Supplementary information

A saturated map of common genetic variants associated with human height

In the format provided by the authors and unedited

A Saturated Map of Common Genetic Variants Associated with Human Height

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TABLE OF CONTENTS

Acknowledgements (p. 3)

Supplementary Figures

Suppl. Fig. 1. Principal components analysis of contributing studies to the height meta-analysis alongside 26 genetic ancestry groups from the 1000 Genomes Project (p. 45).

Suppl. Fig. 2. Frequency and Imputation Accuracy distribution of HapMap 3 SNPs across five ancestry groups (p. 46).

Suppl. Fig. 3. Biases in conditional and joint analyses (p. 47).

Suppl. Fig. 4. Effect of collinearity on prediction accuracy of polygenic scores based on SNPs effects from conditional and joint analyses (p. 48).

Suppl. Fig. 5. Quantification of confounding due to population stratification in various European ancestry GWAS of height (p. 49).

Suppl. Fig. 6. Quantification of confounding due to population stratification in non-European ancestry GWAS meta-analyses (p. 50).

Suppl. Fig. 7. Quantification of confounding due to population stratification in the cross-ancestry GWAS meta-analysis (p. 51).

Suppl. Figs. 8 - 12. Correlation of marginal effects of genome-wide significant SNPs across ancestry groups (p. 52 – 56).

Suppl. Fig. 13. Correlation of marginal effects of sub-significant SNPs across ancestry groups (p. 57).

Suppl. Fig. 14. Replication of marginal associations in the Estonian Biobank (p. 58).

Suppl. Fig. 15. Schematic representation of the measure of signal density (p. 59).

Suppl. Fig. 16. Distribution of the density of genome-wide significant SNPs within 100 kb (p. 60).

Suppl. Fig. 17. Independent signal density at the ACAN gene locus across ancestries (p. 61).

Suppl. Fig. 18 – 19. Variance explained by SNPs within GWS loci (p. 62 – 63).

Suppl. Fig. 20. Optimal weighting of PGS and parental information in simulated data (p. 64).

Suppl. Fig. 21. Selection of the number of gene set clusters using the "Elbow method" (p. 65).

Suppl. Fig. 22. Heritability enrichment within gene sets prioritised with MAGMA and DEPICT (p. 66).

Suppl. Fig. 23. Gene-level saturation of GWAS discoveries as a function of sample size (p. 67 – 68).

Suppl. Fig. 24. Variant-level saturation of GWAS discoveries as a function of sample size (p. 69).

Suppl. Fig. 25. Partitioning of low-frequency SNP-based heritability within GWS loci (p. 70).

Supplementary Notes

Note 1. Sensitivity Analyses of COJO results (p. 71).

Note 2. Investigation of population stratification in a large of height (p. 72).

Note 3. Distinguishing loss of tagging from multiplicity of causal variants at the ACAN locus (p. 77).

Note 4. Optimal weighting of PGS and parental information for height prediction (p. 78).

Note 5. Saturation of GWAS signals within pathways and gene sets (p. 84).

Note 6. Quantification of the enrichment of SNP-based heritability from low-frequency variants within loci containing common SNPs associated with height (p. 86).

Supplementary Tables (additional data - spreadsheet)

Suppl. Tab 1. Study descriptive (and samples QC)

Suppl. Tab 2. Genotyping QC

Suppl. Tab 3. Phenotype Summary

Suppl. Tab 4 – 8. List of COJO SNPS from ancestry specific GWAS

Suppl. Tab 9. List of non-EUR ancestry specific COJO SNPS

Suppl. Tab 10. List of COJO-SNPs from trans-ancestry fixed-effect meta-analysis

Suppl. Tab 11. List of OMIM genes

Suppl. Tab 12. Lis of genome-wide significant loci

Suppl. Tab 13. List of Top gene sets per cluster of pathways

Suppl. Tab 14. List of OMIM genes per cluster of pathways

Suppl. Tab 15. Similarity in gene prioritisation within and across ancestries

Suppl. Tab 16. List of genes prioritised by summary data-based Mendelian Randomization

Supplementary References (p. 87)

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INSPIRE_AF

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The Multiethnic Cohort (MEC) is a population-based prospective cohort study including approximately 215,000 men and women from Hawaii and California. All participants were 45-75 years of age at baseline, and primarily of 5 ancestries: Japanese Americans, African Americans, European Americans, Hispanic/Latinos, and Native Hawaiians. (PMIDs: 10695593; 23449381) MEC was funded by the National Cancer Institute in 1993 to examine lifestyle risk factors and genetic susceptibility to cancer. All eligible cohort members completed baseline and follow-up questionnaires.

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Vejle Biobank

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Viking Health Study - Shetland (VIKING)

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Suppl. Fig. 1. Principal components analysis of contributing studies to the height meta-analysis alongside 26 genetic ancestry groups from the 1000 Genomes Project. Using data from 2,504 samples from the 1000 Genomes Project (1KGP), genotypes for 354,568 HapMap3 SNPs with frequency data from all participating studies were extracted. LD-pruning was subsequently performed using PLINK with a window size of 1Mb, a shift size of 50 variants, and an LD *r*² cut-off of 0.1 (PLINK command: --indep-pairwise 1000 50 0.1). After LD-pruning, 18,125 SNPs remained for subsequent analysis. Allele frequencies for the pruned set of variants were subsequently calculated within each of the 26 1KGP ancestral groups and aligned to the same reference allele. Principal components analysis was subsequently performed by using the 1KGP frequency data to build the model prior to projection of participating studies, having ensured study allele frequencies were also aligned to the same 1KGP reference allele.



Suppl. Fig. 2. Frequency and imputation accuracy distribution of HapMap 3 SNPs across ancestry groups. **Panel a**. Minor allele frequency (MAF) distribution of HapMap 3 SNPs across 5 ancestries: European (EUR), Hispanic (HIS), African (AFR), East-Asian (EAS) and South-Asian (SAS). **Panel b**. Average (across cohorts) proportion (y-axis) of HapMap 3 SNPs with a imputation accuracy statistic (INFO) above a certain threshold (x-axis). Vertical lines highlight two thresholds (0.3 and 0.9) commonly used to ascertained SNPs on imputation accuracy. Overall, **Panel b** shows that HapMap 3 SNPs are well imputed across all ancestry groups with >98% of SNPs with INFO>0.3 and >80% of SNPs with INFO>0.9.



Suppl. Fig. 3. Biases in conditional and joint effect estimates. Panel a: Prediction accuracy (squared correlation R²) of polygenic scores (PGS) based on genomewide significant (GWS) SNPs identified in 5 ancestry groups (EUR: European, EAS: East-Asian, HIS: Admixed Hispanic ethnicity, AFR: African (mostly Admixed African American) and SAS: South-Asian). For each set of GWS SNPs, Panel a compares the prediction accuracy obtained when the PGS is calculated from marginal SNP effects (PGS_{GWAS}) versus when the PGS is calculated from joint SNP effects (PGS_{C010}) estimated with the GCTA-COJO algorithm using default parameters. In ancestry groups, except HIS and AFR, the accuracy of PGS_{C010} is larger than that of PGS_{GWAS}. **Panel b** contrasts the per-chromosome correlation between PGS_{GWAS} and height (x-axis) with the per-chromosome correlation between PGS_{C010} and height (y-axis). These correlations were calculated in 2 samples of African ancestry participants from the UK Biobank (UKB, N_{AFR-UKB}=6,911) and the PAGE study (N_{AFR-PAGE}=8,238) and in 1 sample of Admixed Hispanic individuals also from the PAGE study (N_{HIS-PAGE}=5,798). **Panel c** represents for each chromosome (x-axis) the slope from regressing marginal SNP effects on joint SNP effects (y-axis). Regression slopes were estimated for GWS SNPs identified on each chromosome in GWAS meta-analyses in African and Hispanic ancestry groups. These results are further described and discussed in **Suppl. Note 1**.



Suppl. Fig. 4. Impact of the collinearity threshold (CT) used in the GCTA-COJO algorithm on prediction accuracy of polygenic scores (PGS) based using estimates joint effects. By default, the GCTA-COJO algorithm implements a stepwise model selection to identify sets of jointly significant SNPs such that the variance of genotypes at any SNP retained in the final model is not explained at more than CT=90% by other SNPs included in the model. We varied the value of the CT between 0.9 (least stringent) and 0.1 (most stringent) and monitored the prediction accuracy of PGS in different samples. Each panel represents CT on the x-axis and the prediction accuracy on the y-axis in a given ancestry group match with the ancestry of GWAS participants. Red dots represent prediction accuracies of PGS calculated from joint effects (PGS_{COJO}) and black that from marginal effects (PGS_{GWAS}). Overall, using stringent CT values tend to degrade the performances of PGS_{COJO} in all ancestry groups (EUR: European, EAS: East-Asian and SAS: South-Asian) except in admixed individuals with African ancestries (AFR) and of Hispanic ethnicity (HIS). These results are further described and discussed in **Suppl. Note 1**.



Suppl. Fig. 5. Quantification of confounding due to population stratification (PS) in various European ancestry (EUR) GWAS of height. UKB-456k (BOLT-LMM): GWAS in 456,414 EUR participants of the UKB. UKB-350k (unrelated): GWAS in 348,501 unrelated (i.e. estimated genetic relatedness < 0.05) EUR participants of UKB. 23andMe-EUR: GWAS in EUR participants of 23andMe. GIANT-EUR: GWAS meta-analysis of 173 EUR cohorts from the GIANT consortium. Within-family (UKB): Family-based GWAS performed in 17,942 independent EUR sibling pairs from the UKB. Panel a represents the relationship between strength of association between 101,360 independent (LD r²<0.1) HM3 SNPs and height (x-axis: 30 SNP bins) and height-increasing allele frequency differences between the British (GBR) and Tuscan (TSI) samples from the 1,000 Genomes Project (1KGP). A significant slope (β_{PS}) indicates uncorrected PS. **Panel b** shows estimates of β_{PS} for different GWAS and their associated leave-one-SNP-bin-out jackknife standard errors (S.E.). Panel c shows the variance in estimated SNP effects from various height GWAS that is explained by SNP loading on genotypic principal components (PC) calculated among 503 EUR samples from the 1KGP. The x-axis in **Panel c** indicates number of vectors of PC loadings including in the regression model (SNP effect regressed on PC loading). Panel d shows on the y-axis the slope ($S_{PS} = cov(\beta_{GWAS}, \beta_{SIB})/var(\beta_{GWAS})$) from regressing SNP effects estimated in a familybased GWAS (β_{SIB}) onto SNP effects estimated in a standard population-based GWAS (β_{GWAS}). The x-axis in Panel d is the -log10 of the p-value threshold used to ascertain SNPs for estimating the regression slope. For each p-value threshold, the effects of ascertained SNPs were corrected for winner's curse (Methods). The horizontal red dotted line represented the expected slope under assortative mating (AM) assuming an equilibrium heritability $h^2 = 0.8$ and a spousal correlation r = 0.25 (Suppl. Note 2).



Suppl. Fig. 6. Quantification of confounding due to population stratification (PS) in various non-European ancestry (non-EUR) GWAS of height. Panels **a** and **e**, **b** and **f**, **c** and **g**, **d** and **h** represent quantifications of PS in GWAS conducted in individuals from the African (AFR), East-Asian (EAS), South-Asian (SAS) and Hispanic (HIS) ancestry groups, respectively. The x-axes in all the top panels (**a** – **d**) represent pairs of subpopulations in the 1000 Genomes Project (1KG) within the corresponding ancestry groups. The y-axes in Panels (**a** – **d**) show estimates of β_{PS} (+/- standard errors; S.E.) for SNP effects estimated in the corresponding ancestry group along axes of genetic differentiation between subpopulations indicated on the x-axis. Red dots on top of each bar indicate statistical significance as defined in **Suppl. Note 2** based on different thresholds according to the number of pairs of subpopulation within ancestry groups. The x-axes in all the bottom panels (**e** – **h**) correspond to 20 principal components (PC) calculated in 1KGP samples from the corresponding ancestry group. The y-axes in Panels **e** – **h** show the squared correlations between PC loadings and marginal SNP effects in the corresponding ancestry-specific GWAS meta-analysis. These results are further described and discussed in **Suppl. Note 2**.



Suppl. Fig. 7. Quantification of confounding due to population stratification (PS) in our cross-ancestry GWAS meta-analysis of height. The x-axis in panels (a – e) shows pairs of subpopulations in the 1000 Genomes Project (1KG) within 5 ancestry groups indicated by the title of the panel (African: AFR, East-Asian: EAS, South-Asian: SAS, HIS: Hispanic, European: EUR). The y-axis in panels (a – e) shows estimates of β_{PS} (+/- standard errors; S.E.) for SNP effects in our cross-ancestry meta-analysis along axes of genetic differentiation between subpopulations indicated on the x-axis. Each dot in **Panel f** represents the squared correlation (y-axis) between SNP effects and loadings of principal components (PC: 1 to 20, indicated on the x-axis) calculated in 5 ancestry groups indicated in the panel legend. These results are further described and discussed in **Suppl. Note 2**.



Suppl. Fig. 8. Correlation of marginal SNP effects between European ancestry (EUR, on the x-axis) and non-EUR GWAS (i.e. Hispanic (HIS), African (AFR), East-Asian (EAS) and South-Asian (SAS) on the y-axis). Correlations r(b) were corrected for estimation errors as described in the **Methods** section. Each estimate of the correlation of SNP effect is based on SNPs reaching marginal genome-wide significance in any of the 5 ancestries analysed. Standard errors for r(b) were obtained using jackknife. Error bars denote standard errors of SNP effects.



Suppl. Fig. 9. Correlation of marginal SNP effects between East-Asian ancestry (EAS, on the x-axis) and non-EAS GWAS (i.e. Hispanic (HIS), African (AFR), European (EUR) and South-Asian (SAS) on the y-axis). Correlations r(b) were corrected for estimation errors as described in the **Methods** section. Each estimate of the correlation of SNP effect is based on SNPs reaching marginal genome-wide significance in any of the 5 ancestries analysed. Standard errors for r(b) were obtained using jackknife. Error bars denote standard errors of SNP effects.



Suppl. Fig. 10. Correlation of marginal SNP effects between Hispanic ethnicity (HIS, on the x-axis) and non-HIS GWAS (i.e. European (EUR), African (AFR), East-Asian (EAS) and South-Asian (SAS) on the y-axis). Correlations r(b) were corrected for estimation errors as described in the **Methods** section. Each estimate of the correlation of SNP effect is based on SNPs reaching marginal genome-wide significance in any of the 5 ancestries analysed. Standard errors for r(b) were obtained using jackknife. Error bars denote standard errors of SNP effects.



Suppl. Fig. 11. Correlation of marginal SNP effects between African ancestry (AFR, on the x-axis) and non-AFR GWAS (i.e. Hispanic (HIS), European (EUR), East-Asian (EAS) and South-Asian (SAS) on the y-axis). Correlations r(b) were corrected for estimation errors as described in the **Methods** section. Each estimate of the correlation of SNP effect is based on SNPs reaching marginal genome-wide significance in any of the 5 ancestries analysed. Standard errors for r(b) were obtained using jackknife. Error bars denote standard errors of SNP effects. Error bars denote standard errors of SNP effects.



Suppl. Fig. 12. Correlation of marginal SNP effects between South-Asian ancestry (SAS, on the x-axis) and non-SAS GWAS (i.e. Hispanic (HIS), African (AFR), East-Asian (EAS) and European (EUR) on the y-axis). Correlations r(b) were corrected for estimation errors as described in the **Methods** section. Each estimate of the correlation of SNP effect is based on SNPs reaching marginal genome-wide significance in any of the 5 ancestries analysed. Standard errors for r(b) were obtained using jackknife. Error bars denote standard errors of SNP effects.



Suppl. Fig. 13. Cross-ancestry correlation of marginal SNP effects ascertained at various significant thresholds. The x-axis in each panel represents significance thresholds used to ascertained SNPs and the y-axis the correlation *r(b)* of estimated marginal effects (**Methods**) across 10 pairs of GWAS performed in 5 ancestry groups (African: AFR, East-Asian: EAS, South-Asian: SAS, HIS: Hispanic, European: EUR). Each panel represents which of the five ancestry-group specific GWAS was used to ascertain SNPs. SNPs were ascertained using GCTA-COJO with a linkage disequilibrium reference set from the corresponding ancestry group. Within each panel, correlations were calculated using the subset of COJO SNPs, which marginal significance also met the significance threshold indicated on the x-axis. Each colour represents a pair of ancestry group.



Suppl. Fig. 14. Correlation of marginal and conditional SNPs effects between discovery and replication (Estonian Biobank – EBB) GWAS. Panels a and **b** show correlations of marginal SNP effects for a subset of jointly associated SNPs (identified using the GCTA-COJO methods; **Methods**), which marginal effects also reach genome-wide significance. **Panels c** and **d** represent joint effect re-estimated using approximate conditional analyses (implemented in the GCTA software). Genotypes of ~350,000 unrelated participants of the UK Biobank were used as linkage disequilibrium (LD) reference.



Suppl. Fig. 15. Schematic representation of the measure of signal density. The horizontal arrow represents a chromosome and each circle a specific association. For each association, the density is defined as the number of other independent associations within a certain window. In the example above, the window around the first SNP contains 1 SNP, so its density is 1. Similarly, the density at the third SNP (from the left) is 0 because the window around it does not contain any other association.



Suppl. Fig. 16. Distribution of signal density. Signal density (x-axes) is defined for each height-associated SNP as the number of other associations detected within 100 kb based on the META_{FE} and ancestries group specific meta-analyses. Y-axes represent the number of height-associated SNPs with a signal density indicated on the x-axis.



Genomic Position (in Mb)

Suppl. Fig. 17. Independent signal density at the *ACAN* **gene locus across ancestries**. Independent associations were identified from GWAS performed in 5 ancestries (African: AFR; European: EUR; East-Asian: EAS; South-Asian: SAS and Hispanic: HIS) as well as from the meta-analysis of all ancestries (ALL). Genomic segments with a signal density >1 are found in each ancestry group.



Suppl. Fig. 18. Variance of height explained by SNPs in genome-wide significant (GWS) loci defined with various window sizes. Stratified SNP-based heritability (h_{SNP}^2) estimates were obtained for three partitions of the genome: (1) GWS SNPs alone vs. all other HapMap 3 (HM3) SNPs; (2) GWS SNPs +/- all HM3 SNPs within 10 kb vs. all other HM3 SNPs and (3) GWS SNPs +/- all HM3 SNPs within 35 kb vs. all other HM3 SNPs. Analyses were performed in samples of four different ancestries: European (EUR: meta-analysis of UK Biobank (UKB); N=14,587 + Lifelines data; N=14,058), African (AFR: UKB), East-Asian (EAS: UKB) and South-Asian (SAS: UKB). Estimates from stratified analyses were compared with SNP-based heritability estimates obtained from analysing all SNPs jointly (horizontal red bar; dotted lines represented standard errors). Analyses were repeated using a random set of 12,111 SNPs (and redefining loci relative to those), which minor allele frequency and linkage disequilibrium distribution matched that of GWS SNPs (RND: gold bars).



Suppl. Fig. 19. Variance of body mass index (BMI) explained by height-associated genome-wide significant (GWS) loci defined with various window sizes. Stratified SNP-based heritability (h_{SNP}^2) estimates were obtained for three partitions of the genome: (1) GWS SNPs alone vs. all other HapMap 3 (HM3) SNPs; (2) GWS SNPs +/- all HM3 SNPs within 10 kb vs. all other HM3 SNPs and (3) GWS SNPs +/- all HM3 SNPs within 35 kb vs. all other HM3 SNPs. Analyses were performed in UK Biobank samples of four different ancestries: European (EUR), African (AFR), East-Asian (EAS) and South-Asian (SAS). Estimates from stratified analyses were compared with SNP-based heritability estimates obtained from analysing all SNPs jointly (horizontal red bar; dotted lines represented standard errors). Analyses were repeated using a random set of 12,111 SNPs (and redefining loci relative to those), which minor allele frequency and linkage disequilibrium distribution matched that of GWS SNPs (RND: gold bars).



Suppl. Fig. 20. Optimal weighting of PGS and parental information in simulated data. We simulated a population of N=2,000 individuals and a trait controlled by M=1,000 causal variants. For simplicity, we assumed that a variable proportion of causal SNPs is used to calculate the PGS, and that SNP effects are estimated with negligible errors. We show below in Equation (3.11) how this proportion is chosen to achieve the desired prediction accuracy. We considered two scenarios: (i) random mating, i.e. r=0 (Panels a and b) and assortative mating (for 20 generations) based on a spousal phenotypic correlation r=0.25 (Panels c and d). In all simulations, we assumed a heritability $h^2 = 0.8$ and varied the expected prediction accuracy (R_{SNP}^2) between 0.05 and 0.8. The notation R²_{SNP} is general and applies to any PGS based on independent SNPs, not just genome-wide significant as described in the main text. For each simulated population, we compared our predictions from Equation (S3.1) and (S3.2) with estimated regression coefficients obtained from regressing y on \hat{y} and \bar{y}_{n} . The vertical green bar in panel c, denotes the threshold above which PGS information outweighs parental information. The vertical grey bar in panels **a** and **c** denotes the threshold when $R_{SNP}^2 = h^2/2$. This threshold is predicted using Equation (S3.4). We also compared our variance explained by fitting both predictors with our predicted expectation from Equation (S3.3). Each dot is generated using 100 replicates. Overall, we found a perfect consistency between our theoretical and simulation results, which provides an empirical validation of these predictions.





Suppl. Fig. 21. Selection of the number of gene set clusters using the "Elbow method". Gene sets were hierarchically clustered at different sizes and the distance between each cluster evaluated. 20 clusters was chosen as an appropriate number of gene set clusters to evaluate for enrichment.



Suppl. Fig. 22. Proportional heritability (h²) explained, enrichment, and normalized τ estimates for MAGMA (panels A-C) and DEPICT (panels D-F). The error bars represent the 95% confidence interval, calculated as estimate +/- 1.96*standard error. The labels for each subpanel indicate the ancestry represented in the GWAS used for LDSC, and the x-axis labels indicate the ancestry represented in the "discovery" GWAS used to prioritize the genes. EUR: European ancestry; AA: African-Americans of admixed European and African ancestries; EAS: East Asian ancestry. Analyses underlying this figure are further described in Suppl. Note 5.



Suppl. Fig. 23. Gene-level saturation of GWAS discoveries as a function of sample size. Increase in sample size from ~4 million to ~5 million is achieved by including ~ 1 million participants of non-European ancestry. **Panel a** shows the enrichment of genome-wide significant (GWS) SNPs identified from an approximate conditional and joint (COIO) analysis within 462 genes associated with skeletal growth disorders from the Online Mendelian Inheritance in Man (OMIM) database (vaxis) as a function of GWAS sample size (x-axis). Standard Error (S.E.) were calculated as the standard deviation of enrichment statistics (odds ratio in the 2x2 contingency table contrasting for each gene: "is the gene an OMIM gene" vs. "does the gene contain a GWS SNP") across 1,000 randomly sampled sets of 462 non-OMIM genes length-matched with OMIM genes. The average enrichment calculated across the 1,000 random gene sets is represented with dotted lines. Presence of a GWS SNP within a gene was assessed relative to gene start and stop position, considering flanking regions within 0 kb, 10 kb, 20 kb and 30 kb. **Panel b** shows the proportion of OMIM overlapping genes with at least one GWS SNPs (y-axis). As in **Panel a**, dotted lines represents the null distribution from 1,000 random sets of genes length-matched with OMIM genes. Standard errors (S.E.) were calculated as the standard deviation of the proportion observed across the 1,000 draws from the null distribution. **Panel c** represents the proportion of OMIM genes near GWS SNPs after subtracting the mean of the null distribution at each sample size. **Panel d** represents the enrichment of OMIM genes as a function of the strength of association of 12,111 independent GWS SNPs identified in our largest GWAS (N~5.4M). GWS SNPs were grouped into 10 decile groups of ~1,211 SNPs. Enrichment near OMIM genes is stronger of SNPs explaining a larger proportion of height variance (top decile). **Panel e** shows the median per-SNP variance explained (y-axis) as a function of the median distance to the closest OMIM gene. Large GWAS tend to identify variants with smaller effect sizes and further away from OMIM genes. **Panels f** shows the number of genes prioritised using Summary-data based Mendelian Randomization (SMR; $P < 5 \times 10^{-8}$), which expression may act a mediator of the effects of SNP on height. SMR analyses were based on expression quantitative trait loci (eOTL) identified in the GTEx and eOTLgen studies (Methods). The z-axis (in red) shows the number of OMIM genes overlapping with SMR genes identified from analysing GWAS with various sample sizes (x-axis).



Suppl. Fig. 24. Variant-level saturation of GWAS discoveries as a function of sample size. Increase in sample size from ~4 million to ~5 million is achieved by including ~1 million participants of non-European ancestry. **Panel a** shows number of independent genome-wide significant (GWS) SNPs and loci identified at various GWAS sample sizes (Details about down-sampled GWAS are given in Table 2). GWS loci were defined using various window sizes including 35kb, 50kb and 100 kb. **Panel b** shows the percentage of the genome covered by GWS loci. Coverage was calculated as the cumulative length of GWS loci in Mb divided 3,039 Mb, the estimated length of the human genome. **Panel c** shows the prediction accuracy (R_{GWS}^2) of various polygenic scores on GWS SNPs identified at various sample sizes. In **Panels a** and **c**, dotted lines represent y-axis values for our largest European ancestry GWAS (N~4 million).



Suppl. Fig. 25. Partitioned SNP-based heritability of height in African ancestry individuals. Panels a represent partitioned SNP-based heritability estimates from a sample of 6,911 unrelated African ancestry (AFR) individuals from the UK Biobank, independent of our discovery GWAS. This analysis focuses on 16,374,566 SNPs with a minor allele frequency (MAF)>1% in AFR. These SNPs were further stratified according to their MAF in European ancestry (EUR) populations: 7,365,878 SNPs with MAF>1% in EUR (47%) vs. 8,114,046 SNPs with MAF<1% in EUR (53%) and their position within vs. outside genome-wide significant (GWS) loci. Panel b shows the MAF distribution of the 16M SNPs in AFR and panels (c - d) the distribution of these SNPs in EUR. The SNP-based heritability contributed by SNPs within GWS loci is denoted h_{GWS}^2 , while that contributed by SNPs outside these loci is denoted h_{other}^2 . These results are further discussed in **Suppl. Note 6**.

SUPPLEMENTARY NOTES

Supplementary Note 1: Sensitivity Analyses of COJO results

Long range LD in admixed populations can bias estimation of approximate conditional SNP effects

We compared the prediction accuracy of polygenic scores (PGS) based on genome-wide significant (GWS) SNPs identified in each ancestry groups. For each set of ancestry-specific GWS SNPs we calculated a PGS using either marginal SNP effects (hereafter denoted PGS_{GWAS}) or conditional effects (hereafter denoted PGS_{COJO}) approximated using GCTA-COJO (Methods). Given that COJO is designed to detect secondary signals, i.e. explaining additional trait variance, we expect the prediction accuracy of PGS_{COJO} to be similar, if not outperform, that of PGS_{GWAS}.

Consistently, we found that PGS_{COJO} yields a higher accuracy than PGS_{GWAS} in most cases except in HIS and AFR (**Suppl. Fig. 3a**). We further investigated that observation and found that the poor performances of PGS_{COJO} relative to PGS_{GWAS} in HIS and AFR were driven by specific chromosomes such chromosome 6, 9 and 20 (**Suppl. Fig. 3b**), where estimated conditional effects were abnormally large (**Suppl. Fig. 3c**).

We hypothesized that these unexpected observations could be explained by estimation errors during the stepwise model selection procedure, e.g., because of collinearity between SNPs included in the model. Note that GCTA sets a default threshold of 0.9 for collinearity between SNPs, which means that the variance of genotypes at a given SNP included in the model cannot be explained at >90% by all other SNPs included in the model. To explore the impact of this parameter on our observations we performed a sensitivity analysis by varying the collinearity threshold between 0.1 and 0.9.

We found that using a more stringent collinearity threshold reduces the prediction accuracy of PGS_{COJO} in EUR and EAS (accuracy in SAS remained unchanged) but produces an opposite effect in AFR and HIS (**Suppl. Fig. 4**). More specifically, setting the collinearity threshold below 0.5 restored the prediction accuracy of PGS_{COJO} up to a level comparable to that of PGS_{GWAS}. Therefore, our sensitivity analyses suggest that stringent collinearity thresholds are preferable when applying COJO to GWAS from admixed ancestry groups such as HIS and AFR.

Consequently, the COJO results presented in the main text are based upon a collinearity threshold of 0.1 for HIS and AFR and the default threshold of 0.9 for all other COJO analyses. We chose 0.1 because it produces the most parsimonious model (i.e. fewer number of associations) without impacting prediction accuracy.

Impact of ancestry composition of LD reference panel on COJO results

We re-analysed summary statistics from our cross-ancestry GWAS meta-analysis using two LD reference sets. First, we randomly selected 37,900 EUR, 4,400 EAS, 4,250 HIS, 2,750 AFR and 700 SAS individuals (i.e. 50000 individuals in total) to form a LD reference set with ancestries proportions matching that in our cross-ancestry meta-analysis. The second set contained 50,000 individuals with EUR ancestries. We restricted analyses with both LD reference sets to 882,755 HM3 SNPs, which passed quality control (Hardy-Weinberg Equilibrium test, missingness and imputation quality) in all five ancestry groups.

We found that COJO based on the multi-ancestry LD panel only detected 3,635 (3380 using a collinearity-threshold of 0.1) independent associations vs. 11,001 associations using the EUR LD reference. The latter number is smaller than the 12,111 reported in the main text but consistent with a ~10-15% smaller number of HM3 SNPs used as input. We also repeated analyses using the 37,900 EUR individuals as LD reference and found that COJO detects 11,065 SNPs, indicating that using this multi-ancestry LD panel leads to underestimation by COJO of the number of associations. This
conclusion is supported by the fact that a PGS based on 11,001 COJO SNPs detected using a EUR LD panel explains a significantly larger amount of height variance than that of a PGS based on only 3,380 COJO SNPs detected with a multi-ancestry panel (EUR: 38.2% vs 26.4%; SAS: 20.3% vs 13.4%; EAS: 19.5% vs 13.3% and AFR: 9.0% vs 5.0%). Moreover, we ran another COJO analysis of our cross-ancestry GWAS using LD information from 10,636 AFR individuals (i.e. same LD panel for our AFR GWAS meta-analysis). Note that 242,891 / 882,755 (i.e. 27.5%) SNPs were filtered out by GCTA prior to analysis because of expected large differences in allele frequencies between our cross-ancestry GWAS including >75% of EUR individuals and the AFR LD panel (by default GCTA exclude SNPs with an absolute frequency difference is >0.1). Nevertheless, we detected 5,701 quasi-independent joint associations (i.e. more associations than using a mix-ancestry panel), explaining 24.6%, 13.2%, 10.9% and 3.5% of height variance in EUR, SAS, EAS and AFR individuals respectively. The latter predictive performances are lower to that obtained with a PGS from 3,380 COJO SNPs.

Altogether, these results demonstrate that COJO with a composite LD reference panel does not improve and likely hinders the detection of associations in our cross-ancestry GWAS meta-analysis. We emphasize that extending the COJO methodology for analysing multi-ancestry GWAS is an independent research question, which goes beyond the scope of our study.

Supplementary Note 2: Investigation of population stratification in large GWAS of height

Assessment of population stratification in European ancestries GWAS

Recent studies^{9,10} have shown evidence of significant confounding in estimated SNP effects induced by uncorrected population stratification (PS) in summary statistics from the Wood et al. (2014)²⁰ study. Importantly, Wood et al. (2014) also reported residual PS mostly affecting estimated effects of SNPs weakly associated with height (Figure 2a-c in ref.²⁰). To ensure increased robustness and reliability of our findings, we perform here a series of analyses to quantify confounding effects of residual PS in all GWAS results reported in this study.

LD score regression analysis of European ancestries GWAS

First, we performed a LD score regression (LDSC) analysis¹⁶ of our GWAS meta-analysis of EUR participants (N=4,080,687). We assessed the degree of PS using the attenuation ratio statistic (R_{LDSC}), which provides a quantification of PS that is independent of sample size. The estimated R_{LDSC} is ~3.8% (S.E. 0.8%), suggesting that most of the inflation of association test statistic is explained by polygenicity and not PS. In comparison, GWAS of height without any adjustment for population stratification produce values of R_{LDSC} ~10-13%.⁶⁷ Our estimated R_{LDSC} is slightly smaller than that from LDSC analyses of previously published GWAS of height (Wood et al. (2014): 4.3% (S.E. 1.3%); Yengo et al. (2018)³ 4.0% (S.E. 1.2%)), which suggests a reduced effect of residual PS on our results. Note that the estimated RLDSC shown here are obtained from analysing imputed GWAS summary statistics from Wood et al. (2014) and Yengo et al. (2018) (**Supplementary Methods**), which have a better coverage of HM3 SNPs; and thus explaining the difference with the \sim 6.0% (S.E. 1.0%) reported in Yengo et al. (2018). However, as a measure of PS, RLDSC is not strictly comparable across studies. In fact, the expectation of RLDSC (across repeated GWAS) not only depends on how much trait variance is explained by PS, but also on the degree of genetic differentiation between cohorts (F_{ST}) and the trait heritability within each cohort.¹⁶ The last two factors can vary from one GWAS meta-analysis to another as a function of cohort composition. In summary, these LDSC analyses suggest that uncorrected PS only marginally affects SNP effects from our large GWAS of height in EUR participants.

Assessment of allele frequencies for height increasing alleles across the North-South axis of Europe reveals attenuated correlation relative to previous studies

As an alternative to R_{LDSC}, we next quantified PS in our GWAS using the correlation between strength of association (p-value) and height-increasing allele frequency differences between Great Britain (GBR sample in the 1000 Genomes Project – 1KGP) and the Italian Tuscan population (TSI sample in 1KGP). This statistic was previously introduced by Sohail and colleagues¹⁰ to reveal biases in SNP effect estimates from the Wood et al. study, that were induced by uncorrected PS along the North-South gradient of Europe. More precisely, the strategy implemented by Sohail et al. consists in grouping SNPs based on strength of association, then regress the mean height-increasing allele frequency differences between GBR and TSI for each SNP bin onto the mean p-value of the corresponding bin. The slope of that linear regression (β_{PS}) measures the degree of PS. We estimated β_{PS} using 101,360 near independent HM3 SNPs with MAF>1% and calculated standard errors using a bootstrap strategy based on 1,000 independent draws.

As previously reported, we found a significant β_{PS} of ~1.28% (S.E. 0.08%; $P = 2.3 \times 10^{-61}$) using summary statistics of the Wood et al. (2014) study but no significant β_{PS} from within-family GWAS in 17,942 independent UKB siblings pairs (β_{PS} =-0.08%, S.E. = 0.07%; P=0.27). We show in **Suppl. Fig. 5a-b** estimates of β_{PS} from GWAS summary statistics of Yengo et al. (2018), EUR participants of 23andMe (23andME-EUR), all EUR participants of the UKB (UKB-456k; GWAS using BOLT-LMM), unrelated EUR participants of the UKB (UKB-350k; GWAS using PLINK), the meta-analysis EUR participants from multiple cohorts of the GIANT consortium (GIANT-EUR; N~1.6M); and the meta-analysis of GIANT-EUR and 23andMe-EUR. Overall, we find that β_{PS} decreases with sample size, consistent with an increased signal-to-noise ratio. In particular, β_{PS} is ~0.13% (P=0.1) in our largest GWAS meta-analysis of N~4.1M

EUR participants, which demonstrates a better correction of PS than previously published EUR GWAS of height.

Furthermore, we assessed the squared correlation between estimated effects at these 101,360 independent HM3 SNPs and SNP loadings from 20 principal components (PCs) calculated in 503 EUR samples from 1KGP. Across SNPs, we found that SNP loadings on PC2 explain most of the variance in estimated SNP effects (**Suppl. Fig. 5c**). This observation is not surprising given that PC2 is the PC that correlates the most with the North-South axis of Europe, and therefore explains the consistency with our results based on β_{PS} . However, <0.3% of the variance of SNP effects estimated in our largest GWAS is explained by SNP loadings, which is much lower than ~2.3% obtained when analysing SNP effects from Wood et al. (2014).

Comparison of estimated SNP effects between GWAS meta-analyses and family-based GWAS

Finally, we directly compared SNP effects from our GWAS (β_{GWAS}) with that of a within-family GWAS in 17,942 independent UKB siblings pairs (β_{SIB}). We used $S_{PS} = cov(\beta_{GWAS}, \beta_{SIB})/var(\beta_{GWAS})$ as our metric of interest in this comparison, where both $cov(\beta_{GWAS}, \beta_{SIB})$ and $var(\beta_{GWAS})$ are calculated across SNPs. When SNP effects are estimated using ordinary least-squares (OLS) regression, the expectation of S_{PS} in the absence of PS is $E[S_{PS}] = 1$. Therefore, a significant deviation of S_{PS} below 1, may indicate confounding due to residual PS. However, the statistical properties of S_{PS} based on SNP effects estimated using linear mixed models (LMM) (or meta-analyses of OLS and LMM estimates) are not well characterised, which may affect our interpretation below.

We found that estimates of S_{PS} based on SNPs strongly associated with height are much closer to 1 than when all SNPs are used, i.e. regardless of strength of association (P<1; **Suppl. Fig. 5d**). We observed the lowest value of $S_{PS}\sim0.29$ (S.E. 0.01) when using effects of all 101,360 SNPs estimated in the Wood et al. study. In comparison, estimated SNP effects from our largest EUR GWAS yields an $S_{PS}>0.8$ regardless of strength of association, yet still significantly lower than 1 ($P < 7 \times 10^{-30}$).

Lee et al.⁶⁸ previously showed that assortative mating (AM) on height can produce values of $S_{PS} < 1$. Under the assumption that the population has reached an equilibrium after many generations of AM with a constant spousal correlation (r), they showed that

(1.1)
$$E[S_{PS}] = 1 - rh^2$$
,

where h^2 is the full narrow-sense heritability in the current generation (at equilibrium). We note here an error in the Supplementary Notes of Lee et al. (2018), who used in their derivations the heritability in the base population undergoing random mating (h_0^2) instead of the equilibrium heritability, h^2 . In practice, differences between $h_0^2 = (h^2 - rh^4)/(1 - rh^4)$ and h^2 are small. Therefore, using one or the other heritability has a limited impact on the expected value of S_{PS} . Using Equation (1.1) and assuming an equilibrium heritability, $h^2 = 0.8$ and a spousal correlation, r = 0.25, we expect S_{PS} to be $\sim 1 0.8 \times 0.25 = 0.8$, which is consistent with our observations (**Suppl. Fig. 5d**).

Altogether, these analyses show that estimated SNP effects from our EUR GWAS are inflated by ~ 10 -20% relative to that from a family-based GWAS and that this inflation is not larger than expected because of phenotypic AM on height.

Assessment of population stratification in non-European ancestries GWAS

We extended the previous analyses performed in EUR to quantify the impact of residual PS in GWAS of height performed in the four other ancestry groups, i.e. HIS, SAS, EAS and AFR.

LD score regression analysis of non-European ancestries GWAS

We performed LD score regression analyses using LD scores estimated from the same ancestrymatched samples as in our COJO analyses (i.e. 10,636 AFR samples, 5,875 EAS samples, 9,448 SAS samples and 4,883 HIS samples). LD scores were calculated from imputed HapMap3 SNPs using the LDSC software (version 1.0.1) with a window size of 1 cM.

The R_{LDSC} statistic was 6.7% (S.E. 2.2%) in AFR, 9.5% (S.E. 1.4%) in HIS, 11.1% (S.E. 1.7%) in EAS, and 25.6% (S.E. 3.7%) in SAS. Previous studies have shown that longer range LD in admixed populations as compared to non-admixed populations can bias estimates from LD score regression.⁸ Therefore, we repeated our analyses in AFR and HIS using 20 PCs adjusted LD scores based on a 20 cM window, as recommended by Luo et al. (2021).⁸ The R_{LDSC} statistic decreased from 6.7% (S.E. 2.2%) to 0.9% (S.E. 1.9%) in AFR and from 9.5% (S.E. 1.4%) to 7.5% (S.E. 1.7%) in HIS. Importantly, using PC adjusted LD scores based on a 20 cM window did not change estimates of R_{LDSC} in SAS (25.6%; S.E. 3.7% vs. 25.9%; S.E. 3.7%) nor in EAS (11.1%; S.E. 1.7% vs. 11.1%; S.E. 1.7%).

It is noteworthy that values of R_{LDSC} above 20%^{*} as observed in our SAS GWAS may also reflect strong LD differences between GWAS participants and samples used to estimate LD scores. We applied the DENTIST method (Detecting Errors iN analyses of summary staTISTics) to distinguish these two potential explanations. In brief, DENTIST compares the observed distribution of Z-scores from GWAS to an expected distribution based on a reference LD matrix. Deviations from that expected distribution reflect errors in the GWAS summary statistics or inconsistencies in LD patterns. DENTIST detected 213 outlier SNPs in the SAS GWAS ($P < 5 \times 10^{-8}$) relative to LD patterns from 9,448 unrelated SAS from the UKB. However, excluding these 213 outliers SNPs did not substantially affect the value of the RLDSC statistic (26.2%; S.E. 3.6%).

Altogether, these LD score regression analyses suggest the presence of residual PS that might potentially confound estimates of SNP effects in our HIS, EAS and SAS GWAS.

Correlation between for height-increasing alleles frequencies and genetic differentiation within four ancestry groups

Next, we estimated β_{PS} for each non-EUR GWAS meta-analysis along various axes of within-continent genetic differentiation defined by pairs of 1KGP subpopulations. For example, we estimated β_{PS} in our AFR GWAS meta-analysis along an axis that differentiates Yoruba populations in Nigeria (West Africa) from Luhya populations in Kenya (East Africa), as well as in our EAS GWAS meta-analysis along an axis that differentiates Japanese populations from Han Chinese populations. We used ancestry-specific significance thresholds calculated as 0.05 divided by the number of pairs of subpopulations within the corresponding 1KGP ancestry group. More specifically, we considered 7 subpopulations in AFR (21 pairs), 5 subpopulations in EAS (10 pairs), 5 subpopulations in SAS (10 pairs) and 4 subpopulations in HIS (6 pairs).

We found significant β_{PS} in each non-EUR GWAS meta-analysis (**Suppl. Fig. 6a-d**). The largest magnitude of β_{PS} was observed in the SAS GWAS meta-analysis along the India-Bangladesh axis (β_{PS} =0.89%, S.E. 0.11%, P=6.2 × 10⁻¹⁷, **Suppl. Fig. 6c**) and the second largest in the HIS GWAS meta-analysis along the Colombia-Puerto Rico axis (β_{PS} =0.75%, S.E. 0.08%, P=1.2 × 10⁻¹⁷, **Suppl. Fig. 6d**). Importantly, estimated β_{PS} in non-EUR are significantly lower than 1.28% observed in the Wood et al. (2014) study.

Finally, we assessed the squared correlation between SNP effects estimated in each non-EUR GWAS meta-analysis and SNP loadings of 20 PCs calculated in corresponding superpopulations from 1KGP (**Suppl. Fig. 6e-h**). Overall, all squared correlations were smaller than 0.3% as observed with our largest EUR GWAS (N=4M), where PS was better controlled (**Suppl. Fig. 5c**).

^{*}a rule-of-thumb recommended by the authors of the LDSC software.

In conclusion, we detected a small amount residual PS in all non-EUR GWAS meta-analyses, in particular in SAS (smallest sample size).

Effect of residual population stratification on cross-ancestry GWAS meta-analysis

In this final section, we focus on SNP effects from our cross-ancestry GWAS meta-analysis (referred to as META_{FE} in the main text). Using these estimated SNP effects, we quantified β_{PS} along multiple axes of within-continent genetic differentiation and also the squared correlations between SNP effects and within-ancestry PC loadings and SNP effects (as in the previous section). Overall, β_{PS} remain below 0.5% across all pairs of 1KGP subpopulations (**Suppl. Fig. 7a-e**), and the squared correlation between SNP effects and PC loadings was also smaller than 0.15% (**Suppl. Fig. 7f**).

In summary, the various analyses shown here demonstrate that residual PS has a minimal confounding effect on estimated SNP effects from our cross-ancestry GWAS meta-analysis.

Supplementary Note 3: Distinguishing loss of tagging from multiplicity of causal variants at the *ACAN* locus

We observed the largest density of independent associations around rs4932198, where 24 other GWS SNPs were detected within less than 100 kb on each side (**Fig. 2**; **Suppl. Fig. 17**). We hereafter refer to the set of these 25 GWS SNPs as *ACAN* GWAS signals. A large density of signals may reflect the presence of multiple causal variants or the presence of poorly tagged causal variants with large effects at this locus. To disentangle these two possible explanations, we first used statistically phased haplotypes from 346,959 unrelated UKB participants of EUR and tested their association with height. We analysed 14,117 haplotypes covering a 100 kb long genomic region at this locus (hg19 genomic coordinates: chr15:89,307,521-89,407,521) and that were present in at least 5 UKB participants. We tested the association between each haplotype and height but could not identify a single haplotype with a large enough effect that can explain the majority of signals at this locus (**Extended Data Fig. 5**). In fact, *ACAN* GWAS signals cumulatively explain ~0.3% of height variance, while the two most associated haplotypes (*P*<10⁻⁷) jointly only explain 0.01% of height variance.

Next, we used genotypes at this locus from 291,683 unrelated EUR participants of the UKB to simulate a trait controlled by a single rare biallelic variant (MAF<1%) explaining between η^2 =0.5% and 5% of variance, then performed a GCTA-COJO analysis to estimate the density of independent signals. Previous studies have shown that large discrepancies in sample size between discovery GWAS and LD reference may contribute to inflate the number of independent associations detected with GCTA-COIO.⁶⁹ Therefore, to mimic that effect we used a random subset of 10,000 unrelated EUR participants of the UKB as LD reference, i.e. $\sim 1/30^{\text{th}}$ of the discovery sample. On average over 100 simulation replicates for each value of n^2 , we observed a signal density lower than 2.3 associations per 100kb (Extended Data Fig. 5). The largest density of 10 associations per 100 kb was observed only when the simulated causal variant explains 5% of trait variance (i.e. β between ~2 and ~43 trait SD/allele), which is an extreme and unrealistic scenario. In contrast, even when the simulated causal variant explains 0.5% of trait variance, which in this case corresponds to a median allelic effect of \sim 1.4 SD/allele (~10cm, so very large) across simulations, we found that signal density never exceeded 7 associations per 100 kb. Altogether, the results of our haplotype- and simulation-based analyses suggest that a multiplicity of independent causal variants is the most likely explanation of our observations, although signal density is not a standard estimator of the number of causal variants.

Finally, we sought to quantify how much the presence of a recently identified ^{21,70} height-associated variable-number-of-tandem-repeat (VNTR) polymorphism in *ACAN* may contribute to the observed density of GWS SNPs. Therefore, we regressed VNTR length imputed in UKB participants²⁸ onto allele counts at *ACAN* GWAS signals and found that these 25 SNPs explain ~73%, ~47%, ~42% and ~40% of VNTR length variation in SAS (N=9,219), EUR (N=414,429), AFR (N=7,543) and EAS (N=1,496) respectively (**Extended Data Fig. 5e**). Consistent with partial tagging of VNTR length variation, *ACAN* GWAS signals explain ~0.24% ($R_{VNTR}^2 = 0.21\%$ vs. $R_{VNTR+25 SNPs}^2 = 0.45\%$; P=8.7 × 10⁻⁵⁵) additional height variance in EUR over what is explained by VNTR length variation alone (**Extended Data Fig. 5f**). In summary, these complementary analyses suggest that a large density of independent GWS SNPs near *ACAN* is partially explained by the presence of a VNTR at this locus and also by additional causal variants not yet identified.

Supplementary Note 4: Optimal weighting of PGS and parental information to maximize prediction accuracy in the presence of assortative mating

Overview of theory, simulations and application to real data from the UK Biobank

For a given individual, we denote y their phenotype, y_m and y_f the phenotypes of their mother and father respectively, $\bar{y}_p = (y_m + y_f)/2$ the average of their parents' phenotypes and \hat{y} their own PGS. We consider combined predictor that is a linear combination of \hat{y} and \bar{y}_p . Under the assumption that the resemblance between relatives is solely due to genetic factors, our main result is that the optimal weighting $\alpha_{PGS}\hat{y} + \alpha_{PA}\bar{y}_p$ is given by

(S3.1)
$$\alpha_{PGS} = \frac{R_{\hat{y},y}[1 - h^2(1 + r)/2]}{1 - R_{\hat{y},y}^2(1 + r)/2}$$

and

(S3.2)
$$\alpha_{\text{PA}} = \frac{h^2 - R_{\hat{y},y}^2}{1 - R_{\hat{y},y}^2(1+r)/2}$$

where h² denotes the heritability of the trait in the current population, *r* the correlation between spouses phenotypes in the population, and $R_{\hat{y},y}^2 = \operatorname{corr}(\hat{y}, y)^2$, the prediction accuracy of the PGS. The expected accuracy $(R_{\hat{y}+\bar{y}_p}^2)$ of the combined predictor using these optimal weights, is given by

(S3.3)
$$R_{\hat{y}+\bar{y}_p}^2 = \frac{R_{\hat{y},y}^2 + \left(\frac{h^2}{2}\right)(1 + r)[h^2 - 2R_{\hat{y},y}^2]}{1 - R_{\hat{y},y}^2(1 + r)/2}$$

Suppl. Fig. 20 shows the results of simulations performed to verify the results from Equations (S3.1-S3.3). These simulations use an arbitrary number of SNPs included in the PGS and are not designed to match the number of SNPs used in various PGS analyses presented in the main text. Nevertheless, our conclusions are general and applicable to our empirical data under the assumption that each SNP in the PGS contributes about the same amount of genetic variance. We define the regression weights as $\omega_{PGS} = \alpha_{PGS}/(\alpha_{PGS} + \alpha_{PA})$ and $\omega_{PA} = \alpha_{PA}/(\alpha_{PGS} + \alpha_{PA})$. Therefore, values of ω_{PGS} such that $\omega_{PGS} > 0.5$ imply that the PGS has a stronger weight that the parental average.

Under assortative mating, **Suppl. Fig. 20** shows that ω_{PA} remains above 0.5 even when the PGS explains 50% of h². We show below that $\omega_{PGS} = \omega_{PA}$ if

(S3.4)
$$R_{\hat{y},y} = \frac{-[1-h^2(1+r)/2] + \sqrt{[1-h^2(1+r)/2]^2 + 4h^2}}{2}$$

For example, with r = 0.25 and $h^2 = 0.8$, Equation (S3.4) predicts an equal contribution of the PGS and parental information if $R_{\hat{y},y}^2 \approx 0.46$.

Next, we estimated α_{PGS} , α_{PA} and $R_{\hat{y}+\bar{y}_p}^2$ in 981 trios from the UK Biobank (**Methods**). For this analysis, we used a PGS based on 12,111 GWS SNPs identified in our largest GWAS meta-analysis. We found $\hat{\alpha}_{PGS} \sim 0.375$ (S.E. = 0.025) and $\hat{\alpha}_{PA} \sim 0.634$ (S.E. = 0.034). The variance explained by fitting both predictors is $\hat{R}_{\hat{y}+\bar{y}_p}^2$ = 0.542 (S.E. = 0.032), which is larger than the accuracy of each single predictor ($R_{\hat{y}}^2$ = 0.38, S.E. 0.031; and $R_{\bar{y}_p}^2$ = 0.439, S.E. 0.032). Next, we estimated the spousal correlation \hat{r} = 0.233 (S.E. = 0.031) and the heritability \hat{h}^2 = 0.894 (S.E. = 0.032) using mid-parent regression. Besides, the prediction accuracy of the PGS is $\hat{R}_{\hat{y},v}^2 \sim 0.4$. Therefore, from these estimates of r, h^2 and $R_{\hat{y},v}^2$

we predict using Equations (S3.1-S3.3) that $\alpha_{PGS} = 0.377$, $\alpha_{PA} = 0.656$ and $R_{\hat{y}+\bar{y}_p}^2 = 0.599$. These three predictions are not statistically distinct from estimated values, which further validates our model.

Proof of theoretical results

The linear combination (y_{opt}) of \hat{y} and \bar{y}_p that maximises prediction of y is derived from multivariate linear regression theory:

$$(3.1) \quad y_{Opt} = \alpha_{PGS} \hat{y} + \alpha_{PA} \bar{y}_p$$

where

$$(3.2) \ \alpha_{PGS} = \frac{\operatorname{var}(\bar{y}_p)\operatorname{cov}(\hat{y}, y) - \operatorname{cov}(\hat{y}, \bar{y}_p)\operatorname{cov}(\bar{y}_p, y)}{\operatorname{var}(\bar{y}_p)\operatorname{var}(\hat{y}) - \operatorname{cov}(\hat{y}, \bar{y}_p)^2} = \frac{\operatorname{var}(\bar{y}_p)\operatorname{var}(\hat{y})}{\operatorname{var}(\bar{y}_p)\operatorname{var}(\hat{y})} \times \frac{\operatorname{cov}(\hat{y}, y)/\operatorname{var}(\hat{y}) - \frac{\operatorname{cov}(\hat{y}, \bar{y}_p)\operatorname{cov}(\bar{y}_p, y)}{\operatorname{var}(\bar{y}_p)\operatorname{var}(\hat{y})}}{1 - [\operatorname{cov}(\hat{y}, \bar{y}_p)^2]/[\operatorname{var}(\bar{y}_p)\operatorname{var}(\hat{y})]}$$

and

$$(3.3) \ \alpha_{PA} = \frac{\operatorname{var}(\hat{y})\operatorname{cov}(\bar{y}_{p}, y) - \operatorname{cov}(\hat{y}, \bar{y}_{p})\operatorname{cov}(\hat{y}, y)}{\operatorname{var}(\bar{y}_{p})\operatorname{var}(\hat{y}) - \operatorname{cov}(\hat{y}, \bar{y}_{p})^{2}} = \frac{\operatorname{var}(\bar{y}_{p})\operatorname{var}(\hat{y})}{\operatorname{var}(\bar{y}_{p})\operatorname{var}(\hat{y})} \times \frac{\operatorname{cov}(\bar{y}_{p}, y)/\operatorname{var}(\bar{y}_{p}) - \frac{\operatorname{cov}(\hat{y}, \bar{y}_{p})\operatorname{cov}(\hat{y}, y)}{\operatorname{var}(\bar{y}_{p})\operatorname{var}(\hat{y})}}{1 - [\operatorname{cov}(\hat{y}, \bar{y}_{p})^{2}]/[\operatorname{var}(\bar{y}_{p})\operatorname{var}(\hat{y})]}$$

Without loss of generality, we assume that y and \hat{y} are both centred (i.e. $E[y] = E[\hat{y}] = 0$) and scaled (i.e. $var[y] = var[\hat{y}] = 1$). Assuming that var[y] = 1 implies that $var[\bar{y}_p] = (1 + r)/2$, where r denotes the phenotypic correlation between mates in the population.

We also denote $R_{\hat{y},y} = corr(\hat{y},y) = cov(\hat{y},y)$, $R_{\overline{y}_{p},y} = corr(\overline{y}_{p},y)$ and $R_{\hat{y},\overline{y}_{p}} = corr(\overline{y}_{p},y)$. Therefore, Equations (3.2) and (3.3) simplify as

$$(3.2') \ \alpha_{PGS} = \frac{\operatorname{cov}(\hat{y}, y) / \operatorname{var}(\hat{y}) - \frac{\operatorname{cov}(\hat{y}, \overline{y}_{p})}{\sqrt{\operatorname{var}(\overline{y}_{p}) \operatorname{var}(\hat{y})}} \times \frac{\operatorname{cov}(\overline{y}_{p}, y)}{\sqrt{\operatorname{var}(\overline{y}_{p}) \operatorname{var}(y)}} \times \sqrt{\frac{\operatorname{var}(y)}{\operatorname{var}(\hat{y})}} = \frac{R_{\hat{y}, y} - R_{\hat{y}, \overline{y}_{p}} R_{\overline{y}_{p}, y}}{1 - R_{\hat{y}, \overline{y}_{p}}^{2}}$$

and

$$(3.3') \quad \alpha_{PA} = \frac{\frac{\operatorname{cov}(\bar{y}_{p}, y)}{\sqrt{\operatorname{var}(\bar{y}_{p})\operatorname{var}(y)}} \times \sqrt{\frac{\operatorname{var}(y)}{\operatorname{var}(\bar{y}_{p})} - \frac{\operatorname{cov}(\hat{y}, \bar{y}_{p})}{\sqrt{\operatorname{var}(\bar{y}_{p})\operatorname{var}(\hat{y})}} \times \frac{\operatorname{cov}(\hat{y}, y)}{\sqrt{\operatorname{var}(\hat{y})\operatorname{var}(y)}} \times \sqrt{\frac{\operatorname{var}(y)}{\operatorname{var}(\bar{y}_{p})}} \\ 1 - R_{\hat{y}, \bar{y}_{p}}^{2} \\ = \sqrt{\frac{2}{1+r}} \left(\frac{R_{\bar{y}_{p}, y} - R_{\hat{y}, \bar{y}_{p}}R_{\hat{y}, y}}{1 - R_{\hat{y}, \bar{y}_{p}}^{2}} \right)$$

and further as

(3.2")
$$\alpha_{PGS} = \frac{R_{\hat{y},y} - R_{\hat{y},\overline{y}_{p}}R_{\overline{y}_{p},y}}{1 - R_{\hat{y},\overline{y}_{p}}^{2}}$$

and

(3.3")
$$\alpha_{PA} = \sqrt{\frac{2}{1+r}} \left(\frac{R_{\bar{y}_{p},y} - R_{\hat{y},\bar{y}_{p}}R_{\hat{y},y}}{1-R_{\hat{y},\bar{y}_{p}}^{2}} \right)$$

Equations (3.2") and (3.3") are expressed in function of $R_{\hat{y},y}$, $R_{\overline{y}_{p},y}$, $R_{\widehat{y},\overline{y}_{p}}$ and r.

<u>We assume that $R_{\hat{y},y}$ is known</u>, e.g., from quantifying the accuracy of the PGS in some validation sample. If we denote h^2 as heritability in the current population (which could be undergoing assortative mating, i.e. $r \neq 0$) and assume no shared environmental effects between parents and offspring then

(3.4)
$$h^2 = cov(\bar{y}_p, y)/var(\bar{y}_p) \implies R_{\bar{y}_p, y} = h^2 \sqrt{\frac{1+r}{2}}$$

Finally, denote \hat{y}_p as the average PGS of parents. We can express \overline{y}_p as a function of \hat{y}_p as follows

(3.5)
$$\bar{y}_{p} = \frac{\text{cov}(\bar{y}_{p}, \hat{y}_{p})}{\text{var}(\hat{y}_{p})}\hat{y}_{p} + \varepsilon_{p}$$

where ε_p is a residual term with mean 0 and such that $cov(\varepsilon_p, \hat{y}_p) = 0$. Given that both phenotypes and PGS are centred, $cov(\bar{y}_p, \hat{y}_p)$ can be expressed as

$$\operatorname{cov}(\bar{\mathbf{y}}_{\mathrm{p}}, \hat{\mathbf{y}}_{\mathrm{p}}) = \frac{1}{4} E \left[\mathbf{y}_m \hat{\mathbf{y}}_m + \mathbf{y}_f \hat{\mathbf{y}}_f + \mathbf{y}_f \hat{\mathbf{y}}_m + \mathbf{y}_m \hat{\mathbf{y}}_f \right] = \frac{1}{2} E \left[\mathbf{R}_{\hat{\mathbf{y}}, \mathrm{y}} + E \left[\mathbf{y}_f \hat{\mathbf{y}}_m | \mathbf{y}_m \right] \right] = \mathbf{R}_{\hat{\mathbf{y}}, \mathrm{y}} (1+r)/2$$

Using a similar reasoning, we can show that $var(\hat{y}_p) = (1 + rR_{\hat{y},y}^2)/2$. Therefore, Equation (3.5) can be rewritten as

(3.5')
$$\bar{y}_{p} = R_{\hat{y},y} \left(\frac{1+r}{1+rR_{\hat{y},y}^{2}}\right) \hat{y}_{p} + \varepsilon_{p}$$

Besides, we can also write

$$(3.6) \quad \hat{y} = \hat{y}_p + \varepsilon_m,$$

where ϵ_m (Mendelian segregation) is independent of \hat{y}_p . Combining Equations (3.5') and (3.6) leads to

$$(3.7) \quad \operatorname{cov}(\bar{y}_{p}, \hat{y}) = R_{\hat{y}, y} \left(\frac{1+r}{1+rR_{\hat{y}, y}^{2}} \right) \operatorname{cov}(\hat{y}_{p}, \hat{y}) + \operatorname{cov}(\hat{y}, \varepsilon_{p}) = R_{\hat{y}, y} \left(\frac{1+r}{1+rR_{\hat{y}, y}^{2}} \right) \operatorname{var}(\hat{y}_{p}) + \operatorname{cov}(\varepsilon_{m}, \varepsilon_{p})$$

which, assuming $\operatorname{cov}(\varepsilon_{\mathrm{m}}, \varepsilon_{\mathrm{p}}) = 0$, implies that $\operatorname{cov}(\overline{y}_{\mathrm{p}}, \hat{y}) = R_{\hat{y}, y}\left(\frac{1+r}{1+rR_{\hat{y}, y}^2}\right)\operatorname{var}(\hat{y}_{\mathrm{p}}) = R_{\hat{y}, y}(1+r)/2.$

Therefore,

(3.8)
$$R_{\hat{y},\bar{y}_p} = \operatorname{corr}(\bar{y}_p, \hat{y}) = \frac{R_{\hat{y},y}(1 + r)}{\sqrt{2(1 + r)}}.$$

It follows that

$$R_{\hat{y},\bar{y}_p}^2 = \frac{R_{\hat{y},y}^2(1+r)^2}{2(1+r)} = R_{\hat{y},y}^2(1+r)/2 \Leftrightarrow \frac{1}{1-R_{\hat{y},\bar{y}_p}^2} = \frac{1}{1-R_{\hat{y},y}^2(1+r)/2}$$

We now express below α_{PGS} and α_{PA} as a function of h^2 , $R_{\hat{y},y}$, and r.

We first recall that $\alpha_{PGS}=\frac{R_{\hat{y},y}-R_{\hat{y},\bar{y}p}R_{\bar{y}p,y}}{1-R_{\hat{v},\bar{v}}^2}$

$$R_{\hat{y},\bar{y}_{p}}R_{\bar{y}_{p},y} = \frac{R_{\hat{y},y}(1+r)}{\sqrt{2(1+r)}} \times h^{2}\sqrt{\frac{1+r}{2}} = R_{\hat{y},y}h^{2}(1+r)/2.$$

 $R_{\hat{y},y} - R_{\hat{y},\overline{y}_p}R_{\overline{y}_p,y} = R_{\hat{y},y}[1 - h^2(1 + r)/2].$

To calculate
$$\alpha_{PA} = \sqrt{\frac{2}{1+r}} \left(\frac{R_{\bar{y}_{p},y} - R_{\bar{y},\bar{y}_{p}}R_{\bar{y},y}}{1 - R_{\bar{y},\bar{y}_{p}}^{2}} \right)$$

 $\sqrt{\frac{2}{1+r}} \left(R_{\bar{y}_{p},y} - R_{\bar{y},\bar{y}_{p}}R_{\bar{y},y} \right) = \sqrt{\frac{2}{1+r}} \left[h^{2} \sqrt{\frac{1+r}{2}} - \frac{R_{\bar{y},y}^{2}(1+r)}{\sqrt{2(1+r)}} \right] = h^{2} - \frac{R_{\bar{y},y}^{2}(1+r)}{1+r} = h^{2} - R_{\bar{y},y}^{2}$

Finally,

$$(3.2''') \ \alpha_{PGS} = \frac{R_{\hat{y},y} - R_{\hat{y},\overline{y}_{p}}R_{\overline{y}_{p},y}}{1 - R_{\hat{y},\overline{y}_{p}}^{2}} = \frac{R_{\hat{y},y}[1 - h^{2}(1 + r)/2]}{1 - R_{\hat{y},y}^{2}(1 + r)/2}$$

and

$$(3.3''') \ \alpha_{PA} = \sqrt{\frac{2}{1+r}} \left(\frac{R_{\bar{y}_{p},y} - R_{\hat{y},\bar{y}_{p}}R_{\hat{y},y}}{1-R_{\hat{y},\bar{y}_{p}}^{2}} \right) = \frac{h^{2} - R_{\hat{y},y}^{2}}{1-R_{\hat{y},y}^{2}(1+r)/2}$$

Special case: r = 0

$$\alpha_{PGS} = \frac{R_{\widehat{y},y}[1 - h^2/2]}{1 - R_{\widehat{y},y}^2/2} \text{ and } \alpha_{PA} = \frac{h^2 - R_{\widehat{y},y}^2}{1 - R_{\widehat{y},y}^2/2}$$

The relative contribution of \hat{y} and \bar{y}_p , defined above as $\omega_{PGS} = \alpha_{PGS}/(\alpha_{PGS} + \alpha_{PA})$ and $\omega_{PA} = \alpha_{PA}/(\alpha_{PGS} + \alpha_{PA})$ can be expressed as

$$\omega_{PGS} = \frac{R_{\hat{y},y}[1 - h^2(1 + r)/2]}{R_{\hat{y},y}[1 - h^2(1 + r)/2] + h^2 - R_{\hat{y},y}^2} \text{ and } \omega_{PA} = \frac{h^2 - R_{\hat{y},y}^2}{R_{\hat{y},y}[1 - h^2(1 + r)/2] + h^2 - R_{\hat{y},y}^2}$$

These two relative contributions are equal when $\omega_{PA} = \omega_{PGS} = 1/2$, i.e. when

$$2h^{2} - 2R_{\hat{y},y}^{2} = R_{\hat{y},y}[1 - h^{2}(1 + r)/2] + h^{2} - R_{\hat{y},y}^{2} \iff R_{\hat{y},y}^{2} + R_{\hat{y},y}[1 - h^{2}(1 + r)/2] - h^{2}$$

or equivalently, when

$$R_{\hat{y},y} = \frac{-[1 - h^2(1 + r)/2] + \sqrt{[1 - h^2(1 + r)/2]^2 + 4h^2}}{2}$$

This therefore proves Equation (S3.4).

Prediction accuracy from a linear regression model fitting both PGS and parental average The expected prediction accuracy $(R_{\hat{y}+\bar{y}_p}^2)$ from combining PGS and parental information can be expressed as

$$R_{\hat{y}+\overline{y}_{p}}^{2} = \alpha_{PGS}cov(\hat{y}, y) + \alpha_{PA}cov(\overline{y}_{p}, y) = \frac{R_{\hat{y}, y}^{2}[1-h^{2}(1+r)/2] + h^{2}(h^{2}-R_{\hat{y}, y}^{2})(1+r)/2}{1-R_{\hat{y}, y}^{2}(1+r)/2}$$

which can be simplified as

(3.9)
$$R_{\hat{y}+\bar{y}_p}^2 = \frac{R_{\hat{y},y}^2 + \left(\frac{h^2}{2}\right)(1+r)\left[h^2 - 2R_{\hat{y},y}^2\right]}{1 - R_{\hat{y},y}^2(1+r)/2}$$

Prediction accuracy and proportion of causal variants captured

We assume that the trait of interest in underlain by M independent causal SNPs and that m (m \leq M) of them are included in a PGS. Moreover, we assume that the population has been undergoing assortative mating for multiple generations, until an equilibrium is reached. We derive below how large m needs to be for the prediction accuracy of the derived PGS, in the equilibrium population, to equal $R^2_{\hat{v},v}$.

We denote $\rho = rh^2$, $f_0 = m/M$, $\gamma = \rho/(1-\rho)$, $\alpha = \gamma/(2M)$ the expected correlation between traitincreasing alleles induced by assortative mating, and $\sigma_{g,0}^2$ and $\sigma_{g,eq}^2$ the genetic variances in a randomly and assortatively mating populations, respectively.

In the equilibrium population, the variance of the PGS can be expressed as

(Int. 3.1) $\operatorname{var}(\hat{y}) \approx \sigma_{g,0}^2 f_0(1 + \gamma f_0)$, and the covariance between y and \hat{y} as

(Int. 3.2) $\operatorname{cov}(\hat{y}, y) \approx \sigma_{g,0}^2 f_0(1+\gamma).$

Equations (Int. 3.1) and (Int. 3.2) are proven below.

Therefore,

(3.10)
$$R_{\hat{y},y}^{2} = \frac{\operatorname{cov}(\hat{y},y)^{2}}{\operatorname{var}(\hat{y})\operatorname{var}(y)} \approx \sigma_{g,0}^{2} f_{0} \frac{(1+\gamma)^{2}}{1+\gamma f_{0}}$$

We divide the previous equation by $\sigma_{g,eq}^2$ and define $\phi_{eq} = R_{\hat{y},y}^2/\sigma_{g,eq}^2$. Therefore, Equation (3.10) implies that

$$(3.11) \qquad (1+\gamma f_0)\phi_{eq} \approx \left(\frac{\sigma_{g,0}^2}{\sigma_{g,eq}^2}\right) f_0(1+\gamma)^2 = f_0(1-\rho)(1+\gamma)^2 \Leftrightarrow f_0 \approx \frac{\phi_{eq}}{(1-\rho)(1+\gamma)^2 - \gamma \phi_{eq}}$$

where $\phi_{eq} = R_{\hat{y},y}^2/\sigma_{g,eq}^2$. Note that $\sigma_{g,eq}^2/\sigma_{g,0}^2$ is the inflation in genetic variance due to assortative mating, which is predicted in theory to equal $1/(1-\rho)$.

Using a similar reasoning, Yengo et al.⁷¹ (Eq. 1.20 in their Supplementary Note) derived the relationship between f_0 and the proportion $f_{eq} = h_{SNP}^2/h^2$ of equilibrium heritability explained by the m SNPs included in the PGS as:

(3.12)
$$f_0 = \frac{1-\rho}{2\rho} \left[\sqrt{\left(1 + \frac{4f_{eq}\rho}{(1-\rho)^2}\right)} - 1 \right] \underset{|\rho| \ll 1}{\approx} f_{eq} / (1-\rho).$$

Proof of Equation (Int. 3.1) and (Int. 3.2)

We assume an infinitesimal model, where each causal SNP explains the same amount of trait variance. For simplicity, we assume the squared effect size of each causal SNP to equal $b^2 = \sigma_{g,0}^2/M$; and that SNP

effects are estimated with negligible errors so that they could be assumed to be equal to their true value. Finally, we assume that the m first SNPs are included in the PGS.

Under these assumptions, the PGS (i.e. \hat{y}) can be written as

$$\hat{\mathbf{y}} = \left(\frac{\sigma_{g,0}^2}{M}\right) \sum_{j=1}^m z_j$$

where $(z_j - 2p_j)/\sqrt{2p_j(1 - p_j)}$ is the centred and scaled count of trait-increasing allele at SNP j and p_j the trait-increasing allele frequency at that same SNP. By definition, we have that $var(z_j) = 1 + \alpha$, and that $cov(z_j, z_k) = 2\alpha$. It follows that

$$\operatorname{var}(\hat{y}) = \frac{\sigma_{g,0}^2}{M} [m(1+\alpha) + m(m-1)2\alpha] = \sigma_{g,0}^2 \left(\frac{m}{M}\right) [1 + (2m-1)\alpha] = \sigma_{g,0}^2 f_0 \left[1 + \left(f_0 - \frac{1}{2M}\right)(2M\alpha)\right]$$

For large values of *M*, this simplifies as $var(\hat{y}) \approx \sigma_{g,0}^2 f_0(1 + \gamma f_0)$.

Similarly, we can write $\operatorname{cov}(\hat{y}, y) \operatorname{as} \operatorname{cov}(\hat{y}, y) = \frac{\sigma_{g,0}^2}{M} [m(1 + \alpha) + m(M - 1)2\alpha] \approx \sigma_{g,0}^2 f_0(1 + \gamma).$

Supplementary Note 5: Saturation of GWAS signals within pathways and gene sets

Overview and main results

We assessed the enrichment of broad categories of biological pathways for different GWAS sample sizes, using two different gene set enrichment methods, DEPICT⁴² and MAGMA.⁴³ Specifically, we evaluated the prioritization of 14,462 gene sets, hierarchically clustered into 20 groups of related gene sets based on gene set membership (see Methods below, **Suppl. Fig. 21, Suppl. Table 13**). We observed an enrichment of OMIM genes in clusters 1, 2, 5, 6, 11, 16, and 17 (Bonferroni P < 0.05 vs. random genes (**Extended Data Fig. 8, Suppl. Table 14**). At all sample sizes tested (range N=130,010 to N=5,314,291), similar sets of the clusters consistently showed significant enrichments in DEPICT (clusters 2, 5, 11, 16, and 17) and MAGMA-prioritized gene sets (clusters 5, 11, 16, and 17; **Suppl. Fig. 21**). Thus, the broad patterns of gene set enrichment are apparent even at moderate sample sizes and remain quite stable as sample sizes increase.

In contrast with clusters of gene sets, individual genes may require larger sample sizes or multiple ancestries to be implicated by GWAS. To address these questions, we assessed the fraction of OMIM genes that contain an approximately independent genome-wide significant signal (identified with COJO) across the range of GWAS sample sizes. As sample size increases and the number of independent signals increases, the percent of the 462 OMIM genes overlapping a signal also increases (**Suppl. Fig. 23b**); however, after subtracting the null background from randomly sampled sets of 462 genes, the percentage above background of OMIM genes that overlap GWAS signal plateaus at a sample size of ~ 2.5 M (**Suppl. Fig. 23c**). In comparing the trans-ancestry meta-analysis with the largest European-ancestry-only GWAS with, we did not observe a noticeable increase in overlapping OMIM genes above background.

We also sought to examine more directly whether the height GWAS results implicate highly similar biology across different continental ancestries. We used MAGMA and DEPICT to prioritize genes based on GWAS results for EUR, EAS, and AA ancestries. We then compared the enrichment of heritability with stratified LD score regression (LDSC)^{39,40} for each set of prioritized genes, evaluated either in the same ancestry or in the other two ancestries. Genes prioritized in one ancestry by both MAGMA and DEPICT showed comparable enrichment of heritability when evaluated either in that ancestry or in the other two ancestries (**Suppl. Fig. 22, Suppl. Table 15**), strongly confirming the shared biology implicated by GWAS results from different ancestries.

Methods

Evaluation of gene set enrichment analysis (GSEA) methods across sample sizes.

For GWAS summary statistics from multiple sample sizes (**Tables 1 - 2**) two GSEA approaches were applied (DEPICT and MAGMA). DEPICT release 173 was used; the top 1000 SNPs pruned by p-value from each set of summary statistics were used as input for each sample. MAGMA version v1.07b was used; SNPs were annotated with genes within 100kb, and genes were removed if the missingness of their pathway membership was over 0.2.

To evaluate the ability of GSEA methods to identify groups of gene sets at different sample sizes, 14,462 gene sets, each consisting of Z-scores for 19,987 genes (gene sets selected and gene membership Z-scores calculated in ref.⁴²), were hierarchically clustered into 20 clusters as follows. Pairwise distances between gene sets were defined as the Euclidean distance between the gene sets' Z-scores and the elbow method was used to choose the number of clusters, evaluating average distances between cluster centroids as the number of clusters is varied (**Suppl. Fig. 21**). For DEPICT and MAGMA, enrichment of prioritization in each cluster was defined as the number of prioritized gene sets in each cluster divided by the size of each cluster; a gene set was considered prioritized if it was in the top 10% of gene sets as prioritized by the GSEA method. Enrichment of OMIM genes in each gene set divided by the proportion of all genes in OMIM, and then enrichment of OMIM genes in each cluster was defined as the average of the

enrichment of OMIM genes in each gene set in that cluster. Genes were defined to be "in a gene set" if the gene's gene-set Z-score is > 1.96, as described previously.⁷² Null distributions for each cluster were generated by randomly selected prioritized gene sets (for DEPICT and MAGMA) or prioritized genes to evaluate enrichment significance.

To evaluate saturation of height-associated gene identification, the percentage of OMIM genes overlapping independent COJO signals was calculated. "Overlapping" was defined as having at least one COJO SNP within the gene body, as defined with the plink version 1.9 hg19 gene list (URL: <u>https://www.cog-genomics.org/static/bin/plink/glist-hg19</u>). A null distribution was calculated by drawing an equivalent number of random genes (binned by size into 20 bins, same number of genes per bin) to match OMIM genes, and calculating the percent of the random genes near a COJO SNP.

Benchmarking of gene prioritization across different ancestries

We applied DEPICT and MAGMA to prioritize genes on height GWAS of European, African-American and East Asian ancestry, resulting in three sets of prioritized genes for each method. To allow for a fair comparison, we used subsets of the available cohorts to create three equally sized GWAS (N~100,000). For MAGMA, we converted gene set prioritizations to gene prioritizations as described previously.⁷² For both DEPICT and MAGMA, we then used Benchmarker⁷² to evaluate the performance of these three sets of genes in each of the three different ancestries, resulting in three within-ancestry and six cross-ancestry scenarios.

The Benchmarker method is based on a leave-one-chromosome-out approach where one chromosome is withheld, and GWAS results for the remaining 21 chromosomes are used to prioritize genes on the withheld chromosome, iterating across each withheld chromosome. For each of the discovery GWAS ancestries, we selected the top 10% of the prioritized genes on each left out chromosome, resulting in 1,893 prioritized genes. We subsequently annotated SNPs within 50kb of the prioritized genes to generate a LD score annotation for these SNPs using LDSC.¹⁶ Lastly, we applied stratified LDSC³⁹ (S-LDSC) to compare the three annotation sets to the full GWAS results for each of the three ancestries to determine whether the performance of genes prioritized and then evaluated across the same ancestry would be more enriched for heritability compared with those prioritized and evaluated in different ancestries. Reference panels were based on the 1000 Genomes Phase 3 reference panels⁵ for LD score estimation, matching the reference panel ancestry with the GWAS results for that same ancestry. In addition, a category of SNPs that locate within 50kb of any gene in the prioritization method and a set of 53 annotations of known genomic importance were included in the S-LDSC as conditional covariates. The analysis was based on 1,217,311 HapMap3 SNPs. The results of the S-LDSC is summarized using proportional h_{SNP}^2 (proportion of heritability explained by the annotation), the regression coefficient (average per-SNP contribution of the annotation to heritability), and enrichment in heritability (h² divided by the proportion of SNPs in the annotation). To assess the performance difference between two annotations, we calculated p-values based on standard errors from the different estimates.

Supplementary Note 6: Enrichment of SNP-based heritability from low-frequency variants within loci containing common SNPs associated with height

In this note, we quantify the enrichment of SNP-based heritability due to low-frequency SNPs (MAF<1%) in genomic loci containing common SNPs (MAF>1%) associated with height.

Heritability enrichment from low-frequency variants in European ancestry participants

We first analysed imputed SNPs (INFO>0.3) from 3 samples of unrelated European ancestry (EUR) individuals independent from our discovery GWAS. This analysis included 44,312 participants from the Estonian Biobank (EBB), 14,587 participants of the UK Biobank (UKB) and 14,058 participants from the Lifelines Biobank (LLB), so that the total sample size is N=72,957. We partitioned SNP-heritability estimates in each of the 3 samples, then meta-analysed the results using an inverse-variance weighting scheme. The number of SNPs with MAF>0.1% was 13,040,176 in UKB (incl. 8,547,170 SNPs with MAF>1%), 11,492,146 in LLB (incl. 7,659,695 SNPs with MAF>1%) and 13,695,032 in EBB (incl. 8,620,105 SNPs with MAF>1%). We stratified SNPs into 4 classes: (1) 0.1%<MAF<1% within genome-wide significant loci (GWS), (2) 0.1%<MAF<1% outside GWS loci, (3) MAF>1% within GWS loci and (4) MAF>1% outside GWS loci. Then, we calculated genetic relationship matrices (GRM) for each group of SNPs using GCTA and estimated SNP-based heritability from fitting these 4 GRMs jointly.

Extended Data Fig. 10 shows estimates of SNP-based heritability for each group of SNPs and each sample, as well as the meta-analysis of these estimates across the 3 EUR samples. We found consistent patterns across these samples and, therefore, hereafter focus on meta-analysed estimates. Approximately 88% (i.e. 5.7/(5.7 + 0.78)) of the SNP-based heritability of height explained by variants with 0.1%<MAF<1% is due to SNPs located within our 7,209 height-associated loci. Importantly, these analyses only implicate a fraction (approximately 4/5th, Wainschtein et al.⁵⁰) of low-frequency variants with an imputation accuracy score >0.3, which limits generalisability to all low-frequency and rare variants. Nevertheless, these results suggest that rarer variants associated with height are likely be detected in (or near) the 7209 loci identified in this study.

Height-associated rare variants in European ancestries but common in African ancestries are enriched within GWS loci

Next, we analysed 16,374,566 SNPs with MAF>1% in African ancestries (AFR; N=661) individuals from the 1000 Genomes Project (1KG). We stratified these SNPs in two classes defined by their MAF in EUR individuals from 1KG (N=504). The first class contained 7,365,878 SNPs with a MAF>1% in EUR (47% of which had a MAF<0.1% in EUR; **Suppl. Fig. 25**), and the second one 8,114,046 SNPs with a MAF<1% in the same EUR individuals. We then quantified the enrichment of SNP-based heritability within GWS loci for both classes of variants in 6,911 AFR individuals from the UKB.

Overall, we found similar enrichments of SNP-based heritability within GWS loci for both classes of variants (**Suppl. Fig. 25a**). Therefore, assuming that causal variants for height are shared across ancestries, these results suggest that rare variants in EUR that are associated with height (at least those common enough in AFR) are also likely to be detected within these 7,209 genomic regions. Note that this class of rare variants in EUR could, in principle, be detected with large GWAS of height in AFR.

Conclusions

In summary, we performed two orthogonal analyses, with results suggest that rare variants associated with height in EUR are enriched within our GWS loci. Additional analyses using whole-genome sequence data in large samples are required to confirm these findings as well larger GWAS of height in non-EUR populations.

SUPPLEMENTARY REFERENCES

- 67. Loh, P.-R., Kichaev, G., Gazal, S., Schoech, A. P. & Price, A. L. Mixed-model association for biobankscale datasets. *Nature Genetics* **50**, 906–908 (2018).
- 68. Lee, J. J. *et al.* Gene discovery and polygenic prediction from a genome-wide association study of educational attainment in 1.1 million individuals. *Nat. Genet.* **50**, 1112–1121 (2018).
- 69. Chen, W. *et al.* Improved analyses of GWAS summary statistics by reducing data heterogeneity and errors. *bioRxiv* 2020.07.09.196535 (2020) doi:10.1101/2020.07.09.196535.
- 70. Mukamel, R. E. *et al.* Protein-coding repeat polymorphisms strongly shape diverse human phenotypes. *bioRxiv* 2021.01.19.427332 (2021) doi:10.1101/2021.01.19.427332.
- 71. Yengo, L. *et al.* Imprint of assortative mating on the human genome. *Nature Human Behaviour* **2**, 948 (2018).

72. Fine, R. S., Pers, T. H., Amariuta, T., Raychaudhuri, S. & Hirschhorn, J. N. Benchmarker: An Unbiased, Association-Data-Driven Strategy to Evaluate Gene Prioritization Algorithms. *Am J Hum Genet* **104**, 1025–1039 (2019).