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From Medical Tourism to Health Diaspora Diplomacy: Strategic Framework for Leveraging Expatriate Healthcare Networks in Emerging Markets

Sağlık Turizminden Sağlık Diasporası Diplomasisine: Yükselen Ekonomilerde Yurtdışı Sağlık Ağlarını Stratejik Olarak Kullanma Çerçevesi

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Abstract

Medical tourism has evolved from a niche patient mobility phenomenon into a strategic economic lever for many emerging markets, generating substantial foreign exchange while exposing domestic health systems to both opportunities and pressures. This review synthesizes global trends in medical tourism, with emphasis on key destinations such as India, Thailand, Turkey, and Malaysia, and examines its implications for health system capacity, equity, and workforce dynamics. It then conceptualizes the shift toward "health diaspora diplomacy" a more sustainable, networked approach that harnesses expatriate healthcare professionals and diaspora communities not merely as occasional returnees or remitters, but as active transnational agents for knowledge transfer, capacity building, and bidirectional health innovation. Drawing on evidence from WHO, OECD, and diaspora engagement frameworks, the article proposes an original strategic framework comprising four pillars: policy orchestration, network activation, incentive alignment, and impact evaluation. This framework aims to transform transient medical tourism flows into enduring health system strengthening in emerging economies. Policy implications highlight the need for integrated governance to balance economic gains with domestic equity, while future research should prioritize longitudinal studies of diaspora-led interventions. By reimagining expatriate networks as diplomatic assets, emerging markets can advance toward resilient, inclusive, and globally competitive health ecosystems. This study adopts a narrative review methodology, synthesizing peer-reviewed literature and institutional reports from databases such as PubMed, Google Scholar, WHO IRIS, OECD iLibrary, and IOM publications between 2010 and 2025. The analysis is based on a purposive selection of sources focusing on medical tourism trends, diaspora engagement, and policy frameworks in emerging economies.

Keywords
Medical tourism, Health diaspora, Diaspora diplomacy.

Öz

Tıbbi turizm, yükselen ekonomilerde kısa vadeli ekonomik bir araç olmaktan çıkarak daha sürdürülebilir ve stratejik bir modele evrilme potansiyeli taşımaktadır. Bu derleme, Hindistan, Tayland, Türkiye ve Malezya gibi önde gelen destinasyonlardaki tıbbi turizm eğilimlerini sentezlemekte, sağlık sistemlerinin kapasitesi, eşitlik ve iş gücü dinamikleri üzerindeki etkilerini incelemektedir. Makale, "sağlık diasporası diplomasisi" kavramını ortaya koymakta; yurtdışındaki sağlık profesyonellerini ve diaspora topluluklarını yalnızca geçici katkılar sunan aktörler olarak değil, bilgi transferi, kapasite geliştirme ve iki yönlü sağlık yeniliği için aktif transnasyonal ajanlar olarak konumlandırmaktadır. WHO, OECD ve diaspora katılım çerçevelerinden elde edilen bulgular ışığında, dört temel sütundan oluşan özgün bir stratejik çerçeve (HEDiN) önerilmektedir: politika koordinasyonu, ağ aktivasyonu, teşvik uyumu ve etki değerlendirme. Bu çerçeve, tıbbi turizmin geçici hasta akışlarını, yükselen ekonomilerde kalıcı sağlık sistemi güçlendirmesine dönüştürmeyi hedeflemektedir. Politika önerileri, ekonomik kazanımları yerel eşitlikle dengelemek için bütünleşik yönetişimin gerekliliğine vurgu yapmakta; gelecekteki araştırmalar ise diaspora öncülüğündeki müdahalelerin uzun dönem etkilerine odaklanmalıdır. Yurtdışı ağlarını diplomatik bir varlık olarak yeniden hayal ederek, yükselen ekonomiler daha dirençli, kapsayıcı ve küresel ölçekte rekabetçi sağlık ekosistemlerine doğru ilerleyebilir. Bu çalışma, 2010 ile 2025 yılları arasında PubMed, Google Scholar, WHO IRIS, OECD iLibrary ve IOM yayınları gibi veri tabanlarından elde edilen hakemli literatürü ve kurumsal raporları sentezleyen anlatısal bir inceleme metodolojisi benimsemektedir. Analiz, gelişmekte olan ekonomilerdeki tıbbi turizm trendleri, diaspora katılımı ve politika çerçevelerine odaklanan kaynakların amaçlı seçimine dayanmaktadır.

Anahtar Kelimeler
Tıbbi turizm, Sağlık diasporası, Diaspora diplomasisi.

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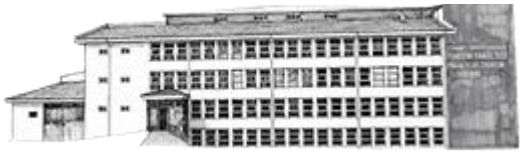

Introduction

The globalization of healthcare has profoundly reshaped access to medical services, with patient mobility commonly termed medical tourism emerging as a prominent feature of international health markets (Connell, 2015). Defined by the Organisation for Economic Co-operation and Development (OECD) as consumers intentionally travelling across borders to receive medical treatment, this phenomenon has grown rapidly, driven by cost differentials, long waiting times in high-income countries, and advancements in quality accreditation among providers in middle-income settings (OECD, 2024; Lunt, 2011). Emerging markets, particularly in Asia (India, Thailand, Malaysia) and the Middle East (Turkey), have positioned themselves as competitive destinations, attracting millions of international patients annually and generating billions in revenue (Connell, 2015; WHO Regional Office for Europe, 2023)

Recent estimates indicate that the global medical tourism market, valued at approximately USD 75–95 billion pre-pandemic, is rebounding strongly, with projections suggesting continued expansion as healthcare costs in OECD countries rise and elective procedures face persistent backlogs (OECD, 2024; NaRanong & NaRanong, 2011). In key emerging destinations, medical tourism contributes not only to foreign exchange earnings but also to infrastructure upgrading and specialist skill retention (Johnston et al., 2010). However, this growth has sparked debate regarding unintended consequences: potential crowding out of local patients, workforce migration toward private international facilities, and widening inequities in access to care (Chen & Wilson, 2013; Pocock & Phua, 2011).

Parallel to these developments, migration scholarship has illuminated the role of diasporas as powerful transnational actors (Taslakian et al., 2022). Health professionals and medically trained expatriates from emerging economies often maintain strong ties to their countries of origin, contributing through remittances, short-term clinical engagements, virtual consultations, and knowledge exchange (Abbara et al., 2025; Dafallah & Witter, 2025). Yet, the literature has largely treated medical tourism and diaspora engagement as separate domains. (Syafitri et al., 2025) This review argues for conceptual convergence: transitioning from episodic, inbound-patient-focused medical tourism toward health diaspora diplomacy, a strategic, networked diplomacy that systematically leverages expatriate healthcare networks to foster bidirectional health system strengthening, innovation transfer, and long-term resilience

This synthesis addresses three core objectives: (i) to map the current landscape and health system impacts of medical tourism in emerging markets; (ii) to explore the underutilized potential of health diasporas as agents of sustainable development; and (iii) to propose an actionable strategic framework for policymakers to orchestrate expatriate networks in support of national health priorities. By bridging these domains, emerging economies can move beyond short-term economic extraction toward a visionary model of global health partnership that aligns diaspora capital with domestic needs and international equity.

This study contributes to multiple stakeholder groups. For policymakers, it offers a strategic framework to better integrate diaspora resources into national health systems. For healthcare institutions, it provides insights into leveraging international networks for capacity building and innovation. For academics, it advances the conceptual literature by bridging medical tourism and diaspora studies under a unified framework. Ultimately, it aims to support emerging economies in developing more sustainable and equitable health system strategies.

Literature Review

Medical tourism has solidified its position as a high-growth sector within the broader globalization of healthcare, particularly in emerging economies that have strategically invested in private-sector infrastructure, international accreditation, and targeted marketing (Connell, 2015; OECD, 2024). Key destinations India, Thailand, Turkey, and Malaysia illustrate the diversity and scale of this phenomenon, each leveraging comparative advantages such as cost differentials, procedural expertise, and cultural appeal to capture significant shares of the global patient mobility market.

Global Market Dynamics and Key Destinations

Recent analyses indicate a robust post-pandemic recovery and continued expansion of medical tourism. The global market, valued at approximately USD 75–95 billion prior to COVID-19 disruptions, is projected to grow substantially, with emerging markets in Asia and the Middle East leading volume increases (OECD, 2024; Frehywot et al., 2019). In 2023–2025 data, India recorded over 650,000 foreign medical arrivals in 2024 alone, with cardiovascular, oncology, and orthopedic procedures forming major demand segments (Ministry of Tourism, 2020–2025). Thailand maintains its reputation for high-volume, high-quality care in cosmetic, wellness, and complex interventions, supported by a growing number of internationally accredited facilities (Johnston et al., 2010; WHO EMRO & IOM, 2021). Turkey has rapidly emerged as a leader in hair transplantation, aesthetic surgery, and dental care, attracting large volumes of international patients in recent years (Biswakarma & Basnet, 2025). Malaysia, meanwhile, benefits from government-backed promotion and strategic positioning within the global health market, emphasizing multidisciplinary care and technological advancement (OECD, 2024; Singh et al., 2025).

These destinations collectively illustrate a shift toward specialized clusters: India excels in high-complexity procedures (e.g., cardiac and oncologic surgery), Thailand in wellness-integrated treatments, Turkey in aesthetic and elective interventions, and Malaysia in balanced medical-tourism packages.

Economic and Clinical Drivers

The primary drivers remain cost differentials: treatments in these emerging markets often cost 30–80% less than equivalent procedures in OECD countries, combined with reduced waiting times and perceived quality improvements (OECD, 2024; Lunt, 2011). Accreditation by bodies such as the Joint Commission International (JCI) has enhanced patient confidence, while English-speaking staff, advanced technology adoption, and integrated hospitality services further strengthen competitiveness (Connell, 2015; OECD, 2011). Push factors in high-income countries include rising domestic healthcare costs, insurance coverage gaps for elective procedures, and persistent backlogs for non-urgent surgeries (OECD, 2024; Chen & Wilson, 2013).

From an economic perspective, medical tourism generates meaningful foreign exchange and stimulates ancillary sectors (hospitality, transport, pharmaceuticals). In Thailand, for instance, it contributes the equivalent of approximately 0.4% of GDP while supporting infrastructure upgrades (Johnston et al., 2010). Similar multiplier effects are observed in India and Turkey, where private hospitals reinvest revenues into equipment and training (Ministry of Tourism, 2020–2025; Chen & Wilson, 2013).

Opportunities and Challenges for Domestic Health Systems

The opportunities are substantial: medical tourism can drive quality enhancement, technology transfer, and retention of skilled professionals in private facilities that might otherwise migrate abroad (Frehywot et al., 2019). In several emerging markets, revenues from international patients have funded expansion

of tertiary care capacity, indirectly benefiting domestic populations through spillover effects (e.g., more specialists and better-equipped hospitals) (Johnston et al., 2010; Ministry of Tourism, 2020–2025).

However, significant challenges persist. A landmark study on Thailand demonstrated that rapid growth in medical tourism has exacerbated physician and nurse shortages by drawing personnel toward higher-paying international-patient facilities, contributing to internal brain drain and upward pressure on private-sector salaries (Johnston et al., 2010). This dynamic has raised costs in both private and public hospitals and strained the universal coverage scheme serving the majority of Thai citizens (Johnston et al., 2010). Similar patterns have been documented in other destinations: crowding out of local patients in high-demand specialties, widening equity gaps, and potential distortion of training priorities toward procedures favored by foreign payers (Chen & Wilson, 2013; Pocock & Phua, 2011; Taslakian et al., 2022).

Scoping reviews consistently highlight these dualities economic gains versus risks to access and equity emphasizing that without deliberate policy safeguards, medical tourism may inadvertently undermine progress toward universal health coverage (Chen & Wilson, 2013; Ministry of Tourism, 2020–2025). In low- and middle-income settings, the concentration of advanced care in urban private hospitals risks further marginalizing rural and underserved populations (Pocock & Phua, 2011; WHO EMRO & IOM, 2021).

In summary, while medical tourism has propelled select emerging markets onto the global healthcare stage, its net impact on health systems remains context-dependent. Sustainable benefits require active governance to mitigate distortions and channel revenues toward broader system strengthening a prerequisite for the transition toward more networked, diaspora-inclusive models explored in subsequent sections.

The Health Diaspora: Transnational Networks and Contributions to Global Health

While medical tourism focuses on inbound patient flows, the health diaspora represents a parallel and increasingly powerful transnational resource: highly skilled healthcare professionals and medically trained individuals living abroad who maintain active connections with their countries of origin (Dafallah & Witter, 2025; Lunt, 2011; WHO, 2024). This section conceptualizes the health diaspora, examines its migration patterns, and highlights contributions that extend far beyond traditional remittances.

Conceptualizing the Health Diaspora and Patterns of Migration

The health diaspora encompasses physicians, nurses, researchers, and allied health professionals from low- and middle-income countries (LMICs) who have migrated to high-income settings yet retain identity, networks, and commitment to their homelands (WHO Regional Office for Europe, 2023). Global migration statistics reveal that millions of people live outside their country of birth, with health workers forming a disproportionately mobile subgroup due to chronic shortages in origin countries and demand in destination nations (WHO Regional Office for Europe, 2023). In the Eastern Mediterranean Region alone, protracted crises, low wages, and limited professional development have accelerated outward migration, creating large pools of expatriate clinicians in Europe, North America, and the Gulf (NaRanong & NaRanong, 2011).

Unlike passive remittance senders, modern health diasporas operate as organized networks. A systematic inventory identified numerous medical diaspora organizations in high-income countries, many of which function as formal associations facilitating collective action and transnational collaboration (Johnston et al., 2010).

Beyond Remittances: Knowledge Transfer, Networks, and Return Engagement

Contemporary diaspora engagement moves decisively beyond financial transfers. Scoping reviews document diverse modalities, including short-term clinical missions, virtual mentorship and telemedicine, joint research and training programs, curriculum development, and temporary or permanent return migration (Lunt, 2011). These activities directly address brain drain by rebuilding workforce capacity, transferring advanced clinical techniques, and strengthening research infrastructure in origin countries

For example, diaspora-led partnerships have supported specialist training in oncology, cardiology, and emergency medicine in resource-constrained settings, often at lower cost and with greater cultural relevance than traditional North–South aid (Lunt, 2011; NaRanong & NaRanong, 2011). During the COVID-19 pandemic, diaspora health professionals provided critical remote consultations, supplied medical equipment, and advocated for policy changes, demonstrating rapid-response capacity that formal aid systems sometimes lack (Singh et al., 2025).

Return engagement whether physical or virtual has proven particularly impactful. Programs facilitated by international organizations have enabled diaspora experts to contribute short-term professional service, creating sustainable knowledge pipelines and strengthening institutional capacity in origin countries (Singh et al., 2025).

Evidence from Emerging Economies

Empirical evidence from emerging markets underscores both potential and underutilization. In the Eastern Mediterranean Region and broader LMIC contexts, diaspora organizations have delivered humanitarian aid, established specialized clinics, and influenced national health policy through advocacy networks (Singh et al., 2025; NaRanong & NaRanong, 2011). Governments in many LMICs have established dedicated diaspora engagement mechanisms, yet policymakers often lack awareness of best-practice models or strategies to translate diaspora willingness into measurable health-system gains (Chen & Wilson, 2013).

Scoping reviews conclude that diaspora interventions most frequently target workforce shortages and capacity building but face persistent barriers, including inadequate funding mechanisms, lack of coordination, communication gaps, and political instability (Abbara et al., 2025). These findings highlight that while the health diaspora possesses substantial human, social, and financial capital, its contributions remain episodic and under-leveraged without systematic policy orchestration.

In summary, the health diaspora constitutes a ready-made, culturally attuned network capable of bidirectional knowledge flow and innovation transfer. The transition from viewing diasporas merely as remitters or occasional volunteers toward recognizing them as strategic diplomatic assets sets the stage for the conceptual bridge explored next: health diaspora diplomacy.

Conceptualizing Health Diaspora Diplomacy: Transitioning from Medical Tourism

Medical tourism and health diaspora engagement have historically operated in parallel silos: the former as a market-driven, inbound flow of patients seeking cost-effective, high-quality care, and the latter as a migration-led, often informal network of expatriate contributions (Taslakian et al., 2022; Lunt, 2011). Yet both phenomena share common roots in globalization, mobility, and transnational ties, particularly in emerging markets where skilled health professionals emigrate while their origin countries simultaneously attract foreign patients (WHO Regional Office for Europe, 2023; Lunt, 2011). This section conceptualizes health diaspora diplomacy as the intentional, policy-orchestrated convergence of these

domains: transforming transient medical tourism into a sustainable diplomatic instrument that leverages expatriate healthcare networks for bidirectional system strengthening, innovation diffusion, and long-term global health equity.

Linking Medical Tourism to Diaspora Diplomacy

Medical tourism often involves diaspora patients individuals returning to their country of origin for culturally resonant, affordable care combined with family reconnection (Taslakian et al., 2022). Evidence from Turkey, India, and Malaysia shows that diaspora returnees constitute a significant share of international patients, motivated by trust in familiar providers, lower costs, and emotional ties (Biswakarma & Basnet, 2025; Chen & Wilson, 2013). In parallel, expatriate health professionals frequently facilitate referrals, provide pre- and post-treatment advice virtually, and occasionally return for short-term service delivery, thereby creating informal bridges between destination and origin health systems (Mohammed,2025).

These overlaps suggest untapped potential: medical tourism infrastructure including internationally accredited hospitals, English-speaking staff, and digital platforms can serve as nodes for diaspora engagement, while diaspora networks can channel knowledge, talent, and advocacy back into domestic health systems. Governments in emerging markets are beginning to recognize this synergy. For instance, Turkey's rapid rise in aesthetic and transplant tourism has coincided with active diaspora outreach initiatives, and India's medical tourism promotion increasingly incorporates diaspora networks for branding and patient navigation (Ministry of Tourism, 2020–2025; Chen & Wilson, 2013).

Theoretical Foundations and Real-World Examples

Health diaspora diplomacy draws on migration and development theories, particularly the "diaspora option" (circular migration and knowledge transfer) and soft power diplomacy frameworks (Lunt, 2011; Singh et al., 2025). Unlike traditional aid or remittances, it positions expatriates as strategic partners in national health resilience, analogous to economic diplomacy but applied to healthcare.

Real-world precedents illustrate the concept. In the Eastern Mediterranean Region, diaspora physicians have supported public health responses during crises, including COVID-19 supply chains and remote training, while origin countries have used medical tourism revenues to upgrade facilities attractive to returning diaspora talent (Johnston et al., 2010). Initiatives led by international organizations advocate coordinated diaspora engagement to mitigate brain drain, with examples of virtual mentorship programs and temporary return schemes that complement inbound patient flows (Abbara et al., 2025; NaRanong & NaRanong, 2011).

Despite these examples, integration remains limited. Medical tourism policies tend to prioritize marketing and accreditation, while diaspora strategies often emphasize remittances or humanitarian aid, thereby missing opportunities for systemic alignment.

Methodology

This study employs a narrative review approach to synthesize existing knowledge on medical tourism and health diaspora engagement in emerging economies. Unlike systematic reviews, a narrative review allows for a broader conceptual integration of interdisciplinary literature, which is appropriate given the exploratory and theory-building nature of this study.

Data were collected through purposive sampling of peer-reviewed articles and institutional reports published between 2010 and 2025. Key sources include PubMed, Google Scholar, The Lancet, WHO IRIS, OECD iLibrary, and International Organization for Migration (IOM) publications.

The selection criteria focused on three main themes: (i) global medical tourism trends and their health system implications, (ii) diaspora engagement in healthcare and transnational knowledge transfer, and (iii) policy frameworks relevant to emerging markets.

The analysis followed a thematic synthesis approach. First, relevant literature was categorized according to recurring themes. Second, relationships between medical tourism and diaspora engagement were identified. Finally, these insights were integrated into the development of the proposed HEDiN framework.

While this approach enables conceptual depth and flexibility, it does not aim to provide statistical generalization, but rather analytical and theoretical contributions.

Gaps in Current Approaches

Current approaches suffer from fragmentation: the absence of dedicated governance mechanisms, mismatched incentives (e.g., private hospitals prioritizing high-paying foreign patients over diaspora-led capacity building), and limited evaluation of long-term impacts (Biswakarma & Basnet, 2025; Dizo-Conteh et al.,2025; Singh et al., 2025). Moreover, equity concerns persist: medical tourism can exacerbate internal disparities, while diaspora contributions often remain ad hoc without policy scaffolding.

To address these gaps, health diaspora diplomacy reframes expatriate networks as diplomatic assets not merely sources of occasional support, but structured channels for mutual benefit and sustainable health system transformation.

Table 1. Transition from Medical Tourism to Health Diaspora Diplomacy: Key Dimensions

Dimension	Medical Tourism (Current Paradigm)	Health Diaspora Diplomacy (Proposed Evolution)	Strategic Transition Opportunity
Primary Focus	Inbound patient flows for economic gain	Bidirectional knowledge, talent, and innovation transfer	Use tourism infrastructure as diaspora engagement hubs
Key Actors	Private hospitals, tourism boards, international patients	Expatriate professionals, governments, diaspora organizations	Integrate diaspora networks into national health strategy
Time Horizon	Short-term (episodic visits)	Long-term (sustained networks and circular mobility)	Shift from one-off treatments to ongoing partnerships
Main Benefits	Foreign exchange, infrastructure upgrades	Capacity building, equity enhancement, resilience	Channel tourism revenues toward diaspora-led initiatives
Risks / Challenges	Equity gaps, workforce distortion, crowding out locals	Coordination failures, political instability, under-funding	Develop monitoring frameworks and incentive alignment
Policy Example	Accreditation & marketing (e.g., Thailand, India)	Diaspora offices & return programs (e.g., IOM/WHO models)	Hybrid policies linking tourism promotion to diaspora engagement

In summary, health diaspora diplomacy offers a visionary reorientation: from viewing medical tourism as an isolated revenue stream to positioning it as the entry point for a networked, diplomacy-driven model of health system development. The next section translates this concept into a concrete strategic framework tailored to emerging markets.

A Strategic Framework for Leveraging Expatriate Healthcare Networks

Building on the conceptual bridge established in the previous section, this part presents the core original contribution of the article: a practical, implementable strategic framework that enables emerging market governments, ministries of health, and major private hospital groups to systematically convert the currently underutilized potential of health diasporas into a long-term, sustainable health system strengthening mechanism.

The proposed framework is called: HEDiN – Health Diaspora Network Activation Framework and It consists of four interdependent strategic pillars. Figure 1 will visually represent the whole framework.

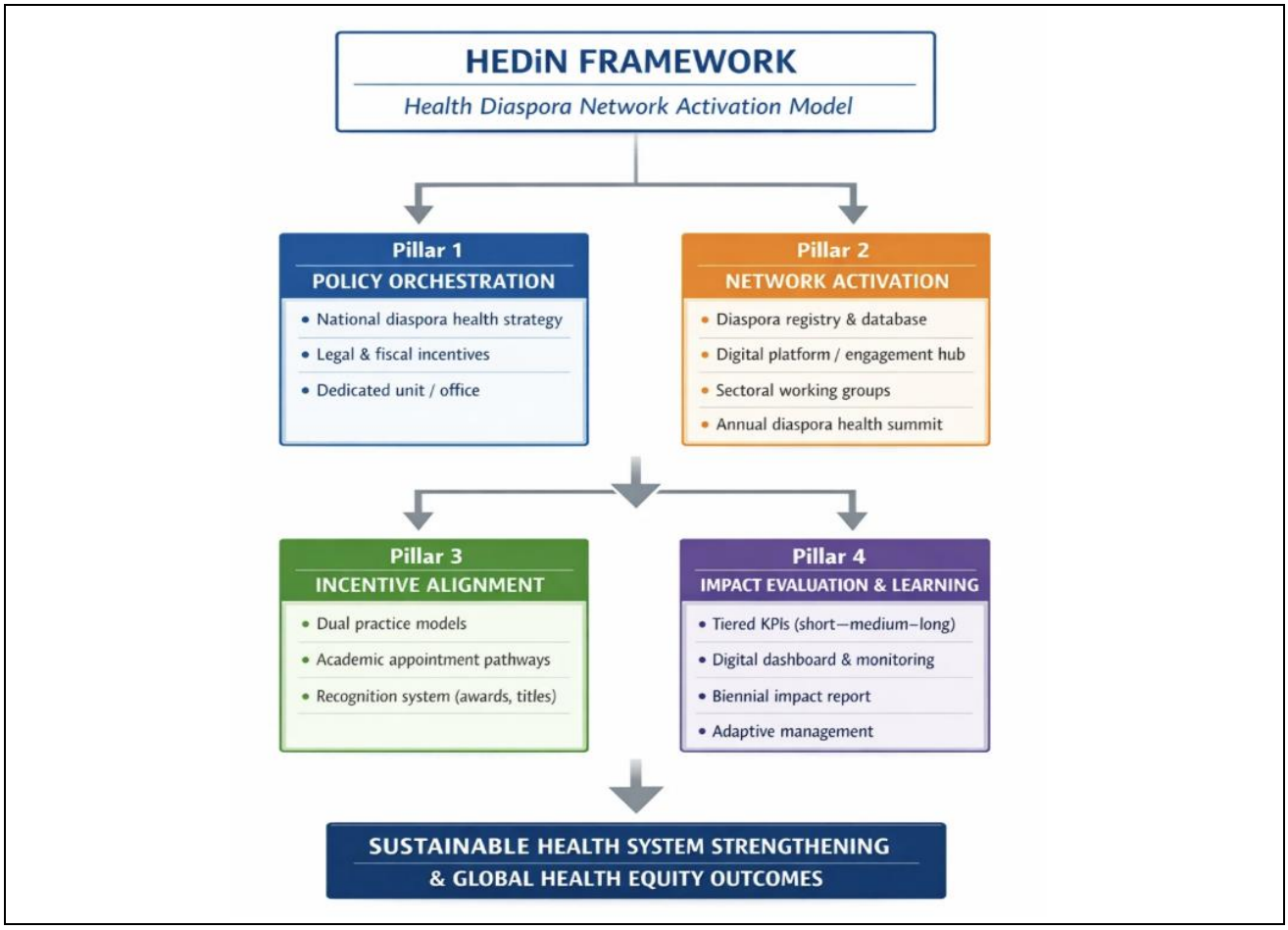

Figure 1. HEDiN Framework: Health Diaspora Network Activation – Strategic Model for Emerging Markets

Conclusion and Recommendations

This review traces the evolution from medical tourism long viewed as a short-term economic driver in emerging markets such as India, Thailand, Turkey, and Malaysia to a more strategic and sustainable model termed health diaspora diplomacy. While medical tourism has delivered substantial foreign exchange,

infrastructure upgrades, and quality improvements, it has also produced well-documented challenges, including workforce distortions, crowding out of local patients, and widening inequities within domestic health systems. In parallel, the health diaspora expatriate physicians, nurses, and health researchers represents a powerful, yet largely underutilized transnational resource capable of delivering knowledge transfer, virtual mentorship, specialist training, crisis support, and circular talent flows far beyond conventional remittances. The article introduces the HEDiN Framework (Health Diaspora Network Activation Model), a four-pillar approach that integrates policy orchestration, network activation, incentive alignment, and rigorous impact evaluation to systematically harness these networks. By deliberately linking medical tourism infrastructure and revenues with structured diaspora engagement, emerging economies can move beyond episodic patient inflows toward resilient, bidirectional health partnerships that simultaneously strengthen domestic capacity and contribute to global health equity. The proposed shift calls for integrated governance, mutual-benefit incentives, continuous learning mechanisms, and equity safeguards. Future research should focus on longitudinal outcome studies, comparative effectiveness analyses, and the scalability of digital diaspora platforms. Ultimately, health diaspora diplomacy offers a forward-looking reimagination: transforming globalization from a source of temporary gains into a strategic lever for health sovereignty, inclusive development, and shared prosperity in emerging markets.

This study contributes to the literature by integrating two previously fragmented domains medical tourism and diaspora engagement into a unified conceptual framework. By introducing the concept of health diaspora diplomacy and operationalizing it through the HEDiN framework, the article extends existing discussions on global health governance and transnational networks. From a policy perspective, the findings highlight the importance of coordinated governance mechanisms that align medical tourism strategies with diaspora engagement policies. Governments and healthcare institutions can utilize the proposed framework to design targeted programs that encourage knowledge transfer, facilitate return migration, and promote sustainable health system development.

This study is limited by its reliance on secondary data and narrative synthesis, which may introduce selection bias. The absence of empirical validation and quantitative analysis restricts the ability to generalize findings across different country contexts. Future studies should focus on empirical validation of the proposed framework through case studies and quantitative analysis. Comparative country analyses, longitudinal studies examining long-term diaspora impact, and the role of digital diaspora platforms in facilitating transnational collaboration represent promising avenues for further research. In particular, future research could examine the effectiveness of digital diaspora platforms in facilitating real-time collaboration, assess policy outcomes through longitudinal tracking of diaspora-led interventions, and conduct cross-country comparative analyses to identify best practices across different institutional contexts.

Contribution Rate Declaration
Authors declare that they have contributed equally to this article.

Conflict of Interest Statement
The authors of the article declare that there is no conflict of interest among them.

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Ethics committee approval is not required for this article.

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