aspects of their operations to independent third-party providers.

In the following article we look at some key aspects of the Financial Services Authority (FSA)'s guidance on outsourcing. We also consider what impact direct insurers' outsourcing their underwriting and claims handling functions may have on reinsurance relationships and the apportionment of liability. The FSA's principles for businesses require all regulated companies to exercise reasonable care in supervising any outsourced functions. We should all be aware of this requirement and consider it alongside any other internal or external issues surrounding insurance risk and operational risk that could arise – in particular from outsourcing underwriting and claims.

So, what is Hannover Life Re (UK)'s view on the impact of outsourcing on the reinsurance relationship? Where underwriting and claims are concerned, the most important factor to be aware of is that any binding authorities within a treaty are specifically extended to the ceding company in its own name – and may not be passed to a third party. Binding authorities are normally given after a formal pre-quotation audit where possible including assessment of policy, philosophy and process and are liable to continuous audit and scrutiny. Based on audit findings and the level of expertise within the ceding company, such binders can be high. Above all they recognise the ceding company's participation in the risk.

We are aware that our clients follow the FSA rules and guidance in relation to outsourcing. So if an outsourcing arrangement is already in place when treaty cover commences we need to be made aware of this. If, however, an arrangement is entered into during the life of the treaty, we do ask for prior notice. One of the reasons for this is that we need to agree formally that – irrespective of whether outsourcing occurs before or after treaty commencement Hannover Life Re (UK) still holds the client (ceding company) responsible and accountable for the actions of the service provider.

We hope the article above contains some information and insight to those of you already outsourcing, and those considering the possibilities.

Julie Hopkins
Chief Underwriter

The FSA has also provided additional guidance under systems and controls for insurers in relation to outsourcing. For example, the guidance includes:

1. Issues to consider when entering into the outsourcing arrangements:
   - an analysis of how it will affect the company's risk profile and business strategy and
   - to conduct due diligence of the service provider's financial stability and expertise and
   - consider how the company will ensure a smooth transition to the outsourcer
2. Suggested content of the contract with the supplier

The FSA has provided a non-exhaustive list of areas to consider when negotiating a contract with the service provider. A few examples follow:

- reporting and notification requirements to be imposed on the service provider
- information ownership rights, confidentiality terms and segregation of data
- the extent to which the service provider will provide business continuity
- management and approval process for changes to the arrangement
- termination rights
- adequate flow of information from the supplier
- agreement by the supplier to adequate audit rights for both internal and external auditors
- provisions for action and an escalation process in the event that the supplier's performance is inadequate

As the regulated entity remains responsible for the outsourced services it is imperative that the contract details clearly how the parties would like the relationship to work and provides adequate remedies.

We hope you enjoy In Focus and we welcome your feedback, please forward any comments to Kirsteen Grant. If you wish to be added to our mailing list contact Kirsteen on 01344 846833 or email uk.marketing@hannover-re.com.

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In Focus

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Dementia: disease or symptom?

Why should we as underwriters or claims assessors be interested in diseases of old age such as dementia? Alzheimer's and pre-senile dementia are already named as conditions under critical illness policies, and both conditions are commonplace in those applying for an enhanced or impaired annuity. The over-65s are currently the fastest growing segment of the UK's population, and census figures for 2001 revealed that 18.4 per cent of the population were old enough to qualify for a pension. Whilst the over-65s may not be the most obvious target group for underwritten insurance products, there is a growing awareness of potential sales opportunities in the so-called silver market.

Cognitive activities

Dementia is described as the loss of function in cognitive ability in an awake and alert individual with previously 'normal' intellectual function. Cognition is the act or process of thinking, perceiving and learning. Cognitive activities impaired in dementia include:

- decision-making
- perception
- memory
- orientation
- verbal communication
- judgement

This loss of function must be sufficiently severe to interfere with the activities involved in work, social interaction and in daily life (e.g. dressing, feeding, continence, mobility, transfer and washing).

Dementia is not a disease as such, but a symptom of other disease processes such as Alzheimer's.

Dementia may not be progressive if due to trauma or hypoxia-which is the decrease of oxygen supply to the brain, which could result from, amongst other things, cardiac arrest or complications of general anaesthesia. It may be reversible or irreversible, primary or secondary and does not usually effect the entire brain.

In an ideal NHS world, all patients showing signs of dementia would be seen not only by a neurologist but also by other specialists to exclude reversible or secondary causes like alcohol addiction, tumours, infections such as syphilis, and metabolic disfunction – thyroid abnormalities, for example. Dementia may also arise as part of an existing neurological condition such as Multiple Sclerosis or Parkinson's disease. It may occur in the context of systemic illness – for example diabetes, or renal disease.

More often a psychiatrist may identify a case of depression or 'depressive pseudodementia', this latter group is the worried well, where an essentially healthy person finds their psychomotor skills slowing or suffers from stress-related fluctuations of mood. One of our own medical officers recounts the history of a patient diagnosed with Alzheimer's disease by his GP. Following his admission to hospital he was seen by a specialist who treated him with drugs appropriate to depression, resulting in his rapid recovery and return home. The main obstacle to neurologists seeing every suspected case of dementia is that there are only around 300 consultant neurologists in the whole of the UK. This represents one per 200,000 of the population: the lowest per capita ratio in the European Union. Most patients with dementia are seen by either geriatricians or psychiatrists, with neurologists tending to see only those under 65 years old.

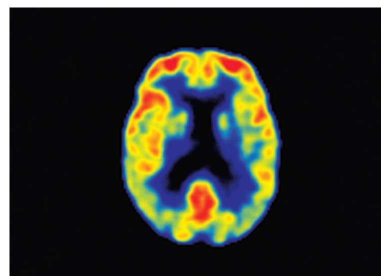
Continues over page.

Dementia – the facts

Dementia is a term commonly used to describe intellectual decline.

- It can occur at any time of life, but the chances of having the condition rise sharply with age. According to the Alzheimer's society, 1 in 20 people over the age of 65, and 1 in 5 over 80, will develop dementia.
- The society also estimates that there are currently over 700,000 people in the UK with dementia, of whom only 18,500 are under 65.
- The number of sufferers is expected to rise to 840,000 by 2010 and to 1.5 million by 2050, when today's twenty-somethings will retire.
- Dementia is currently seen more frequently in women due to their increased life expectancy.

Topics: Dementia: disease or symptom? • Outsourcing – Managing the Risks



So if dementia is not a disease per se how can it be diagnosed. The most sure-fire way is at post mortem but this is not appealing or convenient for most of us!

Neuropsychological profile is a less intrusive tool. This is a measure of the cognitive activities that are described above.

As with any disease, early diagnosis allows early treatment, and there are many tools available to the neurologist to assist in diagnosis. These include MRI scanning, which can detect changes in brain activity in patients with Alzheimer's disease, and functional neuroimaging (SPECT), a nuclear medicine technique used to image brain function, which is also very helpful in diagnosing both Alzheimer's and fronto-temperal dementia.

The key is to identify at-risk groups, allowing earlier treatment and hopefully an improved outcome. Mild cognitive impairment is the transitional state between normal cognition and Alzheimer's disease. The term refers to a specific type of memory loss. People with this disorder have sharp thinking and reasoning skills, but their short-term memory declines. Typically, those affected have most difficulty recalling recently acquired information. Their recall of events long past may remain intact. They may vividly remember the coronation of 1952 but remember little or nothing of the previous day.

How many times have you walked upstairs then forgotten what you went up for?

Memory loss in the over 65s is commonplace, with 40 per cent of over 65s suffering age-associated memory loss, and around 10 per cent have mild cognitive impairment. It is estimated that the transition rate from mild cognitive impairment to Alzheimer's is between 7 and 20 per cent per year. The estimated incidence in the over-70s is 3 per cent per year, compared with 1-2 per cent per year with dementia. There are, of course, problems with a diagnosis of mild cognitive impairment and there are also other factors to be taken into account, such as education, social background and first language. It is an unstable state, with around 40 per cent of patients reverting to normal over a five-year period.

The vast majority of dementia cases are not caused by an inherited genetic fault. However, three causative genes for Alzheimer's have been identified to date: the Amyloid precursor protein (APP) gene on chromosome 21, the Presenilin –1 (PSEN1) gene on chromosome 14, and PSEN2 gene on chromosome 1. These genes account for between one and five per cent of all cases of Alzheimer's disease. There is a 50 per cent risk of a parent with the gene passing on the mutation (autosomal dominant). If a child inherits these mutations he or she will develop the disease, and risk passing the gene on to their offspring in turn. If they do not inherit the gene they will not develop familial Alzheimer's disease and thus not pass it on to their children. The disease does not skip generations.

As for older people with Alzheimer's, the link is with a gene called Apolipoprotein E (ApoE), see illustration 1 for further information.

The ApoE risk is different from familial Alzheimer's. ApoE4 increases the chances of developing the disease, but does not make it inevitable. Some other factor, not yet understood, must also contribute. Some researchers believe that ApoE4 influences not whether a person will develop the disease but when, causing those with ApoE4 to develop the disease before those with ApoE2.

Other genes may be found that contribute to Alzheimer's disease, but the degree of risk involved is likely to be small.

Illustration 1

We all have two copies of the ApoE gene, which may be the same or different.

- ApoE4 is associated with a higher risk of Alzheimer's. About a quarter of the population inherits one copy of the ApoE4 gene, which increases their risk of developing Alzheimer's by up to four times.
- Two per cent of the population gets a 'double dose' of the ApoE4 gene, one from each parent. Their risk of developing Alzheimer's disease is increased by about ten times.
- Sixty per cent of the population have a 'double dose' of the ApoE3 gene and are at 'average risk'. Around half the individuals in this group will develop Alzheimer's by their late 80s.
- ApoE2 is least associated with Alzheimer's. One in six people carry it. People with one ApoE2 gene and one ApoE3 gene (11 per cent of the population) have a 50 per cent chance of developing Alzheimer's when they reach their late 90s.
- One in 200 people inherits two copies of the ApoE2 gene and stands a lower risk of developing Alzheimer's.

Familial Alzheimer's disease, where there is a family link is more common amongst younger people, diagnosed under the age of 65. Research has shown that, even where there is a strong family history of early onset Alzheimer's, only 50 per cent of cases are caused by a genetic defect. These people often develop Alzheimer's at a young age, between 30 and 40.

There are a variety of drugs available for the treatment of Alzheimer's disease. These include acetylcholinesterase-inhibiting drugs such as Reminyl (galantamine), Aricept (donepezil hydrochloride) and Exelon (rivastigmine). Research has shown that the brains of people with Alzheimer's contain insufficient Acetylcholine. These drugs prevent the enzyme acetylcholinesterase from breaking down acetylcholine in the brain. They are used for cases of mild to moderate Alzheimer's disease, and – whilst they do not provide a cure – may stabilise some of the symptoms for a limited period of time. Side effects can include diarrhoea, nausea, insomnia, fatigue and loss of appetite.

The National Institute for Clinical Excellence (NICE) has recommended that Aricept, Exelon and Reminyl should be available on NHS prescription for all who could benefit. In the first instance only a consultant can prescribe these drugs. The patient's GP can issue subsequent prescriptions. The current cost of these drugs to the NHS ranges from £800 to £1,000 per patient per annum.

The drugs are available by private prescription, where the cost will be greater, since consultation fees, prescription charges and a dispensing fee will also apply.

Ebixa (memantine) is a new drug not yet available in the UK. Ebixa belongs to a group of medicines called NMDA-receptor antagonists. The brain contains so-called NMDA-receptors which play a role in transmitting nerve signals important in learning and memory. Ebixa acts on these, improving the transmission of nerve signals and the memory, and is used in the middle and later stages of Alzheimer's disease. It does not offer a cure for Alzheimer's disease, but can temporarily slow the progression of symptoms. It has also been suggested that Exiba may retard the disease process itself. Ebixa was due to be considered by NICE in December 2003, however it has been reported that this has now been postponed until 2004 and that NICE is not due to issue guidelines until May 2005.

In conclusion it is clear from the above that if we continue to extend the entry age for life assurance products we will need to recognise the therapies mentioned above and their uses as disclosed in either application forms or GPR reports. We must also remember that dementia is the symptom and not the diagnosis, and keep up to date with the known causes of dementia and the differences in life expectancy by underlying disease. We might also want to consider adding questions designed to measure cognitive function to application forms for products specifically targeted at a minimum entry age of 65 or above. Last, but not least, we must seek to understand the impact and relevance of genetics in diseases of older age.

Caroline Froude
Manager-Underwriting & Claims

A memory test

Answer the following question without referring back to the article.

In the 2001 census what percentage of the population was of pensionable age?

For those of you who got it right – congratulations!

For those who couldn't remember – never mind, it will happen to us all one day!

Outsourcing – Managing the Risks

Today's financial services industry is more focussed than ever on keeping down new business acquisition costs, and we have all become used to working within strict budgets. As a result insurance companies have been increasingly willing to consider outsourcing non-core aspects of their operations wherever they perceive an opportunity to realise significant economies. Outsourcing, in itself, is nothing new: insurance companies have been turning to reputable investment firms to provide an external investment management service for many years now. But the phenomenon has taken off in recent years to the extent where it is no longer surprising to hear of customer call centres located overseas.

Cost-efficiency is – and must be – a major driver for outsourcing. But equally significant is the guaranteed availability of suitably qualified people as and when required. Staffing levels in this industry today are often set to manage standard business levels, with contract workers used to manage peaks in business or to handle any backlogs that may arise.

At Hannover Life Re (UK) we have noticed that more and more of our clients are outsourcing – or are considering outsourcing – some of the technical customer service