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## **Outward medical tourism**

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## INTRODUCTION

The term medical tourism has been coined to describe people seeking medical treatment in a country other than that where they reside. In the context of this brief it refers to UK residents seeking elective, non-emergency medical treatment abroad. It does not include:<sup>1,2</sup>

- Cross-border care (i.e. medical treatments commissioned by a health provider in one country from another)
- Reciprocal arrangements covering emergency treatments under schemes such as the European Health Insurance Card (EHIC)
- Other (health) services defined under the General Agreement on Trade in Services, including foreign investment in joint projects such as hospitals or the movement of health professionals between countries
- General health and well-being treatments provided by, for example, spas.

Some writers have objected to the use of the term medical tourism because they consider it has connotations of leisure, frivolity and pleasure that may be inappropriate when applied to those seeking medical treatments such as dental care, fertility treatments, or bariatric or cosmetic surgery. However, the term has become widely used to describe such behaviour. This briefing outlines the nature of the global medical tourism industry, the number of UK residents seeking medical treatments abroad, the types of treatments sought and the reasons for seeking them, the countries visited, and examines the issues raised for the patients and for the NHS on their return.

## THE NATURE OF THE MEDICAL TOURISM INDUSTRY

There is widespread agreement that the medical tourism industry has grown over the past decade or more. However, trying to put a figure on the size of the global medical tourism industry is difficult as there are no authoritative data on patient flows available from international bodies such as the World Health Organization or OECD.<sup>3</sup> In the absence of such data the published estimates that are available are based on various assumptions. For example, the consultancy Deloitte estimated that 750,000 US citizens sought medical treatments abroad in 2007,<sup>4</sup> and projected that this figure would rise to 3–5 million by 2010. It is not clear what the basis of this estimate is, and other studies have yielded much lower estimates than this. For example, a 2010 study put the number of US citizens seeking medical treatments abroad at between 50,000 and 121,000.<sup>5</sup> Deloitte suggested that American citizens represent around 10% of the global medical tourism market, although again it is unclear what this assumption is based on. This would put the size of the global market as somewhere between 0.5 million and 50 million people a year.

A number of researchers have documented patterns in global medical tourism.<sup>6</sup> Some of these patterns are regional and based on long associations between countries. For instance, Thailand has long served as a destination for patients from Japan,<sup>1</sup> Laos,<sup>7</sup> and Burma (Myanmar).<sup>8</sup> Patients from mainland China have a history of seeking treatment in Hong Kong,<sup>9,10</sup> and both India<sup>11</sup> and South Africa<sup>12</sup> serve as hubs for patients from surrounding countries. Other regions and countries that are noted as medical tourism destinations include Eastern Europe (particularly for dentistry) and Spain (for fertility treatments).<sup>1</sup>

Another pattern that emerges from research on medical tourism is that of diaspora medical tourism – people returning to their country of origin or a familial country for medical treatments.<sup>13</sup> This has been documented in a range of settings around the world including Mexican-Americans returning to Mexico for medical treatments and Korean migrants to the USA, New Zealand and Australia returning to South Korea for treatment.<sup>3</sup> Factors contributing to diaspora medical tourism may include practical difficulties in accessing healthcare in the adopted country, cost, the opportunity to visit family and friends or to undertake a religious pilgrimage on the same trip, language considerations, and preference for treatment in the country in question.

The factors underlying the above patterns include close historical links between countries, familiarity and cultural similarity. Such factors may challenge conventional notions of medical tourism as a market that can be

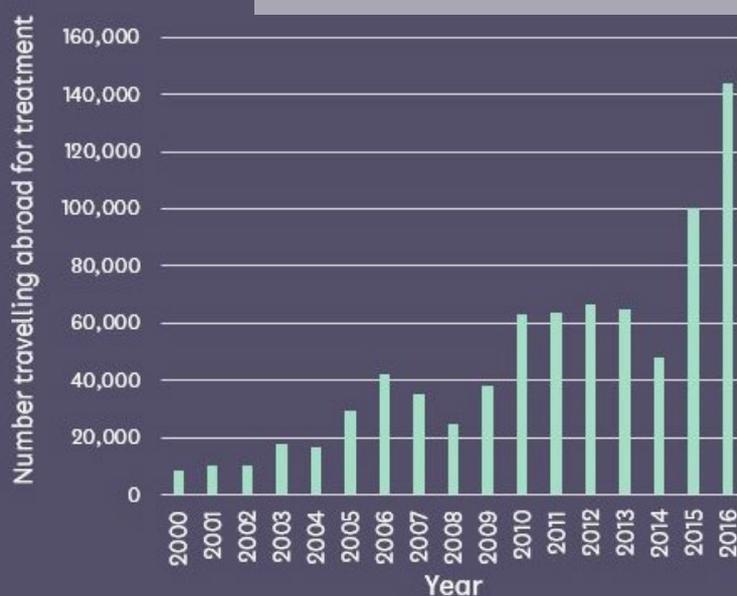
exploited by national governments.<sup>3</sup> Nevertheless, there is evidence that some countries have sought to position themselves as centres for medical tourism, although the extent of involvement of government agencies varies. For example, a 2014 review noted that the Hungarian Ministry of Health had funded a medical tourism symposium in London that appeared to be part of a wider national strategy to promote Hungary as a medical tourism destination.<sup>14</sup> The review also noted that the Thai Government had invested in infrastructure to promote medical tourism to Thailand and had introduced a special visa for medical tourists. Other governments that have actively promoted their country as a medical tourism centre at international trade fairs or via economic development and/or tourism policy include those of India,<sup>15</sup> Malaysia,<sup>16</sup> Singapore and Turkey.<sup>3</sup>

## THE NUMBER OF UK CITIZENS SEEKING MEDICAL TREATMENT ABROAD

As with the case of trying to estimate the size of the global medical tourism industry, there is a dearth of authoritative information available on the number of UK citizens travelling abroad for medical treatment. The main source of information is the International Passenger Survey (IPS) conducted each year by the Office for National Statistics (ONS). Travellers arriving or leaving at all of the main UK sea terminals, airports and Eurostar terminals are randomly selected to complete a survey. In addition to providing basic demographic information, one of the questions in (one part of) the survey asks travellers what the main purpose of their trip is, with ‘medical treatment’ being one of the permitted answers. Around 250,000 travellers complete the survey each year, which represented a small (0.23%) sample of the total number of travellers (108.4 million) entering or leaving the UK in 2016.

This small sample size raises questions about how representative the IPS data is of the total number of UK citizens travelling abroad. However, despite its limitations, the IPS represents the best data set

**Figure 1.** Trends in the number of UK citizens travelling abroad for medical treatment (2000–2016)



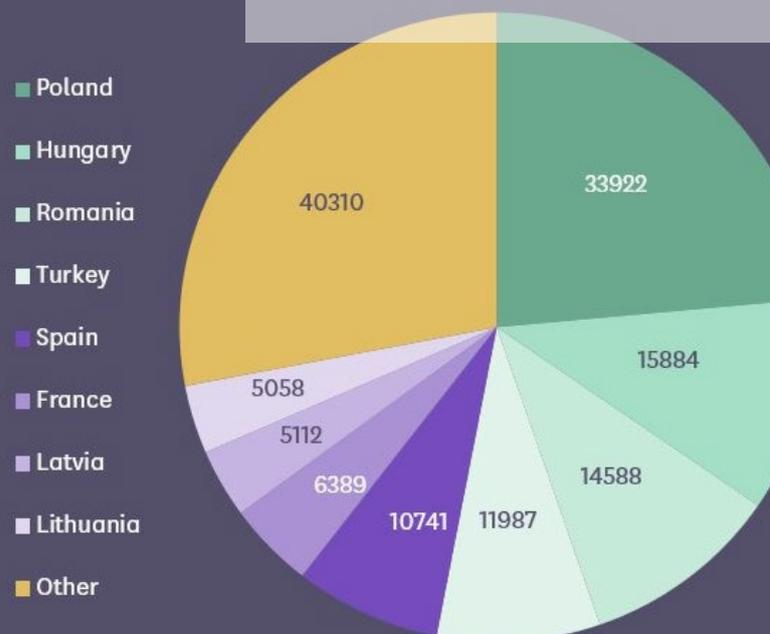
available for assessing trends in the number of UK citizens travelling abroad for medical treatment (Figure 1) and for identifying the countries they visit (Figure 2). As illustrated in Figure 1, between 2000 and 2010 the number of UK citizens citing medical treatment as the primary purpose of their trip abroad rose from under 10,000 to over 60,000, albeit with a couple of dips (2004 and 2008). Between 2010 and 2013, the number stayed fairly constant at 63,000–66,000, dropped in 2014 to 48,000 and then rose sharply in 2015 (just over 100,000) and 2016 (nearly 144,000).

## DESTINATIONS FOR UK OUTWARD MEDICAL TOURISTS

In 2016 UK citizens travelled to 31 different countries for medical treatment. Eight countries accounted for 72% of all such visits (Figure 2). Top of the list was Poland, which accounted for nearly 34,000 visits, followed by Hungary (15,884) and Romania (14,588). The next most popular destinations were Turkey (nearly 12,000 visits) and Spain (10,741), with France, Latvia and Lithuania each accounting for more than 5000 visits. Of the remaining 28% of visits, the three most frequently visited destinations in 2016 were Switzerland (4165), Greece (3885) and India (3867), with Bulgaria, the Canary Islands, Germany, Slovakia and the USA each accounting for more than 2000 visits.

Information on the types of procedures sought in these destinations is not collected as part of the IPS. Instead such information has to be gleaned from smaller-scale interviews and surveys of people who have undertaken or are considering undertaking medical treatment abroad. Such studies are often recruited through online fora and support group newsletters or mailings and therefore often focus on individuals seeking specific types of treatment

**Figure 2.** Main destinations for UK outward medical tourists (2016)



# TYPES OF TREATMENT SOUGHT AND REASONS FOR TRAVELLING ABROAD

The type of treatments sought abroad varies considerably and includes everything from dental surgery to gender reassignment. A 2014 review of the medical tourism literature identified four main types of treatment commonly sought by UK citizens abroad:<sup>1</sup>

- Fertility treatments
- Cosmetic surgery
- Bariatric surgery
- Dental surgery

## Fertility treatments

A study for the European Society of Human Reproduction and Embryology (ESHRE) in 2010 collected data from 46 fertility clinics in six European countries (Belgium, Czech Republic, Denmark, Switzerland, Slovenia and Spain).<sup>17</sup> Extrapolating from the data collected, it estimated that around 24–30,000 cycles of cross-border fertility treatment involving 11–14,000 patients were performed in Europe each year. The study included 53 UK patients, with Italian and German patients being the most frequently represented nationalities. Among the main reasons cited for travelling abroad to obtain fertility treatments in this European study were:

- General legal restrictions on access to fertility treatments in the patient's home country.
- Restrictions on access to fertility treatments for specific groups of people (such as single women or same-sex couples) in the patient's home country.
- Perceived higher success rates in the country travelled to than in the patient's home country.
- And to obtain access to donated gametes (donor eggs or sperm).

More recently, an audit by Fertility Europe and the ESHRE was published in March 2017.<sup>18</sup> It compared fertility policy in nine European countries: Czech Republic, Germany, France, Italy, Poland, Romania, Spain, Sweden and the UK. Overall, it estimated that around 25 million people in the EU were affected by infertility. The report found wide variations in infertility policy, the treatments available, screening and diagnostic services (such as pre-implantation genetic diagnosis) and the eligibility criteria for funding. It noted that these variations contributed to citizens seeking fertility treatment

abroad and that the Czech Republic and Spain were two of the most favoured destinations. For example, the number of in vitro fertilisation (IVF) cycles given to non-nationals in the Czech Republic increased from 1795 in 2010 to 3080 in 2014.<sup>19</sup>

A 2014 review included interviews with nine UK citizens who had travelled abroad for fertility treatments, five of whom were seeking treatments involving an egg donor.<sup>20</sup> All of the people interviewed cited difficulty in accessing fertility treatment in the UK as a major factor in seeking treatment abroad. Some of the participants were out with the age range for eligibility to treatment on the NHS, whereas others were considered to have too low a chance of success to be eligible for publicly funded treatment. Long waiting times was a common complaint among the interviewees, particularly for those seeking donor eggs. One participant who was eligible for NHS-funded treatment travelled abroad because she was told that she may have to wait for 5 years before donor eggs became available.

Another study of UK patients who had travelled abroad for fertility treatments or who were considering such travel involved semi-structured interviews with 41 cases (a case being an individual or a couple seeking treatment, even where only one of the couple took part in the interview).<sup>21</sup> 29 of the 41 cases were seeking donor gametes (reproductive cells), whereas the remaining 12 were using their own gametes in the treatment. Each group gave different reasons for seeking the treatments abroad.

In the group seeking donor gametes, most (27/29) cited a shortage of donors in the UK as a reason for seeking treatment abroad. Cost (treatment abroad being cheaper than treatment in the UK) and higher perceived success rates abroad were the next most cited reasons (each given by 7/29 patients). Four of the 29 patients seeking donated gametes abroad were ineligible for fertility treatment on the NHS by virtue of their age and four described treatment as their “last chance” of achieving the desired pregnancy. Other reasons cited for travelling abroad for treatment were to obtain a wider choice of donor, a lack of satisfaction with the treatment received in the UK, concern over the age of UK donors, and the desire to seek donor anonymity (each cited by 3/29 patients).<sup>21</sup>

In the group seeking to use their own gametes, the two most cited reasons for seeking fertility treatment abroad were cost and the desire to be treated in a less stressful environment (each cited by 6/12 patients). Five of the 12 patients in this group cited the perceived higher success rates of treatment abroad and 4/12 their lack of satisfaction at the treatment they had received in the UK as reasons for seeking treatment abroad. Other reasons for travelling abroad were to “try something new”, because it was more convenient than seeking treatment in the UK, or because they were ineligible for NHS treatment by virtue of their age (each cited by 2/12 patients).<sup>21</sup> In contrast to the ESHRE study<sup>22</sup>, none of the participants in the UK study cited

legal restrictions on access to fertility treatments as reason for seeking treatment abroad.

Across the 41 cases followed in the UK study, Spain was the most popular choice of destination (18 cases) followed by the Czech Republic (8), USA (5), Barbados (3), South Africa (3), Norway (2), Greece (2), Ukraine (2), Russia (2), Cyprus (2), India (1), Denmark (1) and Hungary (1).<sup>23</sup> In total the 41 cases received 69 cycles of treatment, with the number of embryos being transferred varying from one destination to another (Table 1). Most (48/69) of the cycles involved the transfer of two embryos, with the highest number of embryos transferred being five, in a single cycle of treatment in the USA (see Implications for the NHS section). The 69 treatment cycles resulted in 26 successful live births or pregnancies, with six of the pregnancies resulting in twins.<sup>21</sup>

**Table 1.** Variations in the number of embryos transferred by country of treatment

No. embryos transferred	No. cycles of treatment	Countries
1	4	Spain, Czech Republic
2	48	Spain, Czech Republic, Norway, Barbados, USA, Greece, Russia
3	12	Czech Republic, Russia, Ukraine, USA, South Africa, Barbados
4	4	Ukraine, India, USA
5	1	USA

A more recent UK survey by the charity Fertility Network UK and the online hub Fertility Clinics Abroad was conducted between August 2016 and February 2017. It canvassed the views of 241 respondents who had either sought or were considering seeking fertility treatment abroad.<sup>24</sup> Most (152) of the respondents had received fertility treatment in the UK, and 44% (106/241) had undergone such treatment abroad. The most common fertility treatment sought by respondents was IVF using their own gametes (46%), with 29% seeking IVF using donor gametes and 5.5% seeking IVF with donor embryos.

Among the main reasons cited by respondents for seeking or considering treatment abroad were cost (69% of respondents stated that the availability of cheaper treatments abroad was a factor) as well as perceived higher success rates (50%) and the positive reputation (46%) of clinics abroad.<sup>25</sup> Other factors cited as being positive features of treatment abroad included shorter waiting times (45%), access to egg donors (31%) and a wider range of treatment options (27%), anonymity of donors (25%), and fewer restrictions on the number of embryos transferred (16%). As with the 2011

study,<sup>21</sup> Spain was the most popular destination chosen or considered for treatment (by 60% of respondents), followed by Greece, the Czech Republic, France, Denmark and the USA.

## Cosmetic surgery

In 2008, the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) conducted a survey of 208 UK plastic surgeons to find out how many of them had seen patients with complications following cosmetic surgery abroad. The findings provide an interesting snapshot of cosmetic surgery tourism at that time. 37% of respondents reported seeing such patients with most (83%) providing further details of the procedures undertaken, the region where the surgery took place and the nature of the resulting complications for more than 200 patients.<sup>26</sup> The survey showed that complications were seen in patients following breast augmentation (61 patients), abdominoplasty (tummy tucks, 53), breast reduction (33), face/neck lifts (22), breast lifts (12), eyelid surgery (11), rhinoplasty (nose surgery, 10) and a small number of other or unspecified treatments (8 patients). Most of the patients had received their treatment in Eastern (82 patients) or Western (67) Europe. However, some had travelled further than this to destinations such as Asia (22), South America (6), the Middle East (5) and North America (3). Most (145) of the patients reported by the surgeons presented with complications that required further treatment, with 52 requiring emergency surgery, 65 electing to have further surgery and 86 needing non-surgical treatments as an inpatient or outpatient.

A literature review published in 2014 included interviews with nine UK patients who had travelled abroad for various cosmetic procedures.<sup>1</sup> It identified cost as a major factor in determining cosmetic surgery tourists' choice of destination. It also highlighted the need for routine care after patients had returned to the UK, for example to remove stitches. Another (ESRC-funded) study, published in 2014, conducted interviews with 105 patients from the UK, Australia and China travelling abroad for cosmetic treatment as well as with the surgeons, other staff and agency workers involved in the treatment.<sup>27</sup> The UK patients largely travelled to mainland Europe for their treatment, with Poland, Spain and Belgium being the most common destinations (Figure 3). Patients from Australia favoured Thailand

**Figure 3.** Destinations chosen by UK patients for cosmetic surgery.<sup>27</sup>



and Malaysia for their treatment, while the Chinese travellers chose South Korea.

Patients from the UK and Australia sought similar cosmetic treatments, with the largest single category in each case being breast augmentation. Other treatments sought by UK and Australian patients included rhinoplasty, abdominoplasty, liposuction and face/neck lifts. In contrast, the Chinese patients sought nose, eyelid, jaw or cheek surgery. Whereas Australian and UK patients cited cost (treatments being cheaper abroad than they were at home) as a main reason for seeking treatment abroad, the Chinese patients travelled to obtain higher quality surgery than that available in China.

## Bariatric surgery

Bariatric surgery comes in two main forms: gastric bypass (an invasive surgical procedure whereby part of the patient's stomach is partitioned to reduce their capacity to absorb food) and gastric banding (a less invasive procedure that involves fitting a loop around the top of a patient's stomach to limit their food intake). Both types of bariatric surgery require long-term follow-up as gastric bands may need to be adjusted from time to time, and gastric bypass patients need to be monitored to ensure that they obtain enough vitamins and minerals. The National Institute for Health and Care Excellence (NICE) first introduced guidance for bariatric surgery in the UK in 2002, and the number of bariatric surgical operations recorded in the NHS rose steeply between 2002 and 2008.<sup>28</sup> During that period, gastric bands were also introduced together with minimally invasive surgical procedures.

A 2014 study of medical tourism included interviews with 11 patients who had travelled abroad for bariatric surgery.<sup>1</sup> Seven of the patients underwent surgery to fit gastric bands, one had a gastric wrap (where the outcome is similar to having a band fitted but the stomach restriction is obtained by surgery), two had gastric bypasses, and two had more complex bariatric procedures. Nine of the patients had their bariatric operations in Belgium, one travelled to Poland, one to France and another to the Czech Republic.<sup>29</sup>

The patients were asked about their motivations for travelling abroad for bariatric surgery. Many of the patients said that they had chosen to travel to Belgium as it was a perceived centre of excellence for bariatric surgery at the time. Five noted that they felt that Belgian bariatric surgeons had more experience than their UK counterparts at performing such operations. Seven of the patients cited the lack of availability on the NHS of the bariatric procedure of choice, because they were judged to be ineligible for such surgery, the waiting lists were unacceptably long, or because NHS funding was not available for such procedures in their area. Only two of the patients cited cost as the sole reason for travelling abroad, although cost was mentioned along with other factors by six patients.

One limitation of this review is that the patients interviewed had received their treatments between 2004 and 2009, a time when bariatric surgery was in its infancy in the NHS. At that time there was wide variation in the regional provision of bariatric surgery, and this may help to explain the patient interview comments about lack of availability or long waiting lists for bariatric treatment.<sup>30</sup> Since this time, the provision of bariatric surgery across the NHS has improved considerably. For example, figures from the National Bariatric Surgery Registry show that between 2009/10 and 2015/16 a total of nearly 40,000 bariatric operations were conducted in NHS hospitals at an average rate of 5000–6000 a year.<sup>31</sup> The in-hospital mortality rate of such procedures was very low, at less than 1 death per 1000 operations. A more recent study of bariatric surgery tourism would be required to show whether the patient motivations regarding availability, long waiting times and lack of experience within the NHS are still relevant today.

## Dental tourism

Dentistry is a sector where high levels of UK dental tourism might be expected, given the well-publicised difficulty in accessing NHS dental services. For example, in 2017 The Times published a story suggesting that dentists in 24 local authorities in England were only taking on new private patients.<sup>32</sup> A subsequent press release by the British Dental Association suggested that this was because of the cost-limited funding system for dentistry in the NHS.<sup>33</sup> This difficulty in accessing NHS dental services, combined with the relatively high costs of private treatment in the UK, means that dental surgery is popular among UK medical tourists. For example, a 2008 survey by the consumer group Which? estimated that dental surgery is the most commonly sought treatment by UK medical tourists,<sup>34</sup> and a survey of dental clinics in Hungary and Budapest showed that 20% of the patients treated were from the UK.<sup>35</sup>

A study in 2014 of interviews with 11 UK patients who had travelled abroad for dental treatment included questions on their motives for seeking such treatment abroad.<sup>1</sup> In all cases, participants cited a range of different motivations including:

- Lack of availability of dental services on the NHS.
- Distrust of NHS dentistry.
- Dissatisfaction with previous NHS dental treatment.
- Cost.
- Cultural reasons (for example diaspora travel, or visiting family and friends).
- Tourism (respondents were more likely to cite combining dental treatment with a holiday than respondents in surveys relating to other types of treatment).

## ISSUES

Literature reviews and surveys have identified a number of issues that may be faced by people seeking treatment abroad. This section examines these issues, including:

- Additional risks associated with treatments abroad.
- Professional advice available to patients.
- Quality assessment and accreditation of treatments.
- Legal aspects of treatment abroad.
- Advice used by patients.
- Regulation of advertising of medical treatments.
- Follow-up care and other implications for the NHS.

### **Additional risks associated with treatment abroad**

The specific risks faced by a patient travelling abroad for medical treatment will vary depending on the type of treatment sought and the chosen destination for that treatment. However, the National Travel Health Network and Centre (NaTHNaC) has identified a number of general issues that travellers may face.<sup>36</sup> One such risk is exposure to antibiotic resistance factors, which is a global problem, but that is more prevalent in some regions than in others. One particular type of resistance factor that has been a source of concern is the New Delhi- $\beta$ -lactamase-1 (NDM-1) enzyme as it confers resistance to a wide range of antibiotics. It has been isolated from patients in Sweden, Canada, USA, UK, Asia and Europe and is thought to have originated in India.<sup>37</sup> One UK study found NDM-1 in bacteria isolated from 29 patients, 17 of whom had recently travelled to India or Pakistan, and 14 of whom had received hospital treatments while they were there.<sup>38</sup>

Other potential additional risks that may be faced by medical travellers include:<sup>39</sup>

- Potential for exposure to blood-borne viruses such as hepatitis B virus or HIV arising from the reuse of medical equipment or through inadequate screening of donor blood.
- Increased risk of exposure to tropical diseases such as malaria, dengue and Zika viruses if travelling to tropical or sub-tropical countries for treatment.
- Use of poor quality (or counterfeit) medicines.
- And the increased risk of deep vein thrombosis (DVT) that is thought to be associated with patients who fly following surgery.

## Professional advice available to patients seeking treatments abroad

A range of professional bodies have published advice for patients thinking of seeking treatment abroad. For example, the NHS publishes information on the NHS Choices website about accessing medical treatment abroad.<sup>40</sup> Advice on seeking specific treatments abroad includes the General Dental Council's guidance on dental treatments abroad,<sup>41</sup> while the Royal College of Surgeons of England,<sup>42</sup> British Association of Aesthetic Plastic Surgeons (BAAPS)<sup>43</sup>, British Association of Plastic Reconstructive and Aesthetic Surgeons,<sup>44</sup> the International Society of Aesthetic Plastic Surgery,<sup>45</sup> and the General Medical Council (GMC)<sup>46</sup> have all published advice for patients seeking cosmetic surgery. When seeking treatment abroad in general, the advice is to:

- Check whether the staff and medics at the clinic can communicate in English.
- Research the experience and qualifications of the surgical team that will perform the operation.
- Find out how the clinic is regulated (for example by a national regulator or as part of an external quality assurance system, see next section).
- Check details of success, infection and mortality rates.
- Enquire about the provision of after-care treatment.
- Clarify what the quoted costs cover (for example whether additional charges may apply for drugs).
- Clarify who will pay for any additional costs incurred by complications with the treatment.
- Ensure that you have valid medical insurance that covers elective procedures abroad.

For cosmetic surgery the advice from each of the professional bodies is similar, recommending that patients carefully research the treatment they are considering before committing to it. All of the organisations advise those travelling abroad for cosmetic surgery to ensure that they allow sufficient recovery time before flying back to reduce the risk of DVT, with BAAPS recommending 5–7 days following breast or liposuction surgery and 7–10 days for abdominoplasty or facial surgery.<sup>47</sup> Finally, the advice recommends patients ensure that any insurance they take out covers any additional costs incurred by complications arising from their treatment, and to seek advice on appropriate after-care from their own GP.

Other types of medical treatment present different issues for UK citizens considering going abroad. For example, the Human Fertilisation and Embryology Authority (HFEA) advises UK citizens seeking fertility treatments abroad to check a clinic's multiple pregnancy rate before signing up.<sup>48</sup> This is because UK policy is for most women to be offered a single embryo transfer at a time to reduce the risks to mother and babies associated with multiple pregnancies. In other countries the transfer of anything up

to five embryos at a time may be allowed in an attempt to increase the success rate of fertility treatments (Table 1). HFEA also advises women to be careful when comparing claimed success rates between clinics in the UK and those abroad to ensure that they are comparing like-with-like. This is because HFEA has a standardised way of presenting success rates of UK clinics, whereas some clinics abroad may quote selective figures involving treatments of just those women under 35 years of age or quoting number of pregnancies rather than successful live births.

## Quality assurance and accreditation

UK healthcare facilities, such as hospitals (NHS and private), GP practices, walk-in centres, out-of-hours services and residential and nursing care homes, are subject to regulation and inspection by the Care Quality Commission (CQC). UK clinics offering more specialist treatments may also be regulated and inspected by the HFEA (fertility treatment), Human Tissue Authority and Medicines and Healthcare products Regulatory Authority. Following on from problems with PIP breast implants, the Department of Health published a review of the regulation of cosmetic interventions in 2013.<sup>49</sup> This was followed by guidance for doctors providing cosmetic treatments in the UK from the General Medical Council,<sup>50</sup> as well as from the Royal College of Surgeons<sup>51</sup> (both in 2016). Patients receiving treatment in the UK can therefore be reasonably confident that the care provided will be of a high quality.

Within the EU, the Treaty of Lisbon maintained member states' independence in areas pertaining to healthcare. However, the European Commission has undertaken initiatives to develop benchmarking systems for the treatment of certain diseases (notably breast cancer),<sup>52,53</sup> and Directive 2011/24/EU on patient rights in cross-border healthcare aims to provide patients with information about receiving treatment abroad, provide a network of contact points for such patients and encourage the development of European reference networks for complex and rare diseases.<sup>54</sup> Despite these initiatives, quality assurance (QA) systems may vary considerably from one member state to another. In addition, patients travelling abroad for treatment outside of the EU may encounter facilities that are subject to less robust quality assurance systems than those in place in the UK.

Hospitals and clinics in countries that do not operate mandatory state-run QA systems can opt to sign up for external QA programmes provided by independent organisations. These include the US-based Joint Commission International, Accreditation Canada, the UK-based Quality Healthcare Advice Trent, the Australian Council on Healthcare Standards and the International Society for Quality in Health Care. Such organisations offer education, surveys of healthcare providers' facilities and practices, advice, accreditation and certification for periods of 2–4 years. Finally, many clinics advertise compliance with International Organization for Standardization

(ISO) standards.<sup>55</sup> These cover a wide range of medical services, including laboratory testing (such as diagnostics), medical devices, occupational health and safety, sterilisation of healthcare products and health informatics systems.

## Legal aspects of treatment abroad

Patients who sustain injuries following NHS treatment can choose to have the case investigated through the NHS complaints procedure or take legal action through the courts. Going through the courts is likely to be expensive (legal aid is only available in certain cases) and time-consuming. Patients must pursue such claims within 3 years of the injury becoming apparent.<sup>56</sup> For injuries received following treatments abroad, patients must pursue compensation through the courts. If the treatment was advertised and/or consulted on in the UK and took place in the EU, then patients may be able to pursue their claims through the UK courts.<sup>57</sup> Otherwise, patients have little option but to pursue a case through the courts of the country where the treatment took place. Legal rights, costs and likely levels of compensation vary considerably from one country to another.

Fertility treatments raise potential legal issues that may vary from one country to another. For example HFEA advises women to check the legal status of any:

- Treatment they are seeking in a particular country (some countries do not offer such treatments to single women or same-sex couples).
- Donor of gametes used in the treatment (for example whether they have the right to remain anonymous, have any legal rights to access the child, how they have been recruited, and whether their medical history has been screened).
- Surrogates used in the treatment (relating both to the rights of the surrogate and the legal rights of any child born abroad to enter the UK).

## Advice used by patients when considering treatment abroad

The extent to which the sources of information cited above are used is unclear. Interviews with people who either have had, or are considering, treatment abroad suggest that they obtain information from a wide range of sources.<sup>1</sup> Those patients seeking fertility treatment or bariatric surgery are often well-informed about the treatments available, the likely chances of success and the risks involved because they are likely to have already engaged with NHS staff on these issues. Patients seeking access to other treatments, such as cosmetic surgery, may be less likely to have engaged with healthcare professionals as such procedures are not routinely offered

on the NHS and private consultations can be expensive. Such patients may be more likely to use the internet to research their treatment options.

One potential source of information on the internet are the websites from clinics offering medical tourism treatments. Systematic reviews of the quality of the information available on such sites suggest that they tend to downplay the risks of the procedures of the treatments offered,<sup>58</sup> and provide little in the way of information about the treatment process or about post-operative care or issues of redress should complications arise.<sup>59,60,61</sup> Interviews with patients suggest that they consult a wide range of internet resources including support networks and forums, particularly when choosing locations and clinics. One review noted that it appears that medical tourists often pay more attention to ‘soft’ information (such as informal networks or advice from friends) than ‘hard’ information (such as clinical outcomes).<sup>6</sup>

## Regulations on the advertising of medical treatments

In the UK, the Committee of Advertising Practice and the Advertising Standards Authority (ASA) have published guidance on the advertising of surgical and non-surgical procedures.<sup>62</sup> It covers the use of exaggerated or unrealistic claims (such as exaggerated success rates of fertility treatments or the use of unrealistic before and after photos for breast enhancement), warns against the trivialisation of such treatments, expresses concern over the targeting of adverts at specific groups of people, highlights the prohibition of advertising prescription-only medicines and offers guidance on the use of words such ‘qualified’, ‘skilled’, ‘consultant’ and ‘specialist’ in adverts.

The ASA deals with any complaints generated by an advert. Its remit extends to both broadcast (TV and radio) and non-broadcast (print, websites and social media) paid advertising and marketing messages, but only in the UK. In July 2018, the Mental Health Foundation and others complained to the ASA that adverts for breast enhancement surgery strategically placed during the ITV programme *Love Island* painted a “false picture of perfection” and “exacerbated young people’s insecurities”.<sup>63</sup> In October 2018, the ASA ruled that the adverts were “irresponsible and harmful” and “went beyond presenting the lifestyle of women who had breast enlargement in a positive light and implied that the women were only able to enjoy the aspirational lifestyle shown, and to be happy with their bodies, because they had undergone that surgery”.<sup>64</sup> Following the ASA ruling the BAAPS published a statement suggesting that companies are aware that they are flouting the guidelines but do so knowing that “they will ultimately get just as much (or more) exposure from the negative reactions, and that they face little to no consequences”.<sup>65</sup>

## Follow-up care and other implications for the NHS

Follow up care is usually needed after a surgical operation, although the extent of the treatment required varies from one procedure to another and will also depend on its clinical outcome. The nature of medical tourism means that in many cases the patient will have returned to the UK and will depend on the NHS to conduct the follow-up treatment. In some cases the treatment is fairly straightforward, consisting of little more than the removal of stitches from a surgical wound. However in cases where there are complications the level of follow-up treatment required may be more extensive. For example, in the BAPRAS survey, 70 of the 215 cosmetic surgery patients who presented to consultants with complications were referred via the NHS (62 via emergency departments and eight by NHS consultants) with 52 requiring emergency surgery.<sup>66</sup> Even where there are no complications following surgery, the level of care needed after some types of surgical procedure are extensive and long-term. For instance, patients fitted with gastric bands often need to have their bands adjusted and gastric bypass patients require long-term monitoring to ensure that they are getting sufficient vitamins and minerals. This has significant resource implications for the NHS.

Fertility treatments also raise a number of issues for the NHS. The main problem here is multiple pregnancies, which are more likely to result from fertility treatment than from natural conception. In the UK, the proportion of multiple births from IVF treatments has been falling (from around 25% of all IVF births in 2008 to around 11% in 2016) in recent years, largely as a result of UK policy to encourage clinics to transfer just a single embryo during each round of treatment.<sup>67</sup> However, clinics abroad may not face the same pressure to transfer single embryos. Indeed, data from a 2011 study (Table 1) show that many clinics abroad transfer two embryos at a time, with some countries allowing up to five embryos to be transferred.<sup>21</sup>

Multiple pregnancies pose increased risks for both mother and baby. Mothers face increased risk of miscarriage, pregnancy-induced hypertension, gestational diabetes, pre-eclampsia and emergency caesarean section.<sup>68</sup> These factors contribute to an increased risk of maternal mortality of around 2.5 times higher for mothers of twins compared with singleton births. The resulting twins are more likely to be born early (with around half being born before 37 weeks' and 10% before 32 weeks' gestation) and have a lower average birthweight (between 800 and 1000 g less) than singleton births. Twins are also ten times more likely to be admitted to a neonatal unit than their singleton counterparts and six times more likely to suffer from cerebral palsy. All of these complications mean that the average multiple birth costs the NHS nearly three times as much as the average singleton birth (an estimated £13,959 compared with £4892, respectively).<sup>68</sup>



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