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## Health Shocks and Housing Downsizing: How Persistent Is 'Ageing in Place'?

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## ABSTRACT

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# Health Shocks and Housing Downsizing: How Persistent Is 'Ageing in Place'?\*

Individual preferences for 'ageing in place' (AIP) in old age are not well understood. One way to test the strength of AIP preference is to investigate the effect of health shocks on residential mobility to smaller size or value dwellings, which we refer to as 'housing downsizing'. This paper exploits more than a decade worth of longitudinal data to study older people's housing decisions across a wide range of European countries. We estimate the effect of health shocks on the probability of different proxies for housing downsizing (residential mobility, differences in home value, home value to wealth ratio), considering the potential endogeneity of the health shock to examine the persistence of AIP preferences. Our findings suggest that consistently with the AIP hypothesis, every decade of life, the likelihood of downsizing decreases by two percentage points (pp). However, the experience of a health shock partially reverts such culturally embedded preference for AIP by a non-negligible magnitude on residential mobility (9pp increase after the onset of a degenerative illness, 9.3pp for other mental disorders and 6.5pp for ADL), home value to wealth ratio and the new dwelling's size (0.6 and 1.2 fewer rooms after the onset of a degenerative illness or a mental disorder). Such estimates are larger in northern and central European countries.

**JEL Classification:** I18, G51, J61, R31

**Keywords:** ageing in place, housing downsizing, health shocks at old age, Europe, residential mobility, mental degenerative mental illness, mental disorder

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## 1. Introduction

In many western countries, individuals exhibit a preference for ageing in their own homes which is known as ‘ageing in place’ (AIP) (Wiles et al; 2012 Costa-Font et al, 2009). That is, individuals expect to remain in their homes (or their spouse's/partner's) unless personal circumstances require other arrangements (Quinn et al. 2009). However, the viability of AIP is dependent on the availability of local support networks, adequate housing, and access to informal and community care (Luanaigh and Lawlor, 2008). As a result, individual preferences may change in response to unexpected events, such as health shocks.

Behavioural explanations for preference for AIP point to the role of *status quo bias* giving rise to state dependent preferences (Samuelson and Zeckhauser, 1988). That is, individuals’ judgements on the suitability of their dwelling tends to be anchored on an independent living which is taken as the baseline (status quo) and, might ignore other features that become relevant only at older age. Hence moving away from such baseline is perceived as a loss, which gives rise to ‘inertial preferences for not changing residence’. Similarly, a preference for AIP might suggest that individuals face a *present bias* with regards to their housing needs. Accordingly, housing decisions get postponed until adverse health or care needs arise, such as health shocks. However, whether such health shocks cause people to match their living needs to the most suitable dwelling (Beach, 2016), remains an empirical question. This paper contributes to this question.

In most countries, housing assets are the primary source of wealth, so AIP has a significant financial impact on household finances (Venti and Wise, 1996). Indeed, AIP allows families to keep most of their housing wealth in the event of disability, preventing such assets from being depleted after admission to a (non-fully subsidised) nursing home (Chappell et al., 2004). Furthermore, AIP is at odds with interventions encouraging

housing downsizing, that is to encourage older people to live in smaller dwellings (Kneale et al., 2013). Housing downsizing frees up assets for other uses and frequently allows people to adapt their homes to their specific needs as they age, preventing accidental falls and other environmental hazards (Banks et al, 2007; Bradbury, 2010; Luborsky et al., 2011).

This paper investigates whether people downsize to smaller homes after a health shock, including whether such a move encompasses a reduction in people's housing assets, freeing up wealth for other purposes such as paying for elderly care. In making housing choices, individuals' homes are instrumentally perceived as an investment, or to consume housing services, but they have an emotional and symbolic value providing individuals with feelings of comfort, security, belonging and even personal achievement (Faulkner and Bennet, 2002)<sup>1</sup>. Some studies even find that the preference for AIP prevails even when individuals exhibit a deteriorating health and need personal care (Judd et al., 2010). However, what are the main drivers of the persistence of such a preference AIP?

This paper examines the effect of health shocks on housing downsizing to determine the persistence of a preference for AIP. However, to date we still know little about what explains residential mobility at old age and downsizing after a health shock (Beer et al. 2006; Painter and Lee 2009; Bonnet et al., 2010; Calvo et al, 2009; Angelini and Laferrère, 2011). Pannell et al. (2016) identify several 'push' and 'pull' factors underpinning residential mobility decisions. *Pull factors* include energy bills, difficulties with steps or stairs and the need for care or support. Access to local shops and services, as well as the desire to be closer to other family members alongside cognitive or emotional

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<sup>1</sup> Some evidence even suggests that individuals are willing to pay to reduce the likelihood of being institutionalised (Costa-Font, 2016), and enjoy such features even under a middle health shock.

attachment to an individual's home are all *pull factors*<sup>2</sup>. Ostrovsky (2002) documents that people with health problems limitations are more likely to move, even though health status does not explain mobility. Consistently, Clark and Duerloo (2006) show that older households tend to keep extra living space for as long as possible, only giving it up when forced to, primarily for health reasons, and Painter and Lee (2009) find that having a disability increases the likelihood for a household to exit homeownership. This paper makes three distinct contributions to the literature:

First, we study the experience of a health shock to oneself or the spouse on three measures of housing downsizing, which includes residential mobility, value of the new residence (the home value of the new dwelling and the home value to wealth ratio) and home size considering the potential endogeneity of such health shocks, as well as the potential endogeneity of having changed residence in explaining home size.

Second, we use longitudinal data from the five waves of SHARE (Survey of Health, Ageing, and Retirement in Europe) for a group of nine countries for about a decade. The availability of a panel data sample from 2004 to 2015 allows us to account for both time variant and invariant unobserved individual heterogeneity. To the best of our knowledge, this is the first paper to use this empirical approach to investigate the effect of a health shock on downsizing decisions in such many European countries.

Finally, unlike previous research, we distinguish four types of health shocks (degenerative mental illness, other mental disorders, non-mental illness and basic activities of daily living). The evaluation of different health shocks allows us to evaluate

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<sup>2</sup> Other important behavioural drivers include the emotional attachment to the current home, the desire to maintain social networks within the immediate community (particularly with neighbours), as well as the disruption and costs associated with moving, alongside the fear that an unfamiliar future home will not live up to the current home in terms of convenience or comfort (Ball and Nanda, 2013).

the hypothesis that the effect of every type of health shock on the decision to downsize is not equivalent<sup>3</sup>.

We find the following results. First, although consistently with an AIP preference, age reduces probability of residential mobility (by 2pp for every decade of life) consistently with an AIP preference, such probability reduction reverts after a health shock. The probability of residential mobility increases between 4.8pp and 9pp depending on the type of health shock. These results suggest that *AIP is contingent on the absence of a health shock* in the household, and such effect is also observed for the spouse or partner. However, such residential change is less likely to take place when individuals live in a house where home adaptations have already taken place. In examining residential mobility, we find that the home value to wealth ratio falls by 8.9 percentage points for after the onset of a degenerative mental disorder and 4.2 percentage points for after a non-mental illness. In these cases, the new home has 0.6 and 1.2 fewer rooms, respectively. When looking at the results by country, the Nordic countries meet all of the downsizing definitions examined, whereas Southern European countries tend to move to smaller, but higher-value, residences.

The rest of the article is structured in the following sections. Section 2 provides a review of the literature. Section 3 explains the econometric models. Section 4 presents the data and descriptive statistics. Section 5 presents the results, and finally, in section 6, the conclusions.

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<sup>3</sup> We also investigate whether living in a dwelling that has been modified to improve its habitability reduces the likelihood of changing residence in the event of a health shock, whether there are significant differences between countries, and whether a gradient (Northern-Southern European countries) can be identified.



## 2. Related Literature

### 2.1 *Housing downsizing and its meanings*

There is no common definition of housing downsizing. Whilst some authors define downsizing as moving to smaller quarters (Ekerdt and Sergeant, 2006; Luborsky et al., 2011), others define it as cashing in housing equity (Bradbury, 2010; Jefferson et al., 2017; French et al., 2018), or combine such criteria (Banks et al., 2007; Nguyen et al., 2021). One can consider two perspectives, namely physical consumption, and financial consumption. Physical downsizing denotes a change to a dwelling with a lower number of rooms, whereas financial downsizing refers to the change to a dwelling of lower value to relax equity for other purposes. Consistently, Angelini et al. (2011) observe that Europeans downsize late in life by selling an expensive home and buying a cheaper one. Whelan et al. (2019) report that, among the older Australian population, 40% of older Australians moving home experience financial downsizing. Some older people may move to smaller houses that nevertheless have the same value as their old house (e.g., if it is in a better location)<sup>4</sup>. This would not involve house downsizing. Therefore, by considering both physical and financial downsizing to capture better the phenomenon under study.

### 2.2 *Motivations for housing downsizing*

Housing mobility decisions typically are explained by the so-called the housing balance model and/or the life-cycle model, addition to other explanations. According to the *housing balance model*, older households tend to be in ‘*disequilibrium*’, as they consume more housing than they need. Overconsumption of housing increases with age,

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<sup>4</sup> Existing studies that do examine preferences for housing attributes indicate that, as people age, preferences for lift access, housing without stairs or with an adapted bathroom increase (Abramsson and Anderson, 2016; Jong et al., 2012; Fox et al., 2017; Anderson et al., 2019). In contrast, the preference for a garden and additional space in the home, e.g., for the family to stay, for social events and for hobbies, is observed to decrease with age (Anderson et al., 2019).

especially in the 60-69 years 'empty nester' stage, where almost all households in this age group overconsume<sup>5</sup>. The proportion of households with excessive consumption is higher among homeowners' singles and individuals in higher income categories (Clark and Duerloo, 2006). Housing overconsumption among over 60s can create a bottleneck in the housing market that limits younger households' access to more spacious housing<sup>6</sup>. Alternatively, *the life-cycle model* posits that older people expect to use accumulated assets to support themselves in old age<sup>7</sup>. Given that housing assets are the largest share of people's wealth, older people are likely to downsize or rent to release some wealth for other purposes (Beer et al. 2006)<sup>8</sup>.

Other life cycle explanations include *bequest motives* (Feinstein and McFadden, 1989) and *empty nest decisions* (Wulff et al., 2010). The former suggests that homeowners with children are expected to reveal higher savings trajectories. However, evidence from Hurd (1992), documents similar trajectories between homeowners with and without children. On the other hand, Venti and Wise (1989) found that, for older homeowners, housing equity decisions are found not to depend on the presence of children. Wulff et al. (2010) suggests that the transition to 'empty nester' status increases mobility among mid-life empty-nesters couples compared with couples that still had

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<sup>5</sup> Clark and Duerloo (2006) in their study on housing in the Netherlands (2006) differentiate four categories: neutral housing (defined as one room more than the number of people living in the household), crowded (any living situation with less space than neutral housing), spacious (two rooms more than the number of people) and very spacious (three or more rooms than the number of people).

<sup>6</sup> Painter and Lee (2009) suggest that the sharing of non-financial resources between children and their older parents explains why older people retain ownership of their family home. Older people may be reluctant to move and release housing because of the difficulties their younger children face in accessing housing, and they are also increasingly providing a home for their adult children in the housing crisis, often providing a home for much longer periods than was provided for them when they were young.

<sup>7</sup> Consistently, the life-cycle theory considers precautionary planning and the performance of the housing market and attachment to the home as explanations for housing decisions (Ostrovsky, 2002).

<sup>8</sup> The downsizing decision is complicated due to the dual nature of housing as being both an asset and a commodity, e.g., people have to live somewhere, so there is an implicit liability for housing services that is not recorded on any balance sheet (Sinai et al. 2007).

children at home<sup>9</sup>. Finally, a final set of reasons includes widowhood ( Venti and Wise(2004, Painter and Lee, 2009)<sup>10</sup>, yet the effects are country specific. Banks et al. (2007) found that widowhood leads to a reduction in the number of rooms in older households in the United States but has a much smaller impact in the United Kingdom, where the overall residential mobility of older people is much lower. In contrast, Bonnet et al. (2010) in a study for France, found that new widows are more likely to move into smaller dwellings, flats and the rental sector.

### *2.3 Housing effects of health shocks*

Residential mobility is often unexpected, and is often triggered by the sudden deterioration of a family members' health. Other common life events underpinning downsizing are divorce, marriage, divorce, and deaths (Helderman, 2007). Calvo et al. (2009) found that there were very strong qualitative differences in residential mobility of older households that had experienced such shocks and those that had not<sup>11</sup>. Consistently, Clark and Duerloo (2006) and Painter and Lee (2009) note that older households tend to reduce their housing consumption following a sudden deterioration in health<sup>12</sup>. Documenting the effect of health shocks at older age in measures of housing downsizing is the main purpose of the rest of this paper.

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<sup>9</sup> Consistently, Woodbridge (2003) document that moving to a smaller and more manageable home freed up funds to cushion future expenses arising from declining health, or care after a health shock.

<sup>10</sup> People who had recently become widowed, can switch to renting in the private market (Wood et al. 2008).

<sup>11</sup> They found that those who moved after a shock experienced an average decrease in home value of about \$26,000. In contrast, those who moved without a shock experienced an average increase of almost \$33,000. The authors suggest that this means that *older people who have suffered a shock, such as illness or widowhood, may have chosen to downsize*, while those who have not are more likely to have planned to move to a more expensive home in an area with better amenities

<sup>12</sup> However, some evidence finds that uncertainty about future medical expenses may prevent older people from downsizing, especially if housing is seen as an asset of last resort that will only be used to pay for nursing care or to support a surviving spouse (Ostrovsky, 2002).

### 3. The Data

#### 3.1 The Sample

We use cross-sectional data from SHARE (Survey of Health, Ageing and Retirement in Europe) corresponding to Wave 1 (2004), Wave 2 (2006/2007), Wave 4 (2011), Wave 5 (2013) and Wave 6 (2015)<sup>13</sup>. SHARE is largest pan-European social science study for studying the effects of health, social, economic and environmental policies over the life-course of people aged 50 or older. The data contains 380,000 in-depth interviews<sup>14</sup>. Table 1 shows the initial composition of the sample considering only countries that have participated in all waves (160,388 observations for respondents). To construct the longitudinal sample, we consider individuals participating in all waves (33,535 observations for 6,707 respondents).

**[Insert Table 1 about here]**

#### 3.2 Attrition

Given the significant reduction in the number of observations when we build the balanced panel data sample, we examine the existence of attrition bias. To investigate this issue, we next estimate a series of attrition probits (Fitzgerald et al., 1998) and perform pooling tests for the equality of coefficients from the initial sample with and without attritors, using the Beckett-Gould-Lillard-Welch test (Beckett et al., 1988). To compute

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<sup>13</sup> Unfortunately, wave 3 could not be included as it is not comparable with the other waves and wave 7 does not contain the question concerning change of household.

<sup>14</sup> The SHARE data collection has been funded by the European Commission through FP5 (QLK6-CT-2001-00360), FP6 (SHARE-I3: RII-CT-2006-062193, COMPARE: CIT5-CT-2005-028857, SHARELIFE: CIT4-CT-2006-028812), FP7 (SHARE-PREP: GA N°211909, SHARE-LEAP: GA N°227822, SHARE M4: GA N°261982, DASISH: GA N°283646) and Horizon 2020 (SHARE-DEV3: GA N°676536, SHARE-COHESION: GA N°870628, SERISS: GA N°654221, SSHOC: GA N°823782) and by DG Employment, Social Affairs & Inclusion. Additional funding from the German Ministry of Education and Research, the Max Planck Society for the Advancement of Science, the U.S. National Institute on Aging (U01\_AG09740-13S2, P01\_AG005842, P01\_AG08291, P30\_AG12815, R21\_AG025169, Y1-AG-4553-01, IAG\_BSR06-11, OGHA\_04-064, HHSN271201300071C) and from various national funding sources is gratefully acknowledged (see [www.share-project.org](http://www.share-project.org)).

this test, first we regress the outcome variables from the first wave on household characteristics, an attrition dummy, and the attrition dummy interacted with the other explanatory variables. Next, we test for the joint significance of the interaction variables and the attrition dummy to determine whether the coefficients from the explanatory variables differ between households who attrit or remain in the panel. Results (on Table A.1) indicate that attrition is random and therefore, it is unlikely to bias our estimates<sup>15</sup>.

### 3.3 Trends in Residential Change and Health Shocks

According to Figure A1, the probability of residential mobility between two consecutive waves is around 3%-4% for waves 1-2 and 2-4 but increases to 8% for waves 4-5 and 5-6. Considering that the individuals are observed in all waves are the same, this implies that the probability of residential mobility increases with age<sup>16</sup>. Similarly, Figure A2 displays the probability of having suffered a health shock between two consecutive waves for four types of health shocks, namely non-mental health shock, degenerative mental health shock, other mental health disorders shock and a disability shock affecting individuals' limitations in personal activities of daily living (ADL).

A *non-mental health shock* occurs when the respondent has been diagnosed of heart attack, stroke, cancer or lung disease between two consecutive waves. A degenerative *mental health shock* occurs when the respondent has been diagnosed of Alzheimer's disease or Parkinson's between two consecutive waves. Other mental health disorder related shock is a binary variable taking the value 1 if the respondent has started to take drugs for anxiety or depression between two consecutive waves. Finally, a shock

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<sup>15</sup> Additionally, the small pseudo-R-squared from the attrition probits, which can be interpreted as the proportion of the attrition that is not random, from the Beckett-Gould-Lillard-Welch test (Outes-Leon and Dercon, 2008), reinforces our previous diagnostic.

<sup>16</sup> Considering the entire sample, we find that 6.5% of all respondents have changed their residence between two consecutive waves (Table 1), with a maximum value in Sweden (10.3%) and a minimum in Spain (4%).

on basic *activities of daily living (ADL) shock*<sup>17</sup> takes place when number of limitations for doing daily living activities increases between two consecutive waves. In the analysis, we report health shocks affecting both the respondent and spouse or partner.

As expected, the probability of experiencing a health shock increases with age from 5% for the youngest cohort (50-54 years) to approximately 30% for individuals aged 85 and over. We find that the probability is higher between waves 2 and 4, which may be related to the effects of the economic downturn (Thomson et al., 2014). Table 1 reveals that when we distinguish between health shocks, we find that 11.71% have suffered a non-mental illness shock, 9.57% a ADL shock, 3.55% other mental disorders shock and 1.44% a degenerative mental shock.

### 3.5 Dependent variables

Four outcome variables are defined to accommodate different measures of downsizing. First, "*residential mobility*" which is a binary variable taking the value 1 if the individual has changed residence between two consecutive survey waves. Second, "*home value to wealth ratio*" which can only be calculated for homeowners and is defined as the ratio of the value of the home (reported by the individual in the survey<sup>18</sup>) to wealth (which includes bank accounts, bond, stock and mutual funds, savings for long-term investments, value of own business, value of home, value of cars and value of other real estate)<sup>19</sup>. Third, the difference in housing value (new - old) expressed in 1,000,000PPP

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<sup>17</sup> We follow Coile's (2004) intuition in considering ADL shocks (e.g., an increase in activities of daily living). Given that the severity of a health shock varies between individuals, indicators of health states related to illnesses may mask significant heterogeneity. This reasoning is also consistent with Jones et al (2020) shock-induced impairment shock approach.

<sup>18</sup> In relation to the reliability of home value statements, it has been found that families with short tenure and high-value homeowner provide unbiased estimates of home value (Kiel and Zabel, 1999).

<sup>19</sup> Some theoretical studies have examined on how the relationship between home value and household wealth influences households' asset allocation decisions (Flavin and Yamashita, 2002; Cocco, 2005). If there is a mortgage, a higher home value to wealth ratio exposes homeowners to a higher risk of mortgage commitment, which will induce them to adjust the level of risk in other assets. Conversely, if there is no mortgage debt, a higher home value to wealth ratio indicates that more of homeowners' wealth is locked up in highly illiquid real estate. Therefore, the home value to wealth ratio may be considered as indicative

(2012). Finally, we consider the variable "*difference in the number of rooms*" which measures the difference in the number of household rooms between two consecutive waves (including bedrooms but excluding kitchen, bathrooms, and hallways). This variable is defined for all those who have changed residence.

Table 2 reports the descriptive statistics for the dependent variables per country, conditional on having suffered a health shock or not (non-mental illness, degenerative mental illness, other mental health disorders or ADL limitation)<sup>20</sup>. The share of home value to wealth is 3 percentage points higher among households that have experienced a health shock (74% vs. 70%) and remains practically stable after the residential mobility<sup>21</sup>.

**[Insert Table 2 about here]**

Next, we report four different event-study for the four outcome variables conditional on health shock on residential mobility and health shock. Time 0 is identified as the time at which the health shock occurs. The results, shown on Figure A4, are highly suggestive showing that the occurrence of a health shock leads to: (i) a significant increase in the probability of residential change, (ii) a decrease in the value of the new residence

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of the fraction of assets that can be mobilised to defray long-term care expenses (associated with a health shock), with an inverse relationship between the two variables (Davidoff and Welke, 2007).

<sup>20</sup> Figure A3 summarises the behaviour of the above-mentioned dependent variables by country. The red areas have been used to reflect the percentage of households that have moved to a household with fewer rooms, which is above 70% in Belgium, France, Italy and Spain. The purple bricks denote the percentage of households that have moved to a dwelling that represents a smaller percentage of total wealth. For all countries it is above 40%, reaching values above 50% in Germany and Sweden. The maximum value corresponds to Switzerland (50.76%) and Sweden (47.28%), and the minimum to France (9.65%) and Italy (7.72%). The green circles represent the percentage of households that have moved to lower value housing, with the highest values in Denmark (45.77%) and Sweden (29.88%), and the lowest values in Spain (1.62%) and Italy (5.08%).

<sup>21</sup> In the case of a health shock, the percentage of new dwellings of lower value is higher (23.23% vs. 13.13%, respectively) as well as the percentage of new dwellings with a lower number of rooms (73.96% vs. 68.57%).

acquired, (iii) an increase in the probability that the new residence has fewer rooms, and (iv) a reduction in the home-value to wealth ratio.

### *3.6 Control variables*

We consider the following controls, namely socio-demographic characteristics (age, sex, marital status, level of education, relation with economic activity, adjusted household income (dividing total household income by the square root of household size), household size and size of municipality of residence. We also include health status at baseline. See Table A2 for descriptive statistics. We define home adaptations as a binary variable that takes the value 1 if the home has any of the following facilities (widened doors or corridors, ramps or street level entrances, handrails, automatic or easy open doors or gates, bathroom or toilet modifications, kitchen modification, stair glides, alerting devices), 0 otherwise<sup>22</sup>. Finally, country and regional (at NUTS-2 level) fixed effects are also included which can capture the effect of different urbanisation policies and year fixed effects to take into consideration possible time effects.

### *3.7 Instruments*

In the model for residential mobility, we consider the potential endogeneity of the occurrence of a health shock. We propose six instruments for which the literature documents a relationship with the potentially endogenous variable, conditionally on the other covariates, and for which it is plausible to assume that they are not correlated with the error term of the outcome equation (residential mobility)<sup>23</sup>. In addition, when we study

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<sup>22</sup> The SHARE questionnaire does not provide the detail of how many of these adaptations have been made in the household. It is only known whether the household has any or all of the adaptations mentioned in the list.

<sup>23</sup> The proposed instruments are being a (1) smoker, (2) former smoker (Courtney-Long et al., 2014; Rissanen et al., 2019)<sup>23</sup>, (3) being obese, (4) overweight (Vidoni et al., 2011; Pozzobon et al., 2018; Zhang et al., 2019), (5) regular alcohol consumption (Salonsalmi et al., 2017; Ilic et al., 2018; Peng et al., 2020) and (6) sedentary lifestyle (Pozzobon et al., 2018; Onambele-Pearson et al., 2019; Narita et al., 2020).



changes in the home value to wealth ratio, difference in home value and difference in the number of rooms, we consider the potential endogeneity of residential mobility (interacted with health shocks)<sup>24</sup>. Definition and descriptive statistics for all variables are provided on Tables A3 and A4 of Appendix A<sup>25</sup>.

#### 4. Empirical Strategy

In this section we present three econometric models considering the different nature of our dependent variables, which might be country specific. Indeed, in modelling residential change as a binary event, a dynamic probit is proposed. However, in modelling the home value to wealth ratio, a fractional model is used instead. Finally, when estimating the difference in home value and the difference in the number of rooms, we draw on a generalised method of moments. However, all models consider the potential endogeneity of the health shock (of the individual and/or his/her spouse/partner) or of the residential mobility as discussed below.

##### *4.1 Dynamic probit estimator for residential mobility*

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<sup>24</sup> To instrument residential change, the following five instrumental variables are proposed: (i) cooling degree days: measure of the need of air-conditioning (at NUTS-2 level), (ii) heating degree days: measure of the need of heating (at NUTS-2 level), (iii) housing price index: price index of residential property (2004=100) (at NUTS-2 level), (iv) growth rate of housing price index: annual growth rate of residential property price (%) (at NUTS-2 level) and (v) number of daughters at home.

<sup>25</sup> The reasons underlying the choice of these variables are the following. In relation to weather, Banks et al. (2012) observe an increase in the mobility of older Americans residing in colder areas, who seem to be more likely to move to warmer areas. Thus, one would expect to see an increase in mobility in regions with a higher number of heating days. There is a body of literature that has found that lower house prices lead to lower household mobility for two reasons. First, because risk-averse people do not want to sell their property for less than what they once paid (Engelhardt, 2003). Second, the reduction in the value of the house may limit the amount of the potential mortgage that could be obtained for the new house (Schulhofer-Wohl, 2012). Finally, several research studies support that the daughters are more likely to become caregivers for parents (Szebehely and Ulmanen, 2009), and that daughters or their elderly parents tend to move when parental care needs are high (Artamanova et al., 2020).

Given that individuals face state dependence, namely past experience affects current behaviour, residential change decisions typically are modelled using a dynamic framework. According to the descriptive estimates in Table 1, only 6.5 percent of respondents have ever moved. 7.1 percent of those who have never experienced a health shock and 5.7 percent of those who have experienced a health shock have moved more than once. Accordingly, we have specified as dynamic probit for the probability of changing residence:

$$C_{it}^* = \alpha_0 C_{it-1} + \sum_{j=1}^{j=3} \alpha_j SH_{it}^R + \sum_{j=4}^{j=6} \alpha_j SH_{it}^P + Z'_{it} \gamma + \eta_i + R_r + T_t + \varepsilon_{it} \quad (1)$$

$$i = 1, \dots, N; t = 1, \dots, T$$

where  $C_{it}^*$  is the latent dependent variable,  $C_{it-1}$  represents the residential change decision in the previous period,  $Z'_{it}$  is a vector of explanatory variables (age, sex, previous health status, marital status, level of education, relation with economic activity, adjusted household income, household size, home adaptations),  $\eta_i$  is a term capturing unobservable heterogeneity.  $R_r$  and  $T_t$  denote regional (at NUTS-2 level) and time fixed effects and  $\varepsilon_{it}$  is an error term following a normal distribution with mean zero and variance normalised to one. The subscripts  $i$  and  $t$  refer to cross-sectional units (individuals) and years (waves), respectively. In this model, we include four types of shocks of the respondent  $SH_{it}^R$  according to previous definitions (non-mental, degenerative mental, other mental disorders, ADL shocks) and four analogous shocks as experienced by the partner or spouse  $SH_{it}^P$ . The observed binary outcome variable (having residential mobility or not) is defined as:

$$C_{it} = 1[C_{it}^* \geq 0], t = 2, \dots, T \quad (2)$$

The number of cross-sectional units ( $N$ ) are assumed to be long, bin contrast the number of periods are small, implying that the asymptotic properties depend only on  $N$ . Modelling this relationship using a random effects probit would assume that conditional on  $Z'_{it}$ , the unobservable heterogeneity is normally distributed with zero mean and variance  $\sigma_\eta^2$ , and independent of  $\varepsilon_{it}$  and  $Z'_{it}$ . Under these assumptions, the probability of residential mobility for individual  $i$  at time  $t$ , given  $\eta_i$  is:  $Pr[C_{it}|Z_{it}, C_{it-1}, \eta_i] =$

$$\Phi \left[ \frac{(\alpha C_{it-1} + \sum_{j=1}^{j=4} \alpha_j SH_{it}^R + \sum_{j=5}^{j=7} \alpha_j SH_{it}^P + Z'_{it}\gamma + \eta_i + R_r + T_t)}{(2C_{it} - 1)} \right] \quad (3)$$

We incorporate the effects of unobservable heterogeneity following Wooldridge (2005) proposed a conditional maximum likelihood estimator<sup>26</sup>, specifying an approximation for the density of  $\eta_i$  conditional on the initial value  $C_{i1}$ :

$$\eta_i|C_{i1}, Z_{it} \sim N(v_0 + v_1 C_{i1} + \tilde{Z}'_{it}\varrho, \sigma_v^2) \quad (4)$$

$$\eta_i = v_0 + v_1 C_{i1} + \tilde{Z}'_{it}\varrho + v_i$$

For simplicity of notation,  $\tilde{Z}'_{it}$  includes both  $Z'_{it}$  and the health shocks. This specification considers the correlation between  $C_{i1}$  and  $\tilde{Z}'_{it}$  and gives rise to a new unobservable heterogeneity term ( $v_i$ ), unrelated to the decision in the initial period. Substituting in the probability of residential mobility:

$$Pr[C_{it}|C_{i1}, v_i] = \Phi[(\alpha C_{it-1} + Z'_{it}\gamma + v_0 + v_1 C_{i1} + \tilde{Z}'_{it}\varrho + v_i + R_r + T_t)] \quad (5)$$

Then, the likelihood function of individual  $i$  is given by:

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<sup>26</sup> To estimate the dynamic probit model, we make some assumptions regarding the initial value of the decision to change residence ( $C_{i1}$ ) and its correlation with the unobservable heterogeneity term. If the initial decision is assumed to be exogenous, a random effects probit model could be used to estimate the model. However, this would lead to biased coefficient estimates since it is unrealistic to assume exogeneity, given that the initial decision of households is unobservable. This implies that the decision made in the previous period ( $C_{it-1}$ ) is correlated with  $\eta_i$ . This problem is known as the "initial conditions problem".

$$L_i = \int \prod_{t=2}^T \Phi(\alpha C_{it-1} + Z'_{it}\gamma + v_0 + v_1 C_{i1} + Z'_{it}\varrho + v_i + R_r + T_t) (2C_{it} - 1) \phi d\phi \quad (6)$$

where  $\phi$  denotes the normal probability density function of the new unobservable term. This estimator is the Wooldridge Conditional Maximum Likelihood Estimator. This estimator allows for correlation between the unobserved heterogeneity and the explanatory variables, which is realistic in a random effect framework.

One potential concern is the endogeneity of health shocks. Individuals more susceptible to health shocks (e.g., a fall) may live in poor quality housing, hence becoming more likely to move after an adverse event<sup>27</sup>. However, some other respondents may still see their home as ‘their safe space’ consistently with the AIP hypothesis<sup>28</sup>. We therefore propose a dynamic correlated random effect model (Wooldridge, 2005)<sup>29</sup>.

We specifically focus on the effect of the moderating variable and distinguish two moderating effects: a structural moderating effect arising from the non-linearity of the model and a secondary moderating effect arising from the inclusion of an interaction variable in the model<sup>30</sup>. Therefore, an analytically correct significant moderating effect

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<sup>27</sup> Indeed, it is likely that unobservable dimensions related to the individual's preferences for staying in his or her environment (e.g., proximity to medical centres and knowledge of the doctors who usually treat him or her) are correlated with the probability of changing residence not only in the current period, but also in future periods.

<sup>28</sup> Figure A5 shows that changes in housing mobility, computed at NUTS-2 level, are positively associated with the variation in the occurrence of health shocks, suggesting that the probability of a residential change declines after health shocks. The red line shows the non-parametric lowness plot and highlights non-linearities in the bivariate relationship. Although in the results section we will also report the estimations of a pure random effects model, we already anticipate that this model is unrealistic as it relies on the assumption of independence between unobservable heterogeneity, initial conditions and exogenous variables in the model.

<sup>29</sup> First, we use the Mundlak approach by estimating a regression for each health shock by pooled OLS (using current smoker, past smoker, current alcohol consumption, overweight, obese, and sedentary lifestyle as instruments). Residuals are then obtained and averaged for everyone. Then a probit model for the probability of residential mobility is estimated and includes the explanatory variables, the predicted residuals, and the average of the residuals per conditional MLE. Bootstrapping is used to retrieve the standard errors.

<sup>30</sup> Note that as Ai and Norton (2003) describe that the sign and significance of the coefficient is conditional on the explanatory variables, unlike the interaction effect in linear models. Therefore, the sign of the estimated coefficient does not necessarily indicate the sign of the interaction effect (Karanca-Mandic et al., 2012). The analytically correct moderating effect is the partial cross-derivative of the conditional expectation of the dependent variable of the model, first with respect to the focus variable and then with respect to the moderating variable.

may reflect only the inherent structural features of the non-linear model used, and not the secondary moderating effect arising from the inclusion of an interaction variable in the model. Conversely, the lack of significance of the analytically correct moderating effect may mask that the moderating hypothesis underlying the introduction of the interaction is valid. In this paper we use the test proposed by Bowen (2012), which extends the results of Ai and Norton (2003) for logit and probit models to a general class of non-linear models which tests for the significance of both the effects including and excluding the interaction variable.

#### *4.2 Fractional response model for ratio value of new home with respect to wealth*

In examining whether residential mobility due to a health shock affects the value of the new residence to which one moves, we use a fractional model (Papke and Wooldridge, 2008). The fractional model is appropriate since the two dependent variables is binary, so that estimation of a linear model for the conditional mean could obviate important non-linearities<sup>31</sup>. Papke and Wooldridge (2008) proposed a Quasi-Maximum Likelihood Estimator and extends the fractional response model to panel data. For each individual  $i$ , we have  $T$  observations  $t=1,2,\dots,T$  and the response variable ( $HW_{it}$ ) which denote the home value to wealth ratio is bounded:  $0 \leq HW_{it} \leq 1$ .

$$E[HW_{it}|X_{it}, \eta_i] = \Phi\left(\lambda_0 C_{it} + \sum_{j=1}^{j=4} \lambda_j SH_{it}^R + \sum_{j=5}^{j=7} \lambda_j SH_{it}^P + X_{it}\beta + \eta_i + R_r + T_t\right), t = 1, 2, \dots, T \quad (7)$$

where  $X_{it}$  is a vector of explanatory variables and  $\Phi$  denotes the standard normal cumulative distribution function. We also include health shocks of the respondent ( $SH_{it}^R$ )

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<sup>31</sup> In this regard, Papke and Wooldridge (2008) point out that the main limitation of Papke's (2005) analysis is its use of a linear probability model with IV for a fractional dependent variable. Yet, considering the endogeneity of one of the regressors is much more important when considering the non-linearity of the underlying relationship (Papke and Wooldridge, 2008).

and the partner/spouse ( $SH_{it}^P$ ), having changed of residence between two waves ( $C_{it}$ ).  $\eta_i$  corresponds to individual heterogeneity and  $R_r$  and  $T_t$  denote regional and time fixed effects. The estimation method of Papke and Wooldridge (2008) also makes it easy to obtain average partial effects. In the case of binary regressors, the partial effect is given by:

$$\Phi(X_{it,(1)}\beta + \eta) - \Phi(X_{it,(0)}\beta + \eta) \quad (8)$$

where  $X_{it,(1)}$  and  $X_{it,(0)}$  denote the discrete change in the explanatory variable. In the case of continuous regressors, the partial effect for regressor  $j$  is given by:

$$\frac{E[HW_{it}|X_{it},\eta]}{x_{it,j}} = \beta_j \phi(X_{it} + \eta) \quad (9)$$

However, the average partial effects depend on unobserved heterogeneity ( $\eta$ ), so in order to identify them, two additional assumptions are required. Papke and Wooldridge (2008) propose to combine the Mudlak-Chamberlain approach with the control function method, which yields consistent parameter estimates. First, they assume that the regressors, conditional on unobservable heterogeneity, are strictly exogenous:

$$E[HW_{it}|X_{it},\eta_i] = E[HW_{it}|X_i,\eta_i], t = 1, \dots, T \quad (10)$$

And second, introduce the assumption of conditional normality (Chamberlein, 1980):

$$\eta_i|x_{i1}, x_{i1}, \dots x_{i1} \sim N(\psi + \bar{x}_{i\xi}, \sigma^2), \quad \bar{x}_i = \frac{\sum_{t=1}^T x_{it}}{T} \quad (11)$$

No assumption on the serial dependence of the response function is required and, at the same time, the potential endogenous regressors are allowed to be correlated with unobservable shocks in other periods. To account for the potential endogeneity of residential mobility we use the following instruments for the decision to move: (i) the

number of heating and cooling days, (ii) housing price index and its growth rate and (iii) number of daughters in the household, and a control function (CF) approach, the standard errors are adjusted by bootstrapping.

#### 4.3. *Generalized method of moments for the difference in home value and the difference in the number of household rooms*

In this model we consider the difference in home value in 1,000,000PPP (12012) ( $DHV_{it}$ ) and the difference in the number of rooms in the dwelling ( $DR_{it}$ ) between two consecutive waves as the dependent variable. As in the previous models, we introduce as regressors having changed residence ( $C_{it}$ ), health shocks of the individual ( $SH_{it}^R$ ) and of his/her spouse or partner ( $SH_{it}^P$ ):

$$DR_{it} = \varpi_0 C_{it} + \sum_{j=1}^{j=4} \varpi_j SH_{it}^R + \sum_{j=5}^{j=7} \varpi_j SH_{it}^P + W_{it}'\gamma + \eta_t + R_r + T_t + \varepsilon_{it} \quad (12)$$

$$i = 1, \dots, N; t = 1, \dots, T$$

To address concerns on the exogeneity of the residential mobility, a two-stage GMM estimation using the same instruments for residential switching as in section 4.2 is proposed (the number of heating and cooling days, housing price index and its growth rate and number of daughters in the household).

## 5. Results

### 5.1. Residential Change

Table 3 displays the pure random effects and correlated random effects. For each model, the results are shown considering both the exogeneity and endogeneity of the health shock (using control function (CF) strategy). Table A6 shows the results of the first

stage estimation<sup>32</sup>. When we do not correct for the endogeneity of health shock (left-hand side of the table) we observe a negative association between health shocks and the probability of residential change. Given the evidence shown in Figure A5, it would be expected that short-term variations in the residential mobility would be correlated with wave-to-wave changes in health shocks. The right part of the table reports pure random effects and correlated random effects considering the endogeneity of health shocks<sup>33</sup>. When using instrumental variables and controlling for simultaneity bias, *health shocks are found to be positively associated with the probability of switching to another residence*. The reduction in the value of the coefficient of the delayed residential mobility suggests upward bias the presence of unobservable heterogeneity in previous estimates.

The probability of residential change increases after the onset of a health shock (9pp for degenerative mental illness, 6.5pp for ADL, 6.1pp for mental disorders, and 4.8pp for non-mental health shock) but decreases 2pp for every 10 years of life. However, the interaction between age and health shock is positive and significant (22.5pp for

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<sup>32</sup> Being a smoker increases the probability of non-mental shock by 3pp and of ADL shock by 1.1pp. Having been a smoker (not now) significantly increases the probability of non-mental shock (7pp). Having a sedentary lifestyle increases the probability of non-mental shock by 8.2pp, degenerative mental health shock by 3.6pp, other mental disorders by 3.3pp and of ADL limitations by 6.7pp. The effect of obesity is considerably higher than that of being overweight (5.5pp for non-mental shock and 6.7pp for ADL limitations). And drinking alcohol increases the probability of non-mental and other mental disorders shock by 3pp and 1.6pp, respectively. The test for endogeneity is not done using the traditional Hausman or Durbin-Wu-Hausman approaches, but instead uses a variation of the Durbin-Wu-Hausman test that is robust to heteroskedastic and clustered errors (Cameron and Trivedi (2010) discuss the robust test (page 190) as the “robustified” Durbin-Wu-Hausman test). The robustified Durbin-Wu-Hausman tests indicate that the exogeneity hypothesis cannot be rejected. Similarly, we use the Kleibergen Paap F-statistic to test for weak instruments, since we cannot formally test for weak instruments when errors are heteroskedastic, serially correlated, or clustered (Pflueger and Wang, 2015). Given that F-statistics may be high even under weak instruments, setting the confidence level to 5%, we compare the effective F test to the critical values under different values of  $\tau$  (e.g., fraction of a “worst case scenario” situation in which the instruments are completely uninformative and first- and second-stage errors are perfectly correlated). The Nagar bias is the approximate asymptotic bias under weak instruments. The Montiel-Pflueger F-statistics allow us to test whether the Nagar bias exceeds a certain fraction of the “worst case” benchmark (Olea and Pflueger, 2013; Pflueger and Wang, 2015). The test rejects the null for a weak instrument threshold of  $\tau = 5\%$ . These results show that the instrument is reasonably strong under all specifications.

<sup>33</sup> As expected, the lagged coefficient of residential mobility is significant and positive, indicating strong persistence in housing mobility, both in pure random effects and in correlated random effects.



degenerative mental illness, 9.2pp for non-mental illness, 7.6pp for other mental disorders, 6.3pp for ADL). The same pattern of behaviour is observed when shock affect the spouse or partner<sup>34</sup>. Having done home adaptations decreases the probability of changing residence (-18.1pp). If the homeowner undertook home adaptations and suffered from ADL shock or a degenerative mental illness, the probability of changing residence decreases by 19.6pp and 11pp, respectively. The same results are observed if the spouse/partner suffers a health shock.

**[Insert Table 3 about here]**

## *5.2. Home value to wealth ratio*

Next, we turn to examine the effects of a health shock on the ratio of home value to wealth. The first three specifications treat residential mobility as exogenous: (i) pooled OLS fixed effects, so that it is comparable to quasi-maximum likelihood (QML) estimation in which the time averages of the explanatory variables; (ii) pooled Bernouilly QML where the serial dependence is considered as a nuisance that is corrected through the standard errors; (iii) fractional probit<sup>35</sup> using generalised estimation equation (GEE; Liang and Zejer, 1986). In contrast in the fourth specification, the change in residence is allowed to be correlated with time-constant individual heterogeneity (although the change in residence is not allowed to respond to idiosyncratic shocks affecting the outcome

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<sup>34</sup> The probability of moving increases when the spouse/partner has suffered a degenerative mental illness shock (5.3pp) or ADL shock (4pp), and although age has a negative effect on mobility, the interaction between age and health shock (of the spouse/partner) also has a positive and significant effect.

<sup>35</sup> The linear probability model is very appealing because of its ease of estimation, and it does a good job in estimating the average effects, but on the other hand, it does not guarantee the predictions of the outcome variables (change of residence and home value to wealth ratio). In this sense, Papke and Wooldrige (2008) highlight that the main drawback in Papke's (2005) analysis is the use of a linear probability model with IV for a fractional dependent variable. Finally, taking into account the non-linearity of the underlying relationship is much more crucial when considering the endogeneity of one of the regressors (Papke and Wooldrige, 2008).

variable)<sup>36</sup>. To ensure that the proposed instruments are exogenous we estimate a pooled OLS regression (with fully robust variance matrix) for the change in residence and its interactions with health shocks. In the specification we consider as regressors the averages of the other explanatory variables, allowing them to be correlated with the individual unobserved effect<sup>37</sup>.

The fractional model is estimated drawing on a control function approach proposed by Papke and Wooldridge (2008). The reduced-form residuals are retrieved from a pooled fractional probit model together with controls and their time averages. It should be noted that the coefficients obtained are scaled and it is necessary to obtain the APEs to compare them with the results of the linear model. Table 4 reports the results of the four estimations. For all four specifications, the APEs obtained for age, sex and marital status are very similar: lower for men, higher for widowers and for individuals aged 65-80. However, the coefficients and APEs resulting from the estimation of the fractional model controlling for the endogeneity of health shocks reveal important differences with respect to the other three specifications. Having changed of house is not significant neither in the OLS nor in the fractional model (without IV). However, it turns significant and positive in the fractional probit models (GEE and with IV), increasing the ratio home value to wealth by 22.1pp-25.1pp, respectively.

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<sup>36</sup> In choosing our instruments (heating and cooling days, housing price index, housing price growth rate and number of daughters at home), our identifying assumption is that the home/wealth ratio depends on unobservable heterogeneity in a "smooth fashion".

<sup>37</sup> First-stage estimates for the probability of residential change are reported on Table A6. The probability of changing residence increases by 1.5pp. for each heating degree day and decreases by 5.6pp. for each cooling degree day. The effect of the housing price index is significant and positive, although smaller in magnitude. Living in an area where housing prices are increasing decreases the probability of changing residence and each co-resident daughter in the household decreases the probability of changing residence by 2.7pp. We have performed the same endogeneity test and tests for weak instruments as in previous first-stage estimation. See footnote 11.

Concerning health status: (i) having been previously diagnosed a degenerative mental illness increases the ratio by 19.1pp, by 14.3pp in case of other mental disorders and by 3.1pp for ADL; (ii) new health shocks are associated with an increase in the ratio home value with respect to wealth (degenerative mental illness (19.1pp), ADL (16.9pp), other mental disorders (14.3pp) and non-mental (6.3pp); (iii) the same positive effect is found for health shocks suffered by the spouse or partner. This may be due to an increase in health expenditure at the expense of household savings (money in current accounts, sale of shares or investment funds), thus increasing the share of housing in wealth. However, the interaction between residential mobility and health shock has a negative effect: -20.7pp for degenerative mental shock, -15.8 for non-mental shock, -10.7pp for other mental disorders and -8.5 for ADL.

**[Insert Table 4 about here]**

### *5.3 Difference in home value*

Results for the difference in home value (1,000,000 PPP2012) are reported on columns 1 and 2 of Table 5. Although when buying a new property, there is an increase in the value of the property compared to the old one (17,000 PPP2012), this effect becomes negative in case of a health shock, especially for degenerative mental illness (-37,000 PPP2012) and ADL (31,000 PPP2012). The fact of having a worse health status at baseline is not significant. On the other hand, a significant and negative effect is observed for the age cohorts 80-84, 85+ and for those who are widowed.

**[Insert Table 5 about here]**

### *5.4 Difference in the number of rooms*

Results for the difference between the number of rooms are reported on columns 3 and 4 Table 5. We find that neither the previous health status nor a health shock exerts

a significant effect. The variable ‘having purchased a new residence turns significant in the GMM estimation, although the coefficient is rather small (+0.17 rooms). There is no significant effect for any of the age cohorts. In contrast, being widowed leads to a reduction in the size of the dwelling (-0.07 rooms), e.g., . of much smaller magnitude compared to the interaction effect of the health shock and the purchase of a new dwelling.

#### *5.6. Predicted effects by type of shock and country*

Next, we have computed the effects of health shocks on the different measures of downsizing by country and type of health shock (Table 6). The probability of residential mobility for any health shock is significantly higher in Germany and Sweden compared to the situation without health shocks, and especially for health shocks involving limitation in ADL (9.35% in Germany and 9.09% in Sweden). In Denmark, the probability of a residential mobility increases by 14.85% in case of a degenerative mental shock. The situation in Spain is particularly noteworthy, with the lowest probability of residential mobility without a health shock (3.36%), but on the other hand, exceeds 12% for degenerative mental health shock and ADL shocks.

Turning to the effect of health shocks on home value to wealth ratio we find a slight increase after the residential mobility for all countries in the case of non-health shocks. In the absence of a health shock, there is a very slight increase in the number of rooms, while the opposite is true when a shock occurs. The predicted difference in housing value shows increases for all countries when there is no health shock. However, when there is a health shock, *a very strong decrease is observed in Denmark and Sweden, and in contrast, we observe an increase in Spain and Italy*. Finally, the largest reduction in the number of rooms corresponds to an ADL shock (-1.6 in Germany, -2.67 in Denmark) and in Sweden in the case of a mental shock (-2.9).

Hence, the picture that emerges is that Nordic countries (Denmark and Sweden) meet all definitions of downsizing. In contrast, the Southern European countries (Spain and Italy) do show an increase in mobility associated with health shock and a slight decrease in the size of the new dwelling, but such dwelling tends to be of higher value, which may be related to the higher propensity to commute to urban centres (see section 5.7).

**[Insert Table 6 about here]**

### *5.7 Spatial heterogeneity*

In this section we have estimated whether there is any relationship between the incidence of a health shock and moving to more populated municipalities by country and considering the same explanatory variables and specifications. Table B1 shows significant evidence of spatial heterogeneity. In Southern countries show an increase in household size after non-mental illness shock and degenerative mental shock (1.5pp and 1.2pp). In contrast, we find a decrease the household size in Central countries when suffering other mental disorders (2.9pp) and non-mental health shock (1.8pp)<sup>38</sup>. However, in Southern countries we find an increase in the probability of moving from small village/rural area to large town (2.6pp for degenerative mental and 2.99 for ADL shock)

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<sup>38</sup> This finding may be related to the north-south gradient in care (Bolin et al., 2007, Brandt, 2013; Muir, 2017), which is usually interpreted as arising from supply-side factors, such as the capacity of public bodies, the character of the welfare state and the existence of different attitudes as regards who should bear the responsibility of care (the state or the family). Moreover, for the provision of home care and according to Genet et al. (2012) there seems to be not only a north to south gradient but also a west to east gradient. Countries in the north-west offer a dense network of home care, whereas countries on south-eastern rim of Europe exhibit the weakest care networks in the European Union and care of dependent people mainly relies on informal carers. Therefore, the decrease in household size is justified if another person in the family does not move in with the person who has suffered the health shock.

while Northern countries exhibit an increase in the probability of moving to small town/rural area (2.7pp for degenerative mental and 1.8pp after an ADL shock).

### *5.8 Entry into nursing home*

AIP can reduce the likelihood of admission to nursing home (Giles et al., 2007). Hence, as an extension, we have considered the extent to which moving to another residence and suffering a health shock affects the likelihood of entering a nursing home<sup>39</sup>. 1.27% of the respondents have been temporarily in a nursing home<sup>40</sup>. Among those who have changed residence, only 0.62% have been temporarily in a nursing home, compared to 1.31% among those who have not changed residence. So, we examine whether moving into a home with home adaptations affects the likelihood of entering a nursing home in the event of a health shock. Table B2 shows the results for the probability of institutionalisation following similar specifications as before. Results show that: (i) home adaptations decrease the probability of institutionalization by 1.6pp; (ii) having changed residence in a previous period is not significant, unless combined with having moved to a house with home adaptations, in which case the probability of entry into nursing home decreases by 1.4pp; (iii) having suffered a shock increases the probability of nursing home entry (8.4pp for degenerative mental illness and 3.8pp for ADL shock), but the

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<sup>39</sup> Previous literature points out that nursing home admission is motivated by a deterioration of the older adult's health beyond the capacity of the family and others to provide sufficient care (McAuley and Usita, 1998; Gaugler et al., 2003).

<sup>40</sup> According to the 2011 census, the percentage of the population living in nursing homes in Europe stood at 1.7% (in our sample, 1.27% of respondents have stayed temporarily in a nursing home). Among those aged 85 and over, the share was more than seven times as high, reaching 12.6%. De Luca et al. (2015) report an underestimation of the institutionalised population according to SHARE figures. In our analysis, we do not consider the probability of living permanently in a residence, but rather the probability of a temporary stay, to test whether moving to a home adaptation dwelling decreases the probability of temporary entry into a residence. On the other hand, The SHARE questionnaire provides information on stays in long-stay or convalescent homes, although not for all waves, which makes it impossible to replicate the analysis carried out for temporary stays in nursing homes. On the other hand, there is no variable that specifically captures stays in psycho-geriatric centres.

effect is negative when individuals have moved earlier to a dwelling with home adaptations.

## **6. Conclusion**

In this paper we study the persistence of the preference for ageing in place (AIP) which is typically reflective of inertial preferences, reflecting status quo bias of present biasness in making housing choices at old age. We have examined whether housing downsizing defined in different ways is influenced by such health shocks. Our findings suggest that whilst ageing decreases the probability of residential change, health shocks increase it hence reverting the preference for AIP. More specifically, the onset of degenerative mental illnesses or new limitations in performing activities of daily living increase the likelihood of a residential mobility, an effect that is greater the older the individual is. This suggest that the magnitude of AIP preferences as a phenomenon depends on the presence of by life events influencing an individual or a partners health status. Furthermore, the effects are highly heterogeneous across European countries, which suggest that AIP might be more culturally embedded in some parts of Europe than others.

These results carry relevant policy implications as in settings when individuals hold strong AIP preferences even after a health shock, policy interventions should strengthen the existing links with the physical and social environments that are supposed to promote older person's well-being, including the support networks developed throughout their lives. In contrast, when individual's hold a strong preference to 'downsize' after a health shocks, policy interventions should focus on supporting the housing search as it can have implications in delaying or avoid entry into more costly forms of residential or hospital care, to promote continued independence, and to better manage physical and mental decline. Another welfare effect of downsizing has been that

it offers wider economic benefits by ‘freeing up’ larger housing for younger families currently owned or rented by older households, thus creating more activity along the housing market chain.

## References

- Ai, C., Norton, E. (2003). Interaction terms in logit and probit models. *Economics Letters* 80(1), 123–9.
- Angelini, V., LaFerrère, A. (2012). Residential mobility of the european elderly. CESifo Working Paper Series 3280.
- Angelini, V., Brugiavini, A., Weber, G. (2011). Does downsizing of housing equity alleviate financial distress in old age? In Börsch-Supan A, Brandt M, Hank K, Schröder M (eds.) *Individual and the welfare state. Life histories in Europe*. Springer, Heidelberg, pp 93–101.
- Artamonova, A., Gillespie, B., Brandén, M. (2020). Geographic mobility among older people and their adult children: The role of parents’ health issues and family ties. *Population, Space and Place* 26(8), e2371.
- Ball, M., Nanda, A. (2013). Household attributes and the future demand for retirement housing. *International Journal of Housing Markets and Analysis* 6(1), 45–62.
- Banks, J., Blundell, R., Oldfield, Z., Smith J. (2007). Housing price volatility and downsizing in later life. NBER Working Paper No. 13496.
- Banks, J., Blundell, R., Oldfield, Z., Smith, J. (2012). Housing mobility and downsizing at older ages in Britain and the United States. *Economica* 79(313), 1-26
- Beckett, S., Gould, W., Lillard, L., Welch, F. (1988). The panel study of income dynamics after fourteen years: an evaluation. *Journal of Labor Economics* 6 (4), 472–492.
- Beer, A., Faulkner, D., Gabriel, M. (2006). 21<sup>st</sup> Century housing careers and Australia’s housing future: Literature review, Research Paper. Melbourne: Australian Housing and Urban Research Institute.
- Bolin, K., Lindgren, B., Lundborg, P. (2007). Informal and formal care among single-living elderly in Europe. *Health Economics* 17(3), 393-409.
- Bonnet, C., Gobillon, L., LaFerrère, A. (2010). The effect of widowhood on housing and location choices. *Journal of Housing Economics* 19(2), 94-108.
- Bowen, H. (2012). Testing moderating hypotheses in limited dependent variable and other nonlinear models: secondary versus total interactions. *Journal of Management* 38(3), 860-889.
- Bradbury, B. (2010). Asset rich, but income poor: Australian housing wealth and retirement in an international context. In Social Policy Research Centre (ed.), *Social*



Policy Research Paper. Canberra: Australian Government – Department of Families, Housing, Community Services and Indigenous Affairs.

Brandt, M. (2013). Intergenerational help and public support in Europe. A case of specialization? *European Societies* 15, 26–56.

Calvo, E, Haverstick K., Zhivan, N. (2009). Determinants and consequences of moving decisions for older Americans. Working Paper 2009-16. Boston: Center for Retirement Research.

Cameron, A., Trivedi, P. (2010). *Microeconometrics using Stata*. Revised Edition, Stata Press.

Chamberlain G. (1980). Analysis of covariance with qualitative data. *Review of Economic Studies* 47(1):225–238.

Chappell, N. L., Havens, B., Hollander, M. J., Miller, J. A., McWilliam, C. (2004). Comparative costs of home care and residential care. *The Gerontologist* 44(3), 389–400.

Cho, S., Sane, R. (2013). Means-tested age pensions and homeownership: is there a link?. In: *Macroeconomic Dynamics*. Cambridge University Press, vol. 17(6), pp. 1281-1310.

Clark, W., Deurloo, M. (2006). Aging in place and housing over-consumption. *Journal of Housing and the Built Environment* 21(3), 257-270.

Cocco, J. (2005). Portfolio choice in the presence of housing. *Review of Financial Studies* 18(2), 535-567.

Coile, C. (2003), Health shocks and couples' labor supply decisions. NBER Working Paper No. 10810.

Costa-Font, J., Elvira, D., Mascarilla-Miró, O. (2009). Ageing in place? Exploring elderly people's housing preferences in Spain. *Urban studies*, 46(2), 295-316.

Costa-Font, J. (2017). “Institutionalization aversion” and the willingness to pay for home health care. *Journal of Housing Economics* 38, 62-69.

Courtney-Long, E., Stevens, A., Caraballo, R., Ramon, I., Armour, B. (2014). Disparities in current cigarette smoking prevalence by type of disability, 2009-2011. *Public Health Reports* 129(3), 252–260.

Davidoff, T., Welke, G. (2007). Illiquid housing as self-insurance: the case of long-term care. UC Berkeley. Fisher Center Working Papers.

De Luca, G., Rossetti, C., Malter, F. (2015). Sample design and weighting strategies in SHARE Wave 5. In Malter, F. and Börsch-Supan, A., *SHARE Wave 5: Innovations & Methodology* (pp. 75-84). Munich.

Ekerdt, D., Sergeant J. (2006). Family things: attending the household disbandment of older adults. *Journal of Aging Studies* 20(3), 193–205.

Engelhardt, G. (2003). Nominal loss aversion, housing equity constraints, and household mobility: Evidence from the United States. *Journal of Urban Economics* 53(1), 171– 195.

Eurostat (2015). People in the EU: who are we and how do we live? Publications Office of the European Union, Luxembourg.

Faulkner, D., Bennet, K. (2002). Linkages among housing assistance, residential (re)location, and use of community health and social care by old-old adults: shelter and non-shelter implications for housing policy development. Final Report. Australian Housing and Urban Research Institute: Melbourne.

Fiedler, J. (2008). Time for Older Persons' Housing Action. *Parity* 21(7), 2.

Fitzgerald, J., Gottschalk, P., Moffitt, R. (1998). The impact of attrition in the panel study of income dynamics on intergenerational analysis. *Journal of Human Resources* 33 (2), 123–134.

Flavin, M., Yamashita, T. (2002). Owner-occupied housing and the composition of the household portfolio. *American Economic Review* 92(1), 345-362.

French, D., Mckillop, D. Sharma, T. (2018). Housing equity withdrawal in later life: regional pension inadequacy and the local economy. Program on the Global Demography of Aging at Harvard University Working Paper No. 154.

Genet, N., Boerma, W., Kroneman, M., Hutchinson, A., Saltman, R. B. (2012). Home care across Europe: Current structure and future challenges. European Observatory on Health Systems and Policies. World Health Organization.

Giles, L. C., Glonek, G. F. V., Luszcz, M., Andrews, G. R. (2007). Do social networks affect the use of residential aged care among older Australians? *BMC Geriatrics* 7(1), 1–10.

GjØra, L., Strand, B., Bergh, S., Borza, T., Brækhus, A., Engedal, K., Johannessen, A., Kvello-Alme, M., Krokstad, S., Livingston, G., Matthews, F., Myrstad, C., Skjellegrind, H., Thingstad, P., Aakhus, E., Aam, S., Selbæk, G. (2021). Current and future prevalence estimates of mild cognitive impairment, dementia, and its subtypes in a population-based sample of people 70 years and older in Norway: the HUNT Study. *Journal of Alzheimers Disease* 79(3), 1213-1226.

Guzman-Castillo, M., Ahmadi-Abhari, S., Bandosz, P., Capewell, S., Steptoe, A., Singh-Manoux, A., Kivimäki, M., Shipley, M., Brunner, E., O'Flaherty, M. (2017). Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study. *Lancet Public Health* 2(7), e307-e313.

Helderman, A. (2007). Once a homeowner, always a homeowner? An analysis of moves out of owner-occupation. *Journal of Housing and the Built Environment* 22(3), 239–261.

Heiss, F., Hurd, M., Borsch-Supan, A. (2005). Healthy, wealthy, and knowing where to live. In D. A. Wise (ed.), *Analyses in the economics of aging*, pp. 241-280. Chicago: University of Chicago Press.

Ilic, M., Grujicic, S., Ristic, B., Ilic, I. (2018). Myocardial infarction and alcohol consumption: A case-control study. *PloS One* 13(6), e0198129.

- Jefferson, T., Austen, S., Ong, R., Haffner, M., Wood, G. (2017). Housing equity withdrawal: perceptions of obstacles among older Australian home owners and associated service providers. *Journal of Social Policy* 46(3), 623-64.
- Jones, A., Rice, N., Zantomio, F. (2020). Acute health shocks and labour market outcomes: Evidence from the post-crash era. *Economics & Human Biology* 36, 100811.
- Judd, B., Olsberg, D., Quinn, J., Groenhart, L., Demirbilek, O. (2010). How well do older Australians utilise their homes? AHURI Research and Policy Bulletin Issue 126. Melbourne: Australian Housing and Urban Research Institute.
- Karaca-Mandic, P., Norton, E., Dowd, B. (2012). Interaction terms in nonlinear models. *Health Services Research* 47(1), 255–74.
- Kiel, K., Zabel, J. (1999). The accuracy of owner-provided house values: the 1978–1991 American Housing Survey. *Real Estate Economics* 27 (2), 263–298.
- Klevmarken, Anders, Bengt Swensson, and Patrik Hesselius (2005). The SHARE sampling procedures and calibrated design weights”. In Börsch-Supan, A. and Jürges, H. (eds.), *The Survey of Health, Ageing and Retirement in Europe – Methodology*. Chap. 5: 28–37.
- Laferrière, A. (2012). Housing wealth as self-insurance for long-term care. In: Joan Costa-Font and Christophe Courbage (ed.), *Financing Long-Term Care in Europe*, chapter 5, pp. 73-90, Palgrave Macmillan.
- Liang, K., Zeger, S. (1986). Longitudinal data analysis using generalized linear models. *Biometrika* 73, 13–22.
- Lorenzoni, L., et al. (2019). Health Spending Projections to 2030: New results based on a revised OECD methodology. OECD Health Working Papers, No. 110, OECD Publishing, Paris.
- Low, L. F., Yap, M., Brodaty, H. (2011). A systematic review of different models of home and community care services for older persons. *BMC Health Services Research* 11(1), 1–15.
- Luanaigh, C. Ó., Lawlor, B. A. (2008). Loneliness and the health of older people. *International Journal of Geriatric Psychiatry* 23(12), 1213–1221.
- Luborsky, M, Lysack, C Van Nuil, J. (2011). Refashioning one’s place in time: Stories of household downsizing in later life. *Journal of Aging Studies* 25(3), 243–252.
- Muir, T. (2017). Measuring social protection for long-term care. OECD Health Working Papers, No. 93. OECD Publishing: Paris, France.
- Mundlak, Y. (1978). On the pooling of time series and cross section data. *Econometrica: Journal of the Econometric Society* 46, 69–85.
- Narita, M., Tanji, F., Tomata, Y., Mori, K., Tsuji, I. (2020). The mediating effect of life-style behaviors on the association between personality traits and cardiovascular disease mortality among 29,766 community-dwelling Japanese. *Psychosomatic Medicine*, 82(1), 74–81.

- Nguyen, H., Mitrou, F., Zubrick, S. (2021). Retirement, housing mobility, downsizing and neighbourhood quality: a causal investigation. Life Course Centre Working Paper No. 2021-09.
- Norton, S., Matthews, F.E., Brayne, C. (2013). A commentary on studies presenting projections of the future prevalence of dementia. *BMC Public Health* 13, 1 (2013).
- Olea, J., Pflueger, C. (2013). A robust test for weak instruments. *Journal of Business and Economic Statistics* 31 (3), 358–369.
- Onambele-Pearson, G., Wullems, J., Doody, C., Ryan, D., Morse, C., Degens, H. (2019). Influence of habitual physical behavior – sleeping, sedentarism, physical activity – on bone health in community-dwelling older people. *Frontiers in Physiology* 10, 408.
- Ostrovsky, Y. (2002). A longitudinal study of the residential mobility of the elderly in Canada. SEDAP Research Paper 78. SEDAP Research Program, McMaster University.
- Oswald F., Wahl H.W., Schilling O., Nygren C., Fänge A., Sixsmith A., Iwarsson S. Relationships between housing and healthy aging in very old age. *Gerontologist* 47, 96–107.
- Outes-Leon, I. and Dercon, S. (2008). Survey Attrition and Bias in Young Lives. Young Lives Technical Note 5. Oxford: University of Oxford.
- Painter, G., Lee, K. (2009). Housing tenure transitions of older households: life cycle, demographic, and familial factors. *Regional Science and Urban Economics* 39(6), 749–760.
- Pannell, J., Aldridge, H., Kenway, P. (2016). Market assessment of housing options for older people. Shelter and the Joseph Rowntree Foundation.
- Papke, L. (2005). The effects of spending on test pass rates: evidence from Michigan. *Journal of Public Economics* 89, 821–839.
- Papke, L., Wooldridge, J. (1996). Econometric methods for fractional response variables with an application to 401 (k) plan participation rates. *Journal of Applied Econometrics* 11 (6), 619–632
- Papke, L., Wooldridge, J. (2008). Panel data methods for fractional response variables with an application to test pass rates. *Journal of Econometrics* 145 (1–2), 121–133.
- Pearlin, L. I., Zarit, S. H. (1993). Research into informal caregiving: Current perspectives and future directions. En S.H. Zarit, L.I. Pearlin and KW. Schaie (ed.), *Caregiving systems: formal and informal helpers* (pp. 155–167). Londres: Taylor and Francis.
- Peng, B., Yang, Q., B Joshi, R., Liu, Y., Akbar, M., Song, B. J., Zhou, S., Wang, X. (2020). Role of alcohol drinking in Alzheimer’s disease, Parkinson’s disease, and amyotrophic lateral sclerosis. *International Journal of Molecular Sciences* 21(7), 2316.
- Pflueger, C., Wang, S. (2015). A robust test for weak instruments in Stata. *The Stata Journal* 15 (1), 216–225.

- Pozzobon, D., Ferreira, P., Blyth, F., Machado, G., Ferreira, M. (2018). Can obesity and physical activity predict outcomes of elective knee or hip surgery due to osteoarthritis? A meta-analysis of cohort studies. *BMJ Open*, 8(2), e017689.
- Quinn, J., Judd, B., Olsber, D., Demirbilek, O. (2009). Dwelling, land and neighbourhood use by older homeowners. Australian Housing and Urban Research Institute: Melbourne.
- Rissanen, I., Oura, P., Paananen, M., Miettunen, J., Geerlings, M. (2019). Smoking trajectories and risk of stroke until age of 50 years – The Northern Finland Birth Cohort 1966. *PloS One* 14(12), e0225909.
- Salonsalmi, A., Rahkonen, O., Lahelma, E., Laaksonen, M. (2017). The association between alcohol drinking and self-reported mental and physical functioning: a prospective cohort study among City of Helsinki employees. *BMJ Open*, 7(4), e014368.
- Samuelson, W.; Zeckhauser, R. (1988). Status quo bias in decision making. *Journal of Risk and Uncertainty*. 1: 7–5.
- Schulhofer-Wohl, S. (2012). Negative equity does not reduce homeowners' mobility. *Quarterly Review* 35(1), 2– 14.
- Szebehely, M., Trydegård, G. (2012). Home care for older people in Sweden: A universal model in transition. *Health and Social Care in the Community* 20(3), 300– 309.
- Tatsiramos, K. (2006). Residential mobility and housing adjustment of older households in Europe. IZA DP No. 2435
- Thomson, S., Figueras, J., Evetovits, T., Jowett, M., Mladovsky, P., Maresso, A., Cylus, J., Karanikolos, M., Kluge, H. (2014). *Economic crisis, health systems and health in Europe: impact and implications for policy*. Maidenhead: Open University Press.
- Venti, S., Wise, D. (2004). Aging and housing equity: another look. In D. A. Wise (ed.) *Perspectives on the economics of aging*, pp.127–180. National Bureau of Economic Research. Chicago: University of Chicago Press.
- Vidoni, E., Townley, R., Honea, R., Burns, J. (2011). Alzheimer disease biomarkers are associated with body mass index. *Neurology* 77(21), 1913–1920.
- Vitorino, L., Paskulin, L., Vianna, L. (2013). Quality of life of seniors living in the community and in long-term care facilities: a comparative study. *Revista Latino-Americana de Enfermagem*, 21(SPE), 3–11.
- UN (2019). United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, vol. I: Comprehensive Tables (ST/ESA/SER.A/426).
- Whelan, S., Atalay, K., Barrett, G., Edwards, R. (2019). Moving, downsizing and housing equity consumption choices of older Australians, AHURI Final Report No. 321, Australian Housing and Urban Research Institute, Melbourne.
- Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2012). The meaning of “aging in place” to older people. *The gerontologist*, 52(3), 357-366.

Woodbridge, S. (2003). Coping with change: comparing the retirement housing decisions of older people. In R. Bradley, L. Buys and J. Lyddon (eds.), *Social change in the 21<sup>st</sup> century conference proceedings*. Brisbane, Qld: Centre for Social Change Research, Queensland University of Technology.

Wooldridge, J. (2005). Simple solutions to the initial conditions problem in dynamic, nonlinear panel data models with unobserved heterogeneity. *Journal of Applied Econometrics* 20 (1), 39-54.

Wulff, M., Champion, A., Lobo, M. (2010). Household diversity and migration in mid-life: understanding residential mobility among 45–64-year-olds in Melbourne, Australia. *Population, Space and Place* 16(4), 307-321.

Zhang, Y. S., Saito, Y., Crimmins, E. (2019). Changing impact of obesity on active life expectancy of older Americans. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, 74(12), 1944–1951.

## Tables and Figures

**Table 1. Description of the sample by countries**

	Initial sample		Panel data sample		Change residence (%)	Baseline health status				Health shock between 2 waves			
	# obs.	# indiv.	# obs.	# indiv.		Non-mental Illness (%)	Deg. mental (%)	Other mental disorders (%)	ADL (%)	Non-mental Illness (%)	Deg. mental (%)	Other mental disorders (%)	ADL (%)
Austria	15,808	1,274	1,985	397	5.73	19.26	2.33	4.91	9.39	11.57	2.46	2.96	8.73
Belgium	23,824	3,295	7,020	1,404	5.13	21.22	1.41	8.19	12.30	10.66	1.39	3.72	9.84
Denmark	14,502	1,507	3,230	646	9.53	21.77	1.08	5.42	7.58	11.07	0.93	2.55	6.76
France	20,416	2,480	3,680	736	4.84	22.33	0.95	9.04	11.19	11.31	0.82	4.35	9.97
Germany	17,410	3,143	2,870	574	5.52	23.46	0.91	3.88	9.75	12.80	1.35	2.18	9.93
Italy	19,197	3,407	4,740	948	6.96	21.18	1.21	6.12	11.33	12.38	1.66	4.35	10.02
Spain	20,815	2,182	3,710	742	4.05	18.41	2.32	9.94	11.07	10.32	2.66	6.03	9.69
Sweden	16,276	1,658	4,320	864	10.27	20.87	1.39	4.77	7.12	10.34	1.10	2.00	7.29
Switzerland	12,140	1,046	1,980	396	9.67	14.00	0.51	5.11	5.79	7.71	0.63	2.53	5.28
North	30,778	3,165	7,550	1,510	10.01	21.18	1.26	5.05	7.29	10.60	1.03	2.24	7.10
Centre	89,598	11,238	17,535	3,507	5.45	22.32	1.23	6.94	10.22	11.86	1.30	3.38	9.68
South	40,012	5,589	8,450	1,690	5.65	19.93	1.70	7.80	11.24	11.47	2.10	5.09	9.88
All	160,388	19,992	33,535	6,707	6.51	21.61	1.36	6.73	10.53	11.71	1.44	3.55	9.57

Initial sample: all respondents at least one wave of SHARE (1, 2, 4, 5 and 6). Statistics for have been computed using sampling weights. Panel data: respondents who have answered the five waves of SHARE (1, 2, 4, 5 and 6).

Netherlands: did not participate on wave 6; Greece: did not participate on waves 4 and 5; Croatia, Czech Republic, Estonia, Ireland, Hungary, Luxembourg, Poland, Portugal, Slovenia did not participate on wave 1.

Group of countries: North (Denmark and Sweden), Centre (Austria, Belgium, France, Germany and Switzerland); South (Italy and Spain)

Baseline (non-mental) illness: 1 if respondent has been diagnosed at baseline of one of the following pathologies (heart attack, stroke, cancer or lung disease); 0 otherwise.

Baseline degenerative mental: 1 if respondent has been diagnosed at baseline of Alzheimer's disease or Parkinson; 0 otherwise.

Baseline other mental disorders: 1 if respondent has started to take drugs for anxiety or depression at baseline; 0 otherwise.

Baseline ADL: 1 if respondent reports a limitation for doing personal activities of daily living (dressing, including putting on shoes and socks, walking across a room, bathing or showering, eating, such as cutting up your food, getting in or out of bed and using the toilet, including getting up or down); 0 otherwise.

Shock (non-mental) illness: 1 if respondent has been diagnosed of heart attack, stroke, cancer or lung disease between two consecutive waves; 0 otherwise.

Shock degenerative mental: 1 if respondent has been diagnosed of Alzheimer's disease or Parkinson between two consecutive waves.

Shock other mental disorders: 1 if respondent has started to take drugs for anxiety or depression between two consecutive waves; 0 otherwise.

Shock ADL: 1 if respondent has become limited for doing personal activities of daily living between two consecutive waves (dressing, including putting on shoes and socks, walking across a room, bathing or showering, eating, such as cutting up your food, getting in or out of bed and using the toilet, including getting up or down); 0 otherwise.

Residential mobility: 1 if respondent has changed of residence between two consecutive waves (0 otherwise).

**Table 2. Comparison of home value with respect to wealth, home value (in real terms) before/after residential mobility and household size after residential mobility (%)**

	Residential mobility (%)	Difference in number of rooms			Ratio home value/wealth (%)		Decrease home value after residential mobility (%)
		Upsize (%)	Same size (%)	Downsize (%)	Before change resid.	After change resid.	
<b>No health shock</b>							
Austria	5.24	14.81	23.39	61.79	73.23	75.51	8.00
Belgium	4.06	13.08	12.15	74.77	69.75	69.89	20.22
Denmark	8.61	11.31	21.49	67.21	62.32	60.38	35.52
France	4.06	10.05	15.55	74.40	72.41	71.42	7.08
Germany	4.70	9.19	32.97	57.84	71.96	70.66	10.86
Italy	7.38	9.55	13.87	76.58	81.45	85.12	2.10
Spain	3.43	14.20	16.98	68.83	75.89	75.35	2.20
Sweden	8.19	8.59	25.42	65.99	58.18	55.12	19.99
Switzerland	9.50	9.91	22.39	67.69	63.89	64.50	17.86
All	5.94	11.08	20.35	68.57	70.63	71.00	13.13
<b>Health shock</b>							
Austria	5.46	9.02	21.31	69.67	81.52	82.38	13.39
Belgium	4.97	11.18	12.35	76.47	71.91	71.82	38.31
Denmark	10.51	9.93	13.91	76.16	61.66	62.15	58.10
France	5.34	8.09	12.50	79.41	72.97	75.05	13.29
Germany	4.94	7.37	24.21	68.42	75.41	73.22	16.17
Italy	8.52	10.37	13.41	76.22	85.50	86.83	5.94
Spain	3.02	12.10	15.32	72.58	76.88	75.36	1.71
Sweden	8.51	7.80	19.15	73.05	63.87	59.27	38.81
Switzerland	6.48	7.37	24.21	68.42	62.67	64.34	26.93
All	6.22	9.43	16.61	73.96	74.15	74.75	23.23

Source: Own work using waves 1, 2, 4 5 and 6 from SHARE. Using sampling weights.

Decrease in home value: 1 if home value of new dwelling is smaller than home value of previous residence (both in PPP2012).



**Table 3. Results for the probability of residential mobility**

	Health shock treated as exogenous				Health shock treated as endogenous			
	Control function (pure RE)		Control function (correlated RE)		Control function (pure RE)		Control function (correlated RE)	
	Coef.	APE	Coef.	APE	Coef.	APE	Coef.	APE
Residential mobility (lag)	0.406*** (0.049)	0.064*** (0.006)	0.390*** (0.070)	0.067*** (0.006)	0.578*** (0.067)	0.048*** (0.006)	0.554*** (0.067)	0.044*** (0.006)
Home adaptations	-0.043*** (0.020)	-0.044*** (0.020)	-0.064*** (0.020)	-0.066*** (0.020)	-0.110*** (0.020)	-0.112*** (0.020)	-0.181*** (0.020)	-0.181*** (0.020)
Shock: no mental	-0.387 (0.286)	-0.050 (0.029)	-0.390 (0.292)	-0.040 (0.029)	0.038*** (0.014)	0.039*** (0.009)	0.489*** (0.216)	0.048*** (0.022)
Shock: degenerative mental	-0.150*** (0.032)	-0.138*** (0.032)	-0.134*** (0.033)	-0.122*** (0.034)	0.112*** (0.034)	0.097*** (0.035)	0.080*** (0.036)	0.090*** (0.045)
Shock: other mental disorders	-0.045 (0.035)	-0.050 (0.036)	-0.058 (0.038)	-0.065 (0.039)	0.072** (0.040)	0.079*** (0.032)	0.086*** (0.043)	0.061*** (0.026)
Shock: ADL	-0.697*** (0.302)	-0.140*** (0.055)	-0.709*** (0.308)	-0.140*** (0.050)	0.240*** (0.031)	0.140*** (0.046)	0.833*** (0.163)	0.065*** (0.010)
Home adaptations and								
Shock: no mental	-0.047*** (0.007)	-0.047*** (0.007)	-0.051*** (0.007)	-0.054*** (0.007)	-0.057*** (0.007)	-0.051*** (0.007)	-0.056*** (0.007)	-0.051*** (0.007)
Shock: degenerative mental	-0.085 (0.050)	-0.083 (0.052)	-0.087 (0.053)	-0.091 (0.055)	-0.129*** (0.047)	-0.110*** (0.040)	-0.105*** (0.043)	-0.110*** (0.045)
Shock: other mental disorders	-0.006 (0.014)	-0.006 (0.014)	-0.005 (0.015)	-0.005 (0.016)	-0.005 (0.017)	-0.005 (0.018)	-0.005 (0.019)	-0.005 (0.020)
Shock: ADL	-0.206*** (0.010)	-0.204*** (0.010)	-0.202*** (0.010)	-0.201*** (0.011)	-0.200*** (0.011)	-0.199*** (0.011)	-0.197*** (0.011)	-0.196*** (0.011)
Age	-0.006*** (0.002)	-0.001*** (0.000)	-0.006*** (0.002)	-0.001*** (0.000)	-0.010*** (0.003)	-0.001*** (0.000)	-0.011*** (0.003)	-0.002*** (0.000)
Age * Shock(no mental)	0.036*** (0.010)	0.036*** (0.010)	0.040*** (0.012)	0.041*** (0.012)	0.080*** (0.032)	0.089*** (0.032)	0.091*** (0.032)	0.092*** (0.023)
Age * Shock (deg. mental)	0.126*** (0.041)	0.110*** (0.042)	0.105*** (0.043)	0.101*** (0.043)	0.194*** (0.044)	0.186*** (0.035)	0.218*** (0.039)	0.225*** (0.042)
Age * Shock (other mental dis.)	0.093*** (0.031)	0.085*** (0.032)	0.091*** (0.033)	0.086*** (0.035)	0.086*** (0.036)	0.087*** (0.038)	0.079*** (0.030)	0.076*** (0.030)
Age * Shock(ADL)	0.010** (0.005)	0.001** (0.001)	0.010** (0.005)	0.001 (0.001)	0.420*** (0.146)	0.033*** (0.006)	0.387*** (0.142)	0.063*** (0.006)
Age partner	-0.004** (0.002)	-0.002** (0.000)	-0.005*** (0.002)	-0.002*** (0.000)	-0.020*** (0.003)	-0.002*** (0.000)	-0.021*** (0.003)	-0.002*** (0.000)
Shock partner: no mental	0.079 (0.071)	0.011 (0.009)	0.080 (0.072)	0.011 (0.009)	0.072 (0.100)	0.012 (0.010)	0.384*** (0.108)	0.033*** (0.010)
Shock partner: degen. mental	0.054*** (0.009)	0.037*** (0.009)	0.045*** (0.009)	0.047*** (0.009)	0.052*** (0.009)	0.057*** (0.010)	0.054*** (0.010)	0.053*** (0.010)
Shock partner: other mental dis.	0.024*** (0.009)	0.025*** (0.009)	0.026*** (0.009)	0.026*** (0.009)	0.027*** (0.009)	0.027*** (0.010)	0.027*** (0.010)	0.027*** (0.010)
Shock partner: ADL	0.178* (0.092)	0.025* (0.012)	0.181** (0.094)	0.025*** (0.012)	0.216 (0.137)	0.026 (0.014)	0.267*** (0.080)	0.040*** (0.016)
Home adaptations and								
Shock partner: no mental	-0.081*** (0.018)	-0.079*** (0.018)	-0.080*** (0.018)	-0.082*** (0.018)	-0.084*** (0.018)	-0.085*** (0.018)	-0.086*** (0.019)	-0.040*** (0.019)
Shock partner: degen. mental	-0.049*** (0.007)	-0.051*** (0.007)	-0.055*** (0.007)	-0.060*** (0.007)	-0.165*** (0.007)	-0.171*** (0.007)	-0.177*** (0.007)	-0.184*** (0.007)
Shock partner: other mental dis.	-0.038 (0.045)	-0.033 (0.048)	-0.030 (0.050)	-0.026 (0.053)	-0.024 (0.055)	-0.020 (0.059)	-0.017 (0.063)	-0.015 (0.067)
Shock partner: ADL	-0.035*** (0.005)	-0.036*** (0.005)	-0.038*** (0.005)	-0.039*** (0.005)	-0.242*** (0.005)	-0.245*** (0.005)	-0.2*** (0.005)	-0.251*** (0.005)
Age * Shock partner(no mental)	0.073*** (0.023)	0.071*** (0.021)	0.083*** (0.023)	0.081*** (0.021)	0.081*** (0.039)	0.087*** (0.039)	0.092*** (0.038)	0.092*** (0.038)
Age * Shock partner(deg. mental)	0.075*** (0.030)	0.078*** (0.031)	0.086*** (0.031)	0.096*** (0.032)	0.107*** (0.033)	0.117*** (0.035)	0.124*** (0.036)	0.122*** (0.038)
Age * Shock partner(other mental dis.)	0.042*** (0.014)	0.044*** (0.015)	0.048*** (0.015)	0.054*** (0.016)	0.061*** (0.016)	0.070*** (0.017)	0.082*** (0.018)	0.098*** (0.018)
Age * Shock partner(ADL)	0.012*** (0.003)	0.001*** (0.000)	0.012*** (0.003)	0.000 (0.001)	0.086*** (0.037)	0.031*** (0.006)	0.093*** (0.031)	0.039*** (0.006)
Man	0.005 (0.029)	0.001 (0.004)	0.006 (0.030)	0.001 (0.004)	0.025 (0.040)	0.001 (0.004)	0.015 (0.041)	0.001 (0.004)
Married	-0.197*** (0.055)	-0.030*** (0.009)	-0.202*** (0.057)	-0.029*** (0.009)	-0.197*** (0.055)	-0.030*** (0.009)	-0.202*** (0.057)	-0.029*** (0.009)
Separated/divorced	0.273*** (0.045)	0.046*** (0.008)	0.278*** (0.047)	0.046*** (0.008)	0.274*** (0.045)	0.047*** (0.008)	0.280*** (0.047)	0.045*** (0.008)
Widow	0.217*** (0.039)	0.033*** (0.006)	0.222*** (0.041)	0.033*** (0.006)	0.216*** (0.039)	0.033*** (0.006)	0.222*** (0.041)	0.032*** (0.006)
Initial condition				0.082*** (0.013)				0.409*** (0.115)
N	33,535		33,535		33,535		33,535	

Interaction terms computed using Ai and Norton (2003). Significance of the interaction terms tested using Bowen (2012). All models include level of education, household adjusted income, household size, country and year fixed effects. Standard errors between parenthesis. APE after bootstrap with 500 replications. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Table 4. Estimations for home value to wealth ratio**

OLS. Fixed effects	Fractional probit QAMLE	Fractional probit GEE	Fractional probit Pooled GMLE (with IV)
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	Coef	Coef	APE	Coef	APE	Coef	APE
Residential mobility	0.000 (0.010)	0.002 (0.053)	0.000 (0.011)	1.116*** (0.100)	0.221*** (0.019)	1.241*** (0.128)	0.251*** (0.054)
Before: no mental	0.012*** (0.005)	0.051 (0.031)	0.011 (0.006)	0.053** (0.027)	0.011** (0.005)	0.040 (0.031)	0.015 (0.006)
Before: degenerative mental	0.067*** (0.007)	0.096*** (0.007)	0.102*** (0.007)	0.163*** (0.007)	0.169*** (0.007)	0.238*** (0.007)	0.245*** (0.007)
Baseline: other mental disorders	0.045*** (0.017)	0.054*** (0.017)	0.060*** (0.017)	0.072*** (0.018)	0.086*** (0.018)	0.110*** (0.018)	0.142*** (0.018)
Before: ADL	0.027*** (0.007)	0.131*** (0.048)	0.031*** (0.009)	0.140*** (0.042)	0.031*** (0.008)	0.089** (0.048)	0.031** (0.009)
Shock: no mental	0.026 (0.030)	0.072 (0.171)	0.016 (0.034)	0.120 (0.158)	0.025 (0.032)	0.169*** (0.064)	0.063*** (0.012)
Shock: degenerative mental	0.109*** (0.003)	0.119*** (0.003)	0.125*** (0.003)	0.143 (0.003)	0.154 (0.003)	0.169*** (0.003)	0.191*** (0.003)
Shock: other mental disorders	0.123*** (0.039)	0.126*** (0.039)	0.122*** (0.039)	0.174*** (0.040)	0.129*** (0.040)	0.206*** (0.040)	0.143*** (0.040)
Shock: ADL	0.015 (0.014)	0.107 (0.073)	0.024 (0.015)	0.066 (0.067)	0.014 (0.013)	0.212*** (0.071)	0.169*** (0.069)
Change * Shock(no mental)	-0.014*** (0.006)	-0.051 (0.035)	-0.019 (0.010)	-0.017*** (0.003)	-0.014*** (0.006)	-0.167*** (0.112)	-0.158*** (0.030)
Change * Shock (degen. mental)	-0.104*** (0.016)	-0.202*** (0.017)	-0.208*** (0.018)	-0.207*** (0.018)	-0.209*** (0.019)	-0.211*** (0.020)	-0.197*** (0.020)
Change * Shock (other mental dis.)	-0.020*** (0.008)	-0.109*** (0.046)	-0.024*** (0.009)	0.155*** (0.044)	-0.134*** (0.009)	-0.128*** (0.031)	-0.107*** (0.023)
Change * Shock(ADL)	-0.062*** (0.018)	-0.037** (0.019)	-0.072*** (0.019)	-0.063*** (0.020)	-0.062*** (0.020)	-0.087*** (0.020)	-0.085*** (0.021)
Shock partner: no mental	0.008 (0.009)	0.037 (0.049)	0.008 (0.010)	0.025 (0.045)	0.005 (0.009)	0.148*** (0.060)	0.056*** (0.010)
Shock partner degenerative mental	0.075*** (0.009)	0.077*** (0.009)	0.078 (0.009)	0.083*** (0.009)	0.084*** (0.009)	0.085*** (0.009)	0.086*** (0.009)
Shock partner: other mental disorders	0.020*** (0.006)	0.018*** (0.006)	0.017 (0.006)	0.017*** (0.007)	0.017*** (0.007)	0.017*** (0.007)	0.017*** (0.007)
Shock partner: ADL	0.020 (0.031)	0.098 (0.192)	0.021 (0.039)	0.114 (0.180)	0.025 (0.036)	0.148 (0.083)	0.078 (0.036)
Change * Shock partner(no mental)	-0.011 (0.006)	-0.057*** (0.014)	-0.020*** (0.010)	-0.058*** (0.011)	-0.057*** (0.006)	-0.043*** (0.009)	-0.042*** (0.010)
Change * Shock partner(degen. mental)	-0.051*** (0.007)	-0.059*** (0.007)	-0.064*** (0.007)	-0.070*** (0.007)	-0.076*** (0.007)	-0.082*** (0.007)	-0.089*** (0.008)
Change * Shock partner (other mental dis.)	-0.034*** (0.011)	-0.030*** (0.011)	-0.028*** (0.011)	-0.026*** (0.011)	-0.025*** (0.011)	-0.031*** (0.012)	-0.029*** (0.012)
Change * Shock partner(ADL)	-0.020*** (0.008)	-0.093*** (0.016)	-0.021*** (0.009)	0.093*** (0.011)	-0.022*** (0.009)	-0.104*** (0.011)	-0.037*** (0.021)
Man	-0.021*** (0.004)	-0.094*** (0.026)	-0.022*** (0.006)	-0.094*** (0.019)	-0.022*** (0.004)	-0.096*** (0.026)	-0.023*** (0.006)
Age: 55-59	0.000 (0.011)	-0.001 (0.041)	0.000 (0.009)	-0.004 (0.046)	-0.001 (0.011)	-0.013 (0.041)	-0.003 (0.009)
Age: 60-64	0.007 (0.010)	0.026 (0.045)	0.006 (0.010)	0.036 (0.044)	0.008 (0.010)	0.027 (0.044)	0.006 (0.010)
Age: 65-59	0.021** (0.010)	0.080* (0.047)	0.019 (0.011)	0.097*** (0.045)	0.024*** (0.010)	0.092** (0.047)	0.022** (0.011)
Age: 70-74	0.039*** (0.010)	0.135*** (0.048)	0.039*** (0.011)	0.138*** (0.047)	0.041*** (0.011)	0.139*** (0.047)	0.041*** (0.011)
Age: 75-79	0.045*** (0.011)	0.144*** (0.053)	0.046*** (0.012)	0.145*** (0.050)	0.047*** (0.011)	0.144*** (0.052)	0.045*** (0.012)
Age: 80-84	0.041*** (0.012)	0.137*** (0.061)	0.041*** (0.014)	0.142*** (0.057)	0.043*** (0.013)	0.138*** (0.060)	0.041*** (0.014)
Age: 85+	0.031*** (0.015)	0.106 (0.078)	0.027 (0.019)	0.136** (0.071)	0.039** (0.016)	0.123 (0.078)	0.033 (0.018)
Married	-0.009 (0.009)	-0.047 (0.059)	-0.010 (0.014)	-0.035 (0.047)	-0.007 (0.010)	0.000 (0.061)	0.000 (0.014)
Separated/divorced	0.025** (0.012)	0.098 (0.074)	0.023 (0.017)	0.100 (0.057)	0.024 (0.013)	0.109 (0.073)	0.027 (0.016)
Widow	0.037*** (0.011)	0.143*** (0.068)	0.043*** (0.016)	0.143*** (0.054)	0.042*** (0.012)	0.144*** (0.068)	0.044*** (0.015)
N	24,732	24,732		24,732		24,732	

Interaction terms computed using Ai and Norton (2003). Significance of the interaction terms tested using Bowen (2012). All models include level of education, household adjusted income, household size, country and year fixed effects. Standard errors between parenthesis. APE after bootstrap with 500 replications. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Table 5. Results for the difference in the number of bedrooms**

	Difference in home value (1,000,000; PPP2012)		Difference in the number of rooms	
	Panel OLS, FE	GMM (IV)	Panel OLS, FE	GMM (IV)
Purchased new house	0.005*** (0.002)	0.017*** (0.003)	-0.066 (0.070)	0.170** (0.074)
Before: no mental	0.001 (0.005)	-0.003 (0.005)	0.000 (0.015)	-0.002 (0.015)
Before: degenerative mental	0.000 (0.007)	0.006 (0.008)	0.187 (0.181)	0.234 (0.233)
Baseline: other mental disorders	0.006 (0.007)	0.003 (0.008)	-0.091 (0.065)	-0.070 (0.071)
Before: ADL	-0.005 (0.006)	-0.012* (0.007)	0.029 (0.022)	0.033 (0.023)
Shock: no mental	-0.005 (0.009)	-0.013 (0.010)	0.018 (0.022)	-0.470 (0.396)
Shock: degenerative mental	0.013* (0.007)	0.016* (0.008)	0.662*** (0.263)	0.673*** (0.268)
Shock: other mental disorders	0.009 (0.024)	0.020 (0.032)	-0.014 (0.101)	-0.012 (0.102)
Shock: ADL	-0.020 (0.037)	-0.021 (0.054)	0.015 (0.026)	0.046 (0.082)
Purchased new house * Shock(no mental)	-0.013*** (0.003)	-0.019*** (0.02)	-0.056 (0.059)	-0.157*** (0.064)
Purchased new house * Shock (degen. mental)	-0.032*** (0.004)	-0.037*** (0.005)	-0.510*** (0.120)	-0.626*** (0.122)
Purchased new house * Shock (other mental dis.)	-0.008*** (0.002)	-0.010*** (0.004)	-0.318*** (0.121)	-0.319*** (0.125)
Purchased new house * Shock(ADL)	-0.024*** (0.009)	-0.031*** (0.010)	-0.713*** (0.122)	-1.218*** (0.084)
Shock partner: no mental	-0.017 (0.046)	-0.033 (0.089)	0.013 (0.036)	0.216 (0.302)
Shock partner degenerative mental	-0.019 (0.065)	0.038 (0.104)	-0.017 (0.073)	-0.024 (0.074)
Shock partner: other mental disorders	-0.025 (0.057)	0.035 (0.075)	-0.061 (0.048)	-0.049 (0.053)
Shock partner: ADL	0.002 (0.004)	0.003 (0.004)	0.004 (0.053)	-0.170 (0.481)
Purchased new house * Shock partner(no mental)	-0.010*** (0.002)	0.0012*** (0.003)	-0.064 (0.061)	-0.139*** (0.067)
Purchased new house * Shock partner(degen. mental)	-0.027** (0.008)	-0.035*** (0.007)	0.536*** (0.080)	0.658*** (0.084)
Purchased new house * Shock partner (other mental dis.)	-0.010*** (0.003)	-0.014*** (0.003)	-0.190*** (0.060)	-0.198*** (0.068)
Purchased new house * Shock partner(ADL)	-0.033*** (0.008)	-0.035*** (0.008)	-1.126*** (0.125)	-1.106*** (0.125)
Man	-0.021** (0.009)	-0.009 (0.009)	0.002 (0.013)	-0.002 (0.013)
Age: 55-59	-0.019* (0.010)	-0.023* (0.012)	0.006 (0.021)	0.005 (0.021)
Age: 60-64	-0.021 (0.013)	-0.002 (0.022)	-0.021 (0.021)	-0.022 (0.021)
Age: 65-59	0.004 (0.009)	0.006 (0.010)	0.012 (0.022)	0.008 (0.022)
Age: 70-74	0.008 (0.010)	0.018* (0.010)	0.001 (0.024)	-0.001 (0.024)
Age: 75-79	0.007 (0.009)	0.011 (0.010)	0.028 (0.028)	0.028 (0.028)
Age: 80-84	-0.006*** (0.001)	-0.007*** (0.001)	-0.036 (0.035)	-0.037 (0.035)
Age: 85+	-0.009*** (0.030)	-0.010*** (0.003)	0.035 (0.051)	0.038 (0.051)
Married	-0.014 (0.028)	-0.021 (0.030)	0.044 (0.024)	0.054 (0.025)
Separated/divorced	-0.003 (0.008)	-0.003 (0.009)	-0.027 (0.029)	-0.026 (0.029)
Widow	-0.008*** (0.02)	-0.010*** (0.002)	-0.067*** (0.028)	-0.067*** (0.028)
N	24,732	24,732	2,135	2,135
J-Hansen test (p-value)		0.623		0.566
C-statistic (p-value)		15.127		14.804
IV redundancy test (p-value)		0.220		0.116

Interaction

terms computed using Ai and Norton (2003). Significance of the interaction terms tested using Bowen (2012). All models include level of education, household adjusted income, household size, country and year fixed effects. Standard errors between parenthesis. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Table 6. Predicted outcomes (by country) conditioned on the occurrence of health shocks**

*Predicted prob. change of residence (from Table 3)*

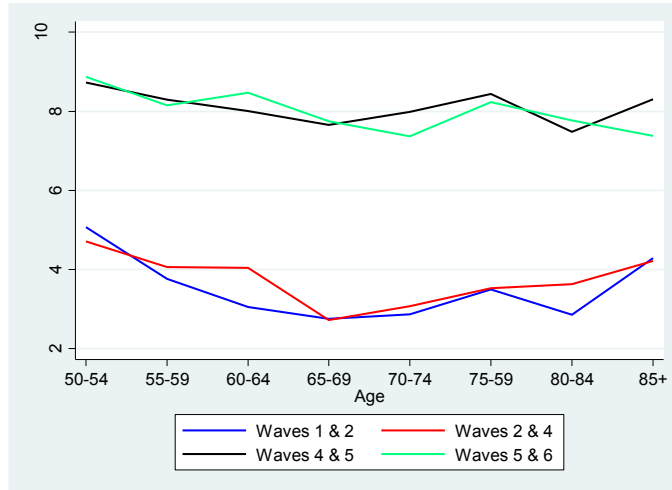
	No shock	Non mental	Degenerative mental illness	Other mental disorders	ADL
Austria	6.515	6.700	4.635	2.396	6.623
Belgium	4.018	3.680	4.387	2.349	3.362
Denmark	7.747	6.924	14.849	6.715	7.254
France	3.888	3.849	5.811	2.536	4.512
Germany	4.225	6.486	8.602	2.435	9.347
Italy	6.311	5.840	7.224	2.550	4.699
Spain	3.362	9.440	13.136	1.428	12.498
Sweden	6.359	6.866	10.682	2.072	9.089
Switzerland	7.050	5.458	8.797	2.409	5.379
<i>Predicted (difference in home value to wealth) · 100 (from Table 4)</i>					
Conditioned on residential mobility					
	No shock	Non mental	Degenerative mental illness	Other mental disorders	ADL
Austria	2.746	-3.310	-11.022	-1.995	-6.551
Belgium	2.267	-6.016	-4.323	-2.482	-2.950
Denmark	1.659	0.880	-5.241	-0.408	-12.093
France	0.080	8.411	-3.763	-2.557	-1.166
Germany	1.100	1.079	-29.736	-29.552	-9.756
Italy	3.302	3.412	1.217	1.134	1.460
Spain	1.230	2.407	3.354	2.139	0.770
Sweden	0.110	-13.353	-19.618	-2.480	-19.290
Switzerland	3.164	3.631	-0.472	-0.461	-1.146
<i>Predicted difference in home value (PPP 2012) (from Table 5)</i>					
Conditioned on residential mobility					
	No shock	Non mental	Degenerative mental illness	Other mental disorders	ADL
Austria	22.234	-1.458	-3.048	-304	-2.955
Belgium	5.233	-18.077	-18.114	-1.964	-19.203
Denmark	2.786	-119.308	-118.927	-9.098	-119.973
France	23.707	-1.067	-456	-70	-786
Germany	19.203	-2.872	-3.361	-386	-5.233
Italy	23.783	21.982	23.531	1.459	2.371
Spain	119.973	23.792	24.081	536	2.379
Sweden	2.955	-24.883	-23.305	-2.471	-22.234
Switzerland	10.627	-10.422	-10.305	-1.038	-10.627
<i>Predicted (difference number of rooms) (from Table 5)</i>					
Conditioned on residential mobility					
	No shock	Non mental	Degenerative mental illness	Other mental disorders	ADL
Austria	0.030	-0.762	-1.124	-0.916	-0.200
Belgium	0.430	-0.120	-0.395	-0.366	-1.124
Denmark	0.650	-0.170	-0.341	-0.319	-2.772
France	0.200	-0.080	-1.000	-0.833	-0.302
Germany	0.310	-3.332	-1.446	-1.118	-1.652
Italy	0.160	-0.424	-0.820	-0.704	-0.050
Spain	0.300	-0.060	-0.364	-0.340	-0.372
Sweden	0.929	-0.506	-2.974	-1.826	-1.620
Switzerland	0.200	-1.471	-0.968	-0.916	-0.330

Source: Own work using waves 1, 2, 4 5 and 6 from SHARE. Using sampling weights.

## ONLINE APPENDIX

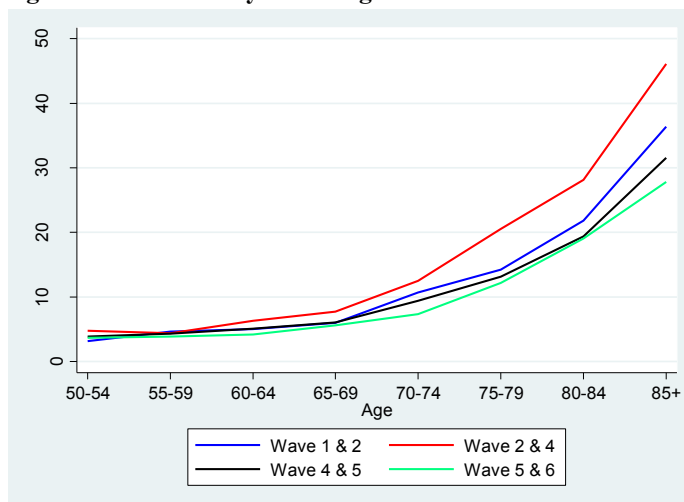
### Appendix A

**Figure A1. Probability of having changed of residence between two consecutive waves**



Source: own work using waves 1, 2, 4, 5 and 6 from SHARE. Total sample: 33,535 observations (6,707 individuals).

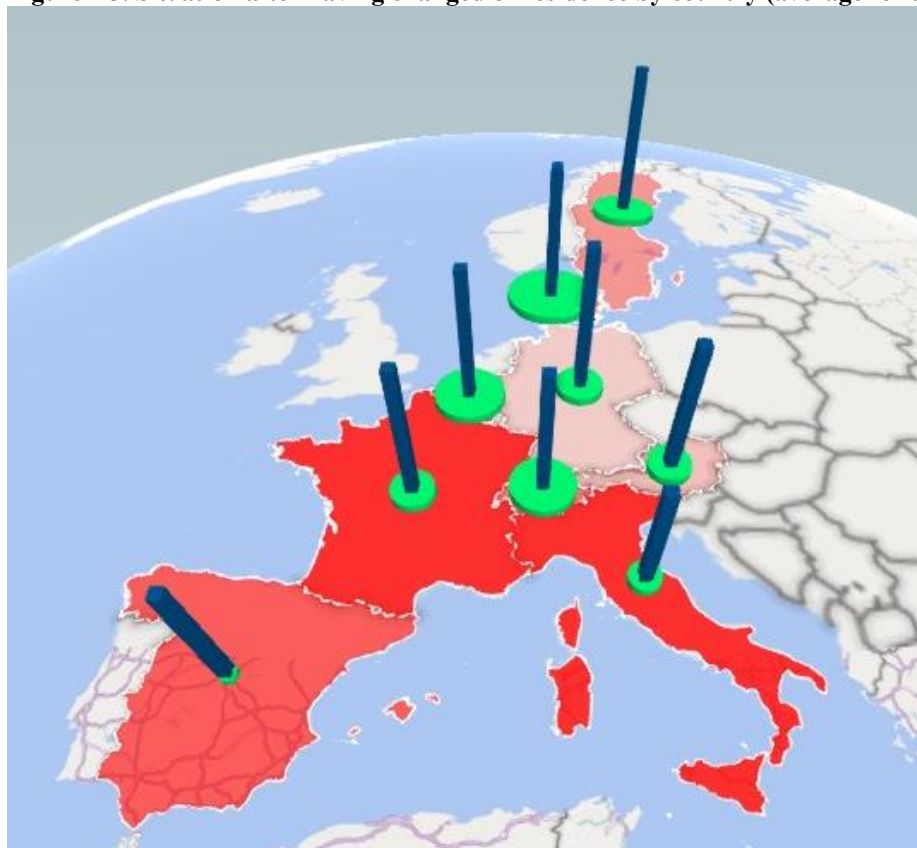
**Figure A2. Probability of having suffered a health shock between two consecutive waves**



Source: own work using waves 1, 2, 4, 5 and 6 from SHARE. Total sample: 33,535 observations.

Health shock: binary variable that takes the value 1 if the individual has suffered any type of health shock (mental shock, non-mental shock, ADL shock) between two consecutive waves.

**Figure A3. Situation after having changed of residence by country (average for all waves)**



Red areas: percentage of households who have moved to a house with a smaller number of rooms.

Navy blue bricks: percentage of households who have moved to a house with lower value with respect to total wealth.

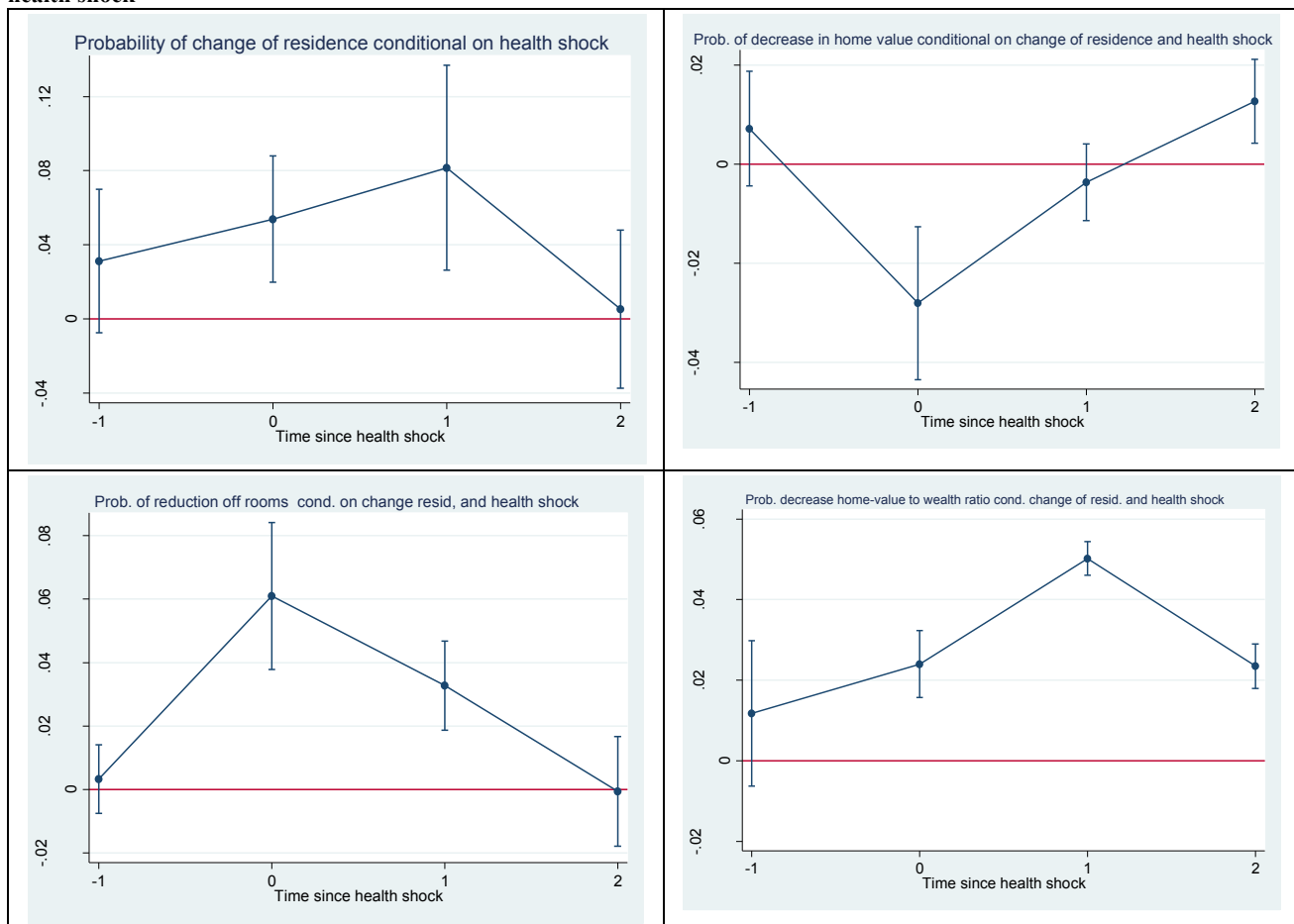
Green circles: percentage of households that have moved to lower-value housing.

Wealth = Bank accounts+ Bond, stock and mutual funds+ Savings for long-term investments + Value of own business + Value of home + Value of cars + Value of other real state

	Have reduced ratio home value/wealth after residential mobility (%)	Have reduced number of rooms after residential mobility (%)	Have reduce home value (in real terms) after residential mobility (%)
Austria	48.42	60.00	10.04
Belgium	47.65	77.56	25.41
Denmark	46.77	66.40	45.77
France	49.84	78.78	9.98
Germany	51.41	59.89	11.65
Italy	40.95	78.73	5.08
Spain	45.98	72.67	1.62
Sweden	52.72	65.22	29.88
Switzerland	46.21	68.18	20.77

Source: own work using waves 1, 2, 4, 5 and 6 of SHARE.

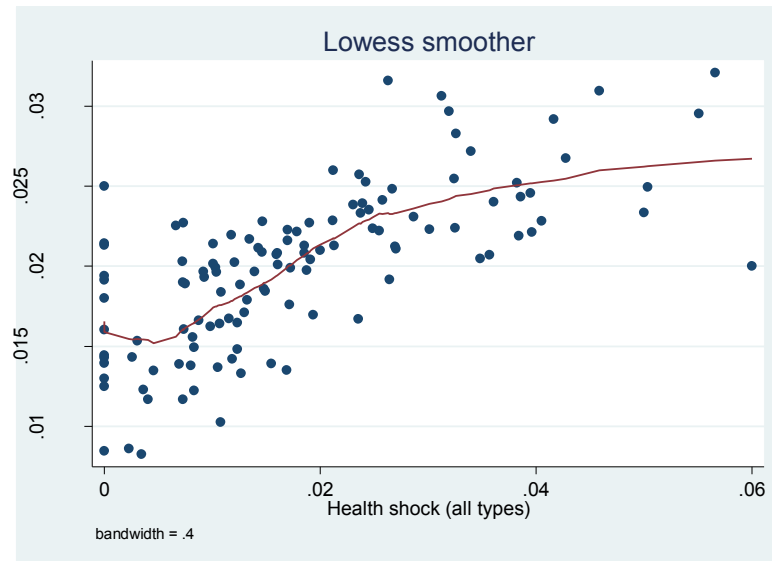
**Figure A4. Event-study for the probability of residential mobility, probability of decrease in home value, reduction in the number of rooms and reduction in home value to wealth ratio conditional on health shock on health shock**



Time 0 is identified as the time at which the health shock (any of the four types of health shocks) occurs.

This figure corresponds to an event study created by regressing the outcome variable for a respondent-by-year cell on a full set of event time indicators interacted with a binary variable for “health shock” and on a set of control variables (gender, age, age squared, education, marital status at baseline, relation with economic activity at baseline, housing tenure at baseline, area of residence, wealth and income at baseline, country fixed effects). Each figure reports the coefficients for event-time, that is, the time path of outcome variables in treated vs. untreated individuals before and after of policy implementation and the 95% confidence intervals with robust standard errors clustered at the region-level.

**Figure A5. Change in housing mobility versus occurrence of health shocks (%)**



Source: Own work using waves 1, 2, 4 5 and 6 from SHARE. Using sampling weights.

Red line shows the locally weighted regression of changes in housing mobility over changes in the occurrence of health shocks.



**Table A1. Attrition regressions (OLS) and Beckett-Gould-Lillard-Welch test**

	Residential mobility	Difference in number of bedrooms	Home value to wealth ratio	Home value (1,000, 000 ; PPP2012)
Attrition	-0.002 (0.004)	-0.345 (0.847)	0.001 (0.003)	0.001 (0.003)
Men	-0.086** (0.037)	0.013*** (0.002)	0.105*** (0.031)	0.143*** (0.033)
Attr*Men	0.002 (0.009)	-0.020 (0.346)	0.002 (0.007)	0.004 (0.008)
Age	0.002*** (0.000)	-0.004*** (0.000)	0.001*** (0.000)	0.001*** (0.000)
Attr*Age	-0.002 (0.007)	0.004 (0.009)	-0.001 (0.005)	-0.002 (0.006)
Never married	-0.061*** (0.009)	-0.004 (0.006)	0.020*** (0.007)	0.023*** (0.008)
Divorced	-0.048*** (0.008)	0.037*** (0.005)	0.026*** (0.006)	0.034*** (0.007)
Widow	-0.032*** (0.006)	0.008* (0.004)	0.031*** (0.005)	0.034*** (0.005)
Attr*Never married	0.010 (0.016)	0.008 (0.013)	-0.013 (0.013)	-0.012 (0.014)
Attr*Divorced	0.008 (0.013)	0.025 (0.031)	0.015 (0.011)	0.005 (0.011)
Attr*Widow	0.032*** (0.012)	-0.002 (0.236)	-0.012 (0.010)	-0.009 (0.010)
No education	0.040*** (0.009)	0.013** (0.006)	0.020*** (0.008)	0.017** (0.008)
Primary education	0.088*** (0.010)	0.022*** (0.006)	0.022*** (0.008)	0.019** (0.009)
Lower secondary	0.083*** (0.009)	0.050*** (0.006)	0.026*** (0.008)	0.023*** (0.008)
Upper secondary	0.201*** (0.014)	0.171*** (0.009)	0.050*** (0.011)	0.051*** (0.012)
Post-secondary non tertiary	0.131*** (0.010)	0.064*** (0.006)	0.028*** (0.008)	0.026*** (0.008)
Tertiary education	0.239*** (0.027)	-0.018 (0.018)	-0.012 (0.022)	-0.021 (0.024)
Attr*No education	-0.010 (0.021)	0.043 (0.409)	-0.000 (0.017)	0.005 (0.018)
Attr*Primary education	-0.018 (0.021)	0.029 (0.043)	0.011 (0.018)	0.007 (0.019)
Attr*Lower secondary	-0.013 (0.021)	0.013 (0.323)	0.000 (0.017)	0.009 (0.018)
Attr*Upper secondary	-0.201 (0.329)	0.009 (0.014)	-0.003 (0.024)	0.008 (0.026)
Attr*Post-secondary non tertiary	-0.131 (0.222)	0.009 (0.011)	0.009 (0.018)	0.015 (0.019)
Attr*Tertiary education	-0.239*** (0.371)	0.081 (0.101)	0.140 (0.158)	0.132 (0.162)
Shock(no mental)	-0.016*** (0.006)	-0.001 (0.004)	-0.007 (0.005)	-0.006 (0.005)
Attr* Shock(no mental)	0.016 (0.012)	0.007 (0.257)	0.008 (0.010)	0.018 (0.011)
Shock(ADL)	-0.027** (0.012)	0.007 (0.008)	0.011 (0.010)	0.012 (0.011)
Attr*Shock(ADL)	0.027 (0.024)	0.002 (0.015)	0.002 (0.019)	-0.014 (0.021)
Shock (degenerative mental illness)	-0.007 (0.009)	-0.005 (0.006)	-0.013* (0.007)	-0.011 (0.008)
Attr*Shock (deg. mental illness)	0.007 (0.018)	0.021 (0.87)	0.014 (0.015)	0.018 (0.016)
Shock (other mental disorders)	0.005 (0.015)	-0.005 (0.009)	-0.006 (0.012)	-0.007 (0.013)
Attr* Shock (other mental disorders)	-0.005 (0.028)	0.057 (0.080)	-0.025 (0.023)	-0.018 (0.025)
Constant	0.086*** (0.018)	0.285*** (0.012)	-0.056*** (0.015)	-0.045*** (0.016)
N	22,119	22,119	22,119	22,119
R2	0.147	0.083	0.009	0.014
Beckett-Gould-Lillard-Welch test	0.836	0.255	0.181	0.523

Attrition is a dummy variable taking value 1 if the respondent only appears in wave 1 and does not continue in the following waves: 0 otherwise. All models also include household adjusted income (and interaction with attrition), household size (and interaction with attrition), country and year fixed effects. Standard errors between parenthesis. APE after bootstrap with 500 replications. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Table A2. Descriptive statistics**

	All sample	Residential mobility		Health shock between two consecutive waves				
		Yes	No	Non-mental illness	Degenerative mental illness	Other mental disorders	Limitation for ADL	None
Man	44.62	41.22	44.83	47.57	45.85	25.81	37.49	45.53
Woman	55.38	58.78	55.17	52.43	54.15	74.19	62.51	54.47
Age	65.33	64.95	65.35	69.56	78.44	70.21	73.10	63.95
	(10.51)	(10.77)	(10.49)	(10.59)	(8.66)	(9.89)	(11.24)	(9.90)
Change of residence	5.99	100.00	0.00	6.28	5.18	5.98	6.55	5.93
Previous health shock								
No mental illness	21.44	21.72	21.42	24.95	32.64	21.83	36.14	19.17
Degenerative mental illness	1.36	1.80	1.33	2.54	3.89	3.46	6.45	0.82
Other mental disorders	6.73	7.65	6.67	8.52	12.95	0.00	12.81	6.18
ADL	10.42	11.48	10.36	17.79	29.27	14.38	24.22	7.84
Health shock between two waves								
Shock (non mental illness)	11.66	11.29	11.68	100.00	25.39	18.68	24.90	0.00
Shock (degenerative mental illness)	1.44	1.24	1.45	3.33	100.00	6.30	6.98	0.00
Shock (other mental disorders)	3.55	3.54	3.55	6.04	15.54	100.00	8.00	0.00
Shock (limitation for ADL)	9.61	9.83	9.60	20.53	37.56	17.42	100.00	0.00
Level of education								
No education	6.41	5.63	6.46	9.27	49.22	33.16	12.70	5.29
Primary education	23.01	21.10	23.13	27.93	14.25	18.68	31.77	21.23
Lower secondary	15.58	13.66	15.70	15.18	18.91	22.67	16.40	15.60
Upper secondary	32.78	32.98	32.77	30.14	1.30	0.94	27.46	33.82
Post-secondary non tertiary	2.37	3.14	2.32	1.93	16.06	16.79	1.22	2.54
Tertiary education	19.84	23.50	19.62	15.55	0.26	0.21	10.44	21.52
Marital status								
Married	70.19	55.88	71.19	65.81	58.55	62.85	59.01	71.83
Registered partnership	1.57	1.82	1.55	1.28	1.30	0.73	1.09	1.64
Cohabiting	1.17	1.92	1.12	1.06	0.78	1.15	0.94	1.20
Single	6.04	7.65	5.93	5.82	6.22	6.09	6.05	6.04
Separated/divorced	8.04	14.91	7.56	7.29	3.37	7.66	7.13	8.18
Widow	12.99	17.83	12.65	18.74	29.79	21.51	25.77	11.10
Economic activity								
Retired	52.38	51.86	52.42	66.36	74.52	53.62	65.41	49.53
Employed	29.08	31.49	28.92	14.85	3.84	16.65	9.36	32.90
Unemployed	3.11	3.21	3.10	2.69	0.82	2.49	1.92	3.25
Disabled	2.99	3.97	2.92	4.09	2.47	4.86	6.51	2.44
Homemaker	11.30	8.17	11.51	10.76	18.36	22.27	15.18	10.83
Other situations	1.14	1.30	1.13	1.25	0.00	0.11	1.63	1.06
Tenure								
Owner	73.75	59.43	74.63	68.31	70.24	74.36	66.39	75.22
Tenant/sub-tenant	20.08	33.86	19.24	24.04	4.83	1.69	24.62	19.11
Member of cooperative	0.83	1.62	0.79	0.76	15.82	17.90	0.77	0.86
Rent-free	5.34	5.09	5.35	6.89	9.12	6.04	8.22	4.81
Home adaptations	1.83	2.42	1.79	1.83	2.59	2.41	2.36	1.77
Size of municipality								
Big city	12.73	15.60	12.56	12.98	12.10	12.70	13.88	12.38
Suburbs of a big city	11.62	12.09	11.59	11.23	13.44	11.41	10.27	11.91
Large town	13.35	13.65	13.33	12.50	15.32	16.47	14.01	13.36
Small town	29.00	29.86	28.95	29.47	34.14	30.46	30.11	28.84
Rural area or village	33.30	28.80	33.58	33.82	25.00	28.96	31.73	33.51
Household composition								
Has daughters at home	7.29	7.52	7.27	5.00	1.55	4.62	5.87	7.79
Number of Daughters at home	1.22	1.29	1.21	1.12	1.17	1.18	1.21	1.23
	(0.48)	(0.50)	(0.47)	(0.36)	(0.41)	(0.76)	(0.48)	(0.48)
Smoking habit								
Smokes now	19.29	22.80	19.07	20.53	11.92	15.42	15.78	19.42
Never smoked	55.48	50.45	55.79	53.73	84.97	79.75	62.17	54.88
Smoked before. Not now	25.23	26.75	25.14	25.74	3.11	4.83	22.05	25.71
Body mass index								
Underweight	3.11	3.20	3.10	3.70	2.20	2.07	5.50	2.72
Normal weight	36.99	38.27	36.91	32.40	43.53	35.37	31.31	38.20
Overweight	40.37	37.98	40.52	39.51	40.50	42.58	38.01	40.77
Obese	19.53	20.56	19.47	24.39	13.77	19.98	25.18	18.31
Sedentary lifestyle	44.96	46.74	44.85	55.87	29.02	16.47	68.23	40.72
Drinks alcohol	25.76	24.49	25.84	24.70	48.19	48.27	20.20	26.62
Income (1,000PPP)	30.97	30.09	31.02	27.20	16.43	16.35	23.08	32.45
	(37.78)	(41.69)	(37.53)	(40.19)	(26.80)	(20.62)	(29.89)	(38.13)
Wealth (1,000PPP)	257.89	222.72	260.03	209.30	251.87	265.58	188.49	272.05
	(424.72)	(537.78)	(416.74)	(303.85)	(316.77)	(335.61)	(347.38)	(444.92)
Stay at nursing home	1.27	0.62	1.31	2.34	11.66	3.36	6.41	0.70
N	33,535	2,183	31,352	3,914	386	953	3,209	26,619

Standard deviations between parenthesis. Using calibrated sampling weights.

Home adaptations: 1 if the home has any of the following facilities (widened doors or corridors, ramps or street level entrances, hand rails, automatic or easy open doors or gates, bathroom or toilet modifications, kitchen modification, stair glides, alerting devices), 0 otherwise.

**Table A3. Heating and cooling degree days (NUTS-2 level)**

	Wave 1	Wave 2	Wave 4	Wave 5	Wave 6
<b>Heating days</b>					
Mean	2,818.63	2,574.02	2,520.57	2,865.40	2,566.51
Std. Dev.	993.226	938.347	949.105	998.44	936.993
Maximum	6,436.43	6,186.31	5,908.44	6,144.02	5,930.12
Minimum	Övre Norrland (SE) 99.44 Canarias (SP)	Övre Norrland (SE) 142.10 Canarias (SP)	Övre Norrland (SE) 48.35 Canarias (SP)	Övre Norrland (SE) 104.51 Canarias (SP)	Övre Norrland (SE) 190.36 Canarias (SP)
<b>Cooling days</b>					
Mean	66.79	63.43	74.82	80.10	124.37
Std. Dev.	104.2	99.41	109.8	101.2	142.6
Maximum	469.74	395.85	420.52	462.06	504.76
Minimum	Extremadura (SP) 0.00 Hovedstaden (DK) Sjælland (DK) Syddanmark (DK) Nordjylland (DK) Tirol (SW) Småland med öarna (SE) Sydsverige (SE) Västsverige (SE) Mellersta Norrland (SE) Övre Norrland (SE) Zentralschweiz (SW)	Puglia (IT) 0.00 West-Vlaanderen (BE) Hainaut (BE) Hovedstaden (DK) Sjælland (DK) Syddanmark (DK) Midtjylland (DK) Nordjylland (DK)	Andalucía (SP) 0.00 Syddanmark (DK) Midtjylland (DK) Nordjylland (DK) Stockholm (DK) Östra Mellansverige (SE) Småland med öarna Sydsverige (SE) Västsverige (SE) Norra Mellansverige (SE) Mellersta Norrland (SE)	Extremadura (SP) 0.00 Nordjylland (DK) Stockholm (DK) Östra Mellansverige Småland med öarna (SE) Norra Mellansverige Mellersta Norrland (SE) Övre Norrland (SE)	Extremadura (SP) 0.00 Syddanmark (DK) Midtjylland (DK) Nordjylland (DK) Stockholm (DK) Övre Norrland (SE)

Be: Belgium; IT: Italy; DK: Denmark; SE: Sweden; SP: Spain; SW: Switzerland.

Source: Eurostat. [http://ec.europa.eu/eurostat/cache/metadata/en/nrg\\_chdd\\_esms.htm](http://ec.europa.eu/eurostat/cache/metadata/en/nrg_chdd_esms.htm)

Heating degree days (HDD) and cooling degree days (CDD) are weather-based technical index designed to describe the need for the heating or cooling (air-conditioning). Both measures are derived from meteorological observations of air temperature, interpolated to regular grids at 25 km resolution for Europe and aggregated at NUTS-2 level.

The calculation of HDD relies on the base temperature (15°C), defined as the lowest daily mean air temperature not leading to indoor heating.

$$HDD_i = \begin{cases} \sum_{t=1}^{365} (18 - T_{m_i}) & \text{if } T_{m_i} \leq 15^\circ\text{C} \\ 0 & \text{if } T_{m_i} > 15^\circ\text{C} \end{cases}$$

The calculation of CDD relies on the base temperature (24°C), defined as the highest daily mean air temperature not leading to indoor cooling:

$$CDD_i = \begin{cases} \sum_{t=1}^{365} (T_{m_i} - 21) & \text{if } T_{m_i} \geq 24^\circ\text{C} \\ 0 & \text{if } T_{m_i} < 24^\circ\text{C} \end{cases}$$

**Table A4. Housing price index (NUTS-2 level)**

	Wave 1	Wave 2	Wave 4	Wave 5	Wave 6
<b>Housing price index</b>					
Mean	100	134.54	119.76	120.61	126.13
Std. Dev.	-	39.82	41.20	47.32	51.17
Maximum	205.82	345.1	241.1	291.9	357.4
	Stockholm (DK)	Berlin (DE)	Berlin (DE)	Berlin (DE)	Berlin (DE)
Minimum	51.1	52.7	42.07	35.26	30.71
	Emilia-Romagna (IT)	Liguria (IT)	La Rioja (SP)	Galicja (SP)	Asturias (SP)
<b>Growth rate housing price index (%)</b>					
Mean	6.65	1.82	-1.20	3.88	3.12
Std. Dev.	9.92	10.23	10.15	13.67	9.60
Maximum	50.55	56.50	74.20	71.62	55.4
	Brussels (BG)	Berlin (DE)	Bremen (DE)	Brussels (BG)	Bremen (DE)
Minimum	-38.9	-46.60	-40.53	-45.24	-37.34
	Hamburg (DE)	Hamburg (DE)	La Rioja (SP)	Pais Vasco (SP)	Navarra (SP)

BG: Belgium; DE: Germany; DK: Denmark; IT: Italy; SP: Spain.

The House Price Index captures price changes of all kinds of residential property purchased by households (flats, detached houses, terraced houses, etc.), both new and existing. It market prices are considered. The land component of the residential property is included. (Base year=2004).

Growth rate of housing price index (%): computes the growth rate with respect to previous year.

Austria: STATcube. Statistical Database. Available at: <http://statcube.at/statistik.at/ext/statcube/jsf/login.xhtml>

Belgium: For Flanders, Statistiek Vlaanderen. Available at: <http://www.statistiekvlaanderen.be/interactieve-data>. For Wallonie, Walstat. Available at: <https://walstat.iweps.be/walstat-accueil.php>

Denmark: STATbank Denmark. Available at: <http://www.statbank.dk/statbank5a/default.asp?w=1920>

France: Institut National de la Statistique et des études économiques. Available at: <https://www.insee.fr/fr/statistiques?debut=0&idfacette=3>

Germany: Statistische ämter des bundes und der Länder. Available at: [https://www.statistik-bw.de/Statistik-Portal/en/en\\_impressum.asp#Copyright](https://www.statistik-bw.de/Statistik-Portal/en/en_impressum.asp#Copyright)

Italy: Raporto Immobiliare 2017. Il settore residenziale. Osservatorio del Mercato Immobiliare. Available at: [http://www.uil.it/documents/OMI%20I\\_2017\\_QuadroGenerale\\_15052017.pdf](http://www.uil.it/documents/OMI%20I_2017_QuadroGenerale_15052017.pdf)

Spain: Ministerio de Fomento. Available at: <http://www.fomento.gob.es/be2/?nivel=2&orden=35000000>

Sweden: Statistics Sweden. Available at: <http://www.statistikdatabasen.scb.se/pxweb/en/ssd/?rxid=86abd797-7854-4564-9150-c9b06ae3ab07>

Switzerland: Swiss National Bank. Available at: [https://www.snb.ch/en/iabout/stat/id/statpub\\_dataportal](https://www.snb.ch/en/iabout/stat/id/statpub_dataportal)

**Table A5. First stage regressions for the probability of having suffered a health shock**

	Non mental illness	Degenerative mental illness	Other mental disorders	Limitation for ADL
Current smoker	0.030*** (0.004)	-0.004** (0.002)	0.001 (0.003)	0.011*** (0.003)
Smoked before, not now	0.070*** (0.008)	0.009*** (0.003)	-0.018*** (0.004)	0.007 (0.006)
Sedentary lifestyle	0.082*** (0.003)	0.036*** (0.003)	0.031*** (0.004)	0.067*** (0.002)
Overweight	0.013*** (0.003)	0.004** (0.002)	0.001 (0.003)	0.008*** (0.002)
Obese	0.055*** (0.004)	0.011*** (0.002)	0.013*** (0.003)	0.067*** (0.003)
Drinks alcohol	0.030*** (0.003)	0.005*** (0.002)	0.016*** (0.002)	0.004** (0.002)
N	33,535	33,535	33,535	33,535
R <sup>2</sup>	0.858	0.760	0.642	0.809
F-statistic	348,351	154,575	124,040	515,365
p-value	0.000	0.000	0.000	0.000
Endogeneity tests				
Robustified Durbin - Wu-Hausman	0.5595	0.590	0.590	0.589
F-statistic	37.642	37.190	37.102	36.893
Montiel Olea-Pflueger robust weak instrument test	0.000	0.000	0.000	0.000
Critical values (%worst case base: $\tau=20\%$ )		15.062		
Critical values (%worst case base: $\tau=10\%$ )		23.109		
Critical values (%worst case base: $\tau=5\%$ )		30.612		

Standard deviation between parenthesis. Estimations using sampling weights.

Smokes now: 1 if smokes at baseline, 0 otherwise

Smoked before, not know: 1 if has smoked before, not at baseline, 0 otherwise

Overweight: 1 if body mass index at baseline lower between 25 and 30, 0 otherwise

Obese: 1 if body mass index at baseline higher than 30, 0 otherwise

Sedentary lifestyle: 1 if respondent is engaged in vigorous physical activity (such as sports, heavy housework, or a job that involves physical labour) hardly ever or never, 0 otherwise.

Drink alcohol: 1 if has drunk any alcoholic beverage (like beer, cider, wine, spirits or cocktails) five or six days a week or almost every day, 0 otherwise.

Other variables included in the regressions: gender, age, age squared, education, marital status at baseline, relation with economic activity at baseline, housing tenure at baseline, area of residence, wealth and income at baseline, country and year fixed effects. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Effective F statistics and critical values shown are for the Montiel Olea-Pflueger robust weak instrument test with confidence level of  $\alpha=5\%$  and obtained with the weakivtest command in Stata (Pflueger and Wang, 2015). Standard errors clustered by NUTS-2.

**Table A6. First stage regressions for the probability of having changed of residence**

	Change of residence	Interaction Residential mobility			
		Health shock (non-mental illness)	Health shock (degenerative mental illness)	Health shock (other mental disorders)	Health shock (limitation for ADL)
Heating degree days	0.015*** (0.001)	0.002 (0.002)	0.012*** (0.004)	0.001 (0.002)	0.008*** (0.002)
Cooling degree days	-0.056*** (0.013)	-0.061*** (0.015)	0.001 (0.000)	0.000 (0.001)	-0.029*** (0.013)
Housing price index	0.006*** (0.002)	0.002** (0.001)	-0.004*** (0.001)	-0.001 (0.005)	0.018*** (0.003)
Growth rate housing price index	-0.015*** (0.007)	0.016*** (0.007)	-0.026*** (0.004)	0.003 (0.005)	0.016*** (0.006)
Number of daughters at home (at baseline)	-0.027*** (0.009)	-0.007*** (0.003)	-0.024*** (0.007)	0.057*** (0.018)	-0.012*** (0.003)
N	33,535	33,535	33,535	33,535	33,535
F-statistic	18.052	177.126	214.274	158.174	634.599
p-value	0.000	0.000	0.000	0.000	0.000
Endogeneity tests					
Robustified Durbin - Wu-Hausman	0.621	0.130	0.541	0.601	0.689
F-statistic	32.131	35.891	34.714	39.781	36.925
Montiel Olea-Pflueger robust weak instrument test	0.000	0.000	0.000	0.000	
Critical values (%worst case base: $\tau=20\%$ )		15.062			
Critical values (%worst case base: $\tau=10\%$ )		23.109			
Critical values (%worst case base: $\tau=5\%$ )		30.612			

Standard deviation between parenthesis. Estimations using sampling weights.

Other variables included in the regressions: gender, age, age squared, education, marital status at baseline, relation with economic activity at baseline, housing tenure at baseline, area of residence, wealth and income at baseline, country and year fixed effects.

Heating degree days and cooling degree days expressed in 1,000 units degree days.

Housing price index taking as reference 2004

Growth rate housing price index expressed on a per unit basis

Effective F statistics and critical values shown are for the Montiel Olea-Pflueger robust weak instrument test with confidence level of  $\alpha=5\%$  and obtained with the weakivtest command in Stata (Pflueger and Wang, 2015). Standard errors clustered by NUTS-2.

## Appendix B

**Table B1. Probability of household size variations after residential mobility and probability of moving to a different size municipality. Differences between European countries.**

	Household size after residential mobility			Size of municipality before and after residential mobility				
	Smaller household size	Equal household size	Bigger household size	From small village/rural area to large town	From small town/rural area to big city	From large town to big city	From big city to small town/rural area	From large town to small town/rural area
Northern	-0.018* (0.010)	0.043*** (0.012)	0.025*** (0.006)	-0.001 (0.005)	-0.027*** (0.005)	-0.009 (0.005)	0.011** (0.005)	0.036*** (0.006)
Southern	0.108*** (0.011)	-0.122*** (0.012)	0.014** (0.006)	0.038*** (0.006)	0.024*** (0.005)	0.019*** (0.006)	-0.001 (0.006)	-0.026*** (0.006)
Shock(non mental illness)								
Northern	0.003 (0.018)	0.017 (0.020)	-0.020* (0.011)	-0.004 (0.010)	-0.004*** (0.001)	-0.022** (0.009)	0.004*** (0.001)	0.005** (0.002)
Centre	0.018*** (0.004)	0.018 (0.015)	-0.001 (0.008)	-0.014** (0.005)	-0.007*** (0.002)	-0.005 (0.007)	0.003*** (0.001)	0.009 (0.008)
Southern	-0.059*** (0.019)	0.043** (0.021)	0.015*** (0.001)	0.002 (0.010)	0.006 (0.009)	0.009 (0.010)	-0.018*** (0.003)	-0.012*** (0.002)
Shock(mental degenerative)								
Northern	-0.027 (0.053)	0.048 (0.059)	-0.021 (0.031)	-0.007 (0.028)	-0.025*** (0.005)	-0.007*** (0.002)	0.013*** (0.002)	0.027*** (0.004)
Centre	0.003*** (0.001)	0.008 (0.041)	-0.011 (0.021)	-0.002 (0.019)	-0.004*** (0.001)	-0.000 (0.019)	0.002 (0.019)	0.012*** (0.002)
Southern	-0.039*** (0.007)	0.050 (0.042)	0.012*** (0.002)	0.026*** (0.004)	0.003 (0.018)	0.003** (0.001)	-0.006*** (0.001)	-0.026 (0.021)
Shock(other mental dis.)								
Northern	0.076* (0.039)	-0.070 (0.044)	-0.005 (0.023)	-0.026*** (0.004)	-0.011*** (0.002)	-0.025*** (0.005)	0.022 (0.020)	0.002 (0.023)
Centre	0.029*** (0.002)	-0.054** (0.025)	0.025* (0.013)	-0.016*** (0.003)	-0.008*** (0.002)	-0.001 (0.012)	0.006*** (0.002)	0.006** (0.003)
Southern	-0.011** (0.005)	0.002 (0.028)	0.008 (0.015)	0.029** (0.013)	0.007 (0.012)	0.012 (0.013)	-0.002 (0.013)	-0.016 (0.014)
Shock (ADL)								
Northern	0.009 (0.023)	-0.006 (0.025)	-0.003 (0.013)	-0.005 (0.012)	-0.015*** (0.003)	-0.019*** (0.003)	0.018*** (0.002)	-0.015 (0.013)
Centre	0.025* (0.015)	0.032* (0.017)	-0.007 (0.009)	-0.003*** (0.001)	-0.003*** (0.001)	-0.021*** (0.008)	0.005 (0.008)	0.004 (0.009)
Southern	-0.006 (0.020)	-0.028 (0.022)	0.034*** (0.012)	0.008*** (0.01)	0.004*** (0.001)	0.010 (0.010)	-0.021** (0.010)	-0.026** (0.011)
Constant	0.103*** (0.009)	0.846*** (0.010)	0.051*** (0.005)	0.024*** (0.004)	0.044*** (0.004)	0.031*** (0.004)	0.035*** (0.004)	0.019*** (0.005)
N	2,183	2,183	2,183	2,183	2,183	2,183	2,183	2,183
r2	0.314	0.321	0.309	0.517	0.533	0.525	0.514	0.505
F	8.809	13.161	5.503	14.301	11.886	12.866	12.189	13.229
p	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

Group of countries: North (Denmark and Sweden), Centre (Austria, Belgium, France, Germany and Switzerland); South (Italy and Spain)

Other variables included in the regressions: gender, age, age squared, education, marital status at baseline, relation with economic activity at baseline, housing tenure at baseline, area of residence, wealth and income at baseline, country and year fixed effects.

Standard deviation between parenthesis. Estimations using sampling weights.

**Table B2. Probability of institutionalization (in nursing home)**

	R1	R2	R3	R4	R5
Residential mobility in previous waves	-0.003 (0.002)	-0.002 (0.002)	-0.003* (0.002)	-0.003 (0.002)	-0.000 (0.002)
Home adaptations		-0.010*** (0.003)	-0.014*** (0.004)	-0.016*** (0.004)	-0.016*** (0.004)
Residential mobility in previous waves * Moved from to dwelling with home adaptations			-0.013* (0.007)	-0.013** (0.007)	-0.014** (0.007)
Shock: no mental				0.002 (0.002)	0.004 (0.002)
Shock: degenerative mental				0.071*** (0.006)	0.084*** (0.006)
Shock: other mental disorders				0.011*** (0.004)	0.013*** (0.004)
Shock: ADL				0.036*** (0.003)	0.038*** (0.003)
Residential mobility to dwelling with home adaptations in previous waves * Shock: no mental					-0.010* (0.005)
Residential mobility to dwelling with home adaptations in previous waves * Shock: degenerative mental					-0.064*** (0.014)
Residential mobility to dwelling with home adaptations in previous waves * Shock: other mental disorders					-0.005*** (0.001)
Residential mobility to dwelling with home adaptations in previous waves * Shock: ADL					-0.008*** (0.001)
Constant	0.031*** (0.005)	0.031*** (0.005)	0.031*** (0.005)	0.025*** (0.005)	0.024*** (0.005)
N	26,828	26,828	26,828	26,828	26,828
r2	0.448	0.448	0.448	0.463	0.464
F	74.266	70.809	67.448	74.887	65.310
p-value	0.000	0.000	0.000	0.000	0.000

Other variables included in the regressions: gender, age, age squared, education, marital status at baseline, relation with economic activity at baseline, health shocks at baseline, housing tenure at baseline, area of residence, wealth and income at baseline, country and year fixed effects.