# **INTRODUCTION**

## **Epidemiology of the outcome**

The NIH’s National Heart, Lung, and Blood Institute defines high cholesterol as having total blood cholesterol (TC) levels greater than or equal to 200 mg/dL (National Institutes of Health, 2001). More than one third of the United States adult population has high TC and therefore are at a heightened risk for cardiovascular disease (CVD) and stroke (Virani et al., 2021). Established risk factors of high cholesterol include obesity, lack of physical activity, diet high in saturated and trans fat, type 2 diabetes, smoking, age, gender, and familial hypercholesterolemia (CDC, 2020).

According to the American Heart Association’s *Heart Disease and Stroke Statistics—2021 Update*, adults aged 20 and older in 2015-2018 had a mean TC of 190.6 mg/dL (Virani et al., 2021). Healthy People, an evidence-based initiative that sets national 10-year goals to improve the population health of the United States, chose to target a mean TC of 177.9 mg/dL by the year 2020 (Healthy People, 2022). Therefore, the mean TC during 2015-2018 was not within the Healthy People goal for 2020. It was also estimated that 93.9 million, or 38.1%, of U.S. adults had greater than 200 mg/dL TC (Virani et al., 2021). For TC greater than 240 mg/dL the estimated affected adults were 28 million, or 11.5%. Although the prevalence of high TC in adults had decreased from 18.3% in 2000 to 10.5% in 2018, the report states that the decline is likely due to greater uptake of medications rather than changes in lifestyle. The estimated economic burden of managing and preventing high cholesterol in the U.S. is between $18.5 million and $77 million every year. The estimated burden of CVD, an outcome from having high cholesterol, is $219 billion (Ferrara et al., 2021).

## **Epidemiology of the exposure**

The U.S. Bureau of Labor Statistics reported full-time employees spent an average of 8.78 hours per workday on work or work-related activities (2019). This becomes 43.9 hours throughout a 5-day workweek. Globally, 36.1% of workers exceed 48 hours each week (Rivera et al., 2020). These numbers surpass many developed countries’ standards and recommendations. The Australian government mandates employers must not work their employees over 38 hours per week without reason (Reynolds et al., 2018). The European Union states that employers ensure their workers do not exceed an average of 48 hours per week including overtime (Your Europe, 2021). The U.S. *Fair Labor and Standards Act* (1938) requires overtime pay after 40 hours in a week for nonexempt employees, and there is no maximum number of hours.

When defining long working hours in research, prior studies have used various cut points such as >40 per week (Rivera et al., 2020), >80 hours per week (Lee et al., 2016), and >11 hours per day (Lemke et al., 2017). According to the U.S. *Patient Protection and Affordable Care Act* (2010), employees working at least 30 hours per week on average are considered full-time. Working long hours leaves less time for reaching the CDC’s guidelines of recommended exercise, diet, and sleep (Artazcoz et al., 2009). It also can expose individuals to greater amounts of work strain and psychological stress. These experiences have been shown to increase other biomarkers such as blood pressure and heart rate instability (Kivimaki & Steptoe, 2018).

## **Literature review**

Past studies measuring the effect of working hours on cholesterol health have typically found negative associations, though results are not quite consistent and study populations vary greatly.

Twenty-two-year-old participants from the Western Australian Pregnancy Cohort Study had no differences in TC or low-density lipoprotein (LDL-C) measurements when comparing those who were working more than 38 hours each week with those working 38 hours or less (Reynolds et al., 2018). Reynolds et al. did observe that high-density lipoprotein cholesterol (HDL-C) in the group working greater hours was lower by 4.0 mg/dL. These results were adjusted for education level, shift work status, workload, and smoking.

Data on French participants of the CONSTANCES cohort study showed results in a similar direction after adjusted for age, socioeconomic status, alcohol use, physical activity, depression symptoms, and chronic disease (Virtanen et al., 2019) Men who were currently working days longer than 10 hours had a higher mean TC, higher LDL-C, and lower HDL-C, compared to men who had never worked longer than 10 hours in a day. Results for women and all cholesterol measurements were insignificant.

In the United States, a cross-sectional study on truck drivers used linear regression to estimate the effects of various factors such as age, daily working hours, and sleep quality on TC, LDL-C, and HDL-C measurements (Lemke et al., 2017). Working greater than 11 hours daily was associated with an increase in LDL-C by 14.2 mg/dL. No significant effect was observed on TC or HDL-C.

Japanese engineers in the machinery manufacturing industry had a difference in TC between working hours groups when stratifying by age (Sasaki et al., 2019). Participants that were aged 30-39 and worked 57-63 hours in a week had a higher mean TC than participants of the same age group that worked less than 57 hours. This higher mean TC was also observed when compared to participants of the same age that worked more than 63 hours. All other age groups had no differences within their various levels of working hours.

Researchers examining data from the Korean NHANES data showed 1.76 times higher odds of coronary heart disease for men and 1.63 times higher odds for women working more than 80 hours per week compared to those working 40 hours per week (Lee et al., 2016). The risk of stroke in these two working groups for men was insignificant, but women working more than 80 hours had 2.32 times higher odds of stroke than women working 40 hours.

A 27% increased risk of stroke in working 49-54 hours per week compared to 35-40 hours was observed in a meta-analysis of long working hours, coronary heart disease, and stroke (Kivimaki et al., 2015). The risk of those working more than 55 hours was 33% greater than the 35-40 hours group.

**Gaps in the Literature**

Studies that examined working hours and cholesterol levels were often not base in the United States. Also, specific industries were frequently targeted rather than a general population. Another common theme was having very high cut points when defining the categories for working hours, such as separating two groups at the 10-hours per day or 60-hours per week marks. These limitations prevent much of the results of previous research from reflecting whole working populations in a nation.

## **Theoretical framework**

**Diagram

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The biological pathway of working hours affecting blood cholesterol shown above is used as the framework in designing the hypothesis for this study.

## **Summary**

U.S. adults spend an average of 8.78 hours per workday on work-related activities, exceeding the standardized 40-hour workweek and reducing available time for healthy behaviors such as sleep and exercise, and increasing exposure to job-related stress. During 2013-2016 U.S. adults had a mean TC of 190.6 mg/dL, which is above the Healthy People 2020 goal of 177.9 mg/dL. 93.9 million adults (38.1%) had a TC of 200 mg/dL or greater. 28 million adults (11.5%) had a TC of 240 mg/dL or greater. High cholesterol is estimated to burden the U.S. with a cost between $18.5 million and $77 million each year. CVD, a result of having high cholesterol, is estimated to cost the U.S. $219 billion dollars.

Prior research has examined long working hours and its association with blood cholesterol levels but they either studied populations outside of the U.S. or had very high cut points for working hours. This analysis is unique in that it studies a random selection of U.S. adults and lowers the cut points to produce results more closely related to the general U.S. adult population.

## **Research question**

Are greater self-reported hours worked in the prior week associated with higher measurements of TC among men and women aged 18-80 years who participated in NHANES 2017-2018?

## **Research hypothesis**

**H0**: There is not an association between working hours in the past week and TC.

**H1**: There is a significant positive association between greater working hours in the past week and high TC.

# **METHODS**

## **Study design and setting**

The National Center for Health Statistics (NCHS) administered the National Health and Nutrition Examination Survey (NHANES) in-person to adults and adolescents in the United States during 2017 and 2018. This survey recorded cross-sectional health information and measurements for the purpose of estimating nationwide disease prevalence and aiding in health policy development. The sample design was a complex multi-level process that oversampled and undersampled certain demographics that later became weighted to represent the whole noninstitutionalized civilian population of the United States. Participants were interviewed about their personal demographics, health status, and behaviors, while measurements were recorded by a mobile clinic during a standardized physical examination.

## **Study population**

During 2017-2018 the National Health and Nutrition Examination Survey (NHANES) recruited 9,254 participants. Of these participants, 1,715 were selected based on their blood tests and questionnaire results. All selected observations had recorded TC measurements, at least 30 total hours worked at all jobs during the week prior to being surveyed, were not currently taking cholesterol medication, and were at least 18 years of age. Participants without data for their BMI and income-to-poverty ratio were also removed as this information was needed in the multivariable analysis.

Diagram

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## **Data sources and measurement**

*Outcome:* TC was recorded by a combined effort of collecting blood samples by the mobile examination clinic and enzymatic assay methods performed by contracted laboratories. Collection of the samples occurred immediately prior to questionnaire data was obtained. After the completion of the laboratory analyses, TC was recorded as discrete values with units of milligrams per deciliter (mg/dL) of blood. No parameters were placed to make exclusions based on these results.

*Exposure:* Total working hours in the week prior to the survey administration was obtained from a series of questions. First participants were asked “In this part of the survey I will ask you questions about your work experience. Which of the following were you doing last week?” The options to answer this question were as followed: Working at a job or business; with a job or business but not at work; looking for work; not working at a job or business; refused; or don’t know. Only those who responded that they worked at a job or business were considered for this study. A follow-up question was asked to those who responded as such: “How many hours did you work last week at all jobs or businesses?” Those who answered between 1 and 5 hours were recorded as “5”. Six to 78 hours were recorded as discrete values. No respondent~~s~~ reported 79 hours, and those who reported 80 or more were recorded as “80”. Refusals to report and “Don’t know” were also recorded. The goal of this study was to examine full-time workers, so observations were dropped from the analysis if they worked less than 30 hours, refused to report, or did not know how many hours they worked last week.

*Covariates:* Variables included in the study were chosen based on modern knowledge of risk factors related to high TC, along with common covariates of past research with similar topics. Two variables were modified from the NHANES 2017-2018 dataset to consolidate similar categories. Those who self-reported being Mexican American or Other Hispanic were collapsed into a single Hispanic category. Also, having not attended high school was combined with not finishing high school or obtaining a GED. This group was considered as No High School Diploma.

## **Efforts to address bias**

Those who worked less than full-time in the prior week, defined as less than 30 hours, were removed from the study to prevent a potential bias that could come from observations who had not worked at all or worked very little. Children and adolescents were removed as they may not have lived long enough to observe direct effects of working hours on TC. The final model controlled for the effects of the selected covariates to measure the association more accurately between prior week working hours and TC.

## **Statistical methods**

Descriptive and analytic statistics were calculated with R 4.1.1 “Kick Things” and utilized the weights included with the NHANES 2017-2018 dataset. No unweighted statistics are listed in Tables 1-3. TC was normally distributed amongst the weighted population; therefore, the mean and standard deviation were included in Table 1. All other continuous variables were nonnormal and the medians with minimum and maximum values were reported.

Simple linear regression was used to determine the effects of the continuous variables on TC for the bivariate analysis. Pearson’s correlation was used to describe the strength of these effects. Bartlett’s test for homogeneity was used to determine the inclusion of a categorical variable in the bivariate analysis. Independent t-tests and ANOVA were performed to calculate differences in means for the included categorical variables. Multiple linear regression was used to build the adjusted model of determining the effect of prior week working hours on TC.

# **RESULTS**

## **Key findings**

* 37.0% of the weighted population had clinically high TC.
* 47.0% reported working more than 40 hours in the prior week.
* Each hour worked was associated with a decrease of TC by 0.28 mg/dL after adjusting for covariates.
* Race and vigorous recreational activity had the largest effect on TC in the adjusted model.

## **Study Population**

The NHANES 2017-2018 dataset consisted of 9,254 observations that was reduced to 1,715 observations due to the exclusion criteria of this study. The final study population was weighted to represent 95,960,477 non-institutionalized adults of the United States.

## **Demographics**

The weighted interquartile range for age was 29 – 51 years old. A BMI of 25 or greater was recorded for 72.9% of the weighted population (SE = 1.6%). The prevalence of either college attendance or completion of an advanced degree was 66.2% (SE = 1.7%). Household income at or below poverty lines was calculated in 9.0% of the weighted population (SE = 0.7%).

## **Total Blood Cholesterol**

TC was normally distributed within the weighted population and had a mean of 190.0 mg/dL (SE = 1.4). Approximately 37.0% had a clinically high TC of over 200 mg/dL (SE = 1.8%) and 9.9% had a very high TC of 240 mg/dL or higher (SE = 1.1%).

## **Working Hours**

Approximately 33.6% of the weighted population worked exactly 40 hours (SE = 1.7%) and 46.9% worked more than 40 hours (SE = 1.8%). The proportion of those who worked between 30-39 hours was 19.4% (SE = 1.4%). Male mean working hours was 46.7 hours (SE = 0.6) whereas the female mean was 42.8 hours (SE = 0.5).

Table 1. Frequencies, means, and medians of select characteristics of U.S adults from NHANES 2017-2018 (n = 1,715)

|  |  |  |  |
| --- | --- | --- | --- |
| **Characteristic** | **Unweighted n** | **Weighted n** | **Value** |
| Total blood cholesterol (mg/dL) a | 1,715 | 95,960,477 | 190.0 (1.4) |
| Prior week working hours b | 1,715 | 95,960,477 | 40.0 (30.0 – 80.0) |
| Age b | 1,715 | 95,960,477 | 39.0 (18.0 – 80.0) |
| BMI b | 1,715 | 95,960,477 | 28.4 (15.5 – 68.2) |
| Gender c  Male  Female | 917  798 | 53,762,535  42,197,943 | 56.0 (1.8)  44.0 (1.8) |
| Doctor says cholesterol is high c  Yes  No | 306  1,404 | 17,815,106  77,993,989 | 18.6 (1.5)  81.4 (1.5) |
| Sitting minutes daily b | 1,712 | 95,871,954 | 300.0 (2.0 – 1,140.0) |
| Vigorous work activity c  Yes  No | 551  1,163 | 33,618,508  62,313,737 | 35.0 (1.7)  65.0 (1.7) |
| Vigorous recreational activity c  Yes  No | 553  1,162 | 33,773,462  62,187,015 | 35.2 (1.8)  64.8 (1.8) |
| Race/Ethnicity c  Hispanic  Non-Hispanic White  Non-Hispanic Black  Non-Hispanic Asian  Other race or Multi-Racial | 414  553  380  282  86 | 15,809,379  60,436,789  9,793,855  5,381,098  4,539,357 | 16.5 (1.0)  63.0 (1.5)  10.2 (0.6)  5.6 (0.4)  4.7 (0.8) |
| Education c  No H.S. diploma  High school or GED  Some college or AA degree  College graduate or above | 232  388  561  490 | 7,288,350  24,621,029  33,284,597  30,055,543 | 7.7 (0.7)  26.1 (1.6)  31.8 (1.6)  34.4 (1.8) |
| Income-to-poverty ratio b | 1,715 | 95,960,477 | 3.5 (0.0 – 5.0) |

a Value is weighted mean (SE)

b Value is weighted median (min – max)

c Value is weighted percentage (SE)

## **Bivariate Analysis**

Prior week working hours had a weak negative unadjusted correlation with TC (R = -0.08) and accounted for a decrease in TC by 0.31 mg/dL for every hour worked (95% CI = -0.53 – -0.09). The strongest positive unadjusted correlation with TC were age (R = 0.31) and BMI (R = 0.12). An increase of 1 year in age was associated with an increase of 0.93 mg/dL (95% CI = 0.72 – 1.1) in TC. For BMI, an increase of 1 unit was associated with an increase of TC by 0.65 mg/dL (95% CI = 0.32 – 0.97). Taking part in vigorous recreational physical activity reduced TC by 11.1 mg/dL (95% CI = 5.8 – 16.3). Non-Hispanic Blacks had the lowest mean TC (mean = 182.5 mg/dL, SE = 2.2) while the Other and Multi-racial category had the highest (mean = 200.0 mg/dL, SE = 5.3). Higher levels of education generally decreased mean TC, but these differences were not significant.

Table 2. Unadjusted associations with total blood cholesterol

|  |  |  |
| --- | --- | --- |
| **Bivariate correlations with total blood cholesterol** | | |
| Variable | Weighted n | Correlation |
| Prior week working hours | 95,960,477 | -0.08\*\* |
| Age | 95,960,477 | 0.31\*\*\* |
| BMI | 95,960,477 | 0.12\*\*\* |
| Sitting minutes daily | 95,871,954 | 0.03 |
| Income-to-poverty ratio | 95,960,477 | 0.10\*\* |
|  |  |  |
| **Mean total blood cholesterol by categorized features** | | |
| Variable | Weighted n | Mean (SE) |
| Gender  Male  Female | 53,762,535  42,197,943 | 190.3 (1.8)  189.7 (2.0) |
| Doctor says cholesterol is high  Yes  No | 17,815,106  77,993,989 | \*\*\*  213.9 (3.2)  184.5 (1.4) |
| Vigorous work activity  Yes  No | 33,618,508  62,313,737 | 189.5 (2.5)  190.3 (1.6) |
| Vigorous recreational activity  Yes  No | 33,773,462  62,187,015 | \*\*\*  182.8 (2.0)  193.9 (1.8) |
| Race/Ethnicity  Hispanic  Non-Hispanic White  Non-Hispanic Black  Non-Hispanic Asian  Other race or Multi-Racial | 15,809,379  60,436,789  9,793,855  5,381,098  4,539,357 | \*\*  191.0 (2.3)  189.6 (2.0)  182.5 (2.2)  196.3 (2.4)  200.0 (5.3) |
| Education  No H.S. diploma  High school or GED  Some college or AA degree  College graduate or above | 7,288,350  24,621,029  33,284,597  30,055,543 | 198.0 (3.9)  189.9 (3.2)  190.0 (2.3)  190.0 (2.2) |

~ p<0.10

\* p<0.05

\*\* p<0.01

\*\*\* p<0.001

## **Multivariable Analysis**

The adjusted model more accurately predicted the variance in TC (Adjusted R2 = 0.12) compared to the unadjusted model of prior week working hours (Adjusted R2 = -0.0004), though both were not strong predictors. Each hour worked was associated with an average reduction in TC by 0.28 mg/dl (95% CI = -0.44 – -0.11) after adjusting for age, BMI, rigorous recreational activity, income-to-poverty ratio, and race/ethnicity. Race and self-reporting vigorous recreational physical activity had the largest effects on TC in the adjusted model.

**Table 3.** Multiple Linear Regression Analysis of Total Blood Cholesterol using NHANES 2017-2018 data of men and women aged 18 years and older

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Adjusted Parameter Estimates | | | | |
| **Characteristic** | **Estimate** | **95% Confidence Interval** | **p-value** |
| Intercept | 149.6 | 137.0 – 162.1 | \*\*\* |
| Working hours | -0.3 | -0.4 – -0.1 | \*\* |
| Age | 0.8 | 0.7 – 1.0 | \*\*\* |
| BMI | 0.5 | 0.2 – 0.7 | \*\*\* |
| Vigorous recreational activity | -4.9 | -8.7 – -1.1 | \* |
| Income-to-poverty ratio | 1.7 | 0.5 – 2.8 | \*\* |
| Race / Ethnicity |  |  |  |
| White | Reference |  |  |
| Hispanic | 5.3 | 0.4 – 10.2 | \* |
| Black | -4.5 | -10.4 – 1.4 | 0.14 |
| Asian | 9.2 | 1.6 – 16.8 | \* |
| Other / Multiple | 10.1 | 1.9 – 18.3 | \* |

~ p<0.10

\* p<0.05

\*\* p<0.01

\*\*\* p<0.001

# **DISCUSSION**

## **Principal Findings**

More than 1 in 3 represented U.S. working adults in this study had clinically high cholesterol, and nearly half of the study population worked more than 40 hours in the prior week. The hypothesis that a positive association between working hours and TC was not supported, and rather a negative association was observed. Although significant the predictability of working hours on TC was weak.

## **Comparison to other studies**

Past research has had varying results such as no associations or significant declining of cholesterol health with higher working hours. Sisaki, Iwasaki, and Hisanaga (1999) observed a mean TC of 202 mg/dL along with a mean of 60 hours worked in a week. Although their mean TC reflects the results of this NHANES study, the difference in mean working hours is notable. Their research concluded that TC did not differ across various levels of working hours. These results are interesting because of the high working hours of the population, but there may be many unaccounted factors when comparing with NHANES since their study population was machinery manufacturing workers in Japan.

The Reynolds et al (2018) cohort study resulted with no difference in TC between those who worked 38 hours or fewer in a week compared to those who worked more than 38 hours in a week. They did note that HDL-C was significantly lower in the group that worked more hours. Their determination of working hours may have been more accurate than the NHANES method because in Reynolds et al they asked participants about their usual workweek length as opposed to the most recent work week. This difference changes the hypothesized mechanism from an immediate effect to a long-term exposure effect.

On the other hand, Virtanen et al. (2019) resulted with males currently working more than 10 hours in a day having higher TC than males who had never worked more than 10 hours in a day. This difference was mostly attributed to the men who were currently working more than 10 hours in a day that also had over 15 years of this exposure. Fewer years of exposure reduced the strength of this effect. There was no significance in the difference with their female participants. Virtanen et al. had observed a slightly older population from France, with the mean age being 48 years old compared to the median age of 39 in this NHANES study. Comparability is also affected by the difference in how working hours data was collected. Virtanen et al. used daily working hours rather than weekly hours. Weekly hours cannot be calculated because the number of days worked each week are not reported.

## **Strengths, limitations, and bias**

Working hours and total cholesterol as continuous measurements preserved analytical power when computing associations. This allowed for the use of a linear regression model that would not be affected by biases in categorization. Weighting observations increased the generalizability to a large portion of the U.S. working adult population. Inclusion of physical activity inside and outside workplace environments increased accuracy of the adjusted association between working hours and total cholesterol. Also, using income-to-poverty ratios rather than raw household income accounts for differences in cost of living due to geographic location.

Limitations from NHANES 2017-2018 were inherited to this study as this was the sole source of data. Much of the data was collected as self-reported information and accuracy was subject to the participants’ responses. Serum collection only occurred once and working hours information was asked of only a single week, which can leave randomness unidentifiable. The cross-sectional design of this study prevents the determination of causal associations.

Since only one measurement of TC and working hours was recorded for each participant, the result of that one recording may not represent the truth. The implication of this is that participants could be misclassified based on that one result. By limiting the study population to only those participants who are currently working at the time of the NHANES 2017-2018 data collection, the results of this study may be influenced by the healthy worker effect. Those observations that worked many hours may have only been able to do so because of good health, meaning it is possible that unobserved persons who were negatively affected had to reduce their hours or even stop working entirely.

## **Findings Implications**

The results of this study and comparisons to past research suggest that TC may not be at risk of worsening due to long working hours. When researching health effects of work week standards, it may be more important to examine other biomarkers such as blood pressure or micronutrient deficiency. These implications are generalizable to the working adult-aged population in the United States because of the weighting method used in the NHANES dataset.

The cross-sectional design and nature of the questionnaire data used leaves the long-term exposure associations unaddressed. Therefore, future study into working hours and TC should adopt a longitudinal design in which multiple blood samples are collected and working hours are examined over a period of time. Additionally, the healthy worker effect could be controlled for by including persons who are no longer working. Other effects of working long hours could be identified by asking participants questions regarding specific experiences at work such as stress or eating habits.

# **CONCLUSION**

Increased working hours was associated with decreased TC. This result differs from past research that concludes with no association or declining health with increased hours. A potential explanation could be that the healthy worker effect caused the bias in this direction. Further research should apply a longitudinal study design to determine causality, and adults no longer working should be included to control the healthy worker effect.

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**CODEBOOK**

|  |  |  |
| --- | --- | --- |
| **Variable Description** | **Response Options** | **Final Categorization** |
| **Outcome:** | | |
| Total cholesterol (mg/dL), laboratory measurement | Discrete values | Discrete values |
| **Key Exposure:** | | |
| Working Hours  “How many hours did you work last week at all jobs or businesses?” | Discrete values;  Refused;  Don’t Know | Discrete values;  Refused & don’t know are excluded |
| **Covariates:** | | |
| Age  Age in years of the participant at the time of screening. Individuals 80 and over are top-coded at 80 years of age. | Discrete values;  80: includes ≥80 | Discrete values;  80: includes ≥80 |
| BMI  Body Mass Index (kg/m2), laboratory measurement | Continuous | Continuous |
| Gender  Gender of the participant. | Male;  Female | Male;  Female |
| Doctor Says High Cholesterol  “Have you ever been told by a doctor or other health professional that your blood cholesterol level was high?” | Yes;  No;  Refused;  Don’t Know | Yes;  No;  NA |
| Daily Sitting Time  “How much time do you usually spend sitting on a typical day?” | Discrete values;  Refused;  Don’t Know | Discrete values;  NA |
| Work Activity  “Does your work involve vigorous-intensity activity that causes large increases in breathing or heart rate like carrying or lifting heavy loads, digging or construction work for at least 10 minutes continuously?” | Yes;  No;  Refused;  Don’t Know | Yes;  No;  NA |
| Recreational Activity  “In a typical week do you do any vigorous-intensity sports, fitness, or recreational activities that cause large increases in breathing or heart rate like running or basketball for at least 10 minutes continuously?” | Yes;  No | Yes;  No |
| Race  Recode of reported race and Hispanic origin information, with Non-Hispanic Asian Category. | Mexican American;  Other Hispanic;  Non-Hispanic White;  Non-Hispanic Black;  Non-Hispanic Asian;  Other Race – Including Multi-Racial | Hispanic;  Non-Hispanic White;  Non-Hispanic Black;  Non-Hispanic Asian;  Other Race – Including Multi-Racial |
| Education  “What is the highest grade or level of school you have completed or the highest degree you have received?” | Less than 9th grade;  9-11th grade (Includes 12th grade with no diploma);  High school graduate/GED or equivalent;  Some college or AA degree;  College graduate or above;  Refused;  Don’t know | No high school diploma or equivalent;  High school graduate/GED or equivalent;  Some college or AA degree;  College graduate or above;  NA |
| Poverty Ratio  A ratio of family income to local poverty guidelines. | Continuous up to 5 | Continuous up to 5 |