

When It Rains It Pours: The Long-run Economic Impacts of Salt Iodization in the United States*

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Abstract

In 1924, The Morton Salt Company began nationwide distribution of iodine-fortified salt. Access to iodine, a key determinant of cognitive ability, rose sharply. We compare outcomes for cohorts exposed *in utero* to iodized salt with those of slightly older, unexposed cohorts, across states with high versus low iodine deficiency rates prior to salt fortification. Incomes for cohorts who benefited from iodized salt access went up by 11%; labor force participation rose by roughly .75 percentage points; and the probability of working more than 50 weeks in a year went up by over 1 percentage point. These impacts were driven entirely by females. We find large impacts on economic outcomes early in women's adult lives and muted effects later in life. Women married at later ages and experienced a small increase in educational attainment.

Keywords: fetal origins, iodine, cognitive ability, female labor force participation

JEL Codes: I12, I15, I18, J24, N32

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1 Introduction

Inadequate access to essential micronutrients such as iron, vitamin A, iodine, and zinc has staggering costs in terms of mortality, poor health, and lost productivity in low-income countries (Black et al., 2013). The benefits of improving micronutrient availability in the short term, especially for young children, are clear (Bhutta et al., 2013). But less is known about long-run impacts, particularly of large-scale supplementation policies. How long do the effects of improved access to vital micronutrients last? Do health effects spill over onto socioeconomic outcomes? Which individuals are most affected by blanket campaigns? With notable recent exceptions (Clay et al., 2015; Feyrer et al., forthcoming; Niemesh, 2015; Politi, 2014, 2015), these questions have received scarce attention, and are the focus of the present study.

We draw lessons from the historical experience of the United States, where, until the mid-1920's, natural access to iodine was limited in some areas of the country compared to others. An essential micronutrient, iodine regulates thyroid hormone availability, which determines the density of fetal neural networks (Lamberg, 1991). Physiological studies suggest that iodine deficiency negatively affects cognitive function at all ages, but is particularly detrimental during gestation, when even mild deficiency can greatly hamper cognitive development (Cao et al., 1994). Moreover, the effects of fetal iodine deficiency disorder (IDD) are irreversible: an inadequate supply of iodine in the first trimester of gestation permanently reduces intelligence quotients (IQ), regardless of subsequent supplementation (Hetzl & Mano, 1989; Pharoah & Connolly, 1987; Zimmermann, 2009).¹

We study the economic impacts of rapid, large-scale salt iodization in the twentieth century US. The Morton Salt Company, the largest salt producer in the US, initiated nationwide iodized salt distribution shortly after the invention of iodine-fortified salt in the mid 1920s. In less than half a decade, the US went from zero to nearly universal availability of iodized salt (Markel, 1987). Iodine deficiency rates plummeted in the following decade, most markedly in areas that were highly iodine deficient prior to the introduction of iodized salt (Brush & Atland, 1952; Hamwi et al., 1952; Schiel & Wepfer, 1976). Feyrer et al. (forthcoming) show that IQ rose substantially – by around 15 points – as a result. Building on this important work, we ask: what happened to the economic outcomes of those whose *in utero* access to iodine improved? Did increased IQ affect incomes, as was true in Switzerland (Politi, 2015),

¹It bears mention that studies from the medical literature are either correlational or based on animal studies: causal evidence on the effects of iodine exposure in humans is limited. The study by Feyrer et al. (forthcoming) is important in this sense, because it provides the most rigorous evidence to date of the impact of fetal iodine access on adult cognitive performance.

and labor supply? Did men and women benefit differentially? How did these impacts evolve over the life cycle? Did related outcomes like educational attainment and marriage respond?

To identify these effects, we compare outcomes for cohorts born just before iodization (1920-1923) to those born during (1924-1927) and after (1928-1931), across areas with varying pre-iodization deficiency rates. For the latter source of variation, we use pre-iodization rates of goiter, the main physical manifestation of IDD (Love & Davenport, 1920; Olesen, 1929). We follow these cohorts through their productive lives, using data from the 1950-1980 censuses, during which these individuals were 19 to 60 years old. We present estimates of early career outcomes, pooling the 1950 and 1960 censuses, and later career outcomes, using the 1970 and 1980 censuses.

Individuals affected by salt iodization saw improved economic outcomes. Income increased by 11% on average, and labor force participation rose by about 0.75 percentage points in the pooled sample of individuals aged 19-60 in the 1950-1980 censuses. Women experienced the largest changes in employment (greater than 1 percentage point) and income (16 percent); indeed, nearly *all* of the pooled effect on these outcomes comes from women. This is consistent with medical evidence that female fetuses are more sensitive to maternal thyroid deficiency than male fetuses (Field et al., 2009; Friedhoff et al., 2000), and also likely reflects the larger scope for improvement among females who exhibit lower employment rates and incomes at baseline.

These estimates mask much larger employment and income effects on females early in their careers (before age 40). We do not see strong evidence that employment effects persist in later census years: individuals affected by salt iodization are not significantly more likely to be in the labor force in the 1970 and 1980 censuses. Impacts on female incomes do persist at later ages, but are smaller and less precisely estimated. This pattern is consistent with impacted women transitioning out of the labor force at later ages to raise families, as has been documented previously, in particular the “career then family” cohorts discussed in Goldin et al. (1997); Goldin & Katz (2002). Supporting this idea, we find that impacted women married at later ages (nearly a quarter of a year) and stay in school for slightly longer.

Like Politi (2014), which focuses on Switzerland’s historical experience with salt iodization, we find a small but precisely estimated positive effect on educational attainment. Theoretical effects of increased cognition on schooling are ambiguous, as the direct wage returns to ability in entry-level labor opportunities may counteract any impacts of ability on schooling returns at early ages. Because the magnitude of our estimated effect is very small (equivalent to about two weeks of school), we

interpret this result as evidence that both of these opposing effects are in play.²

Our study aims to contribute to three literatures. First, we add to the literature on the long-term effects of early life conditions.³ Much of this “fetal origins” work has focused on demonstrating the impacts of traumatic experiences (disease, natural disasters, environmental factors, etc.) in early life. Fewer studies have estimated the gains to exposure to the purposeful large-scale distribution of resources. The distinction between the two types of studies is important because the latter “shock” can yield actionable information: policies with demonstrated positive impacts can be advocated for and reproduced. A growing set of studies—including Hoynes et al. (2012), Bleakley (2007), Bleakley (2010), Field et al. (2009), Almond et al. (2010), Politi (2014), Bhalotra & Venkataramani (2012), and Feyrer et al. (forthcoming)—have recently made strides in this direction. We build on this evidence base: the results of these studies and ours offer lessons from historical policy experiments from which present-day policymakers, particularly in developing countries, might profitably draw.

Second, we contribute to the understanding of women’s decisions regarding the labor force in the historical United States. We find that labor market effects of iodine are particularly pronounced for women, consistent with evidence from recent studies on the effects of other early life interventions (Bleakley, 2007; Field et al., 2009; Hoynes et al., 2012; Maccini & Yang, 2009). Moreover, this pattern relates to important previous work on the drivers of the marked rise in labor force participation of women over the 20th century. Goldin (1991) and Goldin & Olivetti (2013) estimate that WWII led to a roughly 20 percent rise in female participation for higher-educated women in cohorts born between 1915 and 1924. Bailey (2006) and Goldin & Katz (2002) show that increased access to oral contraceptives led to later marriage, higher likelihood of professional and graduate training in high skill occupations, and increased rate and duration of labor force participation among cohorts born after 1940. We present complementary evidence documenting that salt iodization also contributed to the rise in female labor force participation, generating a 3 percent increase among females born in between the two sets of cohorts studied in these papers.

Finally, we add evidence on the long-run effects of micronutrient fortification campaigns, and in particular mass salt iodization as a means of eradicating iodine deficiency. Nearly 2 billion people worldwide—a third of the world’s population—do not have adequate access to iodine (Andersson et al., 2010; de Benoist et al., 2004). Recent estimates from the economics literature suggest that the incidence

²This is consistent with Bleakley (2010), who finds mixed results on the effect of malaria eradication on schooling in four different countries.

³See Heckman (2006), Almond & Currie (2011), and Currie & Vogl (2012) for useful syntheses.

of iodine deficiency, and thus the returns to reducing IDD, may be very large (Feyrer et al., forthcoming; Field et al., 2009; Politi, 2014). Policymakers in IDD-endemic countries, as well as the WHO, UNICEF, and other international organizations, have made increasing access to iodine a high priority (WHO, 1992). Mass salt iodization to prevent IDD is, far and away, the preferred policy: iodizing salt is much cheaper than continuous supplementation in populations with iodine-deficient diets, and, taken with other micronutrients such as iron, is highly cost-effective in terms of fetal and infant deaths averted (Center, 2008).

The rest of the paper is organized as follows. Section 2 discusses iodine deficiency and its prevalence in the early twentieth century, as well as the history of salt iodization in the US. Section 3 discusses our data sources, section 4 our empirical strategy, and section 5 the results. Section 6 concludes with a discussion of the size of the economic benefits of iodization.

2 Background

2.1 Iodine Deficiency and its Consequences

Iodine is crucial to the functioning of every body cell.⁴ The thyroid gland in the lower part of the neck uses iodine from foods to produce thyroid hormones, which are released into the blood stream to control metabolism (the conversion of oxygen and calories to energy). Optimal iodine intake as recommended by the WHO is very small: a daily dose of 90 μg for infants of 0-59 months, 120 μg for ages 6 to 12, 150 μg for older ages (which is the amount found in half a teaspoon of iodized salt), and 200 μg for pregnant and lactating women (Clar et al., 2002). Foods with high iodine content include some milks, leafy vegetables, and seafood, but individuals in areas without natural access to iodine – far from the ocean or in mountain regions susceptible to erosion (Hetzl, 1989) – are at risk of not meeting these recommended levels of iodine intake.

At any point from the fetal stage to adulthood, insufficient iodine intake can cause a number of functional and developmental abnormalities, often referred to as iodine deficiency disorders (IDD). The main physical manifestation of IDD is goiter (the enlargement of the thyroid gland),⁵ but other IDDs include hypothyroidism (which results in fatigue, lethargy, slow speech and thought), impaired mental function, retarded physical development, and increased susceptibility of the thyroid gland to

⁴<http://www.endocrineweb.com/thyfunction.html>

⁵Goiter may not be visible if iodine deficiency is minimal. On the other hand, iodine deficiency is the primary, but not exclusive, cause of goiter. Goiter, when sufficiently large, may cause complications such as respiratory difficulty.

Figure 1: Simple Goiter Incidence Among US Drafted Men in World War I and Iodine Content of Drinking Water in the US



Simple goiter among drafted men in the US in WW I

Black areas: High goiter incidence, i.e. 6 and more goiter cases per 1,000 drafted men
 White areas: Low goiter incidence, i.e. 5 and less goiter cases per 1,000 drafted men

Source: McClendon (1939)



Iodine content in drinking water in the US

Black areas: Iodine-poor, i.e. 22 and less parts of iodine per hundred billion parts of water
 White areas: Iodine-rich, i.e. 23 and more parts of iodine per hundred billions parts of water

Source: McClendon and Hathaway (1924)

nuclear radiation (WHO, 2004). This paper focuses on the availability of iodine *in utero* because fetal iodine levels are particularly crucial for brain development: insufficient iodine intake during gestation can cause irreversible cognitive damage (De Escobar et al., 2004; Zimmermann, 2009).

2.2 The Geography of Iodine Deficiency in the US

The map on the left in Figure 1 illustrates the geographic distribution of goiter incidence across the US based on data from the 1917 WWI draft examinations, which is, to our knowledge, the first nationwide goiter survey in the US. The second map in Figure 1, which highlights areas with low iodine content in drinking water, as reported by then prominent scientist Jesse Francis McClendon, shows a similar “goiter belt” in the northern states.⁶ Starting in 1924, Robert Olesen, a surgeon at the U.S. Public Health Service, began collecting data on goiter rates across the country by consulting independent thyroid surveys and directly communicating with state, county and city health officers. Olesen (1929) concluded that his data from elementary school to college aged samples were consistent with the geographic variation in goiter incidence among WWI recruits in areas where he was able to collect data.

⁶In our estimations, we do not use the water iodine content data, as the author presents numerical information for only 27 states, many of which use data from only one location.

Evidence from these other sources suggest that the draft statistics offer a good representation of the geographic pattern of iodine availability for the general population. Summarized in Table A1, these draft statistics show considerable variation in goiter prevalence across states even within regions defined by the nine Census divisions. This variation is crucial as it allows us to control for region-level time effects to remove any systematic coincidence between the goiter distribution and geographic differences in economic development over time, such as the North-South divide.

2.3 Introduction of Iodized Salt in the US in 1924

The hypothesis that iodine can help prevent goiter has existed since the mid-1800's (Zimmermann, 2008). It was not until 1895, however, that iodine was first discovered in the thyroid gland (Baumann, 1896). After this, experiments were conducted to study the impact of changes in iodine content on the incidence of goiter in different kinds of animals (Marine & Feiss, 1915; Marine & Lenhart, 1909; Smith, 1917). In the United States, Hall (1914) and Olesen (1915) were the first to record goiter rates in humans in an organized manner. An experiment started in 1917 by scientist David Marine and colleagues, which involved providing iodated syrup to school girls in Ohio, offered the first direct evidence that iodine supplementation could control and prevent goiter in humans (Marine & Kimball, 1917, 1920). This evidence inspired Switzerland to set up prophylactic programs, one of which used salt as an iodization vehicle.

Around the same time as the Ohio experiment, a few other factors placed focus on goiter in humans as a health problem in America (Annegers & Mickelsen, 1973). These included (a) the decline of other childhood diseases, which allowed more attention to shift to goiter, (b) McClendon's discovery of the relationship between goiter and the iodine content of drinking water, (c) the WWI draft examinations, which revealed the nationwide extent of goiter prevalence, and (d) a large incidence of goiter in Michigan (Levin, 1919).

According to Levin (1919), roughly 24 percent of army recruits from Houghton County, Michigan had simple goiter and 2.4 percent of the men were disqualified for the army based on the size or cystic type of goiter.⁷ Dr. David Cowie, of the University of Michigan, became interested in eliminating widespread simple goiter in his home state. Cowie organized a symposium of the Michigan State Medical Society in June 1922, which created the Iodized Salt Committee to explore the feasibility of

⁷"If these men were considered unacceptable to the US Army because of decreased mentation, inability to complete average mental or physical labor, dyspnea, cardiac, and metabolic abnormalities seen in patients with severe colloid goiter, how useful were they considered in daily functions and work productivity in civilian life?" (Markel, 1987, pg 221)

adding iodine to salt in Michigan. The committee initially entertained the idea of proposing a law prohibiting non-iodine fortified salt (Markel, 1987), but they were swayed to allow the profit motives of salt manufacturers to lead them to distribute a product endorsed by medical experts. Introducing iodine to salt was relatively costless as it could be added at the same time as magnesium, which is included to regulate salt flow from the container (Markel, 1987).

Cowie worked with several small salt manufacturers based in Michigan, who were eager to supply a product that they perceived would have a large demand with little extra cost to produce. The Executive Council of the Michigan State Medical Society officially endorsed salt on March 12, 1924 and iodized salt appeared in Michigan groceries on May 1, 1924. The product proved so popular that Morton Salt Company, who initially resisted because of concerns about the high cost of separating a different version of salt for Michigan retailers, began nationwide distribution a few months later. With educational efforts of the Michigan State Medical Society, which gave lectures on the medical benefits of iodized salt, and zealous advertisements by salt producers,⁸ iodized salt rapidly grew popular. By 1930, iodized salt sales were eight times plain salt sales (Markel, 1987).

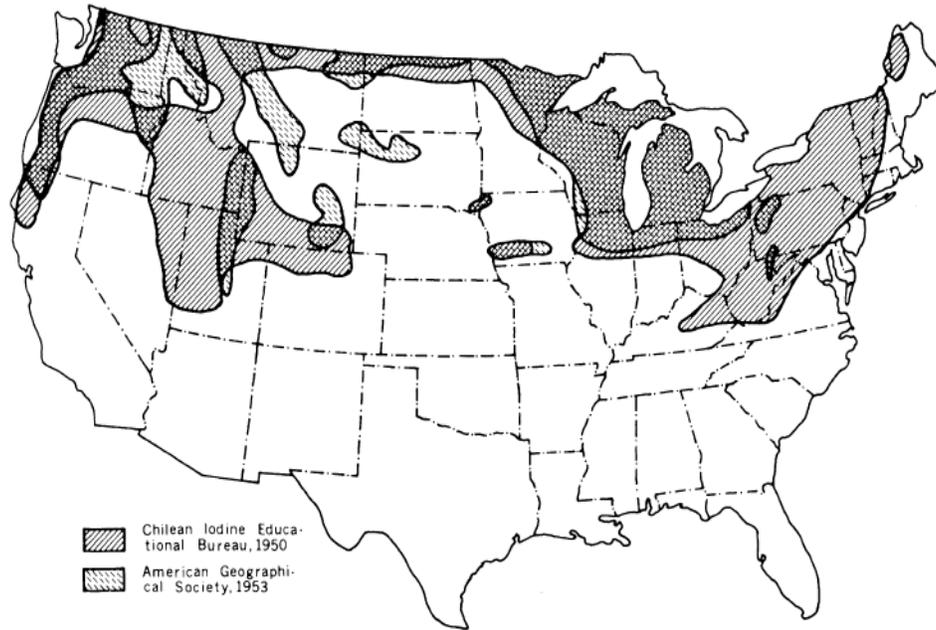
Many later surveys found marked decreases in thyroid enlargement, especially among continuous users of iodized salts. Interestingly, Schiel & Wepfer (1976) found that, among Michigan school children in 1924-51, there was a decline in goiter rates among non-users. Cowie attributed this to ingestion of iodized salt without realizing it, such as in school canteens and restaurants, which seems plausible given that iodized salt made up 90% of salt sales in Michigan at the time (Markel, 1987). This observation alleviates concerns about self-selection into using iodized salt and supports the approximate universality of the intervention. Figure 2 shows U.S. goiter survey results compiled by the Chilean Iodine Educational Bureau in 1950 and the American Geographical Society in 1953. While it is unclear what definition of endemic goiter was used for these maps, prevalence decreased considerably between the WWI draft era (Figure 1) and 1950, and the diminishing trend continued to 1953.

2.4 Goiter and Confounding Factors

Marine's 1917-19 experiment was the first to inform the US public that iodine supplementation could prevent and treat goiter; hence there is little reason to suspect a *direct* role of iodine in residential selection or selection into iodine-rich diets. Supporting this claim, Figure 1 shows that goiter incidence

⁸Advertisements would often contain phrases such as "Remember, too, that Morton's Iodized Salt protects children against simple goiter - that often unnoticed nutritional disease which is frequently accompanied by underdevelopment, irritability and backwardsness at school." (Women's Home Companion, June 1934)

Figure 2: U.S. goiter distribution in the early 1950s



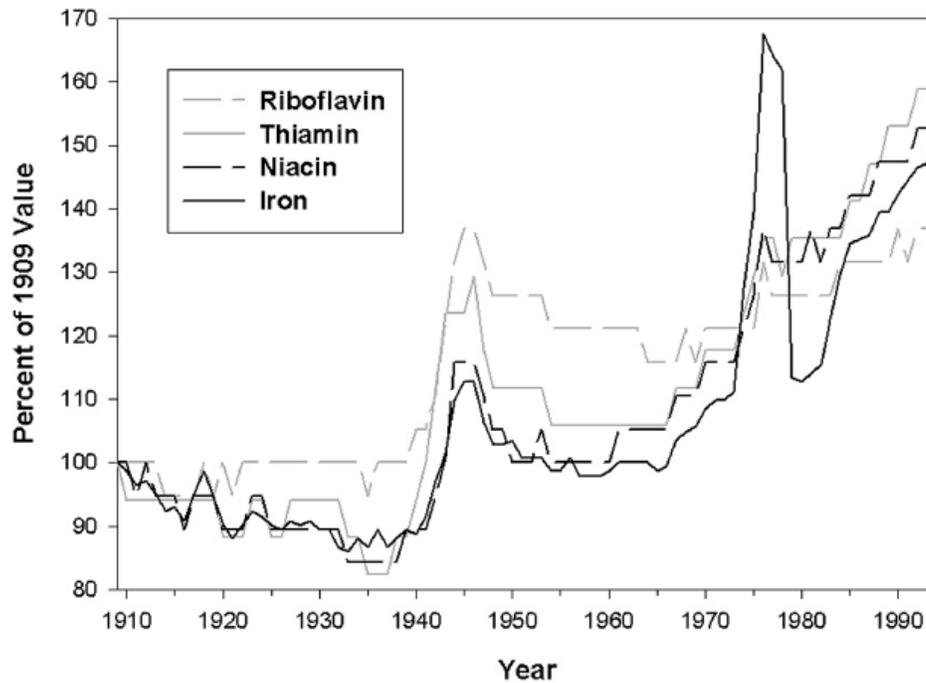
Source: Schiel and Wepfer (1976)

was concentrated in the northern states, which were socioeconomically better off compared to the southern states.

However, one might worry that there may have been other important changes in the US diet, concurrent with the roll out of iodized salt. In fact, food fortification in the US began with salt iodization in 1924, with discoveries of the role of vitamin and mineral deficiencies in many diseases and sicknesses (Backstrand, 2002). However, the knowledge remained mostly in the laboratory until May 1941, when President Roosevelt called a National Nutrition Conference for Defense. Figure 3 shows the change in the per capita riboflavin, iron, niacin, and thiamin contents of American food between 1909 and 1994, which does not coincide with the timing of salt iodization.

Similarly, one might still suspect that high goiter areas prior to iodization were also more likely to have high incidence of other nutrient deficiencies or health issues such as malaria or tuberculosis. In order to address concerns about the contemporaneous eradication of these infectious diseases, we check the robustness of our main results to controlling for baseline geographic variation in the prevalence of malaria and tuberculosis, interacted with a post-iodization dummy. The robustness of our results alleviates concerns about the geographic pattern of goiter incidence, and hence the pattern of expected benefits from iodized salt, coinciding with the geographic pattern of other health-related

Figure 3: Change in the per capita riboflavin, iron, niacin, and thiamin content of the U.S. food supply between 1909 and 1994



Source: Backstrand (2002)

improvements.

3 Data

3.1 Goiter Data

Our information on the geographic distribution of goiter before 1924 comes from the data used to create the first map in Figure 1: medical examinations of over two and a half million drafted men aged 18 to 30 before World War I. Conducted on a large sample of men from all over the United States within a short period of time between 1917 and 1918, these examinations offer a snapshot of the geographic distribution of various mental and physical defects prior to the iodization of salt.⁹ Love & Davenport (1920) documents prevalence rates in this sample for over 200 medical conditions, including goiter.

⁹Because this paper focuses on *in utero* exposure to iodine, the ideal dataset would consist of goiter rates from a representative sample of women of childbearing age, instead of men. In the data collected by Olesen (1929), there is a high correlation (0.87) between goiter rates among school-aged girls and boys, which suggests that the distribution of female goiter rates across states should be similar to what is captured by the goiter rates in Love & Davenport (1920), calculated from men of the relevant age range. We do not use the Olesen (1929) goiter rates as our measure of iodine availability because the samples are not representative of each state and numerical rates are only available for 37 states.

In this paper, we use state-level prevalence rates, although rates for smaller regions (collections of counties known as sections) were recorded as well.¹⁰ Table A1 reports for each state the goiter rate recorded in Love & Davenport (1920). The median goiter rate is .214% and the maximum is 2.69%.

3.2 Census Data

We also use data from the United States Decennial Census (Ruggles et al., 2015), restricting to individuals born in the twelve-year period spanning 1920 to 1931, which includes the years before, during, and after the nationwide spread of iodized salt. We are interested in labor, education, and marriage outcomes for this cohort in the 1950 to 1980 censuses, during which they were working-aged adults aged 19 to 60.

Individuals are assigned to the goiter rate in their state of birth, which proxies for their risk of being born to an iodine deficient mother. Individuals are also grouped according to their birth year. Those born in the years 1920 to 1923 are marked as “pre-iodization,” those born from 1924 to 1927 are classified as born “during iodization,” and those born from 1928 to 1931 are considered “post-iodization.” Iodized salt first appeared in grocery stores in 1924 and was reported to have generated eight times more sales than regular salt by 1930 (Markel, 1987). In creating the “during” category, we allow four years of leeway following the initial introduction of iodized salt to ensure that the after cohort was exposed to an environment with sufficiently widespread iodized salt availability.

3.2.1 Outcome and Control Variables

We are primarily interested in labor market outcomes. To represent employment, we use two variables: a dummy for labor force participation (which includes job-seekers as participants) and a dummy for employment (which is set to zero for job-seekers). Individuals who report working in the last year also report the number of weeks they worked (in intervals). We create an indicator variable to represent the largest category – individuals who worked at least 50 weeks – to study the intensive margin of labor supply. We also look at total income, which includes income from all sources, including wages and self-employment income. We transform total income using the inverse hyperbolic sine function.¹¹ In addition to these labor market outcomes, we also study years of educational attainment, marital status,

¹⁰Unfortunately, we cannot use the section-level goiter data because we only have state of birth, not county of birth, for the individuals in our sample.

¹¹ $\sinh^{-1}(\widehat{\text{Income}}) = \ln(\widehat{\text{Income}} + (\widehat{\text{Income}}^2 + 1)^{1/2})$. The income variable is therefore not conditional on working, and includes zeros for those who do not work.

Table 1: Summary Statistics

	(1)	(2)	(3)
	Whole Sample	Females	Males
1(Employed)	0.642 (0.480)	0.426 (0.495)	0.870 (0.336)
1(Participated in Labor Force)	0.668 (0.471)	0.446 (0.497)	0.904 (0.295)
1(Worked at least 50 weeks)	0.656 (0.475)	0.517 (0.500)	0.738 (0.440)
Total Income	19425.2 (20240.9)	8663.6 (12500.9)	30967.3 (20593.0)
1(Ever Married)	0.864 (0.342)	0.895 (0.306)	0.831 (0.375)
Age at First Marriage	22.45 (4.944)	21.20 (4.649)	23.81 (4.897)
Years of Schooling	11.11 (3.139)	11.09 (2.865)	11.13 (3.408)
Number of Observations	2289711	1188488	1101223

Notes: Sample includes all individuals born 1920 to 1931 in the 1950 to 1980 censuses. Statistics are calculated using person-level weights provided by the census. Total income in 1999 dollars.

and age of first marriage.

Additional variables taken from the Census include gender and race. In addition to including female and black indicator variables as controls, we also control for pre-iodization demographic conditions in the individual's state of birth. This is done by calculating the black and female proportions from the 1920 Census in the individual's state of birth. For more details on the construction of variables, see the Data Appendix.

3.2.2 Summary Statistics

Table 1 reports summary statistics for our sample population (individuals born between 1920 and 1931) using the 1950 to 1980 censuses. The first column summarizes our outcome variables for the entire sample, the second restricts to females, and the third focuses on males. Women have much lower labor force participation, labor supply, and income than men. Marriage rates, age at first marriage, and years of schooling are more similar across both genders, although women are more likely to be married and

get married slightly earlier.

3.3 Geographic Controls

Because of the clear regional patterns in the distribution of goiter, an important part of our strategy involves allowing for differential birth cohort trends by region. We use the nine Census Bureau divisions, listed in Table A1, to categorize states into regions. Another way we control for regional patterns is by using the average latitude of each individual's state of birth.¹²

3.4 Robustness Check Controls

In our robustness checks, we control for the pre-iodization rates of two other diseases: malaria and tuberculosis. We take tuberculosis rates from the Love & Davenport (1920) data, which also recorded rates of various other "defects" found in recruits. For malaria, we use the malaria mortality rates from the 1890 Census, used in Bleakley (2010).

In order to allow for differential trends across states that may have been affected differently by the Great Depression, we use state-level unemployment rates calculated from the 1930 census.

We also include years of compulsory schooling as an additional control. We obtained this variable from state-level data used in Lleras-Muney (2002), compiled from multiple sources. This data reports the number of years of required schooling (either by compulsory attendance laws or implied by child labor laws) in each state in each year from 1915 to 1939. Using the same strategy as Lleras-Muney (2002), we match each individual to the law in place in their state of birth in the year they turned 14 (the minimum leaving age across all states and years), as this is arguably the most relevant to their schooling continuation choices.

Finally, we also use WWII state mobilization rates, obtained from Acemoglu et al. (2004). If WWII mobilization had any impact on these individuals, it must have affected them during their young adult or adult life: we therefore use mobilization rates in the individual's state of residence rather than their state of birth.

¹²These numbers were obtained from the online database, MaxMind: http://dev.maxmind.com/geoip/legacy/codes/state_latlon/

4 Empirical Strategy

4.1 Overview of strategy

As described in section 2, once Morton Salt Co.'s decision to iodize its supply was made, the spread of iodized salt was wide scale and fairly rapid. Since iodization happened nationwide, however, there was no true exclusion from exposure. In the spirit of Bleakley (2010), Hornbeck (2012), and others, our basic strategy is to compare trends in economic outcomes in states with different levels of pre-iodization iodine deficiency rates. Feyrer et al. (forthcoming) use a similar strategy to identify the impacts of iodization on recruits' placement into the Army v. the Air Force.

We use the spatial distribution of goiter in 1924 in the continental US to identify differences in pre-iodization deficiency rates. As described in section 3, we use data from the Love & Davenport (1920) survey of military recruits. We link each individual in the census to a goiter rate using their state of birth. We use state of birth to draw focus to the effects of *in utero* exposure to iodine rather than exposure through one's life.

We interpret the goiter value as a proxy for the extent of iodine deficiency in one's state of birth during early life. This proxy will, of course, not fully reflect actual iodine exposure. Nevertheless, as shown in the previous sections, as well as in Feyrer et al. (forthcoming), the spatial distribution of goiter generally mirrors the distribution of iodine content in water sources. While admittedly an imperfect proxy, the distribution allows a rough ordering of individuals according to their exposure to iodine *in utero*.

We study the outcomes of three cohorts: those born before (1920-1923), during (1924-1927), and after (1928-1931) salt iodization. We consider the middle ("during") group because, while the proliferation of iodized salt across the US was rapid, we do not have data on the geographic pattern of this nationwide spread. During the proliferation period, it would be possible to find muted effects simply because iodized salt had not yet reached some markets. To allow for this, we separate the "during" and "after" iodization periods. We interpret differences in trends in economic outcomes coincident with the proliferation of iodized salt across individuals born in states with varying pre-iodization levels of goiter as causally related to salt iodization. Because all three cohorts were eventually exposed to iodized salt by late childhood and for the remainder of their lives, we are identifying the impact of differential exposure to iodine specifically *in utero*, which is our primary interest because of the irreversible nature of the cognitive damage that can be caused by lack of iodine during the fetal period.

Our estimates are therefore somewhat conservative because they do not consider the potential benefits of increased iodine availability later in life, which all of our cohorts (including our control cohort) may have experienced.

4.2 Specification

The basic difference in differences strategy, then, is to compare the outcomes of cohorts born before to those born during and after iodization, across individuals born in states of varying levels of iodine deficiency. We estimate the following specification, for individual i born in year t in state s (census division d), for outcome y recorded in census year c , where G is the continuous goiter rate, D is a dummy for belonging to the “during” cohort, and A is a dummy for belonging to the “after” cohort:

$$y_{ist} = \beta_1 G_s A_t + \beta_2 G_s D_t + \mu_s + (\zeta_d \times \delta_t) + (\lambda_c \times \delta_t) + \eta X_{ist} + \varepsilon_{ist}. \quad (1)$$

Here, β_1 and β_2 are the main coefficients of interest, measuring the difference in birth cohort trends in outcome y across individuals exposed to different levels of iodine deficiency. The specification includes state of birth (μ_s) and year of birth fixed effects (δ_t , which are interacted with census waves as well as census divisions), which absorb the main effects of G_s , D_t , and A_t . The census division of birth by birth year interactions ($\zeta_d \times \delta_t$) are crucial because they control for any regional trends over time that may coincide with the national goiter distribution. By including division-by-birth-year fixed effects, we ensure that we are comparing outcome variable trends (by birth cohort) across high and low goiter states of birth in their deviations from each Census division’s mean non-linear trend. ($\lambda_c \times \delta_t$) are census wave by birth year interactions, included to account for differential trends in the outcome variables as the cohorts age. Included in X are individual controls for race and gender, as well as controls for the proportion of the population that is female and that is black (measured in 1920) in the individual’s state of birth, interacted with the during and after dummies. Finally, we also include average latitude interacted with during and after dummies in order to alleviate concerns about differential trends for Northern and Southern states confounding our estimates. Standard errors are clustered at the state of residence level to allow for arbitrary correlation of the errors for individuals residing in the same state.

We conduct this analysis on all individuals born between 1920 and 1931, using the 1950 to 1980 censuses. We then look at men and women separately. In order to trace out the effects of salt iodiza-

tion on labor market outcomes as our cohorts age, we also run these by-gender regressions separately for the 1950-1960 censuses (when our sample was aged 19 to 40) and the 1970-1980 censuses (when they were aged 39 to 60). We test the robustness of our results to the inclusion of controls for contemporaneous disease eradication programs (related to tuberculosis and malaria), unemployment rates in 1930, compulsory schooling laws, and WWII mobilization rates in an individual’s state of residence.

In order to rule out the existence of differential pre-trends across high and low goiter states (which would indicate a potential violation of our difference-in-difference assumptions), we expand our sample to include individuals born in 1916-1919 and run the following regression:

$$y_{ist} = \beta_1 G_s A_t + \beta_2 G_s D_t + \beta_3 G_s P_t + \mu_s + (\zeta_d \times \delta_t) + (\lambda_c \times \delta_t) + \eta X_{ist} + \varepsilon_{ist}. \quad (2)$$

Here, P_t represents an indicator variable for those born in the “pre-trend” period (1916-1919). If there were no differential cohort trends across the goiter distribution prior to the introduction of iodized salt, we should be unable to reject the null that β_3 is equal to zero.

5 Results

5.1 Labor Supply and Income

In all of the regressions discussed in this section, our coefficients of interest are the after-by-goiter rate interaction and the during-by-goiter rate interaction: these represent the effect of salt iodization on our outcomes of interest. Although the following tables only report these two coefficients, all specifications also include state of birth fixed effects, year of birth by census wave interactions, census division of birth by birth year interactions, a female dummy, a black dummy, and after and during dummies interacted with average state latitude and 1920 state-level female and black proportions. We multiply each relevant coefficient by the inter-quartile range of the goiter distribution (0.709) to obtain a value that can be interpreted as the effect of moving from a relatively low goiter state (at the 25th percentile) to a high goiter state (at the 75th percentile) when discussing the results.

Table 2 reports the full-sample regression results for our labor outcomes of interest. The effects of salt iodization on the probability of being employed (column 1) and labor force participation (column 2) are both positive and significant, with effect sizes of just under 0.8 percentage points. We also find

Table 2: Effects of Salt Iodization on Labor and Income Outcomes

	(1)	(2)	(3)	(4)
	1(Employed)	1(Participated in the Labor Force)	1(Worked at least 50 weeks)	$\sinh^{-1}(\text{Income})$
After x Goiter Rate	0.00762*** (0.00242)	0.00747*** (0.00250)	0.0115** (0.00534)	0.111*** (0.0343)
During x Goiter Rate	0.00389 (0.00326)	0.00362 (0.00289)	0.00981** (0.00463)	0.0307 (0.0293)
Observations	2289711	2289711	1466682	2042232
Mean of Dep. Var.	0.642	0.668	0.656	7.883

Notes: Standard errors, clustered by state of residence, in parentheses (** p<0.01, * p<0.05, * p<0.1). Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). After is a dummy equal to 1 for those born 1928-1931. During is a dummy equal to 1 for those born 1924-1927. These regressions use the 1950 to 1980 censuses, restricting to individuals born in 1920-1931. All regressions include state of birth fixed effects, year of birth x census year dummies, census division of birth x birth year dummies, gender, race, and During and After dummies interacted with average state latitude and 1920 state-level female and black proportions. $\sinh^{-1}(\text{Income})$ takes the inverse hyperbolic sine of total income, including zeros for those not working.

that salt iodization increased the likelihood of working a full year, conditional on having worked in the last year, by about 1 percentage point. In addition, we find an 11% increase in total income.

Our interpretation of these coefficients relies on attributing the change in trends after 1924 to the introduction of iodized salt. If high and low goiter states were trending differently before 1924, however, this would suggest that the difference in trends after 1924 may not be due to salt iodization. In order to test for the existence of differential pre-trends, we run the regression specified in equation 2, including cohorts born in an even earlier period: 1916 to 1919. Results are reported in Table 3, where the pre-trend-by-goiter coefficient estimates the difference across the goiter distribution in cohort trends prior to the introduction of iodized salt. Across all specifications, these pre-trend coefficients are smaller in magnitude than both the during and after coefficients, and not significantly different from zero. This alleviates concerns that states were experiencing different cohort trends – before 1924 – systematically correlated with the goiter distribution. Moreover, the after-by-goiter coefficient estimates are almost identical to those in the previous table.

Table 3: Pre-Trends in Labor and Income Outcomes

	(1)	(2)	(3)	(4)
	1(Employed)	1(Participated in the Labor Force)	1(Worked at least 50 weeks)	\sinh^{-1} (Income)
After x Goiter Rate	0.00763*** (0.00243)	0.00747*** (0.00250)	0.0114** (0.00532)	0.113*** (0.0343)
During x Goiter Rate	0.00390 (0.00327)	0.00361 (0.00290)	0.00980** (0.00462)	0.0315 (0.0294)
Pre-Trend x Goiter Rate	-0.00254 (0.00286)	-0.00214 (0.00265)	-0.00572 (0.00390)	0.0198 (0.0339)
Observations	2991888	2991888	1848404	2661783
Mean of Dep. Var.	0.633	0.658	0.659	7.912

Notes: Standard errors, clustered by state of residence, in parentheses (** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$). Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). Pre-Trend is a dummy equal to 1 for those born 1916-1919. After is a dummy equal to 1 for those born 1928-1931. During is a dummy equal to 1 for those born 1924-1927. These regressions use the 1950 to 1980 censuses, restricting to individuals born in 1916-1931. All regressions include state of birth fixed effects, year of birth x census year dummies, census division of birth x birth year dummies, gender, race, and Pre-Trend, During, and After dummies interacted with average state latitude and 1920 state-level female and black proportions. \sinh^{-1} (Income) takes the inverse hyperbolic sine of total income, including zeros for those not working.

Table 4: Effects of Salt Iodization on Labor and Income Outcomes, By Gender

	(1)	(2)	(3)	(4)
	1(Employed)	1(Participated in the Labor Force)	1(Worked at least 50 weeks)	\sinh^{-1} (Income)
Panel A: Females				
After x Goiter Rate	0.0121*** (0.00376)	0.0135*** (0.00394)	0.0184*** (0.00599)	0.161*** (0.0595)
During x Goiter Rate	0.00639 (0.00431)	0.00704 (0.00470)	0.0187*** (0.00532)	0.0325 (0.0500)
Observations	1188488	1188488	579715	1060779
Mean of Dep. Var.	0.426	0.446	0.517	5.569
Panel B: Males				
After x Goiter Rate	0.00161 (0.00402)	-0.000833 (0.00341)	0.00696 (0.00631)	0.0246 (0.0239)
During x Goiter Rate	0.000295 (0.00378)	-0.00108 (0.00266)	0.00455 (0.00719)	0.00352 (0.0254)
Observations	1101223	1101223	886967	981453
Mean of Dep. Var.	0.870	0.904	0.738	10.36
Panel C: Female-Male Difference				
After x Goiter Rate	0.0105* (0.00612)	0.0135** (0.00562)	0.0114 (0.00736)	0.136** (0.0630)
During x Goiter Rate	0.00610 (0.00463)	0.00812 (0.00495)	0.0141 (0.00991)	0.0290 (0.0544)

Notes: Standard errors, clustered by state of residence, in parentheses (***) $p < 0.01$, ** $p < 0.05$, * $p < 0.1$). Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). After is a dummy equal to 1 for those born 1928-1931. During is a dummy equal to 1 for those born 1924-1927. These regressions use the 1950 to 1980 censuses, restricting to individuals born in 1920-1931. All regressions include state of birth fixed effects, year of birth x census year dummies, census division of birth x birth year dummies, gender, race, and During and After dummies interacted with average state latitude and 1920 state-level female and black proportions. \sinh^{-1} (Income) takes the inverse hyperbolic sine of total income, including zeros for those not working.

5.1.1 Gender Heterogeneity

We next ask whether this cognitive shock impacted labor market outcomes differently for men and women. Table 4 reports the results of two separate regressions: one for women (Panel A) and one for men (Panel B), along with the difference in our main coefficients across the two specifications (Panel C). Stark gender differences are apparent. All of the positive effects on labor supply and income reported in the previous tables are driven by women. In fact, there are no significant coefficients in the male regressions, and for all but one outcome, the after interaction coefficients are significantly larger for women than for men. These results are consistent with the hypothesis that female fetuses are more sensitive to maternal thyroid deficiency than male fetuses, for which supporting evidence exists in both the economic and biological literature (Field et al., 2009; Friedhoff et al., 2000). Comparing the dependent variable means for men and women, it is also clear that women have much lower labor supply and income than men during this period, implying much larger scope for improvement in all of these outcomes.

The next table breaks our sample down even further in order to study how the effects of salt iodization may have differed over the course of these individuals' careers. In particular, we are interested in comparing effects in young adulthood and prime ages to effects in later adulthood. Focusing on women, who were the only ones significantly impacted by salt iodization, we run our labor market outcome regressions using only the 1950 and 1960 censuses (during which our sample individuals were aged 19 to 40) and then using only the 1970 and 1980 censuses (during which they were 39 to 60 years old). Table 5 reports these regressions in Panels A and B, respectively, and reveals a clear pattern. The effects of salt iodization on labor supply and income seem to be entirely driven by the large impact salt iodization had on women early in their careers. For all outcomes, the early census coefficients are larger in magnitude than the late census coefficients. With the exception of income – for which we see a marginally significant 8% increase even in later census waves – none of the late census coefficients are significantly different from zero. This positive shock to cognitive ability appears to have made women more employable and increased their earning potential early in their careers. Later in life, these women may have gotten married and dropped out of the labor force (as a result of higher-earning husbands or family responsibilities), leaving them no more likely to be employed than their unaffected counterparts. In the appendix, Table A2 reveals no effects for men in either census wave pair.

Table 5: Effects of Salt Iodization on Female Labor and Income Outcomes in Early and Late Censuses

	(1)	(2)	(3)	(4)
	1(Employed)	1(Participated in the Labor Force)	1(Worked at least 50 weeks)	\sinh^{-1} (Income)
Panel A: 1950-1960 Censuses (Ages 19 to 40)				
After x Goiter Rate	0.0185*** (0.00612)	0.0221*** (0.00679)	0.0339** (0.0128)	0.241** (0.106)
During x Goiter Rate	0.0133* (0.00678)	0.0135* (0.00771)	0.0352*** (0.0104)	0.0309 (0.0989)
Observations	306087	306087	80777	180375
Mean of Dep. Var.	0.357	0.374	0.442	4.534
Panel B: 1970-1980 Censuses (Ages 39 to 60)				
After x Goiter Rate	0.00454 (0.00414)	0.00320 (0.00421)	0.00637 (0.00586)	0.0800* (0.0424)
During x Goiter Rate	-0.00207 (0.00390)	-0.00102 (0.00379)	0.00372 (0.00549)	0.0341 (0.0328)
Observations	882401	882401	498938	880404
Mean of Dep. Var.	0.507	0.528	0.588	6.774

Notes: Standard errors, clustered by state of residence, in parentheses (***) $p < 0.01$, ** $p < 0.05$, * $p < 0.1$. Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). After is a dummy equal to 1 for those born 1928-1931. During is a dummy equal to 1 for those born 1924-1927. These regressions restrict to women born in 1920-1931. All regressions include state of birth fixed effects, year of birth x census year dummies, census division of birth x birth year dummies, gender, race, and During and After dummies interacted with average state latitude and 1920 state-level female and black proportions. \sinh^{-1} (Income) takes the inverse hyperbolic sine of total income, including zeros for those not working.

5.2 Robustness

There are a number of reasons why trends in labor market outcomes across birth cohorts in the 1920's might differ across states. In order to interpret the coefficients discussed above as causal estimates of the effect of iodized salt specifically, we must assume that any other drivers of these differential birth cohort trends across states are uncorrelated with the distribution of goiter. A violation of this assumption means that we are omitting important variables that are potentially correlated with our outcomes of interest as well as our after-by-goiter and during-by-goiter interactions. To rule out alternative explanations for the effects that we find, we control for a number of important events or policies that could have potentially affected the state-specific trends in outcomes across our before, during, and after cohorts.

First, we consider contemporaneous health improvements, such as the eradication of diseases or development of new treatments, which occurred roughly contemporaneously to the roll out of iodized salt. In particular, malaria eradication programs, concentrated in the South, took place in the 1920's (Bleakley, 2010). The 1940's, on the other hand, brought about improvements in the treatment and prevention of tuberculosis, which could have had contemporaneous effects on the labor market outcomes of our sample cohorts.¹³ The correlation between early 1900's goiter rates and prevalence of tuberculosis and malaria are weak and negative (-0.24 and -0.33, respectively) and thus unlikely to be driving our results. We validate this, however, by including controls for pre-iodization prevalence rates of tuberculosis and malaria, interacted with the during and after dummies.

We also address the possibility that changes in compulsory schooling laws, implemented at different times across states, resulted in differential trends in labor outcomes, which we are attributing to introduction of iodized salt. We use data collected by Lleras-Muney (2002), which records the minimum years of schooling required by law in each state from 1915 to 1939. Like Lleras-Muney (2002), we match each individual to the compulsory schooling laws in place in their state of birth at age 14 (the lowest minimum leaving age across all states). For the analysis discussed here, we use the number of years of school required according to compulsory attendance laws, although the results are similar when we use the number of years required according to child labor laws.

It is also well-documented that state mobilization rates for World War II affected labor force partic-

¹³Though first discovered several decades prior, the BCG vaccine began to gain acceptance in the United States after World War II (Comstock, 1994). Moreover, the first antibiotic and first bacterial agent effective against tuberculosis were discovered in 1944 (Daniel, 2006).

Table 6: Effects of Salt Iodization on Female Labor and Income Outcomes, with Additional Controls

	(1)	(2)	(3)	(4)
	1(Employed)	1(Participated in the Labor Force)	1(Worked at least 50 weeks)	\sinh^{-1} (Income)
Panel A: Females, 1950-1980 Censuses				
After x Goiter Rate	0.0135*** (0.00433)	0.0152*** (0.00441)	0.0125 (0.00808)	0.174** (0.0672)
During x Goiter Rate	0.0112*** (0.00396)	0.0126*** (0.00426)	0.0177*** (0.00571)	0.0542 (0.0620)
Observations	1179112	1179112	574618	1052355
Mean of Dep. Var.	0.425	0.445	0.517	5.558
Panel B: Females, 1950-1960 Censuses				
After x Goiter Rate	0.0168** (0.00722)	0.0211*** (0.00757)	0.0215 (0.0173)	0.238** (0.118)
During x Goiter Rate	0.0197*** (0.00635)	0.0204*** (0.00710)	0.0321** (0.0125)	0.0792 (0.117)
Observations	303569	303569	79894	178802
Mean of Dep. Var.	0.356	0.373	0.441	4.520
Panel C: Females, 1970-1980 Censuses				
After x Goiter Rate	0.00866* (0.00448)	0.00688 (0.00463)	0.00570 (0.00668)	0.0952** (0.0377)
During x Goiter Rate	0.000415 (0.00448)	0.00250 (0.00438)	0.00471 (0.00609)	0.0156 (0.0412)
Observations	875543	875543	494724	873553
Mean of Dep. Var.	0.506	0.528	0.587	6.766
Additional Controls	state-of-birth compulsory schooling, state-of-residence WWII mobilization rates, state-of-birth unemployment rates in 1930 (interacted with During and After), state-of-birth tuberculosis and malaria prevalence rates (interacted with During and After)			

Notes: Standard errors, clustered by state of residence, in parentheses (** p<0.01, * p<0.05, * p<0.1). Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). After is a dummy equal to 1 for those born 1928-1931. During is a dummy equal to 1 for those born 1924-1927. These regressions restrict to women born in 1920-1931. All regressions include state of birth fixed effects, year of birth x census year dummies, census division of birth x birth year dummies, race, and During and After dummies interacted with average state latitude and 1920 state-level female and black proportions. \sinh^{-1} (Income) takes the inverse hyperbolic sine of total income, including zeros for those not working.

ipation, particularly for females during this period (Acemoglu et al., 2004). To control for this, we use the state-level mobilization rate in an individual's state of residence, from Acemoglu et al. (2004).

Finally, all of our sample individuals either lived through the Great Depression or its immediate aftermath, but the before, during, and after cohorts were exposed at different points in their life, which could have had important implications for the severity of the long-term impact on each cohort. If, in addition, the Great Depression hit some states harder than others, it becomes another potential reason for differential birth cohort trends across states. In order to proxy for a state's economic conditions during the Great Depression, we calculate state-level unemployment rates from the 1930 census.¹⁴ We match this to individuals using their state of birth and control for the interaction with during and after dummies.

Table 6 reports the results of regressions that control for all of the potential confounders just discussed. The first panel reports the results for all women, the second restricts to the 1950-1960 censuses, and the third restricts to the 1970-1980 censuses. Across all outcomes and samples, we find very similar results: positive and significant effects on female labor supply and income, primarily in the early part of their careers.

In the Appendix, we also show that increased access to iodine did not affect the mortality rates of our cohorts. Table A3 shows no differential trends across the goiter distribution in terms of cohort size or cohort gender composition, which alleviates concerns about our results being driven by a changing sample composition induced by differential mortality.

5.3 Additional Outcomes

Having established that improved access to iodine substantially improved female labor market outcomes, we next study the effects of this cognitive shock on other dimensions of women's lives. Table 7 reports the results of our main regressions on female educational attainment and marriage outcomes, restricting to the 1970-1980 census waves in order to focus on a sample of women old enough to have completed their schooling and likely to have made their first marriage decisions.

First, we ask whether educational attainment was an important mechanism behind the positive labor market effects of improved cognitive ability. Column 1 of Table 7 suggests that it was not. Although the after-by-goiter coefficient is positive and statistically significant, the magnitude of this coefficient is small, translating to about 2 weeks of school, much too small to be generating the large effects on

¹⁴Unemployment rates are not available in the 1920 census.

Table 7: Effects of Salt Iodization on Female Education and Marital Outcomes

	(1)	(2)	(3)
	Years of Schooling	1(Ever Married)	Age at First Marriage
After x Goiter Rate	0.0783** (0.0361)	0.000604 (0.00180)	0.222*** (0.0674)
During x Goiter Rate	0.0309 (0.0277)	0.000396 (0.00183)	0.0357 (0.0589)
Observations	882401	882401	739097
Mean of Dep. Var.	11.35	0.951	21.51

Notes: Standard errors, clustered by state of residence, in parentheses (** p<0.01, ** p<0.05, * p<0.1). Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). After is a dummy equal to 1 for those born 1928-1931. During is a dummy equal to 1 for those born 1924-1927. These regressions use the 1970 to 1980 censuses, restricting to women born in 1920-1931. All regressions include state of birth fixed effects, year of birth x census year dummies, census division of birth x birth year dummies, gender, race, and During and After dummies interacted with average state latitude and 1920 state-level female and black proportions.

income reported in Table 5. It should be noted that in a standard model of educational attainment (Card, 2001), a positive shock to the ability endowment can lead to either an increase or a decrease in educational attainment because it can raise the returns to education as well as the initial wage earned (without any education).¹⁵ In this case, these two opposing effects appear to almost cancel each other out, leading to a small but significant increase in average educational attainment. For men, as we report in Appendix Table A4, the coefficient estimates are also small in magnitude and not significantly different from the female coefficients.

Next, we ask whether changes in labor market outcomes were accompanied by changes in marital decisions. Increased iodine availability does not appear to have affected overall ever-married rates, which is unsurprising given that 95% of this sample of women has been married at least once. However, this cognitive shock does appear to have resulted in delays in marriage: we estimate a small but statistically significant increase in the age at first marriage of approximately a quarter of a year. Similar to the other outcomes discussed previously, we find no significant effects on men's marital decisions, as shown in Appendix Table A4.

¹⁵If the ability endowment shock increases the initial wage regardless of education and the return to education is relatively low, then lifetime income can increase with lower schooling. If there is disutility associated with schooling then there is further downward pressure on educational attainment.

6 Conclusion

In this study, we document the effects of the rapid nationwide iodization of salt in the United States. We estimate substantial impacts on employment, labor force participation, and incomes. The impacts are strongest for, indeed driven nearly entirely by, women. We also find that employment impacts are strong in young adulthood and at prime ages, but grow weaker as treated women grow older. Additional results show that impacted women marry at later ages, consistent with treated new labor force entrants transitioning out of the work force at later ages to raise families.

Our results contribute to several strands of literature and current policy debates. First, this study contributes to the growing literature on the long-term effects of early-life conditions, particularly the smaller set of recent work estimating gains to purposeful and beneficial large-scale policy interventions like fortification schemes. These results differ from earlier studies of early-life “shocks” in that they validate the impacts of actionable policies which can then be reproduced elsewhere. In this way, the study of historic successes, and failures for that matter, in US and other developed settings, can potentially provide important predictions for academic researchers and policy-makers faced with similar issues in developing countries today.

Second, while previous studies have estimated the roles of historical events, such as World War II and the staged rise in access to contraception, in explaining increases in labor force participation among women (e.g. Goldin (1991), Goldin & Olivetti (2013), Goldin & Katz (2002), and Bailey (2006)), we contribute complementary evidence that salt iodization explains a rise of 2.21 percentage points in early censuses (roughly 6 percent of the total rise from 1950 to 1990). Our evidence pertains to cohorts born after those most affected by the war, but before those most affected by increased access to oral contraceptives.¹⁶ Unlike for these previously studied events, impacts on participation of salt iodization are not focused on higher-educated women but prevail despite negligible impacts on schooling completion.

Additionally, our study provides evidence of the magnitude of benefits from eradication of deficiencies in essential micronutrients such as iodine. Many developing country populations face myriad nutritional constraints which have long-lasting impacts on health, economic livelihoods, and general welfare. Our estimates show that salt iodization led to a roughly 1.35 percentage point rise in female labor force participation. From a base labor force of 13 million women in 1940 (United States Bureau

¹⁶Indeed, we estimate our rise in labor force participation due to salt iodization *relative* to the cohort affected by the war.

of the Census, 1944), this amounts to more than 2 billion USD in additional income using the mean income for the female sample inflated to 2016 dollars ($13 \text{ million} \times 0.0135 \times 12,514 \text{ USD} = 2.2 \text{ billion USD}$).¹⁷

Lastly, it should be noted that the “intervention” cost the taxpayer nothing, in that the roll-out of iodized salt was completely undertaken by the private sector. That is, the cost of salt iodization was fully borne by the salt producer, while the cognitive benefit was realized by the general population. We conjecture that the rapid rise in both supply and demand might be attributable to the efficiency and underlying profit motive of the private firm that undertook the intervention.

¹⁷This calculation does not take into account the value of home production, which could have decreased with more women entering the labor force.

References

- Acemoglu, Daron, David Lyle et al. 2004. Women, war, and wages: The effect of female labor supply on the wage structure at midcentury. *Journal of Political Economy* 112(3). 497–551.
- Almond, Douglas & Janet Currie. 2011. Killing me softly: The fetal origins hypothesis. *Journal of Economic Perspectives* 25(3). 153–172.
- Almond, Douglas, Joseph Doyle, Amanda Kowalski & Heidi Williams. 2010. Estimating marginal returns to medical care: Evidence from at-risk newborns. *Quarterly Journal of Economics* 125(2). 591–634.
- Andersson, Maria, Bruno de Benoist & Lisa Rogers. 2010. Epidemiology of iodine deficiency: Salt iodisation and iodine status. *Best Practice and Research Clinical Endocrinology and Metabolism* 24. 1–11.
- Annegers, J. & O. Mickelsen. 1973. Goiter and iodized salt, a historical review and examination of the present role of iodized salt. Unpublished Manuscript.
- Backstrand, J. 2002. The history and future of food fortification in the united states: A public health perspective. *Nutrition Reviews* 60. 15–26.
- Bailey, Martha J. 2006. More power to the pill: the impact of contraceptive freedom on women's life cycle labor supply. *The Quarterly Journal of Economics* 121(1). 289–320.
- Baumann, F. 1896. Ueber das normale vorkommen von jod im thierkorper. *Physiol Chem* 21. 319–330.
- de Benoist, Bruno, Maria Andersson, Ines Egli, Bahi Takkouche & Henrietta Allen. 2004. Iodine status worldwide: Who global database on iodine deficiency World Health Organization.
- Bhalotra, Sonia & Atheendar Venkataramani. 2012. Shadows of the captain of the men of death: Early life health interventions, human capital investments, and institutions. Working paper.
- Bhutta, ZA, JK Das, A Rizvi et al. 2013. The lancet nutrition interventions review group, and the maternal and child nutrition study group. evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost. *Lancet* 60996–4.
- Black, Robert E, Cesar G Victora, Susan P Walker, Zulfiqar A Bhutta, Parul Christian, Mercedes de Onis, Majid Ezzati, Sally Grantham-McGregor, Joanne Katz, Reynaldo Martorell et al. 2013. Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet* .

- Bleakley, Hoyt. 2007. Disease and development: evidence from hookworm eradication in the american south. *The Quarterly Journal of Economics* 122(1). 73–117.
- Bleakley, Hoyt. 2010. Malaria eradication in the americas: A retrospective analysis of childhood exposure. *American Economic Journal: Applied Economics* 2(2). 1–45.
- Brush, Brock E. & J.K. Atland. 1952. Goiter prevention with iodized salt: Results of a thirty-year study. *The Journal of Clinical Endocrinology And Metabolism* 12(10). 1380–1388.
- Cagnacci, Angelo, A Renzi, S Arangino, C Alessandrini & A Volpe. 2004. Influences of maternal weight on the secondary sex ratio of human offspring. *Human Reproduction* 19(2). 442–444.
- Cao, Xue-Yi, Xin-Min Jiang, Zhi-Hong Dou, Murdon Abdul Rakeman, Ming-Li Zhang, Karen O'Donnell, Tai Ma, Kareem Amette, Nancy DeLong & G. Robert DeLong. 1994. Timing of vulnerability of the brain to iodine deficiency in endemic cretinism. *New England Journal of Medicine* 331(26). 1739–1744.
- Card, David. 2001. Estimating the return to schooling: Progress on some persistent econometric problems. *Econometrica* 69(5). 1127–60.
- Center, Copenhagen Consensus. 2008. Copenhagen consensus 2008. *Fredriksberg, Denmark: Copenhagen Consensus Center* .
- Clar, C., T. Wu, G. Liu & P. Li. 2002. Iodized salt for iodine deficiency disorders: A systematic review. *Endocrinology and Metabolism Clinics of North America* 31. 681–698.
- Clay, Karen, Ethan Schmick & Werner Troesken. 2015. Pellagra and southern welfare: Evidence from the arrival of the boll weevil, and state-level fortification laws .
- Comstock, George W. 1994. The international tuberculosis campaign: a pioneering venture in mass vaccination and research. *Clinical infectious diseases* 19(3). 528–540.
- Currie, Janet & Tom Vogl. 2012. Early-life health and adult circumstance in developing countries. Tech. rep. National Bureau of Economic Research.
- Daniel, Thomas M. 2006. The history of tuberculosis. *Respiratory medicine* 100(11). 1862–1870.

- De Escobar, G Morreale, María Jesús Obregón & F Escobar Del Rey. 2004. Role of thyroid hormone during early brain development. *European Journal of Endocrinology* 151(Suppl 3). U25–U37.
- Feyrer, James, Dimitra Politi & David N. Weil. forthcoming. The economic effects of micronutrient deficiency: Evidence from salt iodization in the united states. *Journal of the European Economic Association* .
- Field, Erica, Omar Robles & Maximo Torero. 2009. Iodine deficiency and schooling attainment in tanzania. *American Economic Journal: Applied Microeconomics* 1(4). 140–169.
- Friedhoff, A., J. Miller, M. Armour, J. Schweitzer & S. Mohan. 2000. Role of maternal biochemistry in fetal brain development: Effect of maternal thyroidectomy on behaviour and biogenic amine metabolism in rat progeny. *International Journal of Neuropsychopharmacology* 3. 89–97.
- Goldin, Claudia, R Ehrenberg & F Blau. 1997. Career and family: College women look to the past. *Gender and Family Issues in the Workplace* .
- Goldin, Claudia & Lawrence F. Katz. 2002. The power of the pill: Oral contraceptives and women's career and marriage decisions. *Journal of Political Economy* August 2002. [revised version of NBER Working Paper no. 7527](#); [p2](#).
- Goldin, Claudia & Claudia Olivetti. 2013. Shocking labor supply: A reassessment of the role of world war ii on women's labor supply. *American Economic Review: Papers and Proceedings* 103(3). 257–262.
- Goldin, Claudia D. 1991. The role of world war ii in the rise of women's employment. *The American Economic Review* 81(4). 741–756.
- Hall, D. 1914. The prevalence of goiter in the northwest, based on the examinations of 3,339 students entering the university of washington. *Northwest Medicine* 6. 189–391.
- Hamwi, George J., Albert W. Van Fossen, Robert E. Whetstone & Izola Williams. 1952. Endemic goiter in ohio school children. *American Journal of Public Health* 45(10). 1344–1348.
- Heckman, James J. 2006. Skill formation and the economics of investing in disadvantaged children. *Science* 312(5782). 1900–1902.
- Hetzel, Basil S. 1989. *The story of iodine deficiency: An international challenge in nutrition* chap. The Biology of Iodine. Oxford University Press.

- Hetzel, Basil S. & Mark T. Mano. 1989. A review of experimental studies of iodine deficiency during fetal development. *Journal of Nutrition* 119(2). 145–151.
- Hornbeck, Richard. 2012. The enduring impact of the american dust bowl: Short- and long-run adjustments to environmental catastrophe. *American Economic Review* 102(4). 1477–1507.
- Hoynes, Hilary W, Diane Whitmore Schanzenbach & Douglas Almond. 2012. Long run impacts of childhood access to the safety net. Tech. rep. National Bureau of Economic Research.
- Lamberg, Bror-Axel. 1991. Endemic goitreiodine deficiency disorders. *Annals of Medicine* 23(4). 367–372.
- Levin, Simon. 1919. Discussion of goiter in 583 registrants. *Journal of Michigan State Medical Society* 18. 98–104.
- Lleras-Muney, Adriana. 2002. Were compulsory attendance and child labor laws effective? an analysis from 1915 to 1939. *Journal of Law and Economics* 45(2). 401–435.
- Love, Albert G. & Charles B. Davenport. 1920. *Defects found in drafted men. statistical information compiled from the draft records showing the physical conditions of the men registered and examined in pursuance of the requirements of the selective-service act.* Washington DC: Government Printing Office.
- Maccini, Sharon & Dean Yang. 2009. Under the weather: Health, schooling, and economic consequences of early-life rainfall. *American Economic Review* 99(3). 1006–1026.
- Marine, D. & H. Feiss. 1915. The absorption of potassium iodid by perfused thyroid glands and some of the factors modifying it. *Journal of Pharmacology and Experimental Therapeutics* 7. 557–576.
- Marine, D. & O. Kimball. 1917. The prevention of simple goiter in man. *Journal of Laboratory and Clinical Medicine* 3. 40–48.
- Marine, D. & C. Lenhart. 1909. Effects of the administration or withholding of iodine-containing compounds in normal, colloid, or actively hyperplastic thyroids of dogs. *Archives of Internal Medicine* 4. 253–270.
- Marine, David & OP Kimball. 1920. Prevention of simple goiter in man: fourth paper. *Archives of internal medicine* 25(6). 661–672.

- Markel, Howard. 1987. When it rains it pours: Endemic goiter, iodized salt and david murray cowie, md. *American Journal of Public Health* 77(2). 219–229.
- Niemesh, Gregory T. 2015. Ironing out deficiencies: Evidence from the united states on the economic effects of iron deficiency. *Journal of Human Resources* 50(4). 910–958.
- Olesen, R. 1915. Goiter, its prevalence in chicago, as shown by the examination of 800 individuals. *Illinois Medical Journal* 27. 16.
- Olesen, R. 1929. Distribution of endemic goiter in the united states as shown by thyroid surveys. *Public Health Reports* 44. 1463–87.
- Pharoah, Peter & Kevin Connolly. 1987. A controlled trial of iodinated oil for the prevention of endemic cretinism: A long-term follow-up. *International Journal of Epidemiology* 16(1). 68–73.
- Politi, Dimitra. 2014. The impact of iodine deficiency eradication on schooling: Evidence from the introduction of iodized salt in switzerland. Working Paper.
- Politi, Dimitra. 2015. The effects of the generalized use of iodized salt on occupational patterns in switzerland. Working Paper.
- Ruggles, Steven, Matthew Sobek, Catherine A Fitch, Patricia Kelly Hall & Chad Ronnander. 2015. *Integrated public use microdata series: Version 6.0 [machine-readable database]*. Minneapolis: University of Minnesota.
- Sanders, Nicholas J & Charles Stoecker. 2015. Where have all the young men gone? using sex ratios to measure fetal death rates. *Journal of health economics* 41. 30–45.
- Schiel, Joseph B. Jr. & Anita Joan Wepfer. 1976. Distributional aspects of endemic goiter in the united states. *Economic Geography* 52(2). 116–126.
- Smith, G. 1917. Fetal athyreosis. *Journal of Biological Chemistry* 29. 215–225.
- Trivers, Robert L & Dan E Willard. 1973. Natural selection of parental ability to vary the sex ratio of offspring. *Science* 179(4068). 90–92.
- United States Bureau of the Census. 1944. *Sixteenth census of the united states: 1940. population. estimates of labor force, employment, and unemployment in the united states, 1940 and 1930*. Washington: U.S. Government Printing Office.

WHO. 1992. National strategies for overcoming micronutrient malnutrition. Unpublished.

WHO. 2004. Iodine status worldwide. global database on iodine deficiency.

Zimmermann, Michael B. 2008. Research on iodine deficiency and goiter in the 19th and early 20th centuries. *The Journal of Nutrition* 138(11). 2060–2063.

Zimmermann, Michael B. 2009. Iodine deficiency in pregnancy and the effects of maternal iodine supplementation on the offspring: a review. *The American Journal of Clinical Nutrition* 89(2). 668S–672S.

A Additional Tables

In Table A1, we list all states (excluding Hawaii) by Census division, along with their corresponding goiter rates from Love & Davenport (1920).

Table A1: Regional Classification of States

Census Division	State	Love and Davenport (1920) Goiter Rate (ppt)
New England	Connecticut	0.089
New England	Maine	0.066
New England	Massachusetts	0.032
New England	New Hampshire	0.070
New England	Rhode Island	0.055
New England	Vermont	0.214
Middle Atlantic	New Jersey	0.043
Middle Atlantic	New York	0.119
Middle Atlantic	Pennsylvania	0.410
East North Central	Illinois	0.779
East North Central	Indiana	0.649
East North Central	Michigan	1.143
East North Central	Ohio	0.559
East North Central	Wisconsin	1.402
West North Central	Iowa	0.668
West North Central	Kansas	0.125
West North Central	Minnesota	0.804
West North Central	Missouri	0.399
West North Central	Nebraska	0.214
West North Central	North Dakota	0.873
West North Central	South Dakota	0.409
South Atlantic	Delaware	0.059
South Atlantic	District of Columbia	0.139
South Atlantic	Florida	0.025
South Atlantic	Georgia	0.052
South Atlantic	Maryland	0.094
South Atlantic	North Carolina	0.181
South Atlantic	South Carolina	0.094
South Atlantic	Virginia	0.338
South Atlantic	West Virginia	0.789
East South Central	Alabama	0.056
East South Central	Kentucky	0.141
East South Central	Mississippi	0.064
East South Central	Tennessee	0.196
West South Central	Arkansas	0.040
West South Central	Louisiana	0.062
West South Central	Oklahoma	0.072
West South Central	Texas	0.030
Mountain	Arizona	0.121
Mountain	Colorado	0.529
Mountain	Idaho	2.691
Mountain	Montana	2.100
Mountain	Nevada	0.638
Mountain	New Mexico	0.088
Mountain	Utah	1.572
Mountain	Wyoming	1.537
Pacific	Alaska	1.314
Pacific	California	0.445
Pacific	Oregon	2.631
Pacific	Washington	2.340

Table A2 reports the results of our labor regressions on men, separately for early and late census waves.

Table A2: Effects of Salt Iodization on Male Labor and Income Outcomes in Early and Late Censuses

	(1)	(2)	(3)	(4)
	1(Employed)	1(Participated in the Labor Force)	1(Worked at least 50 weeks)	\sinh^{-1} (Income)
Panel A: 1950-1960 Censuses (Ages 19 to 40)				
After x Goiter Rate	0.00385 (0.00620)	0.00377 (0.00538)	0.00833 (0.0114)	0.0350 (0.0455)
During x Goiter Rate	0.000883 (0.00636)	0.000452 (0.00463)	0.00410 (0.0133)	-0.00530 (0.0440)
Observations	287149	287149	162305	170601
Mean of Dep. Var.	0.874	0.912	0.681	9.870
Panel B: 1970-1980 Censuses (Ages 39 to 60)				
After x Goiter Rate	-0.000125 (0.00317)	-0.00386 (0.00315)	0.00386 (0.00320)	0.0110 (0.0130)
During x Goiter Rate	0.000109 (0.00291)	-0.00259 (0.00296)	0.00406 (0.00480)	0.0137 (0.0175)
Observations	814074	814074	724662	810852
Mean of Dep. Var.	0.866	0.894	0.806	10.95
Notes: Standard errors, clustered by state of residence, in parentheses (***) $p < 0.01$, (**) $p < 0.05$, (*) $p < 0.1$. Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). After is a dummy equal to 1 for those born 1928-1931. During is a dummy equal to 1 for those born 1924-1927. These regressions restrict to men born in 1920-1931. All regressions include state of birth fixed effects, year of birth x census year dummies, census division of birth x birth year dummies, gender, race, and During and After dummies interacted with average state latitude and 1920 state-level female and black proportions. \sinh^{-1} (Income) takes the inverse hyperbolic sine of total income, including zeros for those not working.				

In order to assess whether the increased availability of iodine affected mortality, we take all individuals born between 1920 and 1931 in the 1940 census (the first census to record all of our birth cohorts of interest) and collapse to the birth-year birth-state level, counting the total number of individuals as well as calculating the male fraction of each cohort. If salt iodization affected mortality, we would expect to see effects on cohort size. We might also see effects on the male fraction because male fetuses are more vulnerable *in utero* (Cagnacci et al., 2004; Sanders & Stoecker, 2015; Trivers & Willard, 1973). We therefore regress cohort size and the male proportion on our after-by-goiter and during-by-goiter variables of interest, controlling for birth state and birth year fixed effects, along with after and during dummies interacted with state latitude and 1920 female and black proportions. We find no differential changes across the goiter distribution in cohort size or gender composition after the introduction of iodized salt. None of the coefficients in Table A3 are significantly different from zero (in terms of magnitude, they are at most a few hundredths of a standard deviation), suggesting that salt iodization did not affect our sample composition.

Table A3: Salt Iodization and Cohort Composition

	(1)	(2)
	Cohort Size	Fraction Male
After x Goiter Rate	525.7 (416.1)	0.00602 (0.00619)
During x Goiter Rate	-146.4 (316.5)	-0.0330 (0.0217)
Observations	596	596
Mean of Dep. Var.	46912.7	0.495
Standard Deviation of Dep. Var.	43529.8	0.0660

Notes: Standard errors, clustered by state, in parentheses (** p<0.01, ** p<0.05, * p<0.1). Each observation represents a birth-state birth-year combination. Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). After is a dummy equal to 1 for birth years 1928-1931. During is a dummy equal to 1 for birth years 1924-1927. These regressions use the 1940 census, restricting to birth years 1920-1931. All regressions include During and After dummies interacted with average state latitude and 1920 state-level female and black proportions.

Table A4 reports the results of our regressions on marital and education outcomes, for men.

Table A4: Effects of Salt Iodization on Male Education and Marital Outcomes

	(1)	(2)	(3)
	Years of Schooling	1(Ever Married)	Age at First Marriage
After x Goiter Rate	0.0402 (0.0434)	0.00260 (0.00189)	-0.0212 (0.0632)
During x Goiter Rate	0.0990** (0.0421)	0.000807 (0.00224)	0.0156 (0.0754)
Observations	814074	814074	671287
Mean of Dep. Var.	11.53	0.937	24.23

Notes: Standard errors, clustered by state of residence, in parentheses (***) $p < 0.01$, ** $p < 0.05$, * $p < 0.1$). Goiter Rate is the goiter rate in the individual's state of birth from Love and Davenport (1920), scaled by the difference between the 75th and 25th percentile of the goiter distribution (0.71). After is a dummy equal to 1 for those born 1928-1931. During is a dummy equal to 1 for those born 1924-1927. These regressions use the 1950 to 1980 censuses, restricting to men born in 1920-1931. All regressions include state of birth fixed effects, year of birth x census year dummies, census division of birth x birth year dummies, gender, race, and During and After dummies interacted with average state latitude and 1920 state-level female and black proportions.

B Data Appendix

B.1 Independent Indicator Variables

- *Before*=1 if individual was born in 1920-1924; *Before*=0 otherwise
- *During*=1 if individual was born in 1924-1927; *During*=0 otherwise
- *After*=1 if individual was born in 1928-1931; *After*=0 otherwise

B.2 Outcome Variables

B.2.1 Basic Outcomes

- $1(\textit{Participated in Labor Force})=1$ if the individual participated in the labor force (by either working or looking for work) in the last week;
 $1(\textit{Participated in Labor Force})=0$ if the individual did not participate in the labor force.
- $1(\textit{Employed})=1$ if the individual was employed in the last week;
 $1(\textit{Employed})=0$ if the individual did not work, irrespective of whether the individual looked for a job.
- $1(\textit{Worked at least 50 weeks})=1$ if the individual reported working 50-52 weeks in the last year.
 $1(\textit{Worked at least 50 weeks})=0$ if the individual worked fewer than 50 weeks in the last year. This variable is missing for individuals who did not work in the past year.
- *Total Income*: This is the inverse hyperbolic sine of the total annual income earned by the individual. All values are adjusted to 1999 prices according to Census-provided multipliers. Although this variable is top-coded differently across Census years, we applied the top-coding from the 1950 Census to all years (setting the maximum income to \$70,000). The inverse hyperbolic sine transformation was made after all of the adjustments were made.
- *Years of Schooling*: Years of schooling completed by the individual.

B.3 Other Variables

- *female*=1 for females; *female*=0 for males
- *black*=1 for black individuals; *black*=0 for all other races

- *1920 female share*: The state-level proportion of the population that was female in the individual's state of birth, calculated from the 1920 Census.
- *1920 black share*: The state-level proportion of the population that was black in the individual's state of birth, calculated from the 1920 Census.
- *1930 unemployment rate*: The state-level unemployment rate in the individual's state of birth, calculated from the 1930 census.
- *Tuberculosis*: Pre-iodization tuberculosis rate in state of birth according to Love & Davenport (1920)
- *Malaria*: Pre-iodization malaria rate in state of birth according to Bleakley (2010)
- *Compulsory Schooling*: Number of years of schooling required by compulsory attendance laws in the individual's state of birth in the year they turned 14 (which is the minimum leaving age across all states and years), from Lleras-Muney (2002).
- *Mobilization Rate*: WWII mobilization rate for individual's state of residence, from Acemoglu et al. (2004).
- *Latitude*: Average latitude for the individual's state of birth