2017

The health and health preparation of long-term Australian travellers

Elizabeth J. Halcomb
University of Wollongong, ehalcomb@uow.edu.au

Moira Stephens
University of Wollongong, moiras@uow.edu.au

Elizabeth A. Smyth
University of Wollongong, esmyth@uow.edu.au

Shahla Meedya
University of Wollongong, smeedya@uow.edu.au

Sarah Tillott
University of Wollongong, stillott@uow.edu.au

The health and health preparation of long-term Australian travellers

Abstract

A growing number of Australians are travelling domestically for extended periods. This creates challenges in both continuity of health care and burdens on health services. This paper reports a cross-sectional survey aimed to explore the health needs and health planning of long-term travellers. In total, 316 respondents who had travelled for more than 3 months consecutively in the last year participated. Most respondents were retired (n=197; 62.3%); however, ages ranged from 26 to 89 years. Nearly half of the respondents or their travel companion had a long-term illness that affected their daily life (n=135; 42.7%). Nearly half of respondents visited a GP (n=133; 42.1%), nearly one-quarter visited an Emergency Department (n=72; 22.8%) and 19.9% (n=63) visited another health provider while travelling. The level of preparation around health while travelling varied between participants. This study highlights that long-term travellers have significant health needs and are likely to require health services during their extended travel. Additionally, it identifies that currently few strategies are used to plan for health care during travel. This raises issues for rural and remote health services in terms of both capacity and continuity of care.

Disciplines
Medicine and Health Sciences | Social and Behavioral Sciences

The health and health preparation of long-term Australian travellers

Authors:

Dr Elizabeth Halcomb RN BN(Hons) PhD FACN

Professor of Primary Health Care Nursing

School of Nursing,

Faculty of Science, Medicine & Health

University of Wollongong

Northfields Ave Wollongong NSW 2522

P: +61 2 4221 3784 | F: +61 2 4221 3137 | E: ehalcomb@uow.edu.au

Dr Moira Stephens RN, BSc (Hons), PG Cert Ed, PG Cert Onc, MSc, PhD

Senior Lecturer

School of Nursing,

Faculty of Science, Medicine & Health

University of Wollongong

Northfields Ave Wollongong NSW 2522

Elizabeth Smyth BSc MPH

Research Officer

School of Nursing

University of Wollongong

Northfields Ave Wollongong NSW 2522

Dr Shahla Meedya

Lecturer

School of Nursing,

Faculty of Science, Medicine & Health

University of Wollongong

Northfields Ave Wollongong NSW 2522

Sarah Tillott

Lecturer

School of Nursing,

Faculty of Science, Medicine & Health

University of Wollongong

Northfields Ave Wollongong NSW 2522

Corresponding author: Prof Elizabeth Halcomb, School of Nursing - Building 41, University of Wollongong, Northfields Ave Wollongong NSW 2522 Email: ehalcomb@uow.edu.au

- What is known about the topic?

  An increasing number of older people are travelling around Australia for extended periods yet little is known about their health or health planning.

- What does this paper add?

  This paper provides an overview of the health needs and health planning strategies used by long-term travellers within Australia.

Abstract

A growing number of Australians are travelling for extended periods within Australia. This creates a range of challenges in terms of both continuity of health care and the burden on health services. This paper reports a cross-sectional survey which aimed to explore the health needs and planning strategies of long-term travellers within Australia. The survey tool explored demographic, travel issues, health status, risk factors, health planning and quality of life (WHOQOL-BREF). Three hundred and sixteen respondents who had travelled for more than three months consecutively in the last year completed the survey. Most respondents were retired (n=197; 62.3%), however, ages ranged from 26 years to 89 years. Nearly half of the respondents or their travel companion had a long term illness which impacted on their daily life (n=135; 42.7%). Nearly half of respondents visited a GP (n=133; 42.1%), nearly a quarter visited an Emergency Department (n=72; 22.8%) and 19.9% (n=63) visited another health provider during their travels. The level of preparation about their health needs whilst travelling varied between participants. This study highlights that long-term travellers have significant health needs and are likely to require health services during their extended travel. Additionally, it identifies that currently few strategies are used to plan for health care during travel. This raises issues for rural and remote health services in terms of both capacity and continuity of care.

INTRODUCTION

Australia's varied climate and vast landmass encourages people with time to take to the roads and travel for lengthy periods (Hillman 2013). The growth in the population, lower fuel prices and historically low interest rates suggest that the number of domestic self-drive travellers is likely growing (Tourism Research Australia 2015). For some this may be a seasonal lifestyle, whilst others travel continuously as a way of life (Hillman 2013).

Many, but not all, of these travellers are older Australians and are often referred to as 'grey nomads' (Higgs and Quirk 2007, Hillman 2013). Older age and retirement leads to a reduction in work and family responsibilities and a time to enjoy life and seek self-realisation (Higgs and Quirk 2007). In 2008 Australia's grey nomad population was estimated to be about 2 per cent of the total population, or about 450,000 people (Davies 2011). The growth in the population over retirement age, lower fuel prices and historically low interest rates suggest that the number of domestic self-drive grey nomad travellers is likely growing (Tourism Research Australia 2015). However, there are also young travellers and families who partake in extended travel for various reasons (Tourism Western Australia and Tourism Research Australia 2007). A report from Tourism Western Australia and Tourism Research Australia (2007) demonstrated that 50% of the visitors in Western Australian caravan parks in 2006 were aged 55 years old or more, 34% were younger people, 13% were families with children and 3% were international tourists (Tourism Western Australia and Tourism Research Australia 2007).

Considering that long-term travellers are not a homogenous group they will have different health needs and requirements for planning around health needs during their travels. These health needs, however, can provide challenges for both receiving and delivering health care. There is significant evidence that interventions to improve lifestyle risk factor profiles and optimal management of chronic conditions can enhance quality of life and longer term health outcomes (Wagner, Austin et al. 2001). However, delivering such health care to travellers clearly presents some unique challenges around consistency of care and access to services.

In their survey of 260 travellers at a single location in remote WA over a five day period Tate (2006) concluded that older people were "poorly prepared for travel in

remote Australia" (p. 70). They also identified that travellers can have a deleterious impact on local health resources (Tate 2006). Other qualitative investigations confirmed these findings, with Holloway (2009) reporting that grey nomads lacked medical preparedness and Raven (2015) asserting that grey nomads negatively impact on the resources of rural/remote health services. In contrast, Hillman (2013) identified that the older participants in her study did express concerns about health issues and had contingency plans during their travels.

There is a paucity of empirical research on Australian long-term travellers (Raven 2015). Literature focuses on the economic impact of tourism, work (Prideaux and McClymont 2006, Mahadevan 2013, Raven 2015) and the travel benefits of long-term travellers (Sheng, Simpson et al. 2014). Given this gap in the literature and the growing popularity of long-term travel amongst Australians, this paper seeks to explore the health needs of Australian long-term travellers and their current planning strategies for health and health care. These data will provide an important insight which can inform the delivery of services to better meet the needs of these individuals.

METHOD

Study Design & Setting

This study used an online survey tool to collect cross-sectional data to investigate the study aims. Participants were recruited using social media (Facebook, Twitter, Blogs, Forums and Web newsletters) between September 2015 and February 2016. Participation was voluntary and anonymous unless participants chose to provide their contact details for further research.

Sample

Of the 424 individuals who consented to participate, 382 were either currently travelling continuously for 3 or more months or had done so in the previous 12 months. Respondents were included in the analysis if they completed over 25% of the survey. This resulted in 316 included participants.

Instruments

Data were collected online using Survey Monkey^{TM} (SurveyMonkey Inc. 2015). The survey comprised of items about; demographics, quality of life, travel, health conditions, planning and needs. Demographic characteristics were collected for participants and, if appropriate, their travel companions. The QOL-BREF (World Health Organisation 2002) was used to measure Quality Of Life. This scale includes two items about overall quality of life and general health together with 24 items divided into four domains; Physical health; Psychological health; Social relationships; and Environment. Each of these items is scored on a five-point Likert scale which captures data on various response scales including; 'how much', 'how completely', how often', 'how good' or 'how satisfied' the individual felt in the last 2 weeks (Skevington, Lotfy et al. 2004). A higher score in each domain indicates a higher quality of life. Three items are negatively scored and are reversed during the analysis process. Other items focussed on medication management, health equipment, health checks and follow-up and overall health.

Data analysis

Data was exported directly from Survey Monkey into the Statistical Package for the Social Sciences (SPSS) Version 21.0 (IBM Corp. 2013). The data were analysed using descriptive statistics to summarise the data. To determine if some categorical items were influenced by other items, chi-square tests were conducted with a significance level of $p < 0.05$.

Ethical considerations

Approval for the study was gained from the Human Research Ethics approval from the University of Wollongong Research Ethics Committee (Approval Number HE15/366). An information sheet was provided as the opening page of the survey. Respondents selected a tick box at the bottom of this page indicating their understanding of the information sheet and providing consent for the use of their data.

RESULTS

Demographic Data

Most respondents were retired (n=197; 62.3%), however, respondents ages ranged from 26-89 years (Mean 60.2 years, SD=10.9)(Table 1). Similarly, travel companions had a mean age of 59.8 ± 12.3 years. Just over half of the respondents were female (n=167; 52.8%). Whilst 28.2% (n=89) respondents received the aged pension, a further 11.4% (n=36) received a disability pension. Only 7.3% of respondents were travelling whilst on paid leave from their employment.

INSERT TABLE 1 HERE

Travel History

Respondent's longest trip in the past year was an average of 24.6 weeks (SD = 15.2) (Table 2). Approximately one fifth of respondents (n=63; 19.9%) had travelled for more than 46 weeks in the preceding year. Most respondents used a caravan as their predominant mode of accommodation (n=212; 67.1%).

Nearly half of respondents (n=150; 47.5%) were currently travelling, with most travelling in a caravan (n=212; 67.1%) or motorhome (n=49; 15.5%). As shown in Table 2, the anticipated duration of current trips was variable, although over half (n=80; 53.3%) were planning to travel for 10 months or more or indefinitely. Travel plans included all States and Territories of Australia, with the most respondents planning to visit New South Wales (n=124; 39.2%) and Queensland (n=123; 38.9%) and the smallest proportion planning to visit Tasmania (n=42; 13.3%).

INSERT TABLE 2 HERE

Lifestyle Risk Factors

Nearly two in five respondents (n=118; 37.3%) had a BMI over 30 (Table 3). Few respondents (n=18; 5.7%) and travel companions (n=10; 3.7%) reported being smokers. Around half the respondents (n=157; 49.7%) and companions (n=137; 50.2%) estimated that they consumed 1-3 standard drinks per day. Approximately one-third of the respondents (n=86; 27.2%) and travel companions (n=95; 34.8%) were reportedly consuming alcohol 6-7 days per week.

Current Health

The most common medical issues amongst respondents were high blood pressure (n=127; 40.2%), arthritis (n=72; 22.8%), other health conditions (n=54; 17.1%) and diabetes (n=41; 13.0%). A small group of respondents (n=62; 19.6%) and travel companions (n=35; 11.1%) reported having ceased work due to illness or disability. Nearly half of the respondents reported that either themselves or their travel companion had a long term illness that impacted on their daily life (n=135; 42.7%). In the past year 8.9% (n=28) respondents had returned from their travels due to poor health.

Approximately one quarter of respondents (n=75; 23.7%) reported that either they and/or their travel companion required ongoing prescription medication. Just over half of the respondents requiring medication (n=57; 57.0%) reported having prescriptions filled during the trip and 24.0% (n=24) sought medical attention during their travel to obtain prescriptions for medications. Approximately one quarter of respondents (n=75, 23.7%) carried a list of medications. These lists were either self-prepared (n=33; 44.0%), prepared by a doctor (n=32; 42.7%) or a pharmacist (n=10; 13.3).

Quality of Life

From the four domains measured by the WHOQOL-BREF it is clear that respondents (n=316) perceive their environmental quality of life (Mean 77.9) to be their highest domain followed by their psychological (Mean 74.9), physical (Mean 70.7) and social relationships (Mean 69.6) (Table 4).

The majority of respondents rated their quality of life as good or very good (n=284; 89.8%), with very few rating it as poor or very poor (n=12; 3.8%). However, in terms of the level of satisfaction with their health, many (n=224; 70.9%) reported being satisfied or very satisfied, however, some 15.2% (n=48) respondents reporting being dissatisfied or very dissatisfied.

Health Planning

Most respondents (n=206; 65.2%) and travel companions (n=179; 74.0%) reported having a health check with their GP prior to travelling. However, only 32.3% (n=102) carried information about their health prepared by the GP during their travels. Fewer respondents (n=91; 28.8%) and travel companions (n=73; 30.2%) reported having a health check with a GP whilst travelling.

Many respondents (n=122; 38.6%) and travel companions (n=106; 39.0%) reported that their health was somewhat or much better during their travels. Only a few respondents (n=25; 7.9%) and travel companions (n=22; 8.1%) reported a worsening of their health. Despite this nearly half of respondents visited a GP (n=133; 42.1%), nearly a quarter visited an Emergency Department (n=72; 22.8%) and 19.9% (n=63) visited another health provider whilst travelling.

Social Support

Most respondents (n=270; 85.4%) reported carrying a mobile phone to maintain contact with family / friends and many reported using email (n=238; 75.3%) or social media (n=209; 66.1%). Just over half of the respondents reported having a VHF/UHF radio for emergency use (n=182; 57.6%).

DISCUSSION

This is the first national survey of the health and wellbeing of long-term travellers in Australia. As such is provides important baseline information to inform the development of interventions to support this group, as well as service planning and health policy development. However, the study has a number of limitations. Firstly, the short time frame for the project meant that respondents were best recruited via social media and key organisations. Additionally, data were also collected via an online survey. More sophisticated recruitment strategies may allow for a larger sample size and include additional respondents who don't engage in social media and online communication.

The relatively high prevalence of chronic disease and lifestyle risk factors in respondents, was similar to the broader Australian population (National Vascular Disease Prevention Alliance 2012, Australian Institute of Health and Welfare. 2016),

and previous studies of long term travellers (Tate 2006). However, there was a slightly higher prevalence of some factors, such as obesity, amongst respondents (37% respondents versus 28% Australians). Additionally, whilst fewer Australians are consuming alcohol in harmful quantities (Australian Institute of Health and Welfare 2014), half of the respondents and their companions reported usually consuming 1-3 standard drinks per day. Given that lifetime risky drinkers are defined as those exceeding an average of >2 standard drinks per day over a year (Australian Institute of Health and Welfare 2014), many respondents were at or approaching this definition. This demonstrates the high potential risk and the importance of lifestyle risk factor reduction in this group. Future research should develop and test innovative strategies to enhance lifestyle risk factor reduction in long term travellers. Such strategies need to engage travellers in evidence-based interventions to improve risk factor profiles and promote healthier lifestyles. These strategies also need to consider how travellers can remain connected to consistent health care providers to provide the kind of continuity that has been demonstrated to be important to good primary care (Bodenheimer, Ghorob et al. 2014).

Within the Australian context a number of services exist or are emerging that could enhance the delivery of health care to this group. For example; the national electronic 'My Health record' offers a potential solution to providing access to medical records across the country (Australian Government - Australian Digital Health Agency. 2017). However, the full potential of this service remains unrealised as a result of the suboptimal uptake amongst providers and consumers (Authors own). Given the limited electronic sharing of medical records printed health summaries may address this gap. Such a strategy requires the traveller to actively seek their care summary from health professionals prior to travel. Given that only 65% of respondents and 74% of their companions had a health check with their GP prior to travel in this study, further education could assist in raising awareness of the value of this strategy.

Telehealth is another strategy which has been shown to be effective in chronic disease management in rural and remote areas (Moffatt and Eley 2010). However, most models of telehealth to date have focussed on enhancing access for rural residents to city-based specialist services rather than servicing the health needs of travellers. There is scope, however, to explore how telehealth services might be effectively used to promote access to services and provide continuity of care for those who are travelling for an extended period.

Also currently available are telephone help and triage lines, such as After-hours GP lines and Healthdirect. These services can provide medical advice and telephone triage to Australians regardless of their location. Whilst these services can assist individuals in making decisions about the need for GP care or Emergency Department presentation, they are not a substitute for ongoing chronic disease support. In their study of help line usage McKenzie, Williamson et al. (2016) identified that those in capital cities and younger individuals were the highest users. This highlights a potential gap in the delivery of these services to support long-term travellers.

Respondents' quality of life was slightly higher than Australian normative data in both the psychological (mean 74.9 vs 70.6) and environment (mean 77.9 vs 75.1) domains (Hawthorne, Herrman et al. 2006). This supports the perception of the positive impact of the travelling environment on mental health (Hillman 2013). However, respondents reported slightly lower quality of life than the Australian population norms (Hawthorne, Herrman et al. 2006) in both the physical (mean 70.7 vs 73.5) and social relationships (mean 69.6 vs 71.5) domains. These findings might reflect the physical demands of travel and the distance away from family and social networks whilst travelling. Concerns around social connectedness have been previously reported amongst travellers (Hillman 2013), however, those living in their own homes have been reported to have scores lower than population norms in these domains in some studies (Robinson, Ghosh et al. in press). This highlights the need for further research around the factors impacting on quality of life for travellers, particularly given the links between quality of life and perceptions of health.

Of particular note in this study were the findings of high health service utilisation and low levels of planning for health related issues. Tate (2006) also identified that older Australians were poorly prepared for remote area travel regarding their health needs. In this study, a lack of health summaries and low supplies of regular medications impacted on health care delivery (Tate 2006). Raven (2015) concurs, concluding that inadequate health planning by long-term travellers places a burden on rural and remote health services. Strategies to improve the preparedness of travellers can assist in reducing this burden and empowering individuals to enhance their self-management. These strategies likely include mechanisms to support travellers accessing their medical records and/or health histories whilst travelling, the development of proactive care plans to guide self-management during travel and

11

facilitating improved planning for medication management. Whilst this study has gone some way to providing some insight into the health of long-term Australian travellers, further research into self-care, health service utilisation and specific disease groups is required.

CONCLUSION

With the increase in longevity and the number of people touring Australia it is critical to ensure health and social services are appropriate for Australians to maintain health and wellness for longer (Higgs and Quirk 2007). The large distances between health services in the areas that people travel and the short supply of health professionals in rural and regional areas highlights a need to develop evidence of travellers use of self-care strategies and use of health services to plan for the future.

REFERENCES

Australian Government - Australian Digital Health Agency. (2017). "My Health Record." Retrieved January 20th, 2017, from https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/content/home.

Australian Institute of Health and Welfare (2014). National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. no. PHE 183. Canberra, AIHW.

Australian Institute of Health and Welfare. (2016). Australia's Health. Canberra, ACT, Australian Government.

Bodenheimer, T., A. Ghorob, R. Willard-Grace and K. Grumbach (2014). "The 10 building blocks of high-performing primary care." The Annals of Family Medicine **12**(2): 166-171.

Davies, A. (2011). "On constructing ageing rural populations: 'Capturing' the grey nomad." Journal of Rural Studies **27**(2): 191-199.

Hawthorne, G., H. Herrman and B. Murphy (2006). "Interpreting the WHOQOL-Brèf: Preliminary Population Norms and Effect Sizes." Social Indicators Research **77**(1): 37-59.

Higgs, P. F. and F. Quirk (2007). ""Grey Nomads" in Australia." Annals of the New York Academy of Sciences **1114**(1): 251-257.

Hillman, W. (2013). "Grey Nomads travelling in Queensland, Australia: social and health needs." Ageing and Society **33**(04): 579-597.

Hillman, W. (2013). "Grey Nomads travelling in Queensland, Australia: social and health needs " Ageing & Society **33**: 579-597.

Holloway, D. J. (2009). Grey nomads: Retirement, leisure and travel in the Australian context, Edith Cowan University.

IBM Corp. (2013). IBM SPSS Statistics for Windows. Armonk, NY.

Mahadevan, R. (2013). "Understanding Senior Self-Drive Tourism in Australia Using a Contingency Behavior Model." Journal of Travel Research **53**(2): 252-259.

McKenzie, R., M. Williamson and R. Roberts (2016). "Who uses the'after hours GP helpline'?: A profile of users of an after-hours primary care helpline." Australian family physician **45**(5): 313.

Moffatt, J. J. and D. S. Eley (2010). "The reported benefits of telehealth for rural Australians." Australian Health Review **34**(3): 276-281.

National Vascular Disease Prevention Alliance (2012). Guidelines for the management of absolute cardiovascular disease risk.

Prideaux, B. and H. McClymont (2006). "The changing profile of caravanners in Australia." International Journal of Tourism Research **8**(1): 45-58.

Raven, M. (2015). "Health of grey nomads: On the move and under the health sector radar." Aust J Rural Health.

Robinson, K., A. Ghosh and H. E. J. (in press). "Manufactured Home Villages in Australia – A Melting Pot of Chronic Disease?" Australian Journal of Primary Health: accepted 15/13/16.

Sheng, X., P. M. Simpson and J. A. Siguaw (2014). "U. S. winter migrants' park community attributes: An importance–performance analysis." Tourism Management **43**: 55-67.

Skevington, S. M., M. Lotfy and K. A. O'Connell (2004). "The World Health Organization's WHOQOL-BREF quality of life assessment: psychometric properties and results of the international field trial. A report from the WHOQOL group." Quality of life Research **13**(2): 299-310.

SurveyMonkey Inc. (2015). "SurveyMonkey." 2015, from https://www.surveymonkey.com/.

Tate, J., Mein, J, Freeman, H, Maguire, G (2006). "Grey Nomads - Health and health preparation of older travellers in remote Australia." Australian Family Physician **35**(1/2): 70-72.

Tourism Research Australia (2015). State of the Industry 2015. Canberra.

Tourism Western Australia and Tourism Research Australia (2007). Understanding the Caravan Park Industry in WA. Perth, Tourism Western Australia.

Wagner, E. H., B. T. Austin, C. Davis, M. Hindmarsh and et al. (2001). "Improving chronic illness care: Translating evidence into action." Health Affairs **20**(6): 64-78.

Table 1: Demographic Characteristics

Characteristics	Survey Participant n (%)	Travel Companion n (%)
Age	**Mean=60.2 ± 10.9 yrs**	**Mean=59.8 ± 12.3 yrs**
26 to 29yrs	4 (1.3)	1 (0.4)
30 to 34yrs	9 (2.8)	11 (4.0)
35 to 39yrs	7 (2.2)	9 (3.3)
40 to 44yrs	13 (4.1)	17 (6.2)
45 to 49yrs	15 (4.7)	6 (2.2)
50 to 54yrs	14 (4.4)	18 (6.6)
55 to 59yrs	43 (13.6)	33 (12.1)
60 to 64yrs	81 (25.6)	64 (23.4)
65 to 69yrs	72 (22.8)	63 (23.1)
70yrs and over	45 (14.2)	50 (18.3)
Missing Data	*13 (4.1)*	*1 (0.4)*
Employment Status		
Retired	197 (62.3)	168 (61.5)
Unemployed	28 (8.9)	23 (8.4)
Full-time employment	22 (7.0)	27 (9.9)
Casual employment	21 (6.6)	22 (8.1)
Part-time employment	16 (5.1)	11 (4.0)
Missing Data	*32 (10.1)*	*22 (8.1)*
Income (multiple income sources recorded)		
Superannuation	106 (33.5)	79 (28.9)
Aged Pension	89 (28.2)	86 (31.5)
Disability Pension	36 (11.4)	22 (8.1)
Paid Leave from employment	23 (7.3)	19 (7.0)
Casual/temporary work	31 (9.8)	29 (10.6)
Savings	107 (33.9)	84 (30.8)
Other	39 (12.3)	34 (12.5)
Missing Data	*13 (4.1)*	*30 (11.0)*
Private Health Insurance		
Yes	199 (63.0)	174 (63.7)
No	102 (32.3)	91 (33.3)
Missing Data	*15 (4.7)*	*8 (2.9)*
Volunteer Work		
Yes	43 (13.6)	29 (10.6)
No	258 (81.6)	240 (87.9)
Missing Data	*15 (4.7)*	*4 (1.5)*

Table 2: Travel Times and Travel Plans

Travel Characteristics	Participants n (%)
Duration of Longest Trip in the last 12 months	**Mean 24.6 ± 15.2 wks**
Less than 15 weeks	67 (21.2)
16-30 weeks	133 (42.1)
31-45 weeks	31 (9.8)
46-61 weeks	60 (19.0)
>62 weeks	3 (0.9)
Missing Data	*22 (7.0)*
Average time spent travelling each year	
Less than 1 month	37 (11.7)
2-4 months	91 (28.8)
5-8 months	71 (22.5)
9-12 months	110 (34.8)
Missing Data	*7 (2.2)*
Planned length of current trip	
≤ 3 months	17 (11.3)
4 – 6 months	12 (8.0)
7 – 9 months	9 (6.0)
10 – 12 months	38 (25.3)
≥13 months	28 (18.7)
Indefinite travellers	14 (9.3)
Other – No time frame; Undecided; no plans as yet	7 (4.7)
Missing Data*	*25 (16.7)*

*Missing Data : excluding 166 who were not currently travelling

Table 3: Lifestyle factors

Lifestyle Risk Factors	Survey Participant n (%)	Travel Companion n (%)
BMI	[Mean=30.7]	[Mean=29.3]
≤18.49	1 (0.3)	2 (0.7)
18.5 to 24.99	52 (16.5)	48 (17.6)
25 to 29.99	92 (29.1)	90 (33.0)
30+	118 (37.3)	87 (31.9)
Missing Data	*53 (16.8)*	*46 (16.8)*
Smoking Status		
Current Smokers	18 (5.7)	10 (3.7)
Standard Drinks per day		
0	74 (23.4)	61 (22.3)
1-3	157 (49.7)	137 (50.2)
4	35 (11.1)	21 (7.7)
5 or more	14 (4.4)	32 (11.7)
Missing Data	*36 (11.4)*	*22 (8.1)*
Number days per week consume alcohol		
1 to 2 days	54 (23.4)	38 (17.8)
3 to 5 days	91 (39.4)	80 (37.6)
6 to 7 days	86 (37.2)	95 (44.6)

Table 4: WHOQOL-BREF domain results

Domain	<=50 n (%)	51-75 n (%)	>=76-100 n (%)	Mean
Physical Health	48 (15.2)	128 (40.5)	140 (44.3)	**70.7 ± 19.5**
Psychological	22 (7.0)	147 (46.8)	145 (46.2)	**74.9± 14.0**
Social Relationships	60 (19.0)	151 (47.9)	104 (33.0)	**69.6± 19.4**
Environment	11 (3.5)	124 (39.2)	181(57.3)	**77.9± 13.1**
TOTAL	17 (5.4)	144 (45.6)	146 (46.2)	**73.3 ± 13.2**