

Regulating Aesthetic Medicine in Pakistan: A Proposition for an Inclusive, Tiered Practitioner Framework

A White Paper and Policy Submission to the Government of Pakistan

Prepared by the Association of Aesthetic Physicians of Pakistan (AAPP) and contributing practitioners June 2026

Executive Summary

Aesthetic medicine is one of the fastest-growing medical sectors in the world. Globally, the non-surgical cosmetic procedures market was valued at approximately USD 35.99 billion in 2025 and is projected to reach USD 64.07 billion by 2033 [1]. Pakistan, with a population exceeding 240 million, a rapidly expanding urban middle class, and a growing appetite for minimally invasive cosmetic procedures, is positioned to benefit enormously from this global trend — provided it establishes a sound, evidence-based regulatory framework.

At present, Pakistan's aesthetic medicine sector operates in a state of regulatory ambiguity. The Pakistan Medical Commission (PMC), and subsequently the Pakistan Medical and Dental Council (PM&DC), have made commendable initial efforts to define credentialing pathways, but these have been inconsistently implemented, frequently revised, and have failed to address the full spectrum of practitioners and procedures involved in the field. The result is a fragmented industry in which turf wars between specialties, unaccredited short-course proliferation, and the exclusion of competent allied health professionals have all undermined both patient safety and professional development.

This white paper draws upon the experience of the United Kingdom — particularly the frameworks developed by the Joint Council for Cosmetic Practitioners (JCCP) and the Save Face accreditation scheme — as well as regulatory models from the United States, Australia, and Canada, to propose a comprehensive, tiered, and inclusive regulatory framework for aesthetic medicine in Pakistan. The central argument of this paper is that aesthetic medicine should not be the exclusive domain of any single medical specialty. Rather, it must be governed by a competency-based, risk-stratified model that allows all appropriately trained healthcare professionals — including MBBS doctors, dentists, nurses, physiotherapists, and pharmacists — to participate at the level appropriate to their training and the risk profile of the procedure.

This paper concludes with a concrete action plan for the Government of Pakistan, the PM&DC, and Provincial Healthcare Commissions, outlining the legislative, institutional, and educational steps required to establish a world-class regulatory environment for aesthetic medicine in Pakistan.

1. Introduction: The State of Aesthetic Medicine in Pakistan

1.1 A Growing Industry Without a Governing Framework

The demand for minimally invasive cosmetic procedures (MICPs) in Pakistan has grown substantially over the past decade. Procedures such as botulinum toxin (Botox) injections, hyaluronic acid dermal fillers, chemical peels, laser hair removal, platelet-rich plasma (PRP) therapy, and microneedling are now widely available in urban centres across the country, offered in a diverse range of settings from hospital-based clinics to standalone beauty salons.

Despite this growth, Pakistan lacks a comprehensive, enforceable regulatory framework governing who may perform these procedures, under what conditions, and with what level of training. This regulatory vacuum has created a dangerous environment in which a patient may receive the same procedure from a board-certified dermatologist, a newly graduated MBBS doctor with a weekend certificate, or a beauty therapist with no medical training whatsoever — with no reliable mechanism for the patient to distinguish between them.

The Pakistan Medical Commission (PMC), in 2022, took a landmark step by developing the *Credentialing Pathways for Aesthetic Medicine Practice in Pakistan*, which classified aesthetic procedures into non-invasive, minimally invasive, and invasive categories, and established distinct registers for Aesthetic Physicians and Aesthetic Surgeons [2]. However, with the transition from PMC to PM&DC, implementation stalled, and the framework was not fully adopted. In December 2024, the PM&DC issued a directive recognizing Aesthetic Medicine as a specialty requiring structured postgraduate training of at least two years, and expressing concern about short-term online certifications [3]. While this directive addresses the problem of unqualified

practitioners, it risks overcorrecting by creating barriers so high that the vast majority of competent, experienced practitioners are excluded.

1.2 The Dermatology Claim: A Political Quagmire, Not a Clinical Argument

The most persistent and damaging feature of Pakistan's aesthetic medicine debate is the attempt by dermatology, as an organized specialty, to claim exclusive or primary authority over aesthetic procedures. It is important to state clearly at the outset that this is a **political and institutional claim, not a clinical one**, and it does not withstand scrutiny on either workforce or training grounds.

Dermatology is a noble and critically important specialty. Pakistan faces an enormous burden of skin disease — from psoriasis and pemphigus to skin cancer and chronic eczema — and its 840 registered dermatologists are already catastrophically outnumbered by the medical need, serving a population of over 240 million at a ratio of just 0.34 per 100,000 against an internationally recommended benchmark of 3.0 per 100,000 [4]. This is not a specialty with spare capacity. It is a specialty in crisis, unable to meet the basic dermatological healthcare demands of the population it is meant to serve.

To then argue that this same overstretched, numerically depleted specialty should additionally monopolize aesthetic medicine — a field that is, by definition, concerned with non-pathological enhancement rather than disease — is not a patient safety argument. It is a **professional territory claim** dressed in clinical language. The political motivation is transparent: aesthetic medicine is profitable, and controlling it protects revenue streams for a small number of practitioners.

The clinical argument is equally weak. Aesthetic medicine — the injection of botulinum toxin, the placement of dermal fillers, the administration of chemical peels and laser treatments for cosmetic purposes — is not taught in dermatology residency programmes in Pakistan to any meaningful degree of clinical competency [5]. A dermatologist who has spent five years studying skin pathology, biopsy technique, and immunodermatology has not, by virtue of that training, acquired the injection anatomy, product knowledge, or hands-on technique required to safely administer facial injectables. This is not a criticism of dermatologists; it is simply a fact about what their training covers. In the United Kingdom, this is formally acknowledged: even consultant dermatologists and plastic surgeons are required to complete the same aesthetic medicine training courses as general practitioners in order to obtain professional indemnity insurance for these procedures [5]. The insurer's logic is sound — the specialty credential does not confer aesthetic competency.

The consequence of allowing dermatology to dominate this regulatory conversation is threefold. First, it creates an artificial and dangerous scarcity of qualified aesthetic practitioners, driving up costs, reducing access, and pushing patients toward unregistered providers. Second, it diverts dermatologists' attention and advocacy away from the genuine public health crisis in medical dermatology. Third, and most perniciously, it creates a regulatory environment in which the specialty claiming authority is simultaneously the least available to exercise it — a recipe for a black market, not a regulated industry.

1.3 Plastic Surgery: A More Pragmatic Position

It is important to distinguish the position of plastic surgery from that of dermatology in this debate. Plastic surgeons in Pakistan have, by and large, been less aggressive in attempting to monopolize the aesthetic medicine space, and this reflects a more pragmatic professional self-awareness. Plastic surgery's natural domain is surgical: rhinoplasty, facelifts, breast augmentation, reconstructive procedures following trauma or cancer. These are high-complexity, high-risk interventions that genuinely require the years of surgical training that plastic surgeons receive.

The minimally invasive procedures that constitute the bulk of aesthetic medicine — Botox, fillers, laser hair removal, chemical peels — are, frankly, below the skill ceiling of a trained plastic surgeon. They are not particularly challenging for someone who routinely performs complex reconstructive surgery, and most plastic surgeons recognise this. The more intellectually honest position within plastic surgery is that these procedures are not the specialty's primary concern, and that the energy spent on regulatory gatekeeping would be better directed at ensuring that the genuinely high-risk surgical aesthetic procedures (liposuction, fat transfer, thread lifts, implants) are properly regulated and reserved for those with surgical training.

This white paper therefore does not position plastic surgery as an adversary of reform. Rather, it invites plastic surgeons to support an inclusive framework that reserves surgical aesthetic procedures appropriately for those with surgical training, while releasing the non-surgical tier to the broader qualified workforce.

1.4 The Dentist's Paradox: The Most Qualified, the Most Neglected

Of all the anomalies in Pakistan's current approach to aesthetic medicine, the marginalization of dentists is the most clinically indefensible — and, in a significant sense, the most self-inflicted.

Consider the objective clinical facts. The face is the dentist's primary operating theatre. Every working day, a dentist performs multiple precise injections into the facial soft tissues, navigating the complex neurovascular anatomy of the infraorbital nerve, the inferior alveolar nerve, the mental nerve, the buccal nerve, and the greater palatine nerve [6]. Dental students in Pakistan, as in the UK and globally, spend five years studying the anatomy of the skull, mandible, temporomandibular joint, infratemporal and pterygopalatine fossae, nasal cavity, oral cavity, and orbital structures in a level of detail that no other healthcare training programme matches. The BDS curriculum is, in anatomical terms, the most face-focused medical education available anywhere in the healthcare system.

When a dentist completes their degree and begins practice, they are already performing — daily, without incident — the precise injection skills that form the technical foundation of facial aesthetic medicine. The transition to botulinum toxin and dermal filler administration, for a dentist who has completed appropriate aesthetic training, is not a leap into the unknown. It is a lateral extension of an existing, well-practised skill set into an adjacent anatomical application. A peer-reviewed review published in the *Journal of Pharmacy & Bioallied Sciences* in 2025 confirms this, concluding that dentists are uniquely positioned among all healthcare professionals for facial aesthetic practice, with their anatomical knowledge and injection experience providing a natural and superior foundation for procedures such as botulinum toxin and dermal filler administration [7].

International practice reflects this reality. In the United Kingdom, the General Dental Council (GDC) explicitly permits registered dentists to practice facial aesthetic medicine, and the Save Face register — the UK's government-approved accreditation scheme — accepts dentists on equal terms with doctors and nurses [8]. In the United States, dentists are permitted to administer Botox and dermal fillers in the majority of states, with several state dental boards actively promoting the expansion of dentists into aesthetic practice [9]. In these markets, dentists are not merely tolerated in aesthetic medicine — they are recognized as among its most technically proficient practitioners.

Why, then, are dentists in Pakistan so marginalized in this space? The answer lies not only in external political pressure from the medical community but, critically, in a degree of **professional self-neglect within dentistry itself**. The dental profession in Pakistan has, historically, been slow to advocate for its own scope of practice in aesthetic medicine. Dental associations have not mounted a coherent, evidence-based campaign to assert dentists' natural qualifications for facial aesthetics. Individual dentists who have entered the aesthetic field have often done so quietly and defensively, rather than confidently asserting the clinical basis for their involvement. This reticence has allowed a narrative to take hold — largely unchallenged — that aesthetic medicine is a medical rather than a dental domain.

This white paper calls on the Pakistan Dental Association (PDA) and individual dental practitioners to recognize and assert their clinical advantage in facial aesthetic medicine. The evidence is unambiguous. The anatomy is on their side. The daily practice is on their side. The international precedent is on their side. What is required is the professional confidence and collective advocacy to claim a rightful place at the centre of Pakistan's aesthetic medicine framework — not at its margins.

1.5 The Untapped Potential of Allied Healthcare Professionals

In the United Kingdom and the United States, a significant proportion of aesthetic procedures are performed by nurses — specifically aesthetic nurses or nurse injectors — who operate either independently or under the oversight of a prescribing physician [10]. This model has proven safe and effective, and it is the backbone of the UK's aesthetic medicine industry. Nurses, physiotherapists, and pharmacists bring clinical training, patient care experience, and professional accountability to the aesthetic setting, making them well-suited for a range of procedures.

In Pakistan, the potential of allied healthcare professionals in aesthetic medicine has been almost entirely overlooked. The current regulatory conversation focuses almost exclusively on doctors and specialists, ignoring the fact that a well-trained nurse or physiotherapist is far better qualified to perform laser hair removal or superficial microneedling than an untrained beauty therapist — and that restricting these procedures to doctors is an inefficient use of scarce medical resources.

2. International Frameworks: Lessons from the UK and Beyond

2.1 The United Kingdom: A Model of Voluntary Standards and Emerging Legislation

The United Kingdom's experience with regulating non-surgical cosmetic procedures is the most directly relevant international precedent for Pakistan, given the historical and professional links between the two countries' medical systems.

2.1.1 The Keogh Review and Its Legacy

The regulation of cosmetic procedures in the UK was galvanized by the 2013 *Review of the Regulation of Cosmetic Interventions*, commissioned by the Department of Health and led by Professor Sir Bruce Keogh [11]. The Keogh Review found that the cosmetic sector was poorly regulated, that training standards were inconsistent, and that patients were inadequately protected. It recommended the introduction of a mandatory licensing scheme and minimum training standards. While the government of the time did not implement mandatory regulation, the review set in motion a process of voluntary standard-setting that has shaped the industry ever since.

2.1.2 The Joint Council for Cosmetic Practitioners (JCCP)

The JCCP was established as a formally constituted charitable body in response to the Keogh Review, working alongside its sister organization, the Cosmetic Practice Standards Authority (CPSA) [12]. The JCCP operates a voluntary register for practitioners and training providers, open to all healthcare professionals — doctors, nurses, dentists, and pharmacists — who meet its competency standards. It does not discriminate by specialty.

The JCCP's *Competency Framework for Cosmetic Practice* (2018) is a landmark document that defines the required competencies of practitioners providing cosmetic treatments, with an explicit emphasis on *competency level* rather than *professional role* [13]. The framework recognizes two categories of practitioner: those with existing Professional Statutory and Regulatory Body (PSRB) registration (e.g., GMC, NMC, GDC) and those without. For PSRB-registered practitioners, the framework outlines competencies in holistic assessment, consent, injection technique, complication management, and continuing professional development.

The JCCP's training standards include specific practical milestones. For each modality, practitioners are expected to observe a minimum number of procedures and perform a minimum number under supervision before practicing independently. This “observe and perform” model — commonly summarized as a minimum of ten observations and ten supervised performances per modality — provides a practical, measurable benchmark for competency that is applicable across all practitioner types [13].

2.1.3 Save Face: Government-Approved Accreditation

Save Face is a UK government-approved, independent accreditation scheme for aesthetic medical professionals and clinics, accredited by the Professional Standards Authority (PSA) [14]. To achieve Save Face accreditation, practitioners and clinics must pass a rigorous 116-point assessment process covering practitioner qualifications, clinical environment, patient consultation protocols, emergency preparedness, and complaint management [15].

Crucially, Save Face is open to doctors, nurses, and dentists alike. Its assessment is based on universal standards of safety and competence, not on the practitioner's primary specialty. This model demonstrates that a single, inclusive accreditation scheme can effectively raise standards across a diverse practitioner community.

2.1.4 The New Licensing Scheme

In 2022, the UK's *Health and Care Act* gave the Secretary of State for Health and Social Care the power to introduce a licensing regime for non-surgical cosmetic procedures [16]. Following a public consultation in 2023, the government published its response in August 2025, proposing a risk-stratified licensing scheme that categorizes procedures into three tiers:

- **Green (Low Risk):** Procedures that may be carried out by any licensed practitioner meeting agreed standards.
- **Amber (Medium Risk):** Procedures that non-healthcare practitioners may perform only under the oversight of a named regulated healthcare professional, while qualified healthcare professionals may perform independently if they meet required standards.
- **Red (High Risk):** Procedures restricted to suitably qualified and regulated healthcare professionals, subject to Care Quality Commission (CQC) regulation [17].

This risk-stratified model is directly applicable to Pakistan and forms the basis of the framework proposed in Section 4 of this paper.

2.2 The United States: State-Level Regulation and the Nurse Injector Model

In the United States, the regulation of aesthetic medicine is primarily a state-level matter, resulting in significant variation across jurisdictions. However, several consistent principles emerge from the American experience.

Botulinum toxin is a prescription-only medicine (POM) in the US, meaning its administration must be authorized by a licensed prescriber (physician, nurse practitioner, or physician assistant). However, the actual administration of the injection can, in many states, be delegated to registered nurses (RNs) and, in some cases, to licensed practical nurses (LPNs) operating under physician oversight [18]. Nurse practitioners (NPs) can often practice independently in aesthetic medicine in states with full practice authority.

The American experience demonstrates that the nurse injector model is safe, effective, and scalable. It also demonstrates the importance of clear scope-of-practice definitions and supervision requirements to prevent harm.

2.3 Australia: Comprehensive Reform in Progress

Australia's Ahpra (Australian Health Practitioner Regulation Agency) has undertaken significant reforms to regulate the cosmetic procedures sector. In 2025, Ahpra introduced new guidelines for registered health practitioners performing and advertising non-surgical cosmetic procedures, requiring practitioners to demonstrate specific competencies and to operate within defined scopes of practice [19]. The Australian model emphasizes the importance of informed consent, psychological assessment, and post-procedure follow-up — principles that are equally applicable in Pakistan.

2.4 Canada: Emerging Regulation with Provincial Variation

In Canada, aesthetic medicine regulation varies by province, but the general principle is that doctors, nurse practitioners, and registered nurses can perform aesthetic procedures within their scope of practice [20]. There are currently no specific national regulations or additional educational requirements for doctors or nurses entering aesthetic medicine, though training courses are widely available and increasingly expected by professional bodies. The Canadian experience highlights both the opportunities and the challenges of a decentralized regulatory approach.

3. Market Sizing and the Logistical Impossibility of Specialty Monopolies

To understand why a tiered, inclusive framework is not just an option but a logistical necessity for Pakistan, it is essential to quantify the current and future demand for aesthetic medicine and compare it against the available specialist workforce.

3.1 Pakistan's Demographic Potential

Pakistan is the world's fifth most populous country, with a population projected to reach approximately 245 million by 2026 and 278 million by 2031 [22]. The country is urbanizing rapidly, with the urban population growing at over 2.3% annually [23]. This expanding urban middle class, combined with rising disposable incomes and increased exposure to global beauty standards via social media, is driving unprecedented demand for cosmetic procedures.

If we look at comparable emerging markets, the growth trajectory is clear. India's aesthetic medicine market, which shares demographic similarities with Pakistan, was valued at over USD 2 billion in 2024 and is projected to grow at a CAGR of over 15% [24]. Pakistan's market is currently at an earlier stage of maturity but is poised for similar exponential growth.

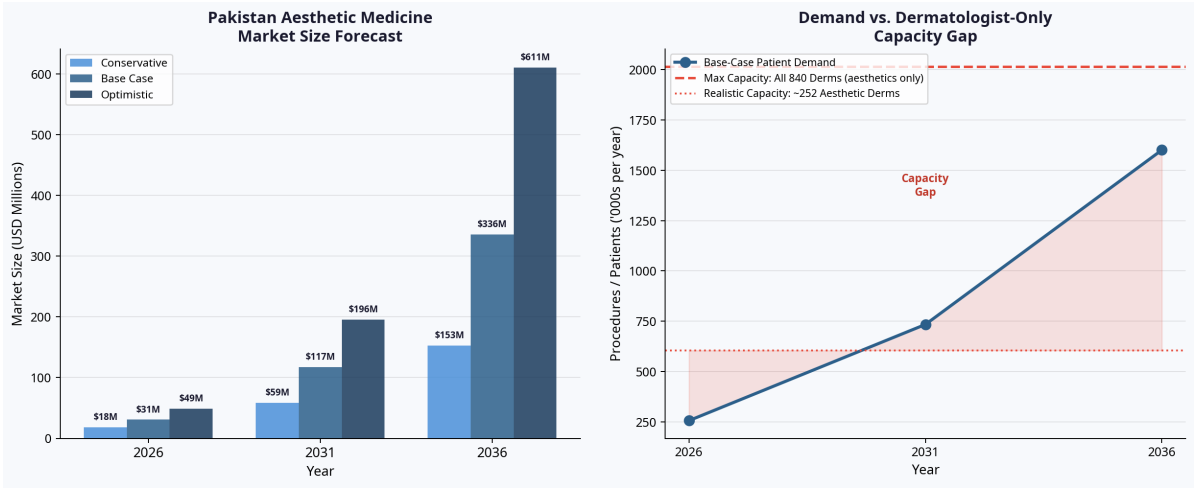
3.2 Market Size and Patient Demand Forecast

Based on demographic data, urbanization rates, and penetration benchmarks from comparable South Asian markets, we have modelled the projected demand for aesthetic procedures in Pakistan over the next decade.

Focusing on the core target demographic (urban adults aged 18–60) and applying conservative, base-case, and optimistic penetration rates, the patient volume and market value (USD) projections are as follows:

Year	Scenario	Est. Patients (Procedures)	Estimated Market Value (USD)
2026 (Now)	Base Case	256,000	\$31 Million
	Optimistic	409,000	\$49 Million
2031 (+5 yrs)	Base Case	733,000	\$117 Million
	Optimistic	~1.22 Million	\$196 Million
2036 (+10 yrs)	Base Case	~1.60 Million	\$336 Million
	Optimistic	~2.91 Million	\$611 Million

Note: Market value assumes an average revenue per procedure blending Tier 1, 2, and 3 treatments, rising as the market matures and adopts higher-value procedures.



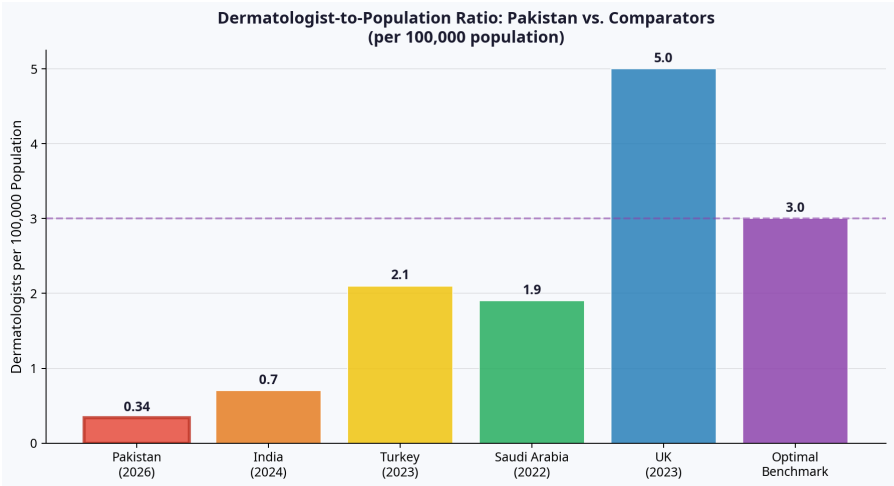
Even under a base-case scenario, the Pakistani market is expected to nearly quadruple in value over the next five years, driven by a tripling of patient volume as aesthetic procedures become mainstream.

3.3 The Dermatologist Capacity Deficit: Numbers That End the Argument

If the political and training arguments against a dermatology monopoly are compelling, the workforce arithmetic is simply conclusive. No reasonable reading of the numbers can sustain the position that dermatologists should be the primary or exclusive gatekeepers of aesthetic medicine in Pakistan.

According to the Pakistan Association of Dermatologists and cited in a 2025 WHO Eastern Mediterranean Health Journal publication, there are approximately **840 registered dermatologists** in Pakistan for a population of over 240 million [25]. This equates to a dermatologist-to-population ratio of **0.34 per 100,000** — less than one-ninth of the internationally recommended benchmark of 3.0 per 100,000 [26].

Country	Dermatologists per 100,000 Population
Pakistan (2026)	0.34
India (2024)	0.70
Saudi Arabia (2022)	1.90
Turkey (2023)	2.10
United Kingdom (2023)	5.00
Optimal Benchmark	3.00



Pakistan currently faces a deficit of over **6,500 dermatologists** simply to meet the basic medical dermatological needs of its population — the diagnosis and treatment of skin disease, skin cancer, psoriasis, eczema, and the hundreds of other conditions that fall within the specialty's legitimate domain. These are patients who need dermatologists. They are not getting them. The specialty is already failing to serve its core public health mission.

Against this backdrop, the claim that dermatologists should additionally monopolize aesthetic medicine becomes not merely politically motivated but **logistically absurd**. The arithmetic is straightforward:

If a generous 30% of Pakistan's 840 dermatologists — approximately 252 practitioners — were to dedicate their practice primarily to aesthetics, seeing 8 patients per day across 250 working days per year, their maximum combined annual capacity would be approximately **604,800 procedures**. This is the ceiling — the absolute maximum output of the entire aesthetic-focused dermatology workforce in the country.

Our base-case demand forecast projects **733,000 procedures by 2031** and **1.6 million by 2036**. Even in the most generous possible scenario — one in which every single one of Pakistan's 840 dermatologists abandoned all medical dermatology entirely and devoted their entire working lives to aesthetic procedures — the combined capacity of the specialty would reach approximately 2.016 million procedures per year. This figure would only barely meet the optimistic demand scenario for 2036, and it would do so at the catastrophic cost of leaving Pakistan's entire population of skin disease patients without specialist care.

The political quagmire is therefore self-defeating on its own terms. A dermatology monopoly on aesthetic medicine does not protect patients. It does not raise standards. It does not ensure quality. What it does is guarantee that the vast majority of the population seeking aesthetic procedures will be forced to seek them from unregistered, unaccountable providers operating outside any regulatory framework — because the regulated providers simply do not exist in sufficient numbers to serve them.

The only rational, patient-centred conclusion is that aesthetic medicine must be opened to a broad, trained, multi-disciplinary workforce. The numbers demand it.

4. The Case for an Inclusive, Competency-Based Framework

4.1 Aesthetic Medicine Is Not a Single Specialty

A fundamental premise of this white paper is that aesthetic medicine is not, and should not be treated as, the exclusive preserve of any single medical specialty. It is an interdisciplinary field that draws on dermatology, plastic surgery, oral and maxillofacial surgery, pharmacology, anatomy, and patient psychology. No single specialty encompasses all of these domains in its training curriculum.

The Pakistan Medical Commission's 2022 credentialing framework acknowledged this reality by recognizing both "Core Specialists" (dermatologists, plastic surgeons, and certain other surgical specialists) and "Non-Core Specialists" (MBBS doctors, BDS dentists, and practitioners of other specialties) as eligible for the Aesthetic Physicians Register, provided they met the relevant training and experience requirements [2]. This inclusive approach was well-conceived and should be reinstated and expanded.

4.2 The Dentist's Unique Qualification: A Case That Should Have Been Made Long Ago

The case for dentists in aesthetic medicine is not merely strong — it is, on the specific question of facial injectable treatments, arguably the strongest case that can be made for any practitioner group. The tragedy is that this case has not been made loudly or consistently enough by the dental profession itself.

Dentists routinely perform at least ten distinct injection and nerve block techniques as part of daily clinical practice, including inferior alveolar nerve blocks, infraorbital nerve blocks, mental nerve blocks, buccal nerve blocks, and greater palatine nerve blocks [6]. These are not simple subcutaneous injections. They require precise knowledge of facial neurovascular anatomy, confident needle placement at depth, and the ability to manage adverse reactions — all skills that are directly and immediately transferable to botulinum toxin and dermal filler administration. A dentist who has performed thousands of inferior alveolar nerve blocks has, in terms of injection confidence and anatomical precision, more relevant hands-on experience than a physician who has never injected the face before attending an aesthetic training course.

The dental undergraduate curriculum in Pakistan — as in the UK and globally — places the strongest emphasis of any healthcare training programme on head and neck anatomy. The BDS student spends five years studying the skull, mandible, temporomandibular joint, infratemporal and pterygopalatine fossae, nasal cavity, oral cavity, and orbital structures in a level of detail that no MBBS curriculum approaches [6]. This is not incidental. It is the core of dental education, because the face is the dentist's operating environment.

For facial aesthetic procedures — which are, by definition, confined to the face, head, and neck — dentists are not merely qualified. They are, in terms of the foundational knowledge and practical skills required, the **most naturally prepared** of all healthcare practitioners. The argument that they should be excluded from, or treated as subordinate to MBBS doctors in, facial aesthetics is not supported by anatomy, evidence, or international practice. It is a professional boundary dispute, and it is one that the dental profession has too often conceded without contest.

This white paper makes the explicit recommendation that **BDS-qualified dentists should be recognized at Tier 2 of the proposed framework as a matter of right**, with the same standing as MBBS doctors for all facial injectable procedures, and with a natural pathway to Tier 3 advanced practice for those who complete the relevant fellowship training. The Pakistan Dental Association should formally adopt this position and advocate for it in all regulatory discussions.

4.3 The Allied Healthcare Professional Workforce

The global aesthetic medicine industry depends on a tiered workforce. At the base of the pyramid are technicians and allied health professionals who perform lower-risk, non-invasive or minimally invasive procedures. In the middle are trained practitioners — doctors, nurses, dentists — who perform injectable and energy-based treatments. At the apex are advanced practitioners and specialists who manage complex cases, complications, and surgical procedures.

In Pakistan, the middle and lower tiers of this workforce are almost entirely absent from the regulatory conversation. Nurses, physiotherapists, and pharmacists — all of whom have clinical training, professional registration, and the capacity to be trained in aesthetic procedures — are not recognized as legitimate aesthetic practitioners. This is a significant missed opportunity.

Procedures such as laser hair removal, superficial chemical peels (below certain acid concentrations), basic microneedling (to superficial depths), and non-ablative energy treatments do not require a medical degree to perform safely. What they require is

specific training in the procedure, knowledge of contraindications, and the ability to recognize and escalate complications. These are skills that allied health professionals can acquire through structured training programmes.

4.4 The Training Gap and the Private Sector

Proper training in aesthetic medicine is not an accredited residency pathway in any country in the world. It is delivered primarily through postgraduate diplomas, certificate courses, and hands-on training programmes in the private sector [21]. This is not a failing of the system; it reflects the nature of aesthetic medicine as a field that evolves rapidly, relies on proprietary products and devices, and requires practical, hands-on skill development that is difficult to incorporate into traditional medical curricula.

The UK's JCCP has developed guidelines that have been widely adopted by private training providers, creating a de facto standard for aesthetic training that is recognized by insurers, employers, and regulators. Pakistan needs a similar mechanism: a set of nationally recognized training standards, developed by a multidisciplinary body, that private training providers must meet to have their programmes accredited.

5. Proposed Tiered Regulatory Framework for Pakistan

This paper proposes a three-tier, risk-stratified regulatory framework for aesthetic medicine in Pakistan, adapted from the UK's emerging licensing model and the JCCP's competency framework. The framework is designed to be inclusive, competency-based, and proportionate to the risk profile of each procedure.

5.1 Tier 1: Low-Risk Procedures (Green Category)

Definition: Non-invasive and minimally invasive procedures that target the epidermis only, or that involve superficial penetration of the integument with minimal risk of serious complications.

Examples of Procedures:

- Laser hair removal (all body areas)
- Intense Pulsed Light (IPL) treatments
- Superficial chemical peels (e.g., glycolic acid up to 20%, salicylic acid up to 15%)
- Basic microneedling (to superficial dermal depth, without PRP or other additives)
- Non-ablative energy treatments (radiofrequency, ultrasound for superficial skin tightening)
- HydraFacial and similar device-based treatments
- Microdermabrasion

Authorized Practitioners:

- Allied Healthcare Professionals (Registered Nurses, Physiotherapists, Pharmacists) with a recognized Tier 1 aesthetic certificate
- MBBS Doctors (fully licensed) with or without additional aesthetic training
- BDS Dentists (fully licensed) with or without additional aesthetic training
- Aesthetic Technicians with a nationally accredited Level 3 or Level 4 aesthetic qualification

Training Requirements:

- A nationally accredited certificate programme of a minimum of 40 hours, including theoretical instruction and supervised practical training
- Minimum of five supervised procedures per modality before independent practice
- Annual continuing professional development (CPD) of a minimum of eight hours

Oversight Requirements:

- Allied healthcare professionals and technicians must operate under the general governance of a registered medical director (MBBS or BDS) who is responsible for the clinical protocols of the facility
- No requirement for the medical director to be physically present for each procedure

5.2 Tier 2: Medium-Risk Procedures (Amber Category)

Definition: Minimally invasive procedures involving the injection of prescription-only medicines or the placement of materials into the dermis or subcutaneous tissue, with a moderate risk of complications including vascular compromise, infection, or asymmetry.

Examples of Procedures:

- Botulinum toxin (Botox) injections (all facial and neck areas)
- Hyaluronic acid dermal fillers (superficial to mid-dermal placement)
- Platelet-Rich Plasma (PRP) injections (face and scalp)
- Medium-depth chemical peels (e.g., TCA up to 20%)
- Advanced microneedling with PRP or growth factors
- Superficial sclerotherapy
- Skin booster injections (e.g., Profhilo, Restylane Skinboosters)

Authorized Practitioners:

- MBBS Doctors (fully licensed, post-house job) with a recognized Tier 2 aesthetic diploma or certificate
- BDS Dentists (fully licensed) with a recognized Tier 2 aesthetic diploma or certificate — for facial and neck procedures within the head and neck region
- Registered Nurses (with prescribing authority or operating under a valid Patient Group Direction) with a recognized Tier 2 aesthetic diploma

Training Requirements:

- A nationally accredited diploma programme of a minimum of 80 hours, including theoretical instruction, anatomy review, pharmacology, and supervised practical training
- Minimum of ten observed procedures and ten supervised performances per modality (the JCCP “observe and perform” standard) [13]
- Competency assessment by an approved assessor before independent practice
- Annual CPD of a minimum of 16 hours, including at least four hours of complication management training

Oversight Requirements:

- Independent practice permitted for MBBS doctors and BDS dentists who have met the training requirements
- Nurses must operate under a valid prescribing arrangement (either independent prescribing authority or a Patient Group Direction signed by a registered prescriber)
- All practitioners must hold appropriate indemnity insurance covering aesthetic procedures

5.3 Tier 3: High-Risk Procedures (Red Category)

Definition: Invasive or complex minimally invasive procedures with a significant risk of serious complications, requiring advanced anatomical knowledge, surgical skills, or the management of complex patient presentations.

Examples of Procedures:

- Deep chemical peels (e.g., phenol peels, TCA above 30%)
- Ablative laser resurfacing (CO2, Erbium)
- Thread lifts (PDO, PLLA, PCL)

- Complex volume restoration (e.g., full-face liquid facelift, deep plane filler placement)
- Hair transplantation (FUT and FUE)
- Fat transfer (autologous fat grafting)
- Phlebectomy
- Liposuction and body contouring

Authorized Practitioners:

- Aesthetic Physicians with an advanced postgraduate diploma or fellowship in Aesthetic Medicine (MBBS + advanced qualification)
- Aesthetic Surgeons with recognized surgical training in the relevant procedure (MBBS + postgraduate surgical qualification)
- Dermatologists and Plastic Surgeons who have completed specific aesthetic training in the procedure
- BDS Dentists with advanced postgraduate training, for procedures within the head and neck region (e.g., thread lifts of the face, hair transplantation)

Training Requirements:

- A nationally accredited advanced diploma or fellowship programme of a minimum of six months, including structured clinical rotations and supervised practice
- Logbook documentation of a minimum of 25 supervised procedures per modality
- Exit examination or competency assessment by an approved examining body
- Annual CPD of a minimum of 24 hours

Oversight Requirements:

- All Tier 3 procedures must be performed in a registered, fully equipped clinical facility that meets the standards set by the relevant Provincial Healthcare Commission
- Facilities must have emergency protocols, resuscitation equipment, and access to a hospital with vascular surgery capability for management of serious complications
- Practitioners must hold advanced indemnity insurance covering high-risk aesthetic procedures

5.4 Summary Table: Proposed Tiered Framework

Tier	Risk Level	Example Procedures	Authorized Practitioners	Minimum Training	Oversight
1 (Green)	Low	Laser hair removal, superficial peels, basic microneedling, IPL	Allied HCPs (nurses, physios, pharmacists), MBBS, BDS, trained technicians	40-hour accredited certificate; 5 supervised cases per modality	Medical director governance; no on-site requirement per procedure
2 (Amber)	Medium	Botox, dermal fillers, PRP, medium peels, skin boosters	MBBS (fully licensed), BDS (fully licensed, head/neck), Registered Nurses (with prescribing)	80-hour accredited diploma; 10 observed + 10 supervised per modality	Independent practice; valid prescribing arrangement for nurses; indemnity insurance required
3 (Red)	High	Deep peels, ablative lasers, thread lifts, hair transplants, liposuction	Aesthetic Physicians/Surgeons (advanced diploma/fellowship), Dermatologists, Plastic Surgeons, BDS (head/neck, advanced training)	6-month+ fellowship; 25 supervised cases per modality; exit exam	Registered clinical facility; emergency protocols; advanced indemnity insurance

6. Institutional Framework: Governance and Accreditation

6.1 A National Aesthetic Medicine Council

This paper recommends the establishment of a **National Aesthetic Medicine Council (NAMC)** under the auspices of the PM&DC, with representation from the following stakeholder groups:

- PM&DC (Chair)
- Provincial Healthcare Commissions (Punjab, Sindh, KPK, Balochistan)
- Association of Aesthetic Physicians of Pakistan (AAPP)
- Pakistan Medical Association (PMA)
- Pakistan Dental Association (PDA)
- Pakistan Nursing Council (PNC)
- College of Physicians and Surgeons Pakistan (CPSP)
- Consumer/patient representatives

The NAMC should be responsible for developing and maintaining the national competency frameworks for each tier, accrediting training providers, maintaining the national Aesthetic Practitioner Register, and advising the government on regulatory matters.

6.2 A National Aesthetic Practitioner Register

The PM&DC should establish and maintain a publicly accessible **National Aesthetic Practitioner Register** that lists all practitioners who have met the training and competency requirements for each tier. The register should be searchable by the public, allowing patients to verify the credentials of their practitioner before undergoing a procedure.

Entry to the register should be open to all licensed healthcare professionals — MBBS doctors, BDS dentists, registered nurses, physiotherapists, and pharmacists — who have completed the relevant accredited training programme. The register should be

tiered, clearly indicating which procedures each practitioner is authorized to perform.

6.3 Accreditation of Training Providers

The NAMC should develop a rigorous accreditation process for training providers offering aesthetic medicine programmes. Accreditation criteria should include:

- Curriculum alignment with the national competency frameworks
- Availability of qualified trainers with at least three years of clinical experience in the relevant modalities
- Access to appropriate clinical facilities for hands-on training
- Minimum patient-to-trainer ratios for practical sessions
- Assessment and examination processes that meet national standards
- Continuing quality assurance through periodic inspection

Private training academies that currently operate without accreditation should be given a transition period of 18 months to apply for accreditation, after which unaccredited programmes should not be recognized for the purposes of registration.

6.4 Clinic Accreditation: A Save Face Model for Pakistan

Provincial Healthcare Commissions should develop a clinic accreditation scheme modeled on the UK's Save Face programme. This scheme should assess aesthetic clinics against a standardized set of criteria covering:

- Practitioner qualifications and registration status
- Premises hygiene, infection control, and cleanliness
- Availability of emergency equipment and protocols
- Patient consultation and consent processes
- Complaint management procedures
- Product and device safety standards

Accredited clinics should be listed on a publicly accessible register, enabling patients to make informed choices. Clinics that fail to meet accreditation standards should be subject to enforcement action by the relevant Provincial Healthcare Commission.

7. Addressing the Training Gap: Practical Recommendations

7.1 Recognizing the Private Sector's Role

Aesthetic medicine training will, for the foreseeable future, be delivered primarily by the private sector. This is not a problem to be solved but a reality to be managed. The government's role is not to deliver training itself, but to set and enforce the standards that private training providers must meet. This is the approach taken in the UK, where the JCCP accredits private training providers against its competency framework, and it has proven effective.

7.2 Transitional Arrangements for Existing Practitioners

A significant number of practitioners in Pakistan have been performing aesthetic procedures for many years, often with considerable skill and experience, but without formal accreditation. Any new regulatory framework must include fair transitional arrangements for these practitioners, recognizing their experience while requiring them to meet minimum competency standards.

We recommend a **grandfather clause** that allows practitioners with documented evidence of at least three years of aesthetic practice (prior to the implementation of the new framework) to apply for registration on the basis of their experience, subject to a competency assessment. This is consistent with the approach taken by the PMC in its 2022 credentialing framework, which recognized practitioners with more than five years of experience [2].

7.3 Continuing Professional Development

All registered aesthetic practitioners should be required to complete a minimum number of CPD hours per year, as specified for each tier. CPD activities should include attendance at conferences, completion of online or in-person training modules, peer review, and case-based learning. The NAMC should develop a CPD framework and maintain a log of practitioners' CPD activities as part of the registration process.

8. Patient Safety and Consumer Protection

8.1 Informed Consent

All aesthetic procedures, regardless of tier, should be preceded by a thorough informed consent process. Practitioners must ensure that patients understand the nature of the procedure, the risks and potential complications, the expected outcomes, and the alternatives. Consent should be documented in writing and retained as part of the patient record.

8.2 Psychological Assessment

Aesthetic medicine practitioners should be trained to recognize signs of body dysmorphic disorder (BDD) and other psychological conditions that may make a patient unsuitable for aesthetic procedures. The JCCP competency framework includes specific competencies in psychological assessment and safeguarding [13]. These should be incorporated into Pakistan's national competency framework.

8.3 Complication Management

All practitioners performing injectable procedures (Tier 2 and above) must be trained in the recognition and management of serious complications, including vascular occlusion, infection, and anaphylaxis. They must have access to emergency medications (including hyaluronidase for filler-related vascular occlusion) and must have a clear protocol for escalating emergencies to hospital care.

8.4 Advertising Standards

The advertising of aesthetic procedures in Pakistan is currently unregulated. Practitioners and clinics make claims about the safety and efficacy of procedures that are often exaggerated or misleading. The NAMC should develop advertising standards for aesthetic medicine, prohibiting misleading claims and requiring that all advertising include a statement of the practitioner's qualifications and registration status.

9. Action Plan for the Government of Pakistan

The following action plan outlines the steps required to implement the proposed framework, with suggested timelines.

Priority	Action	Lead Body	Timeline
Immediate (0–6 months)	Establish the National Aesthetic Medicine Council (NAMC) with multidisciplinary representation	PM&DC	0–3 months
Immediate (0–6 months)	Issue a moratorium on enforcement actions against fully licensed MBBS and BDS practitioners performing Tier 1 and Tier 2 procedures pending the new framework	PM&DC	0–1 month
Short-term (6–18 months)	Develop and publish national competency frameworks for Tiers 1, 2, and 3	NAMC	6–12 months
Short-term (6–18 months)	Launch the National Aesthetic Practitioner Register	PM&DC / NAMC	12–18 months
Short-term (6–18 months)	Develop and publish accreditation criteria for training providers	NAMC	6–12 months
Short-term (6–18 months)	Develop transitional (grandfather clause) arrangements for existing practitioners	PM&DC / NAMC	6–12 months
Medium-term (18–36 months)	Launch clinic accreditation scheme through Provincial Healthcare Commissions	PHCs	18–24 months
Medium-term (18–36 months)	Accredit existing training providers against new standards	NAMC	18–30 months
Medium-term (18–36 months)	Develop advertising standards for aesthetic medicine	NAMC / PEMRA	18–24 months
Long-term (36+ months)	Introduce mandatory registration for all aesthetic practitioners	PM&DC	36+ months
Long-term (36+ months)	Introduce mandatory clinic licensing for aesthetic facilities	PHCs	36+ months

10. Conclusion

Pakistan stands at a pivotal moment in the development of its aesthetic medicine sector. The demand for minimally invasive cosmetic procedures is growing rapidly, driven by a young, urbanizing population with rising disposable incomes and increasing exposure to global beauty trends. The question is not whether aesthetic medicine will grow in Pakistan, but whether it will grow safely, equitably, and professionally.

The framework proposed in this white paper offers a path forward that is inclusive, evidence-based, and proportionate. It draws on the best practices of the UK, USA, Australia, and Canada, adapted to the specific context of Pakistan's healthcare system, practitioner landscape, and regulatory environment.

The core principles of this framework are simple. Aesthetic medicine should be governed by competency, not by specialty. Dentists, who possess superior anatomical knowledge of the head and neck, should be fully included as aesthetic practitioners. Allied healthcare professionals, including nurses, physiotherapists, and pharmacists, should be empowered to perform lower-risk procedures with appropriate training. All practitioners — including dermatologists and plastic surgeons — should be required to demonstrate specific aesthetic competency before practicing independently. And the private sector should be recognized as the primary vehicle for aesthetic medicine training, subject to rigorous national accreditation standards.

By implementing this framework, Pakistan can protect its patients, empower its practitioners, grow its aesthetic medicine industry, and position itself as a regional leader in safe, high-quality aesthetic care.

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This white paper was prepared for submission to the Government of Pakistan, the Pakistan Medical and Dental Council (PM&DC), and Provincial Healthcare Commissions. It represents the professional views of its authors and contributing practitioners and is intended to inform evidence-based policy development in the field of aesthetic medicine.

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