Chapter I

INTRODUCTION

Throughout human history, people have migrated to escape poverty and persecution and to improve their life chances and living standards. Migration takes place within countries from rural to urban areas; within regions from poorer to better-off countries and across continents since “a better life and livelihood are at the root of the decision to migrate” (WHO, 2006, p.99). There are far more international migrants in the world today than ever previously recorded, and their number has increased rapidly in the last few decades. There were an estimated 214 million international migrants in the world in 2010, representing an increase of almost 40 million in the first decade of 21st century, and over double the number of international migrants in 1980 (IOM, 2010). In concordance with the global migratory movements, though not on similar lines, international migration of Indians, that began long time ago, continues to grow in scale and diversity. One of the largest concentrations of migrant workers, especially Indian workers, in the world can be found in the six Gulf states - Saudi Arabia, Kuwait, Bahrain, Qatar, the United Arab Emirates, and Oman: members of the 1981 established the Gulf Cooperation Council (GCC). The unprecedented scale of development projects of the GCC countries following the October 1973 “oil boom” led to an extremely rapid increase in the demand for foreign labour, as the GCC national workforces at that time were too small and without the required skills to execute these projects (Winckler, 2010).

Emigration from India to the Gulf countries takes place mainly from seven states – Kerala, Andhra Pradesh, Punjab, Gujarat, Goa, Maharashtra and Tamil Nadu (Nair, 1983). Kerala held the premier position among the migrant sending states in India “because its relations with the Gulf countries were more intense than those of other states” (Paul, 2008, p.439). Despite the implementation of labour nationalization policies to replace the foreign labourers with national workers in both public and private sectors, the GCC region continues to rely on migrant workers, especially, from Asian countries including India, to facilitate the unhindered progress of its economy.

1.1. The Temporary Migration of Contract Workers

The movement of workers to the Middle East is a temporary migration, as distinct from the permanent emigration to the industrialized countries (Nayyar, 1994; Sekher,
1997) and, people recruited for employment in the GCC region are contract workers. By and large, “contract workers are people who move to another country on a temporary basis in order to perform a specific type of work” (Bodvarsson & Berg, 2009, p.14).

1.2. Return Emigration as the Logical End of Contract Migration

Return migration is a “process whereby people return to their country or place of origin after a significant period in another country or region” (King, 2000, p.8). Throughout the world, return migration has been an integral part of the labour migration (Zhao, 2002), and return is inevitable, especially, when people depart the home country in order to get contract employment in the receiving country. Contract migration is absolutely different from settlement migration as in the latter case migrants employed in the host country, eventually settle there and, very often become citizens. When a movement of migrants back to their homelands, for resettlement, occurs, it is called return migration.

1.3. The Research Problem

The economic models of migration posit that individuals will migrate if the expected utility of moving to an alternative location is greater than the expected utility of remaining in their current location. Migration, of course, is a process that enables accumulation of material wealth and acquisition of human capital, through learning new skills and work experience, and migrants are especially active and courageous people. They are mostly young, and their health is above average compared with the population in their own country of origin. In total concordance with this conjecture, emigration to the Gulf countries from Kerala has been a direct result of the prevailing idea that jobs there are more lucrative than those found in Kerala or even in the rest of India. This idea turned out to be absolutely true, to a great extent, for many. But all the emigrants, ultimately, have to return after a stint in the Gulf countries. Most of them return at a potentially productive age in today’s standards. This, apparently, confers a demographic dividend for the Kerala state by raising the working age ratio. An increase in the working age ratio, unquestionably, is a necessary but not a sufficient condition for economic growth. People in the working age group are to be able and healthy enough to pursue productive employment so as to contribute, positively, to the economic growth of the state. Disability or debilitating health conditions, on the other hand, do incite the people to leave the
employment market, leading to huge waste of human resources. Even when they are at work, they may not be as productive as they were prior to the onset of debilitating illness. Many of the return emigrants might have achieved monetary benefits from overseas employment.

However, such transitory incomes from temporary employment abroad do not guarantee good health for the rest of their lives. Given the fact that migrant workers in the Gulf, very often, suffer from ultra-exploitation at work, yet are hardly covered by any labour protection and social security measures, migration may turn a healthy worker to an ill person. 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 themselves, but also have important implications for the households and society and, even greater implications for the economy. If the return emigrants remain out of work for the rest of their lives, the dependency ratio of the state would increase and this in turn would adversely affect the state that is already engulfed by an ageing population. Also, soaring expenditure on health care, on return, coupled with the inability to pursue any productive occupation has wider ramifications for the individuals who had to work hard in the desert to amass wealth, even, at the expense of their health.

1.4. Objectives of the Study

Most investigations on emigration and return emigration, in Kerala, were focused on the ‘success – failure’ dichotomy, based on accumulation of material wealth by the migrant households. Such empirical elucidations, however, did not go deeper into the current conditions of the return emigrants. This study, therefore, has departed from this conventional approach and has focused more on the return emigrants rather than their households. As a general setting for the most relevant research questions, this study, (a) looks into the determinants and economic consequences of human health problems, (b) suggests an appropriate indicator of health status in the Kerala situation, and (c) traces the theoretical explanations of migration and attempts to portray the Kerala experience of international migration.

The study is intended, specifically, to explore the benefits and costs of temporary migration by looking into the health status of the return emigrants from the GCC region and, therefore, has sought to address the following pertinent questions:
1. Whether the socioeconomic dynamics of the return emigrants and their migration episodes are inter-linked?

2. 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?

3. 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?, and

4. 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?

1.6. Theoretical Approaches to Return Migration

Return migration, as an issue, was the most neglected area in migration literature and the topic got prominence only in the last quarter of the twentieth century. “While scholarly approaches related to return migration can be traced back to the 1960s, there is no question
that, with hindsight, it was in the 1980s that stimulating scientific debate among scholars took place on the return phenomenon and its impact on origin countries” (Cassarino, 2004, p.254). It might, perhaps, be the result of the views that the neoclassical economists had on return migration.

The neoclassical economics of migration views return migration as the outcome of migrants’ failed migration experiences abroad. Successful migration, according to this approach, involves permanent settlement in the host country. On the contrary, the new economics of labour migration views return migration as the “logical outcome of a calculated strategy defined at the level of the migrants’ household, and resulting from the successful achievement of goals or target” (Cassarino, 2004, p.255). The two schools, accordingly, posit fundamentally different theoretical expositions on return migration by focusing on the success or failure aspects of migratory movements and, in total disregard to the real situations like socioeconomic features, legal stipulations and migration policies in host as well as in home countries. Also, these theories did not take into consideration the personal attributes and attitudes of the migrants while explaining return migration.

1.6.1. Types of Return Emigrants

On the bases of personal attributes, aspirations and needs, four types of return emigrants can be identified (Cerase, 1974): (i) people who could not integrate, successfully, into the host country; (ii) people with a preplanned idea of returning home with enough resources; (iii) people retired from regular employment in the host country; and (iv) people who are “prepared to make use of all the means and new skills they have acquired during their migratory experiences” (Cerase, p. 251).

1.6.2. Gains from Return Migration

Some economists (Dustmann et al., 2010) argue in favour of encouraging return migration because the brain drain is mitigated as those who return come with augmented local skills that are more applicable in the home country. If the proportion of those who return is large enough, aggregate output and even output per capita may increase, implying a brain gain. Return migration may be optimal if the host country currency has a higher purchasing power in the home country, and if there are higher returns in the home country on human capital, acquired in the host country (Dustmann, 1999). In such an advantageous
environment, no doubt, there will be much passion for return to the homeland. Furthermore, higher rate of return on self employment activities in the home country may trigger a return migration (Dustmann & Kirchkamp, 2002).

1.7. Return Emigration from the Gulf

Return emigration from the Gulf, as pointed out, already, stems from the very temporary nature of contract employment there. Once admitted, contract workers are not allowed to change jobs and are expected to leave the country of employment upon completion of their contract, irrespective of whether the work they do continues or not (Zachariah et al., 2002).

During the mid 1980s, the return flow of workers started from the Gulf countries, “mainly due to the completion of many of the infrastructural projects and developmental activities” (Sekher, 1997, p.15). Since then, the return flow of emigrants has been increasing but has not been consistent throughout and, every year, the State receives back a large number of return emigrants from the Gulf, adding new issues to the Kerala economy, polity and society.

Though the return emigration to Kerala from the Gulf countries began in the 1980s, it has assumed large dimensions only in recent years. This increase in the return emigration is unshakably coupled with the increase in emigration. “The larger the emigration, the larger would be return emigration. The number of return emigrants in 1998 was 7.4 lakh and, it rose to 8.9 lakh in 2003 and, again to 11.6 lakh in the year 2008.

There is visible geographical disparity, just like the case with emigration, in the return emigration to Kerala. Maximum number of the return emigrants live in Malappuram district (see table 1.1) where as the hilly districts of Idukki and Wayanad have only very few return emigrants.
Table 1.1: Return Emigrants by District of Domicile 1998, 2003 and 2008

<table>
<thead>
<tr>
<th>Districts</th>
<th>Return Emigrants</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Thiruvananthapuram</td>
<td>118878</td>
<td>103059</td>
<td>215280</td>
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<tr>
<td>Kollam</td>
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<td>68860</td>
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<td>Thrissur</td>
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<td>174655</td>
</tr>
<tr>
<td>Palakkad</td>
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<td>85318</td>
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</tr>
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<td>Wayanad</td>
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<td>1930</td>
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<tr>
<td>Kerala</td>
<td>739245</td>
<td>893942</td>
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</table>


1.8. Methodology and Data Base

In order to capture, properly, the impact of migration on the health status of return emigrants, research designs should be longitudinal in which the migrants are to be followed from before emigration to sometime after emigration and on return to the country of origin. However, longitudinal investigations, in practice, are beset with limitations in the form of prohibitive cost and the requirement of a very long period of time to complete the study. To overcome this limitation, the present study has taken recourse to retrospectively oriented cross sectional investigation. This study has been carried out, on the basis of data collected from return emigrants in Kerala from the six GCC countries, with the help of a structured and pre tested survey schedule. The greatest advantage of the data collected through household surveys is that they provide individual or household
based health statistics relative to the episode or event based data collected through health providers.

The survey was based on a multi stage stratified sample design. From the fourteen districts of Kerala, five districts with higher than state average intensity rate of return emigrants were identified on the basis of secondary data (see table 1.2). The districts thus identified were: (i) Thiruvananthapuram, (ii) Kollam, (iii) Pathanamthitta, (iv) Thrissur, and (v) Malappuram. These five districts together accounted for more than two thirds of the total return emigrants in the state. For the calculation of return emigrants’ intensity rate, district-wise data on population and the estimated stock of return emigrants in each district were obtained from secondary sources. The intensity rates were calculated by dividing the number of return emigrants by the projected population of the respective districts for the year 2008, and by multiplying the quotient by 1000, so as to express its relative significance.

The return emigrants’ intensity rate for the entire state was also calculated by applying the same method. A decisive selection of two taluks from the chosen districts – Kollam taluk from Kollam district and Tirur taluk from Malappuram district - was made, tenaciously, to ensure representativeness of different economic, socio-cultural, religious and historical backgrounds spanning across the length and breadth of Kerala. Kollam and Tirur represent the erstwhile Travancore and Malabar respectively – the two distinct entities at the time of the formation of Kerala. The Kerala state was created, on linguistic ground, in 1956, by joining together the erstwhile native states of Travancore and Cochin, and the region of Malabar from the old province of Madras. The Malabar region was very much behind Travancore and Cochin in social development (including literacy and life expectancy – and mortality rates generally). But by the 1980s, Malabar had caught up with the rest of Kerala that it could no longer be seen in divergent terms (Sen, 1997). This implied that there were glaring divergences, on many fronts, between Travancore and Malabar before 1980s. Since a greater majority of the return emigrants must have been born prior to 1980s, stratified sampling technique was adopted to increase the efficiency of sampling by picking up units from the two historically divergent regions.

The chosen districts constituted the first stage units and the taluks the second stage units and the return emigrants and their households formed the third stage units. The return emigrants were identified through local enquiries and, from the membership records of
different ‘Pravasi Malayali’ associations in Kerala. The two taluks, with a total return emigrant population of 129,598 (Kollam – 68,222 and Tirur – 61376), were ranked second and fourth respectively among the Taluks with largest return emigrants in Kerala in 2008 (CDS, 2009). The other Taluks were Thiruvananthapuram (First), Chirayinkeezhu (Third) and Ernad (Fifth).

The taluk selection was followed by the construction of separate sampling frames, comprising three per cent of the return emigrants in each taluk. Accordingly, an identification list of 2050 return emigrants made up the sampling frame for Kollam taluk and 1850 return emigrants composed the sampling frame for Tirur taluk. A total of 390 return emigrants (10 per cent from each stratum) were selected through systematic sampling procedure. However, a few people in the selected sample could not be located and a few selected units had to be deleted owing to non-response/non-cooperation and incomplete information. The whole process ended up with a final, pooled, sample size of 360 units (Kollam – 190 and Tirur – 170).

The survey was carried out during the months of January, February and March 2011. The survey results on health do not reflect acute diseases and its concomitant predicaments as the investigation focused absolutely on chronic disease morbidity. Each return emigrant was asked to respond on a good number of wide ranging and interconnected questions (see Appendix) regarding the pre migration, post migration and post return phases of their life. Data on household profile were also obtained from the return emigrants. The investigation regarding recurring health expenditure was with reference to the 30 days preceding the date of enquiry; a period of one year preceding the date of enquiry was taken to estimate the prevalence rate of chronic disease morbidity and to assess the cost of admitted treatment. In order to shun the problems of variation in the respondents’ perception of illness, only clinically diagnosed – prescription medication cases were taken into account. Detailed information pertaining to every hospitalization case that the return emigrants experienced during the last one year was obtained. For the analysis of data SPSS-19 software package was used and appropriate statistical measures such as logistic regression, correlation, arithmetic mean, percentages and ratios were obtained for analytical purpose.
Table 1.2: District-wise Intensity Rate of Return Emigrants – 2008

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Districts</th>
<th>Population (Projected)</th>
<th>Return Emigrants (REM)</th>
<th>REM Intensity Rate</th>
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</thead>
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<td>Thiruvananthapuram</td>
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<td>2</td>
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<td>124066</td>
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<tr>
<td>3</td>
<td>Pathanamthitta</td>
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<td>60554</td>
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<td>4</td>
<td>Alappuzha</td>
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<td>Kottayam</td>
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<td>13</td>
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<td>Ernakulam</td>
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</table>

Sources: Zachariah and Rajan (2009); http://kannurservices.gov.in/pdf/PLS-2006/1-POPULATION/1.10-districtwise_projected_population.pdf

Note: REM intensity rate is calculated as the number of return emigrants per 1000 Population.

1.9. Definitions of Concepts

Definiteness on meaning of particular terms is crucial for any analysis. As the present study is focused on the health status of return emigrants from the Gulf, two concepts that are fundamental to the study are introduced here for clarity.

1.9.1. Health Status

Health status refers to the level of health of the individual, group, or population as subjectively assessed by the individual or evaluated by more objective measures. The World Health Organization defines health as “a state of complete physical, mental and social wellbeing, not merely absence of disease or infirmity” (WHO, 1948). This ideal state, however, is unattainable for a population or for a community within the population. In 1978, at the Alma-Ata conference, the world Health Organization equated good health at par with the level of health that would permit the people to lead a socially and economically productive life. To lead a productive life in the long run, one must be free from degenerative diseases. This study, therefore, used chronic disease morbidity as the
indicator of health status (the rationale for using morbidity as a measure of health status is discussed, in detail, in the fourth chapter). Health status is treated, here, as a dichotomous variable – presence or absence of chronic disease morbidity.

**Why Chronic Disease Morbidity (CDM)?**

Chronic disease, often associated with lifestyle and working and living environment, refers to a disease that is ongoing or recurring but is not caused by infection and is not passed on by contact. Chronic diseases acquired from work in a foreign land are more serious than any other health problems. Victims of chronic diseases often develop symptoms only after returning to home country for resettlement. Such diseases strike individuals in their productive ages, need high treatment costs, and result in premature death. Chronic diseases are now the major cause of death and disability worldwide. Deaths from infectious diseases, maternal and perinatal conditions and nutritional deficiencies combined are projected to decline by 3% over the next 15 years. In the same period, deaths due to chronic diseases are projected to increase by 17% (WHO, 2005) and this, no doubt, justifies the reliance on CDM as a consistent pointer of health.

Moreover, in India, a decline in communicable diseases and an increase in chronic diseases resulted in more than 50 percent of total deaths in 2005 due to chronic diseases (Reddy et al., 2005). This upshot, especially in the contemporary circumstances, is quite disturbing for Kerala as the state is having a high prevalence of major risk factors for chronic diseases (Thankappan et al., 2010). A high morbidity and mortality burden to the state and the resultant rise in medical expenditure (Sugathan, 2010) will have intricate ramifications, and this serious state of affairs would further be aggravated by the still greater tribulations of the return emigrants.

**1.9.2. Return Emigrant**

The United Nations Statistics Division for collecting data on international migration defines return emigrants as “persons returning to their country of citizenship after having been international migrants (whether short-term or long-term) in another country and who are intending to stay in their own country for at least a year” (UN, 1998). In this study, return emigrants refer 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; this definition allows at least fifteen months
of stay at home for the return emigrants. Although there was no guarantee that these return emigrants would not seek employment in the Gulf again, the fifteen month duration of stay at home was long enough for them to participate in economic activities. Also, ‘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.

1.10. Scope of the Study

Measurement of health status, of a specific group or community, by taking recourse to the prevalence rate of non communicable or chronic disease morbidity alone would be too narrow in scope. The socioeconomic background of the households; age and education profiles of the individuals in question, their exposure to hazardous working conditions and the related issues supplement a lot in setting the plausible determinants of their current state of health and activity status.

An individual’s decision to get involved in economic activity, especially after returning from an unfamiliar, unfriendly and, very often, perilous working and living environment, is likely to be influenced by both their current state of health and accumulated wealth. Moreover, the economic consequences of health status can be ascertained only through a detailed analytical examination of the direct and indirect cost of illness including the occupational status and saving or dissaving behaviour of the individuals.

Direct costs usually represent the costs associated with medical resource utilization, which include the inpatient, outpatient, and pharmaceutical services within the healthcare delivery system. The term indirect cost has come to be defined as the expenses incurred from the cessation or reduction of work productivity as a result of disease morbidity. The indirect costs include wages or income lost by people who lose work time because of their illness or disability as well as time lost from work by family members who are compelled to look after their dear ones suffering from disease morbidity.

Also, a proper understanding of the economic impact of the health status entails an assessment of the human capital, in the form of skills, training and work experience, acquired by the individuals and the level of its current utilization. Hence, the scope of this
study, by taking into account all these factors, is widened to include the pre emigration, post emigration and the post return profiles of the individuals against the backdrop of their households’ socioeconomic footing.

1.11. Chapter Scheme

This study is presented in eight chapters including this introductory chapter. The second chapter exemplifies analytically the scholarly investigations, both theoretical and empirical, on the determinants of international migrants’ health. A concise appraisal of the migration related studies in Kerala is also given in this chapter. The third chapter looks into the varied facets of the multidimensional concept of health - from its meaning to the numerous factors influencing it, the linkage between health and economic growth and its various routes. The fourth chapter underlines the relative significance and inadequacies of different health indicators and attempts to put forward an appropriate norm for measuring health status in the present-day Kerala setting. The fifth chapter examines the theoretical underpinnings of migration and explores, methodically, the dynamics and dimensions of Gulf specific migration from Kerala. A thorough analysis, based on the sample survey, on migration episodes and the socioeconomic dynamics of the return emigrants in Kerala is given in the sixth chapter. The seventh chapter makes a comprehensive analysis of the primary data on the return emigrants’ current state of health and evaluates its socioeconomic implications. The final chapter presents the summary and conclusions of the study.

1.12. Limitations of the Study

The study is beset with all the limitations of a retrospectively oriented cross section study. Moreover, the survey could not elicit information on HIV/AIDS, alcohol consumption and chronic mental health problems. Also, suppression of facts, especially of experiences abroad and of value of household assets, by the respondents might have tainted a bit the quality of data.
References


