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Travel Insurance, Clinical Trials and Access to Emerging Therapies

Amir Afzul, Henrique Freitas, Abuzer Hanif, Krishnakumar Radhakrishnan

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Abstract

Patients enroll in clinical trials to access novel therapies and contribute to medical progress, yet those who travel frequently still encounter unexpected barriers from travel insurers. Participation in a clinical trial is often treated as a generic red flag, with some insurers refusing cover or quoting unaffordable premiums solely on the basis of trial involvement, even when the intervention is low risk or the medicine is already approved elsewhere. Recent statements from the Association of British Insurers (ABI), supported by the Academy of Medical Royal Colleges (AoMRC) and the Health Research Authority (HRA), clarify that trial participation does not in itself imply increased risk and should not automatically lead to higher premiums or refusal of cover. However, implementation remains inconsistent and underwriting policies rarely distinguish between trial phase, intervention risk or the safety infrastructure that characterises modern UK research governance. This perspective argues that travel insurance policies must evolve in parallel with contemporary clinical trial practice, particularly as trials provide key pathways for patients to access emerging preventive and disease-modifying therapies. We outline practical changes to underwriting frameworks, trial documentation and incident reporting that could reduce unnecessary barriers for participants, support honest disclosure and align insurance practice with evidence-based research regulation.

Keywords: clinical trials; travel insurance; risk-based underwriting; UK; research governance; emerging therapies; longevity medicine

Introduction

When patients enroll onto clinical trials, they do so with purpose: access to novel treatments and the opportunity to contribute to medical progress. For many, especially those with chronic or progressive conditions, research offers one of the few routes to emerging preventive or disease-modifying therapies that may influence long-term outcomes. Yet those who travel frequently face unexpected barriers; not from science, but from travel insurers who assume all trial participation is automatically high risk. This broad-brush approach penalises honesty and restricts freedoms during legitimate trial participation.

The Association of British Insurers (ABI), which represents around 250 companies that between them provide approximately 90% of domestic insurance services sold in the UK[3], has explicitly stated that participation in a clinical trial "is not something that of itself would be expected to lead to increased premiums or insurance refusal, as it does not carry increased risk above that associated with the condition under trial".[1] In nearly all cases, travel insurers do not even ask about trial participation; if they do, the question must be clear and answered honestly.[1,2] Where trials pose genuinely elevated risk, for example, early-phase or first-in-human studies, insurers may assess on a case-by-case basis and, if unable to cover, should signpost to specialist providers.[1]

Despite this, the authors regularly encounter patients who have been refused cover or quoted unaffordable premiums solely because they disclosed trial involvement, even in instances where the intervention was low risk or already approved elsewhere. This not only creates unfair barriers but also pressures individuals to withhold information, an ethically fraught workaround that undermines trust between participants, investigators and insurers.

Clinical Trials and Travel Insurance: A Governance Disconnect

Clinical trials are often more tightly regulated than routine clinical practice, with defined protocols, regular monitoring and transparent reporting. In the UK, the governance framework overseen by bodies such as the HRA and MHRA ensures that trial design, risk assessment and participant safety are scrutinised before approval, with ongoing oversight during conduct. Yet the disconnect is clear: insurers continue to treat participation as an ambiguous red flag. This reflects a pertinent knowledge gap and the absence of standardised underwriting guidance that distinguishes between trial phase, intervention risk or the safety infrastructure supporting the research.

The current landscape presents a paradox. Trials intended to help patients and to generate evidence that informs future care pathways, including those relevant to longevity and preventive medicine, become barriers to their travel, with insurers applying outdated heuristics instead of evidence-informed distinctions. When patients discover mid-trial that they cannot obtain travel insurance or must pay prohibitive premiums, it affects more than morale. It threatens retention, risks protocol deviations and increases trial costs for sponsors. Replacing participants or managing missing data disrupts timelines, increases the risk of regulatory scrutiny and weakens the overall value of the research.

ABI's Voice is Necessary, but Not Sufficient

The ABI's statement, endorsed and publicised via the Academy of Medical Royal Colleges and the Health Research Authority, was a constructive step.[1,2] Unfortunately, their guidance remains insufficiently implemented. Many insurers have not updated application forms or underwriting rules, and patients continue to report wide variation in experience when disclosing trial participation.

To date, the ABI has not issued tiered risk guidance; it remains up to individual firms to consider each trial. The ABI's original 2019 position was updated in 2024, confirming no new exclusionary policies but still allowing discretion for high-risk trials.[2] This means the message is strong—but not yet enforced or standardised across all insurers. From a clinical research perspective, this gap represents a misalignment between contemporary UK research governance and insurance practice.

What Could Change?

Several practical steps could bring insurance practice closer to modern trial realities while preserving honest disclosure and participant safety.

First, the adoption of a standardised risk-based underwriting framework. A best-practice template would stratify trials by design, phase and safety profile—for example, distinguishing low-risk observational or pragmatic studies from high-risk first-in-human interventions. The ABI, or regulatory bodies such as the MHRA or NIHR, could develop a tiered framework that insurers can adopt, providing clarity and consistency.

Second, the inclusion of clearer guidance in trial consenting materials. Trial sponsors should include the ABI's position in Participant Information Sheets, ensuring participants are aware they should truthfully disclose participation and that, in most cases, this should not automatically preclude cover.

Third, the creation of trial-specific insurance templates. For low-risk or observational studies, pre-approved insurance policy templates could streamline underwriting, reducing insurer hesitancy and complexity for participants. These templates might incorporate standard wording about the nature of the intervention, monitoring arrangements and risk assessment.

Fourth, the development of incident reporting mechanisms. Following ABI and AoMRC guidance, cases where participants face unjust insurance refusals or premium hikes solely due to trial enrolment should be escalated to a central body (for example, AoMRC), enabling the ABI to investigate and address systemic issues.[1,2]

Finally, the establishment of structured cross-sector dialogue. Bridging the gap requires convening insurers, researchers, regulators and patient representatives. Joint workshops or formal statements from MHRA/NIHR with ABI backing would help clarify expectations on both sides and embed trial-related considerations into routine underwriting practice.

Why Now? And Why it Matters.

The UK, with its robust NIHR-supported infrastructure and global research partnerships, is uniquely positioned to lead reform. Clinical research is a strategic growth area for the UK which attracts international funding, supporting innovation and offering better outcomes for participants, who are often enrolled because they have the condition under study. As more emerging therapies are evaluated in trials, including preventive and disease-modifying interventions relevant to healthy ageing and long-term disease management, unnecessary barriers to participation risk undermining public trust in research.

When patients learn mid-trial that they cannot obtain travel insurance, the consequences ripple beyond individual inconvenience. It affects retention, increases the likelihood of protocol deviations and may discourage future engagement with research, including studies that underpin longevity medicine and other preventive disciplines. From the perspective of trial sponsors and clinicians, these barriers add avoidable complexity and cost to an already regulated environment.

Conclusion

By clarifying policy and collaborating across sectors, we can align insurance practice with modern trial realities. As research physicians, the authors urge the ABI, regulators and insurers to evolve standards so that trial participation is viewed through a precise, fair lens and not a one-size-fits-all warning label. Without this, one thing remains certain: if there were a barrel of instances where participants and the public lose the ability to benefit from legitimate trial participation because of outdated underwriting policies, we are yet to reach the bottom.

Declarations

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