

The Privatization Paradox

Unpacking the Systemic Trade-Offs of Private Medical Education in Nepal

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Executive Summary

This report examines the role of the private sector in undergraduate medical education in Nepal. Since the early 1990s, Nepal has undergone a transformation of its medical education landscape, moving from a public-only system to a one driven in large part by private sector investment. This change followed the National Health Policy of 1991, which encouraged private participation to address physician shortages and reduce the drain of foreign exchange. Today, Nepal's medical education landscape has expanded from a single public medical school to 28 institutions – including 12 public not-for-profit medical schools and 16 private for-profit schools.

The regulatory environment is currently governed by the National Medical Education Act of 2019, which established the Medical Education Commission (MEC) as the apex regulatory authority. The MEC has consolidated functions previously held by universities and the Nepal Medical Council, centralizing control over admissions, tuition fees, and accreditation. The current framework mandates that private colleges reserve between 10% and 20% of their seats for merit-based scholarships, effectively leveraging private capital to meet public social objectives. Almost half of these merit-based scholarship seats are allocated to students from marginalized groups.

From a financial standpoint, the private sector has mobilized significant capital, with Rs 8.1 billion (USD 55.86 million) of private equity and Rs 21.9 billion (USD 151.03 million) in loans currently invested across 16 for-profit private medical schools. These institutions have created an infrastructure with total assets valued at over Rs 57 billion (USD 393.10 million), with a significant portion of this valuation driven by the appreciation of land value. The high Debt-to-Equity ratio (2.69) reflects a significant level of pressure on institutions to generate short-term income through high tuition fees and associated hospital charges, potentially at the expense of academic quality or affordable clinical services. Hospital Services revenue (Rs 10.06 billion / USD 69.43 million) has now surpassed Medical School Fees revenue (Rs 8.77 billion / USD 60.53 million) as source of income for the sector.

The sector's financial health is complex. While the average Return on Equity (ROE, calculated as net annual income divided by shareholders' equity averaged over the last two years) stands at 11.72%. However, this figure masks high volatility, with institutional returns ranging from a high of 16.5% to a low of -29.56%, indicating that "medical education" is not a guaranteed profit-making venture. However, the National Medical Education Act's mandate for these for-profit entities to transition to a non-profit model within ten years has created uncertainty and potentially poses a significant financial challenge for the state if it will require to compensate private investors, especially given the sector's cumulative net worth of Rs 18.6 billion (USD 128.28 million). This also raises questions about the involvement of the private sector in health broadly, not to mention constitutionally enshrined freedoms to operate businesses within the purview of the law.

The increased number of locally-trained doctors is a major outcome of this expansion. Physician density has increased five-fold, rising from 2.1 per 10,000 people in 2004 to 10.9 in 2024, placing Nepal ahead of several regional neighbors like India and Bangladesh. While only 17.2% of doctors licensed in 1997 were trained domestically, that figure rose to over 82% by 2026. For the Academic Year 2026, a total of 2,685 undergraduate medical spots were approved across 28 institutions (1,840 private and 845 public). Nepal has also begun positioning itself as an international destination for medical education, with 749 seats reserved for foreign enrollees in 2026, with a potential to generate an estimated USD 38.94 million in annual tuition revenue.

Private medical education has led to substantial direct financial savings for the state. If the tuition fees for all students currently enrolled in private medical schools were supported using public funds, based on current tuition reimbursement rates for public medical schools, the cost would be about Rs 4.97 billion (USD 34.2 million) per year. This does not include the savings to the public exchequer from not having to pay for the academic infrastructure the private sector has created.

Additionally, domestic access to medical education provides major savings for families. If the 1,840 students currently enrolled in private schools had pursued their degrees in popular regional destinations like Bangladesh, they would have faced a collective additional expenditure of at least Rs 3.8 billion (USD 26.21 million) per year in tuition fees alone (although fees are lower than in Nepal in destinations like China and the Philippines).

However, these gains are countered by concerns about educational quality and health equity. For the last reported non-specialist licensing examination (May 2026), pass rates for private medical school graduates were only 73% (compared to 88% for public medical schools). Historically, overall licensure rates have usually hovered below 60% (licensure rates for foreign medical graduates are well below 50%). Between January 2025 and January 2026, 2,180 failures were reported (some of them were likely repeat test-takers) in the medical licensing examination. This represents significant economic and social wastage, as thousands of graduates are unable to practice. In addition, while there has been an expansion in undergraduate medical education, there has not been a commensurate growth in graduate medical education training pathways.

The medical education and health system also faces significant out-migration and geographic maldistribution of doctors. High tuition fees, ranging from Rs 4.1 -- 4.5 million (USD 27,586 -- 31,034), make medical education financially burdensome for many students, incentivizing graduates to seek a high-paying-specialty practice in urban areas, or move abroad to recoup their investments. In 2023, the number of doctors seeking certification for emigration (2318) nearly equaled the number of new licenses issued that year. In the fiscal year 2023/24, 2,518 doctors received Good Standing Certificates (GSC) for emigration, compared to 2,394 new registrations. There is also a persistent rural-urban divide, with physician density in urban areas like Kathmandu being more than 10 times greater than in some rural areas.

Finally, the impact of private sector-led expansion of medical education on key health system goals such as better access to health services, more functional health systems and improved health outcomes are not entirely clear.

Nepal's experience with private medical education thus highlights a paradox: while private investment has successfully expanded medical education capacity without incurring additional public costs, expanded capacity alone may not achieve broader societal objectives. For this to happen the state must also implement effective and appropriate oversight and a forward-looking regulatory framework to translate this growth into a high-quality, equitably distributed, and domestically retained healthcare workforce that translates into better and more equitable health outcomes for people.

1. Introduction

With the adoption of liberalisation and deregulation policies toward the 1990s, Nepal took steps to open up medical education to private investment. It was believed that increasing the number of private medical schools would address doctor shortages and increase access to health services; save foreign exchange spent on medical school fees abroad; and possibly increase foreign revenue by attracting international medical students.^{1,2}

Several decades later, Nepal's medical education sector is now dominated by the private sector. Medical school training positions have significantly expanded, and most medical students are now trained at for-profit private medical schools. However, the increased number of medical students has also coincided with an accelerated emigration of doctors abroad in search of better career opportunities, while the country still struggles with doctor shortages. In Nepal, private sector involvement has dramatically altered medical education, but the net societal impact of private sector led expansion of medical education remains unclear.

Medical education policy choices have a direct bearing on the health system and ultimately health outcomes.^{3,4} Because the physician health workforce plays a pivotal role within the health system, it is helpful to understand the involvement of the private sector in medical education in the context of the broader health system.

While Nepal has made substantive improvements in health outcomes over the past three decades, future improvements hinge on its ability to create a well-trained workforce capable of providing quality health services.⁴⁻⁶ Yet it encounters significant structural and fiscal impediments in successfully doing so. In terms of nominal spend, the health sector is underfunded, with total health expenditure limited to USD \$84 per capita.⁷ This fiscal constraint worsens workforce shortages, exacerbates urban-rural physician maldistribution, and impacts health services delivery in Nepal. While Nepal's health workforce density, including physicians, is improving, it is still below international benchmarks.⁸ Therefore, medical education is an important health policy and planning priority for Nepal.

A comparison of the policy approaches toward medical education adopted by two South Asian neighbours – Nepal and Sri Lanka – is illustrative. Over the past few decades, Nepal and Sri Lanka took contrasting policy approaches on the role of the private sector in expanding medical education. Nepal began to open its health sector, including medical education, in the early 1990s, through a wave of economic liberalisation and deregulation. In the three decades that followed, from having only one (public) medical school matriculating about 33 students per year until the early 2000s, the country today has 28 medical schools matriculating about 2,700 medical students per year.⁹ This proliferation of medical schools and increase in the number of students came after Nepal's first National Health Policy (1991) encouraged private investors to invest in health.¹⁰ Subsequently, the first private medical school in Nepal opened in 1994. The country today has 12 public not-for-profit medical schools and 16 private for-profit schools.¹¹ And more

medical schools are being planned.

In contrast, in Sri Lanka, medical education is delivered entirely by 12 non-fee levying state medical faculties.¹² In 2024, Sri Lankan medical schools admitted 2,049 students. These students are guaranteed employment in the public healthcare system.¹³ However, they have no mandatory public service obligations, and publicly-funded medical education has not prevented the emigration of Sri Lankan doctors; between 2022 to 2024, an estimated 1,489 doctors emigrated, resulting in worsening physician shortages and more than \$41 million in financial losses for the taxpayers.¹⁴ Although previous attempts to privatise medical education in Sri Lanka have been unsuccessful, there are renewed attempts to do so.

Despite the increase in the number of medical graduates, the quality of medical education in Nepal leaves much to be desired. In January 2025, over two-thirds of new doctors who took Nepal Medical Council's licensing exam failed to pass their exams.¹⁵ The availability of opportunities for post-graduate education and further specialisation is also limited. The public sector recruitment of doctors has not kept up with the number of medical graduates produced in the country. Pay and incentives, both within the public and private sector, are not attractive enough, resulting in many medical graduates leaving the country.^{16,17} In the financial year 2023/24 alone, 2,518 doctors – almost as many as the number of new doctors licensed that year – sought certification from Nepal Medical Council in order to migrate from the country.^{17,18}

The expansion of private medical education in Nepal over the past three decades represents a major shift in health workforce development policy. While the growth in the physician workforce was expected to address physician shortages and improve healthcare access, concerns remain regarding educational quality, equity, and the long-term impact. Understanding its overall societal impact necessitates a nuanced analysis of the benefits as well as the costs. Nepal's experience with the expansion of medical education could also offer policy insights for countries like Sri Lanka looking to make similar policy choices in the future.

2. Aim and Methods

We conducted this study to estimate the scale and trajectory of private financial investment in undergraduate medical education since the 1990s, and to the extent possible, quantify trends in student enrollment and licensure rates among private medical schools, comparing these outputs with those of the public sector. We also sought to map the regulatory landscape of medical education in Nepal.

We employed a mixed-methods approach to investigate the impact of private sector involvement in undergraduate medical education in Nepal. This design enabled us to quantify patterns in capital investment, financial status, student throughput and outcomes, while contextualizing health systems and physician density indicators. We conducted document reviews, financial data synthesis and analysis, and where required, stakeholder interviews for data triangulation. We mapped the regulatory landscape through a descriptive qualitative study of legislative frameworks governing major regulatory bodies like the Medical Education Commission (MEC), the Nepal Medical Council (NMC), along with universities and medical schools.

To estimate the scale of private investment and the cost of medical education, we synthesized data from institutional records, including annual reports, and audited financial statements. This was supplemented by tuition fee schedules mandated by the MEC and government archives regarding institutional licensing and accreditation. Further data clarification was provided through interviews with administrators, and other relevant stakeholders. From these sources, we extracted indicators for capital expenditures and investments, operational budgets, tuition revenues, and infrastructure investments. Descriptive statistics were then used to estimate the financial situation of the private medical education sector in the country. We also estimated the financial costs and savings due to a largely private-sector-led medical education system in Nepal.

Ethical approval for this study was granted by the Nepal Health Research Council (NHRC) Ethical Review Board. All data were managed securely and utilized strictly for research purposes to maintain institutional and participant confidentiality.

3.1. The Governance of Medical Education in Nepal: Legal and Institutional Topology

There are two important Acts – the National Medical Education Act and the Nepal Medical Council Act (with additional amendments) which provide the legal and regulatory foundations for medical education in Nepal. In addition, there are other Acts and Laws to establish Universities, Health Science Academies, and the Nepal Health Research Council.

There are also National Medical Education Regulations 2020 (with additional amendments) and various relevant government policies such as the National Health Policy (1991/2014/2019), Policy on Quality Assurance in Health Care Services (2007) and National Human Resource for Health Strategy (2021-2030).^{2,19–26} These Acts, Regulations, and Policies have given rise to a system of institutions and mechanisms that govern medical education in Nepal as shown in Table 1.

Table 1: An institutional topology of medical education governance in Nepal

	Governing Body Type	Governing Body
1	Regulatory Bodies	1.1 Medical Education Commission 1.2 Nepal Medical Council
2	Universities and Academic Bodies	2.1 Kathmandu University 2.2 Tribhuban University 2.3 Other Universities 2.4 Health Sciences Academies
3	Government Ministries	3.1 Ministry of Health 3.2 Ministry of Education 3.3 Other Ministries (Finance, Home)
NB: Kathmandu and Tribhuban University are explicitly listed here because historically they have granted affiliation to privately owned medical schools other than their constituent medical schools. Other universities have not done so.		

In Supplementary Appendix (SA1), we describe the legal and regulatory architecture of medical education and the roles and responsibilities of institutions and actors in more detail.

3.2. Private Medical School Approval and Supervision

The establishment of new medical colleges in Nepal is governed by the provisions of the National Medical Education Act 2019 and its associated regulations. Previously private medical school regulation fell under the purview of the Nepal Medical Council, universities, the education ministry, and related government entities – there was no one specific law that regulated medical education in Nepal.

Currently, many of these functions, including private medical school approval and supervision, fall under the purview of the Medical Education Commission (MEC). The MEC is the apex statutory regulatory authority for medical education. A 31-member board chaired by the Prime Minister governs it. The composition of the board is given in the Supplementary Appendix. While the board itself is high-powered, it is unclear how well it serves its purpose of regulating medical education, and whether a leaner and technical board would have served the purpose better.

The National Medical Education Act has restricted the establishment of new medical schools within the Kathmandu Valley until the year 2026 to check the proliferation of for-profit medical schools. Consequently, prospective investors in medical education have two primary pathways: (i) acquisition, partnership, or co-investment in already-established medical schools, or (ii) development of new medical schools outside the Kathmandu Valley, provided all regulatory conditions are met.

Any entity wishing to establish a new medical school must first obtain a Letter of Intent (LoI) from the MEC. This is mandatory before proceeding with detailed planning or investment activities. To qualify for the issuance of an LoI, the applicant must fulfill several stringent criteria. These include:

1. Identification of a legally compliant site that does not fall within restricted or prohibited zones as defined by prevailing regulations.
2. Availability of an operational teaching hospital meeting minimum infrastructure requirements: at least 300 or more beds for undergraduate medical programs. The hospital must have been in continuous operation for a minimum of two years and must maintain an average bed occupancy rate of at least 60%.
3. Submission of a formal application disclosing all potential conflicts of interest.
4. Provision of a comprehensive project proposal, including environmental impact considerations, infrastructure planning, academic framework, and data quality assurance measures.

Following submission, the proposal is evaluated in a full board meeting of the Medical Education Commission, which assesses compliance with statutory, academic, and infrastructural standards. If the application meets all requirements, the Commission may grant the Letter of Intent.

Upon obtaining the LoI, particularly in cases where prospective teaching hospitals are already functional, the investing party may proceed with detailed due diligence, financial planning, and subsequent steps required for formal establishment and accreditation. Final approval for operation (including student intake) requires further compliance with standards set by regulatory bodies and adherence to national policies on seat allocation, faculty requirements, and fee structures. These post-LoI requirements are critical determinants of both feasibility and long-term financial performance of medical institutions in Nepal.

The next mandatory step for a private institution is to obtain academic affiliation from a recognized university. This affiliation is essential for the institution to legally offer medical programs such as MBBS. At present, the Tribhuvan University Institute of Medicine (TU IOM) has adopted a restrictive approach toward granting new affiliations for private medical schools owing to concerns over its own lack of regulatory capacity. However, other universities may consider granting affiliation upon evaluation of the submitted project plan and the LoI.

Once university affiliation is provisionally secured and the required infrastructure – both academic and hospital-based – has been developed, the institution must undergo a pre-commencement inspection. This is conducted prior to the admission of students and is designed to ensure that the institution meets all prescribed minimum standards. These standards are assessed against structured yardsticks and validated checklists, covering infrastructure, hospital facilities, faculty strength, academic resources, and governance systems.

If the institution satisfies these requirements, it is granted permission to commence academic activities. Thereafter, the institution is subject to regular annual inspections, which are mandatory and continuous. These inspections are carried out objectively using standardized evaluation tools and are critical for maintaining accreditation status.

Both the affiliating university and the MEC play central roles in this regulatory process. The university primarily evaluates academic standards and institutional compliance with its affiliation criteria, while the MEC conducts parallel and complementary inspections focusing on broader regulatory requirements. These include infrastructure adequacy, clinical service capacity, human resources (both academic and hospital staff), faculty qualifications, teaching-learning provisions, and stakeholder feedback, including ground-level performance indicators.

It is important to note that, prior to the implementation of the National Medical Education Act 2019, such inspection and accreditation functions were largely under the jurisdiction of the Nepal Medical Council (NMC) and the university granting affiliation. These responsibilities have now been consolidated under the MEC. Despite this shift, inspection teams typically include representatives from the universities and the NMC, along with experts from the public and private sector, ensuring multidisciplinary and standardized evaluation.

Based on the findings of these inspections, particularly those conducted by the MEC, and the annual self-appraisal report submitted by the concerned institution, the number of student seats allocated to each institution is determined. This allocation is dynamic and may be revised periodically depending on the institution's compliance with required standards.

Tuition fees for Nepali students are determined and regulated by the Government of Nepal through the MEC, ensuring a degree of standardization across institutions. Currently approved tuition fees for undergraduate medical education, last revised in June 2022, are Rs 4.596 million (Rs 4.168 million inside the Kathmandu valley).^{27, 28} This fee covers tuition charges for the entire degree. Exam fees, hostel fees and other ancillary fees are charged extra. For foreign students, universities set an upper fee limit, generally allowing charges of up to three times the fee prescribed for Nepali students. While fees for Nepali students are heavily regulated by the government, private medical schools retain autonomy to determine their own fee structures for foreign students within this limit mentioned above.

3.3. The Scale of Private Investment in Medical Education in Nepal

Between 1993 and 2014, Nepal saw the establishment of 16 privately owned for-profit medical schools. These medical schools were primarily established through equity investments by Nepali investors. Two of the medical schools were heavily promoted by Indian investors, one of which has since exited (See Table 3).

The following analysis details the scale and nature of financial investment across Nepal's 16 private-for-profit medical institutions, drawing on the most recent audited financial data. All monetary values are expressed in Nepali Rupees (NPR) with US Dollar (USD) equivalents in brackets, calculated at an exchange rate of 1 USD = 145 NPR.

3.3.1. Scale of Financial Investment and Capital Structure

Since the inception of the private-led model in the early 1990s, the sector has mobilized significant private capital. The 16 established institutions have a cumulative Total Equity (Share Register) of Rs 8.15 billion (USD 56.21 million).

The total Asset base of these institutions has reached Rs 57.8 billion (USD 398.62 million). The average institution now possesses assets valued at Rs 3.61 billion (USD 24.90 million), though individual institutional valuations vary significantly from as low as Rs 1.03 billion (USD 7.10 million) to as high as Rs 11.33 billion (USD 78.14 million). These asset valuations are largely driven by the escalation of the valuation of their real estate holdings (medical schools are required to have land holdings above a statutorily fixed minimum). This reflects a significant infrastructure and asset build-up, with cumulative net worth (assets minus loans and liabilities) of all the private medical schools standing at Rs 18.6 billion (USD 128.28 million).

However, the asset expansion has been heavily fueled by debt. As of the latest reports, these schools carry a total loan burden of Rs 21.9 billion (USD 151.03 million). This reflects a high degree of financial leverage, with total loans nearly 2.7 times the initial equity investment. These loans are with Nepali banking institutions and are often securitised against the medical schools' real estate holdings. These medical schools also have combined liabilities (other than bank loans) payable to vendors and other creditors of about 17 billion rupees.

3.3.2. Revenue Streams and Operational Performance

In the most recent fiscal period for which data were available, the private medical education sector generated a Total Revenue of NPR 21,983.59 million (USD 151.61 million). The following lists the source of this revenue:

1. Revenue from Hospital Services: Rs 10.06 billion (USD 69.38 million), representing 45.8% of total income.
2. Revenue from Medical School Fees: Rs 8.77 billion (USD 60.48 million), representing 39.9% of total income.
3. Pharmacy and Other Revenue: Combined Rs 3.13 billion (USD 21.59 million).

Hospital Services have now overtaken Medical School Fees as the primary revenue driver, indicating improving clinical operations of affiliated teaching hospitals. This diversification suggests that the "teaching hospital" component is no longer just a regulatory requirement but an important contributor of financial resource for many institutions. However, Total Operating Expenses remain substantial at Rs 20.48 billion (USD 141.24 million), leading to a combined Net Income of Rs 1.09 billion (USD 7.52 million).

3.3.3. Institutional Financial Performance

To understand the sector's financial health, the 16 schools can be categorized into three distinct groups based on their financial outcomes:

- i. Group A: High-Profit Performers (4 institutions): These institutions reported individual net incomes ranging from NPR 108 million (USD 0.74 million) to NPR 351.23 million (USD 2.42 million). The top-performing institution in this group accounts for roughly 32% of the entire sector's total net income. These schools typically boast the largest asset bases and the highest revenue from hospital operations.
- ii. Group B: Moderate-Profit Performers (9 institutions): This is the largest group, maintaining profitability but with narrower margins. Their net incomes range from Rs 4.04 million (USD 0.03 million) to Rs 78.64 million (USD 0.54 million). While sustainable, these institutions are more sensitive to fluctuations in regulatory fee structures or changes in student enrollment.
- iii. Group C: Loss-Making Institutions (3 institutions): This group currently operates at a deficit. Total combined losses for these three schools reached NPR 175.81 million (USD 1.21 million) in the last reported cycle. Notably, one institution in this group reported a loss of Rs 119.16 million (USD 0.82 million), in part due to below average tuition revenues as the school was allocated fewer undergraduate spots.

4. Key Insights on Medical School Finances

The financial data reveal several trends regarding the private medical education sector:

4.1. Real Estate as a Valuation Driver

A significant portion of the Rs 57.88 billion (USD 399.17 million) in total assets is likely driven by the rapid appreciation of land value in Nepal rather than purely academic or clinical infrastructure (medical schools are mandated to ensure landholding above a statutory minimum). In many cases the net worth, as reported in the latest audited financial statements, of an institution has grown significantly despite relatively modest annual net profits, suggesting that these medical schools have effectively become large real estate holdings. Nevertheless, these extensive real estate holdings do not necessarily represent a liquid asset class, as medical schools are statutorily restricted from divestment of their land. Consequently, any appraisal of total assets based on real estate valuations must be considered with caution.

4.2. Medical School Debt Burden

With nearly Rs 22 billion (USD 151.72 million) in outstanding loans, the sector is deeply driven by the need to service their debt with the Nepali banking system. This debt service requirement may create immense pressure on administrators to prioritize short-term cash flow – mainly through tuition and associated fees or hospital charges – potentially at the expense of students and their families, and patients.

4.3. Return on Equity (ROE)

The Average Return on Equity (ROE, calculated as annual net income divided by shareholders' equity averaged over the last two years) for the sector stands at 11.72%. However, this average masks variation. For example, the top-performing school reported an ROE of 16.5% for the year, while others saw negative returns as much as -29.56%. This indicates that "medical education" is not a guaranteed profit-making venture but is dependent on institutional management, geographic location, and other factors.

In summary, the private sector has successfully offloaded the cost of healthcare infrastructure from the public exchequer, creating a multi-billion rupee industry. However, the high levels of debt and the concentration of profits among a few elite institutions raise questions about the long-term economic resilience of the broader medical education landscape in Nepal.

Based on the financial analysis and the analytical insights from the previous section, the following tables summarize the fiscal landscape of Nepal's private medical education sector. All monetary figures are

presented in Millions of Nepali Rupees (NPR) with US Dollar (USD) equivalents in brackets, based on an exchange rate of 1 USD = 145 NPR.

In Tables 2 to 5, we summarise key financial metrics for the 16 for-profit private medical schools in Nepal, outlining their cumulative financial position, infrastructure valuation, revenue streams, operational performance, and compare them against a financial benchmark of their peer-group.

Table 2: Sector-Wide Financial Scale and Capital Structure

Financial Metric	Amount in NPR (Millions)	Amount in USD (Millions)
Total Equity (Share Register)	8,151.49	56.21
Total Loans (Debt)	21,902.66	151.05
Total Asset Base	57,884.98	399.21
Cumulative Net Worth	18,626.68	128.46
Average Assets per Institution	3,617.81	24.95

Table 3: Revenue Streams and Operational Performance

Operational Metric	Amount in Rs (Millions)	Amount in USD(Millions)	% of Total Revenue
Total Revenue	21,983.59	151.61	100.0%
Revenue: Hospital Services	10,067.19	69.43	45.8%
Revenue: Medical School Fees	8,776.77	60.53	39.9%
Pharmacy & Other Revenue	3,139.63	21.65	14.3%
Total Operating Expenses	20,482.01	141.26	—
Combined Net Income	1,091.79	7.53	5.0% (Margin)

Table 4: Institutional Performance Segmentation

Performance Group	Number of Schools	Net Income Range (NPR Millions)	Net Income Range (USD Millions)
Group A: High-Profit (>100M)	6	103.79 to 351.23	0.72 to 2.42
Group B: Stable (0-100M)	7	4.04 to 78.64	0.03 to 0.54
Group C: Loss-Making (<0)	3	(1.96) to (119.16)	(0.01) to (0.82)
NB: All data is synthesized from the latest available audited financial statements of the 16 private medical schools in Nepal			

Table 5: Key Financial Ratios and Industry Benchmarks

Benchmark Metric	Value
Average Return on Equity (ROE)	11.72%
Highest Reported Institutional ROE	16.48%
Lowest Reported Institutional ROE	-29.56%
Debt-to-Equity Ratio (Sector-wide)	2.69
Asset Utilization (Revenue/Assets)	0.38

5. The Challenges of Not-for-Profit Transition

Under the National Medical Education Act of 2019, for-profit medical institutions are statutorily required to convert to a service-oriented, not-for-profit model or be made public within a ten-year timeframe. This legislative requirement was born out of the specific political exigencies prevalent during the Act's drafting. Confronted by sustained advocacy and public demonstrations led by Dr. Govind KC against perceived heavy commercialization and the degradation of academic standards, the State integrated these restrictive measures to curb private sector participation in medical education.

However, as the political climate has stabilized, the initial momentum driving this mandate appears to have moderated, raising significant questions regarding the government's current commitment to implementing the transition. Although it has been seven years since the mandate was passed, no valuation method or compensation mechanism has yet been established to operationalise this mandate. Given the current Rs 18.63 billion (USD 128.48 million) cumulative net worth and the billions in private equity at stake, not to mention the significant exposure of the Nepali banking sector to the private medical education sector, the state faces a monumental financial challenge if it intends to compensate or facilitate the conversion of these private assets into a public or trust-based ownership model.

This transition of private medical schools also raises concerns about broader freedoms encapsulated within the constitution of Nepal. Article 17(2)(f) of Nepal's constitution explicitly states the freedom to "establish and operate any industry, trade and business in any part of Nepal".²⁹ Although the same Article carves out exceptions and grants the State authority to legislate laws to curtail this freedom on grounds of public health, without due process that all the related parties may consider fair, it is not hard to imagine that, as it stands, the government's attempts to convert private medical schools to a non-profit trust-based ownership model or public ownership are likely to be heavily controversial and could be challenged in the courts.

Such a transition as the one has been proposed, while not without international precedent in the medical education sector, is likely to have broader implications for the health sector and the society.³⁰ Before initiating such a transition, the government may wish to review and redefine its position on the involvement of the private sector in health, including in the provision of health services. The government could also benefit by explaining to the public and presenting its argument on the advantages and possible consequences of why it needs to restrict privately owned medical schools and convert them to public or a trust-based ownership model, likely at a substantial cost to the tax-payers.

6. Medical School Outcomes

6.1. The Availability of Undergraduate (MBBS) Positions in Medical Schools

For the Academic Year 2026, MEC, the body responsible for approving and allocating the number of places available for medical schools, approved 2,635 undergraduate medical school spots for a Bachelor of Medicine and Bachelor of Surgery (MBBS) degree across 28 medical schools. Of these, 1,840 spots are with the 16 private medical schools, and 845 spots with the 12 public medical schools (Table 6). This allocation is based primarily on the assessed capacity of medical schools rather than on estimated national need.

10% (20% in medical schools owned by foreign investors) of the spots at private for-profit medical schools are available as scholarships, allocated according to merit and other affirmative action criteria (merit-based scholarships at private medical schools cover tuition fees, students may still need to pay room and board fees, and other ancillary fees such as examination fees). The rest are available for full fee-paying students. About 75% of the spots in the public medical schools are available as merit-based scholarships with heavily subsidized fees. The remaining 25% spots are available for fee-paying students. For 2026, a total of 691 merit-based scholarship spots are available across the 28 medical schools. 1,146 spots across all schools are designated for Nepali students while 749 spots are designated as fee-paying spots for foreign students.

To make access to medical education more inclusive, affirmative admission policies have been adopted. About 45% of the scholarships available for MBBS positions are reserved for students based on their gender, ethnicity, and other pre-determined socio-economic criteria (see Supplementary Appendix). Based on these criteria, the MEC allocates merit-based scholarships to students using a computerised matching algorithm.

Table 6: Undergraduate Medical (MBBS) positions approved by the Medical Education Commission per year (2024–2026)

No	Medical School	Code	2026	2025	2024
I	PRIVATELY-OWNED & FOR PROFIT				
1	B&C Medical College	BCMC	60	50	0
2	Manipal College of Medical Sciences	MCOMS	120	100	100
3	Kathmandu Medical College	KMC	130	100	100
4	Nepal Medical College	NMC	130	100	100
5	College of Medical Sciences (COMS)	COMS	130	100	100

6	KIST Medical College	KIST	120	100	100
7	Universal College of Medical Sciences	UCMS	120	100	100
8	National Medical College	NatMC	120	100	100
9	Janaki Medical College	JMC	60	50	50
10	Nobel Medical College	NobMC	130	100	100
11	Chitwan Medical College	CMC	130	100	100
12	Devdaha Medical College	DMC	90	75	50
13	Nepalgunj Medical College	NgMC	130	100	100
14	Lumbini Medical College	LMC	120	100	100
15	Gandaki Medical College	GMC	120	100	100
16	Birat Medical College	BMC	130	100	100
	Total – Private (For Profit)		1840	1475	1400
II.	PUBLICLY-OWNED NOT FOR PROFIT				
17	BP Koirala Institute of Health Sciences	BPKIHS	100	100	100
18	Karnali Academy of Health Sciences	KAHS	50	50	50
19	Kathmandu University School of Medical Sciences	KUMS	130	100	100
20	Madan Bhandari Academy of Health Sciences	MBAHS	50	50	0
21	Madesh Institute of Health Sciences	MIHS	50	50	0
22	Maharajgunj Medical Campus	MMC	100	100	100
23	Nepalese Army Institute of Health Sciences	NAIHS	100	100	100
24	Patan Academy of Health Sciences	PAHS	65	50	0
25	Pokhara Academy of Health Sciences	PkrAHS	50	50	0

26	Purbanchal University School of Health Sciences	PUSHS	50	0	0
27	Rapti Academy of Health Sciences	RAHS	50	50	0
28	Saheed Dasarath Chand Health Sciences Univ.	SDHSU	50	0	0
	Total – Public (Not For Profit)		845	700	450
	GRAND TOTAL (Public and Private)		2685	2175	1850

NB: These figures are obtained from the official publications of the Medical Education Commission (MEC), the statutory body responsible for approving and allocating the number of available positions for medical school admissions in Nepal. The MEC also conducts a unified national entrance examination for medical schools, and matches prospective students to medical schools using a preset criteria. For the purposes of this report, a public medical school denotes a medical school that does not have shareholders and is not profit-making. Kathmandu University and its School of Medical Sciences (KUSMS) are sometimes classified as a private university and medical school. However, unlike other private medical schools, the University and KUSMS are not for-profit institutions and do not have shareholders. Therefore we have classified KUSMS as a public medical school. Source documents are available at: <https://entrance.mec.gov.np/>

6.2 Nepal Medical Council Licensure Rates

After medical students finish their undergraduate medical education and pass their university exams, and following a mandatory year-long rotating internship at a teaching hospital, they are eligible to practice independently after obtaining a non-specialist license. The licensing exam is conducted by the Nepal Medical Council, the statutory body for physician licensing in Nepal. All doctors, irrespective of where they finished their medical school, need to pass this licensing exam before they are allowed to practice in the country.

Below (Table 7) we present non-specialist licensure rates for the past several years, as published by the Nepal Medical Council.¹⁷ Of note in the May 2026 examination, while the overall licensure rates for graduates of Nepali medical schools was 76.8%, it was 88.7% for public medical schools, and 73.1% for private medical schools. Licensure rates for graduates of foreign medical schools were significantly lower: including 15.04% from China (20/133) and 41.1% from Bangladesh (151/367). In the supplementary appendix, we present additional data on historical trends in licensure trends for the Nepal Medical Council Licensing Examination.

Table 7: Medical school-wise success rates for non-specialist Nepal Medical Council Licensing Examination held in May 2026

Ownership	Medical School Name	Total Candidates	Passed	
Private	Chitwan Medical College	58	54	93.1
Private	Gandaki Medical College	51	44	86.27

Private	Nepalgunj Medical College	63	54	85.71
Private	Nepal Medical College	61	52	85.25
Private	Kathmandu Medical College	66	52	78.79
Private	Lumbini Medical College	82	64	78.05
Private	Devdaha Medical College	34	26	76.47
Private	Kist Medical College	79	60	75.95
Private	Manipal College of Medical Sciences	54	40	74.07
Private	Universal College of Medical Sciences	65	48	73.85
Private	College of Medical Sciences	66	44	66.67
Private	Janaki Medical college	41	26	63.41
Private	Birat Medical College	60	38	63.33
Private	Nobel Medical College Teaching Hospital	93	51	54.84
Private	National Medical College	81	44	54.32
	Sub-Total (Private)	954	697	73.06
Public	B.P. Koirala Institute of Health Sciences	77	71	92.21
Public	Nepalese Army Institute Of Health Sciences	88	79	89.77
Public	K. U. School of Medical Sciences	71	63	88.73
Public	Maharajgunj Medical Campus	56	47	83.93
Public	Patan Academy of Health Sciences	8	6	75
	Sub-Total (Public)	300	266	88.67
	Grand Total	1254	963	76.79

Table 8: Country-wise pass percentage for non-specialist Nepal Medical Council Licensing Examination held in May 2026.

	Country	Total Candidates	Passed	
1	Nepal	1254	963	76.79
	International			

2	Saudi Arabia	1	1	100
3	Pakistan	6	4	66.67
4	India	26	11	42.31
5	Bangladesh	367	151	41.14
6	Philippines	42	12	28.57
7	China	133	20	15.04
8	Ukraine	1	0	0
9	Russian Federation	3	0	0
10	Kyrgyzstan	2	0	0
11	Egypt	2	0	0
	International Total	583	199	34.1

Table 9: The annual increase and the total cumulative number of registered medical practitioners registered at Nepal Medical Council.³¹

Fiscal Year (AD)	Number of Increased Registrations	Cumulative Sum of Registered Doctors
2017/18	—	23,751
2018/19	2,595	26,346
2019/20	2,131	28,477
2020/21	1,716	30,193
2021/22	2,085	32,278
2022/23	2,692	34,970
2023/24	2,394	37,364

7. Discussion

Over the past 35 years, since the government opened up medical education for private investments, Nepal has seen a significant expansion in medical education. During this period, the private sector has invested more than Rs 8 billion (USD 55.17 million) worth of equity into medical education, and private investors have opened 16 medical schools in the country. Private investors have mobilized investments through banking and financial institutions, leading to an asset build up of more than Rs 57.9 billion (USD 399.31 million) in private medical education. Nepal's 16 private medical schools now have a combined net worth of Rs 18.6 billion (USD 128.28 million).

This private medical education infrastructure is expected to matriculate 1,840 medical students in the private medical schools alone for the academic year 2026. This is in addition to the 845 students who are expected to matriculate in 12 public medical schools for the same academic year. This is a significant expansion in the capacity for medical education in the country. There have been some direct consequences of this expansion of private medical education in Nepal. Some of these have been positive, while others have not been so. We discuss them in the following, starting with the positive consequences of the expansion of private medical education:

7.1. Increased Access to Medical Education

The first, and the most obvious is that there has been a substantial increase in the number of students who have access to medical education, and this has resulted in an increase in the number of physicians that are licensed in the country. In the year 1997, the number of physicians licensed by the Nepal Medical Council that year was only 116. Of those 116 doctors, only 20 were educated within Nepal (at the Tribhuvan University Institute of Medicine). The rest were educated in India (63), Russia (18), Bangladesh (7), China (5), Pakistan (1), Others (2).³²

As private medical schools began matriculating students, by 1997 the number of Nepali medical students that began their medical training in Nepal increased to 278 (80 in public medical schools and 198 in private medical schools).³² In the 2026 academic year, 2685 medical students will enroll in 28 medical schools, public and private, throughout the country. Out of these 1840 will enroll in the 16 private medical schools in the country. Only 20 out of 116 (17.2%) of the doctors licensed in 1997 were trained in Nepal. In May 2026, of the 1162 doctors who passed their non-specialist licensing examination, 963 (82.7%) were trained in Nepal.

7.2. Increased Physician Supply

Increased access to medical education within the country has led to an increase in the number of physicians produced. Throughout the 1990s, the number of physicians who were licensed by the Medical Council was less than 200 per year (142 in 1990, and remained similarly low until the late 1990s). Two and a

half decades later, by the year 2023, the annual number of doctors licensed by the Nepal Medical Council increased to 2692.³³ This expansion of the number of doctors registered annually represents a greater than 15-fold increase over three decades. As a result, the cumulative number of doctors ever registered is now close to 40,000. Between the years 2000 and 2025, the number of doctors who were ever registered to practice medicine in Nepal increased by more than 10-fold from 3460 to 37,364 in 2026.³⁴

This is a substantial increase in physician supply in the country. Although authoritative data on the number of actively practicing doctors are lacking, even with a conservative assumption that only doctors who have been licensed to practice since the year 2000 are actively practising medicine, Nepal would still have had 35,000 doctors practicing, this could be enough to meet WHO recommended skilled health workforce density. Although accelerating trends of physician emigration are likely to make the number of doctors available in the country lower than that, data from the WHO show that between 2004 to 2024, Nepal's physician density increased 5-fold, from 2.1 per 10,000 people in 2004, to 10.9 in 2024. Nepal's physician density now compares favorably with many of its neighbors, with India's (9.55), Bangladesh's (7.22), and Bhutan's (5.53) per 10,000 people.³⁵

7.3. Reduced Burden on Public Finances

Then there are the advantages to consider given the counterfactual scenario where all of medical education was financed using public money. At public medical schools like the Tribhuvan University's Maharajgunj Medical Campus, the government pays the medical school Rs 2.7 million per student to reimburse tuition charges for their undergraduate medical education. Furthermore, if the government were to educate 1840 medical students currently enrolled in private medical schools using public funds, the cost of tuition alone would be Rs 4.97 billion (USD 34.2 million) per year.

In addition, what would the cost of a public sector led effort to build sixteen medical schools have been to the public exchequer? The example of the Saheed Dasharath Chand Health Sciences University in Geta, Dhangadi offers an insightful example. The University was constructed with an initial cost of more than Rs 6 billion (USD 41.38 million). In addition, the government has now allocated Rs 2.58 billion to begin operations at the university and its teaching hospital.³⁶ This is comparable to the Rs 8 billion (USD 55.17 million) in equity investment private investors have made across 16 private medical schools in Nepal. Although the Saheed Dasharath Chand University's example may be a particularly egregious one given the allegations of corruption and government inefficiency,³⁷ this does lend validity to the debate about whether public medical schools are the most optimal use of public finances and tax-payer money.

7.4. Financial Savings for Students

The third consequence of this increased access to private medical education has been financial. If all of 1840 students studying at private medical schools in Nepal were to obtain their medical education on a fee paying basis in Bangladesh (a popular destination for private medical education for Nepali students earlier), where total tuition fees are USD 40,000 and above, students would have to spend at least USD 14,000 more in tuition fees alone compared to Nepal.³⁸ Such a scenario would have resulted in a combined additional spending of USD 25.76 million in total tuition fees per year. If all the students chose to pursue this route to medical education, the actual additional spending would be higher given other ancillary expenses like travel and housing. It is unclear if this would have been the counterfactual scenario for certain because private medical education is cheaper in countries like the Philippines and China than in Nepal; students may have chosen those cheaper destinations over the more expensive ones were private medical education not available in Nepal.^{39,40}

7.5. Positive Impacts on Equity in Medical Education

It can be argued that domestic access to medical education has also made it more equitable, because private investment has made medical education accessible to people who would otherwise not have been able to pursue it. It is likely that not all of the students who have been able to pursue medical education at private medical schools would pursue medical education were that opportunity not available within Nepal. Access to medical education within Nepal may have benefited female students more, given they may be less likely to travel outside the country to get medical education. Indeed, the available evidence points toward this possibility: In several medical schools, female student enrollment is comparable to male enrollment, with some medical school classes reporting higher female enrollment.^{41,42,41,42} The gender ratio of recently licensed medical doctors reveals the same pattern. On the other hand, recent evidence suggests that the number of students who obtain a No Objection Certificate to study at a foreign medical school is skewed toward male students by a ratio of about 3:2.⁴³

7.6. Nepal as a Destination for Medical Education

The expansion of private medical education has enabled Nepal to provide medical education to foreign students. For the 2026 academic year, 749 seats have been allotted across Nepal's private medical schools for foreign students (see Supplementary Appendix). Not only is this provision likely to benefit foreign students, medical schools are also likely to benefit from this arrangement. Medical schools are allowed to charge USD 55,000 (double the fees for Nepali students) or more per student. This is still cheaper than what Indian students pay for private medical education in India.⁴⁴ Even if each of the 749 students were paying only USD 55,000 for their medical education in Nepal, this is likely to result in tuition revenues of USD 41.19 million

from foreign medical students alone. The total economic activity generated by foreign medical students is likely to be higher when accounting for other ancillary expenditures like room and board fees, as well as other expenditures. Being able to educate foreign students has allowed Nepal to burnish its image as a potential destination for professional education, with the associated advantage that such a cachet offers.

7.7. The Quality of Medical Education

Over the past two decades, questions about the quality of medical education have animated discussions in Nepal. The National Medical Education Act of 2019, and the Medical Education Commission that it established, was in fact the consequence of a series of protests over the cost and quality of private medical education led by Dr. Govind KC, a professor (now retired) at the Tribhuvan University Institute of Medicine.^{45,46}

This concern over the quality of medical education is justified, as demonstrated by success rates in the Nepal Medical Council Licensing Examination (sometimes below 60%). While success rates are heavily weighed down by candidates who repeatedly fail their licensure exams and by students who have obtained their medical education abroad, as the data for the licensing examination conducted in May 2026 show, 24% of students who obtained their medical education in Nepal failed their licensing examination. Failure rates were higher for students from private medical schools (27%) compared to public medical schools (12%). For graduates of foreign medical schools, failure rates were significantly higher.

With the global medical education transitioning to competency-based evaluation systems and certification, the Nepal Medical Council is also revising its licensure exams to include measures of competence. This shift in licensing examinations is expected to better inform the true quality of the graduates of Nepal's medical schools, both public and private.

7.8. Financial and Related Wastage

Between January 2025 and January 2026, 2,180 students failed the medical licensing examination. Although it is difficult to establish the exact number of unique candidates that failed the examination (several candidates who failed repeatedly take the exam, with some candidates failing the exam more than a dozen times), or the number of candidates who ever fail to get a license, based on the above, it is safe to assume that the 2180 students who failed their licensing examination were unable to practice medicine for at least six months. This is a significant societal loss, in terms of the time that is lost, as well as the financial resources that were spent on medical education.

Assuming that 1000 recurring candidates account for the 2,180 failed licensure attempts (some candidates repeatedly fail the exam), these failed candidates end up spending Rs 4.5 billion (USD 31.03 million) on tuition alone, not to mention the other costs of medical education. This is not just an economic loss

but also a social loss. Among medical students, academic pressure leading to mental health issues has previously been reported, and repeatedly failing their licensing examinations could conceivably worsen this trend.^{47,48} This also has several other consequences, where the media narrative of poor licensure pass rates hurts public perception of the quality of medical education; and may erode public trust in doctors and the medical community. This is especially problematic because medical practice hinges on the trust that patients place on their doctors. In fact, this may partly account for the several incidences of violence against doctors when there have been adverse patient outcomes.

7.9. Profit Over Quality of Education

There are public perceptions that private medical schools prioritise revenue generation and profits over the quality of the education and services that they provide. Private medical schools are alleged to have poor infrastructure in comparison to public medical schools, and their affiliated teaching hospitals are not as functional, with limited number of patients in many private teaching hospitals, limiting the ability of medical students to acquire clinical skills.⁴⁹ In many departments, private medical schools are also often short of the faculty required to adequately precept and supervise medical student learning.

Annual appraisal reports from medical schools submitted to regulatory authorities highlight persistent gaps in infrastructure and teaching faculty. In some circumstances, there aren't adequate numbers of patients in private teaching hospitals to facilitate teaching learning activities. As we highlighted previously, although there are supervision, oversight, and enforcement mechanisms in place to ameliorate these issues, it is unclear if commensurate regulatory oversight and enforcement actions have been taken to ensure the quality of medical education in private medical schools. Private medical schools may lose revenue if they are penalised as a result of regulatory enforcement actions. While private medical schools' goal is also to provide medical education and patient services, they are a for-profit business with an incentive to maximize profits.

As has been previously established, an entirely market-economy based approach is unlikely to maximise societal welfare in health.⁵⁰⁻⁵² If the goal is to improve societal welfare while allowing the private sector to participate in medical education, institutional oversight and regulatory mechanisms ought to enable an acceptable balance between for-profit medical schools' fiduciary goal of making a profit for its investors and providing equitable access to quality medical education.

7.10. Accelerating Emigration of Doctors

The impact of increased access to medical education on health services delivery is not clear. While the increased supply of doctors will certainly have contributed toward increasing access to services, a few other factors work against it. First is the increasing tendency of doctors to migrate out of the country.^{53,54} Although it is hard to estimate the exact number of Nepali medical doctors practising outside Nepal, an

estimate from 2015 said 36% of Nepali doctors were abroad,⁵⁵ with the United States, UK, India and Maldives forming the top 4 destinations for Nepali doctors. For example, in the year 2023, according to news reports, 843 doctors were issued Good Standing Certificates (GSC) to go the United States, 505 to the UK, 395 to Maldives, 186 to India, 166 to Australia, and 395 to doctors who intended to migrate to other countries. In total 2582 doctors got GSCs to go abroad compared to the 2692 doctors that were registered that year.¹⁷ Since 2020 alone, 11,000 doctors have applied for Good Standing Certificates, demonstrating an intent to migrate; 3000 of those applications were for migration to the United States.¹⁶

However, the tendency to emigrate appears to be even greater among graduates of public medical schools. Between 1983-2004, of the 727 medical students that graduated from the Tribhuvan University Maharajgunj Medical Campus -- Nepal's oldest medical school -- 36% were found to have migrated abroad, with another 37% working in the Kathmandu valley, and 27% working outside the valley.⁹⁹ Of the class of 2011 at the same school, 87% of the graduates were found to have migrated abroad.⁵⁶ Although data for recent years are not available, anecdotal evidence suggests that this trend has not slowed over the years.

7.11. Geographic Maldistribution of Doctors

It is not entirely clear how the increase in physician supply over the last few decades has impacted the geographic distribution of doctors in Nepal. Nepal's physician distribution is heavily skewed toward urban areas, mostly around the center of the country, all the while several health centers and hospitals in rural areas are still without doctors.^{57,58} Recently 600 applicants applied for a job vacancy for a few medical officers at the Tribhuvan University Teaching Hospital.⁴⁹ Even with the increased supply of physicians, physicians have been found to prefer a medical practice in urban or peri-urban areas.⁵⁹

A 2012 survey revealed that 88% of Nepal's medical students intended to practice in an urban area.⁶⁰ While doctors who have studied at public medical schools or with a government scholarship at private medical schools have a mandatory obligation to work for the government for two years, doctors who paid for their medical education are under no obligation to serve at remote locations. Even among doctors who benefited from government scholarships, there has been a documented tendency to prefer peri-urban areas, mostly in the central region of the country.⁵⁹ It stands to reason then that doctors who paid for their own medical education, because they do not have a mandatory bond obligation to serve in an underserved area, are likely to preferentially choose an urban practice.

7.12. Training Pathways and Job Opportunities

While there has been an expansion in undergraduate medical education, post-graduate medical education is still not as accessible, as there are a limited number of residency positions available. In 2026, there were 1230 post-graduate medical education spots (918 clinical and 312 non-clinical; see Supplementary

Appendix). Since more than 2500 students are matriculating into undergraduate medical education, this mismatch leaves a substantial fraction of medical graduates without an option for post-graduate medical education within the country. Granted, there still is the question of whether everyone needs post-graduate medical education. As a result, many students go abroad for their residency. At the same time, while the available pool of doctors has expanded, there hasn't been a commensurate expansion of available jobs in the public sector. In fact, the number of jobs available in the public sector has been stagnant for several decades now. The number of private hospitals and job availability in private hospitals has expanded. However, young doctors are often underpaid owing to the oversupply of doctors seeking these limited jobs. This problem is worsened by the lack of enforced regulations on physician pay in the private sector.

7.13. Equity Concerns

The expansion of private medical education in Nepal presents a complex paradox for health equity. On one hand, the private sector has become an essential partner in fulfilling the state's social obligations. Given that the government cannot fully subsidise the high cost of medical training for everyone, it leverages private infrastructure to provide scholarship seats that would otherwise not exist. Under Section 17 of the National Medical Education Act, private colleges with domestic investment must reserve 10% of their seats for free scholarships, while those with foreign or joint investment must reserve 20%. About 45% of these seats are allocated to students from marginalized groups – including women, Dalits, Madhesis, and those from backward regions – effectively using private capital to facilitate social mobility for the most disadvantaged.

Conversely, this model risks entrenching a differential access to medical education that correlates academic opportunity with socioeconomic status. While economically disadvantaged students enter through a rigorous and highly competitive admission process, students from affluent backgrounds may secure admission with lower admission test rankings. Furthermore, the high personal cost of self-financed education – averaging between Rs. 4.1-4.5 million (USD 27,586–31,034) in 2026 – exerts a financial burden on students, especially when there are no easy provisions for educational loans. However, an argument can also be made that affluent students are subsidising medical education for those students who benefit from scholarships at private medical schools. Private medical school graduates who have incurred significant financial expenses for their education are incentivised to pursue high-paying urban specialties or emigration to recoup their investment, thereby exacerbating the rural-urban divide and challenging the long-term sustainability of equitable healthcare delivery across Nepal.

8. Next Steps

This rapid study of Nepal's private medical education sector provides some preliminary findings. To fully understand the long-term societal impact, the following research priorities are important:

1. **Explore Downstream Effects:** Although there has been a rapid growth in the number of physicians in the country, the second and third order effects on the availability and accessibility of health services and systems, and health outcomes haven't been fully understood. The systemic consequences of a private sector led expansion of the physician workforce needs to be studied, vis-à-vis countries like Sri Lanka, that have taken a public sector led approach to expansion of the physicians workforce.
2. **Address Data Gaps on Physician Numbers, Distribution, Migration:** Conduct a comprehensive study to track the number of physicians actively working in the country, and their geographic distribution. Conduct a comprehensive cohort study to track post-graduation outcomes and career choices, including specialty enrollment, rural service, and the precise rates and drivers of emigration for both public and private medical school graduates. This is essential to understanding the net impact of capacity expansion.
3. **Educational Quality Assessment:** Conduct in-depth qualitative research to compare the true quality of education across institutions, focusing on differences in faculty recruitment, teaching hospital patient volumes, and clinical exposure, as well as competency based student evaluation, and compare this with international benchmarks. This will clarify the persistent quality gaps suggested by the unsatisfactory licensing exam success rates.
4. **Transition Policy Feasibility:** Model the economic and policy implications of the mandated conversion of for-profit medical colleges to a non-profit model, considering the substantial private equity and cumulative net worth (Rs 18.6 billion / USD 128.28 million) at stake.
5. **Geographic Equity Interventions:** Investigate or review the effectiveness of various policy interventions – such as financial incentives, mandatory rural service and bond schemes – to address the geographic maldistribution of the current physician workforce.

9. Conclusion

Nepal's pivot toward private-sector-led expansion of medical education since the early 1990s has transformed the country's healthcare landscape, increasing the number of medical schools from one to 28. This shift has resulted in a significant increase in physician supply, with physician density rising to 10.9 per 10,000 people by 2024. By leveraging over Rs 8 billion in private equity to build an infrastructure with an asset base of more than Rs 57 billion, the state has avoided massive public expenditures while increasing domestic access to medical training and attracting international students. This has also resulted in substantial savings for the students and their families, and the state, by substantially reducing the outflow of capital for medical education.

However, this quantitative success is undermined by challenges in educational quality and health equity. Although some private medical schools appear to do well in the Nepal Medical Council Licensing Examination, on average private medical school graduates do not fare as well as public medical school graduates. This results in significant financial and social wastage, as many graduates are unable to practice despite their high personal investment. Furthermore, the expected societal benefits of a larger workforce are diluted by accelerated physician emigration (this is a systemic issue that relates to both public and private schools) and a stark geographic maldistribution, leaving rural areas underserved while doctors congregate in urban centers.

The National Medical Education Act of 2019 and the establishment of the Medical Education Commission have consolidated and streamlined regulatory oversight. The MEC now controls and oversees several aspects of private medical education, including student admissions, fee schedule, monitoring, evaluation and accreditation, helping standardise and improve medical education in the country. As the regulatory mechanism evolves, an effective and forward-looking mechanism will likely need to calibrate the regulatory approach to institutional performance, recognizing the contributions made by well-performing medical schools, while enforcing effective oversight with remedial support on poorly performing ones.

Ultimately, Nepal's experience with private medical education highlights a complex paradox: while the private sector can rapidly scale education capacity and save public resources, without complementary policy interventions and regulatory mechanisms, this growth may not necessarily result into a high-quality, equitably distributed health workforce that could benefit the health system and translate into better health outcomes for people.

Supplementary Appendix

SA1: A summary of the roles and responsibilities of institutions and actors involved in the governance and regulation of medical education in Nepal.

	Governing Body and (Act/ Regulation/ Policy)	Institutions and Actors Governed	Roles and Responsibilities in Medical Education Governance
1.	Nepal Medical Council Act 1964 (Amendments in 1987, 1990, 1999, 2001) ²⁰	1. Nepal Medical Council 2. Registered medical practitioners (individual doctors) 3. Applicants for registration (including foreign-qualified doctors) 4. Medical and Dental Colleges / Institutions (limited scope) 5. Universities (indirect and limited role) 6. Hospitals and training institutions (indirect and	A. Core Regulatory Functions 1. Regulates modern medical practice to ensure ethical, scientific care and professional accountability (Preamble). 2. Registers, removes, and re-registers medical practitioners and maintains the official register (Sections 12, 13, 17, 20). 3. Recognizes domestic and foreign medical qualifications and inspects examinations and institutions (Sections 21, 21A–21C). 4. Conducts licensing and special examinations to ensure minimum professional standards (Section 21D). 5. Enforces professional discipline, prohibits unregistered practice, penalizes misuse of qualifications, and recommends prosecution (Sections 17, 20, 26–28). B. Institutional and Secondary Regulatory Functions 6. Establishes the Council as an autonomous statutory body with defined composition, tenure, and administrative structure (Sections 3–5, 12–13). 7. Provides procedural safeguards, including rights of appeal and legal protection for acts done in good faith (Sections 19, 25). 8. Enables government oversight, delegation of authority, transparency, and rule- and bye-law-making powers (Sections 8, 18, 30A, 32, 33).

		functional role)	
2.	National Medical Education Act 2019 ¹⁹	1. Medical Education Commission 2. Executive Committee and Committees of the Commission 3. Medical and Dental Education Institutions (Colleges) 4. Universities 5. Students (including scholarship recipients) 6. Provincial Governments 7. Government employed medical professionals (as actors)	A. Core Regulatory Functions 1. Establishes the Medical Education Commission as the apex authority to regulate, manage, and coordinate medical education in Nepal in line with national needs, quality, equity, accountability, geographic balance, and social justice (Preamble; Section 3). 2. Determines national policy, standards, and criteria for medical education at all levels and disciplines, including integrated entrance examinations and accreditation policy (Section 6(a)–(d)). 3. Regulates admissions, merit order, student intake capacity, tuition fees, scholarships, and reservation quotas to prevent commercialization and ensure equitable access (Sections 6(b), 6(c), 6(h), 16). 4. Oversees establishment of medical education institutions through issuance, renewal, and withdrawal of Letters of Intent based on compliance with academic, infrastructural, financial, and managerial standards (Sections 11 and 12). 5. Regulates affiliation and revocation of affiliation of medical and dental institutions in coordination with universities (Sections 13 and 14). 6. Conducts inspection, monitoring, and evaluation of medical education institutions and programs to ensure compliance with prescribed standards (Section 14). 7. Enforces bond service obligations for scholarship students and monitors compliance with admission, reservation, and service conditions (Sections 16 and 18). 8. Mandates non-profit, service-oriented transition of medical education institutions within ten years and requires each province to establish at least one medical education institution (Sections 19 and 20). 9. Prohibits dual practice by government-employed medical professionals during official working hours (Section 21).

			B. Institutional and Secondary Regulatory Functions 10. Constitutes the Commission as an autonomous corporate body with perpetual succession and authority to acquire property, enter contracts, and sue or be sued (Section 4). 11. Defines the composition, tenure, and representation of the Commission, ensuring inter-sectoral and inclusive governance (Section 5). 12. Provides for meetings, quorum, decision-making, and conflict-of-interest rules of the Commission (Section 7). 13. Establishes an Executive Committee and other committees to assist in implementation and coordination (Sections 8–10). 14. Provides for transitional arrangements, coordination with existing laws and institutions, and protection for actions taken in good faith (Sections 22–24). 15. Empowers the Government of Nepal, in consultation with the Commission, to frame Rules for effective implementation of the Act (Section 25).
3.	Universities (Tribhuvan University Act 1992. Original Act passed in 1959)²¹ N.B. Provisions of the Acts that establish the 2 major universities that grant affiliations to private medical schools, Tribhuvan University and Kathmandu University have been discussed here. In addition, we also discuss provisions of three other Acts that establish and regulate other public universities and health sciences academies, as an example. There are	A. Tribhuvan University	A. Core Regulatory Functions 1. Establishes the Affiliation Committee (Sambandhan Samiti) and the Affiliation Management Directorate as the institutional mechanisms for regulating affiliation, expansion, and oversight of affiliated campuses, including medical colleges (Rules 3 and 6). 2. Classifies medical education institutions as technical campuses and prohibits operation of any academic or medical program without prior affiliation approval (Rules 2(d) and 10). 3. Regulates the affiliation procedure, including documentation, feasibility studies, inspections, and academic recommendations, grants temporary affiliation, and subjects continuation to monitoring and renewal (Rules 11, 12, and 14). 4. Restricts increase in student intake, introduction of new programs, or academic expansion without prior approval based on infrastructure, faculty, and academic justification (Rule 12(1)).

	other similar Acts that govern and regulate the other public medical schools (not discussed here).		5. Empowers Tribhuvan University to inspect, monitor, and enforce compliance, including suspension or revocation of affiliation in cases of non-compliance (Rule 16). 6. Introduces differentiated financial regulation for community and private medical colleges through affiliation and service fees and disclosure requirements, and classifies affiliated campuses by institutional nature (Rules 17 and 18). B. Institutional and Secondary Regulatory Functions 7. Regulates institutional naming, issuance of necessary directions, adoption of Campus Bidhan, formation and functioning of the Sanchalak Samiti, coordination with Tribhuvan University, and saving and transitional arrangements (Rules 33–39). 8. Constitutes Schools and Educational Councils as internal academic bodies responsible for programme implementation, teaching, and research in health disciplines (Sections 17–18). 9. Empowers the University to frame Rules and By-laws to operationalize regulation of medical and health education in coordination with national medical education legislation (Section 22). C. Quality Safeguards, Accountability, and Student Protection 10. Requires affiliated institutions to maintain scholarship and student welfare funds, ensure adequacy of human resources and infrastructure, and maintain such standards after affiliation (Rules 22–24). 11. Provides for combination or adjustment of campuses, revocation of affiliation, procedural fairness through opportunity to explain, protection of enrolled students' right to complete studies, handover of property and records, and continuing institutional accountability (Rules 27–32).
	Kathmandu University Act 1991	B. Kathmandu University	A. Core Regulatory Functions 1. Establishes Kathmandu University as an autonomous regulatory authority and vests regulatory power over medical and health education in internal University bodies, principally the Senate and Academic Council (Sections 2–5, 8–9). 2. Empowers the Academic Council to regulate

			curriculum, teaching quality, examination standards, admission criteria, faculty qualifications, and research, constituting the core academic regulatory mechanism for medical and health education (Sections 8–9). 3. Authorizes the establishment and regulation of Schools and institutions for medical, nursing, public health, and allied health sciences (Section 10). 4. Mandates compulsory entrance examinations for admission to medical and health education programmes, subject to national medical education laws (Section 20). 5. B. Quality Safeguards, Accountability, and Student Protection 6. Provides quality and accountability safeguards through Academic Council control over academic standards, faculty qualifications, evaluation methods, and research policy, rather than through an external inspection or affiliation regime (Sections 8–9). 7. Ensures institutional oversight through executive and academic authorities responsible for implementation of academic and regulatory decisions affecting medical and health education institutions (Sections 6–7, 12–16). 8. C. Institutional Governance and Ancillary Functions 9. Establishes the Executive Council and University authorities to manage administrative, financial, and institutional affairs of medical and health education institutions (Sections 6–7, 12–16). 10. Constitutes Schools and Educational Councils as internal academic bodies responsible for programme implementation, teaching, and research in health disciplines (Sections 17–18). 11. Empowers the University to frame Rules and By-laws to operationalize regulation of medical and health education in coordination with national medical education legislation (Section 22).
	1. Pokhara University Act 1997⁶¹ 2. Patan Academy of Health Sciences Act, 2008⁶² 3. Karnali Academy of Health Sciences (KAHS) Act 2011⁶³	C. Other Universities and Academies Pokhara University Patan Academy of Health Sciences Karnali Academy of Health Sciences	A. Core & Regulatory Functions of Pokhara University 1. Establishes Pokhara University as an autonomous corporate institution empowered to establish, operate, and regulate higher education institutions, including medical and health education institutions (Sections 2–4). 2. Sections 7–9 (Senate) gives the University Senate the authority to approve academic programmes, establish and affiliate campuses, determine degrees to be

			awarded, issue policy directions, and approve rules and regulations, thereby constituting the apex regulatory authority for medical and health education. - Sections 10–11 (Academic Council) establish the Academic Council and vest it with powers to determine curriculum, standards of study and teaching, modes and standards of examinations, evaluation systems, admission qualifications and numbers, minimum qualifications of teachers, and research policy, forming the core academic regulatory mechanism for medical and health education. - Sections 15–19 authorize the establishment and operation of Faculties, Research Centres, Education Councils, Campuses, and the Curriculum Development Centre, enabling regulation and delivery of medical, nursing, public health, and allied health programmes. - Section 20 authorizes the University to grant affiliation to private campuses subject to prescribed conditions, making the Act applicable to private medical and health education institutions. - Sections 31–32 empower the University to confer degrees, diplomas, and certificates and to recognize equivalency of qualifications, including in medical and health sciences. B. Regulatory Functions of Patan Academy of Health Sciences - The PAHS is established as an autonomous body with authority to regulate academic, administrative, structure of the Academy and institutional affairs. Section (3-7). - The act further provides for the constitution of key governing and regulatory bodies including the senate, academic council, constitution of executive council, constitution of service commission along with the function of each commission from (Section 7-13). - The provision of educational council faculty and research center, its establishment and operation of educational institutions, operation of hospital, management committee. (Sections 14-17) C. Core Functions of Patan Academy of Health Sciences
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			1. The section provides details related to the teaching, training, research , international training , production of skilled human resources, and organized workshops and performing activities to strengthen the academy. 2. The section 16 of the Act mentions the establishment of the hospital to carry out the research activities and provide qualitative health service. 3. The section 31 also mentions restriction of establishment of any institution in affiliation to PAHS. 4. The section 35 mentions about the mandatory scholarship for 15% of the total students and partial scholarship also can be granted. 5. The students who have received the scholarship from the organization must provide remote service for 4 years for full scholarship and 2 years scholarship if received partial scholarship. D. Regulatory Functions of KAHS 1. The KAHS is established as an autonomous body to provide health services in the backward region of the country with perpetual succession to enter into contract, acquire property where the main office will be located in Jumla. (Section 1-2) 2. The Act further provides a governing body as an Assembly constituting 18 members. Also other committees are established such as the academic council, the executive council, selection committee under this act which clearly outlines the powers, duties, and functions of each body to ensure academic regulation, policy formulation, and administrative control. (Section 7-17) 3. The act also mentions the operation of the educational institutions and teaching hospitals with the formation of new hospital management committees.(Section 15-17) E. Core Functions of KAHS 1. The Act mentions the production of health care professions with quality health care service in backward regions by strengthening the research and international collaboration .(section 6) 2. The section 10 of the act empowers for the Approval of curriculum by determining students qualifications, conduct examinations, and publish results select students and recommend successful candidates for degree furthermore this act also evaluates academic, research, and training programmes,determines
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			academic and training fees 3. The act also mentioned in section 15 that it allows the KAHS to operate and run the health institution for health education and research along with that it provides provisions for establishment of hospitals to run the programmes in mandatory .This specifically mentioned One health care institutions under this Act. . 4. Section 30 restricts giving affiliation to other institutions.
4.	National Health Policy 1991/ 2014/ 2019 ^{24,11}	Health Ministry	1. The National Health Policy 1991 opened up medical education to the private sector, allowing for-profit private investors to invest in medical education. 2. The Policy assigns the Ministry of Health responsibility for health policy formulation, service delivery, health workforce planning, and programme supervision, but does not itself constitute a regulatory framework for medical education.
5.	Policy on Quality Assurance in Health Care Services 2007 ²⁵	Health Ministry	3. To ensure the quality of services provided by the governmental, non-governmental and the private sector according to set standards. 4. An autonomous institute will be established to ensure the quality of education provided for health care service providers working in governmental and non governmental institutions.
6.	Nepal Health Research Council Act 1991 ²²	Nepal Health Research Council.	1. Establishes a national framework to ensure that health research supports evidence-based policymaking, equity, ethical standards, and alignment with national health priorities. 2. Provides for the coordinated regulation, prioritization, ethical governance, capacity development, and utilization of health research to inform health policy and practice. 3. Designates the Nepal Health Research Council as the apex statutory authority responsible for oversight, ethical review, coordination, and facilitation of health research at national and international levels. 4. Envisages the establishment of specialized committees and coordination mechanisms to undertake ethical review, technical assessment, monitoring, and implementation, supported by appropriate legal and administrative arrangements.

			- Ensures the quality of services provided by the governmental, non-governmental and private sector according to set standards. - Works as an autonomous institute established to ensure the quality of education provided for health care service providers working in governmental and non governmental institutions.
7.	Education Act 1971	Education Ministry	- Section 1 establishes the statutory objective of producing human resources necessary for national development. which includes Health and medical professionals as well. - Section 6(१) of the Education Act, 2028 recognizes technical and vocational secondary education as a category within the education system. - Section 6(1) of the act authorizes the inclusion of practical training in technical and vocational education where prescribed by law or curriculum. - Section 7 (1) mentions the National Education Council as a regulatory body chaired by the Education Minister or State Minister along with 12 members. - Section 10 authorizes the establishment of a District Education Office in each district, headed by a District Education Officer responsible for implementing and administering education laws at the local level.
8.	Scholarship Act 1964	Education Ministry	- The Preamble of this act establishes the financial and policy foundation for supporting higher education and training, including health, medical, and technical education, through state-sponsored scholarships. - Section 2 restricts the grant of scholarships exclusively to Nepali citizens, thereby ensuring that state-supported educational and training resources including those for health and medical education are reserved for national manpower development. - Section 4 regulates the post-scholarship obligations of recipients by requiring reporting after completion of study or training, permitting the Government to mandate service in government-owned or government-funded institutions for a prescribed period, and restricting subject change or discontinuation without prior government approval. - Section 7 empowers the Government of Nepal to fix the amount recoverable from a scholarship holder who violates scholarship conditions, based on the subject,

			level, duration, and institutional cost of the study or training, and provides that such amount shall be recovered as government dues.
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SA2: Composition of the governing council of the Medical Education Commission

Pursuant to Section 5 of the National Medical Education Act (2019), the Governing Council of the Medical Education Commission (MEC) is established as an inclusive 31-member assembly. The composition of this council is structured to integrate political leadership, regulatory oversight, and academic expertise across several functional categories:

1. **Executive Governance (4):** Comprising the:
 - a. Prime Minister (Chairperson),
 - b. Minister of Education
 - c. Minister of Health (Co-Chairpersons),
 - d. the Vice-Chairperson (Executive Head).
2. **Strategic Planning (1):** A representative from the health sector within the National Planning Commission (NPC).
3. **Bureaucratic Leadership (4):** Secretaries from the Ministries of Education, Health, and Finance, together with the Chairperson of the University Grants Commission (UGC).
4. **Regulatory & Research Bodies (7):** Leadership from the six health-related regulatory councils (Medical, Nursing, Health Professional, Pharmacy, Ayurveda, and Health Research) and the Member-Secretary of CTEVT.
5. **Institutional Representatives (5):** Vice-Chancellors of state-supported universities offering medical curricula and selected institutional Deans.
6. **Appointed Experts & Stakeholders (10):** A specialized group with statutory gender representation requirements:
 - a. 3 Medical Education Experts (*minimum of 2 women*)
 - b. 2 Civil Society Delegates (*minimum of 1 woman*)
 - c. 2 Professional Association Representatives (*minimum of 1 woman from medical/nursing fields*)
 - d. 2 Representatives from the private medical college sector
 - e. 1 Student representative

The **Member-Secretary** coordinates between this high-level council and the administrative directorates, completing the **31-member voting body**.

SA3: Undergraduate medical education (MBBS) scholarship spots allocation based on affirmative action criteria.

	MBBS Scholarships spots	Previous	Current (2026)
1	General Scholarship (55% of total scholarship)	313	380
2	Reservations for (45% of total scholarship)	258	311
2.1	Female (28%)	71	85
2.2	Dalit Female (3%)	9	10
2.3	Muslim Female (2%)	6	8
2.4	Dalit (9%)	24	27
2.5	Adibasi Janajati (15%)	37	46
2.6	Khas Arya (17%)	43	51
2.7	Madheshi (9%)	23	28
2.8	Madhesi Dalit (3%)	8	10
2.9	Tharu (4%)	11	12
2.10	Muslim (2%)	6	7
2.11	Backward Areas (4%)	10	12
2.12	Handicapped (2%)	5	8
2.13	Martyred Family Pariwar (2%)	5	7
	Total	571	691
NB: All scholarship spots are divided into general category and reserved categories. Of the reserved categories, they are further allocated into various subcategories (rows 2.1 through 2.13) based on pre-set affirmative action criteria. The total at the bottom represents the sum of General and Reservation spots. Source: https://edusanjal.com/scholarship/mbbs-scholarships-seats-in-nepal/.			

SA4: Undergraduate medical education (MBBS) scholarship positions available at medical schools in Nepal

	Medical School	Type	Total Seats	Scholarship Seats
1	BP Koirala Institute of Health Sciences	Public	100	75
2	Karnali Academy of Health Sciences	Public	50	37
3	KU School of Medical Sciences	Public	130	13
4	Madan Bhandari Academy of Health Science	Public	50	37
5	Maharajgunj Medical Campus	Public	100	75
6	Purbanchal Univ. School of Health Sciences	Public	50	37
7	Nepalese Army Institute of Health Sciences	Public	100	38
8	Patan Academy of Health Sciences (PAHS)	Public	65	49
9	Pokhara Academy of Health Sciences	Public	50	37
10	Rapti Academy of Health Sciences	Public	50	38
11	Madhesh Institute of Health Sciences	Public	50	37
12	Saheed Dasarath Chand Health Sc. Univ.	Public	50	
	Public Not-for-Profit Sub-Total			473
13	B & C Medical College	Private	60	6
14	Birat Medical College	Private	130	16
15	Chitwan Medical College	Private	130	13
16	College of Medical Sciences	Private	130	26
17	Devdaha Medical College	Private	90	9
18	Gandaki Medical College	Private	120	12
19	Janaki Medical College	Private	60	6
20	Kathmandu Medical College	Private	130	13
21	KIST Medical College	Private	120	12
22	Lumbini Medical College	Private	120	12
23	Manipal College of Medical Sciences	Private	120	24
24	National Medical College	Private	120	12
25	Nepal Medical College	Private	130	13
26	Nepalgunj Medical College	Private	130	13
27	Nobel Medical College Teaching Hospital	Private	130	19
28	Universal College of Medical Sciences	Private	120	12
	Private Sub-Total			218
	Total			691

NB: Kathmandu University and its School of Medical Sciences (KUSMS) are sometimes classified as a private university and medical school. However, unlike other private medical schools, the University and KUSMS are not for-profit making institutions and do not have shareholders. Therefore we have classified KUSMS as a public medical school.

SA5: Number of Undergraduate medical education (MBBS) available for foreign medical students for the academic year 2026.

	Medical School	Type	Affiliation	Foreign Seats
1	B.P. Koirala Institute of Health Sciences (BPKIHS)	Public	Autonomous	9
2	Maharajgunj Medical Campus (IOM)	Public	Tribhuvan Univ.	9
3	Patan Academy of Health Sciences (PAHS)	Public	Autonomous	6
4	Karnali Academy of Health Sciences (KAHS)	Public	Autonomous	5
5	Pokhara Academy of Health Sciences	Public	Autonomous	4
6	Rapti Academy of Health Sciences (RAHS)	Public	Autonomous	4
7	Madan Bhandari Academy of Health Sciences	Public	Autonomous	4
8	Madhesh Institute of Health Sciences	Public	Autonomous	4
9	Nepalese Army Institute of Health Sciences	Public	Tribhuvan Univ.	4
10	Purbanchal University School of Health Sci.	Public	Purbanchal Univ.	4
11	Saheed Dasharath Chand Health Sciences University	Public	Autonomous	
12	Kathmandu Univ. School of Medical Sci. (KUSMS)**	Private	Kathmandu Univ.	43
-	Subtotal Public			53
13	College of Medical Sciences (CMS)	Private	Kathmandu Univ.	65
14	Manipal College of Medical Sciences	Private	Kathmandu Univ.	60
15	Kathmandu Medical College (KMC)	Private	Kathmandu Univ.	43
16	Nepal Medical College (NMC)	Private	Kathmandu Univ.	43
17	Nobel Medical College	Private	Kathmandu Univ.	43
18	Birat Medical College	Private	Kathmandu Univ.	43
19	Nepalgunj Medical College	Private	Kathmandu Univ.	43

20	Chitwan Medical College (CMC)	Private	Tribhuvan Univ.	43
21	KIST Medical College	Private	Tribhuvan Univ.	40
22	Gandaki Medical College	Private	Tribhuvan Univ.	40
23	Universal College of Medical Sciences (UCMS)	Private	Tribhuvan Univ.	40
24	National Medical College	Private	Tribhuvan Univ.	40
25	Lumbini Medical College	Private	Kathmandu Univ.	40
26	Devdaha Medical College	Private	Kathmandu Univ.	30
27	Janaki Medical College	Private	Tribhuvan Univ.	20
28	B & C Medical College	Private	Kathmandu Univ.	20
	Subtotal Private			696
	TOTAL			749

NB: Kathmandu University and its School of Medical Sciences (KUSMS) are sometimes classified as a private university and medical school. However, unlike other private medical schools, the University and KUSMS are not for-profit making institutions and do not have shareholders. Therefore we have classified KUSMS as a public medical school.

SA6: Non-specialist physician licensure trends in Nepal Medical Council Licensing Examination (NMCLE).³¹

Fiscal Year (BS)	Fiscal Year (AD)	Pass Percentage
2074/75	2017/18	55.5%
2075/76	2018/19	51.3%
2076/77	2019/20	61.7%
2077/78	2020/21	53.3%
2078/79	2021/22	42.0%
2079/80	2022/23	44.2%
2080/81	2023/24	55.4%

SA7: Non-specialist physician licensure trends in Nepal Medical Council Licensing Examination (NMCLE) for 2025–2026.⁶⁴

Exam Session	Total Candidates (MBBS)	Passed	Pass Percentage
January 2025	753	241	32.01%
May 2025	1120	465	41.5%
September 2025	894	389	43%
January 2026	842	334	39.67%
May 2026	1830	668	63.50%

SA8: Availability of post-graduate medical spots across medical schools and hospitals across Nepal.

Based on data from the Medical Education Commission, here is the comprehensive breakdown of total, filled, and vacant postgraduate seats across all specialties and institutions. This list does not include post-graduate spots in dental education.

Overall Seat Breakdown

1. Total Available Seats: 1,230
2. Total Admitted (Filled): 981
3. Total Vacant (Remaining): 269

Seat Distribution by Medical School or Program Type

The utilization rates vary significantly depending on whether the seats are hosted in public universities, private colleges, or under the National Board of Medical Specialties (NBMS):

Post-graduate Program Type	Total Medical Seats	Filled (Admitted)	Vacant (Remaining)	Fill Rate (%)
Public	540	450	90	83.3%
Private	618	441	177	71.4%
NBMS	72	70	2	97.2%
Total	1,230	961	269	78.1%

NB: NBMS stands for National Board of Medical Examiners. NBMS is an alternate pathway for post-graduate medical education, and is academically administered by the Medical Education Commission itself, unlike other programs that are academically administered by the respective universities. Data are from internal records of the Medical Education Commission, updated as of June 17, 2026.

SA9: Postgraduate medical seat distribution between clinical and non-clinical specialties. (Excluding Dental programs)

Specialty Category	Total Available Seats	Filled (Admitted)	Vacant (Remaining)	Fill Rate (%)
Clinical Specialties	918	912	6	99.3%
Non-Clinical Specialties (Inc. Pathology)	312	49	263	15.7%
Total Medical Seats	1,230	961	269	78.1%

Insights into Vacancies

1. Clinical vs. Non-Clinical: The 269 vacant seats are almost entirely concentrated in non-clinical or para-clinical basic science departments (such as Anatomy, Physiology, Biochemistry, Pharmacology, Microbiology, and Pathology) across both public and private medical schools.
2. Clinical Fields: Major clinical postgraduate specialties like Internal Medicine, General Surgery, Radiodiagnosis, Pediatrics, Orthopedics, and Dermatology have reached 100% capacity across virtually every institution.
3. NBMS: The National Board program stands out with an exceptionally high capacity fulfillment rate (97.2%), leaving only 2 empty spots out of 72 available slots.

SA10: The number of Good Standing Certificates issued by the Nepal Medical Council to registered doctors.³¹

Fiscal Year (BS)	Fiscal Year (AD)	Number of Certificates Issued
2076/77	2019/20	1,087
2077/78	2020/21	1,502
2078/79	2021/22	2,189
2079/80	2022/23	2,582
2080/81	2023/24	2,518

NB: This data represents the annual volume of good standing certificates issued by the Nepal Medical Council to registered medical practitioners. These certificates are generally required for practicing or studying abroad. A Good Standing Certificate, while a good measure of an intent to emigrate, is not a measure of how many doctors have emigrated.

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