Medical Tourism

Ensuring UK Patient Safety in the Global Medical Tourism Industry

February 2026

Michael Ilsemann, Dr Iseult Roche, Dr Paul Charlson

20/20health

In Collaboration with
Conservative
Health

Contents

About the Authors **3**
Executive Summary **4**
1. Introduction **6**
2. Medical Tourism: The Facts **7**
3. Factors Driving Medical Tourism **8**
3.1. Costs and Affordability 8
3.2. Greater Availability of Treatments 8
3.3. Waiting Times 9
3.4. Centres of Clinical Excellence 10
3.5. Travel and Tourism 10
3.6. Social Media and the Influence of the Influencer 10
3.7. Changing Societal Trends: Greater Patient Choice and Control 11
4. The Risks and Challenges of Medical Tourism **13**
4.1. The Level of Required Clinical Expertise 13
4.2. Unregulated Facilities 13
4.3. Absence of Legal Protections 14
4.4. Inadequate Pre-Operative Screening and Language Barriers 14
4.5. Lack of Aftercare 15
4.6. Is A Suitable Treatment or Procedure Being Provided? 15
5. The Advantages of Medical Tourism **17**
5.1. Patient Choice 17
5.2. A Short Cut to Waiting Times 18
5.3. The Benefits to the Host Country 18
5.4. The Benefits to the NHS 19
6. Case Studies **20**
6.1. Cases 20
6.2. Case Study Analysis 21
7. International Comparison **22**
7.1. Outward Medical Tourism 22
7.2. Inbound Medical Tourism 24
8. Policy Recommendations **27**
8.1. Establish a UK Medical Tourism Accreditation Association 27
8.2. Minimum Aftercare Standards 28
8.3. Mandatory Medical Tourism Insurance 28
8.4. National Data Registry 29
8.5. Advertising & Influencer Regulation 29
8.6. Public Awareness Campaign 30
8.7. Possible NHS Reform? 31
8.8. Expected Impact 32
9. Conclusion **33**
Acknowledgements **33**
References **34**

About the Authors

MICHAEL ILSEMANN

Michael qualified as a barrister in 2008 but now works as a public affairs and business consultant specialising in the healthcare and legal sectors. Combining legal expertise with hands-on engagement in clinical and healthcare settings, he has advised organisations on clinical policy, regulatory compliance and service delivery. Previous consultancy work includes supporting a health supplement business on clinical efficacy and market regulation, and investigating how business energy costs affect pharmaceutical operations, healthcare providers, and community health outcomes.

Michael brings a clinically informed and multidisciplinary approach to research, bridging legal, commercial, and public health perspectives to advance evidence-based healthcare policy and practice.

DR PAUL CHARLSON FRCGP FBCAM DPD DRCOG DOccMed

Paul is an experienced Aesthetic Doctor and GPwER in Dermatology

He has been President of the British College of Aesthetic Medicine and Chair of Conservative Health and a Parliamentary Candidate.

He is a founder of the JCCP a body developed to regulate the aesthetic industry and a former GP trainer and program director.

DR ISEULT ROCHE

Iseult is Director of 2020health and a specialist doctor within the NHS. Her clinical experience spans surgery and medicine, including endocrinology, complemented by expertise in public health policy, health finance, and the broader implications of healthcare reform.

Iseult has experience in the critical analysis of health-related opportunities and a strong understanding of European governmental differences in health systems and global health politics. She has previously been a special adviser and served as Portfolio Holder for Community Health and Sport in regional government, and has represented both the British Medical Association and NHS Health Education Kent, Surrey and Sussex.

Executive Summary

Our understanding of the impact of modern medical tourism (whilst a concept that has existed for generations) has evolved considerably in the first quarter of the 21st century. Initially seen in the context of inward medical tourism (i.e. foreign patients travelling to the UK for medical care), UK medical tourism post 2010 is now focused on UK patients travelling abroad for their healthcare.

This White Paper evaluates the drivers behind outward medical tourism, why UK patients may seek treatment abroad, the risks they are potentially exposing themselves to and the wider implications outward medical tourism will have on the NHS and the UK healthcare sector. Our focus throughout shall be on *outward* medical tourism, rather than *inward*.

What is driving outward medical tourism? Firstly, it should not be a surprise that its rise has coincided with the digital age and modern globalisation. It has never been easier to travel and to make travel arrangements, whilst also researching medical treatments. The modern phenomenon of the influencer also has important ramifications. Patient understanding has increased to levels not seen in previous generations. Secondly, we have identified changing societal trends, emphasising the value UK citizens place on choice as well as other factors such as immigration and the desire for greater control (and responsibility) for their treatment plans.

Thirdly, there are the medical reasons. Outward medical tourism is an effective way to shortcut excessive NHS waiting times and recent investment (both private and government) in health systems across the world have led to the rise of centres of clinical excellence which did not excess 20 years ago. This leads to the other important driver: private medical treatment abroad is cheaper with greater availability of treatments than comparative treatment in the UK.

Whilst these are important considerations for UK patients, it is more important to consider the risks. There is concern that the regulatory and standard of care expected by UK patients is not to the same standards they will receive in the UK. Case studies analysed later in this White Paper demonstrate a clear lack of patient care and lack of sterile clinical environments in some facilities (which can be private villas). Further, aggressive advertising techniques (especially within cosmetic treatments) raises concerns that vulnerable or impressionable patients are being specifically targeted for inappropriate medical treatment performed by unqualified practitioners.

A serious risk for patients is the serious harm (and in some cases, death) that these patients are being exposed to.

To protect patients, this White Paper has identified a series of proposals to protect outward medical tourism. UK policymakers should establish a UK medical accreditation association, standards in aftercare need to be improved, mandatory medical tourism insurance needs to be introduced and tougher (and more effective) advertising regulation is a minimum requirement.

A meaningful public awareness campaign explaining the dangers is a key ingredient for success.

It is important to note at the outset that it is easy to fall into the trap that outbound medical tourism is intrinsically wrong. To do so misses the point that medical tourism can bring some benefit to associated healthcare systems and ignores many of the more nuanced factors which drive it. Further, the beneficial impact of the regulatory reforms proposed in this paper will only be felt in the long-term. Educating the public and increasing awareness amongst patients remains the most effective short-term measures UK policymakers can introduce.

There is one further consideration which this White Pater will discuss; that outward medical tourism could be systemic of a wider attitude being demonstrated by society. Perhaps outward medical tourism is a sign that patients want something else from their healthcare in the 21st

century? They may want a greater degree of freedom, responsibility or choice which is denied to them by the NHS. As uncomfortable as this may be for policymakers to hear, perhaps outward medical tourism is a symptom rather a problem, that it is time for policymakers to evaluate the role mid-20th century health philosophy has within 21st century UK healthcare provision?

These are the questions 2020health shall seek to answer and we implore readers to consider the submissions put forward with an open mind, to the benefit of all UK patients.

1.Introduction

This White Paper was developed following a roundtable event hosted by Conservative Health in association with 20/20health in October 2025. The event examined the factors driving medical tourism and their implications for patient wellbeing and the NHS. Insights from these discussions informed the policy recommendations presented in this paper.

The paper focuses on outward medical tourism, where UK citizens seek medical treatment abroad, as opposed to inbound medical tourism, which involves non-UK patients seeking treatment in the UK. This is an important distinction and reflects a change in priority for policymakers. It should be noted that outward medical tourism is not cross-border care, nor does it involve reciprocal arrangements across different healthcare systems.

During the New Labour governments of 1997 to 2010, public focus was on inbound medical tourism, specifically the pressures it placed on the NHS and the ramifications for UK patients (higher tax, extended waiting times, risk of staff burnout). In recent years, attention has increasingly focused on outward medical tourism, driven by the rapid growth in UK citizens seeking medical care abroad. Urgent action is therefore needed to establish safeguards that protect UK patients from malpractice abroad and reduce the consequent impact on the NHS.

The White Paper begins with a discussion of factors driving medical tourism, before analysing the challenges and the potential benefits of medical tourism. It highlights risks through a series of case studies and evaluates international perspectives by comparing different domestic regulations across the US, EU and other developed countries. The paper concludes with a detailed discussion of policy recommendations, why they are important and why they should be adopted.

2. MEDICAL TOURISM: THE FACTS

The global medical tourism industry is currently valued at between $48.53bn to $278.2bn, depending on the sources and the metrics used. This figure is expected to rise to between $146.6bn to $840.4bn for the years 2030 to 2034.[i,ii]

Globally, popular destinations for medical tourism include Canada, Costa Rica, Mexico, the US, Singapore, Thailand, Saudi Arabia, Malaysia, India, the Philippines, Taiwan, South Korea and Turkey. However, there is a misconception as to the type of treatments sought by patients.

In the West, the common perception of medical tourism is of people travelling for cosmetic and clinical aesthetic procedures, with hair transplants, rhinoplasty, Brazilian butt lifts (BBL), dental and dermal fillers, and weight-loss procedures among the most high-profile and popular. However, recent data indicate that the majority of outward medical tourism relates to cancer treatments, IVF, organ transplants related to an underlining health condition and orthopaedic procedures, such as hip and knee replacements.[iii,iv,v]

The ONS estimates that Britons made 523,000 visits abroad for medical treatment in 2024, representing a 50% increase on 2023 (348,000). Turkey was the most popular destination in 2024, accounting for nearly 40% of UK medical visits, followed by Poland, Romania, Portugal and India.[vi] Further popular destinations include Spain, France, Latvia, Lithuania and Greece.[vii]

While many procedures are performed to high clinical standards, surgical failures and poor aftercare can result in complications such as infections, reopening of surgical wounds and perforated organs. These complications invariably result in the death of the patient either during or in the immediate hours following the procedure. In early 2025, the Foreign, Commonwealth and Development Office (FCDO) announced that at least 28 UK citizens had died in Turkey as a result of medical tourism since 2019.[viii] For balance, whilst each death is a tragedy, this figure is still only 0.003% of the approximately 818,000 who travelled to Turkey for medical procedures over this six-year period.

The NHS costs associated with health complications deriving from medical tourism are not fully known. One rapid literature review found costs ranging from £1,058 to £19,549 per patient (2024 prices).[ix] Interestingly, the same review found no studies that reported on the benefits of outward medical tourism. In terms of average costs, one retrospective case review in Scotland suggested £9,328 per patient,[x] while the British Association of Aesthetic Plastic Surgeons (BAAPS) has estimated a higher figure for cosmetic tourism, at £15,000.[xi]

A further study, reported by the BBC in 2024, indicated that it costs the NHS more to address the complications resulting from weight-loss surgery abroad than to carry out the operation itself. Among 35 patients attending five London hospitals in 2022, complications from gastric surgery abroad had resulted in symptoms such as severe malnutrition, vomiting, sepsis, hernias and haemorrhaging. The average hospital stay was 22 days, at an average cost of £16,000.[xii]

Whilst NHS costs associated with *inward* medical tourism are substantial (around £250m over three years from 2021 to 2024, according to the thinktank Policy Exchange[xiii]) it remains unclear whether, on balance, outbound medical tourism yields net cost benefits for the NHS and the wider economy. Potential mechanisms (such as reduced waiting lists and an earlier return to economic productivity) are examined later in this paper.

3. FACTORS DRIVING MEDICAL TOURISM

The rise of outward medical tourism has occurred alongside socio-economic changes and the emergence of social media, although it is important not to over-simplify the reasons why many patients are now seeking treatment abroad. The drivers are varied, often inter-connected and reflect a range of opportunities not afforded to UK patients in previous decades.

3.1. Costs and Affordability

One indirect effect of a free and universal healthcare service such as the NHS is that, by shaping workforce availability, capacity and regulatory expectations, it can contribute to higher costs in the private healthcare market, including both cosmetic and non-cosmetic treatment. At the same time, medical inflation has historically outpaced inflation, driving up the costs of treatment across both public and private healthcare. For many individuals, therefore, the cost of private healthcare in the UK is prohibitive. In this context, the availability of low-cost air travel, combined with substantially lower treatment costs in developing economies, has created viable opportunities for medical tourism.

Bariatric surgery is a popular example. In the UK the procedure typically costs in the region of £10,000–£15,000, whereas in Turkey prices start at approximately £2,500.[xiv] In 2024, around 5,000 UK patients underwent bariatric surgery overseas, slightly more than the 4,500 treated annually by the NHS.[xv] IVF is another frequently cited example, with own-egg IVF treatment in countries such as Poland and the Czech Republic costing €2,100-€3,500 per round, roughly half the price of the same treatment in the UK. Certain cancer treatments are reportedly around 30% cheaper in Germany[xvi] and from 50%–80% cheaper in countries such as Israel, Turkey and India than in the UK and US.[xvii,xviii]

Whereas private medical treatment for illnesses such as cancer or bone disease was once the reserve for only those who could afford it, the evidence now indicates that private treatment abroad can be up to 40% cheaper than comparable treatments in the UK. This therefore makes it affordable to many patients who previously would not have been able to consider private healthcare as an option.

Similar cost differences are evident in cosmetics, which were once considered to be available only to the wealthy and influencers such as Kim Kardashian. More efficient development of cosmetic treatments combined with a greater range of available products has helped reduce the cost of aesthetics worldwide.

For example, cosmetic procedures in Turkey cost between 40–60% less than in the UK, a differential helped by currency exchange rates and lower living and operating costs. A rhinoplasty may only cost £2,500 in Turkey, compared to £5,000–£7,000 in the UK. It is inevitable that cost implications will remain a driving force behind many UK citizens undertaking medical tourism whilst there remains such a discrepancy in prices for comparative treatment offered in the UK and abroad.

3.2. Greater Availability of Treatments

Another consequence of a free universal healthcare model such as the NHS is the perceived lack of choice afforded to patients. NHS patients are allotted their medical team, place of treatment and the treatment itself and whilst the opinion of the patient is sought, it is not always the driving factor behind the final treatment plan decided, which are often constrained by clinical guidelines and resource availability. It is not the intention of this White Paper to start evaluating the NHS, but it is worth highlighting now that in no other area of life is choice so highly restricted (we shall return to this shortly).

All medication and treatments provided on the NHS must be approved by the National Institute for Health and Care Excellence (NICE), based upon clinical effectiveness and cost efficiency. Medication which fails to meet the dual NICE test are not approved for patient use and are therefore made unavailable within the public health system.

Even for those with private medical insurance, who typically have access to a wider range of treatments, can find themselves on the wrong side of a financial model.

Medical tourism can enable patient access to treatments abroad that are either unavailable or are very limited within the UK. For example, the cancer drug Enhertu is available in 19 European countries, but is denied to English and Welsh patients, having failed NICE's cost efficiency test for routine NHS funding.[xix,xx] Until recently, another example would have been Abiraterone (used for in the early stages of prostate cancer) which was only available in Wales and Scotland but not in England until January 2026.[xxi]

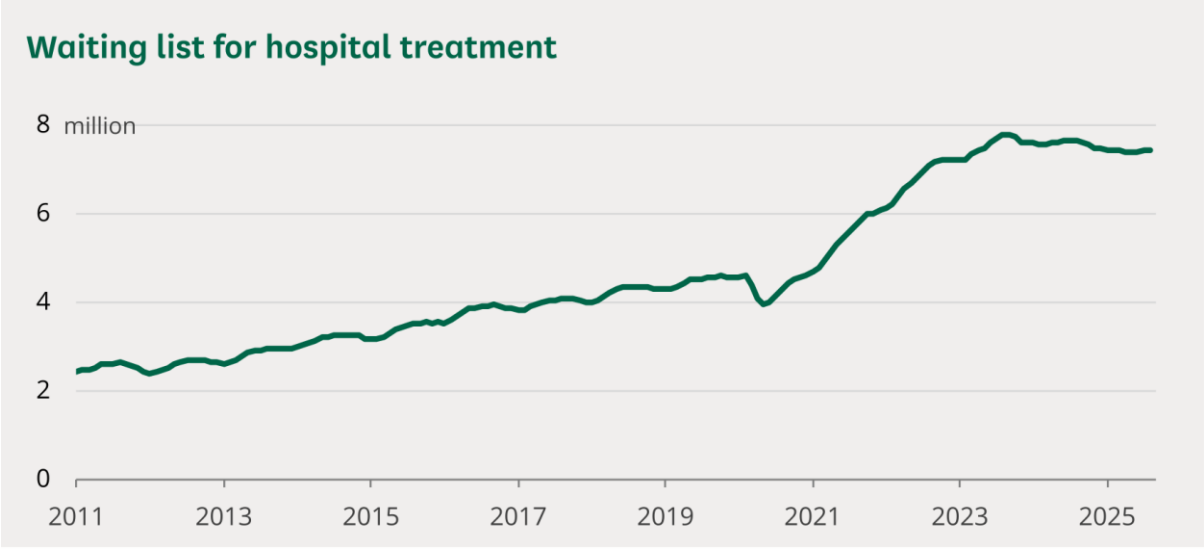
Medical tourism is a way in which patients can better access this and other important life-improving or life-extending drugs.

3.3. Waiting Times

The effects of lengthy NHS waiting times are well documented and have quite rightly been the focus of successive governments for decades. At the start of 2025, the average waiting time for a hip replacement was 27.4 weeks,[xxii] and for a knee replacement 28.7 weeks.[xxiii] These are averages only, meaning much longer waiting times for a sizeable proportion of patients in various parts of England and Wales.

In England there were 7.4 million people awaiting hospital treatment in August 2025, up from around 2.5 million in 2011 (Fig. 1). Data from NHS England reveal that the NHS 18-week treatment target has not been met since 2016.[xxiv] In cancer care, the standard waiting time is much less, at just under 9 weeks (62 days). In 2013, around 13% of those referred for cancer treatment following GP referral were waiting for more than 62 days; in August 2025, the proportion was 31%.[xxv]

Figure 1. NHS England: waiting list for hospital treatment, 2011–2025



Source: NHS England, Consultant-Led Referral to Treatment Waiting Times. Published by UK Parliament: https://commonslibrary.parliament.uk/research-briefings/cbp-7281/

International travel has never been easier, with an ease and frequency of foreign travel which would have astounded previous generations. Combined with the emergence of centres of clinical excellence worldwide and supportive foreign governments, medical tourism is seen by

many patients facing the agony of many months (or even years) on an NHS waiting list as a preferred, affordable and quicker solution than remaining in the UK. The exponential growth in medical tourism in recent years suggests that rising a public intolerance of waiting times, with prolonged delays for elective surgery, is a key driver.[xxvi]

Until such a point as a UK government can solve the Gordian knot which is hospital waiting times, it seems this will remain a driving force behind medical tourism for the years ahead.

3.4. Centres of Clinical Excellence

The significant rise in outward medical tourism from the UK over the last decade has coincided with the emergence of global centres of clinical excellence. Many countries have invested heavily in their healthcare services in recent years, with governments at the same time recognising medical tourism as

important drivers of their own domestic economies.

India is now considered to be a leader in bone marrow transplants, bariatric and obesity surgery, eye surgery, cardiac and orthopaedic surgery. Mexico is a leading country for IVF and dental procedures, whilst Thailand and South Korea specialise in cosmetic and reconstructive surgeries. Malaysia, Singapore and the UAE are top destinations for orthopaedic surgery.[xxvii]

Turkey has invested extensively in healthcare, with 41 Joint Commission International (JCI) accredited hospitals, advanced private facilities, and surgeons who are internationally trained.[xxviii]

Further, it has never been easier for foreign citizens to access these clinics and medical centres. There is limited regulation as to who can be treated, and several governments have introduced special medical visas, such as India's Ayush Visa, South Korea's Medical Tourism Visa and Dubai's Dubai in One Day.

Combined, these measures, specialisms and openness to treatment options create a perception of improved patient experience, focusing on treatment, travel, accommodation and aftercare, with specialist concierge services.

3.5. Travel and Tourism

While often overlooked, travel and tourism intersect with many of the drivers already discussed. Although, it would be inappropriate to suggest that individuals suffering serious health conditions such as cancer, heart disease or kidney failure would view treatment as an opportunity for leisure, it does stand to reason that certain areas of medical tourism do lend themselves to tourism more generally.

Procedures such as a single-day hair transplant in Turkey, followed by a fortnight recovery in a warm climate, or a hip replacement followed by several weeks of convalescence in a high-end resort in the UAE, may be perceived as more appealing than undergoing recovery during the winter months in the UK. Further, there is always the opportunity for wider family holidays, and it is not uncommon for a traditional fortnight holiday to involve a minor procedure for a parent or other senior family member.

Similarly, individuals undergoing IVF abroad may spend their required stay in the host country to explore local culture, whether in destinations such as Mexico, Albania or Georgia. The wider connection between tourism and medical tourism is reflected in complete travel packages that can be made available to patients and their families as part of a concierge service, noted above.

3.6. Social Media and the Influence of the Influencer

The rise of cosmetic medical tourism is closely connected to the growth of social media platforms and the extensive reach of famous influencers. Kim Kardashian (BBLs), Kylie Jenner (lip augmentation), Megan Fox (aesthetics/cosmetics) and Chrissy Teigen (liposuction) are

examples of celebrities able to use their followings on platforms such as TikTok, Instagram, Facebook and YouTube to showcase the search for the “perfect body.”

Further, many clinics around the world harness the power of social media to drive aggressive marketing packages, highlighting promotions which often minimise risks, focusing instead on price and lifestyle appeal.

There is a growing danger that teenagers and adolescents are exposed to cosmetic medical tourism, with social media advertising normalising and promoting high-risk cosmetic procedures. First-hand accounts from young people to demonstrate how platforms such as Instagram and TikTok amplify unrealistic beauty standards through filters, algorithms and covert influencer marketing.

These pressures contribute to body dissatisfaction, anxiety, and impulsive decision-making, encouraging some teenagers (including those under the legal age of consent) to seek cosmetic surgery abroad where regulation, age checks and aftercare are often inadequate. This in turn leads to significant psychological, physical, legal and financial risks associated with cosmetic tourism for young people, which includes severe medical complications, long-term mental health impacts and increased strain on public healthcare systems when complications are treated domestically.

Neurodivergent adolescents are identified as a particularly vulnerable group due to higher levels of anxiety, impulsivity, and susceptibility to online manipulation.

For those who suffer from mental health conditions, body dysmorphia or are simply more impressionable, these adverts can be extremely damaging and promote the perception that it is possible for an ordinary person to attain the perfect body, an achievement which is usually only be achieved by either a professional sportsman or a Hollywood actor.

Recognising the role of social media in driving medical tourism, the UK government announced in August 2025 that it would collaborate with influencers Midwife Marley and Doc Tally (approximately 38,000 and 260,000 followers on TikTok respectively)[xxix] to help counter both celebrity and clinic marketing.

3.7. Changing Societal Trends: Greater Patient Choice and Control

As already noted, one limitation of a universal healthcare model is the relative lack of patient choice. The desire for greater choice and control over healthcare decisions has become an important driver of medical tourism.

The NHS is a product of an era, which is different to the 21st century UK; first mooted in the 1930s but formed a decade later before globalisation and privatisation, society then was used to what is now considered to be limited consumer choice and was much more rigid in social dogma based upon class. UK citizens in 2025 now have an unprecedented level of choice in every other aspect of their lives, from energy providers, to cars, banks, insurance companies, solicitors, accountants, train operators (within reason), credit card, supermarkets, food and just about every decision that impacts upon a citizen’s life.

Many in modern society now desire similar levels of choice in healthcare. A more fluid society expects choice (and the availability of choice) in a way in which was not available even for millennials until the rise of the fully digital age.

Healthcare remains the big outrider; a UK citizen has the right of choice for the treatment their pets receive but not for their own healthcare when they need it. Outward medical tourism allows for that choice, and the opportunity for a UK citizen to accept responsibility for their own health.

A further societal change that has undoubtedly influenced medical tourism is immigration. Emerging medical tourism destinations such as India, Turkey, the UAE and the Far East reflect the cultural and religious diversity of multi-cultural Britain. Whereas previous generations may have had preconceived opinions on seeking medical treatment abroad, 21st century Britain has

changed sufficiently that such barriers no longer exist. Further, it can be no surprise that a UK citizen with second or third generation Indian heritage may seek medical treatment in India, especially if there remains either a family or cultural connection.

4. THE RISKS AND CHALLENGES OF MEDICAL TOURISM

Unfortunately, behind the glossy brochures and the slick online marketing campaigns, there is a darker side to medical tourism, with less reputable clinics and practitioners being very successful at hiding its risks.

There is, however, an important distinction to be made; there are many first clinics providing an excellent service to UK citizens and as the national statistics demonstrate, it is only a small minority of UK patients who experience the very worst of outcomes. It is important for the sake of balance to highlight that by no means does every case of medical tourism ends in disaster.

It should also be stressed that any risks highlighted in this White Paper are not the reserve of a specific country nor are they widespread across specialisms. They are, however, examples that have arisen out of specific case studies and are the accepted risks highlighted by numerous western governments.

Regardless, risk and challenges remain.

4.1. The Level of Required Clinical Expertise

Some UK citizens may assume that the regulatory standards applied within the UK extend to medical treatment received abroad, and that they will therefore be treated by appropriately qualified practitioners. Such qualifications would include accredited training, recognised credentials and relevant experience within the practitioner's chosen field. However, such requirements do not always extend to other countries, and cases of medical failure often appear to involve foreign doctors practising without attaining relevant qualifications, specialisation or experience.

The risks posed by unqualified practitioners extend across the entire patient journey, from pre-operative screening to the procedure itself and aftercare. Surgical failures are invariably caused by the severing of a blood vessel, blocking a blood vessel or the perforation of an organ, mistakes that are unlikely to have occurred if undertaken by a more experienced practitioner.

This risk can, with greater public awareness, be identified by the prospective patient at the research stage. Red flags typically include practitioners refusing to share evidence of medical qualifications and board certification. They would also provide misleading claims about professional memberships, particularly if working within the cosmetics and aesthetics industry. Prospective patients should expect to see international society membership, such as the International Society of Aesthetic Plastic Surgery (ISAPS), or that of a national body, such as the Turkish Society of Plastic Reconstructive and Aesthetic Surgeons (TSPRAS).

4.2. Unregulated Facilities

It is not uncommon for some clinics to have lapsed membership of the required domestic medical association and, in extreme cases, to have never registered in the first instance. A lack of a proper oversight of medical providers within certain countries has contributed to some procedures being offered in private villas or other non-medical premises. These lack necessary A&E access and are typically unsterilised environments, which encourage bacteria, thereby leading to a higher chance of post-procedure infections.

As the case studies indicate, it is within cosmetic surgery that the risk of harm is greater. This is not surprising, considering it is cosmetic patients who tend to be more impressionable and more easily led by influencers, while those with underlying medical conditions tend to be more experienced and considered. Further, these procedures tend to require greater specialist expertise and it is harder to successfully fake qualifications and a following.

As we shall discuss, a cancer patient would be expecting a sterile clinical environment, whereas a patient wanting a gastric band may be suffering from such poor mental health that their judgement could be temporarily impaired.

In short, cosmetic patients are more willing to accept the vague assurances as to why a non-clinical location is being used for their procedure, especially when the trusting nature of the relationship between doctor and patient is considered.

4.3. Absence of Legal Protections

An additional impact of the lack of effective regulation is that it provides limited legal recourse for the patient (and family) against both the national authorities and the clinic should anything go wrong. Once again, the focus is more on cosmetic treatment due to the factors driving medical tourism and the inexperience of those seeking it.

An absence of suitable legal protection is not just a lack of recourse, but the lack of suitable safeguards across the entire patient journey, from onboarding to the initial consultation, to the procedure, discharge and aftercare.

In some cases, patients are not provided with a formal contract or a cooling off period. This prevents patients from claiming refunds or exercising consumer rights, even if they had the requisite knowledge of the legal protections for that specific jurisdiction. Further risks include unsafe payment practices, with some providers insisting on cash payments. This raises concerns about tax evasion and leaving patients without proof of transaction and treatment provided.

Travel insurance frequently excludes procedures performed abroad. Responsibility for organising and paying for remedial treatment for complications arising from medical tourism invariably falls to the patient or their family. In the absence of thorough research and a clearly defined contractual agreement, the patient may become liable for hidden expenses and costs associated with their treatment, including extended hospital stays, follow-up treatments and travel expenses.

4.4. Inadequate Pre-Operative Screening and Language Barriers

Language is an important but often overlooked factor in medical tourism. While English is often regarded as the universal language of healthcare (and UK citizens perhaps expecting medical professionals abroad to speak English), there is no guarantee of effective communication. Doctors and patients may not easily understand each other and there is always the chance that important medical information will be “lost in translation.”

Of course, this does not take into account possible shared heritage as discussed above, but there is always the possibility that language barriers could lead to a failure to check the patient’s BMI, pre-existing conditions, or medications, which will put the patient at risk at the commencement of the chosen procedure.

Due to the nature of medical tourism, most pre-operative consultations take place online, with the patient and doctor meeting face-to-face only in the hours leading up to the procedure (if at all). There is also a risk that some patients are deemed medically ineligible for the procedure only after travelling abroad, with the costs implications which this brings. The greater risk is that pre-operative screening is rushed, placing the patient in danger of serious complications due to a potential lack of understanding of the patient’s unique circumstances, such as pre-existing conditions or current medication.

It is vital for the doctor to ascertain a full understanding of the patient and their medical history before commencing procedures. This is as true for a rhinoplasty or BBL as it is for a knee replacement or a kidney transplant. The issue with medical tourism arises when it is treated more as a business than as medical care. There is a danger that clinics are run at the behest

of investors, usually businesspeople with little care for the provision of medical care beyond reputation and a balance sheet.

It can become too easy for patients to be considered by some clinics to be nothing more than an ATM and not as patients requiring a special level of care. A lack of adequate pre-operative consultations is indicative of a lowering in the standard of healthcare provision, where the priority for the clinic is the balance sheet and not on patient outcome.

4.5. Lack of Aftercare

The issues arising out of a suitable lack of aftercare share the same genesis with those causing inadequate pre-operative screening. As before, it is the less reputable providers of cosmetics that carry the risks; these are the clinics which are run as businesses and which consider a procedure undertaken for aesthetic appeal as being less clinically important as medically necessary procedures (such as chemotherapy or organ transplant), even if the cosmetic ambition is an indication of an underlying mental health condition.

These are the clinics which cut corners by prioritising profit margins, thereby increasing their patients' exposure to risk.

There is the added commercial pressure, especially for those clinics run more like a business than a medical centre. A cosmetic procedure conducted abroad is a commercial act like any other. The patient (or client) pays a fee in return for the procedure (the service). Naturally, the procedure is considered the most important part of the transaction; for the client who will be left with perceived enhanced aesthetic appeal, for the clinic as this is the main point of charge (i.e. income generation). Whereas most business models will ensure a charge for pre and post procedure consultations, private clinics suffer from the same commercial pressures as every other business. The focus is on securing clients and conducting the procedure; it is a sad inevitability that less scrupulous clinics which will place practitioners' focus on a higher turnover of procedures, ensuring that post procedure aftercare falls into secondary importance.

Case studies have highlighted patients being discharged within 48 hours, with minimal post-procedural checks being conducted. A lack of aftercare includes a failure to safeguard against immediate air travel, which increases the risk of blood clots and thrombosis (medical and air industry guidelines advise against air travel within 10 to 14 days, even following the most basic medical procedures).

It is somewhat inevitable that as many cosmetic patients fly within days of a procedure, complications do not arise until after they have returned to their home country. Whilst air travel itself may cause or exacerbate the issue (such as with thrombosis), medical staff not part of the original procedure are the ones left to deal with the medical emergency.

Precious time is lost while this new medical team conduct their own investigations, sometimes with patients who are unable (or incapable) of providing the vital information that could save their lives.

Ideally, foreign clinics should be encouraged to seek collaborative partnerships with UK-based clinicians. Patient aftercare will, therefore, be better co-ordinated. If there is an emergency, then this would reduce diagnosis time, leading to quicker administration of suitable treatment. Unfortunately, this has proven somewhat difficult to implement; not only due to the lack of a co-ordinating body but also possible reluctance amongst some foreign clinics to enter into such partnerships in case they open themselves up to negligence claims.

4.6. Is A Suitable Treatment or Procedure Being Provided?

There is an additional problem arising out of a lack of suitable patient onboarding (centred around a lack of proper pre-procedure screening) relating to the suitability of the treatment being provided. Although affecting only a minority of cases, it remains an important consideration.

Simplistically, how does a cancer patient know for sure that they will not adversely react to the new drug? Can a patient ever be fully confident that a hip replacement abroad will be as effective as one undertaken in the UK, where weeks of pre-operative consultations will have ensured the best possible results?

These somewhat simplistic questions are indicative of the discussion that needs to be had on medical tourism.

The issue is somewhat more nuanced for those who seek cosmetic procedures abroad. Of course, the majority of patients seek a one-off procedure: a hair transplant, a rhinoplasty or perhaps some form of reconstruction following trauma.

Further, the UK Parliament reported in July 2020 that there are additional dangers patients are placing themselves in through outward medical tourism. Parliament was concerned that patients were exposing themselves to illnesses not prevalent in the UK, such as blood-borne viruses, tropical diseases or viruses growing resistant to antibiotics.[xxx]

However, there are those who seek some form of cosmetic surgery due to other underlying health or psychological issues. These include individuals who have been body-shamed into seeking procedures such as gastric band surgery, or those with learning disabilities who are more vulnerable to influencers and aggressive marketing. There are other patients who develop obsessive concerns about their appearance, perhaps due to body dysmorphic disorder or other mental health conditions. For these individuals, seeking cosmetic procedures through medical tourism is often a symptom of an underlying medical issue, rather than an end in itself.

These are the individuals for whom cosmetic treatment is wholly inappropriate; but due to their underlying health or psychological conditions, they are more likely to make ill-advised, unconsidered decisions, having failed to identify red flags, thereby placing themselves at increased risk.

5. THE ADVANTAGES MEDICAL TOURISM CAN BRING

Many of the factors driving medical tourism in the last 15 years reflect the advantages as perceived by patients. Costs and affordability, ready availability of treatments, an avoidance of waiting times, emerging centres of clinical excellence and an opportunity for travel and tourism; these are always the leading factors listed on any patient information website.

As inconvenient as it may be for policymakers to hear, the rise in medical tourism could be systemic of the issues facing 21st century healthcare provision in the UK, and therefore symptoms of the problems facing the NHS, as opposed to being a threat to it.

For that reason, this section focuses on two issues already mentioned in this White Paper (choice and waiting times) and will indicate a potential need for wider NHS reform.

5.1. Patient Choice

It is easy to see medical tourism to be exclusively concerned with cosmetic procedures, but as this White Paper has explained, medical tourism exists across a vast array of healthcare and medical provision. It is just as possible for a patient to elect to go abroad for a hip replacement than they are for a rhinoplasty.

It is those patients who travel abroad for treatment previous generations would have expected to receive in the UK that should be a focus, as they highlight a concerning trend that should not be ignored.

As discussed, healthcare remains the only area of life in which the average Briton lacks freedom of choice. At one level, there is nothing wrong with this. It makes sense to be allotted to the local surgery, to seek advice from a local GP and to be referred to a local hospital in an emergency. It is the most efficient way to manage a universal healthcare system.

The issue arises, however, when the patient is uncomfortable with the allotted medical plan that they have been given. A clash of personality with the consultant, a desire to pursue an alternative treatment plan, a want to change hospitals, a disagreement over the quality of care provided, the need to avoid a waiting list; these are all legitimate reasons why some patients may seek an alternative route.

Of course, there is a choice; the patient can go private, although private medical insurance is usually impossible to acquire once a patient has been diagnosed with a serious underlying illness. Further, this argument misses the point regarding private healthcare in the UK. Private medical insurance in the UK, owing to the existence of a universal healthcare system, is amongst one of the most expensive insurance choices anywhere in the world.

For many UK nationals, the choice provided by private insurance is simply not available due to cost.

As uncomfortable as this may be for policymakers, NHS staff and clinicians to hear, the rise in medical tourism may reflect a wider society attitude, that may be a current subconscious thought but could become more apparent in the years to come.

UK society in the 21st century is more fluid than in 1948 when the NHS was founded. Unsurprisingly, there is now a longer life expectancy, better quality of life, greater freedom of choice, and the population as a whole is more questioning and not quite so reliant upon the principle that the “doctor knows best” as their parents and grandparents once were. Further, there now exists generations who have matured post boomer years who are used to their own decision-making at the click of a handheld device.

This is not meant to sound overtly critical of the NHS' current healthcare model but rather highlights an interpretation that the rise in outward medical tourism is indicative of a growing change in expectation of what patients may want out of their healthcare.

Put another way, do the current generation of Britons want the same out of the NHS as what their grandparents wanted?

5.2. A Short Cut to Waiting Times

Since the 1990s, ever increasing waiting times have been a perennial problem for the NHS regardless of any increase in funding and staff recruited. Seeking treatment abroad is an obvious way to circumvent a prolonged wait, especially when involving many months of pain and discomfort.

For example, it is possible to book an appointment with an orthopaedic surgeon in Turkey within 1 to 2 weeks, with the operation taking place 4 to 6 weeks later. Minor surgeries in UAE (such as cataracts) can be conducted within 10 days, IVF within 2 to 3 weeks and a knee replacement within 6 weeks.[xxxi] This compares to the 28 week waiting orthopaedic waiting time referred to earlier in this White Paper, the average cataract waiting time on 3 to 12 months on the NHS and the average 6 to 12 month waiting time for IVF on the NHS.[xxxii]

However, the issue may be more nuanced and the drive behind escaping a waiting list is perhaps more complicated than it may seem.

The private healthcare insurance model in the UK is unique amongst almost anywhere in the developed world other than the US, a consequence of the almost uniqueness of the NHS itself. There are many UK citizens who aspire to private medical insurance, yet have either been unable to or have struggled to find suitable policies due to underlining or pre-existing medical conditions. What they can do, however, is pay for alternative treatment abroad (through loans, remortgaging, equity release and savings), which acts as a compromise.

A cheaper alternative, a centre of clinical excellence and the ease of travel makes this a more viable commercial decision rather than the alternative of the patient paying for the same treatment in the UK. Further, private health insurance providers are increasingly looking abroad when handling a client's claim.

If there is to be a wider discussion in regard to the NHS, then perhaps medical tourism is indicating that the public may want to see a move towards the health union model seen in Europe.

5.3. The Benefits to the Host Country

This may seem of limited initial interest, but the benefits medical tourism brings to host nations warrant consideration. As long as foreign governments invest (or encourage investment) in their own domestic healthcare infrastructure, and clinics provide solutions for a demand from foreign patients, then medical tourism will remain a driving force within international healthcare.

Alongside the improvements in healthcare infrastructure, such investment brings important benefits to the host country, which are essentially economic and reputational.

Medical tourism can boost national and local GDP. It provides local employment and the building of new health clinics leads to investment in infrastructure which in turn brings a substantial improvement to the local supply chain. For example, a new clinic will require water and sewage treatment works, product, support staff, public transport, road infrastructure and inter-city, town and airport connectivity.

Further, as already discussed, tourism itself can be seen as a driving factor behind outward medical tourism. Many international governments consider attracting medical tourists as an important means in which to encourage tourism.

Finally, medical tourism is seen by many developing countries as a way of enhancing their international standing and prestige. This is best illustrated by the work countries such as Mexico, Turkey and Albania have done in recent years to attract world renowned clinicians who would previously have practised in the US or out of Harley Street.[xxxiii] These countries can then approach global investors who are reassured by the presence of world leading doctors. Medical tourism is a driver for reputation enhancement as much as it is for economic reasons.

The cycle of ever-greater national investment therefore continues.

5.4. The Benefits to the NHS

The focus of any commentary in relation to medical tourism is on the cost it brings to the NHS, usually in treatments, time and salaries in providing remedial care to patients. Understandably, it is the emotive human elements to these stories which propels them to the forefront of media coverage and public consciousness. Undoubtedly, these individual tragedies do come at a cost, but let us consider the wider impact medical tourism may have and if there are any benefits it may bring.

When an NHS patient seeks treatment abroad, they are freeing up a place on a waiting list, or an organ or treatment for another patient for whom medical tourism is not an option. This helps reduce NHS costs and eases waiting times for other patients.

Further, an economic argument is that this helps patients return to work more quickly, thereby allowing them to continue contributing to the UK's GDP. By cutting the waiting time for a procedure or an operation, these patients are shortening the time before they return to work, hobbies, shopping, manufacturing or any other activity which can help drive their local economies and therefore the wider UK GDP.

Patients seeking medical treatment abroad are essentially acting as case studies for the NHS and NICE, which furthers the UK's own understanding of new and innovative medicines, procedures and technologies. This could help such government agencies make more informed decision on availability of treatment.

It is too easy to see medical tourism as a threat, as an enemy rather than accepting it as an integral part of 21st century UK, identifying where it can bring real benefit and help it drive up the UK's own clinical standards.

6. CASE STUDIES

It is somewhat unfortunate that reported case studies of outward medical tourism almost invariably focus on treatments or procedures that have gone tragically wrong. This is perhaps inevitable, as the media always appears to prefer a bad news story. It may be that the level of media attention reflects the level of harm caused, itself relatively minimal. Further, it is only the unsuccessful cases that are investigated by the coroner and the relevant health authorities, whereas the vast majority of successful cases are conducted away from scrutiny and attract little media interest.

The cases of "medical tourism gone wrong" are very much the minority. However, it is important to reflect on such cases and identify lessons that can be learnt.

6.1. Cases

Kaydell Brown, 38 years old from Sheffield, died in Turkey in March 2024 having paid £5,400 for a "Mummy MOT," which included a BBL, tummy tuck and breast augmentation. The estimated cost of the procedure in the UK would have been £15,000. The fees included flights, hotel accommodation and the procedure itself.

Ms Brown died during the five-hour procedure, with the operating clinic blaming her death on fat blocking a blood vessel rather than through malpractice. When Ms Brown was eventually repatriated to the UK, the pathologist conducting the post mortem (on the instructions of the coroner) discovered that Ms Brown's brain, heart, lungs and part of her intestines had been removed, ensuring that it was impossible to determine the cause of death.[xxxiv]

Emma Morrissey, 44 years old from Warrington, died in Turkey in July 2022 after spending £2,800 for a gastric sleeve. Ms Morrissey died within 24 hours of the operation due to internal bleeding, the operating surgeon having perforated an organ with a surgical instrument. The UK coroner concluded, firstly, that the medical tourism company relied upon a "patient self-declaration of health and made no independent enquiries to satisfy themselves that Emma was fit for the gastric sleeve procedure before making the arrangement for her to have surgery."[xxxv]

Second, there was no adequate pre-operation consultation when Ms Morrissey arrived at the clinic. Third, "the surgeon perforated her abdomen with an instrument. The area was packed to stem the bleed but no platelets for blood clotting were administered causing continued bleeding and her sad death." Four, there was no evidence of any investigation by the Ministry of Health in Turkey or internal hospital investigation; the surgery was completed and the cause of death was given as natural.[xxxvi]

Finally, Ms Morrissey's body was not properly embalmed by the Turkish authorities, meaning that it was at risk of infection during repatriation and was a health threat to the professionals who received her body once it had returned to the UK.

Melissa Kerr, 31 years old from Gorleston in Norfolk, died in November 2019 in Turkey after paying £3,200 for a BBL, following a conversation with a Turkish hospital worker over WhatsApp. Ms Kerr was said by her friends to have been a "bit nervous" before the operation and the coroner noted that Ms Kerr had received only a limited assessment prior to the procedure, which did not include discussion with a medical practitioner.

The cause of death was given as pulmonary thromboembolism, after injected fat entered a blood vessel and subsequently blocked Ms Kerr's pulmonary artery.[xxxvii]

Hayley Butler, 40 years old from Norwich, died in late October 2024 after traveling to Ozel Gozde Hospital in Izmir, Turkey, for liposuction. Ms Butler was charged £2,500, which included flights, accommodation, pre-op tests and medication. Ms Butler fell ill following her return to the UK after what had appeared to be a successful procedure. Ms Butler contracted sepsis and

died in a specialist unit in Luton a month later; her consultant surgeon in the UK found fluid in her abdomen and four perforations of internal organs.[xxxviii]

6.2. Case Study Analysis

What do these cases studies tell us? That it is primarily women under the age of 50, who are seeking cosmetic surgery abroad for substantially cheaper fees who are putting themselves in danger. There are very few, if any, cases of adverse medical tourism for non-cosmetic patients. As has been discussed, this reflects the difference in what drives medical tourism; older more experienced patients seeking a clinical treatment for a specific health condition are more likely to take a considered decision based upon research of the skills of the clinicians and reputation of the clinic.

Cosmetic medical tourists are younger, less worldly and more conscious of the cost; that is, they are more likely to be working to a tighter budget and therefore more suspectable to a perceived good deal. Cosmetic medical tourism can also be indicative of an underlying mental health condition, such as body dysmorphia, but the issue goes deeper than just one mental illness.

Out of the cases studies listed above, two (Ms Morrissey and Ms Butler) were known to be concerned about their weight. Ms Kerr's friends commented during her inquest that she was also very concerned by her physical appearance. Whist she had never been formally diagnosed with body dysmorphia, she had received other cosmetic procedures in the past, including breast augmentation 10 years previously. That she elected to travel abroad based upon a WhatsApp conversation demonstrates a lack of reasoned decision-making.

Whilst Ms Brown was in every possible meaning a healthy woman, her sister has subsequently testified that her desire to return to her pre-childbirth figure drove her desire to undertake a "mummy MOT." Indeed, Ms Brown's sister was in the same ward and about to undertake the same procedure by the same medical team when she was told of her sister's death. She was subsequently handed an envelope full of cash (along with her passport) and advised by clinic staff to leave Turkey.

Of course, men are just as likely to seek cosmetic surgery abroad. Hair transplants and body sculpting (as well as other body enhancement surgeries) remain the most popular procedures. However, the sheer scale of cosmetic options, combined with the almost never-ending social media and marketing campaigns, places the focus of cosmetic medical tourism firmly on women.

Budget constraints, various degrees of body-image anxiety and a susceptibility to aggressive marketing techniques can impair reasoned and considered decision-making. Together these factors significantly increase the risk of adverse outcomes, including tragic cases such as those outlined above.

7. INTERNATIONAL COMPARISONS

7.1. Outward Medical Tourism

It is worthwhile to reflect on how governments are tackling the challenges arising from medical tourism. Direct action is somewhat limited; by its very definition, medical tourism operates in different jurisdictions, so for a government to regulate outward medical tourism to the same standard (and enforce any punitive measures) as their own health systems is all but impossible.

Any outright domestic ban on foreign medical travel (even if there was sufficient appetite) would be as impossible to police as it would be politically damaging to legislate. Further, it would be such a disregard to the benefits medical tourism brings that any such ban would be deeply disproportionate.

Instead, governments need to consider more holistic policies when attempting to protect their citizens.

The United States: owing to a lack of universal healthcare, burgeoning medical bills, the size of its population and ease of travel for US citizens, it is unsurprising that the US has one of the highest rates of outward medical tourism anywhere in the world.[xxxix] Statistically, US citizens are at greater risk of harm arising from medical tourism than those in the UK, given the higher proportion of patients travelling abroad for treatment. For this reason, the American Society of Plastic Surgeons (ASPS) actively warns against unverified medical tourism and advocates for stronger insurance coverage. However, as with many professional associations and representative bodies, there is a degree of protectionism to this directive.

The US does not directly regulate outward medical tourism, but the Department of State (DOS) and the Centers for Disease Control and Prevention (CDC) provide warnings, guidance and recommendations. Most starkly of all, the US government reminds its citizens that it will not (and is under no obligation to) pay a citizen's medical bills in the event of any complications arising out of treatments conducted abroad. The CDC's Yellow Book remains the "go to" for advice regarding outward US medical tourism.

The DOS and CDC recommend that US citizens:

- Research clinicians and facilities thoroughly by making use of JCI accreditations, local/national accreditations, reviews and reputations.
- Obtain specialist health insurance, as normal US insurance policies will not cover medical tourism.
- Arrange consultations with domestic (i.e. US) HCPs 4 to 6 weeks before travel and a follow-up consultation upon return to the US. This should mitigate inappropriate or unnecessary medical procedures, confirm that the patient is in a suitable state of mind, ensure that the procedure is being conducted for the "right reasons," and identify any complications which may result in serious harm or death.
- Ensure that all medical records and documents are up to date and that there are open lines of communication with the foreign providers. This includes taking all necessary medical records when travelling, using the services of a translator (where necessary) and ensuring there are suitable pre and post procedure consultations.

Despite the best endeavours of Obamacare, the lack of a universal healthcare system in the US ensures that the driving force behind medical tourism is reducing costs. This ensures that reform of medical tourism is more dependent on political factors than anywhere else in the world. An effect of the return of US protectionism and trade tariffs could see a reduction in outward US medical tourism, as retaliatory measures by foreign governments could see higher prices or a closing of markets to US citizens.

As the focus of outward US medical tourism is on cost rather than quality, US policymakers are aware that regulation is heavily connected with an acceptance of domestic healthcare reform. US policymakers are aware that the cost for the consumer will be reduced should the US adopt a universal healthcare model reducing the need for medical tourism.

A further shortcoming in US oversight of medical tourism is its reliance upon the JCI (a shortcoming which affects any government with the same policy). JCI accreditation is voluntary only; there is no international legal obligation for hospitals and clinics to join it. Further, there are concerns regarding the quality of reviews, and to what extent a patient can trust the word of another.

Finally, the Federal Trade Commission (FTC) is a regulatory agency whose function includes establishing consumer protection regulation, which includes curbing deceptive advertising. Although it is not feasible for the FTC to regulate the health and travel aspect of non-US medical advertising, it can regulate the quality and the honesty of domestic advertising. Whilst these limitations will ensure that policing of harmful content will only be partially successful, policymakers in the US have become more reliant on the FTC to help combat social media content and the targeting of vulnerable patients.

The European Union has divided outward medical tourism into two distinct policy areas: that between member states and medical tourism beyond the EU.

Medical tourism within the EU is covered by EU Directive 2011/24/EU, which establishes patients' rights across member states. In summary, patients' rights are:

- Access healthcare in any other EU country.
- Redress and reimbursement of the emergency medical fees by the home country's health system, to either the same amount or the equivalent amount for the same procedure in the home country.
- A national contact point to provide and drive quality and safety standards across member states.
- A continuity of care in the home country once the patient has returned.

Whilst medical tourism is not explicitly mentioned, the Directive does provide a degree of certainty to EU patients; namely, mitigating aftercare issues arising from procedures, such as associated costs and the right to ongoing medical care. EU citizens are less exposed to risks stemming from government inertia than citizens in the US.

Outward medical tourism beyond the EU is not covered by the Directive: EU citizens are not protected by EU reimbursement, redress is limited to the national law of the domestic and host countries, and continuity of care is governed by the patient's rights as established and governed by each member state. There is, therefore, limited oversight beyond EU boundaries.[xl]

Until recently, outward medical tourism was not seen as an EU concern, as it was considered an issue best dealt with by policymakers in each individual member state. However, with ever greater EU integration, combined with its greater resources, political and international influence, and the rise in medical tourism post the 2011 directive, the EU is now seen as the most appropriate engine in which to police and regulate outward medical tourism.

In April 2025, MEPs called on the EU to implement better cross-border healthcare rules between EU and non-EU nations, for the EU to protect its citizens by providing them with more and better information regarding medical tourism and to ensure that nations seeking EU membership implement higher domestic healthcare standards to become more in line with higher European standards.[xli]

The issue of healthcare standards was targeted more at Turkey, following a 2023 report published by the European Centre for Disease Prevention and Control (ECDC), which linked 87 cases of botulism in the EU to cheaper Botox administered in Turkey.[xlii]

In response, the EU Health Commissioner, Olivér Várhelyi, announced that the EU would examine ways to tackle the issues arising from outward medical tourism. Significantly, it would appear that regulation is not the approach the EU will take. As Várhelyi stated, there is only so much that the EU and its member states can do to improve the standards in other jurisdictions, save for encouragement and regulating the advertising.[xliii]

Instead, Várhelyi highlighted the main issue as the challenge of providing effective aftercare, due to a lack of access in the home country to medical records of procedures conducted abroad. Education of its citizens, regulating foreign advertising and co-ordination between member states and non-EU providers will be the EU's priority post 2025.

7.2. Inbound Medical Tourism

It is important to consider the regulation of inbound medical tourism in some of the largest medical markets. The domestic regulatory frameworks of Turkey, Mexico, Thailand and the UAE (four of the largest global markets and popular destinations for UK patients) are considered.

In 2017, Turkey introduced the International Health Authorisation Certificate, requiring health centres to meet specific service standards and implement an international medical tourism unit to co-ordinate patient admissions, treatment, billing and other operational matters. Mandatory complication insurance was also a requirement for all surgical and clinical procedures.[xliv]

The Turkish Ministry of Health was responsible for oversight and regulatory enforcement, with any compliance failure to result in penalties and potential suspension of the tourism licence.

In theory, this sounded very effective. Unfortunately, a lack of effective enforcement in practice (combined with high international demand) resulted in unlawful providers continuing to operate, contributing to the issues and case studies already referred to in Section 6.

Understanding the need for change, the Turkish government (in 2025) announced reforms to the International Health Authorisation Certificate and introduced the Regulation on International Medical Tourism and Tourist Health Guidelines.[xlv] From now on, all health clinics offering services to foreign patients must progress their accreditation through USHAS, the state-owned international health services company.

Key updates include:

- All clinics, facilities and *intermediaries* organising travel (as well as medical procedures) must hold an authorisation certificate.
- Travel agency rules have been revised to include travel agents and organisers in requiring an authorisation certificate; travel agents are now considered intermediaries and are required to advertise to the same standards as clinics.
- All clinics must have complication insurance in place.
- Public verification of all clinics is now required.
- USHAS now serves as the operations hub.

The measures were introduced partly to protect and enhance Turkey's reputation, but also to help improve and monitor Turkey's healthcare system as it looks to expand into the emerging markets of geriatric care, stem cell therapy, robotic surgery and thermal tourism.

It should remain a priority for UK policymakers to monitor the impact of Turkey's 2025 reforms and whether these will have the desired effect in raising standards and protecting foreign patients. Success of these reforms could be key considerations for when UK policymakers decide which of these regulations any UK reforms post 2025.

Mexico has no single regulatory policy governing inbound medical tourism, but rather a combination of policies through an accreditation scheme for hospitals, general health law and the establishment of the National Medical and Wellness Tourism Board.

There is also regulatory oversight provided by the Federal Commission for the Protection Against Sanitary Risk (COFEPRIS), which oversees health regulated products and services.[xlvi] Unsurprisingly for a jurisdiction lacking in coordinated oversight of a complex sector, issues have emerged. These are:

- Weak and limited appetite for enforcement.
- No requirement for medical negligence insurance.
- Lack of legal recourse for patients.

There is an additional issue facing medical tourists, almost unique to Mexico: internal security and domestic crime. As has been highlighted, cost savings remain an important driver for medical tourism. Due to the geographical location of Mexico, cost savings will be seen to be a more important consideration for US rather than UK patients. However, UK nationals travelling to Mexico are just as likely to face risks.

And the issue? Unfortunately, cheaper clinics offering cheaper procedures are more likely to be located in areas of high violent crime, where foreign nationals are seen as easy prey for criminal gangs. Medical tourists are no exception. Street crime, kidnapping, extortion, drugs, sexual assault and murder are the most common crimes affecting tourists.

Due to misleading or opaque marketing techniques, clinic locations remain hidden, and it is unfortunate that some medical tourists may only become aware of this additional danger until it is too late. Foreign patients are thereby exposed to both physical and clinical danger.

The focus for those who seek medical tourism in 5-star resorts is invariably on quality of care rather than cost, and due to the Mexican economy's reliance upon tourism, these are invariably located in much safer government-controlled areas.

The example of Mexico remains an important example of the need for effective oversight of foreign advertising and education amongst domestic nationals.

The priority in Thailand is on visa control rather than actual regulation. Medical tourists travelling to Thailand are eligible for a 90-day visa, instead of the standard 60 days. The Thai government views advancement in medical provision and medical tourism as important drivers for wider economic recovery and has invested heavily in recent years into reforming the healthcare system and improving clinical standards.

To further both clinical advancement and the economy, the Thai government has adopted a threefold strategy:

- Strategy 1: the improvement of competitive capabilities in medical, wellness, service and academia.
- Strategy 2: the creation of an ecosystem to support integrated medical services within the Thai healthcare system.
- Strategy 3: adopt a comprehensive international public relations and medical advertising campaign primarily for Thai medical tourism.[xlvii]

It is unsurprising, given its popularity as a tourist destination, that the Thai government has identified the country's potential as a hub for international medical tourism. Unfortunately, despite the work of the Department of Health Service Support (DPHSS), a sub-department within the Ministry of Health, regulatory oversight has not yet caught up with Thai ambition.

The UAE, concerned that potentially negative perceptions of medical tourism could undermine its international reputation as a safe and respectable destination, has perhaps done the most (along with Turkey) to bring proper regulatory reform to inbound medical tourism.

In 2014, there were just 39 JCI accredited clinics, compared with 214 in 2023.[xlviii] This reflects the work undertaken to improve regulatory oversight by the Emirates. As with Turkey, there is

now mandatory accreditation for all clinics through the Ministry of Health and Prevention (MOHAP).

Further, the patient journey has been improved, driving standards in advertising as well as pre- and post-procedure consultations. Each Emirate must have its own patient portal, a single window smart application and digital gateway for medical tourists, which is responsible for booking procedures, consultations, VISAs and packages.

All procedures must be booked through these portals; it is unlawful for a clinic to practise without accreditation, whilst an inbound medical tourist must also register their medical treatment VISA. The Dubai Health Exchange (DHX) and the Abu Dhabi Medical Tourism e-portal are two examples.

Further, the UAE patient bill of rights provides medical tourists with redress in the event of complications and provides a duty of aftercare on the clinic responsible. As a sign of its commitment to improving medical tourism, Dubai has recently updated its own public health laws as a mechanism to improve healthcare, food safety, disease prevention and energy awareness.

Whilst the long-term impact of these measures has not yet been seen, and therefore remain debatable, one other area of inbound medical tourism under scrutiny in the UAE is the role of advertising and social media. In a drive to protect its reputation for transparency and integrity, the Emirates have identified the harm caused by irresponsible advertising and have introduced a more stringent regulatory framework as a means to attract international patients.

The UAE is yet another country that has identified the potential harm of advertising and the impact influencers may have on the sector. Any regulatory reform introduced by a UK government should be developed in coordination with measures proposed by international counterparts.

8. POLICY RECOMMENDATIONS

The following policy recommendations are proposed with the priority of providing meaningful impact and protection for outbound UK medical tourists, combined with realistic implementation prospects. As this White Paper has indicated, one intrinsic weakness of policy reform in this area is that this is a cross-jurisdiction issue, and there is little point in any government introducing policy that relies upon the cooperation of other governments to drive standards, especially if enforcement is required for any regulatory breaches.

Impactful policy reform is therefore limited to before the medical tourist leaves the UK or upon their return. Education and awareness remain the best policy for driving foreign standards once the UK patient has landed in the host country.

8.1. Establish a UK Medical Tourism Accreditation Association

As a first step, the UK government should establish the UK Medical Tourism Accreditation Association (UKMTAA), which will be a national body created to accredit foreign providers serving UK patients.

It would be wrong to recommend a blanket banning of outward medical tourism; not only would it be disproportionate to the benefit outward medical tourism brings, but it would also be politically impossible due to the predicted unpopularity of the policy combined with the curtailing of freedom of choice (always a sensitive area for governments). The resources required to police (combined with the relative ease in which patients can evade such a policy) would ensure that any outright ban would be almost impossible to enforce.

It is also absurd to suggest that emergency treatment in the UK should be withdrawn to British patients experiencing post-procedure complications; it is inconceivable to expect UK medical staff to withdraw treatment to a seriously ill patient, whatever the circumstances.

Rather, the UKMTAA would provide a formal mechanism for advancing comprehensive regulatory reform. The first stage is for the UKMTAA to establish a public registry of approved clinics, divided across specialisms and treatments offered. This will aid patient research and encourage patients who might otherwise rush decisions based upon dubious advertising techniques (especially within cosmetic procedures) to make more considered, informed decisions.

The process of gaining accredited membership will focus on standards of:

- advertising
- care and procedures provided
- national healthcare regulations in each host country
- the package provided
- aftercare and emergency provision.

The comparative standard to be used will be UK healthcare regulation, so there will be no marked difference in care patients can expect to receive. Further, historical performance records based upon success and patient outcomes will also be required as part of the membership process.

Accreditation will be based on quality of care, the standards of healthcare and regulation within each medical destination and the adherence of the clinics to these said standards. Published reviews of patients who have undergone similar procedures will aid considered decision making.

The UKMTAA will have a complaints mechanism that mirrors existing complaints procedures within UK healthcare. It will be within the powers of the UKMTAA to implement a series of sanctions against clinics that have complaints against them upheld. The most powerful sanction will be the suspension of accredited status, which will remain on public record.

At first, membership should be voluntary and encouraged through various incentives, such as reduced subscription, earlier access to markets and an emphasis on co-operation on redress for any negligent clinic rather than just punitive sanctions for early members. It is envisaged that the voluntary membership period would last three years, running adjacent to public awareness and advertising campaigns, as well as providing opportunity for the UKMTAA to increase its own recognition amongst foreign clinics. At the three-year mark, membership should become mandatory.

Membership of the UKMTAA (which may appear to be somewhat easy for foreign clinics to ignore) will be encouraged through the tighter reform discussed below. In short, it is about making public awareness such that it becomes almost impossible for clinics to ignore. The intention is that as UK patients will only use the UKMTAA, it will become necessary for those clinics which want to attract UK patients to join.

Success of the UKMTAA will be based upon long-term objectives and other policy recommendations, which are all detailed below. Its success will also be due in large part on the public's awareness and use of its services. For that reason, the following recommendations should be seen as a whole, rather than as separate policies.

8.2. Minimum Aftercare Standards

An overriding issue arising when discussing updating medical tourism policy, as already stated, concerns clinical procedures being conducted in a foreign jurisdiction. As much as UK policymakers may want to regulate outward medical tourism, there is very little they can do to protect the tourist once they are abroad and to hold negligent clinics to account.

As ideal as it would be to introduce standards to which foreign clinics must adhere to, it is unfortunately impossible to implement.

One constant area of concern remains the standards of aftercare. This has rightly been identified not only as a significant risk to patient safety but also as the aspect of medical tourism that imposes the greatest cost on the UK. It has previously been mooted that the government should introduce mandatory partnerships between foreign clinics and CQC-registered UK clinics.[xlix] This is a worthy recommendation and there is some potential to it, especially if it is tied into membership of the UKMTAA.

However, this is not a short-term option; it will take time and commitment to build the UKMTAA and it is naïve to think the UK government could force a foreign clinic into a partnership agreement with a UK counterpart.

To guarantee impact, membership of the UKMTAA should be the only way in which foreign clinics can obtain access to UK patients. In the immediate to short-term, UK patients should be advised to insist upon access to written aftercare plans (in English), which can be easily accessed by either the patient or next of kin in the event of an emergency. Once the UKMTAA is operational and inter-clinic partnerships have been created, then in the medium to long-term, the need for patient or next of kin disclosure will be circumvented as the UK clinic will have automatic access to the patient's international medical records, easing the process for patient aftercare. Mandatory partnerships will include a confirmed 7-day post-return follow-up with the UK partner.

8.3. Mandatory Medical Tourism Insurance

The requirement that UK medical tourists must carry specialist insurance covering complications, repatriation and aftercare, should be a prerequisite for membership of the UKMTAA. This is another recommendation whose success will be felt more in the long-term than short-term.

It should be the ambition of any meaningful reform in medical tourism that overseas clinics only accept UK patients with such valid insurance coverage. While the more established clinical

providers may already have insurance in place, any such policy will only confirm what is an already established practice, and formalising this requirement would help standardise best practice and extend protections.

The counter argument goes further; the danger within medical tourism is within the “cash in hand” cosmetic procedures in which little consideration, if any, is given to aftercare. The issue may become one in which mandatory insurance will push up the price, making patients who are either on a budget or who suffer from mental health problems seek cheaper, unregulated procedures.

This argument does have some merits to it, and it is important that UK policymakers do not exacerbate an already complex issue through clumsy implementation, and policing such policy needs to be well-thought through. Realistically, how will the relevant authorities know if a patient has insurance until it is too late? Will the insurance cover complications arising in the UK or in the host country?

As the case studies demonstrate, complications can be more long-term and arise when the patient has returned to the UK. Unfortunately, short-term complications invariably involve the death of the patient either during the procedure or in the immediate hours afterwards. Either way, and as tragic as this is, such costs incurred by UK authorities will include repatriation and the inquest, which do not affect NHS budgeting.

Considering also that many of the more dangerous cosmetic procedures are sold with a recovery time of days only (and can therefore be carried out within a week or a fortnight window), many of these procedures are sold as packages. As far as the both the UK and the host country’s authorities are concerned, there is no need for a VISA, as the patient is travelling for pleasure rather than for medical reasons.

A UKMTAA accredited clinic must ensure that the patient has insurance in place; but as has been discussed, these clinics will be the more reputable ones. It is the less-reputable clinics which require the greater oversight. Unfortunately, mandatory insurance could make the situation worse, or will at least be ignored.

8.4. National Data Registry

The UKMTAA’s ability to track complication rates, insurance claims and outcomes will be aided by the creation of a National Data Registry. This will provide the UKMTAA with proper oversight of outward medical tourism and determine which of its members are performing to the standards set. The sharing of anonymised data with NHS trusts and insurers will improve monitoring and provide solid research for an effective public awareness campaign—by far the most cost-effective short-term policy UK policymakers can introduce.

8.5. Advertising & Influencer Regulation

As has been discussed, the role of influencers has been a primary driving force behind the rise of outward medical tourism over the last 15 years. Limiting the impact of influencers promoting the fantasy of an ideal unattainable to lesser mortals should be a key priority for any government seeking to introduce meaningful reform.

Greater control over advertising can be achieved in two ways. Firstly, the government can ban all unaccredited providers (i.e. non-members of the UKMTAA) from advertising within the UK. This will strengthen the effectiveness of UKMTAA membership, as accreditation would become the only guarantee of exposure to the UK market.

Unfortunately for policymakers, the rise of outward medical tourism has also coincided with a change in advertising techniques. Advertising is now primarily conducted through the internet and social media; advertising is virtually non-existent in the more traditional forms of advertising (television, radio and newspapers). It is just as unfortunate that these advertising channels are

owned by some of the largest global digital corporations. Considering these companies previous records for ignoring government policy, co-operation is all but essential.

The second option is more workable and has a more realistic prospect of success, and that is stronger regulatory safeguards on clinic advertising.

It should become a basic requirement for advertising to contain risk disclaimers in all promotions, in much the same way as they are tobacco products, financial services and, of course, medicines and health products. Whilst risk disclaimers only have a limited impact as it will never fully stop unconsidered medical tourism (people still smoke and invest in somewhat dubious financial schemes), the intention is for it to run in conjunction with a public awareness campaign (more below).

There have been calls to introduce penalty fines for influencers and platforms promoting unsafe or unverified clinics. This is a worthy argument, but it may fail one key practicality test, the majority of influencers are international celebrity who are based abroad. There is the key issue of enforcement; how do you enforce a fine against an individual in Los Angeles without a long, arduous legal process? Further, a fine will need to be sufficiently large enough to make this process financially viable for the government to pursue, whilst remaining proportionate enough so that the government does not attract any adverse publicity. This is a difficult balancing act, and even if there was sufficient appetite to ban the Kim Kardashians and Kylie Jenners of this world, any such ban may cause more publicity and drive more vulnerable persons to their posts than before.

An example of the issues arising out of advertising regulations can be found in the 2018 season of Love Island. The Mental Health Foundation (MHF) complained to the Advertising Standards Agency (ACA) that advertisements for breast enhancements were painting a “false picture of perfection” and “exacerbated young people’s insecurities”.[l] ACA rued in October 2018 that the adverts were “irresponsible and harmful.”[li]

In response, BAAPS published a statement suggesting that cosmetic companies purposefully ignore advertising guidelines, safe in the knowledge that “they will ultimately get just as much (or more) exposure from the negative reactions, and that they face little to no consequences”.[lii]

The key is prevention, not just punishment.

Further, stricter regulation of social media advertising will provide enhanced protections for minors vulnerable to less reputable social media advertising discussed earlier in this White Paper.

Regulating the advertising and ways in which to reduce public access to unaccredited providers will curtail the impact of influencers more than a policy of fines and punishments. By curtailing an influencer’s access to their audience, a government will reduce their influence more effectively than a fine would (even if enforced).

8.6. Public Awareness Campaign

Improving the public’s knowledge of the risks associated with outward medical tourism is the most effective short-term policy the government can introduce. It can be achieved by educating patients on risks and red flags, targeting social media platforms where younger people are most exposed, and promoting safer decision-making via NHS and government websites. This will directly influence the provision of cosmetic medical tourism, which carries the greatest level of risk within the sector.

Improving public awareness would also demonstrate that the higher-risk areas of medical tourism (such as cosmetic procedures) should be seen more as part of a wider medical issue rather than as isolated consumer choices. Body dysmorphia is an obvious example, but there are many strands of anxiety which could lead a UK citizen into making an unconsidered and poorly thought-out decision.

The red flags are cash payments, WhatsApp conversations, a lack of pre-procedure consultation or lack of access to doctors, lack of national accreditation, a failure to disclose (or even have) clinical reputation and a focus on a high turnover of procedures rather than effective aftercare.

These may seem obvious, but it goes to the entire crux of the matter; outward medical tourism is more dangerous for those patients who make the rushed, ill-thought-out decisions, and for whom other pressures and influences may prevent what would otherwise be reasonable and obvious considerations for an individual to make.

A sustained public awareness campaign on social media and other popular platforms would help curtail the power of the influencer, restrain the advertising power of unaccredited clinics and divert the viewer towards the UKMTAA. The intention of a public awareness campaign is not necessarily to reduce outward medical tourism, but rather to make the individuals carefully consider their options. A key aspect of the campaign would be to highlight NHS services for those who may suffer from body image anxiety and signpost them to UK clinicians, thereby potentially negating the need for travel in the first place.

It will be possible (by focussing part of the public awareness campaign on schools, families and communities) to promote supportive conversations about body image amongst adolescents and emphasise prevention through education and informed decision-making rather than stigma or blame.

The public awareness campaign would become the glue which highlights the founding of the UKMTAA and associated regulatory reforms.

8.7. Possible NHS Reform?

It has already been stated that is possible to see the rise of outward medical tourism in the last 15 years as an indication in the change of societal attitude towards healthcare and change societal attitude more generally.

It may now be time for policymakers, the media, users and stakeholders to acknowledge that that there should now be a mature discussion on how the NHS can adapt to changing societal trends and remain true to its founding principles.

Is it possible that the 523,000 foreign visits a year for medical treatment should not be seen as a threat to the NHS, but rather as potential avenues of improvement once the reasons for medical tourism have been more clearly understood?

Perhaps the benefits of outward medical tourism (or at the very least, its drivers) are a demonstration of what the patients would their universal healthcare model to become; i.e. greater freedom of choice, a wider selection of treatments, an assumption of responsibility and greater control in their health. Perhaps it is even the public's reaction to the perception that the near limitless availability of funds by successive governments encourages waste and increases inefficiency?

These are some of the topics which a meaningful conversation on the implications of outward medical tourism on the NHS could include.

Could the rigid adherence to the policy of encouraging a spiral of near endless spending as opposed to meaningful structural change be a driver for UK patients seeking treatment abroad? It may therefore be time for a grownup, mature discussion to take place. This is not to say that cosmetic procedures based purely on aesthetics should be made available free of charge. Far from it, but the basic principle of choice which is available throughout Europe but is denied to UK patients may have become a subconscious desire amongst UK citizens to seek alternatives and a say in the decision-making process which affects patients when they are at their most vulnerable.

Medical tourism could be used as a catalyst to highlight the need for a wider discussion on NHS reform, focussing on the population's priorities for what they would like their NHS to be for the remainder of 21st century.

Greater choice would lead to a greater sense of ownership in healthcare and a sense of attachment to the decision-making process, along with their obvious participation as patients. A greater sense of involvement could also lead to greater patient satisfaction, one overriding complaint amongst patients is a sense of detachment from decision making. Medical tourism should be seen as an aid towards improving NHS standards, if a government or a political party with ambitions to form a government had the confidence to utilise it.

8.8. Expected Impact

The domestic impact of implementing these reforms will be profound. A UK government would help protect UK patients from unsafe or exploitative practices while also reducing pressure on the NHS' burden by lowering the costs of managing post-procedure complications.

It is important to remember that it will take time for the benefits of the reforms to be felt; time and patience are as valuable investments as other resources. It will take time for the UKMTAA to build its membership and engage with international stakeholders, for the public awareness campaign to be fully established and for the public to be guided by its messaging.

The expected domestic impact may not be properly felt until close to 2030. Unfortunately, this has to be a realistic prospect; it will take time to engage with the public and for the UKMTAA to engage with international stakeholders. Momentum is important: if policymakers intend to generate meaningful reform, then it is vital for outward medical tourism to remain top of the agenda.

It is too easy for this matter to become forgotten if other issues take its place.

Internationally, policy reform will improve global accountability among medical tourism providers. This will benefit not just UK citizens, but medical tourists from across the globe who are subject to the same risks as their UK counterparts. Any benefits the government can secure for its patients will position the UK as a world leader in responsible medical tourism regulation and improve the nation's reputation within global healthcare.

9. CONCLUSION

Outward medical tourism can provide patients with greater choice, cost savings and access to advanced healthcare abroad, which may not be readily available domestically. It is too easy to fall into the trap of focussing solely on negatives associated with medical tourism, without acknowledging that it does bring benefit.

However, it must be acknowledged that without stronger safeguards, UK patients remain exposed to unnecessary risks from less reputable clinics. Mitigating the risks of outward medical tourism must remain the joint responsibility between government and patients. Many risks persist due to the lack regulation, but patients also have a responsibility to conduct thorough research and make considered decisions. That dual responsibility underscores the vital importance of a comprehensive public awareness campaign.

It is important to remember that as with most policies healthcare related, no reforms provide a quick fix. It will take time, effort and engagement from policymakers, healthcare professionals and patients to ensure that meaningful reform will have beneficial impact.

The recommendations proposed by this White Paper (including accreditation, insurance, advertising reform, and aftercare standards) are just the beginning. Effective implementation will require coordination among policymakers to establish a coherent framework and engage relevant stakeholder groups. By following the guidance presented, a comprehensive plan can be developed that will protect patients, reduce NHS costs and promote responsible global healthcare practices.

ACKNOWLEDGEMENTS

This White Paper was written in co-operation with Conservative Health and 20/20health would like to thank them for their co-operation, influence and ideas, which helped to shape the policies proposed.

REFERENCES

[i] iHealthcareAnalyst 2025. Global Medical Tourism Services Market $245 Billion by 2033 Global medical tourism market to reach $704.8 billion by 2033, CAGR of 19.08% | ITIJ https://www.ihealthcareanalyst.com/global-medical-tourism-services-market/ Medical Tourism Market Size, Share, Global Growth Report, 2034

[ii] International Travel & Health Insurance Journal 2025. Global medical tourism market to reach $704.8 billion by 2033, CAGR of 19.08%. https://www.itij.com/latest/news/global-medical-tourism-market-reach-7048-billion-2033-cagr-1908#:~:text=Asia%20Pacific%20currently%20dominates%20the,of%20over%2025.5%25%20in%202024.

[iii] Qunomedical 2016. The Top 10 Treatments People Travel Abroad for | Qunomedical https://www.qunomedical.com/en/blog/the-top-10-treatments-people-travel-abroad-for

[iv] NaTHNaC 2023. Travelling abroad for treatment? https://travelhealthpro.org.uk/news/699/travelling-abroad-for-treatment#:~:text=Cosmetic%20surgery%20abroad%20can%20be,treatment)%20for%20more%20detailed%20information.

[v] Border P, 2020. Outward Medical Tourism. UK Parliament Post (research briefing). https://researchbriefings.files.parliament.uk/documents/POST-PB-0038/POST-PB-0038.pdf

[vi] ONS 2025. Estimated number of visits by residents of Great Britain to overseas countries for medical treatment, 2024. https://www.ons.gov.uk/peoplepopulationandcommunity/leisureandtourism/adhocs/3021estimatednumberofvisitsbyresidentsofgreatbritaintooverseascountriesformedicaltreatment2024

[vii] Border P, 2020. Outward Medical Tourism. UK Parliament Post (research briefing). https://researchbriefings.files.parliament.uk/documents/POST-PB-0038/POST-PB-0038.pdf

[viii] https://hansard.parliament.uk/Commons/2024-03-12/debates/D4C7041F-DDEC-468C-8912-144B36637CFE/ForeignCommonwealthAndDevelopmentOffice

[ix] Health and Care Research Wales 2025. Complications and costs to the NHS due to outward medical tourism for elective surgery: a rapid review. https://researchwalesevidencecentre.co.uk/medical_tourism

[x] Roberts, J. L., Eckersley, M., Davies, K. J., & Gilmour, A. (2024). The cost of cosmetic surgery tourism complications to the NHS: A retrospective analysis. Surgeon, 22(5), 281–285. https://doi.org/10.1016/j.surge.2024.04.012

[xi] BAAPS n.d. Cosmetic Tourism: What You Need To Know. https://baaps.org.uk/patients/safety_in_surgery/cosmetic_tourism.aspx

[xii] BBC 2024. Bariatric tourism care costs NHS more than actual surgery - study. https://www.bbc.co.uk/news/uk-england-london-67946049#:~:text=The%20interventions%20at%20the%20five,Metabolic%20Surgery%20Society%20(BOMSS).

[xiii] Wolfson, S. 2025. National Health Service or National Safe Haven. https://policyexchange.org.uk/wp-content/uploads/National.Health.Service.or_.National.Safe_.Haven_.pdf

[xiv] https://publishing.rcseng.ac.uk/doi/10.1308/rcsbull.2024.105

[xv] https://www.rcn.org.uk/congress/congress-events/health-tourism-2025

[xvi] Booking Health 2025. Cancer Treatment Abroad. https://bookinghealth.com/blog/medical-tourism/treatment-abroad-guides/302838-is-cancer-treatment-truly-better-abroad.html

[xvii] Bookimed 2025. Cancer Treatment Abroad: Best Centers and Costs in 2025. https://us-uk.bookimed.com/article/cancer-treatment-abroad/

[xviii] Hyde, A., 2025. Move over Turkey – these are the new frontiers of medical tourism. Telegraph. https://www.telegraph.co.uk/travel/news/countries-britons-choosing-faster-medical-care/

[xix] NICE 2024. https://www.nice.org.uk/news/articles/nice-publishes-final-draft-guidance-on-enhertu-after-commercial-discussions-conclude

[xx] Parallel Parliament 2025. Trastuzumab Deruxtecan. https://parallelparliament.co.uk/question/98645/trastuzumab-deruxtecan

[xxi] Thousands more men in England offered abiraterone, one of our prostate cancer treatment breakthroughs - Cancer Research UK - Cancer News

REFERENCES

[xxii] UK Parliament 2025, 10 February. Hip Replacements: Waiting Lists. https://questions-statements.parliament.uk/written-questions/detail/2025-02-10/HL4888/
[xxiii] UK Parliament 2025, 24 February. https://questions-statements.parliament.uk/written-questions/detail/2025-02-10/HL4889/
[xxiv] UK Parliament 2025. NHS key statistics: England. https://commonslibrary.parliament.uk/research-briefings/cbp-7281/
[xxv] Ibid
[xxvi] Lawford, M. 2023, 27 February. How NHS waiting lists are driving a British health tourism boom. The Telegraph. https://www.telegraph.co.uk/business/2023/02/27/how-nhs-waiting-lists-driving-british-health-tourism-boom/
[xxvii] Best Hospitals For Bone Marrow Transplant In India, Bariatric Surgery in India, IVF in Mexico | Complete 2026 Guide, 50 Things You Should Know About Getting Dental Care in Mexico – Beyond Borders Dental | Top Quality & Affordable Dental Care in Mexico, What Drives the Medical Tourism Market in 2025? | Shortlister, Best Countries for Medical Tourism Partnerships in 2026, sskmedtour.com
[xxviii] Find Accredited International Organizations | Joint Commission, Why Turkey Is #1 for Medical Tourism in 2025: Cost & Quality | Dose Group, alexandria-cg.mfa.gov.tr
[xxix] https://www.tiktok.com/@midwifemarley, https://www.tiktok.com/@doctally
[xxx] POST-PB-0038.pdf
[xxxi] How long does it take to get an orthopedic appointment in turkey? - Can Hospitals : Can Hospitals, Medical Tourism in UAE- A Step-by-Step Guide for International Patients, A Complete Guide to Medical Travel in UAE
[xxxii] A Complete Guide to Medical Travel in UAE
[xxxiii] U.S. vs. European Medical Tourism and Integrative Care | A Comparatative Analysis
[xxxiv] British mother-of-two, 38, dies during £5,400 'mum MOT' of Brazilian butt lift, tummy tuck and boob job in Turkey | Daily Mail Online
[xxxv] Devonish, J. (2023). Regulation 28: Report to prevent future deaths – Emma Morrissey (Ref. 2023-0317). Courts and Tribunals Judiciary. https://www.judiciary.uk/wp-content/uploads/2023/09/Emma-Morrissey-Prevention-of-future-deaths-report-2023-0317_Published.pdf
[xxxvi] Ibid
[xxxvii] Melissa Kerr - Prevention of future deaths report - 2023-0330, Brazilian butt-lift surgery death prompts Turkey-UK meeting - BBC News
[xxxviii] Doctor warns of rise in problems from Turkish weight loss surgery - BBC News
[xxxix] The Rise of Medical Tourism: Why Americans Are Seeking Healthcare Abroad
[xl] Overview - Public Health - European Commission, Cross-Border Healthcare Directive - European Reference Network, EU Directive 2011/24/EU on the application of patients' rights in cross-border healthcare: Legislation Guidance for Patient Organisations
[xli] What are the risks of health tourism? Why MEPs are calling for better protection of patients abroad | Euronews, EU launches plan to strengthen preparedness for cross-border health crises
[xlii] Update on iatrogenic botulism cases in Europe
[xliii] What are the risks of health tourism? Why MEPs are calling for better protection of patients abroad | Euronews
[xliv] Turkey Introduces Rules for Medical Tourism Sector, Including Regulated Prices - Moroğlu Arseven, Turkey introduces rules for medical tourism - LaingBuisson News
[xlv] Major Changes To Turkey's Medical Tourism Sector: 2025 Regulatory Update - Healthcare - Turkey, Turkey's 2025 Medical Tourism Regulations: A New Framework for a Growing Industry | Global Doctor Review
[xlvi] What is COFEPRIS? Mexico's Health Regulator Explained | Glossary, What is COFEPRIS?, Mexico's COFEPRIS
[xlvii] Thailand—A Global Health Hub - THAILAND.GO.TH, 3 Strategies to Propel Thailand as a Medical Hub - THAILAND.GO.TH
[xlviii] A review of the United Arab Emirates healthcare systems on medical tourism and accreditation - PMC, (PDF) A review of the United Arab Emirates healthcare systems on medical tourism and accreditation
[xlix] CQC Changes Explained: What Providers Need to Know for 2026–2028, https://assets.publishing.service.gov.uk/media/5a7f83cbed915d74e33f6e88/bis-16-150-crt-review-adult-social-care.pdf
[l] Suicidal thoughts | Mental Health Foundation, POST-PB-0038.pdf

REFERENCES

[li] asa.org.uk/rulings/mya-cosmetic-surgery-ltd-a18-459775.html, POST-PB-0038.pdf

[lii] BAAPS Statement on ASA Ruling for Love Island Cosmetic Surgery Adverts | The British Association of Aesthetic Plastic SurgeonsBAAPS Statement on ASA Ruling for Love Island Cosmetic Surgery Adverts | The British Association of Aesthetic Plastic Surgeons, POST-PB-0038.pdf