience, they find cash – where necessary – and arrange for transport. Agents help patients wade through foreign bureaucracies and cryptic travel documents. Fixers expedite and fine-tune the logistics, setting up and weaving together financial and information systems. These local professionals bridge potential black holes that could adversely impact a patient’s eventual recovery. Furthermore, field agents know how to get to the hospital. They know when the power usually goes out, for how long, and what to do about it. For local agents, power cuts, Internet blackouts, and water issues are not catastrophes, they are part of daily life. Agents prepare accordingly, with portable generators, car chargers, batteries, bottled water, and extra phones. Because most medical providers in remote and dangerous places often don’t accept credit cards, bank wires, or cheques, good field agents have guarantee of payment arrangements already set up at hospitals and clinics. They know where to get cash day and night and can personally front the cash in emergencies. Not only are the local agents savvy on the ground, they also understand their customers’ language and cultural needs. This level of care can’t be phonied in. Local knowledge can literally fill black holes and save lives. Let’s have a look at how Mr. Singh’s situation panned out:

Mr. Singh contacted the assistance company and told them of his situation. Based on the location of the accident, the regional office identified several possible medical facilities, and started dispatching agents to investigate. As the telephones were down, agents personally visited all the local hospitals and clinics.

Customers need to talk to well-trained people capable of assessing the caller’s level of need and providing immediate information and reliable solutions – even for the most remote or challenging regions.

Within three hours, all 10 victims were found, assessed, and some were moved to alternative medical settings. The injuries included a crushed pelvis, broken femurs, head traumas, and minor cuts and bruises. The agents paid the medical bills of the previously discharged patients, who, thanks to a prearranged billing system, could get on with the business of getting better, and confirmed the financial arrangements for those needing further care. The family of the deceased were notified, and the remains prepared for repatriation. Meanwhile, other field agents got busy collating and translating official police documents about the crash, and all the medical records into Mr. Singh’s language. Once the cause of the accident was determined, they updated the translation. Field agents continued following up on the crash victims. Medical training made a difference for one patient, whose doctor would not address his pain. The medically trained agent had the patient assigned to a different doctor, who started him on a new treatment regimen and he began to recover more rapidly. A few months later, most of Mr. Singh’s employees were back at work, and the rest were making excellent progress.

When mainstream international assistance companies utilise subcontractors to deliver services in areas of the world that are either too remote or are complicated by conflict, they might use one company for transportation, another company to deliver medical services, and yet another to review and transmit medical claim information back to the home office. In this scenario, the chain of accountability has many links and many opportunities to fail. Using an assistance company with a centralised command and control structure that specialises in delivering medical and other assistance services in remote and dangerous places should be considered. Specialised field experts don’t come easy, however. Educated, multilingual, polite yet firm, and cool under pressure, such specialist assistance providers strike a balance between business and compassion that makes all sides happy, while smoothly navigating multiple borders and cultures. If mainstream international assistance companies choose to offer their services in dangerous places, they should look to work with experts that have experience in meeting the unique challenges found in such places.

The local agents are the heroes in Mr. Singh’s story – as they are in so many other cases – and are the key to meeting client and insurer expectations in areas that are traditionally more difficult or challenging in which to deliver assistance. Call centre workers can talk to on-call doctors, but it takes first-hand observation to make sure patients are getting the most appropriate care in the most timely manner – agents with medical backgrounds who are qualified to make educated, on-the-ground assessments and recommendations for patients are invaluable. Without knowledge of local bureaucracy, police reports and medical records can be unobtainable. Without extensive linguistic skills, a local understanding of healthcare delivery and how it is paid, injured parties can face treatment and discharge delays. Dedicated local agents with these key skills, local security knowledge and an ‘insider’s’ ability to get the job done, make the difference between black holes and successful outcomes.

Sasha Gainullin is chief operations officer at Tangiers International Ltd, a global medical case management and emergency assistance company located in Malta (EU). Tangiers is focused on providing in-country medical and administrative support for government contractors, multinational employers, aid workers, interpreters, journalists, embassy staff, missionaries, and marine crew in conflicted, dangerous and remote locations worldwide. Prior to joining Tangiers, Sasha had a 12-year career managing international assistance centres for a number of major international insurance companies.
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Caribbean headway

As the Caribbean has maintained its allure for visitors old and new, the global assistance industry has enhanced its service provision in the area, and there are now many more options in the region for patients in need of medical care. Tatum Anderson looks at the logistics of providing assistance in the Caribbean today.

Exotic, far-flung beaches, powder-white sand, palm trees and translucent water: it’s no wonder the Caribbean Basin makes the perfect paradise getaway. The region also has a diverse range of rich and distinct histories, languages, geopolitical and economic territories; and stretches west from Florida along the Gulf Coast waters of the US to South America and the Caribbean Sea. It encompasses the archipelago islands of the West Indies, the coastal ports of Guyana and Suriname, the mainland resorts of Mexico and Panama, and even Bermuda, itself consisting of 138 coral islands and islets in the Atlantic Ocean.

Up to 25 million tourists visited this region in 2012 and spent US$1 billion more than the year before. European and Canadian tourists generally come to winter in Cuba, the Dominican Republic and European-influenced islands such as Guadeloupe, St Maarten and St Barts. American tourists, on the other hand, often choose to vacation on Mexico’s Riviera Maya, the Bahamas, the British Virgin Islands and Jamaica.

Assistance companies have mushroomed in recent years to cater to this flourishing tourism industry, says Alberto Carson, director of operations at Air Evac International, an air ambulance company serving the region. He says: “Over the past decade, assistance provision in the Caribbean has grown exponentially. Assistance companies have a presence in almost every island and territory in the region. They are extremely organised.”

The growing cruise ship industry is in no small part responsible for the increase in medical assistance provision in the region. Hundreds are disembarked from leisure cruise liners every year following illness or injury, often with family, luggage and durable medical equipment in tow — and requiring assistance. Learning from this experience, many assistance companies in the region now have good working relationships with local port agents, cruise companies, hospitals and air ambulance providers, making it easier to provide streamlined and cost-effective assistance services to disembarked patients.

There do remain a number of challenges, however, when considering assistance and repatriation.
options in the Caribbean. The geography of the region, the uneven spread of suitable medical facilities, and the culture of the region, have all shaped the development of assistance provision and determined the course of how medical care is best delivered to those in need.

**Finding a facility**

Because the Caribbean region is so dependent on tourism, there has been significant investment in building resorts and accompanying infrastructure to support the influx of visitors. That, says Europ Assistance, has in turn helped improve medical infrastructure across many of the islands. In particular, the Dominican Republic, with over four million visitors a year and resorts a-plenty, has seen significant improvements in medical care because of the growth of the tourism industry there; and the US Department of State says that high quality medical care is available in Nassau and Freeport in the Bahamas.

In Puerto Rico, Hospital Pavia, Los Hospitales HIMA and San Pablo are a group of ‘state-of-the-art’ hospitals in the northeast of the island, while Howard Johnson Centro Cardiovascular San Juan specialises in cardiovascular medicine.

In addition, there are private hospitals such as Doctors Hospital in the Bahamas, Medical Associates in Jamaica and St Clair Medical Centre in Trinidad, a 60-bed facility that offers services ranging from a 24-hour accident and emergency department to open heart surgery. Such high-quality facilities can be found throughout the region – the job is knowing where each one is. Generally, though, where there are larger populations, there are better economies of scale and expertise in cardiac, trauma, orthopaedics and neurology, and some hospitals on the larger islands can handle burn victims. According to Brian Weisz, chief operations officer of air ambulance firm Reva, ‘the larger islands in the Caribbean have hospitals that are university programme supported, also known as centres of excellence’. The Queen Elizabeth Hospital (QEH) is Barbados’ primary acute care medical facility and an accredited teaching hospital affiliated with the University of the West Indies.

At the same time, medical facilities on the smaller islands can be extremely limited. As with anywhere in the world, remote getaways make a place enticing, but often also make it a challenge from a medical viewpoint. Thus, the fact is that small island nations simply don’t have sufficient medical infrastructure to deal with complex cases.

Take the British Virgin Islands, with 36 islands and a tiny population of 32,000. It attracted 914,000 tourists in 2008, but has just one small general hospital on the main island of Tortola. This medical facility, Peebles Hospital, has an emergency room staffed 24 hours a day by physicians, and offers inpatient, paediatric, basic diagnostic services, general surgery, neonatal, intensive care and renal dialysis; but the government plans to reduce the staff there under a new reorganisation (there are 33 doctors at the moment, and there will shortly be 31, but with more specialisms; while nursing staff will be reduced by almost half). The hospital also boats a good physiotherapy unit, which is used for rehabilitative care, and there are many outlying clinics that are attached to the hospital and which combine with it to provide healthcare across the island. Furthermore, there is one public and one private clinic on Virgin Gorda, and both this island and Tortola are served by ambulances staffed with paramedics. There is also a clinic staffed by a government nurse on both Jost Van Dyke and Anegada; but there are no medical facilities on the other Virgin Islands.

Shai Gold, managing partner of International Triage, spoke to ITIJ about the lack of consultants available on the smaller Caribbean islands: “In many medical facilities in the region suffer from poor maintenance, staffing, medical education or funding, and are just not prepared for critically ill patients. In addition, hurricanes have battered many facilities and caused years of decline. Allianz Global Assistance has audited and rated 1,760 hospitals in 113 countries around the world, but found just 74 Caribbean facilities that meet its minimum standards for adequate care.

A limited range of medical facilities from which to choose has several implications for assistance companies, and narrows their options for medical care within the region. It has also shaped the relationship between local hospitals and assistance providers, resulting in a range of challenges for the industry.

**Finding your feet**

With a limited choice of medical facilities available in the Caribbean, assistance companies have less bargaining power and are not easily able to set more favourable terms. Kellee Hinshaw, assistant manager for international provider relations at US-based Seven Corners, says many treatment providers know that they may be the only choice on a particular island for a particular treatment, diagnostic test, scan or inoculation and, as a result, set their own terms and conditions. For instance, they may decide not to partner with international insurance companies, instead demanding upfront payments or charging higher rates for foreign patients. “If you’re the only hospital on the island, or the only clinic with the capability to provide X-rays on-site, you’re in a pretty good position of being able to demand without fear of losing business,” she says. “Having a competitor down the street who will direct bill foreign insurance companies, offer discounted rates or special package prices for foreigners is not something providers in the Caribbean have to worry about.”

A particular issue within the region is the demand for payment in cash rather than using traditional billing routes. “Many providers simply want their money at the time of service, no questions,” she adds. The fact is that charges for such outpatient visits are typically minimal, so providers are reluctant to make direct billing arrangements with an international insurance company. For a $30 office visit, they may incur [an equivalent] bank charge to receive payment via wire transfer, or cash a cheque issued in US dollars.”

Europ Assistance (EA) agrees that in the Caribbean, cash is king. In most other industrialised countries, patients presenting with an emergency condition will be treated regardless of their ability to pay. In many of the smaller Caribbean nations, this is not necessarily the case. Even if the tourist has medical insurance, the hospital may hold the patient’s passport and delay discharge until an account is settled because they do not direct bill third parties. EA says that it can guarantee costs with a wire transfer or credit card payment, where these are accepted, if the patient has this benefit through their insurance or employer. In rare cases where cash payment is required, EA asks its local agent to deliver cash...
FrontierMEDEX says some private facilities in the Dominican Republic have even begun to adopt American CPT Codes (a numerical coding system used by hospitals and insurance companies in the US to classify procedures and the cost associated with them). However, costs at such facilities can be extremely expensive in relation to comparable services elsewhere in the Caribbean. For example, a cerebral CT scan at a well-qualified hospital that does not cater specifically to tourists could cost a patient or insurer around $230. But, the same scan in a resort area in the Dominican Republic could easily increase to $600 to $800 per scan. Despite this, the development of healthcare facilities in the Dominican Republic, Puerto Rico, Cuba, Barbados, Trinidad, Jamaica and other nearby destinations is slowly influencing assistance and repatriation decisions in the Caribbean. Medical facilities within the region are now able to perform procedures such as cardiac catheterisations, MRI scans and orthopaedic surgery that previously necessitated evacuation to the US. Where, traditionally, patients would have been automatically aiftift to Miami for treatment, they are now able to remain in the Caribbean at a suitable facility or be taken to less expensive nearby destinations such as Mexico, Puerto Rico, Costa Rica, Panama, and Venezuela, where standards of medical care have improved dramatically in recent years and where the cost of medical treatment can be half that of the US. FrontierMEDEX now often evacuates patients to what it terms ‘regional centres of excellence’ in Santo Domingo. It has also started to move patients with US visa restrictions to Bogota, Colombia, because it sees that standards of medical care there have risen sharply over the years. Likewise, Europ Assistance often moves patients to Martinique, an overseas department of France. Medical care here is very good, and cheaper than the US for Canadians and Americans who may not have medical coverage outside their home country. It can cope with extremely unstable patients for whom movement to the US would take too long. “One of the best hospitals in the region is in Martinique, which is comparable to a government hospital in France,” says Dr Delaune. “Outside of Martinique, neurological, interventional cardiology, aorto-arterial surgery and paediatric specialties (including PICU care) are limited and patients requiring these services are usually best served in Florida or Puerto Rico.” The University Hospital of Martinique (UHM, Centre Hospitalier Universitaire de Martinique) is the largest French hospital in France,” says Dr Delaune. “Outside of Martinique, neurological, interventional cardiology, aorto-arterial surgery and paediatric specialties (including PICU care) are limited and patients requiring these services are usually best served in Florida or Puerto Rico.”

“Having a competitor down the street who will direct bill foreign insurance companies, offer discounted rates or special package prices for foreigners is not something providers in the Caribbean have to worry about.”
always easy or cost effective, warns Dr Delaune. That’s because commercial transportation between the islands is limited and pricey, and the patient may ultimately need to be airlifted home – an added complication. There is sometimes no difference in cost between bringing the patient to Florida and bringing them to another Caribbean island and then home, Dr Delaune explains.

A wider choice of better medical facilities in and around the Caribbean has naturally influenced patterns of air repatriations, however, and the spread of air ambulance provision throughout the region is also growing.

Brian Weisz of Reva says: “Air ambulance companies are showing up quite a bit on different islands in the Caribbean.” International Air Link and Emed of Jamaica, and the Dominican Republic’s Helidos Air Ambulance are a few examples. They tend to provide transfers between islands rather than longer flights to South America or the US, however. It should be noted that air ambulances are not as tightly regulated in the Caribbean as they are in other parts of the world. Rich Knignt, senior logistics manager atEurop Assistance, says that some air ambulance teams in the Caribbean are also fairly basic and do not always use dedicated air ambulance aircraft. “They may be an air ambulance on one day and flying tourists around the next day,” Knight says. The regulation of aircraft is taken into consideration when co-ordinating evacuations, but assistance companies don’t always have a great deal of choice, especially when time is of the essence and a patient needs to be moved quickly. Often, assistance companies that usually only work with accredited air ambulance providers will assess local non-accredited providers to partner with as and when the need arises, on a case-by-case basis.

Making headway

As assistance provision continues to develop and expand across the Caribbean region – aided by the higher standards of nearby medical facilities outside of the US and the expansion of air ambulance operations throughout the region – those involved in caring for insured patients will continue to find their feet in this corner of paradise. Headway has certainly been made when it comes to developing relationships with local medical providers, and these relationships will undoubtedly evolve as the availability and standard of medical provision in and around the Caribbean continues to grow. The assistance industry will be boosted by the continuing expansion of tourist numbers to the region, as well as by the growing number of workers coming to the islands from such industries as oil and gas, construction, and relief organisations. Although the challenges of providing timely and far-reaching assistance is difficult due to the geography of the Caribbean, the global assistance industry is adept at meeting the needs of their clients in even the most difficult of circumstances, and this region is no exception.
Planets, boats and automobiles

27 April 2012 began as a normal, routine day at LIFESUPPORT Patient Transport, but as the morning unfolded, our dispatch received a call from a client advising us that a young woman had been involved in a motorcycle accident in a remote area of Nicaragua. As the motorcycle landed on her in the accident, the red-hot muffler inflicted a large second-degree burn on the patient’s lower leg. The patient had managed to find her way to Bluefields, Nicaragua, to what is best described as a Third-World clinic, with just a few beds and no access to advanced medical care. Our mission was clear – rapidly respond to the patient’s location, assess and treat her wounds, and evacuate her as quickly as possible. Following consultation with the client, we determined that dispatching one of our specially trained rapid response flight nurses via commercial airline from our Vancouver, Canada,
base would be the quickest and most appropriate way to reach the patient. The flight nurse, a former deputy sheriff, international triathlete and now an intensive care flight nurse, was handpicked for this complex mission. A quick check of the map and closest airport details revealed that a fairly routine mission was soon to be complicated by significant geography. Located on the eastern side of Nicaragua, on the Caribbean Sea, Bluefields is a tucked away harbour and former hideout for Dutch pirates during the 17th Century. Currently, the only access to Bluefields is via a small airstrip, with no scheduled service, or via riverboat from El Rama. Given the urgent need to evacuate the patient, our flight nurse was dispatched from Vancouver to the closest major city, Managua, without delay, equipped with extra medical supplies such as IV antibiotics and a burn kit. As our flight nurse was en route to Managua, our dispatch team worked on a plan to access Bluefields.

Outgoing journey
After several hours of research and multiple phone calls to verify our assumptions, we quickly realised that the only way into Bluefields was to navigate the Escondido River via speedboat. Despite the lack of available healthcare, our client was able to keep in touch with the patient via telephone in order to obtain frequent updates on her condition. Once our flight nurse landed in Managua, he checked into his hotel and began preparations for the journey, which would start at first light. Our dispatch team secured a large passenger van for the four-hour backcountry road journey to the river launch point at El Rama. From there, our flight nurse donned a life jacket, boarded a speedboat and set out for the five-hour trip down river to Bluefields. Remarkably, clear cellular telephone service was available throughout the entire journey, allowing our flight nurse to provide regular updates to our dispatchers back home in Vancouver. The river’s primary use as a transportation corridor was made clear, given the large scale crops growing behind the rows of corn along its banks. On arrival in Bluefields, the local Red Cross ambulance met us at the river dock. Given its somewhat poor state of repair, the nurse’s first task was to help the paramedics push the ambulance to the hospital, where the paramedics worked on getting the ambulance running again while the patient was assessed. After a quick assessment, the patient, ambulating well but with an infection setting in, was taken to the boat launch and then up river to Managua. The journey was uneventful, thankfully, with the flight nurse managing the patient’s pain to ensure that she was as comfortable as possible during the boat and van ride. Two rooms were booked at the Hilton Hotel in Managua that evening. The patient’s room was transformed into a small hospital, the wound debrided and dressed, IV antibiotics administered and the patient’s pain managed. The consensus was to continue the evacuation back to Canada on the next available flight. The patient rested comfortably throughout the night, in sanitary conditions, and under the watchful eye of the flight nurse. Early the next morning, the flight nurse and patient boarded the commercial aircraft for their first-class flight to Vancouver via Houston. Upon arrival in Vancouver, the patient was transported to the Vancouver General Hospital Emergency Department, home to the Provincial Burn Unit, where she was admitted and treated.

Graham Williamson is the chief executive officer of LIFESUPPORT Patient Transport, a worldwide provider of patient transportation services based in Vancouver, British Columbia, Canada and Honolulu, Hawaii, US.
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Delivering integrated assistance to the oil and gas industry

The demand for carbon fuels is taking oil and gas companies to increasingly challenging and remote locations. As these companies go farther to explore and drill the logistics of ensuring their employees’ health and safety become complex. Dr Phil Sharples examines how an integrated approach to medical delivery and assistance is helping ensure optimum health for employees in the oil and gas industry.

When a company’s staff are days from the nearest hospital, making sure they are safe in the event of an emergency requires detailed planning and training. Solutions are inevitably tailored to location, the political climate and local resources, so when it comes to providing medical care and assistance to workers on remote oil fields, it’s unlikely that any two contingency plans for any two locations will be the same. Understanding each project is key to ensuring things go right when something goes wrong.

Assessing the risks
The traditional focus for assistance in the oil and gas industry has been managing medical emergencies, where a local risk assessment is fundamental to good planning. But this is just one aspect of an intricate process: designing appropriate health, safety and assistance services is a product of many factors. These are typically detailed in a Medical Emergency Response Plan – or MERP – tailored for each individual oil and gas client.
A MERP is a detailed document that identifies both key stakeholders and the medical and logistical resources available in the event of a medical emergency. The stakeholders include all the players that interact to make sure a patient is well taken care of: the captain/master or operations managers at the rig; the company’s Health, Safety and Environmental department; the shore agents; the assistance company; and the health insurance company. The MERP clarifies the roles and responsibilities for each person involved in coordinating the necessary assistance, and assesses local medical assets together with alternative international destinations where more appropriate healthcare could be accessed. The end product is a document that includes a clear process for primary evacuation from the rig to an appropriate nearby hospital and evacuation to an international centre of excellence. It details contingency contacts including local agents, such as those that might be used to co-ordinate a ground ambulance to get into a port, for example; and describes the information needed from the medic, the rig master, or ops manager – or any combination of them – when making an assistance call. Such information will include passport details, a medical report, and socio-cultural data for the patient. The MERT also identifies pre-accredited hospitals and those to avoid, and examines resources for transportation – both air and ground. It also looks at security information pertaining to the primary evacuation city, such as kidnapping risks, political issues and any security issues potentially affecting transportation to the airport. If a significant risk is detected, the assistance company will involve its security department to best manage that risk. It’s a valuable resource that keeps control of the decision to initiate an assistance procedure firmly in the hands of the client. Most importantly, in an emergency, the MERP can be put into action immediately – no intermediaries, no delays.

Minimising the risks
Besides carrying out a local risk assessment, the second key factor in evaluating what assistance services are needed in any given situation is to look at the employees/crew’s overall fitness – an issue that is increasingly important when dealing with oil and gas clients. A medical director in the oil and gas industry recently revealed that employees working at his remote site finish their first year away an average of 10 kilograms heavier than the day they started. Many organisations are tracking a rise in Body Mass Index among their employees – the oil and gas industry is no exception. Chronic diseases, such as heart disease, high blood pressure and diabetes, are a daily challenge for teams trying to ensure duty of care for oil and gas crews. In a sector at the forefront of health and safety, the oil and gas industry has, however, achieved a significant reduction in work-related injuries over the last 30 years. Yet this success is not reflected by an equivalent fall in the number of medical evacuations. The real health threats to oil and gas workers are acute medical conditions rather than trauma and accidents.

Pre-deployment screening can identify employees who carry a significant medical risk, such as a staff member who may be suffering from diabetes that is not well-controlled. In this situation, the best advice might be that the staff member does not take part in a particular remote project because of the high risks it would involve.

Innovation through integration
One of the most significant factors attributable to enhancing assistance to remote exploration operations is the ability to integrate essential services to improve the speed and appropriateness of response. This often involves combining the support of an onsite medic and integrated medical case management with international network reach, security analysis and family support. In an emergency, the factors for success are often the things that lead to the best medical decision-making. The analysis and support provided...
by an onsite medic means that sometimes an unnecessary medevac, which is never without risk, can be avoided. An integrated global network of pre-accredited hospitals gives the assistance team greater flexibility in planning their response: the right solution and equipment may not be in-country, but still only a short hop away.

At the point when an incident becomes an emergency, a close relationship between the medic and the assistance team is vital to improving outcomes. The mutual understanding between medic and assistance team of each other’s practices, protocols and skill levels can significantly enhance decision-making for all parties, saving valuable time when time is of the essence.

**Self-sufficiency at sea**

A remote medic is essential for off-shore operations where crews are operating so far from land that an emergency evacuation by helicopter isn’t an option. The solution is to be medically self-sufficient onboard, with a trained emergency medic and equipment to stabilise a patient while the ship or transfer vessel heads for shore. In addition, where there is an onsite medic, they can help the crew enhance its life-saving skills, improving overall response in an emergency, through first-aid training.

Here’s a real-life example of how such training has been used: In Turkey, in September 2012, a FrontierMEDEX remote medic was able to stabilise and evacuate four oil and gas personnel injured with gunshot and shrapnel wounds when their outbound helicopter was hit by heavy small-arms fire. At the medic’s side was a client drilling team, one member of which had been trained by the medic onsite to help in worst-case scenarios. This member’s ability to perform life-saving tasks — applying pressure to bleeding and maintaining airways — under extreme duress was critical in the successful evacuation and outcomes of all involved personnel.

**Localisation on land**

For long-term, land-based operations, oil and gas companies are now looking to develop local resources, building medical delivery and assistance solutions around investment in local communities that will leave a long-term legacy, not only for the company itself, but often for the whole country. In Iraq, FrontierMEDEX is helping one oil company train local people as ambulance drivers, with a view to launching a local ambulance service, the first of its kind in-country and an innovation in planning assistance. The company has also opened a clinic staffed by Western doctors in the Rumaila oilfield in Iraq and helped a leading African oil company to pioneer the training of local doctors in Uganda. The integration of Western-standard clinics able to provide emergency treatment and in-country diagnostics, together with more local doctors trained to Western standards, will help the oil and gas industry rethink its approach to assistance, replacing a reliance on evacuation by air with an ability to support more employees on the ground, while at the same time saving on costs without compromising on standards.

**Offshore – in reach**

Alongside localisation initiatives, new technology is transforming medical delivery and assistance in remote places. Telemedicine — medical and communications technology — is channelling
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The oil and gas industry has been hit by more than just medical challenges over the last few years.

Planning for change
The oil and gas industry has been hit by more than just medical challenges over the last few years. Political instability across the Middle East and other parts of Africa put a sharp focus on the need to prepare for uprising and unrest. Rapid response planning and up-to-date security intelligence are becoming essential for an industry that is increasingly a target, especially when considering that costs for organisations who prepare are ten times less than those that leave it to chance. In a world of change, one thing is constant. Wherever it goes, the oil and gas industry continues to set challenges for the assistance industry, and the assistance industry continues to look ahead and rise to them. It’s a process of enhancement that makes us all, wherever we are, safer and more productive.

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Author
Dr Phil Sharples has been medical director at FrontierMEDEX since 2006 and is responsible for managing all aspects of remote medical delivery, including healthcare governance, quality and clinical excellence. Prior to this, he spent nine years in the Royal Army Medical Corps and eight years as a senior partner in an NHS general practice, before working for Chevron as part of its international medical team in Kazakhstan and Nigeria. Phil is a member of the combined OGP and IPIECA health committee and deputy chairman of the Institute External Advisory Group of the Institute of Remote Healthcare.
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Why did EA Belgium decide to commence the large-scale snowplane repatriations?
During December 1980 to January 1981, we were confronted with difficulties in repatriating clients who had been injured during their stay at ski resorts over the holidays—there was just not enough room on commercial airlines to repatriate them all. All the clients were in the same region of the French Alps, and their stays all ended around the same date.
Europ Assistance Belgium took the decision to rent a Fokker 50 to repatriate its clients. This model was very noisy, but was also practical, because it was low to the ground and was equipped with a cargo door through which we could load patients on stretchers.
This project allowed us to bypass the many limitations of commercial flights, the biggest of which is limited seating availability at busy times of year. As far as our most senior colleagues can remember, we got inspiration for the snowplane flight abroad (they had similar projects in the Netherlands), but we were the first to do it in the Belgian market.
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In the last seven years, the biggest group of patients we had to repatriate was in 2012, with 22 patients, accompanied by 18 family members, occupying a total of 100 seats.

What makes the snowplane feasible for EA?
This kind of group repatriation is only possible when you have several patients at or around the same location with the same travel dates and similar injuries. Therefore, there are only a few times of the year when this type of project is suitable: school holidays with a lot of Belgian people on holiday at the same time, and popular locations with a lot of Belgians in the same place. The spring break, or ‘Carnival Week’, as it is known, is one such time. It is a school holiday that falls in February or March, and during this time it is extremely popular to go to ski resorts in the Alps, whether on the French, Swiss, or even the Italian side, or in Austria in the vicinity of Innsbruck. This fever for skiing holidays began in the early 80s and shortly afterwards, the first Fokker was organised after the Christmas holiday in January 1981, and deemed a success, so we started to organise the ‘Carnival-snowplane’ at the end of the Carnival Week every year after that.
In 1983, we rented a Boeing, although we kept on using the Fokker 50 as an additional aircraft in case the Boeing was full. At that time, there were no low-cost flights or charter companies around Europe on offer, and thus the organisation of this yearly snowplane was a necessity, not only for our company, but also for all the other assistance companies on the market, as there were no other logistical solutions to bring everybody home on the Saturday at the end of the Carnival Week.

What improvements have you made to the format since it began?
Over the years, we tried several flight plans: rent one aircraft, start very early in the morning, send it first to Austria, gather the patients, come back to Brussels, unload the patients, then go to Chambery in the French Alps, gather the patients there, and come back to Brussels. These two rotations were a little heavy for the flying personnel, but also, as soon as there was the slightest delay at one of the stops, the rest of the journey was compromised. Over the years, our experience led us to switch to two aircraft—one in Chambery and one in Innsbruck. Since the snowplane operation began, we have also changed the destination airports we use. Chambery in the Alps is a small, complicated airport in a valley, and not only must the pilots have special licences to land there, but also, the slightest fog closes down the airport. We tried Geneva as an alternative, but it is a large international airport, and with the tight security, it is quite complicated to jump through all the hoops with our own plane. We have now settled in a small but dynamic airport in Grenoble, at the foot of the Alps. This

A DAY IN THE LIFE OF …
Anne-Catherine Melis, operations director of Europ Assistance Belgium, talks to ITIJ about her role in organising the mass repatriation of injured winter sports enthusiasts from across Europe on the annual ‘snowplane’ flight.
airport services mainly low-cost, charter and private flights, and is perfect for our operation. On the Belgian side, we have always worked with Brussels Airport, and with Belgian airlines such as Sabena and Sobelair, until we switched to Air Berlin in the last couple of years. Since its inception, the project has evolved along with changes in our business, changes in holiday habits and the development of charter flights, amongst other things. Some charter companies have specialised in the repatriation of injured people, and today we divide our repatriations between a collaboration with a charter company based in Austria (Tyrolean Air Ambulance) by taking an option on a certain amount of seats on their flights out of Innsbruck, and the organisation of our own snowplane out of Grenoble. Today, we rent one plane (an Airbus A320) to make the French Alps rotation (Brussels-Grenoble-Brussels). We are the only company on the Belgian assistance market who still organises this sort of group snowplane, and every year we sell a certain amount of seats in the plane to either other Belgian assistance companies, or even international Europ Assistance subsidiaries (mainly Europ Assistance France). While our priority is always to provide a service to our own clients, we are happy to work with assistance providers to facilitate their repatriations.

What are the benefits to you, to the insurers, and to the injured?
The motive for us has never been cost-saving – it is rather client service-oriented, as well as having logistical advantages. Nonetheless, a return-on-investment analysis is done every year to monitor the break-even point between all options. The fact is that when you have a lot of patients that need to be repatriated on the same day from the same region, and there is no room on the commercial flights, then unless you rent your own plane, you will have to delay your client’s repatriation until the next day or later, and the ensuing hotel costs have to be integrated in the overall cost comparison.

The private snowplane wins every time for being cost efficient, but it also provides a better service to our clients.

What is your personal role in the organisation of the snowplane repatriations?
I have worked for Europ Assistance for 23 years and I started as an assistance agent on the platform. Over the years, I have had the opportunity to participate in this project on different levels: dealing with the assistance cases on the phone, accompanying patients in the plane, co-ordinating at the airport in Geneva, or Grenoble, or here in Brussels.

Today, as operations director, I oversee the whole operation, from the moment we rent the actual plane in the autumn, to the administrative handling of the last bill. On the day itself, I make use of long experience in organising this kind of event and can put my hand to most tasks, which includes everything from working with our travel business line manager, to drawing the seating plan of the patients in the plane, or even confirming how many sandwiches we need to order in Grenoble to feed our clients while they wait for the plane to pick them up. As I don’t like to fly too much, during the flight I remain in Brussels, but I monitor every step of the operation. To keep me up to date, the colleagues that are in Grenoble or on the plane send me text messages to confirm take-off and landing of the plane, and upon arrival in Brussels, I monitor the disembarkation of the patients and their safe loading in the ambulances that will take them home.
How many staff are involved in organising and operating a snowplane repatriation?
At this point in time, I would be what you would call the project manager, as I oversee the whole thing from start to end, as explained above. As we are a small company and with a rather flat hierarchy, a lot of people have hands-on jobs. As for the assigned roles, some organisational roles are directly linked to people’s jobs:

- the service procurement manager is in charge of developing and running our supplier networks and will be in charge of renting the plane, making the arrangements with the airline, clearing security with the airport, informing our Belgian ambulance services beforehand that we will need a lot of ambulances on that day and that they should foresee that in their planning and inform their personnel;
- the business line manager runs the team that handles the medical files, and will oversee the follow-up on the files, a task that includes the decision whether to put clients in the plane or not;
- the team of doctors and nurses will be called upon to accompany the patients in the plane(s);

The rest of the crew are all volunteers from the operations team. Some of them have been working on this project for some years, but every year some new members join the crew. We don’t allow just any member of staff to participate, because this kind of mission is hard work, requiring a great deal of patience and professionalism with the clients, but also a high level of stress resistance and concentration capabilities, which not everyone has.

What are some of the key logistical considerations in planning such a large-scale repatriation?

The logistical considerations always start with renting a plane, then making arrangements with the airline, which has to have special authorisation to run a flight with so many injured people onboard. Then comes the discussions with the airports. We have been operating between Brussels and Grenoble for some years now, but even so, every year we send a small team to Grenoble around December-January to reacquaint themselves with Grenoble airport’s team, go over the logistical aspects, debrief the year before, decide what could go better, and get acquainted with new members of the team.

The date of the event is defined by the school holiday calendar. We always organise the plane on the Saturday at the end of the Carnival Week. As for the patients, we treat their medical file as we would any other medical file. We assess their injuries with our doctor, and then we decide how they should travel: sitting upright, sitting but with leg room, or lying down. During the days before the flight, we follow up with the patients, with the treating doctor abroad, with the family, and if the patient needs to be hospitalised upon arrival (in severe cases), we organise the admission in the chosen hospital. The only difference with other medical files is that when we need to book our patient on a plane, it will be on the snowplane we operate ourselves, and not on a commercial aircraft.

What crew members are typically taken onboard the snowplane flights? And how stable does a patient have to be to be signed off as fit to fly?

Onboard the plane, the airline provides a security team, which is mandatory so they can allow us to fly a plane full of injured people. Usually, this team comprises a physician and two nurses, all with credentials to evacuate a plane in case of crash landing. They usually don’t really take care of the patients during the flight, although they sometimes help with loading or deplaning patients. On regular commercial flights, they don’t allow more than two or three injured people, simply because in case of incidents, they are a major risk factor, so a full plane is quite an undertaking.

In our own team, we will have one physician, who will monitor the most severe cases, usually the people flying on a stretcher (no more than six stretchers are taken onboard for any one flight), and a nurse who will monitor the other patients and administer pain medicine or tend to minor discomfort. The doctor and the nurse are experienced and have been working with us for a long time.
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a number of years, either on the plane, or assisting us on other repatriation missions throughout the year. We do not put ICU patients on the snowplane. Ninety-five per cent of the cases are related to ski injuries, and they vary from a sprained wrist to a broken femur, or even some back injuries. No infectious diseases are allowed on the plane, so there will be nobody with the flu or a fever, because that would be a contagion hazard for the injured. We also avoid acutely severe cases because that would be a disservice for the patient as well as for the other passengers. Sometimes, when a child has a very minor injury, the parents will hesitate to accept a flight on the snowplane because they fear it will be traumatising for the kid. We try to explain that nobody has ever suffered from shock after flying on our plane, but for some people, it is unsettling to be confronted with so many injured people. That’s also a reason why we avoid overly severe cases onboard.

The long line of ground ambulances at the receiving airport must be a welcome sight. What are the challenges of organising ground transportation for the snowplane’s passengers?
Organising the ambulances on departure and arrival can be tricky. We ask for an exceptionally high number of vehicles and crews that will not be necessary again the rest of the year. Of course, we try to distribute the missions amongst all the available suppliers to avoid putting too much volume on a few providers, but even so, it is not an easy endeavour. Also, they have to accept long waiting times because often we need them to bring the patients to the door of the plane if, for example, they are on a stretcher or cannot walk. We try to find the right balance between having all the ambulances at the airport on time, and having them wait too long for the boarding. Even though we pay for the time the ambulance crews are waiting, we also try to alleviate this by offering the ground ambulance staff food and drink together with our clients, and we try to gather patients in a couple of ambulances if possible, so we can let some others go … nevertheless, such waits can be a sore point.

How do you plan for the unexpected?
As the logistics have to be confirmed long before the Carnival Week starts, we cannot wait to see how many patients fall or what the weather is like to start organising it. So at the beginning of the week, everything is ready, and during the week, as people fall on the snow slopes, we start filling the plane. It’s a family holiday, so people who fall in the beginning of the week often agree to wait for the Saturday to come home, so that the rest of the family can keep on skiing. If the patient is the only one who can drive the car, for example, then the whole family will fly on the snowplane. The last patients are confirmed on the plane at the end of the day on Friday after the ski slopes close. Our doctor delivers the last fit-to-fly documents around 6:00 p.m. or 7:00 p.m. on the Friday, and then we close the list – anyone having a ski accident on the Saturday morning will be repatriated some other way. As we operate the plane ourselves, the decision to allow a patient on the plane lies with us, and only us, which makes the fit-to-fly process easier.
Closing the list on Friday allows us to finalise the logistics, the seating, the boarding cards, the final count of ambulances on departure and on arrival. In earlier years, we would accept new patients on the Saturday morning, but this tended to cause major disruption. The key challenges lie in the unknown elements. How is the weather and the snow? How many people will fall this year? Will the people have severe injuries? What will the state of the roads be coming down the mountain on the day of the flight? Will the ambulances be stuck in traffic? Will we have to delay the plane? Those are questions that are impossible to answer beforehand, but will determine if the event goes smoothly or not. All we can do is to run everything else as smoothly and efficiently as possible, so that the only thing left unanswered is the weather and the number of patients. Once the sun comes up on the Saturday morning, we have to trust in what we were able to foresee, and be prepared for any incident along the way, and find solutions for those incidents as we go along.
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TO 13 COUNTRIES IN THE MIDDLE EAST AND NORTH AFRICA.

Since its inception in 1999, CONNEX Assistance has been the leading provider of medical, technical, and funerary assistance in the Middle East. With offices in Egypt, UAE, and Sudan, and a network of over 5,000 medical providers, it has consistently raised the bar for reliability, cost efficiency, and service quality in region.
Care co-ordination

Flying a patient from wherever they are in the world to their home nation for ongoing care is a complex process that necessitates the organisation and amalgamation of a great deal of logistical and medical details and personnel. Doing it right takes a lot of effort, expertise and experience. Dafna Givati and Dr Amiram Lev describe how it can be achieved safely and efficiently.

Does this sound familiar? 03:00 a.m. The phone rings, and one of your doctors is on the line. He is on a mission to escort a young patient (s/p road accident, #T6-10) on a commercial stretcher from Rio de Janeiro back home to Tel Aviv. It was quite difficult to get a stretcher on an Air France flight on 20 December, but the insurance company is pushing for this date, and the family is already nervous. The medical escort doctor had flown to Rio the day before, he met the patient and the treating doctor, and informed you that everything was ready for the repatriation. Then you answer the phone, and the medical escort doctor says: “There is no passport.” He arrived to pick the patient up from the hospital and take him to the airport, and found out that the patient’s passport was locked in the hospital’s safe box. The key was with the administrative manager, who was spending his weekend on the beach 100km north of Rio.

Nightmare?
Yes, but you could prevent it by simply providing your medical escort with a checklist of all the information that he must obtain during his hospital visit.

Check list - before you set off:

• Can the patient sit? If so, for how long? Can they use a wheelchair? Is a stretcher required, or is a first-class seat suitable?
• Patient’s weight – can they pass through the aircraft door? Can they sit in a normal airline’s business-class seat?
• Does the patient require oxygen on the ground? Are they mechanically ventilated? What is the oxygen flow/FIO2? What is the O2 saturation/PaO2? Can they use a nasal cannula, or just a face mask? Can it be intermittent flow? Can you use an oxygen concentrator? How many oxygen cylinders do you need on your air ambulance? What is the maximal flow that the airline will provide? Can you use electricity on board? And/or do you have enough batteries for the whole trip?
• Can the patient use the toilet? Is there a urinary catheter? Diaper?
• Decide what equipment you are going to take. Make sure that the airline allows you to take it onboard. Check, and re-check all the equipment. Never count on someone else (I once had a very urgent case of a ventilated patient on a commercial flight. I just returned from another flight, and I didn’t have a ventilator with me. I was told that an ambulance was going to bring a ventilator to the aircraft. The ambulance was stuck in a traffic jam, I was already onboard, and in the minute that the driver handed the ventilator to the flight attendant, they closed the door, and we took off! The ventilator was ok, but guess what was missing? There was no patient tubing set.)
• Check the itinerary and the tickets. Sometimes you know better than the travel agent what problems may occur (don’t agree to a one-hour connection in St Petersburg between international and domestic flights: you have no chance of making your connection)
• Most important – try to plan a bed-to-bed escort. Try not to meet your patient at the airport. It will take more time to meet them at the hospital, but will prevent a lot of problems and missing items (for example – a woman with a hip fracture who was brought from Casablanca to Malta by an air ambulance, and we continued with an Israeli air ambulance to Tel Aviv. I was told that she had a urinary catheter. We waited at Malta airport, and when the air ambulance landed, the first thing that the doctor said, is that he urgently needs a pot for the patient. Luckily, we had diapers on our aircraft.). And try to meet the patient and the treating doctor one day before the repatriation (if it is not an urgent case), or at least early enough before the flight. It is, of course, better to come during day time, when all the relevant staff are available.
The mission of AIMS is to become the premier provider of medical management and assistance within South Africa and neighboring countries.

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- Arranging Inter-hospital transfers
- Medical AIR Evacuations /Repatriations
- Doctor and nurse escorts
- Accommodation
- Repatriation of mortal remains
- Accompany to out patient appointments
- Emergency Cash Advance

“I could not fault the medical care and the interest shown by the AIMS staff who came to see me every day. Neither could I overstate the attention afforded me by your case manager, who visited me at least every other day to make sure if I needed anything which she could get for me”

Susan UK

“My greatest thanks to Alliance International I was picked up and taken to the Clinic on the day of appointment. Even though it is a simple procedure but my whole experience was so wonderful. I had a translator with me the whole time. The Clinic was so clean, modern and of high standard”

Michael

“My wife and I, would like to express our appreciation and thanks from the bottom of our heart to AIMS, for the wonderful help and services given to us”

P. Adams

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Data gathering
Preparation for an air ambulance case or a patient escort on a commercial flight is a process that is composed of many logistical and medical details and is often carried out under time constraints. The first step in any such case, therefore, should always be to get as much information as possible surrounding the patient and their repatriation.

At this stage, most of the work is done through emails and phone calls by the assistance company case managers or by the medical director. The information they gather includes the patient’s medical condition (it’s always better to get a written document detailing the patient’s condition, even if it is in a doctor’s handwriting), and logistical information such as where the hospital is located, the nearest airport, and so forth. While this may sound, in theory, like a simple task, this is not always the case, thanks to disrupted phone lines, time differences, language barriers, unco-operative doctors (perhaps because he wants to keep the patient for a few more days, or because he wants to escort the patient himself), differing medical practices in different countries (there are still places that keep an acute MI patient in bed for a week), and so forth.

Once all the necessary information has been gathered and repatriation is called for, a medical escort can be sent. However, in some cases, questions about the ability to repatriate the patient may remain. For example, a recent case involved an asthmatic Israeli woman, who was in a hospital in Addis Ababa for two weeks with pneumonia. It was proving impossible to get all the details about the patient’s condition, although a short document sent from the treating hospital mentioned suspected TB (although all sputum cultures were negative) and the declaration was that the patient was ‘not fit to fly’. The assistance company decision was to send a medical escort to Addis in order to check the patient for themselves. The medical escort declared the patient ‘fit to fly’ on an air ambulance and she was escorted back to her home country.

As an escorting doctor, you should always check all details yourself before you set off to retrieve a patient. It is the escorting doctor’s responsibility to have final say on whether the patient is fit to fly, and to make sure the patient is equipped with all necessary medicine, equipment and documentation prior to setting off for the treating hospital.

Check list - when you come to the hospital:

- Try to get as much information from the patient, the family, the treating doctor, and the treating nurse. They may not speak your language and they may not have the same medical facilities or treating methods. Sometimes they are just tired (as you are). Be patient, smile, don’t push too much. Get familiar with the current medical condition. Is the patient physically and mentally ready for the repatriation? Provide him with all the details. It will make him more relaxed.
- Check the patient, the documents, X-rays, blood tests, and so forth. Make sure that you have all the required medical information.
- Collect patient’s passport, medical report, X-rays, CT scans, and so forth. If it is the day before the flight, and you may not take it all with you, make sure that you know where it is.
- Ask to prepare all the medications that the patient is going to need during the flight and enough for at least another 24 hours. There are hospitals that won’t provide medications for the trip (especially private hospitals in South America). Sometimes you need to get a prescription and purchase the medication in a nearby pharmacy.
- Make sure that the transportation to the airport is going to come on time. If it is an ambulance, try to see it. The level of ambulance services is different from country to country. Do they have enough oxygen? Does the oxygen connector fit to your respirator? Is there a place for the family, luggage, and your equipment? How much time will it take to get to the airport? Do they know how to enter the airport? Are they familiar with boarding a stretcher patient?

Authors

Dr Dafna Givati, MD is chief executive and medical director of International Medical Escort. Dr Givati is a senior anesthesiologist. Dr Givati served as a military doctor in the IDF (1986-1990), followed by being deputy to the head of PICU dept. in Nahariya hospital (1999-2001). Dr Givati was the medical director of the IDF and the civil paramedics training and the assistant director of the paramedics academy of Magen David Adom (2005-2011). Dr Givati has 12 years of experience in medical flights (air ambulances and commercial flights), all over the world.

Dr Amiram Lev has been the head of general and pediatric intensive care units at the Emek Medical Center, Israel, for more than 24 years. He is a specialist in internal, pulmonary, and intensive care medicine. Dr Lev studied medicine in Israel and the US, and served as a field medical officer in the IDF special units for four years. He has extensive experience in transporting even very complex patients.
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To find out how the LIFESUPPORT Patient Transport Rapid Response Team works or how we can meet your everyday worldwide patient transportation needs, contact Graham Williamson, CEO - Graham.Williamson@LifeSupportTransport.com
ITIJ spoke to Dr Mark Simpson, medical director of Bupa International, about delivering high-quality medical care and assistance on a global scale, fair medical underwriting and ultimate job satisfaction.

Where were you born, where did you study, and where do you live now?

I was born in Southampton, England and undertook my pre-clinical studies at the University of St Andrews in Scotland, followed by four years in Cambridge to complete my training. I now live in Eastbourne, which is just along the coast from the Bupa International office in Brighton, so when in the UK I commute to the office by train.

How did you come to work in the global assistance industry, and more specifically, how did you come to your role at Bupa International?

I spent the last 12 to 13 years working in a number of roles with AXA. One of these was working on a joint venture with AXA Assistance, which provided a range of assistance services, including medical. While I was there, I completed a review of the clinical governance process, with a view to improving patient safety and outcomes.

I was approached for my current role at Bupa International in August last year. The role leapt off the page, as it built on my previous international experience running projects in India, South Africa and the Middle East, as well as fitting perfectly with my previous assistance experience. Working for a brand so focused on being a healthcare partner to its members, as well as improving global standards, was an opportunity I couldn’t refuse.

What are your key responsibilities at Bupa International, and what are you working on at the moment?

I am responsible for all of the medical underwriting at Bupa International, as well as all of our clinical governance reporting. I also have clinical responsibility for the Worldwide Medical Assistance (WMA) service in Copenhagen, and for investigating and resolving any serious clinical incidents or complaints.

Another key part of my role is management of the hospital quality assurance programme (HQP). This is one of the main ways we make sure key hospitals meet internationally recognised standards of care. Bupa International’s HQP was developed in collaboration with Joint Commission International (JCI), a leading international healthcare accreditation company.

Other day-to-day responsibilities include supporting all parts of the business with anything health-related – I bring my experience to bear across the board, from supporting product development through to working on advice content provided by our marketing and account teams.

Why and when was Bupa’s HQP set up, and what is its ultimate aim?

The programme was set up three years ago to help us explore the quality of the hospitals we contract with in depth. We wanted a way to measure quality and to help hospitals to participate in improvement programmes. HQP gives a detailed perspective, allowing us to better understand and act on the unique demands of our customers. Our programme combines bespoke assessments of each hospital with customer feedback and complaints data to give a holistic view of a provider’s performance.

Of course, the programme helps us to monitor and control costs on behalf of our customers. More generally, however, it sits at the heart of our aim to be a healthcare partner to our members, allowing them to access the highest quality healthcare.

How did you start to tackle the process of accrediting some of the 7,500 hospitals recognised by Bupa globally – did you begin with a specific geographic region or specific countries?

It was a big undertaking and certainly an ambitious task. We looked at which hospitals our members were accessing the most and used this as our starting point. Our dedicated team worked hard to roll out the programme across the globe.
As part of this quality assessment process, do you seek to expand your list of providers in some countries where currently you have fewer recommended medical providers?

The programme is ongoing. It ensures a consistent standard of care for our members. It also helps our medical partners to improve and deliver best practice services to every patient that comes through their doors. We’ve also noted that hospitals see Bupa International in a very different light after participating in the programme. We share an appreciation of the wider benefits: it’s about the multiplier effect that we can have in improving care for everyone to benefit, not only Bupa International members, but broader communities too.

To what extent do you work with JCI on this assessment process?

While we worked with JCI to develop the programme, our accreditation now sits separately from their own. Our work with JCI produced our self-assessment tool, which hospitals initially complete themselves. We then score them and follow up with an onsite inspection. The inspection team usually consists of a minimum of one of our hospital quality team, plus a clinician, and each inspection takes a full day to undertake. So far, we have evaluated close to 400 hospitals. We have already produced a map of the accredited hospitals in Singapore, and are currently working on a range of guides to other assessed facilities.

What led Bupa International to launch its Worldwide Medical Assistance (WMA) arm, and how has WMA developed since its launch?

Bupa International started providing Worldwide Medical Assistance around five years ago when we acquired our Danish business, ihi, which is based in Copenhagen. Since then, it has become an increasingly important part of our offering to customers around the world, and something we’ve honed to meet their changing needs.

Some of our clients do have separate assistance cover – for example with International SOS. Where that’s the case, we work with them to make sure they have the right blend of cover to suit their circumstances. Our hospital quality programme dovetails with the assistance function. On the one hand, it helps us identify where people should be evacuated to when in remote locations. On the other, it helps us to identify high-quality local care that patients can access quickly, rather than experiencing a time delay for treatment due to being evacuated to a different country. This helps us provide appropriate treatment, at an appropriate cost.

If, for example, we’ve assessed a hospital in Jakarta and found that it’s perfectly competent to remove an appendix, this can prevent the patient from being unnecessarily evacuated to Singapore. ‘Moments of truth’ are critical to our relationships with customers, and there is no greater moment of truth than an emergency. The customer feedback we receive is uniformly fantastic, and the language skills and experience of all of our staff in Copenhagen are superb. Many members of staff are fluent in multiple languages.

Bupa International works with a number of renowned partners to deliver assistance and healthcare in different parts of the world. How have these relationships developed in recent years, and how do you see them evolving in the future?

Our partnerships allow us to provide the highest quality services to our members, no matter where they are in the world. International SOS, for example, is one of our highly valued partners. We have invested a lot of effort in maintaining good relationships both with our own assistance function and International SOS, working together to provide a seamless service to our members. Another example is our partnership with UnitedHealthcare, which gives our members access to an outstanding network of hospitals in the US.

How could assistance companies and hospitals better work together to minimise delays in exchanging information and improve care coordination?

Assistance companies and hospitals actually work very well together, and we continue to help hospitals act in the patients’ best interests when working with them in assistance cases. But partnership working isn’t always straightforward. When delivering care in some developing countries, for example, you need to think through how you work with your partners to deliver the highest quality care in what can often be less-developed healthcare environments. You might be surprised to learn, for example, that the fax machine still gets a lot of use. If you’re dealing with a tiny hospital in the Democratic Republic of the Congo, you need to use the tools that are readily available – and take a totally different approach to that which you might use working with a facility in Paris, New York or London.

Assistance apps are proliferating in the global traveller marketplace. Does Bupa International have any plans to develop an assistance-based app? This will certainly be a consideration for our assistance business development strategy. At the moment, you can access the website from mobile devices, meaning customers can also access MembersWorld (our customer portal) to identify facilities. MembersWorld also helps customers to access their insurance cover information, view and update their membership details and even order a new member card. We do have an app that helps our members find healthcare providers quickly and easily, and that also provides customers with a link to MembersWorld.

However, we know that many of our customers value being able to talk to the staff in Copenhagen, who have the appropriate databases and knowledge of facilities around the world. For many, the human touch we provide to our members is still highly valued.

How is the company using technology in other ways to reach out to its clients in different parts of the world?

We offer customers the opportunity to undertake online claims management, and providers can access their online payments through MembersWorld. We continue to work on making more information about facilities available on MembersWorld, and are committed to improving healthcare navigation, particularly for those in unfamiliar parts of the world.

What are some of the key challenges you face as medical director of a global insurer and assistance provider? How are these challenges being overcome?

Providing healthcare to over 800,000 customers in 190 countries presents enormous challenges. We have to be aware of these challenges and effectively prioritise them. The biggest challenge is championing our customers’ access to quality care, and helping them when they become ill and require our help. That’s where the hospital quality programme becomes invaluable. We continue to maintain the medical upskilling of our staff, so that they can provide members with clinical advice about the best care for them. We also work hard to ensure access to quality healthcare in politically unstable and undeveloped markets. Ultimately, we want to make sure medical underwriting is fair to the customer, giving them the right combination of choices with their policy.

If you could work in any other profession, what would you do and why?

I can’t think of anything else I would want to do more than my current role – honestly!

What are you most proud of – both personally and professionally?

Personally, I am most proud of my family. I’ve been married for 27 years and have three children, aged 21, 19 and 17. My daughter has just returned from her gap year travels to India and southeast Asia and my son is in Borneo working for Operation Raleigh. Professionally, I have ended up with a fascinating career that I never expected to have when I left medical school. I’ve been able to develop the hospital quality management programme, which will continue to touch many more lives and is a great source of pride for me.

What do you like to do in your spare time?

Play golf (badly) and assemble all the IKEA furniture my wife keeps buying!

Where is your favourite holiday destination, and where would you like to visit next?

Bali. Both for its scenery and light, but more for the characters and personalities and the way the Balinese live their lives.

My brother is about to emigrate to Calgary and I am looking forward to visiting him and his wife and seeing more of Canada, as I have never been there.
The assistance industry has steadily turned out mobile applications in recent years, but who uses them, have they been successful, and how do you build the ultimate app for an assistance company? Manjit Rana shares his thoughts

The average user now interacts with their smartphone 30 times a day – people even use their bathroom time to get their Facebook updates; so what makes these devices so addictive? Firstly, they are not just a phone: under-20s rarely have a voice conversation on their devices. Networks are happy to give away unlimited minutes and charge based on data volumes – because now it’s all about the data that goes in and out of these devices.

This data can relate to anything from real-time stock market information to how to find your nearest McDonalds, or from flight booking information to how to find your nearest medical provider – there’s an app for all of these . . . and so much more. It’s such apps, with their useful capabilities that enable users and inform them instantaneously, often providing interaction based on GPS settings, that have been developed by the global assistance industry to provide an enhanced travelling experience for their clients.

With some assistance providers reporting hundreds of thousands of downloads for their apps, it’s safe to say these apps have been a success. What’s the key, then, to building a popular app, and just what is it about apps that makes the assistance industry keen to develop such software for the mobile world?

**Why apps?**

Smartphones and tablet computers have had a huge impact on consumer behavior – we now think nothing of sharing our experiences in real-time. If we like something we click and post it to Twitter, Instagram, Snapchat, Facebook, Google+, or the like; if we don’t like something we do the same. Apps are developed with the aim of providing a service, enhancing users’ experience of a company, or enhancing users’ ability to fully utilise a service – and the assistance industry is a perfect fit in this regard. Travel insurers may not always get good press, but if they can associate themselves with an app that assists travellers at various stages of their journey, or an app that is to hand when a medical or other emergency arises when a user is abroad, they could be on their way to receiving more positive feedback in the online world of instantaneous social media. At the same time, established assistance companies that offer apps that have proven to be successful in terms of user satisfaction, business enhancement and/or cost saving, are placing themselves in a good market position amongst their peers. Over 70 per cent of social network users use their smartphone to access their social networking sites daily whilst travelling, although the vast majority will wait till they get access to a Wi-Fi signal rather than using their data allowance due to the heavy roaming charges experienced. The high cost of roaming charges has made it difficult for app providers to create solutions that rely on the smartphone user having their smartphone connected to data networks whilst travelling. That, in Europe at least, is about to change as roaming fees for voice calls, texts and Internet access are likely to be a thing of the past from 2014, effectively enabling consumers to utilise their data allowance anywhere in Europe without incurring additional costs.

The smartphone, then, is becoming the de facto channel for communicating with individuals for all sorts of industries. Consumers are now more likely to access services via a mobile device than via a laptop or desktop PC. Consumers use their smartphones to find restaurants, get directions, compare services, check their bank balance and book hotel rooms ‘on the fly’. That behavioral pattern inevitably carries across when they are travelling on business or for a holiday.

There are, thus, dozens of travel-related apps on the market ranging from language translation apps such as iTranslate and Worldlens to itinery management apps such as Worldmate, medical first aid apps such as those provided by the Red Cross, comprehensive medical record-keeping apps such as MyMedical, and SOSAlert, which can be used to enable your friends to locate and track you in an emergency. Apps provided by the global assistance industry could – and do – integrate many of these functions, and have built on the concept of providing help to travellers in need to integrate cost control measures. They provide an important service to their users, while at the same time being of real value for the company.

**App challenges**

Apps developed by many assistance providers are generally ‘conceptualised’ internally within the business, but developed in conjunction with external digital or app development agencies. The starting point tends to focus on what benefits the business can achieve, such as directing the traveller to a preferred facility or reducing the cost of claims processing, reducing call centre costs or getting the brand ‘front of mind’ for the consumer, but the real challenge is getting the app onto the traveller’s
smartphone before they embark on their journey. With this in mind, apps developed predominantly for corporate travellers could achieve impressive levels of penetration in their target market as they could potentially be pre-installed on employees’ devices or stipulated as part of a company policy for employees that need to travel internationally, resulting in the app being installed and available when the user needs it.

Once an app is installed, though, how do you make sure the user keeps it for longer than it takes to download the next app of choice? With so many apps competing for ‘shelf space’ on our smartphones and tablets, it’s just as important to have a strategy to keep the app installed long term. Research has shown that about 70 per cent of smartphone users will remove any given app from their device within three months of installation. ‘Appicide’ occurs when a mobile app provides a below-par or no-longer-relevant experience to the user, so they choose to uninstall it. Those numbers have got to be pretty scary for app developers, but that’s just the nature of the game.

What is encouraging, though, is that in 2012 the average smartphone user had over 40 apps on their phone – up 28 per cent on the previous year. And the global assistance industry has recognised the importance of the growing appetite for mobile applications.

Apps created by the assistance industry generally provide direct access to a 24/7 assistance hotline, location-specific travel advice and security warnings, as well as other relevant travel and health alerts or advice. For corporate travellers, the app concept ties in nicely with companies’ duty of care, while for holidaymakers, apps can provide a range of services that can assist with any number of travel-related scenarios – from menu translations to how to find your nearest ATM. A key benefit of any assistance app, though, is that it can help direct users to in-network medical providers which, of course, potentially makes way for huge cost savings in terms of medical treatment received and paves the way for a better customer experience. If, via a mobile application, an assistance provider can steer patients to hospitals in their network, the investment in creating the app can potentially be recouped within a matter of months.

Moving with the times
One of the early adopters of smartphone technology was Zurich subsidiary World Travel Protection with its Nomadz app, which was initially launched back in 2009. At the time, the primary device used by the professional community was the BlackBerry, so the company decided to focus its attention on that platform. This provided the added advantage that the app could be pushed to the BlackBerry device and auto-installed rather than having to rely on the individual to go looking for the app in an app store. Today, there are two versions of the app available – Nomadz and Nomadz Lite, providing proactive, location-aware safety and security solutions as and when needed. According to Abasse Asgaraly, director of strategic business development and global partnerships at Zurich World Travel Protection: “Our biggest challenge was not being a software developer, and as the mobile devices evolve constantly, it’s a catch-up game where timing is critical.”

Similar sentiments regarding up-to-the-minute apps were expressed by Alison Griffiths, marketing director, Northern Europe, for International SOS’ Assistance UK Ltd, who said that the biggest challenge to creating a compelling assistance app was in creating a simple interface from a highly complex set of information, and ensuring that it is useful, functional, effective and constantly up to date. The International SOS app provides simple and direct access to local medical and security assistance, pre-travel advice, and global emergency support, and has topped up over 200,000 downloads to date. One of the newer additions to the assistance app market is Travel Guardian, having only been launched in the app store at the end of March for the iOS platform and the end of April for Android. Key provisions of the app are a one-touch alert to friends and family of an emergency situation, GPS tracking, 24/7 access to an emergency assistance hotline, and a database of useful facts covering over 200 countries. Declan Meighan, chief executive of Maxwell Lucas Travel Security and Consultancy Services, which provides the app, commented: “As with any app, some of the biggest challenges we faced were the cost of development, time to market and supporting multiple platforms. The first challenge was scoping out and writing up the specification to pass for development, which is a laborious and time consuming exercise – in particular trying to control feature creep, as after a demo you’ll often hear the words ‘That’s great, but can we add this…’ It can be very tempting to cater to all requests, but this can be a slippery slope as you’ll end up with a complex product that has many functions, none of which it does particularly well.” Meighan went on to say that you can’t be all things to all people, and that when developing an app it’s best to concentrate on your areas of expertise, keeping the feature set limited and making sure they are best in class. Content can often be very difficult to provide, says Meighan, but as the Travel Guardian app is based on information the company already provides on a daily basis, it was fairly straightforward to make this information accessible in a mobile format, which was the main aim of the app. He also cited keeping apps up to date as a key focus: “The biggest challenge of all has to be at the end of the development cycle, how do you keep your app current.”

A new set of challenges
Because assistance apps aimed at the general travel market are not pre-installed on a company-owned device or part of a company policy, and because there is a much greater level of competition within the app market for the general consumer, greater thought needs to be given to how to get travellers to download such mobile applications or how to integrate assistance services into related or partner apps. The general idea here is to make the focus of the app traveller-centric – by putting yourself in the traveller’s shoes, you can start to anticipate the kinds of things that they are likely to be thinking about pre, during and post-holiday. The concerns of the leisure traveller compared to the business traveller are likely to be fairly different. A family going on holiday may go through the following thought processes:

A few weeks before the holiday:
- What’s the weather going to be like? What should I pack? This could be a good opportunity to provide some early information on country and city profiles, cultural issues and etiquette, dress code restrictions, location of embassies and consulates, passport and visa requirements, driving safety and internal transportation recommendations, currency, compatibility of electrical items, tips for business etiquette, calendar of local events and holidays.
It would be nice to learn a few words of the local language before we get there a potential opportunity to help them learn some key phrases that they may find useful and start regular interaction with the traveller to build some trust and increase app usage.

Are my passports/EHIC/visas valid and to hand? Consider providing a secure travel document vault where the consumers can store details of their flight tickets, hotel bookings, passport details and maybe travellers cheques, so that they can be easily replaced in case of loss or theft.

With the amount of news about social and political unrest in certain countries, are we going to be safe? Updates on high-risk areas to avoid may be useful, along with tips on how to reduce the chances of being kidnapped. Security information profiles on personal safety, petty crime, violent crime, social unrest, rule of law, and corruption could also be of use.

I am travelling to somewhere more exotic, what vaccinations am I likely to need, where can I get them from and how far ahead of the travel date do I need to have them? Also include medical records/pre-existing condition details/allergies, all automatically translated into the local language determined by the location of the device.

Closer to the travel date:

What are my flight details? What terminal/gate do I need to be at and at what time? Itinerary management apps such as Worldmate and TripIt are excellent examples of what can be achieved.

If I have a stopover, what facilities are available at the interim airport?

What’s the best currency rate and how far ahead do I need to order it?

Are there travel delays on my route to the airport and do I need to allow extra travelling time? Have any of my friends been to the same location and what did they enjoy doing and what did they dislike?

Do I have all my travel documents to hand with back-up copies on my smartphone?

What’s the maximum weight allowance permitted for my bags?

Early notification of any flight delays.

Are there any special shopping/restaurant deals in the duty free area?

Even if an app is capable of answering all the above questions, as well as providing emergency medical and/or security assistance services, travellers are unlikely to be aware of the extent of all the features and functionality of a comprehensive travel-based assistance app unless it’s relevant to the situation. The key is to ensure that the user experience and interface is simple and obvious so that they are not searching through menus and options at a critical point in need. It’s also important to give the user the option to customise the level of support they prefer: whilst some users may be comforted by receiving regular tips, others may get irritated by the constant interruption.

When looking at distribution channels for apps aimed at the general travel market, we need to look at related service providers. Take, for example, banking apps – especially now that there is such a push to encourage consumers to join the mobile money/mobile wallet community, where the phone becomes the payment mechanism instead of cash or credit/debit cards. Bundling assistance facilities into such apps may be a great idea if you have a relationship with a specific bank, credit card company, or mobile network provider.

The key is to ensure that the user experience and interface is simple and obvious

The aim is to ensure that the medical assistance features are on the traveller’s phone before they need to call on the service. Think of the medical assistance facility as a transparent Trojan horse – the traveller is more interested in the horse i.e. the more relevant functionality, such as language translation, currency exchange calculator, and so forth, but knows that the assistance features are lying there dormant in the app in case they are needed to be called upon.

As such, once a consumer has booked their holiday or flight, an email confirmation could easily include a link to download such an app for free, so tie-ups with tour operators could be a good idea. Because you already know the make-up of the travelling party, the travel dates and the destination, you could easily auto-populate the data into the app and start to provide some immediate value, such asFive things they must do at that destination, or advice on what vaccinations are required for the country, or any local customs that they need to be aware of. Regular interaction with the consumer via their smartphone is essential to keep the app retained on their phone, so a short weekly lesson on essential local phrases could be part of that interaction. This builds a tighter relationship with the consumer, but don’t forget to add a button into the app enabling users to switch off such alerts if they feel they don’t need them.

Data capture

One feature that may be useful for any type of traveller – from students to business executives – is a once daily request by the app for a four-digit code, with the request frequency being increased in the event of local disasters or the traveller going into a higher-risk area. If the code is not entered, the location of the device is automatically transmitted to a pre-selected set of individuals. This could be a useful way to potentially identify the location of a traveller when they are not in a position to be able to respond directly.

Key to improving the chances of an app being used in an emergency is ensuring that the consumer is aware that the app is on their device and ‘front of mind’ in a crisis. One of the ways to do that is to have built up a relationship with the consumer through regular and useful interaction leading up to the event. In the event of a disaster, it may also be possible to send all clients within the relevant area a message with a link directly to the app to save them having to search for it on their smartphone.

The data collected in the app – which could include the user’s medical records, travel insurance policy details, allergy advice, and current medication – should be automatically uploaded to a secure cloud-based service that the local PPO or hospital can access in the event of an emergency, as the patient may be in no fit state to unlock his phone or may well not have access to it. Having the data held in a secure cloud service also makes it easier to replicate the data onto a replacement mobile phone should the original device get lost, stolen or damaged. Smartphones are very sophisticated and powerful devices that consumers are prepared to invest in, and this provides a very cost-effective eco-system through which to deliver assistance services. Assistance apps are already proving popular, and even if only a fraction of the people who download such apps actually use it to contact their emergency assistance provider, the app still provides peace of mind, as well as additional added-value services, that enhances customer loyalty and puts your brand at the front of users’ minds.

Author

Manjit Rana is founder and director of Ingenin, an award-winning technology company created to help insurers grow their business through the adoption of emerging and more established mobile technologies, focusing its expertise on travel, health, home and motor insurance.
In Spain, it is compulsory for all non-living aircraft passengers to be embalmed before boarding a flight. However, the deceased can fly into Spain without first being embalmed.

In France, only French-registered funeral companies can collect the deceased. French funeral companies can send staff abroad to make collections, but foreign companies cannot travel to France to do the same.

A death must be registered in the country where the person died. Deaths at sea are registered according to the nationality of the vessel.

Livestock and living plant cargo take priority over the shipment of mortal remains.

As a proportion, UK nationals are more likely to die in the Philippines than in any other country, due to the large numbers of elderly British expats living there.

The Agreement on the Transfer of Corpses 1973 (‘the Strasbourg Agreement’), which concerns the movement of human remains across international borders, requires impervious, sealed coffins to be used, but only 23 countries have signed the agreement.

In the 2011/12 period, 6,237 Brits died abroad, according to UK Foreign and Commonwealth Office figures.

In many countries, there is no requirement to advise the funeral director that organs have been removed.

A coffin transported as an ordinary consignment should be packaged so as not to look like a coffin, according to the Strasbourg Agreement.

In Spain, it is compulsory for all non-living aircraft passengers to be embalmed before boarding a flight. However, the deceased can fly into Spain without first being embalmed.

In countries that are signed up to the Strasbourg Agreement, the deceased should travel with a ‘Laissez-Passer’ form completed in one of the official languages of the issuing country, plus one of the official languages of the Council of Europe. Problems can arise when the form is written only in the language of the issuing country.
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