Beyond the NEET Paper Leak: Medical Education is at a Crossroads in India

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India's medical college count has nearly doubled in a decade. But more seats does not automatically translate to better distribution and quality of health care.

Representative image of All India Institute of Medical Science (AIIMS), Delhi. Photo: Wikimedia Commons.

The controversy around the National Eligibility-cum-Entrance Test (NEET), including allegations of paper leaks, has sparked debate over the state of medical education in India. But the present crisis is not merely about the integrity of one entrance examination. It is also a moment to reflect on deeper structural concerns within the country's education system.

Over the past decade, medical education in India has undergone unprecedented expansion, driven by a rapid increase in the number of colleges and seats. While this expansion was necessary, it has raised difficult questions around quality, affordability, equity, regulation, curriculum and the future of the MBBS (Bachelor of Medicine and Bachelor of Surgery) degree itself, bringing medical education in India to a crossroads.

The quest for numbers

The expansion of medical intake have been heavily driven by the pursuit of numbers, often justified by the World Health Organisation's (WHO's) benchmark of one doctor per 1,000 population, a reference point that no longer officially exists. In fact, the WHO now emphasises the combined density of doctors, nurses and midwives, while recognising that

health workforce needs vary according to disease burden, demography and health system design.

According to the latest data from the National Medical Commission (NMC), India has 822 medical colleges, of which 449 are in the public sector and 373 in the private sector. The total number of MBBS seats offered is nearly 1.3 lakh, with more than 68,000 postgraduate seats. India also has a parallel postgraduate training pathway through the Diplomate of National Board (DNB) programmes, run by the National Board of Examinations in Medical Sciences. Together, these figured represent a near doubling of institutions and seats within a decade. Moreover, official estimates suggest that India had already achieved a doctor-population ratio of 1:811 by 2025.

What the numbers are hiding

This aggregate doctor-population ratio conceals deeper structural problems. The simple arithmetic of increasing the number of seats does not automatically ensure an equitable distribution of doctors. Doctors remain concentrated in cities, richer states and the private sector, while rural areas, poorer states and public facilities continue to face shortages. Despite difficult working conditions in the private sector, doctors continue to prefer it over the public service. In many parts of the country, particularly rural India, informal and unqualified providers still dominate as the first point of care.

The rapid expansion of institutions and intake also raises questions about quality. Regulatory norms have been loosened and minimum criteria revised to accommodate the growth. Recruiting qualified faculty, maintaining required patient load and ensuring sufficient practical clinical training persist as common challenges faced by newer institutions in both the public and private sectors. Other critical issues are whether students receive effective bedside teaching, whether standards are consistently monitored and whether graduates are adequately prepared for independent practice.

The cost of a medical degree

Affordability has become another significant consideration alongside quality. Private colleges charge between Rs 60 lakh and Rs 1.5 crore as tuition fee for the MBBS course and up to Rs 3-4 crore for postgraduate seats in clinical specialities. Such exorbitant fees deepen inequality and push medical education increasingly beyond the reach of middle-class Indian families, a trend that erodes merit and risks making the profession less socially representative.

The admissions process compounds these inequities. NEET was introduced to bring uniformity, ensure minimum standards and reduce the burden of multiple entrance examinations, but it is widely criticised for favouring students from urban backgrounds,

central boards, English-medium schooling and expensive coaching ecosystems, leaving students from rural areas, state boards and vernacular-medium schools at a disadvantage from the outset. Moreover, while high-ranking students generally secure government seats, those with lower ranks are often left with only expensive private institutions, affordable to just a limited few.

Concurrently, the policy push to expand postgraduate (MD/MS) seats to a level where everyone, including candidates with a "zero" percentile, can gain admission risks further undermining the value of the MBBS degree as a standalone qualification. India's health system will continue to require a significant number of competent primary care physicians at the MBBS level, yet very few young doctors aspire to remain MBBS practitioners serving in remote public facilities. Thus, raising the question of whether the expansion of seats and specialisation is truly aligned with public health goals.

The way forward

To address these issues, there is an urgent need for broader policy reform and comprehensive health workforce planning. A good first step would be a detailed exercise to project future workforce requirements based on disease burden, demographic transitions and geographic distribution. Such practices are routine in countries like Canada and Australia, which use them to regulate seats and distribution.

The next critical step is strengthening regulation to go beyond infrastructure checks to focus on educational outcomes, including teaching quality, research output, ethics and clinical competence. To address faculty shortages, recruitment policies must abandon current regressive norms and be open to accomplished clinicians and researchers to enter medical academia at all levels.

Public medical education must remain central to reform, since government colleges tend to be more equitable and socially representative and are critical to strengthening public health systems. More importantly, their governance at the state level requires greater decentralisation through autonomous institutional structures to enable faster and more effective decision-making.

Finally, India's healthcare future depends not only on producing more doctors, but also on producing doctors with the right skills and deploying them where they are needed the most. The race cannot be for seats alone. It must be for excellence, equity and relevance. If India gets medical education right, it will strengthen the health of generations to come. If it gets it wrong, the consequences will be felt for decades.

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