

Travelling with heart disease: restricted choice and restrictive cost

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Residents of the United Kingdom (UK) took more than 58 million holidays abroad in 2019,¹ and after a prolonged period of social isolation and travel restrictions in 2020, many are eagerly planning overseas travel. A large and growing proportion of travellers are older people, many of whom have chronic health conditions.² A small proportion will be affected by acute illness whilst abroad, which is likely to have significant associated cost. For example, the mean cost of a myocardial infarction hospitalisation in the USA was \$18,931 in a recent registry study.³ In addition to direct medical costs, those without travel insurance may require medical repatriation costing £16,000 within Europe, or up to £85,000 from further afield.⁴

Travel insurance is recommended to indemnify individuals for these potentially financially ruinous costs.⁵ This advice is particularly important for those with chronic diseases, including cardiovascular disease,⁶ who may be at risk of decompensation or vulnerable to additional medical problems.⁷ However, for those with pre-existing health conditions, obtaining travel insurance can be time-consuming and costly.

In this issue of the *Journal*, Bennett et al. have compared travel insurance premiums for a ten-day holiday in Spain for people with myocardial infarction, Marfan syndrome or dilated cardiomyopathy with matched controls.⁸ Unsurprisingly, insurance premiums were substantially higher for people with any of the three conditions and there was a decreased choice of providers offering cover. However, the authors helpfully identified factors that were associated with a lower premium for travellers with these conditions and that may



help to minimise insurance costs of an overseas trip. These included increasing the interval between an acute event and a trip, waiting until any scheduled investigations have been completed, and medically optimising symptoms as much as possible prior to an insurance application. The potential savings that they identified were substantial. For example, the median annual premium for a patient following a myocardial infarction was £251 immediately, but £63 at six months. This correlates with a ‘higher-risk’ period in the early period following a heart attack,⁹ and has important implications for affordability. A similar pattern was seen in Marfan syndrome and dilated cardiomyopathy; in all three conditions the greatest number of providers and the lowest premiums were available 12 months after an acute event.

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Two other important and topical considerations emerged in light of this study. The work was based on a hypothetical holiday in Spain, where UK residents with a European Health Insurance Card are currently entitled to state-provided healthcare at a reduced or no cost.¹⁰ This leads to a reduction in the potential liability of insurance companies, and helps keep premiums low. The current provision is under Brexit transitional arrangements, but the situation for travellers thereafter is unknown. There could be substantial increases in the cost of travel insurance for European visits, particularly for older people and those with pre-existing health problems.¹¹ This may reduce the ability of those with chronic conditions to afford foreign travel. This is compounded by the fact that older people in poor health and those with lower disposable income are amongst the most likely to be 'digitally excluded'¹² and unable to access the best deals. The authors identified substantial variation in the premiums offered between 16 providers, which highlights that whilst there is the potential for cost-savings through multiple quotations, this may not help those that would benefit the most.

Failure to declare pre-existing medical conditions could result in any claim being declined by the insurer.⁶ Whilst

(understandably) little is known about the extent of under-reporting of medical conditions to insurance companies, one study of 107 people under follow-up for adult congenital heart disease found that of those that had bought travel insurance, 23% did not declare a pre-existing heart condition.¹³ It may be that this was a deliberate omission, or because of a lack of awareness. Notably, 83% of these respondents felt that insurance had not been fully addressed in clinic.

It seems that there is scope to improve the advice that we offer our patients with chronic health conditions who are hoping to travel. Firstly, there is a need to make them aware of the importance of obtaining insurance before travel; secondly, of providing written confirmation of the diagnosis such as through a clinic letter that can be shared with the insurer, and; thirdly, of sharing the key messages of the linked paper: that by optimising symptoms, completing investigations and waiting for a period of stability, travel insurance is likely to be cheaper. Importantly, with these measures, travel may also be safer. **!**

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