Rural migration and health care

A review of the literature

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Abstract

This literature study focuses on possible links between access to health services and migration in rural areas. Why do people move to or from rural areas or why do they stay? What determines where people settle? And, in this context, do local health care services play an important or minor role, or no role at all? First, the paper reports on key findings from rural migration studies, in order to shed light on two migration trends: urbanization and counter-urbanization. Then we take a closer look on settlement preferences in rural areas, including the impact of health care facilities. Finally, we end up with a more deep-going review of the relatively small number of studies, which explicitly deal with settlement preferences related to access to health care.

Keywords: Rural Health Care, Rural Migration, Rural Settlement, Literature Survey
JEL classification: H20, R11, R58

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Contents

1. Introduction

This literature study focuses on possible links between access to health services and migration in rural areas. Why do people move to or from rural areas or why do they stay? What determines where people settle? And, in this context, do local health care services play an important or minor role, or no role at all?

A common belief is that a decrease in population leads to a decrease in services. Moreover, recent studies (e.g. Cloke et al. 1994; Hope et al. 2000) indicate that rural residents often see health care as fundamental to community life. Therefore, it is relevant to ask whether a reduction of health services (e.g. in the form of reduction of local hospitals and health centres) influences settlement patterns, and, if so, to what extent.

Empirical evidence suggests that everyday health service is relatively equally accessible in rural and urban areas in the Scandinavian countries (see e.g. Skjeggedal 2001). However, it has also been documented that there is more limited access to specialist health care in certain rural areas, e.g. accident and emergency units (see e.g. Farmer et. al. 2004, Rankin et al. 2004). How do the inhabitants experience this and can it be one of the motivating factors for leaving a rural area? Can good access to health care facilities have an influence on people

choosing to stay in rural areas? And, in the long run, will people consider moving to rural areas if local health care facilities are well developed?

An introductory assumption can be that health services of high quality will nonetheless have a certain impact of the quality of life in rural area. Thus, increasing the quality of health care *might* be *one* of many factors that can make rural areas – and here, not least, *peripheral* rural areas suffering from population decline – more attractive for locals, as well as for potential newcomers. Taking the new technological revolutions within the electronic media into consideration, it might be worthwhile to consider eHealth solutions as a viable means to sustain and, maybe even, provide better health care services in rural areas. Thus, on this background the main purpose of the paper is to let the literature shed light on the important question: *Can rural eHealth contribute to counteract out-migration?*

Section 2 presents important findings from rural migration studies, in order to shed light on two migration trends. Section 3 takes a closer look on settlement preferences in rural areas, including the impact of health care facilities. Section 4 is a more deep-going review of the relatively small number of studies, which explicitly deal with settlement preferences related to access to health care. Finally, Section 5 concludes the paper.

2. Rural migration: Two trends

Post-war, rural migration literature traces two major trends: Urbanisation and counter-urbanisation. *Urbanisation* means out-migration from peripheral rural districts to central locations. *Counter-urbanisation* means that migration is directed towards rural locations, that is demographic decentralisation. Some of the forces influencing counter urbanisation might in fact be a reaction against the urbanisation process, such as the rising property prices and increased congestion, e.g. traffic, in central areas.

Since the end of World War II there has been a general migration from rural/peripheral to urban areas. Especially peripheral rural areas have experienced a negative population development (e.g. Orderud et al. 1998; Sørlie 2003; Ærø et al. 2005). This centralisation tendency is evident in the Nordic countries and, more recently, in the former Communist Eastern European countries, whereas it is weaker in e.g. Great Britain and Western Europe. Overall, net migration movements in the post war years have followed a centralizing pattern.

Counter-urbanisation implies population growth in rural areas. It has been widely documented that counter-urbanisation processes have prevailingly taken place in rural areas close to cities.

Urbanisation processes in the Nordic countries have largely happened due to small populations living in large areas and a population structure based on few metropolitan poles. In particular, this is the case for Sweden and Norway, whereas the situation in Denmark is somewhat different due to area size and certain policies, e.g. the decentralized housing policy.

Obviously, the population base in the Nordic countries in general is not strong enough to operate regional metro-poles with a variety of services. Hence, the capital regions tend to become dominating growth poles (Mønnesland 1997).

Traditionally, regional policies in the Nordic welfare societies have aimed to obtain balanced regional growth, and not without success. Thus, since the 1970s the equality model has secured economic growth in remote regions as well, taking care that rural service levels equalized levels in the cities (ibid.). Denmark, for example, has been one of the countries with the highest degrees of regional economic equality in Europe (Ærø et al. 2005). It is however important to notice that the country at present is witnessing an extreme concentration tendency, where the differences within the country are increasing (Miljøministeriet 2003).

Danish peripheral areas have severe problems with keeping up with the national economic growth. For example, initiatives in the recently issued The *Danish Regional Growth Strategy* (Økonomi og Erhvervsministeriet 2003), aim to strengthen the industrial development and settlement in these areas.

Summary:

- Two trends have dominated since World War II: Migration from rural to urban areas (*urbanisation*), and, to a lesser extent, migration from urban to rural areas (*counter-urbanisation*)
- Counter-urbanisation has mostly been directed towards near-urban, rural areas
- Urbanisation in the Nordic countries have largely happened due to small populations living in large areas, combined with few metropolitan poles
- The centralisation/urbanisation tendency clearly prevails, not least in the Nordic countries
- In particular, Nordic peripheral rural areas have been depopulated in recent years

3. Migration motives, settlement preferences and socio-economic background

In order to assess the relative importance of health care services for migration, we first need to know why people decide to move, which places they prefer, and whether their socio-economic background has an impact on migration motives and settlement preferences.

Motives

Overall, peoples' motives for migrating appear to vary (e. g. Lundholm et al. 2004; Orderud et al. 1998; Hordland Fylkeskommune 2000, Pedersen 2000; Sørlie 2000, 2003; Ærø et al. 2005).

In the literature, the most decisive motives have been divided into two categories: labour related migration and individual preference migration. *Labour related migration* implies new spatial division of labour, e.g. centralisation/globalisation of industries, the growth of public services in rural areas in the 1970s and 'ruralisation' of industry. *Individual preference migration* implies new usage of the rural space. The latter is the case in rural areas rich on 'soft factors' such as rural idyll, a good cultural image, and well-functioning networks as Mälerdalen and Dalarne in Sweden (Kåks et al.. 1994; Stenbacka

1997), certain rural districts in Mid- Norway (Villa 1999, Berg 1998) and Rønhave in Denmark (Solvang 1999).

A significant part of in-migration to rural areas, including the abovementioned places, consists in return migration. Thus, a common picture has been that people move from remote rural regions to central locations to educate themselves and many return to raise their families. Now however the remote areas are gradually loosing their roles as raising areas for children, one explanation is that a new generation of well educated women finds it hard to find relevant jobs in the remote areas (Mønnesland 1997). Thus the number of returning migrants is in most places not sufficient to fill up the gap after the larger number of out migrants.

Hence, 'soft factors' should not be underestimated, in a sole focus on labour markets. For example, a recent study of inter-regional migration in the Nordic countries (Lundholm et al. 2004) shows that only one of five migrants ranges employment as a major motive for moving. Environmental and social factors are often more important.

In sum, we may conclude that migration motives vary and therefore call upon multi-variable explanations including an, until now, unexplored health care factor.

Preferences

The choice of settlement should be seen as a combination of people's demands and wishes for a good life and the quality of the place (see e.g. Orderud 2001; Anvik 1999; Berg 1998).

In respect to wishes for a good life, a recent Danish survey (Deding et al. 2004) shows that the most important factor for choice of settlement is family related causes, in the form of meeting partners, divorce, educational and care facilities for children etc. Only 20% of respondents inform that the primary reason for choice of destination is due to work related causes, similar to the Nordic study (Lundholm et al. 2004). Important to notice here is that these surveys are treating the population in general (the labour active pop.) and do not specifically look upon whether the respondent is moving to or from a rural area. See e.g. Graversen et al. (1997) for a review of migration in Denmark between rural and urban districts.

In respect to the quality of the place, an analysis by Norstrand et al. (2002) shows that there is more in-migration to municipalities that have attractive living conditions, i.e. municipalities with low living costs, low tax level and an adequate service level, and positive qualities in form of attractive nature and cultural institutions. Although health services are not specified as a factor, it is likely to assume that it is a service of relevance for living conditions in general.

Socio-economic background

Rural *in- migrants* consist of a varied group. The literature has stressed differences between (1) new migrants and returning migrants and (2) between groups of young families with children and old people. A significant part of rural *out-migrants* consists of very young people. A tendency to be aware of in the future is the out-migration of people already in the workforce, e.g. due to closure of firms and an increasing difficulty for those that have a higher education to find relevant jobs in the remote areas.

Often such groups not only have different localization motives and preferences, but also different socio-economic backgrounds (e.g. Orderud et al. 1998). Such differences have major impacts on rural health care services.

Regarding differences between new and returning migrants, Ærø et al. (2005) discern between "the locals", "the outreaching" and "the free and independent". Similar categories are used by Orderud et al. (1998). Here, the new migrants are motivated by job/career, adventure, or a particular lifestyle. Those motivated by *job/career* are mostly younger people, who have recently finished a higher education, and who are willing to migrate in order to gain relevant job experience. This group is highly mobile and most of them are singles. Those seeking *ad-*

venture will e.g. look upon a job in a rural area as a means of experiencing something different (environment, people) before settling down. Finally, migrants seeking a particular *lifestyle* are often couples with children, who want to improve their daily life, seeking better living conditions in a manageable, small local community, outside the city and closer to the nature. The returning migrants are mainly motivated by job opportunities, environment and retreat. Regarding *job opportunities,* getting a job often becomes the means to fulfil an old dream of moving back to one's native place. The particular *environment* has a special value for couples willing to sacrifice big careers for other values. For returning migrants on the retreat, a familiar and secure environment is the most important factor, since they often return due to broken marriages, career/job/education failures, or due to being single parent families.

The importance of age groups has been stressed in recent research, among an increasing number of Scandinavian rural studies, which focus on individual decisions (livsløpssstudier). Examples are studies of rural or urban settlement preferences among younger groups (see e.g. Grimsrud 2000; Orderud 2001, Førlandsås 2001, Engesæther 2004).

Regarding younger age groups, the longing of the rural idyll seems to be closely related to the *family* sphere. For example,

young Norwegian parents' idea of a perfect childhood is associated with a close relationship with nature (Berg 1998, Villa 1999). Hence, for families with children the countryside is an attractive place to settle. When talking about out-migration, a large part of rural-urban migrants are younger people without children. For example, in Graversen et al. (1997) it is documented that the mobility is highest among youngsters at the age of 15-24, who migrate from rural/peripheral areas to urban municipalities, primarily to get access to education. Regarding older age groups, e.g. Nivalainens (2003) study of migration to rural areas in Finland shows that – besides a main group of couples with children – another main group consists of pensioners, who want to relocate as a part of a retirement strategy.

Thus, overall we see that rural and urban areas can be attractive in different stages of life. The tendency to be become more "rural" in settlement preferences seems to increase with age. Also evidence from British studies suggests that counter-urbanization links to life cycles, that is, similar to the Scandinavian results (e.g. Champion 1994; Cloke 1994; Halfacree 1997; Halfacree et al. 1998; Lewis 1998).

The two main rural immigrant groups – young families and older, retired people – can be expected to have special needs for good access to health care. Social security, healthy environment, access to good schools is mentioned as important for

families with children. (Orderud 2001). Moreover, it is important to notice that many family migrants move to attractive, well-reputed and relatively wealthy, near-urban rural areas, while there is a tendency that migrants on retirement move to relatively poor, peripheral municipalities. (Nivalainen 2003). Thus, a demographic imbalance occurs: in the most remote areas there is a net migration deficit of young people and a net migration surplus of old pensioners and early retired people outside the labour market. Although there is some return migration of younger families moving back to the countryside to raise their children, this return migration does not up weigh the out migration of youths moving to the urban areas to educate themselves (and, many of them, staying there).

Naturally, such demographic changes effect the provision of rural public services, not least in peripheral communities. As will be shown in the last section of this paper, this includes health care services.

Summary:

- Migration motives and location preferences vary and have both important economic and social aspects. Therefore, they call upon multi-variable explanations, including an until now unexplored health care factor

- Migration patterns have led to a demographic unbalance in remote rural areas, in the form of a net migration surplus of old retired people and a deficit of young people
- The two main rural immigrant groups – young families and older, retired people – can be expected to have special needs for good access to health care
- In remote rural areas in particular, the increasing number of old, retired people can be expected to create an increased demand for certain health care services

4. Access to services in rural areas

Access in general

Previous research (see e.g. Glesbygdsverket 2004) shows two main tendencies. First, that access to basic services is something people take for granted, no matter in which part of the country they are living.[1] Secondly, that people who move to more remote areas are well aware of lower levels of service. The limited service level is however outweighed by a number of advantages, including adventure; social surroundings and cultural belonging (see e.g. Wiborg et al. 2000 and Anvik et al. 1998).

[1] Scandinavian welfare system, focusing on equality for all, to a certain degree.

Overall, education, childcare, post office, police and health/emergency services are seen as important to have relevant access to (see e.g. Glesbygdsverket 2004, Vilstrup 1996, Orderud 2001 and Farmer 2004)

Country surveys

Access to services varies from country to country. On the one hand we have countries like England, Scotland, Norway, Finland and Sweden, where access to services in major remote areas often is difficult and time-consuming. Due to a much smaller area, the situation in Denmark is different, and access is only a problem in small 'pockets' of margin areas – especially the small islands.

Generally, however, there does not seem to be a feeling of serious lack of access to services among the rural populations (Glesbygdsverket 2004). Evidence from a Danish survey also confirms that there is a difference between the actual level/quality of services and the perceived satisfaction with services. Even though people in rural areas have a lower level of available services they are still as satisfied as the people living in more central locations with the services (AKF 2000).

From *Norway*, Orderud (2001) reports that education and health care facilities are perceived as relatively good by young rural inhabitants. The health services for everyday needs and

care facilities are well developed; here the access is better in the smaller placer than in the cities. In remote rural areas there is however problems with recruiting and maintaining the stability of medical expertise like doctors. Other studies (Skjeggedal 2000; see also Skjeggedal et al. 2001) reveal that, among potential newcomers, the provision of education and health care facilities is third on the list of important qualities of a place when determining whether to settle there or not. Ranked first and second is a safe and healthy environment for children and possibilities for finding employment.

A survey by Såheim et al. (1997, in Lolle 2000) investigates the connection between the municipality size and satisfaction with services. An interesting finding is that certain services, like care and education facilities are evaluated to be more satisfactory in the smaller rural municipalities than in larger urban municipalities. The explanation for this is that the social networks in the smaller municipalities are more capable of initiating communication between the personnel and users, and this increases the satisfaction and the quality of the services.

From *Denmark*, an important publication is the report *At bo på landet* (Living on the countryside) by Vilstrup Research (1996). Here both respondents living in rural areas and those considering moving to the countryside were asked to mention the positive and negative sides of living in rural areas. On the

positive side respondents stress the abundance of space, fresh air, being close to nature, quietness – i.e. the physical environment. Also the social environment in the form of close social contacts is seen as a comparative advantage by both groups, although more so by the ones already living in rural areas than the potential newcomers. On the negative side expensive and time-consuming transport to work and education and poor collective transport are mentioned. Moreover, scarcity of local shops and private/public services (bank, post office, doctors, hospitals and pharmacies) is also a concern.

From *Sweden*, a recent report (Glesbygdsverket 2004) focuses on how important the distance to different services is for various rural populations, and how satisfied they are with the actual distance and possibilities to access services. At a national level, the survey shows that access to groceries, stores, emergency centrals, pharmacy, hospital and postal services represents the highest medium values regardless of the age/socioeconomic status of respondents. The overall result is that all respondents find service accessibility as expected. This includes respondents from the most rural and peripheral areas. This gives evidence to the fact that there is a different attitude to distance outside the urban and near-urban regions (see also Anvik et al. 2003). It is however important to note that respondents across regions are *least* satisfied with access to police stations and hospitals. Finally, 30% of rural migrants reported that

accessibility to services was of importance. Access to services should therefore not be seen as a *major* concern for *most* of the movers (Glesbygdsverket 2004).

Access to health care services

As mentioned above, there exist concerns about access to health care services, not least hospitals, although we do not detect serious discontent. When talking specifically about access to health care service, there seems to be particular many factors in play, including geographical variations, socio-economic status, gender and ethnicity. Especially when looking at countries where the differences in socio economic status is more prominent than the Scandinavian countries, and were the public intervention is more limited, we find that access to health services can create a further divide in the population.

Studies from the UK and USA, where wealth is unevenly distributed among social groups as well as in space, show that remote, isolated rural areas and deprived metropolitan areas are especially vulnerable (e.g. Curtis et al. 1996).

Thus, from *USA*, studies show that lack of access to health services is closely connected to rural deprivation – even in wealthy nations. There is a general concern to the reductions in numbers of hospital beds in rural areas (Cromley 1993; Hart 1993). For example, Muus (1993) has done a study in a North

Dakota community that in 1991 experienced a hospital closure. According to respondents, the closure was caused by a number of things, including too few patients, dwindling population, poor and unstable local physician care and poor management. Findings further indicate that residents were most concerned with poor access to *emergency* medical care as a result of the closing. Furthermore, residents feared that the closure would lead to loss of local jobs, further worsening of the local economy, transportation problems and out-migration.

Can we find similar tendencies in the European and Nordic countries?

Overall, access to health care service does play an important role in the European countries and has recently has been put on the political agenda in the EU. Thus, promotion of equity and accessibility of health and care systems are key elements in the debate on social protection in Europe.

In respect to documentation, a recent European survey[2] gives a summary of health status and satisfaction with health in EU member countries. It shows that satisfaction with the quality of health and social services is highest in the EU15 countries[3] and

[2] European Foundation for the improvement of Living and Working (2004): *Quality of Life in Europe.*

[3] Scale 1-10. Austria 8.1 , Belgium 7.6, Finland 7,3 , France and Luxembourg 7.1, Denmark 7.0 , Sweden and the Netherlands 6.7, Germany 6.5 , UK 6.4, Spain 6.3, Italy 5.8, Ireland 5.3, Greece 5.1 and Portugal 4.9.

lowest in the candidate countries and the new member states. Most important for our context, it shows that access to health services is not seen as a major problem. From a public health perspective, there are however concerns about access to, and quality of, health services related to factors like space (urban/rural areas), income, gender and age (European Parliament 2004). The most significant factor, however, was *country of residence*. Thus, in some Mediterranean countries, in the new Eastern European member states as well as in candidate countries access was reported to be partly problematic. Interestingly, the report shows that within these countries rural/urban locations are generally not seen as important for health care service. This can partly be explained by the fact that access to health services is defined as accessing a doctor in a clinic or general practice. And severe problems in getting to a doctor are not widespread.

Health care provision is often included among a list of services noted as being fundamental to community life (Cloke et al. 1994; Hope et al. 2000). At national level, a qualitative study conducted in *Scotland* shows that many people consider good health and education services to be key advantages of rural life (Shucksmith et al. 1996). Also the British Social Attitude Survey of 2000 (Stratford and Christie 2000) confirms that rural respondents are more satisfied with local services, such as schools and health facilities, compared to urban people. A

more recent study (Farmer et al. 2004) considers attitudes and opinions about access to health services, focusing on remote Scottish rural areas. It shows that a little more than 80% were satisfied with the local health care. Moreover, that satisfaction was highest in remote rural areas. However, nearly 40% found that the major Accident and Emergency Unit (A&E) was too far away. A majority felt that there should be equity of services in rural/urban areas, even though this can only be achieved by spending more money in rural areas compared with urban areas.

Rural inhabitants generally thought their area was a good place for older people to live, in contrast to urban respondents. Likewise, remote rural respondents were less likely to think older people from rural locations should consider moving to town to access the health services they might need. Instead, they encouraged older people to move to rural areas. Finally, an interview study (Highlands and Islands Health Research Institute 2004) explores the extent, to which health and healthcare influence old residents' decision to relocate. Two principal reasons for relocating were identified: improvement of life quality and being closer to family, who then better can take care of them. Generally, interviewees were very satisfied with the quality of local health services. More interesting, maybe, access to health services is regarded as more important than being closer to care-taking relatives. Nevertheless, older people moving to ru-

ral areas appear to give little consideration to their future health and health care requirements. Increasing need for care (in the ageing rural population) and reduced accessibility (because of centralisation of services) may therefore lead to a mismatch between supply and demand.

In Denmark, a recent study (Ærø 2005) based on data and interviews with migrants in 45 rural municipalities' shows that the quality of the services is perceived as being the same as in the rest of the country. The hospital coverage in the areas is regarded as a crucial factor, and many of the rural migrants have this in mind before deciding to move. Nevertheless, few had a clear knowledge of the hospital coverage in the area, to which they have moved. The informants are all well informed about the general Danish debate on the closure of hospitals, and they typically feel that the coverage is getting worse. Nevertheless, most informants feel that the hospital coverage is acceptable. Like many other studies, this study only touches lightly upon the theme of health services and its role in the migration process. It documents that, in particular, access to local hospitals has been *reflected* upon in the migration process, but this does not imply that access to health services directly influences the migration decision. Nor does it signify, how significant a role health care service plays compared to other factors.

Summary:

- Generally, rural dwellers are satisfied with access to local health care, but especially Accident & Emergency Units are considered to be too far away in remote rural areas
- Access to basic services is often taken for granted, and people moving to remote rural areas are generally aware of limited service levels
- Empirical evidence shows that citizens health care facilities are considered important to have access to, here not least hospitals
- Both in USA and Europe there is an increasing political concern for the linkage between access to health service and social protection
- Among EU populations, access to health services is generally not seen as a serious problem. However, in some Mediterranean countries, as well as in the new and coming member states access is reported to be partly problematic
- A Scottish study shows that old people, who want to migrate, see access to rural health services as more important than living closer to care-taking relatives.
- Among migrants, access to health services is often reflected upon but does not seem to directly influence the decision to migrate. This mirrors of lack of knowl-

edge of how *significant* a role health care service plays, compared to other factors

5. Conclusion and hypothesis

A common assumption is that high quality health services have an impact on the quality of life in rural areas. Therefore, to increase the quality of health care might be one of many factors that can make rural areas more attractive for locals and potential newcomers. In this respect, eHealth solutions might be a viable means to provide better health care services in rural areas. On this background, and mainly in a Northern European setting, the main purpose of this review paper was to answer the question: *Can rural eHealth contribute to counteract out-migration?*

In section 2 the literature on rural migration was reviewed, whereas section 3 treated migration motives and preferences. On this background we finally reviewed the literature on the importance of health care services in rural areas in section 4.

Overall, we found a lack of literature on rural health services generally, and absence of literature on rural eHealth specifically, with relevant evidence from the Scandinavian countries.

This was especially the case when looking for evidence connected to people's migration decisions. Thus, more empirical research is strongly needed – a gap, which our eHealth project in the Nordic countries contributes to fill out.

In Section 2, we traced two dominant migration trends in recent time, namely migration from rural to urban areas (*urbanisation*), and migration from urban to rural areas (*counter-urbanisation*). Important results are that counter-urbanisation has mostly been directed towards near-urban, rural areas, while urbanisation in the Nordic countries have largely happened due to small populations living in large areas, combined with few metropolitan poles. Moreover, that a centralisation/urbanisation tendency clearly prevails, not least in the Nordic countries. Especially, Nordic peripheral rural areas have been depopulated in recent years.

In Section 3, research results showed, overall, that migration motives and location preferences vary to a large extent, and have both important economic and social aspects. Therefore, they call upon multi-variable explanations, including until now an unexplored health care factor. Migration patterns have led to a demographic unbalance in remote rural areas, implying too many old and too few young people. Especially young families and older, retired people can be expected to have special needs for quick access to health care.

Particularly in the most remote rural areas, the increasing number of old, retired people can be expected to create an increased demand for certain health care services.

In Section 4, it was shown that rural dwellers in general are satisfied with access to local health care, including the Nordic populations. However, especially Accident & Emergency Units are considered to be too far away in *remote* rural areas. Furthermore, we saw that access to basic services is often taken for granted, which does not prevent citizens from considering health care facilities as important to have access to, not least hospitals. Reviewing the surveys at national levels, we saw that both in USA and Europe there is an increasing political concern for access to health service, also in rural areas, as a means to secure social protection. Although access to health services is generally not seen as a serious problem in the EU, access is partly problematic in some Mediterranean countries, as well as in the new and coming member states.

Generally, it is striking how little we know about which role health care service *specifically* plays to migration patterns, in comparison to other, more traditional and more explored factors such as education and labour market.

Therefore, on the background of main results within previous literature it will be relevant for future research to empirically test the following hypothesis:

> *Peripheral rural areas are vulnerable to population decline and an unbalanced population structure (too many old and too few young people). High quality health care generally, and eHealth service specifically, can contribute to hinder out-migration.*

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