Lifestyle and Health in the Asia Pacific Region

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This issue of the journal brings an emphasis on lifestyle and public health. As it becomes available, the United Nations System will be preparing for the meeting on chronic disease to be held in September. The balance of public health in our region has tipped in this millennium from a focus on infection to an emphasis on noncommunicable disease. Although the burden of infectious disease and malnutrition remains, most preventable death and disability in our region is now due to chronic disease. Lifestyle has become a major focus of public health. This has been defined for the public health community by Prof John Last¹ as

The behaviour pattern, customs, and habits of persons or groups, generally considered in the context of consequences for health, and including nature and amount of exercise, dietary habits, and use of tobacco, alcohol, coffee, tea, stimulant and sedative substances (licit or illicit), and recreational time.

This definition implies that public health actions must include both personal and group (population) strategies to move the way that we live to a healthier trajectory.

There needs to be more emphasis on making the environment conducive to a healthy lifestyle. Swinburn and de Silva-Sanigorski² and Swinburn³ have written at length about the obesogenic environment that modern Western societies have created that makes obesity almost inevitable. These Western lifestyle and environmental influences are expanding into many parts of the Asian Pacific region. Every new Western-style fast food store in the region creates more obesity and more diabetes. This is to be regretted. Research has shown that many traditional approaches to diet and lifestyle remain the healthiest. For example, the replacement of the traditional teashop with sugar-laden beverages is not in the interest of public health.

To deal with chronic disease and lifestyle, public health must follow the traditional approach of science. We must refine our methods of measurement of lifestyle variables and document the prevalence in our communities. But the task of measurement is not easy. Even something that should be simple, the prevalence of obesity is made complex by the varying ways it is measured, for example, by self-report or by actual measurement. Cutoff points for obesity and overweight and the growth reference also vary. A recent review shows that depending on the reference and cutoff points chosen, the prevalence of overweight of children in the Czech Republic varied from 5% to 25% depending on the reference used.⁴ In the face of such inaccurate data how can public health actions be implemented? In the Asia Pacific region there is the added complexity of body

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