



EDITORIAL

**For-Profit Companies Can Set Up Medical Colleges Under PPP Mode: A Strategic Reform for India's Health System**

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**The Context: Supply-Demand Mismatch in Medical Education**

India stands at an inflection point in health workforce planning. The country's aspiration for universal health coverage, expansion of quaternary care, digital health integration, and research-led precision medicine demands a dramatic scale-up of medical education capacity. Public systems alone cannot finance or operationalize this expansion at the required velocity.

Allowing for-profit companies to establish medical colleges under a well-regulated Public-Private Partnership (PPP) framework is therefore not a dilution of public responsibility—it is a strategic structural reform.

India has expanded medical seats significantly in the last decade (Table 1 and Figure 1) with policy support from the National Medical Commission. Yet structural gaps remain:

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**For-profit companies can set up medical colleges under PPP mode: NMC chief**

The Hindu Bureau  
VIJAYAWADA

National Medical Commission (NMC) Chairman Abhijat Chandrakant Sheth on Wednesday said that the regulation of allowing only non-profit companies to set up medical colleges has been shelved to enable both non-profit and for-profit companies to run them.

Addressing the media at Dr. NTR University of Health Sciences, Mr. Sheth said, "Earlier, only non-profit Section 8 companies were allowed to set up medical colleges but a recent board meeting has removed this regulation, paving the way for both non-profit, and for-profit companies to set up medical colleges under Public Private Partnership," said Sheth, who met Chief Minister N. Chandrababu Naidu today, in a release.

The NMC is of the belief that public and private entities teaming up together will enable the efficient utilisation of available resources for medical education, he said.

As hospitals run under PPP mechanism will be under State governments' purview, he said patients will receive treatment on either free or subsidised basis, he said.

As part of enhancing medical education quality, Sheth said clinical research has been made compulso-



ry, including embracing AI, futuristic technologies and digital healthcare, among others.

He said that NMC is raising awareness among the public about preventive measures to check diseases and the mental well-being of students.

New PhD speciality and sub-specialty courses would be introduced and clinical research will be made mandatory to enhance the quality of medical education, he said, adding that the accreditation process for medical colleges would be simplified.

Later, Dr. NTRUHS Vice-Chancellor P. Chandrasekhar said steps are being taken to increase PG seats to match the MBBS seat numbers.

To address the shortage of doctors in taluk-level hospitals and hospitals with 50-100 beds, a new 'Family Medicine' initiative is being introduced, which will make approximately 500 seats available.

NMC Chairperson Abhijat Chandrakant Sheth addressing the media at Dr. NTRUHS in Vijayavada India. K.V.S. GIRI.

With inputs from PTI

- Uneven geographic distribution of colleges
  - Faculty shortages
  - Limited super-specialty exposure in district-linked institutions
  - Inadequate research ecosystems
  - Infrastructure-finance bottlenecks in state universities
- Simultaneously, tertiary care demand is rising due to epidemiological transition, demographic shifts, and health insurance expansion.

Table 1. NEET Undergraduate Trajectory Over the Years (2015–2025)

Year	Registered Candidates (Approx.)	Key Policy / System Development
2015	~6.3 lakh ( <i>AIPMT era</i> )	Pre-uniform phase; multiple entrance exams (AIPMT + state exams)
2016	~8.0 lakh	NEET introduced as single national exam (phased implementation)
2017	~11.4 lakh	Full nationwide adoption; state exams merged
2018	~13.2 lakh	Increased private/deemed university participation
2019	~15.2 lakh	Rise in repeat aspirants (“drop-year culture”)
2020	~15.9 lakh	Pandemic stress test; exam continuity maintained despite COVID
2021	~16.1 lakh	Major surge from Tier-2/3 cities; digital coaching expansion
2022	~18.7 lakh	Expansion of new AIIMS & Government colleges announced
2023	~20.9 lakh	Record participation; widening competition gap
2024	~24.0 lakh	Policy debate intensifies on capacity vs demand mismatch
2025	~24.5–25.0 lakh ( <i>projected/early estimates</i> )	System saturation → Calls for distributed training models & new medical colleges

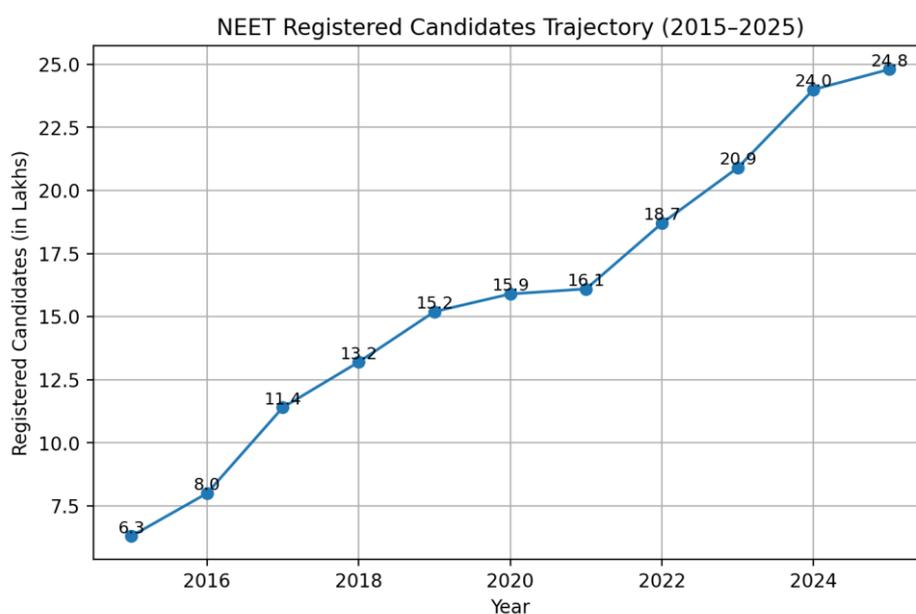


Figure 1. NEET Undergraduate Trajectory Over the Years (2015–2025; Numbers in Lacs)

If India aims to reach a sustainable doctor–population ratio while ensuring quality and research output, **capital infusion and managerial efficiency from the private sector become indispensable.**

### Why PPP with For-Profit Participation Makes Economic Sense

A modern medical college with a 500+ bed teaching hospital requires capital outlay running into ₹800–1200 crore, depending on location and scope. State governments often struggle with:

- Budgetary constraints
- Delayed capital expenditure cycles
- Procurement inefficiencies and uncertainties
- Faculty recruitment rigidities

For-profit entities bring:

1. **Capital efficiency** – Access to structured finance and faster project execution

2. **Operational management systems** – Lean hospital administration, digital integration
3. **Technology adoption** – AI diagnostics, simulation labs, tele-education platforms
4. **Industry-linked research funding** – Translational medicine and clinical trials

When structured under PPP, land and policy support can come from the state, while capital investment and operational management come from industry partnership.

### Addressing the Core Concern: Profit Privates Public Good

The opposition to this type of medical education often stems from fear of commercialisation. These concerns are legitimate—but manageable (Figure 2).



Figure 2. PPP Framework

**A robust PPP framework must incorporate:**

- Fee regulation mechanisms
- Mandatory scholarship quotas
- Reservation compliance
- Outcome-based accreditation metrics
- Transparent admission through NEET
- Service obligations in underserved areas
- Research performance benchmarks

The regulator—currently the National Medical Commission—must function as a quality assurance authority rather than a licensing bottleneck.

**Profit cannot be allowed to distort merit or ethics. However, profit PPP under regulation is not inherently unethical; opacity is.**

**International Precedents**

Globally, many leading institutions operate within hybrid financial ecosystems:

- **Johns Hopkins University** integrates private philanthropy, research grants, and clinical revenue.
- **Harvard Medical School** functions within a complex financial model involving private endowments and hospital revenue.

While not strictly “for-profit colleges,” these models demonstrate that **private capital participation in medical education is not antithetical to academic excellence.**

India can design a uniquely regulated for-profit PPP model suited to its demographic and economic context.

**Strategic Advantages for India**

- **Accelerated Seat Expansion**  
PPP models can rapidly establish colleges in aspirational districts.
- **Faculty Incentivization**  
Flexible pay structures can attract diaspora and super-specialists.
- **Research & Innovation Clusters**  
Linkage with biotechnology firms and med-tech startups can create translational hubs.
- **Integration with Digital Health**  
Alignment with the national digital ecosystem under the National Health Authority and Ayushman Bharat Digital Mission can create real-time data-driven teaching hospitals.

For a country investing in state-wide biobanks and EMR ecosystems—as envisioned in precision medicine initiatives—PPP medical colleges can serve as anchor academic nodes (Table 2).

Table 2. Risks and Mitigation Architecture

Risk	Mitigation Strategy
<b>Excessive tuition</b>	Fee caps + income-linked scholarships
<b>Urban concentration</b>	Incentivised land grants in Tier-2/3 districts
<b>Faculty poaching</b>	National faculty pool and rotation models
<b>Ethical lapses</b>	Independent ethics oversight boards
<b>Clinical compromise</b>	Mandatory NABH-equivalent accreditation

Quality assurance must shift from infrastructure inspection to **outcome measurement: graduate competence, patient outcomes, and research productivity.**

**Ethical Framing: Education as Public Good, Delivery via Mixed Economy**

Medical education is a public good because it produces human capital critical to national health security. However, public good status does not necessitate exclusive public provisioning.

**The key principle should be:**

Public purpose, privately financed, transparently regulated.

India’s infrastructure expansion in highways, airports, and metro systems has benefited from PPP frameworks. There is no structural reason why medical education—arguably more vital—cannot adopt similar governance discipline.

Such a model ensures alignment of incentives rather than ideological confrontation (Tables 3-5).

**A Policy Blueprint for Implementation**

1. The state provides land on long-term lease.
2. For-profit entity builds and operates under defined service obligations.
3. Government retains golden-share oversight.
4. Fee structure partially regulated, partially market-driven within caps.
5. Mandatory rural health service rotation.
6. Integrated digital compliance dashboard.
7. Annual public disclosure of financial and academic metrics.

Table 3. Structural Model Options

Model A Land-Lease PPP	Model B District Hospital Upgrade PPP	Model C Hybrid Academic-Research Cluster
<ul style="list-style-type: none"> <li>• State government provides land for a lease time</li> <li>• Corporate partner builds and operates</li> <li>• Regulated fee + inherent scholarship mandate</li> </ul>	<ul style="list-style-type: none"> <li>• Existing district hospital converted into a teaching hospital</li> <li>• Corporate invests in expansion &amp; faculty</li> <li>• Shared clinical revenue model</li> </ul>	<ul style="list-style-type: none"> <li>• Linked to biotech / med-tech industrial corridor</li> <li>• Integrated translational research unit</li> <li>• Mandatory postgraduate &amp; super-specialty seats</li> </ul>

Table 4. Governance Architecture\*

Regulatory Layer	Institutional Governance
<ul style="list-style-type: none"> <li>Academic regulation: National Medical Commission</li> <li>Digital compliance: National Health Authority</li> <li>Integration with Ayushman Bharat Digital Mission</li> </ul>	<p><b>*Board composition:</b></p> <ul style="list-style-type: none"> <li>40% Corporate nominees</li> <li>30% Government nominees</li> <li>20% Independent academic experts</li> <li>10% Public health representative</li> </ul> <p><b>Government retains “Golden Share” veto for:</b></p> <ul style="list-style-type: none"> <li>Fee hikes beyond cap</li> <li>Seat diversion</li> <li>Academic dilution</li> </ul>

\*Tentative figures

## Financial Architecture

Table 5. Capital Expenditure (Indicative)\*

Component	Estimated Cost (₹ Crore)
Land (state provided)	—
Academic block	250–300
500-bed teaching hospital	400–500
Simulation & research labs	100–150
Digital & IT integration	50–75
Total Capex	800–1,200

\*Tentative figures

The revenue streams comprise tuition collected within a regulated fee band, income generated from clinical services, and insurance reimbursements under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). Additional sources include research grants and clinical trials, structured industry collaborations, and enrollment of international students within a capped quota.

Profit governance is guided by defined financial safeguards. For example, a maximum return on investment (ROI) band may be prescribed, such as a 12–15% internal rate of return (IRR) cap. Furthermore, a mandatory reinvestment

ratio can be implemented, whereby a fixed proportion of surplus—such as 20%—is reinvested into research, academic development, and scholarships to ensure long-term institutional growth and public benefit.

### Academic Safeguards

Admissions are conducted entirely through the NEET merit system, ensuring that 100% of seats are allocated based on merit through transparent, centralized counselling.

The fee structure is rationalised across different seat categories: 50% of seats fall under the regulated state quota, 35% are offered within a controlled

institutional fee band, and 15% are reserved for NRI or international candidates, with higher fee realisation enabling cross-subsidisation of scholarships.

A structured scholarship mandate ensures that a minimum of 20–25% of seats receive need-based financial support. In addition, income-linked repayment options may be provided to enhance affordability

and promote equitable access to medical education.

Faculty norms are designed to balance flexibility and accountability, incorporating flexible salary bands, performance-linked incentives, and mandatory academic output benchmarks to maintain academic excellence and institutional credibility. Outcome-Based Accreditation Framework (Table 6).

Table 6. Move from infrastructure inspection to measurable outcomes

<b>Domain</b>	<b>Metrics</b>
<b>Academic</b>	Rank, competency scores, OSCE performance
<b>Clinical</b>	Mortality-adjusted outcomes, infection rates
<b>Research</b>	Publications, patents, funded projects
<b>Social Impact</b>	Rural service coverage, outreach camps
<b>Digital</b>	ABDM integration compliance

#### **Annual public disclosure is mandatory**

The Geographic Equity Strategy is designed to address regional imbalances in medical education and healthcare access by incentivising public–private partnerships (PPPs) in Tier-2 and Tier-3 districts. Policy enablers may include additional Floor Area Ratio (FAR) or Floor Space Index (FSI) benefits, tax concessions linked to measurable rural service delivery outcomes, and land cost subsidies aligned with the district backwardness index to ensure targeted development in underserved regions.

The Ethical and Compliance Framework mandates strong institutional safeguards. Each institution must establish an independent Institutional Ethics Committee, implement a robust whistleblower protection mechanism, and obtain mandatory NABH-level

accreditation through the National Accreditation Board for Hospitals & Healthcare Providers. Financial transparency is ensured through annually published audited statements, alongside a strict zero-tolerance policy toward capitation practices.

Under the Digital Integration Blueprint, every PPP medical college is required to fully integrate with the Ayushman Bharat Digital Mission stack, adopt interoperable electronic medical records (EMR), maintain advanced digital skill laboratories, provide real-time performance dashboards to regulators, and establish linkage with national disease registries to support surveillance, research, and policy planning (Table 7).

This aligns academic training with India's digital health architecture.

Table 7. Risk Mitigation Matrix

Risk	Mitigation
<b>Commercialization bias</b>	Fee caps + scholarship floor
<b>Urban clustering</b>	Location-linked incentives
<b>Faculty migration from public sector</b>	Shared faculty exchange pool
<b>Academic dilution</b>	Outcome-based accreditation
<b>Regulatory capture</b>	Independent oversight board

### Core Design Principle

**Public Purpose + Private Capital +  
Regulatory Discipline = Sustainable  
Expansion**

The debate should not be ideological. The question is whether India can afford **not** to leverage regulated corporate capital in medical education.

With strong governance, PPP-based for-profit medical colleges can become:

- Workforce multipliers
- Research accelerators
- Regional healthcare anchors
- Economic growth nodes

This blueprint provides a scalable, accountable, and economically viable pathway for implementation.

India's medical education system stands at a structural crossroads. The demand for competent physicians, specialists, and clinician–scientists is expanding faster than traditional public financing can sustain. The question is no longer whether capacity must expand—it is how to expand responsibly, equitably, and sustainably.

**In this context, the proposition that for-profit companies may establish medical colleges under a regulated Public–Private Partnership (PPP) framework represents not a departure from public health ethics, but a pragmatic recalibration of resource mobilisation.**

Under the present Chairman- **Dr. Abhijat Sheth**, the National Medical Commission has increasingly emphasized transparency, competency-based training, digital compliance, and outcome-driven regulation. A PPP-enabled model aligns with this reform trajectory—provided governance is uncompromising.

### The Way Forward

India's healthcare transformation—in the range of life sciences specialities, whether in pediatric super-speciality care, quaternary neonatal surgery institutes, or state-wide precision medicine biobanks—requires academic ecosystems that are agile, well-capitalised, and accountable.

The debate should move beyond “for-profit versus non-profit” to “regulated efficiency versus stagnation.”

**Allowing for-profit companies to establish medical colleges under the PPP mode is not privatisation of medical education; it is professionalisation of capital deployment under sovereign oversight.**

If designed prudently and implemented with strong regulatory safeguards, this reform has the potential to significantly expand access to medical education and healthcare services, enhance academic and clinical quality standards, boost national research output, reduce outbound medical migration for education and treatment, and ultimately strengthen overall national health resilience.

The imperative is not whether private capital should participate—but **how intelligently the state structures that participation.**

India's health future depends on that design.

### **The Structural Imperative**

India's vast demographic scale, ongoing epidemiological transition, and insurance-led hospital expansion under schemes such as Ayushman Bharat Pradhan Mantri Jan Arogya Yojana necessitate the rapid addition of MBBS and postgraduate seats, strengthening of district-linked teaching hospitals, integration of digital health competencies into curricula, and the development of research-enabled academic ecosystems.

### **For-profit participation—when embedded in PPP—offers:**

For-profit participation—when embedded within a well-structured public-private partnership (PPP) framework—can offer capital velocity, operational efficiency, faster technology integration, and clearer managerial accountability. The ethical question is not whether profit exists, but whether the partnership operates within a clearly regulated public purpose.

### **Private and Public Good: A False Binary**

The perceived dichotomy between private participation and public good is often overstated. Resistance to for-profit entities in medical education typically arises from legitimate concerns about commercialization; however, such risks are manageable through strong regulation. Within the regulatory architecture of the National Medical Commission, safeguards can include 100% admissions through NEET merit, fee band regulation, mandatory scholarship quotas, rural service obligations, transparent digital disclosure dashboards, and outcome-based accreditation. The regulator must evolve from being primarily an infrastructure inspector to becoming a competency auditor. When governance is robust, profit becomes an incentive for efficiency rather than exploitation.

### **PPP as a Governance Instrument**

PPP should be understood not as privatization but as structured risk-sharing. A viable governance model may include state-provided land on long-term lease, corporate-funded infrastructure and operations, a government “golden share” veto on fee hikes and seat diversion, mandatory public disclosure of financial and academic metrics, and independent ethics oversight. Integration with the National Health Authority and alignment with the Ayushman Bharat Digital Mission can enable real-time compliance tracking, thereby reducing opacity that historically fueled mistrust. Regulation, therefore, must be algorithmic rather than discretionary.

### **Global Learning without Blind Imitation**

Globally respected institutions such as Johns Hopkins University and Harvard

Medical Schools operate within mixed financial ecosystems that combine private funding, clinical revenue, and research grants. While India's context differs, the broader principle remains: private capital participation does not inherently erode academic excellence; regulatory weakness does. India must therefore design its own model—socially accountable yet economically viable.

### **Safeguards That Cannot Be Compromised**

Any policy enabling for-profit medical colleges under PPP must incorporate non-negotiable safeguards, including transparent fee structures with cross-subsidization, a scholarship floor of at least 20–25%, geographic incentives for Tier-2 and Tier-3 districts, faculty performance benchmarks, mandatory research output targets, and annual public audit reports. Accreditation systems must assess competency outcomes, patient safety indicators, infection control metrics, research productivity, and community health engagement. Expansion without quality would ultimately be self-defeating.

### **The Strategic Opportunity**

Strategically designed, PPP-enabled medical colleges can accelerate seat expansion toward workforce

sufficiency, create research clusters linked to biotechnology and medical technology, strengthen district hospital ecosystems, integrate digital health into mainstream curricula, reduce outbound medical migration, and support precision medicine and biobank networks. In a nation investing heavily in digital public infrastructure, medical education cannot remain analogue in governance or financing.

### **Belief**

The debate must move beyond ideological binaries, as India today requires scale, speed, and uncompromising standards in expanding its healthcare workforce. Allowing for-profit entities to establish medical colleges within a rigorously regulated Public–Private Partnership framework is not a withdrawal from public responsibility, but rather an adaptive strategy to strengthen national health security. The true measure of success will lie not in permitting participation, but in designing precise, transparent, and accountable regulatory oversight. If structured thoughtfully, this reform can widen access, enhance quality, and better align medical education with India's 21st-century healthcare needs. The opportunity is structural, the responsibility is regulatory, and the moment to act is now (Table 8).

**ASTER Algorithm Flow**

Table 8. PPP Medical College Governance Framework

<b>Phase</b>	<b>Step</b>	<b>Key Actions / Criteria</b>	<b>Outputs / Regulatory Control</b>
<b>Pre Phase 1: National Needs Mapping</b>	Workforce Deficit Modeling	Doctor-population ratio, specialist gaps, disease burden, insurance growth, UG/PG seat deficit	<b>District Priority Score (DPS)</b>
	Infrastructure Feasibility Index	Land, district hospital upgrade scope, connectivity, faculty availability	<b>PPP Eligibility Zone (PEZ): A/B/C (Only A &amp; B proceed)</b>
<b>Phase 1: Competitive Selection</b>	Prequalification Filter	Net worth threshold, healthcare experience, no blacklisting, ESG compliance	<b>Algorithmic Risk Score (ARS)</b>
	Weighted Bid Evaluation	Capital (25%), backwardness (20%), fee moderation (15%), scholarships (15%), research (15%), digital readiness (10%)	<b>Composite Governance Score (CGS)</b>
<b>Phase 2: Concession Design</b>	Risk Allocation	Construction–Private; Regulatory–Shared; Demand–Private; Emergencies–Shared	Defined contractual liability
	Golden Share Clause	Govt veto on fees, seat diversion, scholarships, academic dilution	Public-interest safeguard
<b>Phase 3: Infrastructure &amp; Digital Compliance</b>	Outcome-Based Verification	500-bed teaching hospital, simulation labs, research infra, telemedicine, EMR integration	Real-time digital compliance dashboard
	Data-Driven Regulation	Live occupancy, EMR logs, biometrics, infection metrics	Reduced need for physical inspection
<b>Phase 4: Academic Control</b>	Admission Integrity	100% merit-based entry, centralized counseling	Automated anomaly detection

	Fee Governance	50% regulated quota, 35% controlled band, 15% cross-subsidy	Fee cap = CPI + 2%
	Scholarship Floor	≥25% need-based aid; 10% full waiver	Penalty + seat freeze if violated
<b>Phase 5: Faculty &amp; Training Quality</b>	Faculty Competency Index	Publications, clinical load, teaching hours, CME	Recruitment mandate if below threshold
	Student Competency Monitoring	OSCE scores, exit exam, logbooks, patient exposure	Seat reduction if persistent underperformance
<b>Phase 6: Clinical Outcome Oversight</b>	Quarterly Metrics	Mortality-adjusted outcomes, infection rates, complication rates, fraud index	Corrective Action Protocol (CAP)
<b>Phase 7: Research Obligation</b>	Innovation Mandate	≥1% revenue to research, ethics compliance, trial registry	PG expansion linked to research output
<b>Phase 8: Social Accountability</b>	Community Integration	Rural rotation, tele-outreach, district MoUs, annual impact report	Service-linked accreditation value
<b>Phase 9: Financial Transparency</b>	IRR Cap Mechanism	Max IRR 12–15%; excess profit partly reinvested	Prevents profiteering
	Public Disclosure	Revenue, fees, scholarships, outcomes, research	Financial transparency enforcement
<b>Phase 10: Continuous Risk Calibration</b>	Institutional Integrity Index (III)	Academic, clinical, financial, satisfaction, public health contribution	Grades: <b>A (Expand) / B (Monitor) / C (Probation) / D (Seat Freeze/Takeover)</b>

### Five-Year Rollout Simulation

The five-year rollout simulation envisions a phased and carefully monitored expansion of PPP medical colleges. In Year 1, ten pilot PPP colleges would be operationalized to test governance, regulatory, and financial frameworks. During Years 2 and 3, an additional twenty-five colleges would be established, scaling

the model based on early performance indicators. Year 4 would focus on conducting the first comprehensive outcome audit to evaluate academic standards, financial transparency, patient care metrics, and research productivity. By Year 5, more than fifty PPP medical colleges would be fully operational.

**Five-Year Rollout Simulation envisions a phased and carefully monitored expansion of PPP medical colleges.**

- Year 1: 10 pilot PPP colleges
  - Year 2–3: 25 additional
- Year 4: First outcome audit
  - Year 5: 50+ operational

## Summary

### ***Projected Outcome***

The projected outcomes of this expansion include the addition of over 25,000 MBBS seats and more than 10,000 postgraduate seats, along with measurable strengthening of district hospital infrastructure and a significant expansion of the national research ecosystem.

**Quality assurance** — must shift from infrastructure inspection to **outcome measurement: graduate competence, patient outcomes, and research productivity.**

### **For-profit participation—when embedded in PPP—offers**

For-profit participation—when embedded within a well-structured public–private partnership (PPP) framework—can offer capital velocity, operational efficiency, faster technology integration, and clearer managerial accountability. The ethical question is not whether profit exists, but whether the partnership operates within a clearly regulated public purpose.

### **Private and Public Good: A False Binary**

The perceived dichotomy between private participation and public good is often overstated. Resistance to for-profit entities in medical education typically arises from legitimate concerns about commercialization; however, such risks are manageable through strong regulation. Within the regulatory architecture of the

National Medical Commission, safeguards can include 100% admissions through NEET merit, fee band regulation, mandatory scholarship quotas, rural service obligations, transparent digital disclosure dashboards, and outcome-based accreditation. The regulator must evolve from being primarily an infrastructure inspector to becoming a competency auditor. When governance is robust, profit becomes an incentive for efficiency rather than exploitation.

### **Core Oversight Philosophy**

The core oversight philosophy underpinning this model emphasizes systemic reform in regulation. Traditional inspection-based mechanisms would be replaced with real-time digital monitoring. Ideological debates would give way to measurable outcome indicators. Opaque, discretionary permissions would be substituted with transparent, algorithmic scoring systems. Episodic audits would transition into continuous compliance frameworks enabled by digital dashboards and integrated data systems.

### **Final Governance Formula**

The final governance formula recognizes that while scale is delivered by capital, speed is attained by managerial efficiency, and standards by data-driven regulation. If India aims to align medical education with 21st-century healthcare priorities—such as digital integration,

precision medicine, and universal health coverage—this structured, algorithm-based framework enables for-profit participation without compromising public purpose. Ultimately, the success of this reform will

depend not merely on permitting private participation, but on engineering oversight with precision, transparency, and accountability.

For a country investing in state-wide biobanks and EMR ecosystems—as envisioned in precision medicine initiatives—PPP medical colleges can serve as anchor academic nodes.

- Allowing for-profit companies to establish medical colleges under the PPP mode is not privatisation of medical education; it is professionalisation of capital deployment under sovereign oversight.
- India must design its own model—socially accountable yet economically viable.

### **The Strategic Opportunity**

For India, PPP-enabled medical colleges can:

- Accelerate seat expansion toward workforce sufficiency
- Create research clusters linked to biotechnology and med-tech
- Strengthen district hospital ecosystems
- Integrate digital health into the curriculum
- Reduce outbound medical migration
- Support precision medicine and biobank networks

In a country investing heavily in digital public infrastructure, medical education must not remain analogue in governance or financing.

- The opportunity is structural, the responsibility is regulatory, and the moment to act is now.
- The debate must move beyond ideological binaries, as India today requires scale, speed, and uncompromising standards in expanding its healthcare workforce. Allowing for-profit entities to establish medical colleges within a rigorously regulated Public–Private Partnership framework is not a withdrawal from public responsibility, but rather an adaptive strategy to strengthen national health security. The true measure of success will lie not in permitting participation, but in designing precise, transparent, and accountable regulatory oversight. If structured thoughtfully, this reform can widen access, enhance quality, and better align medical education with India’s 21st-century healthcare needs.