MILLIMAN WHITE PAPER

UK private medical insurance in 2030 and beyond

Assessing the relevance and financial sustainability of the current proposition

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The UK private medical insurance market has undergone significant transformation over the last few years and seen a boost in covered lives since 2021. We examine some current trends and discuss our analysis demonstrating the fundamental challenges that remain around affordability.

Prior to early 2020, at the start of the worldwide COVID-19 pandemic, the individual UK private medical insurance (PMI) market had been shrinking in overall enrollment for many years, while the employer-paid market had been mostly static. In 2021, approximately 11%[1] of the UK population was covered by PMI, with significant concentration in London and the South East of England and in more affluent segments of the population. Circa three out of every four people with PMI have their premiums paid for by their employers, while the remainder pay their own premiums for individual (retail) policies. Post-COVID-19, the market has seen some topline growth with expansions in all segments, including retail, small and medium groups and large corporate. However, the numbers are still relatively small in terms of percentage of population covered by PMI. In addition, a substantial part of the increase in enrollment in the corporate sector has come from existing corporate PMI schemes broadening eligibility to a wider range of employees, rather than new corporates starting to offer PMI benefits.

In this paper, we examine key trends in the UK PMI market and offer thoughts on the direction of these trends. The purpose of this paper is to highlight considerations around the future strategic direction of the UK PMI market to help product and proposition development. We consider what these trends mean for the benefit design, customer service proposition and future affordability for both companies and individual/retail customers. We present the results of a series of interviews we carried out with experts in the industry to supplement our insights into the future direction of trends and drivers shaping the industry, as well as our affordability analysis. We conducted around circa 20 interviews with market stakeholders, including providers, established insurers and underwriters, technology providers and start-ups.

An important caveat is that our analysis assumes no fundamental change with the current National Health Service (NHS)/private payer structure of healthcare in the UK. Essentially, we assume that the NHS carries on in its' current form, as a tax-funded service available to the entire population, largely free at point of use, but without a clearly defined universal benefit package. Designing supplemental or complementary PMI products with mass market appeal is difficult under the existing system, as there is a limited designated role for privately funded healthcare within the current NHS infrastructure.

Trend 1: Extension of the PMI benefit package

While the apparent UK PMI benefit package and proposition have remained similar (typically faster access to elective surgery and diagnostics coverage in private facilities), the mix of claims seen by the industry has altered materially in the two decades leading up to COVID-19. Cancer claims, generally less than 1% of claims cost 20 years ago, have, in many portfolios, become increasingly significant, with increases in both the frequency and average cost of claims. In 2014, only 3% of cancer patients accounted for approximately one-third of claims costs[2] and earlier analysis showed that a significant proportion of these claims (approximately 75%) was directly due to the cancer treatment.[3] This is mainly due to the increasing availability of new and expensive specialty drugs, which have helped move cancer from a chronic condition, largely not covered by PMI insurers, to an "acute" condition.

In the wake of COVID-19, the claims cost mix has changed again, with materially higher mental health utilisation, higher frequencies of diagnostic services and significantly higher usage of what were once peripheral and scarcely used benefits, such as online and telephone general practitioner (GP) and counselling services. At the same time, well-documented NHS access problems[4] have driven a greater proportion of people to use their PMI coverage where perhaps once they would have accessed the NHS for health needs in the first instance. The increases in utilisation seem unlikely to keep accelerating at the recent elevated rates, but equally it seems unlikely that the level of claims for diagnostics, mental health and primary care services will fall back to pre-pandemic norms.

In discussing the potential future benefit packages with stakeholders, we identified several drivers for benefit package trends:

- Increasing lack of access to NHS primary care
- Increasing concern about lack of access to urgent/emergency care
- Urgent employer need to reassure employees of a "health solution" as a key employee retention tool, but also as a way to improve employee health and reduce the burden of sickness-related absence
- Concern about the large numbers of expensive drugs in the pipeline for cancer care and the inability of the NHS to reimburse them within the current budget envelope
- Increasing difficulty in maintaining the current scope of PMI as "acute and curable," given the potential for existing chronic diseases to become curable with new treatment advances
- Increasing customer demand for personalisation of benefit packages through more modular products, bespoke networks and customer-segment targeted propositions

Several of the drivers above imply an extension of the traditional PMI package, which in turn implies a higher cost for PMI over and above "normal" medical inflation—at least for the "average" person. Given challenges with affordability, we see a potential for more bespoke plans and a potential hollowing out of the middle types of claims—the fairly predictable surgical costs and diagnostics. A proposition that once relied on selling faster access to hospitals and nicer surroundings for routine operations may instead focus on all or some of the following elements:

- Fast access to primary care and associated services to keep customers well, including minor injuries/urgent care services, more customised and targeted wellness and disease management support.
- Advice on where to access routine elective surgical care and chronic diseases treatment at preferentially negotiated rates, but perhaps not covering the cost through insurance, or with a very high excess. Insurers would advise the customer on where to access care, the likely cost and how to finance the excess.
- Reimbursement and hence risk pooling of catastrophic costs such as cancer, high-cost cardiac and other events for customer peace of mind.

For a high proportion of individuals and insurers, covering all three elements will simply not be affordable and so plans may allow a mix and match approach, or just focus on one element.

Trend 2: PMI insurers become "risk-poolers" again

As noted above, large parts of PMI costs are now used to pay for cancer care. The historical view of PMI as a product that largely provides fast access to medium- and high-frequency diagnostic services and follow-on curative surgery has not held in the current environment, given the increasing proportion of the premium that goes towards claims with average costs that would have been viewed as severe outliers 15 to 20 years ago. Life-extending and life-saving treatments for cancer that run at £10,000 to £20,000 a month for many months or years are not unusual now. While most of the insurers we spoke to have not seen the flood of chimeric antigen receptor T-cell (CAR-T) therapy claims they initially feared, the era of the £1 million PMI claim is surely upon us already.

On the one hand, this may be good news for insurers. Paying for one-off catastrophic events that need large risk pools to spread the cost, is, after all, a core competency and their raison d'etre. It is easy to demonstrate customer value for risk-pooling, but harder to justify administrative margins for processing low-value claims, or for aggregating claims and using purchasing power volumes to push prices down at hospitals as a way of creating customer value.

On the other hand…

1. Even a small increase in the number of large claims has a material impact on medical inflation and, as more and more expensive drugs and treatments get released, this impact will accelerate. The pipeline for cancer drugs is significant, and curative treatments for chronic diseases are in sight, which raise significant affordability challenges.
2. The increasing trend towards personalisation of premiums that reflect risk factors more precisely undermines the risk-pooling role of the insurance industry but seems inevitable in a competitive market (absent regulation to limit the rating factors and underwriting processes that can be used by the market).

One solution may be the final emergence of high-deductible coverage—often discussed, but never a mass market product in the UK and now only offered by a limited number of insurers. This would have the benefit of providing primary care access through insurer-provided services, leaving the patient or employer to fund low-cost diagnostic and elective surgical interventions and the insurer to fund catastrophic care. Essentially this extends the existing Healthcare Trust[5] model with stop-loss for employers, making it available to smaller groups and individuals. An individual/retail equivalent could be accelerated through a health savings account (HSA) or similar strategy, but that seems unlikely given the current political sentiment.

Trend 3: The traditional NHS gatekeeper model is moribund

The historical business model of PMI insurers, where the NHS GP acts as a gatekeeper for PMI claims, worked reasonably well when NHS GPs were not under pressure and the proportion of the population with PMI stayed relatively small and static. Now it is difficult for many to even access their NHS GP, but comparatively easy to call an online GP private service. Insurers have embraced the concept of moving their "add-on" GP phone services to centre stage on the premise that controlling the start of the pathway is an opportunity to steer PMI customers towards preferred and more efficient providers and hence save secondary care costs. The opening up of the supply of private GP services via virtual access has allowed insurers to offer direct access to primary care and associated services, including physio and mental health services—and customers appear to have welcomed this wholeheartedly.

The first issue for insurers is that all are using third-party private GP services paid on a fee-for-service (FFS) or capitated basis. Most of these services do not have sufficient incentive to not refer customers onto secondary care. Therefore, while the pathways might be less costly when initiated, if more secondary care pathways are initiated, then the overall cost could be higher. We do not see this trend unwinding. PMI customers have shown they value this highly convenient primary care access and are unlikely to move back to NHS primary care for most things, even if NHS access improves. We can expect more remote care, extending into chronic disease management, wellness and an even bigger role for mental health outpatient treatment and hence more pressure on medical inflation and premiums.

The second issue for insurers is that, under this trend, they are acting as aggregators of third-party services. While, in this capacity, they are able to bring new and desirable services to their customers, it is difficult for them to add material value that offsets the added overhead and integration costs. Furthermore, third-party services are often difficult to integrate into existing PMI offerings, which can lead to poor customer experiences and failure to fully take advantage of the enhanced services. Insurers will increasingly be concerned about their dependence on third-party suppliers for key parts of the value chain and will seek closer integration with primary care—perhaps directly employing their own GPs and primary care professionals. However, it is a race to see who gets to the customer first (see Trend 4).

Trend 4: Payers should expect increasing competition from hospital and other care providers

We have increasingly seen providers move into the payer space by launching their own financing products for customers who want to self-pay and offering subscription packages for access to care. These are still niche pursuits for providers and, while providers might like to cut insurers out of the chain, our prediction is that these provider-supplied products are unlikely to become mainstream. The traditional PMI insurer is likely to still dominate the medical insurance market for the foreseeable future—for several reasons:

A) Product distribution (access to customers) will always be important. While product design, pricing, customer experience and quality of care are important, you cannot deliver on these differentiators if you cannot reach the customer.

B) Referring to Trend 2, (where PMI insurers become risk poolers), customers will still need catastrophe protection against cancer and other large claims, which they get from PMI.

C) Employers will still be a dominant player in the market and, while they can theoretically deal directly with the local hospital if they have a concentration of employees in one location, most have distributed workforces and will not want a very narrow network product that reduces employee choice or convenience.

D) Providers often overlook the fact that the administrative side of managing claims and enrollment requires specialist skills and continues to evolve, with significant investment in digitisation (see Trend 5 below) to both manage providers and enhance the customer experience.

E) Unless there is significant expansion in the market, the private provider landscape will still be limited in scope — both in services and geographically.

F) Finally, it is a fundamental precept of healthcare financing that insurers and providers have different financial incentives that are difficult to align. Providers talk about value-based care, but struggle with understanding and managing insurance risk.

For the market to evolve, collaboration between insurers and providers is paramount. Most of the stakeholders we talked to expressed a fervent wish for better coordination and integration between providers and insurers, and for using technology and data to create more alignment in the focus on customer proposition (both quality of care and customer service). While value-based care has been on the agenda of conferences for many years, progress in the UK private sector has been slow, largely limited by lack of data sharing, lack of investment, poor incentives to change business models and lack of clear leadership to drive change.

Trend 5: Digitisation and technology are promising

It has long been documented[6] that healthcare ecosystems are slow adopters for new technology, both on the provider and payer sides. While medical insurers were putting "Amazon" disrupter selective lapsing scenarios into their stress testing capital scenarios a few years ago and predicting the end of risk-pooling, in reality the impact of technology has been slow and steady, rather than "big bang." Despite heavy investment, many insurers are still stuck in digital "transformation" programmes, trying to decommission legacy systems at the same time as promoting digital start-ups and apps within an inflexible systems framework.

On the insurance side, health insurers have tended to be even more conservative than other lines of general insurance in adopting technology for business transformation. Apps abound, but the overall customer experience and provider integration are too often clunky. Partly that just reflects the complexity of healthcare, which has confounded many a tech start-up that have tried (and failed) to bring simplicity to the market.

The current wave of generative artificial intelligence (AI) seems to hold more promise to transform the customer experience in both the insurer and provider/delivery contexts. However, a significant portion of healthcare customers expect a face-to-face in-person experience at what is often a highly traumatic and stressful time. While we do expect potentially significant reductions in administrative staff for insurers, it is less sure that there will be material reductions of staff for providers. A significant limitation for digital adoption on the provider side has been the disaggregated nature of the specialist supply. While that is changing with changes in the staffing model, such as the introduction of the consultant salaried employment model and more specialists being employed by the large virtual GP operators, progress is still slow. However, we see opportunities in the following:

1. For insurers: Efficiencies in back-office administrative work (legal, compliance, actuarial, finance, claims management), customer service digital propositions, digital broker and provider interaction. Part of the customer service propositions will be an acceleration of the current trend for using technology to support wellness and prevention programmes in much more streamlined ways than currently, where customers have to deal with multiple, disaggregated apps and interfaces.
2. For providers: Some efficiencies in the delivery of medical care, due to standardisation of decision-making and protocols that seek to eliminate variation, back-office administrative streamlining and better patient-management and booking systems.

The answer to the question of whether technology will result in decreased costs for delivering healthcare is a mixed bag. History would suggest that any efficiencies are more than outweighed by the increasing numbers of new treatments that are enabled by technology. Generally long-term estimates of medical trend estimate an additional one to two percentage points of inflation to allow for new technologies and medicines.[7] It seems plausible that technology will allow the ever-faster development of new drugs and medicines to treat illnesses that are currently untreatable, therefore increasing costs overall, even if technology will drastically reduce the cost of delivering existing treatments.

One outstanding question is the impact of technology on the broker/intermediary market. In the history of insurance, the demise of the intermediary and the consequent cost saving has been wrongly predicted many times. But in a world where a customer can ask a large language model (LLM) for the "best medical insurance to meet the needs of my employees,"[8] is there a significant broker role? The answer seems to be "it depends," at least for now.

It is hard to predict what digitisation and technology will look like in 2025, let alone further out, but it seems likely that it will have a significant impact both on the way healthcare is delivered and the way insurers manage their funding role for customers. Customers will expect much slicker interfaces between employers, patients, providers, brokers and insurers, but a material reduction in insurers' expense ratios or providers' costs seems unlikely.

Trend 6: Move to net zero

Trends related to climate change are moving from the medium/long term to the near term. Whereas last year we considered climate change to be on the emerging risks radar, this year the risks appear more near-term.

Amongst the stakeholders we talked to, there was a recognition that a significant impetus existed for change on the provider side. However, insurers seem slow to move from "emerging risk climate modelling" mode to "implementation model." We do believe, however, that we will start to see transformational products and benefits that both support patients through adaptation to physical changes in the environment and reassure customers that insurer's supply chain management is focused on providers that are firmly committed to carbon reduction. Insurers, like other service firms,[9] tend to have a relatively light carbon footprint compared with other industries, but delivery of their emission reduction targets is going to require taking more proactive approaches over supply chains and working with providers to understand how to develop more environmentally friendly propositions.

The broader wholesale macroeconomic disruption envisaged by some climate scenarios is also worth commenting on. To the extent that a poorly managed transition to net zero implies a significant reduction in economic growth, the affordability of PMI will be a drag on market growth. However, if the private insurance and provider sector can prove their green credentials[10] over a slow-moving NHS public sector, there is an opportunity to broaden the appearance of the private hospital sector more generally.

What do these trends mean for medical inflation and affordability?

UNDERSTANDING MEDICAL INFLATION

Of the trends talked about above, several affect affordability, as measured by the proportion of available/disposable income to purchase private medical coverage. The table in Figure 1 sets out the trends and our comments on the potential effect on medical inflation and affordability.

FIGURE 1: IMPACT OF TREND ON MEDICAL INFLATION AND AFFORDABILITY

TREND	MEDICAL INFLATION	AFFORDABILITY
Broadening benefit coverage	Increase	Decrease
PMI insurers become risk-poolers	Depends on extent of coverage.	Depends on extent of coverage, but high-deductible plans can increase affordability. However, without regulation, increasing numbers of higher-risk people may be excluded from the market.
No NHS gatekeeper	Neutral or increase unless private GPs can control onwards utilisation and insurers have better management of GPs.	Decrease, as insured customers pay twice for primary care (once for NHS and once for private), although potentially some offset if better pathway steerage.
Hospital providers become payers	Increase as limited incentive to manage costs for providers.	Decrease unless providers can operate at reduced administrative margins and control provider inflation better.
Digitisation and technology	May increase provider costs, but may decrease administrative costs.	Potentially lower distribution and servicing costs and more scalable low-cost solutions.
Transition to net zero	Increase due to scale of investment required in the short to medium term.	Large scale macroeconomic disruption likely to impact disposable incomes and employer margins.

Medical inflation is problematic to measure accurately, but historically portfolios have experienced rates of claims cost inflation which are several percentage points higher than the consumer price index (CPI) or retail price index (RPI)[11] and, critically, higher than wage growth, leading to decreasing affordability for both employers and individuals.

Medical inflation rates are a mix of increases in utilisation as more and better treatments become available and unit cost increases. In some portfolios, they are exacerbated by selective lapsing, whereby healthier risks are less likely to renew their coverage, leaving less healthy risks in the portfolio. In addition, individual portfolios, where preexisting conditions are excluded from coverage for a time, encounter worsening claims experience as the effects of that initial medical underwriting decline over time.

The concept of medical inflation is therefore difficult to grasp for the health insurance market as a whole, as it tends to vary materially at a portfolio level, particularly the utilisation element. At a micro level, when considering unit costs for treatment, it is worth remembering that ultimately provider inflation depends largely on medical wage inflation (which in turn in the UK is closely linked with NHS pay awards) and other input costs, such as energy, rent, utilities and equipment. Without a significant increase in productivity of the people, building efficiency and/or equipment, the unit cost of a treatment is unlikely to increase at a rate below wage inflation over the medium term. Understanding these provider-side dynamics is critical for insurers, but too often they rely on negotiated index-related provisions in contracts to estimate future costs.

To understand the affordability point in more detail, we modelled current claims costs and future claims costs for a typical PMI plan to 2030. We analysed the impact of different trends for different services on overall medical inflation—specifically to look at the impact of higher costs for services such as cancer claims and new drugs and technologies. We then compared our overall projections of claims costs and premiums to disposable incomes at different parts of the income distribution to determine how affordability has changed over time and how it might change in the future. We used Milliman UK's Health Cost Guidelines™[12] (HCGs) to estimate current and future claims costs and converted these costs to premiums using an assumed average ratio of 65% of claims or retail premiums to convert claims into retail premiums (including insurance premium tax).

Figure 2 summarises the calendar year (CY) 2023 medical premium costs, assuming a 65% loss ratio on a per member per month (PMPM) basis relative to the average monthly disposable incomes[13] for residents in the United Kingdom. Historically, most individuals covered in the private insurance market have been among the top wage earners in the country. As a result, we have chosen to split the figure into two scenarios that compare the top 15% and bottom 85% of wage earners in Scenario 1 and the top 30% and bottom 70% of wage earners in Scenario 2.

FIGURE 2: CY 2023 PMI MEDICAL PREMIUM COSTS AND MONTHLY DISPOSABLE INCOME

	SCENARIO 1 (IN £)		SCENARIO 2 (IN £)	
FINANCIAL ITEM	**TOP 15%**	**BOTTOM 85%**	**TOP 30%**	**BOTTOM 70%**
Premium Cost	198	198	198	198
Monthly Income	2,597	1,160	2,231	1,010

Note: PMI medical costs assumed constant across income levels.

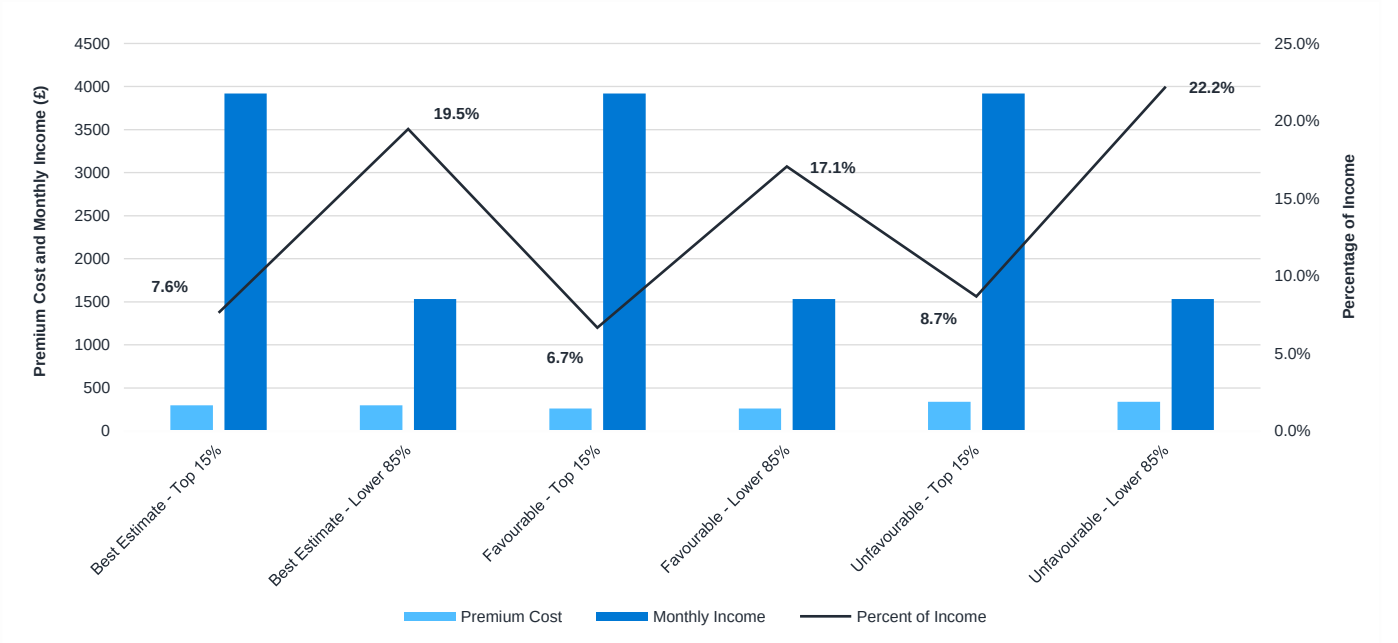
Please note that income data was obtained from the Office of National Statistics and reflects the post-tax income for a single resident in a household consisting of two equal earning individuals.

Unsurprisingly, there is a significant difference in affordability when comparing the top earners in each scenario to the remaining percentage of the population. In general, top earners are assumed to spend anywhere between 7% to 9% of their monthly disposable income on private insurance compared to the approximately 17% to 20% of income that people with disposable incomes below the top 15% or top 30% would need to find. These are average proportions of income — we note that, in reality, PMI premiums are also related to geography, prior health claims or health status and several other rating factors.

There is not a significant difference in terms of PMI insurance affordability when comparing the top 15% and the top 30% of residents as proxy individuals most representative of our traditional PMI beneficiaries. For this reason, all other figures in this section will focus specifically on the affordability differences between the top 15% and the bottom 85% of wage earners illustrated in Scenario 1 of Figure 2.

Figure 3 shows the CY 2030 medical premium cost under three different annual inflation scenarios and compares these premiums to the projected monthly disposable income for individuals in the top 15% and bottom 85% of earners in the United Kingdom during the same year.

FIGURE 3: CY 2030 PMI MEDICAL PREMIUM COSTS AS PERCENTAGE OF MONTHLY DISPOSABLE INCOME FOR TOP 15% AND LOWER 85%



Note: Medical inflation scenarios reflect a +/- 2% change to annual best estimate trends.

We made the following assumptions when projecting the future medical premium costs and disposable income between 2023 and 2030:

1. The tax burden distribution does not change during the projections period.
2. The projected annual wage inflation relies on composite estimates from the Office of National Statistics through March 2025. Thereafter, we assumed the annual wage inflation would remain constant at 4% for the entire population based on our review of historical wage trends and its relationship with the CPI and RPI over time.
3. The expected annual wage inflation for the top 15% of wage earners is assumed to be 150% of all other residents in the United Kingdom. This assumption represents disparities observed over the last 10 years, with additional weight assigned to the most recent five-year span. This effectively assumes a continuation of the recent trends with widening income distribution over time.
4. The estimated premium costs are calculated using a 65% medical claims loss ratio in CY 2023 and CY 2030.

Based on our best estimate for the annualised medical inflation rate through 2030, Figure 3 indicates that PMI policies will remain equally affordable in the medium term for the top 15% of earners in the United Kingdom. Specifically, we would expect individuals in the top 15% to pay anywhere from 6.7% to 8.7% of their monthly disposable income towards PMI policies in 2030. Even though we forecast higher medical inflation than CPI due to many of the trends we discuss earlier in this paper, the additional wage growth among higher earners means that PMI does not get less affordable overall. That is without any significant expansion in benefits to cover more primary care and emergency costs.

However, PMI costs will become even more unaffordable for lower-income populations, largely due to medical inflation outstripping wage inflation and widening income disparities. This suggests that individual/retail PMI in its current form is unlikely to become mainstream and will need significant benefit redesign and the introduction of lower-cost options for a wholesale expansion of lives covered in the market.

For corporate payers, the picture is more nuanced. PMI benefit coverage has not historically been a huge area of spending relative to other employer benefits, such as pensions. However, pressure on employers to discharge their duty of care for employees will likely lead to a wide range of low-cost options to fulfil this responsibility. Employers with high-income/high-earning populations and difficulty in attracting specialist skills may have to increase their benefit spend on PMI materially over the next few years.

In the modelling, we also looked at the proportion of cancer claims as a total of overall claims costs by 2030. If cancer claims continue on current trends, we estimate they will make up over 30% of claims costs (compared with 20% to 25%) in the future for a comprehensive plan. This illustrates the pressure of new medicines and technologies on premiums, but also highlights the increasing challenge the NHS has to keep pace with new technologies for an ever-aging population.

Conclusions

The PMI market in the UK has undergone substantial change over the last few years—some trends predate COVID-19, but were accelerated by the pandemic, while others were a direct result of COVID-19. The opening up of the private provider supply that has been made possible by virtual medicine is significant and leads to several interesting innovations that have fundamentally changed and will continue to change the market. The advent of generative AI and digitisation initiatives will change both the way healthcare is delivered and the way that insurers interact with customers, brokers and suppliers, but opportunities for cost reduction will likely be limited.

Many of the trends suggest that the UK health system will look much more like a “two-tier” system in future, where higher-income populations get the vast majority of their care from private providers and have limited contact with the NHS, rather than the “mix and match” model that existed before COVID-19, where even high earners would still expect to have much of their health system interaction within the NHS. That suggests that, while the population covered may remain relatively static, there are significant topline opportunities for health insurers to broaden the range of services they sell to their existing customer base and opportunities for private providers to expand. Given the proportion and cost of cancer claims in the future, it also suggests a potential widening of the availability of cancer and other serious disease coverage between the richest and the poorest.

We do not see medical insurance being largely replaced by subscription and other models offered by private providers, given their limited distribution capabilities and operational challenges. Insurers will continue to provide a useful function of risk-pooling for catastrophic costs, providing administrative services and managing claims spend on behalf of employers and individuals. However, there is a caveat—insurers’ moves towards personalisation and smaller and smaller risk pools risks undermining their own business models and usefulness for customers. If that personalisation journey goes too far and insurers attract significant regulation around pricing, then the market outlook could change fundamentally. Already there are UK discussions about the European “Right to be Forgotten” legislation,[14] which, if implemented in the UK market, would prohibit insurers from using any prior cancer treatment in pricing and underwriting decisions.

Medical inflation is likely to remain elevated above CPI, driven by higher provider costs, new treatments and medicines and the transitional costs of carbon reduction, but less likely to outstrip the buying power of high-earning households, which is positive news for insurers with existing blocks of business. However, it is hard to see a huge expansion in the population covered, despite the pressure on the NHS easing in the short to medium term. Insurers will need to be creative in offering lower-cost propositions to both corporate and individual markets, rather than a one-size-fits-all tiered set of PMI benefits.

Finally, climate change impacts are likely to be profound across the entire economy but are only just now starting to be understood. We expect to see commitments from insurers and providers that will change the way they interact and measure the success of contracts and perhaps change the product and proposition landscape in the long term.

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