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## Privatization of medical education in Asia

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### Abstract

**Background:** The past decades have seen a rapid expansion in the number of private medical schools in Asia.

**Objectives:** To summarize the evidence currently available on the nature of this trend of privatization, the driving forces behind it, the benefits and downsides of it and guidelines for initiating need-based reforms.

**Methods:** Relevant literature published in the last decade was searched using different databases. Reference lists of articles identified through the primary search were also hand searched.

**Results:** Extracted articles identified economical, social and geopolitical factors responsible for this trend in Asia. Privatization is helpful in enhancing access of health care to all sections of society, creating more job opportunities and obviating the bureaucracy involved in government organizations. Arguably, challenges in terms of professional competence of medical students, physical infrastructure, and availability of qualified faculty and patients are to be carefully handled in these institutions. Additionally, the financial strain on students, lack of racial and socio-economic diversity of students and regional inequality in location of schools in favour of urban areas to rural areas are the problems that are to be dealt with. Guidelines to be followed to initiate need-based reforms can be: imposition of accreditation processes, reforms in curriculum, appropriate student selection criteria, faculty-development programmes, standardization of fee structure and use of regulations on the number and location of medical schools in richer and urban areas.

**Conclusion:** Privatization is a powerful tool which should be used cautiously to contribute to the betterment of health of the nation.

**Keywords:** Education, undergraduate, medical schools, private sector

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### Introduction

The past decades have seen a prolific growth of private medical schools in Asia. Most medical schools in Asia are government colleges attached to large teaching hospitals. This recent trend has changed the equation with private medical schools accounting for a major stake in medical education.

Privatization of medical education can be defined as "Medical Education imparted by an organization not a part of the government

bureaucracy" (Shehnaz, 2010). Private schools are funded by various means and have varying levels of control by the Government, meaning, the totally autonomous or the partially autonomous institutions. They can be profit generating institutions or non-profit society-centred institutions. However, the latter are a rarity in Asia.

Worldwide, Asia has 44% of the total number of medical schools, serving 60% of the global population. Significantly, six of the top ten countries with the most medical schools are in Asia. Nevertheless, the physician density is considerably lower than Europe and North America (Boulet *et al.*, 2007). Moreover, the quality and standard of Asian medical education is beset with problems intimately linked with this explosive privatization. Though this trend is regional, it has worldwide implications due to increasing globalization and cross border education.

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Given the magnitude of this trend, the main research questions investigated through this literature review were: what is the nature of this trend in Asia? What are the factors responsible for the dramatic increase in privatization in Asia? What are the pros and cons of privatization which may highlight their ramifications? What are the guidelines for initiating need-based reforms in Asian private medical colleges?

## Methods

Medline/Pubmed, Ingenta, Topics in Medical Education (TIMELIT), Blackwell Synergy (for the journal *Medical Education*), Informa Healthcare (for the journal *Medical Teacher*) and Google Scholar were searched for

publications related to private medical schools in Asia. Primary search terms *Education, medical, undergraduate, medical schools, private sector, Asia* were used in various combinations. In Medline (MESH database) the search terms *Education, medical, undergraduate or medical schools* were used in MAJR (main subject heading) combined (AND) with *private sector* and *Asia*. All search terms were “exploded”.

To ensure up-to-date knowledge, articles were restricted to the past ten years. Reference lists of articles identified through the primary search were also hand searched. The concepts emerging from primary search articles were the targets of a secondary search (Table 1).

**Table 1: Inclusion and Exclusion Criteria for Publications on Privatization of Medical Education in Asia**

Parameter	Inclusion criteria	Exclusion criteria
Medical Education	Undergraduate medical education	Other curricula including nursing, dentistry, veterinary education
Countries	Asian	Non-Asian
Medical students	Undergraduate medical students	Postgraduate students Doctors Residents
Design	Systematic reviews Reviews Editorials Original research	Letters Opinion pieces Critiques of prior studies
Language	English	Non-English
Publication date	January 2000–December 2010	Before January 2000 and after December 2010

Information available in World Directory of Medical Schools published by WHO (2007), International Medical Education Directory by FAIMER (2008) and Medical councils of the respective Asian countries was also utilized.

## Results

The pre-defined search strategy identified 95 articles. Data regarding privatization of medical education in Asia was restricted to 35 of these. The findings are discussed under the headings: nature of the trend, driving forces behind it, benefits, downsides and guidelines for privatization in Asia.

### **Nature of the trend in Asia**

Wide variations are seen in the distribution of Asian private medical colleges (Table 2). India has the largest number of private medical schools in the world (Boulet, *et al*, 2007). More than half of the schools in Nepal, Bangladesh, Pakistan, Japan, South Korea and Taiwan are

private, while Iran and Mongolia have fewer private institutions. In South-East Asia, private education has taken off in a big way in the Philippines (FAIMER, 2008), Malaysia (Lim, 2008) and Cambodia, but Vietnam (Hoat, *et al*, 2007) and Thailand (Wibulpolprasert & Pengpaibon, 2003) do not have many private colleges. In the Middle East, Yemen, Bahrain, Qatar have totally privatized their medical education and United Arab Emirates and Oman also have many private medical schools (Abdulahman, 2008; Bajammal, 2008). Turkey, however, has fewer private schools (Kurdak, *et al*, 2008). Post Soviet Union era, most of the schools in central Asia remain government funded (FAIMER, 2008). Similarly, China, North Korea, Myanmar, Israel, Kuwait and Sri Lanka have medical training under the full control of the State. Maldives, Bhutan and Brunei do not have any medical schools, either private or state funded (FAIMER, 2008; Mendis, *et al*, 2004).

*Table 2: Private medical schools in Asia*

Sub-region & Country	Medical schools		% of private schools (of total number)
	Private	Total	
<b>South Asia</b>			
India	137	271	51
Pakistan	36	64	56
Bangladesh	25	40	63
Iran	10	48	21
Nepal	10	13	77
Sri Lanka	-	6	0
<b>Eastern Asia</b>			
Japan	29	50	58
South Korea	31	41	76
Taiwan	8	11	73
Mongolia	1	6	17
China	-	172	0
North Korea	-	10	0
Hong Kong	-	2	0
<b>South-East Asia</b>			
Philippines	24	30	80
Malaysia	11	21	52
Viet Nam	2	10	20
Cambodia	1	2	50
Singapore	-	2	0
Thailand	1	12	8
Myanmar	-	3	0
<b>Western Asia</b>			
Republic of Turkey	7	42	17
Saudi Arabia	5	14	36
Yemen	4	4	100
United Arab Emirates	3	5	60
Bahrain	2	2	100
Qatar	1	1	100
Oman	1	2	50
Kuwait	-	1	0
Israel	-	4	0
<b>Central Asia</b>			
Uzbekistan	-	10	0
Kazakhstan	-	7	0
Kyrgyzstan	-	7	0
Tajikistan	-	2	0
Turkmenistan	-	1	0

Bottom of Form

### ***Driving forces behind privatization in Asia***

The population explosion in developing countries of Asia resulted in rising demands for medical admissions which could not be accommodated by the available infrastructure. Moreover, the “low income or lower income economies” of 66% of Asian countries obstructed their Governments from meeting the medical needs of their society. Furthermore, the recent economic boom, burgeoning of the middle class and cultural changes leading to more aspirants from lower social strata for higher education necessitated wider avenues for private medical education (Mudur, 2006). Relaxation of Governmental regulatory restraints in many Asian countries

has catalyzed privatization. Parties with vested interests, such as politicians and business communities, helped themselves with substantial earnings from private medical schools. Another disturbing trend was the policy of appeasement of minority electorate by regional authorities taking recourse to medical education; hence the establishment of private medical schools by specific minority and ethnic groups (Mahal & Mohanan, 2006). The high prevalence of alleged corruption in Bangladesh, India, Indonesia, Nepal, Pakistan, and Philippines could have led to the bypassing of regulatory restraints and enhanced privatization in these countries (Amin, et.al, 2010).

In the developed countries of Asia (Japan, Taiwan, Singapore, South Korea and Israel), the increased medical need due to increased dependence on recent advances in medicine and higher average life spans of the population along with the ambition to be the premier regional medical hub has led to setting up of private colleges (Hwang, 2005).

Globalization has resulted in an increased flow of skilled professionals from low-income Asian countries to the West. India, Pakistan and the Philippines are the principal sources of foreign trained physicians in the UK, US, Canada, Australia and New Zealand (Mullan, 2005). This demand from the export oriented market and the lure of increased income may have contributed to more aspirants into health professions, resulting in more private medical schools (the cross border educational providers) in these countries.

The new trend of “medical tourism”, involving the practice of travelling across international borders to obtain hi-tech medical care, may be another trigger factor. India, Singapore, Thailand and Malaysia are currently the four main countries involved in this “trade”. Quality care, relatively economical services coupled with the high median wait time in Western governmental health institutions, package deals and cheap services from the tourism and hospitality sectors are the key attractions for the “medical tourists” visiting these countries (Reddy & Qadeer, 2010).

Total or partial lack of educational facilities (Maldives, Bhutan, and Brunei; Mendis, 2004), political instability and insecurity (Sri Lanka, Afghanistan) or stringent admission criteria (Sri Lanka; de Silva, *et al.* 2006) may also have resulted in the residents of these countries immigrating to other countries for their medical education.

### **Benefits of privatization**

An increase in medical institutions goes in tandem with the population expansion and physician density in a region. Increase in medical schools will definitely meet demands for healthcare facilities of the society, alleviate the deficiency of physician density and minimize dependency of the local population on expatriate doctors for their healthcare needs (Boulet, *et al.*, 2007).

The added advantages of an increase in medical schools, whether public or private, accrue as a result of better access to advanced medical facilities and more job

opportunities for people in all fields- technical, administrative or infrastructure (Muula, 2006). Indirectly, more private medical institutions will have a salutary effect on Government schools with stagnant performance wherein monopoly of medical education had set in. Also, better openings and alternatives will be available to students and the community. There will be automatic and sustained improvements in standards of medical education, health care facilities and avenues open to research (Hwang, 2005).

Another mitigating factor in having privatization is that these institutions will not be fully driven by Government and political policies. They will have the freedom to decide and enforce their own policies to a large extent. This, along with sound financial backing, could introduce state-of-art technology, infrastructure and facilities for students, which the Government institutions mostly lack.

Private medical colleges are well recognized for quicker acceptance of recent educational trends like problem based learning and community oriented teaching as they are immune to government bureaucracy (Amin, 2004).

Eligible aspirants of the middle class, denied government medical college admission due to the lack of capacity, may have an opportunity of realizing their dreams. The other option open for these students would be expensive offshore education with at least a few of them obtaining dubious unrecognized degrees. Thus, the setting up of well accredited private colleges in their own home country would definitely be a better option than foreign education (Khan, 2004).

### **The downside of privatization**

Common to almost all private institutions is their exorbitant cost of education compared to their public counterparts (Bhatt, 2006). This is unbearable to candidates from economically challenged Asian countries. Another connected issue is the demand for steep “capitation fee” by private institutions, despite regulations to the contrary. Consequently, affluent strata of the society gain increased entry into these colleges. This questionable validity of student-selection policies may mar the quality of the products (doctors) of these institutions (Supe & Burdick, 2006).

Questionable quality of training in Asian private colleges resulting from acute shortage of faculty is rampant. This shortage can be

attributed to non-availability of qualified personnel, annual decrement, stringent eligibility criteria for teachers and migration to lucrative foreign countries (Kumar, 2004). Consequently, fraudulent practices like short term appointed teachers (appointed only for the purpose of accreditation), part-time teachers (engaging in full time private practice) and faculty with dual appointments are used to enhance the faculty count (Amin, *et al.*, 2010). Insufficient Faculty development programmes or total lack of teacher training facilities in some countries has also compromised the quality of teaching (Bansal & Supe, 2007).

Inadequate equipment, laboratories, cadavers or prosected specimens and clinical exposure are other important issues marring the quality of training in Asian private colleges. Lack of access to patients is compounded due to the high consultation fees in the private hospitals as compared to the highly subsidized government hospitals (Sood, 2008).

Medical educational research also takes a back seat in the developing countries of Asia. A strong medical educational research base results in "best evidence medical education" and has a potent social impact on teaching practices and therefore clinical practice. The lack of medical educational research can be attributed to the tight budgeting in private medical colleges and other factors common to Asian medical schools (private or public) such as lack of research grants, lack of leadership, inexperience with education research methodology and inadequacy of educational research to enhance career (Majumder, 2004).

Medical education in Asia is rarely subjected to robust accreditation systems and if any exist, they are not at par with international standards (Mendis *et al.*, 2004). Accreditation agencies, though endeavouring to ensure adequate infrastructure and faculty, turn a blind eye on measures of quality of education and outcomes (Supe & Burdick 2006).

The socio-economic gap between the affluent class and the under privileged minority group gives rise to lack of social and racial diversity in these private institutions as the underprivileged find it difficult to access medical education (Azila & Tan, 2005). This factor assumes prominence where improved healthcare delivery for the ethnic minority, maintenance of high quality medical education, and positive effect on medical and public health research has to be established.

There is differential growth pattern of the private medical colleges with many being set up in richer and healthier states. Poor and rural areas are underserved due to this imbalance. This is due to the increase of wealth amongst a subset of society interested in investing in these schools and willing to pay for the costly private education. The availability of a large number of qualified faculty in these regions is also facilitating this lopsided growth (Sood, 2008). Rural areas are more likely to be represented by medical students from rural areas (Bhatt, 2006). Resultantly, these factors will create an imbalance of medical resources in critical areas needing healthcare.

In retrospect, it is easy to predict a glut in the medical professionals with the mushrooming of medical schools, thereby creating redundancy in this sphere. As an offshoot of this oversupply of doctors, malpractices have become rampant like the unnecessary treatment of healthy people and bribing doctors to refer patients to laboratories/scan centres for expensive investigations.

Certain private medical schools give low priority to healthcare, assuming themselves as an exclusive educational industry. Off shore medical schools in Israel catering to US citizens substantiates this fact. All immigrant medical students in these schools are sent back to their home countries on completion of their education (Reis, *et al.*, 2009).

### **Guidelines for privatization of Medical Education**

The vulnerabilities perceived in Asian private medical colleges can be remedied by enforcing international standards. Rigid sanctions for institutions that bend the rules should be enforced. Admission fees need to be regulated. More stringent validated selection criteria for non cognitive and intellectual attributes need to be imposed for candidates so that the professional competence of the graduates is maintained.

The problem of faculty shortage has to be addressed to maintain the 'ideal' overall teacher-student ratio. To sustain the appeal of a medical education career, medical educational units (MEUs) can be established and these have the potential to become Regional Centres of medical educational research and be instrumental in enhancing the quality of medical education.

Faculty development programmes emphasizing current teaching and educational research methods can be initiated. The development of "culturally relevant" regional guidelines for medical education, consolidation of medical educational knowledge base, active commitment of institutions to medical education on basis of sound needs analysis, affiliation of professional advancement to educational research and creation of research environment will improve medical education besides strengthening the research competencies in medical education (Majumder, *et al.*, 2004). On-line faculty development and learning as advocated by FAIMER is a conceivable and fairly feasible concept for the cash strapped countries of Asia (FAIMER, 2008).

Medical education should cater to the healthcare needs of the community. Hence, to resolve the inadequacy of clinical exposure, private universities can emphasize community-based education where students' are exposed to patients in the community and learn the utility of the existing health services (Kurdak *et al.*, 2008). A community-oriented curriculum is beneficial for the students (increases social responsibility, ability to relate theory to practice, competency in areas related to community health needs), the private schools (establishes closer communication between institution and community), and most importantly for the community itself (improves the quality of health services available to the community). Alternatively, medical schools without training hospitals can have some agreement with other Government/private hospitals for the clinical training of their students. Private institutions with adequate financial resources can also set up multidisciplinary clinical skills laboratories with models, simulators, simulated patients, and standardized patients.

Accreditation systems should focus not only on content and assessment standards assessing the final products but also on "process standards" assessing the whole process of education. Accreditation standards which are consistent but at the same time flexible enough to include current evidence based trends will benefit the development of medical education in the resource deprived countries of Asia (Supe & Burdick, 2006). External national/regional quality assessment utilizing dynamic standardized examinations can support the accreditation systems by maintaining consistency in assessment methods and subsequently ensuring that

minimum acceptable competencies of a medical graduate are met, while strengthening public trust and confidence in national health services (Bajammal *et al.*, 2008). Regulating accreditation boards need to ensure that educational objectives are based primarily on the health needs and health problems prevalent in the community. Simultaneously, accreditation systems can be made as cost effective as possible so as not to burden the institutions. Continuous internal curriculum evaluations receiving feedback from the stakeholders and continuous adaptations to recent advances in science, medical education and health can be emphasized (Majumder, *et al.*, 2004). Student-centred teaching and learning methods with provisions for self-directed learning, early clinical contact, analytical and problem-solving abilities need to be fostered. It is imperative that the predominantly developing countries of Asia should have primary health care as a prominent fixture in the curriculum for which community-based teaching can be introduced earlier and continued throughout the curriculum.

In view of globalization of medical education and to bring Asian Schools to international standards, the global minimum essential requirements based on guidelines by Institute for International Medical Education (IIME) or World Federation for Medical Education (WFME) can be enforced by the Accreditation bodies.

With the above aims in view, it will be vitally important to ensure that the establishment of private medical colleges is regulated. Simultaneously, more medical colleges need to be established in rural areas to increase access to medical education for students from ethnic and social minorities. Likewise, as is done in India, an affirmative action can be undertaken by introducing reservation of seats for lower economic and social classes.

## **Conclusion**

In view of the limited inputs available on the subject, it will not be possible to conclude decisively on the merits and demerits of privatization. Notwithstanding this, one cannot deny that privatization has been responsible for alleviating certain problems faced in medical education and substituting deficiencies in healthcare resources in Asia. However, this powerful tool should be used cautiously, so that it causes more benefit rather than harm.

Mandatory accreditation has to be practiced and non-compliant institutions should be placed on probation with their student enrolment suspended or accreditation withdrawn. These institutions should be made goal oriented and outcome focused, thereby accountable for their end product – doctors; health services delivery and research outputs. In the process, they will be morally bound to accept judgment for their good work as well as shortcomings.

Government and other agencies should not be denied necessary controls over privatization. On the contrary, these authorities should be instrumental in curbing unauthorized and substandard medical education which is not meeting stipulated standards. Quality should be prioritized over quantity, as rightly advocated by Flexner, a century ago. The growth of private and public institutions aiming for the overall betterment of health of the nation has to be the final word in medical education.

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