Health shocks make the elderly less likely to ‘age in place’

‘Ageing in place’ is a term typically used to refer to people’s preference for staying in the same home as they age. However, the suitability of one’s home at old age varies with the exposure to health shocks. ***Joan Costa-Font*** *and* ***Cristina Vilaplana*** *show that while ageing decreases the probability of residential change, health shocks revert this trend.*

Economists tend to view people’s homes as an investment or a means to obtain housing services (Costa-Font, 2013). Homes also have an emotional and symbolic significance that gives residents a sense of security, comfort, community and even personal success (Faulkner and Bennet, 2002). In a recent paper, we discuss elderly people’s housing decisions, especially when they go through a health shock.

“Ageing in place” (AIP) refers to a person’s expectation to live in their own house (or that of their spouse or partner) until special circumstances demand otherwise. In choosing a home, people may overlook certain aspects that are only important as they age. Assessments of how suitable a home is for them as they age are often based on independent living situations (individual housing with communal amenities), which are seen as the standard. Moving away from the standard is perceived as a loss, which gives rise to ‘inertial preferences for not changing residence’. Similarly, a preference for AIP might suggest that individuals are present-biased with regards to their housing needs.

Irrespectively of its behavioural explanations, aging-in-place can enhance health by giving people a feeling of community and autonomy (Grabowski, 2006). Even if AIP is largely uniform across nations, it is unclear what motivates people to relocate, and more especially, how individual preferences shift in reaction to unforeseen circumstances, such as health shocks, that impact how suitable a place is for them to live. AIP is possible thanks to the existence of neighbourhood support systems, suitable housing, and unpaid and communal care. A fact that strengthens AIP is that housing assets are the main source of wealth, exerting a large financial influence on household finances (Venti and Wise, 2004). That happens especially in a context of rising house prices,

which lead to significant inequality (Fitzenberger et al, 2018). As some have shown (Paz Pardo, 2022), young households cannot or prefer not to risk making large illiquid investments.

Downsizing at old age

Some studies find that the preference for 'ageing in place' prevails even when individuals' health deteriorate and they need personal care (Judd et al., 2010). Angelini et al. (2011) document that Europeans tend to downsize later in life by selling an expensive home and buying a cheaper one, namely by downsizing. However, it is important to distinguish two different perspectives, namely physical and financial downsizing. Physical downsizing denotes a move to a dwelling with fewer rooms, whereas financial downsizing refers to moving to a dwelling of lower value.

Such housing mobility decisions are explained by three motives:

Housing imbalance: older households use more housing than they actually require. Housing consumption rises with age, peaking in the 'empty nester' stage of 60–69 years, when most households overuse their housing services, especially single homeowners and those in higher income brackets (Clark and Duerloo, 2006). Such excessive housing consumption clogs the housing market, preventing younger households from accessing larger homes.

Life-cycle effects: people expect to use accumulated assets to support themselves in old age. 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.

Other life cycle explanations: include bequest and empty nest motives.

Health shocks change housing preferences

Health shocks are an alternative explanation for downsizing. We investigate whether they lead people to downsize to a smaller home (physical downsizing) and lower value (financial downsizing). And we try to find out whether such a move encompasses a reduction in people's housing assets, freeing up wealth for other purposes. We study the effect of a health shock to the respondent or their spouse on three measures of

downsizing, namely **residential mobility**, the **value of a new residence** (measured as the value of the new dwelling and the home-value-to-wealth ratio) and the individual's **home size**. We consider the potential endogeneity of health shocks and residential mobility.

Our research draws on the five waves of the Survey of Health, Ageing and Retirement in Europe (SHARE), which followed individuals in nine countries for about a decade. We find that *age reduces the probability that someone will move house by 2 percentual points (pp) for every decade of life (consistent with the 'ageing in place' hypothesis). However, a health shock reverts this probability.* In other words, 'ageing in place' is contingent on the absence of a health shock that may affect a member of the household, such as a spouse or partner. Forward-looking people who adapt a house to the needs of the elderly prevent downsizing. Since their house is made suitable, they are less likely to move.

In examining financial downsizing, we find that the home-value-to-wealth ratio falls by 8.9 percentage points after the onset of a degenerative mental disorder and 4.2 percentage points after a non-mental illness. In these cases, the new home has 0.6 and 1.2 fewer rooms, respectively. Finally, we document significant country heterogeneity. People in Nordic countries meet all of the downsizing definitions examined, whereas those in Southern European countries tend to move to smaller, but higher-value residences, mainly driven by investment (or bequest) reasons.

Policy implications

Ageing reduces the likelihood of moving and 'ageing in place' is still a fundamental behavioural feature in explaining housing mobility at old age in Europe. Nevertheless, health shocks reverse these effects. More precisely, the chance of residential mobility is increased with the beginning of degenerative mental disorders or new limits in performing activities of daily living (ADL), and this effect increases with age. Hence, the degree to which AIP preferences exist is contingent upon an individual's or their partner's health. Additionally, the results vary greatly throughout European nations, indicating that AIP may be more deeply ingrained in southern Europe.

These results carry relevant policy implications. They suggest that in settings where individuals exhibit strong AIP preferences even after a health shock (Costa-Font et al,

2009; Costa-Font and Vilaplana, 2022), policy interventions should strengthen the existing links with physical and social environments that are supposed to promote an older person's well-being, including the existing support networks developed throughout their lives. In contrast, when individuals hold a strong preference to 'downsize' after experiencing a health shock, policy interventions should focus on supporting such housing search, to avoid or delay entry into more costly forms of residential or hospital care, and to better manage physical and mental decline.

Finally, a knock-on effect of getting older individuals to downsize includes the wider economic benefits of 'freeing up' larger houses they own or rent, thus serving other urban policy goals. Combined with fiscal incentives for individuals to downsize, providing more housing choices for seniors can help younger individuals access a home in large and crowded cities.

- *This blog post is based on Health shocks and housing downsizing: how persistent is 'ageing in place'?, Journal of Economic Behavior & Organization.*
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