The authors offer two explanations—financial (material) and emotional (psychosocial) factors, respectively. It will be probably a bit of both.

On the one hand, not receiving financial assistance from those who emigrated has obvious consequences on income and material circumstances of those who stayed at home. Material deprivation is one of the main factors driving emigration. It has been estimated that the amount of money sent home by Latin American migrant workers to their families exceeds the combined total of all direct foreign investment and foreign aid. In Albania, it has been estimated that money send from abroad accounted for 14% of GDP and approximately one-third of total household income in 2005. These are staggering amounts, and it is likely that money from abroad provides the receiving families with a considerable advantage. Despite the difficulties with measuring income (including transfers) and its effects, it is likely that material deprivation caused by the lack of transfers, in this case remittances, has an effect on the health in the population studied.

On the other hand, as Burazeri and colleagues discuss, not receiving money from abroad is also a marker of low family cohesion and low social support. There is evidence that major life events requiring emotional adjustment are associated with increased risk of cardiovascular events. Emigration of close relatives and the associated loss of social support can have consequences similar to bereavement or poor social networks. The view that the effects of emigration are not exclusively driven by material factors is supported by the fact that, in this study, adjustment for total household income did not make much difference to the estimated association between acute coronary syndrome and emigration. It is also not clear how exactly would material factors affect cardiovascular risk; classical risk factors are unlikely candidates.

The question as to whether emigration affects health of those who remained at home is an important one, both for research and for public health. If the results are replicated by further studies and in different populations, emigration of close family members may be another interesting social exposure, sharing both material and psychosocial features. Since, in contrast to many other social determinants, this is a reversible exposure, and one which varies over time, it may provide new opportunities to investigate the contribution of different aspects of social environment to health.

Conflict of interest: None declared.

References

4 http://news.bbc.co.uk/2/hl/business/6465297.stm (last accessed on 18 October 2007).

Commentary: Kisses or money for Penelope?

Oliver Razum

Migration can be hazardous to the health of those who leave their home, a fact well known since ancient times. Odysseus, the archetypal wanderer, migrated from Ithaca to Troy, where he found employment in the fields of construction (of a wooden, horse-shaped contraption) and demolition (of cities). The jobs were risky, and mortality among his fellow migrants was high. Odysseus survived, thanks to his wit and courage.

Homeward bound

After completing his task and making some money Odysseus headed back home towards Ithaca. Return migration poses its
own risks, as he and his companions were soon to learn. Storms, an ill-disposed Cyclops, the man-eating Lairstyrones, the Sirens, as well as Scylla and Charybdis, took a heavy toll. A charming nymph by the name of Calypso almost convinced Odysseus that there can be sweeter pleasures than home. But he could not forget his native land and continued his voyage, reaching Ithaca shipwrecked and desolate, two decades after his departure.1

Homer reports in much detail on Odysseus’ travels and the health hazards he faced. The epic provides us with hardly any information on the health of Odysseus’ wife Penelope who remained back home in Ithaca, looking after the house and their son Telemachus. For 20 years, she did not have a clue whether she would ever embrace and kiss her husband again. Odysseus never sent money back home, and the longer his absence lasted, the harder Penelope had to struggle to keep the house in order and to maintain her place in society.1

Homer’s focus on the migrants and the health hazards they faced, rather than on the health and well-being of their relatives remaining behind, is reflected in today’s migrant research. The health of migrants has frequently been studied, but rarely ever that of the spouses and children they leave behind.2 Genc Burazeri from Albania and his colleagues aim to fill this gap. In this issue of the journal they report on cardiovascular risk in the Burazeri’s study, an increase in CHD risk was experienced time since emigration had an effect on CHD risk. And while years.5,6 Burazeri

Some broken hearts never mend
Burazeri et al. conducted a case-control study in which they investigated the associations between emigration of a close family member, financial remittances sent back by the emigrants, sex and acute coronary syndrome (ACS) among non-migrating family members in Albania. The authors make two claims: First, that they may have identified emigration of a close family member—in particular of a husband—as a novel independent risk marker for coronary heart disease (CHD). Secondly, that the resulting risk is attenuated if the emigrant sends back remittances.

Given the abundance of studies claiming to have identified new risk markers for CHD, some caution seems appropriate.5 Have similar findings been reported? In the absence of studies looking at the health of emigrants’ relatives, other scenarios of separation could be assessed. They would have to reflect the breakdown of social support and the failure to cope with stress presumably experienced by the relatives. An extreme example is the death of a spouse. Bereavement is known to have a measurable effect on mortality and on CHD risk, but only for a relatively short time period (6 months to 2 years).3,5,6 Burazeri et al. unfortunately did not examine whether time since emigration had an effect on CHD risk. And while in Burazeri’s study, an increase in CHD risk was experienced predominantly by women, excess morbidity and mortality after bereavement tends to be highest among men.5,6 Thus, alternative explanations for the findings of Burazeri et al. such as residual confounding by socioeconomic status cannot be ruled out: as in many other places, well-off women in Albania might have a lower CHD risk than their disadvantaged sisters.

Can’t buy me love
The most striking finding in this article is the attenuation of an excess CHD risk among relatives by remittances received from the emigrants. The authors speculate that ‘non-remittance of funds might be perceived of as lack of caring (i.e. absence of emotional support)’. This is a strong statement. Taken to the extreme, it implies that love alone is not good enough—or worse, that embraces and kisses can be replaced by remittances. Again, there is reason for caution. The variable ‘financial remittance’ is neither properly defined nor quantified in this study. ‘Remittance’ could thus mean anything from small amounts of money sent back only once, at irregular intervals, or for a short period of time, to substantial sums sent regularly over many years. Following the authors’ line of argument, there would have to be a discernible gradient in ACS risk with size and regularity of remittances. As long as this has not been shown, residual confounding by socioeconomic status should again be considered as an alternative explanation.

Kisses sweeter than wine
Odysseus found no opportunity to kiss Penelope for 20 years. He never sent her money and even lost all his boots on the way home.1 Globalization and new technologies have since helped to improve the lives of migrants and their families. Money can now be transferred safely and quickly around the globe. But it is too early to conclude that all will be well in terms of the health of family members as long as emigrants send back remittances: The role of direct emotional support—exemplified by kisses—has not as yet been studied. With short travel times, low airfares and transnational families, some of today’s migrants and their families have found ways to reunite more often than Odysseus and Penelope.7 Thus, the study population of Burazeri et al. presumably includes migrants who see their family on a regular basis. If these were largely the same ones who are also sending remittances, the lower CHD risk may in fact be due to more frequent visits home. Until additional evidence has been produced, money should not be given preference over kisses.

References