

# The Cognitive Effects of Micronutrient Deficiency: Evidence from Salt Iodization in the United States

James Feyrer\*, Dimitra Politi<sup>†</sup> and David N. Weil<sup>‡</sup>

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## Abstract

Iodine deficiency is the leading cause of preventable mental retardation in the world today. The condition, which was common in the developed world until the introduction of iodized salt in the 1920s, is connected to low iodine levels in the soil and water. We examine the impact of salt iodization on cognitive outcomes in the US by taking advantage of this natural geographic variation. Salt was iodized over a short period of time beginning in 1924. We use military data collected during WWI and WWII to compare outcomes of cohorts born before and after iodization in localities that were naturally poor and rich in iodine. We find that for the one quarter of the population most deficient in iodine this intervention raised IQ by approximately one standard deviation. Our results can explain roughly one decade's worth of the upward trend in IQ in the US (the Flynn Effect). We also document a large increase in thyroid-related deaths following the countrywide adoption of iodized salt, which affected mostly older individuals in localities with high prevalence of iodine deficiency.

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\*Department of Economics, Dartmouth College, and NBER. Email: james.feyrer@dartmouth.edu.

<sup>†</sup>School of Economics, The University of Edinburgh. Email: Dimitra.Politi@ed.ac.uk.

<sup>‡</sup>Department of Economics, Brown University, and NBER. Email: David\_Weil@brown.edu. We would like to thank Hoyt Bleakley, Kenneth Chay, Andrew Clausen, Joseph Ferrie, seminar participants at Tel Aviv University, Boston College, Brown University, Northwestern University, and conference participants at the NBER's Cohort Studies Meeting, AEA Meetings and SIRE's Young Researchers Forum for helpful comments. Desislava Byanova, Federico Droller, Bryce Millett Steinberg, and Young Min Kim provided excellent research assistance.

# 1 Introduction

Deficiencies in the consumption of micronutrients, the vitamins and minerals required in trace amounts for proper metabolic functioning, are a major contributor to poor health in developing countries.<sup>1</sup> Elimination of deficiencies in micronutrients such as vitamin A, zinc, iron, and iodine has been a major focus of development efforts around the world. Nutritional supplementation programs are widely seen as cost-effective interventions with potentially large effects on human capital, though their impact can be hard to evaluate, since their benefits may not be observable for several decades.<sup>2</sup> Until the second half of the 20th century micronutrient deficiencies were a problem in currently developed countries as well. This paper focuses on the historical experience of the United States and the impact of its successful eradication of iodine deficiency.

The World Health Organization estimates that nearly 50 million people suffer some degree of mental impairment due to iodine deficiency, and that this is the leading cause of preventable mental retardation in the world. Eliminating iodine deficiency around the globe is an ongoing project, largely through the introduction of iodized salt.<sup>3</sup> In the US iodine deficiency was a significant problem in the early part of the 20th century with rates of deficiency similar to those faced by the worst afflicted developing countries today. The United States virtually eliminated iodine deficiency with the introduction of iodized salt in 1924.<sup>4</sup>

The most important detrimental effects of iodine deficiency are on the cognitive devel-

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<sup>1</sup>In 2005 667,000 deaths of children under five were estimated to be attributable to vitamin A deficiency. The mortality burden of zinc deficiency was roughly two-thirds as large (Black et al. (2008)). Anemia caused by iron deficiency affects 1.6 billion people around the globe (de Benoist et al., eds (2008)).

<sup>2</sup>The 2008 Copenhagen Consensus ranked zinc and vitamin A supplementation for children as the most cost effective potential intervention for global welfare. Iron and iodine supplementation was the third most cost effective potential intervention (Copenhagen Consensus Center (2008)). In a notable recent paper Field et al. (2009) exploit delays and gaps in the implementation of the iodization program in Tanzania, and find that treatment of mothers with iodated oil resulted in a rise in schooling of 0.33 years among children, with a larger effect for girls.

<sup>3</sup>In China, the fraction of salt iodized rose from 30% to 96% between 1990 and 2000. India banned the sale of non-iodized salt for human consumption in 2006 (Mannar and Bohac (2009) and Micronutrient Initiative (2009)).

<sup>4</sup>Food fortification in the US began in 1924 with iodized salt, followed by vitamin D fortified milk in 1932, and vitamin B fortified flour in 1941. These interventions largely eliminated micronutrient deficiencies in the US.

opment of fetuses in utero, and these effects are not reversible later on in life. Eradication of iodine deficiency is thus a candidate explanation for part of the Flynn Effect, the gradual rise in measured IQ that has been observed in developed countries over the course of the twentieth century. As we show below, the benefits of iodization were large, but there were also very significant health costs (several thousand premature deaths) associated with it.

We exploit the interaction of pre-existing geographic variation in iodine deficiency with a national program of salt iodization to identify the program impact. Iodine deficiency is linked directly to geography through the food and water supply. In adults, the most noticeable symptom of iodine deficiency is goiter, the enlargement of the thyroid gland. Prior to salt iodization, endemic goiter was present in regions of the US where the iodine content of the soil and water was low. In 1924 iodized salt was introduced in the United States explicitly to reduce the goiter rate. Since there are large in utero effects of iodine deficiency, we expect to see a significant difference in cognitive ability between those born before and after the introduction of iodized salt in locations with low levels of environmental iodine. Those living in high-iodine regions provide a control group.

We use two unique data sources to look at the effects of iodine deficiency eradication on cognitive ability. From World War I draft physicals we know the incidence of goiter in recruits for 151 geographic regions before the introduction of iodized salt. This provides us with a measure of spatial variation in iodine deficiency prior to treatment.<sup>5</sup> Our outcome measure is provided by an extensive data set of men who enlisted in the Army during World War II. Upon enlistment, each recruit took the Army General Classification Test (AGCT), a forerunner to the Armed Forces Qualification Test (AFQT). The Air Force was assigned draftees with significantly higher average test scores than the Ground Forces. The probability

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<sup>5</sup>Generally speaking, population surveys record much higher rates of goiter than military data. This is because females are much more prone to goiter (and thyroid disorders in general) than males. A second reason is that, in deficient populations, goiters grow with age, so recorded prevalence rises when one includes older cohorts, rather than just men of military age. In this paper we rely primarily on military data for two reasons: first, other markers of iodine deficiency used today, such as urinary iodine concentrations, are not available for that time period. Second, population surveys of goiter prevalence prior to iodization are rare, they tend to focus on a few localities, and they suffer from lack of uniformity in measurement.

of assignment to the Air Force rises significantly for those born in high-goiter (i.e. low-iodine) locations in the years after the introduction of iodized salt. Using information about average scores of Air and Ground Force recruits we infer a one standard deviation increase in average test scores in these regions. Our results explain roughly one decade’s worth of the Flynn Effect in the US.

In addition to the positive cognitive effects of iodizing salt we document a significant negative side effect. Chronic iodine deficiency followed by a sudden large intake of iodine can cause iodine-induced hyperthyroidism, which can be fatal. We find a large rise in thyroid-related deaths in iodine deficient regions following the introduction of iodized salt. We estimate that at least 10,000 deaths over the period 1925-1942 were the result of iodization.

The paper proceeds as follows: Section 2 provides some background on iodine deficiency disorders. Section 3 outlines the history of salt iodization in the US. Section 4 describes our data and provides some background on their collection. In Section 5 we present previously undocumented evidence on the spike of thyroid-related mortality following iodization. Section 6 explains our identification strategy and Section 7 presents our results. In Section 8 we present two robustness checks which corroborate our main findings. Section 9 puts our results in the context of related research on the effects of iodization on cognitive ability. Section 10 concludes.

## 2 Iodine Deficiency Disorders

Recent work has shown that the quality of maternal health and nutrition during pregnancy has persistent effects on adult health outcomes.<sup>6</sup> Iodine is one of the “big three” micronutrients, deficiencies in which are a major source of ill health in developing countries (the other two are vitamin A and iron). Iodine deficiency is the leading cause of preventable mental retardation in the world. Nearly one third of the world’s population are at risk, in

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<sup>6</sup>See, for example, Almond (2006), and Behrman and Rosenzweig (2004). For an excellent review of the literature, see Almond and Currie (2011).

the sense that their iodine intake is considered insufficient. 241 million school-age children receive inadequate amounts of iodine in their diet (Andersson et al. (2012)).

Iodine Deficiency Disorders is a term used to describe a set of conditions that result from inadequate intake of iodine. The thyroid gland contains 70-80% of the total iodine content in the human body (Fleischer et al. (1974)). The thyroid gland uses iodine to produce thyroxin, a hormone that regulates metabolism. When there is too little iodine in the diet, the thyroid compensates for the shortage by enlarging in order to produce more thyroxin per unit of iodine. When dietary iodine is only slightly inadequate, the enlarged thyroid will be able to produce sufficient thyroxin for normal body functioning. This enlargement is known as euthyroid goiter. At lower levels of dietary iodine, the enlarged thyroid will produce inadequate thyroxin, a condition known as hypothyroid goiter, characterized by slow metabolism, lethargy, and weight gain.

Goiters due to iodine deficiency are often reversible after an increase in dietary iodine. However, in some people with this condition, increased iodine consumption results in the thyroid gland producing excessive quantities of thyroxin, resulting in hyperthyroidism: an overly accelerated metabolism, with symptoms including rapid heartbeat, weight loss, temperature elevation, nervousness, and irritability. This “iodine-induced thyrotoxicosis” is most likely to occur in individuals who have experienced long periods of iodine deficiency.<sup>7</sup>

Iodine deficiency early in pregnancy causes irreversible brain damage to the foetus. Severe iodine deficiency can result in cretinism, which is characterized by “profound mental deficiency, dwarfism, spastic dysplasia and limited hearing” (Scrimshaw (1998, p.364)). In endemic areas cretinism can affect up to 15% of the population (de Benoist et al., eds (2004)). However, as Scrimshaw points out, “even in areas where cases of cretinism due to iodine deficiency in the mother are few, the linear growth of the infant, its intellectual

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<sup>7</sup>Goiter and hyperthyroidism can also result from Graves Disease, also called Basedow disease, an immune condition in which the thyroid is stimulated to produce excess thyroxin. Iodine-induced thyrotoxicosis is also called Jod-Basedow disease. “Jod” is German for iodine. The name indicates that iodine consumption is resulting in the symptoms of Basedow disease. Examining the rise in thyroid disease that followed the introduction of iodized bread in Tasmania, Connolly (1971) found that most patients with iodine-induced thyrotoxicosis had pre-existing goiter, and few had Graves disease.

capacity, and certain other of its neurological functions are permanently compromised to varying degrees.”<sup>8</sup> In other words, even if iodine deficiency does not result in cretinism, an iodine-deficient population will experience a continuum of cognitive impairment. Deficient populations typically see a leftward shift in the entire IQ distribution.<sup>9</sup> In a meta-analysis of 18 studies Bleichrodt and Born (1994) estimate that the average IQ of iodine-deficient groups is 13.5 points lower than non-deficient groups. While widely cited, this result is based primarily on cross-sectional comparisons of observational data, which makes the identification of a causal effect questionable.

Historically, the geographical characteristics of an area determined the endemicity of iodine deficiency. Ocean water is rich in iodine, which is why endemic goiter is not observed in coastal areas. Iodine is transferred from the ocean to the soil by rain. Heavy rainfall can cause soil erosion, in which case the iodine-rich upper layers of soil are washed away. The last glacial period had the same effect: iodine-rich soil was substituted by iodine-poor soil from crystalline rocks (Koutras et al. (1980)). This explains the prevalence of endemic goiter in regions that were marked by intense glaciation, such as Switzerland and the Great Lakes region of the USA. Iodine, when present in the soil, is absorbed by plants and can reach humans through the food chain. Iodine is also present in subsurface water in some locations. Finally, deposits of mineral salt (the remains of evaporated seawater) contain iodine, but this is lost when the salt is refined.

Iodine was first isolated in 1811 by Courtois. Over a century of clinical research proved iodine’s essential role in prophylaxis against iodine deficiency disorders. Doctors and public health officials have used different methods of iodine supplementation. Salt iodization has emerged as the cheapest and widest-reaching way to protect a population from iodine deficiency.<sup>10</sup>

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<sup>8</sup>Scrimshaw (1998, p.351).

<sup>9</sup>Scrimshaw (1998) provides a list of studies and experiments documenting the hindering effects of iodine deficiency in utero on mental development.

<sup>10</sup>Alternatives have included the iodization of water supplies and bread, as well as the provision of iodine-enriched chocolates or milk to babies and schoolchildren, and injections of slow-releasing iodated oil. Iodization of water supplies proved wasteful since only a small proportion of water is used for drinking and cooking

### 3 Salt Iodization in the United States

Salt iodization was the first step in the systematic fortification of food for public health reasons. It was made possible by the nearly simultaneous discovery of a widespread health problem and of its underlying cause. In the First World War draft a little more than 2.5 million draftees were examined for various physical and mental shortcomings. Statistics from these physicals showed the geographic distribution of many diseases and defects, among them goiter, across the United States (Love and Davenport (1920)).

According to the draft examinations almost 12,000 men had goiter and a third of these were judged unfit for service because the size of their neck was too big for the military tunic to be buttoned (Kelly and Snedden (1960, p.34)). Most of them came from states in the Northwest (Washington, Oregon, Idaho, Montana) and the area around the Great Lakes. In Northern Michigan, for instance, more draftees were judged unfit for service “for large and toxic goiters than for any other medical disorder” (Markel (1987, p.221)). On the other hand, goiter was rare in people coming from coastal areas.

This led to multiple surveys of goiter, which confirmed the geographical variation in the prevalence of the disease. By that time there was medical and veterinary evidence showing that goiters could be reduced by adding iodine to the diet.<sup>11</sup> These observations prompted a public debate on whether and how to provide iodine prophylaxis to the American population. Although there was discussion of possible negative side effects in the form of hyperthyroidism, the medical consensus was that small amounts of iodine in the diet were beneficial for the vast majority of iodine-deprived populations.

Public health authorities in Michigan, one of the worst-afflicted states, held a symposium on thyroid disease in 1922. The idea of salt iodization (first implemented in Switzerland in

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purposes. Bread iodization was used in the Netherlands as a wartime measure (Matovinovic and Ramalingaswami (1960)). Ancient civilizations treated goiter with burnt sponge or seaweed, which are rich in iodine (Curtis and Fertman (1951), Langer (1960)).

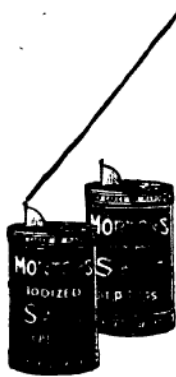
<sup>11</sup>Experiments with schoolchildren confirmed that the size of goiters decreased after receiving iodine. The first such experiment took place in Akron, Ohio in 1917, under the direction of David Marine and O.P. Kimball. For details see Marine and Kimball (1921), and Carpenter (2005).

Figure 1: Iodized salt advertisements

## Goiter strikes 1 out of 3

*Prevent it with*

**Morton's IODIZED Salt**



Alike—except one  
contains IODINE



WHEN IT RAINS—IT POURS

**MORTON'S SALT**

**F**EW under 18 escape this health sapping, deforming malady—yet none need suffer.

For iodized salt prevents goiter. The Swiss stamped out goiter thus.

Morton's Iodized Salt is the salt approved everywhere by physicians.

Be safe—get Morton's—it tastes no different. It was prepared at the request of high medical authorities—it *must be right.*

Ask for Morton's Iodized Salt at your grocer's.

Write Dept. 205 for  
**FREE BOOK**

**MORTON SALT COMPANY**  
CHICAGO

**FOR THE PREVENTION OF SIMPLE GOITER**

**Read what the Health  
Officers of West Virginia  
Say about Iodized Salt**

"The exclusive use of Iodized Salt by people living in goiterous districts will have a far reaching effect in the prevention of simple Goiter. I feel that the retail grocer who handles Iodized Salt exclusively in our goiterous sections of the United States is rendering an invaluable service to his patrons and to the community."

M. V. ZIEGLER, M. D.  
Director Division of Preventable Diseases  
West Virginia Department of Health

Dr. W. T. HENSHAW, the State Commissioner of Health, West Virginia, says: "He is pleased to know that the salt manufacturers have seen fit to comply with the recommendations of the Michigan State Medical Society and the Michigan State Board of Health relative to placing on the market an Iodized Salt for the prevention of simple Goiter."

Girls are more subject to Goiter than are boys. A bulletin issued by the Health department states that in one town in West Virginia 50 per cent of the girls have goiter in another 56 per cent; in another 60 per cent; and in another 64 per cent.



**MULKEY'S  
IODINE  
SALT**

For prevention of simple Goiter the same bulletin recommends: "Every girl in West Virginia should keep her thyroid gland saturated with Iodine, between the ages of eleven and sixteen inclusive."

**MULKEY'S IODINE SALT** is now available to every family. It is produced in co-operation with this great public health movement—the eradication of Goiter.

Ask your grocer for **MULKEY'S IODINE SALT**; if not in stock he can get it for you.

Use **MULKEY'S IODINE SALT** just as you do ordinary Table Salt. No difference in the taste, color or seasoning quality of the Salt.

Our pamphlet on Goiter mailed free upon request

**MULKEY SALT COMPANY**  
DETROIT, MICHIGAN

(a) "The Bee", Danville,  
Virginia, May 11th 1925

(b) "Middleboro Daily News",  
Kentucky, June 24th 1924

1922) was introduced by David Murray Cowie, M.D. as a cheap and effective means of providing iodine to all population groups, regardless of social status. The Iodized Salt Committee, chaired by Cowie, was set up to investigate the matter further. The Committee agreed upon the launch of a statewide educational campaign on goiter and its prevention through iodized salt, sponsored by the Michigan State Medical Society.

The Committee also contacted the state's salt manufacturers. The actions of the Michigan salt producers were important, because Michigan was the largest producer of salt for human consumption in the country.<sup>12</sup> The salt producers, although convinced about the

<sup>12</sup>Salt production takes three forms: evaporated, rock salt, and the production of liquid brine. In 1924 the quantities produced by these three methods were 2.22, 2.06, and 2.51 million short tons, respectively. Brine was used exclusively as a feedstock by the chemical industry. According to the Salt Institute (<http://www.saltinstitute.org>), as of today, virtually all food grade salt sold or used in the United States is produced by evaporation. This was the case in 1924 as well (personal communication from Richard Hanne-



public-service character of the project, had initial qualms about its economic feasibility and profitability; it would be financially impossible to separate the salt intended for the Michigan market and then add iodine to it. Instead, the Salt Producers Association decided to launch iodized salt nationwide. Through aggressive advertising of the “new salt,” salt companies contributed to the educational campaign throughout the country (Markel (1987, p. 224)). Figure 1 shows two newspaper advertisements from this period.

Michigan was the first state to introduce iodized salt in May 1924. Morton Salt Company, the largest producer in the country at the time, began selling iodized salt on a nationwide basis in the fall of 1924.<sup>13</sup> At the same time public awareness of the problem, especially in those areas that were worst afflicted, was gaining momentum. Articles in newspapers and magazines around the country advocated the use of the new salt for all cooking and eating purposes, making references to successful goiter prophylaxis in Switzerland. In advertisements for iodized salt the new commodity bore the endorsement of state or national medical associations, and educational booklets were provided by the salt companies upon demand. Many newspaper sources show the generalized availability and use of iodized salt from 1924 onwards. In addition, as we show in Section 5, the rapid rise in thyroid-related mortality, not only in Michigan but throughout the country, further indicates that iodine supplementation diffused quite rapidly.

## 4 Data Sources

To implement our identification strategy we need data on the prevalence of iodine deficiency before 1924, as well as data on outcomes of individuals born in these areas both before and

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man, President, Salt Institute, March 6, 2008). In 1924, Michigan was the largest producer of evaporated salt in the country, accounting for 36% of total salt production. The next largest producers were New York (18%) and Ohio (14%) (Katz (1927)).

<sup>13</sup>Markel (1987). Collusion in the evaporated salt industry was widespread, and Morton acted as the price setter. Many companies literally made copies of Morton’s price schedule, simply replacing their company letterheads for that of Morton (Fost (1970)). Morton’s decision to iodize salt in 1924 would thus likely have affected a large percentage of households, both directly and through Morton’s influence on smaller companies.

after 1924. Our primary data sources take advantage of two previously unused surveys of prime age American males in the early part of the twentieth century.

## 4.1 World War I: Defects Found in Drafted Men

For data on the prevalence of iodine deficiency before 1925 we use a volume entitled *Defects Found in Drafted Men* (henceforth referred to as *Defects*), published by the War Department in 1920 (Love and Davenport (1920)).<sup>14</sup> *Defects* summarizes the results of all the physical exams performed on draftees during World War I for both accepted and rejected men. Data on prevalence rates per 1,000 are recorded for 271 different medical conditions. The data are regional, organized by units called sections. All but the lowest population states are broken down into multiple sections. Illinois and New York, for example, are each broken down into 8 sections. Each section is defined as a collection of counties.<sup>15</sup> In total, *Defects* has data on 151 separate regions of the country.

The medical condition of interest for our study is simple goiter, which is a direct result of iodine deficiency. We use simple goiter as a proxy for underlying iodine deficiency. Simple goiter is relatively common in the data, with a population weighted average prevalence of about 5 cases per 1,000. Across states, rates range from a high of almost 27 per 1,000 in Idaho to a low of 0.25 per 1,000 in Florida. Figure 2 is a histogram of the distribution of goiter across the 151 sections in *Defects*. Though there are no sections with a zero rate of simple goiter, about one third of the sections have rates of less than 1 per 1,000. The fact that the data are at a finer level of aggregation than the state level is important because there is significant regional variation within the high-goiter states. For example, in the five sections in Michigan the rates reported in *Defects* range from over 25 in the Upper Peninsula to less than 10 in Detroit and the surrounding areas.

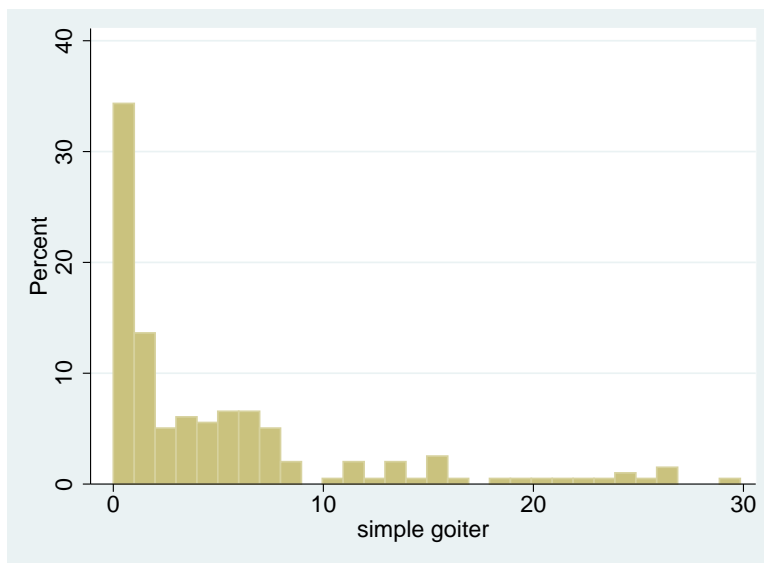
The conclusion that spatial variation in goiter rates, as documented in *Defects*, was

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<sup>14</sup>Many thanks to Hoyt Bleakley for making us aware of this marvelous book.

<sup>15</sup>Since county borders in the US are relatively static, it is straightforward to map the *Defects* sections to present day US counties.

Figure 2: Distribution of goiter rates across World War I sections

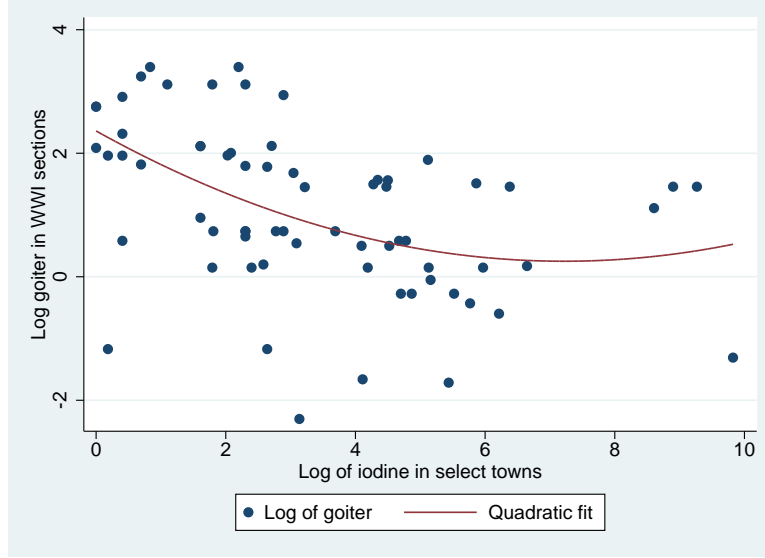


Source: Love and Davenport (1920)

caused by variation in the underlying geological characteristics across locations is supported by the fact that goiter rates correlate well with measures of the iodine content of water across localities. In a paper published in the *Journal of the American Medical Association* in 1924, J.F. McClendon and Joseph C. Hathaway provided measures of the iodine content of drinking water from 67 localities (some of them in the same county) across the US. These measures came from lakes, springs, rivers and wells. Their paper includes US maps with the low-iodine areas being shaded, and other maps where the high-goiter areas are shaded (their data on goiter come from the *Defects Book*). The two shaded areas in the two maps largely overlap (McClendon (1924)). Figure 3 is a scatterplot of the log of iodine in a certain locality against the log of simple goiter in the corresponding section from *Defects*.

Figure 3 shows that goiter prevalence is a matter of geography; goiter is higher where the iodine content of water is lower. The variability in goiter across low-iodine areas arises, to some extent, from measurement issues. The goiter data come from comprehensive physical examinations of World War I recruits, whereas the data on the iodine content of water come from selected lakes, springs, rivers and wells. It is possible that, while the water source in

Figure 3: Goiter and iodine content of water



Source: McClendon (1924) and Love and Davenport (1920)

one area was iodine-poor, neighboring areas (belonging to the same section) had access to an iodine-rich supply of water, driving the section goiter prevalence down. Another source of variability is distance from the ocean. Even if a town had a low content of iodine in its water supply, the population in the surrounding areas would have been spared if iodine were plentiful in the air. In our estimation we do not use the iodine content of water as our main measure of iodine deficiency because it is only available for a small number of counties. We do, however, use it as an alternative measure of iodine deficiency in a robustness check, and show that it supports our main results.

## 4.2 World War II: Army Enlistment Data

The World War II enlistment data are from the National Archives and Records Administration (NARA). They originated in punch cards produced during the enlistment process for the United States Army. It includes both volunteers and draftees. After the war these punch cards were converted to microfilm. In 1994 NARA hired the census department to scan the microfilm into a collection of over 9 million enlistment records from 1938-1946. Though

not complete, these records represent the majority of the enlistment into the Army during this period. Of the 1,586 rolls of microfilm, 1,374 (87%) were successfully scanned, leaving approximately 1.5 million punch cards unrecorded. The missing rolls are not sequential, and there are no indications that the records are missing in any systematic fashion. In addition to the missing rolls, several hundred thousand individual records were unreadable. As far as we know, the only other study to date using this data is Ferrie et al. (2012) which studies the effect of lead exposure on the outcome of World War II enlistees.

Though the format of the punch cards changed somewhat over the course of the war, the coding for basic demographic information was consistent. The demographic fields are name, serial number, state and county of residence, place and date of enlistment, place and year of birth, race, education, and marital status. In addition, the particular branch of the Army that the enlistee entered is coded. One can also infer through the serial number whether the person was drafted. There are no records for individuals who entered the Navy or Marines.

The sample we have available to us is very large and the timing of the draft is nearly perfect for our purposes. Limiting our sample to white men, we have data on over 300,000 from each birth year between 1921 and 1927, giving us extremely good coverage on both sides of the 1924 salt iodization date. Unfortunately, the data do not include the county of birth, only the state. We therefore limit our sample to individuals whose birth state is identical to their state of residence and we assume that the county of residence upon enlistment is the county of birth.<sup>16</sup> This eliminates 24.1% of the sample. Further limiting our attention to white males born between 1920 and 1928 and enlisting between 1940 and 1946 leaves us with 2.27 million records.

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<sup>16</sup>Classical measurement error in the county of birth will introduce attenuation bias in our estimates, which should therefore be seen as lower bounds.

### 4.3 Test Scores and Assignment to the Air Forces

All enlistees were given the Army General Classification Test (AGCT).<sup>17</sup> Unfortunately, the score only appears in our data for a brief time period too early in the war to be useful for our study.<sup>18</sup> We can, however, make some crude inferences about the test scores by examining which army branch the enlistees were assigned to.

Each test taker was assigned a grade of I, II, III, IV, or V, with class I being the highest. Skilled positions like mechanics tended to get class I or II enlistees, while lower-skill jobs, like cooks tended to get class IV or V enlistees. We do not know the particular job assignment of each recruit. However, we can identify enlistees who were assigned to the Army Air Force (AAF) versus those who were assigned to the Army Ground Forces (AGF).<sup>19</sup> Roughly 14% of all enlistees were assigned to the Air Force over the course of the war, though this proportion varied from year to year.

Table 1 summarizes our enlistment data. It gives the total sample size and the percentage of recruits going to the Air Force for each cohort and each enlistment semester. The number of enlisted men peaks in the second half of 1942 and the first half of 1943. Men born after iodization enlisted in large numbers starting the first semester of 1943. The proportion of recruits going to the Air Forces was particularly low in 1943, reflecting changes in war demands, as ground operations in Europe began in November 1942.

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<sup>17</sup>The AGCT was a predecessor to the Armed Forces Qualification Test (AFQT) that is currently given to enlistees.

<sup>18</sup>See Ferrie et al. (2012) for a more detailed description of AGCT scores in the NARA data.

<sup>19</sup>During World War II military aviation was part of the Army and not a separate branch. The Army Air Force was established in June of 1941 as a semi-autonomous group within the Army. Prior to this reorganization the aviation wing of the Army was known as the Army Air Corps. We will refer throughout to the Army Air Force even though our data span this renaming.

Table 1: Sample size and probability of joining the AAF by birth year and enlistment semester

semester of enlistment	Year of birth										Total
	1920	1921	1922	1923	1924	1925	1926	1927	1928		
Jan-June 1940	19.05 42	12.90 62	6.67 30							13.43 134	% AAF Sample size
July-Dec 1940	14.64 24580	12.93 28167	13.64 20492							13.70 73239	% AAF Sample size
Jan-June 1941	19.13 19593	15.78 17651	20.58 15445	35.94 3052						19.39 55741	% AAF Sample size
July-Dec 1941	37.70 33757	68.03 6628	60.74 6171	56.87 6511						46.52 53067	% AAF Sample size
Jan-June 1942	16.45 73433	33.07 32665	45.40 11995	39.76 10164	30.34 2864	21.69 83				25.35 131204	% AAF Sample size
July-Dec 1942	7.17 105570	6.61 182286	16.32 148683	59.17 44544	59.91 29485	24.44 90				17.22 510658	% AAF Sample size
Jan-June 1943	5.60 19894	8.65 22683	4.26 59447	1.67 152767	1.38 141765	1.60 28716	8.51 94			2.49 425366	% AAF Sample size
July-Dec 1943	7.00 10404	8.44 10382	8.08 10175	5.69 14951	4.30 27783	9.04 70236	31.25 64			7.53 143995	% AAF Sample size
Jan-June 1944	3.74 14374	5.66 10830	6.40 9159	5.23 9563	4.39 10969	18.11 40914	26.33 29866			14.32 125675	% AAF Sample size
July-Dec 1944	1.06 11368	1.55 9021	1.57 6879	0.79 8652	0.31 10938	1.45 15779	13.02 75560			7.63 138197	% AAF Sample size
Jan-June 1945	0.91 4734	1.15 4255	0.87 4032	0.26 4967	0.13 6724	0.21 8227	19.70 56122	7.24 29750	10.00 50	11.26 118861	% AAF Sample size
July-Dec 1945	28.10 8694	25.59 9598	22.52 9346	19.43 10773	14.94 13091	10.63 15767	11.51 40479	12.18 81021	37.18 9628	15.54 198397	% AAF Sample size
Jan-June 1946	37.42 5320	32.82 6553	29.79 6669	25.00 7583	19.12 9229	14.20 11306	12.09 19160	11.05 78868	27.09 65417	19.11 210105	% AAF Sample size
July-Dec 1946	40.69 1826	39.51 1987	38.92 2297	36.70 2455	30.73 3114	21.53 3604	16.78 5000	10.43 20148	18.82 49459	19.25 89890	% AAF Sample size
Total	14.23 333589	12.49 342768	15.60 310820	15.97 275982	10.50 255962	9.53 194722	16.17 226345	10.89 209787	24.58 124554	14.00 2274529	% AAF Sample size

Source: National Archives and Records Administration (2002)

## 4.4 The Battle for the Best Enlistees

The Army Air Force (AAF), which was still part of the Army during World War II, had a large proportion of jobs that required skilled recruits relative to the Army Ground Forces (AGF). Throughout the war, the AAF pushed to have a large proportion of the more highly skilled recruits assigned to them. In February 1942, the AAF successfully got the “75% rule” put into place. Under this rule, 75% of the men assigned to the AAF were to have scored above 100 (the median score) on the AGCT.<sup>20</sup> From this, we can infer that individuals assigned to the AAF during this period have, on average, higher test scores than those assigned to the AGF.

Unsurprisingly, the AGF was not pleased with this arrangement, and this rule was not in place for the entire war. Though lower skilled recruits could easily be used in the infantry, the AGF was concerned about having a supply of recruits who could become high-quality combat leaders. The AGF successfully lobbied the War Department to change the rule on August 1, 1942 so that the proportion of above average men received by the AAF was reduced to 55%.<sup>21</sup>

The AAF fought back against this change by using a second test, the mechanical aptitude (MA) test, as a screen for AAF recruits. At first, they simply requested that a higher proportion of men assigned scored above average on the MA test. This was later formalized. From December 1942 until June 1943, the AAF was supposed to be assigned 55% of their new recruits from the group with scores greater than the mean on both the AGCT and the MA tests. Combining the two tests was obviously more restrictive than just using one test. In fact only 37.5% of all recruits were above average on both tests.<sup>22</sup> This rule was allowed to expire, but it is clear that the AAF continued to get higher quality of recruits. For example, for those inducted in 1943, 41.3% of soldiers assigned to AAF were class I or

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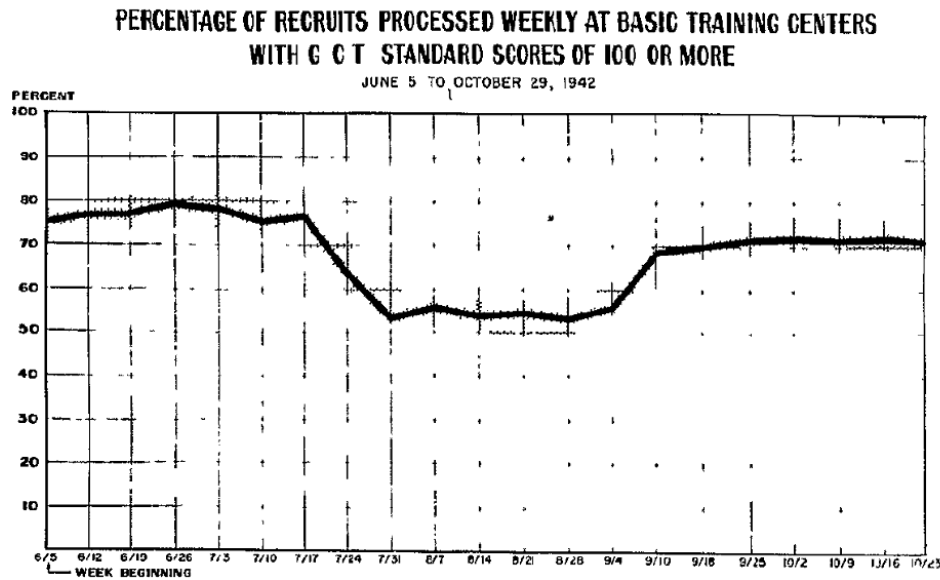
<sup>20</sup>US Air Force Historical Study #76, Classification and Assignment of Enlisted Men in the Air Arm 1917-1945, p. 44.

<sup>21</sup>ibid, p.46.

<sup>22</sup>ibid, p.56.



Figure 4: Percentage of Air Forces Recruits with above average AGCT scores



Source: US Air Force Historical Study #76:  
Classification and Assignment of Enlisted Men in the Air Arm, 1917-1945.

II. This percentage is higher than the one corresponding to Ground Combat Arms (29.7%) and Services (36.5%) (Palmer et al. (1948)).

Figure 4 is a graph from the War Department showing the percentage of recruits assigned to the AAF with above average AGCT scores during the period of time that these rule changes were occurring. During the early part of the graph, the 75% rule was clearly in operation. At the end of July, the abolition of the 75% rule can be seen, with the AAF only getting 55% of recruits from the above average group. By September, the AAF had almost managed to return to the old proportions via the 55% mandate on both the AGCT and MA tests.

Additional evidence on the positive selection of men with high cognitive function into the AAF comes from an anomaly in the WWII enlistment data. As mentioned above, all new enlistees in the army took the AGCT test, but this test result was not generally recorded on the punch cards that are the primary source for the enlistment data. However, from March to

May 1943, AGCT scores were recorded in the field marked “weight” for almost all recruits.<sup>23</sup> The fact that AGCT was coded in this field for some subset of the war is suggested in the documentation. Observing the actual distribution of values in the “weight” field confirms this is true for a subset of observations. Examining observations from enlistments through 1942, the weight field has a mean of 147 and a standard deviation of 28. For the period of March through May of 1943, the mean is roughly 106 and the standard deviation is about 80. Once we eliminate values which are below 20 and over 180, which clearly do not correspond to test scores (3.7% of observations), the mean becomes 98 and the standard deviation 21. These numbers are very close to the intended mean and standard deviation of the AGCT.<sup>24</sup>

Figure 5 shows a histogram of AGCT scores for recruits entering the Air Forces alongside a histogram for all other recruits.<sup>25</sup> For the non Air Forces group there are 175,731 reported scores with a mean of 97.7 and a standard deviation of 21.1. This distribution matches the normal distribution of the AGCT (mean of 100 and standard deviation of 20). The second panel shows the histogram of recruits entering the AAF in this period. The mean of 124.1 suggests that the AAF was, at this point, receiving substantially better recruits than the ground forces. However, as seen in Table 1, this was also a period in which very few recruits entered the Air Forces. This histogram is based on only 541 AAF recruits.<sup>26</sup>

The preferential treatment of the AAF lasted until the end of 1943, when the “infantry crisis” broke out. The need for high-quality ground forces grew more acute in 1944 and lasted until the end of the war, while, at same time, air operations were not as important

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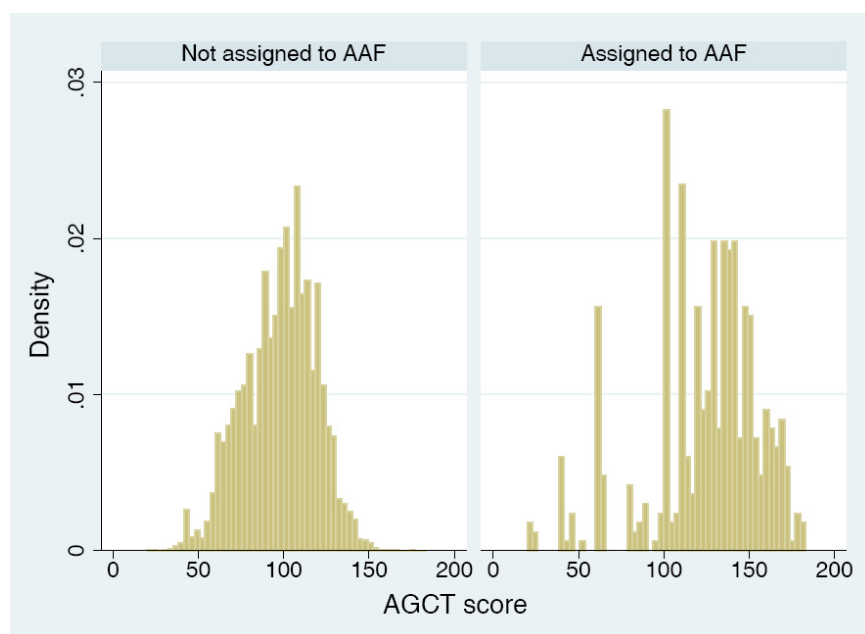
<sup>23</sup>Many thanks to Joe Ferrie for pointing this out to us.

<sup>24</sup>We must also note that correlation of the “weight” field with education is much stronger for this limited time period, at about 65%, compared with no correlation for the rest of the sample. This strong correlation, however, is only true for cohorts born up to 1925. It drops to 35% for the 1926 cohort, which only consists of 28 observations. There are no observations for the 1927 and 1928 cohorts.

<sup>25</sup>We only include values between 20 and 180, which are realistic test score values. The vast majority of observations (96.3% of the sample) are in this range. In addition, because the recording of AGCT scores in this field was for such a short period of time, there is some question as to whether all enlistment places coded this field the same way. For this reason we also drew the histograms using only data from enlistment places with over 500 recruits and where the mean of the weight field is between 80 and 120 within the enlistment place. This eliminated less than 11,000 observations and did not substantially change the distributions.

<sup>26</sup>Out of the 541 recruits who were assigned to the Air Forces over that period, none of them was born in 1926 or later, and only 37 individuals were born in 1925.

Figure 5: AGCT scores for AAF versus all other enlistees



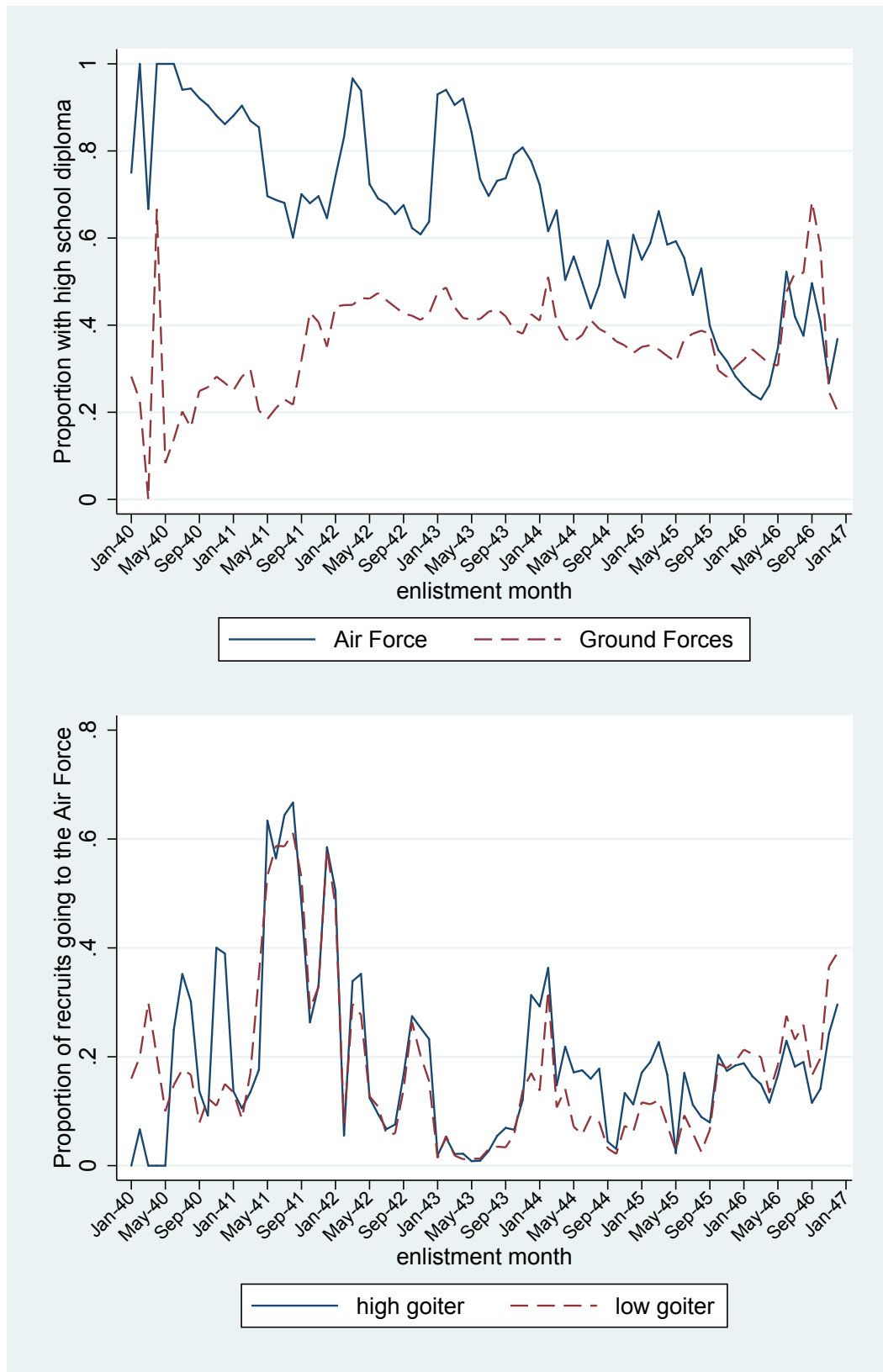
Source: National Archives and Records Administration (2002)

as in previous years. This meant that priorities between the AAF and the AGF shifted in favor of the latter, and the Army classification system was revised to allow for better-quality soldiers to join the Ground Forces.<sup>27</sup>

Figure 6 shows selectivity and demand for Air Force recruits monthly over the course of the war. The upper plot in Figure 6 shows the percentage of total recruits who had a high-school degree in the Air Force and the Ground Forces. The lower plot shows the percentage of all recruits being assigned to the Air Force. The Air Force received a significantly higher proportion of high-school graduates until November 1945, though the degree of selectivity varies. There is a spike in the proportion of high-school graduates in the Air Forces around February 1942, when the 75% rule was put into effect. The temporary decrease in the second half of 1942 corresponds to the withdrawal of the 75% rule. In late 1942 and early 1943, when the Mechanical Aptitude Test was put into use, the Air Force returned to the

<sup>27</sup>The New classification procedure was based on “The Physical Profile System”, which became operative in 1944, and classified recruits into three profiles, according to their ability to withstand strenuous combat conditions. 80% of men assigned to the AGF had to belong to the top profile, whereas only 10% of the AAF recruits came from the top group.

Figure 6: Air Force demand and selectivity in WWII



Source: National Archives and Records Administration (2002)

Table 2: Proportion of high-school graduates by birth year and branch.

Birth Year	<b>High-school Graduation Rate</b>		
	Air Force	Ground Forces	Total
1920	76.1	42.9	47.6
1921	76.1	41.4	45.7
1922	70.3	39.8	44.6
1923	60.6	43.7	46.4
1924	52.2	39.5	40.8
1925	56.9	35.9	37.9
1926	51.0	36.8	39.1
1927	33.3	38.5	37.9
1928	26.4	40.7	37.2
Total	59.2	40.2	42.9

Source: National Archives and Records Administration (2002)

preferential-treatment status it enjoyed before.

The lower-figure plots demand for Air Force recruits separately for high- and low-goiter sections. Fluctuations in these curves are driven by war events that dictated specific Army needs. For example, the US first engaged in air combat, driving up the demand for Air Force recruits in the beginning of the war. Right after ground operations got underway, in the end of 1942, there was higher demand for recruits in the Ground Forces, with a corresponding decrease in the numbers assigned to the Air Force for 1943.

Table 2 gives the proportion of high-school graduates in each branch by birth year. Later cohorts were less likely to have a high-school degree than the earlier cohorts because as the war progressed the demand for manpower led to the drafting of ever younger men. There is clear positive selection into the Air Force for cohorts born before 1927. About half of the 1927 and most of the 1928 birth cohorts enlisted after positive selection for the Air Force had ended. As we will show, the fact that there was *no* positive selection into the Air Force for the 1928 birth cohort is consistent with our empirical results. For our purposes, positive

selection into the Air Force for birth cohorts from 1920 until 1926 gives us good coverage of pre- and post-treatment enlistees.

We take advantage of selection into the Air Forces in two ways. First, if iodine deficiency affects cognitive ability we should expect a jump in the relative rate of assignment to the AAF for recruits born after 1924 in those counties where goiter rates were high in the *Defects* data. Second, by exploiting the normal distribution of the AGCT test, we can interpret our estimation results in terms of IQ gain for those regions where iodine deficiency was eradicated.

## 5 The Rise in Thyroid-Related Deaths

As discussed earlier, the treatment designed to help goiter sufferers sometimes ended up killing them. In Europe, the potential negative side-effects of iodine treatment had been discussed as early as the nineteenth century (McClure (1934) and Carpenter (2005)) and made universal iodine prophylaxis a controversial public health measure. In this Section, we document a large increase in deaths linked to the adoption of iodized salt, which we have not seen previously discussed in the literature.

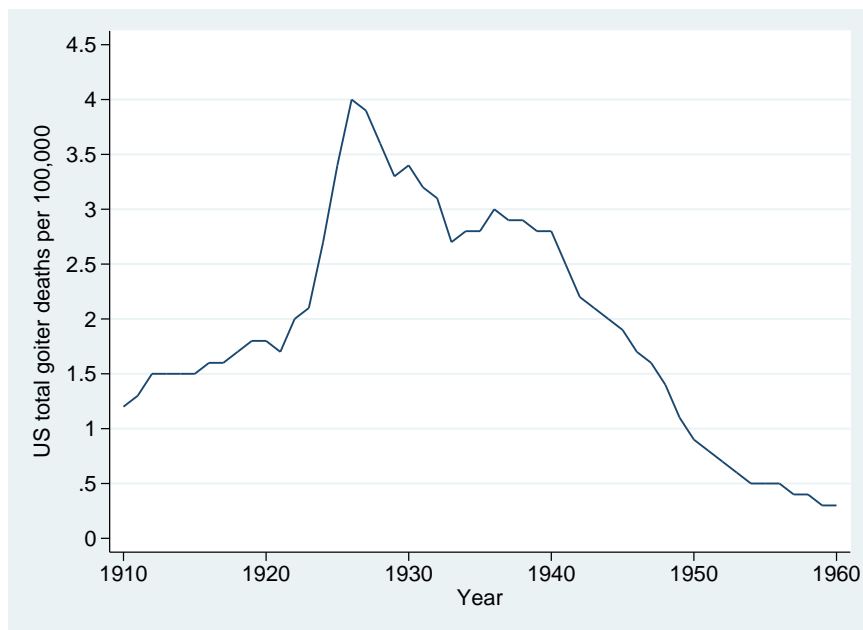
Figure 7 shows the annual rate of deaths in the US over the period 1910-1960 due to exophthalmic goiter, which accounted for the overwhelming majority of deaths due to thyroid disease over this period.<sup>28</sup> There is an extremely large rise in the death rate at the time of iodization. Between 1921 and 1926 the death rate nearly doubled from 2.1 to 4 per 100,000. Deaths due to goiter remained elevated for at least a decade. There was also a large gender disparity in death rates. In 1926 death rates were over 6 times as high for women as for men.<sup>29</sup> The population of the United States in 1926 was 117 million, and so the rise of approximately two deaths per 100,000 people represented an extra 2,340 deaths in that year.

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<sup>28</sup>Source of data: Grove and Hetzel (1968). Exophthalmic goiter is an enlargement of the thyroid accompanied by bulging of the eyes, which is sign of hyperthyroidism. While some medical dictionaries use the definition stated here, others define exophthalmic goiter as being synonymous with Graves disease, which is the dominant cause of the condition today. It is clear that the definition used in the text was being applied in the vital statistics data.

<sup>29</sup>1.1 per 100,000 for men, 7.0 per 100,000 for women.

Figure 7: US deaths from exophthalmic goiter, 1910-1960



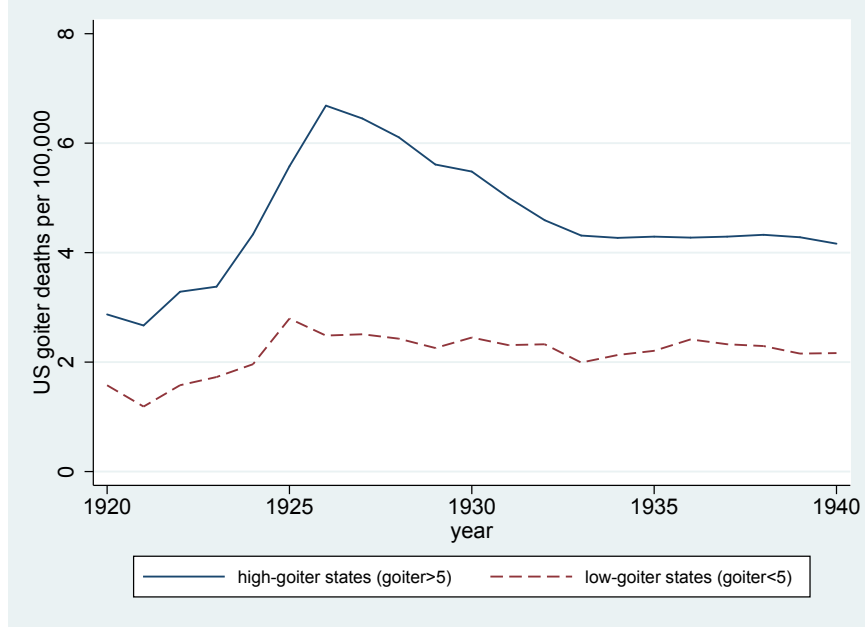
Source: Grove and Hetzel (1968)

Over the period 1925-1942 there appear to be at least 10,000 excess deaths that resulted from the introduction of iodized salt. We have found little discussion in the literature of what appears to be a high short-term price the country paid for long-run benefits resulting from this public health intervention.<sup>30</sup>

The medical literature suggests that iodine-induced hyperthyroidism is most common among those with long-standing iodine deficiency. Consistent with this, the rise in the death rate was highest, and persisted the longest, among older age groups. Deaths in the 25-34 age category less than doubled from 1921 to 1926, and had fallen below their 1921 level by 1935. In the 65-74 age category, deaths more than tripled between 1921 and 1926, and were still three times their 1921 level in 1935. The link between iodine deficiency and the rise in deaths at the time of iodization is also apparent looking across states. Figure 8 plots goiter deaths over the period of salt iodization separately for high- and low-goiter states. We label a state as high-goiter if its goiter prevalence in *Defects* is higher than 5 cases per

<sup>30</sup>An exception is McClure (1934) who notes that goiter deaths in Detroit spiked in the second year following iodization.

Figure 8: Deaths from exophthalmic goiter, by state group, 1920-1940



Source: U.S. Department of Commerce (various years)

1,000.<sup>31</sup> The trends between the two state groups are similar except for the period from 1925 to 1932. There is a sharp rise in deaths in high-goiter states in 1925 and 1926, which we do not observe for low-goiter states. As expected, large increases in mortality all took place in states that had high levels of goiter due to iodine deficiency. In addition, the rise in goiter deaths occurs sharply after 1924, which is when salt iodization began in Michigan. The evidence from mortality rates suggests, therefore, that iodization spread quickly around the country after its introduction in Michigan in 1924.

## 6 Identification

Our identification strategy relies on spatial variation in the extent of pre-existing iodine deficiency along with temporal variation arising from the introduction and rapid spread of iodized salt. High-goiter areas provide the treatment group and low-goiter areas the control

<sup>31</sup>High-goiter states are: Idaho, Oregon, Washington, Montana, Utah, Wyoming, Wisconsin, Michigan, North Dakota, Minnesota, West Virginia, Illinois, Iowa, Indiana, Nevada, Ohio, and Colorado.



group. Years before 1924 are pre-treatment and years after 1924 are post-treatment.

Our baseline regression specification is the following Linear Probability Model:

$$y_{iste} = \alpha + \sum_{t \neq 1924} \beta_t [goiter_s \cdot I(t = \text{birth year})_t] + controls_{ste} + \epsilon_{iste}$$

where  $y_{iste}$  is an indicator variable equal to 1 if an individual  $i$  born in year  $t$  in locality  $s$  and joining the Army at time  $e$  was assigned to the Air Force, and equal to 0 otherwise.<sup>32</sup>

The goiter rate interacted with a set of birth year dummies provides the main coefficients of interest. We choose 1924 as the excluded category, so that the coefficients of interest correspond to differences relative to the 1924 cohort. Iodized salt first became available in May 1924, and take-up, while rapid, was not instantaneous. Field et al. (2009) provide evidence that the first trimester of gestation is the most relevant period for the cognitive impact of iodine deficiency. Thus the majority of those born in 1924 would not have been treated at all. The pattern of coefficients on the interaction of goiter and birth year dummies will show how the relationship between the geologically determined level of iodine deficiency and cognitive ability changes over time. The iodization of salt in 1924 should make these coefficients significantly larger for the later cohorts. Note, however, that we do not impose any particular pattern in the coefficients of interest; we let the data tell the story of whether and how the probability of enlisting in the Air Force changed for cohorts born in affected areas, and we check whether that matches the introduction of iodized salt.

In all the regressions we include a full set of *Defects* section fixed effects, as well as a set of state-specific trends. The latter control for gradual changes at the state level, which might affect each cohort's probability of enlisting in the Air Force. In our first specification, we also include a full set of birth year fixed effects interacted with enlistment year indicator variables, to control for the changing demands of the war and the need for Air Force recruits. The interaction of birth year and enlistment year fixed effects also implicitly provides a control for enlistment age. In another specification, we include full sets of both birth year fixed effects and enlistment month fixed effects.

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<sup>32</sup>We also estimated a Logit model, with similar results (available upon request).

In our final sample we include all white males born between 1920 and 1928, who joined the Army between January 1940 and December 1946, who reside in their state of birth, and who were between 17 and 26 years old when they enlisted.<sup>33</sup> Since our identification relies on variation within a given birth - enlistment year cohort, we only use birth year - enlistment year cells with more than 100 observations.<sup>34</sup> Finally, because our theory relies on the Air Force getting preferential treatment, for most of the analysis we focus on the enlistment period up to November 1945, which is when positive selection for the Air Force ends.

We use two-way clustering for standard errors, at the *Defects* section level and the birth year level. To corroborate our findings, we conduct several robustness checks: first, we check that our estimates are not confounded by changes in demand for Air Force recruits. The enlistment year - birth year interactions should control for changing demand conditions, but we also show that our results hold for different parts of the distribution of demand. Second, we use an alternative measure of underlying iodine deficiency, the iodine content of drinking water, which is available for a few locations. The estimates from this check are consistent with the results using goiter as our measure of iodine deficiency. We also did a falsification exercise using all the other diseases that were measured at the section level in *Defects*, to show that our pattern of coefficients is not generally replicated with diseases that were not affected by iodization. Results from this falsification exercise can be found in an online Appendix.<sup>35</sup>

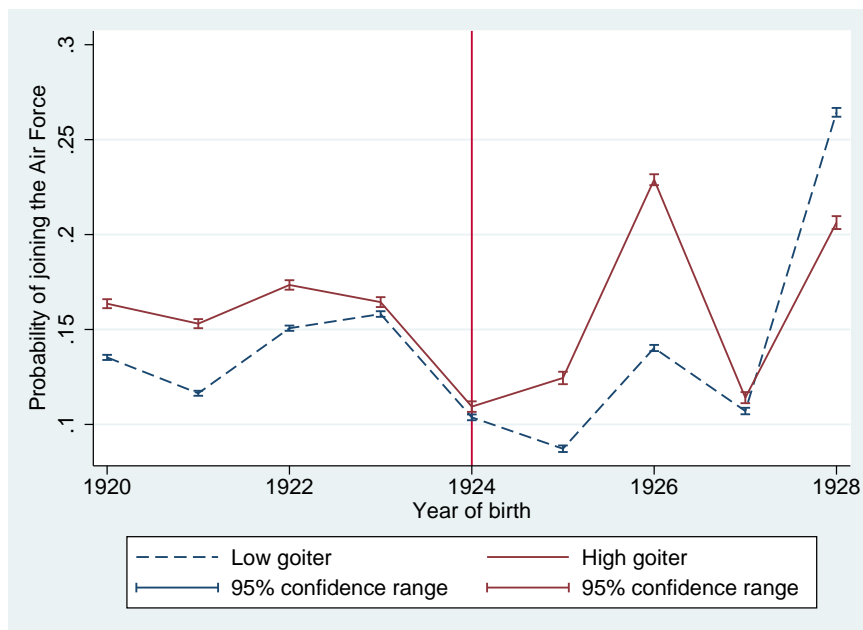
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<sup>33</sup>We drop recruits from Alaska, because there was no variation in their enlistment branch (only one individual is registered in the Air Force throughout our enlistment period).

<sup>34</sup>This means that enlistment for the 1923 birth cohort starts in January 1941, for the 1924 cohort it starts in January 1942, and for the 1927 cohort it starts in January 1945.

<sup>35</sup>We ran similar specifications with the same datasets using education as an outcome variable, but found no effect of iodization on education. We also tried using Census Data to identify an effect of iodization on education, using the goiter level at the *state* of birth, rather than the *section* of birth. We have not found any effect of iodization on education levels. While surprising, this finding is consistent with the fact that in our data we find a very weak correlation between AGCT scores and education. Specifically, the correlation between AGCT scores and graduation from high school is 14%, while the correlation between AGCT scores and having one year of college or more is just 9%.

Figure 9: Probability of joining the Air Forces



Source: National Archives and Records Administration (2002)  
and Love and Davenport (1920)

## 7 Results

Figure 9 is a first graphical preview of our results. We plot the probability of joining the Air Force for each cohort of recruits, by high-goiter and low-goiter group, according to the goiter level in their section of birth. The 95% confidence band around the means is very small, because our sample is large. The high-goiter group contains *Defects* sections which are at the top 25% of the distribution with a cutoff of 5.4 goiter cases per 1000. Figure 9 shows a jump in the probability of joining the Air Forces for the 1925 cohort coming from a high-goiter area relative to the same cohort coming from a low-goiter area. The jump is even more pronounced for the 1926 cohort. Note that half of the 1927 cohort and all of the 1928 cohort only enlisted after the Air Force stopped receiving preferential treatment among Army commands.

Figure 10 is a regression-adjusted graphical presentation of our results. Figure 10 plots the average residuals for each cohort - goiter group combination, after regressing an Air

Figure 10: Residual probability of joining the Air Forces



Source: National Archives and Records Administration (2002) and Love and Davenport (1920)

Force indicator variable on enlistment month fixed effects for each birth cohort separately. The 95% confidence band is, again, very narrow. Figure 10 accounts for changing demand conditions over the course of the war, and it shows that those cohorts born after iodization in a previously high-goiter area had a sudden increase in their probability of joining the Air Force (as long as they enlisted when there was positive selection into the Air Force), as opposed to those coming from low-goiter areas. Figure 10 also shows evidence of *negative* selection into the Air Force for the 1928 cohort, who enlisted during the final phase of the war.

Table 3 displays estimates from a linear probability model of assignment to the Air Force. The dependent variable is an indicator switching on if the individual entered the Army Air Force (AAF). The regressors of interest are the interactions of birth year dummy variables with a continuous measure of goiter in the section where the recruit was born. The excluded year is 1924, which is when iodized salt was introduced. The coefficients correspond to changes in percentage points in the probability of joining the Air Force. Columns (1) and

Table 3: Baseline results: Probability of enlisting in the Air Force

	(1) All enlistment months	(2) All enlistment months	(3) Positive selection months	(4) Positive selection months
Goiter X Born in 1920	-0.318 (0.225)	-0.312 (0.233)	-0.0229 (0.184)	0.00668 (0.173)
Goiter X Born in 1921	-0.156 (0.156)	-0.106 (0.162)	0.0491 (0.137)	0.113 (0.124)
Goiter X Born in 1922	-0.134 (0.0972)	-0.122 (0.128)	-0.0352 (0.0707)	-0.0187 (0.0641)
Goiter X Born in 1923	-0.167*** (0.0520)	-0.197*** (0.0685)	-0.135** (0.0533)	-0.169* (0.0934)
Goiter X Born in 1925	0.509*** (0.168)	0.468*** (0.127)	0.516*** (0.158)	0.494*** (0.124)
Goiter X Born in 1926	0.819** (0.323)	0.771** (0.324)	0.726*** (0.259)	0.693*** (0.243)
Goiter X Born in 1927	0.462** (0.233)	0.394** (0.198)	0.491** (0.209)	0.441** (0.181)
Goiter X Born in 1928	-0.0501 (0.415)	-0.152 (0.440)	-0.370 (0.399)	-0.518 (0.337)
Constant	149.9*** (10.80)	-146.1 (2,437)	77.03*** (16.81)	107.2 (2,516)
Observations	2,274,529	2,274,529	1,935,444	1,935,444
R-squared	0.131	0.134	0.153	0.167
Birth X Enlist. year FE	YES	NO	YES	NO
Section FE	YES	YES	YES	YES
State trends	YES	YES	YES	YES
Birth year FE	NO	YES	NO	YES
Enlist. month FE	NO	YES	NO	YES

Notes: Robust standard errors in parentheses: \*\*\* p<0.01, \*\* p<0.05, \* p<0.1; Coefficients correspond to changes in percentage points. Disturbances are clustered at the section and birth year levels. Columns (1) and (2) include enlistment months January 1940 to December 1946. Columns (3) and (4) include enlistment months January 1940 to November 1945.

Table 4: Probability of enlisting in the Air Force for high-goiter sections

	(1) top 20th percentile	(2) top 25th percentile	(3) top 30th percentile
High goiter X Born in 1920	1.602 (2.249)	-0.0967 (2.787)	0.905 (2.781)
High goiter X Born in 1921	2.249 (1.680)	1.432 (2.066)	2.784 (2.076)
High goiter X Born in 1922	0.0927 (1.268)	0.185 (1.606)	0.467 (1.619)
High goiter X Born in 1923	-0.930* (0.496)	-1.462** (0.680)	-0.908 (0.661)
High goiter X Born in 1925	3.796*** (1.223)	5.580*** (1.802)	5.267*** (1.582)
High goiter X Born in 1926	6.886*** (1.528)	10.00*** (2.421)	8.581*** (2.093)
High goiter X Born in 1927	4.421*** (1.654)	6.698*** (2.151)	3.507* (2.071)
High goiter X Born in 1928	-4.181 (2.904)	-7.360 (5.431)	-7.568 (5.276)
Constant	59.24*** (12.35)	67.71*** (14.97)	54.88*** (15.95)
Observations	1,935,444	1,935,444	1,935,444
R-squared	0.153	0.154	0.154
Birth X Enlist. year FE	YES	YES	YES
Section FE	YES	YES	YES
State trends	YES	YES	YES

Notes: Robust standard errors in parentheses: \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ ; Coefficients correspond to changes in percentage points in the probability of enlisting in the Air Force for enlistment months January 1940 to November 1945. Disturbances are clustered at the section and birth year levels. Column (1) treats the top 20% of the population-weighted goiter distribution as high-goiter. Column (2) treats the top 25% of the population-weighted goiter distribution as high-goiter. Column (3) treats the top 30% of the population-weighted goiter distribution as high-goiter.

(2) of Table 3 use all enlistment months in the estimation. In columns (3) and (4) we focus on the positive selection period, which ends in November 1945. Our theory relies on the Air Force getting preferential treatment in the cognitive ability of its enlistees, so we focus on this enlistment period in all other specifications. Columns (1) and (3) include interactions of birth year and enlistment year fixed effects. Columns (2) and (4) include birth year fixed effects and enlistment month fixed effects as controls.

The pattern of coefficients suggests a clear break before and after 1924. Cohorts born after 1924 in high-goiter sections are more likely to join the Air Force compared to other recruits. The 1923 cohort, which was the last cohort born before iodization in high-goiter areas, was less likely to be assigned to the Air Force compared to the cohorts that would have enlisted at the same time. The positive effect disappears for the 1928 cohort. This is consistent with the fact that the 1928 cohort enlisted when positive selection into the Air Force was largely over, as can be seen in Figure 6.

The effects that we estimate are large in high-goiter areas. The coefficients for 1925, 1926, and 1927 are between 0.4 and 0.8 percentage points. The most affected areas in our sample have goiter levels of roughly 30 per 1000 cases. Multiplying the coefficients by 30 indicates that the *most* affected areas saw a 12-24 percentage point increase in the likelihood of joining the AAF if they were born after 1924.

In Table 4 we run a specification similar to column (3) of Table 3, but instead of using a continuous measure of goiter, we separate the sample into high- and low-goiter sections, and include interactions of birth year dummy variables with a high-goiter indicator as our regressors of interest. We define high-goiter to correspond to the top 20% (column (1)), the top 25% (column (2)) and the top 30% (column (3)) of the population-weighted goiter distribution.<sup>36</sup>

The results of Table 4 echo the earlier results, but they are easier to interpret. Depending on how we define “high-goiter” and which cohort we are looking at, individuals born

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<sup>36</sup>The high-goiter cutoff for each percentile of the distribution is 6.65 goiter cases per 1000 for the top 20th percentile, 5.4 goiter cases per 1000 for the top 25th percentile, and 5.21 for the top 30th percentile.

post-iodization in high-goiter areas see a 3.8-10 percentage point increase in the probability that they enter the Air Forces compared to earlier cohorts. Given that the average rate of assignment to the Air Force is roughly 14% for the entire sample, this is a large effect.

In summary, the pattern of coefficients from the linear probability model suggests a big, sudden increase in the probability of assignment to the Air Force for later cohorts born in high-goiter areas. The timing of the change corresponds to the introduction of iodized salt, and is consistent with cognitive gains in utero for the treated populations.

## 8 Robustness checks

### 8.1 Changes in Demand for Air Force Recruits

In our main specification, the birth and enlistment cohort control variables account for changes in the overall demand for Air Force recruits over time, which, as shown in Figure 6, were dictated by war circumstances. In this Section, we check directly if our main results are affected by overall demand for manpower in the Air Force, by cutting the sample across different demand periods.

In Table 5 we rerun the linear probability model in column (3) of Table 3 limiting the sample by the proportion of recruits assigned to the Air Force in a particular month. Columns (1) and (2) looks at enlistment months when demand was above and below the median.<sup>37</sup> Columns (3) and (4) omit periods of very high and very low demand.<sup>38</sup>

Our main results are largely unaffected when we cut the sample across different parts of the distribution of demand for Air Force recruits. The estimates for periods of below-median demand are smaller than the estimates for periods of above-median demand but the pattern of coefficients is very similar to our baseline specifications. The estimates in columns (3) and (4) show that our results are not being driven by periods of exceptionally high or low demand

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<sup>37</sup>The median demand for Air Force recruits across the sample is 10.6%.

<sup>38</sup>The 10th percentile of the distribution of demand is 1.5%. The 90th percentile is 22.6%, the 25th percentile is 5.4% and the 75th percentile is 17.8%.



for Air Force recruits. The fact that coefficients for the 1927 cohort are not always robust to changes in demand is not surprising, given that only half of the 1927 cohort enlisted when there was positive selection into the Air Force in the first place.

## 8.2 Iodine Content of Drinking Water

The statistics compiled during the WWI draft and summarized in *Defects* provide a comprehensive and detailed survey of goiter prevalence throughout the US. To our knowledge, there is no higher-quality dataset on iodine deficiency across the US prior to the introduction of iodized salt. That said, goiter is not the only measure of iodine deficiency. In this Section we use the iodine content of drinking water in a given location as another measure of underlying iodine deficiency. Our data come from McClendon (1924), and they were collected from lakes, springs, rivers and wells across 67 localities in the US (see discussion in Section 4.1). These data are not as comprehensive as the goiter data, and they suffer from measurement issues, since the iodine content of a single source of drinking water might not be representative of a whole county’s access to iodine. They can serve, however, as a robustness check of our main results. Figure 3 shows that, as expected, the iodine content data correlate negatively with the goiter data from *Defects*.

We match the localities for which we have iodine content data to the county in which they belong. Some counties had more than one measures of iodine content. In those cases we calculate the average for the county. We end up with data on the iodine content of drinking water in 59 counties across 30 states. We then merge the iodine content data with our WWII enlistment data, and run a linear probability model similar to the one in column (3) of Table 3, using interactions of birth year dummy variables with the logarithm of iodine content in a given county. Our sample size is much smaller since we only have data from 59 counties; we lose almost 90% of observations. Instead of section fixed effects, we include county fixed effects. Similarly to column (3) of Table 3, we include birth year fixed effects interacted with enlistment year fixed effects, and we cluster standard errors both at the county and the birth

Table 5: Robustness check: Probability of enlisting in the Air Force in different demand periods

	(1) Above median demand for AAF	(2) Below median demand for AAF	(3) 10th-90th percentile demand for AAF	(4) 25th-75th percentile demand for AAF
Goiter X Born in 1920	-0.0290 (0.227)	0.284 (0.269)	-0.0140 (0.182)	-0.0999 (0.140)
Goiter X Born in 1921	0.170 (0.173)	0.237 (0.199)	0.0227 (0.123)	-0.102 (0.0768)
Goiter X Born in 1922	0.00252 (0.108)	0.161 (0.107)	1.33e-05 (0.0551)	-0.186*** (0.0653)
Goiter X Born in 1923	-0.0987 (0.0831)	-0.0339 (0.0701)	-0.0928* (0.0527)	-0.0903 (0.0661)
Goiter X Born in 1925	0.841*** (0.273)	0.221*** (0.0731)	0.466*** (0.161)	0.385*** (0.130)
Goiter X Born in 1926	0.935*** (0.344)	0.472 (0.327)	0.628** (0.266)	0.458* (0.241)
Goiter X Born in 1927	0.736** (0.308)	0.116 (0.198)	0.392** (0.176)	0.141 (0.161)
Goiter X Born in 1928	0.0709 (0.431)	-0.566 (0.423)	-0.613 (0.426)	-0.855* (0.504)
Constant	176.1*** (25.65)	91.02 (21,243)	16.60*** (5.164)	-11.89 (9.083)
Observations	990,063	945,381	1,429,928	902,809
R-squared	0.135	0.091	0.139	0.126
Birth X Enlist. year FE	YES	YES	YES	YES
Section FE	YES	YES	YES	YES
State trends	YES	YES	YES	YES

Notes: Robust standard errors in parentheses: \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ ; Coefficients correspond to percentage point changes in the probability of enlisting in the Air Force. Disturbances are clustered at the section and birth year levels. Demand for Air Force recruits is defined as the proportion of all recruits who enlist in the Air Force in a given enlistment month, for the enlistment period January 1940 to November 1945. Column (1) (column (2)) includes enlistment months above (below) the median of the population-weighted distribution of demand for Air Force recruits. Column (3) (column (4)) includes enlistment months within the 10th-90th (25th-75th) percentiles of the population-weighted distribution of demand for Air Force recruits.

Table 6: Robustness check: Probability of enlisting in the Air Force using the log of iodine content of drinking water in 59 counties

	(1) Air Force	(2) Air Force
log iodine X Born in 1920	-0.964 (0.831)	0.581 (0.538)
log iodine X Born in 1921	-0.771 (0.718)	0.178 (0.574)
log iodine X Born in 1922	-0.398 (0.585)	-0.0141 (0.576)
log iodine X Born in 1923	-0.378 (0.234)	-0.315 (0.251)
log iodine X Born in 1925	-1.454 (0.978)	-1.373* (0.725)
log iodine X Born in 1926	-1.830 (1.426)	-2.720 (2.193)
log iodine X Born in 1927	-1.048* (0.563)	-1.776 (1.276)
log iodine X Born in 1928	3.342*** (1.239)	1.206 (0.875)
Constant	-95.50*** (24.50)	41.12*** (5.993)
Observations	224,022	224,022
R-squared	0.175	0.158
Birth X Enlist. year FE	YES	YES
County FE	YES	YES
State trends	YES	NO

Notes: Robust standard errors in parentheses: \*\*\* p<0.01, \*\* p<0.05, \* p<0.1; Coefficients correspond to percentage point changes in the probability of enlisting in the Air Force during the enlistment period January 1940 to November 1945. Disturbances are clustered at the county and birth year levels.

year levels. We include state-specific trends, but they are only identified for the 14 states with multiple iodine content data. In addition, only 7 of those states have more than two county observations. This is why we also estimate the model without state trends.

Table 6 presents estimation results. Column (1) includes state-specific trends, whereas column (2) omits them. We generally do not have enough power to get statistically significant results (except for the 1925 cohort in column (2)), but the pattern of coefficients matches our earlier results. Cohorts born in high-iodine counties after the introduction of iodized salt have a lower probability of enlisting in the Air Force. The relationship breaks down for the 1928 cohort, similarly to our baseline results, reflecting the end of preferential treatment for the Air Force. The log of iodine ranges from 0 to 9.8 in our data, so going from the lowest to the highest iodine increases the probability of enlisting in the Air Force by 12.8 percentage points (using the point estimate for the 1925 cohort in column (2)). This estimate is very similar to the lower bound suggested by our baseline results.

## 9 Interpretation of Coefficients

In this Section we translate the results of our regressions in Section 7 into a measure of the implied intelligence increases in the population following iodine supplementation. To do so, we construct a simple model of the selection in to the Army Air Forces. We write the model in terms of IQ scores, which are a more conventional measure than the AGCT scores that were actually used in the selection of recruits.

Consider a pool of recruits composed of two populations. A fraction  $(1 - \phi)$  of recruits are from regions in which there is no iodine deficiency. Let their intelligence be represented by a random variable  $IQ$  that is distributed normally with mean of 100 and standard deviation of 15. A fraction  $\phi$  of recruits are from iodine deficient regions. Prior to treatment, their intelligence is given by the random variable  $IQ_d$ , distributed normally with a mean of  $X$  and a standard deviation of 15. The average level of IQ in the population would be  $\overline{IQ} =$

$\phi X + (1 - \phi)100$ . After treatment, the distributions are assumed to be identical.

As discussed above, a specific fraction of AAF recruits scored above the mean on the AGCT. Given this, we wish to examine how the probability of entering the AAF differs between the two populations before and after treatment. Let  $\psi$  be the fraction of recruits entering the AAF that had AGCT scores above the mean, and let  $\theta$  be the fraction of the overall pool of recruits that entered the AAF.

The sources that we have available do not describe the exact process by which the target percentage of above-average recruits in the AAF was achieved. Here we consider a simple and robust algorithm that would have produced this result. Suppose that initially, the AAF draws randomly from the pool of recruits until it has filled its quota for recruits *below* the mean. Since half the distribution is below the mean, this would fill a fraction  $2(1 - \psi)$  of the allotted slots. To fill the remaining available slots, the AAF would draw randomly from the pool of recruits with AGCT score above the mean.

Under such an algorithm, we can calculate the probability of someone from a low-iodine region entering the AAF as the sum of the initial draw from the entire distribution and the secondary draw where only the top half of the distribution is considered.

$$P(AAF|\text{iodine deficient}) = 2(1 - \psi)\theta + \frac{(2\psi - 1)\theta \cdot P(IQ_d > \overline{IQ})}{(1 - \phi)P(IQ > \overline{IQ}) + \phi P(IQ_d > \overline{IQ})}$$

Similarly, the probability of someone from a non-deficient region entering the AAF is:

$$P(AAF|\text{non-deficient}) = 2(1 - \psi)\theta + \frac{(2\psi - 1)\theta \cdot P(IQ > \overline{IQ})}{(1 - \phi)P(IQ > \overline{IQ}) + \phi P(IQ_d > \overline{IQ})}$$

The difference between these two probabilities corresponds to the regression coefficient in our specification. The difference is the increase in the probability of entering the AAF resulting from iodization<sup>39</sup>.

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<sup>39</sup>There is one subtle issue, which is how the cutoff for entry into the AAF would have changed when treated cohorts from iodine-deficient regions began to enter the recruit pool. At this time, the average level of AGCT scores would have gone up, and if the test were continuously re-normed, the cutoff for entry into the AAF would have gone up as well. We do not have any information about whether this took place. In the calculations presented here, we make the assumption that the cutoff did not change.

Table 7: Interpretation of coefficients

$X$ (Mean IQ)	Regression Coefficient
100	0
95	.015
90	.029
85	.041
80	.052
75	.060
70	.065

$$(2\psi - 1)\theta \frac{P(IQ > \overline{IQ}) - P(IQ_d > \overline{IQ})}{(1 - \phi)P(IQ > \overline{IQ}) + \phi P(IQ_d > \overline{IQ})}$$

We apply this model to our setting as follows. First, Figure 4 suggests that, on average, across all the different recruitment periods (the 75% rule period, the period with no rule, and the period with two rules), about 70% of Air Force recruits had an AGCT score above the median. Thus we set  $\psi = 0.70$ . Second, according to our data the fraction of all recruits going to the Air Force was 14%. We use this value for  $\theta$ . Finally, we need a measure of the fraction of recruits coming from iodine-deficient regions. In practice, there was a range of iodine deficiency as recorded in the *Defects* data. In column (2) Table 4 we defined our “high-goiter” dummy as corresponding to the one-quarter of sections with the highest prevalence of goiter. Thus we use a value of  $\phi = 0.25$ , and evaluate the coefficient from the regression that used this dummy variable.

Using these parameters, Table 7 shows the implied effect of iodization on the probability of entry into the AAF for a range of possible values of  $X$ , the mean level of IQ in the iodine-deficient regions. The estimated coefficient on the high-goiter dummy in Table 4 is in the range 3.8-10 percentage points. Comparing these estimates to Table 7, we see that the lower range of these estimates are consistent with iodization raising IQ by 15 points (that is,  $X = 85$ ), which is a reasonable expectation given the work of (Bleichrodt and Born 1994). However, the higher range of estimates is larger than any reasonable estimate of the increase

in IQ that would have resulted from iodization. Given the uncertainty surrounding the selection process and prior literature on iodization we do not consider the larger results plausible. In any case, our results are consistent with a substantial effect, in line with the existing literature.<sup>40</sup>

Our estimates and their interpretation are based on a sample of male recruits. However, there is evidence suggesting that females are more prone to the development of iodine deficiency disorders than males. Field et al. (2009) discuss experimental evidence that, in animals, females are more likely to suffer cognitive damage in utero as a result of iodine deficiency. Both Field et al. (2009) and Politi (2010) find larger effects of iodization programs on graduation rates for females than for males. Therefore, the effect of iodization on the general population might well be larger than our estimates suggest.

## 10 Conclusion

Iodization of salt in the United States was one of the first instances of broad-based food fortification, a practice that continues in wealthy countries to this day and is spreading rapidly to the developing world. The experience of the US offers a useful natural experiment for identifying the long-term effects of an important micronutrient deficiency that many developing countries still struggle with today. Prior to iodization, there was significant geographic variation in iodine deficiency, resulting from identifiable soil and water conditions. This variation can be measured using data on the prevalence of goiter, allowing us to clearly distinguish between treatment and control groups. Iodization of salt was national in scope and implemented rapidly. The key period in which iodine deficiency affects cognitive development is a narrow window during gestation. Thus we are able to easily differentiate treated from

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<sup>40</sup>As mentioned above, we do not know the algorithm that was applied in order for the AAF to hit the target number of recruits with AGCT scores above the average. An alternative to the method presented here would be for the AAF to set a minimum AGCT score such that, if it took all recruits with scores above this minimum, it would hit the target percentage above the median. For a given value of  $X$  (the average IQ in iodine deficient areas), such a method would produce a larger effect of iodization on the probability of entering the AAF – and thus imply a lower rise in IQ – than the method that we consider.

non-treated cohorts.

We find that cognitive abilities of men born in iodine-deficient regions rose relative to those born in non-deficient regions for cohorts in utero after the advent of iodization. Our measure of cognitive ability is the probability of a man being assigned to the Army Air Forces, entry into which was partially based on performance on a standardized intelligence test. Interpreting our measure in terms of IQ, our finding is that in iodine-deficient regions, iodization raised IQ scores by roughly one standard deviation, or 15 points. Given that one-quarter of the population lived in such regions, this implies a nationwide increase in average IQ of 3.5 points. In developed countries, average IQ rose at a rate of roughly three points per decade for much of the twentieth century. This is the Flynn Effect, which is thought to be largely attributable to reduced health and nutrition insults in utero and among children. Thus our results are consistent with the elimination of iodine deficiency in the United States accounting for roughly one decade's worth of the Flynn Effect.

From the few pre-iodization surveys of goiter prevalence in the general population<sup>41</sup>, we know that iodine deficiency in the worst-afflicted parts of the United States was of a magnitude similar to that encountered in goitrous areas of developing countries and considered a serious public health concern many decades later.<sup>42</sup> Therefore, our results are relevant for current iodine supplementation efforts around the world.

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<sup>41</sup>See, for example, Cowie (1937) for a survey of a few counties in Michigan.

<sup>42</sup>To list a few examples from Kelly and Snedden (1960), in surveys conducted in 1954 Nicaragua had an average rate of goiter of 22.6% among children, with some departments recording rates over 50%. In the late 1940s Colombia had rates reaching 81% (in Caldas) among schoolchildren. In the mid-1950s many endemic regions in Sierra Leone and Sudan had population goiter rates exceeding 40%. Similar rates were recorded around the same time in Malaysia, Indonesia, and other countries.



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