**How far is a long distance? An assessment of the issue of scale in the relationship between limiting long term illness and long distance migration in England and Wales**

**Abstract**

Research consistently shows that those in poor health are less likely to migrate over long distances, but analyses rarely consider what constitutes a long distance in this context. Additionally, the migration literature often fails to account for place of residence effects on migration behaviour. This paper addresses these issues through analysis on the distance of residential moves by working age adults in the year preceding the 2011 Census. Multilevel logistic regression models predict the odds of having moved long distance relative to short distance, for different definitions of long distance: 10km+, 20km+ and 50km+. We test whether those reporting a Limiting Long Term Illness (LLTI) are less likely to move long distance in all models, controlling for local authority at the time of the 2011 Census. We find no evidence for health-selectivity in long distance migration in the 10 and 20km models, but uncover a significant effect in the 50km model. By age, the odds of having moved long distance do not vary for middle-working age adults (25-54) by LLTI, whilst those with an LLTI in the pre-retirement age group (55-64) are less likely to move long distance in all models. We uncover clusters of local authorities where those with an LLTI are more likely to have moved long distance in the 10km and 20km models, but in the 50km model only two of these areas remain significantly positive. We conclude that health selection in distances moved occurs above a cut-off somewhere between 20km and 50km.

# Introduction

A large body of research is dedicated to establishing whether variations in health behaviours and outcomes are the result of ‘places’ affecting health, or a reflection of varying population characteristics across areas (Kearns and Moon, 2002; Smyth, 2008). The role of internal migration is often overlooked as a driver of these spatial variations in health (Norman *et al.*, 2005). In the UK, healthy people tend to move to less deprived areas, whilst those in poor health tend to move to more deprived areas; these migration patterns widen regional health inequalities as some areas of the UK have a positive net migration for unhealthy migrants, whilst others have a negative net migration (Brimblecombe *et al.*, 1999; Boyle *et al.*, 2009; Norman and Boyle, 2014). The size of this effect is small, as the majority of migrants move between areas with similar mortality patterns (Green *et al.*, 2015), but migration patterns do have a significant effect on geographies of health. This phenomenon is not particular to the UK, as similar patterns have been found for rates of smoking in New Zealand (Pearce and Dorling, 2010) and poor self-rated health in the Netherlands (Dijkstra *et al.*, 2015).

Migration leads to a change in an individual’s environment, thus migration is selective for characteristics which are related to adaptability (Lu, 2008). In this framework, distance is as an intervening obstacle for migrants (Thomas *et al.*, 2015), increasing distances are associated with loss of social networks (Brown, 2002) and greater financial costs due to searches and moves (Flowerdew, 1976). Thus there are characteristics which are not only selective for the propensity to move, but also selective of the distances moved among migrants. Long distance migrants are younger, have higher levels of education attainment (Thomas *et al.*, 2015) and are more likely to be in the higher social classes (Boyle and Shen, 1997) than the general population, for example. Migration over long distances is relatively uncommon, an estimated 9.3% of the population living in England and Wales at 2001 moved to an address 50km or further away by 2011, compared to 27.5% moving less than 10km (Champion and Shuttleworth, 2015). The literature suggests that these long distance moves are driven primarily by employment, housing, amenities and education (Champion *et al.*, 1998).

The healthy migrant hypothesis posits that good health is one of the characteristics which relates to adaptability (Fennelly, 2007). Individuals in good health are more able to move over long distances, as they are free of constraints on physical mobility and reliance on long-term healthcare. Conversely, the onset of poor health can lead to long distance migration. Individuals may move back to their area of origin due to place-based ties and the family being seen as factors aiding recovery from ailments, a phenomenon known as the ‘salmon bias’ (Abraído-Lanza *et al.*, 1999). Analysis of the British Household Panel Survey shows that individuals who died during the survey tended to have recently moved back to their area of birth (Brimblecombe *et al.*, 1999). Evidence for the salmon bias is mixed, as no evidence of such flows are found when moves between England and Scotland are considered (Wallace and Kulu, 2014). The lack of accessible rural healthcare in the UK (Jordan *et al.*, 2004) may also drive long distance migration for those in poor health. Administrative records from New York and Western Australia show that the onset of mental disorder leads to rural residents moving towards urban areas surrounding hospitals (Breslow *et al.*, 1998; Moorin *et al.*, 2006), a similar effect may exist for physical health conditions.

The healthy migrant hypothesis for long distance migration has largely been supported by research based in the UK since the 1980s. Long distance migrants are healthier than those who do not migrate (Strachan *et al.*, 1995; Boyle *et al.*, 2002) and are healthier than those who migrate over short distances (Boyle et al., 2001; Fox et al., 1982). In addition, the association between health and long distance migration varies by age: sickness rates decrease with increasing distances moved for those aged 21-44, but converge for short and long distance migrants at ages 45+ (Bentham, 1988). Outside of the UK however, several measures of poor health are found to be associated with long distance migration. For example, mental health disorders (except schizophrenia) in the US (McCarthy *et al.*, 2007), chronic diseases in the US (Findley, 1988) and health specialist usage in Australia (Larson *et al.*, 2004) are associated with long distance moves. It is plausible that there is an opposing ‘unhealthy migrant effect’: the onset of health conditions which require long-term health care leads to moves from rural to urban areas, where there is a greater degree of health service provision. Evidence from outside of the UK supports this explanation (Breslow *et al.*, 1998; Moorin *et al.*, 2006), whereas this idea has not been tested explicitly within the UK. In this paper we aim to assess the healthy migrant theory for distances moved. First, we draw on the literature to determine how a long distance move may be measured within the UK context.

## The issue of scale – how long is long distance?

The association between good health and long distance migration is established in several UK studies (Bentham, 1988; Boyle et al., 2001, 2002; Fox et al., 1982; Strachan et al., 1995). It is common in the internal migration literature for the Euclidean distance moved between residences to be calculated, and those who migrate over distances greater than a certain value (cut-off) are then considered to be long distance migrants. Alternatively, moves between administrative areas may be referred to as long distance moves, whilst moves within such areas are referred to as short distance moves. There is disagreement in the literature over which cut-off is considered to be indicative of long distance migration (Table 1).

**Table 1 – Definitions of long distance in selected studies investigating the association between health and long distance migration**

<Table 1 here>

All of the studies within the UK find evidence for the healthy migrant effect regardless of the way in which poor health is measured, whilst studies from outside the UK find evidence for an ‘unhealthy migrant effect’. The issue of scale is problematic for the understanding of the health and migration relationship, as it is unclear at which distances health selection occurs. For example, two studies authored by Boyle and colleagues (2001; 2002) find that long distance migrants are healthier than short distance migrants, using the 50km and 10km cut-offs respectively. The 2001 study uses microdata from the Scottish Census whilst the 2002 study uses microdata from the England and Wales Census, so it is not apparent whether the association persists at and above the 10km cut-off in England and Wales, nor at and above the 50km cut-off in Scotland. Recent work on internal migration in the UK which does not include health in their analysis has also defined long distance migration using 5 mile (8km) (Cho and Whitehead, 2013) and 20km cut-offs (Sapiro, 2016). These definitions have not been explored in the health literature. Several studies define moves across administrative regions as long distance, this is also problematic as individuals living near boundaries can move relatively short distances to cross such boundaries and be considered a long distance migrant. There is a distinct lack of justification for the use of cut-off points, and little evidence of reflection on the implications this may have for findings. Of the aforementioned studies, only Sapiro (2016:16) justifies the usage of a cut-off, stating that “only one person in eight commut[es] further than [20km]”. We conclude that as there is little theoretical justification in defining long distance migration using one cut-off over another, in this paper we will test whether there is evidence for the healthy migrant effect using the 10km, 20km and 50km cut-offs previously used to define long distance migration in the UK context.

In addition to inconsistent definitions of long distance, research on migration and health in the UK often fails to account for multilevel structures in migration behaviour (Thomas *et al.*, 2015). Individual (micro) behaviours are shaped by the environments in which individuals operate (macro), and controlling for these macro influences is necessary when inferences are made on the behaviours of individuals (Goldstein, 2011). Recent advances in methodology show regional variation in distances moved by destinations, with movers to coastal and rural areas in the north of England tending to move further than average, whilst movers to metropolitan cores tend to move shorter distances (Thomas *et al.*, 2015). This regional variation in distances moved has not been linked to health. We expect the population in poor health to be reliant on healthcare provision, and therefore less likely to move over long distances into rural areas relative to the population in good health, as healthcare provision is less accessible in rural areas of the UK. This has implications for previous studies which show that poor health is associated with short distance migration; selection may play a role, as those in poor health are concentrated in urban and deprived areas (Dorling, 2013) where short distance moves are more common (Kearns and Parkes, 2003; Champion, 2005), thus exaggerating the role of health in determining short distance moves.

There are three aims of our study, drawn from the above review of the literature. In models accounting for the areas individuals live in at the time of the 2011 Census, we test whether there is an association between health and long distance migration using different definitions of long distance found in the literature. Second, we test whether the association between health and long distance migration varies by age. Third, we assess whether there is spatial variation in the likelihood of long distance migration by health status.

# Methods

## Data

This analysis uses data on internal migrants living within England and Wales in 2011, drawn from the 2011 Census Individual Secure Sample (CISS). The UK census is a mandatory decennial questionnaire for UK residents (Office for National Statistics, 2011a), and we use data from the England and Wales version of the census. Ten percent of individuals within each Output Area are randomly selected for inclusion in the CISS by the Office for National Statistics (ONS) to ensure that the sample represents the usually resident population of England and Wales (Office for National Statistics, 2011b). The lowest available level of geography in the CISS is Local Authorities (LAs); there are 348 LAs in England and Wales each containing an average of 120,000 individuals. Due to small LA sizes, we combine the Isles of Scilly with Cornwall, and exclude those living in the City of London. We use LAs as an analytical level to reflect regional variations in pull factors (employment rates, access to healthcare, tenure composition) which are known to be determinants of long distance moves (Boyle and Shen, 1997; Breslow *et al.*, 1998; Thomas *et al.*, 2015). The LA an individual lived within one year before the Census (origin) and the LA they live within at the time of the Census (destination) are provided in the CISS. Although there is evidence of variation in distances moved both at the origin and destination (Thomas *et al.*, 2015), the measure of health used in this analysis only captures health at the time of the Census (when individuals lived within their destination LA), not one year prior (when individuals lived within their origin LA). If we were to include origins as an analytical level, an unknown quantity of individuals with an LLTI would not have reported an LLTI one year prior when they lived within origin LAs and vice versa. As a result, we only include destination LAs in our analytical models.

CISS microdata may only be accessed at the ONS Virtual Microdata Laboratory. Access is granted for approved research projects conditional on disclosure control training. Due to the risk of disclosure from sensitive individual level microdata, all analytical outputs are vetted by the ONS before release.

## Inclusion criteria

We limit our study to working age adults (aged 16-64) at the time of the census in line with previous studies on internal migration using census microdata (Bailey and Livingston, 2005; Wilding *et al.*, 2016), as recent research shows that the drivers of migration among the very young and very old differ from the working age population (Thomas *et al.*, 2016). Migration is measured using the question “one year ago, what was your usual address” (Office for National Statistics, 2011a), respondents may answer “the address on the front of this questionnaire” (non-movers), write in a different address within the UK (movers), or write in the country where they lived one year ago (recent immigrants). We exclude non-movers and those who lived outside of England and Wales 12 months prior to the Census, as distances are calculated by the ONS only for those who moved within England and Wales. Students who move from a term-time address to another address are also excluded, as distances are not calculated for this group by the ONS. Those who report living rent free are also excluded from our sample, this is likely a very heterogeneous group whom experience very different drivers of migration than those in other living arrangements. Excluding participants with missing data for family status (902), whether they are part of a wholly moving household (257) or report living rent free (5,821), our final sample contains 442,340 working-age adult internal migrants.

## Outcome

The outcome measures in this analysis derive from a variable containing the straight line distance (in kilometres) between an individual’s address at the time of the 2011 Census and their address 12 months prior. The Euclidean (straight line) distance between the two residences are calculated from household to household by the ONS (Office for National Statistics, 2014), and provided as a continuous measure. To explore the issue of scale we use three definitions of long distance migration, where moves are considered long distance if an individual moved: 1) 10km or further 2) 20km or further 3) 50km or further; herein referred to as the 10km model, 20km model and 50km model respectively. These outcomes allow us to test whether there is an association between health and long distance migration across these definitions of long distance, drawn from the literature (see Table 1).

## Exposure variable

There are two measures of health captured by the Census, a measure of self-rated health (“how is your health in general”) and a measure of Limiting Long Term Illness (LLTI). The exposure variable used in this analysis is LLTI. LLTI is measured by the question: “Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age” (recoded as 0= no and 1= yes, limited a little or yes, limited a lot) in line with other studies exploring the relationship between health and migration (e.g. Norman et al., 2005). We expect those with an LLTI to be less likely to move long distance (Bentham, 1988; Boyle et al., 2001; Fox et al., 1982). We find no significant differences if self-rated health is used instead of LLTI in fully adjusted models. We proceed with LLTI as our exposure variable, as LLTI has been used in previous studies based on Census microdata (Boyle *et al.*, 2002, 2004; Norman *et al.*, 2005; Norman and Boyle, 2014).

Self-reported measures of health are often used as proxies for morbidity in social science research (Curtis *et al.*, 2009). Although LLTI is a subjective valuation of health, those reporting an LLTI have higher rates of mortality, hospitalisation and serious conditions than those who do not report an LLTI (Payne and Saul, 2000; Manor, 2001) and are more likely to access health services in the future (Jordan, 2003). Comparisons of different dimensions of health show that LLTI is closely aligned with physical limitations, and less associated with mental and social wellbeing (Cohen *et al.*, 1995), whilst area rates of LLTI correlate with the number of cases of chronic heart disease and hypertension (Martin and Wright, 2009). It is important to note that LLTI is measured at the time of the Census, and migration in the year preceding the Census, so it is not possible to ascertain whether there is a difference in pre and post move health status.

## Covariates

We include twelve covariates in our analysis, to control for factors confounding the association between distance moved and LLTI, shown in table 2.

**Table 2 – Covariates included in the analysis and their relationship to distances moved**

<Table 2 here>

## Modelling strategy

All models are estimated using multilevel logistic regression with individuals nested within LA at destination, as we expect the average distance moved to vary by destination (Thomas *et al.*, 2015). We allow the effect of LLTI to vary randomly across destination LAs, to test whether those with an LLTI are less likely to have moved long distance in all LAs.

We model the log odds of having moved long distance (P = 1|X) relative to the odds of having moved short distance (P = 0|X) for migrant i living in LA j as follows (van Ham *et al.*, 2001):

(1)

Where is a fixed constant, is the matrix of fixed covariates defined in table 2, is the fixed coefficient for individuals with an LLTI, is the random intercept associated with LA j, is the random slope for individuals with an LLTI in LA j, an additional effect for the population with an LLTI and an error term for individual i. We use the random effects approach, such that and have a mean of 0 and a standard deviation equal to and respectively. Utilising random intercepts and slopes we investigate whether health-differences in the log-odds of having moved long distance vary across LAs and definitions of long distance. The average log-odds of having moved long distance for an individual without an LLTI is given by the parameter , the average log-odds of having moved long distance for an individual without an LLTI in LA j is given by the parameters and the average log-odds of having moved long distance for an individual with an LLTI in LA j is given by the parameters .

The odds are then converted into a percentage using the following transformation:

(2)

We estimate models using the xtmelogit command in Stata 12.1 (Statacorp LP, 2013). Fixed effect coefficients are estimated in a similar manner to standard logistic regression whilst random effect coefficients and log-likelihood values are estimated using Laplacian approximation (adaptive quadrature), the distribution of which is assumed to be Gaussian (Statacorp LP, 2015).

We include interaction terms between age and LLTI to test whether the relationship between health and long distance migration differs across age groups. In order to calculate confidence intervals for the log odds for each age group by LLTI, we use the lincom command in STATA. As the 16-24 age group are used as a reference category, the log odds for an individual without an LLTI are given by the parameter and for those with an LLTI by the parameters . Thus the difference in log odds for the 16-24 age group shows the overall effect of LLTI on long distance migration. For all other age groups, the log odds for an individual without an LLTI are given by the parameters and for those with an LLTI by the parameters .

# Results

In this section we examine the relationship between health status and long distance migration. In our sample, 404,004 movers (91.3%) do not report an LLTI whilst the remaining 38,336 (8.7%) report an LLTI. Individuals without an LLTI have a higher mean and median for distances moved, as well as greater variation as indicated by the standard deviation. These differences in continuous distance moved are statistically significant at the 99% level (Table 3). Turning to the distance cut-offs, the percentages suggest increasing health-selectivity over greater distances, as the ratio of probabilities shifts further from one.

**Table 3 – Cross-tabulation of long distance migration and LLTI**

**<Table 3 here>**

Having established that LLTI is associated with lower odds of long distance migration, we consider whether there are variations in the relationship between health and definitions of long distance, after controlling for demographic characteristics. Table 4 shows the results of multilevel logistic regressions for the 10km, 20km and 50km models. All coefficients are shown as additive effects on the log odds of having moved long distance (see equation 1). Coefficients greater than zero indicate that this characteristic is associated with greater odds of having moved long distance in each model, whilst the inverse is true of coefficients lower than zero. The estimate and confidence intervals for the standard deviation of the random intercept ( and slope (are also shown.

**Table 4 – Multilevel logistic regressions predicting the log-odds of having moved long distance relative to short distance**

**<Table 4 here>**

Comparing coefficients across the three models, the direction of effects is consistent in the majority of cases and conforms to our expectations (Table 2), thus many of the characteristics we control for are scale invariant. Figure 1 presents the estimates by health and age across the three models, transformed into percentages predicted to move long distance (equation 2), and their associated 95% confidence intervals. Comparing the difference in probabilities by health for the 16-24 age group, LLTI is associated with a lower likelihood of having moved long distance only in the 50km model, as the odds for those with and without an LLTI overlap in the 10 and 20km models, despite a p value <.01 in the latter model. After taking the uncertainty in the estimate of the constant into account (Wolfe and Hanley, 2002), health selection occurs above a cut-off somewhere between 20 and 50kms, as the confidence intervals for those with and without an LLTI overlap in the 20km model, but do not in the 50km model. Looking at the differences for other age groups, the only significant difference is found in the 55-64 age group, where having an LLTI is associated with a lower likelihood of having moved long distance in all models. This suggests that the healthy migrant effect for long distance migration is specific to the youngest and oldest working age groups.

**Figure 1: Percentage predicted to have moved long distance by model, age and LLTI status**

<Figure 1 here>

Comparing probabilities across age and model, for the population with and without an LLTI we observe that the relationship between age and long distance migration is u-shaped. Adults in the youngest and oldest age groups (16-24 and 55-64) and more likely to move long distance relative to those in the 25-34, 35-44 and 45-54 age groups. For the population without an LLTI, the predicted percentages are significantly higher for the 16-24 and 55-64 age groups relative to all other age groups in the 10, 20 and 50km models; except adults aged 45-54 are not significantly less likely to move long distance in the 10km model. For the population with an LLTI the u-shaped distribution is less pronounced, those aged 25-34 are less likely to move long distance than those aged 16-24 or 55-64 in the 50km model, whereas all other age differences overlap. The Variance Partition Coefficient (Browne *et al.*, 2005) shows that a relatively small proportion of the variance in long distance migration is explained at the destination LA level (6% in the 10km model and 5% in the 20 and 50km models), with the remainder explained at the individual level.

## Random intercepts and slopes

Having explored effects at the individual level, we turn to effects at the destination LA level. Figure 2 (a-c) illustrates these transformed parameters. The percentage predicted to have moved long distance for each LA is represented on the y axis, and the ratio of predicted percentages for those with an LLTI relative to those without an LLTI on the x axis. If the ratio is greater than one, this indicates that those with an LLTI are more likely to move long distance in this LA, whilst the inverse is true if the ratio is less than one. Reference lines illustrate the global mean for the percentage predicted to move long distance (30.8%, 20.3% and 12.5%) in the 10, 20 and 50km models respectively.

In the 10km model we observe that the population with an LLTI are more likely to have moved long distance than those without an LLTI in destinations with higher than average rates of long distance migration (top-right quadrant). In the 20km model the same trend is found, however the distribution of ratios shifts to the left, such that there are fewer areas where the population with an LLTI are more likely to have moved long distance. Finally, in the 50km model the distribution of ratios shifts further to the left, the population with an LLTI are more likely to have moved long distance only in two LAs (of a total of 346). Thus there is no evidence of health selection in the 10km model, but the effect is present in the 20km model and strongest in the 50km model.

**Figure 2: Ratio of health differences in long distance migration by LA and model**

<Figure 2a-c here>

To explore the spatial pattern of these residuals for destination areas, we plot the values for LAs using ArcMap 10.4.1 (ESRI, 2014). The ratio of predicted percentages from Figure 2 are shown for the 10km, 20km and 50km models in Figures 3a, 3b and 3c respectively. Destinations where those with an LLTI are more likely to have moved long distance are hatched, whilst destinations where those without an LLTI are more likely to have moved long distance are shaded in grey. Areas with a random intercept () within 1SD from the mean are unshaded, to investigate the relationship between health and destination specific probabilities in the more extreme ends of the distribution.

Figure 3a shows that there are a greater number of areas where those with an LLTI have higher odds to have moved long distance (55%) in the 10km model, clustered in London, southern Wales and eastern England. Areas with higher odds for those without an LLTI are clustered in the South of England, south east from London and north from London. Figure 3b shows that there is a clearer spatial pattern in the 20km model. Areas where those with an LLTI have higher odds are fewer in number (22%), and these are now clustered in London and south Wales, whilst areas with higher odds for those without an LLTI are spread across the South, North and East of England. Figure 3c shows that in the 50km model there are only two areas (2%) where those with an LLTI have higher odds, Powys and Methyr Tydfil in south Wales.

**Figure 3: Ratio of predicted odds to have moved long distance by model and LLTI**

<Figure 3a-c here>

# Discussion

The work here must be placed in context of its shortfalls. Our measure of health (LLTI) is a self-reported measure, whilst the healthy migrant theory is mainly drawn from research on mortality (Abraído-Lanza *et al.*, 1999), which find that individuals who move have lower future mortality rates than those who do not move. It is plausible that conditions which are conducive to mortality in working age adults are barriers to long distance migration, whilst our measure does not have enough specificity to distinguish forms of poor health which drive long distance moves. The focus on working age adults is in contrast with the fact that rates of LLTI are much higher at post-retirement ages, the relationships between health and long distance migration may differ in this older age group. Additional cut-off points are found in the wider migration literature, but are beyond the scope of the present paper. The issue of scale in the health and long distance migration relationship may be unique to the data source used here, or to England and Wales, thus further work is needed from other countries to assess the robustness of the association.

Our first aim in this analysis is to test whether there is an association between health and long distance migration across a range of definitions of ‘long distance’. Adjusting for mediators and taking into account the uncertainty present in the models, we find evidence of health selection on the propensity to have moved long distance only when the definition of 50km or more is used. This finding contradicts research from Scotland (Boyle *et al.*, 2002) and Great Britain (Bentham, 1988) which find evidence of health selection at the 10km and inter-district cut-offs respectively, but confirms research on England and Wales using 1991 data (Boyle *et al.*, 2001). We conclude that for migration within England and Wales, the healthy migrant effect occurs above a cut-off somewhere between the 20 and 50km cut-offs.

There are several plausible explanations for the lack of healthy migrant effect at the 10 and 20km cut-offs. First, covariates in our model which are not present in previous research (nativity and whether the individual moved as part of a wholly moving household) may explain the heterogeneity in migration behaviour of those in good and poor health. Second, the healthy migrant effect may not be present at the 10 and 20km cut-offs specifically in England and Wales, with studies showing contrary results being drawn from Great Britain and Scotland data. Third, the inclusion of multilevel modelling may also influence the direction of the relationship, as the error of the health effect is partitioned into the individual and destination LA levels, and the variance explained by individual health may be too small at the 10 and 20km cut-offs to remain significant. Finally, this is an analysis of individuals and their migration behaviour, whilst the characteristics of one’s family also influence migration behaviour. For instance, if an individual’s partner is unwell then they may be particularly reluctant to move over long distances, despite being coded as ‘healthy’ in our design. It is not possible to control for this in the CISS as not all household relationships are preserved, although an analysis of ‘unhealthy households’ and their migration behaviour could be conducted using the household counterpart of the dataset.

Our second aim is to test whether the association between health and long distance migration varies by age across definitions of long distance. Our findings contradict past research showing that poor health is associated with moves over shorter distances in all working age groups (Bentham, 1988), as we find evidence for the healthy migrant effect only in the youngest (16-24) and oldest (55-64) working age groups. We identify a scale dimension to the health and long distance migration relationship, LLTI is associated with reduced odds of having moved long distance for the 16-24 age group at the 50km cut-off, whilst this difference is not significant at the 10 and 20km cut-offs. There is one effect which is consistent across all models, among the oldest age group (55-64) those without an LLTI are more likely to move long distance. We conclude that the healthy migrant effect is scale-invariant at pre-retirement ages (55-64), observable only over great distances for the youngest age group (16-24), and is not present for adults of mid working-age (25-54). This reinforces recent calls for age differences in the health and migration relationship to be accounted for (Norman and Boyle, 2014).

Our third aim is to assess whether there is spatial variation in long distance migration by health status. We identify that those with an LLTI who moved to London, south Wales and eastern England are more likely to have moved long distance, relative to those without an LLTI in the 10km model. Over greater distances however, long distance migration becomes increasingly health selective, and for the furthest moves those with an LLTI are more likely to move long distance to only two LAs in southern Wales. These findings show that those with and without an LLTI are attracted to different areas over distances less than 20km, but those with an LLTI are not more likely to move further than 20km to most areas relative to those without an LLTI. We conclude that, the healthy migrant effect is apparent in destination LAs for residential moves of 20km or further, and the effect is even stronger when only moves of 50km or further are considered to be long distance.

In terms of policy, we find health differences in the spatial pattern of long distance migration. We find that the youngest (16-24) and oldest (55-64) working age adults with an LLTI are less likely to move over very long distances (50km+), health services can adequately plan long term provision for those with an LLTI in these age groups with the knowledge that when these populations change residence, these moves are likely to be of distances less than 50km. The population without an LLTI appear to be drawn over long distances to rural areas of England and to Inner London: this reflects wider trends of counter-urbanisation in the UK (Stockdale, 2015) and the migration of healthy young people to London (Norman and Boyle, 2014). The relative lack of very long distance migration into rural areas by the population with an LLTI may be the result of poor rural healthcare provision failing to ‘pull’ this population towards these areas, whilst this factor is considered less important for the population in good health. Given that the incumbent Government is pushing for the devolution of healthcare planning and provision to Local Authorities with the 2016 Cities and Devolution Act (Sandford, 2016), rural LAs will need to account for the needs of incoming long distance migrants, whom may require health services in future as they age.

## Disclaimer and acknowledgements

This work contains statistical data from ONS which is Crown Copyright. The use of the ONS statistical data in this work does not imply the endorsement of the ONS in relation to the interpretation or analysis of the statistical data. This work uses research datasets which may not exactly reproduce National Statistics aggregates.

This work was supported by the Economic and Social Research Council (grant number [ES/J500161/1](http://www.sciencedirect.com/science/article/pii/S0277953616304828#gs1)) and the Administrative Data Research Centre for England. Data used in this study were provided through the ONS′ Virtual Microdata Laboratory in Titchfield.

# References

Abraído-Lanza AF, Dohrenwend BP, Ng-Mak DS, Turner JB. 1999. The Latino mortality paradox: a test of the ‘salmon bias’ and healthy migrant hypotheses. *American Journal of Public Health* **89**: 1543–1548 DOI: 10.2105/ajph.89.10.1543

Bailey N, Livingston M. 2005. Determinants of individual migration : an analysis of SARs data. 3. Glasgow.

Bentham G. 1988. Migration and morbidity: implications for geographical studies of disease. *Social science & medicine* **26**: 49–54 DOI: 10.1016/0277-9536(88)90044-5

Boyle P, Shen J. 1997. Public housing and migration: a multi-level modelling approach. *International Journal of Population Geography* **3**: 227–242 DOI: 10.1002/(SICI)1099-1220(199709)3:3<227::AID-IJPG69>3.0.CO;2-W

Boyle P, Gatrell AC, Duke-Williams O. 2001. Do area-level population change, deprivation and variations in deprivation affect individual-level self-reported limiting long-term illness? *Social Science & Medicine* **53**: 795–799 DOI: 10.1016/S0277-9536(00)00373-7

Boyle P, Norman P, Popham F. 2009. Social mobility: Evidence that it can widen health inequalities. *Social Science & Medicine* **68**: 1835–1842 DOI: 10.1016/j.socscimed.2009.02.051

Boyle P, Norman P, Rees P. 2002. Does migration exaggerate the relationship between deprivation and limiting long-term illness? A Scottish analysis. *Social Science & Medicine* **55**: 21–31 DOI: 10.1016/S0277-9536(01)00217-9

Boyle P, Norman P, Rees P. 2004. Changing places. Do changes in the relative deprivation of areas influence limiting long-term illness and mortality among non-migrant people living in non-deprived households? *Social Science & Medicine* **58**: 2459–2471 DOI: http://dx.doi.org/10.1016/j.socscimed.2003.09.011

Breslow RE, Klinger BI, Erickson BJ. 1998. County drift: A type of geographic mobility of chronic psychiatric patients. *General Hospital Psychiatry* **20**: 44–47 DOI: 10.1016/S0163-8343(97)00117-5

Brimblecombe N, Dorling D, Shaw M. 1999. Mortality and migration in Britain, first results from the British Household Panel Survey. *Social Science & Medicine* **49**: 981–988 DOI: 10.1016/S0277-9536(99)00195-1

Brown DL. 2002. Migration and Community: Social Networks in a Multilevel World. *Rural Sociology* **67**: 1–23 DOI: 10.1111/j.1549-0831.2002.tb00091.x

Browne WJ, Subramanian S V, Jones K, Goldstein H. 2005. Variance partitioning in multilevel logistic models that exhibit overdispersion. *Journal of the Royal Statistical Society: Series A (Statistics in Society)* **168**: 599–613 DOI: 10.1111/j.1467-985X.2004.00365.x

Champion T. 2005. Population Movement Within the UK. In *Focus on People and Migration*, Chappell R (ed.).Office for National Statistics: London.

Champion T, Shuttleworth I. 2015. Are people moving home less? An analysis of address changing in England and Wales, 1971-2011, using the ONS Longitudinal Study. 177. London.

Champion T, Fotheringham S, Rees P, Boyle P, Stillwell J. 1998. *The determinants of migration flows in England: a review of existing data and evidence: a report prepared for the Department of the Environment, Transport and the Regions*. The Department of Geography, University of Newcastle upon Tyne: Newcastle upon Tyne.

Cho Y, Whitehead C. 2013. The immobility of social tenants: is it true? Does it matter? *Journal of Housing and the Built Environment* **28**: 705–726 DOI: 10.1007/s10901-012-9331-4

Cohen G, Forbes J, Garraway M. 1995. Interpreting self reported limiting long term illness. *BMJ* **311**: 722–724 DOI: 10.1136/bmj.311.7007.722

Curtis S, Setia MS, Quesnel-Vallee A. 2009. Socio-geographic mobility and health status: a longitudinal analysis using the National Population Health Survey of Canada. *Social science & medicine (1982)* **69**: 1845–53 DOI: 10.1016/j.socscimed.2009.08.004

Dijkstra A, Kibele EUB, Verweij A, Van Der Lucht F, Janssen F. 2015. Can selective migration explain why health is worse in regions with population decline?: A study on migration and self-rated health in the Netherlands. *European Journal of Public Health* **25**: 944–950 DOI: 10.1093/eurpub/ckv192

Dorling D. 2013. *Unequal health: The scandal of our times*. University of Sheffield, United Kingdom.

ESRI. 2014. ArcGIS Help Available at: http://resources.arcgis.com/EN/HELP/MAIN/10.2/index.html#//016w0000005w000000 [Accessed 26 October 2015]

Fennelly K. 2007. The ‘healthy migrant’ effect. *Minnesota medicine* **90**: 51–53

Fielding T. 2012. *Migration in Britain: paradoxes of the present prospects for the future*. Edward Elgar Publishing Ltd: Cheltenham.

Findley SE. 1988. The directionality and age selectivity of the health-migration relation: evidence from sequences of disability and mobility in the United States. *International Migration Review* **22**: 4–29 DOI: 10.2307/2546583

Finney N. 2011. Educational constraints of immobility? Examining ethnic differences in student migration in Britain using Census microdata. *Documents d’Anàlisi Geogràfica* **57**: 413 DOI: 10.5565/rev/dag.235

Finney N, Simpson L. 2008. Internal migration and ethnic groups: evidence for Britain from the 2001 Census. *Population, Space and Place* **14**: 63–83 DOI: 10.1002/psp.481

Flowerdew R. 1976. Search strategies and stopping rules in residential mobility. *Transactions of the Institute of British Geographers* **1**: 47 DOI: 10.2307/621312

Fox AJ, Goldblatt PO, Adelstein AM. 1982. Selection and mortality differentials. *Journal of Epidemiology and Community Health* **36**: 69–79

Goldstein H. 2011. *Multilevel statistical models*. John Wiley & Sons, Ltd: New York.

Green MA, Subramanian S V, Vickers D, Dorling D. 2015. Internal migration, area effects and health: Does where you move to impact upon your health? *Social science & medicine (1982)* **136**–**137C**: 27–34 DOI: 10.1016/j.socscimed.2015.05.011

van Ham M, Mulder CH, Hooimeijer P. 2001. Spatial flexibility in job mobility: macrolevel opportunities and microlevel restrictions. *Environment and Planning A* **33**: 921–940 DOI: 10.1068/a33164

Jordan H, Roderick P, Martin D, Barnett S. 2004. Distance, rurality and the need for care: access to health services in South West England. *International Journal of Health Geographics* **3**: 21 DOI: 10.1186/1476-072X-3-21

Jordan K. 2003. Previous consultation and self reported health status as predictors of future demand for primary care. *Journal of Epidemiology & Community Health* **57**: 109–113 DOI: 10.1136/jech.57.2.109

Kearns A, Parkes A. 2003. Living in and leaving poor neighbourhood conditions in England. *Housing Studies* **18**: 827–851 DOI: 10.1080/0267303032000135456

Kearns R, Moon G. 2002. From medical to health geography: novelty, place and theory after a decade of change. *Progress in Human Geography*  **26**: 605–625 DOI: 10.1191/0309132502ph389oa

Larson A, Bell M, Young AF. 2004. Clarifying the relationships between health and residential mobility. *Social science & medicine (1982)* **59**: 2149–60 DOI: 10.1016/j.socscimed.2004.03.015

Lu Y. 2008. Test of the ‘healthy migrant hypothesis’: a longitudinal analysis of health selectivity of internal migration in Indonesia. *Social Science & Medicine* **67**: 1331–1339 DOI: 10.1016/j.socscimed.2008.06.017

Manor O. 2001. Self-rated health and limiting longstanding illness: inter-relationships with morbidity in early adulthood. *International Journal of Epidemiology* **30**: 600–607 DOI: 10.1093/ije/30.3.600

Martin D, Wright JA. 2009. Disease prevalence in the English population: A comparison of primary care registers and prevalence models. *Social Science & Medicine* **68**: 266–274 DOI: http://dx.doi.org/10.1016/j.socscimed.2008.10.021

McCarthy JF, Valenstein M, Blow FC. 2007. Residential mobility among patients in the VA health system: associations with psychiatric morbidity, geographic accessibility, and continuity of care. *Administration and policy in mental health* **34**: 448–55 DOI: 10.1007/s10488-007-0130-2

Moorin RE, Holman CDJ, Garfield C, Brameld KJ. 2006. Health related migration: evidence of reduced ‘urban-drift’. *Health & place* **12**: 131–40 DOI: 10.1016/j.healthplace.2004.10.013

Norman P, Boyle P. 2014. Are health inequalities between differently deprived areas evident at different ages? A longitudinal study of census records in England and Wales, 1991-2001. *Health & place* **26**: 88–93 DOI: 10.1016/j.healthplace.2013.12.010

Norman P, Boyle P, Rees P. 2005. Selective migration, health and deprivation: a longitudinal analysis. *Social science & medicine (1982)* **60**: 2755–71 DOI: 10.1016/j.socscimed.2004.11.008

Office for National Statistics. 2011a. 2011 Census questionnaire for England Available at: http://www.ons.gov.uk/ons/guide-method/census/2011/the-2011-census/2011-census-questionnaire-content/2011-census-questionnaire-for-england.pdf [Accessed 10 July 2015]

Office for National Statistics. 2011b. Secure Microdata Files – User Guide Available at: http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/census-microdata/census-in-the-virtual-microdata-laboratory/secure-microdata-user-guide.pdf [Accessed 21 October 2015]

Office for National Statistics. 2014. 2011 census variable and classification information: part 4 Available at: http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/2011-census-user-guide/information-by-variable/part-3--standard-variables.pdf [Accessed 22 October 2015]

Paksarian D, Eaton WW, Mortensen PB, Pedersen CB. 2015. Childhood residential mobility, schizophrenia, and bipolar disorder: a population-based study in Denmark. *Schizophrenia Bulletin* **41**: 346–354 DOI: 10.1093/schbul/sbu074

Payne N, Saul C. 2000. What common disorders do those reporting limiting long-term illness experience, and what is their survival and health service utilization experience? *Journal of Public Health* **22**: 324–329 DOI: 10.1093/pubmed/22.3.324

Pearce JR, Dorling D. 2010. The influence of selective migration patterns among smokers and nonsmokers on geographical inequalities in health. *Annals of the Association of American Geographers* **100**: 393–408 DOI: 10.1080/00045601003595537

Sandford M. 2016. Devolution to local government in England. 7029. London.

Smyth F. 2008. Medical geography: understanding health inequalities. *Progress in Human Geography* **32**: 119–127 DOI: 10.1177/0309132507080628

Statacorp LP. 2013. Stata statistical software: release 12

Statacorp LP. 2015. Stata help for xtmelogit Available at: http://www.stata.com/help.cgi?xtmelogit [Accessed 7 October 2015]

Stockdale A. 2015. Contemporary and ‘messy’ rural in-migration processes: comparing counterurban and lateral rural migration. *Population, Space and Place* **22**: 599–616 DOI: 10.1002/psp.1947

Strachan DP, Leon DA, Dodgeon B. 1995. Mortality from cardiovascular disease among interregional migrants in England and Wales. *BMJ* **310**: 423–427 DOI: 10.1136/bmj.310.6977.423

Thomas M, Stillwell J, Gould M. 2015. Modelling multilevel variations in distance moved between origins and destinations in England and Wales. *Environment and Planning A* **47**: 996–1014 DOI: 10.1068/a130327p

Thomas M, Stillwell J, Gould M. 2016. Modelling mover/stayer characteristics across the life course using a large commercial sample. *Population, Space and Place* **22**: 584–598 DOI: 10.1002/psp.1943

Wallace M, Kulu H. 2014. Migration and health in England and Scotland: a study of migrant selectivity and salmon bias. *Population, Space and Place* **20**: 694–708 DOI: 10.1002/psp.1804

Wilding S, Martin D, Moon G. 2016. The impact of limiting long term illness on internal migration in England and Wales: new evidence from census microdata. *Social Science & Medicine* **167**: 107–115 DOI: http://dx.doi.org/10.1016/j.socscimed.2016.08.046

Wolfe R, Hanley J. 2002. If we’re so different, why do we keep overlapping? When 1 plus 1 doesn’t make 2. *Canadian Medical Association Journal*  **166**: 65–66

# Table 1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Study | Country | Measure of health | Distance cut-off | Sample | Finding |
| (Boyle *et al.*, 2001) | England and Wales | LLTI | 50km | 1991 England and Wales Census microdata | Long distance migrants are less likely to report an LLTI (OR .86) than short distance and non-movers. |
| (Strachan *et al.*, 1995) | England and Wales | Stroke | Regional | 1991 ONS LS for England and Wales | Migrants into Greater London have lower rates of stroke-related mortality than non-movers. |
| (Boyle *et al.*, 2002) | Scotland | LLTI | 10km | 1991 Scotland Census microdata | Long distance migrants have lower rates of LLTI than short distance migrants. |
| (Bentham, 1988) | UK | Self-report permanent and temporary ‘sickness’ | Within district vs between district vs between region | 1981 Census | Between district and region migrants have lower rates of permanent sickness than within district migrants. Between region migrants have lower rates of temporary sickness than between and within district migrants. |
| (Larson *et al.*, 2004) | Australia | Numerous self-reported measures | Within postcode mover vs stayer, between postcodes mover vs stayer | Australian Longitudinal Study on Women’s Health 1996 & 1998 (NB study included data on women aged 45-50 in 1996) | Those who expect their health to deteriorate and experience several symptoms are more likely to move over short distances, those with several visits to health specialists are more likely to move long distance. Chronic diseases and smoking are associated with short and long distance moves. |
| (McCarthy *et al.*, 2007) | US | Disability, substance abuse, Schizophrenia, dipolar disorder, depression | Linear distance | US Veterans’ Association data | Disability, substance abuse, bipolar disorder and depression are associated with moves over longer distances, whilst schizophrenia is associated with moves over shorter distances. |
| (Findley, 1988) | US | Onset of chronic disease | 500 miles | National Health Interview Survey 1979 & 1980 | Those who are diagnosed with a chronic disease are more likely to move long distance, this effect is strengthened for those who had a pre-existing condition |

# Table 2

|  |  |  |
| --- | --- | --- |
| Variables | Groupings | Which group(s) are more likely to move long distance |
| Age | 0=16-24 1=25-34 2=35-44 3= 45-54 & 4=55-64 | Those aged 30 and over (Boyle and Shen, 1997; Thomas *et al.*, 2015). |
| Sex | 0= male & 1= female | Men (Boyle and Shen, 1997; Thomas *et al.*, 2015). |
| Ethnicity | 0= White, 1= Indian, Pakistani or Bangladeshi, 2= Chinese or other Asian, 3= African, Caribbean or Black, 4= Other or Mixed | One study finds that all minority ethnic groups move shorter distances (Finney & Simpson, 2008) whilst others report that only the Asian group to move shorter distances than other ethnic groups (Cho and Whitehead, 2013; Thomas *et al.*, 2015). |
| Marital status | 0= single, 1=married or civil partners, 2=divorced, separated or widowed | One study finds that the divorced and separated move shorter distances, with no difference between single and married (Thomas *et al.*, 2015) whilst another finds that the divorced and separated move longer distances (Cho and Whitehead, 2013). |
| Family status | 0= no family or household, 1= in a couple or married family, 2= in a lone parent family | Those living without children (Boyle and Shen, 1997). |
| Country of birth | 0= UK born 1=born outside of the UK | Non-UK born (Finney and Simpson, 2008). |
| Educational qualifications | 0= none, 1= GCSE or apprenticeship, 2= A level, 3=Degree or higher | Higher educated (Boyle and Shen, 1997; van Ham *et al.*, 2001; Fielding, 2012; Thomas *et al.*, 2015). |
| Tenure | 0= private renter, 1= LA or Housing Association renter, 2= owner | Those in LA housing to move shorter distances (Cho and Whitehead, 2013; Thomas *et al.*, 2015) and private renters to move further (Boyle and Shen, 1997; Cho and Whitehead, 2013) |
| Car access | 0= none, 1= one car, 2= two or more cars | Those with access to a car, as a proxy for wealth (Boyle and Shen, 1997) |
| Employment status | 0= employed, 1= unemployed, 2= economically inactive | Economically inactive move further than the employed, whilst the unemployed move the furthest (Boyle and Shen, 1997; Thomas *et al.*, 2015). |
| Wholly moving households | 0= partially moving household 1= wholly moving household | Partial movers (Cho and Whitehead, 2013). |
| Interactions | Age and gender interactions  Age and LLTI interactions | Younger women to be more likely to move long distance (Finney, 2011).  Young adults without an LLTI to be more likely to move long distance (Bentham, 1988). |

# Table 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Overall | No LLTI (a) | LLTI (b) | Ratio (b/a) |
| Mean (km) | 30.1 | 30.4 | 25.7 | 0.84 |
| SD (km) | 66.3 | 66.5 | 61.8 |  |
| Median (km) | 4.1 | 4.1 | 3.7 | 0.90 |
| T-test (b=a) |  | 4.8, p<.01 | |  |
| 10km+ (%) | 32.3 | 32.9 | 28.9 | 0.88 |
| 20km+ (%) | 22.8 | 23.3 | 19.4 | 0.83 |
| 50km+ (%) | 15.2 | 15.6 | 12.5 | 0.80 |
| N | 442,340 | 404,004 | 38,336 |  |
| Source: CISS (Office for National Statistics, 2011b), authors’ own calculations. | | | | |

# Table 4

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 10km |  |  | 20km |  |  | 50km |  |  |
|  | **Logit** | **LB** | **UB** | **Logit** | **LB** | **UB** | **Logit** | **LB** | **UB** |
| Constant | -0.81\*\* | -0.87 | -0.75 | -1.37\*\* | -1.43 | -1.31 | -1.94\*\* | -2.01 | -1.88 |
| Age (ref 16-24) |  |  |  |  |  |  |  |  |  |
| 25-34 | -0.18\*\* | -0.20 | -0.15 | -0.32\*\* | -0.35 | -0.30 | -0.50\*\* | -0.53 | -0.46 |
| 35-44 | -0.12\*\* | -0.15 | -0.09 | -0.23\*\* | -0.27 | -0.20 | -0.42\*\* | -0.46 | -0.37 |
| 45-54 | -0.05\* | -0.09 | -0.01 | -0.15\*\* | -0.19 | -0.10 | -0.28\*\* | -0.33 | -0.23 |
| 55-64 | 0.22\*\* | 0.17 | 0.27 | 0.15\*\* | 0.10 | 0.20 | 0.11\*\* | 0.05 | 0.16 |
| LLTI (ref None) | 0.03 | -0.03 | 0.09 | -0.10\*\* | -0.17 | -0.04 | -0.24\*\* | -0.32 | -0.16 |
| LLTI and age interactions |  |  |  |  |  |  |  |  |  |
| LLTI & 25-34 | 0.06 | -0.02 | 0.14 | 0.16\*\* | 0.08 | 0.25 | 0.28\*\* | 0.17 | 0.38 |
| LLTI & 35-44 | 0.03 | -0.05 | 0.11 | 0.14\*\* | 0.05 | 0.23 | 0.30\*\* | 0.19 | 0.40 |
| LLTI & 45-54 | -0.05 | -0.13 | 0.04 | 0.01 | -0.09 | 0.10 | 0.10 | -0.01 | 0.21 |
| LLTI & 55-64 | -0.23\*\* | -0.32 | -0.15 | -0.14\* | -0.23 | -0.04 | -0.01 | -0.12 | 0.10 |
| Sex (ref Male) | -0.13\*\* | -0.15 | -0.10 | -0.15\*\* | -0.18 | -0.13 | -0.17\*\* | -0.20 | -0.14 |
| Sex and age interactions |  |  |  |  |  |  |  |  |  |
| Female & 25-34 | 0.10\*\* | 0.06 | 0.13 | 0.10\*\* | 0.06 | 0.13 | 0.09\*\* | 0.05 | 0.14 |
| Female & 35-44 | -0.01 | -0.05 | 0.03 | 0.01 | -0.03 | 0.06 | 0.06\* | 0.00 | 0.11 |
| Female & 45-54 | 0.03 | -0.01 | 0.08 | 0.07\* | 0.01 | 0.12 | 0.11\*\* | 0.05 | 0.17 |
| Female & 55-64 | 0.11\*\* | 0.05 | 0.17 | 0.14\*\* | 0.08 | 0.21 | 0.20\*\* | 0.13 | 0.27 |
| Ethnicity (ref White) |  |  |  |  |  |  |  |  |  |
| Indian, Pakistani or Bangladeshi | 0.13\*\* | 0.10 | 0.17 | 0.26\*\* | 0.23 | 0.30 | 0.30\*\* | 0.25 | 0.34 |
| Chinese or other Asian | 0.18\*\* | 0.14 | 0.22 | 0.19\*\* | 0.15 | 0.24 | 0.20\*\* | 0.15 | 0.25 |
| African, Caribbean or Black | 0.21\*\* | 0.17 | 0.25 | 0.24\*\* | 0.19 | 0.28 | 0.25\*\* | 0.20 | 0.30 |
| Other or Mixed | 0.20\*\* | 0.16 | 0.23 | 0.21\*\* | 0.17 | 0.25 | 0.21\*\* | 0.17 | 0.26 |
| Marital status (ref Single) |  |  |  |  |  |  |  |  |  |
| Married or Civil Partners | 0.06\*\* | 0.04 | 0.08 | 0.15\*\* | 0.12 | 0.17 | 0.22\*\* | 0.20 | 0.25 |
| Separated or Widowed | 0.00 | -0.02 | 0.03 | -0.07\*\* | -0.10 | -0.04 | -0.16\*\* | -0.20 | -0.13 |
| Family status (ref None) |  |  |  |  |  |  |  |  |  |
| In a couple or married family | -0.14\*\* | -0.17 | -0.11 | -0.10\*\* | -0.13 | -0.07 | -0.03 | -0.06 | 0.01 |
| In a lone parent family | 0.13\*\* | 0.12 | 0.15 | 0.19\*\* | 0.17 | 0.21 | 0.21\*\* | 0.19 | 0.24 |
| Nativity (ref UK born) | -0.24\*\* | -0.26 | -0.22 | -0.26\*\* | -0.28 | -0.24 | -0.27\*\* | -0.30 | -0.24 |
| Education (ref None) |  |  |  |  |  |  |  |  |  |
| GCSE or apprenticeship | 0.14\*\* | 0.11 | 0.17 | 0.16\*\* | 0.13 | 0.19 | 0.18\*\* | 0.14 | 0.22 |
| A Level | 0.30\*\* | 0.27 | 0.33 | 0.39\*\* | 0.35 | 0.42 | 0.47\*\* | 0.43 | 0.51 |
| Degree | 0.84\*\* | 0.82 | 0.87 | 1.01\*\* | 0.98 | 1.04 | 1.14\*\* | 1.10 | 1.18 |
| Tenure (ref Private renter) |  |  |  |  |  |  |  |  |  |
| LA or charity renter | -0.31\*\* | -0.33 | -0.29 | -0.42\*\* | -0.45 | -0.39 | -0.51\*\* | -0.55 | -0.48 |
| Owns | 0.08\*\* | 0.07 | 0.10 | 0.07\*\* | 0.05 | 0.09 | 0.06\*\* | 0.03 | 0.08 |
| Car access (ref None) |  |  |  |  |  |  |  |  |  |
| One | 0.12\*\* | 0.10 | 0.14 | 0.11\*\* | 0.09 | 0.13 | 0.08\*\* | 0.06 | 0.10 |
| Two or more | 0.16\*\* | 0.14 | 0.18 | 0.08\*\* | 0.06 | 0.10 | 0.02 | 0.00 | 0.05 |
| Employment status (ref employed) |  |  |  |  |  |  |  |  |  |
| Unemployed | 0.42\*\* | 0.39 | 0.45 | 0.56\*\* | 0.53 | 0.60 | 0.67\*\* | 0.64 | 0.71 |
| Economically inactive | 0.32\*\* | 0.30 | 0.35 | 0.47\*\* | 0.44 | 0.50 | 0.55\*\* | 0.51 | 0.58 |
| Student | 0.05\*\* | 0.02 | 0.07 | 0.16\*\* | 0.13 | 0.18 | 0.18\*\* | 0.16 | 0.21 |
| Whole household moved (ref nol) | -0.58\*\* | -0.59 | -0.56 | -0.64\*\* | -0.65 | -0.62 | -0.65\*\* | -0.67 | -0.63 |
| Random effects |  |  |  |  |  |  |  |  |  |
|  | 0.19 | 0.16 | 0.22 | 0.18 | 0.15 | 0.21 | 0.17 | 0.15 | 0.20 |
|  | 0.03 | 0.02 | 0.04 | 0.01 | 0.00 | 0.03 | 0.02 | 0.00 | 0.03 |
| Covariance , | 0.05 | 0.03 | 0.06 | 0.04 | 0.03 | 0.05 | 0.03 | 0.01 | 0.05 |
| VPC | 0.06 |  |  | 0.05 |  |  | 0.05 |  |  |
| Log likelihood | -259862 | | | -220140 | | | -173869 | | |
| N | 442340 | | | 442340 | | | 442340 | | |
| \*\*,\* = significant at the .99 and .95 levels respectively. LB = 95% confidence interval lower bound; UB = 95% confidence interval upper bound; VPC = Variance Partition Coefficient. Source: CISS (Office for National Statistics, 2011b), authors’ own calculations. | | | | | | | | | |