Supporting Information

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SI Text

This study uses data from the Panel Study of Income Dynamics (PSID), which has followed a nationally representative sample of about 5,000 families and their children since 1968 (http://psidonline.isr.umich.edu). Interviews were taken annually from 1968 to 1996 and biennially from 1997 to 2009 with the household head or spouse, including the heads of new households created when children growing up in study families leave home and form their own households.

Our target study sample consisted of the 1,296 individuals who were (*i*) born into the PSID households between 1968 and 1975 and thus, are considered PSID sample members and (*ii*) heads of households or the wives in households in any of the 1999–2009 PSID surveys, because only heads and wives responded to health questions. The 1968–1975 birth cohorts were chosen so that lifetime household economic status could be observed between the prenatal year and into adolescence and respondents could be observed between age 30 and 41 y. The analytical sample consisted of 1,070 respondents who participated in any of the survey years, had valid responses for at least one of the outcome variables, and were not missing data on control variables or income between the prenatal year and age 15 y. All analyses are weighted using the PSID attrition-adjusted weights, which are designed to eliminate bias that might arise from measured differences between the sample of children born between 1968 and 1975 who were not observed in adulthood and the analysis sample.

Dependent Variables: Health and Labor Market Productivity. The PSID provides data on both the physical and mental health of survey respondents. Given the timing of their births, individuals fall into the 30- to 41-y age range in the survey years between 1999 and 2009. In these years, respondents were asked whether a doctor has ever told them that they have (*i*) high blood pressure or hypertension or (*ii*) arthritis or rheumatism. We use this information to create measures of the proportion of interviews taken after age 30 y that each respondent reports for each of these conditions.

Respondents were also asked whether they experienced health or physical disability problems [activities of daily living (ADLs)] in each interview taken between 1999 and 2009. Specifically, they are asked: "Because of a health or physical problem, do you have any difficulty (a) bathing or showering, (b) dressing, (c) eating, (d) getting in or out of bed or a chair, (e) walking, (f) getting outside, or (g) using the toilet, including getting to the toilet?" Our ADL outcome measure is the average number of these ADLs reported in interviews taken after age 30 y.

Between 1999 and 2009, respondents were also asked a subjective health rating, specifically whether their current health is excellent, very good, good, poor, or fair. We test two specifications of the outcome: (*i*) the average value for self-rated health starting at age 30 y, with responses to the health question scored one to five (with higher values indicated worse health), and (*ii*) the proportion of years after age 30 y that the respondent reports being in fair or poor health.

Finally, in the 2001, 2003, 2007, and 2009 interviews, respondents were asked the Kessler Screening Scale for Psychological Distress (K6), which is used widely as a screener for mental health problems and measure of severity of mental health problems (1). The scale consists of six questions (coded response values ranging from zero to four) that are summed (ranges from 0 to 24). We average the respondent's score over all of the interview reports taken when the respondent was age 30 y or older.

Adult productivity is captured with three variables, including earnings, work hours, and wage rate. The natural logarithm of the sample individual's adult earnings, adult work hours, and wage rate was gleaned from all available annual reports of earned income and work hours reported by or for the individual when the individual was age 30 y or older. We inflated the dollar values of earnings to 2010 price levels using the Consumer Price Index. To adjust earnings for age and calendar year, we regressed all of our yearly earnings observations on sets of dummy variables measuring the age of the respondent at the time of the given interview and the calendar year of the given interview. We then generated residuals from this regression for each sample individual's earnings observations and averaged these residuals across all of the yearly earnings observations that a given individual generated. We centered these average residuals around the sample mean by adding them to the overall sample mean earnings. As a final step, we took the natural logarithm. Wage rate is the ratio of average earnings divided by average work hours.

Childhood Socioeconomic Status. We used the PSID's high-quality edited measure of annual total family income inflated to 2010 levels using the Consumer Price Index. We averaged these annual income measures across three periods: the prenatal year through the calendar year in which the child turned 2 y, age 3–5 y, and age 6–15 y. With income reported for calendar years and conceptions occurring continuously, there was some imprecision in matching income to the prenatal year and beyond. If a child was born before July 1, we took the prenatal year to be the prior calendar year. If the birth was after July 1, then the prenatal year was considered to be the year in which the birth occurred.

Our choice of the three childhood stages and the ages within each stage was guided by past research and considerable experimentation. The work by Ziol-Guest et al. (2) uses PSID data and finds that income in the prenatal and birth years has the most powerful association with adult body mass index. The work by Duncan et al. (3) uses PSID data and finds that family income in the interval between the prenatal year and age 5 y has the most powerful association with adult earnings and work hours. The work by Duncan et al. (4) shows that similar earnings patterns emerge in data from the Norwegian income registries. For the current paper, we fit several models of adult health conditions with different configurations of childhood stages and found that the stages of prenatal to age 2 y, age 3–5 y, and age 6–15 y provided the consistently best fit to the data.

Demographics. To avoid attributing to income what should be attributed to correlated determinants of both childhood income and our outcomes of interest, numerous demographic characteristics taken around the time of the child's birth are included. We include dummy variables for seven of eight birth years, a dichotomous variable for race (nonwhite = 1), a dichotomous variable for sex (male = 1), a dichotomous variable for whether the child's mother was married at the time of his or her birth (married = 1), and a dichotomous variable representing whether the child was born in the South (South = 1). Age of the mother is a continuous variable ranging from 14 to 45 y, and the number of siblings is the total number of births to the child's mother minus one (range from 0 to 12). A dichotomous variable representing whether the child was the first birth of the mother (first = 1) was also included. Finally, two characteristics of the head of the household (usually the father in two-parent households or the mother in single-parent households) in which the child was born are included—years of completed schooling and score from a sentence completion test administered in the 1972 interview.

Analysis Plan. Because all of the outcomes are continuous, they were analyzed with ordinary least squares regression (OLS) and run in STATA 11.0 SE using the weights to adjust for differential sampling fractions and attrition in the PSID. We adjust for origin family clustering on the mother using Huber–White methods. To account for a possible differential impact of increments to low as opposed to higher family income, we allowed the coefficients on average income within each childhood period to have distinct linear effects for average incomes up to \$25,000 and incomes \$25,000 and higher. Considerable experimentation confirmed the use of the \$25,000 knot in the case of the adult outcomes most sensitive to variations in early income. Lower-income knots reduced sample sizes for and therefore, the precision of the low-income effect estimates; higher thresholds typically produced noteworthy reductions in the low-income segment coefficients.

Weighted means or proportions and SDs of each of our control and outcome variables are presented in Table S1. Descriptive statistics are presented for the entire sample and then separately for children whose prenatal to age 2 y incomes averaged below \$25,000 (low income; $n = 156$) and \$25,000 or more (higher income; $n = 914$), corresponding to the spline models. The P value column of the table provides information on the statistical significance (two-tailed t or χ^2 test) of the mean differences between the two groups.

Descriptive Results. Table S1 shows that adult health differed markedly depending on a child's family income during pregnancy and infancy, with poorer children more likely to report diagnoses of adult hypertension (19.0% vs. 11.2%, $P < 0.01$) and arthritis (10.6% vs. 4.6%, $P < 0.01$) as well as higher levels of ADLs (0.29 vs. 0.07, $P < 0.001$), worse overall health (2.6 vs. 2.1, $P < 0.001$), and worse mental health (5.2 vs. 3.3, $P < 0.001$). Furthermore, children who were low income between the prenatal year and second year had lower average earnings (\$53,400 vs. \$21,600, $P < 0.01$), annual work hours (1,460 vs. 1,877 h, $P < 0.001$), hourly wage rates (\$13.60 vs. \$26.50/h, $P < 0.01$), and completed schooling (12.3 vs. 13.8 y, $P < 0.001$) in adulthood.

Children who were low income between the prenatal and second year experience increases in household income over their lifetime; however, they continue to have lower incomes in other stages of childhood compared with their higher-income counterparts. Compared with higher-income children, low-income children are more likely to be nonwhite, live in the South, have more siblings, and be born to a younger, unmarried, less educated, or lower test-scoring mother.

Table S2 classifies children according to the average prenatal to age 2 y period (very early childhood) and later incomes, illustrating the sample's income mobility across childhood. Only about one-half of the children with early-life incomes that were below \$15,000 had incomes that low between age 3 and 5 y (53%) or between age 6 and 15 y (59%). Children with early childhood income that averaged between \$15,000 and \$25,000 also saw bigger improvements in household income, with 19% having average annual incomes greater than \$35,000 between age 3 and 5 y and 33% having incomes that high between age 6 and 15 y.

This income volatility enables us to estimate impacts of income very early in childhood while controlling for income in other childhood stages—a key step in controlling for the kinds of omitted variable biases present in most studies of poverty effects. Although numerous factors (e.g., genetic endowments) that might simultaneously influence family income and adult health and productivity are not measured in our data, it is difficult to think of omitted variables correlated strongly with both our outcomes and early childhood income that would not also correlate with income at other childhood stages.

Adult Health. Table S3 presents the regression-based findings for three measures of adult health—the fraction of years respondents reported hypertension or arthritis when interviewed between age 30 and 41 y and the average number of ADL work limitations reported during those same years. Coefficients are scaled as percent of time for the first two health outcomes. Table S3 suggests that increases in early childhood income (between prenatal and second year) are associated with reductions in hypertension, arthritis, and ADLs, but that this association is only statistically significant among low-income children. Specifically, a \$10,000 increase in household income among the low-income children in each year between the prenatal period and second year (a total of 4 y and therefore, an investment of \$40,000) is associated with a 10.6 point reduction [95% confidence interval (CI) = −1.11, −20.01] in the percentage of years hypertension was reported between the age of 30 and 41 y, a 9.6 point reduction (95% CI = −3.09, −16.17) in the percentage of years arthritis was reported, and a 0.16 point reduction (95% CI = −0.023, −0.297) in the ADL index. None of the coefficients on the high-income (>\$25,000 per year) early childhood segments are statistically significant. In all cases, the low-income early childhood coefficient is significantly different from the higher-income coefficient at $P < 0.05$ (Table S3, Different slopes? columns).

Increments to low or higher income between age 3 and 5 y or 6 and 15 y did not have statistically significant associations with hypertension and ADLs. In the case of arthritis, the coefficients on the low-income spline segment on income averaged between age 6 and 15 y were unexpectedly positive and significant. Table S3, bottom row presents the P value for the null hypothesis that all three of the low-income spline segments are equal and shows rejection of the null hypothesis at $P < 0.06$ or lower for all three health outcomes.

The data in Fig. 3 are calculated by estimating the models presented in Table S3, but with income scaled in \$5,000 units instead of \$10,000 units to present the effects in terms that are relevant for policy. (For 2011, a family with two children can receive as much as \$5,112 in earned income tax credits.) We also adjust for the disparate lengths of the three childhood periods by dividing each of the coefficients on Table S3 by the number of years over which income is measured (i.e., four for prenatal to age 2 y, three for age 3–5 y, and 10 for age 6–15 y). Therefore, for example, the −1.10 bar for arthritis and the prenatal to age 2 y period have the interpretation that a \$5,000 income increment for a family with income less than \$25,000 is associated with a 1.1 percentage point reduction in the incidence of age 30–41 y arthritis in each of the 4 y between the prenatal year and age 2 y. (By implication, a \$5,000 increment each year for all 4 y is associated with a 4.4 percentage point reduction.)

Table S3, ADLs columns, also reports the results of tests for the extent to which hypertension and arthritis account for the association between early childhood income and adult ADLs. The inclusion of these diagnoses reduced the coefficient on early childhood by one-half and well below conventional levels of statistical significance. Arthritis was a statistically significant predictor of ADLs.

Although early income had significant associations with these three health outcomes, it was not uniquely predictive of all of health outcomes that we examined. Table S4 presents the same models for mental health and self-rated overall health. There are no significant associations between early childhood income and mental health. However, adolescent income (especially among low-income children) is significantly associated with reductions in self-reported ill health in adulthood.

Adult Productivity. To isolate what role immune-mediated chronic diseases might play in affecting adult productivity, we began by estimating models of two key productivity-related measures—average annual work hours and average annual earnings. In-dependent variables, including childhood stage-specific income spline segments, were identical to those variables used in the health models in Table S3. Results presented in the first and fourth columns (with coefficients) of Table S5 show that low income in very early childhood has the strongest associations with both outcomes. Results in the second and fifth columns show that the addition of hypertension and arthritis reduces the coefficient on early childhood income in the work hours model by 10.2% and that adding the ADL index reduces it by a total of 18.3%. Corresponding reductions for earnings are 15.2% and 18.4%, respectively. The Sobel tests of mediation (5) at the bottom of Table S5 report the *P* values from tests that the immune-mediated chronic diseases mediate the relationship between early childhood income among the low-income children and the adult productivity outcomes. Findings from analyses of hours of work show that arthritis mediates this relationship, and it is responsible for a significant portion of the reduction on the coefficient from column two to column three in Table S5. Similarly for earnings, arthritis mediates the relationship between very early childhood income among low-income children.

Data from Table S5 are used to construct the information in Fig. 4. As with Fig. 3, $5,000 income increments are used, and adjustments are made for the disparate lengths of the three childhood periods. Therefore, for example, the +0.077 bar for earning and the prenatal to age 2 y period has the interpretation that a $5,000 income increment for a family with income less than $25,000 is associated with an 8.0% $[e^{(0.077)} - 1]$ increase in age 30–41 y average annual earnings. Table S6 shows results for a model in which hourly earnings averaged over the age 30- to 41-y period are taken as the dependent variables. The absence of significant effects for early income confirmed that the predictive power of early income for adult annual earnings comes from variation in work hours rather than hourly earnings.

Robustness Checks. One concern with our estimates is that they fail to control for current confounders, such as body mass index and indicators of activation of the sympathetic nervous system. However, if the confounders themselves mediate the immune process relationship between early poverty and the adult outcomes that we investigate, then including them will bias downward the estimated impacts of early poverty. The PSID dataset gathered self-reported information on weight in pounds and height in feet and inches, which we used to calculate body mass index using the formula $(\text{weight}/\text{height}^2) \times 703$, where weight is in pounds and height is in inches. When added to the first three models of Table S3, the coefficients and SEs on the <$25,000 spline segment change from −10.56 (4.82, $P < 0.05$) on hypertension to −5.16 (4.61, not significant); from −9.58 (3.31, $P < 0.01$) on arthritis to −7.65 (3.31, $P < 0.05$); and from −0.16 (0.07, $P < 0.05$) on ADL to −0.15 (0.07, $P < 0.05$). In the case of work hours (Table S5), the coefficients and SEs on the <$25,000 spline segment change from 531.13 (131.13, $P < 0.01$) to 490.19 (132.01, $P < 0.01$). For ln earnings, the change is from 0.63 (0.21, $P < 0.01$) to 0.56 (0.21, $P < 0.01$). Thus, our results linking very early childhood income and adult hypertension are most sensitive to the inclusion of adult body mass.

1. Kessler RC, et al. (2003) Screening for serious mental illness in the general population. *Arch Gen Psychiatry* 60:184–189.
2. Ziol-Guest KM, Duncan GJ, Kalil A (2009) Early childhood poverty and adult body mass index. *Am J Public Health* 99:527–532.
3. Duncan GJ, Ziol-Guest KM, Kalil A (2010) Early-childhood poverty and adult attainment, behavior, and health. *Child Dev* 81:306–325.
4. Duncan GJ, Telle K, Ziol-Guest KM, Kalil A (2011) *Persistence, Privilege, and Parenting: The Comparative Study of Intergenerational Mobility*, eds Erikson R, Jantti M, Smeeding T (Russell Sage Foundation, New York, NY), pp 209–234.
5. Sobel ME (1982) *Sociological Methodology*, ed Leinhardt S (American Sociological Association, Washington DC), pp 290–312.

Table S1. Sample statistics by whether average annual family income between the prenatal year and age 2 y is above or below $25,000

	Total sample (n = 1,070)	Low income (<$25,000; n = 156)	Higher income (≥$25,000; n = 914)	Significant difference between low and higher income
	Mean or % (SD)	Mean or % (SD)	Mean or % (SD)	*P* value
Adult health measures for age 30–41 y [mean (SD)]				
Percent of times reported hypertension condition	11.8 (25.8)	19.0 (33.4)	11.2 (24.9)	0.009
Percent of times reported arthritis condition	5.1 (17.8)	10.6 (28.4)	4.6 (16.5)	0.004
ADLs	0.09 (0.40)	0.29 (0.78)	0.07 (0.34)	<0.001
Ill health (continuous)	2.2 (0.8)	2.6 (0.9)	2.1 (0.8)	<0.001
Percent of times reported fair or poor health	8.1 (22.0)	20.1 (33.1)	7.1 (20.4)	<0.001
K6 mental health	3.5 (3.0)	5.2 (4.9)	3.3 (2.8)	<0.001
Adult labor market and human capital measures for age 30–41 y [mean (SD)]				
Earnings (in $1,000)	50.9 (97.6)	21.6 (19.6)	53.4 (101.2)	0.005
Annual work hours	1,843.3 (771.5)	1,459.7 (885.4)	1,877.0 (751.7)	<0.001
Wage rate	25.5 (34.2)	13.6 (7.3)	26.5 (35.3)	0.002
Stage-specific average annual childhood income in $10,000 [mean (SD)]				
Prenatal to age 2 y	6.1 (3.8)	1.8 (0.5)	6.5 (3.7)	<0.001
Age 3–5 y	6.8 (4.1)	2.3 (1.2)	7.2 (4.0)	<0.001
Age 6–15 y	7.2 (4.1)	2.7 (1.8)	7.6 (4.0)	<0.001
Demographic control variables				
White (%)	81.1	38.9	84.9	<0.001
Male (%)	52.8	46.4	53.3	<0.001
Born into intact family (%)	87.4	37.0	92.0	<0.001
Age of mother at birth [mean (SD)]	25.3 (5.5)	21.9 (4.1)	25.6 (5.5)	<0.001
Born in the South (%)	31.6	59.3	29.1	<0.001
Number of siblings [mean (SD)]	2.1 (1.6)	2.5 (2.0)	2.0 (1.6)	0.008
First born (%)	40.2	49.0	39.4	0.142
Parent test score [mean (SD)]	9.8 (2.1)	7.7 (2.7)	9.9 (1.9)	<0.001
Parent schooling less than HS (%)	25.8	70.4	21.8	<0.001
Parent schooling HS graduate (%)	26.7	17.5	27.5	<0.001
Parent schooling some college (%)	32.7	8.8	34.9	<0.001
Head schooling college graduate (%)	14.8	3.3	15.8	<0.001

All means and proportions (SDs) are weighted using sampling and attrition weights. Low income refers to individuals for whom average annual income between prenatal year and second year of life was less than $25,000, and higher income refers to individuals for whom average annual income between the prenatal year and second year was equal to or greater than $25,000. *P* value is based on the test of the null hypothesis that the mean or proportion is identical between the low- and higher-income groups. All incomes are in 2010 dollars.

Table S2. Family income mobility across childhood

	Average family income between age 3 and 5 y					
Average family income between prenatal year and second year	<$15K %	$15–$25K %	$25–$35K %	$35–$50K %	Above $50K %	All %
<$15K	53	34	6	6	0	100%
$15–$25K	20	27	34	14	5	100%
$25–35K	2	19	30	29	20	100%
$35–$50K	0	5	10	36	49	100%
Above $50K	1	1	1	9	89	100%
	Average family income between age 6 and 15 y					
<$15K	59	16	16	3	6	100%
$15–$25K	23	24	19	22	11	100%
$25–35K	12	19	22	22	26	100%
$35–$50K	1	6	9	22	61	100%
Above $50K	1	2	3	9	84	100%

Table entries show the percentage of the prenatal to 2 y income group in both of the later period income groups.

Table S3. OLS spline regression models of childhood income and adult health and wellbeing

	Hypertension		Arthritis		ADLs		
Childhood income (in \$10,000)	B (SE)	Different slopes? *P* value	B (SE)	Different slopes? *P* value	B (SE)	Different slopes? *P* value	
Average annual income prenatal to age 2 y							
<\$25K	−10.56* (4.82)	$P < 0.05$	−9.58† (3.31)	$P < 0.01$	−0.16* (0.07)	$P < 0.05$	−0.08 (0.07)
>\$25K	−0.23 (0.33)		−0.18 (0.23)		0.00 (0.01)		0.00 (0.00)
Average annual income age 3–5 y							
<\$25K	−2.11 (4.80)	ns	−6.01 (3.30)	$P < 0.10$	−0.03 (0.07)	ns	0.02 (0.07)
>\$25K	0.47 (0.37)		0.04 (0.25)		0.01 (0.01)		0.01 (0.01)
Average annual income age 6–15 y							
<\$25K	5.10 (4.13)	ns	8.45† (2.84)	$P < 0.001$	0.09 (0.06)	ns	0.02 (0.06)
>\$25K	−0.40 (0.33)		−0.16 (0.23)		−0.01 (0.01)		0.00 (0.00)
Hypertension	—		—		—		−0.01 (0.05)
Arthritis	—		—		—		0.79† (0.07)
Number of observations	1,004		1,004		989		989
Adjusted R^2	0.03		0.02		0.05		0.17
P from test of equality of three <\$25K spline segments	0.06		0.00		0.05		0.50

SEs, adjusted for within-family clustering of children, are given in parentheses. Spline models fit a different slope for incomes below and above \$25,000. Sample consists of PSID children born between 1968 and 1975. Incomes are in 2010 dollars, and childhood incomes are scaled in \$10,000. Data in the Different slopes? columns show *P* levels of tests of equality of within-period <\$25K and >\$25K slopes. All regressions include demographic control variables and birth year fixed effects. ns, not significant.

*$P < 0.05$.

†$P < 0.01$.

Table S4. OLS spline regression models of childhood income and additional health outcomes

	K6		Ill health (continuous)		Times reported fair or poor health (%)	
Childhood income (in \$10,000)	B (SE)	Different slopes? *P* value	B (SE)	Different slopes? *P* value	B (SE)	Different slopes? *P* value
Average annual income prenatal to age 2 y						
<\$25K	0.44 (0.51)	ns	−0.12 (0.14)	ns	−0.44 (3.99)	ns
>\$25K	−0.03 (0.04)		0.01 (0.01)		−0.16 (0.27)	
Average annual income age 3–5 y						
<\$25K	−0.73 (0.53)	ns	−0.02 (0.14)	ns	−0.03 (3.97)	ns
>\$25K	−0.03 (0.04)		0.01 (0.01)		0.60* (0.31)	
Average annual income age 6–15 y						
<\$25K	−0.69 (0.45)	ns	−0.15 (0.12)	ns	−9.85† (3.42)	$P < 0.05$
>\$25K	−0.04 (0.04)		−0.04† (0.01)		−1.02† (0.28)	
Number of observations	1,061		1,004		1,004	
P from test of equality of three <\$25K spline segments	0.21		0.85		0.16	

SEs, adjusted for within-family clustering of children, are given in parentheses. Spline models fit a different slope for incomes below and above \$25,000. Sample consists of PSID children born between 1968 and 1975. Incomes are in 2010 dollars, and childhood incomes are scaled in \$10,000. Data in the Different slopes? columns show *P* levels of tests of equality of within-period <\$25K and >\$25K slopes. All regressions include demographic control variables and birth year fixed effects. ns, not significant.

*$P < 0.10$.

†$P < 0.01$.

Table S5. OLS spline regression models of adult work-related outcomes

Childhood income (in $10,000)	Hours of work			Earnings (ln residuals)		
	B (SE)	B (SE)	B (SE)	B (SE)	B (SE)	B (SE)
Average annual income prenatal to age 2 y						
<$25K	531.13* (131.13)	473.81* (130.77)	433.84* (127.49)	0.63* (0.21)	0.48† (0.21)	0.44* (0.21)
>$25K	9.93 (9.96)	8.85 (9.88)	9.41 (9.62)	0.02 (0.02)	0.02 (0.02)	0.02 (0.02)
Average annual income age 3–5 y						
<$25K	59.40 (130.45)	26.82 (129.56)	30.33 (126.36)	0.34 (0.21)	0.27 (0.21)	0.29 (0.20)
>$25K	2.65 (10.15)	3.18 (10.07)	5.86 (9.81)	−0.01 (0.02)	0.00 (0.02)	0.00 (0.02)
Average annual income age 6–15 y						
<$25K	−104.00 (112.17)	−56.40 (111.75)	−49.76 (109.50)	−0.27 (0.18)	−0.15 (0.18)	−0.16 (0.28)
>$25K	6.36 (9.15)	5.24 (9.08)	4.76 (8.85)	0.07* (0.01)	0.07* (0.01)	0.06* (0.01)
Hypertension (0–1)	—	−77.51 (87.27)	−89.67 (87.91)	—	−0.36† (0.14)	−0.34† (0.14)
Arthritis (0–1)	—	−514.08* (126.66)	−212.72 (32.04)	—	−1.13* (0.20)	−0.68* (0.21)
ADLs	—	—	−386.81* (59.39)	—	—	−0.57* (0.10)
Adjusted R^2	0.20	0.21	0.24	0.22	0.25	0.28
Sobel test of mediation (hypertension)	—	0.215	0.189	—	0.072	0.082
Sobel test of mediation (arthritis)	—	0.015	0.104	—	0.009	0.044
Sobel test of mediation (ADLs)	—	—	0.117	—	—	0.119

SEs, adjusted for within-family clustering of children, are given in parentheses. Spline models fit a different slope for incomes below and above $25,000. All regressions include control variables and birth year fixed effects. Sobel test rows report the *P* value associated with the test that the effect of the low-income early childhood spline is mediated by that variable.
*$P < 0.01$.
†$P < 0.05$.

Table S6. OLS spline regression models of childhood income and ln wage rate

Childhood income (in $10,000)	Ln wage rate	
	B (SE)	Different slopes? *P* value
Average annual income prenatal to age 2		
<$25K	−0.11 (0.13)	ns
>$25K	0.02* (0.01)	
Average annual income age 3–5 y		
<$25K	0.25† (0.13)	ns
>$25K	−0.01 (0.01)	
Average annual income age 6–15 y		
<$25K	−0.06 (0.11)	$P < 0.05$
>$25K	0.06‡ (0.01)	
Number of observations	948	
P from test of equality of three <$25K spline segments	0.20	

SEs, adjusted for within-family clustering of children, are given in parentheses. Sample consists of PSID children born between 1968 and 1975. Incomes are in 2010 dollars, and childhood incomes are scaled in $10,000. Data in the Different slopes? columns show *P* levels of test of equality of within-period <$25K and >$25K slopes. All regressions include control variables and birth year fixed effects. Ns, not significant.
*$P < 0.10$.
†$P < 0.05$.
‡$P < 0.01$.