Cambridge Pre-U

**Cambridge Assessment International Education**
Cambridge Pre-U Certificate

**GLOBAL PERSPECTIVES (SHORT COURSE)** **1340/03/PRE**

Paper 3 Presentation **May/June 2019**

PRE-RELEASE MATERIAL

**To be given to candidates**

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**READ THESE INSTRUCTIONS FIRST**

**Guidance for Teachers**

This Resource Booklet contains stimulus material to be used by candidates preparing their presentation for 1340/03. One copy should be given to each candidate.

Presentations must be prepared in a four-week period. This may take place at any point before 31 May 2019, by which date all presentations must have been submitted to Cambridge via the Cambridge Secure Exchange.

The Presentation is marked out of 40.

**Instructions to Candidates**

- You should use the enclosed stimulus material to help you identify the subject for your presentation.
- Your presentation should attempt to answer a question.
- Your presentation must address alternative perspectives on the question you select and must engage directly with an issue, an assumption, evidence and/or a line of reasoning in one or more of the documents within this Booklet (i.e. you should not just pick an individual word or phrase which is not central to the reasoning of or the issues covered by the documents).
- You are expected to reflect on these perspectives using your own research.
- Your presentation should be designed for a non-specialist audience.
- Originality in interpretation is welcomed.
- Your presentation may be prepared in a variety of formats and should normally include an oral commentary.
- The speaking or running time of your presentation should be a maximum of 15 minutes.
- Whether presented or not, the submission must include a verbatim transcript of the presentation.

This syllabus is regulated for use in England, Wales and Northern Ireland as a Cambridge International Level 3 Pre-U Certificate.

This document consists of **9** printed pages and **3** blank pages.

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Cambridge Assessment International Education

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**Document 1**

**'Medical tourism among Americans expected to rise'**

**Adapted from an article by Jack Craver in *Jordan Times*, a Jordanian newspaper, August 2016.**

**The author is a freelance writer based in Austin, Texas.**

One perennial defense of the United States' health care system is the fact that wealthy foreigners regularly come here to receive medical care.

But medical tourism goes both ways. Among those for whom cost is a concern, the U.S. health care system is not an ideal vacation destination.

A new report by Visa Oxford Economics projected that the number of Americans traveling abroad for medical care will increase 25 percent annually over the next decade. That means an estimated 1.4 million will leave the United States for treatment this year.

Americans are traveling abroad for treatment that either isn't covered by their insurance or which, even with insurance coverage, is far cheaper elsewhere.

As the Fiscal Times points out, Indus Care, a company that provides employee medical tourism benefits to employers, estimated that a knee replacement that would cost $35 000 to $65 000 in the United States can be obtained for only $23 000 in Costa Rica or India, and that's including the cost of travel and lodging.

But cost isn't the only factor driving Americans abroad for health care. Some like the idea of turning a medical procedure into an exotic vacation. What better way to recuperate from knee surgery than on the beach in Costa Rica?

Of course, there are plenty of reasons to be reluctant to travel to a foreign country for a serious medical procedure. Language barriers and other cultural differences might complicate an already stressful situation. And of course, depending on where you go, the quality of care could be substantially lower.

"The people who get into trouble are the ones that price shop and don't pay attention to quality," says Josef Woodman, chief executive officer of Patients Beyond Borders, a Chapel Hill, North Carolina-based publisher of medical tourism information.

**Document 2**

**'Medical tourism making India global wellness hub'**

**Adapted from an article in eHealth, an Indian news website, June 2017.**

India's low cost, skilled medical personnel and world-class hospital network serve as a driving force for medical tourism. The other advantage for India includes the high degree of medical specialisation in the country.

Medical tourism, which is pegged at roughly 25 per cent year-on-year growth, has immense scope in India owing to availability of world-class doctors, excellent medical facilities and a bouquet of medical services that covers the whole gamut of modern medicine as well as traditional forms of medicine and yoga.

'As healthcare turns costlier in developed countries, India's medical tourism market is expected to more than double in size from $3 billion at present to around $8 billion by 2020. Cost is a major driver for nearly 80 per cent of medical tourists across the globe,' said Swadeep Srivastava, Managing Partner, India Virtual Hospital.

Another trend that's fast evolving in India, which can be called a 'byproduct' of medical tourism is that many hospitals are starting their operations in African countries. While the low-cost offered by the Indian healthcare sector could be one major factor making medical travellers from developed countries choose India as their destination to avail quality services, non-availability of quality healthcare in many African, South Asian and Middle Eastern countries is opening up a new opportunity for Indian healthcare providers to set up their bases in those countries.

However, there are still many issues that need to be resolved to help accelerate the growth of medical tourism. Lack of ethics and transparency is one major issue that should be resolved by the Indian authorities. Foreigners getting misled by touts should be looked into seriously.

If we need to meet both domestic and international demand in the healthcare sector, the government and the medical fraternity need to pool together resources to build excellent hospitals and medical schools across the country. It is also necessary to build technological prowess and a software interface for health services. Building health cities in India is also a good opportunity to attract foreign medical travellers to the country.

The pillars of clinical excellence in the healthcare sector should include service excellence, preventive healthcare, accessibility to finance and quality assurance. By implementing these pillars, India has the potential to become a global hub for medical tourism.





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**Document 3**

**‘3 Reasons to Consider Medical Tourism’**

**Adapted from an article by Philip Moeller in usnews.com, a US news website, 28 February 2012.**

**The author is a journalist.**

Medical tourism has been promoted as an inexpensive and even enjoyable way to see the world while getting high-quality cosmetic and elective surgeries for pennies on the dollar, compared with U.S. healthcare costs.

Despite that rosy outlook, however, most Americans are just not interested in leaving the country for their healthcare needs. The underlying conditions needed to support medical tourism are largely being met, experts say. The quality and depth of foreign medical facilities has continued to improve. Costs are still a bargain for many procedures, and medical tourism travel brokers have become better at putting together the packages needed for a successful experience.

However, it’s not a top-tier issue for consumers. Deloitte conducts an annual survey of U.S. and global healthcare trends. Among consumers from a dozen countries, Americans are the least likely to go outside their home country for healthcare.

Only 3 percent of Americans would definitely consider traveling outside the United States for either necessary or elective care, Deloitte reported in its 2011 survey. Only 1 percent had actually done so in the past year.

Uninsured consumers are more likely to practice medical tourism, Deloitte reported. In addition, the willingness to travel varies directly by age. More than 30 percent of younger consumers say they would at least consider travel outside the United States for healthcare. The percentages decline for progressively older age groups, and are only 21 percent for baby boomers and 17 percent for seniors.

Three reasons emerge for medical tourism. First, procedures remain far cheaper in many overseas markets than the United States. Second, some needed treatments are more accessible and can be scheduled sooner than at busy U.S. facilities. Third, certain specialized treatments may not even be available in the United States, due to differing healthcare regulations and even cultural acceptance of some healthcare practices.

**Document 4**

**'The scourge of medical tourism'**

**Adapted from an article by Muda Oyeniran in *National Mirror*, a Nigerian newspaper, May 2016.**

**The author is a journalist specialising in healthcare.**

Many influential Nigerians have a penchant for seeking medical treatment abroad despite the fact that their ailment could be handled in our local hospitals. This report examines the recent directive by the federal government that it would no longer sponsor any Nigerian for overseas treatment.

President Muhammadu Buhari said Nigeria loses about $1 billion annually to medical tourism, which is more than the annual budget of some states. Buhari said his administration will not deny any Nigerian his or her fundamental human rights, but will certainly not encourage expending Nigeria's hard earned resources on any government official seeking medical care abroad especially when there is evidence of expertise in Nigeria.

"Nigerians now see travelling for medical treatment as a class issue to the extent that any little medical discomfort is treated abroad. If consultants refuse to give referrals based on the fact that hospitals in Nigeria can handle such cases, the patients become insistent. But the medical consultant has the right to state in the referral note that the patient insisted on seeking help overseas despite the fact that such cases could be treated here in Nigeria. After patients return, there is the challenge of follow-up and feedback. It is not easy for a doctor to effectively review a patient whose case-history was not adequately monitored by home doctors," he added.

Dr Benedictus Ajayi, the Group Managing Director of Eleta Eye Institute, said Nigeria was losing huge sums to medical tourism because of ignorance and inadequate healthcare facilities. Ajayi advised the government to give tax incentives and loans, as in the agricultural sector, to further stimulate investment in the health sector. He said: "If the government encourages the private sector through tax incentives and loans as is being done in the agriculture sector, then we would reduce the amount of money Nigerians pay outside." The secretary general of the Nigerian Medical Association (NMA), Ogun state branch, Dr Adewunmi Alayaki, condemned the attitude of some doctors who referred patients abroad without consulting senior professionals in the field because of the "commission" they received from such referrals.

The chairman, Management Board of the Olabisi Onabanjo University Teaching Hospital, Professor Emmanuel Otolorin, said the organisation of treatment and not personnel were the challenges of Nigeria's health system. Otolorin accused successive governments in the country of establishing health facilities based on political considerations. He said: "Nigeria is blessed. When you look at Africa, we have some of the best practitioners in Africa and even elsewhere in the world. I worked in the UK for a while and I used to laugh when people came from Nigeria to the UK for a service and a Nigerian doctor is the one taking care of them. So we have good healthcare workers but we need to put in place processes and systems that everybody will follow. The problem with us is that people take shortcuts and when you take shortcuts the quality of services you provide will not be optimal. So we need to stop taking shortcuts."

Dr Dayo Adeyanju, Ondo State Commissioner for Health, said there was a need for better specialist and teaching hospitals to provide specialized care for Nigerians. He said: "If the Federal Government can provide standard health facilities it will help to take care of critical ailments, such as heart surgeries, brain surgeries, cancer and others which our people are trooping out of the country to treat. I believe that people don't go abroad to treat common ailments, so the Federal Government needs to strengthen its health institutions and staff to be able to tackle special cases."



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**Document 5**

**'Health tourism is a problem, but doctors should not have to check our passports'**

**Adapted from an article by Hannah Fearn, in *The Independent*, a UK newspaper, November 2016.**

**The author is a journalist, previously covering social affairs for The Independent and The Guardian newspapers.**

I didn't really believe in "health tourism" until an appointment with my GP descended into a longer chat about the future of the NHS and why my near-retirement physician was nearing the end of his tether. At his inner-London practice, my GP had spent many hours of his time and thousands of pounds of his budget treating the relatives of immigrants who flew in to receive NHS treatment for chronic conditions – diabetes, asthma, arthritis, and suchlike – that was totally unavailable in their home countries.

It raises a moral question: where does the responsibility of the NHS to treat free of charge begin and end? Should we ever knowingly leave, say, a diabetic with dangerously-raised blood sugar levels untreated in the UK even though we're aware they don't qualify for NHS care that's free at the point of delivery? So, there is a problem. In cost terms, health tourism only accounts for a tiny proportion of the financial crises facing the NHS – but it does exist. So how do we tackle it?

Here's where we get to the interesting part. Putting aside the question of whether or not it should be a political priority right now, the proposals that have been put to stop health tourism are designed in Whitehall by middle-class people with middle-class lifestyles in mind.

Here's the big idea: we'll ask everyone to show a passport and a utility bill when they arrive at a doctor's surgery, hospital or NHS clinic. If we know you're a Brit, then come on in. But hang on. 20 per cent of residents in England and Wales do not own a British passport. Many (perhaps most) of those will not be able to afford one; it costs a minimum of £72.50 to obtain a passport and, because we do not require that our citizens carry an ID card, there is no free-of-charge alternative. Others hold a passport for another nation, but are nevertheless eligible for NHS care because they are a resident. There's not much that you can tell about a person by the passport after all.

And wait. Not everybody has a utility bill, either. If you don't own your own home, many landlords require that utilities are held in their own name and are paid as part of a combined rent. Even where that's not the case, many of the poorest households pay by meter, not by monthly direct debit. You can't even get a direct debit if you don't have a sufficient income to set up what was once known as a 'chequing account' with the bank.

The result: since we know that poor health is directly correlated to living in poverty, we're proposing to make it deliberately harder for those who are likely most in need of NHS services, and who are legitimately entitled to use them, to access our free healthcare system. It's the law of unintended consequences in one neat case study. Are you spotting a theme here? Those who designed this policy assume everyone has a passport or form of ID and at least one utility bill. They most likely have never met a person in their adult life who does not possess both. Millions, however, don't.

**Document 6**

**'Half a billion people can claim free care — the system just can't cope'**

**Adapted from an article by J Meirion Thomas in the *Mail on Sunday*, a UK newspaper, January 2016.**

**The author was a cancer surgeon based in London.**

The trickle has become a steady stream, and, for once, we can't blame Brussels or Strasbourg.

Our NHS is being flooded by health tourists – people coming here for the sole purpose of receiving free treatment. And the fault lies with our misplaced liberalism and the repeated failure of our governments to protect our health service, its workforce and the British taxpayer.

We are rightly proud of our NHS, but it has a central and possibly fatal flaw. Unlike any other comparable system in the world, entitlement depends on residency and not contributions individuals have made. As a result, any citizen of the EU – population half a billion – is eligible to claim free treatment in our hospitals and clinics. When I explain this to friends from the US, Canada and Australia, they respond with incredulity. Even in mainland Europe, the vast majority of health systems are based on insurance or employment, which is why our problem with health tourism is unique.

As a cancer specialist in London, I have come across all too many examples of this, such as patients from abroad brought to hospital by a relative living in the UK.

In one case, a relative baldly explained that because of a recently diagnosed cancer, the patient could no longer live alone and was migrating to live with family here. No checks of any kind were made – nor under the current rules are they necessary – because the simple test for ordinarily resident status had been met. In another case a father and son from Corfu came clutching recent scans of a pelvic tumour. The son presented a letter from an estate agent to prove his father was moving here for good, as his Corfu house was on the market. In what other country would that work?

British expatriates are guilty too – travelling back for free care that might be ruinously expensive in their chosen country. In one memorable case a university-educated British woman returned, after 48 years abroad, with a large abdominal tumour. She had not resigned from her job nor transferred her home and family, but confidently told me she was now ordinarily resident here, so entitled to free NHS care. She underwent successful surgery, made an uneventful recovery and returned to her family abroad. I have not seen her since. I had to postpone the planned operation of another patient with recurrent cancer to make way for her.

For decades strict immigration control and expensive travel limited the numbers coming here purely for health treatment, so the simple residency qualification proved no real problem.

Now though, we are in danger of inundation. And recent Department of Health guidance has, if anything, made matters worse. It confirms the principle that anyone deemed ordinarily resident in the UK is entitled to free NHS care, and that a person can be ordinarily resident in more than one country at once.

In other words, any EU citizen who chooses to reside in the UK can be ordinarily resident here. Then there is the extended European Union: Albanians on Romanian passports, Russians on Baltic state passports, South Americans on Spanish passports and Brazilians, Angolans and Indians on Portuguese passports. It is clear this approach has failed woefully to keep up with a changing world. Why, despite the chaotic state of our oversubscribed NHS, will our Government not address these debilitating flaws?



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**Document 7**

**'Countries must work together to overcome global challenges'**

**Adapted from an article by Pan Zhongming in *China Daily*, a Chinese newspaper, July 2016.**

Wang Shouwen, Vice-Minister of Commerce, said that countries should work together to overcome global challenges and chart the course for future development. He was speaking at the sideline general debate of the 14th conference of United Nations Conference on Trade and Development (UNCTAD 14) in Nairobi, Kenya.

Amid the lingering unbalanced development between North and South, poverty eradication remains the top priority for developing countries, he said.

'To eradicate extreme poverty, there is no fundamental solution other than the pursuit of development. All members of the international community should assist developing countries in strengthening their capacity for development. It is of crucial importance to improve global economic and financial governance and increase the representation and voice of developing countries, and give all countries equal rights to participate in international rule-making,' Wang said.

He also urged countries to take actions to ensure open development to deliver benefits to all.

'Practices and experiences over the past decade across the globe reveal that fast growth often emerges from countries with an open economy,' Wang said. 'Countries should oppose all forms of protectionism, uphold a free, open and non-discriminatory multilateral trading system, explore ways and means to improve global investment rules, build an open world economy and come to share the development benefits through mutual consultation and joint collaboration.'

Moreover, he urged countries to take actions to ensure common development for all countries.

'In the era of economic globalization, the development of all countries is increasingly interlinked and has impact on one another,' he said.

In this way, all members of the international community need to build a global community of common destiny and shared interest, and support the development of other countries while striving to achieve self-development, so as to achieve prosperity for all.

**Document 8**

**'To think global, first factor in the human scale'**

**Adapted from an article by Sarah Sands in the *Evening Standard*, a UK newspaper, March 2017.**

**The author is a journalist.**

On a spring day, inside an ancient country church, my glamorous City daughter-in-law bashed away panic-stricken at the organ. She had been practising the hymns, accompanied by her cocker spaniel, for hours previously reserved for yoga. But if she did not volunteer to play the organ, there would be no music. That is how communities work. Professionally, my daughter-in-law counts as a citizen of the world. She works in international finance. She is a Londoner. Then, at weekends she is drawn into the quaint ties of village life. There, she is a citizen of the hamlet.

The contrasting personalities are now in conflict. Globalisation and technological perpetual progress are articles of faith in London. We like crowds but are less comfortable with neighbours. We find them "prying", unlike social media. I am selling our home at the moment and am amused that estate agents recommend no family photographs on display. There is a fluidity about the capital, and signs of someone else's imprint or long-term relationships are mildly offensive. Personal freedom and lack of prejudice are the great qualities of cities. The disadvantages are loneliness and lack of integration.

Steve Hilton, David Cameron's former adviser who became an ardent Brexiteer, saw the debate in terms of human versus dehumanising scale. He wanted power devolved away from juggernaut international organisations. His hero was the community organiser, his villain the bureaucracy of Brussels.

David Goodhart, in his book *The Road to Somewhere*, also argues that globalisation goes against human nature. He writes: 'A rootless, laissez-faire, hyper-individualistic, London-like Britain does not correspond to the way most people live – or want to live.'

Tony Blair argues that globalisation is inevitable – 'you might as well debate whether autumn should follow summer' – but nations can in fact intervene. The American tech giants have not cracked China or Russia. If Facebook cannot answer the Home Secretary's instruction to solve encryption because it is global, you could create a national social media company. The joy of Facebook is its global reach, but it began on an American university campus and has kept its essential character, just got richer. We have a national broadcaster, the BBC, why not a UK version of Facebook? Sounds dreary? But UK rules, UK taxes.

The argument against Brexit is that it is stupid and irrational. That the British people have voted against their self-interest. I am struck by the fact that there is far less remorse among voters than you might imagine and I have been trying to work out why. I think it is that taking back control is not just a slogan, it is a profound human impulse. Globalisation needs to understand the human scale.

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