

EDITORIAL

Medical education in South Asia: Challenges and Opportunities

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Medical education in South Asia is characterized by a strong regulatory presence from centralized bodies like councils, a traditional curriculum largely modeled after the British system, and a rapid expansion of private medical colleges. While the region produces a high volume of graduates, it faces challenges with quality standards, rural doctor shortages, and “brain drain” to Western countries. This comprehensive overview details the evolution, systemic hurdles, and reform efforts within South Asian medical education, with a specific focus on the current crisis in Nepal.

REGIONAL HIGHLIGHTS

Expanded medical education across these South Asian nations reflects varying stages of development and infrastructure.^{1,2} **India** reaps benefits from significant historical investment in science and technology. It has numerous “Centres of Excellence” in specialties like cardiology and neuroscience, though a standardized accreditation system for these centers is still developing. **Pakistan** focuses heavily on textbook knowledge and exam performance, though institutions like the Dow University of Health Sciences have introduced undergraduate skills labs to improve practical training. **Nepal's** most medical schools are affiliated with either Tribhuvan University or Kathmandu University. Schools like the Patan Academy of Health Sciences (PAHS) have innovative curricula designed specifically to train doctors for rural service. **Sri Lanka** boasts some of the best health indicators in the region (high

life expectancy, low infant mortality) due to long-term government investment in free education and community-based primary care. **Bangladesh** hosts to a vast medical education network. It is a major hub for international students, particularly from Nepal and India. **Bhutan** established its first medical university, which began its first home-grown MBBS program in early 2026. The **Maldives** National University (MNU) School of Medicine, established in 2018, is the country's first medical school.

KEY CHARACTERISTICS OF THE EDUCATIONAL SYSTEM

The region's medical training is defined by its history and its recent attempts to modernize.^{1,3} Students typically earn an MBBS degree over 5 to 6 years, which includes a mandatory one-year internship. The program begins with two years of foundational sciences followed by intensive clinical rotations. Centralized organizations, like India's NMC, Nepal's MEC and Pakistan's PMDC, establish and enforce academic standards. While government-run colleges offer low-cost or free tuition, private schools can cost between \$30,000 and \$60,000, creating a significant barrier for many students. A surge in private colleges has occurred to meet high demand, creating a system where public seats are subsidized and private seats are high-cost. There is an active transition toward Competency-Based Medical Education, which prioritizes practical clinical skills and integrated learning over traditional, isolated lectures. The focus is

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on objective-based clinical training. There is a growing demand for Master of Public Health programs. As of 2022, over 180 institutions in South Asia offered MPH degrees, with India serving as the largest regional hub.^{4,5} Experts advocate for stronger community-based programs to address the region's vast unmet health needs, particularly in rural areas. Many schools have strong community medicine departments to address regional health challenges, though actual clinical training remains heavily hospital-based.⁴

MAJOR SYSTEMIC BOTTLENECKS AND CHALLENGES¹⁻³

Medical education in South Asia faces several critical “bottlenecks” that hinder the production of high-quality healthcare professionals and the equitable delivery of care. Despite high graduate volumes, several “chokepoints” threaten the quality of care. There is a critical shortage of qualified educators. Many professors lack training in modern pedagogy, and senior clinicians often prefer private practice over teaching. Private institutions often lack the patient volume necessary for student training due to high fees. Furthermore, the “internship crisis” sees students neglecting ward work to study for postgraduate entrance exams. Regulatory oversight is often criticized for being superficial, with some institutions using “ghost faculty” to pass inspections. A majority of colleges produce zero research, leaving the region as a “consumer” rather than a “producer” of medical knowledge. Despite positive perceptions of the learning environment, many institutions face insufficient facilities and a focus on rote knowledge for exams rather than practical application. As doctor-patient dynamics is changing there is an increasing need for communication skills and Medical Humanities training as patients become more autonomous and less accepting of traditional paternalistic models. A significant portion of medical graduates frequently migrate to Western countries for better career progression and lifestyle.

STRATEGIES FOR REFORM^{1,2}

To address these issues, regional authorities are

implementing several modernizing measures: such as introducing Early Clinical Exposure and horizontal/vertical integration (e.g., teaching anatomy and pathology of an organ simultaneously), using high-fidelity simulation labs to supplement low patient exposure and training doctors in Telemedicine for rural service. Integrating Telemedicine and Health Informatics into the core curriculum to prepare doctors for rural service and modern digital health ecosystems, implementing uniform exit exams, such as India's NExT and Nepal's MEC common entrance, to ensure all graduates meet a baseline quality standard and adopting models that recruit students from rural backgrounds to increase the likelihood of them practicing in underserved areas.

THE CRISIS IN NEPAL⁶⁻⁸

In Nepal, medical education is currently at a critical crossroads. While the country has reached the WHO-recommended doctor-to-population ratio of 1:1,000, it faces a severe crisis of “quality over quantity” and a massive exodus of its healthcare workforce. Nepal serves as a good example of the “quantity versus quality” struggle: mainly the issues are licensure failures, the exodus (brain drain), the workforce gap, nursing shortage, postgraduate shift and regulatory and political tension. In early 2025, over 70% of candidates failed the national licensure exam, highlighting a massive gap in undergraduate training quality. While Nepal meets the WHO's doctor-to-population ratio (1:1,000) on paper, the reality is different. Of 45,000 registered doctors, fewer than 15,000 are practicing in-country. Roughly 1,200 doctors are produced annually, but over 6,000 have left the country in just two years, driven by low wages, high burnout (53+ hour weeks), and limited career growth. Provisions in the Medical Education Act (2075) requiring nursing colleges to have their own 100-bed hospitals have led to the closure of many institutions. This has slashed the annual production of nurses from 5,500 to just 1,800, leading to a looming “nursing famine”. For the 2026 academic session, the MEC has allocated 2,030 PG seats. Notably, for the first time, government colleges

(1,031 seats) have been allotted slightly more than private institutions (999 seats). A key 2025 reform mandate ensures that resident doctors in private colleges must receive a living allowance equivalent to an 8th-level government official. Reform efforts are often caught between government officials, private “medical business” interests, and reformists (like Dr. Govinda KC) fighting for ethical expansion and better infrastructure.

CONCLUSION

The medical education system in South Asia requires a comprehensive overhaul, focusing on evidence-based curriculum, active learning, and modernized assessment technologies to enhance regional healthcare. Upgrading these standards is critical for retaining talent and reducing the brain drain of skilled physicians to developed countries.

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