



HOUSE OF LORDS

Select Committee on the European Union

Home Affairs Sub-Committee

Corrected oral evidence Brexit: Reciprocal Healthcare

Wednesday 25 October 2017

11.20 am

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Members present: Lord Jay of Ewelme (The Chairman); Lord Condon; Lord Crisp; Lord Kirkhope of Harrogate; Baroness Pinnock; Lord Ribeiro; Lord Soley.

Evidence Session No. 8

Heard in Public

Questions 60 - 67

Witnesses

I: Hugh Savill, Director of Regulation, Association of British Insurers; Stuart Scullion, Executive Chairman, Association of Medical Insurers and Intermediaries.

Examination of witnesses

Hugh Savill and Stuart Scullion.

Q60 **The Chairman:** Good morning to you both. We are grateful to you for coming to give evidence to us today. The evidence we have taken so far in our inquiry has moved from time to time quite swiftly towards the importance of insurance and the implications for individuals and for insurers of Brexit or our leaving the EU, so we are grateful to you for coming to give evidence to us. This is a public session, so it will be transcribed, and we will send you a transcription of the evidence for your correction. To start with, could you introduce yourselves and the organisations to which you belong so that we can be clear as to what your various responsibilities are?

Hugh Savill: Thank you. My name is Hugh Savill and I am director of regulation at the Association of British Insurers. We represent most of the insurance market in the UK, whether that is life insurance, non-life insurance, catastrophe insurance—we try to cover the waterfront. I think it is fair to say that I am mainly here to talk about travel insurance today. We have tried to divide things between us.

Stuart Scullion: My name is Stuart Scullion. I am the executive chairman of the Association of Medical Insurers and Intermediaries. We are a membership organisation with about 130 members, of which approximately 15 are what we would describe as corporate members. That means that they are either insurers, predominantly in the domestic UK healthcare market with some exposure to international healthcare, and/or cash plan providers who provide some primary care services that can be claimed for while people travel abroad. I am almost the exact opposite of Hugh as my expertise is not in the travel insurance sector, so it will be clear where our answers will come from.

Q61 **The Chairman:** Good; you will complement each other well. I will reverse the first couple of questions of which we gave you notice. Can you give us an overview of the travel insurance and private medical insurance industry in the UK? It would be very helpful, for example, if you could tell us how many UK travellers take out travel insurance each year or how many EU citizens in the UK have private medical insurance. Is any further breakdown of data available—for example, by age, destination, and so on? It would be helpful to have just an overview of the insurance scene before we move on to more detailed questions.

Hugh Savill: I will start with travel insurance. There are basically two kinds of travel insurance: single-trip insurance and multitravel insurance. The latter is an annual policy that covers all your travel for a particular year. We believe that travel insurance will be impacted if the current EHIC arrangements are not continued. Travel insurance covers you for the cost of medical treatment that is not covered by the EHIC card—so, if you like, the residual costs of medical treatment. Logically, if the EHIC card arrangements go, travel insurance will have to absorb the medical costs which are currently covered by the EHIC card.

On the numbers, last year 13.2 million travel insurance policies were written; 2.7 million were single-trip and 10.4 million were multitrIP policies, so the multitrIP policies are far more common and more popular. Those gave rise to claims totalling £369 million. Most of those claims are medical costs and the costs of repatriation. People often think of travel insurance as something that pays when your baggage gets lost or if you miss a flight. Sometimes that depends on the policy you have. But easily the highest cost of travel insurance is medical costs.

If the EHIC arrangements are not continued, the estimated medical costs associated with the treatment of British citizens under the EHIC at the moment is £156 million. So total claims for travel insurers currently are worth £369 million and additional claims under EHIC are worth £156 million. That is just to give you an idea of the magnitude in the travel market of this change.

The Chairman: Does that mean that premiums would go up by about that amount—that is, 50%?

Hugh Savill: It is very difficult to tell. First, insurers will decide on their own prices—they will not do what I say. Secondly, it depends on the behaviour of those who have taken out insurance with you. They may be different. You may be targeting yourself at the ski market, or whatever, and there will be different conditions. But overall, with our finger in the air, we guess that it will be an increase of between 10% and 20%. I have a whole lot more stats about travel insurance which, if you are interested in them, we can send you afterwards. But I will leave it at that point.

The Chairman: I think it would be extremely helpful to have further statistics sent to us afterwards. We will see how many we wrest out of you during the rest of the hearing, but it would be helpful to have that as part of our evidence. Thank you.

Stuart Scullion: On the UK private medical insurance market—I refer here to recent statistics produced by an organisation called LaingBuisson, which is an industry analyst and which tends to do the most comprehensive review—unfortunately, there is not a distinction between what you would consider to be UK domestic private medical insurance and international private medical insurance. Therefore I cannot split the numbers in that way for you. The total market is believed to be about 6.89 million lives, which is just over 4 million policies, and it would provide cover to about 10.5% of the UK population. The market value is about £4.83 billion, of which about 3 million policies and about 5.5 million lives are included within company private medical insurance, some of which will include cover for people who are here through their employment but are actually from another EU country. Consumer private medical insurance runs at just under 1 million policies—about 928,000 policies—and covers about 1.47 million lives, which represents about 2.2% of the population.

There is another element in the UK, which is the self-pay market. These are individuals. Where they are UK residents and originate from the

United Kingdom they will typically be people who are beyond the age of retirement. However, we see people coming from not only the UK but the Arab emirate countries and in the Middle East for the self-pay market, which, typically using London-based hospitals, is currently running at about a 10% increase per annum, which is significantly greater than growth in the PMI market.

I can give you some numbers. There is a relatively short period of time in which to capture and gather information, and unfortunately, I do not have consolidated data. However, I have some specific data from one of the international PMI providers, called Aetna. Its UK market share is something approaching 20%, so it would be fairly reflective of that market. It believes that of Britons living in continental Europe, 65% of them are in company-sponsored schemes, so they are there for their employment, and those policies would include cover for themselves and their immediate families.

Of the individuals living in the EU who are covered by private medical insurance, they are definitely on the increase—or until this point they have been on the increase. As regards Aetna's own information, about 50% of those people are over the age of 50 and about 32% are over the age of 65 and have probably chosen to retire abroad, so they would be directly affected by the detail of your inquiry.

It is very much driven by how popular the destination is for them to retire into, because as we all know, they are likely to want to go somewhere warm and quite sociable. I cannot put numbers on the claim-spend for those people, but because it is an ageing population, their propensity to claim and the nature of those claims becomes increasingly more serious the older they get—which is the same for the UK population.

I will give you some brief numbers to try to give you a comparison of EU nationals who live in the UK, so a comparison against those numbers. The number is also on the rise but its profile is significantly different to the one I have described to you. About 85% of them are company sponsored, therefore by definition they do not choose to come here to retire but for some form of work employment.

Only about 15% of them would be considered to be conscious individuals—so they buy the cover in the UK for the duration of the period they are here. The profile of those people covered under that overall figure is much younger, therefore their utilisation of both in-patient treatment and, by definition, probably the burden—if that is the right word—that they would place on the NHS, is significantly reduced. Only about 11% of them are over the age of 50. I hope that will be useful.

The Chairman: That is very helpful. If there are other figures that you have not given to us but which you could let us have and think would be useful to our inquiry, that would be helpful too.

Q62 Lord Soley: To some extent you have answered the question I was going to ask about the insurance products that your members are offered which

are most likely to be affected. I will put that to one side for a moment and pick up something that the director-general of the ABI said at the Brexit conference. I am looking at his press release, and it follows very much from what you have just been saying. He is looking at what he clearly thinks are the dramatic effects of leaving the single market when he says that there is a risk that insurers may, "lose their licence to do insurance in the customer's jurisdiction, and therefore cannot legally fulfil the contracts". He goes on to say: "This could mean that cross-border pension payments" in both directions "cannot be paid". That is a pretty dire prospect. Can you tell us any more about that?

Hugh Savill: Those are pensions rather than travel or health insurance. None the less, the issue is about insurance contracts signed and agreed some time before we leave the European Union. In the case of a pensions contract, it may have been running for a good 10 years. That is currently legal because of the passporting arrangements in Solvency II. When we leave the European Union, those passporting arrangements fall unless the Government manage to negotiate some other kind of access. Therefore, some insurers will lose the authorisation to do insurance in the country where their current customers live. Yes, pensioners is one, probably the most worrying, example; we may not be able to pay the pensions. We would very much like to pay the pensions; it does not look very good for us at all if we cannot. But if it is illegal to do so, we face a significant dilemma. That is why we have asked the Government to negotiate in the withdrawal agreement a two-way agreement with our former European partners so that those who have European contracts in the UK and those on the continent who have UK contracts should be allowed to run those off in the normal way.

Lord Soley: This is an important area. Can we be clear about this? Presumably, the position of the ABI—and I presume that the Association of Medical Insurers and Intermediaries will agree with this too; tell me if you do not—is that you would prefer to remain in the single market, because then you would not have to worry about the legal reliability of the contracts. However, failing that, would you want a Government-to-Government agreement or a Government-to-EU agreement?

Hugh Savill: Government to EU, otherwise we end up having to agree 27 separate arrangements, which would be no fun at all, and I do not think they would want to do that. They would vastly prefer to work through the existing EU machinery.

Lord Soley: I do not want to lead you too far off the track of what the committee is focused on, which is reciprocal healthcare. However, it strikes me from reading that press release and what Mr Evans was saying at your conference that it has enormous implications if you do not get some sort of agreement for investment in general given that insurance and pension funds are so profoundly important to investments across the board, economically. Is that right?

Hugh Savill: Yes, I think so. The risk is of disruption. The existing arrangements that we have used to do business in Europe, and that

European insurers have used to do business here, may no longer continue. Indeed, trying to negotiate new arrangements under WTO rules is quite complicated. That is why a transitional period is very important. A two-year transition allows us time to pick up all these loose ends that we have not yet thought of and sort them out. But yes, the risk is of disruption. In a way, the impact on insurers is not what worries me. I am worried by the impact on some of our customers, who may not be able to understand what is happening.

Lord Soley: Do you agree with that, Mr Scullion?

Stuart Scullion: Yes, I do. I endorse what Hugh said. We would have a preference to continue with the single market within the financial services sector. In the event that we have to negotiate separately we would prefer to negotiate an agreement with the 27 EU countries for the reasons Hugh has articulated—it would be much easier to reach agreement. There is certainly talk in our association and our insurer member firms about the need for our financial services business generally to stay very much in line and akin with their European counterparts. As we know, the City is a massive financial services sector creator of revenue. One of our members is AXA PPP, which is the healthcare provider for both UK domestic and international, but part of the much wider AXA Group. They are obviously looking at and following very closely whether there will be a suggestion of our not being able to continue to transact business in that way through some form of legal change as distinct from an appetite change.

Lord Soley: I have a brief question, if I may. Just to be clear, are you talking as organisations to equivalent organisations in the EU or are you not involved in anything like that?

Hugh Savill: Yes, definitely. We are members of a body called Insurance Europe, which is a federation of insurance associations from all member states of the European Union as well as European countries that are not members of the European Union. There are very regular committee meetings and we also go on bilateral visits to our sister bodies in France, Germany and Spain, and so on. So that is a closely knit way that industry co-operates on regulatory matters.

Lord Soley: Presumably they are concerned about this too, or perhaps they are thinking about this as a good opportunity to snuffle up a bit of work. Is that right?

Hugh Savill: I think that it is fair to say that we are more obsessed with Brexit than they are, and there are good reasons for that. We find that they are a bit behind. For instance, on this contract continuity issue, we said that we were worried about it nine months ago. About three months ago, we got an agreed paper with them because they realised that they had a problem too.

Q63 **Baroness Pinnock:** On rising travel insurance costs, you have helpfully already given us some statistics about what you expect the changes to be if we do not sign off a deal which includes EHIC-type arrangements. Can

you expand a bit on what you said earlier? If my memory serves me right, you said that £156 million of medical costs are currently covered by EHIC and £169 million by insurance. You estimated between 10% and 20% as an increase in costs of insurance cover. If there is no EHIC, the insurance sector will undoubtedly target different holiday or working arrangements for different policies. Let us take something popular like skiing. What would happen to people who were seeking a policy for skiing—a riskier sort of holiday?

Hugh Savill: It is already more expensive to buy travel insurance because the costs of being airlifted off the mountain—which is what has to happen to you—are significant. If you look at the figures of claims costs per country, strangely, they are highest in Switzerland, France and Austria. So there is a concentration of costs in this area. That said, the answer is that it depends, both on your age and on the health system of the country you are going to. The Austrian health system is very different from the French system, and the EHIC card covers more in some countries than in others. It covers the cost of public treatment. Some countries have almost entirely public treatment, while others have a greater tradition of private care. Therefore it depends where you are going and how likely you are to claim. In the case of skiing, your age matters; for the rest of travel insurance, age also matters, but the other way round: older people are usually more liable to claim and therefore may face a proportionate share of this increase.

Baroness Pinnock: You cannot put your finger in the air and give us a broad-brush indication of how these figures might change.

Hugh Savill: No, it is too early to tell at the moment. The figure I have plucked out of the air of 10% to 20% across the board is plucked out of the air already.

Baroness Pinnock: So all we know is that there will be significant increases.

Hugh Savill: There will be an increase, but it may not happen immediately. If you consider that most travel insurance is bought on price comparison websites, you do not sell much travel insurance unless you are on the front page. Therefore people will be reluctant to put the full cost upfront, and you will see a number of commercial judgments taken about how long they can keep themselves on the front page, knowing that they are likely perhaps to have to absorb some additional cost.

We also need to think about how it is not just a matter of how you underwrite and how you set the price. We need a whole apparatus for handling the claims in the countries. The biggest task that lies ahead for travel insurers is setting up these claims-handling facilities and expanding them to deal with the greater demand.

Stuart Scullion: I can think of another thing in that travel area. I have done some consultancy work for a travel intermediary which is also a

travel insurer. As Hugh has suggested, it is all about newspaper and magazine advertising; that is how it attracts people to come to it in the first instance. Typically, it has a separate underwriter sat behind it—someone who is underwriting the risk—and many of them will also have a separate assistance company sat behind them which will negotiate treatment costs in specific countries, have repatriation arrangements, and in some instances emergency repatriation. Although your question was to do with skiing, in my experience, skiing has been the lesser part of the problem. It tends to be older lives who are taken ill, who have either fallen and broken something, have some form of respiratory problem or a heart attack or stroke. Those are all very expensive things to treat abroad, because the natural thing for the person is that they want to be repatriated back to the UK, and in many instances that will be a single flight—they will be a sole occupant—and the cost of that is enormous.

Hugh Savill: The thing about skiing is that it is expensive, but the systems are very well understood and well set up. I will make one final point on the lead times. As I said, quite a lot of these travel insurance policies are annual policies. That means that we need to start thinking about how we take into account these extra costs and set up these facilities from March 2018, in a few months' time. By April, we will be selling policies that will still be in force after we have left the European Union. So our big ask for government is, "Please can we know whether the EHIC card arrangements will continue, ideally by February"—although we might just about manage March. Any later and it gets quite difficult to price.

Q64 **Lord Ribeiro:** The whole thread of this is about the EHIC card, because it gives you access to urgent and emergency care. That clearly has to be one of the things that is negotiated. However, how might non-resident EU 27 citizens who visit the UK, and EU 27 citizens in the UK who have S1 status—social care, pensions, and so on—access healthcare post Brexit?

Stuart Scullion: They will typically have to buy some form of private medical insurance. There is quite a significant distinction within the private medical insurance market in that UK domestic PMI is typically for secondary treatment, so it does not per se include primary care services. However, to give themselves a competitive advantage, some domestic providers now include online and private GP facilities. You can buy options to include optical and dental, but obviously at an additional cost. So they are benefit-rich policies.

If you look at international private medical insurance, typically it would include at least an element of that primary care service, and if you buy policies at the more comprehensive end, it is likely to go as far as including maternity cover, for example. However, that is extremely expensive if you have a policy which is that benefit-rich. They will therefore have to make some form of provision. I am not suggesting that it would be absolutely in line with the US system, whereby if you are taken to hospital they ask you, "Can we have your credit card and/or the

details of your medical insurance provider?”. However, there is definitely a concern that it will move in that direction, and quite significantly.

Lord Ribeiro: But currently, someone from the EU, even someone from overseas, can see a GP or be seen in A&E without co-paying. In the UK scenario there is an awful lot patients can get, which they will not have if they were in the European Union seeking to get it. So it is about cover for elective care rather than emergency care.

Stuart Scullion: Indeed. In the statistics I gave you which related to Aetna’s individual portfolio you can see that the number of UK citizens who are in Europe and resident under an S1 status is significantly greater than the equivalent in the other direction. So it would affect UK citizens quite significantly.

Hugh Savill: It is worth saying that until we know what the Government have negotiated to replace S1 and S2, it is quite difficult to know what the role of the private sector is. Once we know that, we will step up to the plate. But that has to come first.

Lord Ribeiro: Can you outline the various models of contingency which your members are planning for this inevitable situation, should it happen?

Stuart Scullion: I think that Hugh’s statement there is almost the definition of that. They are working in the background on the what-ifs and are looking at how they may address that situation, but they really need a steer from government and part of the Brexit negotiations. If we end up with an agreement over the single market and over a similar financial services model to the one we have now, and EHIC or its equivalent stays in place, I would not see the market fundamentally altering. But if you take EHIC out of it, part of that could be considered to be an opportunity, because more people will have to buy private medical insurance. I think it will become more costly, because while people who go to Europe at the moment and have a minor injury are likely to have it treated and dealt with under EHIC, in a scenario where that does not apply it would put additional strain on the private sector, because it would then be picking up the cost of all of it. With regard to creating benefits and features of policies, you would see more of them, with more detailed primary care benefits to compensate for the loss and lack of an EHIC or equivalent.

Hugh Savill: The basis of the contingency planning is quite simple. It is EHIC or no EHIC. We are not modelling different relations with the European Union; we are just looking at those two basic scenarios. As I was outlining to Baroness Pinnock, we are looking at how we will underwrite these additional costs and how we will set up claims assistance facilities or expand them in these countries to cope with the increased number of claims. There is also probably a bit of a commercial strategy going on about what you do when the additional costs come in—how quickly you raise your prices. In this huge uncertainty about where the costs are going to fall, that is probably about as far as it goes at the moment.

Q65 Lord Condon: Can we focus on affected groups? I think we gave you notice that we would like to understand more about how your members use knowledge of pre-existing conditions or knowledge gained from predictive tests when determining premiums, and how these practices vary across the EU. Following on from that, do you think that particular groups, such as the disabled or people with long-term disabilities, will disproportionately face higher premiums, or will the premium increases post Brexit be across the board?

Hugh Savill: If someone has a pre-existing condition, it is likely to increase their premium. This reflects the increased risk that they will claim or that the cost of their claim will be higher if they have a condition for which the treatment is particularly expensive. The cost of premiums also varies, depending on where they are going to. If you are travelling to the States, your pre-existing condition will cost you that much more because the cost of healthcare in the States is so much higher. We work with the FCO and charities to publicise this, and we always give two bits of advice. First, always state your pre-existing condition. Sure, you can get a lower price if you keep quiet about it, but you risk not being treated, and nobody wants that. Secondly, when you are planning your holiday, think of the cost of travel insurance before you book it. If you are, say, going on a cruise in the Caribbean, where invariably, if something happens to you, you will be whisked off to the States in a helicopter, it can be very expensive. So think about that before you book rather than doing it as an optional extra afterwards.

Stuart Scullion: The other thing is that in that travel sector, the other parameter is the duration of stay. Someone could go for what you would consider to be a short-term stay—typically, four days. Most travel providers are not keen on providing cover beyond 31 days. If you happen to have the combination of, for example, a pre-existing heart condition and you are going to somewhere where we know that the cost of treatment is already expensive, and you are going for a 31-day trip, all that accelerates the premiums.

Lord Condon: Are there any variations across Europe beyond the variations in the countries' health services? Does the industry have a different market approach to pre-existing conditions across Europe or is it much of a muchness?

Hugh Savill: Not really.

Stuart Scullion: No, it is much of a muchness.

Hugh Savill: You also asked whether particular groups would be affected by Brexit, to which the answer is: directly, no. The removal of the EHIC card will affect everybody. But indirectly, yes, because if you are more likely to claim, as your costs are a greater proportion of that total claims costs, it will fall on you more heavily, so elderly people are likely to bear a higher proportion of these increased costs because they already pay it. They are more likely to claim.

Stuart Scullion: Older life S1s would be mainly affected. What would affect them is that if they are resident abroad, they have taken the conscious decision to go somewhere—typically somewhere warmer—and they tend to have disposable income, although they will use a greater proportion of that disposable income to meet their healthcare costs while residing in an EU country.

Q66 **Lord Crisp:** Certain measures of EU free movement law, particularly the EU's non-life insurance directives, cover health insurance. The basic principle—you know this much better than I do—is home state control of regulation. If this law does not apply, will there be potential opportunities, or would you prefer to see the continuity of its application and therefore regulatory alignment?

Hugh Savill: I do not think that health insurers are in a different position from the generality of insurers on this. The non-life insurance directive is now subsumed in Solvency II, which sets the authorisation and capital requirement standards for insurers across Europe. As ever, if we get a choice—we probably will not—it is a balance between the possibility of removing some of the excess burden of European regulation against the benefits of access to the European market. We are in no great hurry to make radical changes to Solvency II. It cost us north of £3.5 billion to introduce 18 months ago and we do not want to go through that backwards. We can see many ways in which the PRA's interpretation of Solvency II could be less onerous, and we continue to encourage it to do that. It can do that without asking anybody in Brussels.

Is there going to be a large reduction in regulation? I do not think so. Our regulators are just not in the right place for that, and if you think that in many cases this is about protecting consumers, one can understand why they take the view they do. I do not know whether we will retain access to the European Union market. I have said that transitionals are extremely important; to work, a two-year transitional period has to be based on the current single market arrangements—it is too complicated to negotiate anything else. In the longer term, we will need a completely different future relationship with the European Union. That will be really complicated to negotiate; any free-trade deal takes seven-plus years. Obviously, we hope for access to the European market and that the European insurers who work here should be able to continue to work here. We hope that it would be similar to what it is now. Who knows whether we will get there. It is an awfully long way away.

Stuart Scullion: In the healthcare sector, the answer to your question would be yes, we would prefer the status quo to be maintained. If there was one request—and I am sure that it is a request that every single one of us has around the whole Brexit scenario—it would be, "Tell us what's going to happen, and tell us as soon as possible". If we could do that, we would either be very wealthy or we would have a crystal ball. It is about how quickly we can find out what is going to prevail, and then we will deal with it. That is the view.

The Chairman: We need to move towards the end. First Lord Soley, and

then Lord Kirkhope.

Lord Soley: I have a quick question to Mr Savill on this point. You talked about the onerous regulations, which you might benefit from if we were not covered by them. What are the main ones? Which would or could go?

Hugh Savill: There are conduct regulations—how you sell insurance, the things you have to say to somebody, the documents you have to give to them and the many declarations you have to make. That is over the top. Nobody reads all those documents. I could see benefit in a rather stripped-down set of conduct regulations where people are given less paper but clearer explanations.

Q67 **Lord Kirkhope of Harrogate:** Gentlemen, you have given us some sombre evidence this morning—it is suitably serious. However, Mark Dayan of the Nuffield Trust indicated that he saw an “element of opportunity”. My experience of insurance companies has always been—with the greatest of respect—that they are massively opportunistic, always looking for some new market in which they can exploit something. I do not mean exploit in the wrong way, but they are looking to do business. Apart from your sombre analysis, looking ahead at this post-Brexit world, do you have people feverishly working away now—your boffins—on some super new schemes and ideas which you are positively enthusiastic about, if they occur?

Hugh Savill: There is no doubt that disruption creates opportunities. It is just that at the moment, we cannot see them. That reflects what you said about insurers being opportunists. I am sure that opportunities will come; I just do not know what they are at the moment. You are quite right that it is all too easy to appear sombre and to emphasise the negative aspects of this. There will be opportunities. Where we have invested is in the possibility of increased markets overseas by stand-alone UK free-trade arrangements. I have hired one additional person to work precisely on that in the hope that access to markets such as those in China and India will improve when we can set our own free-trade arrangements. This is a very long-term strategy.

Stuart Scullion: Referring back to Mark Dayan’s comments, where he talks about the private insurance market, I do not think it is clear whether what he says relates to the travel insurance market or the healthcare market. To know that would be significant, because the two of them will approach it differently, for some of the reasons we mentioned previously. I do not think that we are full of gloom and despondency, if that is the right terminology. The financial services industry and the insurance industry have been quite vibrant in coming up with things in response to scenarios and situations that have been put in front of it. However, I counter that with a note of caution. There is undoubtedly a view at the moment that there have been products that were launched historically, which were famed and fabled at the time, and which subsequently caused no end of problems. The insurance market is now more conservative with a small “c” in its product development, and does

not have quite that avant-garde “Let’s just go and launch it and see what happens” attitude that perhaps it had in the 1970s and 1980s.

Hugh Savill: It may be that the opportunities are not directly the result of Brexit. The opportunities from increased digital power are huge. There is no doubt that the way you buy and sell insurance and make a claim will be completely different in 10 years’ time—and, I hope, a damn sight easier than it is now—because of the power of digital technology. That will begin to change things and create opportunities. There are increased opportunities for insurance with cyber-risk. If we get round to a proper analysis of that and spread the policies wider than we do at the moment, there are opportunities there.

Stuart Scullion: In my sector, insurance premium tax is seen as a bigger threat at the moment than Brexit. Particularly among older lives who are taking responsibility for their own healthcare, there is a view that the Chancellor is looking to equalise IPT with VAT, which could be catastrophic as regards affordability.

Hugh Savill: We do not want that, either.

The Chairman: We are very grateful to you. Thank you very much indeed. It was important for us to hear from you. You have given us a lot to think about and given us some valuable evidence. We look forward to receiving the figures that we did not extract from you in the course of the discussion and looking at them. On behalf of all of us, thank you both very much indeed for coming and giving evidence to us today.