Chapter VIII

Summary and Conclusions

8.1. Introduction

This doctoral study, besides having looked into the theoretical underpinnings of migration and health, has made an empirical analysis of the benefits and costs of temporary international migration, by assessing the health status of the return emigrants, in Kerala, from the six Gulf Cooperation Council countries. The analytical account of the factors influencing health could, pretty clearly, ascertain that the determinants of health do not exist in isolation from each other but rather function in an intricate web of cause and effect. In particular situations, the same factor may influence health either negatively or positively as demonstrated by the dual effect of income on health or there can be a mutual influence.

The social determinants of health identify both proximal and distal social factors, and the socioeconomic determinants including social class; social stratification; and social and income inequality signify the intricacy of this pertinent issue. Likewise, the effect of environmental factors; individuals’ lifestyle and behavioural patterns, including inherent and acquired behaviours; cultural conditioning; education; social support and network; social exclusion and alienation; differences in working environment; stress at work; attitude of the employers; harassment at the workplace; job insecurity; persons’ position in the social ladder; availability, accessibility, and equitable distribution of health care; medical expenses; doctor-patient rapport; language of communication etc., on the health of individuals, attract our attention to the complexity of the issues to be addressed while investigating the health status of a specific community.

Coming to the link between health and economic performance, a strong causal connection from adult health to economic growth and development, around the globe, has been observed. Broadening the concept of human capital, with the inclusion of health along with education, training and experience, reinforces the theoretical underpinning of the models that trace the path of economic process via human capital and labour productivity leading to economic growth. By contrast, ill health impede economic growth as it impacts on labour productivity adversely.
Scholarly investigations in Kerala, so far, have not focused explicitly on the very vital issue of the health consequences of migration. Given the magnitude and dimension of emigration to the Gulf countries and the concomitant return emigration to Kerala, the health of return emigrants matters not only for them, but also has important implications for the households and society and, even greater implications for the economy. In order to capture, properly, the impact of migration on the health status of return emigrants and to discuss its socioeconomic implications, the study took recourse to a retrospectively oriented cross sectional investigation. The study used chronic disease morbidity as the indicator of health status and, therefore, treated health as a dichotomous variable – the presence or the absence of chronic disease. This binary measure, even though limited in their information about disease severity and disease related functional limitation, did have substantial content validity as it is more narrowly focused than the generic measures of health status. Return emigrants, in this study, referred to people who had returned to Kerala before September 2009, after working in the GCC region for at least one year, and have had no immediate plans to leave their place of origin for employment abroad. ‘Returned before September 2009’ condition was required because a one year recall period was needed for getting information on chronic disease morbidity and episodes of admitted medical treatment. Commensurate with the specific research questions posited – (i.) Whether the socioeconomic dynamics of the return emigrants and their migration episodes are inter-linked? (ii) To what extent chronic disease morbidity related health problems do occur among the return emigrants from the Gulf and whether these problems differ, fundamentally, from the overall state pattern? (iii) Do the prevalence rates of chronic disease morbidity among return emigrants vary significantly due to different backgrounds, especially economic and social, including income and wealth; nature, type, and conditions of employment and duration of stay abroad; religion; education; age; and geographical locations of origin and destination? (iv.) What are the implications of the health state of return emigrants on their current activity status, consumption pattern, saving behaviour, economic conditions, and social life? - and the hypotheses formulated – (i) The return emigrants from the Gulf have always had worse health, and the considerably high rate of chronic disease morbidity among them is a late consequence of adverse circumstances to which they were exposed during their employment abroad. (ii) The human capital, in the form of skill, training, and work experience, acquired abroad by the return emigrants, does remain futile, in the sense that, a greater majority of the return emigrants do not pursue any productive occupation, corresponding to their skills, due to deteriorating health
resultant from chronic illness. (iii) Ill health of the return emigrants takes away a higher proportion of their current earnings or accumulated past earnings to meet the recurring and intermittent health expenditures and as a safeguard against the future they are compelled to curtail their current non-health expenditures - at the beginning, the study came up with the following pertinent findings.

8.2. Migration Episodes and Socioeconomic Dynamics

8.2.1. More than eighty per cent of the return emigrants from the Gulf were from the three GCC countries – Saudi Arabia, United Arab Emirates and Oman.

8.2.2. Muslims who constitute less than a quarter of the population in Kerala make up almost half of the return emigrant community.

8.2.3. A remarkable feature of the level of education of the return emigrants is that there is not even a single illiterate among them.

8.2.4. The mean age at the time of first emigration was 26 years; it changed to 34 on return and the current mean age of the return emigrants is 38 years.

8.2.5. As much as eighty two per cent of the emigrants did not have any technical or professional education at the time of their departure.

8.2.6. Occurrences of marital problems, such as separation and divorce, are very rare among the return emigrants.

8.2.7. The instinctive longing for better standard of living was the prime motive that induced a great many to seek employment in the Gulf.

8.2.8. Only less than a quarter of the return emigrants were dependents, comprising students and unemployed, on the eve of emigration.

8.2.9. The majority of the employed, prior to emigration, were not working in better paid occupations.

8.2.10. Expiry of contract was the leading cause of return emigration to Kerala; health problems and difficult working conditions abroad resulted in the eventual return of many.
8.2.11. Emigrants, on the whole, stayed seven years, on average, abroad; emigrants to Saudi Arabia had the highest duration of overseas stay; Muslims spent maximum period in the Gulf.

8.2.12. The emigrants who were unemployed before their departure had the longest episodes of employment in the Gulf.

8.2.13. Regardless of overseas destinations, the emigrants had to confront many excruciating incidents associated with contract employment abroad. More than fifty six per cent had endured overtime/long work hours; as much as fifty per cent were gripped by work stress; work involved heavy physical labour for forty seven percent while fifty one per cent had to put up with noise, dust, and polluted air; worry about job security haunted one out of every five individuals.

8.2.14. About sixty six per cent of the return emigrants ‘always’ and another fifteen per cent ‘occasionally’ had problems with their fellow workers in the Gulf.

8.2.15. More than seven per cent of the return emigrants ‘always’ had to cope with harassment by superiors while about twenty per cent were ‘occasionally’ subjected to such harassments.

8.2.16. In spite of all the adverse circumstances in the Gulf, more than seventy three per cent had satisfaction over the nature of work and seventy one per cent had satisfaction with the working conditions there.

8.2.17. Contrary to the widespread belief, more than ninety five per cent of the return emigrants had either ‘very good’ or ‘adequate’ accommodation in the Gulf.

8.2.18. About seventy five per cent of the return emigrants had ‘close contact’ with the host population in the Gulf while another nineteen per cent could maintain ‘distant contact’.

8.2.19. There was a positive association between the level of education and the income earned from overseas employment.

8.2.20. Compared to the income from pre emigration employment, there was positive change in the average income by 220 per cent as a result of overseas employment.
8.2.21. Overseas employment had provided ample opportunities to acquire new skills/training and work experience and, therefore, many of the emigrants came back with the added advantage of enriched human capital.

8.2.22. There was a notable increase in income from employment during the post return phase relative to the pre emigration phase.

8.2.23. The relative increase in income was higher for the emigrants who came back with enriched human capital. However, the increase in income could not be, fully, attributed to enriched human capital abroad as many among them had pre emigration technical education.

8.2.24. There was a steady rise in unemployment rate, with age, among the return emigrants belonging to the forty plus age groups.

8.2.25. A discernible link between the employment/unemployment of the return emigrants and their household assets could not be established.

8.3. Relative Extent of Chronic Disease Morbidity

8.3.1. The prevalence rate of chronic disease morbidity among the return emigrants is higher compared to that of the general population in Kerala.

8.3.2. The return emigrants are more susceptible to hypertension, diabetes, cholesterol, cancer, renal and cardiovascular diseases.

8.3.3. There is an early onset of chronic diseases among return emigrants.

8.3.4. The age of return emigrants, their working environment abroad and household assets have statistically significant impact on their current health state as revealed by the respective odds ratio.

8.4. Cross sectional Prevalence Rates of Morbidity

8.4.1. One out of every two return emigrants, with below secondary level education, suffered from chronic diseases while prevalence rate was slightly more than thirty per cent for the return emigrants who are having secondary or above secondary level education.
8.4.2. The return emigrants who were working as domestic servants, construction workers, farm workers, and other unskilled workers, in the Gulf, do have the highest prevalence rate of chronic disease morbidity.

8.4.3. A positive association was found between chronic disease morbidity and the span of overseas employment.

8.4.4. Those who were dissatisfied with the overall working environment in the Gulf were found to have the highest prevalence rate of chronic disease morbidity.

8.4.5. The return emigrants who were, ‘always’ and ‘occasionally’, having problems with the fellow workers and ‘always’ and ‘occasionally’ subjected to harassment by superiors in the Gulf were found to have the highest prevalence rate of chronic disease morbidity.

8.4.6. The prevalence rate of chronic disease morbidity was much higher among the return emigrants who, while in the Gulf, ‘always’ or ‘occasionally’ had anxiety about the relatives at home.

8.4.7. The return emigrants who had ‘no contact’ or ‘distant contact’ with the host population, during overseas stay, have the higher prevalence rate of chronic disease morbidity relative to those who had ‘close contact’ with host population.

8.4.8. The inaccessibility, non affordability and discrimination, in general, had prompted many to be content with ‘self’ treatment during their overseas employment.

8.4.9. About a quarter of the return emigrants had to delay their treatment in the Gulf.

8.4.10. Consulting private doctors in the gulf was very expensive and this was testified by many who were dissatisfied with such consultations.

8.4.11. More than seventy per cent of the return emigrants did not have medical insurance coverage in the Gulf.

8.4.12. The return emigrants who had relatively higher income abroad have, relatively, lower prevalence rate of chronic disease morbidity.

8.4.13. The prevalence rate of chronic disease morbidity increased with the extent of post return stay period.
8.4.14. The, presently, unemployed return emigrants, relative to the employed have slightly higher prevalence rate of chronic disease morbidity.

8.4.15. A greater majority of the return emigrants with chronic diseases belonged to the lower income and lower asset groups.

8.4.16. The cost of admitted treatment and recurring health expenditures coupled with insufficiency/lack of regular income have induced many return emigrants to rely on other sources of finance involving depletion of household assets/wealth and/or leading to debt obligations.

8.5. Conclusion

The categorization of return emigrants into ‘successful’ and ‘failure’ cases, on the bases of economic and non-economic characteristics pertaining to their households seems misleading as such an exercise does not, objectively, take into account the current state of health of the return emigrants and its socioeconomic implications. Even though there is no reliable and conclusive evidence, even at the preliminary level, that the lives of return emigrants are cut short by the chronic disease morbidity, one can, undoubtedly, reach the conclusion that the lives of an alarmingly high proportion of them are blighted by chronic diseases. This undesirable state of health of the return emigrants during the prime ages of their productive life, as conjectured at the beginning of this study, is a late consequence of the experiences they had confronted in the Gulf. Most of the return emigrants, during their employment in the Gulf, could not pay adequate attention to their own health or comforts since the principal personal goal of everyone was to amass as much financial wealth as achievable within the restricted time frame. The debilitating state of health of the return emigrants not only did negate the economic fortunes they have achieved, in the form of material wealth, from their employment abroad but also did leave, relatively, redundant the enriched human capital they have gained in the form of skills/training and work experience abroad and, hence, emigration to the Gulf could not be considered as a positive sum experience.

8.6. Suggestions

On the bases of the conclusions of this study and its policy implications, the following suggestions are made.
8.6.1. Pre-emigration training programmes may be conducted to inform the emigrants about the working and living environment that they are going to confront in the Gulf.

8.6.2. Prior information on the health care provisions in the destination country may be given.

8.6.3. Governmental level efforts, through bilateral agreements, may be made to ensure healthy working and living conditions and affordable and accessible health services for our people working abroad.

8.6.4. Mandatory health insurance coverage, as part of employment contract, may be provided to the emigrants and, with official support, this coverage may be extended to include the return emigrants as well.

8.6.5. A comprehensive data base on non-resident Keralites, covering all aspects of emigrants and return emigrants may be constructed.

8.6.6. The state government in accord with the union government needs to adopt and implement development programmes that utilize the enhanced skills and experiences of the return emigrants.

8.7. Areas for Future Research

During the course of this study, I have identified a number of problems that warrant thorough investigation. These include the broad areas related to mental health, female migration, and the official welfare schemes. The specific topics identified are:

8.7.1. The impact of experiences in the host country on the mental health of the return emigrants.

8.7.2. Health status of the female return emigrants from the Gulf.

8.7.3. The impact of the welfare schemes of the Kerala Non-Resident Keralites’ Welfare Board constituted under the Kerala Non-Resident Keralites Welfare Act, 2008, by the Government of Kerala.