

Present Scenario of Medical Education in India: Challenges, Reforms and Future Directions

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ABSTRACT

Background: Medical education in India has undergone substantial expansion and regulatory transformation over the past decade. The transition from the Medical Council of India to the National Medical Commission has further reshaped the regulatory and educational framework. **Objective:** To review the present scenario of medical education in India, with particular emphasis on its expansion, regulatory reforms, major challenges, and future directions. **Methods:** A narrative review was conducted using relevant published literature, regulatory documents, government reports, and publicly available information concerning medical education in India, particularly during 2016–2026. **Results:** India has witnessed a marked increase in the number of medical colleges and undergraduate and postgraduate medical seats. Despite improved access to medical education, challenges remain regarding faculty availability, infrastructure, clinical exposure, quality assurance, regulatory compliance, teaching-learning processes, and equitable distribution of medical education and healthcare resources. **Conclusion:** Expansion of medical education should be accompanied by strong quality assurance, adequate faculty and clinical resources, competency-based training, transparent regulation, and continuous assessment of educational outcomes. A balanced and quality-oriented approach is essential for producing competent, ethical, and socially responsible medical professionals.

Keywords: Medical Education; National Medical Commission; Medical Council of India; Competency-Based Medical Education; NEET; Medical Colleges; Faculty Development.

INTRODUCTION

At present in India there are almost 827 MBBS medical colleges are running the course, and all are Permitted by parent body i.e. National Medical Commission and Government of India. Total MBBS seats available are 137000 and Total PG seats available are almost 69000 all over India and almost 50000 FMEG students are coming per year to India for Internship each year after completing course outside country¹.

Authorities running medical colleges are-

- Government medical Colleges.
- Private Medical Colleges run under Charitable trust and under company act.
- Deemed to be Universities running medical Colleges.

- State Sponsored Universities.
- Medical colleges run By Medical universities.
- Medical colleges run By Municipal Corporations.
- Medical Colleges under PPP mode.
- Central government run colleges such as AIIMS, JIPMER, PGI ESIC MC etc.
- FMEG Students taking admissions out of India. Government Of India's intention is to improve ratio of doctors to present population i.e.1;1000. To meet this aim Health ministry had taken decision to start new medical college in Each District of every State.

REVIEW METHODOLOGY

This article is a narrative review of the changing landscape of medical education in India, with particular emphasis on developments during the period from 2016 to 2026. Relevant information was identified from publicly available literature, reports, regulatory documents, government publications, and published discussions related to medical education in India. Major areas reviewed included the expansion of medical colleges and undergraduate and postgraduate seats, regulatory reforms, the transition from the Medical Council of India (MCI) to the National Medical Commission (NMC), admission through the National Eligibility cum Entrance Test (NEET), faculty requirements, infrastructure and clinical training, competency-based medical education, and challenges faced by government and private medical institutions.

The review focused primarily on literature and official information relevant to the Indian medical education system during the last decade. Publications and documents addressing medical education policy, regulatory standards, medical college establishment, faculty requirements, student admission, clinical exposure, and quality of medical education were considered. Information from relevant official and publicly available sources was critically reviewed and synthesized to describe the present scenario, major challenges, and possible future directions of medical education in India.

As this was a narrative review based on previously published and publicly available information, no primary patient-level data were collected or analyzed.

EVOLUTION OF MEDICAL EDUCATION IN INDIA: 2016–2026

The period from 2016 to 2026 has witnessed substantial expansion and regulatory transformation in medical education in India. During this period, the country experienced a marked increase in the number of medical colleges and available undergraduate and postgraduate medical seats. This expansion was aimed at improving access to medical education, increasing the availability of doctors, and addressing regional disparities in healthcare manpower.

One of the major regulatory developments during this period was the replacement of the Medical Council of India by the National Medical Commission. The NMC was established with the objective of improving the quality and accessibility of medical education, ensuring adequate standards of medical institutions, regulating medical education and professional practice, and promoting competency-based training.

The introduction and continued implementation of competency-based medical education have also changed the approach to undergraduate medical training. Greater

emphasis has been placed on competency acquisition, clinical skills, communication, professionalism, and integration of theoretical knowledge with clinical practice.

The NEET-based admission system has further standardized entry into undergraduate and postgraduate medical education. At the same time, the rapid expansion of medical institutions has created challenges related to availability of qualified faculty, adequate clinical material, infrastructure, patient exposure, teaching quality, and effective regulatory monitoring.

Thus, the last decade may be considered a period of both quantitative expansion and qualitative transition in Indian medical education. The major challenge for the coming years is to ensure that expansion in the number of institutions and seats is accompanied by measurable improvement in educational quality and clinical competence.

CURRENT SCENARIO OF MEDICAL EDUCATION IN INDIA

Medical education in India is currently characterized by rapid expansion, increasing opportunities for admission, regulatory reforms, and continuing concerns regarding quality and uniformity of education. The increase in the number of medical colleges and MBBS seats has substantially improved the availability of medical education compared with the situation a decade ago. However, expansion alone cannot ensure the production of competent and ethical physicians.

Expansion of Medical Colleges and Seats

The increase in the number of medical colleges has expanded access to undergraduate medical education across different regions of the country. Government institutions, private medical colleges, deemed universities, state universities, municipal institutions, central government institutions, and institutions operating under different partnership models contribute to the current medical education system.

The increase in MBBS and postgraduate seats provides greater opportunities for students to enter medical education. However, the distribution of institutions and seats remains an important consideration because regional variations in healthcare infrastructure and availability of medical professionals continue to exist.

Role of the National Medical Commission

The National Medical Commission has become the principal regulatory authority for medical education and professional standards in India. Its responsibilities include regulation of medical education, recognition and monitoring of medical institutions, formulation of standards, regulation of medical professionals, and promotion of competency-based medical education.

The transition from the earlier regulatory system to the NMC represents an important structural reform. Effective implementation of regulatory standards, transparent assessment procedures, and continuous monitoring remain essential for maintaining educational quality.

Medical College Infrastructure and Clinical Exposure

Adequate infrastructure, laboratories, teaching facilities, libraries, hostels, and clinical departments are fundamental components of medical education. Equally important is the availability of sufficient patient exposure in outpatient and inpatient departments.

Students require adequate clinical exposure to develop history-taking, examination, diagnostic reasoning, procedural, communication, and patient-management skills. Therefore, the numerical availability of infrastructure should be accompanied by actual utilization and meaningful clinical teaching.

Faculty Availability and Development

Qualified and adequately trained faculty are among the most important determinants of the quality of medical education. Rapid expansion of medical colleges has increased the demand for teaching faculty in pre-clinical, para-clinical, and clinical disciplines.

Faculty shortages, uneven distribution of experienced teachers, workload, recruitment difficulties, and limited opportunities for faculty development may adversely affect teaching quality. Continuous professional development and appropriate academic working environments are therefore essential.

Teaching-Learning Methods

Medical education is progressively moving from predominantly lecture-based teaching towards competency-based, student-centred, integrated, and clinically oriented learning. Small-group teaching, case-based learning, simulation, skills training, formative assessment, and digital learning resources can improve student engagement and clinical competence.

However, effective implementation depends on appropriately trained faculty, adequate infrastructure, sufficient teaching time, and active participation by students.

NEET and Medical Admissions

The NEET-based admission system has standardized the entrance process for medical education and provides a common competitive framework for admission. Merit-based selection has improved standardization of entry into medical education. Nevertheless, issues related to affordability, distribution of seats, socioeconomic diversity, and access to quality preparatory education

remain relevant to discussions surrounding medical admissions.

Private and Government Medical Education

Government and private institutions both play important roles in meeting the growing demand for medical education. Government institutions generally provide comparatively lower-cost education and serve as major centres for tertiary healthcare and postgraduate training. Private institutions have contributed substantially to the expansion of medical seats and healthcare infrastructure. At the same time, differences between institutions in faculty strength, patient load, infrastructure, educational resources, and financial accessibility highlight the need for consistent quality standards across all institutions.

Foreign Medical Graduates

India also receives students who complete medical education outside the country and subsequently seek to fulfil the requirements for medical practice or internship in India. Appropriate screening, assessment, internship opportunities, and competency requirements are important to ensure that all doctors entering the Indian healthcare system meet appropriate professional standards.

Overall, the present scenario reflects substantial growth in access to medical education, but the next phase should focus increasingly on quality, competency, clinical exposure, faculty development, ethical practice, and measurable educational outcomes.

Process of Permission of New Medical college²

Anybody from above mentioned body can start medical college now with

- 1.Required Land and Infrastructure for college and Hospital.
- 2.Required Faculty Positions as per MSR.
- 3.MRD documentation and census of OPD, IPD, Investigations, Operations, Deliveries etc.
- 4.Required Certifications-Essentiality, CoA, Fire NOC, Pollution, NA certification of land
5. Proper filing of application online to NMC.
- 6.Surprise Inspection /Assessment by NMC team.
- 7.Issuing of Letter of Permission for specific number of intake of Students.
- 8.Actual Admission process after NEET through counseling process.
- 9.Actual Student admission to start teaching process.

General Hurdles

The government should rethink opening medical colleges in large numbers every year to protect the health of our population going in untrained hands of physicians.

- Location of the Institute

- Land requirement
- Financial Burden
- Time lapse for getting licenses of various types from Government
- Time taken to complete required Infrastructure & Landscaping & Residential requirements
- Water supply
- Electricity Faculties and Generators
- Procurement of Instruments and Equipment, specimens, Models, Charts, etc
- Manpower Requirements- Faculty, Technicians, Clerks, Nursing Staff, House Keeping
- Faculty accommodation in Hospital premises
- Running cost of Hospital and College prior to permission
- Transportation facility

Specific Hurdles

1. Faculty

As at present there are 827+ medical college running. Appointments of faculty in nearby area is not possible and had to depend on faculty residing far away from location of proposed medical college. College authorities have to appoint faculty On Paper mean Attending for inspection days only.

One more thing, Management wants to cut the expenses of payment of salary for full time faculty. Instead, they are ready to negotiate on salary structure and days of attendance of faculty.

Undue Expectations of salary from Faculty of Specific subjects. Time lag of 8-10 months causes faculty to sit idle without any positive task to do and loss of their experience if unluckily institute does not get permission from NMC. Appointments of some of non-medical teachers having Fake degrees from Fake and or Private Universities. Management is reluctant to adjust leaves and vacations causing relocation of faculty from Institute

2. Running of Hospital

- NMC wants 100% Infrastructure, 100% faculty recruitment, Census of Patients as per norms Which is Impossible to maintain everything for newly Established Institute within the period of few weeks or months²
- Fulfillment of Census norms, the Institute has to run its facilities free of cost to attract patients to visit and to take treatment in said hospital.²
- Institute has to purchase costly equipment and Instruments without receiving any financial support and outcome of running those not getting financial fulfillment.²
- Institute has bare heavy billing for electricity, water, BMW charges, Pharmacy and consumables used during treatment.

1. NMC

Inspection Types are

- Physical, Virtual and or Hybrid
 - Surprise and Proposed
 - Routine, by court order and Complaint based
- Inspection process is surprise visits, institute will try to get exact information from office about dates of assessment embracing one and involves money transfers to Office persons, Assessors and even to office bearers and Ministers to get permission in stipulated time via Hawala rackets.

It is easy to get permission now by NMC than time of MCI as assessment involves digital model to assess the things MCI was assessing everything physically and deficiencies are noted in report facing a institute a Compliance Inspection.

Involvement of CBI last year In the assessment process due to financial transaction in 8 medical institutions across India and stopping admission process in those institutions. All of these Institutions got permission for their intake through court orders shows weakness of NMC Hence assessment will be tougher this year.

Even after permission under pretext of Good Medical Education, NMC issues Show cause notices as per NMC act 2019 to Institute about Faculty attendance on AEBAS portal and other irregularities.

2. Admission of students

It does not solve the problems. It is totally NEET merit based. The Institute has to depend on government funding for students getting admitted under reserve categories. About 80 % of total admission of students and that attracts bureaucratic hurdles for fund transfers from government.

3. Teaching Process

Mass appointments of Faculty do not attract dedicated teachers to teach as per the expectations of students. Students are not also interested to learn and to attend classes due to various reasons. Ultimately affecting Learning process and quality of education all over the country.

4. State Governments

Delay in Inspections and permissions. Delay or non-payments of Scholarships of students guaranteed by government.

5. Local University

Delay in Inspections and permissions. Assessors and officials of university expect remuneration from management for permissions. Management of Institution applying for permission also not completing infrastructure, faculty positions and other things for that particular inspection.

6. Local Politics

Local politics especially personal politics hamper much of quality of education as leaders of opposition obstruct the growth of Institution by using governmental policies, making nuisances through their supporters or some time through court orders.

7. Management

Management does not want to appoint Full time faculty to reduce extra financial burden on them. They do not pay regular salary for the teachers and hence teacher leaves Institute as promised by them at the time of appointment. They fail to provide required facilities to students, Residents and faculties. Now a days Private institutes are running on 20-30% of fulltime staff. Due to over burden, faculty opt to leave the institute. Due to shortage of manpower, faculties cannot perform their best. Management Favours some of the faculty even he is junior confronting with senior faculty in the context of relative, shortage of faculty positions or area. Management decides pay band but actually there is gross discrepancy of actual payments offered at time of appointments. Management expects returns of their investment in medical college through fees or misusing governmental schemes.

DISCUSSION

The transformation of medical education in India during the last decade represents a major expansion of the country's medical education capacity. The increase in the number of medical colleges and available seats has improved opportunities for students seeking medical education and has the potential to strengthen the country's healthcare workforce. However, the relationship between the number of medical graduates and the quality of healthcare delivery is not necessarily linear.

A major concern associated with rapid expansion is the availability of adequately qualified and experienced faculty. Medical education requires not only numerical compliance with regulatory requirements but also teachers who are academically committed, clinically competent, and capable of providing effective mentorship. Faculty development and retention should therefore remain central components of future policy.

Clinical exposure is another important determinant of medical education quality. A medical student requires adequate exposure to patients and common clinical conditions to develop diagnostic reasoning and practical skills. Consequently, establishment of a medical college should be accompanied by sustainable clinical services, adequate patient load, functioning departments, and appropriately supervised clinical training.

The transition from the MCI framework to the NMC framework has introduced significant regulatory

changes. The emphasis on competency-based education represents an important shift from knowledge-oriented education towards outcome-oriented training. However, successful implementation requires uniform understanding of competencies, appropriate assessment methods, faculty training, and adequate educational resources.

Private medical institutions have contributed significantly to increasing the number of medical seats in India. Nevertheless, variations in educational resources, infrastructure, clinical workload, faculty availability, and fee structures may influence the quality and accessibility of medical education. Regulatory mechanisms should therefore focus not only on granting permission to establish institutions but also on continuous monitoring of educational outcomes.

Another important consideration is the geographical distribution of medical colleges. Increasing the number of institutions does not automatically ensure equitable access to healthcare. Future expansion should therefore consider population needs, regional healthcare indicators, availability of specialists, rural healthcare requirements, and existing medical infrastructure.

The ultimate objective of medical education should be the production of competent, ethical, compassionate, and socially responsible physicians rather than merely increasing the number of graduates. The quality of undergraduate and postgraduate education should consequently be assessed through objective educational and clinical outcomes, rather than through infrastructure and numerical indicators alone.

A balanced approach combining expansion with quality assurance, faculty development, adequate clinical exposure, transparent regulation, modern teaching methods, and stakeholder participation is therefore necessary for sustainable improvement in Indian medical education.

STRENGTHS OF THE REVIEW

This review provides a broad overview of the transformation of medical education in India during the period from 2016 to 2026. It considers major components of the medical education system, including expansion of medical colleges and seats, regulatory reforms, NMC, faculty availability, infrastructure, clinical exposure, admission processes, teaching-learning methods, and challenges faced by different stakeholders. The review also highlights the need to balance quantitative expansion with educational quality and clinical competence.

LIMITATIONS OF THE REVIEW

This article is a narrative review and does not follow a systematic review or meta-analysis methodology. The findings are based on information available from

published literature, regulatory documents, government sources, and other publicly available material. Differences in definitions, reporting methods, and time periods among various sources may result in variation in reported statistics. In addition, medical education policies, regulatory requirements, and the number of medical colleges and seats may change over time. Therefore, some numerical information may require periodic updating. No primary data were collected, and no statistical meta-analysis was performed.

FUTURE DIRECTIONS

Future development of medical education in India should focus on quality-oriented expansion rather than numerical growth alone. Establishment of new medical colleges should be guided by population needs, regional healthcare requirements, availability of clinical services, and long-term sustainability.

Faculty development should receive greater attention through structured training in teaching methodology, assessment, curriculum implementation, research, and mentorship. Modern educational approaches including simulation-based learning, digital education, case-based learning, artificial intelligence-assisted learning, and competency-based assessment may further strengthen medical education.

There is also a need to improve rural and underserved-area medical education and to ensure adequate clinical exposure for students. Regulatory systems should promote transparency, consistency, and continuous quality improvement. Future research should evaluate the outcomes of medical education reforms using measurable indicators such as graduate competencies, postgraduate performance, clinical skills, patient-care outcomes, and distribution of doctors across different regions.

Greater involvement of students, teachers, healthcare professionals, patients, parents, academic institutions, and policymakers may help develop a more responsive and sustainable medical education system.

RECOMMENDATIONS

1. Expansion of medical colleges should be based on healthcare needs, population distribution, and regional requirements rather than numerical expansion alone.
2. Adequate and sustainable clinical patient load should be ensured to provide meaningful clinical exposure to undergraduate and postgraduate students.
3. Recruitment of appropriately qualified full-time faculty should be strengthened, with emphasis on faculty retention and academic development.
4. Faculty development programmes should be regularly conducted to improve teaching, assessment, mentoring, research, and curriculum implementation skills.

5. NMC regulatory and assessment processes should remain transparent, standardized, evidence-based, and focused on educational outcomes.
6. Competency-based medical education should be implemented effectively with appropriate faculty training, skills laboratories, simulation facilities, and objective assessment methods.
7. Digital learning, simulation-based teaching, interdisciplinary learning, and other modern educational technologies should be appropriately integrated into medical curricula.
8. Rural and underserved regions should receive priority in future medical college development and healthcare workforce planning.
9. Government scholarships and financial support mechanisms for eligible students should be implemented in a timely and transparent manner.
10. Continuous quality assurance mechanisms should assess not only infrastructure and faculty numbers but also teaching quality, clinical competence, student outcomes, and graduate performance.
11. Greater participation of students, teachers, healthcare professionals, patients, and other relevant stakeholders should be encouraged in the development and evaluation of medical education policies.
12. Regular independent evaluation of medical education reforms should be undertaken to determine whether expansion of medical education is translating into improved healthcare delivery and better patient outcomes.

CONCLUSIONS

A Government decision to establish one medical college for approximately 1,000,000 population is intended to improve the doctor-to-population ratio. However, medical workforce planning should consider not only the number of allopathic/MBBS doctors but also the broader healthcare workforce, including practitioners from other systems of medicine and other healthcare professionals. A comprehensive approach to healthcare workforce planning is therefore required.

Establishment of a medical college involves substantial financial investment and requires adequate infrastructure, hospital facilities, qualified faculty, clinical workload, and other resources. Some private medical institutions may face difficulties in maintaining adequate patient load and fulfilling all prescribed regulatory requirements, particularly during the initial stages of establishment. Sustainable hospital services and adequate clinical exposure are essential for effective medical education.

Adequate faculty requirements are equally important for establishing and maintaining the quality of medical education. Institutions may face challenges related to recruitment, retention, remuneration, workload, and

availability of experienced faculty. At the same time, faculty members and institutional management should maintain a balanced and professional approach towards academic responsibilities, working conditions, and institutional requirements.

The ultimate objective of medical education should be to produce competent physicians rather than graduates whose training is primarily focused on theoretical knowledge or examination performance. Excessive dependence on investigations without adequate clinical reasoning and increasing commercialization of healthcare may adversely affect the professional development of medical graduates. Therefore, greater emphasis should be placed on clinical skills, diagnostic reasoning, ethics, professionalism, communication, and patient-centred care.

The reported improvement in examination success rates in recent years should also be interpreted carefully. Higher pass rates may reflect improvements in teaching, curriculum implementation, assessment methods, and student support; however, examination success alone should not be considered a complete indicator of the quality of medical education. Educational quality should also be assessed through competency, clinical performance, professional behaviour, and preparedness for independent medical practice.

Another important consideration is the limited participation of important stakeholders in medical education policy development. Doctors, students, patients, parents, faculty members, academic institutions, and healthcare professionals should have appropriate opportunities to contribute to discussions concerning medical education and healthcare workforce planning.

Improving the quality of medical education therefore requires collective efforts by the Government, regulatory authorities, faculty, students, parents, institutional management, universities, healthcare professionals, and policymakers. Coordinated discussion, evidence-based policymaking, continuous quality assessment, and meaningful stakeholder participation are essential for strengthening medical education and producing competent, ethical, and socially responsible physicians in India.

DECLARATIONS

Ethical Approval

Not applicable. This article is a narrative review based on previously published literature, regulatory documents, and publicly available information and does not involve human participants, patient data, or animal subjects.

Consent for Publication

Not applicable.

Conflict of Interest

The authors declare that they have no conflict of interest.

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Author Contributions

Both authors contributed to the conception of the review, literature review, preparation and critical revision of the manuscript, and approved the final version of the manuscript.

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