EDITORIAL

‘You have to know a little in order to know what you don’t know’

The World Health Organisation (WHO) has declared obesity an epidemic [1]. The Chief Medical Officer for England has declared obesity ‘a priority for action’ [2] and a House of Commons Select Committee recently stated ‘obesity will soon supersede tobacco as the greatest cause of premature death in this country’. The Committee also called on the government to take a number of initiatives, including ‘encourage industry to make workplaces more active perhaps via fiscal incentives from the Treasury’ [3]. The general media is full of articles and television programmes, some sensationalist, some even voyeuristic, but all acknowledging the growing problem of excess weight.

Yet there is very little about this huge public health issue in the occupational health press and literature. Perhaps it is not perceived as important, as not relevant to business, or perhaps it’s just another lifestyle issue which calls for health promotion and self-restraint but certainly does not need any input from occupational health professionals.

All interesting views, but, I would argue, far from the truth.

Obesity in the workplace cannot be ignored, both because of its impact on productivity and performance, on attendance and fitness to work, and because the workplace represents a unique setting to combat some of the trends in society and the way we live that have precipitated this problem.

Obesity is defined by the body mass index (BMI). A BMI of >25 kg/m² is defined as overweight, >30 kg/m² is obese and >40 kg/m² is morbidly obese.

Overweight and obese individuals are increasing in number at an alarming rate. The number of obese women has nearly tripled between 1980 and 2002, from 8 to 23% of the population, and the number of obese men nearly quadrupled, from 6 to 22%, over the same time period [4]. Effectively, this means that over one in five of all people, in all age groups, in all geographical locations and probably in all businesses, is obese.

The workplace issues facing the obese include ergonomic difficulties. These include poor fit of uniforms and personal protective equipment, as well as poor or impossible ergonomic arrangements of workstations and lifting tasks, because central obesity means the person cannot sit near to the desk or hold an object close to their body. There may be financial implications relating to increased costs of travel, e.g. double seats on aircraft, and more likely repatriation or healthcare costs abroad.

Individuals may be unable to pass fitness tests, which are essential for jobs such as fire-fighting and police work, and this will also place demands on occupational health and human resources, who spend time dealing with what are often very emotive and sensitive issues. In terms of safety at work, obesity is associated with sleep apnoea syndrome, and studies have reported seven times the risk of road traffic accidents [5] and twice the risk of occupational accidents [6].

The biggest impact is likely to be from the co-morbidities that accompany obesity and the impact that these have on sickness absence, performance, productivity and ill-health retirement. The two principle health effects of obesity are diabetes and cardiovascular disease. BMI is the most important predictor of type 2 diabetes. An obese female with a BMI of >25 is at five times increased risk of developing diabetes and a BMI of >35 conveys 93 times the risk [7]. In men, the risk of diabetes increases as the BMI climbs above 24, and is 42 times greater if the BMI is >35 [8]. In clinical practice, diabetes is often found in association with altered lipids and hypertension, and this cluster is often referred to as the ‘metabolic syndrome’, which is a powerful predictor of premature death, usually from myocardial infarction.

In addition, increased rates of cancers of the colon and prostate are found in obese men and increased rates of gall-bladder, breast and endometrial cancer are found in women. In fact, so great is the influence of obesity that, after age adjustment, 30% of all endometrial cancers have been attributed to obesity [9].

There is now a consensus of opinion that this explosion in obesity is due partly to genetics and partly to societal changes, which mean that we consume more calories but expend less through the increased use of cars, from the growth of hobbies such as computing and the internet, and from the reduction of physical activity at home and at work. Nature loads the gun and the environment pulls the trigger.

We in the Western world have done an excellent job of promoting obesity and reducing activity at work. This may not be such a good idea, as work is now the only place where some people get any exercise or activity (hence why work can be so tiring). Modern-day workplaces strive to reduce activity—it is viewed as ‘downtime’ when no useful profit-making activity is being undertaken. The workplace is designed to reduce walking—we have extensive car parks near entrances, and lifts and escalators. When we do have staircases, their décor makes them desirable for use only in major emergencies; the message is clear—‘not for everyday use’. We have high-calorie, fat-dense food in restaurants and sugary
drinks (which are sometimes the only drinks) in vending machines. But to top this all, we then indulge, without thinking, in the calorific feast that is ‘the buffet lunch’. Half an hour grazing on samosas, goujon dips and mini bhajis and the day’s calories have been consumed before you go back to the meeting!

I would argue that we, as occupational physicians, need a radical rethink as far as obesity is concerned. It is an occupational health issue and, importantly, its health, safety, financial and ergonomic impacts are all reversible through weight reduction. Major health benefits can be accrued in obese people by the loss of 5–10% of their body weight— their risks of developing diabetes, hypertension and cardiovascular disease are reduced, and there is a concomitant improvement in mobility and level of tiredness. For those able to lose more weight, type 2 diabetes and hypertension can be reversible, which can mean the reduction or even cessation of the need for medication.

We need to get involved now in making workplaces more active through job and task design, and through the facilities available at and through the workplace. Many individuals, notably men, do not attend primary care and will not be captured by GP-based initiatives. Improving activity need not invariably cost businesses money; indeed, it may be viewed as an investment in staff and industrial relations. We also need to look at food and work, ensuring that where facilities are available, they offer not only healthy choices but clearly labelled information, so that people can learn what to eat and what to avoid.

How far occupational health departments go down the road of providing clinics and weighing sessions is up to individual departments and dependent on customer needs, demands and resources. It is also dependent on competence—weight management has moved on in the last few years, and a diet sheet and set of scales is no longer good enough!

Obesity is going to be with us for a long time; it will surface in sickness absence reviews, ill-health retirement and poor performance assessments. It may also appear in the guise of disability under the Disability Discrimination Act 1995, most likely because of the co-morbidities and effects on mobility. In the latter case, arrangements for ‘reasonable accommodation’ will be very interesting: should you reduce the amount of walking and activity an obese person is required to do? Or should you refer them for an exercise programme to increase their activity threshold?

As those two famous twenty-first-century philosophers, Carrie Bradshaw and Donald Rumsfeld, might say, ‘when it comes to obesity are we doing so little because we chose[sic?] to, or because, we don’t know what we don’t know?’

Note
The views are entirely the author’s and do not reflect the views of any employer.

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References