



Fachhochschule für
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Are Fixed-Term Jobs Bad for Your Health? A Comparison of Western Germany and Spain.

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Section: Economics, Law and Political Sciences
Paper No. 27, 11/2006

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Working Papers of
the Institute of Management Berlin at the
Berlin School of Economics (FHW Berlin)
Badensche Str. 50-51, D-10825 Berlin

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ISSN 1436 3151

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Abstract:

In this paper we use panel data to analyse the health effects of fixed-term contract status on men and women in western Germany and Spain. This paper asks whether the changes in the employment relationship due to employment law liberalisation have altered the positive health effects associated with employment (Goldsmith et al. 1996; Jahoda 1982). Using contract type information on switching between unemployment and employment we analyse whether transitions to different contracts have different health effects. We find that unemployed workers show positive health effects at job acquisition, and also find the positive effect to be smaller for workers who obtain a fixed-term job. We also establish surprising differences by gender and country, with women less likely to report positive health effects at job acquisition. For western Germany, this was found to be a function of the dual burden of paid and unpaid care within the home.

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1. Introduction

There is considerable evidence to suggest that losing one's job has negative psychological and physical consequences for the unemployed (Goldsmith et al. 1996; Hamilton et al. 1997, Theodossiou 1998, Romeu Gordo forthcoming). These studies underlined the social dynamics within employment that have positive implications for workers' sense of self and well-being. The employment relationship has changed considerably, however, with the liberalisation of employment law in most OECD countries in the mid-1980s leading to growing numbers of fixed-term contracts (OECD 1999, 2004). The implications of these changes are thought to vary by country (Regini 2000), with more "rigid" economies, such as Germany and Spain, most likely to suffer segmentation as a result of 'partial deregulation' (Adam and Canziani 1998). This paper examines whether the reduced job quality (Kalleberg et al. 2000, Houseman 2001, McGovern, Smeaton and Hill 2004; Gash 2004a) and reduced job security (Gash 2004a; Gash and McGinnity forthcoming) associated with fixed-term contracts, decreases the positive health effects of employment for the unemployed in two "rigid" economies.

The past two decades have seen an increase in fixed-term employment in the majority of OECD countries. This increase has been most dramatic in Spain where one-third of all employment contracts are fixed-term; in contrast, German fixed-term employment rates are below the EU average of 12-13% of employment contracts (Eurostat 2002 p. 173). In Germany, fixed-term contracts account for roughly 8% of total employment (Rudolph 2000). Accordingly, there has been much discussion about the consequences of working in fixed-term jobs with mixed evidence for different countries. While in Spain fixed-term workers often seem to be trapped in a cycle of repeat spells of fixed-term employment and unemployment (Amuedo-Dorantes 2000; Polavieja 2003), there is less supporting evidence for such a scenario in Germany (Bookman and Hagen 2005, McGinnity, Mertens and Gundert 2005). We also know that fixed-term workers receive lower wages, (see e.g. Mertens and McGinnity 2004 for Germany and Jimeno and Toharia 1993 for Spain) and in many cases have fewer work related benefits (OECD 2002). Does this combination of job insecurity and poor working conditions have negative consequences on health? Might workers' experience of fixed-term employment vary in countries with different risks and opportunities for fixed-term workers?

2. Unemployment, job insecurity and health

2.1. Some theoretical considerations

Fixed-term contract workers lose their jobs more frequently than those on permanent contracts simply because their contracts run out within very short periods of usually one to two years. This job loss often results in unemployment (after one year around 13% of fixed-term workers become unemployed in Germany and 20% in Spain¹), which usually causes a deterioration of general health indicators and self-reported health status (see e.g. Schwefel 1986, Dooley et al. 1996, Kasl and Jones 1998, Murphy and Athanasou 1999).² Why do we observe this close link between unemployment and health? In addition to the financial difficulties the unemployed face which, in themselves, have been associated with extreme psychological strain (Pearlin, 1989; Whelan 1992), the unemployed lose many of the latent functions important to individual well-being that employment provides (Jahoda 1982). Employment is seen to provide a structure to one's day, regular contact with others, and a sense of self-worth. Not only does unemployment deprive people of these functions, it also bring with it skill attrition and a loss of, or decrease in, social status (Warr 1987).

We also expect fixed-term contract workers to be disproportionately affected by job insecurity, another factor thought to affect health status. One much cited study by Ferrie et al. (1995) shows that self-reported health status deteriorates when employees expect privatization and the accompanying job change or job loss. Crucially, this relative decline in health status was shown not to be linked with changes in health related behaviour. Burchell (1994, 1999) as well as Bohle et al. (2001) argue that job insecurity has obvious negative effects on physical and psychological well-being.³ The estimated reduction in psychological well-being is very similar in magnitude to that caused by unemployment. One explanation for this could be the inability of fixed-term contract workers to plan and control their lives given the short-term nature of their jobs (Burchell 1994). Therefore, although a fixed-term job fulfils many of the conditions that Jahoda (1982) and Warr (1987) associated with employment, it might still have negative health effects due to the high degree of job insecurity.

¹ Own estimations of ECHP data, cross-sectional analysis of the labour force status of all fixed-term contract workers in 1995 by their labour force status in 1996, weighted data.

² There is also evidence of the positive health effects of reemployment. For instance, Claussen (1999) looks at the health impact of reemployment for the long term unemployed in Norway. He establishes an improvement in mental health after reemployment. Romeu Gordo (forthcoming) using German data also finds that reemployment has a positive effect on health satisfaction. This effect is independent of how long individuals have been unemployed.

³ Bohle et al. (2001) give a very good overview of nearly seventy studies conducted since 1966 that look at the health and safety effects of job insecurity.

In addition to the pressure of job insecurity, there may also be stresses linked to the comparatively poor job quality of some fixed-term jobs. Fixed-term jobs are usually associated with relatively low pay in western Germany, Spain, France and the United Kingdom (Booth et al. 2002, Mertens and McGinnity 2004, Mertens, Gash and McGinnity 2005, Gash and McGinnity forthcoming), poor working conditions in Denmark, France and the United Kingdom (Gash 2004) and reduced access to benefits in the United States and the United Kingdom (Houseman 2001, McGovern, Smeaton and Hill 2004). We anticipate this combination of relatively high job insecurity and lower job status to have implications for psychological health and health status.

The paper presents a cross-national analysis of the health outcomes of contract type for men and women based on anticipated differences by gender and country. We expect women to be more likely to self-actualise in unpaid care work than men, and expect this to protect them from some of the negative consequences of unemployment (Gallie and Russell 1998; Romeu Gordo forthcoming). This is especially likely in the two countries under consideration given relatively low female participation rates of just over 60% in Germany and approximately 50% in Spain. Furthermore, there are also financial aspects which may explain gender differences in job loss impact. The low labour participation rates suggest that the male-breadwinner model still persists in both countries and especially in Spain (Moreno Mínguez, forthcoming). According to this household model, the female contribution to household income is ranked lower in importance than the male contribution; this would also explain gender differences in the effect of job loss on health.

We expect between-country differences in the health effect of job acquisition and contract type as a result of the following: differences in the quality of the fixed-term labour market and levels of unemployment, variations in the size of the fixed-term employment sector, and differing cultural attitudes to unemployment.

First of all, the literature suggests that the implication of holding a fixed-term job means different things in different institutional contexts (Gash and McGinnity, forthcoming). The Spanish literature suggests that Spanish fixed-term workers are highly disadvantaged compared to permanent workers, with employment opportunities for both groups highly polarized (Polavieja 2005). Not only are fixed-term workers exposed to worse job quality than permanent workers (Polavieja 2003, Jimeno and Toharia 1993) but the prevalent market segmentation makes it more likely for them to experience considerable difficulties in their attempts to obtain a permanent job (Amuedo-Dorantes, 2000). In Germany, the evidence does not appear to be as negative over the longer-term. McGinnity, Mertens and Gundert (2005) found that the employment

opportunities of fixed-term and permanent workers converge after a period of five years, while Bookmann and Hagen (2005), using a different dataset, also found no negative impact on future employment for German fixed-term workers. So while the evidence suggests that German fixed-term work is not equal to permanent work in terms of job quality, the ability of German fixed-term workers to move on from these posts does not appear to be as constrained as it is for Spanish workers. For this reason, we could expect Spanish fixed-term employment to have a less positive effect on the health of workers.

Second, while both countries suffer from high unemployment rates, Spanish unemployment rates have been considerably higher and also differ considerably in their composition, with Spanish women experiencing very high unemployment rates relative to Spanish men. It could be argued that higher levels of unemployment will decrease the stigma associated with unemployment, with decreasing stigma likely where higher proportions of one's social network are facing a similar situation (Clark 2003). There is also the suggestion that when the possibility of obtaining employment is very low, i.e. in a period of high and long-term unemployment, people may decide to "reject" the role that paid employment plays in their lives (Gallie and Russell 1998). Hence, in terms of our research, if paid employment is no longer central to how Spanish women evaluate themselves, we can expect them to be the least likely to exhibit positive changes in health status on entry to paid employment.

Third, there are differences between both countries in the proportion of workers on fixed-term contracts. In Spain, where one third of the workforce is on fixed-term contracts, acceptance of these jobs might be higher than in Germany where just under ten per cent of workers have fixed-term contracts. Since fixed-term contracts are more "abnormal" in Germany, we could expect a greater stigma to be attached to them, which might make them marginally more stressful. Alternatively, a smaller fixed-term workforce could be at greater risk of negative health selection, with a fixed-term contract only offered to the less productive worker, or workers with less human capital and work experience as a result of their poor health status. Previous research has found evidence of health-related selection into employment trajectories, with fixed-term workers with initial poor health more likely to experience precarious market transitions in the future (Virtanen et al. 2005). However, this research also revealed that market transitions themselves impact on worker health.

Finally, we could also expect differences in the German and the Spanish work ethic to influence their response to both employment and unemployment. This assumption is based on research suggesting that Spain's work ethic is not as prevalent; consequently, one might expect the Spanish unemployed to suffer less from unemployment (Marsh and Alvaro 1990).

Our theoretical considerations have shown that the health effects of leaving unemployment via permanent and temporary employment are likely to differ by gender and country. Before we analyse these questions empirically we provide a review of the literature in the next section.

2.2. Are fixed-term contracts bad for your health?

There are few studies that analyse the direct health effects of fixed-term contracts and those that do have used a variety of health measures. For our purposes we will summarize the results into psychological and physical health effects.

We have argued that psychological well-being will be negatively affected by fixed-term employment, with these contracts considered stressful. Klein, Hesselink and van Vuuren (1999), using Dutch data, confirm this assumption reporting that roughly 44% of fixed-term workers are worried about job insecurity, while only 15.5% of permanent contract workers worry about insecurity. Similarly, Lasfargues et al. (1999) find evidence of lower psychological well-being amongst temporary workers in France. Nonetheless, fixed-term contract work is unlikely to have the same impact on all workers, as Bauer and Truxillo (2000) argue. Individual characteristics like tolerance for ambiguity and self-monitoring influence responses to stress and the selection process into permanent employment. Not all studies looking at psychological factors confirm our assumptions however. Benavides et al. (2000), in a cross sectional study of 15 European countries, show that non-permanent employees tend to report lower work stress. Similarly, Sverke (2000) et al. report that fixed-term work has no effect on psychological well-being and, likewise, Artazcoz et al. (2005), in a Spanish health survey, find no association between fixed-term contracts and poor mental health.

The literature on physical health is even more ambiguous. While Benavides et al. (2000) find fixed-term workers to have worse physical health than permanent workers and Klein, Hesselink and Van Vuuren (1999) report slightly higher percentages of fixed-term workers with physical health complaints, other researchers have found fixed-term contract workers to have better health. Similarly, Sverke et al. (2000) find fixed-term contract workers to have better physical health compared to permanent workers. Fixed-term workers are sometimes reported to have lower rates of absenteeism than permanent workers (Benavides 2000, Virtanen 2003). Rates of sickness absence even tend to increase when employees move from fixed-term to permanent jobs. It is very unlikely, however, that this is caused by a real deterioration in health. It rather shows that fixed-term workers try to reduce absenteeism due to fears of job loss. Once in a permanent position this fear is reduced. Some studies reveal between country differences with,

for example, Rodriguez (2002) noting that German fixed-term contract workers report poor health relative to permanent workers, although no similar effect was found using the same methodology in the United Kingdom. While other studies reveal different findings within countries, Virtanen et al. (2002 and 2003) show that non-permanent employees in Finland report better health, while Kivimäki et al (2003) identify higher mortality risks among temporary workers compared to permanent workers in Finland.

Finally, two papers discuss the topic closest to our research design. Strandh (2000) looks at the impact of different exit routes from unemployment on mental health in Sweden. He finds that mental health improves for unemployed workers who leave unemployment to enter either education or employment. He also finds that atypical workers, the self-employed and temporary workers, show less improvement in their mental health than permanent workers. Virtanen et al (2003) also look at the impact of workers transitions on physical health and sickness absence in Finland. However, their study is focused on workers in two hospital districts and the number of switchers is very small. They find no change in health indicators when workers move from fixed-term to permanent jobs.

Our empirical study described in the following sections adds to the literature on the health consequences of fixed-term workers by examining the consequences of workers transitions from unemployment to employment on their health status. We use information on switches between unemployment and employment by contract type to analyze these concerns. We expect evidence of an improvement in the health status of unemployed workers who obtain employment. Furthermore, given the pressures of job insecurity and unemployment risk we expect fixed-term contracts to negatively affect health. If this is true we should observe less of an improvement if the contract is fixed-term rather than permanent. We also expect to observe gender differences and differences between countries given the different size of the fixed-term employment sector and the different opportunity structures of fixed-term workers. One of the strengths of our research design is its provision of a comparatively homogeneous group of workers, given their shared prior experience of unemployment. This should provide a control for some of the differences which exist between workers in different types of contract. We use data from the European Community Household Panel (ECHP) and the German Socio-Economic Panel (GSOEP) to test the impact of fixed-term contracts on health status and reveal whether differences by gender, country and duration of employment contract exist.

3. Estimation methods and data used

For our study we use Spanish data from 1994 to 2001 from the European Community Household Panel (ECHP) and the German Socioeconomic Panel waves 1994 to 2004 for western Germany (SOEP Group, 2001). The ECHP provides full information on contract type from 1995 and the GSOEP from 1994 onwards.⁴ The panel component of both datasets allows us to analyse the impact of labour market transitions on changes in health status.⁵ By focusing on unemployed workers we reduce the problem of heterogeneity that comes with a comparison of fixed-term and permanent workers.

For our purposes we follow unemployed workers and compare their health status in at least two consecutive years, excluding respondents with less than two years complete information on our covariates of interest. Moreover, the sample is limited to those aged between 20 and 54 years of age, with those aged over 55 more likely to have lower health status as a result of increasing morbidity.

We analyze the effect of different labour transitions on changes in health status for men and women separately using the following basic OLS model:

$$\Delta \text{health} = \beta_0 + \beta_1 \text{newtemp} + \beta_2 \text{newperm} + \beta_3 X + \varepsilon .$$

Changes in health are measured by self-defined health status.⁶ This change is regressed on a constant, a set of control variables collected in matrix X and dummy variables indicating new temporary (newtemp) or permanent (newperm) jobs with no new job being the reference category. In X we include socioeconomic control variables such as gender, age and education, as well as the health status of the respondent in t-1. Health status in the year prior is expected to

⁴ We cannot identify agency workers at any point in both surveys. Agency workers may or may not classify themselves as on a fixed-term contract. While agency work has risen steadily in Germany in the last decade, it was still only 1.2% of dependent employment in June 2000 (Bundesanstalt für Arbeit, 2001). Similarly Spain agency work accounts for approximately 0.8% of total employment (Storrie 2002). Hence, we do not expect it to bias our results.

⁵ Caution is required when using self-reported health measures in cross-cultural studies (Jürges 2005) with different meanings attached to different response categories. For example, category 4 of our self-reported health status variable is “malo” in the Spanish questionnaire and “weniger gut” in the German questionnaire. However, “weniger gut”, which means a little less than good, has a more positive connotation than “malo”, which means bad. While these differences might affect a comparison of *levels* of health by country, our analysis removes this risk by looking at *changes* in health status.

⁶ Both the ECHP and the GSOEP determine health status by asking respondents: “How is your health in general?”, with 1=“Very good” and 5=“Very Bad”, resulting in a health change variable with nine different categories. We reverse code health status so that decreases in health status are represented by negative coefficients in the models. It should be noted that there is a strong correlation between subjectively defined health status and objective criterion (Table A1 in the appendix).

have a negative impact on current health status, with strong ceiling effects associated with this variable, i.e. respondents with good to very good health are less likely to report improvements as the scale does not go any higher. Finally, we control for potentially stressful life events: marriage, divorce, separation, individuals moving into the family home, birth of a child, individuals leaving the family home or a death in the family home. To test whether unobserved individual heterogeneity influences our results, we compare OLS estimates with those from a random effects regression.⁷

4. Empirical analysis

4.1. Model specification

To test the effect of labour market transitions on self-reported health status we estimate two models: one looking at the short-run immediate implications (Model 1) and another looking at longer run consequences (Model 2).⁸

Model 1: We first select individuals who are unemployed in $t-1$ and consider three possible labour transitions in the following year: (i) the individual remains unemployed; (ii) the individual gets a permanent contract; (iii) the individual gets a fixed-term contract.

Model 2: In the first period ($t-2$) all individuals are unemployed. We then consider three different transitions in the labour market: (i) the individual remains without work till t ; (ii) the individual finds a job with a fixed-term contract in the first period (between $t-2$ and $t-1$) and remains employed till t ; (iii) the individual finds a job with a permanent contract in the first period (between $t-2$ and $t-1$) and remain employed till t . The objective in model 2 is to determine the long-term health implications of obtaining a fixed-term contract, with any positive effect of job gain expected to decrease if the worker becomes aware of reduced opportunities associated with their contract type⁹.

⁷ We decided to use random effect estimators after carry out a Hausman test, which revealed that GLS was the most efficient estimator.

⁸ For a graphic illustration of the model specification see Figures A1 and A2 in the appendix.

⁹ By looking only at this selection of transitions from unemployment we exclude 64% of all observations in Spain and 58% in Germany. The modal category of excluded respondents for both samples consist of those without complete information on labor force status for three years in a row. For those with complete information, the modal categories for our German sample, accounting for 27% of the sample, are those who leave unemployment for employment in $t-1$ and then re-enter unemployment in t and those who remain unemployed for two years and then enter employment in t . For Spain the corresponding figure is 26%. To test whether our emphasis on three very specific transitions lead to biased results we introduce a dummy variable which includes all other possible transitions to the model. Our results were found to be consistent after introducing this dummy variable.

4.2. Estimation results

Model 1

Tables 1 and 2 present the basic results for men and women. We find that for German men transitions from unemployment into employment have a significant and positive effect on health status for both fixed-term and permanent workers. Similarly, in Spain transitions from unemployment into employment have a significant and positive effect on health status for both types of contract but for Spain the effect of permanent employment is significantly larger than that of a fixed-term contract¹⁰. So for Spanish men we can conclude that fixed-term contracts are significantly worse for your health.

For German women, on the other hand, we only find positive effects on health status if the contract is permanent. The transition from unemployment to a fixed-term contract has no significant effect on females' health. Surprisingly, health status of Spanish women does not change in either case.

Now, it is possible that our results are biased because individuals with low levels of health are less likely to obtain a job, and/or to be less successful at obtaining a job with a permanent contract. Therefore, we estimate the same models homogenising the reported level of health in $t-1$. We select individuals whose reported health status in $t-1$ was at least 3, that is those with fair to very good health status. In Germany approximately 11% of individuals report health status lower than 3, while in Spain the figure is 4%. These individuals tend to have serious health problems, which are most likely to impact negatively on their labour market success. This is corroborated by comparing objective health measures for individuals who report health status lower than 3 with individuals whose reported health is at least 3 (see Table A1 in the appendix). The control on a possible health selection effect for Model 1 in tables 3 and 4 shows that while the results for German women don't change, they do change for Spanish women. After health selection, transitions into fixed-term jobs have a significant and negative effect on health status. The results do change for German men. Once we remove individuals with very low health status from our sample, we no longer find a positive relationship between health status and receipt of a fixed-term job. This result suggests that individuals with low health status are more likely to obtain fixed-term contracts, and that they derive a positive effect of obtaining employment. For Spanish men, the positive effect of transitions into fixed-term employment remains significant even after selecting on health and the difference between contract type. This may be due to the fact that fixed-term employment is more widespread in Spain so that health selectivity into fixed-

¹⁰ We conducted nested t-tests to establish whether the difference in the size of the coefficients by contract type was statistically different. The difference is significant at the .05 level for Spain, but is not for Germany.

term employment is less of an issue; many individuals, independently of their level of health, are likely to become fixed-term contract workers.

In summary, we have found that job acquisition improves health status. We have also found contract type to play an important role in health status with workers who obtain a fixed-term contract exhibiting smaller increases in health status, though this is only statistically significant in Spain. We have also found women to exhibit different tendencies to men. For German and Spanish women fixed-term contracts have no effect on health status (with or without health selection). One of the possible explanations of this result is that since women engage in a disproportionate amount of unpaid work within the home, they are less likely to exhibit positive health status change when entering into paid employment. If they are already engaged in unpaid work within the home, in fact, the positive effect of job receipt might be cancelled out by the stressful effects of the double-burden of paid and unpaid work. In order to analyse this question, we test whether the non-significance of the female result is driven by women who are engaged in intensive unpaid childcare duties within the home. Table A2 in the appendix presents the mean hours spent per day in unpaid childcare within the home. While we find full-time working women to have slightly lower levels of unpaid care the average hours spent are still very high, with German women spending 4 hours per day and Spanish women spending 7 hours per day in childcare.¹¹

We test the impact of childcare on health status by comparing the results of women who at t-1 were engaged in intensive child care (more than four hours per day) and women whose child care load was lower (results not shown). In Germany, women who were engaged in intensive childcare and obtain a job do not experience any significant effect on health (irrespective of contract type). However, women engaged in fewer hours of childcare do experience a significant and positive effect on obtaining a permanent job. We carried out the same analysis for Spanish women, but found no significant differences between mothers with high and low child care hours.¹²

¹¹ These figures are not directly comparable however, as the GSOEP data asks respondents how many hours they spent *per working day* whilst the ECHP asks the number of hours *per week*. This distinction is important as there tend to be considerable differences in the number of hours spent in care and household work on the weekend relative to the week.

¹² While we had thought we could attribute the non-significance of the analysis for Spanish women to their disproportionate investment in housework relative to Spanish men (Ahn et al 2003). For instance, Ahn et al (2003) and Alvarez and Miles (2003) find that the majority of domestic work is carried out by women whether they have a job or not, and independently of the type of job. The evidence suggests that West-German women also do considerably more housework than men. In West-Germany women tend to do twice as much housework as German men, 35 hours a week versus 17 hours a week (Rosenfeld, Trappe and Gornick 2004, pp.119-120) while in Spain married women do 35 hours and married men do 4.5 hours a week (Ahn et al 2003, p.29). While Spanish women undoubtedly appear to have considerably less help from their partners than German women do, women in both countries none the less engage in similar amounts of unpaid work within the home.

We also tried to identify fixed-term contract worker heterogeneity by looking at interaction terms of contract type by occupational skill level, education and age. These analyses were not found to be significant, however.

Model 2

From Model 1 we know that getting a job is good for your health, but that getting a permanent job is better. We would now like to know whether the positive effect on health remains once individuals have accommodated to their new status. For instance, we could expect fixed-term workers' health to deteriorate if they believe that their contract will neither be renewed nor converted into a permanent contract.

In the analysis that follows, the dependent variable measures changes in health status between $t-2$ and t . We analyse the effect on health of getting a job between $t-2$ and $t-1$ and remaining in this job till t . Again, we distinguish between becoming a fixed-term and a permanent worker but now analyse the effect on health when individuals remain in their job for more than one year. In table 5 the estimation results for German and Spanish men are presented. We observe that for German men there is still a positive effect on health of obtaining a fixed-term job even if the individual remains in fixed-term employment for more than one year. However, for Spanish men, the positive effect of obtaining a fixed-term job disappears after one year in fixed-term employment. Given the short-term nature of their contracts this may be a function of stress related to their future unemployment risk. So while workers initially exhibit an increase in health status on job acquisition, this effect disappears over time, perhaps when they learn that their job is unlikely to lead to further employment. Table 6 presents the analysis for women where we find that the positive effect of permanent employment remains significant for the random effects estimation for German women.

5. Conclusions

Against the background of increasing numbers of workers employed in insecure fixed-term contracts (OECD 2002), we sought to investigate the relationship between health and contract type. We analysed the health effects of contract type in western Germany and Spain, as we expected different national contexts to influence the market transitions of workers differently (Virtanen, et al. 2005b). In particular, we expected the Spanish labour market to offer considerably worse employment opportunities for fixed-term workers (Polavieja 2005) than the German market (Mertens, Gundert and McGinnity 2003). Our research design focused on unemployed workers exiting unemployment in Spain and Germany and compared the health consequences for different contract types. The strength of this research strategy lies in a

reduction of the heterogeneity that comes with a comparison of fixed-term and permanent workers (Gash and McGinnity, forthcoming). As we know from the literature that unemployed workers should on average experience a deterioration of their health (Schwefel 1986, Dooley et al. 1996, Kasl and Jones 1998, Murphy and Athanasou 1999), we ask whether returning to work helps to restore their health.

As expected, job acquisition improves health status, with the exception of Spanish women. For men, the positive effect is smaller if they obtain a fixed-term job. For women, however, the transition from unemployment to a fixed-term job has none of the positive health effects typically associated with paid employment. These findings contrast with those of Virtanen *et al.* (2005a) who found that women did show positive health effects when they made successful labour market transitions and correspondingly showed decreases in health and psychological well-being when they entered unemployment from fixed-term contracts.

When we compared the longer-term effects of job acquisition after a period of two years, the positive health effects of job acquisition for Spanish men on fixed-term contracts was no longer present, although the positive health effect for permanent contract employment remained. We also found that German men retained the positive effects of fixed-term contract status over the longer-term, which may support our expectation that German fixed-term contract employment provides greater opportunity structures than Spanish fixed-term employment.

Certainly, it is difficult to disentangle health and contract type effects, simply because the causality between contract type and health could run in both directions. On the one hand, the insecurity associated with fixed-term contracts increases psychological pressure and might therefore also reduce physical health. There is strong evidence suggesting temporary workers suffer from increased mortality risks compared to permanent workers. For instance, the study by Kivimaki *et al.* (2003) in Finland found temporary workers to be twice as likely to die from alcohol related causes than permanent workers, and male temporary workers three-times as likely to die from smoking-related cancer than male permanent workers. On the other hand, workers with serious health effects could run into problems finding a permanent job and therefore be condemned to switch alternately between unemployment and fixed-term contracts. This negative health selection effect into precarious labour market trajectories is also established in the literature (i.e. Virtanen 2005).

In spite of this we have found our results to be relatively robust even when we control for health selection effects by excluding unemployed workers with poor health. Even with the exclusion of unhealthy workers we find that fixed-term jobs are not as good for your health as permanent jobs.

To conclude, we believe that rising percentages of fixed-term contracts and the associated rise in insecure employment relationships has negative effects on health. This seems to be especially severe in countries like Spain where one third of all working contracts are fixed-term. Not only are individuals' lives affected by this but there may also be serious repercussions for the productive capacity of an economy.

Future research would do well to analyse the health effects of other forms of atypical employment, such as part-time work. Such an analysis could shed light on the health effects of employment for women who, in principle, are not suffering from the “double burden” of paid and unpaid work. A second avenue would be an analysis of the health effect of atypical employment in more flexible regimes, where fixed-term workers, in principle, are not much more secure in their jobs than permanent workers are.

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Table 1. Effect of different labour transitions on changes in health status. Men.

Changes in Health Status	West-German Men		Spanish Men	
	(1)	(2)	(1)	(2)
<i>(No new job)</i>	-	-	-	-
New job with fixed-term contract	0,164*** (0,059)	0,170*** (0,059)	0,085** (0,031)	0,080** (0,031)
New job with permanent contract	0,201*** (0,050)	0,205*** (0,051)	0,183*** (0,053)	0,168*** (0,053)
Age	-0,187*** (0,051)	-0,185*** (0,055)	-0,010 (0,008)	-0,012 (0,009)
Age*Age	-0,427*** (0,054)	-0,494*** (0,061)	-0,027 (0,278)	-0,064 (0,313)
Health status in t-1	-0,465*** (0,020)	-0,551*** (0,021)	-0,651*** (0,019)	-0,770*** (0,020)
<i>(Less than Second Level Education,)</i>	-	-	-	-
Second Level Education (ISCED 3)	-0,102** (0,043)	-0,115** (0,049)	0,088* (0,046)	0,124** (0,050)
Third level Education (ISCED 5-7)	0,111 (0,077)	0,103 (0,085)	0,085** (0,038)	0,081* (0,041)
Number of children in t-1 (=1)	0,034 (0,042)	0,030 (0,047)	0,002 (0,015)	0,005 (0,018)
Marriage (=1)	-0,173 (0,152)	-0,105 (0,152)	0,091 (0,134)	0,079 (0,132)
Household members move in (=1)	-0,017 (0,124)	-0,005 (0,125)	-0,068 (0,046)	-0,072 (0,045)
Children born in Household (=1)	0,022 (0,101)	0,051 (0,102)	0,101 (0,086)	0,096 (0,084)
Household member move out (=1)	-0,172 (0,138)	-0,191 (0,137)	-0,031 (0,032)	-0,027 (0,032)
Divorce (=1)	0,172 (0,130)	0,159 (0,132)	.	.
Separation from partner (=1)	-0,233 (0,239)	-0,290 (0,239)	-0,089 (0,307)	-0,141 (0,307)
Death in Household (=1)	-1,775** (0,786)	-1,756** (0,805)	0,087 (0,097)	0,094 (0,096)
Constant	1,698*** (0,085)	2,019*** (0,093)	2,946*** (0,697)	3,615*** (0,782)
	N=1530	N=1530 Groups=645	N=2410	N=2410 Groups=1373 Wald chi2=1550.35 ***
	F=37.45*** Adj R-sq=0.263	Wald chi2=687.23*** R-sq=0.270	F=36.10*** Adj R-sq=0.325	R-sq=0.328
New job fixed-term =new job permanent	F=0.34 Prob>F=0.561	chi2=0.28 Prob> chi2=0.594	F = 3.17* Prob>F=0.075	chi2=2.55 Prob> chi2=0.110

*p<0.1, **p<0.05, ***p<0.01. Standard Errors in parenthesis.

(1) OLS estimation.

(2) Random effects estimation.

Table 2. Effect of different labour transitions on changes in health status. Women.

Changes in Health Status	West-German Women		Spanish Women	
	(1)	(2)	(1)	(2)
<i>(No new job)</i>	-	-	-	-
New job with fixed-term contract	0,097 (0,075)	0,098 (0,076)	-0,052 (0,037)	-0,051 (0,037)
New job with permanent contract	0,245*** (0,066)	0,245*** (0,067)	0,075 (0,067)	0,074 (0,068)
Age	-0,185*** (0,064)	-0,190*** (0,065)	-0,039*** (0,011)	-0,043*** (0,011)
Age*Age	-0,392*** (0,067)	-0,400*** (0,069)	0,807** (0,344)	0,875** (0,370)
Health status in t-1	-0,503*** (0,025)	-0,523*** (0,025)	-0,680*** (0,023)	-0,743*** (0,023)
<i>(Less than Second Level Education)</i>	-	-	-	-
Second Level Education (ISCED 3)	0,088* (0,052)	0,087 (0,053)	0,028 (0,041)	0,029 (0,044)
Third level Education (ISCED 5-7)	0,141 (0,090)	0,148 (0,092)	-0,027 (0,040)	-0,012 (0,042)
Number of children in t-1 (=1)	0,069 (0,053)	0,067 (0,055)	-0,010 (0,020)	-0,009 (0,021)
Marriage (=1)	0,356** (0,154)	0,353** (0,155)	-0,012 (0,106)	-0,018 (0,106)
Household members move in (=1)	-0,052 (0,122)	-0,053 (0,123)	0,002 (0,036)	0,004 (0,036)
Children born in Household (=1)	0,149 (0,270)	0,132 (0,270)	0,067 (0,094)	0,062 (0,094)
Household member move out (=1)	0,003 (0,117)	0,003 (0,118)	0,031 (0,045)	0,034 (0,045)
Divorce (=1)	-0,073 (0,161)	-0,073 (0,162)	-0,407 (0,471)	-0,437 (0,473)
Separation from partner (=1)	0,038 (0,218)	0,036 (0,219)	-0,304 (0,250)	-0,306 (0,250)
Death in Household (=1)	-0,262 (0,462)	-0,301 (0,462)	0,067 (0,119)	0,043 (0,119)
Constant	1,630*** (0,104)	1,701*** (0,107)	1,232 (0,842)	1,376 (0,903)
	N=1104	N=1104 Groups=639	N=1801	N=1801 Groups=105 2 Wald chi2=1034.9 1***
	F=29.04*** Adj R-sq=0.276	Wald chi2=455.49*** R-sq=0.286	F=60.52*** Adj R-sq=0.332	R-sq=0.337 chi2=3.04* Prob>F=0.076 chi2=0.082
New job fixed-term =new job permanent	F=2.83* Prob>F=0.0926	chi2=2.76 Prob> chi2=0.097	F =3.14* Prob>F=0.076	

*p<0.1, **p<0.05, ***p<0.01. Standard Errors in parenthesis.

(1) OLS estimation.

(2) Random effects estimation.

**Table 3. Effect of different labour transitions on changes in health status. Men.
 Only individuals with fair to good health status in t-1.**

Changes in Health Status	West-German Men		Spanish Men	
	(1)	(2)	(1)	(2)
<i>(No new job)</i>	-	-	-	-
New job with fixed-term contract	0,081 (0,062)	0,083 (0,062)	0,082*** (0,031)	0,074** (0,031)
New job with permanent contract	0,121** (0,051)	0,119** (0,052)	0,175*** (0,053)	0,152*** (0,053)
Age	-0,161*** (0,055)	-0,160*** (0,059)	-0,011 (0,008)	-0,013 (0,009)
Age*Age	-0,412*** (0,060)	-0,488*** (0,069)	-0,006 (0,282)	-0,062 (0,325)
Health status in t-1	-0,550*** (0,033)	-0,669*** (0,035)	-0,685*** (0,023)	-0,831*** (0,023)
<i>(Less than Second Level Education)</i>	-	-	-	-
Second Level Education (ISCED 3)	-0,101** (0,047)	-0,122** (0,054)	0,080* (0,045)	0,129** (0,051)
Third level Education (ISCED 5-7)	0,131 (0,081)	0,115 (0,090)	0,069* (0,038)	0,066 (0,042)
Number of children in t-1 (=1)	-0,014 (0,046)	-0,026 (0,052)	-0,010 (0,016)	-0,005 (0,018)
Marriage (=1)	-0,093 (0,165)	-0,031 (0,164)	0,095 (0,131)	0,075 (0,129)
Household members move in (=1)	-0,073 (0,131)	-0,069 (0,133)	-0,067 (0,047)	-0,057 (0,046)
Children born in Household (=1)	0,071 (0,106)	0,071 (0,105)	0,107 (0,085)	0,099 (0,083)
Household member move out (=1)	-0,185 (0,160)	-0,191 (0,155)	-0,027 (0,032)	-0,023 (0,032)
Divorce (=1)	0,010 (0,144)	0,013 (0,146)	.	.
Separation from partner (=1)	-0,437 (0,269)	-0,475* (0,269)	-0,099 (0,303)	-0,177 (0,301)
Death in Household (=1)	-1,933*** (0,752)	-1,956** (0,773)	0,128 (0,098)	0,145 (0,095)
Constant	2,096*** (0,141)	2,572*** (0,149)	3,046*** (0,710)	3,896*** (0,813)
	N=1203	N=1203 Groups=716	N=2303	N=2303 Groups=133 9 Wald chi2=1317.3 0***
	F=20.24*** Adj R-sq=0.1936	Wald chi2=402.66*** R-sq=0.2029	F=66.09*** Adj R-sq=0.284	R-sq=0.2871
New job fixed-term =new job permanent	F =0.35 Prob>F=0.5539	chi2=0.29 Prob> chi2=0.5875	F =2.92* Prob>F=0.0879	chi2=2.00 Prob> chi2=0.1572

*p<0.1, **p<0.05, ***p<0.01. Standard Errors in parenthesis.

(1) OLS estimation.

(2) Random effects estimation.

Table 4. Effect of different labour transitions on changes in health status. Women. Only individuals with fair to good health status in t-1.

Changes in Health Status	West-German Women		Spanish Women	
	(1)	(2)	(1)	(2)
<i>(No new job)</i>	-	-	-	-
New job with fixed-term contract	0,033 (0,081)	0,038 (0,083)	-0,073** (0,036)	-0,075** (0,037)
New job with permanent contract	0,197*** (0,073)	0,193*** (0,074)	0,060 (0,066)	0,053 (0,066)
Age	-0,212*** (0,069)	-0,256*** (0,077)	-0,035*** (0,011)	-0,039*** (0,012)
Age*Age	-0,454*** (0,077)	-0,491*** (0,087)	0,691** (0,343)	0,749** (0,377)
Health status in t-1	-0,548*** (0,042)	-0,661*** (0,043)	-0,758*** (0,026)	-0,842*** (0,026)
<i>(Less than Second Level Education)</i>	-	-	-	-
Second Level Education (ISCED 3)	0,100* (0,059)	0,100 (0,067)	0,037 (0,040)	0,038 (0,044)
Third level Education (ISCED 5-7)	0,062 (0,098)	0,105 (0,109)	-0,010 (0,039)	0,013 (0,042)
Number of children in t-1 (=1)	0,036 (0,061)	0,035 (0,067)	-0,015 (0,019)	-0,014 (0,021)
Marriage (=1)	0,324* (0,176)	0,382** (0,179)	-0,012 (0,102)	-0,024 (0,102)
Household members move in (=1)	-0,095 (0,134)	-0,098 (0,136)	0,016 (0,036)	0,020 (0,036)
Children born in Household (=1)	0,182 (0,320)	0,133 (0,314)	0,062 (0,092)	0,050 (0,091)
Household member move out (=1)	-0,062 (0,137)	-0,089 (0,141)	0,034 (0,045)	0,037 (0,044)
Divorce (=1)	-0,078 (0,169)	-0,076 (0,170)	-0,445 (0,456)	-0,487 (0,457)
Separation from partner (=1)	0,003 (0,240)	0,028 (0,239)	-0,187 (0,261)	-0,181 (0,259)
Death in Household (=1)	0,126 (0,772)	0,086 (0,797)	0,106 (0,117)	0,076 (0,117)
Constant	1,871*** (0,177)	2,288*** (0,187)	1,832** (0,842)	2,089** (0,923)
	N=801	N=801 Groups=513	N=1746	N=1746 Groups=1027 Wald chi2=1034.06 ***
	F=12.73*** Adj R-sq=0.1803	Wald chi2=252.47*** R-sq=0.1944	F=57.28*** Adj R-sq=0.326	R-sq=0.332 chi2=3.36 Prob>F=0.057 chi2=0.067
New job fixed-term =new job permanent	F=3.01 Prob>F=0.083*	chi2=2.62 Prob> chi2=0.1056	F=3.62* Prob>F=0.057	chi2=3.36 Prob> chi2=0.067

*p<0.1, **p<0.05, ***p<0.01. Standard Errors in parenthesis.

(1) OLS estimation.

(2) Random effects estimation.

Table 5. Effect of the duration of fixed-term contract on health status. Men.

Changes in Health Status (t-2 /t)	West-German Men		Spanish Men	
	(1)	(2)	(1)	(2)
<i>(No new job)</i>	-	-	-	-
New job with fixed-term contract	0,262** (0,117)	0,288** (0,119)	0,077 (0,047)	0,079 (0,049)
New job with permanent contract	0,227*** (0,076)	0,242*** (0,079)	0,159** (0,076)	0,138* (0,077)
Age	-0,253*** (0,080)	-0,240*** (0,083)	-0,351 (0,419)	-0,410 (0,461)
Age*Age	-0,373*** (0,087)	-0,416*** (0,093)	-0,004 (0,012)	-0,004 (0,013)
Health status in t-1	-0,473*** (0,032)	-0,529*** (0,034)	-0,709*** (0,029)	-0,806*** (0,029)
<i>(Less than Second Level Education)</i>	-	-	-	-
Second Level Education (ISCED 3)	-0,124* (0,070)	-0,144* (0,076)	0,011 (0,081)	-0,007 (0,085)
Third level Education (ISCED 5-7)	0,174 (0,118)	0,138 (0,125)	-0,010 (0,071)	-0,046 (0,076)
Number of children in t-1 (=1)	0,086 (0,068)	0,087 (0,073)	0,015 (0,023)	0,023 (0,026)
Marriage (=1)	-0,294* (0,169)	-0,286* (0,171)	0,109 (0,212)	0,069 (0,207)
Household members move in (=1)	0,106 (0,136)	0,099 (0,137)	-0,090 (0,067)	-0,039 (0,065)
Children born in Household (=1)	0,021 (0,122)	0,026 (0,123)	0,122 (0,130)	0,128 (0,125)
Household member move out (=1)	0,041 (0,145)	0,043 (0,146)	-0,020 (0,054)	-0,038 (0,052)
Divorce (=1)	0,054 (0,165)	0,063 (0,168)	.	.
Separation from partner (=1)	0,336 (0,278)	0,393 (0,293)	-0,490 (0,384)	-0,569 (0,380)
Death in Household (=1)	-0,963 (0,814)	-0,936 (0,822)	-0,002 (0,158)	-0,031 (0,156)
Constant	1,646*** (0,134)	1,855*** (0,145)	4,077*** (1,061)	4,718*** (1,164)
	N=655	N=655 Groups=435	N=1020	N=1020 Groups=703
	F=16.01*** Adj R-sq=0.2561	Wald chi2=271.31*** R-sq=0.2725	F=45.36*** Adj R-sq=0.379	Wald chi2=804.79*** R-sq=0.386
New job fixed-term =new job permanent	F=0.09 Prob>F=0.7693	chi2=0.15 Prob> chi2=0.6977	F=1.06 Prob>F=0.301	chi2=0.55 Prob> chi2=0.456

*p<0.1, **p<0.05, ***p<0.01. Standard Errors in parenthesis.

(1) OLS estimation.

(2) Random effects estimation.

Table 6. Effect of the duration of fixed-term contract on health status. Women.

Changes in Health Status (t-2 /t)	West-German Women		Spanish Women	
	(1)	(2)	(1)	(2)
<i>(No new job)</i>	-	-	-	-
New job with fixed-term contract	0,042 (0,138)	0,095 (0,148)	0,014 (0,062)	0,016 (0,063)
New job with permanent contract	0,143 (0,105)	0,192* (0,113)	0,021 (0,103)	0,020 (0,103)
Age	-0,342*** (0,109)	-0,309** (0,121)	0,835 (0,560)	0,854 (0,586)
Age*Age	-0,673*** (0,112)	-0,678*** (0,130)	-0,039** (0,017)	-0,041** (0,018)
Health status in t-1	-0,582*** (0,040)	-0,697*** (0,043)	-0,688*** (0,038)	-0,710*** (0,038)
<i>(Less than Second Level Education, ISCED 0-2)</i>	-	-	-	-
Second Level Education (ISCED 3)	0,140* (0,084)	0,189* (0,101)	-0,105 (0,080)	-0,107 (0,082)
Third level Education (ISCED 5-7)	0,166 (0,161)	0,242 (0,180)	-0,006 (0,066)	-0,004 (0,069)
Number of children in the household in t-1 (=1)	0,107 (0,085)	0,071 (0,096)	0,030 (0,034)	0,028 (0,035)
Marriage (=1)	-0,253 (0,191)	-0,334 (0,204)	-0,135 (0,171)	-0,137 (0,172)
Household members move in (=1)	-0,070 (0,166)	-0,109 (0,173)	-0,057 (0,055)	-0,051 (0,054)
Children born in Household (=1)	-0,122 (0,361)	-0,152 (0,365)	-0,024 (0,165)	-0,017 (0,164)
Household member move out (=1)	0,118 (0,153)	0,018 (0,158)	0,018 (0,070)	0,015 (0,070)
Divorce (=1)	0,229 (0,197)	0,251 (0,211)	-0,444 (0,673)	-0,456 (0,675)
Separation from partner (=1)	-0,212 (0,241)	-0,184 (0,250)	-0,491 (0,389)	-0,430 (0,387)
Death in Household (=1)	0,343 (0,845)	0,018 (0,796)	0,188 (0,216)	0,162 (0,218)
Constant	2,023*** (0,168)	2,367*** (0,189)	1,142 (1,388)	1,201 (1,450)
	N=476	N=476 Groups=291	N=712	N=712 Groups=476 Wald chi2=361.93* **
	F=15.24*** Adj R-sq=0.310	Wald chi2=280.53*** R-sq=0.329	F=23.21*** Adj R-sq=0.319	R-sq=0.333
New job fixed-term =new job permanent	F=0.46 Prob>F=0.496	chi2=0.40 Prob> chi2=0.529	F =0.00 Prob>F=0.95	chi2=0.00 Prob> chi2=0.971

*p<0.1, **p<0.05, ***p<0.01. Standard Errors in parenthesis.

(1) OLS estimation.

(2) Random effects estimation.

Appendix A1: Objective Health Indicators by Subjective Health Status

	sex	mean(Stays in Hospital)	mean(Doctors Visits)	No Hospitalisation	No doctors visits
WEST-GERMANY					
				%	%
	male	2.78	12.94	92.70	46.43
	female	2.32	14.59	87.77	29.30
	<i>If in Good-Fair Health</i>				
	male	2.28	10.56	94.28	49.48
	female	2.11	12.12	89.14	31.84
	<i>If in Bad Health</i>				
	male	3.99	26.74	77.69	17.31
	female	3.08	28.51	77.53	9.98
SPAIN					
	male	9.56	4.60	94.86	38.35
	female	8.42	6.23	93.77	23.35
	<i>If in Good-Fair Health</i>				
	male	7.66	4.02	95.50	39.40
	female	6.52	5.46	94.50	24.27
	<i>If in Bad Health</i>				
	male	20.01	15.29	77.20	8.29
	female	18.30	18.68	78.70	4.49

Spanish Sample excluding those less than 20 and greater than 54 years.

The precise wording of the questions are the following: During the past 12 months, have you been admitted to a hospital? Doctors visits is a combined category of answers to the following: (1) During the past 12 months, about how many times have you consulted a general practitioner (including home visits by the doctor)? And (2) During the past 12 months, about how many times have you consulted a medical specialist (including out-patient consultations but excluding any consultations during hospitalisation).

German Sample excluding those less than 20 and greater than 54 years.

The precise wording of the questions are the following: (1) How often were you admitted to a hospital last year? Doctor visits is an extrapolation of the answer to the question: (2) Have you gone to a doctor within the last three months? If yes, please state how often.

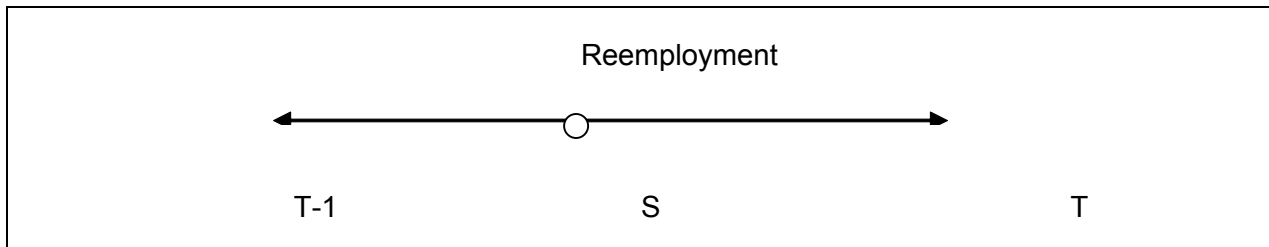
Table A2: Childcare hours per employment status.

	WEST-GERMANY	SPAIN
<i>If UNEMPLOYED</i>		
male	4.40	4.99
female	6.75	8.18
<i>If EMPLOYED full-time (i.e. equal or more than 30 hours a week).</i>		
male	1.95	2.86
female	3.65	7.14
<i>Difference in Childcare Hours between Employment and Unemployment</i>		
male	-2.45	-2.13
female	-3.10	-1.04

*The number of childcare hours for the Spanish sample measures the number of hours per week, for the purpose of this table this amount has been divided by seven.

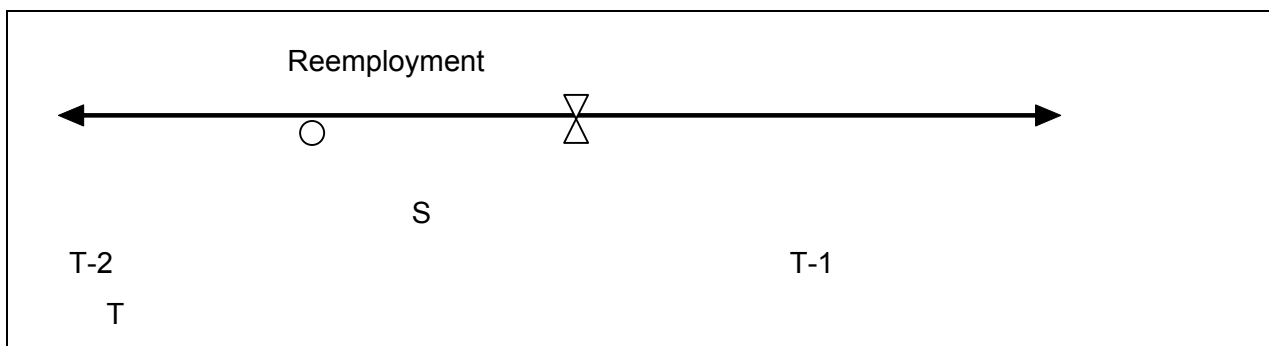
** The number of childcare hours per day for Germany refers only to working days.

Figure A1. Model 1: Short-term effects of re-employment on health



In $t-1$ all individuals are unemployed. These individuals remain unemployed till t or they find a job in S , which is a point in time between $t-1$ and t . At re-employment they obtain a fixed term contract or a permanent contract and remain employed till t .

Figure A2. Model 2: Long-term effects of re-employment on health



In $t-2$ all individuals are unemployed. These individuals remain unemployed till t or they find a job in S , which is a point in time between $t-2$ and $t-1$. At re-employment they obtain a fixed term contract or a permanent contract and remain employed till t .

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