Childlessness and Health in Middle Age and Older Adulthood: Evidence from Singapore*

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Abstract

Health and well-being in mature adulthood are important concerns given the prevalence of individuals aging without children. We exploit two new instruments for childlessness—infertility and the number of childless siblings—and condition our analyses on a rich set of covariates including childhood health and financial status, to investigate the causal relationship between childlessness and health in middle age and older adulthood. Using a nationwide dataset of 1,500 Singaporeans aged 50 and above, we show that OLS underestimates the negative effects of childlessness on health. We find that childlessness leads to higher likelihood of poorer self-reported health and mental distress. The results are robust to a battery of sensitivity analyses, including matching based on observables and bounding the effects by relaxing the exclusion restrictions.

Keywords: health and well-being, childlessness, instrumental variables, bounds, aging
JEL Codes: I10, I31, J13, J14

*We are grateful to Janet Currie, Tomoki Fujii, Aljoscha Janssen, and Hitoshi Shigoeka for their invaluable comments and feedback. We thank attendees at the Asian Workshop on Econometrics and Health, Asian and Australiasian Society of Labour Economics, Asian Meeting of the Econometric Society, and Society of Economics of the Household conferences for insightful comments and suggestions. Data collection support from ML Research Consultants is gratefully acknowledged. This work is supported by Singapore's Ministry of Education Academic Research Fund Tier 2 (MOE2019-T2-2-084). All remaining errors are our own.

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1 Introduction

The proportion of individuals aging without children is an increasing phenomenon worldwide. Nearly a quarter of women born in 1970-1974 in Germany and Spain are childless (Doepke et al., 2023). Meanwhile, 15.5 percent of women aged 50 and above are childless in Singapore (Ho et al., 2023), a number comparable to the 15 percent of childless women aged 55 and above in the United States (Valerio et al., 2021). As children have traditionally been a linchpin of support in old age, concerns have been raised about the health and well-being of those aging without children. Nevertheless, the vast literature is quite mixed on whether the childless have better or worse health compared to parents in middle and older adulthood (Cwikel et al., 2006; Djundeva et al., 2018; Guo, 2014; Pertold-Gebicka, 2022; Stanca, 2012), possibly because past evidence tends to ignore potential selection into childlessness. For instance, there may be unobserved factors, such as childhood health, that drive both childlessness and health in mature adulthood, leading to omitted variable bias. In such a case, being childless does not necessarily *cause* poor health; instead, poor childhood health could both (i) lead to a lower probability of having children and (ii) result in adverse health outcomes in middle age and older adulthood. A few studies indeed find that the associations between childlessness and health change once socio-demographic factors are controlled for (Quashie et al., 2021; Zhang and Hayward, 2001), suggesting that the mixed results in past literature could potentially be due to unobserved confounders or selection effects.

To clearly identify the relationship between childlessness and health, an exogenous source of variation in childlessness status is needed. In this study, we exploit two new instrumental variables (IVs) for childlessness—infertility during reproductive years and the number of childless siblings—to explore the causal effects of childlessness on self-reported health and mental distress of middle aged and older adults. To this purpose, we recruited 1,500 middle aged and older non-institutionalized Singaporeans (500 childless and 1,000 parents) through random stratified sampling, and interviewed them on their fertility history, childhood and family background, socio-demographic characteristics, and health and mental well-being. Our rich dataset allows us to condition our analyses on childhood and youth characteristics including health and socio-economic status at ages 0-16 and desire for children in one's 20s-30s, to account for some of the potential confounders discussed above; specifically, we argue that our IVs are conditionally exogenous given the rich set of controls. Moreover, infertility and the number of childless siblings significantly increase the probability of being childless, indicative of relevant instruments. We further show that background characteristics of the respondents—such as as gender, education, and childhood socioeconomic status—appear to be unrelated to the IVs. Furthermore, neither of the IVs correlate with chronic and non-chronic health conditions, suggesting that they are unlikely to directly affect human capital. Additionally, Sargan-Hansen J tests of overidentification cannot reject the null hy-

pothesis that our overidentifying restrictions are valid. Thus, an indicator variable for infertility during one's reproductive years and the number of childless siblings are plausible instruments for childlessness. We nevertheless also employ various matching techniques such as nearest neighborhood, multivariate distance kernel, and inverse probability weighting to help ensure that those with and without children have equal distributions of characteristics. We further relax the exclusion restrictions in robustness checks and bound the estimated effects.

To the best of our knowledge, this study is the first that explores the causal effects of childlessness on health and well-being in middle and late adulthood. A handful of studies have explored the causal link between the number of children and health in the United States and Europe (Bonsang and Skirbekk, 2022; Cáceres-Delpiano and Simonsen, 2012; Kruk and Reinhold, 2014). These studies use twinning or sex composition of the first two children as IVs for the number of children, and thus, restrict their samples to parents with at least one child or two children, respectively. Such approach identifies the effect of having an additional child on health, conditional on reaching a certain parity.[1]

Our study differs from these past studies in terms of the margin of interest and context. In contrast to the literature that identified the effect of having an additional child conditional on already being a parent (intensive fertility margin) in the Western world, we are interested in the effect of childlessness per se (extensive fertility margin) in an Asian setting. Childlessness is very salient in our context given the centrality of children as a source of support to parents in old age in Singapore (Ho, 2022). For instance, the Maintenance of Parents Act allows Singaporean parents to sue children who fail to provide for them. This aligns with the prominent norms of filial piety across Asia, where parents still rely heavily on adult children for financial, instrumental, or emotional support (Guo and Zhang, 2020; Jayachandran, 2015). In the absence of offspring, the health and well-being of mature adults may be at risk due to a lack of support typically provided by adult children. Given its rapidly aging population and ultra-low fertility rates, Singapore provides a compelling setting to investigate the implications of childlessness on the health of middle aged and older adults.

Our two-stage least squares (2SLS) strategy exploits infertility during reproductive years and the number of childless siblings as instruments, and captures a different Local Average Treatment Effect (LATE) than the one associated with twinning or gender composition of children as instruments. In the case of twinning or sex composition, the LATE captures the impact of having children on compliers with *higher* than initial desired fertility. For instance, parents who desired two children may end up with a third child either because of twinning at the second birth (unexpected increase in fertility) or due to wanting an additional child of the opposite gender when the first two

[1] A budding literature also seeks to estimate the effects of parenthood on mental health using an event study design (Ahammer et al., 2023; Shi and Shen, 2023). These studies focus on parents only and examine the trends in mental health outcomes before and after the birth of the first child (the "event").

were of the same gender (desired increase in fertility due to an exogenous reason). In contrast, in the case of infertility and childless siblings, the LATE captures the impact on compliers with *lower* than initial desired fertility. For example, parents who desired children may end up with no children due to difficulty in conceiving (unexpected decline in fertility) or intra-generational correlations in fertility (decline in fertility due to an exogenous reason).

A few studies have exploited infertility as an IV for the number of children to explore the effect of parenthood or family size on labor supply (Agüero and Marks, 2008, 2011; Bratti et al., 2020; Lundborg et al., 2017; Miller, 2011). Addison et al. (2020) further exploit siblings' fertility timing as IV to estimate the effects of one's own fertility timing on occupational mismatch and there is well-documented evidence on intra-generational correlations in fertility (Balbo and Barban, 2014; Lyngstad and Prskawetz, 2010; Raab et al., 2014). We discuss the relevance and validity of infertility and the number of childless siblings as IVs in the context of examining the effects of childlessness on health in mature adulthood while controlling for a rich set of childhood health and socio-economic characteristics below.

Our results show that the childless have worse health than parents in middle and older adulthood. Without accounting for endogeneity, the childless are 7 percentage points more likely to report poor health and 8.2 percentage points more likely to report mental distress from ordinary least squares (OLS) estimation. 2SLS estimation confirms the sign of the effects but the marginal effects are much larger. From IV estimates, the childless are 45.9 percentage points more likely to report poor health and 45.4 percentage points more likely to report mental distress.[2] The negative effects of childlessness status on health and well-being of middle aged and older Singaporeans are robust to a battery of sensitivity analyses, including accounting for selection of unobservables à la Oster (2019), relaxing the exclusion restrictions following Nevo and Rosen (2012), and using matching techniques such as nearest neighbor matching, kernel matching, and inverse probability weighting.

The rest of the paper is organized as follows. Section 2 presents the data and descriptive statistics of childless individuals and parents. Section 3 introduces our empirical strategy and instrument validity checks. Section 4 discusses the health consequences of childlessness in middle and older adulthood, presents sensitivity analyses, and discusses potential mechanisms behind the results. Section 5 concludes.

[2]The 5-6 times larger estimates from 2SLS compared to OLS align with previous findings from past literature on the effects of caesarean section on mental health after child birth, whereby Tonei (2019) finds 2SLS estimates to be 6 times larger than OLS estimates.

2 Data and Descriptive Statistics

2.1 Survey Data

We conducted a nationwide survey, Childless Aging in Singapore (CAS), comprising of 1,500 Singaporeans and permanent residents aged 50 and above, with oversampling of childless individuals. The sample was randomly selected from a nationally representative listing of residential households with at least one member aged 50 and above. We recruited one individual aged 50+ per household, who was either childless (i.e., with no living children) or a parent.[3] In total, 1,000 parents and 500 childless individuals aged above 50 were interviewed. The survey was conducted in 2022 through face-to-face interviews in respondent homes lasting approximately one hour.

Aside from the oversampling of childless individuals, our sample is quite representative of national averages. From Appendix Table A1, socio-demographic variables such as age, education, and being of Chinese ethnicity are comparable between our sample and those aged 50 and above from the 2020 Census (SingStat, 2021). While the proportion of those currently married is lower in our sample than in the census, this is predominantly driven by the higher proportion of never married childless individuals in our sample. When we focus on parents only, the proportion of currently married individuals stand at 73% in our sample, a number comparable to the 72% of currently married individuals in the census. For the sake of comparison, we also report statistics from two large-scale nationwide surveys of middle aged and older Singaporeans and permanent residents—the Singapore Life Panel (SLP) and the Retirement and Health Study (RHS), although we note that the two surveys are not exactly comparable to the CAS due to some differences in the target age groups (Ho et al., 2023; Ng et al., 2022; Vaithianathan et al., 2021).

Besides the fact that socio-demographic characteristics of the CAS sample align with that of the 2020 census for those aged 50 and above, our dataset is particularly suited to study our research question on the causal effects of childlessness on health and mental well-being of mature adults. First, the data contains rich information on fertility history, childhood and family background, socio-demographic characteristics, and health and mental well-being outcomes. Such detailed information enables us to not only control for additional confounders not controlled for in past literature but also to employ novel instruments for causal identification. Second, since the respondents are aged 50 and above, they are most likely to have completed their fertility decisions and are thus permanently childless (Baetschmann et al., 2016). Third, the high proportion of childless individuals surveyed enables us to have strong statistical power for analysis. Nevertheless, in

[3] Respondents with step children were excluded from interview as they constitute a very small proportion ($\approx 3\%$) of individuals aged 50 and above in Singapore (Ho et al., 2023). If a household had multiple members above 50 years old including a childless member, the childless member was selected for interview. If a household had multiple childless members aged 50+, one childless member was randomly selected for interview. Finally, if a household had multiple members aged 50+ and no one was childless, one member was randomly selected for interview.

sensitivity analyses, we also reweigh the childless in our sample to be comparable to those of the SLP, and show that our results are robust to such re-weighting.

2.2 Analytical Sample

To get the analytic sample, we dropped 31 individuals with missing responses to any of the variables used in our analyses (≈2.07% of the sample), leaving us with 1,469 individuals: 983 parents and 486 childless individuals. Table 1 presents descriptive statistics of the main outcomes, explanatory variables and IVs used in our analyses. On average, 58.6% of our sample are females and respondents are aged in their early to mid-60s. The childless display some expected differences in characteristics compared to parents. In particular, those without children tend to be younger, tend to have higher education, are less likely to be married, are more likely to live in a smaller house, more likely to be of Chinese ethnicity (as opposed to being of Malay, Indian or other ethnicity), and tend to have fewer siblings compared to parents ($p < .01$).

We additionally asked respondents about their childhood and family background ("Youth") characteristics. These include an indicator variable that takes unity if the respondent reported having fair, poor, and very poor health when they were growing up (up to the age of 16), and zero otherwise. Around eight to nine percent of respondents reported having had fair, poor, or very poor health in childhood. We also construct an indicator variable that takes unity if the respondent reported that their family's financial condition was average, below average, or way below average when growing up. Approximately, 86% of respondents report having been financially average or not well-off. Finally, we asked respondents about the ideal number of children they desired when they were in their 20s and 30s. Around 82.5% of parents and 42% of childless individuals reported that they desired children when they were younger although many did not have a specific number that they desired. Unsurprisingly, childless individuals had a lower desire for children compared to parents in their 20s-30s, suggesting that there may be some selection into childlessness.

2.3 Health Measures

Our primary outcomes of interest are poor self-reported health and mental distress. The self-reported health measure is based on the typical survey question "How would you rate your current health status? Would you say your health status is…". It categorizes general health status on a five-point scale, ranging from 1 = very good to 5 = very poor. Such self-rated health measure has been shown to be a very good predictor of other health outcomes, such as subsequent use of medical care or mortality (Idler and Benyamini, 1997). The distribution of the self-reported health for parents and childless individuals is presented in the top panel of Appendix Figure A1. We construct a binary indicator that takes unity if the respondent reported fair, poor, or very poor health.

From Table 1, 42.2% of childless respondents reported fair, poor, or very poor self-reported health compared to 34.7% of parents. The difference between the two groups is statistically significantly different ($p < .01$).

To define mental distress, we use the 10-item Center for Epidemiological Studies-Depression (CES-D) scale, a well-validated scale that captures the frequency with which respondents report experiencing a series of depressive symptoms during the past one week (Bahal et al., 2023; McInerney et al., 2013; Radloff, 1977). The items include statements such as "I was bothered by things that usually don't bother me", "I felt depressed", "I felt that everything I did was an effort", "I was hopeful about the future" (see Appendix Table A2 for all 10 statements). Respondents were asked to indicate how often they experienced each of these feelings and were scored on a 4-item scale: 0 = rarely or none of the time (less than 1 day), 1 = some or a little of the time (1–2 days), 2 = occasionally or a moderate amount of time (3–4 days), or 3 = all of the time (5–7 days). The scores to each statement were then summed to obtain an overall score (answers to positive statements are reverse coded), which ranges from 0 to 30. The distribution of the raw CES-D scores for parents and childless individuals is presented in Figure A1. An individual is said to suffer from mental distress if he/she has a score of 10 or greater, which aligns with the optimal cut-off used by earlier studies to define mental distress (Fu et al., 2022; Singhal, 2019). From Table 1, 15% of childless individuals and 9.5% of parents experienced mental distress in the week prior to interview. The difference between the two groups is statistically significantly different at the 1% level.

3 Empirical Strategy

3.1 Identification Issues

Consider the following linear probability model:

$$\text{Poor Health}_{\text{i}} = \alpha_0 + \alpha_1 \text{Childless}_i + \boldsymbol{\alpha_2}' \mathbf{X}_i + u_i, \tag{1}$$

where $\text{Poor Health}_{\text{i}}$ denotes poor self-reported health or mental distress of individual i. Childless_i is a binary indicator of childlessness status that takes unity if the individual is childless, and 0 otherwise; and $\mathbf{X}_i$ is a vector of covariates. Robust standard errors are estimated in all specifications to account for potential heteroscedasticity.

Our coefficient of interest is α_1, which captures the effect of childlessness status on health. However, OLS estimates of α_1 are likely to be biased due to the presence of unobserved variables in u_i, that may correlate with both the outcome variable, $\text{Poor Health}_{\text{i}}$, and the predictor of interest, Childless_i. For instance, consider a situation where poor childhood health or high desire for

children are omitted from regression (1). Poor childhood health could imply a higher likelihood of remaining childless due to infertility issues (u_i is positively correlated with Childless$_i$), and also imply poorer health in middle and late adulthood (u_i is positively correlated with Poor Health$_i$). OLS would then overestimate α_1. Conversely, those who desire children may also anticipate poorer health in old age. They may thus be less likely to be childless (u_i is negatively correlated with Childless$_i$) and face a higher risk of poorer health in middle and late adulthood (u_i is positively correlated with $Poor\ Health_i$). In such case, OLS would underestimate α_1.

Our rich dataset helps mitigate such concerns regarding omitted variable bias by enabling us to control for a variety of socio-demographic and youth attributes, including health, socio-economic condition, and desire for children when young. Specifically, we consider two empirical specifications, one that controls for socio-demographics and another that additionally controls for youth variables, as described in Table 1. Nevertheless, there may still be other unobserved factors such as personality traits that correlate with both Poor Health$_i$ and Childless$_i$, and that we cannot control for. For example, those with more individualistic self-caring personalities or with higher intelligence may prefer to invest in themselves than in others, and thus be more likely to remain childless (u_i is positively correlated with Childless$_i$) and face a lower risk of poor health in mature adulthood (u_i is negatively correlated with Poor Health$_i$). Indeed, past literature has found that whose with more independence or intelligence are more likely to be childless (Avison and Furnham, 2015; Kanazawa, 2014). There is also evidence that those with higher cognitive ability tend to have lower early mortality rates (Calvin et al., 2011). Thus, OLS could still underestimate α_1. To assess the causal effect of childlessness on the health of middle aged and older individuals, we therefore use an indicator of infertility during reproductive years and the number of childless siblings as IVs for childlessness, which conditioning on a rich set of covariates.

3.2 Instrumental Variable Strategy

The first and second-stage regressions of our 2SLS models are, respectively:

$$\text{Childless}_i = \beta_0 + \beta_1 \text{Infertility}_i + \beta_2 \text{Childless Siblings}_i + \boldsymbol{\beta_3}' \mathbf{X}_i + \varepsilon_i, \tag{2}$$

$$\text{Poor Health}_\text{i} = \alpha_0 + \alpha_1 \widehat{\text{Childless}}_\text{i} + \boldsymbol{\alpha_2}' \mathbf{X}_i + u_i. \tag{3}$$

$\widehat{\text{Childless}}_\text{i}$ is the predicted value of Childless$_i$ from the first stage regression. Childlessness status is instrumented by two variables: (i) Infertility$_\text{i}$ and (ii) Childless Siblings$_i$. Infertility$_\text{i}$ is a binary variable that takes unity if individual i and/or his/her spouse faced difficulties in conceiving, and 0 otherwise. In particular, the infertility indicator takes unity if the respondent answered in the affirmative to any of the following questions: (a) "Was there ever a time when you and/or your

spouse were trying to get pregnant but did not conceive within at least 12 months?" (b) "Have you and/or your spouse ever sought professional help/medical intervention for issues related to difficulties in conceiving?" (c) "Have you and/or your spouse ever been diagnosed by a doctor with infertility?", or the respondent answered negatively to (d) "As far as you know, when you were younger, was it physically possible for you or your spouse to have a baby?" We perform robustness checks on alternative definitions of infertility below. Childless Siblings$_i$ represent the number of childless siblings individual i has.

Relevance. We examine relevance here (strength of the instruments) and discuss validity (the exclusion restrictions) below. Infertility has been used as an instrument in past studies to examine the causal effects of parenthood or family size on labour supply (Agüero and Marks, 2008, 2011; Bratti et al., 2020; Lundborg et al., 2017; Miller, 2011). Specifically, infertility provides a natural experiment whereby nature bounds family size, irrespective of a person's background. It is, therefore, expected that infertility would be positively associated with childlessness. Additionally, there is well-documented evidence on positive intra-generational correlations in fertility, possibly due to common family genetics, background, or preferences (Addison et al., 2020; Balbo and Barban, 2014; Lyngstad and Prskawetz, 2010; Raab et al., 2014). Besides infertility during reproductive years, we thus leverage the number of childless siblings as a novel instrument to identify the causal effects of childlessness status on the health of middle aged and older adults.

First stage regressions of eq. (2) indicate that the instruments are highly relevant to childlessness status. From Table 2, infertility increases the likelihood of being childless by 14 to 15 percentage points while an additional childless sibling is associated with a 1.6 to 1.9 percentage points increase in the probability of being childless. The Kleibergen-Paap Wald F-statistics—which in the case of a single endogenous regressor, is equivalent to a standard F-test with robust standard errors—is reasonably large at 18.4 to 20, suggesting that the instruments are not weak. The Kleibergen-Paap rk LM test also always strongly rejects the null hypothesis of underidentification, which provides greater confidence in the relevance of our instruments.

Validity. For the IVs to be valid, they have to satisfy the exclusion restrictions and be orthogonal to u_i. In other words, the IVs must not be directly correlated with $PoorHealth_i$. We provide several pieces of evidence that point in that direction including balance checks on observables and unobservables, and argue that our instruments are exogenous conditional on our rich set of control variables including childhood health, the total number of siblings, and desire for children.

While there is a well-known positive correlation between infertility and age, past literature suggests that background characteristics such as father's social status and lifestyle factors, for example, smoking are uncorrelated with infertility (Agüero and Marks, 2008, 2011; Bratti et al.,

2020). We provide supplementary evidence to this literature and also show that the number of childless siblings is not correlated with most pre-determined background characteristics. To do so, we follow Agüero and Marks (2011) and regress the instruments on background traits, while controlling for age fixed effects. From Table 3, characteristics such as gender, education and childhood socioeconomic status do not seem to correlate with the IVs. Conversely, as expected, poor childhood health positively correlates with infertility. Desire for children is positively associated with infertility—possibly, because those who desire and thus attempt to have children may be better aware of their infertility—and negatively associated with the number of childless siblings, which is consistent with intra-generational correlation in fertility preferences. The total number of siblings is also positively associated with the number of childless siblings. We control for poor childhood health, desire for children when young, and the total number of siblings in our analyses.

A potential concern is that our instruments may directly impact self-reported health and mental distress among middle aged and older adults. For instance, those who are infertile and underwent in-vitro fertilization (IVF) treatment may be more depressed due to the toll that such treatment exercises on one's body. Nevertheless, using an event study design, Lundborg et al. (2017) finds no evidence that women undergoing IVF treatment are more likely to get depressed, suggesting that fertility treatment per se does not impact mental well-being. Moreover, as neither of the IVs correlate with education or chronic and non-chronic conditions at the 5% level (see Table 3), it is unlikely that they directly affect human capital in mature adulthood.[4]

There may nevertheless be unobserved lineal characteristics such as genetics or family dynamics that correlate both with our instruments and health in adulthood. Besides controlling for childhood health, desire for children when young, and the total number of siblings in our analyses, we perform sensitivity analyses that control for additional proxies of family genetics or dynamics below. Specifically, we control for parental health (death of parents at the age of 60 or earlier or parents having limitations in performing activities of daily living (ADL) / instrumental ADL) and emotional proximity to close family members (could confide in father or mother in childhood, parents had good relationship in childhood, close relationship to siblings in childhood and in mature adulthood) and find the results to be robust to such controls.

To further mitigate concerns about potential correlations between the IVs and unobservable health characteristics, we follow the approach by Tonei (2019) and use the residuals obtained from a regression of each of the IVs on the covariates described in Table 1. Specifically, we regress the residuals on a proxy for unobservable characteristics of health, an indicator of whether the respondent ever smoked, which is a common correlate of health (OECD, 2010). From Appendix Table A3, there are no significant associations between the residuals and the proxy for unobserved char-

[4]Any chronic condition is marginally negatively correlated with infertility ($p < .10$). Such correlation, if valid, would imply that our 2SLS estimates are attenuated, and thus provide lower bound estimates.

acteristics, suggesting that remaining variations in the IVs are orthogonal to health unobservables.

Finally, we report Sargan-Hansen J-tests of overidentification from 2SLS estimation. Across all specifications, we cannot reject the null hypothesis that the overidentifying restrictions are valid, which gives us greater confidence in our IVs.

4 Results

4.1 Main Results

Table 4 reports results from OLS eq. (1) and 2SLS eq. (3) for the outcomes of poor self-reported health and mental distress. We find that the childless have higher likelihoods of poor self-reported health and mental distress compared to parents across all specifications. Specifically, from columns (1) and (5), when we only control for socio-demographic characteristics in OLS regressions, we find that being childless is associated with a 5.3 and 6.9 percentage points increase in the likelihood of poor health and mental distress, respectively. The former association is not statistically significant while the latter association is statistically significant at the 5% level. From columns (2) and (6), when we additionally control for youth variables, we find that the magnitudes of the respective effects increase to 7 and 8.2 percentage points and the statistical significance also increases to 10% and 1%, respectively.

Turning to the second stage of the 2SLS results, we find that childlessness status increases the probability of poor self-reported health by 45.9 to 60.8 percentage points. Meanwhile, being childless increases the probability of being mentally distressed by 45.4 to 52.8 percentage points. The higher effects under 2SLS suggest that OLS underestimates the effects of being childless on the likelihood of poor self-reported health and mental distress. As discussed in Section 3, this could possibly be driven by unobserved characteristics such as having an individualistic self-caring personality or higher intelligence that simultaneously drives up the likelihood of remaining childless and drives down the risk of poor health in middle and older adulthood. These results are robust to a battery of sensitivity analyses discussed below.

4.2 Sensitivity Analyses

4.2.1 Robustness Checks

Family genetics and dynamics. Our above argument is that conditional on the rich set of demographic and socio-economic characteristics, including childhood health and the total number of siblings, infertility and the number of childless siblings make plausible instruments for childlessness. To further mitigate concerns that common family genetics or dynamics may simultaneously

correlate with the IVs and health in mature adulthood, we perform sensitivity analyses where we control for parental health and emotional proximity to immediate family members, as described in Section 2. As can be seen from Appendix Tables A4 and A5, the results are robust to such controls.

Alternative specifications. As our main outcome variables are discrete, it is a somewhat open ended question whether we should rely on the linear model or on a non-linear model (Angrist and Pischke, 2009). Therefore, we re-estimate the empirical models using a probit specification and control function approach. The marginal effects from such models are reported in Appendix Table A6. The results and inferences are very similar to those reported in Table 4. Additionally, we present results from analyses using self-reported health and CES-D score as continuous outcomes in Appendix Table A7. The results are qualitatively similar to those in Table 4. Once again, we find that being childless leads to poorer self-reported health and mental distress, and that the magnitudes are larger from 2SLS than from OLS estimation.

Alternative samples. As individuals with adopted children may differ from those with biological children—for instance, in the strengh of reliance on adult children for old age support, we drop 21 individuals with adopted children from the sample. From Appendix Table A8, the impacts of childlessness on health are very similar to those in Table 4. Additionally, we oversample the childless in our survey, which has the advantage of improving statistical power but the disadvantage of making the proportion of childless individuals non-nationally representative. We thus re-weight the childless in our sample using the proportion of childless in the large scale nationwide SLP. This takes into account the fact that 11 percent of men and 15 percent of women are childless (Ho et al., 2023). We derive the sample weights for parents and childless individuals by dividing the SLP proportion by CAS proportion separately for men and women. The results using the sample weights are given in Table A9. The adverse impact of childlessness on self-reported health and mental distress continue to be robust, albeit with some (expected) loss of statistical power.

Alternative definitions of infertility. As described in Section 3, a respondent is identified as someone who had infertility problems based on four different questions related to difficulty in conceiving. In Appendix Table A10, we combine three of these four questions at a time to construct four different measures of infertility. The results are once again robust and similar to those reported in Table 4. Moreover, as those who desired to have children may be better aware of their infertility, we conduct sensitivity analyses by limiting the sample to those who desired children when young. The results reported in Appendix Table A11 are robust. Similarly, because never married individuals may not be aware of their infertility, most did not answer the questions on infertility. To mitigate such issue, we control for an indicator that takes unity if the answers to the infertility

questions are missing (Appendix Table A12). The inferences once again indicate that childlessness is associated with higher likelihoods of poor health.

4.2.2 Bounding the Effects of Childlessness

Accounting for selection on unobservables using selection on observables. We follow Oster (2019) to bound the effects of childlessness on health using selection on observed variables as a guide to selection on unobserved variables in the OLS model (1). This technique builds on the observation that omitted variable bias is often considered to be limited if a coefficient is stable when observed covariates are added in a regression. To derive the bias-adjusted treatment effect, we adopt the following recommended assumptions from Oster (2019): (a) there is equal selection on observables and unobservables, and (b) the attainable R^2 in a regression with a full set of (observable and unobservable) covariates, R_{max}, is equal to 1.3 times the estimated R^2 from a regression with observable covariates only, $\hat{R}_{OLS}$, as per specification (1). The identified set then lies between the OLS estimate from (1), $\hat{\alpha}_1^{OLS}$, and the bias-adjusted estimate, $\alpha_1^* = \hat{\alpha}_1^{OLS} - \left[\hat{\alpha}_1^0 - \hat{\alpha}_1^{OLS}\right] \frac{R_{max} - \hat{R}_{OLS}}{\hat{R}_{OLS} - \hat{R}_0}$, where $\hat{\alpha}_1^0$ and $\hat{R}_0$ are, respectively, the estimated treatment effect and R^2 from a regression of health on childlessness status without any controls. Figure 1 plots OLS estimates as well as the bounds à la Oster (2019). From the figure, the identified sets of α_1 are fairly tight and are consistent with our inference that being childless is associated with poorer health.

Relaxing the exclusion restriction. For the IVs to be valid in the 2SLS model (2)-(3), they have to satisfy the exclusion restrictions and be orthogonal to u_i conditional on $\mathbf{X}_i$. As discussed in Section 3, our IVs do not correlate with most pre-determined background characteristics, and we also control for rich socio-demographic and youth variables in our analyses. Nevertheless, we perform one additional robustness check and relax the assumption of orthogonality to estimate bounds on the effects of being childless on health for more compelling evidence. Specifically, we follow the method proposed by Nevo and Rosen (2012), which allows the IVs to correlate with the error term in the second stage regression. Under the relatively weak assumptions that (a) the correlation between each IV and u_i has the same sign as the correlation between the endogenous regressor and u_i and (b) each IV is less endogenous than the endogenous regressor, we can derive informative bounds for the causal effects of childlessness on health based on set identification.

In our context, we argue that $\text{Childless}_\text{i}$ is negatively correlated with u_i because there may exist unobserved traits such as self-caring individuality that simultaneously drives up the probability of being childless and drives down the likelihood of poor health. This is consistent with the downward bias from OLS estimates compared to 2SLS estimates in Table 4. We now turn to the two above assumptions. For assumption (a), we posit that $\text{Infertility}_\text{i}$ positively correlates with u_i, that is,

those who are infertile, may be less healthy in general. For this IV to satisfy assumption (a), we thus re-specify the instrument as $-\text{Infertility}_\text{i}$ such that there is also a negative correlation between $-\text{Infertility}_\text{i}$ and u_i. Conversely, we conjecture that Childless Siblings$_i$ negatively correlates with u_i, possibly because those with more childless siblings may take better care of themselves such that they are less likely to have poor health. For instance, Kim et al. (2024) find that childless individuals are more likely to take care of older parents than non-childless individuals. Thus, those with more childless siblings may face lower caregiving burdens and thus better health (Do et al., 2015). This satisfies assumption (a).

Nevo and Rosen (2012) show that under assumption (a), the effect of childlessness on health would be bounded by the 2SLS and OLS estimates. If the assumption (b) additionally holds, then we can obtain tighter bounds that lie between 2SLS and Nevo-Rosen (NR) estimates, $\hat{\alpha}_1^{NR}$, a 2SLS estimator that employs $NR = \sigma_{\text{Childless}}\text{IV}_\text{i} - \sigma_{\text{IV}}\text{Childless}$ as an instrument; σ_{var} denotes the standard deviation of $var = \{\text{Childless}, \text{IV}\}$ and $\text{IV} = \{-\text{Infertility}_\text{i}, \text{Childless Siblings}_i\}$. In the case of multiple instruments, the bounds may be computed for each instrument such that they will lie between $\hat{\alpha}_1^{NR}$ and the 2SLS estimate for one of the IVs. Nevertheless, Nevo and Rosen (2012) note that the bounds may differ from 2SLS estimate when the correlations in (a) are conditional on covariates. The NR bounds for the impact of childlessness on health using $-\text{Infertility}_\text{i}$ as IV are shown in Figure 1. As can be seen from the figure, the bounds provide strong support that being childless is associated with higher likelihoods of poor health and mental distress.[5]

4.2.3 Matching

While the instrumental variable estimates capture the LATE effect, it is also important to calculate the average treatment effect (ATE), which provides a comprehensive estimate of the treatment's overall impact across a population, and not just on compliers. This makes it particularly useful in policy evaluations where results need to be applicable to larger populations. In particular, we use nearest neighbor matching, kernal matching, and inverse probability weighting to derive the ATE (Table 5). While nearest neighbor matching involves pairing each treated unit with the closest control unit based on a specified distance metric, multivariate kernel matching improves upon traditional matching approaches by employing kernel functions to weigh control units according to their proximity to treated units across multiple covariates. Finally, inverse probability weighting (IPW) weighs each subject inversely to their estimated probability of receiving the treatment assignment. The estimates once again suggests that being childless increases the likelihood of self-reported poor health and mental distress.

[5]To be conservative, we do not plot the bounds for the impact of childlessness on health using Childless Siblings$_i$ as IV because its lower bound lies above the upper bound shown in Figure 1, suggesting even stronger effects of childlessness status on the likelihood of poor health. Results are available upon request.

4.3 Potential Mechanisms

There are several potential mechanisms through which childlessness may negatively impact health. First, hormonal changes associated with giving birth (in the case of women) may lead to direct changes in health in old age. In such case, we should observe that the effects of childlessness differ between men and women. From Appendix Table A13, we do not find any gender difference, suggesting that hormonal changes are unlikely to be the main driver of our results. Second, the act of raising children may make parents more active and thus healthier compared to those without children. We look at prevalence of chronic diseases such as high blood pressure, cancer, cholesterol, and non-chronic diseases such as heart attack and stroke, but do not find any direct effect of childlessness on these physical health outcomes (Appendix Table A14), suggesting that this channel is also unlikely in our context.

Third, those who have children may be less lonely and thus less likely to be in poor health compared to those without children. From Appendix Figure A2, while we do not find any evidence that the childless have poorer social network, there is evidence that they have poorer relations and fewer activities with the younger generation. Fourth, a lack of contemporaneous or expected future support in old age may also drive our results. As discussed earlier, children are an important source of support in many countries, including Singapore (Guo and Zhang, 2020; Ho, 2022; Jayachandran, 2015). From Appendix Figure A2, we indeed find that those without children expect lower support in the future, both in terms of financial and instrumental help. Thus, it is possible that the childless may lack the interaction with the younger generation and the support that goes with it.

5 Discussion and Conclusion

This study contributes to the growing literature on the consequences of childlessness. It represents a first attempt to identify the causal effect of childlessness on the health of middle-aged and older individuals in an Asian setting. To do so, we interview 1,500 randomly selected Singaporeans aged 50 and above, and collect rich information on their fertility history, childhood and family background, and socio-demographic characteristics. We show that OLS underestimates the associations between childlessness status and poor health, possibly due to negative selection, whereby an unobserved attribute—such as, for example, having an individualistic self-caring personality or higher intelligence—increases the probability of being childless but also decreases the probability of being in poor health (Avison and Furnham, 2015; Calvin et al., 2011; Kanazawa, 2014).

We present evidence that supports the use of two novel instruments for childlessness, infertility during reproductive years and the number of childless siblings. First, both IVs are highly correlated with childlessness status. Second, we show that our IVs are unrelated to background traits such as

gender, education, and childhood socioeconomic status. Third, our rich dataset allows us to control for potential confounders such as poor health in childhood, desire for children when young, and total number of siblings. Estimates from 2SLS suggest that being childless leads to a greater likelihood of poor self-reported health and mental distress. The results are robust to a battery of sensitivity analyses, including bounding the effects of childlessness using selection on observables à la Oster (2019) and relaxing the exclusion restrictions following Nevo and Rosen (2012) as well as matching on observable characteristics.

Our findings contrast with results from past literature that has examined the effect of having an additional child on health in Western countries, by exploiting twinning or sex composition of the first two children as IVs (Bonsang and Skirbekk, 2022; Cáceres-Delpiano and Simonsen, 2012; Kruk and Reinhold, 2014). Such literature generally finds that an additional child leads to worse late life cognition or well-being. As discussed above, the LATE identified in our context comes from compliers who experience lower than desired fertility while past literature identifies a LATE from compliers who experience higher than desired fertility. We are thus identifying effects for a different subpopulation. Additionally, our setting is one where children are highly valued for old age support, which contrasts with Western settings. Our results are more consistent with Priebe (2020) who finds that an additional child is associated with better subjective well-being and satisfaction in developing countries. This is possibly due to the fact that older parents also tend to be more reliant on adult children in developing economies. Nevertheless, that study focuses on the intensive margin of fertility for women of reproductive ages in developing countries while we focus on the extensive margin of fertility among middle aged and older individuals in a relatively rich Asian setting.

The inferences from this study are important for a number of reasons. First, aging without children is an increasingly salient phenomenon in many countries with childlessness rates among middle aged and older individuals being greater than 20% in countries such as Spain and Germany (Doepke et al., 2023). Second, children are still an important form of support to parents in old age in Asia, where filial piety is highly valued (Guo and Zhang, 2020; Ho, 2022; Jayachandran, 2015). Lack of children may thus be associated with lower support from and interactions with the younger generation as well as higher demands on the childless to care for their own parents (Kim et al., 2024), which may lead to mental distress. Third, poor health and depression in old age can be very severe conditions that limit one's everyday life and the ability to take care of oneself, thus imposing high costs on the individual and society (Schiele and Schmitz, 2023). In light of the increasing prevalence of those aging without children, our findings imply that policymakers may need to factor in the higher demands for both physical and mental health services in planning for the future.

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Table 1: Descriptive Statistics for Parents and Childless Individuals

	Parent		Childless		Difference
	Mean/Prop.	S.D.	Mean/Prop.	S.D.	p-value
	(1)	(2)	(3)	(4)	(5)
Outcome variables					
Poor self-reported health	0.347	0.476	0.422	0.494	0.005
Mental Distress	0.095	0.293	0.150	0.358	0.002
Socio-demographics					
Female	0.583	0.493	0.593	0.492	0.723
Age in years	65.041	8.798	62.862	7.920	0.000
Primary or lower education	0.338	0.473	0.272	0.445	0.010
Secondary education	0.340	0.474	0.331	0.471	0.746
Junior college or higher	0.322	0.468	0.397	0.490	0.005
Currently married	0.734	0.442	0.218	0.413	0.000
Disrupted marriage	0.263	0.441	0.113	0.317	0.000
Never married	0.002	0.045	0.669	0.471	0.000
Housing: $\leq$ 3 room HDB	0.277	0.448	0.568	0.496	0.000
Housing: 4-5 room HDB	0.361	0.481	0.228	0.420	0.000
Housing: Private or other	0.362	0.481	0.204	0.403	0.000
Chinese	0.760	0.427	0.827	0.378	0.003
No. of siblings	5.167	2.929	4.465	2.688	0.000
Youth variables					
Poor health in childhood	0.080	0.272	0.086	0.281	0.692
Not financially well-off in childhood	0.859	0.349	0.864	0.354	0.809
Desire for children in 20-30s	0.825	0.380	0.420	0.494	0.000
Instrumental variables					
Infertility	0.196	0.397	0.185	0.389	0.610
No. of childless siblings	0.595	0.955	0.893	1.229	0.000
No. of observations	983		486		

Notes: Means or proportions and standard deviations are reported. 'Disrupted marriage' is an indicator of divorced, separated, or widowed status, and 0 otherwise. HDB stands for housing development board, government subsidized flats where the majority of Singaporeans reside. The *p*-values of the differences in means or proportions from t-tests or proportion tests, respectively, are reported in Column (5).

Table 2: First-stage Results: Associations between IVs and Childlessness

Dependent variable	Childless	
	(1)	(2)
Infertility	0.140***	0.150***
	(0.026)	(0.026)
No. of childless siblings	0.019**	0.016*
	(0.008)	(0.008)
Youth variables	No	Yes
Kleibergen-Paap Wald rk F-statistic	18.410	20.030
Kleibergen-Paap rk LM p-value	0.000	0.000
Dep. var mean	0.331	0.331
Observations	1,469	1,469

Notes: The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. Robust standard errors are given in parentheses.
***p<.01, **p<.05, *p<.10.

Table 3: Instrument Validity: Balance on Background Characteristics

	Infertility (1)	No. of Childless Siblings (2)
Female	0.037	0.000
	(0.033)	(0.013)
Primary or lower education	-0.008	-0.003
	(0.030)	(0.011)
Secondary education	0.006	0.002
	(0.032)	(0.012)
Junior college or higher	0.002	0.001
	(0.031)	(0.012)
Chinese	-0.051*	0.014
	(0.030)	(0.010)
No. of siblings	0.025	0.592***
	(0.194)	(0.066)
Poor health in childhood	0.076***	-0.003
	(0.022)	(0.007)
Financially well-off in childhood	-0.019	-0.003
	(0.022)	(0.009)
Desire for children in 20s-30s	0.135***	-0.031***
	(0.029)	(0.012)
Any chronic condition	-0.062*	0.010
	(0.033)	(0.012)
Any non-chronic condition	-0.014	-0.003
	(0.019)	(0.007)
Dep. var mean	0.193	0.694
No. of observations	1,469	1,469

Note: Estimates are from separate regressions of each background characteristic on each instrument that control for age fixed effects. 'Any chronic condition' refers to diabetes, high blood pressure, cholesterol, kidney failure, respiratory problem, alzheimer, arthritis and osteoporosis. 'Any non-chronic condition' refers to heart attack, heart failure, chest pain, and stroke.
***p<.01, **p<.05, *p<.10.

Table 4: Impact of Childlessness on Health Outcomes

Dependent variable	Poor Self-Reported Health				Mental Distress			
	OLS		2SLS		OLS		2SLS	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.053	0.070*	0.608***	0.459**	0.069**	0.082***	0.528***	0.454***
	(0.042)	(0.042)	(0.227)	(0.212)	(0.031)	(0.031)	(0.177)	(0.164)
Youth variables	No	Yes	No	Yes	No	Yes	No	Yes
Overid p-val.	–	–	0.459	0.248	–	–	0.740	0.967
Dep. var mean	0.372	0.372	0.372	0.372	0.113	0.113	0.113	0.113
Observations	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469

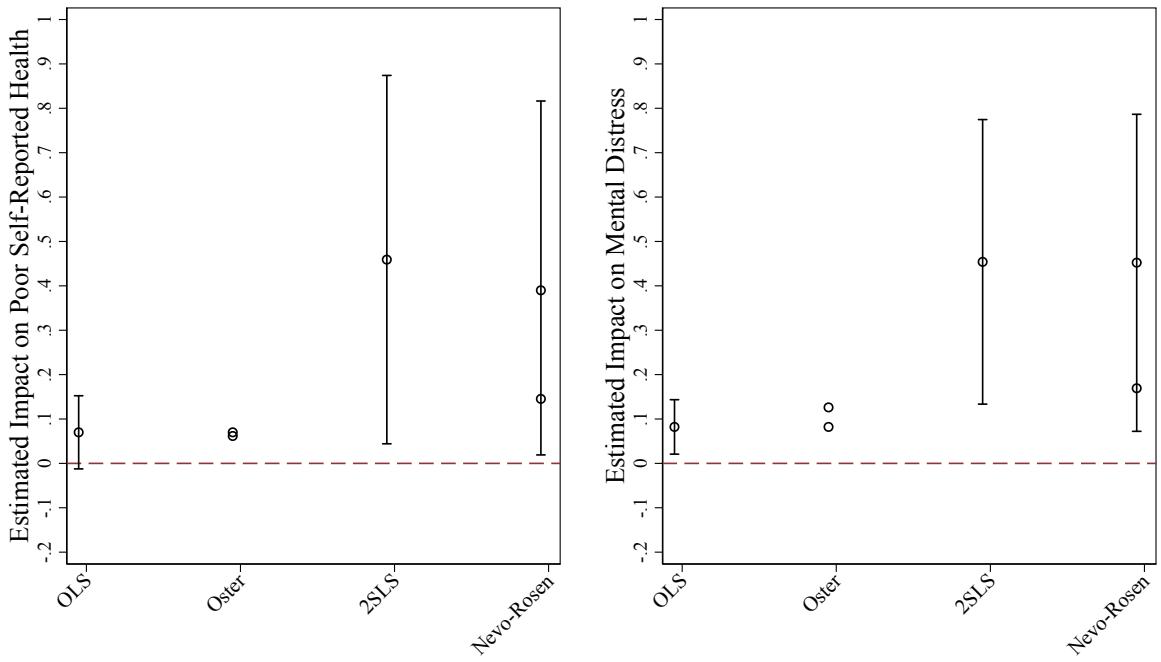
Notes: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table 5: Average Treatment Effect: Impact of Childlessness on Health Outcomes

Dependent variable	Poor Self-Reported Health						Mental Distress					
	Nearest neighbor		Mutivariate distance kernel		Inverse probability weighting		Nearest neighbor		Mutivariate distance kernel		Inverse probability weighting	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Childless	0.038	0.077*	0.072**	0.080***	0.068	0.101*	0.074**	0.069**	0.062***	0.059***	0.084***	0.088***
	(0.047)	(0.042)	(0.030)	(0.029)	(0.069)	(0.052)	(0.036)	(0.033)	(0.021)	(0.020)	(0.031)	(0.033)
Youth variables	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
Dep. var mean	0.372	0.372	0.372	0.372	0.372	0.372	0.113	0.113	0.113	0.113	0.113	0.113
Observations	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469

Notes: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Figure 1: Bounding the Effects of Childlessness on Health



Note: An individual is defined to have 'poor self-reported health' if he/she reported fair/moderate, poor or very poor health. An individual is defined to be suffer from mental distress if the CES-D score is 10 or higher. 95% confidence intervals are reported for OLS 2SLS, and NR bounds.

A Online Appendix

Table A1: Descriptive Statistics from the CAS, Census, SLP, and RHS

	Female		Male		All	
	Parent	Childless	Parent	Childless	Age 50+	
	CAS Sample: Ages 50 and above				CAS	Census
Age	64.52	63.05	65.78	62.60	64.32	64.00
Primary education or less	0.39	0.20	0.26	0.38	0.32	0.31
Secondary inc. junior college	0.42	0.43	0.35	0.34	0.39	0.45
Diploma and above	0.19	0.37	0.39	0.28	0.29	0.24
Currently married	0.63	0.16	0.88	0.30	0.56	0.72
Chinese	0.77	0.85	0.74	0.79	0.78	0.79
Observations	573	288	410	198	1,469	4.02m
	Female		Male		All	
	Parent	Childless	Parent	Childless	55-75	45-85
	SLP Sample: Ages 55 to 75				SLP	RHS
Age	63.20	63.14	64.55	62.57	63.72	60.50
Primary education or less	0.30	0.10	0.19	0.15	0.23	0.45
Secondary inc. junior college	0.45	0.49	0.39	0.45	0.43	0.36
Diploma and above	0.25	0.41	0.42	0.42	0.34	0.19
Currently married	0.78	0.23	0.94	0.45	0.78	0.72
Chinese	0.87	0.90	0.88	0.92	0.92	0.53
Observations	3,014	553	2,808	365	1,469	12.8k

Note: Means or proportions are reported for selected socio-demographic variables available in our sample and in published literature. The 2022 data used in this study is the Childless Aging in Singapore (CAS), a nationwide dataset of Singaporeans and permanent residents aged 50 and and above, selected through random stratified sampling with oversampling of childless individuals. Census data for Singaporeans and permanent residents from Tables 1, 3, 12, and 24 in SingStat (2021) pertain to those aged 50 and above. To compute average age from SingStat (2021), we multiply the number of individuals of a given age by the age and divide by the total across ages 50 and above. To get the proportion of Chinese ethnicity, we divide the number of Chinese aged 50 and above by the total number of individuals aged 50 and above. Similar computations are done to get the remaining proportions reported in the table. The Singapore Life Panel (SLP) is a large scale nationwide survey of Singaporeans and permanent residents aged 50 and 70 in 2015 (when the panel started) and their spouse (who may or may not be within the same age range), with nationally representative sampling (Vaithianathan et al., 2021). The SLP statistics are from Table 1 in Ho et al. (2023) that uses data from the March 2020 wave of the SLP so that most respondents would be aged 55 to 75, although some may be outside of that age range due to the inclusion of spouses. The Retirement and Health Study (RHS) is a large-scale nationally representative sample of Singaporean and permanent residents aged 45 to 85. Statistics for the RHS are from Table 3 in Ng et al. (2022) and pertain to the 2016 wave. As age is reported in bins of 5 years, we perform mid-point imputation to back out the average age.

Table A2: Questions on the CES-D 10 Scale

Sl	Question
1	I was bothered by things that usually do not bother me.
2	I had trouble keeping my mind on what I was doing.
3	I felt depressed.
4	I felt everything I did was an effort.
5	I felt hopeful about the future.
6	I felt fearful.
7	My sleep was restless.
8	I was happy.
9	I felt lonely.
10	I could not get going.

Note: Responses to each of the 10 questions are (i) rarely or none of the time (less than 1 day) (ii) some or a little of the time (1 or 2 days) (iii) occasionally or a moderate amount of time (3 or 4 days) (iv) all of the time (5-7 days).

Table A3: Instrument Validity: Balance on Unobservables

	Residuals from			
	Infertility		No. of Childless Siblings	
Smokes	-0.021	-0.019	0.029	0.027
	(0.024)	(0.023)	(0.064)	(0.064)
Youth variables	No	Yes	No	Yes
Dep. var mean	0.193	0.193	0.694	0.694
Observations	1,469	1,469	1,469	1,469

Note: 'Smokes' takes unity if the respondent ever smoked cigarettes, pipe tobacco or cigars, and 0 otherwise. The above estimates are from separate OLS regressions, where the dependent variable is the residual from regressing each of the instruments on the covariates from our main model. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A4: Robustness Check: Controlling for Parental Health

Dependent variable	Poor Self-Reported Health				Mental Distress			
	OLS		2SLS		OLS		2SLS	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.068	0.069	0.481**	0.473**	0.079**	0.080**	0.472***	0.469***
	(0.043)	(0.043)	(0.223)	(0.222)	(0.032)	(0.032)	(0.172)	(0.172)
Youth variables	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Parental health	No	Yes	No	Yes	No	Yes	No	Yes
Overid p-val.	–	–	0.224	0.197	–	–	0.865	0.832
Dep. var mean	0.361	0.361	0.361	0.361	0.109	0.109	0.109	0.109
Observations	1,380	1,380	1,380	1,380	1,380	1,380	1,380	1,380

Notes: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. 'Parental health' include premature death of either parent (died at 60 or earlier) or whether any living parent has an ADL/IADL limitation. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A5: Robustness Check: Controlling for Emotional Closeness

Dependent variable	Poor Self-Reported Health				Mental Distress			
	OLS		2SLS		OLS		2SLS	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.065	0.053	0.419**	0.356*	0.089***	0.082**	0.457***	0.422**
	(0.045)	(0.045)	(0.213)	(0.214)	(0.033)	(0.032)	(0.165)	(0.167)
Youth variables	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emotional closeness	No	Yes	No	Yes	No	Yes	No	Yes
Overid p-val.	–	–	0.177	0.197	–	–	0.959	0.915
Dep. var mean	0.366	0.366	0.366	0.366	0.112	0.112	0.112	0.112
Observations	1,373	1,373	1,373	1,373	1,373	1,373	1,373	1,373

Notes: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. 'Emotional closeness' include relationship with parents and between parents in childhood, and relationship with siblings in childhood and adulthood. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A6: Robustness Check: Probit Specification

Dependent variable	Poor Self-Reported Health				Mental Distress			
	Simple Probit		IV Probit		Simple Probit		IV Probit	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.054	0.069*	0.613***	0.472**	0.065**	0.075***	0.474***	0.404***
	(0.041)	(0.041)	(0.227)	(0.216)	(0.025)	(0.026)	(0.147)	(0.134)
Youth variables	No	Yes	No	Yes	No	Yes	No	Yes
Dep. var mean	0.372	0.372	0.372	0.372	0.113	0.113	0.113	0.113
Observations	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469

Note: The above estimates are the marginal effects from probit specifications. 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A7: Robustness Check: Continuous Outcomes

Dependent variable	Self-Reported Health				Mental Well-Being			
	OLS		2SLS		OLS		2SLS	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.088	0.112	0.849**	0.627*	0.559	0.858*	10.23***	9.108***
	(0.073)	(0.073)	(0.367)	(0.346)	(0.443)	(0.456)	(2.808)	(2.606)
Youth variables	No	Yes	No	Yes	No	Yes	No	Yes
Overid p-val	–	–	0.422	0.239	–	–	0.557	0.904
Dep. var mean	2.334	2.334	2.334	2.334	4.167	4.167	4.167	4.167
Observations	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469

Note: 'Self-Reported Health' is measured on a likert scale of 1-5, with higher values denoting worse mental health. 'Mental Well-Being' is measured on a scale of 1 to 30, with higher values denoting worse outcomes. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A8: Robustness Check: Dropping Individuals with Adopted Children

Dependent variable	Poor Self-Reported Health				Mental Distress			
	OLS		2SLS		OLS		2SLS	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.052	0.070*	0.571***	0.422**	0.067**	0.080**	0.537***	0.465***
	(0.042)	(0.042)	(0.214)	(0.200)	(0.031)	(0.031)	(0.172)	(0.159)
Youth variables	No	Yes	No	Yes	No	Yes	No	Yes
Overid p-val	–	–	0.366	0.189	–	–	0.702	0.987
Dep. var mean	0.370	0.370	0.370	0.370	0.115	0.115	0.115	0.115
Observations	1,448	1,448	1,448	1,448	1,448	1,448	1,448	1,448

Note: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for demographic—gender, age, education level, marital status, type of residence, race, and number of siblings, and childhood characteristics—childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth—of the individuals. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A9: Robustness Check: Reweighting the Childless

Dependent variable	Poor Self-Reported Health				Mental Distress			
	OLS		2SLS		OLS		2SLS	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.056	0.064	1.227**	0.927*	0.068**	0.077**	0.725**	0.594*
	(0.043)	(0.043)	(0.532)	(0.505)	(0.030)	(0.031)	(0.345)	(0.327)
Youth variables	No	Yes	No	Yes	No	Yes	No	Yes
Hansen J statistic	–	–	0.371	0.210	–	–	0.740	0.979
Dep. var mean	0.372	0.372	0.372	0.372	0.113	0.113	0.113	0.113
Observations	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469

Note: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A10: Robustness Check: Alternative Definitions of Infertility

	Poor Self-Reported Health				Mental Distress			
	a+b+c	a+b+d	a+c+d	b+c+d	a+b+c	a+b+d	a+c+d	b+c+d
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.413**	0.586**	0.449**	0.426*	0.210*	0.526***	0.434***	0.583***
	(0.176)	(0.242)	(0.211)	(0.243)	(0.123)	(0.187)	(0.162)	(0.204)
KP LM statistic	41.762	30.117	36.257	27.584	41.762	30.117	36.257	27.584
KP Wald F statistic	24.058	16.665	19.987	14.847	24.058	16.665	19.987	14.847
Overid p-val	0.225	0.352	0.240	0.212	0.514	0.888	0.926	0.778
Dep. var mean	0.372	0.372	0.372	0.372	0.113	0.113	0.113	0.113
Observations	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469

Note: The table reports 2SLS estimates for different combinations of the infertility measures as IV: (a) "Was there ever a time when you and/or your spouse were trying to get pregnant but did not conceive within at least 12 months?" (b) "Have you and/or your spouse ever sought professional help/medical intervention for issues related to difficulties in conceiving?" (c) "Have you and/or your spouse ever been diagnosed by a doctor with infertility?" or (d) "As far as you know, when you were younger, was it physically possible for you or your spouse to have a baby?" 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for demographic—gender, age, education level, marital status, type of residence, race, and number of siblings, and childhood characteristics—childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth—of the individuals. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A11: Robustness Check: Dropping Individuals who did not Desire Children

Dependent variable	Poor Self-Reported Health				Mental Distress			
	OLS		2SLS		OLS		2SLS	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.122**	0.115**	0.428**	0.312	0.110**	0.106**	0.458***	0.399**
	(0.055)	(0.053)	(0.210)	(0.205)	(0.043)	(0.043)	(0.165)	(0.163)
Youth variables	No	Yes	No	Yes	No	Yes	No	Yes
Hansen J statistic	–	–	0.469	0.435	–	–	0.776	0.768
Dep. var mean	0.372	0.372	0.372	0.372	0.118	0.118	0.118	0.118
Observations	1,015	1,015	1,015	1,015	1,015	1,015	1,015	1,015

Note: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.

***p<.01, **p<.05, *p<.10.

Table A12: Impact of Childlessness on Health Outcomes (Controlling for Missingness in Infertility)

Dependent variable	Poor Self-Reported Health				Mental Distress			
	OLS		2SLS		OLS		2SLS	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Childless	0.053	0.070*	0.579***	0.442**	0.069**	0.082***	0.516***	0.450***
	(0.042)	(0.042)	(0.221)	(0.208)	(0.031)	(0.031)	(0.172)	(0.161)
Youth variables	No	Yes	No	Yes	No	Yes	No	Yes
Overid p-val.	–	–	0.465	0.258	–	–	0.732	0.975
Dep. var mean	0.372	0.372	0.372	0.372	0.113	0.113	0.113	0.113
Observations	1,469	1,469	1,469	1,469	1,469	1,469	1,469	1,469

Notes: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. The 2SLS regressions additionally control for an indicator variable that takes a value of 1 if infertility information is missing for all the four measures (irrespective of marital status), and 0 otherwise. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses. ***p<.01, **p<.05, *p<.10.

Table A13: Heterogeneity by Gender

	Poor Self-Reported Health	Mental Distress
Childless * Female	-0.712	-0.109
	(0.596)	(0.372)
Female	0.245	0.085
	(0.209)	(0.132)
Childless	0.865**	0.527*
	(0.411)	(0.276)
KP LM statistic	16.181	16.181
KP Wald F statistic	4.385	4.385
Overid p-val	0.493	0.366
Dep. var mean	0.372	0.113
Observations	1,469	1,469

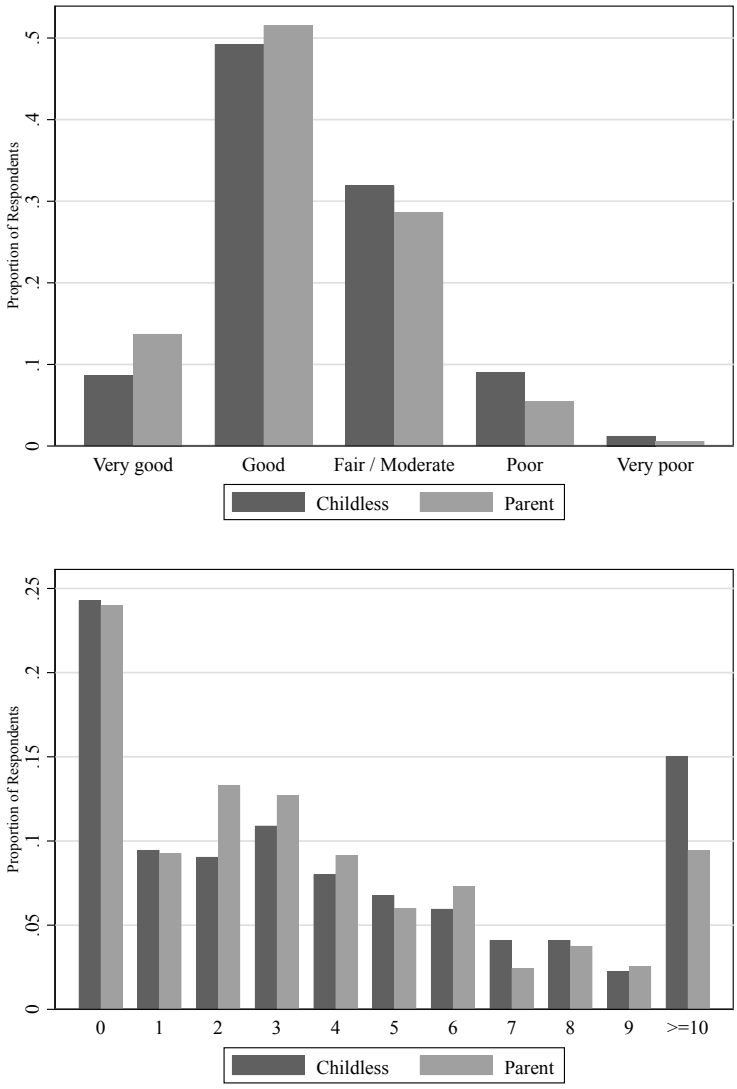
Note: 'Poor Self-Reported Health' takes unity if the individual reports self-reported health as fair/moderate, poor, or very poor, and 0 otherwise. 'Mental Distress' takes unity if the CES-D score of an individual is greater than or equal to 10, and 0 otherwise. The above specifications control for socio-demographic characteristics—gender, age, education level, marital status, type of residence, race, and number of siblings. 'Youth variables' include childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. *P*-values from Sargan-Hansen tests that the overidentifying restrictions valid are reported. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Table A14: Impact of Childlessness on Physical Health

	Any Disease	Any Chronic Disease	Any Non-Chronic Disease
Childless	0.033	0.031	0.002
	(0.040)	(0.040)	(0.027)
Observations	1,469	1,469	1,469
R-squared	0.067	0.065	0.058

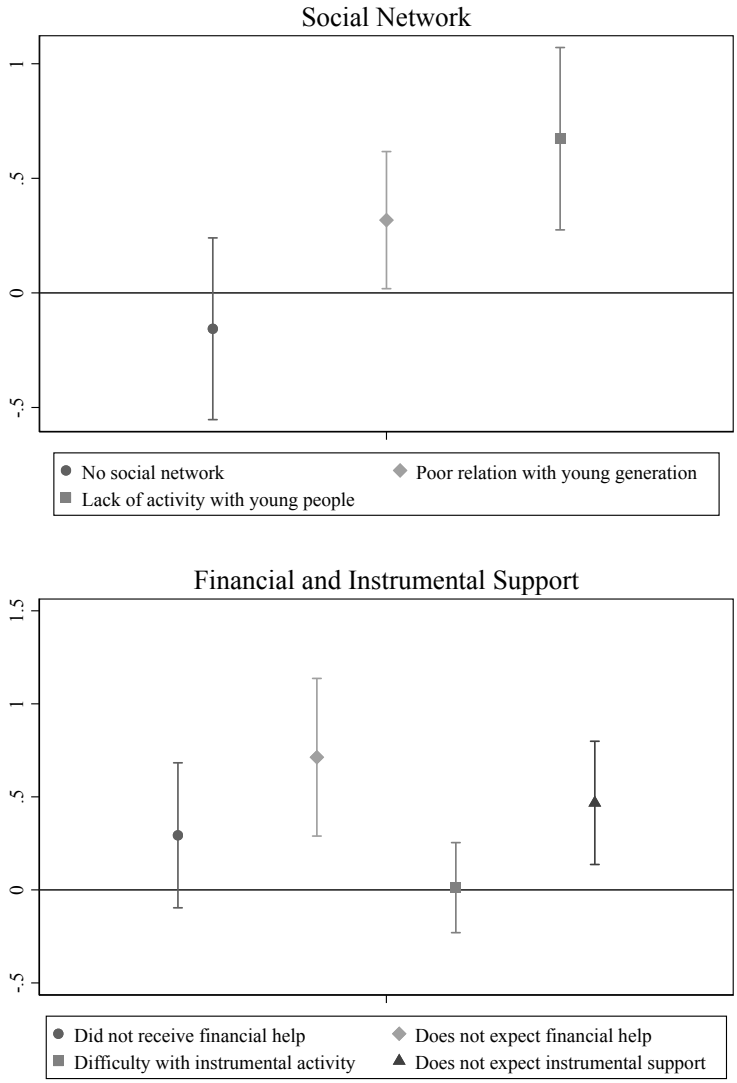
Note: 'Any Chronic Disease' takes unity if the individual had diabetes, high blood pressure, cholesterol, kidney failure, respiratory distress, alzheimer, arthritis, osteoporosis or cancer, and 0 otherwise. 'Any Non-Chronic Disease' takes a value if 1 the individual had ever experienced heart attack, heart failure, chest pain or stroke, and 0 otherwise. 'Any Disease' takes unity if the individual had experienced any chronic or non-chronic disease. The above specifications additionally control for socio-demographic characteristics—age, education level, marital status, type of residence, race, and number of siblings, childhood health status, childhood socioeconomic status, and whether the individual had a desire for children in youth. Robust standard errors in parentheses.
***p<.01, **p<.05, *p<.10.

Figure A1: Distribution of Self-Reported Health (top) and CES-D Score (bottom)



Note: The top panel shows the distribution of self-reported health. An individual is defined to have 'poor self-reported health' if he/she reported fair/moderate, poor or very poor health. The bottom panel shows the distribution of CES-D score. An individual is defined to be mentally distressed if the CES-D score is 10 or higher.

Figure A2: Intergenerational Support and Network



Note: Coefficients and 95% confidence intervals from 2SLS estimation of empirical model (3) for the following outcomes. 'No social network' takes unity if the individual did not feel at ease or keep in touch with any relative/friend. 'Poor relation with younger generation' takes unity if the individual had average, poor, or very poor relation with younger generation. 'Lack of activity with young people' takes unity if the individual never engaged in any activity with them, or engaged with them less than once a month. 'Did not receive financial help' takes unity if the individual did not get any financial assistance from anyone, including family, friends, charitable organizations, and government. 'Does not expect financial help' takes unity if the individual and his/her spouse does not expect to receive financial help from anyone if needed. 'Difficulty with instrumental activity' takes unity if the individual faced difficulty in performing any instrumental activity such as using telephone, walking to places of work, going for shopping, preparing meals, performing household chores, taking own medicine, and handling money. 'Does not expect instrumental support' takes unity if the individual does not expect to receive any financial support in the future.